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Lessons Learned: Strengthening Medicaid to Address Health and
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Lessons Learned: Strengthening Medicaid to Address Health and Economic Emergencies

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SUMMARY. COVID-19 has disproportionately harmed low-income people, especially Black and Latino populations, seniors, and people with disabilities. Medicaid plays an essential role in providing coverage and access to care for these populations. As COVID-19 disrupted employment, earnings, and insurance coverage, Medicaid enrollment increased, in part because Congress offered states increased Medicaid funding in return for maintaining eligibility and enrollment for the duration of the public health emergency (PHE). At the same time, many states expanded eligibility and streamlined enrollment to assure that people could secure and keep coverage. Such policies resulted in more than 5.3 million more Americans having Medicaid coverage during 2020. However, increased demand for Medicaid during the pandemic's economic downturn places pressure on state budgets. The secretary of the Department of Health and Human Services (HHS) and Congress should work together to ensure that the Medicaid enhanced federal match and maintenance of effort requirements continue at least through early 2022 to protect coverage for low-income Americans and to help states weather the economic recovery. HHS should rescind all policies that create barriers to enrollment and access to care. State governments should continue to use temporary emergency authorities to expand eligibility and streamline application and enrollment processes and make them permanent when the PHE ends. Congress should either proceed with President Biden's campaign plan for a federal public option to provide low-cost insurance coverage, particularly important for states that have not expanded Medicaid, or enact an increased federal match for a limited period of time to encourage opt-out states to implement Medicaid expansion.

Introduction: Medicaid's Key Challenges as the Pandemic Began

Medicaid provides medical and long-term care for more 75 million of America's poorest and most vulnerable people, covering nearly a quarter of the population. For decades, Medicaid has covered low-income parents, children, pregnant women, people with disabilities, and seniors. The Patient Protection and Affordable Care Act (ACA) extended eligibility to nonelderly adults including those with no children earning up to 138% of the federal poverty level, narrowing persistent insurance coverage gaps, particularly for people of color and low-wage workers long excluded from employer-sponsored health insurance.

Medicaid is a joint federal-state program that provides open-ended federal matching funds limited only by individual states' contributions. Federal law details mandatory requirements with which state Medicaid programs must comply, but states retain

considerable flexibility to cover optional categories of eligibility and services, and to design delivery systems through state plan amendments. States also can seek waivers from the secretary of HHS to use federal Medicaid funds in ways not authorized by federal statute. Many waivers fall under Section 1115 of the Social Security Act, which gives the secretary authority to waive certain provisions of the Medicaid Act to allow demonstration projects that further the objectives of the Medicaid program. Others are authorized by Section 1915(c), which allows home and community-based long-term services and supports. Section 1135 grants the secretary authority to waive additional provisions of the Medicaid Act when the president declares a national emergency and the secretary declares a PHE. For more information on Medicaid's core features and its vital role in responding to the COVID-19 health and economic emergency, see Chapter 13 in *Assessing Legal Responses to COVID-19: Volume I*.

As America entered the pandemic, three key challenges confronted Medicaid. First, a small number of states, primarily in the South, continued to eschew Medicaid expansion, leaving millions of low-income people, especially minority populations, vulnerable to the health and economic emergency that arose. Second, HHS changed long-standing Section 1115 waiver policies to encourage states to limit enrollment, most notably through work requirements and block grants, a policy that contradicts the purpose of Medicaid and the Affordable Care Act. Third, HHS created new policies designed to gut core statutory protections and make it more difficult for people to stay enrolled in Medicaid.

States Opting Out of Medicaid Expansion

Fourteen states have not implemented Medicaid expansion under the ACA. Pre-COVID-19, this left more than two million uninsured adults in a coverage gap, as they did not qualify for Medicaid and earned too little to qualify for federal tax benefits that help pay for private insurance purchased on an exchange. Nine out of 10 people in the coverage gap live in the eight Southern states that have not expanded Medicaid. (Garfield et al., 2020).

Hundreds of studies show that Medicaid expansion improves coverage and access to care. It is particularly important for minority health: Medicaid expansion helps to address social determinants of health, has reduced historic disparities in coverage and access, and has improved health outcomes for Black

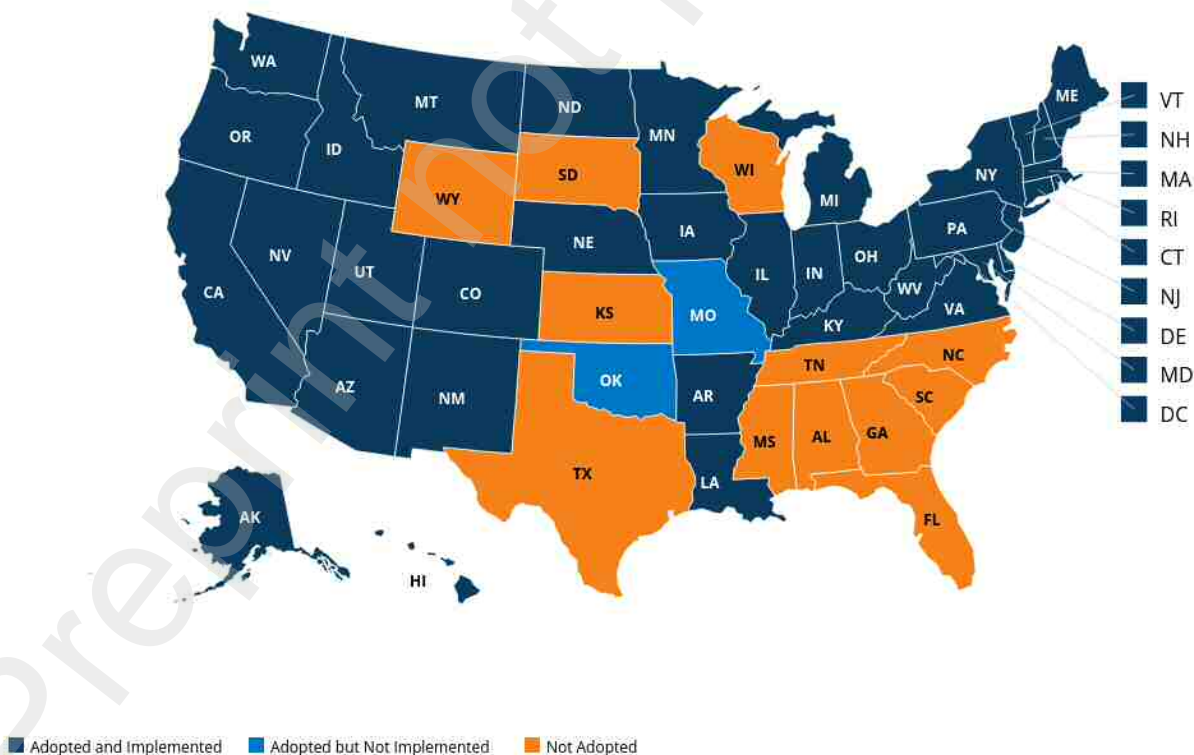
and other communities of color. Though states claim they cannot afford it as a reason to opt out, expansion is a financial benefit for states; numerous studies find expansion provides revenue gains and economic growth for states (Guth et al., 2020). Expansion also supports rural hospitals, which are major employers in their communities and are much less likely to close or limit services in Medicaid expansion states (Sheps Center, 2020).

The non-expanding Southern states have stingy Medicaid and other social programs as well as large Black populations, high poverty rates, and the history of slavery and Jim Crow laws that have led to current race-based health disparities. The decision not to expand Medicaid eligibility exacerbates geographic disparities in health coverage, access, and outcomes, and has amplified the economic and health impact of COVID-19 (Artiga et al., 2019). According to an Urban Institute study, about 40% of people losing employer-sponsored coverage during the pandemic in non-expansion states are expected to become uninsured (Garrett and Gangopadhyaya 2020).

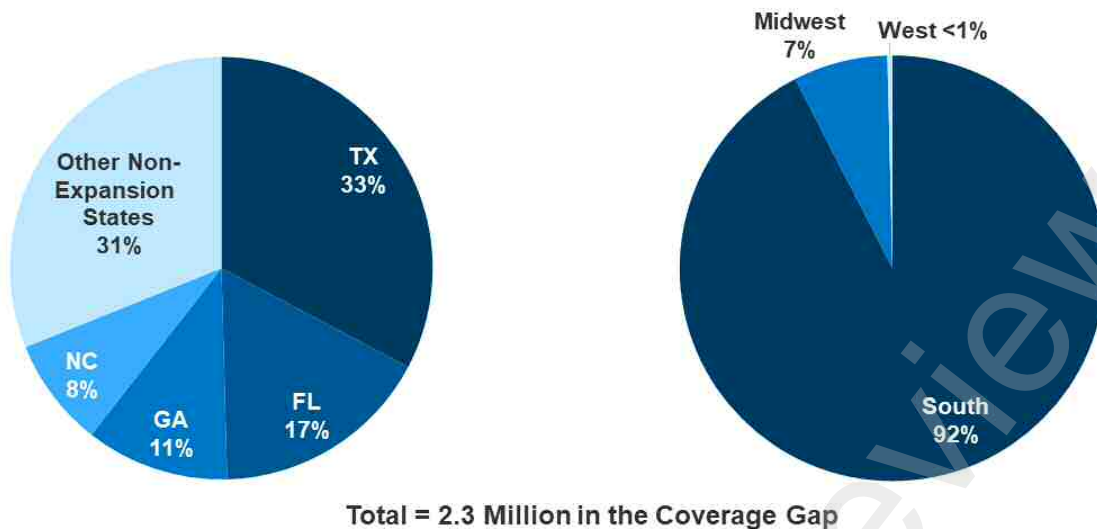
New 1115 Waiver Policies Establishing Barriers to Enrollment

The secretary of HHS has authority under Section 1115 to waive specific Medicaid Act provisions, which allows states to conduct time-limited demonstration projects that further Medicaid’s objective to provide health care for low-income people. Prior administrations focused on increasing eligibility, expanding benefits, and improving delivery systems. However, in November

Figure 14.1. Status of State Action on the Medicaid Expansion Decision



SOURCE: Kaiser Family Foundation, kff.org



NOTE: Totals may not sum due to rounding. There are no individuals in the coverage gap in the Northeast as all states in the Northeast expanded Medicaid.
 SOURCE: KFF analysis based on 2019 Medicaid eligibility levels and 2018 American Community Survey.



Figure 14.2. Distribution of Adults in the Coverage Gap, by State and Region, 2018. Source: Kaiser Family Foundation.

2017, HHS posted revised criteria for evaluating 1115 waiver applications (CMS, 2017). The revision deleted expanded coverage as an objective, instead targeting novel goals like positive health outcomes, program sustainability, upward mobility, responsible decision-making, alignment with commercial health plans, and “innovative” payment and delivery systems. The revision illustrates how the Trump administration sought to reshape Medicaid through sub-regulatory guidance and waivers that limit eligibility, reduce benefits, and cap federal matching funds.

A January 2018 State Medicaid Director Letter encouraged waiver proposals that impose work reporting requirements as a condition of Medicaid eligibility for both expansion enrollees and traditional populations, like low-income parents (CMS, 2018). This letter reversed the position of previous Republican and Democratic administrations, which refused to approve such waiver requests because they did not further Medicaid’s objectives of promoting coverage and access. As of January 2021, eight states had approved work requirement waivers and seven more had requests pending. Another four states (Arkansas, Kentucky, Michigan, New Hampshire) had waiver approvals stayed by federal courts.

So far, federal courts have found that the objective of Medicaid is to provide medical care, and the Secretary of HHS acts in an unlawful arbitrary and capricious fashion when he ignores the decreased coverage work requirements predictably cause. In Arkansas, the only state to implement a work requirement waiver, more than 18,000 people, about 25% of the individuals who were subject to the work requirement, lost coverage in the first five months (*Gresham v. Azar*, 2020). The Supreme Court granted *certiorari* in the cases involving Arkansas and New Hampshire, with oral arguments set for late March 2021. Notably, HHS approved

work requirement waivers for very low-income parents and others in Georgia and South Carolina, both non-expansion states.

Additionally, in January 2020, Centers for Medicare and Medicaid Services (CMS) issued a new State Medicaid Director Letter inviting applications for “Healthy Adult Opportunity” (HAO) waivers (CMS, 2020b). This policy gives states “extensive flexibility” to use Medicaid funds to cover ACA expansion adults, and other “optional” nonelderly adults who do not qualify on the basis of disability, without having to comply with federal Medicaid Act standards for eligibility, benefits, delivery, and oversight. In return, states agree to convert federal Medicaid funding to capped funding structured as an annual block grant or a per capita cap. In the final days of the Trump administration, CMS approved an amendment to Tennessee’s existing 1115 waiver, a modified block grant structure that was filed before the HAO policy was announced but incorporates many of its features. The waiver approval exceeds the secretary’s authority under Section 1115 and is certain to face legal challenges. But, the administration’s attempt to cap federal matching funding by offering states discretion to cut eligibility and benefits destabilizes Medicaid’s financing structure and threatens its consumer protections at the very moment more people are turning to Medicaid for coverage.

Both of these policies undermine the purpose of Medicaid, to pay for coverage and care for low-income populations. These policies also contradict the purpose of the ACA, to attain near-universal insurance coverage through a combination of public and commercial insurance. These Trump administration policies made enrollment more difficult and sought to roll back the ACA Medicaid expansion.

Additional HHS policies creating barriers to care and continuity of coverage

The Trump administration approved a variety of other 1115 waivers that impose enrollment and coverage restrictions on both expansion and traditional Medicaid populations, in both expansion and non-expansion states, that no other administration has allowed (Kaiser Family Foundation, 2020). These waivers include:

- charging premiums above the amounts allowed by federal law (AR, AZ, IA, IN, MI, MT, GA, IN, WI),
- coverage lock-outs for failure to timely renew coverage, report changes affecting eligibility, and non-payment of premiums for non-expansion populations (IN, MI, MT, WI),
- elimination of Medicaid's standard three-month retroactive coverage for nearly all enrollees, including seniors and people with disabilities (AZ, IA, IN, FL, GA, IA),
- making coverage effective the date of the first premium payment instead of the date of application (IN, GA),
- elimination of payment for non-emergency transportation (IA, IN, UT, GA).

The Trump administration also promulgated a sub-regulatory policy designed to make it more difficult to maintain coverage. A June 20, 2019, "Oversight of State Medicaid Claiming and Program Integrity Expectations" guidance encourages states to conduct more frequent eligibility verifications to reduce the number of ineligible people enrolled in Medicaid. However, research and experience show that increased verification requirements lead to decreases in coverage for eligible people who have difficulty providing documentation and navigating administrative processes (Artiga & Pham, 2019).

Before the pandemic, precipitous Medicaid enrollment declines in Missouri, Tennessee, Arkansas, Louisiana, and Texas suggested that growing use of periodic eligibility checks and heightened renewal verification requirements contributed to disenrollment among people legally eligible for coverage as well as increased coverage churn (Artiga & Pham, 2019). Implementation of Medicaid expansion in 2014 led to steadily increasing enrollment for both adults and children. Yet, between December 2017 to June 2019, Medicaid enrollment declined by 2.4 million, a drop that cannot be attributed solely to economic conditions because the uninsurance rate increased. For example, between 2017 and 2018, the uninsured rate increased from 7.9% to 8.5%, driven in part by decreased Medicaid and CHIP coverage (Artiga & Pham, 2019).

Adapting Medicaid during the Pandemic

Medicaid is an important crisis response program because it provides states with open-ended federal funding that increases to match state Medicaid spending increases, which inevitably happens during an emergency. Medicaid enrollment is countercyclical. When the economy deteriorates and unemployment rises, enrollment increases just when states, which must have balanced budgets, experience decreased tax revenues due to a downturn. Congress anticipated that the pandemic would place additional demands on Medicaid and moved quickly to

provide states with enhanced funding on the condition that states protect eligibility and enrollment during the pandemic. Many states went further, taking advantage of temporary regulatory flexibilities to streamline eligibility and enrollment during the COVID-19 PHE.

Congress: Enhanced FMAP and Maintenance of Effort

Congress's first COVID-19 economic stimulus package, the Families First Coronavirus Response Act (Families First Act), offered states a 6.2 percentage point increase in federal matching funds for non-expansion Medicaid spending for the duration of the PHE. To qualify for the enhanced match, states must maintain eligibility and provide continuous Medicaid enrollment for the duration of the pandemic (maintenance of effort, or "MOE," requirements). States may not limit eligibility, impose more restrictive eligibility procedures, charge higher premiums, or disenroll currently or newly enrolled beneficiaries unless they die, move, or request to be disenrolled. All states have accepted the enhanced federal match and are subject to MOE requirements.

The Families First Act effectively paused Section 1115 waiver approvals imposing work requirements, premiums, and other barriers to enrollment and continuous coverage. It also suspended frequent and disruptive redeterminations of eligibility. For the duration of the PHE, states may not terminate enrollees from Medicaid.

HHS and the States: Quick Guidance and New Flexibilities

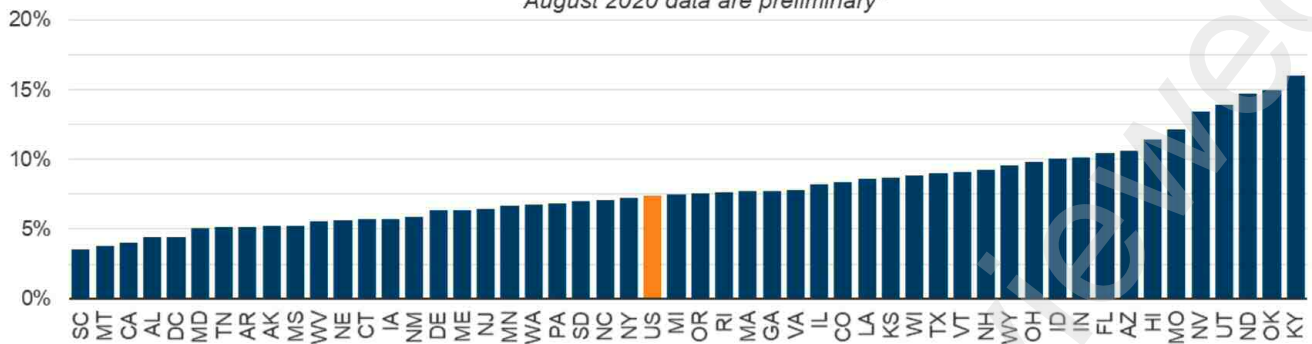
As the pandemic hit, HHS provided guidance and templates for state Medicaid programs to adapt to the PHE. "Sample Disaster Relief State Plan Amendments" showed states how to use Medicaid's statutory flexibility to temporarily expand and streamline eligibility and enrollment. A Section 1115 template focused primarily on demonstration waivers during the PHE. A Section 1915(c) template provided guidance for a plethora of temporary PHE changes to enhance and support home and community-based services. And a Section 1135 Medicaid and CHIP Checklist detailed additional waiver flexibilities during the PHE.

Forty-seven states are using these emergency authorities to streamline eligibility and enrollment to connect people to coverage more quickly during the COVID-19 crisis, going beyond the MOE (Rudowitz, et al., 2020). Over half of states have expanded eligibility for seniors and people with disabilities, and a few states increased the number of home and community-based waiver slots. More than one-third have waived premium and/or cost sharing for seniors and people with disabilities (Rudowitz, et al, 2020). These emergency authorities expire when (or soon after) the PHE ends.

Medicaid Enrollment Increases during the Pandemic

After enrollment declines in 2018 and 2019, Medicaid enrollment increased in 2020 as the pandemic grew. From February 2020 to August 2020, Medicaid enrollment grew by 5.3 million people, or 7.4% (Corallo & Rudowitz, 2020). Every state recorded enrollment increases, ranging from 4% in South Carolina to 16% in Kentucky, with both expansion and non-expansion states reporting increases at the high and low ends.

% Change in Medicaid/CHIP Enrollment from February 2020 – August 2020
 February 2020 data based on updated enrollment reports,
 August 2020 data are preliminary*



NOTES: * August 2020 data are preliminary and subject to change. Medicaid & CHIP enrollment reports are submitted monthly by state Medicaid agencies, reflecting enrollment on the last day of the month. With each update, states often revise data for the previous month(s) to better align with reporting criteria, such as including retroactive enrollment or other criteria.
 SOURCE: CMS, Medicaid & CHIP: Monthly Application and Eligibility Reports, last updated December 22, 2020.



14.3. Enrollment from February 2020 to August 2020 increased in every state. Source: Kaiser Family Foundation (2020).

These Medicaid enrollment increases certainly reflect changes in the economy and job losses, but they also reflect MOE requirements and emergency authorities states used to streamline eligibility and enrollment. As CMS data shows below, even states with relatively low unemployment rates have experienced large increases in Medicaid enrollment. Advocates posit different reasons for these increases. In Kentucky, increased enrollment is credited to use of emergency authority to streamline application processes and allow self-attestation of income when documentation and electronic sources are not available. Missouri’s Medicaid agency points to suspension of rigorous redetermination processes during the MOE as a key reason for its large enrollment increase.

Enrollment will grow as the pandemic continues, because Medicaid enrollment typically lags behind unemployment increases (Corallo & Rudowitz, 2020). As unemployment continues to increase in 2021, even more people will become eligible for Medicaid, helping those who lose employer-sponsored coverage but also exerting pressure on state budgets.

States budgets feel strained by Medicaid enrollment increases, even with the enhanced federal match. The MOE gives states few cost constraint options, except to cut provider payments or increase cost sharing. At the urging of states, on November 23, 2020, CMS issued an Interim Final Rule (IFR) re-interpreting the Families First Act MOE requirements to, among other things, allow states to cut optional benefits like dental, vision, and outpatient rehabilitation services during the PHE. Commentators have challenged the reinterpretation, arguing it violates the letter and spirit of the Families First Act MOE requirements. With the public comment period closing in the waning days of the Trump

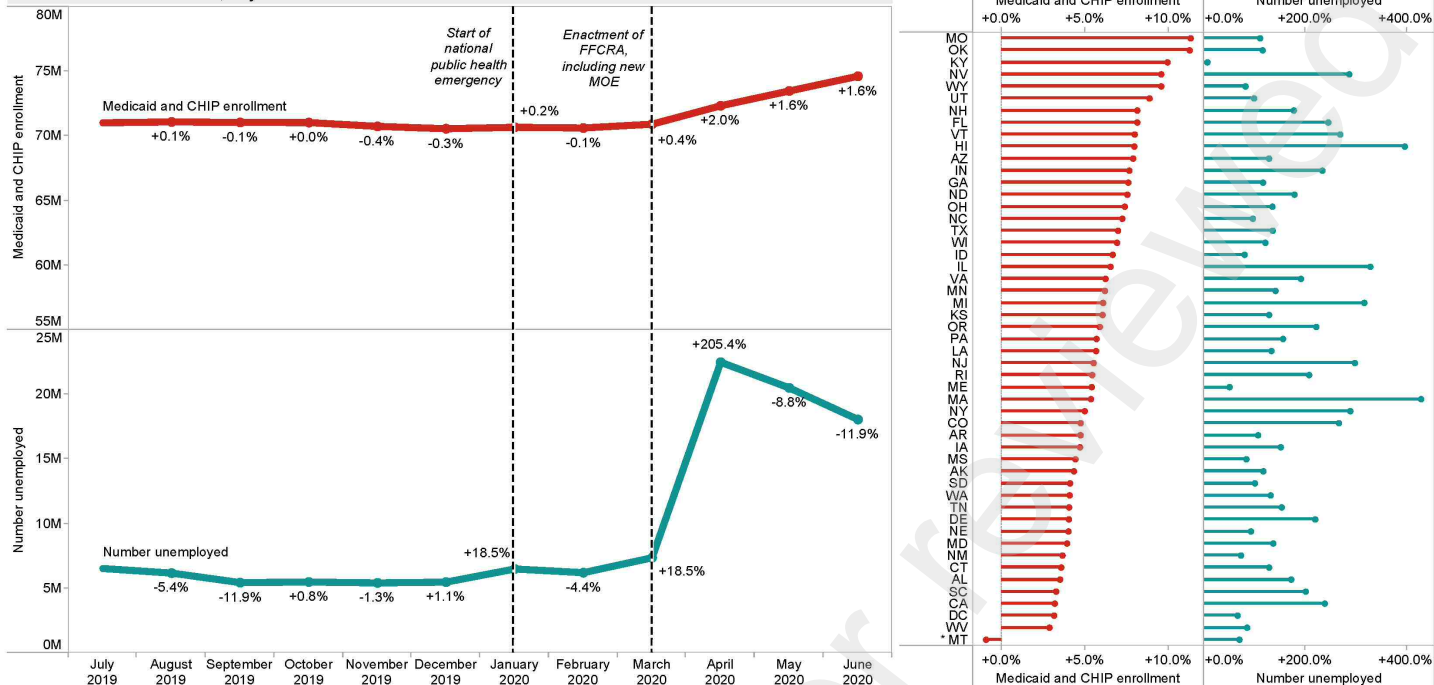
administration, the Biden administration could adjust the rule, especially in light of largely negative public comments.

The Families First Act enhanced federal match lasts until the end of the quarter in which the PHE expires, and the continuous coverage requirement continues until the end of the month in which the PHE expires. The present PHE, renewed January 7, 2021, and effective January 21, 2021, will expire on April 20, 2021. This means the enhanced federal match will continue until at least June 30, 2021, and the MOE requirement would end on April 30, 2021. The Biden administration announced that it will continue to renew the PHE at least through January 2022. If the PHE expires while the economic impact of COVID-19 is still in full force, millions of people will remain out of work and state revenues will continue to be in crisis while Medicaid demand remains high but federal funding decreases. Therefore, the long-term economic impacts of the pandemic must be taken into account when examining how to fine-tune Medicaid’s role.

Lessons Learned

COVID-19 is a stark reminder that illness disproportionately impacts low-wage workers and people of color. COVID-19 also emphasizes the vital role that Medicaid plays in providing coverage for low-wage workers and people of color. While most Medicaid enrollees are white, because of historical structural discrimination, people of color tend to work in low wage jobs and disproportionately rely on Medicaid for insurance coverage. To address health and economic disparities rendered in sharp relief by the pandemic, and to help all who lose employment during the economic downturn, the Biden administration should keep the PHE in place and work with Congress to ensure federal spending will support continued Medicaid coverage through the economic recovery. The enhanced

Figure 4. Medicaid and CHIP enrollment from the CMS Performance Indicator Data compared to unemployment data from the U.S. Bureau of Labor Statistics, July 2019 to June 2020



Sources: (1) Medicaid and CHIP Eligibility and Enrollment Performance Indicators as of August 31, 2020 and (2) State Employment and Unemployment Data (Monthly) from the U.S. Bureau of Labor Statistics as of September 4, 2020.
 Note: This analysis includes data from 50 states and the District of Columbia. "FFCRA" refers to the Families First Coronavirus Response Act. "MOE" refers to the FFCRA's maintenance of effort requirement, which makes available a temporary 6.2 percentage point increase to each state or territory's federal medical assistance percentage (FMAP) during the emergency. As a condition of receiving the FMAP increase, states must meet several requirements pertaining to eligibility and maintenance of enrollment.
 * Data quality: As of August 31, 2020, Montana had not yet provided an explanation for its Medicaid and CHIP enrollment declines in the first half of 2020.

14.4. Medicaid and CHIP enrollment from the CMS Performance Indicator Data compared to unemployment data from the U.S. Bureau of Labor Statistics, July 2019 to June 2020. Source: U.S. Centers for Medicare and Medicaid Services.

match provides broad fiscal relief to states and also supports increases in enrollment, continuous coverage for enrollees, and prevents states from cutting Medicaid eligibility.

The Biden administration notified states that it intends to maintain the PHE at least until January 2022. It also notified states that HHS will give at least 60 days' notice before the end of the PHE to allow state Medicaid programs time to plan their transitions. HHS should provide guidance to ensure those who are eligible stay enrolled when the PHE terminates and assist states to modify policies that expand and streamline eligibility and enrollment from emergency authorities to permanent authorities when the PHE ends.

In 11 of the 14 states that have not implemented the ACA Medicaid expansion, workers who lose their jobs and employer-sponsored health insurance coverage because of the pandemic have no safety net. In these non-expansion states (other than Wisconsin), the only working age adults who qualify for Medicaid are very poor parents, caretaker relatives, and people who qualify due to a disability. If these states expanded Medicaid, nearly four million uninsured low-income adults, including 640,000 frontline workers, could gain coverage (Straw, et al. 2021)

Biden's campaign platform included a federal "public option," federal health insurance that would cover low-income adults in non-expansion states. Enacting a public option would require a 60-vote majority in the Senate due to filibuster considerations.

However, Congress can use the budget reconciliation process to authorize a time-limited enhanced federal match to encourage opt-out states to adopt Medicaid expansion. Under the ACA, states that adopted the Medicaid expansion received 100% federal matching funds from 2014 to 2016, with the match gradually phasing down to 90%, where the match remains today. The February 2021 House committee version of the "American Rescue Plan" authorizes a two-year, 5 percentage point Federal Medical Assistance Percentage (FMAP) increase in states that have yet to expand Medicaid (Straw, et al (2021). This incentive funding is particularly meaningful as states experience higher enrollment and budgetary squeezes related to the COVID-19 related recession and may overcome those reluctant to expand for political reasons.

Additionally, HHS should develop more thorough policies specifying how state Medicaid programs report race, ethnicity, and other demographic data so policymakers, researchers, and the public can better understand the role that Medicaid plays in addressing long-standing health inequities and allow for meaningful cross-state comparisons. ACA Section 4302 provides that the secretary of HHS "shall ensure" that federally supported health care programs "to the extent practicable" collect and report data on race, ethnicity, sex, language, and disability. However, HHS has not required state Medicaid agencies to report uniform demographic data—or even consistent measures. This data is key to efforts in public health and medical care to improve health equity and plan for future emergencies.

Recommendations for Action

Federal government:

- HHS should renew the PHE declaration at least through 2021, so states continue to receive an enhanced federal match and the MOE requirements that prevent cutting eligibility and enrollment stay in place. HHS and Congress should work together to ensure that the enhanced federal match lasts through the economic recovery to relieve state budgets of the burden of continued enrollment increases while the economy improves.
- The administration should stop defending waiver approvals involving work requirements in the lawsuits before the Supreme Court and elsewhere and should revise 1115 waiver policy to encourage expanding coverage; HHS should rescind policies that limit coverage and make it clear that Medicaid exists to support low income populations; HHS should renegotiate restrictive provisions in approved waivers, and refuse renewal requests, making it plain that policies like work requirements do not promote Medicaid's objectives.
- When the PHE ends, HHS should provide guidance for states to help transition emergency policies that have maintained, expanded, and streamlined eligibility during the PHE to permanent Medicaid authorities.
- HHS should require uniform data collection, consistent with ACA Section 4302, as a condition of federal funding and Medicaid participation, so that data regarding key identifying characteristics are collected by state Medicaid agencies.
- Congress should either create a public insurance option or provide a time-limited FMAP increase as a financial incentive to encourage opt-out states to implement Medicaid expansion.

State governments:

- States should continue to use the temporary authorities that allow them to maintain or expand Medicaid eligibility and streamline application and enrollment processes during the PHE and through the economic downturn until recovery is clear.
- States should adapt these policies into permanent features when the PHE ends.

About the Authors

Nicole Huberfeld, JD, is Professor of Health Law, Ethics & Human Rights and Professor of Law at Boston University. Her scholarship explores the health of vulnerable populations by studying health reform, public insurance, federalism, and congressional power. She is author of two casebooks and many book chapters, articles, and commentaries, including a five-year study of early implementation of the ACA (What Is Federalism in Healthcare For?, *Stanford Law Review*, 2018, with A. Gluck) and *Federalizing Medicaid*, cited in the first Supreme Court decision on the ACA.

Sidney D. Watson, JD, is the Jane and Bruce Robert Professor of Law at Saint Louis University Law School where she is Director of the Center for Health Law Studies. Her research focuses on issues relating to access to health care for the poor, racial and ethnic minorities, people with disabilities, and other disenfranchised groups. She has authored more than sixty law review articles, books and other publications, including recent articles on health reform, racial health equity, Medicaid, and rural health care.

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