2022

MEDICAID POLICY REVIEW

INTELLIGENCE THAT WORKS

BRG

HEALTHCARE TRANSACTIONS AND STRATEGY

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Medicaid Policy Review

December 2022

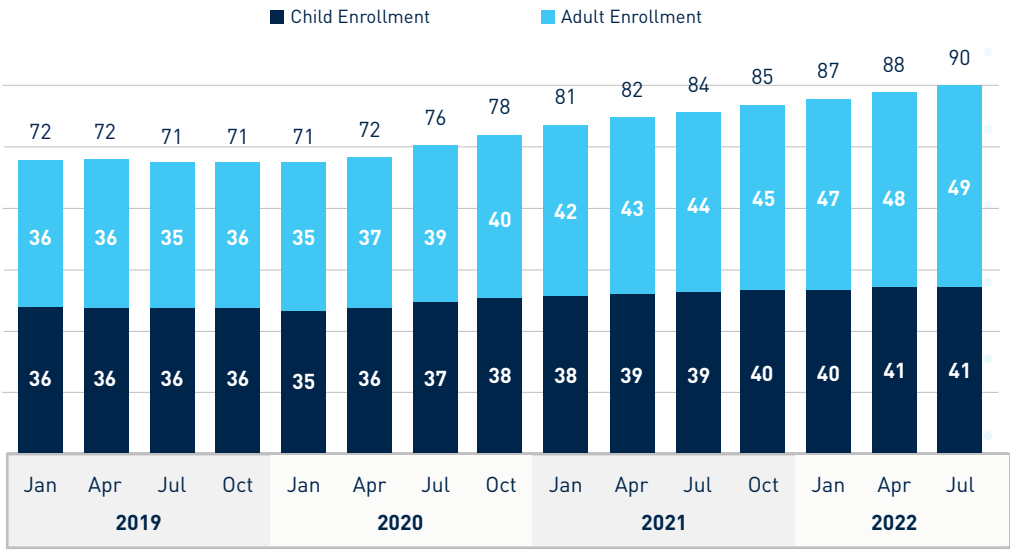
BRG's 2022 *Medicaid Policy Review* focuses on the upcoming unwinding of the public health emergency (PHE) continuous coverage requirement, as well as broader enrollment and rate trends. As states begin to prepare unwinding operational plans, there have been several projections on how the end of the PHE could impact Medicaid programs across the country. This report highlights and summarizes key areas related to enrollment trends and provider-level implications.

Medicaid Continuous Coverage Requirement Tied to PHE Has Led to Record Highs in Enrollment

Several challenges are on the horizon for Medicaid programs as states begin to prepare for unwinding the PHE continuous coverage requirement. In December, Congress passed legislation to allow states to begin redetermining eligibility for Medicaid enrollees beginning April 2023, regardless of the ongoing PHE. States will have about three months to prepare for an unprecedented effort.

In March 2020, the Families First Coronavirus Response Act (FFCRA) increased each state's Federal Medical Assistance Percentage (FMAP), the federal share of Medicaid spending, by 6.2 percentage points for the duration of the PHE, tied to a continuous coverage requirement.[1] The continuous coverage requirement has prohibited states from performing routine eligibility redeterminations and disenrolling those no longer eligible for the program, driving Medicaid enrollment to historical peaks. From February 2020 to August 2022, the national Medicaid/CHIP enrollment increased by 19 million people (27%).[2] Prior to the enrollment spike, national Medicaid enrollment had slowly declined between 2017 and early 2020.[2]

Figure 1. National Monthly Medicaid/CHIP Enrollment (M)



1 Centers for Medicare & Medicaid Services (CMS), FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economist Security Act Implementation Part 43 (June 23, 2020).

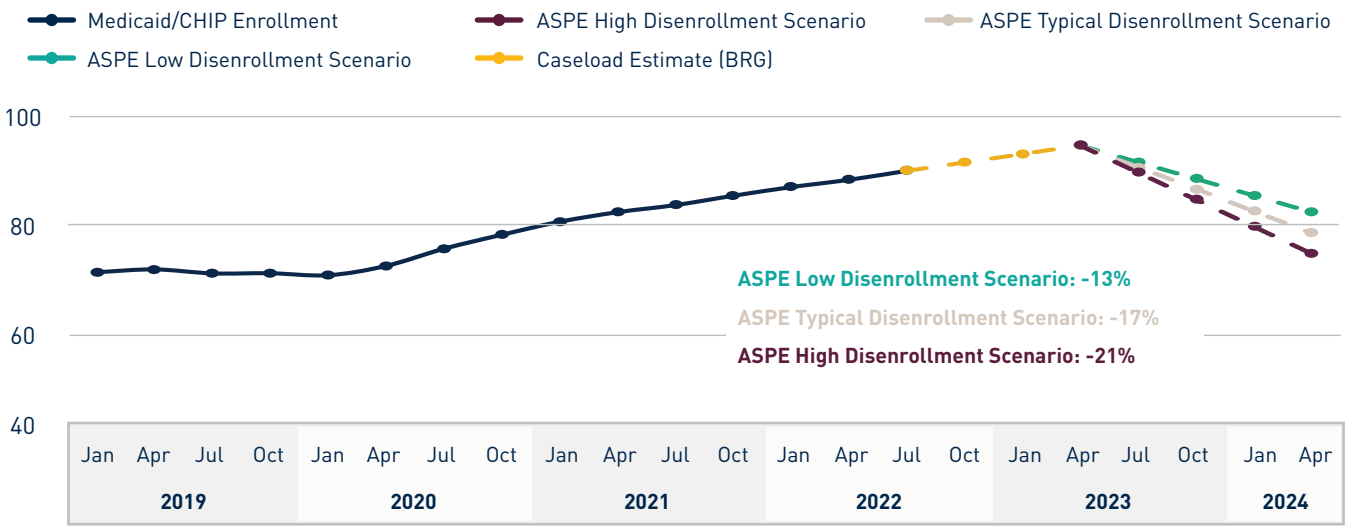
2 CMS, Medicaid, and CHIP monthly applications, eligibility determinations, and enrollment.

Estimated 13 to 21 Percent of Enrollees Projected to Lose Medicaid Coverage Over Twelve-Month PHE Unwinding Period

Beginning in April 2023, states will be required to carry out eligibility redeterminations for all Medicaid enrollees and disenroll those who no longer qualify for the program over a twelve-month unwinding period, with an additional two months to complete any pending actions. The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) projects that between 13 and 21 percent of Medicaid/CHIP enrollees (between 11.6 million and 18.4 million individuals) may lose Medicaid coverage.[3]

Of those predicted to be disenrolled, roughly 55 percent are expected to lose eligibility for Medicaid and 45 percent to lose coverage despite still being eligible, for administrative reasons such as failing to submit paperwork on time—referred to as "administrative churning."[3] Enrollment declines may be partially mitigated in the case of a severe economic downturn, to the degree that more people lose employment and gain Medicaid eligibility. ASPE's analysis assumes new enrollment will partly offset the net decline but, as enrollment was on a downward trend nationally pre-PHE, this new enrollment is not reflected in Figure 2.

Figure 2. National Post-PHE Medicaid Disenrollment Projections (M)



3 ASPE, Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches (August 19, 2022).

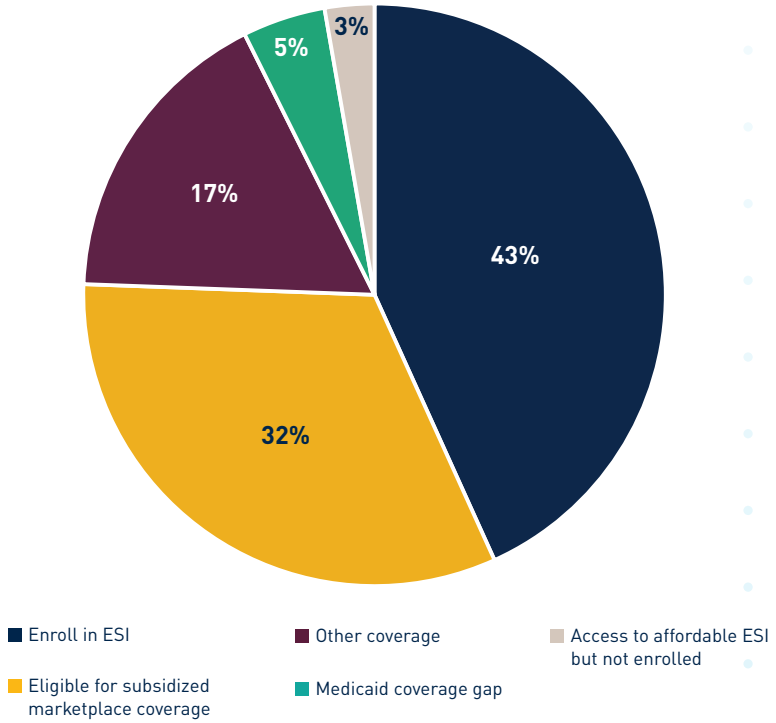
Majority of Those Losing Medicaid Eligibility Post-PHE Expected to Have Access to Other Forms of Coverage

The majority of those losing Medicaid eligibility post-PHE are expected to be eligible for other forms of health coverage, including employer-sponsored insurance (ESI) and subsidized marketplace plans.[4] Roughly 5 percent are expected to fall in the coverage gap—those earning less than 100 percent of the federal poverty level (FPL) and residing in states that have not expanded Medicaid.[4]

Several states have initiatives geared toward facilitating the transition from Medicaid coverage to subsidized marketplace plans, for those eligible, in an effort to minimize spikes in uninsurance rates. States have also launched public awareness and outreach initiatives to minimize disenrollment due to administrative reasons.

Disenrollment is expected to have less of an impact on those with complex medical conditions, disabilities, severe mental illnesses, and seniors, as these populations are less likely to have income fluctuations and often qualify for Medicaid through other eligibility pathways. These populations are also less likely to be impacted by administrative churning, as they generally have more frequent contact with the healthcare system, and lapses in coverage are likely to be noticed quickly. Children, on the other hand, are expected to be greatly impacted by administrative churning, particularly if they are low utilizers of healthcare services. Because Medicaid/CHIP eligibility is more generous for children, disenrollment among children is primarily expected to be due to administrative churning rather than loss of eligibility.

Figure 3. ASPE Predicted Shift in Coverage Among Those Losing Medicaid Eligibility Post-PHE



4 ASPE (2022).

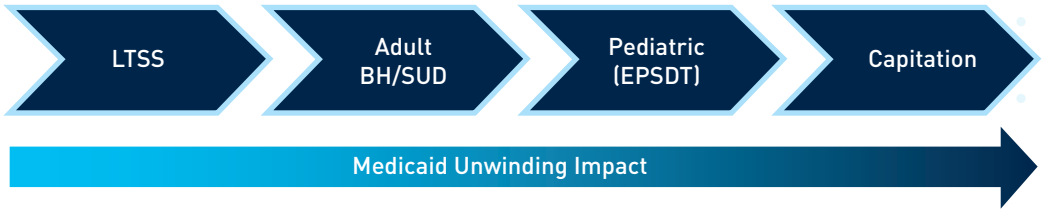
Provider-Level Impact of PHE Medicaid Unwinding Depends on Populations Served

While all Medicaid providers are likely to experience some effects from the unwinding, provider-level impacts will depend on the population served and the method of reimbursement. Capitated entities, including Medicaid managed care organizations (MCOs) and risk-bearing providers, are likely to be the most heavily affected. Under capitation, business are typically paid a fixed per-member-per-month amount and bear responsibility for providing all included services. As Medicaid enrollment has risen, so has capitation revenue, and an enrollment decline will likely result in a decline in revenue. In some cases, this effect may be exacerbated by the fact that disenrollment may be more likely among relatively healthy people who are less likely to use healthcare services. If so, capitated providers could experience a decline in revenue without a comparable decline in the cost of services provided.

Under the federal Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, Medicaid covers a variety of comprehensive services for children and adolescents (which accounts for approximately 50 percent of the Medicaid enrollment population) who may be less well covered by commercial payers.[5] Examples include dental services and speech and occupational therapy. While the vast majority of children losing Medicaid coverage will have access to commercial coverage, providers of these services may be affected by a decline in utilization if the commercial plans do not include the same level of coverage.

Adult behavioral health and substance use disorder treatment providers could see some impact on utilization, especially in the twelve states that have not expanded Medicaid to childless adults. ASPE estimates that about 400,000 adults in these states will lose Medicaid eligibility and not qualify for subsidized exchange coverage and, therefore, may become uninsured.[6] However, the overall impact on these providers may be mitigated by two factors. First, people with substance use disorder (SUD) may be less likely to lose eligibility due to an increase in income, and while these individuals could lose coverage for administrative reasons, their treatment providers can help keep them enrolled.

Figure 4. Medicaid Unwinding Impact by Provider



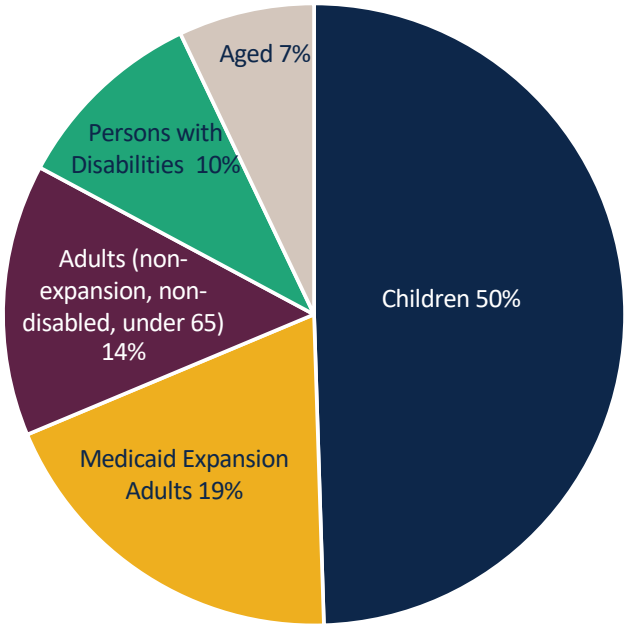
5 CMS, Share of Medicaid & CHIP Population by Eligibility Group, CY2020.
6 ASPE (2022).

Provider-Level Impact of PHE Medicaid Unwinding Depends on Populations Served

Second, state and federal mental health coverage and parity requirements mean that adults losing Medicaid coverage, most of whom will have access to commercial coverage, may be able to continue to access services—potentially at higher commercial rates.

Providers of long-term services and supports (LTSS) for seniors and people with disabilities may be least affected by the unwinding, as this population is less likely to experience a change in circumstances; it therefore saw the smallest PHE-related increase and is expected to see the smallest decrease. The disabled and aged population made up 10 and 7 percent, respectively, of the national Medicaid enrollment share in 2020.[7] While some individuals may have turned sixty-five during the PHE and will qualify for Medicare for acute care, Medicare generally does not cover LTSS. Some administrative coverage loss or interruption is possible, and providers should plan to help their patients maintain enrollment.

Figure 5. National Medicaid Enrollment by Eligibility Group, CY2020



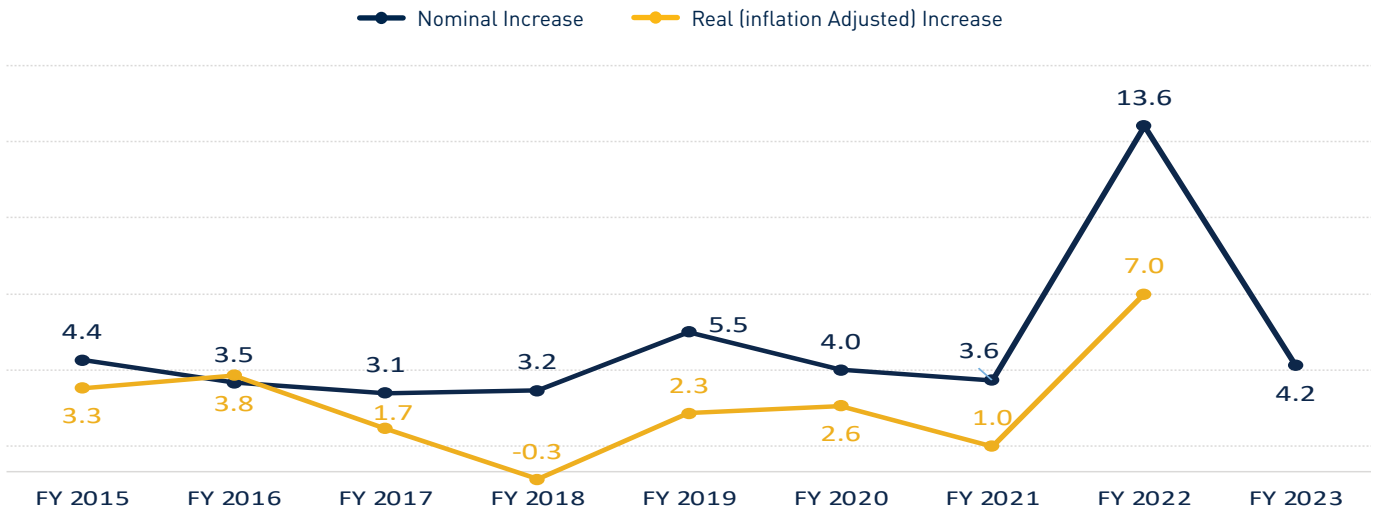
7 CMS, Share of Medicaid & CHIP Population by Eligibility Group, CY2020.

Providers Also Impacted by Other Factors, Including Rate Changes and State Budgets

In contrast to the expected decrease in enrollment due to the unwinding, initiatives are in play that could expand Medicaid coverage to low-income adults in up to two additional states. North Carolina, after unsuccessful attempts by Democratic Governor Roy Cooper to expand without legislative approval, saw the passage of expansion bills in both chambers at the end of the 2022 legislative session, and there are continued bipartisan efforts to agree on an expansion deal. Meanwhile, South Dakota residents recently voted to expand Medicaid to about 40,000 adults, effective July 2023.

Positive state budget environments and resulting rate increases offer another counterpoint to the pressure on Medicaid enrollment that will be brought on by the unwinding. General fund spending for FY 2023 is estimated to increase by 4.2 percent. This follows the largest spending growth in more than forty years, a 13.6 percent increase from FY 2021 to FY 2022.[8]

Figure 6. Annual General Fund Spending Changes, FY 2015–2023 (%)



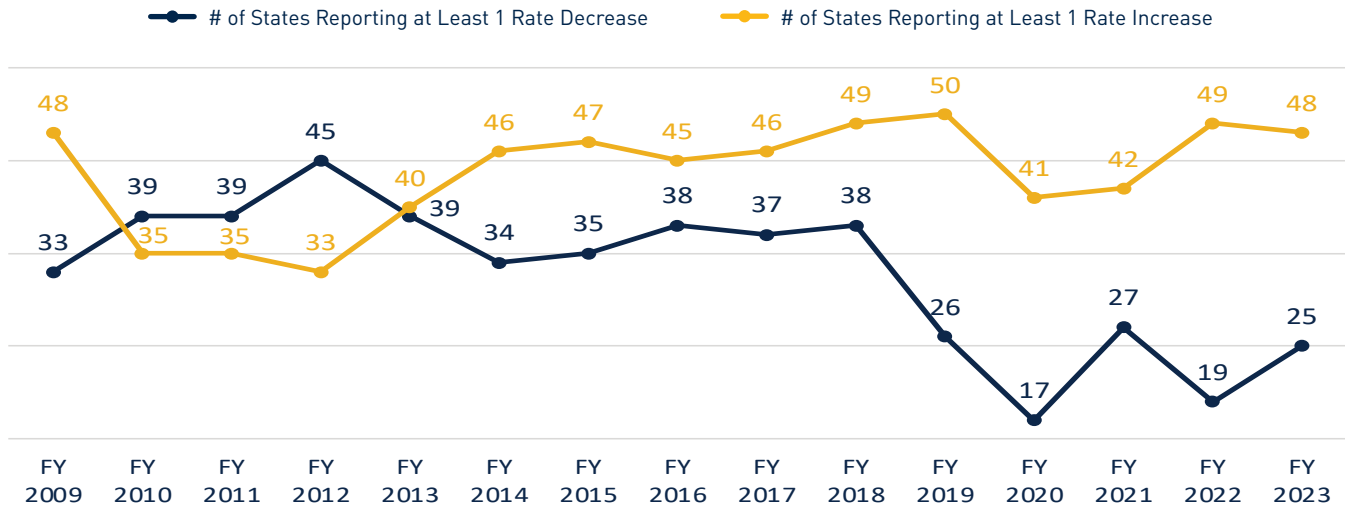
8 National Association of State Budget Officers (NASBO), The Fiscal Survey of States (Spring 2022).

Providers Also Impacted by Other Factors, Including Rate Changes and State Budgets

States generally entered FY 2023 with strong budgets, and Medicaid programs showed evidence of this, as fee-for-service (FFS) rate increases outnumbered rate restrictions, with a focus on improving rates for nursing facilities (forty-four states increased rates in FY 2022 and forty-one in FY 2023), as well as home and community-based services (forty-one states increased rates in FY 2022 and forty in FY 2023), which received enhanced funding as part of the American Rescue Plan Act of 2021 (ARPA). Inpatient hospitals, meanwhile, saw rate restrictions in the most states across both years (Figure 7).[9]

Worsening inflation, coupled with rising labor costs due to workforce shortages, have led to providers and advocates calling for continued rate increases over the next few years, although states will have to contend with a slowdown of federal funding and the possibility of a recession.

Figure 7. FFS Provider Rate Changes in FY 2009–2022, Adopted for FY 2023



9 Elizabeth Hinton et al., How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023, Kaiser Family Foundation (October 2022).

CONCLUSION

The year 2023 will be characterized by heavy state and federal focus on unwinding activities. Capitated entities such as health plans or providers that take risk will see the most impact, while efforts to shift children and adults who lose Medicaid into commercial plans will help maintain levels of coverage for these populations. Meanwhile, federal relief efforts and enhanced FMAP will slow, although healthy reserves should help state Medicaid programs weather potential financial hardships.

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