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Medicaid: Balancing Federal Oversight and State Flexibility

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Reshaping the Health Care System in a Post-Pandemic Era

Agenda

- **Context: Medicaid's Importance and Federalist Structure**
- **Medicaid Priorities and Trends Under the Biden Administration**
  - Access to Coverage; Unwinding the "Continuous Coverage" Requirement
  - Access to Care
  - Addressing Health-Related Social Needs (HRSN)
- **The Role of the Courts**

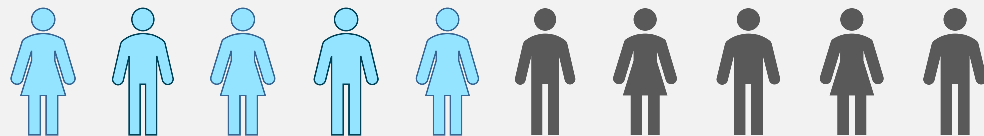
Medicaid is the Primary Source of Health Coverage for Low-Income People

Medicaid & CHIP: Quick Facts

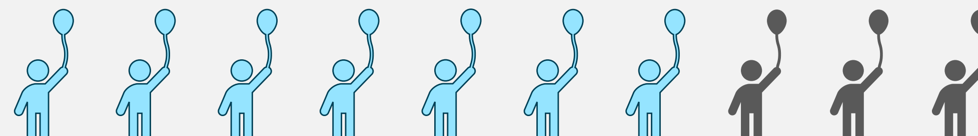
- Medicaid and the Children's Health Insurance Program (CHIP) covered **93.8 million people, or 28% of all Americans** as of May 2023 *(88.8 M in Medicaid, 7 M in CHIP)*
- Together, these programs cover…

> 40% of all births

> 50% of adults with income <200% FPL*

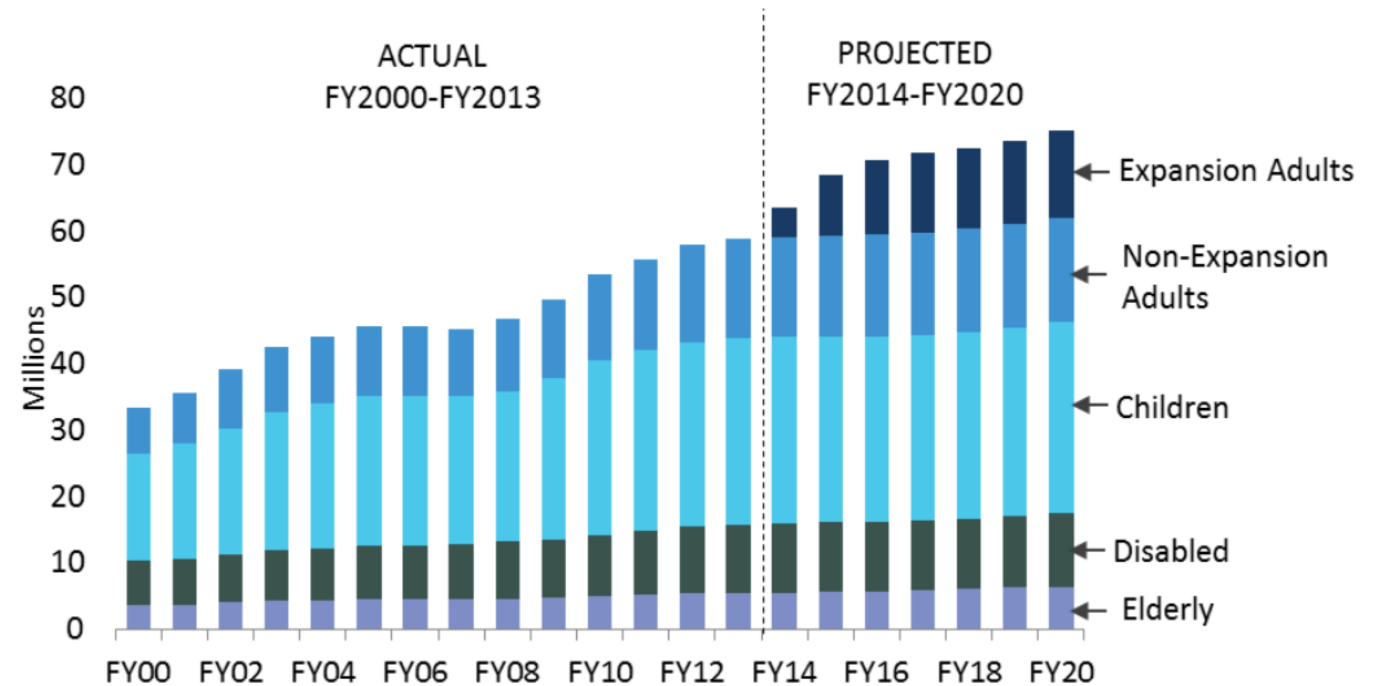


> 70% of children in households < 200% FPL



Medicaid enrollment has risen over time due to policy changes at the federal and state levels.

Past and Projected Medicaid Enrollment, by Population
(FY2000–FY2020)



During the COVID-19 pandemic, Medicaid enrollment grew by 23 million people due to the "continuous coverage" requirement.

Sources: Congressional Research Service, Medicaid: An Overview (2021; 2023); CMS, May 2023 Medicaid and CHIP Enrollment Trends Snapshot; Kaiser Family Foundation (KFF), Health Coverage & Uninsured.
* FPL = Federal Poverty Level

Medicaid is a Joint Federal-State Program

Each states designs its own Medicaid program in accordance with federal law, which defines minimum requirements and areas of state flexibility.

Financing

The federal government pays 50–100% of eligible expenditures, depending on the state, the type of health care service or administrative activity, and the patient's characteristics

	Eligibility	Covered Benefits
Federal Baseline	Mandatory eligibility groups include children, older people, pregnant people, and people with disabilities	Mandatory benefits include hospital, physician, family planning, nursing home, and home health services
State Flexibility	▪ Increase income limits for mandatory populations ▪ Add coverage for new populations (e.g., coverage expansion for childless adults under the Affordable Care Act (ACA), adopted by 41 states)	Add coverage for additional services, including novel benefits through "demonstration projects" authorized under section 1115 of the Social Security Act

Delivery System

States may deliver services on a fee-for-service (FFS) basis. However, states increasingly contract with managed care organizations (MCOs) to administer coverage.

Medicaid Priorities and Trends Under the Biden Administration

Modernizing Procedures

CMS* seeks to standardize and digitize operations for state Medicaid agencies and MCOs, with the aim of:

- Strengthening baseline federal standards
- Increasing transparency and cross-state comparability
- Supporting data-driven oversight by state and federal officials

Corollary: New requirements and implementation burdens for states and MCOs

Commitment to Coverage, Access, and Equity

Across federally funded programs, the Biden Administration seeks to:

- Increase enrollment in health coverage
- Support access to care
- Identify and address disparities based on race and other social drivers of health (SDOH),

These goals align with:

- CMS's Feb. 2022 Request for Information on Medicaid access
- The Administration "whole of government" approach to "advance equity and racial justice"

Focus on Key Service Areas

CMS has devoted special attention to certain Medicaid populations and services, including:

- Primary care
- Behavioral health (BH)
- Perinatal health
- Home and community-based services (HCBS)
- Services for children

* CMS = The Centers for Medicare & Medicaid Services

Access to Coverage: Unwinding the Continuous Coverage Requirement

The end of the federal Medicaid "continuous coverage" requirement is the single largest health coverage event since the first open enrollment of the ACA.

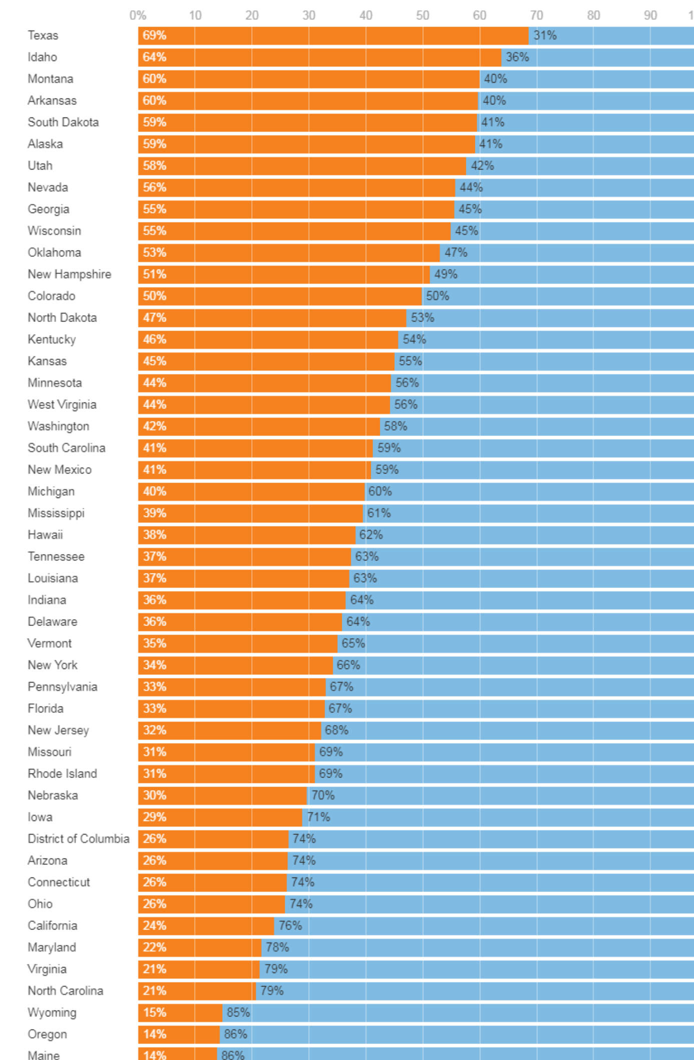
Background

- **During the COVID-19 PHE,** Congress offered states increased federal Medicaid funding with certain conditions, including pausing Medicaid disenrollments.
- **Since April 2023, states have begun the multi-month process of redetermining eligibility for all 94 million Medicaid and CHIP enrollees**. The Consolidated Appropriations Act, 2023 (CAA) defined parameters to minimize coverage disruptions, enhance state reporting, and bolster CMS's enforcement powers.

How Unwinding Is Going

- As of September 26, **~7.5 million people have been disenrolled** from Medicaid and CHIP, representing 37% of all redeterminations.
- **Disenrollment rates vary widely,** from a high of 69% (TX) to a low of 14% (ME & OR).
- The majority of terminations (73% on average) are "procedural."
- CMS is responding to emerging issues, e.g., August letter emphasizing the requirement to assess eligibility at the individual level rather than the household level

Source: KFF, Medicaid Enrollment and Unwinding Tracker.



% of Redeterminations Resulting in Disenrollment vs. Renewal, by State

Disenrollment Rate

Renewal Rate

Source: KFF, Medicaid Enrollment and Unwinding Tracker. Time periods differ by state. Pending renewals are excluded. Several states report unwinding data on redeterminations without enough information to calculate disenrollment and renewal rates.

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Access to Coverage:
Proposed Rule Changes, Expansion of Continuous Eligibility

CMS's Proposed Rule (Aug. 2022)

This is CMS's first large-scale rulemaking on eligibility and enrollment processes in Medicaid/CHIP since ACA implementation in 2012 and 2013. If finalized, these rules would, among other things:

- **Require greater use of "ex parte" renewals,** using existing state data
- **Prohibit certain CHIP access barriers**, incl. waiting periods and premium lock-out periods
- **Strengthen record-keeping requirements**
- **Secure enrollee account transitions** between Medicaid, CHIP, and the Basic Health Program

Continuous Eligibility (CE)

- States must provide **1 year of CE for kids** starting in January 2024 (per the CAA)
- Most states now offer **1 year of postpartum coverage** (temporary option created under American Rescue Plan (ARP), now permanent under CAA)
- Under state-proposed **demonstration projects**, CMS has approved, e.g.:
  - CE for kids up to age 6, and 2-year CE for everyone else (Oregon)
  - 1-year CE upon release from correctional settings and 2-year CE for individuals who are unhoused (Massachusetts).

Access to Care: Proposed Rules

On April 27, 2023, CMS released two complementary proposed rules that would define a new, more integrated framework for defining and monitoring access to care.

Proposed Rule #1
"Managed Care Access, Finance, and Quality"

The proposed rule would, among other things…

- Require **payment transparency** and an **assessment of rate adequacy** for certain services (primary care, OB/GYN, BH, home care)
- Strengthen **access to care and monitoring** through appointment wait time standards and secret shopper/enrollee surveys

Proposed Rule #2
"Ensuring Access to Medicaid Services"

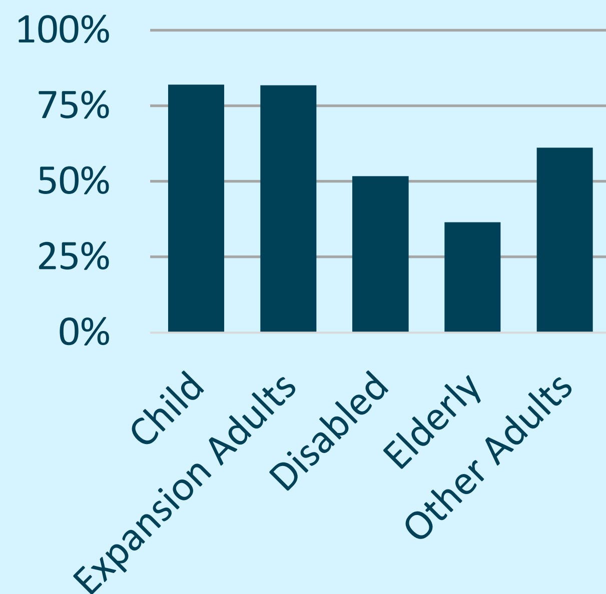
The proposed rule would, among other things…

- Bolster **payment transparency** for all FFS rates
- Require an analysis of **rate adequacy** for certain services (primary care, OB/GYN, BH, home care)
- Strengthen requirements for **access analyses** when a state proposes to reduce or restructure FFS rates
- Strengthen **program advisory groups**
- Update **HCBS program standards** and processes regarding care access, quality, and payment

Rollout of Requirements. The significant new requirements on states and managed care plans would require CMS guidance and technical support. CMS attempts to mitigate the administrative burden by focusing required analyses on a subset of key services or issues and implementing provisions over time.

Access to Care: Oversight of Managed Care Organizations

70% of Medicaid/CHIP beneficiaries receive coverage through an MCO



In recent years, CMS has:

- Released updated templates for MCO reporting and toolkits to support states
- Proposed regulatory changes to:
  - — MCO access standards and monitoring *(as noted)*
  - — Provider payments, including state directed payments (SDPs), in which the state sets parameters for an MCO's payments to providers; SDPs represent $50 billion in annual spending
  - — States' financing of MCOs
  - — Quality strategies

In a July 2023 report, the HHS Office of Inspector General (OIG) found that **MCOs deny one of eight requests for service authorization** – more than double the rate of Medicare Advantage Organizations.

Sources: MACPAC, MACStats: Medicaid and CHIP Data Book 2022; CMS, Proposed Rule: Managed Care Access, Finance, and Quality; OIG, High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.

Health-Related Social Needs

Medicaid Is a Key Driver of Health Equity

As compared to the general population, Medicaid enrollees are more likely to…

- Have low income (by definition)
- Be people of color
- Have a disability or other special health care needs, such as
  - Chronic conditions that require ongoing care
  - Developmental delays for children

Recent Innovations in Addressing HRSN

In recent years, CMS has authorized states to:

- **Cover more services to address HRSN,** such as nutritious meals, housing deposits, housing navigation & tenancy supports, sobering centers
- Draw on federal Medicaid funds for existing **state-funded health-related programs**
- Fund **capacity-building grants**

CMS enhanced state flexibility under:

- 1115 demonstrations, subject to conditions:
  - Limits on HRSN-related funding
  - Provider payment benchmarks for primary care, BH, and OB/GYN
- Managed care value-added and "in lieu of" services (medically appropriate, cost-effective substitutes for covered services)

Justice-Involved Populations

- Historically, federal Medicaid funding was unavailable for people in jails and prisons (the "inmate exclusion")
- People who are incarcerated have higher rates of physical and behavioral health issues, and have an elevated risk of overdose and death when they reenter the community
- In April 2023, CMS issued guidance on **1115 demonstrations to provide services to justice-involved individuals prior to release** in order to support their reentry into the community.

The Role of the Courts

Traditionally, Medicaid litigation involved private entities challenging public policies

- **Medicaid beneficiaries can sue state Medicaid programs** based on alleged violations of their federal rights to enrollment, coverage, or access
  - In 2023, the Supreme Court preserved this legal pathway with its decision in *Health & Hospitals Corp v. Talevski*
  - In August 2023, beneficiaries sued Florida asserting that the state's termination notices are inadequate
- **Medicaid beneficiaries and providers can sue CMS to challenge waivers or rule changes** that harm their interests (e.g., challenges to 1115 demonstrations waivers with work requirements or closed prescription drug formularies)

In recent years, courts have increasingly adjudicated disputes between CMS and states

- **1115 demonstrations**
  - The Biden CMS rescinded approval for certain 1115 authorities that had been approved under the Trump Administration, including all authorizations for work requirements
  - Two states (Texas and Georgia) successfully sued in court to reinstate their waiver approvals, arguing that CMS's revocations failed to offer valid justifications or follow proper procedures
- **Federal guidance.** Texas successfully challenged CMS's February 2023 guidance increasing federal oversight of states that finance their Medicaid programs using taxes on health care providers.

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Thank You!

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