BALANCING MEDICAID BUDGETS AND SERVING STATE RESIDENTS DURING A PANDEMIC

Considerations for Governors

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INTRODUCTION

Governors are faced with unprecedented challenges as a result of the COVID-19 pandemic. States are largely responsible for the frontline public health response and for rapidly developing and implementing policies to serve residents affected by the pandemic.

The pandemic and the resulting strained health care system and economic downturn created unprecedented challenges, further complicated by the uncertainty of the duration of the pandemic. As a result, states face mixed and unpredictable budgets, with the situation depending on their primary sources of revenue, how hard hit the state is by the pandemic, and how quickly they will be able to recover.[1] For many states, revenues declined and remain low and demand for critical social and safety net services is continuing to increase.[2] Temporary, short term federal support has helped, however, states continue to face uncertain futures and Governors must balance budgets, maintain a strong economy, and support residents impacted by the pandemic. Many of the residents most affected by the pandemic are lower-income and often served by state Medicaid programs.[3] Medicaid programs, which required significant state funding before the pandemic, are further straining state budgets because economic downturns increase enrollment.[4] As a countercyclical program, Medicaid experiences increased enrollment during times of economic stress.[5] High unemployment, among other factors, has increased Medicaid enrollment.[6]

Along with unemployment due to the pandemic, state residents have experienced housing insecurity, food scarcity, and challenges paying for usual household expenses.[7] Social determinants of health, such as income, education, access to safe and affordable housing, availability of nutritious food, and physical conditions of communities—impact individual and population health outcomes. As a result, the need for the social safety net is greater than ever.

This paper outlines key factors for Governors and state leaders to consider when balancing state budgets and making difficult decisions about funding Medicaid during the COVID-19 crisis and subsequent economic downturn. It explores the challenges faced by states, the role of Medicaid and the strategies implemented in prior recessions to lower state costs and maintain enrollment. For example, Medicaid agencies may be asked to reduce spending because of a decrease in state revenue while Medicaid enrollment is growing. Governors and state leaders will need to carefully consider potential changes to the program as the demand for services increases. In identifying different strategies to reduce Medicaid spending, considerations include the following:

- **Magnitude of the savings;**
- **Impact on the Broader Economy;**
- **Potential disruptions to recipients and equity implications;**
- **Impact on providers;**
- **Implementation timeline;**
- **Implementation complexity; and**
- **Identifying external strategies.**

BACKGROUND

The Medicaid Program

The Medicaid and CHIP programs fund health care for almost 75.5 million children, pregnant women, individuals and families with low incomes, persons with disabilities, and older adults.[8] Medicaid is a critical payer in the health care system and is the single largest insurer in the United States based on number of covered lives. Medicaid is also an efficient program, averaging lower annual growth rates in spending per enrollee than both Medicare and private insurance.[9] Despite this, because of the number of individuals enrolled in the program and the requirement for states to provide the non-federal share for Medicaid expenditures, in many states, Medicaid is one of the largest total budget items —around 29 percent on average, second only to public education in magnitude.[10]

Traditionally, Medicaid costs are driven by the interplay between:

- **Enrollment** (the number of individuals in the program) **and benefits** (what services are provided);
- **Utilization** (how many services are being used);
- **Prices** (how much the program pays for those services, influenced by market forces and the overall rates needed to ensure sufficient providers will participate in the program); and
- **Administration** (state administrative costs, typically a small portion of overall Medicaid costs and administrative costs of managed care organizations contracted by states to administer and manage the delivery of care to Medicaid recipients).[11]

COVID-19 and Medicaid

In 2020, unemployment in the United States rose from 3.5% in February to 14.7% in April, dropping to 6.3% in January 2021.[12] This increase in unemployment meant many lost their employer-sponsored insurance which, in addition to other factors, has led to increased Medicaid enrollment.[13] Due to increased enrollment, and the expected reduction in federal match rates for the program as federal pandemic relief ends, means states project a 12.2% increase in Medicaid expenditures for fiscal year 2021.[14] Medicaid is a centerpiece of budget discussions even in the absence of a pandemic. At a time when states are looking for overall budget savings, increased Medicaid enrollment makes those savings even more challenging to find.

While states seek budget savings, they should understand the critical role that Medicaid has played, and continues to play, in the COVID-19 response and recovery and the impact reductions may have on Medicaid infrastructure and the availability of services. Medicaid has been a significant source of coverage for COVID-19 testing, vaccines, and treatments. The program serves as a key payer of behavioral health services, covering 26% of adults with serious mental illness, 21% of adults with mental illness, and 17% of adults with a substance use disorder.[15] Medicaid also serves a critical role in providing maternity-related care, financing more than 40% of births.[16] To support all of the aforementioned services, Medicaid funding has been critical as providers experienced significant financial challenges associated with addressing COVID-19 (e.g., increased personal protective equipment (PPE) costs, overtime for certain hospital professionals) as well as lower patient volume associated with individuals avoiding routine care.[17] Medicaid is also the primary payor for the nation's long-term services and support (LTSS) providers. Many Medicaid programs provided additional financial support to LTSS providers to offset a portion of the added costs related to the pandemic and preserve access to critical services for populations at significant risk for severe outcomes due to COVID-19.[18]

Fiscal Relief

Medicaid is a matching program, where the federal government pays a share of the costs and states provide the non-federal share. The federal government pays from 50 to 83 percent of state Medicaid costs, with the federal share varying based on the Federal Matching Assistance Percentage (FMAP) for each state (a formula that takes into

consideration the average per capita income for every State in relation to the national average).[19] Section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127) offered some relief to states by temporarily increasing the matching rate by 6.2 percentage points for each state from January 1, 2020, through the end of the calendar quarter after COVID-19 Public Health Emergency (PHE) ends. Attached to these federal funds are restrictions on states' ability to make certain changes.[20,21] Under these requirements states may not:

- Establish eligibility standards, procedures and methodologies that are more restrictive than those in place as of January 1, 2020;
- Charge premiums higher than those in place as of January 1, 2020;
- Add or impose cost sharing for testing, services and treatments (including vaccines);
- Terminate eligibility of any individual enrolled in Medicaid as of the beginning of the PHE, or enrolled during the PHE;[i] and
- Require political subdivisions to pay a greater share of non-federal costs of the Medicaid program than they were paying as of March 1, 2020.

States have used the current matching rate increase to preserve provider viability as well as cover the costs of increased enrollment associated with the prohibition on ending coverage for those who would no longer be financially eligible for the program without the FFCRA changes. Congress also passed additional COVID-19 stimulus funding in December 2020, however no additional direct state and local aid was provided. The legislation did provide an extension of the deadline by which the Coronavirus Aid, Relief, and Economic Security (CARES) Act Coronavirus Relief Fund (CRF) resources must be spent to December 31, 2021 which provides some additional flexibility for states. As of publication, Congress is currently considering an additional COVID-19 relief legislative package that may include additional funding for states.

STRATEGIES FOR MANAGING MEDICAID DURING AND AFTER THE PANDEMIC

Despite federal assistance, the combination of many unique factors creates fiscal uncertainty for Governors and State Budget Officers. Vaccines coming to market provide some light at the end of the tunnel, however, ongoing questions about vaccine rollout and long-term immunity limit state leaders' ability to reliably forecast the timing of recovery. As Governors navigate these uncharted waters, the Medicaid program will be at the center of many programmatic and budget discussions. Governors and state leaders may consider the following leadership and strategic considerations to inform their management of Medicaid during the COVID-19 pandemic.

LEADERSHIP CONSIDERATIONS

Governors play a critical role in implementing state laws and managing the states' resources. While state legislatures ultimately pass state budgets, gubernatorial leadership is important for shaping, approving and implementing them. Governors' offices and health leaders should consider how to develop their budget fluency and how to successfully engage stakeholders to inform how to address potential budget deficits.

[i] States may disenroll individuals who voluntarily terminate eligibility or those who are no longer residents of the state in question. CMS has also interpreted this requirement for continuous eligibility to mean individuals cannot move to different eligibility groups that offer fewer benefits than they were receiving as of March 18, 2020.

Budget Fluency

Given the importance of state budgeting discussions and Medicaid's significant role in state budgets, leaders in the Governor's Office and state Medicaid agencies should understand and be conversant in the overall state budget and how Medicaid fits in. Understanding the individual components of state budgets will provide insight into the various levers that are available to policymakers during budget discussions that relate to health care. Key aspects include the overall budget status, where Medicaid fits within the state budget, other important large dollar programs and priorities (e.g., education), and projected revenue trends. Within revenue discussions, it is important to understand what funds are available for one-time use (e.g., a Rainy Day fund) compared to those that are recurring sources of revenue.

Governors and Executive Branch staff can also review actions that are within the Governor's authority. For example, Governors can often instruct state agencies to make administrative budget reductions, implement hiring freezes, and reduce discretionary spending. In times of emergency such as the COVID-19 pandemic, Governors can use executive orders that impact spending; for example, allocating emergency funds to address critical public health issues. On the Medicaid programmatic side, in some states, the executive branch can act to reduce provider payment rates, while in other states, such rates are dictated through statutory requirements. Understanding the levers available to the Governor is the first step to being able to make decisions that can position the state for longer-term budget stability.

Engaging Stakeholders

Stakeholder engagement is critical for any budget savings discussion, and Governors and their leadership should develop and implement clear engagement strategies to gather additional ideas and to understand the impact of the structure and timing of decisions. Stakeholders include Medicaid recipients, advocates, providers, health plans, and other vendors associated with the Medicaid program.

In addition, budget reduction decisions are hard because they are rarely without impact to some stakeholder groups. Therefore, fostering understanding of the broader context of these decisions can help facilitate stakeholder buy-in (or at least mitigate opposition). Communication is important for community confidence in the decisions being made. In some states, the appropriate messenger to share information on budgetary changes may be the health or human services director, the Medicaid director, a policy advisor, or even the budget director, if that individual is conversant in Medicaid. The trusted messenger should understand the full complement of budget strategies as well as recognize the impact of the reductions on the community. It is also important to not dismiss the impact of the decisions. Often budget savings options have very real impacts on individuals, businesses, and the community, and messengers should acknowledge these effects. At the same time, it is important to convey the message that there is a path forward to recovery. Economic downturns are only a point in time, and the goals of budget reductions are to preserve the core functionality of state government, including the core of the Medicaid program, through the downturn and into the recovery.

STRATEGIC CONSIDERATIONS FOR MANAGING THE PROGRAM

In order to respond to economic downturns that impact the state budget, state leaders must make difficult decisions; balancing budget constraints with the needs and requirements of managing the Medicaid program. States have a number of tools at their disposal to take quick action. In choosing which budget strategies may be most appropriate for Medicaid, Governors and state leaders should consider a number of factors that may influence the overall impact of a budget strategy.

Magnitude of the savings

Evaluating whether the "juice is worth the squeeze" is important. Generating programmatic savings may be more challenging, both politically and administratively, than administrative changes. However, programmatic changes are more likely to be of sufficient magnitude to impact the overall budget status. At the same time, if all state agencies are producing administrative savings, the Medicaid agency will likely be asked to do the same. In addition, leaders should understand how likely projected savings are to materialize and the risks of not meeting the estimated savings amounts. Some options rely on untested changes that may or may not produce expected savings.

Impact on the Broader Economy

Governors should also consider the overall impact a budget strategy may have on the health care delivery system and the state's economy as a whole. Nationally, Medicaid accounts for $1 out of every $6 spent on health care.[27] Reductions in Medicaid spending can have a significant economic impact, due to the financial underpinning of the program as a state-federal partnership. The federal government funds a significant portion of the program, ranging from 50%-83% FMAP.[28] The National Association of State Budget Officers (NASBO) estimates that 56% of all federal funds spending by states flows through the Medicaid program.[29] This means that when states reduce their Medicaid spend, they are also reducing the amount of federal dollars flowing into the state's economy. This becomes even more significant during the current recession due to the enhanced federal match for the Medicaid expansion (which is currently 90%), which was not in place during previous recessions. As a result of this more recent higher match, the overall match rate for the program has increased from a historical average of 57% to 64% in FY 2019, resulting in even more federal Medicaid dollars flowing to state economies.[30,31]

Capturing Unspent Funds from Managed Care Organizations

In the short term, many states will likely look to capture some of the savings associated with decreased health care utilization during the early stages of the pandemic. The federal Centers for Medicare and Medicaid Services (CMS) noted a "precipitous decline" in certain types of preventive health spending for children (specifically immunizations, screenings, and dental services) between March and May of 2020.[22] Some of these decreases have been offset by a shift to telehealth, and utilization rebounded somewhat after the early days of the pandemic. Through the third quarter of 2020, health spending was an estimated 2.4% below 2019 levels.[23] Some states, such as Ohio, have already announced updates to their Medicaid managed care contracts to capture savings associated with that reduced utilization.[24]

A similar option is establishing or modifying "risk corridors," which are designed to limit managed care profits or losses by establishing a cap on the amount of profit (or loss) a plan can experience. Profits above the cap are returned to the state; losses in excess of a certain level are reimbursed. To the extent that managed care plans have excess revenue due to lower than anticipated expenditures, the risk corridor can capture savings for the state. According to the National Association of Medicaid Directors, at least 19 states reported using risk corridors to ensure excess profit gets returned to the state; of these states, 43% are establishing a risk corridor for the first time.[25] A related strategy requires remittance payments from managed care organizations who do not meet the federally mandated minimal Medical Loss Ratio (MLR, the percent of expenditures on clinical services and quality improvement) of 85%. When utilization is lower than expected, managed care organizations may not meet the required MLR; remittance payments are not required, but states may employ them to recapture unspent funding intended for services.[26] Risk corridors and MLR remittances provide an opportunity for states to recapture unspent Medicaid funding from unanticipated lower utilization, however this funding is likely to be one-time in nature. States will also need to monitor expenditure needs as COVID-19 testing, treatment, and vaccination costs increase, and regular health care utilization rebounds.

Potential Disruption to Medicaid Recipients and Equity Implications

Many budget options have the potential to impact Medicaid recipients through changes in eligibility, benefits offered, out-of-pocket spending, and access to providers.[ii] Governors and their staff should consider these impacts as they evaluate the relative merits of various strategies. COVID-19 has exposed and magnified existing health inequities. Medicaid is an important source of support for communities of color and lower-income individuals who are negatively impacted by health inequities,[32] during COVID-19 and beyond. While many states are working on achieving health equity through broader initiatives,[iii] states should consider how their actions to balance budgets may impact Medicaid recipients and their goals to improve health equity. Cutting investments in social and economic supports can lead to poorer health outcomes and ultimately higher Medicaid costs in the long term as well. In addition, the impacts of changes in eligibility, benefits, out-of-pocket costs, and access to providers may have disproportionate impacts on communities of color and low-income Americans, which should be considered in evaluating options.

Impact on Providers

Reduced Medicaid spending may also have significant impacts on Medicaid service providers (e.g. health care providers, managed care organizations, pharmacies, transportation vendors, etc.). In previous recessions, the health care sector remained one of the economy's bright spots, with jobs and expenditures growing even when other areas were experiencing a downturn.[33] However, market dynamics have changed over the last decade and the unique dynamics of the COVID-19 pandemic have strained the entire health care sector. As discussed, some providers have experienced a decrease in revenue as individuals avoid routine care during the pandemic.[34] For others, such as hospitals, the pandemic has shifted utilization from profitable procedures such as elective surgeries to more costly COVID-19 care. Furthermore, staffing pressures have resulted in increased overtime costs and providers have experienced unexpected costs such as PPE.[35]

In the longer-term, States must preserve a Medicaid provider network beyond any economic downturn in order to serve its members. Therefore, states may consider needed financial investments to support provider groups experiencing significant financial struggles, particularly rural, high-volume, and long-term services and supports providers.

Implementation Timeline

Governors must also consider how long it will take to realize savings from strategies under consideration. For example, a strategy that requires state legislation or approval from CMS will be impacted by the time frames required to complete those actions. Some strategies, such as payment rate reductions or restructuring, require public input before implementation. CMS may also require states to analyze potential impacts before changes are implemented (e.g., an analysis of access to care impacts for provider rate reductions, a recipients impact analysis for benefit changes).[36]

Often, strategies such as benefit or rate changes can be implemented quickly and result in short-term savings, but may also have potential negative impacts for Medicaid recipients. States may prefer to turn to longer-term reforms such as addressing social factors influencing health or improving care coordination for recipients with complex health care needs, because they are designed to produce savings by improving care delivery over time rather than making explicit reductions. However, savings associated with these longer-term reforms often take years to occur. While those savings are important for the long-term sustainability of the Medicaid program, they may not materialize in time to help with shorter-term state financial needs.

[ii] Certain choices that impact recipients are limited by the Maintenance of Effort Requirements established in Section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127) as discussed below.

[iii] States can collect and analyze data to identify inequities by key demographics (race/ ethnicity; region; gender; language; etc.); address social determinants of health to the extent allowable through Medicaid; implement evidence-based practices such as team-based care, community health workers, families and community partners; use contracts to require managed care organizations to address equity and to implement performance incentives; and utilize value-based payment mechanisms to incentivize process changes and reward outcomes changes. See the State Health & Value Strategies Webinar Series on Addressing Health Equity through Managed Care for more.

Implementation Complexity

Policymakers must also evaluate the complexity of implementing the strategies they are considering. Factors that drive complexity include:

- **Policy:** Many requirements and processes are interconnected in state policy so multiple changes may be needed to account for one policy change.
- **Technology:** System changes can be one of the most significant operational changes associated with budget strategies. State information technology resources are often significantly constrained, and many states operate legacy systems which are not always nimble, requiring lengthy processes to change.
- **Contracts:** For states that deliver services through managed care organizations (MCOs), changes often occur through contract changes and the adjustment of rates paid to those vendors, which requires engagement with contracted vendors and CMS.
- **Business Processes:** States administer Medicaid through a variety of complex business processes that interface with recipients, providers, contractors and other businesses. These processes can impact how hard it will be to implement these changes. For example, member notification requirements can be cumbersome and take time. Member notices need to be written, reviewed, translated, produced and distributed. This is just one example of the many processes state Medicaid agencies must consider when implementing program changes.

Identifying External Strategies

Contractors such as MCOs may be able to offer additional potential solutions to address budget constraints. For example, they may have data identifying potential service over-utilization that could be better managed through administrative strategies without reducing benefits. As noted above, stakeholders can also identify on-the-ground solutions that may not be as visible from within state government.

Governors may also evaluate other states' reduction plans. While each state's budget environment and Medicaid program are unique, strategies employed elsewhere can be tailored state-by-state. For example, many states are implementing prescription drug cost containment efforts including increased transparency regarding Pharmacy Benefit Manager costs, spread pricing reforms and value-based purchasing.[37]

Strategies Used in Previous Recessions

Many strategies have been implemented during prior recessions. As Governors navigate the current fiscal environment, they may want to start by evaluating strategies used in prior recessions to see how they might apply to their state. Below is a list of strategies states have considered or implemented during prior recessions:

- Reducing health care provider rates
- Implementing or expanding the use of managed care
- Establishing or increasing cost sharing
- Imposing benefit limits and tightening existing limits (e.g., Durable Medical Equipment)
- Eliminating optional benefits
- Eliminating optional eligibility categories or imposing restrictions on eligibility categories[iv]
- Developing or increasing Medicaid taxes
- Adding new prior authorization requirements
- Restructuring rate methodologies. For example:
  - Moving away from cost-based reimbursement or lower cost-coverage target for rates (e.g., move coverage from 98% of costs to 95%);
  - Shifting inpatient hospital payments to a more efficient payment system such as Diagnosis-Related Groups; and
  - Ensuring inpatient hospital outlier payments represent only 5% or less of claims are paying on an outlier basis; realignment could produce one-time savings.

It is important to note that federal regulations, along with the unique impacts of the pandemic, will affect the viability and long-term success of these reductions during the current economic downturn.

CONCLUSION

Budget planning during this time is incredibly challenging due to the unknown duration of the pandemic, the many moving pieces of how it is affecting the health care system, and the changing economic impacts of public health mitigation strategies. Uncertainty about potential future federal aid and changes to the federal response increases the pressure on Governors to maintain the social safety net in times of extreme economic uncertainty. In addition, the timing of vaccine distribution and work related to its roll-out introduces even greater complexity. Governors are adjusting to economic outlooks that are changing from month to month, and they are at the forefront of decisions not only around the pandemic but also around budget strategies to preserve state government functionality, including the critical work of the Medicaid program.

To figure out how best to make changes to the program, states should work with the provider community, managed care plans, and consumer groups to identify where changes can be made to reduce costs that will have the least impact on providers and people receiving services. Once those changes have been identified, states must evaluate the total impact of those changes on the health care delivery system and health outcomes. Understanding how to continue to improve the program while ensuring efficiency should remain the primary goal.

[iv] Due to Maintenance of Effort restrictions as part of FFCRA, changes in eligibility are not possible during the Public Health Emergency.

ENDNOTES

1 Matthew Butler and Emily Raimes, "Research Announcement: Moody's – 2021 outlook for US states remains negative as pandemic continues to hamper revenue", Moody's Investors Service, December 1, 2020. https://www.moodys.com/research/Moodys-2021-outlook-for-US-states-remains-negative-as-pandemic--PBM_1255581

2 Ibid.

3 Jesse Bennett, Rachel Minkin, and Kim Parker, "Economic Fallout From COVID-19 Continues To Hit Lower-Income Americans the Hardest", Pew Research Center, September 24, 2020. https://www.pewsocialtrends.org/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-americans-the-hardest/

4 "Considerations for Countercyclical Financing Adjustments in Medicaid", Medicaid and CHIP Payment and Access Commission, June 2020. https://www.macpac.gov/wp-content/uploads/2020/06/Considerations-for-Countercyclical-Financing-Adjustments-in-Medicaid.pdf

5 Ibid.

6 Joe Weissfeld, "Rapid Increases in Medicaid Enrollment: A Review of Data from Six Months", Families USA, September 2020. https://familiesusa.org/wp-content/uploads/2020/09/MCD-313_Medicaid-Enrollment-A-Review-of-Six-Months-of-Data-since-COVID-19-Analysis.pdf

7 hBennett, "Economic Fallout From COVID-19".

8 "Medicaid and CHIP Enrollment Trends Snapshot through July 2020", Centers for Medicare and Medicaid Services, July 2020. https://www.medicaid.gov/sites/default/files/2020-10/july-medicaid-chip-enrollment-trend-snapshot.pdf

9 "Trends in Medicaid Spending", Medicaid and CHIP Payment and Access Commission, June 2016. https://www.macpac.gov/wp-content/uploads/2016/06/Trends-in-Medicaid-Spending.pdf

10 "2020 State Expenditure Report", National Association of State Budget Officers, National Association of State Budget Officers, accessed February 19, 2021. https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2020_State_Expenditure_Report_S.pdf

11 "Annual Medicaid & CHIP Expenditures", Medicaid.gov, accessed February 19, 2021. https://www.medicaid.gov/state-overviews/scorecard/annual-medicaid-chip-expenditures/index.html

12 "The Employment Situation - January 2021", Bureau of Labor Statistics, February 5, 2021. https://www.bls.gov/news.release/pdf/empsit.pdf

13 Bradley Corallo and Robin Rudowitz, "Analysis of Recent National Trends in Medicaid and CHIP Enrollment", Kaiser Family Foundation, January 21, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/

14 Madeline Guth, Elizabeth Hinton, Robin Rudowitz et. al., "Medicaid Enrollment & Spending Growth: FY 2020 & 2021", Kaiser Family Foundation, October 14, 2020. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2020-2021/

15 Rachel Garfield, MaryBeth Musumeci, and Julia Zur, "Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals", Kaiser Family Foundation, June 29, 2017. https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/#:~:text=Medicaid%20facilitates%20access%20to%20a,case%20management%2C%20and%20supportive%20housing.

16 "Medicaid's Role in Maternal Health", Medicaid and CHIP Payment and Access Commission, Jun3 2020. https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicaid%E2%80%99s-Role-in-Maternal-Health.pdf

17 "CMS Issues Urgent Call to Action Following Drastic Decline in Care for Children in Medicaid and Children's Health Insurance Program Due to COVID-19 Pandemic", CMS.gov, September 23, 2020. https://www.cms.gov/newsroom/press-releases/cms-issues-urgent-call-action-following-drastic-decline-care-children-medicaid-and-childrens-health

18 Rachel Dolan, Madeline Guth, and MaryBeth Musumeci, "State Actions to Sustain Medicaid Long-Term Services and Supports During COVID-19", Kaiser Family Foundation, August 26, 2020. https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicaid-long-term-services-and-supports-during-covid-19/

19 "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2020 Through September 30, 2021", Department of Health and Human Services, December 3, 2019. https://www.federalregister.gov/documents/2019/12/03/2019-26207/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for

20 "Families First Coronavirus Response Act – Increased FMAP FAQs", Centers for Medicare and Medicaid Services, updated January 6, 2021.

21 Rachel Dolan, MaryBeth Musumeci, Robin Rudowitz, et. al., "Medicaid Maintenance of Eligibility (MOE) Requirements: Issues to Watch", Kaiser Family Foundation, December 17, 2020. https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/

22 "CMS Issues Urgent Call", CMS.gov

23 Krutika Amin and Cynthia Cox, "How have health spending and utilization changed during the coronavirus pandemic?" Peterson-KFF Health System Tracker, December 1, 2020. https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start

24 Allan Baumgarten and Katherine Hempstead, "Recession And Medicaid Budgets: What Are The Options?" Health Affairs Blog, September 10, 2020. DOI: 10.1377hblog20200908.169117

25 Lindsey Browning and Katherine Minnes, "Delivering Care and Stewarding Public Resources in Uncertain Times", MedicaidDirectors.org, September 16, 2020. https://medicaiddirectors.org/blog/2020/09/delivering-care-and-stewarding-public-resources-in-uncertain-times/

26 Eileen Ellis, Kathleen Gifford, Elizabeth Hinton, et. al., "A View from the States: Key Medicaid Policy Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020", Kaiser Family Foundation, October 18, 2019. https://www.kff.org/medicaid/report/a-view-from-the-states-key-medicaid-policy-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2019-and-2020/

27 Maria Diaz, Madeline Guth, Elizabeth Hinton, et. al., "Medicaid Enrollment & Spending Growth: FY 2019 & 2020", Kaiser Family Foundation, October 18, 2019. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2019-2020/

28 "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier", Kaiser Family Foundation, accessed February 19, 2021. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

29 "2020 State Expenditure Report", NASBO.

30 "State and federal spending under the ACA", Medicaid and CHIP Payment and Access Commission, accessed February 19, 2021. https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca/

31 "Federal and State Share of Medicaid Spending", Kaiser Family Foundation, accessed February 19, 2021. https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

32 "How States Can Use Measurement as a Foundation for Tackling Health Disparities in Medicaid Managed Care", Bailit Health, May 2019. https://www.shvs.org/wp-content/uploads/2019/06/Equity-Measures-Brief-FINAL.pdf

33 Kevin A. Schulman and Ben Teasdale, "Are U.S. Hospitals Still 'Recession-proof'?" The New England Journal of Medicine, September 24, 2020. DOI: 10,1056/NEJMp2018846

34 Michael Chernew, David Cutler, Hilary Hatch, et. al., "The Impact of the COVID-19 Pandemic on Outpatient Visits: A Rebound Emerges", The Commonwealth Fund, May 19, 2020. https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits

35 Bethany Cole, "The Impact of the COVID-19 Pandemic on Access to Health Care", National Academy of Social Insurance, July 2020. https://www.nasi.org/sites/default/files/research/Brief%20-%20Pandemic's%20Impact%20on%20Access%20to%20Care.pdf

36 Office of the Federal Register, "42 Code of Federal Regulations, section 447.204", Electronic Code of Federal Regulations, accessed February 19, 2021. https://www.ecfr.gov/cgi-bin/text-idx?SID=812b8a1567ba2a7328814bbdfa172a1f&mc=true&node=pt42.4.447&rgn=div5

37 Ibid.


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