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Medicaid Protections in Families First Act Critical to Protecting Health Coverage

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The Families First Coronavirus Response Act temporarily increased the federal government's share of Medicaid costs (known as the federal medical assistance percentage, or FMAP) to help states deal with the impact of the COVID-19 public health emergency. Similar to temporary FMAP increases during economic downturns in 2009 and 2003, states accepting the additional federal funds are subject to "maintenance of effort" (MOE) protections that keep them from making their Medicaid eligibility standards and eligibility determination procedures more restrictive. This prevents states from cutting coverage while the FMAP increase is in place and ensures that they use the extra federal dollars to keep their Medicaid programs intact.

Because the public health crisis makes it even more important that people have health coverage, the Families First Act MOE adds an additional protection. In addition to prohibiting new eligibility restrictions, the Families First MOE prevents states from terminating people's coverage during the public health emergency. This "continuous coverage" provision not only guarantees that people will be able to access needed care during the pandemic, but also allows state agencies operating with reduced capacity to prioritize enrolling people who lose their jobs and job-based coverage over requiring people to prove they remain eligible.

Unfortunately, there's an ongoing effort to convince Congress that the next round of legislation dealing with the pandemic and recession should weaken the MOE protections. At the end of the debate on the CARES Act, Senate Republicans unsuccessfully sought to insert language that would have let states terminate people's coverage while receiving the added federal funds. And now the Foundation for Government Accountability (FGA) is arguing that the MOE's continuous coverage provision requires states to keep large numbers of ineligible people enrolled, will cost states more than the FMAP increase will save them, and will disqualify some states from the FMAP increase altogether. These arguments are specious. Weakening the MOE during the current crisis could cause hundreds of thousands of people — or more — to lose coverage and become uninsured in the months ahead.

Continuous Coverage Provision Important to Keeping People Insured

Continuous coverage — letting people keep their Medicaid coverage for a set time period, irrespective of changes in their circumstances — isn't a new concept, and there's ample precedent

for it in Medicaid. States have had the option to provide 12 months of continuous coverage to children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) since CHIP's enactment in 1997. This "continuous eligibility" option gives children a full year of coverage regardless of changes in their family's income. States can also elect to provide continuous eligibility to adults through a Medicaid waiver. To date, 23 states have adopted continuous eligibility for children in Medicaid, and 25 have adopted it for CHIP.[1] So far, Montana and New York are the only states with continuous eligibility for adults.

Providing continuous coverage appeals to many states largely because it helps eligible people stay covered. Without continuous coverage, states frequently require eligible people to submit paperwork demonstrating their continued eligibility. Research and decades of experience in enrolling low-income children and adults in coverage show that increasing paperwork exacerbates caseload "churn" by leading eligible people to lose coverage due to difficulties completing processes and providing documentation.[2] Over the past year, in fact, declines in Medicaid coverage for children and adults partly reflect some states' increased emphasis on frequent wage checks, more stringent documentation requirements, and terminations based on returned mail.[3]

In addition, low-income people often experience frequent fluctuations in income that can lead them to become temporarily ineligible for Medicaid but then regain eligibility within a few months.[4] Continuous coverage reduces the churn from these frequent changes in eligibility.

People who churn in and out of coverage are more likely to change doctors, more likely to use the emergency room, and less likely to take medication as prescribed.[5] They also have higher health care costs, some studies suggest.[6] Churn also creates problems for health care providers and Medicaid managed care organizations, limiting their ability to provide effective care and increasing their administrative costs. Churn is costly for states as well, creating extra work to process new applications for people who lose coverage but remain eligible and reapply.

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[1] Tricia Brooks *et al.,* "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," Kaiser Family Foundation, March 26, 2020, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/.

[2] Samantha Artiga and Olivia Pham, "Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage," Kaiser Family Foundation, September 24, 2019, https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/.

[3] Robin Rudowitz *et al.*, "Medicaid Enrollment & Spending Growth: FY 2019 & 2020," Kaiser Family Foundation, October 2019, http://files.kff.org/attachment/Issue-Brief-Medicaid-Enrollment-and-Spending-Growth-FY-2019-2020.

[4] Benjamin D. Sommers and Sara Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," *Health Affairs,* February 2011, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.1000.

[5] Benjamin D. Sommers *et al.*, "Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many," *Health Affairs*, October 2016, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0455.

[6] Anthem Public Policy Institute, "Continuity of Medicaid Coverage Improves Outcomes for Beneficiaries and States," June 2018, https://www.communityplans.net/wp-content/uploads/2019/04/13_Report_Continuity-of-Medicaid-Coverage-Improves-Outcomes-for-Beneficiaries-and-States.pdf.

Continuous Coverage Especially Important During Current Crises

The current public health emergency and economic crisis provide a particularly strong argument for providing continuous coverage and avoiding churn.

First, maximizing the number of people with comprehensive coverage during a pandemic is important for public health. People who are uninsured may delay testing and treatment for COVID-19 because they worry that they won't be able to afford needed care. Providing people with continuous coverage through the public health emergency guarantees they can get care and treatment for all their health care needs. It also frees them from paperwork they would otherwise need to submit to show they remain eligible.

Second, during an economic crisis, most people with Medicaid coverage likely remain eligible, but eligible people are at particular risk of losing coverage due to wage checks against outdated data. With experts now predicting the deepest recession since the Great Depression, few people will likely experience income increases that would lead them to lose Medicaid eligibility. But for people who lose their jobs or see sharp reductions in income, the periodic data matches that states conduct against lagging earnings records often will significantly overstate current income levels. If states continue to terminate coverage based on these checks or require people to submit extra paperwork to prove their income and keep their coverage, large numbers of people will likely lose coverage just when they need it most.

Third, the MOE's continuous coverage provision allows states to prioritize enrolling new applicants who become eligible when they lose their jobs or experience other changes in circumstances.[7] That's important because applications will likely surge in coming months as more people lose jobs and job-based coverage, while social distancing measures have forced states to close eligibility offices and many state caseworkers can't work full time due to caregiving responsibilities stemming from school closures or their own health concerns.

Increased Federal Funds Far Outweigh States' Increased Costs From MOE

The Congressional Budget Office (CBO) confirmed that the MOE adds little to the federal cost of the FMAP increase and will neither outweigh the increased federal funds states will receive nor exacerbate state budget crises, as the FGA claims.[8] According to the CBO estimate, which assumes the public health emergency will last through March 2021, the FMAP bump will increase federal spending by about $50 billion. Most of this $50 billion is due to the 6.2 percentage point increase in state FMAPs, with "only a small additional amount" of the added federal spending due to the MOE's continuous coverage requirement, according to CBO.[9] This indicates that CBO assumes the requirement will have only a small impact on Medicaid enrollment, which means it would have only

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[7] Jennifer Wagner, "Medicaid Agencies Should Prioritize New Applications, Continuity of Coverage During COVID-19 Emergency," Center on Budget and Policy Priorities, March 19, 2020, https://www.cbpp.org/blog/medicaid-agencies-should-prioritize-new-applications-continuity-of-coverage-during-covid-19.

[8] Jonathan Ingram *et al.*, "Extra COVID-10 Medicaid funds come at a high cost to states," Foundation for Government Accountability, April 8, 2020, https://thefga.org/wp-content/uploads/2020/04/Extra-COVID-19-Medicaid-funds-come-at-a-high-cost-to-states-research-paper.pdf.

[9] Congressional Budget Office, Preliminary Estimate of the Effects of H.R. 6201, the Families First Coronavirus Response Act, April 2, 2020, https://www.cbo.gov/system/files/2020-04/HR6201.pdf.

a small impact on state costs — one that wouldn't come close to exceeding states' benefit from the increased FMAP.

Every State Can Qualify for Increased Federal Funds

March 24 guidance from the Centers for Medicare & Medicaid Services (CMS) says that all states can "take steps to be compliant and earn the enhanced funding."[10] The FGA and others claim that some states won't be able to qualify for the enhanced match because they have laws requiring periodic data matching or because their eligibility systems are set up to automatically conduct periodic income checks and redetermine eligibility. In reality, however, state laws do *not* keep states from complying with the MOE, and states can address any operational barriers to compliance by changing their systems or procedures.

All States Can Comply With MOE Regardless of State Laws

The Families First Act requires that people receiving Medicaid benefits as of the law's enactment and those who become eligible during the public health emergency "shall be treated as eligible" during the emergency, regardless of any change in circumstances other than moving out of state. CMS is leaving it up to states whether to suspend or continue income checks or redeterminations during the emergency. Its guidance is explicit, saying that the Families First Act does not prohibit states from conducting regular renewals or conducting periodic data matching, but that the MOE *does* prevent states from terminating coverage during the emergency.[11]

CMS guidance issued on April 2 confirmed CMS' position that states have discretion as long as they don't terminate people's coverage, saying that states can stop acting on changes in circumstances during the public health emergency or stop conducting periodic eligibility checks altogether.[12]

Forgoing periodic income checks is the best course for states, since their priority should be enrolling newly eligible people who lose their jobs. Moreover, data matches conducted over the coming months will be based on data covering the last quarter of 2019 or the first quarter of 2020; clearly, many people's incomes will have fallen since then, so many people will be eligible despite income checks suggesting they are not. States should not require people to obtain proof of job loss or other verification of income while they are practicing social distancing and dealing with the impact of the public health emergency on their families and loved ones.

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[10] Centers for Medicare & Medicaid Services, "Families First Coronavirus Response Act – Increased FMAP FAQs," March 24, 2020, https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf.

[11] The FGA points to nine states (Kentucky, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Tennessee, West Virginia, and Wyoming) that it claims have state laws requiring that they "quickly remove ineligible enrollees." As the footnotes to the FGA's report show, these laws actually require that the state conduct periodic data matches and redetermine eligibility when it receives information that an enrollee's circumstances may have changed. States can still conduct these periodic income checks and eligibility redeterminations and qualify for the increased federal match. But since federal law requires that people remain eligible throughout the public health emergency regardless of changes in circumstances, these state laws do not apply.

[12] Centers on Medicare & Medicaid Services, "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," updated April 2, 2020, https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf.

But a state that wants to conduct periodic data matches (or believes state law requires it to do so) can still comply with the MOE, provided it postpones acting on these data matches during the public health emergency. If the state does that, it will receive the FMAP increase.

Complying With MOE Is Operationally Feasible for States

States have several options to avoid involuntary coverage terminations during the public health emergency. If a state's eligibility system automatically conducts periodic data matches, the state could reprogram the system to stop the matches. If reprogramming is too difficult or would divert resources from other priorities, the state could allow the matches to continue but stop acting on the results. In most states, caseworkers decide whether a request for information should be sent to the enrollee, and they could forgo sending such requests. If the system automatically sends out requests for information, the state could change its system to stop generating or mailing the notices to avoid enrollee confusion and unnecessary paperwork for caseworkers.

Moreover, the CMS guidance makes clear that states will not lose eligibility for the enhanced match if they terminated cases in the weeks immediately following passage of Families First, before they could make systems changes. The guidance recognizes that some incorrect terminations may have occurred and requires a good-faith effort by the state to identify and reinstate these individuals.

As discussed above, the MOE can also alleviate operational strain on states. In particular, it allows states to adjust renewal dates during the public health emergency to eliminate the burden on staff from acting on renewals. Making these operational changes will help state and local agencies that administer Medicaid address the intense pressures from the public health emergency, shifting resources from checking whether people are still eligible to making sure newly eligible and uninsured people can enroll.