

# FAQs on COVID-19's Potential Impact on Medicaid and Medicaid Managed Care Organizations

Medicaid is a joint federal-state program that funds health care services for eligible low-income Americans. Medicaid eligibility currently varies by state. In general, the federal government requires that state Medicaid programs cover low-income families (including parents, pregnant women, and children), low-income adults age 65 and older, and low-income individuals with disabilities.

States have the option to extend Medicaid eligibility to additional groups, including families and individuals above the minimum federal standards and otherwise eligible individuals with high medical expenses who have incomes exceeding the eligibility threshold (i.e., medically needy). To date, 36 states plus the District of Columbia have adopted the Medicaid expansion under the Affordable Care Act,<sup>1</sup> which targets non-elderly (including childless) adults with incomes at or below 138% of the federal poverty level (FPL).

Medicaid's benefit packages also differ by state, and within states by eligibility category. Medicaid typically provides a comprehensive set of health care services, and out-of-pocket costs for Medicaid beneficiaries are low, with no or very low premiums or copayments.

Medicaid is administered by states but is jointly funded by the federal government and the states. States may operate Medicaid programs in which health care providers directly bill the state agency or may utilize managed care organizations (MCOs) that coordinate a beneficiary's health care needs and are paid a capitated rate by the state.

## What will be the impact of COVID-19 on Medicaid enrollment?

Medicaid could experience large increases in enrollment, especially as people losing employer-based coverage shift to Medicaid coverage. A model from Health Management Associates (HMA) estimates that Medicaid enrollment could increase from 71 million people to between 82 million and 94 million people.<sup>2</sup> Increases could vary by state, depending on whether they expanded Medicaid, area job losses, enrollment resources and outreach, population demographics, and the incidence of COVID-19. States that imposed work requirements for Medicaid eligibility have suspended those requirements, most doing so even prior to the outbreak of COVID-19. In addition, to qualify for the increase in the federal medical assistance percentage (FMAP) enacted through the Families First Coronavirus Response Act,<sup>3</sup> states cannot terminate Medicaid enrollment unless the enrollee requests termination, dies, or moves out of state. Over time, this

<sup>1</sup> Kaiser Family Foundation, "[Status of State Medicaid Expansion Decisions: Interactive Map](#)," March 13, 2020.

<sup>2</sup> Health Management Associates, "[COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State](#)," April 3, 2020.

<sup>3</sup> Available at <https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf>.



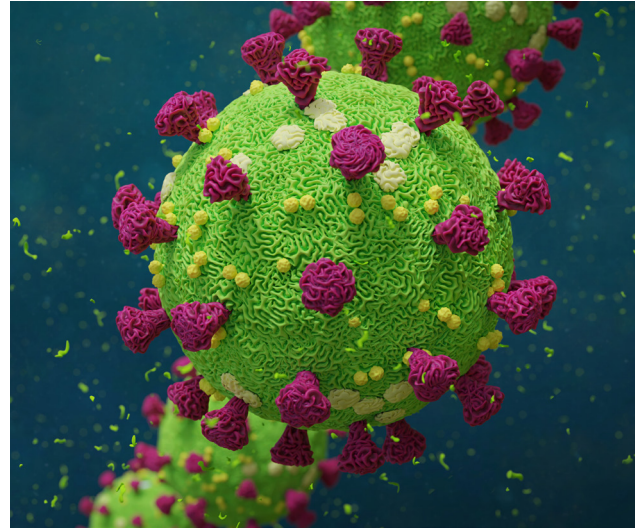
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requirement will contribute to an increase in Medicaid rolls. Additionally, the impact of the increased enrollment may persist for a period of time after the national state of emergency has ended if unemployment rates remain high.

Medicaid enrollment changes may disproportionately impact certain eligibility groups based on their eligibility rules and changes in the economy. For example, children are already eligible for Medicaid and the Children's Health Insurance

Program (CHIP) up to 200% or more of FPL. In contrast, eligibility for adults and parents has generally been limited to 138% of FPL or less. As a result, economic changes might increase enrollment of adults and parents at a greater rate than children. Enrollment increases could also be higher among individuals with disabilities, if (as observed in the Great Recession) they are at greater risk of job loss.<sup>4</sup>



### What will be the impact on per capita Medicaid service expenditures?

The impact on Medicaid service expenditures will depend on many factors, including:

*Higher risks among vulnerable groups.* Some Medicaid eligible groups are especially vulnerable to COVID-19, due to age, disability, or underlying health conditions, potentially leading to higher COVID-19-related Medicaid spending.

*Health status and utilization of new enrollees.* New enrollees who are shifting from employer-sponsored insurance could be healthier on average and have a lower utilization of care. New enrollees gaining Medicaid coverage due to presumptive eligibility determinations at the point of care would likely be sicker and have higher health costs.

*Cost-sharing and prior-authorization waivers.* Medicaid treatments typically have low or no cost-sharing, so waiving cost-sharing for COVID-19 testing or treatments will likely have only a minimal effect on Medicaid spending. At least 40 states have obtained section 1135 emergency waivers that would suspend fee for service prior-authorizations.<sup>5</sup> Waiving prior-authorization for all treatments could increase spending more significantly than waiving cost-sharing, especially when waivers apply to out-of-network providers (in a managed care environment) with higher payment rates and if the duration of the emergency is long.

<sup>4</sup> H. Stephen Kaye, "[The Impact of the 2007-2009 Recession on Workers with Disabilities](#)," Bureau of Labor Statistics, Monthly Labor Review, October 2010.

<sup>5</sup> Kaiser Family Foundation, "[Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19](#)." Accessed on April 13, 2020.

*Reduction in non-COVID-related treatments.* With social distancing and recommendations to delay nonessential services, providers are seeing utilization reductions and revenue losses. Although avoiding or deferring health care could reduce current Medicaid spending (and increase future demand), some payers are being encouraged to provide advance payments to providers or move to capitation arrangements to reflect services that are deferred but will occur at some point in the future in order to stabilize provider revenue.<sup>6</sup>

There are also concerns that vulnerable Medicaid enrollees are having difficulty accessing even essential health care services. Delays in meeting current health care needs, coupled with an increased risk for mental health and substance abuse problems due to the outbreak and the associated social isolation, could increase future medical and behavioral health care needs of the Medicaid population. Greater availability of telemedicine, which is generally being reimbursed at the same rates as in-person visits, could help meet current health care needs. However, the Medicaid population may find it more difficult to access telemedicine services due to limited internet access or availability of cell phone minutes.

With respect to dually eligible (Medicaid and Medicare) enrollees residing in nursing homes, reimbursements to nursing homes may need to increase to accommodate higher costs associated with preventing or managing outbreaks. Costs will shift from Medicaid to Medicare for dually eligible enrollees currently residing in nursing homes who are subsequently hospitalized.

*COVID-19 testing cost.* In addition to testing individuals either with COVID-19 symptoms or who have known exposure to COVID-19, broad and periodic diagnostic and antibody testing may be needed to safely ease social distancing requirements. Medicaid programs will likely incur those costs for their enrollees.<sup>7</sup>

*Drug treatments and vaccine costs.* If particular prescription drugs are determined to effectively treat COVID-19, Medicaid could incur increased spending for those drugs. In addition, Medicaid could incur vaccine costs, when one becomes available, if such costs are not funded through a broader public health program.

## How will the increase in FMAP impact state budgets?

The federal share of Medicaid spending is based on the FMAP, which varies by state and currently ranges from 50% to 77%. States must fund the remainder of the program costs, typically from appropriations or provider assessments. State budgets will be strained not just from the increased costs to address the outbreak, but also from expected delays and reductions in tax collections. The Families First Coronavirus Response Act temporarily increases each state's FMAP for most eligibility groups by 6.2 percentage points, effective as of January 1, 2020, and extending through the end of the quarter in which the emergency declaration ends. (The FMAP for the Medicaid

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<sup>6</sup> The National Association of Medicaid Directors (NAMD) has [urged](#) CMS to allow states to advance payments to essential Medicaid providers through section 1115 waivers. The CARES Act also provides financial resources to providers, but it's unclear how those funds will be disbursed and whether there will be coordination with the states and other payers.

<sup>7</sup> The Families First Coronavirus Response Act gives states the option to cover the COVID-19 testing costs for uninsured individuals not eligible for Medicaid; these costs would be fully reimbursed by the federal government.

expansion population is 90% and is not affected by the temporary FMAP bump.) As noted above, to qualify for the FMAP bump, states cannot terminate enrollment unless the enrollee requests termination, dies, or moves out of state.

The FMAP bump is helpful to states in the short term as the same factors that are influencing service expenditures and enrollment levels (e.g., increases in unemployment, decreases in overall economic activity) are also likely to create shortfalls in the sources of state revenue that support the Medicaid program. State Medicaid burdens will increase over time, however, due to increased enrollment from the influx of newly unemployed individuals and families and the prohibition on terminations. In addition, increased Medicaid costs due to pent-up demand from deferred care and potentially worsening conditions could occur after the FMAP bump is eliminated after the end of the emergency declaration.

### **How will Medicaid managed care organizations (MCOs) be affected?**

States with Medicaid managed care programs pass most of the short-term financial risks to Medicaid MCOs. Medicaid MCOs face many of the same issues addressed above (e.g., increased enrollment, increased costs for enrollees with COVID-19, potential offsets to increased COVID-19 costs due to deferred or avoided services, pressure to advance payments to providers). A few issues are particularly important to consider with respect to managed care programs, including the potential need for risk mitigation mechanisms for 2020 and the need to develop new capitation rates for 2021 amid great uncertainty.

In general, 2021 capitation rates are developed using experience from 2019 (the most recent year for which complete data are available), adjusted for what is known for 2020, and projected forward to 2021. The tremendous uncertainty regarding the number of COVID-19 cases, COVID-19 treatment costs, potential costs associated with a COVID-19 vaccine, Medicaid enrollment and risk pool changes, and the degree of health care avoidance or deferral make setting 2021 capitation rates especially difficult. As such, states and MCOs alike may be more amenable than usual to the use of risk corridors, more frequent rate updates, or other risk mitigation mechanisms for 2020 and 2021 capitation rates. Notably, however, there may be challenges implementing risk adjustment programs as data may be incomplete.

At the same time, MCOs are subject to health care quality and reporting requirements, which are more difficult to achieve during the pandemic for two reasons. First, social distancing restrictions make it more difficult to perform preventive screening services such as mammography, as well as other well visit appointments, which are key quality measures in many states. Although more providers are offering telemedicine in lieu of in-person services, telemedicine is not an alternative to many disease management and full well visit services. Second, data collection itself can be more difficult, as there may be lags and incomplete provider reporting.

In recognition of these circumstances, the Centers for Medicare & Medicaid Services (CMS) has loosened quality-reporting requirements for providers and Medicare plans, including Medicare-Medicaid plans for dually eligible beneficiaries. States have the option of loosening quality reporting and other requirements in their managed care contracts, within parameters defined by CMS.

In addition to the health care quality and reporting requirements themselves, MCOs are often subject to reductions in the capitation rates (i.e., withholds) to encourage meeting the health care quality and reporting requirements. Or, MCOs may receive bonus payments for meeting or exceeding certain health care quality and reporting requirements. As meeting the health care quality and reporting requirements becomes more difficult, the loss of the revenue may further impact the MCOs' ability to operate effectively.

### **What flexibilities are available to address the uncertainties in Medicaid managed care rate setting?**

Medicaid capitation rates must be actuarially sound, meaning that they are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract, reflecting the covered populations, services and time period. One option to address rate uncertainty is direct reimbursement to Medicaid MCOs for COVID-19-related costs outside of the capitation rates. Similar to reimbursement of the federal Health Insurance Tax, states could reimburse MCOs for specific COVID-19-related costs outside of the capitation rates on a fee for service basis with proper documentation. Other options include prospective or retrospective capitation rate adjustments and risk corridors.

### **What are the effects on long-term services and supports (LTSS) utilization and spending?**

*Shift from adult day care to home-based care.* States have moved quickly to suspend adult day care (ADC) and adult health center (AHC) operations in response to public gathering restrictions and social distancing guidelines. Many of these services are likely to be replaced by a combination of home-based options and/or telephonic services, but some utilization is likely to go unreplaced while social distancing restrictions remain in effect. Related services, such as non-emergency transportation, will decline until social distancing measures are lifted. Home- and community-based care could increase if people who would have otherwise entered a nursing home instead use these services.

For states and MCOs, the short-term aggregate impact of these changes may vary due to differences in regional characteristics, models of care, and other factors. Replacing the ADC/AHC services with individualized services will be more costly. That said, utilization decreases have led to financial challenges for some community LTSS providers, including direct care wage workers who provide day-to-day care for LTSS recipients. As a result, Medicaid spending for home- and community-based services could be lower than expected in the short term. A lack of financial viability for ADCs/AHCs could threaten access to these providers in the long term as well as impede the ability of states and MCOs to maintain or improve upon the historical nursing home/community mix, which could increase costs well beyond the end of the pandemic.

Programs for all-inclusive care for the elderly (PACE) could be particularly affected by social distancing protocols, because they focus on providing care in the home, community, or PACE center.

*Changes in nursing home utilization and spending.* Many nursing homes are overburdened managing their populations while COVID-19 protocols are in place. In addition, some states are requiring or encouraging nursing homes to accept COVID-19 patients discharged from hospitals or to move nursing home patients to make room for COVID-19 patients, in order to increase hospital capacity.<sup>8</sup> As a result, it may be more difficult for individuals who might otherwise be admitted to a nursing home to be admitted.

Several states are temporarily increasing Medicaid payment rates to nursing homes to help them deal with the multitude of challenges they are experiencing in managing COVID-19. To the extent that such changes are enacted, adjustments to MCO capitation rates may need to be considered.

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<sup>8</sup> For instance, New York state is requiring that nursing homes take patients discharged from hospitals (see *Wall Street Journal*, "[New York Mandates Nursing Homes Take Covid-19 Patients Discharged From Hospitals](#)," March 26, 2020) and Massachusetts is working to dedicate certain nursing facilities for COVID-19 patients (see [letter](#) from Massachusetts Secretary Marylou Sudders, March 27, 2020).

### Academy Offers Resource Page on Coronavirus Pandemic Information

The Academy has created a [webpage with resources for the ongoing coronavirus \(COVID-19\) pandemic](#). The page includes resources such as links to the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO), the Centers for Medicare & Medicaid Services (CMS) regulatory activity and other legislative and regulatory actions, pertinent articles, and more. The Academy will continue to add resources to this freely available webpage as more information becomes available.

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