Report to Congress on Medicaid and CHIP

MARCH 2021

MACPAC | Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, Section 1900 of the Social Security Act, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

Report to Congress on Medicaid and CHIP

MARCH 2021

MACPAC
Medicaid and CHIP Payment and Access Commission

March 15, 2021

The Honorable Kamala Harris
President of the Senate
The Capitol
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
The Capitol
Washington, DC 20515

Dear Madam Vice President and Madam Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the March 2021 *Report to Congress on Medicaid and CHIP*. This report contains five chapters on issues of interest to Congress: (1) improving Medicaid's responsiveness during economic downturns; (2) addressing concerns about high rates of maternal morbidity and mortality; (3) reexamining Medicaid's estate recovery policies; (4) integrating care for people who are dually eligible for Medicaid and Medicare; and (5) improving hospital payment policy for the nation's safety-net hospitals.

During the summer of 2020, MACPAC announced its intention to focus on the role of Medicaid in addressing systemic racism and racial and ethnic disparities in health. Many of the recommendations in this report are designed to address these disparities. In the months ahead, we plan to continue examining other aspects of Medicaid policy through the health equity lens.

Chapter 1 addresses the challenge that states face during recessions when Medicaid enrollment grows and state revenues decline. Although Congress has often stepped in to provide fiscal relief in the form of increased federal matching funds, the Commission recommends that Congress enact an automatic countercyclical Medicaid financing adjustment. This would ensure that additional federal funds flow quickly to Medicaid during economic downturns and would provide states with greater budget predictability.

Chapter 2 builds on the Commission's descriptive work on Medicaid's essential role in maternal health, focusing on the importance of postpartum care in the year after delivery and the unacceptably high rates of maternal mortality and morbidity among people of color generally and among those covered by Medicaid specifically. Medicaid coverage for individuals enrolled in Medicaid coverage by virtue of their pregnancy ends after 60 days postpartum, causing disruptions to care and access to coverage. Drawing on a deep body of evidence, the Commission recommends that Congress require states to expand postpartum coverage under Medicaid from 60 days to a full year with 100 percent federal match. The Commission also recommends that the postpartum coverage period for individuals who were

eligible and enrolled in the State Children's Health Insurance Program (CHIP) while pregnant be extended to a full year of coverage. A third recommendation would require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

Chapter 3 makes recommendations to ease the burden of Medicaid estate recovery, which often falls on those with modest means, and may disproportionally affect people of color and perpetuate intergenerational poverty. Federal law requires state Medicaid programs to seek recovery from the estates of certain deceased beneficiaries for payments for long-term services and supports (LTSS) and other services. The Commission recommends returning to prior law, making estate recovery optional, rather than mandatory. It also recommends allowing states that cover LTSS under managed care to pursue recovery based on the cost of services where it is less than the capitation payment paid to a managed care plan; and directs the Secretary of the U.S. Department of Health and Human Services (HHS) to establish minimum hardship waiver standards, including a minimum estate value threshold for estate recovery.

Chapter 4 continues the Commission's work on integrating care for individuals who are dually eligible for Medicaid and Medicare. In this chapter, we examine key design issues that would have to be addressed to establish a unified program for the dually eligible population. Medicare and Medicaid are administered and financed differently, and were designed to accomplish different goals, making fully integrating these programs a challenge. A unified program could simplify coverage for beneficiaries, providing care and services under a single umbrella. The chapter draws examples from two existing proposals to create a fully integrated system for dually eligible beneficiaries, illustrating design issues and policy trade-offs.

The final chapter of the March report fulfills MACPAC's annual, statutorily mandated obligation to report on Medicaid disproportionate share hospital (DSH) allotments to states. As in prior years, the Commission continues to find little meaningful relationship between state DSH allotments and the number of uninsured individuals; the amounts and sources of hospitals' uncompensated care costs; and the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations. We also summarize the limited information available about the early effects of the COVID-19 pandemic on safety-net hospitals.

MACPAC is committed to providing in-depth, non-partisan analyses of Medicaid and CHIP policy, and we hope this report will prove useful to Congress as it considers future policy development affecting these programs. This document fulfills our statutory mandate to report each year by March 15.

Sincerely,

Melanie Bella, MBA
Chair

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Table of Contents

List of Boxes

List of Figures

List of Tables

Executive Summary: March 2021 Report to Congress on Medicaid and CHIP

MACPAC's March 2021 *Report to Congress on Medicaid and CHIP* contains five chapters of interest to Congress: (1) improving Medicaid's responsiveness during economic downturns; (2) addressing concerns about high rates of maternal morbidity and mortality; (3) reexamining Medicaid's estate recovery policies; (4) integrating care for people who are dually eligible for Medicaid and Medicare; and (5) improving hospital payment policy for the nation's safety-net hospitals.

During the summer of 2020, MACPAC announced its intention to focus on the role of Medicaid in addressing systemic racism and racial and ethnic disparities in health. Many of the recommendations in this report are designed to address these disparities. In the months ahead, we plan to continue examining other aspects of Medicaid policy through the lens of health equity.

CHAPTER 1: An Automatic Countercyclical Financing Adjustment for Medicaid

Chapter 1 addresses the challenge that states face during recessions when Medicaid enrollment grows and state revenues decline. Medicaid is a countercyclical program: enrollment and spending increase when a downturn in the economic cycle leads to growth in the low-income population and the number of people losing employer-sponsored insurance.

State and federal Medicaid spending supports state economies, and increases in Medicaid spending can counteract other spending reductions during a recession. If state revenue is declining, states can find it hard to finance their share of growing Medicaid expenditures. However, the Medicaid financing formula cannot adjust quickly to reflect lower state revenues. In addition, there is no mechanism for additional federal contributions to stimulate growth during a national recession.

During prior recessions and during the current COVID-19 public health emergency period, Congress has temporarily increased the Medicaid federal medical assistance percentage (FMAP) to provide important financial relief to states. However, the timing and targeting of these actions did not allow states to plan and did not necessarily align well with their needs.

A statutory mechanism to automatically increase the federal share of Medicaid expenditures by adjusting the FMAP under certain conditions would allow federal financial stimulus to be directed to states more quickly during economic downturns and provide states with greater budget predictability.

In this chapter, we make the following recommendation:

- Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include: an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment; an upper bound of 100 percent on countercyclical adjusted matching rates; and an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

CHAPTER 2: Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

Chapter 2 builds on the Commission's prior descriptive work on Medicaid's essential role in maternal health, focusing on the importance of postpartum care in the year after delivery and the unacceptably high rates of maternal mortality and morbidity among people of color generally and among those covered by Medicaid specifically. There is a rich evidence base pointing to the critical role that postpartum care plays in monitoring health after pregnancy as well as in addressing other health care needs such as postpartum depression, substance use disorder, family planning, and chronic conditions.

Under current law, individuals enrolled in Medicaid by virtue of their pregnancy lose their coverage after 60 days, and many of those covered under this eligibility pathway are not otherwise eligible for Medicaid. Our review of the research literature found that the short postpartum eligibility period disrupts coverage and access to care. Among women whose births were paid for by Medicaid, nearly one in four report being uninsured postpartum. Changes in coverage can affect continuity in benefits, cost sharing, and provider relationships for both those who become uninsured and those who shift to another source of coverage.

Inadequate postpartum care may also contribute to persistent racial and ethnic disparities in maternal and infant health outcomes. Black, non-Hispanic women and Indigenous women have higher risks of maternal morbidity and mortality. Women of color are also at greater risk of giving birth to a preterm or low birthweight infant and face difficulties in accessing care. Given the body of evidence on racial and ethnic disparities in maternal and infant health outcomes, an extension of the postpartum coverage period would also serve as a way to improve health equity.

Although a wide array of stakeholders support extending the postpartum period, federal and state efforts to date have been limited in scope, often focusing on individuals with substance use disorder. In the Commission's view, an extension of the postpartum coverage period under Medicaid and the State Children's Health Insurance Program (CHIP) would be a meaningful step to improve poor maternal and infant outcomes by helping to ensure that individuals receive ongoing medical care. Approximately 123,000 uninsured new mothers would become newly eligible for Medicaid or CHIP if states were required to provide such coverage.

States, however, should not be expected to bear the cost of such a mandate, especially in light of the current budget challenges they are facing due to COVID-19 and the accompanying economic downturn. To offset the costs of a mandatory extension, the Commission recommended 100 percent federal funding.

While pregnancy-related services may be broad in scope, the definitions differ across the five states providing pregnancy-only services, and the provision of certain benefits may depend on the provider or plan. To ensure the best possible outcomes, all pregnant and postpartum individuals should have comprehensive coverage and states should not have the option to limit coverage to pregnancy-only services.

In this chapter, we make the following recommendations:

- Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100-percent federal matching rate.
- Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.
- Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

CHAPTER 3: Medicaid Estate Recovery: Improving Policy and Promoting Equity

People who use Medicaid-covered long-term services and supports (LTSS) are a diverse group including people age 65 and older and people with disabilities. To be eligible to receive Medicaid-covered LTSS, they must meet both income and asset limits.

Chapter 3 examines the burden of Medicaid estate recovery, which often falls on those with modest means, and may disproportionally affect people of color and perpetuate intergenerational poverty. Federal law requires that state Medicaid programs seek recovery from the estates of certain deceased beneficiaries for payments for LTSS and other services. Since 1993, estate recovery has been mandatory for individuals expected to be permanently institutionalized; those age 55 or older when they received Medicaid LTSS and related services; and those with long-term care insurance policies, under certain circumstances.

Due to restrictions on Medicaid eligibility for LTSS, older adults covered by Medicaid have few assets. In 2012–2016, three-quarters of Medicaid decedents had net wealth of less than $48,500. Fear of estate recovery may also deter some individuals from seeking Medicaid LTSS. However, the Commission found that awareness and understanding of these policies by potential Medicaid beneficiaries is low.

Although estate recovery has been considered both a way to replenish Medicaid funds and a program integrity tool, current policy raises several concerns. Critics have noted that many people with sizeable wealth are able to legally shield assets from Medicaid estate recovery.

The Commission also identified other areas of concern, including variation in state policies that treat heirs inconsistently. In addition, estate recovery recoups relatively little—only about 0.55 percent of total fee-for-service LTSS spending. Policies for recovering capitation payments for those covered under managed LTSS programs can also be inequitable.

In this chapter, we make the following recommendations:

- Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law.
- Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary was less than the capitation payment made to a managed care plan.
- Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for: (1) any asset that is the sole income-producing asset of survivors; (2) homes of modest value; or (3) any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards.

Given the aging population and the high cost of LTSS, Medicaid will continue to play a key role as the nation's largest payer for LTSS. MACPAC plans to monitor LTSS trends and proposals for LTSS financing reform and assess whether Medicaid eligibility rules should be updated to promote improved equity and access.

CHAPTER 4: Design Considerations in Creating a New Unified Program for Dually Eligible Beneficiaries

Chapter 4 continues the Commission's work on integrating care for individuals who are dually eligible for Medicaid and Medicare. Individuals who are dually eligible for Medicaid and Medicare often experience fragmented care and poor health outcomes due to lack of coordination across the two programs.

A unified program could simplify coverage for beneficiaries, providing care and services under a single umbrella. It also has the potential to reduce federal and state spending on these individuals. However, as of 2019, only about 10 percent of dually eligible beneficiaries received care through integrated models, and integrated options are not available in many areas of the country.

Medicare and Medicaid are administered and financed differently, and were designed to accomplish different goals, making fully integrating these programs a challenge. Given the inherent limitations of integrating care across two separate programs, some stakeholders have begun to explore how to create a unified program that would simplify coverage for beneficiaries, align financial incentives, and improve the ability to meet beneficiary needs for acute care, LTSS, behavioral health, and social services. Establishing such a program would require substantial statutory and regulatory changes at the federal and state levels, affecting policies including benefits, eligibility, and administration.

As a first step, policymakers need to consider the overarching goals of a unified program. Those might include ensuring beneficiaries have access to the services they need, are able to exercise choices about their care, and have adequate consumer protections; and advancing health equity. Decisions would need to be made about specific parameters for eligibility, beneficiary protections and enrollment, benefits, delivery system, care coordination, administration, and financing.This chapter examines many of the policy and design issues and policy trade-offs that would need to be settled in developing a unified program. In doing so, MACPAC draws on the work of two stakeholder groups—the Bipartisan Policy Center and the Dual Eligible Coalition convened by Leavitt Partners—that are promoting a new approach to serving this population.

The wide availability of managed care options envisioned by these proposals is not yet a reality, and states and the federal government would need substantial time to stand up a new structure of coverage for the dually eligible population. In the meantime, the Commission is continuing its work on more immediate ways to improve integration of care for dually eligible beneficiaries and will provide additional insights in its June 2021 report to Congress.

CHAPTER 5: Annual Analysis of Disproportionate Share Hospital Allotments to States

Chapter 5 of the March report fulfills MACPAC's annual, statutorily mandated obligation to report on Medicaid disproportionate share hospital (DSH) allotments to states for payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients.

As in prior years, the Commission continues to find little meaningful relationship between state DSH allotments and the number of uninsured individuals; the amounts and sources of hospitals' uncompensated care costs; and the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.

The number of uninsured individuals and unpaid costs of care for uninsured individuals are increasing nationally. In 2019, 29.6 million people, or 9.2 percent of the U.S. population, were uninsured, an increase of 1.1 million people from 2018, the second consecutive annual increase.

Hospitals reported $40.7 billion in charity care and bad debt on Medicare cost reports in fiscal year (FY) 2018, an increase of $2.8 billion from FY 2017. Medicaid shortfall, the difference between the payments for care a hospital receives and its costs of providing services to Medicaid-enrolled patients, decreased $3.2 billion (14 percent) between 2017 and 2018 according to the American Hospital Association annual survey.

In 2018, total Medicaid shortfall for all U.S. hospitals was $19.7 billion. The Consolidated Appropriations Act, 2021 (P.L. 116-260) addressed a prior MACPAC recommendation related to DSH. Specifically, starting in FY 2022, the DSH definition of Medicaid shortfall for most hospitals will no longer include costs and payments for patients for whom Medicaid is not the primary payer.

The chapter includes a discussion of planned reductions in DSH allotments. In December 2020, Congress once again delayed DSH allotment reductions, pushing them off until FY 2024. Allotments are currently scheduled to be reduced by $8 billion each year for FYs 2024–2027, which is approximately 58 percent of unreduced allotment amounts.

This year, our analysis also looks at the substantial effect of the COVID-19 pandemic on hospital finances due to the increased costs of treating patients with COVID-19 and disruptions in care. Safety-net providers are particularly vulnerable to financial pressures because they typically have low operating margins. However, data are not yet available to examine the full effects of COVID-19 on hospital finances.

Chapter 1:

An Automatic Countercyclical Financing Adjustment for Medicaid

An Automatic Countercyclical Financing Adjustment for Medicaid

Recommendation

1.1 Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted matching rates; and
- an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

Key Points

- Medicaid is a countercyclical program: enrollment and spending increase when a downturn in the economic cycle leads to growth in the low-income population and the number of people losing employer-sponsored insurance.
- State and federal Medicaid spending supports state economies, and increases in Medicaid spending can counteract other spending reductions during a recession. If state revenue is declining, states can find it hard to finance their share of growing Medicaid expenditures. However, the Medicaid financing formula cannot adjust quickly to reflect lower state revenues, nor does it provide any mechanism for additional federal contributions to stimulate growth during a national recession.
- During prior recessions and the current COVID-19 public health emergency period, Congress temporarily increased the Medicaid federal medical assistance percentage (FMAP) to provide important financial relief to states. However, the timing and targeting of these actions did not allow states to plan and did not necessarily align well with their needs.
- A statutory mechanism to automatically increase the federal share of Medicaid expenditures by adjusting the FMAP formula under certain conditions would allow federal financial stimulus to be directed to states more quickly during economic downturns and would provide states with greater budget predictability.
- The Commission supports an automatic countercyclical adjustment that uses objective, timely indicators of an economic downturn; has a trigger that is sensitive but does not generate frequent adjustments; and targets additional federal financing based on state-level factors. The U.S. Government Accountability Office has developed a countercyclical FMAP model that meets these objectives.
- A temporary increase in federal financing should include appropriate limits and conditions, including a maintenance of effort provision, an upper bound or cap on increased FMAPs, and limits on the application of FMAP to special matching rates.

CHAPTER 1: An Automatic Countercyclical Financing Adjustment for Medicaid

Medicaid is a countercyclical program: enrollment and spending increase when a downturn in the economic cycle leads to rising unemployment and growth in both the low-income population and the number of people losing employer-sponsored insurance. The ability to increase spending when the economy goes into recession is seen as an advantage of the program's financing approach and helps Medicaid meet its unique and varied demands as a source of health coverage for low-income populations. However, although Medicaid spending can increase in response to changes in economic activity, the federal-state financing formula, which determines how much states must contribute toward Medicaid expenditures, is adjusted only once per year using data across several years. This formula, which normally helps provide budget stability by minimizing year-to-year changes, also constrains the amount the federal share can increase in response to declining state economic conditions.

The Medicaid financing formula also does not provide a mechanism for increasing federal contributions to stimulate growth during a national recession. State Medicaid spending and the additional federal funds provided to match state expenditures go directly into state economies through payments to providers, which then indirectly support many other businesses and contribute to employment, household spending, and state and local tax collections. Reviews of studies examining the relationships between Medicaid and the economy have found that changes in Medicaid spending have corresponding effects throughout the state economy (KCMU 2013). However, although Medicaid provides the largest source of federal funding for states, the federal share cannot be automatically increased to offset reduced state and private spending on health care during a recession.

During the past two major recessions, Congress temporarily increased the Medicaid federal medical assistance percentage (FMAP) as part of a package of financial assistance to states in fiscal stimulus legislation. More recently, it also increased FMAPs for the duration of the emergency period associated with the COVID-19 pandemic. Our review has found that although such actions have provided important financial relief to states, they have not always aligned with the duration or level of state need. In addition, they have not accounted for differences among states in increased demand for Medicaid and states' ability to generate revenue to finance the state share of increased Medicaid expenditures.

Various organizations have suggested that Congress create a statutory mechanism to automatically increase the federal share of Medicaid expenditures by adjusting the FMAP formula if certain conditions are met. This would allow federal financial stimulus to be directed to states more quickly during economic downturns and provide states with greater budget predictability. Further, an automatic countercyclical adjustment to the FMAP formula could be designed to account for both increased enrollment in Medicaid and decreased state revenue, each of which may vary by state. For example, following each of the last two major recessions, the U.S. Government Accountability Office (GAO) suggested options for Congress to consider, including developing a countercyclical FMAP model that uses standard economic indicators to trigger a temporarily enhanced FMAP with state-specific percentage point changes (GAO 2011a, 2006).

In the Commission's judgment, a statutory change is needed to amend the federal financing formula to automatically increase the federal share of Medicaid expenditures if certain economic conditions are met.

Recommendation 1.1

Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted matching rates; and
- an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

This chapter begins by explaining Medicaid's role as a countercyclical program and how it functions as both an automatic stabilizer and to provide fiscal stimulus during economic downturns. The chapter then identifies several objectives of a permanent countercyclical financing mechanism and several related policy issues. We describe the features of the model proposed by GAO and examine the extent to which the GAO approach satisfies these objectives. The chapter concludes with the Commission's recommendation and rationale.

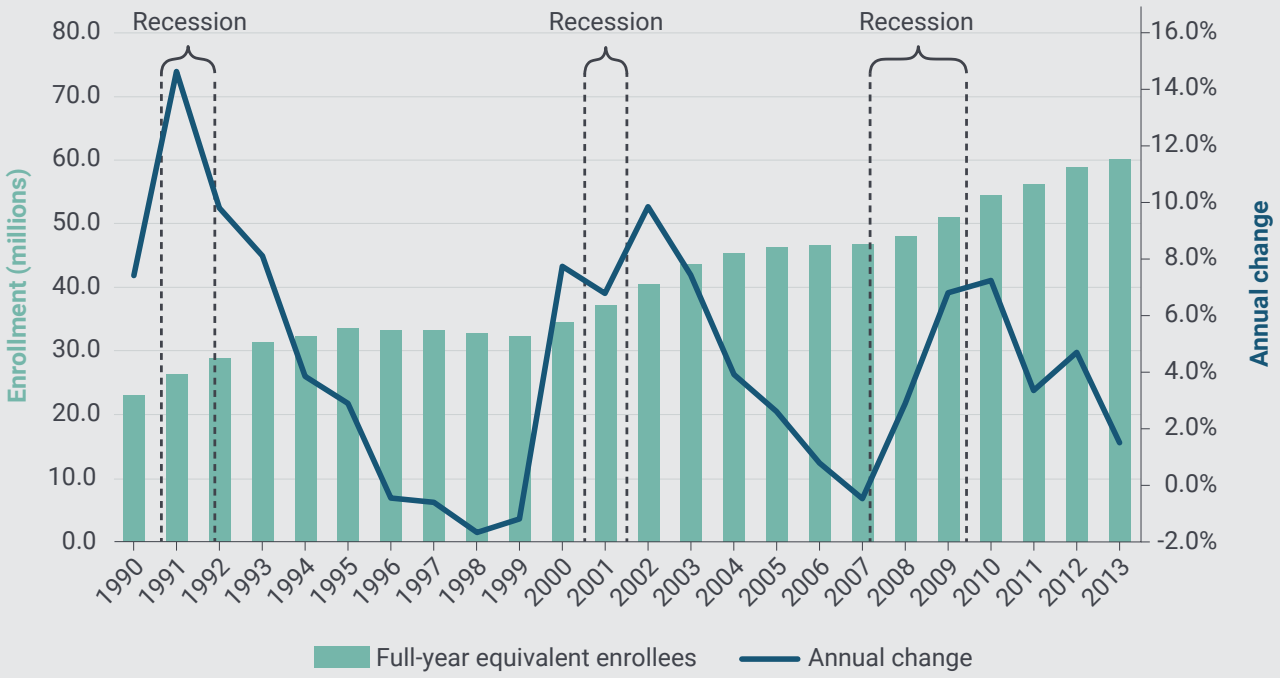
Medicaid as a Countercyclical Program

Medicaid is an open-ended entitlement program that functions as an automatic stabilizer with countercyclical effects: enrollment demand and, consequently, spending increase when a downturn in the economic cycle leads to rising unemployment, which in turn contributes to both increases in the low-income population and the number of people losing employer-sponsored insurance. Similar to other countercyclical programs such as unemployment insurance, increased demand for Medicaid coverage may vary by state. States also differ in their ability to generate revenue to finance the state share of increased Medicaid expenditures resulting from enrollment growth and their willingness to implement measures to reduce expenditures during a downturn.

Program growth

Medicaid enrollment tends to increase every year as the size of the U.S. population grows and as eligibility for the program is expanded through federal and state action. Between 1990 and 2013 (before the expansion of Medicaid to include adults under age 65 with incomes up to 133 percent of the federal poverty level in 2014), the average growth was about 4 percent per year. However, the rate of enrollment growth changes from year to year and is much greater during economic downturns (Figure 1-1). For example, prior to each of the last recessions, the rate of annual Medicaid enrollment growth was low or even declining but at the beginning of each of these downturns, enrollment quickly grew to an annual rate of about 8 percent or more.

FIGURE 1-1. Medicaid Enrollment and Enrollment Growth by Fiscal Year, 1990–2013



Note: Enrollment shows full-year equivalent enrollees, which also may be referred to as average monthly enrollment.

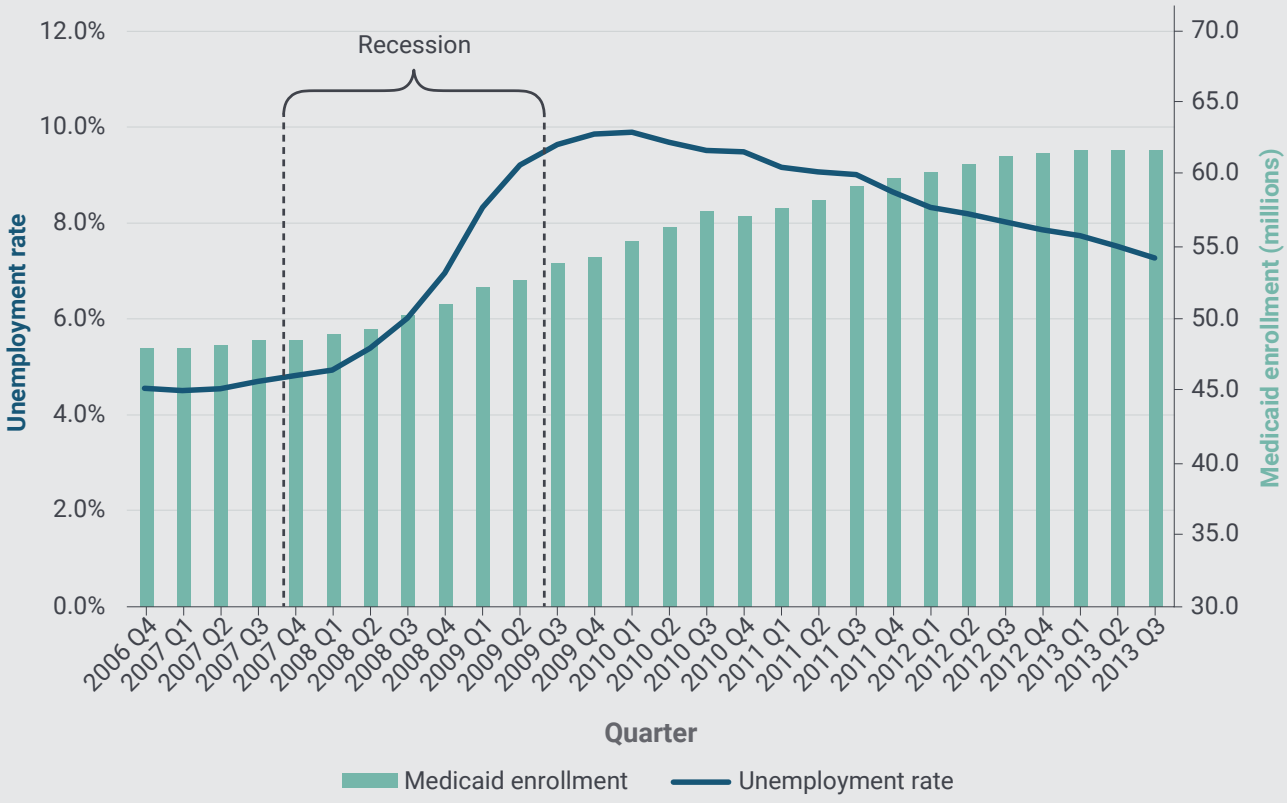
Source: MACPAC 2019.

During an economic downturn, people are likely to become eligible for Medicaid or seek coverage through the program for several reasons:

- individuals lose jobs or have reduced hours, so they or their family members newly meet the income criteria for Medicaid eligibility (whether or not they have access to other sources of health insurance);
- individuals lose employment and access to employer-sponsored health insurance and may be more likely to apply for public sources of coverage for themselves or family members; and
- individuals may be more likely to apply for public benefits (e.g., Supplemental Security Income, cash assistance, nutrition assistance) that directly link to Medicaid eligibility or allow cross-enrollment.

Finally, employment growth tends to lag behind general economic growth following a recession, so individuals who obtain Medicaid during a downturn may not gain employment or private coverage until long after the end of the official recession (Mattoon et al. 2010). For all of these reasons, states may continue to experience higher than average enrollment for several years after the end of an official recessionary period (Figure 1-2).

FIGURE 1-2. Unemployment Rate and Medicaid Enrollment by Quarter, Official Recessionary Period, 2006–2013



Notes: Q4 is fourth quarter. Q1 is first quarter. Q2 is second quarter. Q3 is third quarter. Enrollment shows the number of Medicaid beneficiaries ever enrolled in the quarter. The National Bureau of Economic Research declared a recession from December 2007 through June 2009.

Source: MACPAC, 2021, analysis of BLS 2020 and Medicaid Statistical Information System (MSIS) enrollment data.

State revenues and spending options

During an economic downturn, state revenue often declines due to reduced sales tax and income tax collections. Following the recession in 2008, each 1 percentage point rise in unemployment led to a 3 percent to 4 percent decrease in state general fund revenues (Dorn et al. 2008). Other recent estimates suggest that each 1 percentage point increase in unemployment leads to a $41 billion drop in state tax revenues plus an increase in Medicaid costs, for a total effect on state budget needs of $45 billion (Fiedler and Powell 2020, Fiedler et al. 2019).

Such revenue declines require states to make difficult choices about how to reduce Medicaid spending if they cannot generate enough revenue to finance the state share of program expenditures. They generally have three levers to reduce Medicaid spending: cut provider rates, cut benefits, or cut eligibility. During the 2001 recession, many states introduced premiums and enrollment caps for some children, scaled back outreach and administrative simplifications, and otherwise sought to reduce enrollment to limit state spending despite the additional FMAP available through the Jobs and Growth Tax Relief Reconciliation Act (JGTRRA,

P.L. 108-27) (CCF 2017).[1] In response, Congress included a maintenance of effort (MOE) provision in the 2009 stimulus bill, requiring states to maintain existing Medicaid eligibility standards to receive enhanced federal funding. Although almost every state cut or froze provider rates during the 2007–2009 economic downturn, only one implemented an eligibility cut (Smith et al. 2009).[2]

Medicaid as an Automatic Stabilizer and Fiscal Stimulus

The ability of the open-ended federal Medicaid financing approach to automatically match increases in state spending in response to growing demand helps Medicaid meet its unique and varied roles as a source of health coverage for low-income populations. However, although the program tends to operate as an economic stabilizer, the current formula for sharing Medicaid expenditures between states and the federal government does not allow rapid and targeted increases in federal contributions when state economic conditions decline, nor does it provide additional federal contributions to stimulate growth during a national recession. In addition, there is no statutory mechanism to automatically adjust the FMAP formula during an economic downturn to account for increased enrollment in Medicaid or decreased state revenue. Therefore, Congress stepped in during prior recessions to provide temporary increases in the Medicaid FMAP to states as part of federal fiscal stimulus.

Medicaid as an automatic stabilizer

Automatic stabilizers are fiscal policies that offset cyclical changes in economic activity—as measured by gross domestic product (GDP), unemployment, or other indicators—through normal operations, without any additional governmental action. Automatic stabilizers can include graduated tax systems that lower tax rates as income brackets decline so individuals can keep a higher share of their income when their pay decreases as well as income-support and benefit programs that enroll anyone who is eligible and applies. Medicaid functions as an automatic stabilizer because program spending can change immediately and directly in relation to what each state spends. That is, if a state spends more, there is a proportional increase in federal spending to match state expenditures, and federal expenditures are not capped. If one state or part of the country experiences economic changes that require an increase in Medicaid expenditures, federal spending in those states can increase without additional action on the part of Congress.

This open-ended Medicaid financing approach allows states to draw down additional federal funds, but only to the extent that states also increase their spending. States' ability to obtain increased federal funds as needed to account for additional expenditures does not mean that they will be able to raise enough revenue to cover the state contribution (Lee and Sheiner 2019). In an economic downturn, declining revenues can affect the ability of states to finance the state share. Almost every state is required to balance its budget each year, and even in a downturn, states generally limit themselves to financing deficits only with accumulated reserves (Lee and Sheiner 2019). Thus, even though the federal government is not required to balance its budget each year and can appropriate expenditures in excess of anticipated revenues, the ability of Medicaid to function as an automatic stabilizer during a downturn is limited by the extent to which states can appropriate their share of program expenditures.

In addition, although Medicaid is largely financed by the federal government—in fiscal year (FY) 2019, about 64 percent of Medicaid expenditures were federal—the formula for determining each state's share also limits the effectiveness of Medicaid as an automatic stabilizer (MACPAC 2020a). The federal share for spending on services is determined by each state's FMAP, which is calculated annually using a formula that provides higher matching rates to states with lower per capita incomes relative to the national average (and

vice versa). The formula is intended to account for states' differing abilities to fund Medicaid from their own revenues, and the annual recalculation uses the most recent rolling three-year average per capita income data to help moderate fluctuations in a state's FMAP over time. This is important to states, given that a single percentage point change can mean a difference of tens of millions of dollars in federal funding. However, it also means that the per capita income data used to calculate FMAPs for a given fiscal year are several years old by the time the fiscal year begins and that substantial redistributions of income across states are not fully reflected in the FMAP for several years.[3] Further, because the formula considers each state relative to the national average, a state can experience a recession and still see its FMAP decline if that state's per capita income drop is smaller than other states, no matter how painful it is locally.

Medicaid as a support for fiscal stimulus

A fiscal stimulus is a policy change that encourages economic growth during a recession, such as lowering interest rates or increasing government spending. Additional federal contributions to Medicaid can have a stimulative effect on the economy and encourage economic growth to the extent that these expenditures exceed any decreases in state and private spending on health care. Even if federal contributions only replace prior spending, by mitigating the need for program cuts and covering the cost of newly enrolled individuals, they can blunt the effects of a recession or shorten its duration.

As noted earlier, during the past two major recessions, Congress included temporary increases in the Medicaid FMAP as part of a broader package of financial assistance to states. Congress has also enacted legislation to provide federal stimulus to individual states experiencing temporary economic effects related to natural disasters by boosting the state's FMAP.[4] Most recently, Congress provided additional assistance to states in anticipation of both rising health costs and dropping state revenues associated with COVID-19 by increasing state FMAPs for the duration of the public health emergency (PHE).

2001 recession. The United States experienced a recession from March to November 2001, but many other indicators showed a weak economy over a longer period, between 2000 and 2003 (NBER 2003). In May 2003, Congress enacted the JGTRRA, which increased each state's FMAP by 2.95 percent (JGTRRA § 401(a)). States began receiving enhanced funding in June 2003, when the recession was over and the economy was expanding, although unemployment and Medicaid enrollment were still increasing (GAO 2011a). The Congressional Budget Office (CBO) estimated that the enhanced FMAP would provide states about $10 billion in additional federal funding over 2003 and 2004 (CBO 2003).

2007–2009 recession. The country experienced another recession from December 2007 through June 2009 (NBER 2020). Seeing a number of indicators during 2008 that signaled an economic downturn (e.g., declining GDP, falling stock market, rising unemployment), in February 2009, Congress enacted the American Recovery and Reinvestment Act (ARRA, P.L. 111-5). ARRA provided $787 billion in federal spending to offset reductions in private spending and bolster the economy. A substantial portion of this spending was in the form of an enhanced Medicaid FMAP for nine quarters, retroactive to October 1, 2008. This policy was structured to provide the following:

- a flat 6.2 percentage point increase in the FMAP for all states;
- an increased match to hold states harmless if they would otherwise experience a drop in their FMAP under the normal FMAP formula (which compares states to the national average);[5] and
- an additional change in FMAP for states with particularly high unemployment rates (i.e., decreasing the state share by 5.5 percent, 8.5 percent, or 11.5 percent based upon a state's peak three-month unemployment

rate compared to the lowest three-month unemployment rate of that state since the beginning of 2006).[6]

As in the prior recession, congressional action lagged behind declining economic conditions. By the time the ARRA changes went into effect, the recession had been underway for five quarters (GAO 2011b). The funding was available retroactively, so that states could claim enhanced match for expenditures incurred as of October 1, 2008. However, many states began making program cuts, including provider payment cuts, before ARRA was enacted and retroactive funding became available (Smith et al. 2009).

The average FMAP increase for states under ARRA varied by quarter and was highest during the first quarter of FY 2011, when it ranged from 9.1 to 15.6 percentage points and averaged 10.9 percentage points (unweighted). Congress amended ARRA to extend the recession adjustment period to June 30, 2011, but phased down the increase in the second and third quarters of FY 2011 to 3.2 percentage points and 1.2 percentage points, respectively (P.L. 111-226, § 201). CBO estimated that the enhanced Medicaid FMAP provided through ARRA (as amended) increased federal Medicaid expenditures by $84 billion between 2009 and 2011 (CBO 2015).

An important aspect of the ARRA Medicaid provisions was the MOE requirement. To receive additional FMAP, states had to ensure that their eligibility policies, including eligibility standards, methodologies, and procedures, were no more restrictive during this period than those in effect in the quarter prior to the funding period (i.e., on July 1, 2008). If the state implemented more restrictive eligibility policies, it could not access the increased FMAP until such standards, methodologies, or procedures were restored to those in effect on July 1, 2008.

2020 recession. In early 2020, the rapid spread of COVID-19 led to the declaration of a national PHE on January 31 and a swift economic contraction in March as many businesses closed or furloughed workers due to the public health threat. On March 19, 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA, P.L. 116-127), which includes a temporary enhancement to the Medicaid FMAP and the State Children's Health Insurance Program (CHIP) enhanced FMAP.[7] This temporary increase gives states and territories an additional 6.2 percentage points of federal share for the entire quarter in which the PHE was first declared through the last day of the quarter in which the PHE ends.

There is an MOE provision in effect, so states cannot receive the enhanced FMAP if they implement more restrictive eligibility standards, methodologies, or procedures (including under a waiver) or impose higher premiums than were in effect on January 1, 2020. In addition, the FFCRA established a continuous coverage requirement; to receive the enhanced financing, states must provide coverage to enrollees, including persons newly determined eligible during this period, until the end of the emergency period. Finally, states must agree to provide coverage for testing and treatments associated with COVID-19 (including vaccines, specialized equipment, and therapies) without cost sharing.

A Permanent Medicaid Countercyclical Mechanism

As an alternative to one-off legislative interventions, various policymakers have suggested that Congress could create a permanent statutory mechanism to automatically increase the federal share of Medicaid expenditures. This would allow federal financial stimulus to be directed to states more quickly during economic downturns and provide states with greater budget predictability. For example, GAO developed a countercyclical FMAP model that would automatically trigger an enhanced FMAP when employment trends in more than half the states are declining compared to the previous year, then reverse the additional FMAP when more than half the states have improving employment

trends (GAO 2011c, 2006). Alternatively, researchers at the Hamilton Project at the Brookings Institution have proposed a state-specific approach that would compare each state's unemployment rate to its own long-run average to evaluate the need for an increased FMAP (Fiedler et al. 2019).

A statutory formula change that makes automatic countercyclical adjustments to the FMAP formula during economic downturns could be designed to provide additional federal contributions that account for both increased enrollment in Medicaid and decreased state revenue, while also providing timely and targeted state relief. As noted above, the timing and targeting of previous congressional actions did not necessarily align well with state need.

In considering the design of an automatic financing adjustment, the Commission identified several objectives:

- It should be automatic: There should be objective, timely indicators of an economic downturn that will automatically trigger changes in federal assistance, without the need for additional congressional intervention and inherent delays in the legislative process.
- It should have a trigger that is sensitive but not too sensitive: To provide effective assistance to states, the threshold should be able to signal the beginning or end of an economic downturn quickly, but not be so sensitive that small fluctuations would trigger frequent adjustments.
- Additional federal financing for states should be targeted based on state-level factors: The formula for providing assistance to states should be efficient, varying based on state-specific indicators that reflect differences in resources and need.

In addition, because an automatic countercyclical adjustment will affect the federal share of Medicaid expenditures, the Commission considered a number of refinements that could also be considered as part of any statutory change, including:

- whether additional rules should be attached to the use of federal matching funds (e.g., MOE requirements for eligibility, reporting requirements);
- whether to have an upper bound or cap on increased FMAPs; and
- whether additional FMAP should be applied to special matching rates (e.g., 90 percent FMAP for the new adult group).

Although the GAO and Hamilton Project models mentioned above both include mechanisms to end the increased federal assistance when certain indicators show sustained improvement, they also note that ending assistance when there is a return to economic growth is not the same as ending it after the economy has returned to a prerecessionary level of unemployment, spending, and state revenue. Some economic indicators, such as unemployment, may lag behind others, such as productivity or GDP (Figure 1-2). Depending on the severity of the recession, even a strong recovery—which could trigger an end to additional federal assistance under certain models—might not result in a return to prior levels of economic output for several years. Thus, although directing federal assistance to states at the beginning of a downturn is important, it is also important to ensure that it does not end too abruptly.

GAO Prototype Countercyclical Financing Model

In 2011, GAO proposed a prototype countercyclical financial model that would provide states with timely and targeted federal financial assistance on a temporary basis during a national economic downturn (GAO 2011a). GAO simulated its model using a baseline of funding for state Medicaid program needs during a downturn. However, the model could be scaled up to address broader needs or scaled down to meet a portion of state Medicaid needs. The prototype model aligns with the objectives identified by the Commission, as summarized below.

Automatic indicators to signal the beginning and end of an assistance period

In MACPAC's view, the mechanism should be based, to the extent possible, on objective, readily available economic data that correlate with changes in Medicaid enrollment and state revenues. The GAO model uses employment data to prompt automatic adjustments in FMAP. GAO found that previous recessions in 2001 and 2008 coincided with more than half the states experiencing declining job participation over two consecutive months and simulated its analysis to trigger an automatic increase when 26 or more states show increased unemployment (defined as a decrease in the three-month average employment-to-population ratio over the prior year) for two consecutive months. The GAO model ends the temporary assistance once fewer than half of states show a decline in their year-over-year employment-to-population ratio over two consecutive months (GAO 2011a).

Unemployment and employment data are calculated and published monthly, so they are timely and comparable measures across states. In addition, the unemployment rate may be considered a proxy for changes in demand for Medicaid, because persons losing employment are more likely to meet the income eligibility requirements and seek public coverage (Frenier et al. 2020). State-level employment and unemployment data are available from the U.S. Bureau of Labor Statistics (BLS) Local Area Unemployment Statistics program (BLS 2020). The data for a particular month are typically released during the third week of the following month.

The FMAP increase triggered by the GAO model would go into effect in the first fiscal quarter after the trigger month (the month in which 26 or more states show increased unemployment for the second consecutive month) so an FMAP increase could begin if the threshold were reached in the last month of the prior quarter, although this would not be known until the data were available in the third week of the following month.

Sensitivity to changes in the economy

To provide effective fiscal stimulus to states, an automatic formula would need to be able to respond to an economic downturn quickly but not be so sensitive that small fluctuations would trigger frequent adjustments. In the Commission's view, the GAO approach balances the need for a responsive measure against the creation of an overly sensitive trigger. This is accomplished by comparing each state's three-month average employment-to-population ratio to the prior year and looking for a decline over two consecutive months in at least 26 states. Use of the three-month average allows timely measurement while smoothing out some seasonal changes; looking at a year-over-year trend across two consecutive months allows some trend analysis and controls for seasonal employment differences.

Going back to 1990, GAO found that its model would have triggered assistance three times, corresponding to the recessions of July 1990–March 1991, March 2001–November 2001, and December 2007–June 2009.[8] In the 2001 and 2007—2009 recessions, the GAO prototype would have automatically adjusted the FMAP several quarters earlier than legislative action. Specifically, in response to the 2001 recession, Congress enacted the JGTRRA in May 2003, with a 2.95 percent FMAP increase that went into effect in June 2003. The GAO model would have provided assistance for 13 quarters beginning in July 2001 and ending in September 2004. Similarly, in response to the 2008 downturn, Congress enacted ARRA in February 2009, providing enhanced FMAPs for a 27-month period retroactive to October 1, 2008. The GAO model would have provided increased Medicaid funding beginning in January 2008, three quarters earlier than the retroactive legislative intervention, and would have ended in September 2011, one quarter later than the end of ARRA funding. (Congress did not provide any special Medicaid relief during the 1990–1991 recession so the sensitivity of the GAO model to congressional action cannot be compared.)

Based on state-level employment data from the BLS, we estimate that the GAO model would not have triggered another assistance period until 2020. Although individual states and regions of the country have experienced periodic economic downturns, particularly relating to natural disasters, since the last nationwide recession in 2007—2009, the fact that the GAO model would not have been triggered demonstrates its value as a national approach.

The GAO model would have triggered an assistance period in 2020, because a majority of states experienced a decrease in the average employment-to-population ratio in March and April. Because the trigger was met in April, the assistance period under the GAO model would have gone into effect for the quarter beginning on July 1, 2020. The data also show that all states continued to experience a decrease in the average employment-to-population ratio through September 2020, meaning that the assistance period would have extended through at least December 2020. All states received greater fiscal relief under the FFCRA in the two quarters prior to the first assistance period than they would have had GAO's model been in effect. This is because the legislative intervention was retroactive to January 1, and the first assistance period under the GAO model would have begun on July 1.[9]

Ability to target assistance to state-level economic conditions

Finally, the Commission supports an approach that is economically efficient by providing varying levels of assistance to states based on state-level factors that account for differences in resources and need. In 2003, Congress provided all states with the same increase in the federal share, which offered the benefit of quick implementation but led to uneven effects across states. In 2009, Congress provided all states with an across-the-board federal share increase and then made an additional adjustment based upon state unemployment levels. This approach was more targeted but did not fully take into account differences among states.

The GAO model addresses how much assistance to provide and how to vary it by state with a single formula that provides an increase in the federal contribution based on two state-specific factors:

- increases in state unemployment, as a proxy for increased Medicaid enrollment; and
- reductions in total wages and salaries, as a proxy for decreased revenues to support state Medicaid programs.[10]

The formula would decrease the state share by the corresponding increase in the unemployment rate and decrease in state wages and salaries. For example, if a state's FMAP formula had a 60-percent federal contribution and a 40-percent state contribution, and the unemployment rate went up 10 percentage points, the state share would go down by 10 percent of 40 percent, or 4 percentage points. If the state's total wages decreased 10 percent, the state share would go down by 10 percent of 40 percent, or 4 percentage points. Together, the state share would go down by 8 percentage points, from 40 percent to 32 percent.

Under the GAO model, the first component of the formula increase is based on the percentage point change in a state's unemployment compared to a baseline unemployment rate. The baseline is the lowest quarterly unemployment rate during the look-back period, which goes back at least eight quarters from the current quarter.[11] As noted above, state-level unemployment data for a particular month are typically released during the third week of the following month and there is generally a lag of one quarter to calculate the unemployment assistance portion of the FMAP adjustment. For example, for an assistance period in the third quarter, beginning July 1, the most recent quarterly state-level unemployment data available for analysis would be from the second quarter, April through June.

The second component of the GAO model is based on the percent change in a state's wages and salaries compared to a baseline figure.[12] The baseline is the highest quarterly wage and salary level during the look-back period, which goes back

at least eight quarters from the current quarter. State-level wages and salaries are a component of the Bureau of Economic Analysis (BEA) state quarterly personal income data. These data are typically released at the end of a quarter and have a lag of two quarters. For example, for an assistance period in the third quarter, beginning July 1, the most recent personal income data available for analysis would be from the first quarter, January through March.[13]

GAO has not applied its prototype formula to data from the current period, so MACPAC undertook its own analysis. As discussed above, based on the data available through September 2020, the GAO model would have gone into effect for the quarter beginning on July 1, 2020, and would have lasted at least through December 31, 2020. To estimate the effect of the FMAP increase under the GAO prototype for the current economic downturn, we used current unemployment and wage and salary data to estimate state-specific FMAP increases during the periods of assistance.[14]

To calculate the unemployment assistance component for each state during the first quarter of the assistance period (July–September), we used the most recent quarter of unemployment data available at the beginning of the quarter (April–June) and reviewed all quarters back to the second quarter of 2018 to identify the baseline (lowest) unemployment rate. We applied the GAO formula to calculate how much state share would decrease for each state in the first quarter of the assistance period. We then used July–September unemployment data for the second quarter of the assistance period (October–December) and adjusted the look-back period accordingly. Based on these data, all states would have received an FMAP increase from 1.32 to 8.41 percentage points through the unemployment component for the July–September period. Many states would have seen a decrease in this component for the October–December period because states' unemployment rates improved over the summer, with the FMAP increase for the unemployment component ranging from 0.46 to 5.37 percentage points for this period. If unemployment rates increase in subsequent quarters, then the FMAP change for the unemployment component will see a corresponding increase.

To calculate the wage and salary assistance component for each state during the first quarter of the assistance period (July–September), we applied the GAO formula using the most recent quarter of wage and salary data available (January–March) and looked back to the first quarter of 2018 to identify the baseline (highest) wage and salary level. We then updated these with April–June wage and salary data for the second quarter of the assistance period (October–December) and adjusted the look-back period accordingly. Based on these data, six states would not have received an FMAP increase from the wage and salary component for the July–September assistance period, because their wages and salaries in the proxy quarter were higher than the baseline. For the states that would have received an FMAP increase, the increase would have ranged from 0.002 to 1.26 percentage points. However, we note that the small FMAP increases during that quarter are primarily due to the lag in available data, because the most recent available data include months prior to the implementation of stay-at-home orders that began in March. States would have received a much larger increase in the wage and salary component during the October–December period, when data for April–June (when most states had stay-at-home orders in effect) would have been applied in the formula. All states would have received an FMAP increase under the wage and salary component during the October–December period, with the increases ranging from 0.91 to 5.23 percentage points.

Based on the application of the GAO prototype formula to data from the current recession, we estimate that states would have received a total FMAP increase ranging from 1.34 and 9.11 percentage points for the July–September 2020 assistance period. For the October–December 2020 assistance period, the FMAP increase would have ranged from 1.90 to 10.60 percentage points.

Our findings suggest that the GAO approach is effective at targeting assistance to state-level conditions. However, although the model can differentiate between state-level conditions, rapid changes in economic conditions may not be quickly reflected in an adjusted FMAP due to the lag in available data. Under the GAO model for July through September 2020, 42 states would have received an FMAP increase lower than the 6.2 percentage points received under the FFCRA and only 9 states would have received an FMAP increase greater than what they received under the FFCRA. Most states would have had a larger FMAP increase under the GAO model beginning in the October–December period than in prior quarters, because at that point data from the stay-at-home period would have been included in the wage and salary component of the formula, although most states (41) would still have experienced an increase lower than under the FFCRA.

Additional Policy Issues Related to Countercyclical Financing

An automatic countercyclical adjustment affects the federal share of Medicaid expenditures, and a number of policy issues relating to Medicaid financing should be addressed in conjunction with a permanent change to the federal financing mechanism. These policy issues include:

- whether additional rules should be attached to the use of federal matching funds (e.g., MOE requirements for eligibility);
- whether to have an upper bound or cap on increased FMAPs; and
- whether additional FMAP should be applied to special matching rates (e.g., 90 percent FMAP for the new adult group).

Maintenance of effort

During an economic downturn, states may struggle to raise the funds necessary to finance their share of Medicaid and look to reduce program spending through service or eligibility reductions. To ensure that states use additional federal funds to support the cost of increased Medicaid enrollment and replace reduced state revenues and not as a substitute for state contributions, an automatic FMAP provision could include an MOE requirement.

The MOE provision in ARRA prevented states from implementing more restrictive eligibility standards, methodologies, or procedures as long as they received the enhanced FMAP, but allowed them to continue operating their eligibility and redetermination processes. By contrast, the MOE provision in FFCRA is paired with a continuous coverage requirement that requires states to continue covering all individuals enrolled at the time the provision went into effect or determined eligible after that point, until the end of the month when the PHE expires (although the enhanced FMAP would go through the end of that quarter). An MOE does not have to be paired with a continuous coverage requirement, which arguably was particularly important in 2020 given that the economic downturn was the result of a public health crisis. During the COVID-19 pandemic, access to continuous health care coverage is important to help individuals get diagnosis and treatment.

Upper bound

Policymakers may also want to consider whether there should be an upper bound or cap for states, some of which already have high federal matching rates. The statutory maximum FMAP for Medicaid under the regular formula is 83 percent, although in FY 2020, the highest state FMAP is 76.98 percent (MACPAC 2020b). Because the GAO formula does not have a mathematical maximum, if a state near or at the statutory maximum receives 17 to 20 percentage points on top of its regular FMAP, it could potentially exceed 100 percent FMAP, in which case no state contribution would be required for

medical assistance expenditures (only for program administration and expenditures not eligible for additional FMAP). Congress could specify that the enhanced FMAP could not exceed 100 percent, or another figure between 83 percent and 100 percent. Because a state would be unlikely to require such a large increase in federal contribution unless it was experiencing large increases in state unemployment and large reductions in state revenues, Congress could also consider allowing states to receive the entire amount determined by the GAO formula but impose limitations to support program integrity (e.g., prohibit excessive provider rate increases).

Application of additional FMAP percentage

Traditionally, temporarily enhanced FMAPs have applied only to a state's regular federal match rate, and have not been applied to services that already have higher FMAPs in statute—e.g., family planning services and services provided by the Indian Health Service. Services with higher match rates represent a small proportion of Medicaid spending. A notable exception is the 90-percent matching rate for the new adult group covered under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act).[15] This exception applies to all services received by individuals with this basis of eligibility, apart from services that already have higher FMAPs in statute. In FY 2018, 14.8 million people were in the new adult group; expenditures for this group accounted for about 16.9 percent of total medical benefit expenditures (MACPAC 2020d, 2020e). The FFCRA FMAP increase is the first temporarily enhanced FMAP that has gone into effect since coverage began for the new adult group, and Congress excluded that group from the enhanced FMAP.

Congress has sometimes excluded temporarily enhanced FMAPs from services or programs that have designated allotments—e.g., disproportionate share hospital (DSH) payments, payments to the territories, and CHIP (MACPAC 2020c).[16] For example, when Congress applied a temporary increase to the Medicaid FMAP in 2009, it excluded DSH payments so states would not exhaust their annual allotments more quickly than planned by drawing them down at the higher rate. Congress has sometimes increased federal allotments for capped programs, such as the territories, to give them sufficient funding and allow them to benefit from the stimulative effect of the higher FMAP rate.

Commission Recommendation

In this report, the Commission recommends that Congress adopt a statutory mechanism to adjust the FMAP formula to automatically increase the federal share of Medicaid expenditures if certain economic conditions are met.

Recommendation 1.1

Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted matching rates; and
- an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

Rationale

During the last 20 years, the United States has experienced three nationwide recessions and each time, Congress has acted to provide additional

federal funds to states in the form of enhanced FMAP (among other forms of federal assistance). Although states have welcomed this assistance, during the first two of these recessions–the gradual nature of the economic downturn made it difficult for Congress to be proactive in identifying state need and taking action. In all three recessions, Congress found it hard to proactively determine how long to leave an FMAP increase in place or how to target assistance to states.

A statutory mechanism to automatically increase the federal share of Medicaid expenditures by adjusting the FMAP formula if certain conditions are met could allow federal financial stimulus to be directed to states more quickly during economic downturns. It could be designed to be automatic, using objective, timely indicators of an economic downturn; have a sensitive trigger to signal the beginning or end of an economic downturn quickly but not be so sensitive that small fluctuations would trigger frequent adjustments; and be able to target assistance to states based on state-level factors. In addition, limits can be placed on the use of enhanced federal financing to restrict their use to regular medical assistance expenditures and ensure that additional federal funds do not substitute for available state funds.

We examined the prototype countercyclical financing model developed by GAO and compared it to the legislative interventions during the current and prior two recessions. Overall, we found:

In a regular recession, the GAO prototype would automatically provide assistance to states several quarters before Congress acts. In the 2001 and 2007–2009 recessions, which were part of the regular economic cycle, Congress did not act to provide fiscal relief to states until after several quarters of economic decline. The GAO model, applied to contemporaneous data, would trigger an FMAP increase as much as two years earlier than congressional action. However, in 2020, where the economic contraction was extremely quick, Congress also acted quickly and put relief measures into place faster than economic trends could be compiled. In this case, the GAO model would have increased the FMAP six months later than the stimulus bill.

The GAO prototype appears to be sufficiently sensitive to align with major recessions, but not so sensitive that it triggers an FMAP increase due to minor economic fluctuations. The three periods over the last 20 years that the GAO prototype model triggered an FMAP increase—July 2001–September 2004, January 2008–September 2001, and 2020—also coincide with official recessions as determined by the National Bureau of Economic Research (NBER 2020). NBER uses changes in GDP to determine whether there is a recession. The GAO model uses unemployment data to signal the start and end of an FMAP increase, so although the FMAP increases aligned with the official recessionary periods they would also have continued to provide federal support after the last month of economic contraction (November 2001 and June 2009). Economists have found that unemployment, which can contribute to individuals seeking Medicaid coverage, tends to lag behind the business cycle and is highest after the economy has begun to expand (Mattoon et al. 2010). Thus, the GAO model would provide support to states that continue to see increases in Medicaid enrollment after the official end of each recession.

The GAO prototype adjusts federal relief to state-level conditions. Congress has used both flat enhanced FMAP approaches and ones that vary based on state-level factors, each of which have advantages and disadvantages. The GAO prototype, which uses both unemployment data and wage and salary data to determine the amount of additional FMAP each state will get per quarter, (1) allows the enhanced FMAP to be targeted according to state-level conditions; (2) relates the amount of enhanced FMAP to proxies for both additional demand for Medicaid (unemployment) and decreases in state revenues (wages and salaries); and (3) varies the amount of enhanced FMAP each quarter as new data are available. Together, these factors should direct more enhanced funding to states with greater

need and less enhanced FMAP to states with less need, as measured by these two indicators.

Despite the fact that the GAO prototype model meets the objectives that the Commission identified for a countercyclical financing mechanism, it does not address certain policy issues related to automatic changes in FMAP. Thus, the Commission also recommends that adoption of this model be enhanced by adoption of additional statutory changes similar to those Congress enacted with prior temporary FMAP increases. These include:

- an eligibility MOE requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted FMAPs; and
- an exclusion of the countercyclical adjusted FMAP from services and populations that receive special matching rates (e.g., 90 percent FMAP for the new adult group) or are otherwise capped or have allotments (e.g., DSH, territories).

Adoption of an MOE will help ensure that states use additional federal funds to support the cost of increased Medicaid enrollment and replace reduced state revenues, rather than substituting for state contributions. A cap or ceiling on additional FMAP will ensure that that federal contributions to states for medical assistance are limited to 100 percent of state expenditures, regardless of the formula calculation. Finally, additional FMAP should be applied only to expenditures eligible for regular FMAP as services and populations that have already have statutory exceptions to the regular FMAP should maintain those exceptions and services. Program features with caps or allotments should not be put at risk of drawing down those funds more quickly than anticipated due to a higher than expected FMAP rate.

Implications

Federal spending. The CBO estimates that if Congress amends the Act as recommended, with a countercyclical financing adjustment going into effect for FY 2023, federal Medicaid expenditures would increase less than $1 billion in the first year and between $30 billion and $40 billion over the following 10-year period. This estimate would affect the calculation of the Medicaid baseline for purposes of determining the size of the federal budget, because expenditures authorized by Congress are included in the annual and 10-year budget estimates. The CBO uses updated economic data to reassess the potential severity and timing of a future recession as part of the annual budget process, so the estimated cost of this policy could change in later years.

It is important to note that these estimates assume that Congress will not otherwise act to increase the FMAP in future downturns. Clearly, if Congress does not adopt this recommendation, it could still decide to provide an FMAP increase in response to a future economic downturn by passing specific legislation, as it has done several times in the past, and such changes would increase federal spending. For example, in 2009, Congress authorized a 27-month increase in Medicaid FMAP that added $32 billion in federal Medicaid outlays in FY 2009 and $40 billion in FY 2010 (CBO 2009). These types of stimulus expenditures cannot be factored into routine budgeting processes and are not included in the Medicaid baseline once their authority expires.

States. Increases in federal spending would reduce spending for states, although the amounts would vary depending on state-level unemployment and wage and salary data. The availability of additional federal funding would be predictable, facilitating state decision making and prioritization, and automatic, without the delays inherent in the federal legislative process. However, if the economic indicators in the GAO model do not serve as adequate proxies for increased enrollment and decreased revenues, states may find that the additional funding is not well targeted to state need.

Enrollees. The availability of additional federal funding and the MOE will help ensure that states have the funds and the incentive to support increased Medicaid enrollment during an economic downturn.

Plans and providers. The availability of a predictable source of additional federal funding will help states more effectively determine how to allocate their budgets, and may enable them to delay or avoid provider and plan rate cuts that would otherwise be made to meet a state balanced budget requirement.

Endnotes

[1] States were not allowed to use premiums and enrollment caps in Medicaid, but were allowed to apply these types of policies in the State Children's Health Insurance Program (CHIP), which enrolls children with higher incomes than those enrolled in Medicaid.

[2] If the state had implemented more restrictive eligibility policies, it could not access the increased FMAP until such standards, methodologies, or procedures were restored to those in effect on July 1, 2008. States were given until June 30, 2009, to reverse any known MOE violations and could receive the enhanced FMAP retroactively to October 1, 2008. The increased FMAP period under which the MOE applied expired on June 30, 2011. In March 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA, 111-148, as amended), which extended the Medicaid MOE requirements to 2014, applied them to CHIP, and carried the MOE forward to 2019 for children.

[3] The Commission reviewed a number of economic indicators in addition to those used in the GAO model (e.g., per capita income, GDP, state sales tax collections) for their usefulness in constructing an automatic countercyclical financing mechanism and found that although other indicators have merits, those chosen by GAO meet the objectives identified by the Commission. Further analysis of specific economic indicators is outside the scope of this chapter.

[4] In 2010, Congress included a provision in the ACA to provide an increase in the FMAP to states that have experienced a major statewide disaster in the previous seven years and for which the current year's FMAP, as determined by the regular formula, is 3 percentage points or more below the previous year's FMAP. Qualifying states receive an adjustment to their annual FMAP rate based on a formula specified in statute. Since 2011, each state has been evaluated every year to see if it qualifies for a disaster-adjusted recovery FMAP as part of the process of calculating FMAPs for the following year. Louisiana has been the only state that has qualified for a disaster-recovery adjustment, which it did in fiscal years 2011 through 2014.

[5] The ARRA hold harmless provision (§ 5001(a)) held that for FY 2009, if a state's FY 2009 FMAP was less than the state's FY 2008 FMAP, the FMAP increase would be added to the FY 2008 FMAP. For example: if the FY 2008 FMAP was 60 percent and the FY 2009 FMAP was 58 percent, the 6.2 percentage point increase would be applied to the 60 percent FMAP level that was applicable in FY 2008. For the first calendar quarter of FY 2011, if the state's FY 2011 FMAP was less than the FMAP for FY 2008, FY 2009, or FY 2010, the FMAP increase for the first calendar quarter of FY 2011 would be applied to the greater of the FMAP level of the previous fiscal years.

[6] The unemployment bonus (§ 5001(c)(3)), for states that qualified, was weighted 35 percent and the FMAP increase was weighted 65 percent. ARRA increased the federal share by 5.5 percent, 8.5 percent, or 11.5 percent based upon a state's peak three-month unemployment rate compared to the lowest three-month unemployment rate of that state since the beginning of 2006. The assistance was based on tiers of unemployment growth from 1.5–2.5 percent, 2.5–3.5 percent, or more than 3.5 percent.

[7] The additional FMAP applies only to a state's regular federal match, not to the enhanced 90-percent match rate for the new adult group. The temporary enhanced FMAP applies to the territories, which normally would mean that they would exhaust their annual federal allotments more quickly, but the FFCRA also provided additional funding to territories to supplement the annual allotments.

[8] Note that GAO developed its prototype when the country was not in a recessionary period and could access unemployment data from the same quarter as the assistance period (i.e., retrospectively).

[9] In its discussion of design elements in the prototype formula and alternatives, GAO notes that the model could be designed to allow assistance to be applied retroactively for one or two quarters.

[10] States may still struggle to raise the state share, depending upon the depth of the recession. Although the GAO model uses economic indicators, such as changes in the employment rate and state wages and salaries, as proxies for states' ability to finance Medicaid, it does not address other aspects of states' ability to finance their programs, such as the level of their reserves. State actions will be affected by many factors, such as the amount of reserve funds available and conditions for their use, and we did not consider every factor in making our recommendations. Further, because Medicaid is not isolated from state budget pressures even if additional federal funds are made available, an automatic countercyclical Medicaid financing adjustment could be part of a package of automatic stabilizers (e.g., extended unemployment benefits). These considerations are outside of MACPAC's scope.

[11] The start of the look-back period remains fixed for the first eight quarters of assistance. In the first eight quarters of assistance, the look-back period would extend for 15 quarters. After the first eight quarters of assistance, the look-back period is limited to the prior eight quarters.

[12] The data for state wages and salaries by quarter are expressed in real dollars by dividing Bureau of Economic Analysis (BEA) quarterly wage and salary disbursements by the BEA implicit price deflator for GDP. The wages and salaries are a component of BEA State Quarterly Personal Income and the deflator is from the National Income and Product Accounts.

[13] Both the BLS and BEA may make revisions to their prior estimates. For example, the BEA releases and then revises the state personal income estimates on a regular schedule to incorporate source data that are more complete, more detailed, or otherwise more appropriate than the data that were available when the estimates were initially prepared (BEA 2020). The results presented in this chapter used the first available data to calculate the unemployment and wage and salary components and were not recalculated based on revised data. Revisions to the BLS and BEA could affect the calculation of the FMAP increase in either direction, if applied (that is, they could increase the adjusted FMAP for a state, or reduce it).

[14] Note that GAO developed its prototype after the recessionary period and could access employment and unemployment data from the same quarter as the assistance period (i.e., retrospectively). If policymakers want to calculate the FMAP increases at the beginning of a given quarter (i.e., prospectively), the calculation would need to use the most recently available data, which generally would be from a prior quarter. Our analysis took this prospective approach and used the most recent data that would have been available at the start of a quarter, which required us to use data from an earlier time period than the GAO prototype may assume (i.e., we use data from a prior quarter when GAO would use data from the same quarter).

[15] The new adult group includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[16] An exception is the FFCRA, which added 6.2 percentage points to the Medicaid FMAP and did not specifically state that it should not apply to other programs that derive an FMAP from the Medicaid FMAP. The CHIP program derives its enhanced FMAP using the Medicaid FMAP as a base. Therefore, as the Medicaid FMAP increases for a state, the enhanced FMAP also increases for the state.

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Commission Vote on Recommendation

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation on amending the Social Security Act to provide an automatic Medicaid countercyclical financing model. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 1.1 on January 29, 2021.

An Automatic Countercyclical Financing Adjustment

1.1 Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted matching rates; and
- an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

Yes:	Bella, Barker, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes

Chapter 2:

Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

Recommendations

2.1 Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.

2.2 Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.

2.3 Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

Key Points

- Postpartum care is critical to monitoring health after pregnancy as well as to addressing other health care needs. However, under current law, coverage for those enrolled in Medicaid by virtue of their pregnancy ends after 60 days postpartum and many individuals are not otherwise eligible for Medicaid.
- The short postpartum period disrupts coverage and access to care. Among women whose births were paid for by Medicaid, nearly one in four report being uninsured postpartum.
- Inadequate postpartum care may contribute to persistent racial and ethnic disparities in maternal and infant health outcomes. Black, non-Hispanic women and Indigenous women have higher risks of maternal morbidity and mortality.
- Although a wide array of stakeholders support extending the postpartum period, federal and state efforts to date have been limited in scope, often focusing on individuals with substance use disorder.
- An extension of postpartum coverage would be a meaningful step to improve outcomes by helping to ensure that individuals receive ongoing medical care. Approximately 123,000 uninsured new mothers would become newly eligible if states were required to provide such coverage. It would also serve as a way to improve health equity.
- States, however, should not be expected to bear the cost of such a mandate, especially in light of current budget challenges due to COVID-19 and the accompanying economic downturn. To offset the costs, the Commission recommends 100 percent federal funding.
- Pregnancy-related services may be broad in scope, but the definitions differ across the states providing limited services, and the provision of certain benefits may depend on the provider or plan. To ensure the best possible outcomes, all pregnant and postpartum individuals should have comprehensive coverage.

CHAPTER 2: Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

Postpartum care is critical to monitoring health after pregnancy as well as to addressing other health care needs. However, under current law, coverage for those enrolled in Medicaid by virtue of their pregnancy ends after 60 days postpartum.[1] Many of these women are not eligible under another Medicaid pathway. This disrupts coverage and access to care for postpartum women whose pregnancies were covered by Medicaid.[2]

It is important to note that the federal policy of covering postpartum care for only 60 days is not rooted in modern medical knowledge and does not reflect needs attendant to pregnancy that extend well beyond this period. Women may experience risks to their lives postpartum, with almost 12 percent of maternal deaths occurring in the late postpartum period, and a considerable share of these deaths are potentially preventable. In the year following a pregnancy, multiple health issues may arise. These go beyond the physical recovery from childbirth and include behavioral health needs such as postpartum depression and substance use disorder (SUD), family planning, and chronic conditions that predated the pregnancy or arose because of it. These all may require ongoing medical care. Moreover, racial and ethnic disparities in pregnancy-related mortality and morbidity have been well documented.

Although there has been great interest in extending the postpartum period from a wide array of stakeholders, federal and state efforts have been piecemeal, providing ongoing coverage in just a handful of states, and in many cases, only for individuals with SUD. In light of poor maternal and birth outcomes, unacceptable racial and ethnic disparities, a rich body of evidence, and limited action to address these concerns, the Commission recommends three changes to federal statute to improve maternal health:

- Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.
- Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.
- Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

Given that Medicaid covers 43 percent of all births nationally, extending the postpartum coverage period is an important step in addressing poor maternal and infant health outcomes. A continuation of coverage during this period would help to ensure access to ongoing medical care to address the health and well-being of individuals during the postpartum period. Furthermore, an extension of the postpartum coverage period would improve health equity and help stem persistent and troubling racial and ethnic disparities in maternal outcomes. Finally, as the health of the child is inextricably linked with that of the mother, improving outcomes for the mother would also improve the health of the child.

Requiring states to provide such coverage in both Medicaid and the State Children's Health Insurance Program (CHIP) would ensure that all eligible postpartum individuals receive the same coverage period regardless of where they live or in which program they are enrolled. In the Commission's view, however, given the resource constraints

now facing states, they should not be expected to bear the cost of such a mandate and the federal government should provide full federal funding.

All pregnant and postpartum individuals should also be provided comprehensive coverage to ensure the best possible birth and maternal health outcomes. As such, states should not have the option to limit coverage to pregnancy-only services. Although these actions, if taken by Congress, would likely not by themselves eliminate severe maternal morbidity and mortality, they would represent meaningful steps to improve the lives of women and their families.

The chapter begins by describing Medicaid and CHIP coverage for pregnant women under current law, including eligibility and benefits. It then describes the changes in coverage that occur throughout and following an individual's pregnancy, before turning to the health issues facing postpartum individuals. The chapter then highlights recent state and federal action to extend the postpartum coverage period. It then describes the key areas the Commission discussed during its deliberations, including evidence on the effects on health equity, insurance coverage, and continuity of care, as well as issues related to state flexibility and financing. The chapter concludes with the Commission's recommendations and its rationale.

Medicaid and CHIP Coverage for Pregnant Women

Medicaid has long played a key role in providing maternity-related services for pregnant women, financing more than two out of every five births in 2018 (MACPAC 2020a). Coverage for this population has evolved over time, and today there are dedicated Medicaid and CHIP eligibility pathways specifically for pregnant women.

Historical context

Until the mid-1980s, Medicaid eligibility was closely linked to the receipt of cash payments under the Aid to Families with Dependent Children (AFDC) program. Between 1984 and 1990, Congress expanded Medicaid eligibility for low-income pregnant women, creating new mandatory and optional eligibility groups (Table 2A-1). These new eligibility groups were based on income relative to the federal poverty level (FPL), rather than receipt of cash payments under AFDC. This was a notable shift, because the FPL exceeded most state AFDC eligibility standards and generally increases annually to account for inflation (MACPAC 2020b).

In expanding eligibility, Congress sought to cover more low-income pregnant women in Medicaid, especially during the early stages of pregnancy. The rationale was that improved access to adequate prenatal care would have positive effects on birth outcomes, including reductions in infant mortality and morbidity rates (Ellwood and Kenney 1995).

In 1986, Congress required 60 days postpartum coverage for pregnant women (Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272).[3] Later that year, states were given the option to guarantee continuous Medicaid eligibility to a woman throughout her pregnancy and for 60 days following delivery regardless of changes in income or assets (Omnibus Budget Reconciliation Act of 1986, P.L. 99-509). Thirty-eight states adopted this option (GAO 1989). In 1990, Congress required all states to provide continuous coverage for pregnant and postpartum women for 60 days after pregnancy (Omnibus Reconciliation Act of 1990, P.L. 101-508).

Current eligibility

All states are required to cover pregnant women in Medicaid with incomes up to at least 133 percent FPL, although some states have higher mandatory minimum thresholds because they expanded coverage to higher-income pregnant women prior to this requirement.[4, 5] All but four states have opted to extend Medicaid coverage to pregnant women

with incomes above the required minimum and, as of October 2020, the median eligibility threshold was 195 percent FPL and ranged from 133 percent FPL to 375 percent FPL (Table 2A-2). Eligibility for pregnant women in Medicaid extends through 60 days postpartum.[6] Women who are otherwise eligible for Medicaid (for example, as low-income parents) and become pregnant can retain their existing coverage and generally are not required to shift to a pregnancy-related eligibility pathway; as such, they do not face an end to their coverage at 60 days postpartum.[7]

States may also provide comprehensive health care coverage for uninsured, targeted low-income pregnant women through CHIP, either under a state plan option or through a demonstration program authorized under Section 1115 of the Social Security Act (the Act).[8] Currently, six states (Colorado, Missouri, New Jersey, Rhode Island, Virginia, and West Virginia) cover low-income pregnant women in CHIP, with a median income eligibility level of about 257 percent FPL (Table 2A-2). The 60-day postpartum period also applies to pregnant women covered in CHIP.[9]

At the end of a woman's 60-day postpartum period, states are required to screen her for continued eligibility through all other pathways or transfer her to the federal or state health care exchange if she is no longer eligible for any type of Medicaid.[10] Whether another Medicaid pathway is available depends upon the woman's household income, the state's eligibility threshold for parents, and if the state has adopted the Medicaid expansion for low-income adults as authorized under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Regardless of whether a state has expanded Medicaid, income eligibility for pregnant women is higher in the vast majority of states than it is for any alternative pathway (Table 2A-2).

In the 37 states that have expanded Medicaid to low-income adults, a woman may be eligible for ongoing Medicaid coverage if her income is at or below 133 percent FPL.[11] To retain Medicaid in a non-expansion state, she would need to be eligible through another pathway, likely as a parent.[12] The median eligibility threshold for parents in non-expansion states is about 36 percent FPL (or $6,271 annually for a family of two in 2021). Postpartum women who have income above this threshold, but at or below 100 percent FPL, are not eligible for Medicaid or subsidized coverage on the exchange. Subsidized exchange coverage may be available for women with incomes above 100 percent FPL.[13]

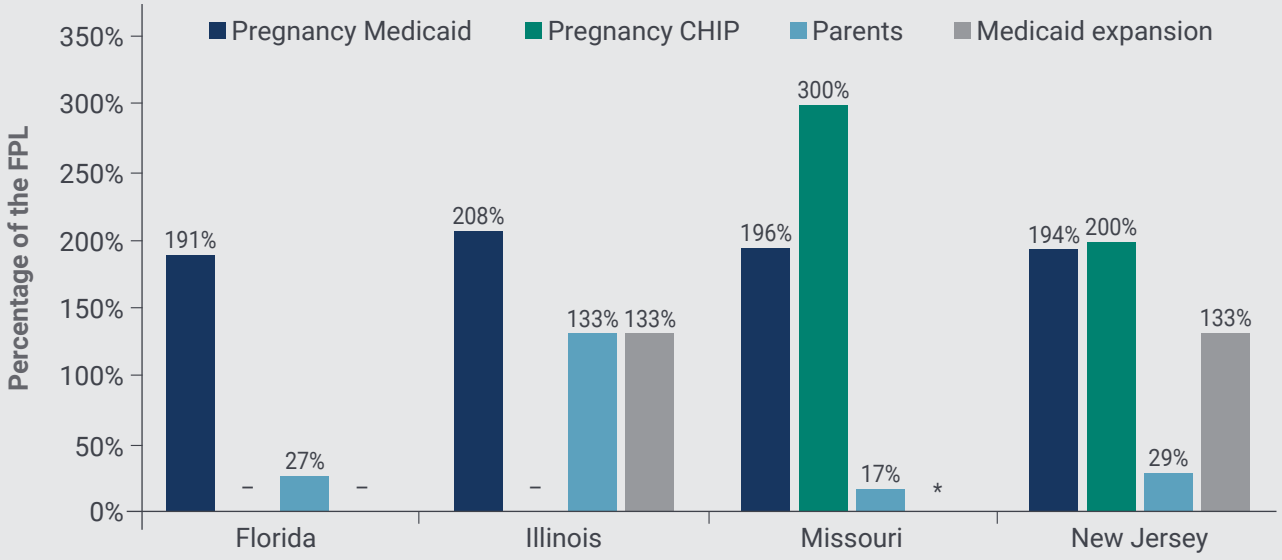
States take different approaches to coverage for pregnant women (Figure 2-1). The variation across the states is a function of the eligibility threshold for pregnant women in Medicaid, whether the state covers pregnant women in CHIP and at what incomes, the eligibility threshold for parents, and whether the state has adopted the Medicaid expansion. These differences dictate the coverage options available for women after the end of the postpartum period. (Some states have sought a Section 1115 demonstration to extend the postpartum period beyond 60 days. We discuss these approaches in greater detail later in the chapter.) The following examples illustrate the variation in state coverage policies:

- In Florida, pregnant women with incomes up to 191 percent FPL are eligible for Medicaid. At the end of the postpartum period, a woman with income at or below 27 percent FPL could remain on Medicaid as a low-income parent. Because the state has not adopted the Medicaid expansion, women with incomes above this level, but below 100 percent FPL, are not eligible for Medicaid or subsidized coverage on the exchange. Women with incomes above 100 percent FPL could be eligible for subsidized exchange coverage.
- In Illinois, pregnant women with incomes up to 208 percent FPL are eligible for Medicaid. Illinois has adopted the Medicaid expansion and covers parents up to 133 percent FPL; as such, at the end of her postpartum period, a woman with income at or below 133 percent FPL could remain eligible for Medicaid. Women

with incomes above 133 percent FPL could be eligible for subsidized exchange coverage.[14]

- In Missouri, pregnant women with incomes up to 196 percent FPL are covered in Medicaid, while uninsured pregnant women with incomes up to 300 percent FPL are covered in CHIP. Following the postpartum period, women with incomes below 17 percent FPL could remain in Medicaid as a low-income parent. (The state has adopted, but not yet implemented, the Medicaid expansion.) Women with incomes above this level but below 100 percent FPL are not eligible for Medicaid or subsidized coverage on the exchange. Women with incomes above 100 percent FPL could be eligible for subsidized exchange coverage.
- In New Jersey, pregnant women with incomes up to 194 percent FPL are covered in Medicaid, while uninsured pregnant women with incomes up to 200 percent FPL are covered in CHIP. Because New Jersey expanded Medicaid, at the end of the postpartum period, a woman with income up to 133 percent FPL could remain eligible for Medicaid. Women with incomes above 133 percent FPL could be eligible for subsidized coverage on the exchange.

FIGURE 2-1. Medicaid and CHIP Income Eligibility Thresholds in Selected States by Pathway as a Percentage of the FPL, October 2020



Notes: CHIP is the State Children's Health Insurance Program. FPL is federal poverty level.

– Dash indicates that the state does not provide coverage under this eligibility pathway.

* Missouri has opted to expand Medicaid to include adults under age 65 with incomes up to 133 percent of the federal poverty level, but has not yet implemented the expansion.

Parent eligibility thresholds reflect Medicaid state plan coverage of the eligibility group for parents and other caretaker relatives. In expansion states, parents and caretaker relatives with incomes above the standard shown here may be eligible for coverage in the new adult group.

Sources: MACPAC, 2020, analysis of CMS 2020b.

Benefits

Pregnant women are typically entitled to the full Medicaid benefit package; however, for women covered by Medicaid through poverty-level pregnancy pathways (i.e., women with incomes above the state's income threshold for the former AFDC program), states may limit services to those related to pregnancy.[15] Pregnancy-related services are defined as those that are necessary for the health of the pregnant woman and fetus, including prenatal care, delivery, postpartum care, family planning services, and services for other conditions that might complicate the pregnancy or threaten carrying the fetus to full term or the safe delivery of the fetus (42 CFR 440.210). If a state proposes not covering certain services or items for pregnant women that it covers for other adults, the state must describe the basis for determining that such services are not pregnancy-related in its state plan (CMS 2012a).

In CHIP, states can model their benefits for pregnant women based on specific private insurance plans, a package equivalent to one of those benchmarks, or coverage approved by the Secretary of the U.S. Department of Health and Human Services (the Secretary) (§ 2112(b)(4) of the Act). (These are the same options available to states for low-income children in CHIP.) The majority of states have elected to provide Secretary-approved coverage that is the same as coverage for pregnant women under Medicaid (Edwards 2021). Therefore, changes to coverage under the state plan for pregnant women covered in Medicaid would also affect pregnant women in CHIP.

Although the vast majority of states provide the full Medicaid package to all pregnant women, five states limit benefits for some pregnant women to only pregnancy-related services. Four states (Arkansas, New Mexico, North Carolina, and South Dakota) provide only pregnancy-related services to pregnant women in their programs with a wide range of incomes; California provides only pregnancy-related services to women with incomes above 133 percent FPL (Brooks et al. 2020, CA DHCS 2020a).[16]

- In Arkansas, pregnancy-related services are provided to women with incomes between 15 percent FPL and 209 percent FPL. The services consist of prenatal care, delivery, postpartum care, and family planning. All services must be pregnancy-related and services that lack a pregnancy code are not covered (AR DHS 2021, Brooks et al. 2020, Gallaher 2020, Golden 2020, CMS 2013a).
- In California, pregnancy-related services are provided to women with incomes between 133 percent FPL and 208 percent FPL. These women receive all medically necessary services related to their pregnancy or for any conditions that may complicate the pregnancy. The treating clinician attests to the need for the covered benefits for these women on the basis of their pregnancy (Mollow 2021; CA DHCS 2020a, 2015; CMS 2020c).
- In New Mexico, coverage for women with incomes between 42 percent FPL and 250 percent FPL is limited to pregnancy-related services (Lovato 2020; NM HSD 2020a, 2019a, 2019b; CMS 2014). However, pregnant women are enrolled in managed care and, in addition to the standard benefit package, each managed care organization offers full Medicaid benefits to pregnant women as a value-added service (NM HSD 2020b).[17]
- In North Carolina, pregnancy-related services are provided to women with incomes between 37 percent FPL and 196 percent FPL. These services must be related to the pregnancy or be for the treatment of illness or injury that in the physician's judgment may complicate the pregnancy. This can include conditions related to the pregnancy, preexisting conditions, and new conditions that may adversely affect the best possible outcome of the pregnancy. Covered services comprise prenatal care, labor and delivery, family planning, pharmacy, physician services, behavioral health, and routine dental care. Other services, such as podiatry, chiropractic, and optical services, may be covered with prior approval (Dowler 2020; NC DHHS 2020, 2011; CMS 2013b).

- In South Dakota, the coverage for women with incomes between 47 percent FPL and 133 percent FPL is limited to services that are directly tied to their pregnancy and delivery, based primarily on the diagnosis on the claim. Coverage also includes 60 days of postpartum care and family planning services (Brooks et al. 2020, Hynes 2020, SD DSS 2020, CMS 2013c).

Given the minimal information defining pregnancy-related services in some states, as well as the discretion left to the provider or plan to determine whether something is pregnancy-related, it is not clear the extent to which states actually limit benefits and the practical effect of those limitations on pregnant individuals. It is also not clear from the state plans or other documentation how postpartum visits are treated or what conditions are considered pregnancy-related following a pregnancy. For example, services that are considered pregnancy-related while a woman is pregnant, such as a flu vaccine, may not be considered pregnancy-related once the pregnancy ends.

In March 2014, the Commission recommended that Congress change the statute to require full Medicaid coverage for women who are eligible through mandatory or optional pregnancy-related pathways. This recommendation sought to align coverage for pregnant women across eligibility pathways and ensure the best possible outcomes for the woman and newborn (MACPAC 2014). Nothing in this recommendation would have prohibited states from providing enhanced pregnancy benefits that are designed to improve maternal and birth outcomes to all pregnant women covered under the state plan.[18] This recommendation has not yet been adopted by Congress.

Transitions following the postpartum period

The experience at the end of the postpartum coverage period (regardless of whether it occurs following the current 60 days or after one year, as recommended by the Commission) differs depending on whether an individual shifts to another Medicaid eligibility pathway, secures coverage on the exchange or through another source, or becomes uninsured.[19]

Women who remain eligible for Medicaid at the end of the postpartum period generally face minimal changes in terms of out-of-pocket costs because the rules on premiums and other cost sharing are fairly consistent across Medicaid eligibility groups. For example, premiums can be imposed on adults, parents, and pregnant women whose incomes exceed 150 percent FPL, and pregnant women may be charged cost sharing for services not related to the pregnancy. Overall expenses for premiums and cost sharing cannot exceed 5 percent of monthly or quarterly household income (MACPAC 2017b). Similar to those covered by Medicaid, pregnant women covered by CHIP cannot be subject to any cost sharing for pregnancy-related assistance, and only one state (West Virginia) requires premiums for this group (§ 2112(b)(6) of the Act, Edwards 2021). For young women (under age 19) who remain eligible for CHIP under the statutory definition of a targeted low-income child after the postpartum period, any applicable cost sharing would resume.

Benefits differ depending on the Medicaid eligibility pathway, especially in states that offer enhanced benefits to pregnant women. For example, 11 states provide additional dental benefits, such as allowing more frequent services to pregnant women (MACPAC 2021). In Virginia, pregnant women are the only adult Medicaid population in the state with access to comprehensive dental coverage (Mathematica 2020). Individuals may lose coverage for these services when transferring to a new eligibility pathway after their postpartum coverage period ends.

Women who become eligible under the Medicaid expansion following the postpartum period would receive the same alternative benefit plan (ABP) offered to anyone in the expansion group.[20] The benefit requirements differ in some key ways. For example, many behavioral health services that are optional under traditional Medicaid are mandatory under the ABP. States have considerable flexibility in determining the scope of coverage under the

state plan and the ABP; as such, it is not possible to generalize about the differences. However, as of August 2018, 25 of 31 expansion states had aligned ABP benefits with traditional Medicaid benefits under the state plan, so women transitioning to the new adult group following the postpartum coverage period in these states would see few, if any, changes to their benefits (CRS 2018).

Women who are ineligible for Medicaid following the postpartum period may be eligible for subsidized exchange coverage if their incomes are above 100 percent FPL. It is important to note, however, that exchange coverage could require considerable premiums and cost sharing. For example, in 2020, individuals with incomes between 133 percent and 150 percent FPL received subsidies that limited the amount they would pay for an exchange plan to between roughly 3 percent and 4 percent of income. Additionally, those with incomes below 250 percent FPL are eligible for cost-sharing reductions. Despite these subsidies, out-of-pocket costs in exchange plans are typically higher than in Medicaid, especially for individuals with extensive health needs (Haley et al. 2021). Studies have shown reduced Medicaid enrollment when premiums are instituted, which suggests that exchange premiums may be a barrier to enrollment for individuals shifting from Medicaid (Dague 2014). Furthermore, as noted above, exchange plans have considerable out-of-pocket costs; research has shown that individuals may forgo care, including necessary care, due to costs (Artiga et al. 2017, MACPAC 2015a, Snyder and Rudowitz 2013).

Shifting to exchange coverage after the postpartum period has additional consequences. First, available benefits may differ when postpartum women shift from Medicaid to an exchange plan.[21] Second, women may have to navigate the special enrollment process and then select a plan to secure coverage on the exchange. Available data suggests that postpartum women are not always successful in transferring to the exchange. About 43,000 uninsured new mothers nationwide had incomes between 138 percent and 200 percent of poverty in 2017 and could likely have qualified for subsidized exchange coverage.[22] There may be several reasons they remained uninsured: they were unaware that such coverage is available, they struggled with the enrollment process, or they could not afford the premiums (McMorrow et al. 2020a).

If postpartum individuals are unable to secure another source of coverage, they may pay out of pocket for services or forgo care completely. As discussed in greater detail below, uninsured new mothers report problems with access to care; about one in five report at least one unmet need due to cost and almost half report not having a usual source of care (McMorrow et al. 2020b).

Coverage Disruptions

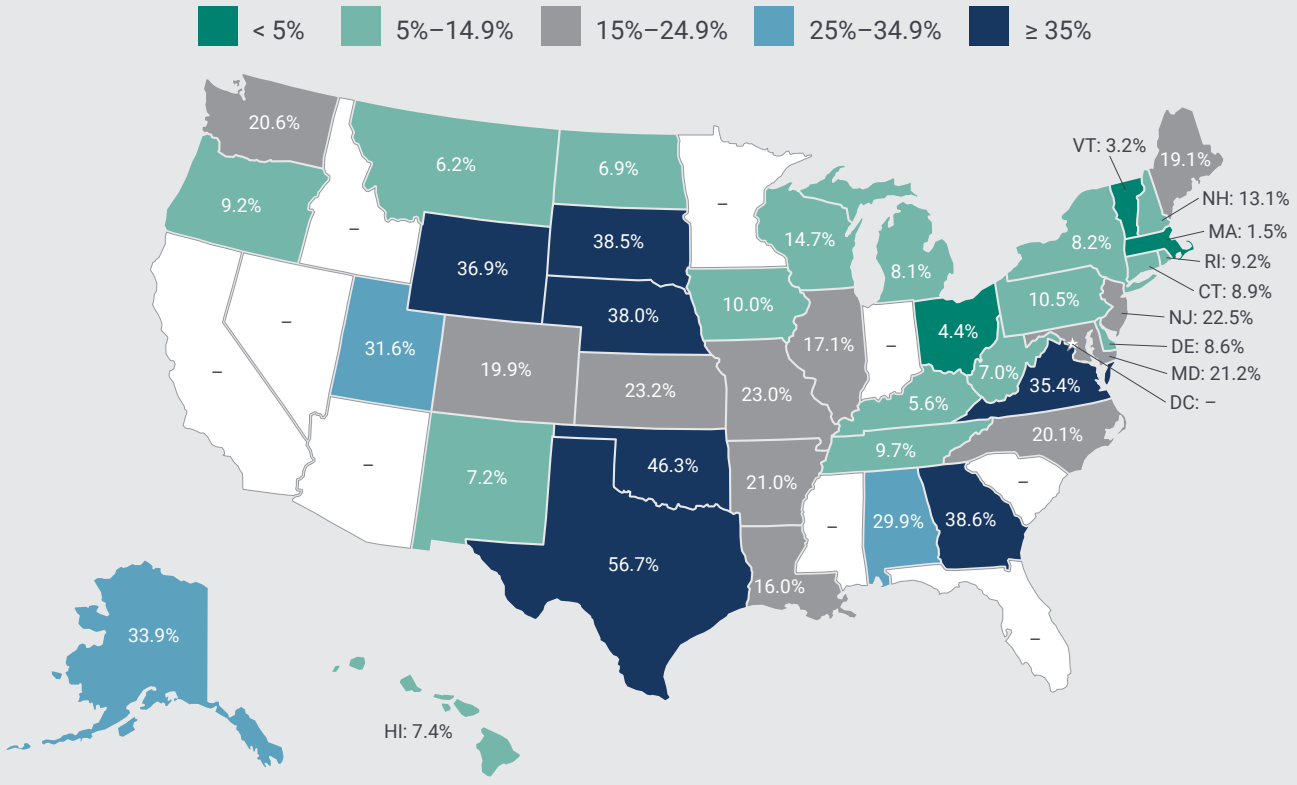
Research shows that insurance coverage facilitates access to prenatal and postpartum care; receipt of these services improves birth outcomes and supports the long-term health of women and newborns. For example, coverage during the prenatal period might allow for services, such as smoking cessation, to address conditions that would otherwise contribute to adverse maternal and birth outcomes. Postpartum care offers the opportunity to monitor recovery from pregnancy and childbirth and to address other ongoing health care needs, including family planning and behavioral health.

However, pregnant women may experience coverage disruptions due to changes in employment, income, and Medicaid eligibility that often accompany birth. A study examining data from 2005–2013 found that nearly 60 percent of pregnant women experienced a change in the type of insurance coverage they had in the nine months before delivery. Half of the women who were uninsured had acquired Medicaid or CHIP coverage by the month of delivery, but 55 percent of these women were uninsured at some point during the six months after birth. The risk factors associated with a loss of insurance after delivery included not speaking English at home, being unmarried, having Medicaid or CHIP coverage at delivery, living in the South, and having a family income between 100 percent and 185 percent FPL (Daw et al. 2017).

Between 2015 and 2017, following implementation of the ACA, the rate of coverage changes during the perinatal period declined. However, one-third of women still experienced a change in health insurance from prepregnancy to postpartum. The disruptions occurred across the pregnancy—25 percent of women experienced a change from prepregnancy to delivery, and almost 29 percent experienced a change from delivery to postpartum. In states that chose not to expand Medicaid, the prepregnancy rate of uninsurance was nearly double and the postpartum uninsurance rate was nearly triple that of expansion states. Overall, in states that expanded Medicaid, a higher proportion of women were continuously insured and the churning rate on and off Medicaid was less pronounced (Box 2-1). The proportion of women who experienced a period of uninsurance from prepregnancy to delivery varied widely among states, with several states reporting uninsurance above 30 percent, including Texas at 46.5 percent, Oklahoma at 38.1 percent, and Georgia at 32.4 percent (Daw et al. 2019).

Among women whose births were paid for by Medicaid between 2015 and 2017, more than half (55.7 percent) were insured by Medicaid three or more months postpartum. Nearly one in four (23.1 percent) reported postpartum uninsurance. The postpartum uninsurance rates were three times higher in states that had not implemented the Medicaid expansion than in states that had (38.2 percent and 12.8 percent, respectively). The postpartum uninsurance rate for women with births paid for by Medicaid varied considerably across states, ranging from 1.5 percent in Massachusetts to 56.7 percent in Texas (Figure 2) (Daw et al. 2021).

FIGURE 2-2. Postpartum Uninsurance Rates among Women Whose Births Were Paid for by Medicaid, 2015–2017



Notes: Dash indicates data are not available. Data are not available in Arizona, California, the District of Columbia, Florida, Idaho, Indiana, Minnesota, Mississippi, Nevada, and South Carolina.

Source: Daw et al. 2021.

Racial and ethnic disparities in continuity of coverage

Women of color are more likely to experience discontinuity in coverage. One study found that 75 percent of white, non-Hispanic women were continuously insured, compared to 55 percent of Black, non-Hispanic women, 50 percent of Indigenous women, and about 20 percent of Hispanic Spanish-speaking women (Daw et al. 2020a). Another study examining changes in uninsurance following implementation of the ACA found declines in uninsurance among white, non-Hispanic, Black, non-Hispanic, and Hispanic new mothers. However, disparities in coverage remained: nearly 25 percent of Hispanic new mothers were uninsured and 12 percent of Black, non-Hispanic new mothers were uninsured, compared to 7 percent of white, non-Hispanic new mothers (Johnston et al. 2019).[23]

Racial and ethnic disparities in postpartum insurance exist among women whose births were paid for by Medicaid. Between 2015 and 2017, Black, non-Hispanic women had a lower rate of uninsurance (12.6 percent) and a higher rate of Medicaid coverage (65.5 percent) compared to white, non-Hispanic women (15.7 percent and 62.7 percent, respectively). More than half (56.3 percent) of Spanish-speaking Hispanic women were uninsured postpartum.[24]

English-speaking Hispanic women had lower rates of uninsurance (29.7 percent), but were still significantly more likely to be uninsured in the postpartum period in comparison to white, non-Hispanic women. Indigenous women were also more likely to report postpartum uninsurance (25.6 percent). For all race and ethnicity groups, postpartum uninsurance rates were significantly higher in non-expansion states (Daw et al. 2021).[25]

Earlier work looking at disparities in insurance status across the perinatal period found the widest racial disparities in uninsurance in the prepregnancy and postpartum period for the lowest-income women. Specifically, when controlling for income, the likelihood of uninsurance was lower or similar for Black, non-Hispanic women compared with white, non-Hispanic women. These data suggest that the overall Black-white disparity in coverage can be largely explained by the lower average household incomes among Black, non-Hispanic women and the corresponding higher rates of Medicaid coverage. The high rates of uninsurance among Spanish-speaking Hispanic women reflects, in part, the more limited coverage options available to immigrant women (Daw et al. 2020a).[26]

BOX 2-1. Effects of the Medicaid Expansion for Pregnant and Postpartum Women

Although not targeted to pregnant women, the Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) has affected coverage, utilization, and disparities.

For example, one study found that Medicaid expansion was associated with an increase in Medicaid coverage and a decrease in uninsurance among new mothers with incomes below 100 percent FPL (Johnston et al. 2020). Another study found that Medicaid expansion resulted in a 10-percentage-point decrease in churning between insurance and uninsurance; the study also found a 7.8-percentage-point increase in continuous Medicaid coverage in expansion states relative to non-expansion states (Daw et al. 2020b).

Other studies have connected Medicaid expansion to a change in utilization. For example, following expansion in one state, postpartum outpatient utilization increased—particularly among women who experienced severe maternal morbidity at delivery—compared to a neighboring non-expansion state (Gordon et al. 2020). Another study found that Medicaid expansion was associated with increased receipt of prepregnancy health counseling, reported daily folic acid intake, and increased postpartum use of the most effective birth control methods (Myerson et al. 2020). A recent study examining the effects of the Medicaid expansion in Oregon found increased enrollment in Medicaid prior to pregnancy, which subsequently increased receipt of timely and adequate prenatal care (Harvey et al. 2021).

Furthermore, some studies suggest that Medicaid expansion may reduce health disparities among new mothers and their infants. A comprehensive review of the literature suggests expansion narrowed disparities in infant and maternal health outcomes for Black and Hispanic individuals (Guth et al. 2020). Another study found that although expansion was not associated with changes in rates of preterm or low birthweight infants overall, there were greater reductions in rates of low birthweight and preterm births among Black infants in states that expanded Medicaid than in states that did not (Brown et al. 2019).[27] Medicaid expansion is also associated with lower maternal mortality, particularly among Black, non-Hispanic mothers (Eliason 2020).

Postpartum Health Issues

A weakness in current Medicaid coverage for pregnant women is that it neglects the clinical importance of the full postpartum period. Clinical standards for postpartum care have evolved since the 1980s, acknowledging that individuals require care well beyond the period during which the body may physically recover from childbirth. What has been termed the fourth trimester—the 12-week period after pregnancy—is marked by considerable biological, psychological, and social changes for the mother. Multiple issues may arise during this time, including stresses on maternal emotional well-being and fatigue; challenges with infant care and feeding; need for family planning; and risks related to substance use (Verbiest et al. 2017). Additionally, chronic conditions that predated the pregnancy or arose because of it may require ongoing medical care, both to improve the woman's health and to reduce the chances of complications during subsequent pregnancies. Many of these concerns continue past the fourth trimester and through one year postpartum. Although these conditions and challenges are not limited to women covered by Medicaid, they are more likely to have

certain risk factors that make them susceptible to poor outcomes in comparison to privately insured women (MACPAC 2020a).

The American College of Obstetricians and Gynecologists (ACOG), along with a coalition of other maternal health providers, recommends that all women have contact with their provider within the first three weeks postpartum. This initial assessment should be followed by ongoing care as needed and a comprehensive postpartum visit no later than 12 weeks after birth to assess the multiple issues that may arise. Women with chronic medical conditions, such as hypertensive disorders, diabetes, and mood disorders, should be advised on the importance of timely follow-up (ACOG 2018). Furthermore, provider groups stress that the interpregnancy period is an opportunity to address complications or medical issues that developed during pregnancy, to assess a woman's mental and physical well-being, and to improve her long-term health (ACOG and SMFM 2019).[28, 29]

Women may experience considerable risks to their health and life during the postpartum period. One-third of pregnancy-related deaths occur postpartum, including almost 12 percent that occur in the late postpartum period (between 43 and 365 days postpartum).[30] Nationally, cardiomyopathy was the leading cause of death in the postpartum period (Petersen et al. 2019a). Drug overdose, suicide, and homicide are also leading causes of death during or within a year of pregnancy (IL HFS 2020, TX DHHS 2018).[31] A considerable share of these deaths may be potentially preventable (Davis et al. 2019).[32] For example, the Illinois Maternal Mortality Review Committee found 71 percent of pregnancy-related deaths that occurred between 61 and 364 days postpartum to be potentially preventable. Moreover, women covered by Medicaid were two and one-half times as likely to die within one year of pregnancy as women with private insurance (IL HFS 2020).[33]

Racial and ethnic disparities in pregnancy-related mortality have been well documented. Black, non-Hispanic women and American Indian and Alaska Native women have two to three times higher pregnancy-related death rates compared to white, non-Hispanic women (40.8 per 100,000, 29.7 per 100,000, 12.7 per 100,000, respectively) (Petersen et al. 2019b). The causes and timing of deaths also differ by race: cardiomyopathy, embolism, and hypertensive disorders contribute to a significantly higher proportion of deaths among Black women in comparison to white women; hemorrhage and hypertensive disorders contribute to a significantly higher proportion of deaths among American Indian and Alaska Native women in comparison to white women (Petersen et al. 2019b). A greater proportion of deaths among Black women occurs in the late postpartum period in comparison to white women (Petersen et al. 2019a).

Researchers have also documented racial differences in severe maternal mortality and morbidity (SMMM), during delivery hospitalizations. Black, non-Hispanic, and American Indian and Alaska Native women have heightened risk of morbidity compared with white, non-Hispanic women (Admon et al. 2018a). Medicaid beneficiaries are almost twice as likely as those with private insurance to experience SMMM. However, there appears to be little variability across payers in racial and geographic disparities in SMMM—the risk for people of color is similar when comparing Medicaid beneficiaries, women with private insurance, and women with other types of coverage (Kozhimannil et al. 2019).

An increasing number of pregnant women have chronic conditions that may require continued medical care in the postpartum period (Brown et al. 2020; CDC 2020; Admon et al. 2018b, 2017; Tyer-Viola and Palan Lopez 2014). Estimates suggest that one-quarter of pregnancies are affected by chronic illness, disproportionately occurring among women with low-incomes and women of color, including women covered by Medicaid (Admon et al. 2017, Tyer-Viola 2014). One recent study identified that at least one chronic condition occurred in nearly 10 percent of all delivery hospitalizations in 2013 and 2014, with increases seen in the prevalence of asthma, chronic hypertension, SUDs, and preexisting diabetes. The study also indicated

higher prevalence and larger increases in the prevalence of chronic conditions among women covered by Medicaid during pregnancy (Admon et al. 2017).

Women also face behavioral health issues in the postpartum period. Perinatal mood and anxiety disorders affect one in seven pregnant and postpartum women, and may be diagnosed well into the year after the end of a pregnancy. Such conditions often go undiagnosed and untreated, with about half of women with a diagnosis of depression receiving any treatment (Luca et al. 2019). Postpartum depression, which is estimated to occur in 5 percent to 25 percent of all pregnant, postpartum, and parenting women, can have adverse effects for both the mother and the child (Earls et al. 2019; USPSTF 2019). Low-income mothers are more likely to experience depression, with rates as high as 40 percent to 60 percent (CMS 2016). Women with a prepregnancy serious mental illness face a high risk of relapse during the postpartum period (Taylor et al. 2019). For women who have a history of tobacco and other substance use, the stresses of pregnancy, childbirth, and parenting are major risk factors for relapse during the postpartum period. For example, after successfully quitting smoking during pregnancy, approximately half of all women resume smoking during the 6 months after delivery (Verbiest et al. 2017). Similarly, although substance use decreases in pregnancy, one study found postpartum relapse among women who used alcohol, marijuana, and cocaine to be common (Forray et al. 2015). Another study found that the highest rate of overdose occurred in the late postpartum period, between 7 and 12 months after delivery (Schiff et al. 2018).

Oral health care is also important for pregnant and postpartum women, both for the positive effect it can have on other health conditions and because of the association between periodontal infections and preterm birth (MACPAC 2015b, ACOG 2013). Overall, relatively few pregnant women receive dental care; and those covered by Medicaid were 24 percent to 53 percent less likely to receive dental care than pregnant women covered by private insurance. There are several possible reasons for this. One is that women may not understand the importance of dental care; a second is that it is not uncommon for both dental and medical professionals to suggest delaying treatment until after delivery. However, by the time a woman obtains an appointment, there may be limited time during the postpartum period for preventive care and treatment, especially if a series of visits is required (Kloetzel et al. 2011).

Lack of coverage can create a barrier to postpartum care. This was a key finding from the Strong Start for Mothers and Newborns Initiative (Strong Start), a four-year federal initiative to test and evaluate alternative enhanced prenatal care for women enrolled in Medicaid or CHIP who were at risk for having a preterm birth (CMS 2015). The evaluation of the initiative identified participant concerns regarding their loss of coverage in the postpartum period and the perceived difficulty of securing Medicaid coverage outside of pregnancy. Participants noted that the lack of coverage affected their access to care (Rodin et al. 2019). In another study, women with continuous Medicaid eligibility had higher postpartum visit rates than women with pregnancy-only Medicaid that ended after 60 days postpartum (DeSisto et al. 2020).

Other factors may also affect receipt of care. About 61 percent of women covered by Medicaid had a postpartum visit within eight weeks of delivery (CMS 2020d).[34] Fewer postpartum visits among Medicaid-enrolled women have been associated with being Black and in some cases Hispanic, being younger; having SUD, depression, a disability, or other children at home; and low attendance at prenatal care visits. Lack of information related to when their coverage would end, the importance of postpartum visits, as well as available programs or services hindered postpartum visit attendance among Strong Start participants. Logistical barriers, such as transportation and child care, also inhibited receipt of postpartum care (Rodin et al. 2019).

State and Federal Action

Both state and federal officials are taking action to extend Medicaid postpartum coverage for a longer period of time.

State action

As of January 2021, 12 states have extended or passed legislation to extend coverage beyond the 60-day postpartum period permitted under federal statute, although they may target a particular population, such as women with a mental health condition or SUD (Table 2-1).[35]

The majority of these states have not yet implemented the extension. To receive federal matching funds for this coverage, states need approval of a demonstration waiver under Section 1115 from the Centers for Medicare & Medicaid Services (CMS), and many states have pending applications.[36] Some of the states are using state-only funds to extend the postpartum period.

Legislation to extend the postpartum period has been introduced in other states (Haley et al. 2021, Eckert 2020, ACOG 2020a, NASHP 2020). In at least three of these states (Tennessee, Virginia, and Washington), legislation was either vetoed or paused in response to COVID-19-related budget constraints, although Virginia has since moved forward (Cirruzzo 2020a, Kelman 2020).

TABLE 2-1. Features of State Postpartum Coverage Policies, January 2021

State	Authority	Implemented	Awaiting CMS approval	Length of extension	Upper income eligibility limit (FPL)	Limitations
California	State only funds	Yes	–	12 months	322%	Women with a mental health condition
Colorado	§ 1915(b) waiver	Yes	No	12 months	195	Women with an alcohol or SUD receive SUD treatment services
District of Columbia	§ 1115 demonstration	No	Not yet submitted	12 months	319	–
Georgia	§ 1115 demonstration	Yes	No	2 years	211	Women who deliver a very low birthweight baby receive family planning and targeted interpregnancy services
	§ 1115 demonstration	No	Yes	6 months	220	–
Illinois	§ 1115 demonstration	No	Yes	12 months	208	–
Indiana	§ 1115 demonstration	No	Yes	12 months	213	Women with an OUD
Michigan	§ 1115 demonstration	No	Not yet submitted	12 months	195	–

TABLE 2-1. (continued)

State	Authority	Implemented	Awaiting CMS approval	Length of extension	Upper income eligibility limit (FPL)	Limitations
Missouri	§ 1115 demonstration	No	Yes	12 months	196	Women with a SUD receive mental health and SUD treatment services
	§ 1115 demonstration	No	Not yet submitted	12 months	196	Women with postpartum depression or another mental health condition receive mental health treatment services
New Jersey	§ 1115 demonstration	No	Yes	6 months	200	Women who are not otherwise eligible for Medicaid
South Carolina	§ 1115 demonstration	Yes	No	12 months	194	Up to 500 women with a SUD or SMI
Texas	State-only funds; § 1115 demonstration	Yes	Yes	at least 12 months	200	Family planning and targeted postpartum care services only
Virginia	§ 1115 demonstration	No	Not yet submitted	12 months	200	Women with income between 133% and 200% FPL

Notes: § 1915(b) is Section 1915(b) of the Social Security Act (the Act). § 1115 is Section 1115 of the Act. FPL is federal poverty level. SUD is substance use disorder. OUD is opioid use disorder. SMI is serious mental illness. The upper income eligibility limit shown here is the level to which the state is applying or will apply the postpartum extension; additional coverage may be available to women under another pathway (e.g., CHIP). In most states, the extension of coverage applies to women in Medicaid. The state-only funded postpartum coverage in California also applies to women covered through the unborn child option; New Jersey and Virginia are proposing to extend the period for women in both Medicaid and CHIP. Texas received approval for a Section 1115 family planning waiver in January 2020; additional services under the program are currently state-funded, but the state has submitted a waiver to receive federal matching funds. Eligibility for the program will be redetermined every 12 months.

– Dash indicates that the category is not applicable.

Sources: MACPAC, 2021, analysis of ACOG 2020a; CA DHCS 2020b; CMS 2020e, 2020f, 2020g, 2019b; GA DCH 2020; IL HFS 2020; IN FSSA 2020; Haley et al. 2021; Mathematica 2020; MI HFA 2020; MO DSS 2020; NJ DHS 2020; TX HHSC 2020a, 2020b; and state legislative materials (District of Columbia, Georgia, Missouri, and Virginia).

The following states have extended or have passed legislation to extend the postpartum period as of January 2021:

- California provides an additional 10 months of postpartum care for women in Medicaid as well as those covered under the CHIP unborn child option who are diagnosed with a maternal mental health condition, using state-only funds (CA DHCS 2020b, Mathematica 2020). The program may be suspended on December 31, 2021, unless further legislative action is taken.
- Colorado extends coverage for substance use treatment for pregnant women in Medicaid who have an alcohol use disorder or SUD for up to one year after delivery under a Section 1915(b) waiver (CMS 2020e, Mathematica 2020).
- The District of Columbia passed legislation to extend coverage for one year for postpartum beneficiaries, directing the mayor to seek CMS approval through a Section 1115 demonstration).[37] The demonstration is not yet funded by the city (DC OB 2021).
- Georgia approved legislation to extend the postpartum period to six months. The state submitted a Section 1115 demonstration application to CMS in December 2020 (GA DCH 2020).[38] Under the state's family planning demonstration, women who had a very low birthweight baby are provided a limited package of interpregnancy care services for two years before being shifted back to the traditional family planning-only group (CMS 2020f).
- Illinois legislation extended coverage for pregnant women to 12 months postpartum. The state submitted a Section 1115 demonstration in January 2020; it is awaiting CMS approval (IL HFS 2020, Mathematica 2020).[39]
- Indiana submitted a Section 1115 demonstration application in October 2020 to extend the postpartum period for one year for mothers with an opioid use disorder as part of the state's Maternal Opioid Misuse initiative; it is awaiting CMS approval (IN FSSA 2020).
- Michigan's fiscal year 2021 budget included funding for an extension of the postpartum period to 12 months (MI HFA 2020). The state has not yet submitted a demonstration application to CMS.
- Missouri is seeking to provide ongoing SUD and mental health treatment for 12 months after the end of pregnancy for women with SUD. The state submitted a Section 1115 demonstration request in February 2020, and is awaiting CMS approval (MO DSS 2020). Subsequent legislation passed by the state would extend the postpartum period for 12 months for mental health treatment services for women with postpartum depression or other mental health issues.[40]
- New Jersey submitted an amendment to its existing Section 1115 demonstration to extend the postpartum coverage period to six months in Medicaid and CHIP for women who do not otherwise qualify for Medicaid (NJ DHS 2020).[41] The amendment was submitted in March 2020 and is awaiting CMS approval.
- South Carolina received approval in December 2019 to extend coverage to as many as 500 postpartum women with SUD or serious mental illness under a Section 1115 demonstration waiver (Mathematica 2020, CMS 2019b). The state originally proposed extending postpartum coverage for all pregnant women earning up to 194 percent FPL to one year postpartum (SC DHHS 2019).
- Texas provides family planning services to women using a Section 1115 demonstration (CMS 2020g). Additional services, including mental health and SUD services, as well as services to address asthma, diabetes, hypertension, and certain cardiovascular conditions, are provided using state-only funds. The state has submitted a Section 1115 demonstration to receive federal

matching funds for these additional services for postpartum women; it is awaiting CMS approval (Cirruzzo 2020b; TX HHSC 2020a, 2020b).

- Virginia's 2020–2022 biennial budget directs the Department of Medical Assistance Services to seek authority to extend the postpartum coverage period to one year for women in Medicaid and CHIP with incomes between 133 percent and 205 percent FPL.[42] The state has not yet submitted a demonstration application to CMS.

Federal action

On September 29, 2020, the U.S. House of Representatives passed H.R. 4996, which would give states the option of extending the Medicaid postpartum coverage period from 60 days to a full year at the state's regular matching rate. Individuals would be entitled to the full Medicaid benefits package and services could not be limited to pregnancy-related services. If states choose to adopt the extension in their Medicaid program, they must also extend the postpartum period to pregnant women covered in CHIP.[43] The Senate did not act on the legislation before the 116th Congress concluded.

As this report went to press, the Biden Administration had not yet announced any plans related to postpartum coverage. The Trump Administration called for a relatively narrow postpartum coverage extension, proposing to allow states to extend Medicaid coverage for pregnant women with SUD to one year postpartum (OMB 2020). Under Secretary Alex Azar, the U.S. Department of Health and Human Services (HHS) also released an action plan describing the steps that HHS would take to address maternal health issues, including setting broader goals, such as reducing maternal mortality by 50 percent. The plan specifically noted support for policies to allow states to extend Medicaid coverage for postpartum women with SUD from 60 days to 365 days after birth (HHS 2020).

In 2019 and 2020, CMS convened an expert workgroup composed of new and returning members of the original expert panel to take stock of the progress of the Maternal and Infant Health Initiative and chart the trajectory of the initiative for the next five years. As one area of focus, the workgroup recommended increasing the use and quality of postpartum care, including expanding and ensuring continuity of coverage in the postpartum period (Bigby et al. 2020). CMS also launched a targeted technical assistance initiative to aid state agencies and their partners through a Postpartum Care Learning Collaborative open to all states that includes a series of informational webinars that began in early 2021. This will be followed by an action-oriented group for states interested in pursuing or continuing a quality improvement project (CMS 2020h).

Considerations in Extending the Postpartum Coverage Period

In considering an extension of the postpartum coverage period, the Commission drew from its analysis of the literature in discussing the effects of such a policy on health equity, insurance coverage, and continuity of care. The Commission also discussed state flexibility and the financial implications.

Improving health equity

Given Medicaid's role in covering births for women of color, extending the postpartum coverage period would be a step toward improving health equity. An extension would increase postpartum coverage among individuals of color who disproportionately experience poor maternal and infant health outcomes.

As discussed above, considerable racial and ethnic disparities exist in maternal and infant health outcomes (Artiga et al. 2020a). Black, non-Hispanic

women and American Indian and Alaska Native women have higher pregnancy-related death rates than white, non-Hispanic women. The causes and timing of deaths also differ by race, with a greater proportion of deaths among Black women occurring in the late postpartum period (Petersen et al. 2019a, 2019b). There are also documented disparities in maternal morbidity, with Black, non-Hispanic and American Indian and Alaska Native women at greater risk (Admon et al. 2018a, Kozhimannil et al. 2019). Women of color are also at greater risk of giving birth to a preterm or low birthweight infant (Martin et al. 2019). Studies have also shown racial and ethnic disparities in access to postpartum care, contraception, and treatment for postpartum depression (Thiel de Bocanegra et al. 2017, Kozhimannil et al. 2011).

Although a number of factors, such as higher prevalence of comorbidities and pregnancy complications, lower socioeconomic status, and less access to prenatal care contribute to these disparities, they do not fully explain the differences in outcomes (Howell 2018). The disparities reflect barriers to care, including coverage and lack of access to culturally and linguistically appropriate care, as well as ongoing discrimination. Even after controlling for insurance status, income, age, and severity of health conditions, people of color are less likely to receive routine medical procedures and they experience a lower quality of care (Artiga et al. 2020a).

Gaps in coverage contribute to the poor maternal and infant health outcomes. Racial and ethnic disparities in insurance status and continuity of coverage for women spanning the prepregnancy to postpartum period exist, including among women whose births were paid for by Medicaid (Daw et al. 2021, 2020a). These coverage disparities are evident in the broader population and, despite gains in coverage following implementation of the ACA, they have persisted. Individuals who are Black, Hispanic, American Indian and Alaska Native, and Native Hawaiian or other Pacific Islander are more likely to be uninsured in comparison to whites (Artiga et al. 2020b, Buchmueller et al. 2016). Uninsured Blacks are more likely than whites to be ineligible for both Medicaid and exchange coverage because a greater share of Black people live in states that have not adopted the Medicaid expansion, including many southern states (Artiga et al. 2020b).

An extension of the postpartum coverage period would increase coverage among individuals of color. Thirty-seven percent of Black, non-Hispanic, uninsured new mothers, 36 percent of uninsured white, non-Hispanic new mothers, and 24 percent of Hispanic uninsured new mothers would become eligible under an extension of the postpartum coverage period (Johnston et al. 2021). More limited, targeted extensions, such as those that focus on SUD, would not address many of the conditions that disproportionately impact people of color. For example, as noted above, cardiomyopathy contributes to a significantly higher proportion of deaths among Black women in comparison to white women. Yet, the condition can manifest up to five months postpartum.

Increasing coverage options

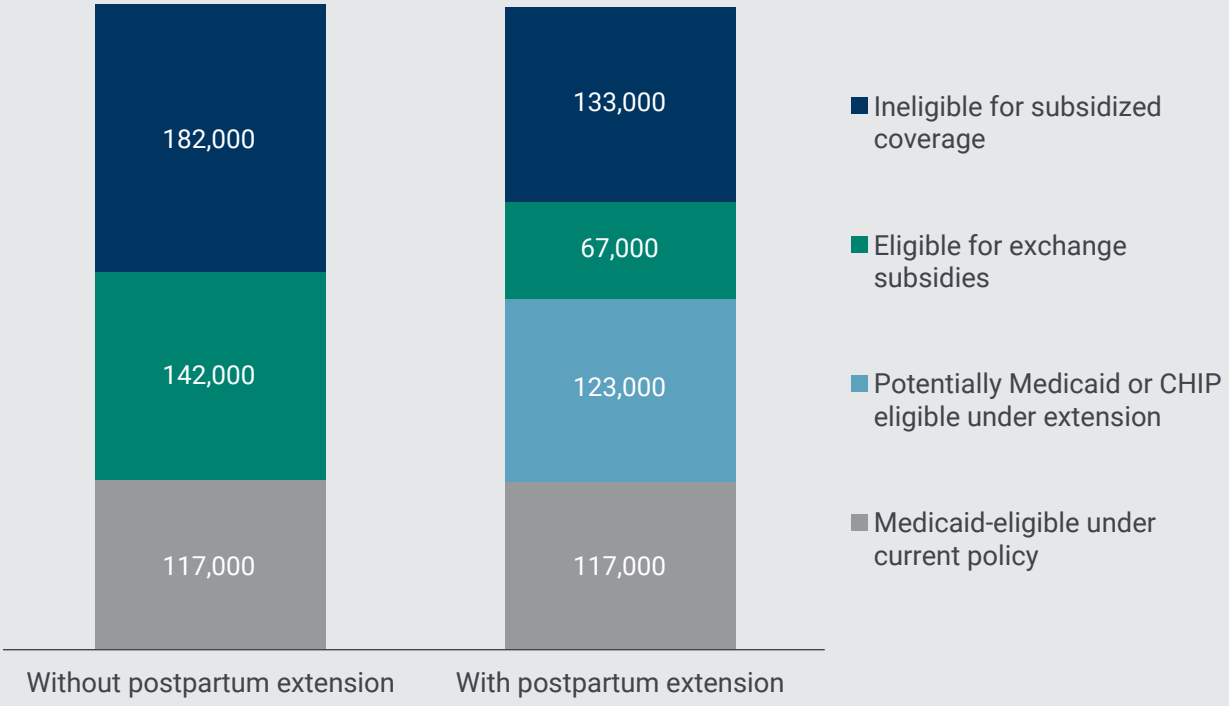
Extending the postpartum coverage period would provide women, including many who may otherwise become uninsured, with new coverage options. As discussed above, the availability of Medicaid coverage for such women depends on household income, the state's eligibility threshold for parents, and whether the state has adopted the Medicaid expansion. Subsidized exchange coverage may be available for women with incomes above 100 percent FPL, but unlike Medicaid for pregnant women, would require premiums and cost sharing. Subsidized exchange coverage is not available for women with incomes below 100 percent FPL. As such, in states that have not adopted the Medicaid expansion, coverage options are extremely limited for women whose incomes fall above Medicaid's upper income eligibility limit for parents and below the eligibility threshold for exchange coverage.

An extension of the postpartum period would address some of the disruptions in coverage, because about half of all uninsured new mothers

reported that losing Medicaid or other coverage following pregnancy was the reason they were uninsured (McMorrow et al. 2020b). A recent study finds, using 2016–2018 data, that of 440,000 uninsured new mothers, approximately 28 percent (123,000) would become newly eligible for Medicaid or CHIP through an extension of the postpartum coverage period; another 27 percent (117,000) were likely already eligible for Medicaid but not enrolled; and 15 percent (67,000) were in the income range for subsidized exchange coverage (Figure 2-3) (Johnston et al. 2021).

Most (83 percent) uninsured new mothers likely to become eligible for Medicaid or CHIP following an extension of the postpartum coverage period live in non-expansion states. Nearly two-thirds of new mothers likely to benefit from a postpartum coverage extension live in five states—Florida, Georgia, Missouri, North Carolina, and Texas. These states have high rates of uninsurance among new mothers, have low eligibility thresholds for parents, and have chosen not to expand Medicaid (Missouri has adopted, but not yet implemented the expansion) (Figure 3) (Johnston et al. 2021).[44]

FIGURE 2-3. Number of New Mothers Uninsured Postpartum and Estimated to be Eligible for Subsidized Coverage under Current Eligibility Rules and a 12-Month Postpartum Medicaid and CHIP Extension, 2016–2018



Notes: Among 440,000 uninsured new mothers. Mothers eligible for exchange subsidies have incomes between 100 percent and 400 percent of the federal poverty level; analysis does not account for whether a mother has access to affordable employer-sponsored insurance. Eligibility categories are mutually exclusive, with Medicaid eligibility preceding exchange subsidy eligibility. Mothers ineligible for subsidized coverage are ineligible for Medicaid and do not qualify for subsidized exchange coverage. Annualized counts are rounded to the nearest 1,000.

Source: Johnston et al. 2021.

Continuity of care

Although individuals would likely experience changes at the end of the 12-month postpartum coverage period just as they do at the end of the current 60-day postpartum coverage period, extending the time frame would avoid disruptions during a critical clinical period. This would allow continuity in terms of benefits, cost sharing, and provider relationships for women who would otherwise be uninsured as well as for women who would have maintained coverage but shifted to another source of coverage. Although states must now screen and enroll a postpartum woman in other coverage (if eligible), additional steps required to apply for and enroll in alternative coverage can lead to gaps in coverage.

Extending postpartum coverage would affect access to care by limiting transitions between sources of coverage. In one study of coverage changes, almost 20 percent of individuals had to change at least one doctor, with 9 percent having to change both their primary care and specialty providers. Shifting providers was more common among individuals who had a gap in coverage. Changing coverage also affected use of prescription medications, with 16 percent of individuals with a coverage change switching prescriptions and 34 percent either skipping doses or stopping taking their medication. Regardless of whether they experienced a gap in coverage, individuals who changed coverage reported negative effects on the quality of care and health (Sommers et al. 2016).

Uninsured new mothers report similar problems with access to care. Within the last year, about one in five uninsured new mothers reported at least one unmet need due to cost. This includes an unmet need for medical care (14 percent), prescriptions (17 percent), and mental health care (2 percent). Slightly more than half (55 percent) of uninsured new mothers reported having a usual source of care, and 82 percent reported seeing an obstetrician-gynecologist in the past year. Among those who lost Medicaid coverage, many women experienced conditions indicating a need for ongoing care, such as obesity (30 percent), gestational diabetes (11 percent), pregnancy-related hypertension (10 percent), and depression during pregnancy (12 percent). About one-third were recovering from a cesarean section (McMorrow et al. 2020b).

For some new mothers, it is especially important to maintain the connection to providers who oversaw their prenatal care and delivery hospitalization because they have established a trusting relationship and their providers understand their health history and ongoing care needs. A lack of continuity of care can lead to missed opportunities to improve outcomes. In its waiver application to extend the postpartum coverage period, Illinois cited poor continuity of care and a lack of care coordination as factors that contributed to death in 93 percent of preventable pregnancy-related deaths during the late postpartum period (IL HFS 2020).

Many of these postpartum individuals may return to Medicaid in the future, and ongoing care may lead to improvements in the women's health and reduce the chances of complications and higher costs during subsequent pregnancies. For example, New Jersey noted in its waiver application to extend the postpartum coverage period that 53 percent of pregnant women who lost Medicaid postpartum re-enrolled at some point over the following two years. If these women do not receive family planning services or care to manage chronic diseases and other health concerns, they may have greater risks with a future pregnancy and the program may face higher costs (NJ DHS 2020). In Colorado, the Medicaid expansion led to an increase in postpartum outpatient utilization, particularly among women who experienced severe maternal morbidity at delivery (Gordon et al. 2020).

Implications for the health of the child

Studies have shown that the health and well-being of a mother can affect that of her child. For example, as discussed above, perinatal mood and anxiety disorders affect one in seven pregnant and postpartum women and can lead to adverse effects for both the mother and the child (Earls et

al. 2019, Luca et al. 2019). Studies have shown that postpartum depression leads to increased costs of medical care, inappropriate medical treatment of the infant, discontinuation of breastfeeding, family dysfunction, and an increased risk of abuse and neglect, and it adversely affects the critical early period of infant brain development (Earls et al. 2019). There are also longer-term effects, with children of women with persistent and severe depression at an increased risk for behavioral problems (Reeves and Krause 2019, Netsi et al. 2018, Ashman et al. 2008).

In 2016, CMS issued an informational bulletin detailing how Medicaid agencies may cover maternal depression screening as part of a well-child visit, which 33 states currently do (Mathematica 2020, CMS 2016). However, screening may have limited utility if the mother is uninsured and cannot access needed treatment services. The CMS guidance also clarified that if the provider identifies a problem, further diagnostic and treatment services exclusively for the mother are covered by Medicaid only if the mother is also enrolled (Boozang et al. 2020, CMS 2016).[45]

Extending coverage for parents can also have implications for coverage and service use among their children. Studies have shown that when parents are covered, their children are more likely to be insured (Rosenbaum and Whittington 2007, Sommers 2006). A recent study of the effect of the Medicaid expansion found that it was associated with increased receipt of recommended pediatric preventive care (Venkataramani et al. 2017). Aligning continuous coverage for both the mother and the deemed newborn might improve ongoing care and later coverage transitions for both of them following the first year postpartum (Johnson et al. 2020).[46]

State flexibility

Whether the postpartum coverage period is a requirement or a state option has implications for state flexibility and the potential reach of the new coverage. Creating a state option to extend such coverage would allow states that have prioritized coverage of this population (presumably as a mechanism to improve maternal health outcomes) to do so without a waiver, which would ease state and federal administrative burden. Making the extension a requirement would be a more directive approach to improving outcomes and would ensure that all eligible postpartum individuals receive the same coverage period regardless of where they live, consistent with the current policy.

A mandatory extension of the postpartum coverage period would also build on the legislative history of extending coverage to pregnant women as a way to address poor maternal and infant health outcomes.[47] Such an approach could help to ensure that all postpartum individuals receive ongoing medical care during their postpartum period, because a lack of coverage can be a barrier to receiving such care. Furthermore, Medicaid plays a considerable role in financing births. In 2018, Medicaid paid for 43 percent of all births nationally and for a greater share of deliveries by Hispanic, Black, and Indigenous women (MACPAC 2020a). Given the federal contribution in matching funds for these births, a mandatory extension of the coverage period could be viewed as an appropriate use of federal authority to improve health outcomes for a vulnerable population.

During the Commission's deliberations, it was noted that states may have different priorities and prefer to focus program resources on other areas. As is the case with many other aspects of the Medicaid program, states vary considerably in the populations and benefits they cover, reflecting deliberate state choices in considering the health needs of their residents and the cost of paying for their care (MACPAC 2016b). As noted above, 13 states did not adopt the option for a continuous 60-day postpartum coverage period prior to Congress requiring them to do so (GAO 1989). However, with better medical knowledge about the clinical importance of the postpartum period, states may now be more interested in providing such coverage than they were in the 1980s. In the current coverage landscape, an option to extend the postpartum coverage period may be more attractive to states

that have not adopted the Medicaid expansion because it would fill an existing gap in coverage for postpartum women. It is reasonable to assume that not all states would adopt an optional extension, leaving some women without coverage after 60 days postpartum. Given the limited reach that an optional expansion would have and the inequities it would perpetuate, the Commission did not pursue this approach.

State and federal approaches to extending the postpartum coverage period to date have typically been limited in scope, primarily targeting women with SUD. Although this represents progress in covering additional postpartum women, such extensions would cover a smaller population relative to a mandatory extension for all individuals who received Medicaid while pregnant. In addition, the existing approaches discussed above may also reach only a segment of the intended population given the administrative challenges of identifying and maintaining coverage for women with a particular diagnosis and the potential for a diagnosis to occur after the traditional 60-day postpartum period has ended. The approach of limiting services to SUD treatment fails to address many of the causes of postpartum morbidity and mortality and does not align with the Commissioners' views that all pregnant and postpartum women should receive comprehensive coverage.

Fiscal implications

Extending the postpartum period would have financial implications for states and the federal government. Under current the financing arrangement, costs to states and the federal government would increase to the extent that women who would otherwise go uninsured are covered. Costs to the federal government might decline to the extent that women losing Medicaid coverage following the postpartum period would have secured subsidized exchange coverage which is wholly federally financed. Effects across states would vary as a function of their current policies for covering pregnant women and other adults (e.g., low-income parents and the new adult group).

The fiscal implications also depend upon whether the policy is mandatory or optional and the state's federal matching rate. Policymakers have used the federal matching rate as a policy lever, increasing the rate—sometimes temporarily and sometimes permanently—to help offset new expenditures or to encourage states to adopt various options (MACPAC 2016b). For example, higher federal matching rates have been used as incentives to states to expand eligibility through CHIP and to defray the cost of the new adult group under the ACA. Higher matching rates have also been made available to improve systems capacity and increase the use of family planning services and supports as well as home- and community-based services.[48]

Recommendations

Recommendation 2.1

Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.

Rationale. An extension of the postpartum coverage period would build on the legislative history of expanding coverage to pregnant women as a way to address poor maternal and infant health outcomes. Individuals may experience considerable risks to their health and life during the postpartum period. One-third of pregnancy-related deaths occur postpartum and an increasing number of pregnant women have chronic conditions and behavioral health issues that may require continued medical care in the postpartum period (Brown et al. 2020; CDC 2020; Luca et al. 2019; Petersen et al. 2019; Admon et al. 2018, 2017; Tyer-Viola and Palan Lopez 2014). An extension of the coverage

period could help ensure that individuals receive ongoing medical care during their postpartum period, because a lack of coverage can be a barrier to receiving such care. Furthermore, given the racial and ethnic disparities in maternal outcomes, an extension of the postpartum coverage period would serve as a way to improve health equity. Finally, the health of the child is interwoven with that of the mother. As such, improving outcomes for the mother may also have implications for the health and well-being of the child (Rosenbaum and Whittington 2007).

The Commission discussed at length whether an extension of the postpartum period should be a requirement or state option. Requiring such an extension would be a more directive approach to improving outcomes and would also ensure that all eligible postpartum individuals receive the same coverage period regardless of where they live, consistent with the current policy. It is also reasonable to assume that not all states will adopt a state option, leaving some women without coverage after 60 days postpartum. Ultimately the Commission determined that a mandatory extension is needed to address gaps in coverage that affect maternal morbidity and mortality. Requiring states to provide a full year of coverage will ensure that the greatest number of postpartum individuals are reached and provides some level of equity across states.[49]

In the Commission's view, however, states should not be expected to bear the cost of such a mandate. Extending the postpartum period could potentially shift individuals who would be eligible under a category with a higher matching rate to coverage as pregnant women. As a pregnant woman, these individuals would instead receive the state's traditional matching rate, likely increasing costs for states. Furthermore, the current budget challenges states are facing due to COVID-19 and the accompanying economic downturn may make the cost of an extension of the postpartum coverage period more difficult for states to assume on their own.

The Commission discussed at great length the level of federal financial assistance states should receive, and eventually narrowed it down to a choice between a 90 percent or 100 percent federal match. On the one hand, a 90 percent match would reinforce that Medicaid is a state-federal partnership. It is a jointly financed program and states should continue to invest in the program. A 90 percent matching rate would still indicate the importance of the extension and would also provide parity with the Medicaid expansion.

The Commission, however, ultimately decided to recommend 100 percent federal funding to help offset the costs of a mandatory extension. As such this extension of coverage would not impose an unfunded mandate, especially given state budget constraints.

This recommendation would not alter the existing flexibility provided to states in establishing income eligibility thresholds for pregnancy-related and other eligibility pathways.

Implications

Federal spending. A mandatory extension of the postpartum coverage period would result in increased one-year federal spending of $750 million to $2 billion. Costs over the 10-year budget window would be between $30 billion and $40 billion. These costs include the extension to CHIP discussed below.

States. Although the federal government would bear a greater share of the cost of an extended postpartum coverage period, states would need to adjust administrative processes to ensure that postpartum individuals remain enrolled through one year and claim the appropriate federal matching rate for them.

Beneficiaries. The Commission heard a number of moving stories in public comment at its January 2021 meeting that reinforced the importance of postpartum care for new mothers and their families. Our analysis indicated that this policy would ensure that postpartum individuals enrolled in Medicaid would be able to maintain their existing coverage for

a full year. Approximately 123,000 uninsured new mothers would become newly eligible for Medicaid or CHIP through an extension of the postpartum coverage period. More than one-third of Black, non-Hispanic, and white, non-Hispanic, uninsured new mothers and one quarter of Hispanic uninsured new mothers would become eligible under an extension of the postpartum coverage period (Johnston et al. 2021). With an extended postpartum coverage period, individuals may be more likely to access care for both complications from pregnancy and ongoing conditions, which may lead to better health outcomes. Furthermore, the recommendation would reduce the transitions in coverage during a particularly vulnerable time, allowing postpartum individuals to maintain their Medicaid coverage, thus keeping the same providers and benefits.

Plans and providers. Extending the postpartum coverage period would help ensure that providers could continue to provide and get paid for services furnished to individuals they have seen throughout pregnancy and delivery. This would allow them to treat conditions that arose because of pregnancy, but may also provide an opportunity to address other chronic conditions. Extending the postpartum coverage period, thereby avoiding the postpartum individual's need to shift coverage 60-days postpartum, could reduce the administrative burden on providers and plans and allow them to improve the management of the enrollee's care. Several professional societies, including ACOG, the American Medical Association, and the Society for Maternal-Fetal Medicine, have endorsed extending the postpartum period to 12 months (ACOG 2020b, SMFM 2020, AMA 2019).[50]

Recommendation 2.2

Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.

Rationale. The same rationale for extending the postpartum coverage period for individuals in Medicaid applies to those who are covered in CHIP.[51] In the Commission's view, requiring an extended postpartum coverage period in both Medicaid and CHIP would ensure that individuals are provided the same length of coverage regardless of the program in which they are enrolled. Such an extension would maintain the consistent application of the coverage period across programs and provide additional protection to postpartum individuals in CHIP who do not currently have a continuous coverage period.[52]

This recommendation would not change the existing matching rate and states would continue to receive the CHIP enhanced matching rate for the extension of the postpartum coverage period.

Implications

Federal spending. The federal cost of the extension is included in the estimate for extending the postpartum coverage period in Medicaid provided above.

States. The six states that cover low-income pregnant women in CHIP would face additional costs to extend the postpartum coverage period from the current 60 days to a full year, given that coverage for these women would be matched at the states' regular CHIP enhanced matching rates. States would also need to adjust administrative procedures to ensure that postpartum individuals receive a full year of continuous coverage. As new states adopt the option to cover pregnant women in CHIP, they would also face the added costs of the extended postpartum coverage period.

Beneficiaries. Similar to the implications for Medicaid, postpartum individuals enrolled in CHIP would maintain their existing coverage for a full year.[53] Such coverage may improve access to services, continuity of care, and health outcomes among postpartum individuals. The estimates presented in Recommendation 2.1 include individuals in CHIP. In fiscal year (FY) 2019, the states electing this option (excluding Missouri and West Virginia) covered 8,671 women, indicating the

approximate number of women in CHIP who will benefit from the extension.[54]

Plans and providers. As with the extension in Medicaid, extending the postpartum coverage period would help ensure that providers could continue to provide and get paid for services to individuals they have seen throughout pregnancy and delivery. An extension could also reduce administrative burden on providers and plans and assist them in efforts to improve the management of enrollees' care.

Recommendation 2.3

Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

Rationale. It is the view of the Commission that all pregnant and postpartum individuals should be provided comprehensive coverage and that states should not have the option to limit coverage to pregnancy-only services. Pregnancy-related services may be broad in scope because they are defined as those that are necessary for the health of the pregnant woman and fetus (42 CFR 440.210). However, the definitions differ across the five states providing pregnancy-only services and the provision of certain benefits may depend on a provider or plan determining that a particular service is pregnancy-related. Furthermore, services that are considered pregnancy-related while a woman is pregnant may not be considered pregnancy-related once the pregnancy ends. Requiring the full Medicaid benefit package for individuals enrolled in all pregnancy-related pathways may help to ensure the best possible birth and maternal health outcomes.

This recommendation would not limit states' ability to provide enhanced pregnancy benefits designed to improve maternal and birth outcomes to all pregnant women covered under the state plan. For example, given the possible link between periodontal disease and an increased risk for preterm birth, some states have extended dental coverage to pregnant women (MACPAC 2020a). At the same time, it would not require states to extend coverage to any specific optional benefit.

Implications

Federal spending. This recommendation would increase federal spending by less than $50 million in one year, and by less than $1 billion over the 10-year budget window. These are the smallest non-zero categories of spending used by the Congressional Budget Office when making budget estimates.

States. If the five states currently covering only pregnancy-related services are not providing a broad benefit package, covering additional medically necessary (but not pregnancy-related) services may increase expenditures. If almost all medically necessary services are already provided, however, expanding coverage to the full Medicaid benefit package should not add substantial costs. This recommendation would also prevent states from restricting coverage to pregnancy-related services in the future.

Beneficiaries. Under this recommendation, pregnant and postpartum women with pregnancy-only coverage in five states would become eligible for additional, non-pregnancy-related services that are not already covered.

Plans and providers. Requiring states to provide full Medicaid benefits would eliminate the need for providers to determine whether specific services are pregnancy related and allow them to bill for all Medicaid-covered services provided to pregnant women with Medicaid. Plans would not need to differentiate services or provide separate benefit packages for pregnancy-only services.

Endnotes

[1] It is important to note that during the public health emergency related to COVID-19, pregnant women who reach the end of their postpartum period cannot be disenrolled due to the continuous coverage requirements tied to the enhanced federal matching rate provided by the Families First Coronavirus Relief Act (FFCRA, P.L. 116-127). FFCRA provides a temporary 6.2 percentage point increase to the federal medical assistance percentage (FMAP) through the end of the quarter in which the public health emergency and any extensions end. Among other requirements, states must provide continuous coverage to validly enrolled beneficiaries. That is, states must continue providing coverage to an individual who enrolled in Medicaid as of the date of enactment or during the emergency declaration period until the end of the month in which the emergency period ends, unless the individual requests to be disenrolled or is no longer a resident of the state. As such, validly enrolled pregnant women who would typically lose coverage at the end of the 60-day postpartum period will continue to have coverage until the end of the month in which the emergency period ends. The continuous enrollment provision does not apply to CHIP (CMS 2021a).

[2] MACPAC uses the terms pregnant and postpartum women because these are the terms used in Medicaid statute and regulations. However, other more inclusive terms are increasingly being used in recognition that not all individuals who become pregnant and give birth identify as women.

[3] The postpartum coverage period is required under § 1902(e)(5) of the Social Security Act (the Act). It begins on the last day of the pregnancy and extends through the end of the month in which the 60-day period concludes (42 CFR 435.4, 42 CFR 440.210(a)(3)).

[4] Specifically, federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of: (1) 133 percent FPL or (2) the income standard, up to 185 percent FPL, that the state had established as of December 19, 1989, for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so (42 CFR 435.116). As such, there are 19 states that have a mandatory minimum eligibility threshold for pregnant women above 133 percent FPL (MACPAC 2014, NGA 1990). Prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing when determining Medicaid and CHIP eligibility. Therefore, the income eligibility for pregnant women is effectively higher than the maximum of 185 percent FPL in a number of states.

[5] To qualify for the full range of benefits offered under Medicaid, individuals must be citizens or nationals of the United States or qualified aliens (which includes legal permanent residents, refugees, and asylees). Legal permanent residents are generally barred from receiving full Medicaid benefits for five years, after which coverage becomes a state option. However, children and pregnant women who are lawfully present may be covered during the five-year bar at state option. Non-qualified aliens (as well as qualified aliens subject to a five-year bar on full benefits) who meet income and all other eligibility criteria for the program can receive limited emergency Medicaid coverage only (MACPAC 2017a).

[6] Pregnant women in all categorically needy and medically needy eligibility groups under § 1902(a)(10) are entitled to continuous eligibility through the 60-day postpartum period, regardless of changes in income that would otherwise result in a loss of eligibility (§ 1902(e)(6) of the Act). This applies both to women whose eligibility is based on pregnancy and to women who are pregnant but eligible under a group unrelated to their pregnancy status (such as a low-income parent). However, women eligible on the basis of their pregnancy will no longer be eligible under the pregnancy-related group at the end of the postpartum period. For a woman covered under another pathway who becomes pregnant, the end of the postpartum period does not itself represent a change in circumstances likely to affect eligibility (CMS 2020a).

[7] Generally, when individuals are eligible for more than one category, they have a choice of which eligibility pathway to enroll in (42 CFR 435.404). States are not required to track the pregnancy status of current enrollees, so unless individuals self-identify, they would remain enrolled in their current eligibility group. Although pregnant women are not eligible for the new adult group that covers individuals with incomes below 133 percent FPL, the self-identification rule still applies, and those already enrolled in the group may remain in the group until the next regular eligibility renewal (CMS 2012a).

[8] To provide CHIP state plan coverage, state Medicaid programs must cover pregnant women with incomes up to 185 percent FPL (or up to the eligibility level the state had in place on July 1, 2008, whichever is higher). The CHIP upper income eligibility limit for pregnant women cannot be higher than the limit set for children, and states may not impose policies such as enrollment caps on targeted low-income children (§ 2112(b)(7) of the Act).

[9] Under CHIP coverage, the postpartum coverage period is 60 days, but the statutory text does not specifically provide continuous eligibility for pregnant women during pregnancy or the postpartum period (§ 2112(d)(2)(A) of the Act).

States also have the option to cover prenatal care for certain pregnant women using Title XXI funds under the unborn child option, defining the fetus as the targeted low-income child. This pathway covers services from conception to birth but not postpartum services (CMS 2002). However, CMS has permitted payment for postpartum care under the unborn child option in some states because the state has a global rate for pregnancy services that includes the cost of prenatal care, labor and delivery, and 60 days of postpartum care (Baumrucker 2008).

[10] For those who are eligible on the basis of pregnancy, the end of the 60-day postpartum period represents a change in circumstance. As such, the standard policies and procedures guiding any change in circumstance would apply. For individuals enrolled through other pathways, if the postpartum period ends after the individual's regularly scheduled renewal (i.e., 12 months after enrollment), the state would conduct a full renewal (42 CFR 435.916, CMS 2020a).

[11] Thirty-eight states and the District of Columbia have adopted the option to expand Medicaid to low-income adults; Missouri and Oklahoma opted to expand by voter referendum but have not yet implemented the expansion.

[12] There may be additional options for coverage in some states for pregnant women following the postpartum period. For example, states can provide Medicaid coverage for family planning services to individuals who are not otherwise eligible for Medicaid. For more, see endnote 35.

[13] Only individuals without access to affordable employer-sponsored insurance (ESI) are eligible for subsidized coverage. Affordable coverage is based on income and defined as self-only coverage with employee costs that do not exceed 9.83 percent of income (CMS 2021b).

[14] In Illinois, pregnant women who are not eligible for Medicaid due to immigration status receive the full Medicaid benefit package for 60 days postpartum under a CHIP Health Services Initiative (HSI).

[15] States can limit coverage to pregnancy-related services for women with family incomes above the May 1, 1988, AFDC levels, but women with family incomes below the 1988 AFDC levels must receive full Medicaid benefits. Specifically, states must provide full Medicaid coverage for certain mandatory and optional pathways under §§ 1931 and 1902(a)(10)(A)(i)(III), (ii)(I), and (ii)(IV). States may limit coverage to pregnancy-related services for other eligibility pathways (coverage under § 1902(a)(10)(A)(i)(IV) and (ii)(IX)) (MACPAC 2014, 2013).

States must provide limited coverage of emergency medical services to non-citizens who would qualify for full Medicaid benefits but for their immigration status, including unauthorized immigrants (§ 1903(v), 42 CFR 435.139, 42 CFR 435.406(b)). Under emergency Medicaid, pregnant women who are otherwise eligible for Medicaid but for their immigration status would receive the same state plan services as other pregnant women, including routine prenatal care, labor and delivery, and routine postpartum care (42 CFR 440.255(b)(2)). States may also provide additional services that may treat conditions that can complicate pregnancy. This differs from emergency Medicaid for non-pregnant individuals who are entitled to emergency services only (42 CFR 440.255(b)(1)).

[16] A related issue is whether such coverage is considered to be minimum essential coverage (MEC) for purposes of exchange subsidy eligibility. Medicaid eligibility, including pregnancy-related coverage that provides full Medicaid benefits, generally makes individuals ineligible for exchange subsidies because it is considered MEC. CMS reviewed state practices in 2016 and found that only three states (Arkansas, Idaho, and South Dakota) provided a limited benefit package that did not constitute MEC (MACPAC 2016a). In 2019, Idaho began providing the full Medicaid benefit package to pregnant women; that coverage would now be considered MEC (ID DHW 2019).

[17] Each managed care organization in New Mexico offers its enrollees additional benefits (termed value-added services) on top of the standard Medicaid benefit package.

[18] A state may provide a greater amount, duration, or scope of services to pregnant women than it provides under its plan to other individuals who are eligible for Medicaid, under the following two conditions. First, these services must be pregnancy-related or related to another condition that may complicate pregnancy (as defined in 42 CFR 440.210(a)(2)). Second, these services must be provided in equal amount, duration, and scope to all pregnant women covered under the state plan (42 CFR 440.250(p)).

[19] Some postpartum individuals would also transition to ESI. Given the variability in the availability of such coverage, as well as the benefits provided and costs associated with such coverage, we do not discuss the implications of shifting to ESI following the postpartum period.

[20] Adults enrolled in Medicaid under the new adult group must be offered an alternative benefit plan (ABP) that covers the 10 essential health benefits (EHBs). These benefits are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and SUD services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The Mental Health Parity and Addiction Equity Act (P.L. 110-343) applies to alternative benefit plans (CMS 2012b).

[21] Exchange plans must also cover the 10 EHBs. The benefit packages in exchange plans may differ from those offered by Medicaid to the new adult group or pregnant women. However, Medicaid may provide enhanced maternity benefits that are not routinely provided by exchange plans, such as the intensive case management.

[22] The ACA set a single income eligibility disregard equal to 5 percentage points of the FPL for groups whose eligibility is determined using modified adjusted gross income. For this reason, eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[23] High uninsurance rates among Hispanic women are attributable, in part, to citizenship status. When the study's authors restricted the analysis to citizens, the 2017 uninsurance rate for Hispanic new mothers (13.8 percent) was still higher than other groups (Johnston et al. 2019).

[24] Some researchers suggest that perinatal outcomes for Hispanic women should be reported separately by country of origin to account for the growing disparity in birth outcomes for U.S. born and non-U.S. born Hispanic women. However, the Pregnancy Risk Assessment Monitoring System (PRAMS) does not include information on maternal place of birth or immigration status. Both analyses by Daw and colleagues use primary language (English or Spanish) as a proxy for country of origin and immigration status for Hispanic women (Daw et al. 2021, 2020a).

[25] Across states, racial and ethnic disparities in the postpartum uninsurance rate tended to be similar in direction but varied in terms of magnitude.

[26] See endnote 5.

[27] There were no significant changes in disparities among Hispanic infants.

[28] The coalition endorsing the postpartum care recommendation included ACOG, the Academy of Breastfeeding Medicine, the American College of Nurse-Midwives (ACNM), the National Association of Nurse Practitioners in Women's Health (NPWH), the Society for Academic Specialists in General Obstetrics and Gynecology, and the Society for Maternal–Fetal Medicine (SMFM). The coalition endorsing the interpregnancy care recommendation included ACNM, ACOG, NPWH, and SMFM.

[29] Interpregnancy care is the care provided to women of childbearing age who are between pregnancies with the goal of improving outcomes for women and infants (ACOG and SMFM 2019).

[30] Pregnancy-related death is defined as the death of a woman while pregnant or within one year of the end of a pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy (CDC 2019).

The National Center for Health Statistics (NCHS) also reports data on maternal mortality through the National Vital

Statistics System (NVSS). These data rely on the definition of maternal mortality used by the World Health Organization (WHO): deaths of women while pregnant or within 42 days of being pregnant, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Due to implementation of the standard death certificate, NCHS did not publish the maternal mortality rate (MMR) between 2008 and 2017 (Hoyert and Miniño 2020). However, in comparison to other countries, the U.S. estimate of the maternal mortality ratio (19 maternal deaths per 100,000 live births), is higher than those seen in Europe (10 per 100,000) and Australia (7 per 100,000). Despite the uncertainty around the rate, it is believed that there have been actual increases in the MMR between 2000 and 2017 in the United States (WHO 2019).

[31] These deaths are considered pregnancy-associated deaths—the death of a woman while pregnant or within one year of the termination of pregnancy, regardless of the cause. However, depending upon the particular circumstances of the case and the criteria used in the review, they may or may not be considered pregnancy-related.

[32] About 60 percent of pregnancy-related deaths overall may be preventable. Preventability did not significantly differ by race or ethnicity, with 57.4 percent of deaths among Black women, 62.7 percent among white women, and 58.3 percent among Hispanic women determined to be preventable. Preventability was also similar by timing of pregnancy-related death: 59.0 percent during pregnancy, 53.3 percent during delivery, 57.1 percent 1–6 days postpartum, 66.7 percent 7–42 days postpartum, and 61.9 percent 43–365 days postpartum (Petersen 2019a).

[33] Other state Maternal Mortality Review Committees (MMRCs) have found that the majority of pregnancy-related deaths are among women with Medicaid, although these findings are not specific to the postpartum period. For example, 62 percent of women who died in Louisiana between 2011 and 2016 had Medicaid; 69 percent of maternal deaths in Texas in 2012 were to women enrolled in Medicaid at the time of delivery; and in 83 percent of the maternal deaths in West Virginia between 2007 and 2013, Medicaid was the primary coverage source during delivery (LA DOH 2018, TX DHHS 2018, WV DHHR 2015).

[34] The technical specifications for the measure limit the postpartum visit time frame to between 21 and 56 days after delivery. As such, women may have received a postpartum visit, but outside of that time frame. The technical specifications for the measure are being updated for the 2021 reporting cycle to encompass a wider time frame and to align with recommendations from ACOG.

Additionally, most states pay for maternity care in Medicaid and CHIP using a bundled payment for professional services provided during the perinatal period, including prenatal care, labor and delivery, and postpartum care. Bundled payments can create data quality and measurement issues because providers bill for the entire bundle rather than the component services, making it hard to track postpartum visits without undertaking costly medical chart review (CMS 2019a).

[35] Medicaid family planning programs are another pathway to provide limited care in the postpartum period. States can provide family planning services through the state plan; however, for a state to limit the services to a particular category of individuals (such as postpartum women), it needs a Section 1115 demonstration waiver. As of January 2020, 29 states offer family planning services through either the state plan option or a waiver (Brooks et al. 2020). Family planning services and supplies are reimbursable at a 90 percent federal matching rate; family planning-related services (e.g., medical diagnosis provided pursuant to a family planning service) are reimbursed at the state's traditional matching rate (CMS 2010). These matching rates apply regardless of eligibility group, meaning that family planning services provided to a postpartum woman enrolled in full Medicaid would also receive the 90-percent matching rate.

[36] States interested in drawing down federal financial support need a waiver to extend coverage beyond the statutorily mandated 60-day postpartum period, regardless of whether the state is targeting a particular category of women (e.g., those with SUD). As of January 2021, South Carolina is the only state that has secured approval of a Section 1115 waiver to extend the postpartum period beyond the provision of family planning services.

[37] D.C. Act 23-390, August 14, 2020, Postpartum Coverage Expansion Amendment Act of 2020, amending D.C. Code § 31-3861 et seq. https://lims.dccouncil.us/downloads/LIMS/42720/Signed_Act/B23-0326-Signed_Act.pdf.

[38] Georgia House Bill 1114, July 16, 2020, Relating to medical assistance generally, amending Ga. Code Ann. § 49-4-159 (2020). http://www.legis.ga.gov/Legislation/20192020/194813.pdf.

[39] Illinois included an extension of the postpartum period for legal permanent residents in the five-year waiting period in its demonstration request.

[40] Missouri House Bill 1682, July 13, 2020, Relating to health care, amending Mo. Rev. Stat. §§ 190.092–610.100 (2020). https://www.house.mo.gov/billtracking/bills201/hlrbillspdf/4231S.06T.pdf.

[41] New Jersey specified in its demonstration application that the extended coverage would apply only to pregnant women who do not otherwise qualify for coverage through another eligibility category. This means that only women with incomes above 133 percent FPL, who would not qualify under the Medicaid expansion, would be affected by the change (NJ DHS 2020).

[42] Virginia House Bill 5005 (Chapter 56), Budget Bill, November 19, 2020. Office of Health and Human Resources, Item 313 (Department of Medical Assistance Services). https://budget.lis.virginia.gov/item/2020/2/HB5005/Chapter/1/313/.

[43] Helping MOMS Act of 2020, H.R. 4996, 116th Cong. (2nd Sess. 2020). https://www.congress.gov/bill/116th-congress/house-bill/4996/text. According to the Congressional Budget Office (CBO), H.R. 4966 would have a net federal savings of $894 million over the next 10 years (CBO 2020). The House legislation offsets the cost of the extension by removing the cap on rebates for outpatient drugs covered by Medicaid (a prior MACPAC recommendation). The CBO score is only an assessment of the pay-as-you-go effects, so there are no further details about the actual cost of extending the postpartum coverage period or estimates of how many individuals might secure coverage.

[44] Most states' Medicaid eligibility rules did not shift dramatically during these three years or since. However, four states (Idaho, Maine, Utah, and Virginia) adopted the ACA's Medicaid expansion following data collection for the 2016–2018 American Community Survey. To avoid overstating potential postpartum eligibility, the researchers classified women who were ineligible for Medicaid under rules during 2016–2018 but below the ACA eligibility threshold of 138 percent of FPL in those four states as already eligible for Medicaid under existing policy.

[45] Mothers who are not eligible for Medicaid may benefit from services, such as family therapy, that are directed to treating the health and well-being of the child.

[46] States must provide Medicaid or CHIP to children from birth until the child's first birthday, without application, if the child's mother was eligible for and received covered services under Medicaid or CHIP. These infants are referred to as deemed newborns (§§ 1902(e)(4), 2112(e); 42 CFR 435.117, 42 CFR 457.360).

[47] As already noted, between 1984 and 1990, Congress repeatedly expanded Medicaid eligibility for low-income pregnant women, creating new mandatory and optional eligibility groups. Some of these expansions started as options, but most were later made mandatory. Chief Justice Roberts noted in his opinion on the ACA that such prior amendments to Medicaid altered and expanded the boundaries of the original coverage groups (disabled, blind, elderly, and needy families with dependent children) (Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012)).

[48] States have not always taken opportunities to draw enhanced federal match. For example, Section 2703 of the ACA provides authority for state Medicaid programs to create health homes for persons with chronic conditions or serious mental illness. Although this option provides a 90-percent federal match for two years, fewer than half of states have adopted it (KFF 2020). As such, even with a higher matching rate, states may choose not to extend the postpartum coverage period if it is not consistent with state priorities.

[49] The principle outlined in the Commission's recommendations is the importance of an extended postpartum coverage period to address the health needs of enrolled individuals. The Commission did not discuss the application of such changes to individuals receiving services under emergency Medicaid and in CHIP under the unborn child option; these may best be addressed through additional changes to the statute or regulations.

[50] MMRCs in a number of states have also recommended extending postpartum coverage for pregnant women (MACPAC 2020a).

[51] See endnote 49.

[52] See endnote 9.

[53] In addition, there may be some young adults (under age 19) covered in CHIP as targeted low-income children who received services while pregnant and are not currently entitled to the 60-day postpartum coverage period. Extending the postpartum coverage period to these individuals may also be addressed through changes in the statute.

[54] Data based on MACPAC analysis of fiscal year 2019 CHIP Statistical Enrollment Data System data as of January 3, 2021. Missouri did not report CHIP enrollment for pregnant women in FY 2019. West Virginia expanded coverage to pregnant women in CHIP in 2019 (WV DHHR 2019).

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation that Congress extend the postpartum coverage period in Medicaid and the State Children's Health Insurance Program (CHIP) and require full Medicaid benefits in all pregnancy-related eligibility pathways. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on the recommendations in this chapter on January 29, 2021.

Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

2.1 Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.

Yes:	Barker, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Szilagyi, Weno	16	Yes
Abstain:	Scanlon	1	Abstain

2.2 Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.

Yes:	Barker, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes

2.3 Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

Yes:	Barker, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes

APPENDIX 2A: Medicaid and CHIP Coverage for Pregnant Women

TABLE 2A-1. Legislative Milestones in Medicaid and CHIP Coverage of Pregnant Women

Year	Statute
1984	Deficit Reduction Act of 1984 (P.L. 98-369): Required states to provide Medicaid to: • a pregnant woman with no other dependent children who would be a single parent (or a parent with the other parent incapacitated) and eligible for Aid to Families with Dependent Children (AFDC) if the child were born; and • a pregnant woman in a family with two able-bodied parents (one of whom must be unemployed), who would be eligible for AFDC if the child were born.
1985	Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272): • required states to cover pregnant women meeting state AFDC income and resource standards, regardless of employment or marital status; • required 60 days postpartum coverage for pregnant women; and • provided that pregnancy-related services available to covered women need not be available to other Medicaid enrollees.
1986	Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509): • gave states the option to cover all pregnant women and children up to age five in families with incomes at or below 100 percent of the federal poverty level (FPL), regardless of their AFDC eligibility status or assets; • gave states the option to provide continuous coverage to a woman throughout her pregnancy and for 60 days following delivery regardless of changes in income or assets; and • permitted states to provide ambulatory prenatal care to women during a presumptive eligibility period of up to 45 days, if: – the woman has begun maternity care with a qualified provider, – the provider determines that the woman's family income falls below the applicable Medicaid standard and notifies the state of the woman's eligibility within five working days, and – the woman applies for such benefits within 14 days of being presumed eligible.
1987	Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203): • gave states the option to extend Medicaid coverage to pregnant women and infants up to 185 percent FPL.
1988	Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360): • required states to phase in Medicaid coverage for all pregnant women and infants in families with incomes up to 100 percent FPL. (Much of MCCA was repealed in 1989, but provisions related to pregnant women were retained.)

Year	Statute
1989	Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239): • required Medicaid coverage for all pregnant women (and children under age six) in families with incomes at or below 133 percent FPL.
1990	Omnibus Reconciliation Act of 1990 (P.L. 101-508): • required states to provide continuous coverage for women throughout pregnancy and through the 60-day postpartum period regardless of changes in income or assets.
1996	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193): • prohibited Medicaid coverage for non-emergency services to otherwise eligible legal non-citizens entering the United States on or after August 22, 1996 (including pregnant women), until they have resided in the United States for five years; and • permitted coverage after the five-year ban at state option.
2009	Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3): • permitted states to cover lawfully residing pregnant women and children through Medicaid and CHIP without regard to the five-year residency requirement; and • allowed states to cover low-income pregnant women under CHIP through a state plan amendment.
2010	Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended): • added tobacco cessation programs for pregnant women and services provided at freestanding birth centers as mandatory benefits.

Sources: MACPAC, 2020 analysis. Medicaid and CHIP Payment and Access Commission (MACPAC). 2013. Chapter 1: Maternity services: Examining eligibility and coverage in Medicaid and CHIP. In Report to Congress on Medicaid and CHIP. June 2013. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2013/06/Maternity-Services-Examining-Eligibility-and-Coverage-in-Medicaid-and-CHIP.pdf.

TABLE 2A-2. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Pregnant Women, Parents, and Other Adults, by State, October 2020

State	Pregnant women in Medicaid[1]	Pregnant women in CHIP[2]	Parents and caretaker relatives of dependent children[3]	Additional individuals age 19–64[4]
Alabama	141%	–	13%	–
Alaska	200	–	132	133%
Arizona	156	–	106	133
Arkansas	209	–	15	133
California	208	–	109	133
Colorado	195	260%	68	133
Connecticut	258	–	155	133
Delaware	212	–	87	133
District of Columbia	319	–	216	210[5]
Florida	191	–	27	–[5]
Georgia	220	–	32[6]	–[7]
Hawaii	191	–	105	133
Idaho	133	–	22	133
Illinois	208	–	133	133
Indiana	208	–	17	133
Iowa	375	–	50	133
Kansas	166	–	33	–
Kentucky	195	–	22	133
Louisiana	133	–	19	133
Maine	209	–	100	133[5]
Maryland	259	–	123	133
Massachusetts	200	–	133	133[5]
Michigan	195	–	54	133
Minnesota	278	–	133[8]	133[8]
Mississippi	194	–	21	–
Missouri	196	300	17[6]	–[7, 9]
Montana	157	–	24	133
Nebraska	194	–	58	133
Nevada	160	–	31	133
New Hampshire	196	–	63	133

State	Pregnant women in Medicaid[1]	Pregnant women in CHIP[2]	Parents and caretaker relatives of dependent children[3]	Additional individuals age 19–64[4]
New Jersey	194%	200%	29%	133%
New Mexico	250	–	42	133
New York	218	–	133[8]	133[8]
North Carolina	196	–	41	–[5]
North Dakota	157	–	49	133
Ohio	200	–	90	133
Oklahoma	133	–	38[6]	–[7, 9]
Oregon	185	–	38	133
Pennsylvania	215	–	33	133
Rhode Island	190	253	116	133
South Carolina	194	–	95	–[7]
South Dakota	133	–	53	–
Tennessee	195	–	96	–
Texas	198	–	14	–
Utah	139	–	41	133[7]
Vermont	208	–	49	133
Virginia	143	200	49	133
Washington	193	–	37	133
West Virginia	185	300	18	133
Wisconsin	301	–	95	95
Wyoming	154	–	51	–

Notes: As of January 2021, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $12,880 for an individual plus $4,540 for each additional family member. Prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing when determining Medicaid and CHIP eligibility. In 2014, uniform modified adjusted gross income (MAGI) rules became mandatory for determining Medicaid and CHIP eligibility for most children and adults under age 65 eligible for Medicaid on a basis other than disability, including the groups shown in this table. As a result, states are now required to use MAGI-converted eligibility levels that account for the change in income-counting rules. The eligibility levels shown in this table reflect these MAGI-converted levels or another MAGI-based income limit in effect in each state for these groups as of October 2020. Under federal regulations, the effective income limits may be 5 percentage points higher than the percentage of FPL shown in this table to account for a general income disregard that applies to an individual's eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

States are required to provide Medicaid coverage for parents and other caretaker relatives (and their dependent children), at or above the state's 1988 Aid to Families with Dependent Children eligibility levels. Under regular Medicaid state plan rules, states may opt to cover additional parents and caretaker relatives, children age 19–20, and other individuals age 19–64 who have incomes less than or equal to 133 percent FPL and are not pregnant or eligible for Medicare. Certain states provide coverage under demonstration programs authorized under Section 1115 of the Social Security Act (the Act), which allow them to operate their Medicaid programs

with additional flexibility outside of regular Medicaid state plan rules. As noted in this table, the covered benefits under these waivers may be more limited than those provided under regular state plan rules and might not be available to all individuals at the income levels shown.

– Dash indicates that state does not provide coverage under this eligibility pathway.

[1] This column includes full-scope coverage and coverage for pregnancy-related services in Medicaid. States can also provide coverage for family planning services to individuals who do not qualify for full Medicaid benefits. Family planning-only coverage is not included here.

[2] This column includes states that have adopted the option to cover pregnant women in CHIP through a state plan amendment or an extension of an existing Section 1115 waiver. States also have the option to cover pregnant women using the unborn child option, defining the fetus as the targeted low-income child. This table does not include the unborn child option because those women are not eligible for postpartum services.

[3] These data show Medicaid state plan coverage of the eligibility group for parents and other caretaker relatives. In states that use dollar amounts rather than percentage of FPL to determine eligibility for parents, dollar amounts were converted to percentage of FPL, and the highest percentage was selected to reflect eligibility level for the group. Parents and caretaker relatives with income above the reported threshold for this group may be eligible for coverage under the new adult group (under § 1902(a)(10)(A)(i)(VIII) of the Act) in states that have adopted the expansion.

[4] Reflects state plan coverage under Section 1902(a)(10)(A)(i)(VIII) of the Act for individuals who are age 19–64, have incomes less than or equal to 133 percent FPL, and are not pregnant or eligible for Medicare; state plan coverage for children age 19–20 where indicated; and Section 1115 waiver coverage that is not subject to the limitations indicated in note 6.

[5] The state covers ages 19 and 20 up to the following levels: DC: 216 percent, FL: 27 percent, MA: 150 percent, ME: 156 percent, and NC: 41 percent.

[6] Reflects parent coverage under the Medicaid state plan. The state has some additional coverage above state plan eligibility standards through a Section 1115 demonstration or a pending demonstration proposal. The demonstration includes limitations on eligibility or benefits, is not offered to all residents of the state, or includes an enrollment cap. Georgia will implement this coverage on July 1, 2021, at the earliest.

[7] The state has a Section 1115 demonstration that provides Medicaid coverage to some low-income adults. The demonstration includes limitations on eligibility or benefits, is not offered to all residents of the state, or includes an enrollment cap. Georgia will implement this coverage on July 1, 2021, at the earliest.

[8] In Minnesota and New York, individuals with incomes greater than 133 percent FPL but not exceeding 200 percent FPL are covered under the Basic Health Program.

[9] Missouri and Oklahoma have opted to expand coverage to the new adult group by voter referendum, but have not yet implemented it.

Source: CMS, 2020, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html.

Chapter 3:

Medicaid Estate Recovery: Improving Policy and Promoting Equity

Medicaid Estate Recovery: Improving Policy and Promoting Equity

Recommendations

3.1 Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law.

3.2 Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary was less than the capitation payment made to a managed care plan.

3.3 Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for: (1) any asset that is the sole income-producing asset of survivors; (2) homes of modest value; or (3) any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards.

Key Points

- States are required to seek recovery from the estates of certain deceased beneficiaries for payments for long-term services and supports (LTSS) and related services. Since 1993, estate recovery has been mandatory for individuals expected to be permanently institutionalized; those age 55 or older when they received Medicaid LTSS and related services; and those with long-term care insurance policies, under certain circumstances.
- Current policy raises several concerns. Pursuit of modest estates contributes to generational poverty and wealth inequity, placing particular burdens on people of color. Variation in state policies treat heirs inconsistently. Estate recovery recoups relatively little—only about 0.55 percent of total fee-for-service LTSS spending. Policies for recovering capitation payments for those covered under managed LTSS programs can also be inequitable.
- Due to restrictions on Medicaid eligibility for LTSS, older adults covered by Medicaid have few assets. Three-quarters of Medicaid decedents had net wealth of less than $48,500.
- Fear of estate recovery may deter some individuals from seeking Medicaid LTSS, however, awareness and understanding of these policies by potential Medicaid beneficiaries is low.
- States should have the option to eliminate estate recovery. This would allow those that determine the return on their investment is low to cease recovery, while permitting states that find estate recovery useful to continue the practice. Changes to recovery of capitation payments would protect beneficiaries who use relatively few services. Clarifying hardship exemption policies would ensure more equitable treatment across states.

CHAPTER 3: Medicaid Estate Recovery: Improving Policy and Promoting Equity

People who use Medicaid-covered long-term services and supports (LTSS) are a diverse group including people age 65 and older and people with disabilities. To be eligible to receive Medicaid-covered LTSS, they must meet both income and asset limits. Asset counting rules allow individuals to obtain Medicaid eligibility while retaining certain assets, such as their primary residence, during their lifetimes. But federal law requires state Medicaid programs to seek recovery from the estates of certain deceased beneficiaries for payments for LTSS and related services. Recovery is sought from assets that were not initially counted when the beneficiary's eligibility for Medicaid LTSS was determined, as well as any additional assets obtained after becoming eligible for Medicaid or newly identified after their death. In fiscal year (FY) 2019, states reported collecting approximately $733.4 million from beneficiary estates. States return a portion of these funds to the federal government based on their federal medical assistance percentage (FMAP).

Estate recovery has been considered both a way to replenish Medicaid funds and a program integrity tool to ensure that people who have resources that could be used to pay for LTSS actually do so, even after death. However, critics have noted that many people with sizeable wealth are able to legally shield assets from Medicaid estate recovery so these can be used for their benefit or passed on to heirs. This leaves the burden of estate recovery to fall primarily on those of modest means; this may also disproportionately affect people of color given disparities in household wealth.

The Commission last engaged on this issue in 2015, when media reports raised concerns that estate recovery could be a barrier to enrollment for the new adult group in states that expanded Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). MACPAC published an issue brief on the implications of estate recovery for the new adult group, but did not make any recommendations (MACPAC 2015).

Recently, media attention has returned to the broader issue of estate recovery for people who use LTSS and has raised concerns about the policy's effects (Corbett 2019). The Commission decided to look more closely at how estate recovery programs are functioning and their effects. Over the past year, our inquiry included:

- reviewing the literature and federal guidance on estate recovery program operations;
- analyzing the results of a survey on assets held by Medicaid decedents age 65 and older;
- analyzing Medicaid state plans to understand the extent to which states pursue recovery beyond minimum federal requirements;
- compiling aggregate data on estate recovery collections for FYs 2015–2019;
- surveying a sample of states regarding the number and size of estates recovered, hardship waivers granted, and probing as to whether these states would continue to pursue estate recovery if this requirement were made optional, as it had been prior to 1993; and
- interviewing stakeholders and reviewing the literature for insights into whether estate recovery has affected access to LTSS.[1]

As a result of this work and multiple discussions at our public meetings, we have concluded that Medicaid estate recovery policy is in need of reform. The program mainly recovers from estates of modest size, suggesting that individuals with greater means find ways to circumvent estate recovery and raising concerns about equity. As such, we have determined that additional beneficiary protections are needed, and that states should have flexibility to eliminate estate recovery.

Specifically, the Commission recommends the following:

- Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law.
- Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary was less than the capitation payment made to a managed care plan.
- Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for: (1) any asset that is the sole income-producing asset of survivors; (2) homes of modest value; or (3) any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards.

This chapter begins by describing policies that define financial eligibility for LTSS and treatment of assets in eligibility determination. It also includes the result of research on the assets held by those over age 65 and discusses Medicaid planning vehicles. It then provides background on Medicaid estate recovery requirements and program administration before moving on to discuss the results of our analyses of state plans, estate recovery collections data, and state survey results. The next section discusses the effects of estate recovery on access to LTSS. The chapter ends with the Commission's recommendations and its rationale for changes to estate recovery policy.

LTSS Financial Eligibility

To qualify for Medicaid, individuals generally must fit into a specific eligibility category and meet income thresholds. To qualify for Medicaid LTSS such as home- and community-based services (HCBS), they must meet additional standards, which generally include asset tests and functional criteria that are based on an individual's physical or cognitive status. Below we focus on the asset tests that generally apply to Medicaid eligibility pathways for people who are age 65 and older or have disabilities.[2]

Financial eligibility pathways for LTSS

There are multiple eligibility pathways for Medicaid LTSS. Although states are generally required to cover beneficiaries who receive Supplemental Security Income (SSI), all states also cover individuals through one or more optional pathways (Table 3-1). Below we provide a brief overview of these optional pathways, including poverty-related, medically needy, Katie Beckett, Medicaid buy-in, special income level, and Section 1915(i). The income and asset limits below apply to single applicants; for married individuals, additional rules are first applied that protect spouses from impoverishment. Those rules are discussed later in this chapter.

Supplemental Security Income-related eligibility. SSI is a federal income support program for people who have limited income and resources and are also age 65 or older, blind, or have disabilities. To qualify, these individuals may have countable monthly income of no more than the federal benefit rate, which in 2021 is $794 per month for an individual and $1,191 for a couple, or 74 percent of the federal poverty level (FPL) (CMS 2021). The value of countable resources (e.g., cash, bank accounts, stocks and savings bonds, land, vehicles, personal property, life insurance) cannot exceed $2,000 for an individual and $3,000 for a couple (SSA 2020).

In most states, individuals receiving SSI are automatically eligible for Medicaid, including LTSS offered under the state plan (MACPAC 2020a). States, however, have the option under Section 1902(f) of the Social Security Act (the Act) to apply different Medicaid eligibility criteria for SSI recipients (Colello and Morton 2019). States that choose this option are known as Section 209(b) states, a reference to Section 209(b) of the Social Security Act Amendments of 1972 (P.L. 92-603) that established this option. As of 2020, eight states have elected the Section 209(b) option, which allows them to apply more restrictive or more generous income limits, income disregards, asset limits, or definitions of disability than the federal SSI rules (MACPAC 2020a, Colello and Morton 2019, KFF 2019).[3] However, Section 209(b) states must have at least one eligibility criterion that is more restrictive than the SSI criteria (Colello and Morton 2019).

Poverty-related eligibility. This optional pathway allows a state to cover LTSS for individuals with incomes up to 100 percent FPL ($12,880 a year for an individual in 2021) who have disabilities or are age 65 and older. Twenty-three states and the District of Columbia use this option (MACPAC 2020a). In 2018, 12 states used the SSI asset limits of $2,000 for an individual and $3,000 for a couple, eight states had asset limits higher than the SSI amount, and one state had no asset limit (KFF 2019).

Medically needy. This pathway allows states to cover certain individuals who have high medical expenses relative to their income. These individuals would be categorically eligible but have income that exceeds the maximum limit for that pathway. States must cover medically needy pregnant women and children, and they may also choose to extend coverage to other groups. Thirty-two states and the District of Columbia use this option to cover individuals age 65 and older and individuals with disabilities, allowing them to become eligible for Medicaid once they have spent a portion of their excess income on their medical expenses (known as the spend-down requirement) (MACPAC 2020a).

States have flexibility in setting the income threshold and the budget period used in medically needy eligibility determinations. The median medically needy income limit in states with this pathway was 45 percent FPL, or $478.50 per month, for an individual in 2020 (MACPAC 2020a). In 2018, all but one state set their medically needy asset limit at or above the SSI level (KFF 2019).

Katie Beckett pathway for children with disabilities. All states use this option to provide Medicaid services for at least some children with severe disabilities whose family income would otherwise be too high to qualify. Income limits for this population are generally 300 percent of SSI ($2,382 per month for an individual in 2021), with a $2,000 asset limit. Only the child's own income and assets are counted (KFF 2019).

Medicaid buy-in. States have the option to cover individuals with disabilities who work and have incomes too high to qualify for Medicaid via other pathways. In 2018, 44 states and the District of Columbia offered this option, and the median income limit for working people with disabilities was 250 percent FPL for an individual. Eight states do not have an asset limit for this group (KFF 2019). Thirty-four states charge premiums for this group, with most calculating premium amounts using a sliding scale based on income (KFF 2019).

Special income level. States may choose to cover individuals who have income up to 300 percent of the SSI benefit rate and who meet level of care (LOC) criteria for nursing facility or other institutional care; these individuals often receive HCBS through waivers authorized under Section 1915(c) of the Act. LTSS users who are dually eligible for Medicaid and Medicare are more likely to enter under this pathway than Medicaid-only LTSS users (MACPAC 2014). Forty-two states and the District of Columbia offer such coverage (MACPAC 2020a). This pathway also includes an asset limit, typically the SSI amount of $2,000 for an individual and $3,000 for a couple (KFF 2019).

Section 1915(i) state plan HCBS. Section 1915(i) of the Act allows states to offer HCBS under the state plan to people who need less than an institutional LOC. The ACA amended this section to create a new eligibility pathway for individuals with disabilities who are not otherwise eligible for Medicaid. States can cover people with incomes up to 150 percent FPL who meet functional eligibility criteria; there is no asset limit. They can also extend this pathway to people with incomes up to 300 percent of SSI who are receiving Section 1915(c) waiver services. Indiana, Maryland, and Ohio are the only states using Section 1915(i) as a Medicaid eligibility pathway. Fourteen other states use Section 1915(i) to authorize HCBS but require beneficiaries to be eligible through another coverage pathway (KFF 2019).

TABLE 3-1. Overview of Selected Eligibility Pathways and Criteria for Medicaid LTSS Coverage

Eligibility pathway	Definition	Number of states using pathway	Income thresholds	Asset limits
SSI-related	SSI is a federal income support program for people who have limited income and resources and are also age 65 or older, blind, or have disabilities. This is a mandatory pathway. In most states, individuals receiving SSI are automatically eligible for Medicaid.	50 states and DC; 8 states have elected the Section 209(b) option	74% FPL ($794 per month for an individual and $1,191 for a couple in 2021)	$2,000 for an individual and $3,000 for a couple
Poverty-related	Optional pathway that allows a state to cover LTSS for individuals with incomes up to 100 percent FPL who have disabilities or are age 65 and older.	23 states and DC	Up to 100% FPL ($12,880 a year for an individual in 2021)	Typically same as SSI limits, but some states have higher limits
Medically needy	Optional pathway that allows states to cover certain individuals who have high medical expenses relative to their income. These individuals would be categorically eligible but have income that exceeds the maximum limit for that pathway. Individuals become eligible for Medicaid once they have spent down their excess income on their medical expenses.	32 states and DC	At state discretion; median was 45% FPL for an individual in 2020	Typically same as SSI limits, but some states have higher limits
Katie Beckett pathway for children with disabilities	Optional pathway that provides Medicaid services for at least some children with severe disabilities whose family income would otherwise be too high to qualify. Only the child's own income and assets are counted.	50 states and DC	300% of SSI benefit rate ($2,382 per month for an individual in 2021)	$2,000

Eligibility pathway	Definition	Number of states using pathway	Income thresholds	Asset limits
Medicaid buy-in	Optional pathway that covers individuals with disabilities who work and have incomes too high to qualify for Medicaid via other pathways. Many states charge premiums for this group.	44 states and DC	At state discretion; median was 250% FPL for an individual in 2018	Eight states do not have an asset limit for this group
Special income level	Optional pathway for individuals who have income up to 300 percent of the SSI benefit rate and who meet LOC criteria for nursing facility or other institutional care.	42 states and DC	Up to 300% of SSI benefit rate	Typically same as SSI limits
Section 1915(i) state plan HCBS	Section 1915(i) of the Social Security Act allows states to offer HCBS under the state plan to people who need less than an institutional LOC.	3 states	150% FPL for individuals who meet functional eligibility criteria, or 300% of SSI benefit rate for individuals receiving Section 1915(c) waiver services	None

Notes: SSI is Supplemental Security Income. FPL is federal poverty level. LTSS is long-term services and supports. LOC is level of care. HCBS is home- and community-based services. For married individuals, spousal impoverishment provisions are applied first (§ 1924 of the Social Security Act).

Sources: CMS 2021, MACPAC 2020a, SSA 2020, Colello and Morton 2019, KFF 2019.

Income and asset treatment in Medicaid LTSS financial eligibility determinations

As noted above, financial eligibility for Medicaid LTSS is determined by both income and asset limits (also called resources). Section 1612 of the Act (described further in regulations at 20 CFR 416.1112 and 416.1124) defines what counts as income. In general, countable income includes earned income, such as wages, and unearned income, such as Social Security benefits, income from trusts, and unemployment benefits. Some income is excluded, such as the first $65 of monthly income plus one-half of a remaining amount, up to certain limits (Table 3-2).

Countable assets may include cash and other liquid resources (e.g., stocks and bonds). Some assets, as detailed in Section 1613 of the Act, are excluded, such as a primary residence, household goods and personal effects, and one automobile (Table 3-2). Although a primary residence is not considered a countable resource for Medicaid eligibility under SSI program rules, its value can affect eligibility for Medicaid LTSS (Colello 2017). If an individual's home equity is above the state's limit, they will be deemed ineligible to receive Medicaid LTSS; for 2021, the federal minimum home equity limit is $603,000 and the maximum limit is $906,000 (CMS 2021). In 2018, 40 states used the federal minimum limit, nine states used the maximum limit, one state, Wisconsin, set a limit in between, and one state, California, had no limit (KFF 2019).[4] The home equity limit does not apply if a beneficiary has a spouse, a child under age 21, or a child with a disability of any age who resides in the home (Colello 2017).

TABLE 3-2. Examples of Income and Assets Used to Determine Financial Eligibility for Disability and Age-Related LTSS Pathways

Type	Excluded	Counted
Income		
First $65 of monthly earned income plus one-half of remaining amount, up to certain limits	✓	
First $30 of infrequent or irregularly received income in a quarter	✓	
First $20 of monthly unearned income	✓	
Certain need-based assistance, such as rent subsidies and SNAP	✓	
Earned income		
Wages		✓
Net self-employment earnings		✓
Payments for services in a sheltered workshop or activities center		✓
Certain royalties and honoraria		✓
Unearned income		
Social Security benefits		✓
Annuities		✓
Pensions		✓
Trusts		✓
Unemployment		✓
Workers compensation		✓
Assets		
Primary residence	✓	
Household goods and personal effects	✓	
Value of a burial space	✓	
One automobile, if used for transportation of applicant or member of applicant's household	✓	
Burial funds of $1,500 or less	✓	
Life insurance policies with a face value of $1,500 or less	✓	
Cash		✓
Liquid resources (e.g., stocks and bonds, mutual fund shares, etc.)		✓
Equity value of nonliquid resources unless otherwise excluded		✓
Life insurance policies with a face value exceeding $1,500		✓

Notes: LTSS is long-term services and supports. SNAP is Supplemental Nutrition Assistance Program. For married individuals, spousal impoverishment provisions are applied first (§ 1924 of the Social Security Act (the Act)).

Source: MACPAC, 2021, analysis of Sections 1612 and 1613 of the Act and 20 CFR 416.1112 and 416.1124.

Medicaid has additional rules related to income after a beneficiary becomes eligible for Medicaid LTSS, known as post-eligibility treatment of income rules. Generally, beneficiaries qualifying through certain eligibility pathways are required to use their income over certain amounts to help pay for the cost of their care (Colello 2017). However, individuals receiving Medicaid LTSS are allowed to retain a certain amount of income for personal needs, as dictated by federal and state limits. Individuals residing in an institution are permitted a personal needs allowance, which is used to pay for items not covered by Medicaid, such as clothing (42 USC § 1396a(q)). The federal minimum is $30 a month for an individual (used by three states), but states can set an allowance greater than this rate. The median allowance was $50 a month in 2018; Florida had the highest personal needs allowance, at $130 per month (KFF 2019).[5] For beneficiaries residing in the community who receive HCBS services through a waiver, states must establish a monthly maintenance needs allowance but have discretion in setting that amount (42 CFR 435.726).[6] In 2018, the median maintenance allowance was $1,840 per month, with a range of $100 per month in Montana to $2,250 (or 300 percent of SSI) in 20 states (KFF 2019).

Additional rules for married applicants. Special rules apply to the counting of income and assets when determining financial eligibility for Medicaid LTSS for couples when one spouse needs institutional care and the other remains in the community (§ 1924 of the Act). These are known as the spousal impoverishment rules, and are intended to protect the community spouse from becoming impoverished or experiencing housing instability. Previously, states had the option to create similar rules for HCBS, but all spouses of individuals using certain HCBS were granted these protections temporarily by the ACA, and subsequent legislation has extended their application through FY 2023. States must set income and asset amounts that the community spouse may retain while allowing the Medicaid-seeking spouse to become eligible, within federal limits (Colello 2017).[7] When determining the patient pay amount and eligibility for the spouse in need of Medicaid LTSS, federal law exempts all of a community spouse's income that is solely attributable to them.[8] If the community spouse's assets are below the community spouse resource standard, then the institutionalized spouse can transfer their share of the resources until the community spouse's share meets the threshold.[9] All other assets of the Medicaid applicant must be depleted before they can become eligible (Colello 2017).

Asset transfer rules

When determining eligibility for Medicaid LTSS, states are required by federal law to review any assets that an individual divested during a certain time period and determine if that transfer affects their Medicaid eligibility. The purpose of these rules is to discourage individuals from transferring assets in order to qualify for Medicaid LTSS or sheltering assets that could be used to pay for their care (Colello 2017). The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) updated Section 1917 of the Act, requiring a look-back period of five years from the date of application for Medicaid; if during that time an applicant or their spouse divested certain assets for less than fair market value, the applicant's eligibility for Medicaid may be affected (Colello 2017).

If a non-exempt transfer was made during the look-back period, a penalty is imposed on the applicant that delays the payment for Medicaid LTSS by a certain number of months. The penalty period is calculated by dividing the monetary value of the transferred asset by the average monthly private pay rate for nursing facility services in the state.[10] The penalty period begins on either the first day of the month in which assets were transferred, or the date on which the individual would otherwise be eligible for Medicaid and would have been able to receive care in an institution, whichever is later. For example, if a non-exempt transfer of $40,800 is made, and the average monthly private pay rate for a nursing facility is $6,800, then the individual

seeking Medicaid LTSS would have to wait six months before becoming eligible for LTSS. Under certain circumstances, states may waive penalties for asset transfers (Colello 2017).

Not all asset transfers are subject to penalties. For example, asset transfers for fair market value to spouses or children with disabilities are excluded. A home may also be excluded if it was transferred to a spouse, a child under age 21, a child with a disability, or an adult child who has resided in the home and provided care that delayed institutionalization of the qualifying Medicaid applicant (Colello 2017).

Medicaid planning

Estate planning is a process that people undertake, often with the counsel of an attorney, to detail what will happen to their assets after they die. This is often done by writing a will and naming beneficiaries. Individuals engage in estate planning for a variety of reasons, many unrelated to Medicaid eligibility. Furthermore, many wealthy individuals who engage in estate planning may have the means to pay for LTSS privately and never pursue Medicaid LTSS. However, attorneys experienced in elder law and special needs planning can assist older individuals and individuals with disabilities with applying for Medicaid, understanding federal and state laws on Medicaid eligibility, or setting up special needs or other kinds of trusts. We refer to these activities as Medicaid planning.

Individuals who engage in Medicaid planning may be able to legally protect some of their assets, thus keeping assets that would otherwise deem them ineligible for Medicaid LTSS. One technique allowed in some states to reduce the length of the penalty period is known as the reverse half-a-loaf mechanism (GAO 2014). This involves a Medicaid applicant gifting countable assets to someone else and then, after receiving an eligibility determination, having a portion of the gift returned to the applicant to cover the cost of their care during the penalty period. This mechanism can only be used in states that choose to consider a partial return of transferred assets in recalculating the penalty period.[11] Another reverse half-a-loaf mechanism would be for the applicant to gift a portion of their countable resources (usually about 50 percent) to someone and convert the rest of their countable resources into an income stream such as an annuity. This approach also incurs a penalty period for the applicant, but the amount of income generated makes up the difference between the applicant's other income (e.g., Social Security) and the cost of their LTSS, enabling the applicant to pay for their care out of pocket while awaiting the end of the penalty period. A U.S. Government Accountability Office (GAO) report from 2014 found that this mechanism is rarely used; in their review of 294 approved Medicaid application files from 2011 and 2012, they found five applicants used one of these two mechanisms (GAO 2014).

Assets held by older adults

States' ability to recover from an estate the cost of care paid for by Medicaid is limited by the value of the estate upon a beneficiary's death. We reviewed the literature to better understand the value of assets held by older adults and learned that home equity (a non-liquid asset) is their greatest source of household wealth, especially for low-income homeowners.

Home ownership. A 2018 report from the Joint Center for Housing Studies of Harvard University provides some context and data on homeownership and net worth of homeowners. The report found that in 2016, 65 million households were headed by individuals age 50 and older, and 76.2 percent of these households owned their homes. When stratified by race and ethnicity, however, the study found that 81 percent of white households age 50 and older owned their home compared to 57 percent of Black households, 60 percent of Hispanic households, and 71 percent of Asian American and other households with heads in this same age group (JCHS 2018). The report also found that in 2016, 41 percent of homeowners age 65 and older still had mortgages on their homes (JCHS 2018).

Household wealth for deceased Medicaid beneficiaries age 65 and older. Data related to household wealth suggest that recoverable assets are quite limited for individuals who receive Medicaid-covered LTSS. The published literature on the assets held by older adults typically focuses on all individuals over a certain age or those with limitations in activities of daily living (JCHS 2018, Johnson 2016). To gain insight into the population of individuals likely to be subject to estate recovery, we contracted with researchers at the LeadingAge LTSS Center @UMass Boston, to review the Health and Retirement Study (HRS) a nationally representative longitudinal survey of adults age 50 and older. They identified Medicaid beneficiaries in the dataset who participated in the HRS and died during the 2012, 2014, and 2016 survey periods. The team then calculated the net value of total wealth based on reported assets, subtracting out the debts individuals held.

In general, this study found that, with some exceptions, the assets of older adults enrolled in Medicaid are quite modest, with a substantial proportion of individuals having little to no wealth (Table 3A-1). Therefore, the assets that Medicaid programs can recover after a beneficiary's death are limited, particularly for individuals who do not own their homes. More specifically, we found that three-quarters of beneficiaries had net wealth below $48,500; additional details are below.

- At age 65 and older, the average net wealth among Medicaid decedents was $44,393.
  - The lowest quartile of the group had negative net wealth—on average this group's debts exceeded its assets by $14,236;
  - the second quartile had an average of $304 in net wealth;
  - the third quartile held an average of $17,709 in net wealth; and
  - the highest quartile held an average of $173,436 in net wealth.
- Average home equity held by the total sample was $27,364.
  - The lowest quartile of the group had negative home equity (-$6,954);
  - the second quartile had an average of $8 in home equity;
  - the third quartile held an average of $12,880 in home equity; and
  - the highest quartile held an average of $98,694 in home equity.[12]

When these data were stratified by demographic characteristics, we found that the average net wealth varied among different groups of Medicaid decedents. In particular, average net wealth was higher for men than for women, higher for married people than for non-married people, higher for white, non-Hispanic individuals than for other racial or ethnic groups, and higher for people with disabilities than for people without disabilities (Table 3A-2). In addition, wealth was lower for decedents age 85 and older than for decedents in younger age groups.

Legislative History and Requirements

Medicaid programs have been permitted to recover assets from the estates of certain beneficiaries as reimbursement for the care provided to them since the inception of the program (Table 3-3). The Social Security Act Amendments of 1965 (P.L. 89-97) allowed, but did not require, states to pursue recovery from the estates of individuals age 65 or over, but only following the death of a surviving spouse, and only if the beneficiary had no children who were under age 21, blind, or had a disability. This law did not specify the benefits for which states were allowed, or prohibited, to seek recovery. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248) subsequently allowed states to impose liens on certain beneficiaries' property before death, which had been previously prohibited.

In 1993, the Omnibus Budget Reconciliation Act (OBRA 93, P.L. 103-66) made estate recovery mandatory for three categories of beneficiaries: (1) individuals who were expected to be permanently institutionalized; (2) individuals who received Medicaid when they were age 55 or older—when they received certain services; and (3) individuals with long-term care insurance policies, under certain circumstances. OBRA 93 specifies a number of additional requirements described below, and also provides states with some flexibility in how they administer their estate recovery programs. Later in this chapter we discuss state uptake of the flexibilities OBRA 93 provides.

TABLE 3-3. Legislative History of Medicaid Estate Recovery Requirements

Statute	Estate recovery requirements
Social Security Act Amendments of 1965 (P.L. 89-97)	States were permitted, but not required, to pursue recovery from the estates of individuals age 65 or over. States were permitted, but not required, to impose post-death liens on a beneficiary's property. States were not permitted to impose pre-death liens on a beneficiary's property.
Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248)	States were permitted, but not required, to impose pre-death liens on a beneficiary's property under certain circumstances. Beneficiaries deemed permanently institutionalized are entitled to a hearing to determine whether or not they are likely to ever return home.
Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)	States were required to pursue recovery from the estates of three categories of beneficiaries: (1) individuals who were expected to be permanently institutionalized; (2) individuals who received Medicaid when they were age 55 or older—when they received certain services; and (3) individuals with long-term care insurance policies under certain circumstances.
Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275)	Excluded Medicare cost sharing for individuals enrolled in Medicare Savings Programs.

Source: MACPAC, 2021, analysis of legislation.

For beneficiaries who received Medicaid when they were age 55 or older, OBRA 93 specified that states are required to seek recovery for amounts at least equal to benefits paid on their behalf for nursing facility services, HCBS, and related hospital and prescription drug services (Table 3-4). (Related hospital and prescription drug services are those provided during a stay in a nursing facility or while receiving HCBS.) States can also opt to seek recovery for other benefits under their state plan, except for assistance with Medicare cost sharing provided to individuals dually enrolled in Medicare and Medicaid.

When benefits are covered under managed care, states are required to seek recovery for some or all of the premiums paid for individuals who would have been subject to estate recovery under fee for service (FFS).[13] If a state elects to pursue recovery for all Medicaid services provided to beneficiaries enrolled in managed care, they must pursue recovery for the total capitation payment for the period the beneficiary was enrolled in the plan (CMS 2020). If a state only pursues recovery for some state plan services, they must pursue recovery for the portion of the capitation payment attributed to those services (CMS 2020). Unlike persons who receive Medicaid on a FFS basis, for whom recovery

would be limited to the actual cost of any services used, recovery for persons enrolled in managed care could encompass the full amount of capitation payments made on the beneficiary's behalf, regardless of service use.

TABLE 3-4. Benefit Categories for Which States Must Pursue Recovery

Requirement	Benefit categories
Mandatory	Nursing facility services Home- and community-based services (HCBS) Hospital and prescription drug services related to care in a nursing facility or HCBS
Optional	Any or all other items and services under the state plan (excluding Medicare cost sharing)

Source: MACPAC, 2021, analysis of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) and the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275).

If a beneficiary has a surviving spouse, recovery must be deferred until after the spouse's death (CMS 2020). States can also choose to exempt such estates from recovery rather than pursue them after the spouse's death. States must also exempt recovery if a beneficiary has a child who is under age 21 or a child of any age who is blind or has a disability. In addition, a home lien cannot be enforced when it is occupied by a spouse, minor child, child who is blind or has a disability, a sibling of the deceased beneficiary who lived there for at least one year prior to the beneficiary's death, or a son or daughter who resided in the home for at least two years prior to the beneficiary's admission to an institution and provided care that delayed a beneficiary's placement in an institution (CMS 2020).[14]

OBRA 93 also required states to establish procedures for waiving estate recovery requirements due to hardships, based on criteria established by the Secretary of the U.S. Department of Health and Human Services (the Secretary). Guidance from the Centers for Medicare & Medicaid Services (CMS) provides examples of potential hardships, but does not require states to use them. These examples include: (1) if an estate is the sole income-producing asset of survivors, such as a family farm or other family business, and produces limited income; (2) if it is a home of modest value—defined as roughly half the average home value in the county; or (3) other compelling circumstances (CMS 2020). States are also required to designate a cost-effectiveness threshold (i.e., the value of an estate they deem cost effective to pursue relative to the administrative cost of recovery).

OBRA 93 requires states to attempt to recover, at a minimum, all property and assets that pass to heirs under state probate laws; however, both the definition of an estate and the priority of Medicaid's claims against an estate's other creditors vary by state (ASPE 2005). In some cases, state Medicaid programs might not recover any funds from an estate if it is first depleted by other, higher priority creditors (e.g., mortgages or unpaid tax bills) (ASPE 2005).

Rationale for Medicaid estate recovery policy

Estate recovery can be considered a program integrity strategy meant to ensure beneficiaries contribute to the cost of their care when assets are available for recovery after their death. This is done by recouping funds from assets that were previously unavailable to pay for a beneficiary's care, such as home equity that was not counted during the eligibility determination process. Proponents of estate recovery argue that it ensures that Medicaid funding is used for the most needy, supplements Medicaid funding to pay for even more needy individuals by replenishing funds spent,

and is a good return on investment (OIG 1995, Goldberg 1993, Rohlfes 1993). State officials have also indicated that estate recovery allows states to spend more on other aspects of Medicaid (Karp et al. 2005). One of the states we surveyed noted that estate recovery is an important source of funding, reserves Medicaid for those with a true financial need, and ensures that Medicaid is the payer of last resort. An interviewee described estate recovery as an important reminder of the cost of long-term care, for which Medicaid is the nation's largest payer.

Criticism of Medicaid estate recovery policy

Critics of Medicaid's estate recovery policy say that it punishes low-income families and recovers little (Corbett 2019). Medicaid beneficiaries generally have few assets, particularly given that most individuals must meet asset limits to qualify for coverage of LTSS (CHCF 2014). As we heard in our interviews with stakeholders, individuals with greater awareness of estate recovery and resources may protect their assets from estate recovery while preserving Medicaid eligibility, allowing resources to be passed on to their heirs. Stakeholders noted that individuals with little income and few assets besides a home, however, are less likely to be aware of estate recovery or have the resources to obtain an attorney. In addition, unless someone is able to protect assets, Medicaid eligibility rules require they impoverish themselves, except for assets that are not counted toward eligibility, as noted above. As a result, the estates that actually get pursued by states are usually modest in size. For heirs of these modest estates, estate recovery may remove a source of income or a residence which, if retained, would protect the heirs from poverty or housing insecurity. As multiple interviewees commented, this contributes to generational poverty and wealth inequality. The policy may also place an unequal burden on people of color, compounding existing wealth inequalities among racial and ethnic groups. Finally, Medicaid estate recovery policies are unique among federal programs. For example, many people who use LTSS are dually eligible for Medicare and Medicaid, yet as one advocate noted, the federal government does not pursue Medicare costs, which can also be quite high (Corbett 2019).

Program Administration

Estate recovery administration is complex and involves a number of steps to notify potential Medicaid beneficiaries, assess and verify assets, inform survivors of estate recovery claims, initiate recovery through the probate process or other means, and provide exceptions in the case of potential hardships. State agencies can perform these tasks or use third-party contractors to carry out some of this work.

Providing public information and meaningful notice

States are required to provide notice to Medicaid applicants explaining the estate recovery policy. A 2005 survey found that all responding states provided notice at the time of application; a minority of states also provided notice at other points such as during eligibility redetermination or upon admission to a certified facility. Those conducting that survey found that the information provided to beneficiaries lacked detail, raising questions about how well applicants comprehended the notice (Wood and Klem 2007).

Some states use websites, brochures, and toll-free numbers to educate beneficiaries and their representatives on estate recovery requirements. For example, the District of Columbia has a fact sheet on its website with information including the definition of an estate and the procedure for applying for a hardship waiver (DC DHCF 2015). Kansas has a similar fact sheet, and Nebraska's website has a brochure on estate recovery and several related forms (NE DHHS 2020, KS DHE 2017). However, our stakeholder interviews suggest that awareness of estate recovery remains low.

Assessing an estate and verifying assets

The definition of an estate is governed by state probate law. OBRA 93 requires states to attempt to recover, at a minimum, all property and assets that pass to heirs under state probate law. Such laws vary, however. For example, Florida law protects the home from many estate claims (ASPE 2005). In addition, states may broaden the definition of estate to include assets that do not go through probate, such as life insurance payouts (ASPE 2005). The priority of creditors' claims against an estate is also established in state law; therefore, a Medicaid program might not recover any funds from an estate if the estate is first depleted by higher priority creditors (ASPE 2005).

Upon application, states verify reported assets for financial eligibility for LTSS, which can later be used to identify assets for potential estate recovery efforts. Early analyses of estate recovery programs following enactment of OBRA 93 raised concerns about states' ability to verify certain types of assets, particularly those held out of state (OIG 1995). The DRA required states to establish electronic asset verification systems (AVS) that enable data exchange with financial institutions, including those not reported by the applicant. These systems, generally run by contracted vendors, establish portals between state eligibility systems and banks or other third-party systems with electronic access to financial information (MACPAC 2020b). As of October 2020, 41 states and the District of Columbia were fully compliant with federal AVS requirements (MACPAC 2020b).[15]

The probate process, discussed later, may also reveal additional assets following a beneficiary's death that were not discovered by the state at the time of application, or were obtained after a beneficiary's eligibility was last determined.

Providing notices of pre-death liens

In 1982, TEFRA authorized states to impose pre-death liens on real property in circumstances for certain institutionalized beneficiaries. TEFRA liens allow the state Medicaid program to declare its claim on the property so that upon the beneficiary's death the lien must be settled. If the property is sold during the beneficiary's lifetime, any equity would be considered to be part of a beneficiary's assets for eligibility purposes and could make them ineligible for Medicaid until those assets are spent down. TEFRA liens cannot be placed if a home is occupied by a spouse, a child under age 21, a child of any age who is blind or has a disability, or a sibling with an equity interest who has resided in the home for at least one year before the beneficiary was admitted to an institution (CMS 2020).

TEFRA liens are the only type of lien allowed before the death of the beneficiary, based on the assumption that the beneficiary will not be returning home (CMS 2020). Such beneficiaries are entitled to a hearing to determine if they cannot be reasonably expected to be discharged from an institution and return home. If the beneficiary does return home, the TEFRA lien must be dissolved (CMS 2020).

Determining a claim amount

For beneficiaries who received benefits through FFS, states must calculate the costs of the services provided to them. A key part of this calculation is identifying which services are included, based on whether the state pursues recovery for mandated benefits only or additional benefits under the state plan. In the next section of this chapter we describe state variation in pursuit of optional benefits.

The calculation of a claim amount for states with managed long-term services and supports (MLTSS) programs is not as straightforward as it is for states that provide LTSS through FFS. As of 2021, 25 states have implemented MLTSS programs, which cover some or all LTSS benefits and shift risk from the state to managed care organizations (ADvancing States 2021, Figure 3B-1). If a state elects to pursue recovery for all Medicaid services, it must pursue recovery for the total capitation payment for the period the beneficiary was enrolled in Medicaid (CMS 2020). If a state only pursues

recovery for some state plan services (e.g., LTSS and related services), they must pursue recovery for the portion of the capitation payment associated with those services (CMS 2020).

Pursuing recovery for some or all of the capitation payment can result in some estates being pursued for a greater amount than was spent on the beneficiary's care; for those who used more care, recovery may be less than what was spent on their care. For example, the estate of an individual who used only a few hours of HCBS per week that is pursued for the full capitation payment would likely pay back more than the amount spent on their care, while the estate of someone who spent several years in a nursing facility would repay a capitation amount that is likely less than the amount actually spent on their care. It may also be the case that an individual is enrolled in an MLTSS plan but receives no care. A letter sent to the Commission by a group of stakeholders described a circumstance in which the estate of an individual with a disability was pursued for over $200,000 even though that beneficiary had not received any care, as he had also been covered through his parent's insurance plan (Carlson 2020).

A number of stakeholders we interviewed said that they do not think people understand what MLTSS capitation payments are, let alone how they affect the estate recovery claim. These stakeholders said that it is easier for people to understand recovery claims that are derived from the direct cost of care. Additionally, several stakeholders said that recovering capitation payments can create inequities, as amounts recovered from individuals using few services will be more than was actually spent on their care and vice versa.

One state we interviewed expressed interest in pursuing recovery based on the actual cost of care provided to beneficiaries rather than the capitation payment, considering it a fairer method. State officials have had some discussions with CMS regarding whether this could be changed. Federal officials told us they do not think they have the statutory authority to allow states to pursue recovery based on the actual cost of care. They also expressed some concern about whether moving to pursue recovery based on the cost of care could affect other policies based on capitation payments.

Providing notices of claims after death for probate process

Upon a beneficiary's death, there are two ways in which states may provide notice of a claim on the estate as part of the state probate process.

- States may provide notice immediately following the beneficiary's death, before the opening of probate in court. This information could be provided to available contacts, including individuals listed in the Medicaid file or the last known address. However, it is uncertain if the notice would reach the appropriate individuals affected if the probate process has not yet started, and may be difficult for heirs to understand such notices without a lawyer or legal aid services (Wood and Klem 2007).
- Alternatively, states may provide notice following the opening of probate in court. At that point, the notice should reach the appropriate heirs as it will be sent to the court-appointed executor or administrator. However, estates are frequently not probated or there may be a long time before probate is opened, which is why states may choose to send notice immediately following death (Wood and Klem 2007).

Pursuing direct collections

States can recover funds directly from nursing facilities, bank accounts, and any trusts that were approved by Medicaid during the application process under conditions that, after death, remaining proceeds would be turned over to the state (Wood and Klem 2007). Collections from nursing homes may include unspent personal needs allowance funds. In cases of small estates, states can sometimes pursue direct collection from banks

using alternative processes to probate court (Wood and Klem 2007).

Granting hardship exemptions

As noted earlier, states are required to establish procedures for waiving estate recovery requirements when they would cause undue hardship, based on criteria established by the Secretary. CMS does not, however, require states to incorporate any of the examples outlined in its guidance (CMS 2020). We describe variation in state policies on hardship waivers in the next section of this chapter.

Hardship waivers raise equity concerns. As one elder law attorney stated, the ability to prove hardship usually requires the help of a lawyer, which not everyone can afford. This attorney also noted that pursuing such waivers is often not a priority for legal aid programs. Even with legal representation, however, interviewees indicated that an individual's success in getting approval for a hardship waiver depends upon state policies. We spoke with elder law attorneys from five different states, and only two indicated that the assistance of an elder law attorney could improve a person's chance of obtaining a hardship waiver. One stakeholder thought it could be beneficial to set out more specific standards for hardship waivers, while another wanted to see the minimum standard in their state raised. Finally, although one stakeholder who assists states with estate recovery said information on hardship waivers is typically included with materials sent to the representatives of a beneficiary's estate, many stakeholders said that few people are aware of the option to apply for a hardship waiver.

State Variation in Estate Recovery Policies

As noted earlier, states retain some flexibility over certain aspects of program administration such as the benefits for which they pursue recovery, hardship waiver policies, and cost-effectiveness thresholds. To gain insight into variation in state policies, we reviewed Medicaid state plans found on state and CMS websites or obtained from CMS, capturing at least partial information for all 50 states and the District of Columbia. (Some state plans were missing certain information.) Full results of our review of information on liens, populations included in estate recovery, services recovered, and insurance treatment are in Appendix 3C.

Generally, we found that states tailor their estate recovery programs, as no options were taken up by every state, and hardship waiver policies and cost-effectiveness thresholds varied substantially.

Liens

Most states do not place either pre- or post-death liens on beneficiaries' property that would allow them to place a claim on the equity in a beneficiary's property prior to its sale. TEFRA liens were the most common lien type (26 of 51 states plans with this information).

Recovery for additional benefits

Most states (36 of 51) seek recovery for additional state plan services received when individuals were age 55 or older. Of those 36 states, 31 indicated that they pursue recovery for all state plan services, while the other five pursue recovery for a more limited set of services. For certain younger individuals who are permanently institutionalized, 27 of 50 states recover for benefits provided to beneficiaries beyond the costs of care in institutions such as intermediate care facilities for individuals with intellectual disabilities.

Estate recovery for the new adult group

In the 38 states and the District of Columbia that have expanded Medicaid (including those where implementation is underway), states may pursue estate recovery for benefits beyond LTSS received by individuals in the new adult group when they

are age 55 or older. Earlier work by MACPAC found that, in 2015, 24 expansion states (including the District of Columbia) were recovering payments for non-LTSS benefits, and 7 were not (MACPAC 2015). Although the number of expansion states has increased since then, the number pursuing such recoveries has declined. In our recent review of state plans, we found that 20 expansion states and the District of Columbia pursue recovery for non-LTSS benefits for individuals who received Medicaid at age 55 or older, and 18 states do not (Appendix 3C).

Treatment of long-term care insurance

Most states (35 of 38) do not seek recovery or adjustment if an individual has insurance through the Long-Term Care (LTC) Partnership Program. This program, available in all but 10 states as of 2014, is a joint Medicaid-private sector program under which individuals pay premiums and then can retain some assets and remain eligible for Medicaid if they first deplete the insurance benefit (AALTCI 2021). These programs were developed to encourage the purchase of LTC insurance by moderate-income individuals who might not otherwise purchase these policies (CHCS et al. 2007). However, only a small number of states (8 of 37) do not seek recovery from assets or resources when beneficiaries hold other types of LTC insurance.

Hardship waivers

Information on hardship waivers in state plans is not standardized, so it is difficult to make comparisons across states. Most states (36 of 48) consider the sample criteria of whether the asset is the sole income-producing asset of the heir (e.g., a family farm), with some states allowing for it to be a substantial but not the only source of income. Few states (8 of 48) consider waiving recovery for a home of modest value, although some additional states may have protected the home under different circumstances or thresholds.

States have also defined their own criteria for granting hardship waivers. For example, Mississippi will waive recovery if the assets in the estate are less than $5,000 and there is no prepaid burial contract or other money set aside for the burial of the deceased beneficiary (MS DM 1995). A number of states waive recovery if it would leave the heir at risk of becoming eligible for public assistance.

Cost-effectiveness thresholds

State approaches to cost-effectiveness thresholds also vary substantially, as states are only required to have a standard and to provide some justification for that standard. Cost-effectiveness standards often consider the value of the estate, the claim value, and the cost of administration. Of the states we examined, 19 of 48 pursue any estate where the amount of recovery exceeds the cost of pursuing recovery or report having no minimum threshold (Table 3C-3). Among the other 29 states, thresholds of $100 or $500 were common. Georgia and South Carolina had the highest cost-effectiveness threshold at $25,000.

Estate Collections

Estate recovery recoups only a small fraction of LTSS spending. Though recovery amounts may be consequential for states, particularly when budgets are tight, overall, the data do not indicate that the program is having its intended effect. Recoveries vary widely by states and reflect numerous factors, such as cost-effectiveness thresholds, resources for program administration, and state priorities.

Aggregate collections

In FY 2019, states collected approximately $733.4 million from beneficiary estates, as reported on the CMS-64 expenditure reports that states file with CMS (Appendix 3E). The five states with the largest estate collections—Massachusetts, New York, Pennsylvania, Ohio, and Wisconsin—account for 38.5 percent of all recoveries in FY 2019.

Two states, Delaware and Vermont, reported no collections for FY 2016–2019. We do not have any details on why these states reported no recoveries.

We sought to compare aggregate collections to national Medicaid LTSS spending, although potential claims may be less than total LTSS spending given the variety of exemptions in federal law and state policy. As a proportion of national Medicaid FFS LTSS spending (managed care data is not reported by service on the CMS-64), recoveries ranged from 0.53 to 0.62 percent during FYs 2015–2019. This is consistent with reports published in the mid-2000s, although amounts have grown in absolute dollars. For example, an AARP study found that estate recoveries were 0.61 percent of LTSS spending in FY 2005 (Wood and Klem 2007). At the state level, estate recovery as a proportion of Medicaid FFS LTSS spending in FY 2019 varied, ranging from a high of 14.49 percent in Iowa to 0.02 percent in Hawaii, Louisiana, and West Virginia. Only eight states recovered more than 1.0 percent, while 28 states recovered less than 0.5 percent of what was spent on FFS LTSS for Medicaid enrollees in that year.

Although our data do not include capitation payments made to MLTSS plans or the claims these plans pay for LTSS, we expect that if such data were available, estate recoveries as a proportion of national and state LTSS spending would be even lower.

State collections are affected by the size of claims, size of beneficiary estates, variation in state policies and administration of estate recovery programs, and where Medicaid stands on the priority creditor list. Research suggests that states do not recover all they could—one study estimated states could have collected 5.5 times more from 2002 to 2011 if all their efforts matched those states that were most effective at estate recovery (Warshawsky and Marchand 2017). However, the study did not factor into its estimate factors such as differences in state probate laws that might limit recoveries, or the costs of program administration that would accompany more aggressive collections.

Number and size of recovered estates

Relatively little information is available on the number and size of estates from which states have sought recovery. The most detailed data available are for FY 2003, when the national average recovery amount per estate was $8,116, with recoveries attempted from 3,242 estates for 42 states and the District of Columbia for which data were available (Karp et al. 2005).

Methodology. To gain more detail than available from state reports to CMS on aggregate collections, we developed a survey regarding the estate collections; hardship waivers; and program administration costs of states. We asked that states provide us with this data for a three-year period. We chose a sample of 15 states that represented a range of aggregate collections and estate recovery policies, and included states with and without MLTSS. Ten states responded to our survey. Several noted that they do not collect certain data (e.g., hardship waiver applications) or were unable to provide customized reports. Thus, the examples below are illustrative and are not completely comparable.

Number and size of recovered estates. Among the states responding to our survey, the number of estates recovered and the average recovery amount, which we calculated using the total recoveries and number of recovered estates, ranged widely (Table 3-5). The average recovery amount ranged from about $2,768 in Missouri to $71,556 in Alaska. In general, states that recovered from fewer estates had higher average recovery amounts, which may be due to differences in cost-effectiveness thresholds across states. For example, Alaska has a cost-effectiveness threshold of $10,000 and had a small number of collections and a higher average recovery amount than others. (Even with a minimum cost-effectiveness threshold, a state may collect an amount below that level for several reasons. For example, the remaining estate may have been smaller than the claim or other estate creditors may have a prior claim that reduces the amount Medicaid is able to recover.) In contrast,

states recovering from several thousand or more estates each year tended to pursue recovery from any estate where the recovery would exceed the administrative costs or indicated there was administrative discretion in determining which estates to pursue.

The survey results also demonstrated a wide range of recovery amounts. Although we did not ask states for details on any particular cases, our interviews provided some potential explanations for the wide variation in values. An estate recovery contractor we spoke with suggested that minimal recovery amounts (e.g., a few cents) could reflect funds from personal needs accounts held by nursing facilities, which generally must return any remaining funds to the state after a resident's death, no matter how small. They could also represent estates that were depleted by higher priority creditors. By contrast, several stakeholders told us that large collection amounts could represent assets held in special needs trusts, which allow individuals with disabilities under 65 to draw down funds for their benefit (e.g., education, supplemental care not covered by Medicaid). However, after a beneficiary dies, funds remaining in the trust must be made available for recovery.

TABLE 3-5. Number and Size of Recovered Estates by Surveyed State

State	Year	Number of estates pursued	Number of estates recovered	Recovery amount			
				Total recoveries	Average	Minimum	Maximum
Alaska	SFY 2018	240-480[1]	12	$858,674.69	$71,556.22	$2,029.00	$125,104.79
	SFY 2019	240-480[1]	8	235,257.47	29,407.18	15,243.31	73,975.09
	SFY 2020	240-480[1]	9	408,139.16	45,348.80	846.66	169,194.06
Arizona	SFY 2018	1,132	176	2,449,952.77	13,920.19	0.13	145.420.48
	SFY 2019	899	188	2,140,842.48	11,387.46	0.03	159,537.96
	SFY 2020	4,008	185	2,905,233.23	15,703.96	0.30	210,474.22
Georgia	FFY 2017	1,177	112	3,966,766.85	35,417.56	937.91	232,230.82
	FFY 2018	2,766	127	4,200,580.34	33,075.44	351.80	168,329.03
	FFY 2019	2,988	108	3,970,013.82	36,759.39	90.00	132,644.30
Iowa	SFY 2018	15,736	3,532	27,189,569.89	7,698.07	0.01	898,392.26
	SFY 2019	15,291	3,359	27,303,246.14	8,128.39	0.01	387,639.19
	SFY 2020	16,279	3,397	25,321,637.73	7,454.12	0.01	428,018.57
Maryland	CY 2017	2,256	363	5,376,302.79	14,810.75	770.00	3,271,183.14
	CY 2018	2,545	456	7,354,961.22	16,129.30	132.81	366,384.08
	CY 2019	2,378	498	7,723,169.43	15,508.37	168.64	485,150.24
Missouri	SFY 2018	1,215[2]	4,812	13,321,042.00	2,768.30	2.40	156,869.94
	SFY 2019	2,201[2]	4,198	14,607,628.00	3,479.66	7.44	327,387.86
	SFY 2020	2,300[2]	4,772	15,580,521.00	3,264.99	3.10	144,849.63

State	Year	Number of estates pursued	Number of estates recovered	Recovery amount			
				Total recoveries	Average	Minimum	Maximum
New York[3]	CY 2017	35,707	6,763	57,652,078.06	–	0.01	455,670.63
	CY 2018	36,146	4,754	53,583,269.15	–	0.01	524,064.08
	CY 2019	28,870	4,222	59,748,611.28	–	0.01	500,373.00
Oregon	Not specified	10,568	4,227	32,700,000.00	7,735.98	0.01	395,000.00
Tennessee	CY 2017	–	1,169	21,845,632.00	18,687.45	–	–
	CY 2018	–	1,162	26,853,611.00	23,109.82	–	–
	CY 2019	–	910	27,692,950.00	30,431.81	–	–
Wisconsin	SFY 2018	7,596	5,125	28,023,523.67	5,468.00	0.01	211,192.30
	SFY 2019	9,882	6,206	31,052,855.37	5,003.68	0.01	358,788.31
	SFY 2020	8,406	6,005	31,690,799.72	5,277.40	0.01	181,540.70

Notes: SFY is state fiscal year. CY is calendar year.

– Dash indicates that the state did not answer this question or said the answer was unknown.

[1] Based on estimate of demands for notice filed each month.

[2] Missouri indicated this only includes newly opened cases, so it is less than the total number of estates recovered that year.

[3] Information provided on the number and size of estates excludes New York City, so we could not calculate an average recovery amount. New York City is accounted for in total recoveries.

Source: MACPAC, 2021, survey on Medicaid estate recovery.

Hardship waivers. Nine of the 10 states that responded to our survey provided information on hardship waiver applications and the number granted (Appendix 3F).[16] These too vary widely among states. The highest number of applications received by a state in one year was 89 (Iowa), and the lowest number was four (Maryland). Iowa also had the highest number of waivers granted by a state in one year (57), in a year when the state recovered from 3,359 estates. Alaska and Missouri reported granting no hardship waivers over a three-year period, and Maryland and New York (New York City excluded) reported approved hardship waivers in the single digits in any given year. Given what we heard from stakeholders regarding hardship waivers, the numbers of hardship waiver applications and approved waivers reported by states suggest that beneficiaries are not aware of the policy, and that it is difficult to complete such applications without assistance.

Administration costs. Only five states provided information on administrative costs. These ranged from about $35,500 in a single year in Alaska to approximately $3 million in one year in Iowa (Appendix 3F). Administrative costs were typically under 12 percent of total recoveries. It is important to note that states that use third-party contractors for estate recovery administration may pay them on a contingency fee basis. We did not ask states to specify whether administrative costs included these arrangements.

Effects of Estate Recovery on Seeking Medicaid Coverage

A criticism of estate recovery policies is that they reduce access to Medicaid-covered LTSS. In our stakeholder interviews, beneficiary advocates, elder law attorneys, and state officials all commented that some people choose to forego or delay Medicaid LTSS for fear of estate recovery and losing their home. As one interviewee noted, this can lead to poor health outcomes.

Although stakeholders could not quantify how many individuals are deterred from seeking Medicaid LTSS due to estate recovery, prior research noted it as a barrier to enrollment in Medicare Savings Programs (MSPs), which provide assistance with Medicare cost sharing (Nemore 2007, Sanchez 2007). As such, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) barred estate recovery collections for premiums, deductibles, and coinsurance made on behalf of individuals participating in MSPs. In addition, as noted earlier, estate recovery as a deterrent to Medicaid enrollment was also raised as a concern for the new adult group when the Commission last explored this issue (MACPAC 2015, Schilling 2015, Brown 2014). A number of states subsequently eliminated estate recovery from populations that they are not required to pursue (MACPAC 2015).

Although fear of estate recovery may deter some individuals from seeking Medicaid LTSS, awareness and understanding of estate recovery policies by the general public and by Medicaid beneficiaries is low. As noted previously, individuals may first learn about estate recovery during the Medicaid application process, as information is included in the rights and responsibilities section of the application. Two stakeholders, however, noted that this can get lost in the fine print of long applications, and questioned how many people read or understand that information. Additionally, interviewees noted that individuals who have urgent needs for services may not have the time or ability to consider estate recovery policies. Finally, one stakeholder pointed out that even though a Medicaid beneficiary may be aware of estate recovery, if they do not pass that information along to the beneficiaries of their estate, it can come as a shock to those individuals after the enrollee's death.

Commission Recommendations

As the Commission deliberated on estate recovery we drew several conclusions. First, estate recovery does not appear to be effective in recouping assets from the estates of beneficiaries with substantial means. Instead, the modest average recovery amounts reported in our survey and comments from stakeholder interviews suggest that states primarily collect from estates of modest size. Because wealthier beneficiaries have found ways to protect assets so they can be passed on to their heirs, current Medicaid estate recovery policy places an unfair burden on beneficiaries with limited means, whose heirs would likely receive substantial protection from poverty or housing insecurity if they were able to retain an estate of even modest size. While seeking ways to correct this situation, the Commission sought to introduce greater state flexibility and ensure minimum federal protections for beneficiaries and their heirs.

The Commission's deliberations resulted in three recommendations. Congress could take up these recommendations independently of each other, but if the first recommendation is adopted, then the second two would only apply in states that continue recovery. Below we share our rationale and implications for these recommendations. We also share estimates by the Congressional Budget Office (CBO) of how these recommendations would affect the federal deficit. As is typical for MACPAC recommendations, CBO produced estimates within specified ranges because the recommendations did not include legislative language that would enable a more detailed estimate.

Recommendation 3.1

Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law.

Rationale

Reverting estate recovery back to a state option would give states increased flexibility, allowing them to cease recovery if they determine the return on their investment is low, while still permitting states that find estate recovery useful to continue the practice. This echoes a similar recommendation the Commission made in 2019, when recommending that Congress make the Medicaid recovery audit contractor program optional given its administrative burden relative to the amount of recoveries (MACPAC 2019). Another concern about current policy is that states may face a compliance risk due to difficulties in recoveries that may not be well understood by the U.S. Department of Health and Human Services Office of Inspector General. Making recovery optional would mitigate this risk.

A number of stakeholders supported making estate recovery optional, noting that the current policy does not affect beneficiaries with sizable resources in their estates after their death and instead affects beneficiaries with modest means. For heirs of those beneficiaries, retention of an inherited home of modest value could provide some protection from poverty or housing instability.

During the Commission's deliberations, a concern was raised that allowing states to discontinue estate recovery would essentially exempt all home equity below the minimum home equity asset standard (currently set at $603,000) used for eligibility determination. Ultimately the Commission decided that issues and concerns related to eligibility determination should be taken up separately from estate recovery.

Were Congress to take this step, we expect that some states would opt out. Prior to OBRA 93, 22 states had estate recovery programs (OIG 1995). A few states were resistant to OBRA's mandate: West Virginia lost a lawsuit against the federal government on the matter, and Michigan began estate recovery only after it faced a potential loss of Medicaid funding (Corbett 2019, Smith 2012). States most likely to opt out would be those with lower collection amounts relative to other states or those that only pursue recovery for mandated benefits. For example, in FY 2019, eight states recovered less than $500,000 each. (The national average amount recovered per state was about $14.4 million.) States choosing to continue estate recovery would likely include those that have recovered larger amounts in recent years, or those whose home equity limits for LTSS eligibility are higher than the federal minimum (KFF 2019). States that view estate recovery as a program integrity tool may also choose to maintain their programs.

Beneficiary advocates and officials from one state were in favor of making estate recovery optional for states, while the elder law attorneys we spoke with favored eliminating the program altogether. All were concerned about the current inequities of estate recovery. In particular, the elder law attorneys we spoke with acknowledged that although planning for and assisting clients with estate recovery is part of their business, they all supported eliminating the policy.

Medicaid officials varied in their views. Although estate recovery does not bring a lot of money back to the state, one interviewee said the policy sends an important message about the substantial cost for LTSS and that Medicaid finances the majority of the nation's LTSS. One state official noted it would be difficult to forego the revenue from estate recovery, echoing comments received through our state survey. Another expressed equity concerns about estate recovery and would be interested in discussing the issue with stakeholders if the policy were made optional.

Implications

Federal spending. CBO estimates that this recommendation would reduce estate recovery

collections from state Medicaid programs, which would increase federal spending on Medicaid. Federal spending would increase by $50–250 million per year between 2022 and 2030, less than $1 billion between 2021 and 2025, and $1–5 billion between 2021 and 2030.

States. States that cease recovery would forgo the revenue. Reductions in recovery would be somewhat offset by reduced administrative costs.

Beneficiaries. If states cease recovery, some individuals may seek Medicaid-covered LTSS who would not have done so previously. In addition, the inheritance of an estate of even modest size could protect heirs from poverty. Given that estate recovery likely only occurs for those without the resources and awareness to avoid it through estate planning, making it optional will help address equity concerns we heard in our interviews.

Plans and providers. This policy change would have no effect on providers and plans.

Recommendation 3.2

Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary was less than the capitation payment made to a managed care plan.

Rationale

Allowing states to pursue recovery for the actual cost of care where it is less than the capitation payment would avoid circumstances in which individuals' estates are pursued for more than the cost of care that was provided to them. Beneficiaries are likely unaware of the amount of capitation paid on their behalf. Moreover, they cannot change their behavior (e.g., by using fewer services) to avoid having their estates recovered for greater amounts, a strategy that would be possible under fee-for-service arrangements. Even if a Medicaid beneficiary over age 55 receives no care from their managed care plan, under current law, the state still retains the right to pursue the beneficiary's estate for the entire cost of all capitation payments paid to the plan by the state. This differs from other federal programs for which there is no recovery. For example, an individual could enroll in a zero-dollar cost-sharing Medicare Advantage plan and never receive care, but would not have their estate pursued for capitation payments.

This approach would be more equitable and easier for heirs to understand, and may remove a barrier to enrollment for individuals who only need small amounts of care. It would also give states greater flexibility in administering their estate recovery program. This recommendation would not allow states to pursue care for more than the capitation payment for individuals who had higher costs, so beneficiary estates would never be worse off under this recommendation.

Implications

Federal spending. CBO estimates that this recommendation would reduce estate recovery collections from state Medicaid programs, which would increase federal spending on Medicaid. CBO was unable to provide a specific estimate for us as the fiscal effects of this recommendation would depend on whether Congress makes estate recovery optional, as it would apply to either all states or just those that continue recovery. We believe the effects would be modest given the data provided by states on the size of recovered estates under current policies.

States. States that opt to pursue recovery based on the actual cost of care would see decreased collections, as they would collect less for beneficiaries for whom the cost of care is lower than the premium. In addition, for those beneficiaries, states would no longer be able to collect the portion of the premium that pays for a health plan's risk and profit margins regardless of beneficiaries' costs of care.

Beneficiaries. This recommendation may remove a barrier to care for individuals who only need small

amounts of care, and would be easier to explain to beneficiaries and their heirs. For beneficiaries who used small amounts of care, a lower amount may be pursued compared to current law.

Plans and providers. There should be little effect on plans as many already submit to states the type of information that would be needed for the state to seek recovery based on the cost of care. There would be no effect on providers.

Recommendation 3.3

Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for: (1) any asset that is the sole income-producing asset of survivors; (2) homes of modest value; or (3) any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards.

Rationale

Setting specific federal standards for hardship waivers would address some concerns we heard about how estate recovery perpetuates poverty, and would provide more consistent treatment of heirs across states. CMS could begin this process by requiring states to follow the sample criteria it currently describes (CMS 2020). For example, current CMS guidance describes the loss of the sole income-producing asset of survivors as a potential hardship. Because it is likely that the loss of the sole income source for heirs would be a hardship regardless of their state of residence, CMS could require all states to grant waivers in these circumstances. In this case, waiving estate recovery would have a clear effect on heirs' economic stability. CMS also describes a potential hardship as a claim against a home of modest value, which the agency defines as roughly half the average home value in the county. Requiring such a waiver would establish the same policy across states while acknowledging that home values are sensitive to local real estate markets. This would also protect heirs for whom the retention of a family home may reduce housing instability. Under this recommendation, states could also continue to use their own criteria that would exceed these minimum standards.

Regarding the recommended estate minimum threshold, during the discussion Commissioners expressed support for protecting estates of some modest value from estate recovery, even if no other hardship criteria applied. Such a policy would help alleviate an inequity in pursuing estate recovery for people who use LTSS but not for those using other services that may also be quite costly to the program. In addition, other federal means-tested programs (e.g., the Supplemental Nutritional Assistance Program) do not have recovery requirements. Finally, estate recovery is a regressive form of program financing, particularly given federal tax policies that provide substantial protection for those with more assets. Having a minimum threshold would not eliminate this concern but would address concerns about the effects on those with extremely modest means.

Only one state currently has a similar policy to a minimum threshold; Georgia has a cost-effectiveness threshold of $25,000 (higher than all other states) and also waives the first $25,000 in value of larger estates. The Commission chose not to recommend a specific level, noting that Congress or the Secretary would be better suited to determine the exact threshold. Our analysis of HRS data on distribution of wealth among Medicaid decedents could inform their decision making, however. For example, based on the data obtained from the analysis of the HRS, it was determined that 75 percent of Medicaid decedents had less than $48,500 at the time of death.

Implications

Federal spending. CBO estimates that this recommendation would reduce estate recovery collections from state Medicaid programs and

increase administrative costs, which would increase federal spending on Medicaid. CBO was unable to provide a specific estimate for us as the fiscal effects of this recommendation would depend on whether Congress makes estate recovery optional, as it would apply to either all states or just those that continue recovery. In addition, the costs would depend on factors we are leaving to Congress or the Secretary to determine, such as the estate value threshold. We believe the effects would be modest given the data states provided us on the size of recovered estates under current policies.

States. States may see a reduction in revenue if more estates qualify for hardship waivers.

Beneficiaries. If the minimum standards for hardship waivers are increased, more beneficiaries will likely qualify for exemptions. Standards would also ensure that classes of assets, such as homes, are treated the same across states, even if the value of those assets varies. In addition, the inheritance of an estate of even modest size could protect heirs from poverty. These changes could also make individuals more willing to seek care given the removal of the recovery threat.

Plans and providers. This policy change would have no effect on providers and plans.

Looking Ahead

Given the aging population and the high cost of LTSS, Medicaid will continue to play a key role as the nation's largest payer for LTSS. The Commission recognizes the growing financial pressures on the LTSS system, and that one way of addressing that pressure could be to explore mechanisms for people with substantial means to fund their own LTSS (e.g., private insurance) instead of seeking Medicaid. As noted above, during the Commission's various discussions on estate recovery policy, a concern was raised about potential abuses of Medicaid planning activities that allow individuals to shield assets to gain Medicaid eligibility. Given that this is a wholly separate issue from estate recovery, the Commission agreed to defer further discussion of that issue for now and explore later whether there is a need for policy improvements related to eligibility. MACPAC will continue to monitor LTSS trends and proposals for LTSS financing reform, and assess whether Medicaid eligibility rules need updating to promote improved equity and access.

Endnotes

[1] We conducted nine interviews with AARP, the Centers for Medicare & Medicaid Services (CMS), estate recovery contractor HMS, retired elder law attorney Jason Frank, Justice in Aging, the National Academy of Elder Law Attorneys, the National Association of Medicaid Directors, and state officials from Oregon and Tennessee.

[2] For other groups, including children, pregnant women, parents, and adults without dependent children, states must use modified adjusted gross income (MAGI) standards for counting income and household size. These groups may not be subject to an assets test for the purposes of Medicaid eligibility.

[3] The states with Section 209(b) programs are Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, and Virginia (MACPAC 2020a).

[4] California is out of compliance and has not implemented any of the provisions of the DRA (Carlson 2021, Miller 2015). As such, the state exempts a person's primary residence when determining Medicaid eligibility (California Welfare and Institutions Code § 14006).

[5] Florida had the highest personal needs allowance in the continental U.S. Alaska is an outlier with an allowance of $1,396 per month in 2018 (KFF 2019).

[6] States may set the maintenance needs allowance at any level, as long as the deduction amount is based on a reasonable assessment of needs and the state establishes a maximum deduction amount that will not be exceeded for any individual under the waiver (42 CFR 435.726).

[7] For 2021, the minimum monthly maintenance needs allowance is $2,155 for all states except Alaska and Hawaii and the maximum is $3,259.50. The community spouse monthly housing allowance is $646.50 for all states except Alaska and Hawaii. And the minimum community spouse resource standard is $26,076 and the maximum is $130,380 (CMS 2021).

[8] For community spouses with limited income, the institutionalized spouse is allowed to transfer income to the community spouse up to the maximum monthly maintenance needs allowance set by the state.

[9] When considering resources available to the community spouse, the minimum allowed by federal law is the greater of the minimum community spouse resource standard or one-half the couple's resources, up the maximum amount for that year. All resources of the couple are combined, counted, and split in half, regardless of which spouse has ownership of the resources (Colello 2017).

[10] States have the option of using the rate of private patient nursing facilities in the community in which the individual is institutionalized at time of application rather than the statewide average monthly rate (§ 1917(c)(1)(E)(i)(II) of the Act). If a state chooses this option, it would be documented in the state plan.

[11] Prior to the DRA, individuals could use the half-a-loaf mechanism, which involved transferring a portion of their assets and waiting out a penalty period before applying for Medicaid coverage. The DRA, however, changed the start date of the penalty period to the date of application, as opposed to the date that the assets were gifted (GAO 2014).

[12] Negative home equity includes housing debt such as mortgages or home loans.

[13] Under managed care, states make monthly capitation payments on behalf of beneficiaries, whether or not the beneficiary uses any services.

[14] The child must be legally residing at the home and have been there continuously since the beneficiary was admitted to a medical institution.

[15] States that do not comply within 12 months of approval of a corrective action plan face a non-compliance penalty outlined at Section 1903(i)(24).

[16] Our results were consistent with a 2005 survey which found that the most common factor states considered was whether the estate was an income-producing asset that was essential to the survivors' livelihood (Wood and Klem 2007). The same survey also obtained information from states on the percent of hardship waiver requests that were granted in 2005, and found that about 58 percent of hardship waivers were granted. However, the number of hardship waivers received by states varied widely, with an average of 41 but with some states having fewer than 10 submitted.

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Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on Medicaid estate recovery. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendations 3.1, 3.2, and 3.3 on January 29, 2021.

Medicaid Estate Recovery

3.1 Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law.

Yes:	Bella, Barker, Brooks, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Milligan, Szilagyi, Weno	13	Yes
No:	Burwell, Scanlon	2	No
Abstain:	Lampkin, Retchin	2	Abstain

3.2 Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary was less than the capitation payment made to a managed care plan.

Yes:	Bella, Barker, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes

3.3 Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for: (1) any asset that is the sole income-producing asset of survivors; (2) homes of modest value; or (3) any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards.

Yes:	Bella, Barker, Brooks, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Scanlon, Szilagyi, Weno	15	Yes
No:	Burwell	1	No
Abstain:	Retchin	1	Abstain

APPENDIX 3A: Medicaid Estate Recovery Policies

TABLE 3A-1. Demographics, Income, and Wealth of Deceased Medicaid Beneficiaries Age 65 and Older in the Health and Retirement Study, 2012–2016

Characteristic	Total sample	Net value of total wealth			
		Quartile 1 (less than $0)	Quartile 2 ($0 to $2,027)	Quartile 3 ($2,028 to $48,499)	Quartile 4 (greater than $48,500)
Demographics					
Age					
Years: mean (median)	81.8 (81.5)	80.1 (79.0)	82.6 (82.4)	82.1 (82.5)	82.0 (81.8)
Gender					
Female	65.4%	58.2%	73.8%	71.1%	55.5%
Male	34.6	41.8	26.2	28.9	44.5
Race					
White, non-Hispanic	52.3	45.5	50.4	56.8	56.4
Black, non-Hispanic	29.1	33.5	29.6	28.8	24.4
Hispanic	16.3	19.4	17.4	12.5	15.9
Other, non-Hispanic	2.4	1.6	2.6	1.9	3.3
Marital status					
Married	27.9	24.9	19.8	29.2	51.5
Non-married	72.1	75.1	80.2	70.8	48.5
Education					
Years: mean (median)	10.1 (11.0)	10.1 (10.7)	10.0 (10.5)	9.8 (11.5)	10.5 (11.0)
Chronic conditions					
Number: mean (median)	4.0 (3.9)	4.4 (4.0)	4.0 (4.0)	3.9 (4.0)	3.5 (3.7)

TABLE 3A-1. (continued)

Characteristic	Total sample	Net value of total wealth			
		Quartile 1 (less than $0)	Quartile 2 ($0 to $2,027)	Quartile 3 ($2,028 to $48,499)	Quartile 4 (greater than $48,500)
Disability status					
Had cognitive impairment	12.9	15.3	14.2	13.1	8.9
Had a disability	28.2	27.8	35.6	30.8	18.4
Work status					
Retired	86.4%	88.5%	84.1%	84.3%	88.8%
Income					
Below 100 percent of federal poverty level	32.4	43.6	32.7	28.6	24.7
Total household income: mean (median)	$19,918 ($14,980)	$13,967 ($11,786)	$15,589 ($13,389)	$18,512 ($14,245)	$30,764 ($19,120)
Wealth					
Home equity: mean (median)	$27,364 ($19,686)	-$6,954 ($0)	$8 ($0)	$12,880 ($2,000)	$98,694 ($75,905)
Additional property equity: mean (median)	$764 ($0)	$0 ($0)	$0 ($0)	$0 ($0)	$2,963 ($0)
Total value of financial assets: mean (median)	$17,364 ($3,845)	$0 ($0)	$275 ($0)	$4,105 ($2,000)	$64,396 ($12,450)
Net value of total wealth: mean (median)	$44,393 ($30,624)	-$14,236 (-$2,900)	$304 ($8)	$17,709 ($12,500)	$173,436 ($112,258)

Notes: The total sample was composed of 578 Medicaid beneficiaries who participated in the Health and Retirement Study and passed away during the 2012, 2014, and 2016 survey periods. Assets are in 2016 dollars.

Source: LeadingAge LTSS Center @UMass Boston, 2021, analysis for MACPAC of the Health and Retirement Study, 2012–2016.

TABLE 3A-2. Income and Wealth of Deceased Medicaid Beneficiaries Age 65 and Older in the Health and Retirement Study, by Demographic Characteristic, 2012–2016

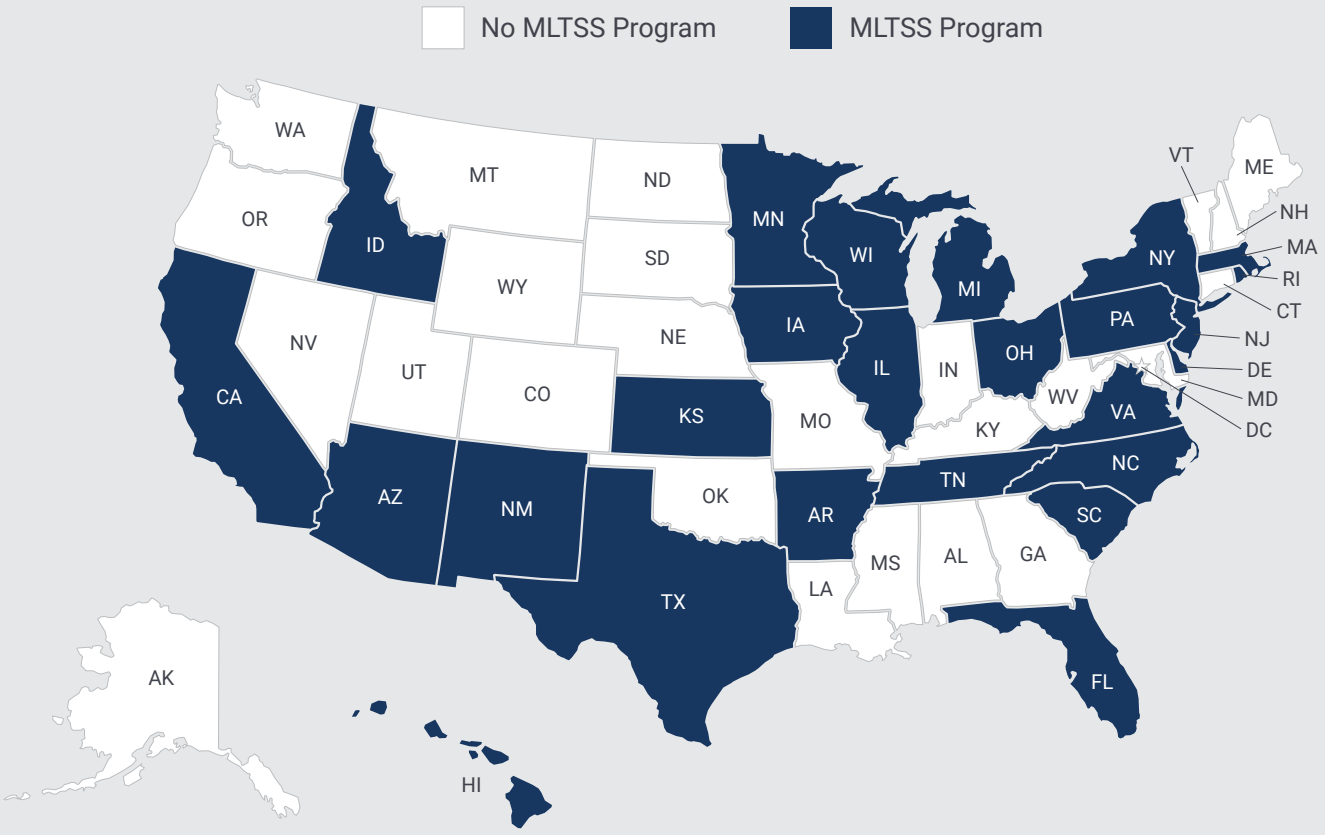
Characteristic	Below 100% federal poverty level	Total household income		Home equity		Additional property equity		Total value of financial assets		Net value of total wealth	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Gender											
Female	34.8%	$16,366	$12,513	$23,465	$0	$796	$0	$11,603	$59	$36,330	$900
Male	25.2	22,491	17,375	34,894	0	758	0	26,318	750	66,277	3,500
Marital status											
Married	19.8	26,600	22,168	50,816	15,000	1,131	0	38,699	3,000	91,217	30,800
Non-married	37.1	13,995	12,000	18,386	0	647	0	8,199	0	29,502	500
Age											
65–74	26.6	25,607	13,878	28,828	0	0	0	29,650	282	59,266	1,800
75–84	35.3	17,714	12,876	31,174	0	357	0	11,970	165	46,740	4,500
≥ 85	29.8	16,883	14,036	23,290	0	1,594	0	13,652	233	39,617	1,250
Race											
White, non-Hispanic	24.5	22,599	14,628	25,784	0	968	0	24,777	800	54,072	2,100
Black, non-Hispanic	38.8	14,947	12,000	25,316	0	648	0	9,864	0	35,502	800
Hispanic	28.6	14,655	13,200	33,989	0	537	0	3,119	0	37,753	1,000
Disability status											
Had a disability	36.3	20,661	12,000	17,952	0	6	0	14,487	0	37,309	475
Did not have a disability	28.4	19,876	14,262	30,619	0	1,044	0	17,441	462	49,863	2,000

Notes: The total sample was composed of 578 Medicaid beneficiaries who participated in the Health and Retirement Study and passed away during the 2012, 2014, and 2016 survey periods. Assets are in 2016 dollars.

Source: LeadingAge LTSS Center @UMass Boston, 2021, analysis for MACPAC of the Health and Retirement Study, 2012–2016.

APPENDIX 3B: States with Managed Long-Term Services and Supports Programs

FIGURE 3B-1. State Adoption of Managed Long-Term Services and Supports Programs, January 2021



Note: MLTSS is managed long-term services and supports. MLTSS program(s) in each state may not cover all regions or populations that use LTSS.

Source: MACPAC, 2021, analysis of ADvancing States 2021.

APPENDIX 3C: Medicaid Estate Recovery Policies

TABLE 3C-1. Medicaid Estate Recovery Policies in State Plans (Liens, Populations, and Services), 2020

State	Liens				Treatment of individuals and services		
	State places lien on real property for Medicaid assistance paid or to be paid	State places lien on real property for benefits incorrectly paid	State imposes TEFRA liens	State imposes post-death lien	State recovers non-mandatory benefits for permanently institutionalized	State determines permanent institutional status for individuals under age 55	State recovers for non-mandatory services for individuals over 55
Total number of states with the specified policy	15	13	26	19	27	16	36
Alabama	✓	–	✓	–	✓	*	✓
Alaska	✓	–	✓	✓	–	–	–
Arizona	✓	✓	✓	✓	–	–	✓
Arkansas	–	–	–	–	✓	✓	–
California	–	–	✓	✓	–	–	✓
Colorado	–	–	✓	–	✓	*	–
Connecticut	✓	✓	✓	✓	✓	*	✓
Delaware	–	–	✓	–	–	–	✓
District of Columbia	–	–	–	✓	–	*	✓
Florida	–	–	–	–	–	–	✓
Georgia	✓	–	–	✓	✓	–	✓
Hawaii	✓	✓	✓	✓	✓	–	✓
Idaho	✓	✓	✓	✓	✓	*	✓
Illinois	–	–	✓	–	✓	–	✓
Indiana	–	–	✓	–	–	–	✓
Iowa	–	–	–	–	–	✓	✓
Kansas	–	–	✓	–	✓	–	✓

TABLE 3C-1. (continued)

State	Liens				Treatment of individuals and services		
	State places lien on real property for Medicaid assistance paid or to be paid	State places lien on real property for benefits incorrectly paid	State imposes TEFRA liens	State imposes post-death lien	State recovers non-mandatory benefits for permanently institutionalized	State determines permanent institutional status for individuals under age 55	State recovers for non-mandatory services for individuals over 55
Kentucky	–	–	–	–	–	✓	✓
Louisiana	–	–	–	–	–	–	–
Maine	–	–	–	–	–	✓	✓
Maryland	✓	✓	✓	–	✓	*	✓
Massachusetts	✓	✓	✓	✓	✓	✓	✓
Michigan	–	–	–	✓	✓	*	✓
Minnesota	–	✓	✓	✓	✓	*	–
Mississippi	–	–	–	–	–	–	–
Missouri	–	✓	✓	–	✓	–	✓
Montana	✓	–	✓	–	✓	✓	✓
Nebraska	–	–	–	–	✓	✓	✓
Nevada	–	–	–	✓	✓	✓	✓
New Hampshire	✓	–	✓	–	✓	✓	✓
New Jersey	–	✓	–	✓	–	–	✓
New Mexico	–	–	–	–	–	*	–
New York	✓	✓	✓	✓	✓	✓	✓
North Carolina	–	–	–	–	✓	✓	✓
North Dakota	–	–	–	–	✓	✓	✓
Ohio	✓	–	✓	✓	✓	✓	✓
Oklahoma	–	–	✓	–	✓	*	–
Oregon	–	–	–	–	✓	–	✓
Pennsylvania	–	–	–	–	–	–	–

TABLE 3C-1. (continued)

State	Liens				Treatment of individuals and services		
	State places lien on real property for Medicaid assistance paid or to be paid	State places lien on real property for benefits incorrectly paid	State imposes TEFRA liens	State imposes post-death lien	State recovers non-mandatory benefits for permanently institutionalized	State determines permanent institutional status for individuals under age 55	State recovers for non-mandatory services for individuals over 55
Rhode Island	–	–	–	✓	–	–	✓
South Carolina	–	–	–	–	–	*	–
South Dakota	✓	✓	✓	–	–	✓	–
Tennessee	–	–	–	–	–	–	✓
Texas	–	–	–	–	–	–	✓
Utah	–	–	✓	✓	✓	–	✓
Vermont	–	–	–	–	–	*	–
Virginia	–	–	–	–	*	✓	–
Washington	–	✓	✓	✓	–	*	–
West Virginia	✓	–	✓	✓	–	✓	–
Wisconsin	–	✓	✓	–	✓	–	✓
Wyoming	–	–	–	–	✓	*	✓

Notes: TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248). Non-mandatory services are services for which states are not required to seek recovery by the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66).

– Dash indicates state does not have the indicated policy.

✓ Check mark indicates the state does have this policy.

* Asterisk indicates this information was missing from the copy of the state plan we reviewed.

Source: MACPAC, 2021, review of state plans and survey on Medicaid estate recovery.

TABLE 3C-2. Medicaid Estate Recovery Policies in State Plans (Insurance and Hardship Criteria), 2020

State	Treatment of insurance					Hardship criteria	
	Disregards assets or resources for individuals with LTC insurance policy as described in Attachment 2.6-A, Supplement 8b	Adjusts or recovers from estate on all medical assistance	Does not adjust for NF or other LTC	Recovers from assets on account of medical assistance	State does not seek recovery or adjustment if individual has LTC insurance partnership	Income producing asset	Home of modest value
Total number of states with the specified policy	8	21	3	9	35	36	8
Alabama	*	*	*	*	✓	✓	–
Alaska	–	–	–	✓	–	✓	✓
Arizona	–	✓	–	–	✓	✓	–
Arkansas	–	–	–	–	✓	✓	–
California	✓	–	–	✓	*	✓	✓
Colorado	–	–	–	–	✓	✓	–
Connecticut	✓	✓	–	–	*	–	–
Delaware	–	✓	–	–	*	✓	–
District of Columbia	–	✓	–	–	–	✓	–
Florida	*	*	*	*	✓	✓	✓
Georgia	–	✓	✓	✓	✓	✓	–
Hawaii	–	✓	–	–	*	✓	–
Idaho	–	✓	–	✓	✓	✓	–
Illinois	✓	✓	–	–	*	–	–
Indiana	✓	–	–	✓	*	✓	–
Iowa	✓	✓	–	✓	✓	–	–
Kansas	–	–	–	–	✓	✓	–
Kentucky	*	*	*	*	✓	–	–
Louisiana	*	*	*	*	✓	✓	–

TABLE 3C-2. (continued)

State	Treatment of insurance					Hardship criteria	
	Disregards assets or resources for individuals with LTC insurance policy as described in Attachment 2.6-A, Supplement 8b	Adjusts or recovers from estate on all medical assistance	Does not adjust for NF or other LTC	Recovers from assets on account of medical assistance	State does not seek recovery or adjustment if individual has LTC insurance partnership	Income producing asset	Home of modest value
Maine	–	–	–	✓	✓	*	*
Maryland	–	–	–	–	✓	*	*
Massachusetts	–	–	–	–	*	–	–
Michigan	–	✓	–	–	✓	✓	✓
Minnesota	–	–	–	–	✓	✓	–
Mississippi	–	✓	–	–	*	✓	✓
Missouri	*	*	*	*	✓	–	–
Montana	*	*	*	*	✓	✓	–
Nebraska	*	*	*	*	✓	–	–
Nevada	*	*	*	*	✓	✓	–
New Hampshire	–	✓	–	–	✓	✓	–
New Jersey	–	✓	–	–	✓	✓	–
New Mexico	–	–	–	–	–	✓	✓
New York	✓	–	✓	–	✓	✓	✓
North Carolina	–	✓	–	–	✓	✓	–
North Dakota	*	*	*	*	✓	–	–
Ohio	*	*	*	*	✓	✓	–
Oklahoma	–	–	–	–	✓	–	–
Oregon	✓	✓	✓	✓	✓	–	–
Pennsylvania	–	✓	–	–	✓	✓	–

TABLE 3C-2. (continued)

State	Treatment of insurance					Hardship criteria	
	Disregards assets or resources for individuals with LTC insurance policy as described in Attachment 2.6-A, Supplement 8b	Adjusts or recovers from estate on all medical assistance	Does not adjust for NF or other LTC	Recovers from assets on account of medical assistance	State does not seek recovery or adjustment if individual has LTC insurance partnership	Income producing asset	Home of modest value
Rhode Island	*	*	*	*	✓	✓	–
South Carolina	–	✓	–	–	*	–	✓
South Dakota	*	*	*	*	*	–	–
Tennessee	✓	✓	–	–	✓	✓	–
Texas	–	–	–	✓	✓	✓	–
Utah	*	*	*	*	✓	✓	–
Vermont	–	✓	–	–	*	✓	–
Virginia	*	*	*	*	*	*	*
Washington	–	✓	–	–	✓	✓	–
West Virginia	–	–	–	–	*	✓	–
Wisconsin	–	✓	–	–	✓	✓	–
Wyoming	–	–	–	–	✓	✓	–

Notes: LTC is long-term care. Supplement 8b to Attachment 2.6-A of the state plan describes resource standards that are more liberal than those used for cash assistance programs. NF is nursing facility.

– Dash indicates state does not have the indicated policy.

✓ Check mark indicates the state does have this policy.

* Asterisk indicates this information was missing from the copy of the state plan we reviewed.

Source: MACPAC, 2021, review of state plans and survey on Medicaid estate recovery.

TABLE 3C-3. Medicaid Estate Recovery Cost-Effectiveness Thresholds, 2020

State	Cost-effectiveness threshold
Alabama	A situation where the state determines that the amount to be recovered exceeds the cost of recovery. Determined on a case-by-case basis.
Alaska	The Department of Health and Social Services will pursue a claim only if it determines that the potential recovery amount would result in twice the administrative and legal cost of pursuing the claim, with a minimum pursuable net amount of $10,000. In assessing the value of an estate, the department will consider all other claims against the estate having precedence under state statute.
Arizona	No initial cost threshold is applied and all potential cases are worked for recovery. However, should an estate enter into litigation, a $5,700 litigation cost threshold has been established which is applied at the point of litigation to determine whether it is cost effective to pursue recovery.
Arkansas	Cost effectiveness will exist when the estimated amount to be recovered from an estate will be greater than the estimated costs of recovery.
California	Because of the volume of cases and limited availability of resources, the Department of Health Care Services has determined that it is not cost effective to pursue continued collection or litigation after a claim/lien is filed if the potential net collection amount is under $5,000. However, when the administrative costs to process a case and continue recovery are very low, usually with cases handled by public administrators/guardians and formal probates, the department may file and pursue continued collection or litigation for any amount. Additionally, in certain circumstances when the debtor has excessive allowable expenses or obligations or when the heir(s) lives out of state and is not responsive to collection efforts, etc., the department may determine that it is not cost-effective to litigate or otherwise pursue recoveries, even though the net assets are over the normal $5,000 threshold.
Colorado	A $500 threshold for liens and estate claims was established in the original operating procedures due to costs in maintaining low-dollar cases on active systems and the costs associated with recovery activities due to lack of automation in Colorado's probate and tax assessment systems.
Connecticut	The Financial Services Center (FSC) does not pursue recovery of a claim against a decedent estate if it determines that the estate lacks sufficient resources to make recovery efforts cost effective. If FSC determines that there are sufficient assets in the estate to allow a recovery on behalf of the state of $100.00 or more, the FSC shall pursue recovery.
Delaware	If there are no resources for burial and the total assets in the estate are less than $5,000, then it is not considered cost effective to pursue because the state's probate law requires that funeral expenses be paid first. If there are resources for burial in the amount of $5,000 then it is considered cost effective to pursue if there are assets in the estate.
District of Columbia	Recovery shall be considered cost effective when the Medical Assistance Administration's claim is over $100. A total medical assistance payment of $100 or less is waived as not cost effective since the court fee (from $15 to $50), standard probate fee ($65), the regular probate fee ($28) and staff time to process the claim exceed the net proceeds to be recovered.
Florida	Liquid assets: $100 Non-liquid assets: automobile ($1,000 minimum value); non-homestead real property ($50,000 equity) [Additional considerations may apply during litigation as described in the state plan.]

TABLE 3C-3. (continued)

State	Cost-effectiveness threshold
Georgia	Estates valued under $25,000 are not subject to recovery. To prevent substantial and unreasonable hardship, the Commissioner for the Department of Community Health shall waive any claim against the first $25,000 of any estate subject to an estate recovery claim for the deceased Medicaid member with a date of death on or after July 1, 2018.
Hawaii	If a contractor is performing the recovery work, it is cost effective if the amount of the recovery is sufficient to yield a contingency fee payment to the contractor which exceeds its cost to recover the asset. If the state is performing the recovery, it is cost effective if the amount of the recovery exceeds the administrative costs, legal fees, travel expenses and other cost factors that may be involved.
Idaho	Recovery shall be considered cost effective when the Department of Health and Welfare's claim is five hundred dollars ($500) or more, or when the total assets subject to recovery are $500 or more, excluding trust accounts or other bank accounts.
Illinois	The State does not make a cost-effectiveness determination.
Indiana	Recovery is not cost effective when the Office of Medicaid Policy and Planning (OMPP) determines that attorneys' fees and other expenses of collection equal or exceed the amount that OMPP expects to collect. If the agency determines that it is most cost effective to compromise the State's claim, the compromise must be approved by the attorney general and the governor.
Iowa	The estate recovery unit attempts estate recovery on all estates for possible recovery; no thresholds for cost effectiveness have been set.
Kansas	The estimated costs involved in filing, pursuing and collecting the estate claim are less than the total expected amount of recovery. These costs include, but are not limited to, administrative costs, court costs, costs of litigation, travel costs, expert witness fees and deposition expenses.
Kentucky	The administrative cost of recovering from the estate is more than the total date-of-death value of the estate subject to recovery. a. The administrative cost shall be comprised of the estimated financial equivalent of agency staff time and resources required to recover the full claim in any individual case. b. This administrative cost shall be compared to actual date of death value, less any exemptions or limitations to recovery known at the time the estimate is made, including any payments made to contractors who may perform the recovery function. If the cost is equal or greater to the value subject to recovery, it shall be determined not cost effective to pursue recovery. c. Based upon a review of historical data regarding the average value of cases, including extrapolated estimates of the expanded value of the estate under current rules, and the staff time and resources involved in securing recovery, the agency has determined that it is not cost effective to recover when the total date-of-death value of the estate is $10,000 or less.
Louisiana	Recovery is deemed to be cost effective when the amount reasonably expected to be recovered exceeds the cost of recovery by an amount equal to or greater than $1,000.
Maine	*
Maryland	*
Massachusetts	In determining cost-effectiveness, the state considers the costs and availability of resources, the amount of its claim, the assets in the estate, and the likelihood of actual recovery.

TABLE 3C-3. (continued)

State	Cost-effectiveness threshold
Michigan	Potential recovery amount of the estate exceeds the cost of filing the claim or if the claim amount is above a $1,000 threshold.
Minnesota	Cost effective for estate claim purposes means that the total amount of the claim that the state is legally entitled to file, or the total amount the state is legally entitled to collect after filing an estate claim is equal to or greater than the estimated costs for filing, pursuing, and collecting the estate claim. In determining that recovery from an estate is not cost effective, the costs to pursue the recovery are considered, including attorney time, travel, court fees, fees for a personal representative, staff and technical support costs.
Mississippi	While the Division of Medicaid will attempt to recover all amounts that are not waived for undue hardship, recovery is not deemed cost effective if the amount to be recovered is less than $2,000 and protracted litigation is required to recover, or the value of the estate is less than 25 percent of the recovery amount making Medicaid's potential recovery less than 25 percent of the recovery amount and protracted litigation will be required to recover. These thresholds are based on the legal time and expense involved in pursuing recoveries through the courts.
Missouri	The state voluntarily defines cost effectiveness as: the cost of the collection will exceed the amount of the claim. However, if a dispute exists, the estate's attorney or other interested parties may raise any disputes, including cost-effectiveness, with the state's attorney over the state's claim filed in probate. If the dispute cannot be resolved, the probate judge will render a ruling in a scheduled probate hearing.
Montana	If a contractor is performing recovery work, it is a cost-effective case if the amount of recovery is sufficient to yield a contingency fee payment to the contractor which exceeds its cost to recover the asset. If the department is performing the recovery, it is a cost-effective case if the amount of recovery exceeds the costs such as administrative, legal fees, travel and the consideration of the factors listed in [other area of the state plan] above.
Nebraska	Recovery is not cost effective when the cost of collection would likely exceed the amount of the Department of Health and Human Services' claim.
Nevada	Cost-effective recovery is accomplished when the amount recovered exceeds the administrative (direct or indirect) expense associated with obtaining the recovery such as, but not limited to, legal fees and expenses.
New Hampshire	No claims are made against estates if the value of the estate is less than $200. Some case-by-case review occurs balancing complexity of issues with likelihood of recovery and the amounts of the potential recovery.
New Jersey	The amount to be recovered is in excess of $500; and the gross estate is in excess of $3,000. In the case of an individual who became deceased on or after April 1, 1995, cost effectiveness shall be found to exist when the expense of the process of collection of the Division of Medical Assistance and Health Services' claim does not exceed the amount likely to be collected. The term "expense" shall include but not necessarily be limited to: division staff salary and benefits; salary and benefits of any ancillary staff, to include the Department of Law and Public Safety, county welfare agencies, etc.; indirect costs, including overhead; the costs of anticipated legal, quasi-legal, or administrative proceedings; and any other incurred or anticipated costs that the division, in its sole discretion, determines are likely to be incurred.
New Mexico	To be cost effective, the administrative cost of recovering from the estate shall be less than the total date-of death value of the estate subject to recovery.

TABLE 3C-3. (continued)

State	Cost-effectiveness threshold
New York	The social services districts are authorized to make judgments as to the cost effectiveness of recoveries based upon their knowledge of the amount of recovery from each type of recovery, and the costs of pursuing each type of recovery.
North Carolina	The gross assets in the estate prior to any disbursements, distributions, or any other payments are below $5,000, or the amount of Medicaid payments subject to recovery is less than $3,000. In either case, the state will waive estate recovery. A waiver based on cost-effectiveness may be a conditional waiver and may specify that the waiver will cease if additional assets are subsequently discovered that may be property of the estate. The state has three years from the date of discovery to pursue any assets subsequently discovered.
North Dakota	North Dakota does not initiate recovery in instance in which the estimated costs of recovery together with the estimated total of other claims with preference over the Medicaid claim exceeds or nearly exceeds the assets in the decedent's estate. Informal estate recovery is limited to estates that have a total asset value of no more than $50,000, include no real property, and involve no person who could assert a hardship claim. In such estates, North Dakota statues permit the Medicaid agency to act as the decedent's "successor," and to collect the decedent's personal property by providing an affidavit to anyone in possession of that property. The primary sources of informal collections are bank accounts in very small estates. More rarely, motor vehicles or other valuable personal property may be collected and liquidated.
Ohio	The state does not perform a cost-effectiveness test or place any predetermined dollar thresholds or real property value thresholds below which recovery is not attempted.
Oklahoma	*
Oregon	Each estate administrator has the authority to determine if an estate will be pursued for collection based on the likelihood of recovering the value of the claim as it compares to the cost of collection.
Pennsylvania	The Department of Human Services does not seek to collect from estates with a gross value of $2,400 or less, unless there is no heir. For estates with a gross value of $2,400 or more, cost effectiveness is determined based on the factual circumstances of each case.
Rhode Island	If probate assets exceed $3,000 at the time of last recertification or if they include real estate, then recovery efforts are initiated upon notification of death.
South Carolina	If the value of the estate is determined (by receipt of affidavit) to be less than $25,000, the department will not file a claim. The assets of the estate must be $25,000 or more and the claims paid by Medicaid must be $500 or more. If the net assets of the estate are less than $4,000 after the payment of all priority expenses, then the department will withdraw its claim. The state may settle its claim for a lesser amount if the state determines that it would be more cost effective and in the best interest of the state to do so than to continue to pursue collection of the full amount of the claim. Criteria to be considered in determining cost effectiveness may include the probability of collecting a larger amount, staff time, cost incurred, legal expense and length of time required to collect.

TABLE 3C-3. (continued)

State	Cost-effectiveness threshold
South Dakota	Cost effectiveness exists if the quotient is greater than one when the amount recovered is divided by the cost of recovery. The average cost of initiating recovery in an uncomplicated recovery case is used as the cost of recovery in determining whether recovery will be cost effective. Because the cost of recovery is subject to periodic fluctuations in personnel and postage costs, no specific dollar threshold is used. However, a recovery of less than $100 is waived as not cost effective. Other guidelines the state uses to determine cost effectiveness are: (a) Because the costs of estate administration can deplete an estate valued at $3,000 or less, the state evaluates each such case individually to determine cost effectiveness; and (b) After consultation with counsel, the state evaluates individually any claims rejected or disallowed in circuit court to determine if initiating further legal action is cost effective.
Tennessee	Collection of any estate recovery claim is presumed to be cost effective. Estate recovery claims are pursued through the probate court and are classified as third priority claims. After payment of the first priority claims (administrative costs) and second priority claims (funeral expenses), TennCare receives the balance of the value of the estate recovery claim. Any remaining value of the estate after payment of the estate recovery claim is then disbursed in accordance with Tennessee probate law.
Texas	Recovery will not be cost effective when the value of the estate is $10,000 or less, or the cost involved in the sale of the property would be equal to or greater than the value of the property. On average, a funeral in Texas costs approximately $10,000. This is just one of six classes of claims under Texas Probate Code that precede estate recovery. Others include estate preservation, safekeeping and management; tax liens and second mortgages; and state taxes, penalties and interests thereon. Given the precedence of these claims and their potential costs the state would incur administrative costs for estates valued at $10,000 or less, but have little chance of regaining those costs.
Utah	The state employs the following procedures to waive estate recovery when recovery is not cost effective: Expenses and claims having priority to the state's claim are subtracted from the assets in the estate to determine if enough recoverable assets remain in the estate to make recovery cost effective. Where expenses having priority leaves less than $500 in recoverable assets, the investigator waives estate recovery.
Vermont	Recovery is considered cost effective in cases where the estate includes liquid resources, such as cash, bank accounts, stocks, bonds, certificates of deposit, IRAs, or real property. There is no minimum threshold, excepted that described in #5. 5. Recovery is waived when it would cause undue hardship (see above). Recovery is waived as being not cost effective in cases where the estate consists only of personal property, such as home furnishings, apparel, personal effects and household goods, which do not exceed $2,000 in value, based on information filed with the probate court.
Virginia	*
Washington	A total medical assistance payment of $100 or less is waived as not cost effective. Guidelines used to establish the cost effectiveness of other cases follow: Because the costs of estate administration may deplete an estate valued at $3,000 or less, each such case is evaluated individually to determine cost effectiveness. After consultation with the attorney general's office, claims rejected (disallowed) in probate court are evaluated individually to determine if initiating legal action is cost effective.
West Virginia	The value of the estate must exceed $5,000 at the time the estate is admitted to probate.

TABLE 3C-3. (continued)

State	Cost-effectiveness threshold
Wisconsin	Claims and liens are adjusted and settled to obtain the fullest amount practicable. Generally, the state will file a claim in a court-supervised estate when the amount of the claim exceeds $100. In the case of assets transferred without court supervision, the state generally will file a claim against the estate when both the claim amount and the amount of assets in the estate exceed $50. The state will act to recover from nursing home personal accounts when both the claim amount and the asset amount exceed $10. Experience has shown that recovery is cost effective at these thresholds in most instances. Estates under $50,000 may be settled by affidavit without court supervision. To achieve cost effectiveness in recoveries from these small sum estates, the state prorates the amounts recovered for the various programs by standard fixed formulas. These formulas are based on the amount of benefits paid by each program in relation to the amount of reported assets of the estate.
Wyoming	The determination by the Department of Health that the expected expenses of a recovery, including, but not limited to, administrative costs, attorneys' fees, court costs, costs of litigation, travel costs, expert witness fees and deposition expenses, are less than the expected amount of the recovery.

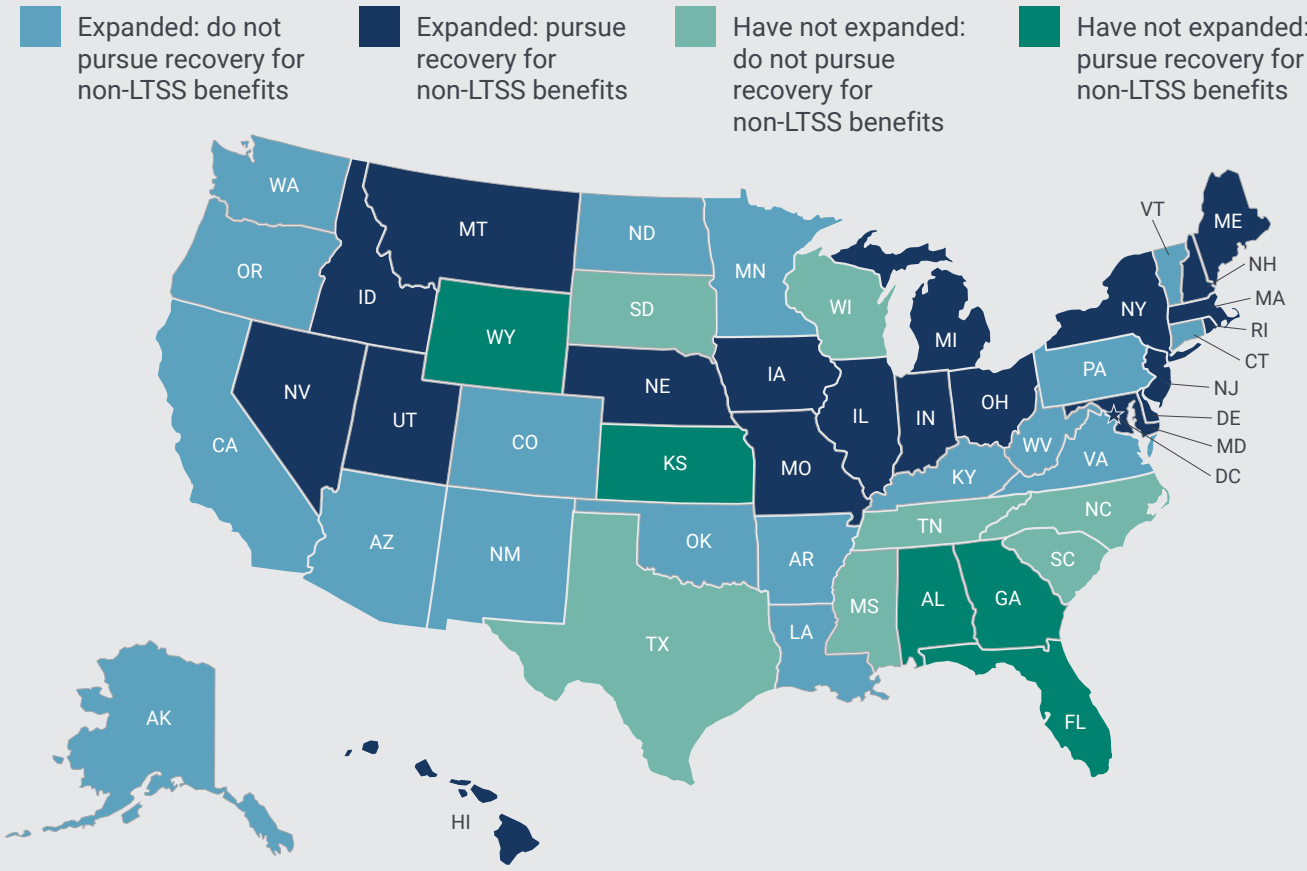
Notes: Text is verbatim from state plan, with minor style changes.

* Asterisk indicates this information was missing from the copy of the state plan we reviewed.

Source: MACPAC, 2021, review of state plans and survey on Medicaid estate recovery.

APPENDIX 3D: Medicaid Expansion and Pursuit of Benefits Other Than Long-Term Services and Supports

FIGURE 3D-1. States That Have Expanded Medicaid and Pursue Estate Recovery for Benefits Other Than LTSS, January 2021



Notes: LTSS is long-term services and supports. Oregon pursues estate recovery for non-LTSS benefits, but only when LTSS services were also received by a beneficiary.

Source: MACPAC, 2021, review of state plans and KFF 2021.

APPENDIX 3E: Medicaid LTSS Spending and Estate Recoveries

TABLE 3E-1. Medicaid LTSS Spending and Estate Recoveries, FYs 2015–2019 (thousands)

State	Fee-for-service LTSS spending[1]					Estate recoveries[2]				
	FY 2019	FY 2018	FY 2017	FY 2016	FY 2015	FY 2019	FY 2018	FY 2017	FY 2016	FY 2015
Total	**$133,124,413**	**$128,133,083**	**$121,984,531**	**$122,118,219**	**$117,920,942**	**-$733,440**	**-$723,872**	**-$754,477**	**-$646,485**	**-$622,291**
Alabama	1,553,753	1,524,362	1,501,517	1,532,514	1,488,324	-7,259	-6,749	-5,686	-5,277	-4,847
Alaska	540,653	530,407	551,435	543,016	520,922	-2,679	-2,245	-3,222	-2,092	-2,890
Arizona	98,491	92,638	85,515	79,855	76,310	-216	-354	-583	-393	-449
Arkansas	1,386,403	1,580,977	1,608,313	1,559,342	1,483,363	-3,796	-2,779	-3,094	-2,632	-2,240
California	17,090,003	16,262,246	12,551,344	12,636,678	11,772,133	-28,987	-41,127	-68,411	-69,613	-71,786
Colorado	2,954,764	1,816,715	2,113,925	2,170,339	1,955,507	-6,409	-8,377	-6,432	-5,599	-7,250
Connecticut	3,441,731	3,509,721	3,504,131	3,361,331	3,352,173	-15,405	-12,078	-8,424	-7,728	-6,460
Delaware	212,739	195,259	224,900	134,060	153,152	–	–	–	–	-25
District of Columbia	971,183	913,379	844,084	809,314	756,611	-1,461	-1,357	-2,283	-2,072	-3,485
Florida	2,771,684	2,511,425	2,229,600	2,094,850	2,086,950	-22,411	-21,327	-16,468	-16,003	-14,537
Georgia	3,017,614	2,784,632	2,609,336	2,427,534	2,406,195	-4,481	-4,939	-5,331	-6,134	-5,903
Hawaii	155,273	140,432	121,588	119,953	116,411	-31	-55	-21	-55	-12
Idaho	732,200	703,188	678,496	633,636	638,895	-11,934	-11,699	-10,202	-10,573	-9,561
Illinois	3,143,948	3,463,518	3,261,887	3,783,703	3,984,962	-25,949	-22,354	-19,731	-19,829	-18,948
Indiana	4,467,450	4,184,202	4,084,689	3,814,853	3,465,602	-13,198	-17,493	-19,077	-17,005	-16,398
Iowa	182,737	170,378	132,304	1,156,396	1,723,990	-26,485	-27,426	-27,664	-24,746	-24,174
Kansas	96,751	111,656	92,507	77,222	83,357	-13,240	-18,199	-12,776	-9,722	-13,114
Kentucky	2,170,633	2,062,536	2,017,133	1,992,137	1,944,007	-7,351	-7,142	-6,254	-8,122	-12,397
Louisiana	2,336,146	2,245,074	2,251,277	2,232,249	2,295,167	-430	-534	-313	-230	-381
Maine	1,104,840	1,033,569	965,128	946,828	898,012	-10,248	-9,847	-11,203	-10,481	-9,195
Maryland	3,077,898	2,844,741	2,734,954	2,473,534	2,535,753	-13,701	-13,734	-14,450	-10,128	-14,972

TABLE 3E-1. (continued)

State	Fee-for-service LTSS spending[1]					Estate recoveries[2]				
	FY 2019	FY 2018	FY 2017	FY 2016	FY 2015	FY 2019	FY 2018	FY 2017	FY 2016	FY 2015
Massachusetts	$4,887,628	$5,091,826	$5,179,353	$4,990,078	$4,632,894	-$83,071	-$73,712	-$63,813	-$59,877	-$55,974
Michigan	3,095,551	2,818,909	2,793,684	2,704,313	2,593,470	-6,478	-5,118	–	-2,114	-4,201
Minnesota	4,814,903	4,451,913	4,116,437	3,885,389	3,664,058	-39,905	-36,561	-35,127	-32,031	-33,078
Mississippi	1,595,550	1,519,152	1,547,610	1,440,114	1,444,609	-399	-684	-947	-691	-559
Missouri	3,719,386	3,417,469	3,246,383	3,003,514	2,827,842	-13,695	-17,382	-15,221	-13,796	-11,394
Montana	439,237	444,120	426,389	414,647	412,055	-4,037	-4,135	-3,614	-2,963	-3,580
Nebraska	923,198	905,206	793,975	846,050	797,544	-4,742	-5,532	-6,681	-3,753	-3,842
Nevada	647,921	592,430	557,674	518,418	493,563	-3,154	-2,545	-1,954	-3,950	-2,351
New Hampshire	798,481	762,260	698,951	694,708	698,878	-7,713	-7,420	-6,248	-5,612	-5,280
New Jersey	3,271,700	3,048,810	3,046,835	3,285,832	3,668,210	-13,840	-18,261	-13,898	-18,596	-12,173
New Mexico	455,435	436,829	420,806	400,594	365,968	-157	-1,005	-67	-349	-301
New York	16,017,895	14,882,081	15,532,615	15,563,161	14,491,863	-59,760	-62,882	-70,036	-67,625	-52,365
North Carolina	2,350,603	2,268,482	1,678,704	2,731,948	2,179,455	-19,842	-17,405	-14,245	-16,118	-12,827
North Dakota	618,490	612,455	616,959	585,356	556,636	-4,490	-4,663	-2,491	-3,020	-3,596
Ohio	6,269,632	5,965,154	5,871,803	6,071,870	5,880,810	-43,795	-40,575	-31,224	-29,357	-35,634
Oklahoma	1,326,817	1,228,156	1,234,564	1,252,017	1,315,575	-5,264	-5,076	-81,875	-4,830	-3,652
Oregon	2,693,291	2,508,042	2,368,980	2,282,140	2,033,381	-31,434	-30,704	-28,225	-25,684	-20,566
Pennsylvania	9,072,796	10,657,467	10,410,341	9,544912	8,711,613	-54,093	-52,133	-54,047	-43,891	-38,106
Rhode Island	561,628	161,915	142,649	171,912	182,557	-5,381	-2,753	-3,785	-3,270	-3,103
South Carolina	1,637,981	1,521,046	1,443,285	1,423,723	1,311,830	-3,844	-5,560	-1,565	-4,093	-4,689
South Dakota	365,348	354,022	340,839	324,648	318,376	-2,714	-3,732	-3,355	-3,229	-3,058
Tennessee	967,300	939,051	933,797	917,676	946,993	-29,437	-24,381	-21,553	-21,017	-20,101
Texas	4,357,004	4,395,505	4,061,900	4,681,227	5,139,604	-4,996	-6,244	-6,178	-4,377	-5,960
Utah	799,716	716,795	693,652	572,992	532,371	-5,488	-4,306	-5,132	-3,944	-4,853

TABLE 3E-1. (continued)

State	Fee-for-service LTSS spending[1]					Estate recoveries[2]				
	FY 2019	FY 2018	FY 2017	FY 2016	FY 2015	FY 2019	FY 2018	FY 2017	FY 2016	FY 2015
Vermont	$209,630	$195,938	$177,007	$125,457	$127,481	–	–	–	–	-$453
Virginia	2,287,579	2,309,002	2,816,447	2,734,993	2,624,540	-$6,130	-$3,999	-$3,593	-$4,312	-1,173
Washington	3,780,124	3,571,035	3,305,743	3,167,292	2,743,637	-16,989	-20,374	-16,196	-15,887	-14,302
West Virginia	1,362,255	1,310,046	1,299,588	1,317,008	1,372,284	-210	-477	-537	-498	-717
Wisconsin	1,988,736	2,069,605	1,774,739	1,610,696	1,853,112	-41,400	-33,059	-17,793	-21,563	-22,931
Wyoming	301,705	297,306	288,756	276,193	261,942	-5,307	-3,379	-3,454	-1,607	-2,450

Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Amounts shown here represent reported spending as of the date the data were collected. Figures presented in this exhibit may change if states revise their expenditure data after this date

– Dash indicates zero.

[1] LTSS includes fee-for-service institutional and home- and community-based LTSS. Does not include LTSS spending provided under managed care. LTSS includes nursing facility, intermediate care facility for individuals with intellectual disabilities, mental health facility, home health, waiver and state plan services, personal care, and certified community behavioral health clinics.

[2] Estate recoveries reflect amounts reported as probate collections. Because these are collections, they are reported as negative spending amounts.

Source: MACPAC, 2021, analysis of CMS-64 FMR net expenditure and collections reports as of June 15, 2020.

APPENDIX 3F: MACPAC Estate Recovery Survey Results

We chose a sample of 15 states that represented a range of aggregate collections and estate recovery policies, and included states with and without MLTSS. Ten states responded. Several responding states noted that they do not collect certain data (e.g., hardship waiver applications) or were unable to provide customized reports.

Hardship Waivers

Nine states were able to provide information on hardship waiver applications and the number granted. Two states reported receiving no hardship waiver applications.

TABLE 3F-1. Estate Recovery Hardship Waivers Granted

State	Year	Hardship waiver applications	Hardship waivers granted	Percentage of hardship applications granted
Alaska	SFY 2018	0	0	–
	SFY 2019	0	0	–
	SFY 2020	0	0	–
Arizona	SFY 2018	34	29	85.3%
	SFY 2019	24	21	87.5
	SFY 2020	21	17	81.0
Georgia	FFY 2017	15	7	46.7
	FFY 2018	28	10	35.7
	FFY 2019	23	17	73.9
Iowa	SFY 2018	46	43	93.5
	SFY 2019	60	57	95.0
	SFY 2020	35	32	91.4
Maryland	CY 2017	6	4	66.7
	CY 2018	4	1	25.0
	CY 2019	5	2	40.0
Missouri	SFY 2018	0	0	–
	SFY 2019	0	0	–
	SFY 2020	0	0	–
New York	CY 2017	6	3	50.0
	CY 2018	10	3	30.0
	CY 2019	14	4	28.6
Oregon	Not specified	27	–	–

TABLE 3F-1. (continued)

State	Year	Hardship waiver applications	Hardship waivers granted	Percentage of hardship applications granted
Wisconsin	SFY 2018	89	28	31.5
	SFY 2019	76	41	53.9
	SFY 2020	81	41	50.6

Notes: SFY is state fiscal year. FFY is federal fiscal year. CY is calendar year.

– Dash indicates that the state did not answer this question, said it was unknown, or question is not applicable.

Source: MACPAC, 2021, survey on Medicaid estate recovery.

Program Administration Costs

Five states provided information on administrative costs, which were typically less than 12 percent of total recoveries for each fiscal year. States that use third-party contractors for estate recovery administration may pay them on a contingency fee basis. We did not ask states to specify whether administrative costs included these arrangements.

TABLE 3F-2. Estate Recovery Program Administration Costs

State	Year	Program administration costs	Total recoveries	Administration costs as percentage of total recoveries
Alaska	SFY 2018	$39,905.93	$858,674.69	4.6%
	SFY 2019	52,311.11	235,257.47	22.2
	SFY 2020	35,525.89	408,139.16	8.7
Georgia	FFY 2017	450,228.04	3,966,766.95	11.3
	FFY 2018	476,765.87	4,200,580.34	11.4
	FFY 2019	450,596.57	3,970,013.82	11.4
Iowa	SFY 2018	2,311,113.44	7,189,569.89	32.1
	SFY 2019	3,003,357.08	27,303,246.14	11.0
	SFY 2020	2,785,380.15	25,321,637.73	11.0
Missouri	SFY 2018	571,304.14	13,321,042.00	4.3
	SFY 2019	571,304.14	14,607,628.00	3.9
	SFY 2020	571,304.14	15,580,521.00	3.7
Oregon	Not specified	2,500,000.00	32,700,000.00	7.6

Notes: SFY is state fiscal year. FFY is federal fiscal year.

Source: MACPAC, 2021, survey on Medicaid estate recovery.

Chapter 4:

Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations

Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations

Key Points

- Dually eligible beneficiaries may experience fragmented care and poor health outcomes when their Medicaid and Medicare benefits are not coordinated. Integrating care has the potential to improve their experience and reduce federal and state spending that may arise from duplication of services or poor care coordination.
- Although Congress has created multiple authorities to improve integration of care, only about 10 percent of dually eligible beneficiaries are enrolled in integrated care and integrated options are not available in many areas of the country.
- Given the inherent limitations of integrating care across two separate programs, some stakeholders have begun to explore how to create a unified program. The idea would be to simplify coverage for beneficiaries, align financial incentives, and improve the ability to meet beneficiary needs for services such as acute care, long-term services and supports, behavioral health, and social services.
- Establishing such a program would require substantial statutory and regulatory changes at the federal and state level, affecting policies including benefits, eligibility, and administration.
- As a first step, policymakers need to consider the overarching goals of a unified program. Those might include ensuring beneficiaries have access to the services they need, can exercise choices about their care, and have adequate consumer protections, as well as advancing health equity.
- Decisions would need to be made about specific parameters for eligibility, beneficiary protections and enrollment, benefits, delivery system, care coordination, administration, and financing.
- This chapter examines many of the policy and design issues that would need to be settled in developing a unified program, highlighting policy choices and trade-offs. In doing so, we draw on the work of two stakeholder groups–the Bipartisan Policy Center and the Dual Eligible Coalition convened by Leavitt Partners–that are promoting a new approach to serving this population.
- The wide availability of managed care options envisioned by these proposals is not yet a reality, and states and the federal government would need substantial time to stand up a new structure of coverage for the dually eligible population.
- The Commission is continuing its work on more immediate ways to improve integration of care for dually eligible beneficiaries and will provide additional insights in its June 2021 report to Congress.

CHAPTER 4: Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations

In 2019, 12.3 million individuals were enrolled in both Medicaid and Medicare (CMS 2020a).[1] These so-called dually eligible beneficiaries include both those age 65 and older and younger beneficiaries with disabilities. They are a diverse group; although many have complex care needs, including multiple chronic conditions, physical disabilities, behavioral health conditions, and cognitive impairments, others are relatively healthy (MACPAC 2020a). On average, dually eligible beneficiaries use more services than those enrolled only in Medicaid or Medicare and have higher per capita costs. Many also face multiple social risk factors that may affect their health status, such as housing insecurity and homelessness, food insecurity, inadequate access to transportation, and low health literacy (Sorbero et al. 2018).[2]

Combined, Medicaid and Medicare cover a broad range of health care services, including preventive services, primary care, inpatient and outpatient services, long-term services and supports (LTSS), and behavioral health care for dually eligible beneficiaries. Medicare is the primary payer for most acute and post-acute care services. Medicaid is the secondary payer and wraps around Medicare by providing assistance with Medicare premiums and cost sharing and by covering services not covered by Medicare, such as LTSS.

The division of coverage between the two programs, however, can result in fragmented care and cost shifting. In addition, there are few incentives for ensuring that services are coordinated and provided based on what is best for the beneficiary. For example, beneficiaries admitted to the hospital, a service paid for by Medicare, may need home- and community-based services (HCBS) paid for by Medicaid to safely transition back into the community. However, the beneficiary's HCBS provider may be unaware of a hospital stay, making it difficult to effect a smooth transition. Because transitions are usually coordinated at the provider level, engaging providers, particularly primary care providers, is critical. Similarly, because hospital readmissions are covered by Medicare, state Medicaid agencies may not have financial incentives to ensure that services that would prevent readmission are provided after the initial discharge because the savings from readmission would accrue to Medicare (Grabowski 2007).

Integrated care is intended to address these concerns by aligning delivery, payment, and administration of Medicaid and Medicare services. The goal of care integration for dually eligible beneficiaries is to improve the beneficiary experience, eliminate incentives for cost shifting, and reduce spending that may arise from duplication of services or poor care coordination.

Over the past 25 years, Congress has created multiple authorities and demonstration opportunities to promote integration (Appendix 4A). Even so, existing integrated care models have not achieved their full potential. For example, the Medicare-Medicaid Plans (MMPs) in the Financial Alignment Initiative (FAI), which offer high levels of integration, are only available in nine states (MACPAC 2020b). Only about 1 million full-benefit dually eligible beneficiaries, or about 10 percent of the full-benefit dually eligible population, are enrolled in integrated models including MMPs and certain dual eligible special needs plans (D-SNPs) (CMS 2020b).

The COVID-19 pandemic has highlighted the need to improve care for dually eligible beneficiaries. As a group, dually eligible beneficiaries are at particular risk during the pandemic due to their age, underlying medical conditions, and their congregate living situations (Archibald and Soper 2020, CDC 2020). Between January 1 and November 21, 2020, of almost 2 million COVID-19 cases in the

Medicare population, about 40 percent were dually eligible beneficiaries (CMS 2020c). Moreover, dually eligible beneficiaries experienced higher rates of hospitalization due to COVID-19 than those enrolled only in Medicare (CMS 2020c). This was true across age, race and ethnicity, and gender (CMS 2020c). American Indian and Alaska Native, Black, and Hispanic dually eligible beneficiaries had the highest rates of hospitalization due to COVID-19 among racial or ethnic groups, being almost two times more likely to be hospitalized because of COVID-19 than white dually eligible beneficiaries (CMS 2020c).

Over the past two years, MACPAC has been examining how to increase enrollment in integrated models and increase availability of such models across geographic areas. This work is ongoing and we expect to include discussions of policies to promote these goals in our June 2021 report to Congress.

However, given that Medicare and Medicaid are administered and financed differently, and were designed to accomplish different goals, the ability to fully integrate is difficult. For example, many state Medicaid programs require mandatory enrollment in managed care, while Medicare beneficiaries enrolled in Part A or Part B have the right to choose either managed care or remain in fee for service (FFS) where they can access any qualified provider. Although automatic enrollment into integrated care models has led to higher enrollment than health plans could otherwise have attained, some stakeholders view it as infringing on beneficiary rights or discriminating against dually eligible beneficiaries relative to other Medicare beneficiaries (Archibald et al. 2019, MedPAC 2018).

Given the limitations inherent in integrating care across two separate programs, some stakeholders have begun to explore how to create a wholly new, unified, program that would replace the fragmented system we have today. A unified program could simplify coverage for beneficiaries, providing acute care, behavioral health services, LTSS, and other social services under a single umbrella. Such a program would have the potential to align incentives, eliminate cost shifting that currently occurs between Medicare and Medicaid, and fill existing gaps in coverage, such as access to expanded HCBS.

Establishing such a program would require substantial statutory and regulatory changes at the federal and state level, affecting multiple policies including the benefits package, eligibility, and administration.[3] This chapter reviews some of the major choices that would need to be made to establish a unified program and the implications of those decisions. It is important to note that the Commission is not recommending wholesale changes at this time; rather, our goal is to contribute to the conversation regarding unified coverage for dually eligible beneficiaries by highlighting the policy choices and trade-offs that would need to be considered in designing such a program.

In this chapter, the Commission examines key design considerations that would have to be addressed to establish a unified program. The chapter begins with background on existing integrated care models, then offers specific policy considerations for issues related to eligibility, beneficiary protections and enrollment, benefits, delivery system and care coordination, administration, and financing. As context for that discussion, the chapter draws examples from two existing proposals to create a fully integrated system for dually eligible beneficiaries. The chapter does not evaluate or provide an exhaustive description of either proposal but uses examples from each to illustrate possible approaches to addressing certain design features.

Existing Integrated Care Models

As noted above, policymakers have developed models to integrate benefits for dually eligible beneficiaries to address challenges that arise from having two different sets of program rules and funding silos. Although these models all aim

to improve health outcomes and reduce overall spending, integrated care models offer varying degrees of financial and clinical integration, with a focus on financial integration as the first step toward integrating care. Because the experience with these models can inform decisions about different aspects of a new program, we describe them briefly below.

Medicare-Medicaid Plans. MMPs provide a high level of integration by enabling dually eligible individuals to enroll in a single plan that is responsible for all aspects of their care, with the goal of making coverage between the two programs seamless for the beneficiary.[4] They operate under a three-way contract—with the state and the Centers for Medicare & Medicaid Services (CMS)—which specifies that the plan provide enrollees with health risk assessments, individual care plans, and access to a care coordinator and an interdisciplinary care team (Ormond et al. 2019). These plans operate under state demonstrations under the FAI that differ in terms of their target population, benefits, and care coordination services. Nine states are using the capitated MMP model, in which plans receive a prospective monthly payment to provide services to enrollees (MACPAC 2020b). Beneficiaries have reported positive experiences with these plans. For example, an analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a beneficiary survey that MMPs are required to conduct every year, found that 63 percent of enrollees gave MMPs the highest possible rating in 2017 (MedPAC 2018).

Financing for MMPs is integrated because CMS and the states jointly develop Medicaid and Medicare capitation rates as part of their contract negotiations (CMS 2019a). MMPs receive a payment that combines Medicaid and Medicare Part A, Part B, and Part D.[5] The portion of the payment related to Medicaid and Medicare Parts A and B is reduced by a percentage based on the amount of expected savings the demonstration will generate. The percentage reduction is set by CMS and each participating state for each year of the demonstration, and generally does not exceed 6 percent (Engelhardt 2021, MACPAC 2018a). MMPs are also subject to a quality withhold in which a portion of the payment rate is withheld pending plans' performance on certain quality measures. The quality withhold typically does not exceed 3 percent but is 4 percent in 2020 in California and Ohio (Engelhardt 2021).[6]

Medicare Advantage dual eligible special needs plans. Statutory changes have incrementally improved the ability to integrate Medicaid and Medicare through D-SNPs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires D-SNPs to hold a contract with the state Medicaid agency in any state in which they seek to operate. Through such MIPPA contracts, states can require D-SNPs operating in their state to offer an aligned managed LTSS (MLTSS) plan and require any MLTSS plan to offer a companion D-SNP (described in greater detail below) (GAO 2020). The Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) required D-SNPs to meet new information-sharing requirements to further coordinate the delivery of Medicaid services, effective in 2021. For example, certain D-SNPs must identify within their MIPPA contracts a process to share information with the state or its designee when certain full-benefit dually eligible beneficiaries are admitted to a hospital or skilled nursing facility (42 CFR 422.107(d)). Most D-SNPs provide little integration beyond such information sharing. This type of D-SNP is available in many states, but a smaller number of states have an MLTSS program or contracts with D-SNPs that have been designated as fully integrated dual eligible special needs plans (FIDE SNPs) that can offer higher levels of integration (MACPAC 2020a).

Medicare Advantage D-SNPs aligned with MLTSS plans provide a higher level of integrated care by enrolling beneficiaries for their Medicaid and Medicare coverage through the same entity.[7] MLTSS plans receive a capitated payment from states to provide LTSS covered by Medicaid, which can include long-stay nursing facility services and services provided at home and in the community, such as personal care, respite care,

meal delivery, adult day care, and transportation. This arrangement can simplify care for enrollees and increase efficiency, while providing greater opportunities for care coordination among services covered by Medicaid and Medicare. D-SNPs are tailored to the unique characteristics and needs of the dually eligible population served and coordinate care and conduct health risk assessments for enrolled beneficiaries (CMS 2016). Although D-SNPs are available in most states, companion MLTSS programs may not operate in the same areas, limiting opportunities for integration through a D-SNP.

Highly integrated dual eligible special needs plans (HIDE SNPs) and FIDE SNPs are D-SNPs that meet a higher level of integration by covering at least some Medicaid benefits or by providing a companion MLTSS plan, a behavioral health organization, or a Medicaid managed care organization that covers behavioral health services to full-benefit dually eligible beneficiaries (CMS 2020d). In states where behavioral health services are carved out of the capitated rate and provided by a separate plan, FIDE SNPs are not required to cover behavioral health services (CMS 2020d). Likewise, where a limited scope of LTSS coverage is carved out, a D-SNP may still qualify as a FIDE SNP or a HIDE SNP.[8] HIDE SNPs and FIDE SNPs receive capitated Medicaid payments. FIDE SNPs may also receive an increased Medicare payment through a frailty adjustment if CMS determines that the beneficiaries enrolled in a FIDE SNP have an average level of frailty similar to that of enrollees in the Program of All-Inclusive Care for the Elderly (PACE) (CMS 2016).

Managed fee-for-service model. Beneficiaries enrolled in the FAI's managed FFS model receive both Medicaid and Medicare services under FFS arrangements but are assigned a care coordinator to coordinate benefits and help them meet care needs. Under this model, a state provides the up-front investment in care coordination and is then eligible for a retrospective performance payment from CMS if it meets an established quality threshold and Medicare achieves a target level of savings (CMS 2012). Washington, the only state currently operating such a model, uses Medicaid health homes to coordinate care for participating dually eligible beneficiaries.[9] Beneficiaries see any Medicaid-enrolled provider participating in a qualified health home. This demonstration also promotes access to community supports and services such as housing assistance (CMS 2012).

Program of All-Inclusive Care for the Elderly. PACE provides health care services to certain frail individuals age 55 and older who meet criteria for a nursing home level of care but are able to live safely in the community. Almost all PACE beneficiaries—90 percent—are dually eligible for Medicaid and Medicare (NPA 2019). PACE sites are designed to serve a specific geographic area, providing a range of care needs, including primary care, social services, and meals. PACE organizations have a physical site and staff who provide many services through an adult day program that serves beneficiaries at the site, in their homes, and elsewhere in the community. PACE organizations also contract with primary care providers and specialists in the community to provide health care to beneficiaries (CMS 2020e). PACE operates through a three-way partnership between CMS, the state, and the PACE organization. Programs receive separate capitated payments from Medicare and the state Medicaid agency.

Key Design Considerations for a Unified Program

Designing a unified program of health coverage for dually eligible beneficiaries is a complex undertaking that is starting to get some attention in the policy community. In thinking about the design of such a program, policymakers need to consider both the overarching goals and the parameters for specific policies. From the beneficiary's perspective, these goals might include ensuring that beneficiaries are able to access the services they need, ensuring that beneficiaries are able to exercise choices about their care and have

adequate consumer protections, and advancing health equity and addressing racial and ethnic disparities (Prindiville 2020). Federal and state officials are likely to start from a perspective aimed at both improving care and containing costs and to focus on increasing financial accountability and delivery system integration between Medicare and Medicaid, increasing enrollment in integrated care, and providing flexibility to design a package of services appropriate for different subsets of the dually eligible population (Miller 2020).

Stakeholders have recently begun discussing potential designs for a fully integrated system for this population. These include the Bipartisan Policy Center's (BPC) July 2020 report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*, and a proposal still in development from the Dual Eligible Coalition, convened by Leavitt Partners (Dual Eligible Coalition 2021, BPC 2020). Both proposals imagine a fully integrated program covering all Medicare and Medicaid benefits with an integrated funding stream to a single entity that manages care for the beneficiary. Both seek to improve care for individuals while providing incentives to reduce spending with the opportunity to reinvest any realized savings.

These proposals differ, however, in the envisioned structure. The BPC proposal builds on the current structure, retaining Medicaid and Medicare as separate programs, but requiring states to adopt a fully integrated program within 10 years after enactment of a new law, to give states time to set up the fully integrated program. States would choose from three existing models: a modified version of FIDE SNPs, PACE, or a new model building off the managed FFS model used in Washington's demonstration. States must notify the Secretary of the U.S. Department of Health and Human Services (the Secretary) of their intention one year after enactment. If states do not establish their own integrated care programs, the federal government would establish one for them in what is referred to as a federal fallback option, within five years of enactment (BPC 2020). Whether the program is operated by states or the federal government, beneficiaries would receive a single set of benefits including medical, behavioral health, and LTSS; a single point of contact; a single set of marketing materials; and a single set of enrollee materials. The proposal would grant full regulatory authority over all programs serving the dually eligible population to the Medicare-Medicaid Coordination Office (MMCO) at CMS.

The Dual Eligible Coalition would establish an entirely new program, under a new title of the Social Security Act, and move all dually eligible beneficiaries into this program along with the Medicare and Medicaid funding that currently pays for their coverage (Dual Eligible Coalition 2021). Those dollars would cease to be Medicare or Medicaid funds and instead would be dedicated to a program uniquely for dually eligible beneficiaries. Although details of this proposal are still under development, a few features are known: There would be a core benefit package including all current Medicaid and Medicare benefits. States choosing to participate would be responsible for delivering care following a set of federal minimum standards. They would use capitated managed care plans or, if requested by the state and approved by the Secretary, what the Dual Eligible Coalition calls at-risk, value-based, alternative fully integrated delivery systems. Financing from Medicare and Medicaid, including the state share of Medicaid expenditures, would be combined into a single funding stream to cover the costs of care for dually eligible beneficiaries. Similar to the BPC proposal, the Dual Eligible Coalition would assign oversight authority to the Secretary, acting through MMCO (Dual Eligible Coalition 2021).

In the sections that follow, we draw out the policy and design issues that would need to be settled in developing a new approach to serving dually eligible beneficiaries. We begin with current policies, then draw on the ongoing work of both BPC and the Dual Eligible Coalition, to the degree that their proposals have addressed each issue. Specifically, we look at issues related to eligibility, beneficiary protections and enrollment, benefits, delivery system and care coordination, administration, and financing.

Eligibility

Eligibility standards for Medicare are uniform while those for Medicaid vary by state. Dually eligible beneficiaries must qualify separately for each program. They can qualify for Medicare by virtue of age (age 65 and older), disability, or, for a small number of individuals (less than 1 percent), because they have end-stage renal disease.[10] Medicaid eligibility is determined based on both financial and functional criteria. However, most dually eligible beneficiaries qualify for Medicaid on the basis of income because they are designated as medically needy or receive Supplemental Security Income (MACPAC and MedPAC 2018). The medically needy pathway allows states to cover individuals with high medical expenses relative to their incomes after spending down to a state-set income level. States may offer these beneficiaries full Medicaid benefits or a limited set of benefits as defined by the state, within certain parameters.[11]

There are a number of eligibility provisions to consider in designing a unified program. The Dual Eligible Coalition would assign responsibility for establishing minimum eligibility standards to the federal government, and MMCO in particular. The proposal specifies, however, that eligibility would be limited to Medicare beneficiaries who are also eligible for full Medicaid benefits and are age 21 and over. It would allow states to choose to go above federally set thresholds and provide more generous coverage, as allowed under current law. The BPC proposal has three specific parameters on eligibility: limiting eligibility to full-benefit dually eligible beneficiaries, allowing automatic enrollment with beneficiary opt outs, and permitting and encouraging states to implement 12-month continuous eligibility for dually eligible beneficiaries. Both proposals appear to allow states to continue setting their own eligibility levels as long as they meet federal thresholds.

Below we discuss several eligibility-related issues that policymakers would need to consider in designing a unified program.

Limiting eligibility to full-benefit dually eligible beneficiaries. Existing integrated care models may include both full- and partial-benefit dually eligible beneficiaries. In MMPs, which offer a high level of integration, enrollment is limited to full-benefit dually eligible beneficiaries, while D-SNPs enroll both groups. As partial-benefit enrollees do not qualify for full Medicaid benefits (their Medicaid coverage provides assistance only with their Medicare premiums and in some cases cost sharing), including them in integrated care models may prevent health plans from offering a single model of care to all enrolled beneficiaries. We discuss this issue in more detail in the delivery system and model of care section below.

Eligibility for a unified program could be limited to individuals who are eligible for full Medicaid benefits. Such beneficiaries are the most likely to benefit from integrated care because they have Medicaid benefits to integrate with their Medicare coverage, while partial-benefit dually eligible beneficiaries do not. Both the Dual Eligible Coalition and the BPC proposals limit eligibility in this way; the Medicare Payment Advisory Commission (MedPAC) has contemplated doing the same for D-SNPs (MedPAC 2019).

In designing a unified program, a decision must be made about how to structure coverage for the partial-benefit population. Issues to be resolved include whether they will continue to enroll in existing integrated models (such as D-SNPs) and the treatment of so-called crossover claims to Medicaid for Medicare coinsurance and deductibles. Providers submit claims to Medicare first, because it is the primary payer, which pays for the service and then crosses over the claim to state Medicaid programs to pay the cost-sharing amounts (MACPAC 2013). States are not obligated to pay the full amount of Medicare cost sharing if the total payment to the provider would exceed the state's Medicaid rate. Instead, states may limit their payment to the lesser of either the Medicare deductibles and coinsurance or the difference between the Medicaid rate and the amount already paid by Medicare (MACPAC 2013).

Continuous eligibility for Medicaid. Eligibility differences between Medicaid and Medicare have long created challenges for coordinating services. While Medicare eligibility, once conferred, does not change over time, most Medicaid beneficiaries must regularly renew their eligibility to account for changes in certain circumstances, such as income, on which their eligibility is based. Because the eligibility renewal process can be cumbersome, even beneficiaries whose circumstances have not changed may lose Medicaid eligibility temporarily, creating gaps in coverage for services not covered by Medicare, such as LTSS.[12] One study found that about 29 percent of full-benefit dually eligible beneficiaries who transitioned to dual status from 2007 to 2009 lost Medicaid coverage for at least one month in the 12 months after transition (Feng et al. 2019). Individuals who transitioned into dual status from Medicaid had a 37 percent lower risk of losing Medicaid coverage than individuals who transitioned into dual status from Medicare (Feng et al. 2019).

Both the BPC and Dual Eligible Coalition proposals would allow states to implement 12-month continuous Medicaid eligibility for the dually eligible population without obtaining a waiver. This would limit the number of renewals for dually eligible beneficiaries to once per year and promote continuity of care. This approach is consistent with current policy for certain Medicaid enrollees, most often children (unless the state has obtained a waiver for adults), who can retain Medicaid eligibility for a specified period of time (typically 12 months) before their eligibility is redetermined. Such continuous eligibility policies help promote continuity of care and reduce the burden on beneficiaries, states, and health plans.

Population carve-outs. States often exclude certain beneficiaries from coverage under their Medicaid managed care plans. For example, dually eligible beneficiaries with intellectual or developmental disabilities (ID/DD) are typically carved out of Medicaid managed care and receive services through FFS. As a result, these dually eligible beneficiaries cannot participate in integrated care models.

States have typically excluded this population from managed care (MACPAC 2018b). Managed care plans and ID/DD service providers often lack experience with each other because Medicaid has typically been the dominant payer for services for this population and those services have been covered under FFS. Lack of experience with managed care has sometimes led to stakeholder mistrust and resistance to efforts to move such beneficiaries to managed care. Individuals with ID/DD may be enrolled in LTSS for much longer periods of time than other LTSS beneficiaries, sometimes for decades, and they often use different types of services, such as employment supports (MACPAC 2018b). Only Arizona and Wisconsin enroll their ID/DD population into MLTSS (MACPAC 2018b). Arizona set up an MLTSS program in 1988 to coordinate care, focus on HCBS, and avoid creating a long waiting list (Lewis et al. 2018). For Wisconsin, setting up MLTSS was important to the state to end the waiting list, improve access and choice, increase quality, and achieve cost efficiencies (Lewis et al. 2018).

The Dual Eligible Coalition proposal would eliminate such carve-outs because it seeks to extend integrated care to most, if not all, full-benefit dually eligible beneficiaries. Recognizing that states and beneficiaries are likely to need time to adapt to a fully inclusive model, the proposal notes that the Secretary should have discretion to allow states to phase in certain populations not typically covered under integrated models over a defined period of time (Dual Eligible Coalition 2021). The BPC proposal does not specify whether states would be allowed to carve out certain populations under a fully integrated program although it notes that the ID/DD population is commonly excluded from managed care (BPC 2020).

Maintenance of effort. A maintenance of effort (MOE) provision would require states to continue existing Medicaid eligibility levels while giving them the opportunity to increase eligibility above current levels. This is designed to keep coverage levels from declining relative to prior law but it limits state flexibility to reduce levels based on individual

state circumstances. For example, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) included an MOE so that states would not reduce their Medicaid eligibility levels in response to the roll-out of new coverage options. The Dual Eligible Coalition would establish an MOE for states for income and asset levels for dually eligible beneficiaries.

Beneficiary protections and enrollment

Under current law, eligible individuals enroll in Medicaid through their state or local Medicaid offices and in Medicare through the federal government. Local organizations like State Health Insurance Assistance Programs (SHIPs) and area agencies on aging (AAAs) are available to assist individuals in understanding their coverage options, particularly in Medicare. In addition, Medicaid enrollment brokers under contract with the state and Medicare agents and brokers under contract with Medicare Advantage plans also provide choice counseling and enrollment assistance. In Medicaid, beneficiaries typically have choices between at least two health plans, except in certain rural areas where beneficiaries only have a choice of provider within a health plan (MACPAC 2020c). In Medicare, they may always choose between receiving care under FFS or from available managed care plans under Medicare Advantage.

Beneficiary choice. The opportunity for individuals to choose their own coverage has been a long-standing policy in Medicare. In Medicaid, choices are more constrained, with states often automatically enrolling beneficiaries into managed care plans, but allowing them to opt out and choose a different plan, thus maintaining a degree of beneficiary choice. Under current law, beneficiaries in both MMPs and D-SNPs who do not select a plan on their own prior to a certain date may be automatically enrolled in a plan that is selected to meet their needs. Following auto-enrollment, beneficiaries typically have 30 days to opt out of that plan and join another plan or enroll in Medicare FFS. This type of automatic enrollment occurs in the MMPs through passive enrollment and into D-SNPs through default enrollment (previously referred to as seamless conversion).[13]

Automatic enrollment is commonplace in Medicaid but controversial in Medicare because it is perceived as limiting beneficiary choice. The Dual Eligible Coalition proposal would maintain existing enrollment flexibilities, such as the option to use default enrollment (Dual Eligible Coalition 2021). The BPC proposal would allow auto-enrollment into fully integrated models while allowing beneficiaries to opt out at any time (BPC 2020).

Another aspect of beneficiary choice relates to the number and types of plans available. Although beneficiary advocates note that maintaining a choice of plans is important, the number of choices currently available may be overwhelming (Prindiville 2020). For example, one study found as many as 43 combinations of coverage available to dually eligible beneficiaries nationwide, although this number varies substantially at the state or county level and in Medicare compared to Medicaid (Rizer 2020). For example, on the Medicaid side, choice is limited by the delivery system the state selects to integrate care, such as an MMP model and the plans participating in that model. Choice on the Medicare side is more complex given the number of individual plan options available to dually eligible beneficiaries, including regular Medicare Advantage plans, stand-alone Part D plans that offer prescription drug coverage only, and a range of Medicare Advantage special needs plans. These include D-SNPs as well as chronic condition special needs plans (C-SNPs) and institutional special needs plans (I-SNPs). D-SNPs are further subdivided into FIDE SNPs and HIDE SNPs, depending on their level of integration. The presence of D-SNPs varies by state because they are required to contract with states to operate there. This requirement does not apply to C-SNPs or I-SNPs.

Policymakers have debated the merits of making fewer plans available. A narrower set of options could make it easier for beneficiaries to compare plans and make an informed choice while still

maintaining their ability to choose a plan (Miller 2020, Prindiville 2020). A narrower set of options may also reduce beneficiary churning among plans that results from individuals disenrolling because the plan does not meet their needs. For example, once they are enrolled, beneficiaries may realize that a particular prescription drug is not covered under the plan and switch to a different plan. Churning also poses challenges for health plans and providers trying to ensure continuity of care for their enrollees. The Dual Eligible Coalition would help beneficiaries navigate their coverage options by requiring states to establish a dedicated ombudsman to help dually eligible individuals, specifically, enroll in coverage. Individuals who choose to opt out of the fully integrated model established under either proposal would typically be enrolled in FFS. The BPC proposal recommends better coordination and education between federal agencies responsible for beneficiary outreach and education and proposes increased funding to states and SHIPs for information and counseling for dually eligible beneficiaries. The BPC proposal does not explicitly address the issue of limiting the number of choices.

A beneficiary's choice of plan may also be affected by the marketing materials used by Medicaid and Medicare. Beneficiaries may receive different marketing materials from each program and may be confused by benefits that overlap between them, such as home health. Both proposals would require one set of marketing materials that provides a clear description of the comprehensive set of benefits covered.

Access to existing providers. Maintaining access to existing providers has been a key concern of beneficiaries when managed care is introduced or when considering plan changes. In California, where eligible beneficiaries have opted out of integrated care at a high rate, the primary reason given was concern over losing access to a provider (Graham et al. 2016). A focus group in California noted that continued access to an existing provider was of primary importance for decisions about enrolling in integrated coverage (Graham et al. 2016).

In establishing a unified program, the composition of provider networks and the feasibility of helping eligible beneficiaries maintain access to their existing providers will be important design considerations. Individuals who are newly dually eligible may rely on a network of providers for their complex care needs that differs from the providers serving the organization's regular Medicare Advantage or commercial populations. Providers have chosen not to participate in integrated care models for a number of reasons including general opposition to managed care and a perception that the requirements of integrated care are overly burdensome (MedPAC 2018, 2016). Some providers opposed to participating in integrated care have also encouraged their patients to opt out (MedPAC 2018). Policymakers could consider whether increasing provider education could improve their participation in integrated care. One state, California, set up a continuity of care period of 12 months during which enrollees in the MMPs could continue to see their existing provider after enrolling in the demonstration if the provider was willing to work with the MMP (CA DHCS 2021).

Enrollment processes. Policymakers need to consider how beneficiaries would voluntarily enroll in a unified program. There may be interest in establishing a so-called no wrong door policy under which eligible individuals could enroll through the state Medicaid program, through Medicare, or through other entities such as AAAs or SHIPs. The ACA created a similar policy for enrollment in Medicaid and the health insurance exchanges that was designed to reduce barriers to enrollment for those seeking coverage. The design of a no wrong door policy should take into account the capacity of existing organizations. For example, SHIPs have small staffs and may have insufficient resources to take on more work unless additional funding is provided.

Dually eligible beneficiaries may receive assistance from Medicare agents and brokers or others in selecting coverage, but concerns have been raised about the role played by such agents and brokers in potentially steering dually eligible beneficiaries away

from integrated products (Lipson et al. 2018). CMS limits the types of products Medicare agents and brokers can sell and their knowledge is generally limited to coverage options they are permitted to market and sell. Incentive structures are such that certain products are more likely to be marketed and sold by Medicare agents and brokers than others. For example, plans are unlikely to market MMPs because Medicare agents and brokers are not permitted to sell them and are not compensated if a beneficiary working with an agent or broker enrolls in an MMP (Lipson et al. 2018). At the same time, their expertise in Medicare Advantage products is often useful in helping beneficiaries navigate a complex system of coverage options, especially individuals coming into dual status from Medicaid who are likely to be less familiar with Medicare products. Medicaid enrollment brokers under contract with the state are independent entities but they may lack expertise in Medicare benefits and in integrated options available to the dually eligible population (Verdier and Chelminsky 2017).[14]

Given these issues, policymakers may want to consider new approaches to helping beneficiaries choose the plan that best meet their needs, such as establishing an independent entity with expertise in both Medicare and Medicaid who can help beneficiaries meaningfully compare integrated care options. Both proposals we reviewed called for increased enrollment assistance for dually eligible beneficiaries. The Dual Eligible Coalition proposal would require states to contract with an independent broker to assist beneficiaries in selecting coverage, and the BPC proposal directs the Secretary to expand training for insurance brokers to include training on fully integrated plans (Dual Eligible Coalition 2021, BPC 2020).

Appeals and grievances. Medicare and Medicaid currently use different processes for filing appeals and grievances. This can create confusion and lead to gaps in coverage during an appeal. For example, Medicaid requires health plans to continue benefits during an appeal; this is not the case in Medicare (42 CFR 438.420).[15] The BPC proposal includes a unified appeals process, and the Dual Eligible Coalition proposal would also establish a unified appeals process and establish a minimum set of federal standards for administering the unified program that includes appeals and grievances. In the MMP models, the process for appeals and grievances is unified. CMS regulations implementing the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) required a unified process in certain HIDE SNPs and FIDE SNPs (42 CFR 422.629–634) (Stringer and Tourtellotte 2020). The FAI also established a dedicated ombudsman program to provide support to beneficiaries with their insurance options, including issues such as appeals and grievances (CMS 2021).

Benefits

Under current law, Medicare covers primary and acute care services and Medicaid wraps around Medicare to cover benefits Medicare does not cover, such as LTSS and non-emergency medical transportation (NEMT). MMPs cover all Medicare and Medicaid benefits under a single plan. FIDE SNPs cover Medicare and some or all Medicaid benefits under one plan including the Medicare acute care package (which covers hospital stays and physician and other outpatient visits), as well as Medicaid-covered LTSS and NEMT. This is a more comprehensive benefit than less integrated D-SNPs in that it covers Medicaid services in addition to Medicare.

A unified program could offer a single benefit package that matches the benefits currently provided by MMPs or FIDE SNPs. In addition to including all existing benefits permitted under current law, policymakers may want to consider whether to expand benefits to services the population is likely to need but that are not typically covered, such as oral health care or additional HCBS that some states currently do not cover (e.g., personal care services that provide assistance with self-care tasks such as bathing or preparing meals). The move away from institutional services to HCBS in recent years reflects both state and beneficiary preferences for these services as well as efforts by CMS to rebalance LTSS. Access to

HCBS has been particularly important during the COVID-19 pandemic because nursing facilities have been vulnerable to high rates of infection, causing beneficiaries and their families to look to alternative community-based options for their care.

Uniform benefit package. A key difference between Medicaid and Medicare under current law is that in Medicare, all beneficiaries are entitled to the same benefit package, but in Medicaid, different types of beneficiaries receive different benefits and benefits vary across states depending on which optional benefits states choose to cover. For dually eligible beneficiaries, Medicare benefits are the same no matter where beneficiaries live, but Medicaid benefits differ depending on their state of residence and sometimes even where they live in the state. For example, in some states, HCBS benefits delivered through a waiver cover only a particular region, rather than the whole state.

A new program may simplify this type of complexity for beneficiaries by providing the same benefit package to all full-benefit dually eligible beneficiaries enrolled in the program. For example, both proposals the Commission reviewed would establish a single set of benefits for all full-benefit dually eligible beneficiaries. The BPC proposal would establish a benefit package that includes medical care, behavioral health, and LTSS, but it is unclear whether state variation would persist, because the proposal would allow states to choose from three different models of care. It is possible that benefits could vary by state either because of the type of model a state selects (e.g., FIDE SNP or PACE) or because a state may choose to be more generous than the requirements (BPC 2020). The Dual Eligible Coalition would establish a core benefit package that covers medical, behavioral, LTSS, and social needs. It would specifically include Medicare Parts A, B, and D; all Medicaid mandatory benefits; and additional behavioral health and social and supportive services that enable flexibility for beneficiaries to achieve better outcomes (Dual Eligible Coalition 2021). Although there are core benefits that would apply to any state that participates in this program, each state would have flexibility to offer additional services.

Medicaid benefit carve-outs. Under current law, states can choose to exclude, or carve out, a Medicaid benefit delivered through managed care. Many states do not provide behavioral health services under their comprehensive managed care contracts due to a combination of financial constraints, policy restrictions, historical precedent, managed care experience and penetration in the state, and stakeholder opposition (MACPAC 2016). Instead, some states contract separately with specialized provider networks or with managed behavioral health organizations to provide these services, which may operate under capitated or FFS arrangements (MACPAC 2016).

Benefit carve-outs occur in integrated care models as well. For example, in the MMP demonstrations, behavioral health benefits are sometimes carved out and instead provided through a Medicaid limited-benefit plan; this separates the financial risk for potentially complex and costly benefits from the MMP. However, it leads to fragmentation for beneficiaries in addressing their physical and behavioral health needs (Soper 2016). For example, when Michigan set up its MMP, it retained the existing carve-out in Medicaid managed care, providing behavioral health services through Medicaid FFS. This created challenges for integrating behavioral health services across Medicare and Medicaid under the demonstration (Walsh 2019).

One consideration for a unified program will be whether to allow such carve-outs. Stakeholders may seek to establish incentives for states to minimize the number of carve-outs rather than prohibiting carve-outs to make the transition easier for states. In the proposal developed by the Dual Eligible Coalition, benefit carve-outs would not be permitted unless an exception was granted by the Secretary. The BPC proposal does not take a position on benefit carve-outs in a fully integrated model, although we understand that it intended to preclude them by establishing a single set of benefits that would include medical, behavioral health, and LTSS (Hayes 2021). The BPC proposal notes the complexities of including behavioral health services

in an integrated model, pointing out that even when those services are included, states may still carve out services for individuals with serious mental illness (BPC 2020).

Delivery system and care coordination

Given that most integrated care models rely on risk-based managed care arrangements, a unified program would most likely rely on a managed care structure, but allow beneficiaries to opt out if they choose not to participate. With managed care, the health plan acts as a central point of coordination between the Medicare and Medicaid programs. Beneficiaries also benefit by having a single point of contact for questions including benefits covered, appeals of a coverage decision, and communications regarding their plan enrollment.

As noted above, allowing beneficiaries to opt out has been key to requiring dually eligible beneficiaries to enroll in managed care, especially in Medicare. Medicare does not typically allow automatic enrollment into managed care because individuals enrolled in Medicare Parts A and B have freedom of choice, which is the right to choose from any participating provider, a right that extends to choosing a Medicare Advantage or Part D plan (Archibald et al. 2019). Automatic enrollment may be seen as infringing on beneficiary rights. For dually eligible beneficiaries, there is an added concern that even when they are given the ability to opt out, they are being treated differently than other Medicare beneficiaries by being required to enroll in managed care which could be viewed as discriminatory (Archibald et al. 2019). Beneficiaries who opt out could be enrolled in FFS for their Medicare and Medicaid benefits.

Presumably, this managed care structure would be designed to provide incentives for improving beneficiary outcomes. For example, at-risk entities providing integrated coverage to dually eligible beneficiaries under a unified program could be accountable for outcomes such as reducing hospitalizations (Miller 2020). Plans could be given some flexibility in how they use the capitated payment; for example, they might be given greater flexibility than now permitted to address the social needs of their enrollees (Miller 2020).

Both proposals we reviewed would rely on entities that manage care. The Dual Eligible Coalition proposal would deliver care through at-risk capitated managed care plans or, at the request of the state, an at-risk, value-based alternative fully integrated delivery system approved by the Secretary (Dual Eligible Coalition 2021). It would also allow PACE to continue operating, at the option of the state. The BPC proposal would allow states to choose from three models, two of which are managed care arrangements: FIDE SNPs modified to include lessons learned from the MMPs; PACE; and a flexible option that would build off Washington State's managed FFS model (BPC 2020, MACPAC 2020a).

It is important to note that even though managed care is the dominant delivery system for most Medicaid beneficiaries and has grown substantially in Medicare, most dually eligible beneficiaries are not enrolled in managed care. In 2018, 37 percent of full- and partial-benefit dually eligible beneficiaries were enrolled in Medicare managed care (CMS 2020b). Some states do not contract with D-SNPs and in many cases, FIDE SNPs are not present in the state. In 2020, 42 states contracted with D-SNPs but only 11 states had FIDE SNPs (MACPAC 2020a). Although D-SNPs can be aligned with MLTSS plans, meaning beneficiaries can be enrolled for their Medicare and Medicaid services through the same entity, in most states, D-SNPs and MLTSS plans do not operate in the same areas; in 2020, only three states had D-SNPs with companion MLTSS programs operating in the same area (MACPAC 2020a).

Given the current situation, the shift to a wholly managed care model for dually eligible beneficiaries could not be immediate and would likely require a lengthy staged transition. Policymakers would need to think about the time it would take to get these models up and running. For example, states that have long histories with managed care for the dually eligible population, such as Arizona,

which implemented MLTSS in 1989, may have an easier time than states such as North Carolina, which will launch statewide managed care in July 2021 for most Medicaid beneficiaries, excluding populations with complex care needs such as those who are dually eligible (ADvancing States 2021; NC DHHS 2020, 2017). This change is occurring after a lengthy period of debate between the governor and the state legislature (ADvancing States 2021, NC DHHS 2020). Policymakers could look to the expansion of coverage of the new adult group under the ACA, enacted in 2010 but not implemented until 2014, as a model for a timeline that would allow states to conduct outreach to newly eligible beneficiaries and set up the infrastructure for the new program before it begins operation. Similarly, the FAI was announced in 2011 when CMS requested letters of intent from states interested in participating, but enrollment in the first demonstration did not begin until 2013 (MACPAC 2018a).

Provider participation. Educating providers on the benefits of integrated care to improve their understanding of a unified program and encourage them to participate will be key to developing a provider network and enrolling eligible beneficiaries. As noted earlier in this chapter, maintaining an existing provider, even after enrolling in an integrated model, is of primary importance to many beneficiaries.

Providers able to participate in MMPs were not limited by states or CMS and included many different types. For example, in California's demonstration, existing health plans developed new products for the demonstration and established provider networks specifically for them. Those networks included primary care providers, federally qualified health centers (FQHCs), hospitals, and LTSS providers (Hollister et al. 2018). However, some eligible beneficiaries who had previously been enrolled in FFS had to switch providers to join the MMP (Graham et al. 2016). This led some beneficiaries to opt out. Beneficiary focus groups in California concluded that keeping an existing provider was a priority and many opted out of the MMP specifically to retain existing relationships with providers (McBride et al. 2017, Graham et al. 2016). In addition, in the MMPs, some providers did not have prior experience with managed care or had a bad experience with managed care requirements (e.g., prior authorization rules resulting in delayed payments) (BPC 2020). They opposed managed care arrangements and refused to participate, encouraging their patients to opt out (BPC 2020, MedPAC 2016).

Primary care providers are important to integrating care for the dually eligible population because of their role in coordinating care but their availability is limited in some parts of the country. One study found that counties with the highest density of dually eligible individuals and the fewest primary care clinicians of any type were concentrated in southeastern states (Xu et al. 2021).

Policymakers will need to consider how to address network adequacy requirements for rural areas. Plans serving rural areas may struggle to meet these because the number of providers and the types of providers are limited. It may be especially difficult for plans to contract with specialists. This may make it difficult for plans to meet network adequacy requirements.

As currently crafted, the proposals we reviewed do not focus on this issue. The BPC proposal notes that network adequacy has been a major challenge of integrated care efforts but that states in the FAI developed provider education toolkits that helped promote provider participation (BPC 2020).

Care coordination requirements. A program established exclusively for dually eligible beneficiaries presumably would require participating plans to establish a model of care that explains how care would be coordinated to meet the needs of that population, as is now the case for D-SNPs (CMS 2016). Models of care typically include a plan for care coordination and care management for the beneficiary, including identifying a care management team and an interdisciplinary care team. The beneficiary is part of the interdisciplinary care team that meets

regularly. The team typically conducts a health risk assessment, develops an individualized care plan reflecting the beneficiary's needs and goals, and coordinates Medicare and Medicaid benefits for the individual. The model of care also serves as a quality improvement tool in that it identifies measurable goals for the beneficiary against which progress can be assessed (CMS 2016). Under current law, CMS requires Medicare Advantage special needs plans, including D-SNPs, to establish a model of care plan and submit it for approval to CMS (42 CFR 422.101). It can include clinical and non-clinical elements, such as behavioral health services, transportation, or meal programs. Neither of the proposals we reviewed included requirements specific to models of care.

One consideration in developing a model of care is enrollment of partial-benefit dually eligible beneficiaries who are not entitled to the same benefits as the full-benefit population. Stakeholders have raised concerns about whether enrolling partial- and full-benefit dually eligible beneficiaries in the same plan dilutes the integration possible under that plan because individuals eligible for partial benefits only do not have Medicaid benefits to integrate with Medicare. As noted earlier, policymakers would have to consider whether partial-benefit dually eligible beneficiaries should be in separate plans from the full-benefit population and if not, how they would be accommodated in a plan that offers benefits to which they are not entitled.

Administration

Under current law, the Medicare program is administered by CMS, and Medicaid programs are administered by the states within broad federal guidelines and under oversight provided by CMS. In thinking about the design of a unified program, there are trade-offs between using a federal versus a state-driven approach. This design decision also has implications for federal and state spending.

Federal oversight. Under current law, CMS is the sole entity responsible for overseeing the Medicare program, while oversight responsibility for Medicaid is shared with states. Both proposals would largely maintain Medicaid's split between federal oversight and state program administration. The BPC proposal would allow states to administer their chosen fully integrated program with oversight from the Secretary through MMCO. In states that do not choose to set up their own program, a federal fallback model would be implemented. Under that model, the Secretary would contract with and oversee Medicare Advantage plans serving the dually eligible beneficiaries in those states (BPC 2020).

The Dual Eligible Coalition proposal would have states administer the unified program, with robust federal standards governing program aspects such as beneficiary protections and access to care. Under this proposal, states would choose whether or not to participate and, as such, this model would not be available for dually eligible beneficiaries in non-participating states (Dual Eligible Coalition 2021).

Both proposals would consolidate federal oversight responsibilities under MMCO, the office within CMS specifically established to focus on this population. Under current law, Medicare Advantage plans, including D-SNPs, are overseen by the Medicare division of CMS. It is our understanding that under the two proposals we reviewed, that responsibility would shift to MMCO for integrated products such as D-SNPs, PACE, and MMPs. Under both proposals, MMCO would continue to be an office within CMS. Our understanding is that regular Medicare Advantage plans that are not integrated products would continue to be overseen by the Center for Medicare.

MMCO may be the best-positioned unit within CMS to provide oversight and develop federal parameters given its expertise and experience with integrated care for the dually eligible population. At the same time, policymakers would need to decide whether MMCO should have full regulatory authority over all programs affecting the dually eligible population, such as PACE, that may interact with the unified program. This is the approach taken by BPC, because under current law, MMCO does not have such authority (BPC 2020). Under the BPC proposal,

MMCO would implement the federal fallback program in states that do not establish their own integrated care program. It would be financed jointly by states and the federal government. States that establish their own programs would administer those with federal oversight. This approach consolidates regulatory authority for all programs affecting dually eligible beneficiaries under a single unit within CMS (BPC 2020).

The Dual Eligible Coalition proposal also provides authority to MMCO to oversee the new Social Security Act title that establishes the unified program but leaves day-to-day administration to states (Dual Eligible Coalition 2021). This approach is similar to how Medicaid functions today. Under the Dual Eligible Coalition proposal, MMCO would be responsible for administering the federal responsibilities for this new title (Dual Eligible Coalition 2021).

State option to participate. State flexibility has been a long-standing feature of the Medicaid program. The program itself is optional for states, and policymakers will have to consider whether to give states the option to participate in a fully integrated program. Another consideration is state capacity to implement an integrated approach. For example, some states have limited experience with managed care or a sparsely distributed population that might make it difficult for them to establish a fully integrated program for dually eligible beneficiaries even if they were interested. Policymakers could follow the example established under the ACA, where states had the option to set up their own health insurance exchange using federal parameters or to use the exchange established by the federal government. Most states opted for the federally run model, although 13 states established their own exchanges (CMS 2020f).

States may have limited capacity to implement a new program, particularly as they struggle with multiple competing priorities and demands. Because of varying levels of capacity among states, some states may be more prepared than others to establish unified programs. In addition, integrated options such as D-SNPs aligned with MLTSS plans are not available to beneficiaries in all states. Although D-SNPs operate in 42 states, they are not available in all counties, particularly in rural areas, and not all of them offer high levels of integration (MACPAC 2020a). Similarly, while most states use comprehensive managed care plans to provide Medicaid services, some, such as Montana and South Dakota, have no or almost no comprehensive managed care presence (MACPAC 2020d). States face resource constraints and competing priorities that make it difficult to develop essential Medicare expertise and limit their ability to finance the up-front costs of establishing integrated care models. In June 2020, MACPAC recommended that Congress provide additional federal funding for states to enhance their Medicare expertise and help them finance these start-up costs (MACPAC 2020b).

Financing

Medicare and Medicaid are financed differently. Medicare benefits are paid from trust funds established by the federal government and financed by payroll taxes, paid by beneficiaries during their working years, and other sources of funding such as general revenues. Medicaid is jointly financed by the federal government and the states.

Managing separate funding streams from Medicare and Medicaid and the different payment rates and rules related to coverage in each program have created challenges for providers and plans participating in integrated care models (CBO 2013). In the MMPs, one of the most highly integrated options available to states, participating plans receive multiple payments (one payment from the state for the Medicaid component of the rate, one payment from CMS for the Medicare Part A and B components, and another payment from CMS for the Medicare Part D component) but rate setting is coordinated between CMS and the states (CMS 2019a). Another fully integrated option, PACE, has something closer to integrated funding because plans have broad authority to combine capitation payments from Medicaid and Medicare (CMS 2011).

A criticism of the current system is that funds flow to integrated models in separate streams (Archibald and Kruse 2015). When there are savings in one program, these are not shared. Proponents of a unified program argue that a single funding stream would strengthen the ability to integrate care. An integrated funding stream would also avoid conflicting financial incentives that exist today where costs may be shifted among programs (Archibald and Kruse 2015). For example, Medicaid programs would have an incentive to reduce costs such as those incurred from hospital readmissions because the costs of those readmissions would be paid out of an integrated funding stream rather than by Medicare only.

Both the BPC and the Dual Eligible Coalition recommend a more streamlined financing approach. The BPC recommends fully aligned financing with a single entity responsible for Medicare and Medicaid funding in all counties or regions of the state (BPC 2020). The Dual Eligible Coalition proposal envisions a single, integrated funding stream that pays plans from the combined funding from Medicare and both the federal and state share of Medicaid (Frizzera 2020).

Federal and state shares of financing. Both proposals we reviewed would maintain a shared financing system between the states and the federal government but make changes in how those shares are determined initially and over time. Although the details of those arrangements are not fully specified, each proposal sheds some light on how it would work.

Under the BPC proposal, the federal fallback option would be financed based on existing state and federal spending on the dually eligible population. The state share would be calculated using state-specific per capita rates set by the Secretary based on state spending on the date of enactment (BPC 2020).

The Dual Eligible Coalition would establish a baseline by blending Medicare and Medicaid spending for dually eligible beneficiaries derived from the federal fiscal year two years prior to enactment of the unified program (Dual Eligible Coalition 2021). The federal government and the states would both contribute to funding the program and states would assume full risk for managing it. For the first year of operation, the federal and state shares of costs would be allocated according to base-year percentages that are calculated for each. The federal share of the costs would include all Medicare costs for full-benefit individuals plus federal Medicaid matching payments for that population. The state share of the costs would include all state Medicaid costs for the full-benefit dually eligible population (including LTSS) plus the state's clawback payments to Medicare Part D.[16] Each subsequent year would be based on the prior year's expenditures. Spending thresholds are not specified but would be set to ensure spending is controlled. The mechanism would be designed to increase the state contribution and decrease the federal contribution if total expenditures exceeded the threshold. If total expenditures were to fall below the threshold, the federal contribution would increase and the state contribution would decrease, meaning states would have an incentive to reduce spending. Exceptions to this adjustment would have to be approved by the Secretary (Dual Eligible Coalition 2021).

Shared savings for states. As noted above, a frequent criticism of existing models is that savings in one program are not shared with the other, limiting state incentives to participate in integrated care models. For example, reductions in hospitalizations would generate savings to Medicare, not to Medicaid. To incentivize states to participate, a unified program could include a mechanism by which states could share in any savings the program generates.

The BPC proposal would provide the authority to the Secretary to establish a guaranteed shared savings program for integrated care where Medicare savings would be shared with states and would be guaranteed in that they would be incorporated into the rates so that the total cost of care would reflect decreases in per capita costs (BPC 2020). The BPC

proposal specifies that states should share in at least 33 percent of total savings (BPC 2020).

The Dual Eligible Coalition proposal requires a reinvestment of savings back into the unified program when the decrease in annual expenditures exceeds a predetermined spending threshold (Dual Eligible Coalition 2021). The state would share in these savings based on the share of the state's contribution to the financing of the program. The state would have the authority to use the savings to promote a number of core principles including prevention and wellness to enable beneficiaries to receive individualized health care focused on improving their outcomes, increased integration with social needs that impact health outcomes, and capacity building to enable access to more community-based care (Dual Eligible Coalition 2021).

This discussion assumes that stakeholders will be able to identify any savings generated by integrated care, even though this has been a challenge in existing models such as the MMPs, and that those savings will exceed the administrative costs of the health plans and allow for savings to be shared with states.

Risk mitigation. The BPC proposal notes that health plans entering a new market face uncertainties in a number of areas, including lack of experience with how much the population enrolled will cost and how many services they will use (BPC 2020). The BPC suggests there are ways to mitigate those risks for plans and promote plan participation through risk mitigation strategies (BPC 2020). For example, FAI demonstrations in some states included additional risk mitigation techniques to share risk between plans and the state, including risk corridors (MACPAC 2018a). With a risk corridor, participating states receive a payment from CMS if their losses exceed a certain threshold, and the plans pay CMS and the state if their gains exceed a certain threshold (MACPAC 2018a). These risk mitigation strategies also help states and the federal government mitigate the uncertainty around developing payment rates.

Establishing spending levels. Depending on how a unified program is financed, decisions would need to be made about how funding amounts for states would be determined, particularly if states are managing the program and assuming the risk. Medicare and Medicaid are open-ended entitlement programs that do not operate with a fixed amount of funding but draw down federal and state dollars to pay for services. Policymakers would need to decide how this open-ended funding approach would work in a unified program. For example, decisions include the choice of a base year for the purposes of setting initial funding amounts based on Medicaid and Medicare spending for dually eligible beneficiaries in each state, and year-to-year growth rates and adjustments to be made in the case of unforeseen events such as pandemics or economic downturns, which may affect enrollment and spending in the program. For example, in the Dual Eligible Coalition proposal, a funding baseline would be established using the federal fiscal year that is two years prior to implementation of the program; it could be adjusted for changes that occur, based on the Secretary's discretion (Dual Eligible Coalition 2021).

The Future of Coverage for Dually Eligible Beneficiaries

In the Commission's view, a unified program designed specifically for the dually eligible population has the potential to address the fragmentation and poor outcomes that result from having two uncoordinated programs. The complexity of designing such a program, however, requires careful consideration of available options and their attendant trade-offs. Moreover, the wide availability of managed care options envisioned by both the BPC and the Dual Eligible Coalition are not yet a reality, and they acknowledge this in their proposals. States and the federal government would also need a substantial amount of time to stand up a new structure of coverage for the dually eligible population. In the meantime, the Commission will continue work aimed at improving the integration of care for dually eligible beneficiaries.

Endnotes

[1] The 12.3 million figure represents all dually eligible beneficiaries. This count is on an ever-enrolled basis. Individuals are counted as ever enrolled if they were enrolled in Medicare and Medicaid at the same time for at least one month of the calendar year. Of this total, 71.1 percent are considered full-benefit dually eligible beneficiaries, eligible for full Medicaid benefits. The remaining 28.9 percent are considered partial-benefit dually eligible beneficiaries because they qualify for Medicaid assistance only with their Medicare premiums and sometimes cost sharing. They do not receive Medicaid services such as long-term services and supports (CMS 2020a).

[2] For more information on the dually eligible population, see MACPAC's June 2020 report to Congress, Chapter 1, Integrating Care for Dually Eligible Beneficiaries: Background and Context (MACPAC 2020a).

[3] For example, the Bipartisan Policy Center published a proposal in July 2020 that would require states to establish a fully integrated system or adopt a federal fallback mechanism (BPC 2020). Another group, the Dual Eligible Coalition, is developing a proposal to establish a new program for dually eligible beneficiaries (Dual Eligible Coalition 2021). We discuss these two proposals in detail later in this chapter.

[4] MMPs were created under the FAI, which was authorized under Section 1115A of the Social Security Act (the Act), as a demonstration program to improve health care delivery to dually eligible beneficiaries and align financial incentives in Medicaid and Medicare (CMS 2020g). Other FAI models include a managed FFS model and an option for states to develop an alternative model.

[5] Medicare Part A covers inpatient hospital and skilled nursing facility care, post-acute home health care, and hospice care. Medicare Part B covers physician services and the services of other practitioners, outpatient hospital care, care in other outpatient settings, home health care not paid for under Part A, other medical services and supplies, and drugs that cannot be self-administered. Part D covers prescription drugs.

[6] For more information on the payment framework in the FAI capitated model, see MACPAC's January 2018 issue brief, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare* (MACPAC 2018a).

[7] To be considered aligned, the state's MLTSS plan contract may be held either with the legal entity providing the D-SNP, the parent organization of the D-SNP, or a subsidiary owned and controlled by the parent organization of the D-SNP.

[8] Such carve-outs must be consistent with state policy. CMS will determine whether a plan may be designated as a FIDE SNP or HIDE SNP based on the specific circumstances (CMS 2020d).

[9] Health homes must provide six core services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care and follow-up; (5) individual and family support; and (6) referral to community and social services. Health homes use an interdisciplinary care team that may include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, or other professionals that would provide services to the enrolled population (CMS 2020h).

[10] To qualify for coverage of Medicare Part A at age 65, individuals must pay Medicare payroll taxes for at least 40 quarters (10 years). Individuals eligible for Social Security Disability Insurance (SSDI) benefits or Railroad Retirement Board (RRB) benefits are eligible for Medicare after qualifying for SSDI or RRB for 24 months (CMS 2019b).

[11] For more information on the pathways to Medicaid eligibility for dually eligible beneficiaries, see the eligibility topic page on the MACPAC website at https://www.macpac.gov/subtopic/dually-eligible-beneficiaries-eligibility/.

[12] In calendar year 2013, 42 percent of full-benefit dually eligible beneficiaries enrolled in FFS used Medicaid LTSS (MACPAC and MedPAC 2018).

[13] Passive enrollment generally refers to automatic enrollment into an MMP and can also be used in somewhat limited circumstances to allow beneficiaries to retain access to integrated care, such as when a Medicaid managed care plan's contract is not renewed by the state. Default enrollment, which was previously called seamless conversion, refers to automatic enrollment into a D-SNP. The focus of default enrollment is on a Medicaid beneficiary who is newly eligible for Medicare (ICRC 2018).

[14] See MACPAC staff presentation, Integration of care for dually eligible beneficiaries: New analyses, at https://www.macpac.gov/publication/integration-of-care-for-dually-eligible-beneficiaries-new-analyses/.

[15] For more information on integrating appeals processes between the two programs, see MACPAC's January 2018 staff presentation, Integrating Appeals Processes for Dually Eligible Beneficiaries, at https://www.macpac.gov/publication/integrating-appeals-processes-for-dually-eligible-beneficiaries/.

[16] States make a monthly payment to the federal government to help finance the cost of prescription drug coverage for full-benefit dually eligible beneficiaries that is covered under Medicare Part D. Prior to 2006, states covered prescription drug costs for dually eligible beneficiaries and this payment was not necessary.

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APPENDIX 4A: Integrated Care Authorities

Over the past 20 years, Congress has created a number of authorities to encourage integration of Medicaid and Medicare and provide a more seamless experience for beneficiaries (Table 4A-1). These actions include establishing the Program of All-Inclusive Care for the Elderly; creating and refining dual eligible special needs plans, a type of Medicare Advantage plan; and designating offices within the Centers for Medicare & Medicaid Services to coordinate Medicaid and Medicare and develop innovative payment and delivery models.

TABLE 4A-1. Federal Legislative Milestones to Integrate Care for Dually Eligible Beneficiaries, 1997–2018

Year	Legislative milestone and key provisions
1997	**Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)** • Establishes the Program of All-Inclusive Care for the Elderly (PACE) as a permanent Medicare program. (Previously, PACE had operated as a pilot program.)
2003	**Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173)** • Establishes Medicare Advantage (MA). • Authorizes three types of special needs plans (SNPs) to serve the needs of subsets of the Medicare population, including dual eligible special needs plans (D-SNPs). • Allows a D-SNP to target enrollment to a subset of the dually eligible population if the D-SNP has an agreement with the state Medicaid agency. • SNPs were initially authorized to operate from 2006 through December 31, 2008, but the authority has been extended repeatedly through subsequent legislation.
2008	**Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)** • Requires all D-SNPs to have contracts with the states in which they operate by 2013. • MIPPA requires these contracts to have eight elements, including, but not limited to, the organization's responsibility to provide or arrange for Medicaid benefits, the Medicaid benefits covered under the D-SNP, the cost-sharing protections, and the identification and sharing of information on Medicaid provider participation.
2010	**Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended)** • Section 2602 of the ACA creates the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office (MMCO), within CMS. MMCO is designed to improve care and reduce spending on care for dually eligible beneficiaries. • Section 3021 of the ACA creates the Center for Medicare and Medicaid Innovation within CMS to test innovative payment and delivery models.
2018	**Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123)** • Permanently authorizes SNPs. • BBA 2018 requires D-SNPs to meet one of three criteria to improve integration or coordination of care beyond what was required in MIPPA and unifies the grievance and appeals process for some D-SNPs. • Strengthens the authority of MMCO to develop rules and guidance related to D-SNPs, with the goals of improving integration, coordinating grievances and appeals, and providing resources to states to support integrated models.

Source: MACPAC, 2020, analysis of legislation and 42 CFR 422.107.

Chapter 5:

Annual Analysis of Disproportionate Share Hospital Allotments to States

Annual Analysis of Disproportionate Share Hospital Allotments to States

Key Points

- MACPAC continues to find no meaningful relationship between disproportionate share hospital (DSH) allotments to states and the following three factors that Congress has asked the Commission to study:
  - the number of uninsured individuals;
  - the amount and sources of hospitals' uncompensated care costs; and
  - the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.
- We find that the number of uninsured individuals and unpaid costs of care for uninsured individuals are increasing nationally.
  - In 2019, 29.6 million people, or 9.2 percent of the U.S. population, were uninsured, an increase of 1.1 million people (3.9 percent) from 2018, the second consecutive annual increase.
  - Hospitals reported $40.7 billion in charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2018, an increase of $2.8 billion (7.1 percent) from FY 2017.
- Medicaid shortfall, the difference between the payments for care a hospital receives and its costs of providing services to Medicaid-enrolled patients, decreased $3.2 billion (14 percent) between 2017 and 2018 according to the American Hospital Association (AHA) annual survey. In 2018, total Medicaid shortfall for all U.S. hospitals was $19.7 billion.
- The COVID-19 pandemic is having a substantial effect on hospital finances due to increased costs of treating patients with COVID-19 and disruptions in care. Safety-net providers are particularly vulnerable to financial pressures because they typically have low operating margins. However, data are not yet available to examine the full effects of COVID-19 on hospital finances.
- Congress once again delayed DSH allotment reductions, pushing them off until FY 2024. The reductions are now scheduled for FYs 2024—2027; allotments will be reduced by $8 billion each year, or approximately 58 percent of unreduced allotment amounts.
- The Consolidated Appropriations Act, 2021 (P.L. 116-260) addressed a prior MACPAC recommendation related to DSH. Specifically, starting in FY 2022, the DSH definition of Medicaid shortfall for most hospitals will no longer include costs and payments for patients for whom Medicaid is not the primary payer.

CHAPTER 5: Annual Analysis of Disproportionate Share Hospital Allotments to States

State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients. The total amount of such payments is limited by annual federal DSH allotments, which vary widely by state. States can distribute DSH payments to virtually any hospital in their state, but total DSH payments to a hospital cannot exceed the total amount of uncompensated care that the hospital provides. DSH payments help to offset two types of uncompensated care: Medicaid shortfall (the difference between the payments for care a hospital receives and its costs of providing services to Medicaid-enrolled patients) and unpaid costs of care for uninsured individuals. More generally, DSH payments also help to support the financial viability of safety-net hospitals.

MACPAC is statutorily required to report annually on the relationship between state allotments and several potential indicators of the need for DSH funds:

- changes in the number of uninsured individuals;
- the amounts and sources of hospitals' uncompensated care costs; and
- the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations (§ 1900 of the Social Security Act (the Act)).

As in our previous DSH reports, we find little meaningful relationship between DSH allotments and the factors that Congress asked the Commission to study. This is because DSH allotments are largely based on states' historical DSH spending before federal limits were established in 1992. Moreover, the variation is projected to continue after federal DSH allotment reductions take effect.

In this report, we update our previous findings to reflect new information on changes in the number of uninsured individuals and levels of hospital uncompensated care. We also provide updated information on deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Specifically, we find the following:

- According to the American Community Survey (ACS), 29.6 million people, or 9.2 percent of the U.S. population, were uninsured in 2019, an increase of 1.1 million people since 2018. This is the second year in a row the uninsured rate has increased.
- Hospitals reported $40.7 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2018. This represented a $2.8 billion increase from FY 2017, and a 0.1 percentage point increase in uncompensated care as a share of hospital operating expenses. Immediately after the coverage provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) went into effect, there were significant declines in uncompensated care. Since 2016, uncompensated care as a share of hospital operating expense has largely remained unchanged.
- Hospitals reported $19.7 billion in Medicaid shortfall on the American Hospital Association (AHA) annual survey for 2018, a 14 percent decline from the amount reported in 2017. (AHA 2020a, 2019a, 2017, 2015).
- In FY 2018, deemed DSH hospitals, which serve a high proportion of Medicaid enrollees

and low-income patients, continued to report lower aggregate operating margins than other hospitals (-2.3 percent for deemed DSH hospitals versus 0.6 percent for all hospitals). Total margins (which include government appropriations and revenue not directly related to patient care) were similar between deemed DSH hospitals (5.9 percent) and all hospitals (6.5 percent). Aggregate operating and total margins for deemed DSH hospitals would have been 3 to 4 percentage points lower without DSH payments.

In this report, we also project FY 2024 DSH allotments before and after implementation of federal DSH allotment reductions. DSH allotment reductions were included in the ACA under the assumption that increased insurance coverage through Medicaid and the health insurance exchanges would lead to reductions in hospital uncompensated care and thereby lessen the need for DSH payments. DSH allotment reductions have been delayed several times; most recently, the Consolidated Appropriations Act, 2021 (P.L. 116-260) delayed implementation of reductions until FY 2024. The amount of reductions will be $8 billion a year between FY 2024 and FY 2027 (amounting to 57.8 percent of FY 2024 unreduced allotments).

MACPAC has made several recommendations for statutory changes to improve the Medicaid DSH program (Box 5-1). Most recently, the Commission recommended changes to the treatment of third-party payments in the DSH definition of Medicaid shortfall, which Congress enacted in the Consolidated Appropriations Act, 2021.[1] In March 2019, the Commission also made a package of three recommendations for how pending DSH allotment reductions should be structured, which have not been implemented. Although DSH allotment reductions have since been delayed, the Commission remains concerned about the issues we previously noted, such as the abrupt reductions under current law and the lack of meaningful relationship between DSH allotments and measures of need for DSH funds.

BOX 5-1. Prior MACPAC Recommendations Related to Disproportionate Share Hospital Policy

February 2016

Improving data as the first step to a more targeted disproportionate share hospital policy

- The Secretary of the U.S. Department of Health and Human Services (the Secretary) should collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Secretary should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.
  - P.L. 116-260 requires the U.S. Department of Health and Human Services to establish a system for states to submit non-DSH supplemental payment data in a standard format, beginning October 1, 2021. However, this system does not include managed care payments or information on the sources of non-federal share necessary to determine net Medicaid payments at the provider level.

BOX 5-1. (continued)

March 2019

Improving the structure of disproportionate share hospital allotment reductions

- If Congress chooses to proceed with disproportionate share hospital (DSH) allotment reductions in current law, it should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in fiscal year (FY) 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029, in order to phase in DSH allotment reductions more gradually without increasing federal spending.
- In order to minimize the effects of disproportionate share hospital (DSH) allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states.
- In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

June 2019

Treatment of third-party payments in the definition of Medicaid shortfall

- To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.
  - P.L. 116-260 enacted this recommendation for most DSH hospitals, effective October 1, 2021.

The Commission also has long held that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income uninsured patients and have higher levels of uncompensated care, consistent with the original statutory intent of the law establishing DSH payments. However, development of policy to achieve this goal must be considered in terms of all Medicaid payments that hospitals receive, and complete data on these payments are not available.[2] In February 2016, the Commission recommended that the Secretary of the U.S. Department of Health and Human Services (HHS) collect and report complete information on Medicaid payments to hospitals to help inform analyses about the targeting of DSH payments.

The Consolidated Appropriations Act, 2021, requires HHS to collect and report data on non-DSH supplemental payments beginning October 1, 2021, which may help inform additional analyses about the targeting of DSH payments. However, HHS is not required to collect and report data on the sources of non-federal share necessary to determine net payments at the provider level.

The COVID-19 pandemic is having substantial effects on hospital finances, but the full effects of the pandemic are still not clear. In addition to reporting increased costs of treating patients with COVID-19 and costs associated with reducing the risk of COVID-19 infection among patients and staff, hospitals reported decreased revenue in April 2020 as a result of delays in elective procedures and other routine services (AHA 2020c).

Safety-net providers that serve a high share of Medicaid and uninsured patients are particularly vulnerable to financial pressures caused by the pandemic because prior to the pandemic they often had low operating margins. In addition, Medicaid-enrolled patients, the majority of whom identify as Black, Hispanic, Native American, or other non-white race or ethnicity, have been disproportionately affected by COVID-19 (MACPAC 2020a).

In March and April of 2020, to help address these financial challenges, Congress provided additional funding to hospitals through a variety of mechanisms, including a $175 billion federal provider relief fund (available to all provider types, not just hospitals). In December 2020, the Consolidated Appropriations Act, 2021, added an additional $3 billion to the provider relief fund. Some state Medicaid programs are also making additional payments to hospitals to supplement federal relief efforts (Gifford et al. 2020).

In April 2020, the Commission sent two letters to HHS expressing concerns that initial distributions of federal provider relief funding were not appropriately targeted to safety-net providers (MACPAC 2020b, 2020c). Since then, HHS has made additional targeted distributions of relief funding to safety-net hospitals. However, it is unclear whether this additional funding has been sufficient to cover the financial losses experienced by safety-net providers. Moreover, as of January 11, 2021, approximately $58 billion in federal provider relief funds had not been spent (HHS 2021a). The Commission plans to continue monitoring the effects of the pandemic on safety-net hospitals and the distribution of state and federal relief funding as more data become available.

This chapter begins with a background of the Medicaid DSH program and then reviews the most recently available data on the number of uninsured individuals, the amounts and sources of hospital uncompensated care, and the number of hospitals with high levels of uncompensated care that also provide essential community services. We also summarize the limited information available about the early effects of the COVID-19 pandemic on safety-net hospitals. The chapter concludes with an analysis of DSH allotment reductions under current law and how they relate to the factors that Congress asked us to consider.

Background

Current DSH allotments vary widely among states, reflecting the evolution of federal policy over time. States began making Medicaid DSH payments in 1981, when Medicaid hospital payments were uncoupled from Medicare payment levels.[3] Initially, states were slow to make these payments, and in 1987, Congress required states to make payments to hospitals that serve a high share of Medicaid-enrolled and low-income patients, referred to as deemed DSH hospitals. DSH spending grew rapidly in the early 1990s—from $1.3 billion in 1990 to $17.7 billion in 1992—after Congress clarified that DSH payments were not subject to Medicaid's hospital payment limitations (Matherlee 2002, Holahan et al. 1998).[4]

BOX 5-2. Glossary of Key Medicaid Disproportionate Share Hospital Terminology

DSH hospital. A hospital that receives disproportionate share hospital (DSH) payments and meets the minimum statutory requirements to be eligible for DSH payments; that is, a Medicaid inpatient utilization rate of at least 1 percent and at least two obstetricians with staff privileges that treat Medicaid enrollees (with certain exceptions for rural and children's hospitals and those that did not provide obstetric services to the general population in 1987).

Deemed DSH hospital. A DSH hospital with a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or a low-income utilization rate that exceeds 25 percent. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Social Security Act (the Act)).

State DSH allotment. The total amount of federal funds available to a state for Medicaid DSH payments. To draw down federal DSH funding, states must provide state matching funds at the same matching rate as other regular Medicaid service expenditures. If a state does not spend the full amount of its allotment for a given year, the unspent portion is not paid to the state and does not carry over to future years. Allotments are determined annually and are generally equal to the prior year's allotment, adjusted for inflation (§ 1923(f) of the Act).

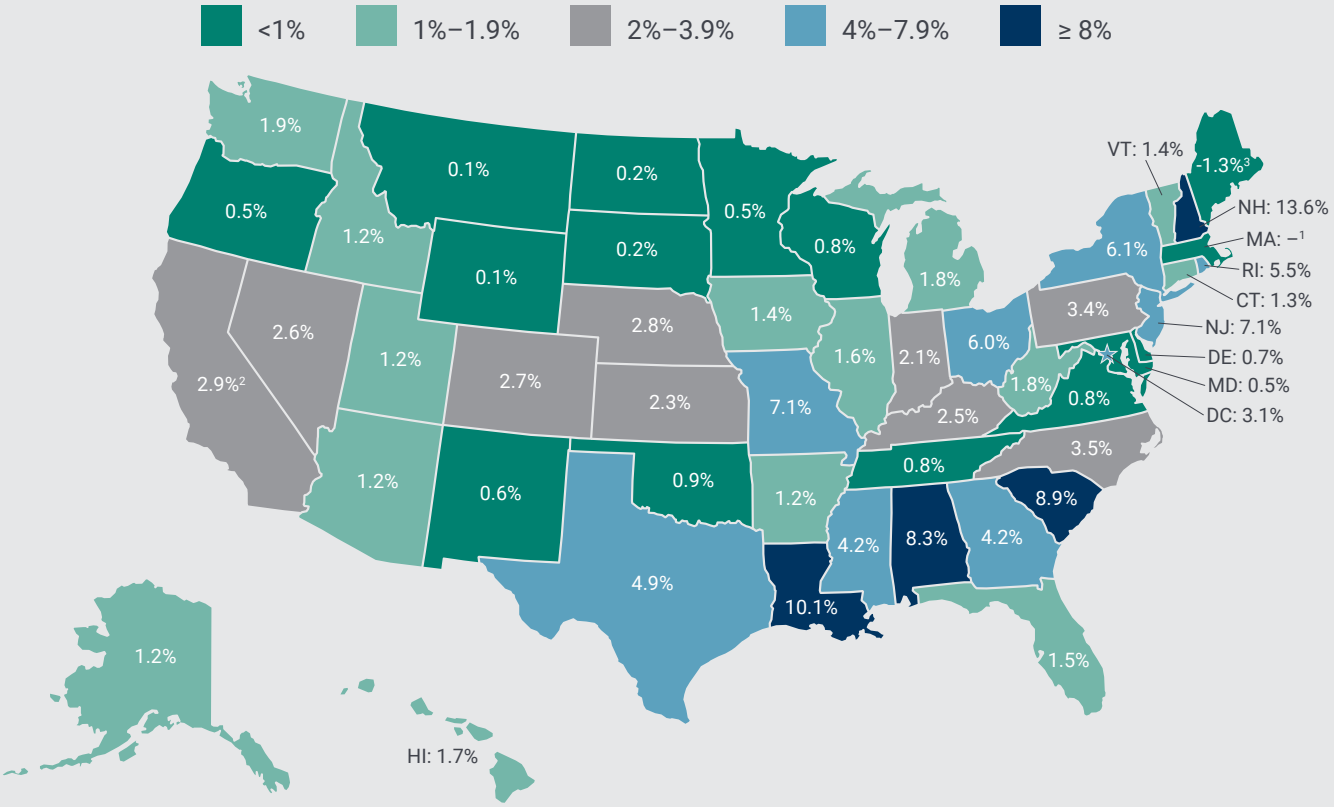
Hospital-specific DSH limit. The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs.

In 1991, Congress enacted state-specific caps on the amount of federal funds that could be used to make DSH payments, referred to as allotments (Box 5-2). Allotments were initially established for FY 1993 and were generally based on each state's 1992 DSH spending. Although Congress has made several incremental adjustments to these allotments, the states that spent the most in 1992 still have the largest allotments, and the states that spent the least in 1992 still have the smallest allotments.[5]

In FY 2018, federal funds allotted to states for DSH payments totaled $12.3 billion. State-specific DSH allotments that year ranged from less than $15 million in six states (Delaware, Hawaii, Montana, North Dakota, South Dakota, and Wyoming) to more than $1 billion in three states (California, New York, and Texas).

Total federal and state DSH payments were $19.7 billion in FY 2019 and accounted for 3.3 percent of total Medicaid benefit spending.[6] DSH spending as a share of total Medicaid benefit spending varied widely by state, from less than 1 percent in 15 states to 13.6 percent in New Hampshire (Figure 5-1).

FIGURE 5-1. DSH Spending as a Share of Total Medicaid Benefit Spending, by State, FY 2019



Notes: DSH is disproportionate share hospital. FY is fiscal year.

— Dash indicates zero.

[1] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act (the Act) allows it to use all of its DSH funding for the state's safety-net care pool instead.

[2] DSH spending for California includes DSH-financed spending under the state's Global Payment Program, which is authorized under the state's demonstration waiver under Section 1115 of the Act.

[3] Maine reported negative DSH spending in FY 2019. A state may report negative spending in a fiscal year due to a prior period adjustment.

Source: MACPAC, 2021, analysis of CMS-64 financial management report net expenditure data as of October 1, 2020.

States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[7] As of the end of FY 2020, $1.3 billion in federal DSH allotments for FY 2018 went unspent.[8] There are two primary reasons states do not spend their full DSH allotment: (1) they lack state funds to provide the non-federal share; and (2) the DSH allotment exceeds the total amount of hospital uncompensated care in the state. As noted above, DSH payments to an individual hospital cannot exceed that hospital's level of uncompensated care. In FY 2018, half of unspent DSH allotments were attributable to four states (Connecticut, Louisiana, Maine, and New Jersey). Three of these states (Connecticut, Louisiana, and New Jersey) had FY 2018 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated

care in the state reported on 2018 Medicare cost reports, which suggests that these states may not be able to spend their full DSH allotments even if they had sufficient state funds to provide the non-federal share. Though it should be noted that uncompensated care is calculated differently on DSH audits and Medicare cost reports.[9]

In state plan rate year (SPRY) 2016, 44 percent of U.S. hospitals received DSH payments (Table 5-1).[10] States are allowed to make DSH payments to any hospital that has a Medicaid inpatient utilization rate of at least 1 percent, which is true of almost all U.S. hospitals. Public teaching hospitals in urban settings received more than half of total DSH funding. Half of all rural hospitals also received DSH payments, including many critical access hospitals, which receive a special payment designation from Medicare because they are small, and often the only provider in their geographic area.

Many states also make DSH payments to institutions for mental diseases (IMDs), which historically have not been eligible for Medicaid payment for services provided to individuals age 21–64.[11] In SPRY 2016, Maine made DSH payments exclusively to IMDs, and DSH payments to IMDs amounted to more than half of DSH spending in four additional states (Alaska, Connecticut, North Dakota, and South Dakota). The amount of a state's federal DSH funds available for IMDs is limited. Each state's IMD limit is the lesser amount of either the DSH allotment the state paid to IMDs and other mental health facilities in FY 1995 or 33 percent of the state's FY 1995 DSH allotment.[12]

TABLE 5-1. Distribution of DSH Spending by Hospital Characteristics, SPRY 2016

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as a percentage of all hospitals in category	
Total	**2,648**	**6,021**	**44%**	**$16,598**
Hospital type				
Short-term acute care hospitals	1,859	3,292	56	13,012
Critical access hospitals	554	1,355	41	370
Psychiatric hospitals	147	593	25	2,886
Long-term hospitals	15	399	4	39
Rehabilitation hospitals	26	287	9	7
Children's hospitals	47	95	49	284
Urban or rural				
Urban	1,428	3,567	40	14,695
Rural	1,220	2,454	50	1,903
Hospital ownership				
For-profit	411	1,803	23	928
Non-profit	1,564	2,974	53	5,796
Public	673	1,244	54	9,874

TABLE 5-1. (continued)

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as a percentage of all hospitals in category	
Total	**2,648**	**6,021**	**44%**	**$16,598**
Teaching status				
Non-teaching	1,822	4,769	38	4,829
Low-teaching	522	836	62	3,269
High-teaching	304	416	73	8,500
Deemed DSH status				
Deemed	744	744	100	10,278
Not deemed	1,904	5,277	35	6,321

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. Excludes 61 DSH hospitals that did not submit a fiscal year 2018 Medicare cost report. Low-teaching hospitals have an intern-and-resident-to-bed ratio (IRB) of less than 0.25 and high-teaching hospitals have an IRB equal to or greater than 0.25. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Total DSH spending includes state and federal funds. Analyses of deemed DSH hospitals is limited to hospitals that received DSH payments and excludes hospitals in California and Massachusetts that received funding from safety-net care pools that are financed with DSH funding in demonstrations authorized under waiver expenditure authority of Section 1115 of the Social Security Act.

Source: MACPAC, 2021, analysis of FY 2018 Medicare cost reports and SPRY 2016 as-filed Medicaid DSH audits.

The proportion of hospitals receiving DSH payments varies widely by state. In SPRY 2016, four states made DSH payments to fewer than 10 percent of the hospitals in their state (Arkansas, Illinois, Iowa, and North Dakota) and two states made DSH payments to more than 90 percent of hospitals in their state (New York and Rhode Island).[13]

As noted above, states are statutorily required to make DSH payments to deemed DSH hospitals, which serve a high share of Medicaid-enrolled and low-income patients. In SPRY 2016, about 12 percent of U.S. hospitals met this standard. These deemed DSH hospitals constituted just over one-quarter (28 percent) of DSH hospitals but accounted for nearly two-thirds (62 percent) of all DSH payments, receiving $10.3 billion in DSH payments. States vary in how they distribute DSH payments to deemed DSH hospitals, from less than 10 percent of DSH payments to deemed DSH hospitals in four states (Alabama, Arkansas, Hawaii, and Utah) to 100 percent in four states (Delaware, Illinois, Iowa, and Maine) and the District of Columbia.

State DSH targeting policies are difficult to categorize. States that concentrate DSH payments among a small number of hospitals do not necessarily make the largest share of payments to deemed DSH hospitals (e.g., Connecticut); conversely, some states that distribute DSH payments across most hospitals still target the largest share of DSH payments to deemed DSH hospitals (e.g., New Jersey) (Figure 5-2). State criteria for identifying eligible DSH hospitals and how much funding they receive vary, but are often related to hospital ownership, hospital type, and

geographic factors. The methods states use to finance the non-federal share of DSH payments may also affect their DSH targeting policies.[14]

More information about state DSH targeting policies is included in Chapter 3 of MACPAC's March 2017 report to Congress (MACPAC 2017).

FIGURE 5-2. Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals, by State, SPRY 2016

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. The share of DSH payments to deemed DSH hospitals shown does not account for provider contributions to the non-federal share; these contributions may reduce net payments. Analysis excludes Massachusetts and California, which have demonstration waivers under Section 1115 of the Social Security Act that allow them to distribute DSH funding to hospitals through safety-net care pools. Based on available data on Medicaid inpatient and low-income utilization rates, no DSH hospitals in Hawaii appeared to meet the deemed DSH criteria in SPRY 2016.

Source: MACPAC, 2021, analysis of 2018 Medicare cost reports and SPRY 2016 as-filed Medicaid DSH audits.

State DSH policies change frequently, often as a function of state budgets. The amounts paid to hospitals are more likely to change than the types of hospitals receiving payments. Over 90 percent of the hospitals that received DSH payments in SPRY 2016 also received DSH payments in SPRY 2015. However, the amount that these hospitals receive can change significantly in subsequent reporting years. For example, our data shows that 25 percent of hospitals that received DSH payments in SPRY 2015 and SPRY 2016 reported that the amount of DSH payments they received in SPRY 2016 differed from the amount that they received in SPRY 2015 by more than 50 percent (including both increases and decreases).

Changes in the Number of Uninsured Individuals

According to the ACS, 29.6 million people were uninsured in 2019 (9.2 percent of the U.S. population), a statistically significant increase from the number and share in 2018 (28.6 million or 8.9 percent) (Table 5-2).[15] This statistic includes individuals who were uninsured at the time of the interview only, and therefore does not include individuals who may have been uninsured for other parts of the year.[16] Statistically significant increases were observed for most ages, races and ethnicities, and income levels (Keisler-Starkey and Bunch 2020). This is the second year in a row in which the overall uninsured rate increased significantly (Berchick et al. 2019).

TABLE 5-2. Uninsured Rates by Selected Characteristics, United States, 2018 and 2019

Characteristic	2018	2019	Percentage point change
All uninsured	**8.9%**	**9.2%**	**0.3%***
Age group			
Under age 19	5.2	5.7	0.5*
Age 19–64	12.5	12.9	0.4*
Over age 64	0.8	0.8	0.0
Race and ethnicity			
White, non-Hispanic	6.0	6.3	0.3*
Black, non-Hispanic	10.1	10.1	0
Asian, non-Hispanic	6.3	6.6	0.3*
Hispanic (any race)	17.9	18.7	0.7*
Income-to-poverty ratio			
Below 100 percent	15.5	16.0	0.5*
100–199 percent	14.6	15.2	0.6*
200–299 percent	11.3	12.3	0.8*
300–399 percent	7.9	8.6	0.7*
At or above 400 percent	3.6	3.9	0.2*

TABLE 5-2. (continued)

Characteristic	2018	2019	Percentage point change
All uninsured	**8.9%**	**9.2%**	**0.3%***
Medicaid expansion status in state of residence			
Non-expansion	12.2	13.1	0.6
Expansion	6.5	7.0	0.4

Notes: Uninsured rates by Medicaid expansion status are based on the American Community Survey. Medicaid expansion status reflects state expansion decisions as of January 10, 2019. In past years, we reported national data on uninsured individuals using the Current Population Survey (CPS) Annual Social and Economic Supplement. However, due to complications related to data collection for CPS 2019 estimates during March–June of 2020 due to COVID-19, we are reporting ACS numbers to align with how Census Bureau are reporting 2018–2019 trends. Numbers do not sum due to rounding. For a discussion on the differences between each survey's uninsured rates, please refer to Appendix 5B.

* Indicates change is statistically different from zero at the 90 percent confidence level.

Source: MACPAC, 2021, analysis of Keisler-Starkey and Bunch 2020.

The uninsured rate in states that did not expand Medicaid to adults under age 65 with incomes at or below 138 percent of the federal poverty level was nearly twice as high as the uninsured rate in states that expanded Medicaid. Virginia and Maine expanded Medicaid at the beginning of 2019. Of the two states, Virginia saw a statistically significant decline in its uninsured rate of 0.9 percentage points, while Maine's uninsured rate did not change significantly, possibly due to low uptake of coverage caused by delays in implementing the state's Medicaid expansion.[17] Idaho, Utah, Nebraska, Oklahoma, and Missouri all recently passed ballot initiatives authorizing the expansion of Medicaid, but these expansions are not reflected in the 2019 uninsured rates (KFF 2020a).

The net 1.3 million increase in the number of uninsured individuals between 2018 and 2019 includes a 1.6 million decline in individuals reporting enrollment in Medicaid and the State Children's Health Insurance Program (CHIP) in 2019 on the ACS. The number of individuals enrolled in Medicaid and CHIP also declined between 2017 and 2018, which was the first national decline in Medicaid and CHIP enrollment since the implementation of the ACA coverage expansions (Keisler-Starkey and Bunch 2020).[18]

The share of Asian and Hispanic individuals who reported being uninsured increased significantly between 2018 and 2019. This may be due, in part, to the so-called chilling effect of a proposed October 2018 rule by the U.S. Department of Homeland Security to change the definition of public charge for the purposes of immigration status to include receipt of public benefits, such as Medicaid.[19] The rule, along with other immigration policies, may have had chilling effects on participation in Medicaid and CHIP among immigrant families and their children, even before its finalization.[20] The Kaiser Family Foundation has estimated that between 2.0 and 4.7 million eligible Medicaid and CHIP enrollees with at least one non-citizen in their family may disenroll as a result of this policy (Artiga et al. 2019).[21]

Looking ahead, the number of uninsured individuals is expected to increase due to the job losses associated with the COVID-19 pandemic. The Congressional Budget Office (CBO) projects a 1 million increase in the number of uninsured individuals from prepandemic levels and estimate that this will increase by another million in 2021, totaling 32 million uninsured individuals in 2021. Likewise, CBO expects the total number of people enrolled in Medicaid to increase from 70 million to 76 million by the end of 2021 (CBO 2020a).

Changes in the Amount of Hospital Uncompensated Care

In considering changes in the amount of uncompensated care, it is important to note that DSH payments cover both unpaid costs of care for uninsured individuals and Medicaid shortfall. Since the implementation of the ACA coverage expansions in 2014, unpaid costs of care for uninsured individuals have declined substantially, particularly in states that have expanded Medicaid. However, as the number of Medicaid enrollees increased between 2014–2017, Medicaid shortfall increased as well.

Definitions of uncompensated care vary among data sources, complicating comparisons and our ability to fully understand effects at the hospital level (Box 5-3). The most recently available data on hospital uncompensated care for all hospitals comes from Medicare cost reports, which define uncompensated care as charity care and bad debt. However, Medicare cost reports do not include reliable information on Medicaid shortfall, which is the difference between a hospital's costs of care for Medicaid-enrolled patients and the total payments it receives for those services. Medicaid DSH audits include data on both Medicaid shortfall and unpaid costs of care for uninsured individuals for DSH hospitals, but these data are not made publicly available by CMS until about five years after DSH payments are made.[22]

BOX 5-3. Definitions and Data Sources for Uncompensated Care Costs

Data sources

American Hospital Association (AHA) annual survey. An annual survey of hospitals that provides aggregated national estimates of uncompensated care for community hospitals.

Medicare cost report. An annual report on hospital finances that must be submitted by all hospitals that receive Medicare payments (that is, most U.S. hospitals with the exception of some freestanding children's hospitals). Medicare cost reports define hospital uncompensated care as bad debt and charity care.

Medicaid disproportionate share hospital (DSH) audit. A statutorily required audit of a DSH hospital's uncompensated care. The audit ensures that Medicaid DSH payments do not exceed the hospital-specific DSH limit, which is equal to the sum of Medicaid shortfall and the unpaid costs of care for uninsured individuals for allowable inpatient and outpatient costs. Forty-five percent of U.S. hospitals were included on DSH audits in 2015, the latest year for which data are available.

Definitions

Medicare cost report components of uncompensated care

Charity care. Health care services for which a hospital determines the patient does not have the capacity to pay and, based on its charity care policy, either does not charge the patient at all for the services or charges the patient a discounted rate below the hospital's cost of delivering the care. Charity care costs cannot exceed a hospital's cost of delivering the care. Medicare cost reports include costs of care provided to both uninsured individuals and patients with insurance who cannot pay deductibles, co-payments, or coinsurance.

BOX 5-3. (continued)

Bad debt. Expected payment amounts that a hospital is not able to collect from patients who are determined to have the financial capacity to pay according to the hospital's charity care policy.

Medicaid DSH audit components of uncompensated care

Unpaid costs of care for uninsured individuals. The difference between a hospital's costs of providing services to individuals without health coverage and the total amount of payment received for those services. This includes charity care and bad debt for individuals without health coverage and generally excludes charity care and bad debt for individuals with health coverage.

Medicaid shortfall. The difference between a hospital's costs of providing services to Medicaid-eligible patients and the total amount of Medicaid payment received for those services (under both fee-for-service and managed care, excluding DSH payments but including most other types of supplemental payments).

- The Consolidated Appropriations Act, 2021 (P.L. 116-260) changes the DSH definition of Medicaid shortfall for most hospitals beginning October 1, 2021, to exclude costs and payments for patients for whom Medicaid is not the primary payer.

Below, we review the most recent uncompensated care data available for all hospitals in 2018 as well as additional information about Medicaid shortfall from the 2018 AHA annual survey.

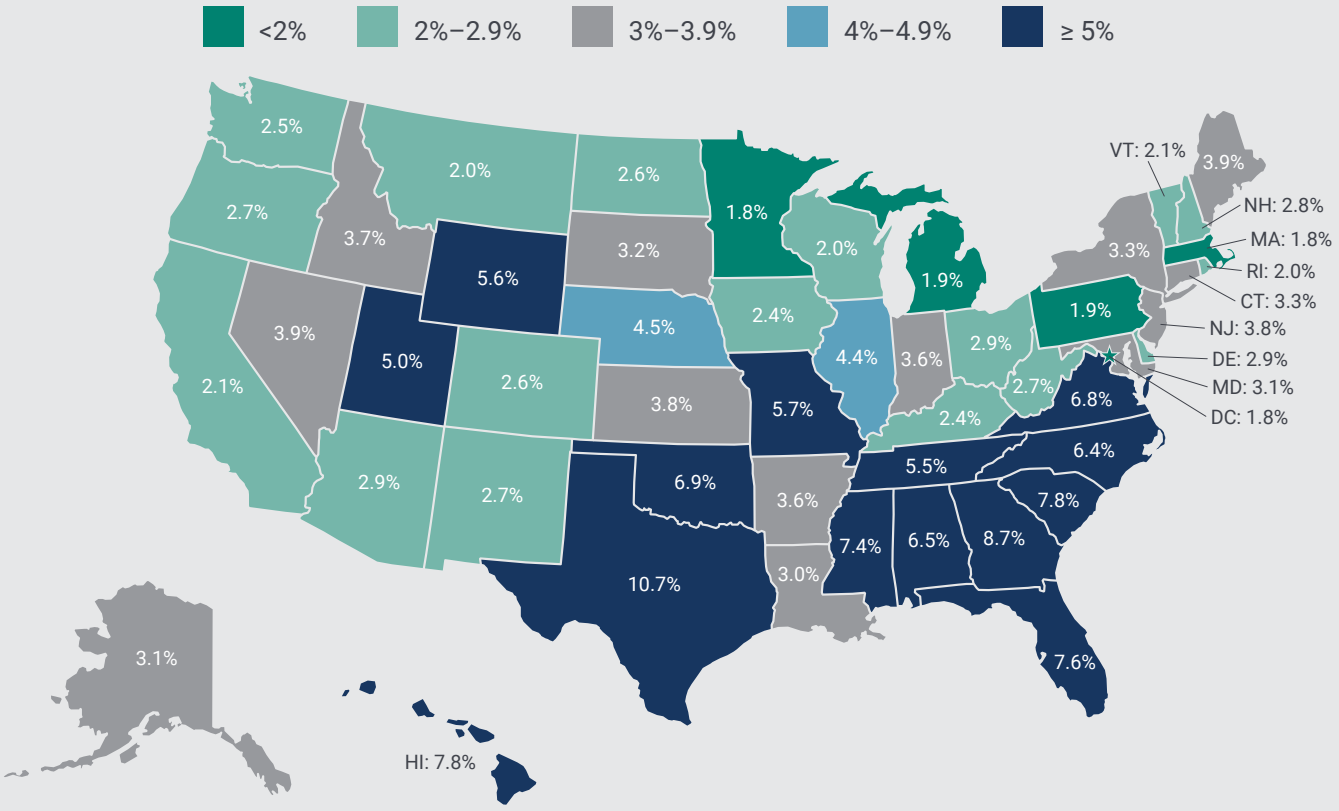
Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of $40.7 billion in charity care and bad debt in FY 2018, comprising 4.2 percent of hospital operating expenses. This is a $2.8 billion (7.1 percent) increase from FY 2017, and a 0.1 percentage point increase as a share of hospital operating expenses, which is similar to the increase between FY 2016 and FY 2017.

Due to changes in Medicare cost report instructions, uncompensated care reported on FY 2018 Medicare cost reports cannot be compared to data from prior to the implementation of the ACA. The changes to the cost report instructions went into effect in FY 2017, and may have had a particularly marked effect on uncompensated care costs reported that year.[23] Moreover, we are no longer observing the large declines in uncompensated care that we observed immediately after the implementation of the ACA coverage expansions in 2014. For example, charity care and bad debt reported on Medicare costs reports declined by $8.6 billion (23 percent) between 2013 and 2015 (MACPAC 2018a).[24]

As a share of hospital operating expenses, charity care and bad debt varied widely by state in FY 2018 (Figure 5-3). In the aggregate, hospitals in states that expanded Medicaid before September 30, 2018, reported uncompensated care that was less than half of what was reported in non-expansion states (2.8 percent of hospital operating expenses in Medicaid expansion states versus 7.0 percent in states that did not expand Medicaid).

FIGURE 5-3. Charity Care and Bad Debt as a Share of Hospital Operating Expenses, FY 2018



Note: FY is fiscal year.

Source: MACPAC, 2021, analysis of FY 2018 Medicare cost reports.

Uncompensated care reported on Medicare cost reports includes the costs of care provided to both uninsured individuals and insured patients who cannot pay deductibles, co-payments, or coinsurance. In FY 2018, about 49 percent of uncompensated care reported was for charity care for uninsured individuals ($20.0 billion), 15 percent was for charity care for insured individuals ($6.3 billion), and 36 percent was for bad debt expenses for both insured and uninsured individuals ($14.6 billion).[25] Uncompensated care for uninsured individuals is affected by the uninsured rate, while uncompensated care for patients with insurance is affected by specific features of their health insurance, such as deductibles, coinsurance, and other forms of cost sharing. When patients cannot pay the amounts associated with cost sharing, these costs might be forgiven as charity care or might become bad debt expenses for hospitals. Within the employer-sponsored insurance market, the share of covered workers with high-deductible health plans has increased from 4 percent in 2006 to 31 percent in 2020, while savings rates among those with health savings accounts remain low (KFF 2020b, Kullgren et al. 2020).

Medicaid shortfall

Medicaid shortfall is the difference between a hospital's costs of providing services to Medicaid-enrolled patients and the total amount of Medicaid payment received for those services.[26] According to the AHA annual survey, Medicaid shortfall in 2018 for all U.S. hospitals totaled $19.7 billion, a decrease of $3.2 billion from 2017. The aggregate Medicaid payment-to-cost ratio reported on the AHA survey was 89 percent in 2018, a modest increase from the 87 percent payment-to-cost ratio reported in 2017 (AHA 2020a, 2019a).

Previously MACPAC found wide variation in the amount of Medicaid shortfall for DSH hospitals reported on DSH audits.[27] For example, in SPRY 2014, 15 states reported no Medicaid shortfall for DSH hospitals and 12 states reported shortfall that exceeded 50 percent of total DSH hospital uncompensated care. Although Medicaid base payments for hospital services are typically below hospital costs, many states make large non-DSH supplemental payments that reduce or eliminate the amount of Medicaid shortfall reported on DSH audits (MACPAC 2019a).

As a result of litigation about the DSH definition of Medicaid shortfall, many states have changed how they report Medicaid shortfall on their DSH audits, which makes it difficult to examine hospital-level shortfall data.[28] At issue in these lawsuits is how Medicaid shortfall should be counted for Medicaid-eligible patients with third-party coverage.

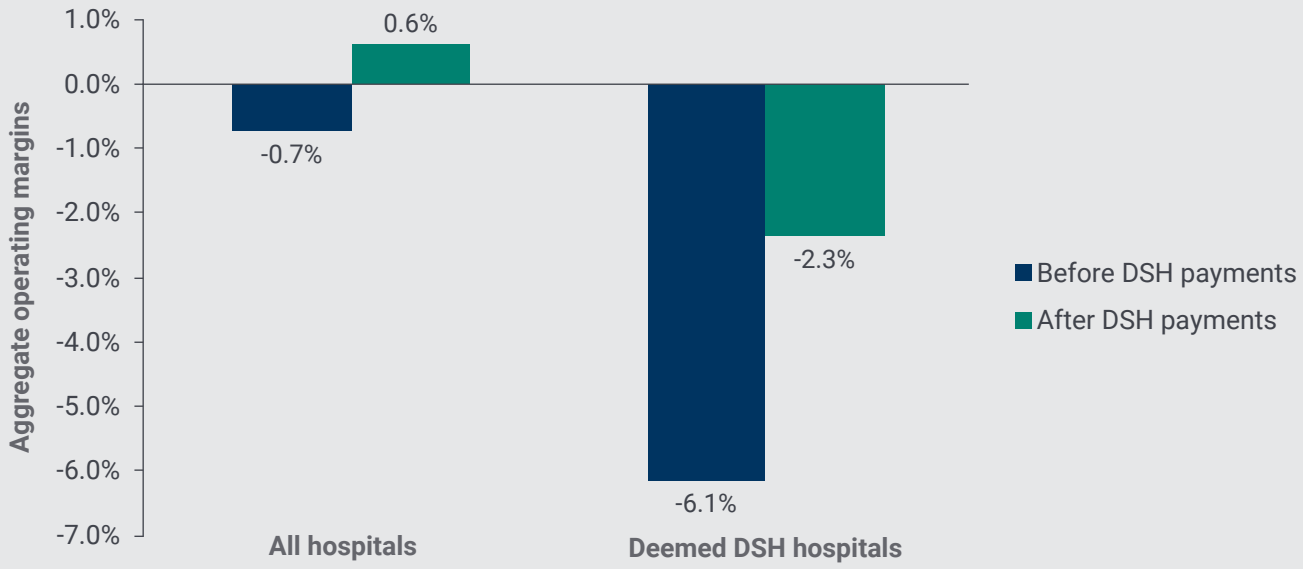
In August 2019, the U.S. Court of Appeals for the District of Columbia ruled that CMS can require states to count third-party payments in the calculation of Medicaid shortfall, and so CMS will be requiring states to calculate Medicaid shortfall according to this method for services furnished on or after June 2, 2017 (CMS 2020).[29] In December 2020, the Consolidated Appropriations Act , 2021, revised the DSH definition of Medicaid shortfall to exclude costs and payments for patients for whom Medicaid is not the primary payer, which will be effective October 1, 2021.

Hospital margins

Changes in hospital uncompensated care costs may affect hospital margins. For example, deemed DSH hospitals report higher uncompensated care costs and lower operating and total margins on average.[30] However, margins are an imperfect measure of a hospital's financial health and can be affected by factors other than uncompensated care.

In FY 2018, aggregate operating margins were positive across all hospitals after including DSH payments (0.6 percent) and were 0.4 percentage points higher than in FY 2017. By contrast, deemed DSH hospitals reported negative aggregate operating margins both before and after counting DSH payments (-6.1 percent and -2.3 percent, respectively) (Figure 5-4).[31]

FIGURE 5-4. Aggregate Hospital Operating Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2018

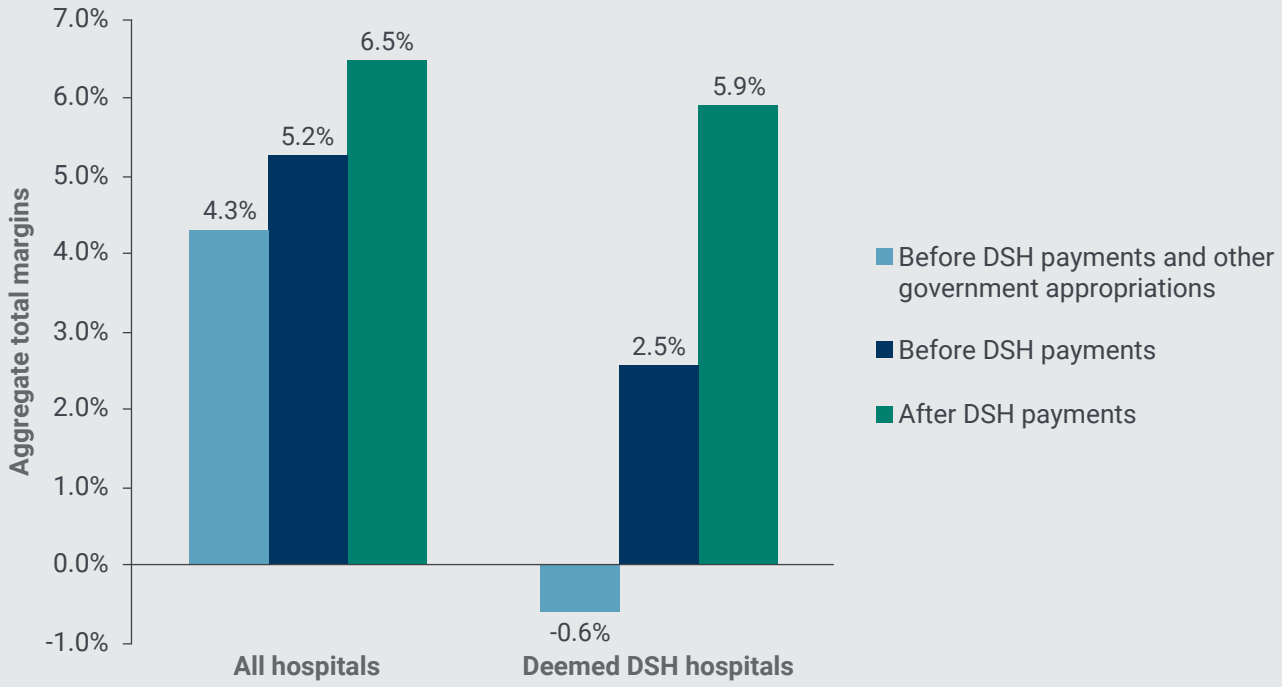


Notes: DSH is disproportionate share hospital. FY is fiscal year. Operating margins measure income from patient care divided by net patient revenue. Operating margins before DSH payments in FY 2018 were estimated using state plan rate year (SPRY) 2016 DSH audit data. Analysis excluded outlier hospitals reporting operating margins greater than 1.5 times the interquartile range from the first and third quartiles. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. This analysis includes hospitals in California and Massachusetts that appear to meet the eligibility criteria for deemed DSH hospitals but did not receive DSH payments because these states instead distributed DSH funding through safety-net care pools authorized under waiver expenditure authority of Section 1115 of the Social Security Act. For further discussion of this methodology and limitations, see Appendix 5B.

Source: MACPAC, 2021, analysis of FY 2018 Medicare cost reports and SPRY 2016 as-filed Medicaid DSH audits.

Total margins include revenue not directly related to patient care (Appendix 5B). The aggregate total margins for all hospitals after DSH payments was 6.5 percent in FY 2018, which is 0.3 percentage points lower than in FY 2017. Before counting DSH payments and other government appropriations, deemed DSH hospitals reported an aggregate total margin of -0.6 percent in FY 2018. However, after counting these payments and appropriations, deemed DSH hospitals reported positive aggregate total margins of 5.9 percent, comparable to the aggregate total margins reported for all hospitals (Figure 5-5).

FIGURE 5-5. Aggregate Hospital Total Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2018



Notes: DSH is disproportionate share hospital. FY is fiscal year. Total margins include revenue not directly related to patient care, such as investment income, parking receipts, and non-DSH state and local subsidies to hospitals. Total margins before DSH payments in FY 2018 were estimated using state plan rate year (SPRY) 2016 DSH audit data. Other government appropriations include state or local subsidies to hospitals that are not Medicaid payments. Analysis excluded outlier hospitals reporting total margins greater than 1.5 times the interquartile range from the first and third quartiles. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. This analysis includes hospitals in California and Massachusetts that appear to meet the eligibility criteria for deemed DSH hospitals but did not receive DSH payments because these states instead distributed DSH funding through safety-net care pools authorized under waiver expenditure authority of Section 1115 of the Social Security Act. For further discussion of this methodology and limitations, see Appendix 5B.

Source: MACPAC, 2021, analysis of FY 2018 Medicare cost reports and SPRY 2016 as-filed Medicaid DSH audits.

Changes in hospital total margins may be affected by multiple factors, such as changes in the prices that a hospital can negotiate because of its competitive position in its market and changes in its costs (Bai and Anderson 2016). Moreover, hospitals that are struggling financially may cut unprofitable services, which would increase their margins in the short term; hospitals that are doing well financially may make additional investments, which could decrease their margins in the short term.

Hospitals with High Levels of Uncompensated Care That Also Provide Essential Community Services

MACPAC is required to provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services. Given that the concept of essential community services is not defined elsewhere in Medicaid statute or regulation, MACPAC has developed a definition based on the types of services suggested in the statutory provision calling for MACPAC's study and the limits of available data (Box 5-4).[32]

BOX 5-4. Identifying Hospitals with High Levels of Uncompensated Care That Provide Essential Community Services for Low-Income, Uninsured, and Other Vulnerable Populations

MACPAC's authorizing statute requires that MACPAC provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services (§ 1900 of the Social Security Act). Based on the types of services suggested in the statute and the limits of available data, we included the following services in our definition of essential community services in this report:

- burn services;
- dental services;
- graduate medical education;
- HIV/AIDS care;
- inpatient psychiatric services (through a psychiatric subunit or stand-alone psychiatric hospital);
- neonatal intensive care units;
- obstetrics and gynecology services;
- primary care services;
- substance use disorder services; and
- trauma services.

We also included deemed DSH hospitals that were designated as critical access hospitals because they are often the only hospital in their geographic area. See Appendix 5B for further discussion of our methodology and its limitations.

Using data from 2018 Medicare cost reports and the 2018 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2016, 92 percent provided at least one of the services included in MACPAC's definition of essential community services, 74 percent provided two of these services, and 59 percent provided three or more of these services. By contrast, among non-deemed DSH hospitals, 39 percent provided three or more of these services.

In reviewing the services that hospitals provide, we included services provided outside of the hospital setting whose costs associated are not included in the calculation of uncompensated care for DSH purposes. Many of these services are considered essential for the community but not provided directly through the hospital. For example, MACPAC found that of the 2,472 hospitals that reported providing primary care services in the 2018 AHA annual survey, one-quarter provided access to primary care outside of the hospital setting, either through clinics owned by the larger system or by contracting directly with the hospital. In recent years, the share of hospitals and physicians affiliated with larger health systems has increased. In 2018, for example, 68 percent of all deemed DSH hospitals were part of larger health systems, representing a slight increase from 66 percent in 2016 (AHRQ 2019).[33] In addition, from 2016 to 2018, the share of physicians affiliated with health systems increased from 40 percent to 51 percent (Furukawa et al. 2020).

Hospital capacity

The COVID-19 pandemic has highlighted the importance of hospitals' ability to aggressively respond to surges in hospital utilization as a result of an infectious disease outbreak. During the pandemic, hospitals have reported lacking the staff, equipment, and space to withstand a large surge in patients (OIG 2020). Many facilities converted beds typically used for elective procedures into intensive care unit (ICU) beds and transferred ICU beds into mobile units (Abir et al. 2020). Meanwhile, some state governments responded by expediting medical license approvals for out-of-state practitioners to strengthen the system's workforce capacity (Tsai et al. 2020).

To examine the role of DSH hospitals in providing surge capacity, we examined prepandemic data on the share of hospital beds in deemed DSH hospitals in different hospital referral regions (HRRs).[34] In FY 2018, our data showed that deemed DSH hospitals accounted for 12 percent of hospitals but 20 percent of ICU beds nationwide. In 34 HRRs, deemed DSH hospitals accounted for the majority of ICU beds. We will continue to monitor how DSH hospitals have responded to the pandemic as more data become available.

Early Effects of the COVID-19 Pandemic

The COVID-19 pandemic is having substantial effects on hospital finances, but its ultimate effects on hospital uncompensated care are still unclear at this time. On one hand, hospitals are reporting increased costs related to treating patients with COVID-19 and implementing new infection control practices to protect patients and staff, which may increase hospital uncompensated care costs to the extent that these are not paid for by other sources. On the other hand, hospitals have been experiencing declines in utilization as a result of a deferred care and postponed non-emergent and elective surgeries, which may reduce the amount of uncompensated care relative to prior years. Although non-COVID 19 admissions rebounded to prepandemic levels over the summer of 2020, the winter surge in COVID-19 hospitalizations is expected to further disrupt usual patterns of hospital care in 2020 and 2021 (Birkmeyer et al. 2020, Mehrota et al. 2020a).

To help address these financial challenges, Congress provided additional funding for hospitals through a variety of mechanisms. Most notably, the Coronavirus Aid, Relief, and Economic Security Act

(CARES Act, P.L. 116-136), the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), and the Consolidated Appropriations Act, 2021, allocated a total of $178 billion in provider relief funding to offset lost revenue or expenses during the pandemic; a portion of this funding is also being used to pay for hospital care for uninsured individuals with COVID-19. The CARES Act also temporarily increased Medicare payments to hospitals for COVID-19 hospitalizations and established the Paycheck Protection Program for businesses with less than 500 employees.[35]

AHA estimates that approximately $70 billion of the $178 billion in provider relief funding had been disbursed to hospitals by October 2020 (AHA 2020b). In April 2020, HHS made a general distribution of provider relief funding to all Medicare-enrolled providers (which includes virtually all hospitals) equal to 2 percent of provider's patient care revenue.[36] In June 2020, HHS made additional, targeted, funding available to safety-net hospitals, defined as those with total margins below 3 percent, uncompensated care costs greater than $25,000 per bed, and a high Medicare DSH patient percentage, which is a measure of the share of patients enrolled in Medicaid and Supplemental Security Income (SSI). HHS has also made additional provider relief funding available to hospitals with a high number of COVID-19 admissions, rural hospitals, children's hospitals, and tribal hospitals. In October 2020, HHS announced another general distribution of relief funding to cover providers' losses during the first half of 2020 (HHS 2021b). In December 2020, the Consolidated Appropriations Act, 2021, required HHS to distribute 85 percent of unspent provider relief funding through a new general distribution that accounts for providers' losses during the second half of 2020 and the first quarter of 2021. As of the week of January 11, 2021, approximately $58 billion in provider relief funds remained unspent (HHS 2021a).

When FY 2020 Medicaid DSH audits are completed, it is not clear how federal relief funds will be accounted for. This is because provider relief funding is not specifically classified as payments for services to Medicaid or uninsured individuals, and DSH payments and provider relief payments are not supposed to pay for the same costs that hospitals incurred during the pandemic. As of the writing of this report, CMS has not issued guidance on how hospitals should report federal provider relief funding and DSH payments. If federal relief funds are counted against hospital uncompensated care costs on Medicaid DSH audits, it could reduce the amount of Medicaid DSH funding that hospitals receive, which may result in an increase in unspent DSH allotments.

Furthermore, during the COVID-19 pandemic, many states have used Medicaid payment policy to help supplement federal provider relief efforts. For example, New Mexico made accelerated DSH payments to providers to help offset the immediate financial disruption caused by the pandemic, and several other states have taken actions to support hospitals by increasing non-DSH payments, such as base payment rates, non-DSH supplemental payments, and directed payments in managed care (NMHSD 2020). Historically, economic downturns have resulted in Medicaid rate cuts for providers, but according to the Kaiser Family Foundation annual state Medicaid budget survey, more states increased payment rates for hospitals than decreased them in FY 2020 (Gifford et al. 2020).

The Families First and Coronavirus Response Act (FFCRA, P.L. 116-127) increased the federal matching assistance percentage (FMAP) by 6.2 percentage points for all Medicaid expenditures incurred during the public health emergency. Although this provision was intended to reduce financial strain on state budgets, it will also indirectly affect the amount of DSH payments a state can make. Given that federal DSH funding is capped for each state, an increased FMAP reduces the total amount of DSH funding available to providers. For example, a state with a $100 million federal allotment would be able to spend a total of $200 million in DSH payments at a 50 percent FMAP

($100 million state and $100 million federal funds) but would make a smaller amount ($178 million) of DSH payments at a 56.2 percent FMAP ($78 million state and $100 million federal funds).

DSH Allotment Reductions

In December 2020, Congress delayed the implementation of FY 2021 DSH reductions until FY 2024 and extended DSH allotment reductions until FY 2027. As such, DSH allotments are scheduled to be reduced by the following annual amounts:

- $8.0 billion in FY 2024;
- $8.0 billion in FY 2025;
- $8.0 billion in FY 2026; and
- $8.0 billion in FY 2027.

DSH allotment reductions are applied against unreduced DSH allotments, that is, the amounts that states would have received without DSH allotment reductions. In FY 2024, DSH allotment reductions will amount to 57.8 percent of states' unreduced DSH allotment amounts and, because unreduced DSH allotments continue to increase each year based on inflation, FY 2027 DSH allotment reductions will be a slightly smaller share of states' unreduced allotments (54.3 percent).[37] In FY 2028 and beyond, there are no DSH allotments reductions scheduled. Thus, under current law, state DSH allotments will return to their higher, unreduced DSH allotment amounts in FY 2028.

DSH allotment reductions will be applied using the DSH Health Reform Reduction Methodology (DHRM). This methodology uses specific statutorily defined criteria, such as applying greater DSH reductions to states with lower uninsured rates and states that do not target their DSH payments to high-need hospitals (Box 5-5).

BOX 5-5. Factors Used in Disproportionate Share Hospital Health Reform Reduction Methodology

The Disproportionate Share Hospital (DSH) Health Reform Reduction Methodology (DHRM), finalized in September 2019, is used by CMS to calculate how DSH allotment reductions will be distributed across states. As required by statute, the DHRM applies five factors when calculating state DSH allotment reductions:

Low-DSH factor. Allocates a smaller proportion of the total DSH allotment reductions to low-DSH states based on the size of these states' DSH expenditures relative to their total Medicaid expenditures. Low-DSH states are defined in statute as states with fiscal year (FY) 2000 DSH expenditures that were less than 3 percent of total state Medicaid medical assistance expenditures for FY 2000. There are 17 low-DSH states, a number that includes Hawaii, whose eligibility is based on a special statutory exception (§§ 1923(f)(5) and 1923(f)(6) of the Social Security Act).

Uninsured percentage factor. Imposes larger DSH allotment reductions on states with lower uninsured rates relative to other states. One-half of DSH reductions are based on this factor.

BOX 5-5. (continued)

High volume of Medicaid inpatients factor. Imposes larger DSH allotment reductions on states that do not target DSH payments to hospitals with high Medicaid volume. The proportion of a state's DSH payments made to hospitals with Medicaid inpatient utilization that is one standard deviation above the mean (the same criteria used to determine deemed DSH hospitals) is compared among states. One-quarter of DSH reductions are based on this factor.

High level of uncompensated care factor. Imposes larger reductions on states that do not target DSH payments to hospitals with high levels of uncompensated care. The proportion of a state's DSH payments made to hospitals with above-average uncompensated care as a proportion of total hospital costs is compared among states. This factor is calculated using DSH audit data, which define uncompensated care costs as the sum of Medicaid shortfall and unpaid costs of care for uninsured individuals. One-quarter of DSH reductions are based on this factor.

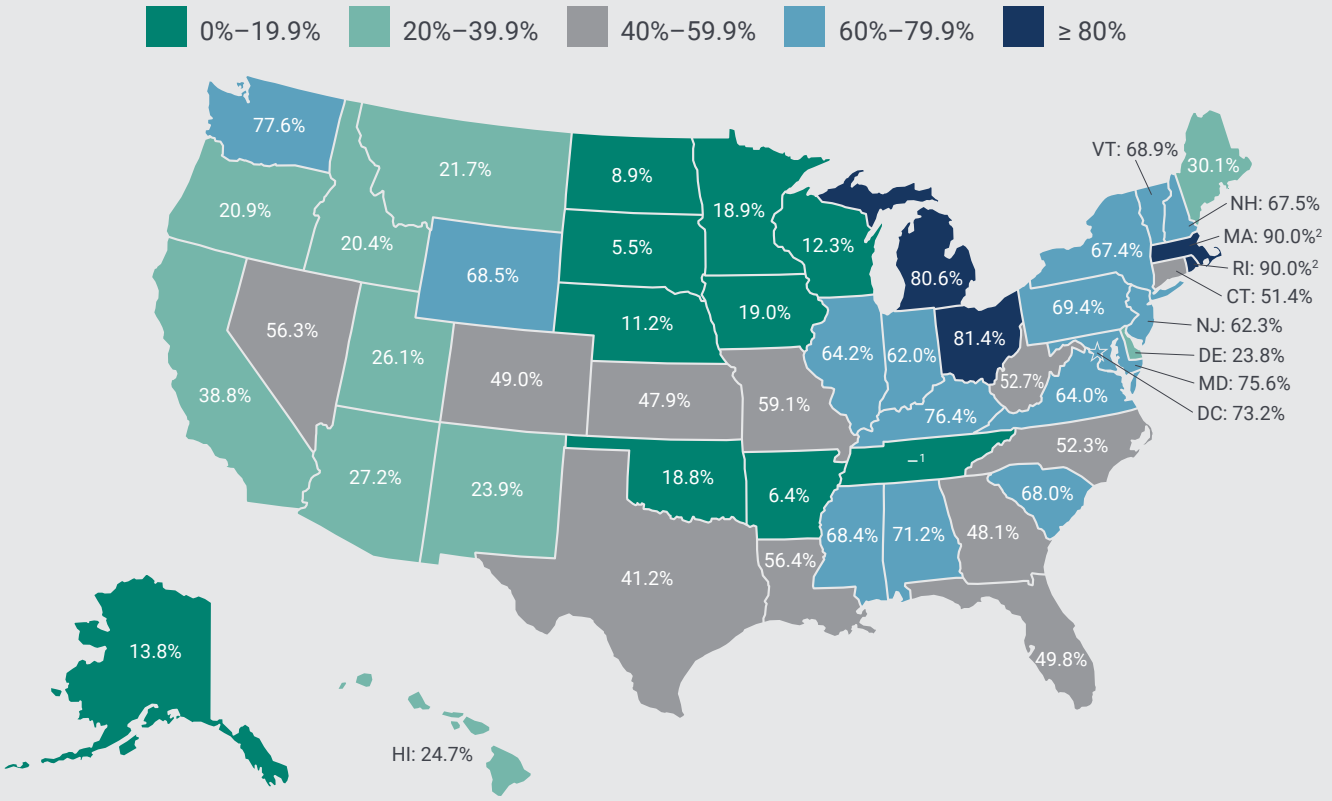
Budget neutrality factor. An adjustment to the high Medicaid and high uncompensated care factors that accounts for DSH allotments that were used as part of the budget neutrality calculations for coverage expansions under waivers under Section 1115 of the Social Security Act as of July 2009. Specifically, DSH funding used for coverage expansions is excluded from the calculation of whether DSH payments were targeted to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care. Any DSH allotment amounts included in budget neutrality calculations for all 1115 waivers approved after July 2009 remain subject to DSH allotment reductions.

Reduced DSH allotments compared to unreduced DSH allotments

To determine the effects of DSH allotment reductions on state finances and DSH funding, we compared states' reduced DSH allotments to their unreduced amounts. For FY 2024, we used the DSH allotment reduction factors that CMS estimated for each state, and projected the DSH allotments in FY 2024. In each of FYs 2024 through 2027, DSH allotments will be reduced by $8 billion. The distribution of DSH allotment reductions among states is expected to be largely the same, assuming states do not change their DSH targeting policies and there are no changes in uninsured rates across states.

Reductions will affect states differently, with estimated reductions ranging from 5.5 percent to 90.0 percent of unreduced allotment amounts (Figure 5-6). Smaller reductions are applied to states with historically low DSH allotments (low-DSH states). Because of the low-DSH factor, the projected percentage reduction in DSH allotments for the 17 low-DSH states (16.4 percent in the aggregate) is about one-quarter that of the other states (59.8 percent in the aggregate). Among states that do not meet the low-DSH criteria, the projected percentage reduction in DSH allotments is larger for states that expanded Medicaid as of January 10, 2019 (62.6 percent in the aggregate) than for states that did not expand Medicaid (52.9 percent in the aggregate). (Complete state-by-state information on DSH allotment reductions and other factors are included in Appendix 5A.)

FIGURE 5-6. Decrease in State DSH Allotments as a Percentage of Unreduced Allotments, by State, FY 2024



Notes: DSH is disproportionate share hospital. FY is fiscal year.

[1] Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act).

[2] DSH allotment reductions are capped at 90 percent of unreduced allotments with the remaining allotment reductions being distributed to other states. This cap only affects the DSH allotment reductions in Massachusetts and Rhode Island in FY 2024.

Source: MACPAC, 2021, analysis of preliminary unreduced and reduced allotment amounts using data provided by CMS as of October 15, 2020, and projected for FY 2024.

DSH allotment reductions will result in a corresponding decline in spending only in states that spend their full DSH allotment. For example, 13 states are projected to have FY 2024 DSH allotment reductions that are smaller than the state's unspent DSH funding in FY 2018. This means that these states could make DSH payments from their reduced FY 2024 allotment equal to the payments that they made from their FY 2018 allotment.[38]

We do not know how states will respond to these reductions. As noted above, some states distribute DSH funding proportionally among all eligible hospitals while other states target payments to a small number of hospitals. States may also take different approaches to reductions, with some states applying them to all DSH hospitals and others reducing DSH payments only at specific hospitals. Because the DHRM applies larger

reductions to states that do not target DSH funds to hospitals with high Medicaid volume or high levels of uncompensated care, states might change their DSH targeting policies to minimize their DSH allotment reductions in future years.[39] However, the DSH audit data used to calculate the DSH targeting factors in the DHRM have a substantial data lag of four to five years. States may be able to offset some of the effects of DSH allotment reductions by increasing other types of Medicaid payments to providers. Each type of Medicaid payment is subject to its own unique rules and limitations. For example, aggregate fee-for-service payments to hospitals, excluding DSH payments, cannot exceed a reasonable estimate of what Medicare would have paid for the same service, referred to as the upper payment limit.[40]

Relationship of DSH allotments to the statutorily required factors

As in our past reports, we find little meaningful relationship between DSH allotments and the factors that Congress asked MACPAC to consider.

- **Changes in number of uninsured individuals.** Unreduced FY 2021 DSH allotments range from less than $100 per uninsured individual in five states to more than $1,000 per uninsured individual in eight states and the District of Columbia. Nationally, the average FY 2021 DSH allotment per uninsured individual is $432.
- **Amount and sources of hospital uncompensated care costs.** As a share of hospital charity care and bad debt costs reported on 2018 Medicare cost reports, unreduced FY 2021 federal DSH allotments range from less than 10 percent in nine states to more than 80 percent in five states and the District of Columbia. Nationally, these allotments are equal to 32 percent of hospital charity care and bad debt costs. At the state level, total unreduced FY 2021 DSH funding (including state and federal funds combined) exceeds total reported hospital charity care and bad debt costs in nine states and the District of Columbia. Because DSH payments to hospitals may not exceed total uncompensated care costs for Medicaid and uninsured patients, some states with DSH allotments larger than the amount of charity care and bad debt in their state may not be able to spend their full DSH allotment.[41]
- **Number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.** Finally, there continues to be no meaningful relationship between state DSH allotments and the number of deemed DSH hospitals in the state that provided at least one of the services included in MACPAC's definition of essential community services.

Endnotes

[1] The changes to the DSH definition of Medicaid shortfall made by the Consolidated Appropriations Act, 2021 are effective beginning October 1, 2021. The law exempts certain hospitals that treat a high number of patients who are eligible for Medicare and receive Supplemental Security Income (SSI) from this change.

[2] Additional information on all types of Medicaid payments to hospitals is provided in MACPAC's issue brief, *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2020d).

[3] Medicare also makes DSH payments. Hospitals are eligible for Medicare DSH payments based on their Medicaid and SSI patient utilization rate. Historically, the amount of Medicare DSH payments a hospital was eligible to receive was based solely on a hospital's Medicaid and SSI patient utilization, but since 2014, the ACA has required that most Medicare DSH payments be based on a hospital's uncompensated care relative to other Medicare DSH hospitals. In addition, the ACA linked the total amount of funding for Medicare DSH payments to the uninsured rate.

[4] Medicaid fee-for-service payments for hospitals cannot exceed a reasonable estimate of what Medicare would have paid in the aggregate. Medicaid DSH payments are not subject to this upper payment limit, but Medicaid DSH payments to an individual hospital are limited to that hospital's uncompensated care costs for Medicaid-enrolled and uninsured patients.

[5] Additional background information about the history of DSH payment policy is included in Chapter 1 and Appendix A of MACPAC's first DSH report (MACPAC 2016).

[6] DSH spending in FY 2019 includes spending funded from prior year allotments. Total DSH spending includes an estimate of the portion of California's spending under their demonstration waiver authorized under Section 1115 of the Act, which is based on the state's DSH allotment.

[7] States are required to submit claims for federal Medicaid funding within two years after the payment is made. However, states can sometimes claim federal match for adjusted DSH payments that are made after the initial two-year window (*Virginia Department of Medical Assistance Services*, DAB No. 1838 (2002), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2002/dab1838.html).

[8] Analysis excludes unspent federal DSH funding that is reported for California and Massachusetts (also $1.3 billion total) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

[9] Uncompensated care is calculated differently on DSH audits and Medicare cost reports. Medicare cost reports define uncompensated care as charity care and bad debt, including uncompensated care for individuals with insurance, which is not part of the Medicaid DSH definition of uncompensated care. Medicare cost reports do not include reliable information on Medicaid shortfall, which is part of the Medicaid DSH definition.

[10] States report hospital-specific DSH data on a SPRY basis, which often corresponds to the state fiscal year and may not align with the federal fiscal year.

[11] The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (P.L. 115-271) provides a state option to cover services provided by an IMD for patients with substance use disorders in FYs 2020–2023. Under Medicaid managed care and Section 1115 waivers, states can also make payments for some services provided by an IMD to Medicaid enrollees age 21–64 (42 CFR 438.6(e)).

[12] Additional information about Medicaid policies affecting IMDs can be found in MACPAC's December 2019 *Report to Congress on Oversight of Institutions for Mental Diseases* (MACPAC 2019b).

[13] California also made DSH payments to fewer than 10 percent of hospitals as reported on the Medicaid DSH audits for state fiscal year 2016. However, this analysis omits California and Massachusetts, because both states have hospitals that receive funding from safety-net care pools authorized under Section 1115 demonstrations that are financed with DSH funding.

[14] In 2012, states that financed DSH payments with above-average levels of health-care-related taxes distributed DSH payments to a proportion of hospitals in the state that was about double the proportion of hospitals receiving DSH funding in states that financed DSH payments with lower levels of health-care-related taxes. States that financed DSH payments with above-average levels of intergovernmental transfers or certified public expenditures distributed a higher share of total DSH spending to public hospitals—about double the share to public hospitals in states that financed DSH payments with lower levels of local government funding (MACPAC 2017).

[15] Due to data collection issues affecting the Current Population Survey (CPS) Annual Social and Economic Supplement during the pandemic, we used American Community Survey (ACS) measures for year-to-year trends in the number of uninsured individuals instead of the CPS as in prior years. (Keisler-Starkey and Bunch 2020).

[16] There are a variety of ways to count the number of uninsured individuals. Estimates in this chapter are based on the ACS and reflect the number of people without health insurance at the time of interview during calendar years 2018 and 2019.

[17] Maine implemented its expansion on January 10, 2019. Although the state formally adopted the expansion through a ballot initiative in 2017, Governor LePage delayed its implementation. On January 3, 2019, Governor Mills signed

an executive order directing the state to begin expansion and make coverage to those eligible retroactive to July 2018. The Maine Department of Health and Human Services projected that 70,000 Mainers would be eligible for MaineCare under the Medicaid expansion. However only 42,000 people signed up in 2019 (KFF 2020a, Andrews 2019, Manatt 2018).

[18] Additional information on potential drivers of the decline in Medicaid and CHIP enrollment in 2017 and 2018 is provided in MACPAC's issue brief, *Changes in Medicaid and CHIP Enrollment* (MACPAC 2019c).

[19] Federal law states that the applications of individuals seeking admission to the United States or seeking to change their status to lawful permanent residents must be denied if, at any time, these individuals are likely to become public charges (Artiga et al. 2019). Public charge has historically been defined as when an individual is primarily dependent on the government for subsistence.

[20] The 2018 proposed rule on Public Charge Ground of Inadmissibility was finalized in 2019, though implementation of the rule has been suspended by several legal challenges (USCIS 2020).

[21] CHIP benefits are not classified as public benefits for the purposes of the public charge rule, but the chilling effect of the rule may also apply to CHIP enrollees.

[22] DSH audit data are not due until three years after DSH payments are made and they are not published until after CMS reviews the data for completeness (42 CFR 455.304).

[23] Specifically, CMS modified the definition of charity care to include uninsured discounts and changed the way that cost-to-charge ratios were applied on Medicare cost reports. Hospitals that partially discount charges to uninsured or underinsured patients report higher uncompensated care costs on the Medicare cost reports under the new formula (MedPAC 2018, CMS 2017a).

[24] As a result of retroactive changes to Medicare cost reports, the adjusted amount of uncompensated care reported by hospitals for 2015 under the new definitions was $9 billion higher than had been reported under the prior definitions. Hospitals have retroactively adjusted their 2015 cost reports to comply with the new definitions, but they are not required to update uncompensated care data from 2013 (MACPAC 2019d).

[25] Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 2018 Medicare cost report data that we report in this chapter have not been audited, so bad debt and charity care costs may not be reported consistently for all hospitals. CMS began to audit charity care and bad debt costs reported on Medicare cost reports in the fall of 2018 (CMS 2018).

[26] Most of costs of care for Medicaid-eligible patients with third-party coverage are paid by other payers because Medicaid is a payer of last resort. Medicaid shortfall is defined in Section 1923g of the Act, and refers to Medicaid eligible patients, in this chapter we discuss Medicaid enrolled because that is often how this provision is operationalized by states.

[27] The amount of Medicaid shortfall reported on the AHA annual survey differs from the amount of Medicaid shortfall for DSH hospitals reported on DSH audits because of differences in the set of hospitals included in each data source and because of differences in how shortfall is calculated (Nelb et al. 2016). For example, on the AHA survey, Medicaid payments are reported after subtracting health care-related taxes, but on DSH audits, health care-related taxes are not subtracted from payments (AHA 2018).

[28] On April 30, 2019, states were informed that CMS would accept revised audits for SPRY 2011–2015. States have two years from April 30, 2019, to submit revised audits with the approval of a good-cause waiver of timely filing requirements by CMS (CMS 2021).

[29] In April 2020, the U.S. Court of Appeals for the Fifth Circuit issued a similar ruling against eight hospitals in Mississippi, contending that CMS acted within its authority in compelling DSH hospitals to count payments from Medicare and private insurers when calculating Medicaid shortfall. The Children's Hospital Association of Texas asked the Supreme Court to review the appeals court decision, a request that was declined (*Baptist Memorial Hospital-Golden Triangle, Inc. v. Azar*).

[30] It should be noted that there is no standard definition for operating versus non-operating margins, and therefore operating margins might be an imperfect measure of a hospital's financial health. This disclaimer does not apply to total margins, because hospitals are supposed to submit financial statements prepared by certified public accountants that match the data in the Medicare cost report schedule G.

[31] Reliability of financial reporting in Medicare cost reports improved substantially after 2010 compared to internal hospital audits; prior to 2010, cost report data was considered to be an imperfect method for determining hospital margins (Dranove et al. 2016, MedPAC 2015).

[32] In Chapter 3 of MACPAC's March 2017 report to Congress, the Commission analyzed other criteria that could be used to identify hospitals that should receive DSH payments (MACPAC 2017).

[33] The Agency for Healthcare Research and Quality defines a health system as a system with at least one hospital and one group of physicians providing comprehensive care that are affiliated with each other through some form of common ownership or joint management (AHRQ 2019). A hospital in this instance is defined as a non-federal acute care hospital.

[34] HRRs are geographic regions developed by the Dartmouth Atlas Project. The Dartmouth Institute defines an HRR as a regional market where people seek highly specialized medical care, and it defines the set of hospitals a patient might be referred to for complications related to COVID (Dartmouth 1999).

[35] In addition, the Families First Coronavirus Response Act (P.L. 116-127) provided an option for states to provide Medicaid coverage for diagnostic testing to uninsured individuals with COVID-19.

[36] In June 2020, HHS made provider relief funds available to Medicaid-enrolled providers who are not enrolled in Medicare (HHS 2021b).

[37] Unreduced allotments increase each year based on the Consumer Price Index for All Urban Consumers, and these inflation-based increases will apply even in years when DSH allotment reductions take effect.

[38] For states to spend the same amount of DSH funding in FY 2020 as they spent in FY 2017, DSH payments to individual hospitals may not exceed those hospitals' uncompensated care costs.

[39] Additional analyses of potential strategic state responses to the DSH allotment reduction methodology proposed by CMS are provided in Chapter 2 of MACPAC's 2016 DSH report (MACPAC 2016).

[40] Additional information on all types of Medicaid payments to hospitals is provided in MACPAC's issue brief, *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2020d).

[41] For Medicaid DSH purposes, uncompensated care includes Medicaid shortfall, which is not included in the Medicare cost report definition of uncompensated care. As a result, the total amount of uncompensated care reported on Medicare cost reports may differ from the amount of uncompensated care costs that states can pay for with Medicaid DSH funds.

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APPENDIX 5A: State-Level Data

TABLE 5A-1. State DSH Allotments, FYs 2021 and 2022 (millions)

State	FY 2021 without FFCRA Adjustment[1]		FY 2021 with FFCRA Adjustment[2]		FY 2022	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,764.0**	**$13,007.8**	**$20,500.2**	**$13,007.8**	**$23,184.1**	**$13,247.7**
Alabama	**502.4**	364.6	**462.8**	364.6	**511.7**	371.4
Alaska	**48.3**	24.2	**43.0**	24.2	**49.2**	24.6
Arizona	**171.5**	120.1	**157.5**	120.1	**174.7**	122.3
Arkansas	**71.8**	51.2	**66.1**	51.2	**73.1**	52.1
California	**2,599.8**	1,299.9	**2,313.0**	1,299.9	**2,647.9**	1,324.0
Colorado	**219.4**	109.7	**195.2**	109.7	**223.4**	111.7
Connecticut	**474.3**	237.2	**422.0**	237.2	**483.1**	241.5
Delaware	**18.6**	10.7	**16.8**	10.7	**18.9**	10.9
District of Columbia	**103.8**	72.6	**95.3**	72.6	**105.7**	74.0
Florida	**382.8**	237.2	**347.9**	237.2	**389.8**	241.5
Georgia	**475.4**	318.7	**435.2**	318.7	**484.2**	324.6
Hawaii	**21.8**	11.6	**19.5**	11.6	**22.2**	11.8
Idaho	**27.7**	19.5	**25.4**	19.5	**28.2**	19.9
Illinois	**500.3**	254.9	**446.0**	254.9	**509.5**	259.7
Indiana	**385.0**	253.5	**351.9**	253.5	**392.1**	258.2
Iowa	**75.6**	46.7	**68.7**	46.7	**77.0**	47.6
Kansas	**82.0**	48.9	**74.2**	48.9	**83.5**	49.8
Kentucky	**238.6**	171.9	**219.7**	171.9	**243.1**	175.1
Louisiana	**1,205.9**	813.0	**1,104.4**	813.0	**1,228.3**	828.1
Maine	**195.5**	124.5	**178.1**	124.5	**199.1**	126.8
Maryland	**180.8**	90.4	**160.9**	90.4	**184.2**	92.1
Massachusetts	**723.3**	361.7	**643.5**	361.7	**736.7**	368.4
Michigan	**490.4**	314.2	**447.1**	314.2	**499.5**	320.0
Minnesota	**177.1**	88.6	**157.6**	88.6	**180.4**	90.2
Mississippi	**232.5**	180.8	**215.4**	180.8	**236.9**	184.2
Missouri	**864.8**	561.8	**789.4**	561.8	**880.8**	572.2
Montana	**20.5**	13.5	**18.7**	13.5	**20.9**	13.7
Nebraska	**59.4**	33.6	**53.5**	33.6	**60.5**	34.2

TABLE 5A-1. (continued)

State	FY 2021 without FFCRA Adjustment[1]		FY 2021 with FFCRA Adjustment[2]		FY 2022	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,764.0**	**$13,007.8**	**$20,500.2**	**$13,007.8**	**$23,184.1**	**$13,247.7**
Nevada	**86.6**	54.8	**78.9**	54.8	**88.2**	55.9
New Hampshire	**379.7**	189.8	**337.8**	189.8	**386.7**	193.4
New Jersey	**1,526.7**	763.3	**1,358.3**	763.3	**1,555.0**	777.5
New Mexico	**32.9**	24.2	**30.3**	24.2	**33.5**	24.6
New York	**3,809.3**	1,904.6	**3,389.0**	1,904.6	**3,879.8**	1,939.9
North Carolina	**519.0**	349.8	**475.3**	349.8	**528.6**	356.3
North Dakota	**21.6**	11.3	**19.3**	11.3	**22.0**	11.5
Ohio	**757.1**	481.7	**689.8**	481.7	**771.1**	490.6
Oklahoma	**63.2**	42.9	**57.9**	42.9	**64.3**	43.7
Oregon	**88.2**	53.7	**80.1**	53.7	**89.9**	54.7
Pennsylvania	**1,274.9**	665.5	**1,139.6**	665.5	**1,298.5**	677.8
Rhode Island	**142.5**	77.1	**127.8**	77.1	**145.1**	78.5
South Carolina	**549.8**	388.3	**505.5**	388.3	**560.0**	395.5
South Dakota	**22.5**	13.1	**20.3**	13.1	**22.9**	13.3
Tennessee[3]	**80.3**	53.1	**73.4**	53.1	**80.3**	53.1
Texas	**1,834.5**	1,133.9	**1,667.2**	1,133.9	**1,868.5**	1,154.9
Utah	**34.5**	23.3	**31.6**	23.3	**35.1**	23.7
Vermont	**48.9**	26.7	**43.9**	26.7	**49.8**	27.2
Virginia	**207.8**	103.9	**184.8**	103.9	**211.6**	105.8
Washington	**438.7**	219.4	**390.3**	219.4	**446.9**	223.4
West Virginia	**106.7**	80.0	**98.6**	80.0	**108.7**	81.5
Wisconsin	**188.8**	112.1	**171.0**	112.1	**192.3**	114.2
Wyoming	**0.3**	0.0	**0.3**	0.2	**0.2**	0.1

Notes: DSH is disproportionate share hospital. FY is fiscal year. FFCRA is the Families First and Coronavirus Response Act (P.L. 116–127) which provided an enhanced federal medical assistance percentage (FMAP) to states during the COVID-19 public health emergency. This table assumes no FFCRA enhanced FMAP for FY 2022.

[1] Totals reflect an FMAP with no FFCRA adjustment for FY 2021.

[2] Totals reflect an FMAP with a FFCRA adjustment for FY 2021.

[3] Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act).

Source: MACPAC, 2021, analysis of CBO 2020 and preliminary unreduced and reduced DSH allotment amounts as of October 15, 2020, provided by CMS.

TABLE 5A-2. FY 2024 DSH Allotment Reductions, by State (millions)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in federal DSH allotments
Total	**$24,212.7**	**$13,835.2**	**$14,054.4**	**$8,000.0**	**57.8%**
Alabama	**534.5**	387.9	**380.3**	276.0	71.2
Alaska	**51.4**	25.7	**7.1**	3.6	13.8
Arizona	**182.4**	127.7	**49.7**	34.8	27.2
Arkansas	**76.4**	54.4	**4.9**	3.5	6.4
California	**2,765.8**	1,382.9	**1,074.3**	537.1	38.8
Colorado	**233.4**	116.7	**114.3**	57.1	49.0
Connecticut	**504.6**	252.3	**259.3**	129.7	51.4
Delaware	**19.8**	11.4	**4.7**	2.7	23.8
District of Columbia	**110.4**	77.3	**80.8**	56.6	73.2
Florida	**407.2**	252.3	**202.7**	125.6	49.8
Georgia	**505.8**	339.0	**243.1**	162.9	48.1
Hawaii	**23.2**	12.3	**5.7**	3.0	24.7
Idaho	**29.5**	20.7	**6.0**	4.2	20.4
Illinois	**532.2**	271.2	**341.8**	174.2	64.2
Indiana	**409.6**	269.6	**253.8**	167.1	62.0
Iowa	**80.5**	49.7	**15.3**	9.4	19.0
Kansas	**87.2**	52.0	**41.8**	24.9	47.9
Kentucky	**253.9**	182.9	**194.0**	139.8	76.4
Louisiana	**1,283.0**	865.0	**723.8**	488.0	56.4
Maine	**208.0**	132.5	**62.6**	39.8	30.1
Maryland	**192.4**	96.2	**145.5**	72.7	75.6
Massachusetts	**769.5**	384.8	**692.6**	346.3	90.0
Michigan	**521.7**	334.3	**420.4**	269.4	80.6
Minnesota	**188.4**	94.2	**35.7**	17.8	18.9
Mississippi	**247.4**	192.4	**169.3**	131.6	68.4
Missouri	**920.0**	597.6	**543.6**	353.1	59.1
Montana	**21.8**	14.3	**4.7**	3.1	21.7
Nebraska	**63.2**	35.7	**7.1**	4.0	11.2
Nevada	**92.2**	58.3	**51.9**	32.9	56.3
New Hampshire	**403.9**	202.0	**272.5**	136.2	67.5

TABLE 5A-2. (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in federal DSH allotments
Total	**$24,212.7**	**$13,835.2**	**$14,054.4**	**$8,000.0**	**57.8%**
New Jersey	**1,624.2**	812.1	**1,011.9**	505.9	62.3
New Mexico	**35.0**	25.7	**8.4**	6.2	23.9
New York	**4,052.6**	2,026.3	**2,731.1**	1,365.5	67.4
North Carolina	**552.1**	372.1	**288.7**	194.6	52.3
North Dakota	**23.0**	12.0	**2.1**	1.1	8.9
Ohio	**805.4**	512.5	**655.9**	417.4	81.4
Oklahoma	**67.2**	45.7	**12.7**	8.6	18.8
Oregon	**93.9**	57.1	**19.6**	11.9	20.9
Pennsylvania	**1,356.4**	708.0	**941.4**	491.4	69.4
Rhode Island	**151.6**	82.0	**136.4**	73.8	90.0
South Carolina	**584.9**	413.1	**397.5**	280.8	68.0
South Dakota	**23.9**	13.9	**1.3**	0.8	5.5
Tennessee[1]	**80.3**	53.1	**–**	–	–
Texas	**1,951.6**	1,206.3	**804.6**	497.3	41.2
Utah	**36.7**	24.7	**9.6**	6.5	26.1
Vermont	**52.0**	28.4	**35.8**	19.6	68.9
Virginia	**221.0**	110.5	**141.4**	70.7	64.0
Washington	**466.8**	233.4	**362.1**	181.0	77.6
West Virginia	**113.6**	85.2	**59.8**	44.9	52.7
Wisconsin	**200.9**	119.3	**24.8**	14.7	12.3
Wyoming	**0.6**	0.3	**0.4**	0.2	68.5

Notes: FY is fiscal year. DSH is disproportionate share hospital. Under current law, federal DSH allotments will be reduced by $8 billion in FY 2024. Totals reflect a federal medical assistance percentage (FMAP) with no Families First Coronavirus Response Act (P.L. 116-127) adjustment for FY 2021.

— Dash indicates zero.

[1] Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act).

Source: MACPAC, 2021, analysis of the preliminary unreduced and reduced DSH allotment amounts as of October 15, 2020, provided by CMS.

TABLE 5A-3. Number of Uninsured Individuals and Uninsured Rate, by State, 2018–2019

State	2018		2019		Difference in uninsured (2019–2018)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**29,000**	**8.9%**	**30,141**	**9.2%**	**1,141**	**0.3%**
Alabama	489	10.0	476	9.7	-13	-0.3
Alaska	93	12.6	89	12.2	-4	-0.4
Arizona	760	10.6	822	11.3	62	0.7
Arkansas	247	8.2	275	9.1	27	0.9
California	2,848	7.2	3042	7.7	194	0.5
Colorado	427	7.5	461	8.0	34	0.5
Connecticut	189	5.3	210	5.9	21	0.6
Delaware	55	5.7	64	6.6	9	0.9
District of Columbia	22	3.2	25	3.5	2	0.3
Florida	2,769	13.0	2835	13.2	66	0.2
Georgia	1,441	13.7	1423	13.4	-18	-0.3
Hawaii	58	4.1	59	4.2	1	0.1
Idaho	195	11.1	193	10.8	-2	-0.3
Illinois	892	7.0	938	7.4	46	0.4
Indiana	555	8.3	586	8.7	30	0.4
Iowa	148	4.7	158	5.0	9	0.3
Kansas	256	8.8	268	9.2	12	0.4
Kentucky	250	5.6	286	6.4	36	0.8
Louisiana	373	8.0	414	8.9	41	0.9
Maine	107	8.0	108	8.0	0	0.0
Maryland	363	6.0	363	6.0	0	0.0
Massachusetts	193	2.8	207	3.0	14	0.2
Michigan	540	5.4	579	5.8	39	0.4
Minnesota	247	4.4	276	4.9	29	0.5
Mississippi	361	12.1	387	13.0	26	0.9
Missouri	576	9.4	614	10.0	38	0.6
Montana	87	8.2	89	8.3	2	0.1
Nebraska	160	8.3	161	8.3	0	0.0

TABLE 5A-3. (continued)

State	2018		2019		Difference in uninsured (2019–2018)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**29,000**	**8.9%**	**30,141**	**9.2%**	**1,141**	**0.3%**
Nevada	340	11.2	351	11.4	11	0.2
New Hampshire	77	5.7	86	6.3	8	0.6
New Jersey	659	7.4	702	7.9	42	0.5
New Mexico	199	9.5	210	10.0	11	0.5
New York	1,055	5.4	1012	5.2	-44	-0.2
North Carolina	1,111	10.7	1185	11.3	74	0.6
North Dakota	55	7.3	53	6.9	-3	-0.4
Ohio	760	6.5	771	6.6	12	0.1
Oklahoma	560	14.2	566	14.3	6	0.1
Oregon	298	7.1	304	7.2	6	0.1
Pennsylvania	704	5.5	743	5.8	38	0.3
Rhode Island	43	4.1	43	4.1	0	0.0
South Carolina	534	10.5	556	10.8	22	0.3
South Dakota	86	9.8	90	10.2	4	0.4
Tennessee	684	10.1	690	10.1	6	0.0
Texas	5,080	17.7	5335	18.4	255	0.7
Utah	297	9.4	311	9.7	14	0.3
Vermont	25	4.0	28	4.5	3	0.5
Virginia	750	8.8	674	7.9	-75	-0.9
Washington	482	6.4	503	6.6	20	0.2
West Virginia	116	6.4	120	6.7	5	0.3
Wisconsin	320	5.5	332	5.7	12	0.2
Wyoming	61	10.5	71	12.3	11	1.8

Note: 0.0 indicates an amount between -5,000 and 5,000 that rounds to zero; 0.0 percent indicates an amount between -0.05 percent and 0.05 percent that rounds to zero.

Source: MACPAC, 2021, analysis of Keisler-Starkey and Bunch 2020 and Census 2020.

TABLE 5A-4. State Levels of Uncompensated Care, FYs 2017–2018

State	Total hospital uncompensated care costs, 2017		Total hospital uncompensated care costs, 2018		Difference in total hospital uncompensated care costs	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Total	**$37,858**	**4.1%**	**$40,659**	**4.2%**	**$2,801**	**0.1%**
Alabama	**686**	6.5	**716**	6.5	**29**	0.0
Alaska	**60**	3.2	**58**	3.1	**-2**	-0.1
Arizona	**373**	2.5	**453**	2.9	**80**	0.4
Arkansas	**217**	3.3	**244**	3.6	**27**	0.3
California	**2,252**	2.0	**2,499**	2.1	**246**	0.1
Colorado	**354**	2.5	**386**	2.6	**32**	0.1
Connecticut	**210**	1.9	**396**	3.3	**185**	1.4
Delaware	**76**	2.6	**91**	2.9	**15**	0.4
District of Columbia	**73**	2.1	**64**	1.8	**-10**	-0.3
Florida	**3,432**	7.2	**3,785**	7.6	**353**	0.4
Georgia	**2,093**	8.5	**2,249**	8.7	**156**	0.1
Hawaii	**279**	8.1	**272**	7.8	**-7**	-0.3
Idaho	**181**	3.7	**196**	3.7	**15**	0.0
Illinois	**1,446**	3.8	**1,744**	4.4	**298**	0.6
Indiana	**828**	3.7	**851**	3.6	**23**	-0.1
Iowa	**223**	2.4	**227**	2.4	**4**	0.0
Kansas	**334**	3.8	**344**	3.8	**9**	0.0
Kentucky	**325**	2.3	**335**	2.4	**9**	0.0
Louisiana	**493**	3.7	**413**	3.0	**-80**	-0.7
Maine	**216**	3.8	**226**	3.9	**10**	0.1
Maryland	**512**	3.3	**487**	3.1	**-25**	-0.2
Massachusetts	**477**	1.8	**490**	1.8	**13**	0.0
Michigan	**545**	1.7	**612**	1.9	**68**	0.2
Minnesota	**319**	1.7	**349**	1.8	**30**	0.1
Mississippi	**606**	7.6	**592**	7.4	**-15**	-0.2
Missouri	**1,150**	5.7	**1,192**	5.7	**42**	0.0
Montana	**99**	2.5	**83**	2.0	**-15**	-0.5
Nebraska	**269**	4.3	**289**	4.5	**20**	0.2

TABLE 5A-4. (continued)

State	Total hospital uncompensated care costs, 2017		Total hospital uncompensated care costs, 2018		Difference in total hospital uncompensated care costs	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Total	**$37,858**	**4.1%**	**$40,659**	**4.2%**	**$2,801**	**0.1%**
Nevada	**228**	3.8	**243**	3.9	**16**	0.1
New Hampshire	**131**	2.8	**141**	2.8	**10**	0.1
New Jersey	**956**	4.1	**925**	3.8	**-31**	-0.2
New Mexico	**147**	2.7	**151**	2.7	**5**	0.0
New York	**2,497**	3.5	**2,556**	3.3	**59**	-0.1
North Carolina	**1,636**	6.0	**1,789**	6.4	**154**	0.4
North Dakota	**94**	2.4	**106**	2.6	**13**	0.2
Ohio	**1,091**	2.9	**1,139**	2.9	**48**	0.0
Oklahoma	**669**	6.6	**728**	6.9	**59**	0.3
Oregon	**286**	2.4	**334**	2.7	**48**	0.3
Pennsylvania	**784**	1.9	**811**	1.9	**26**	0.0
Rhode Island	**69**	1.9	**75**	2.0	**6**	0.1
South Carolina	**922**	7.1	**1,007**	7.8	**86**	0.6
South Dakota	**112**	2.8	**135**	3.2	**24**	0.4
Tennessee	**939**	5.3	**1,074**	5.5	**135**	0.2
Texas	**6,311**	10.3	**6,727**	10.7	**416**	0.4
Utah	**358**	5.1	**369**	5.0	**10**	-0.1
Vermont	**48**	1.9	**56**	2.1	**8**	0.2
Virginia	**1,276**	6.5	**1,409**	6.8	**133**	0.3
Washington	**466**	2.3	**532**	2.5	**66**	0.2
West Virginia	**171**	2.6	**185**	2.7	**14**	0.1
Wisconsin	**439**	2.1	**427**	2.0	**-11**	-0.1
Wyoming	**101**	6.1	**97**	5.6	**-4**	-0.6

Notes: FY is fiscal year. Uncompensated care is calculated using Medicare cost reports, which define uncompensated care as charity care and bad debt. Because of recent changes in Medicare cost report definitions that changed uncompensated care reporting for 2015 and subsequent years, these data are not comparable with data for prior years.

-0.0 percent or 0.0 percent indicates an amount between -0.05 percent and 0.05 percent that rounds to zero.

Source: MACPAC, 2021, analysis of Medicare cost reports for FYs 2017 and 2018.

TABLE 5A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria, by State, FY 2016

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**6,021**	**2,648**	**44%**	**744**	**12%**	**681**	**11%**
Alabama	115	78	68	8	7	7	6
Alaska	25	4	16	1	4	1	4
Arizona	113	40	35	38	34	31	27
Arkansas	103	7	7	3	3	3	3
California[1]	408	29	7	15	4	10	2
Colorado	103	27	26	6	6	6	6
Connecticut	41	10	24	3	7	2	5
Delaware	13	2	15	2	15	2	15
District of Columbia	13	9	69	6	46	5	38
Florida	256	76	30	31	12	29	11
Georgia	166	125	75	23	14	16	10
Hawaii[2]	26	11	42	–	–	–	–
Idaho	51	25	49	8	16	7	14
Illinois	206	19	9	18	9	17	8
Indiana	168	54	32	11	7	11	7
Iowa	121	8	7	7	6	7	6
Kansas	151	63	42	9	6	8	5
Kentucky	115	99	86	40	35	34	30
Louisiana	209	63	30	33	16	30	14
Maine	36	5	14	3	8	3	8
Maryland	60	23	38	15	25	14	23
Massachusetts[3]	97	—	—	—	—	—	—

TABLE 5A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**6,021**	**2,648**	**44%**	**744**	**12%**	**681**	**11%**
Michigan	164	124	76	23	14	22	13
Minnesota	142	34	24	13	9	13	9
Mississippi	109	61	56	15	14	14	13
Missouri	142	102	72	24	17	22	15
Montana	65	33	51	3	5	3	5
Nebraska	97	27	28	12	12	12	12
Nevada	56	22	39	4	7	4	7
New Hampshire	30	25	83	6	20	6	20
New Jersey	97	76	78	22	23	22	23
New Mexico	53	14	26	10	19	8	15
New York	203	190	94	46	23	46	23
North Carolina	129	80	62	18	14	18	14
North Dakota	49	2	4	1	2	1	2
Ohio	235	155	66	16	7	15	6
Oklahoma	153	49	32	16	10	14	9
Oregon	63	46	73	15	24	15	24
Pennsylvania	232	191	82	39	17	35	15
Rhode Island	15	14	93	3	20	2	13
South Carolina	83	61	73	15	18	14	17
South Dakota	61	21	34	12	20	12	20
Tennessee	145	75	52	19	13	14	10
Texas	579	174	30	71	12	69	12

TABLE 5A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**6,021**	**2,648**	**44%**	**744**	**12%**	**681**	**11%**
Utah	60	41	68	6	10	5	8
Vermont	16	13	81	1	6	1	6
Virginia	107	36	34	5	5	5	5
Washington	103	53	51	14	14	12	12
West Virginia	60	46	77	14	23	13	22
Wisconsin	146	95	65	19	13	19	13
Wyoming	31	11	35	2	6	2	6

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 61 DSH hospitals that did not submit a FY 2018 Medicare cost report. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our definition of essential community services includes the following services that we could identify based on the limits of available data: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, primary care services, substance use disorder services, and trauma services.

— Dash indicates zero.

[1] Analysis excludes 12 hospitals that received funding under the state's Global Payment Program as authorized under Section 1115 of the Social Security Act, which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[2] Based on available data on Medicaid inpatient and low-income utilization rates, no DSH hospitals in Hawaii appeared to meet the deemed DSH criteria in FY 2016.

[3] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act allows it to use all of its DSH funding for the state's safety-net care pool. However, at least 10 hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

Source: MACPAC, 2021, analysis of state plan rate year 2016 as-filed Medicaid DSH audits, Medicare cost reports for FYs 2016–2018, and the 2018 American Hospital Association annual survey.

TABLE 5A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals, by State, FY 2016

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**848,379**	**489,764**	**58%**	**154,550**	**18%**	**42,991**	**28,534**	**66%**	**13,100**	**30%**
Alabama	14,787	12,849	87	1,066	7	687	609	89	107	16
Alaska	1,367	622	45	80	6	95	52	55	4	4
Arizona	15,050	7,456	50	7,005	47	990	652	66	622	63
Arkansas	9,255	1,018	11	227	2	331	32	10	5	1
California[1]	82,990	4,701	6	2,172	3	5,331	475	9	214	4
Colorado	10,321	4,155	40	1,498	15	630	322	51	157	25
Connecticut	7,136	2,000	28	657	9	525	228	44	81	15
Delaware	2,614	415	16	415	16	152	33	22	33	22
District of Columbia	3,037	2,587	85	1,178	39	268	250	93	128	48
Florida	91,920	24,741	27	12,385	13	2,760	1,733	63	1,183	43
Georgia	21,577	18,034	84	4,733	22	1,163	1,054	91	378	32
Hawaii	2,419	1,726	71	–	–	180	110	61	–	–
Idaho	3,172	2,476	78	1,203	38	136	121	89	65	48
Illinois	30,910	4,938	16	4,320	14	1,815	427	24	373	21
Indiana	17,282	7,052	41	3,833	22	891	464	52	347	39
Iowa	7,532	2,150	29	2,101	28	354	189	53	188	53
Kansas	8,161	4,505	55	1,912	23	240	170	71	103	43
Kentucky	14,154	13,277	94	5,929	42	853	818	96	487	57
Louisiana	16,505	8,395	51	3,516	21	766	480	63	282	37
Maine	2,989	1,158	39	802	27	137	70	51	46	34

TABLE 5A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**848,379**	**489,764**	**58%**	**154,550**	**18%**	**42,991**	**28,534**	**66%**	**13,100**	**30%**
Maryland	12,708	4,528	36	3,643	29	812	299	37	238	29
Massachusetts[2]	18,674	—	—	—	—	1,370	—	—	—	—
Michigan	23,751	21,750	92	6,779	29	1,294	1,258	97	602	47
Minnesota	11,036	6,505	59	2,548	23	595	468	79	256	43
Mississippi	10,756	6,679	62	2,553	24	447	281	63	153	34
Missouri	18,376	13,218	72	2,221	12	932	522	56	119	13
Montana	2,855	2,104	74	214	7	96	88	92	12	13
Nebraska	5,456	3,751	69	1,794	33	170	162	95	104	61
Nevada	6,799	4,323	64	1,491	22	479	395	83	206	43
New Hampshire	2,641	2,415	91	1,178	45	108	104	96	78	72
New Jersey[3]	34,914	33,294	95	5,865	17	1,104	1,049	95	417	38
New Mexico	4,409	1,968	45	1,151	26	325	199	61	130	40
New York	45,962	45,045	98	10,249	22	3,697	3,621	98	1,159	31
North Carolina	21,917	18,629	85	5,838	27	1,177	1,085	92	423	36
North Dakota	2,548	125	5	25	1	86	0	0	0	0
Ohio	31,758	25,575	81	5,316	17	1,716	1,340	78	498	29
Oklahoma	11,338	6,681	59	1,807	16	477	310	65	102	21
Oregon	6,723	5,797	86	1,950	29	431	418	97	199	46
Pennsylvania	36,975	34,566	93	7,720	21	1,823	1,779	98	649	36
Rhode Island	2,935	2,853	97	885	30	156	156	100	61	39
South Carolina	12,316	11,069	90	4,032	33	583	566	97	327	56
South Dakota	2,783	1,837	66	1,132	41	94	87	93	63	68

TABLE 5A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**848,379**	**489,764**	**58%**	**154,550**	**18%**	**42,991**	**28,534**	**66%**	**13,100**	**30%**
Tennessee	18,848	14,461	77	4,332	23	941	812	86	362	38
Texas	68,256	37,208	55	15,724	23	3,023	2,171	72	1,276	42
Utah	5,618	4,641	83	963	17	231	222	96	75	33
Vermont	1,118	952	85	410	37	53	50	95	29	55
Virginia	16,519	9,442	57	1,699	10	724	499	69	149	21
Washington	25,567	22,719	89	2,571	10	852	704	83	217	26
West Virginia	6,145	5,388	88	1,573	26	305	293	96	132	43
Wisconsin	14,153	11,704	83	3,690	26	561	513	91	257	46
Wyoming	1,345	737	55	165	12	24	15	61	2	10

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 61 DSH hospitals that did not submit a FY 2018 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. For further discussion of the methodology and limitations, see Appendix 5B.

— Dash indicates zero; 0 indicates an amount less than 500 that rounds to zero; 0 percent indicates an amount less than 0.5 percent that rounds to zero.

[1] Analysis excludes 12 hospitals that received funding under California's Global Payment Program demonstration waiver under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[2] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Act allows it to use all of its DSH funding for the state's safety-net care pool. However, at least 10 hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

[3] One hospital in New Jersey misreported its hospital beds, so 2018 data were used to populate this hospital's bed information.

Source: MACPAC, 2021, analysis of Medicare cost reports for FYs 2015–2018 and state plan rate year 2015–2016 as-filed Medicaid DSH audits.

TABLE 5A-7. FY 2021 Unreduced DSH Allotment per Uninsured Individual and Non-Elderly Low-Income Individual, by State

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per uninsured individual		FY 2021 unreduced DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$22,764.0**	**$13,007.8**	**$755.3**	**$431.6**	**$271.4**	**$155.1**
Alabama	**502.4**	364.6	**1,056.3**	766.6	**336.2**	244.0
Alaska	**48.3**	24.2	**541.3**	270.6	**293.3**	146.6
Arizona	**171.5**	120.1	**208.5**	146.0	**83.5**	58.4
Arkansas	**71.8**	51.2	**261.5**	186.3	**72.5**	51.6
California	**2,599.8**	1,299.9	**854.5**	427.3	**249.0**	124.5
Colorado	**219.4**	109.7	**476.2**	238.1	**179.7**	89.9
Connecticut	**474.3**	237.2	**2,254.8**	1,127.4	**717.3**	358.7
Delaware	**18.6**	10.7	**289.3**	167.0	**89.3**	51.6
District of Columbia	**103.8**	72.6	**4,200.4**	2,940.3	**636.0**	445.2
Florida	**382.8**	237.2	**135.0**	83.7	**66.5**	41.2
Georgia	**475.4**	318.7	**334.2**	224.0	**155.8**	104.4
Hawaii	**21.8**	11.6	**366.5**	194.3	**86.9**	46.1
Idaho	**27.7**	19.5	**143.4**	101.0	**54.8**	38.6
Illinois	**500.3**	254.9	**533.5**	271.9	**164.3**	83.7
Indiana	**385.0**	253.5	**657.4**	432.7	**217.7**	143.3
Iowa	**75.6**	46.7	**479.4**	296.0	**104.4**	64.4
Kansas	**82.0**	48.9	**305.8**	182.5	**112.2**	67.0
Kentucky	**238.6**	171.9	**834.6**	601.3	**176.3**	127.0
Louisiana	**1,205.9**	813.0	**2,914.7**	1,965.1	**792.4**	534.2
Maine	**195.5**	124.5	**1,817.9**	1,157.8	**647.1**	412.1
Maryland	**180.8**	90.4	**498.5**	249.3	**166.8**	83.4
Massachusetts	**723.3**	361.7	**3,498.1**	1,749.0	**599.4**	299.7
Michigan	**490.4**	314.2	**846.6**	542.5	**184.5**	118.2
Minnesota	**177.1**	88.6	**641.0**	320.5	**162.1**	81.1
Mississippi	**232.5**	180.8	**601.1**	467.4	**221.0**	171.8
Missouri	**864.8**	561.8	**1,409.0**	915.3	**533.4**	346.5

TABLE 5A-7. (continued)

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per uninsured individual		FY 2021 unreduced DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$22,764.0**	**$13,007.8**	**$755.3**	**$431.6**	**$271.4**	**$155.1**
Montana	**20.5**	13.5	**231.3**	151.7	**73.5**	48.2
Nebraska	**59.4**	33.6	**370.1**	209.0	**130.7**	73.8
Nevada	**86.6**	54.8	**246.7**	156.2	**105.4**	66.7
New Hampshire	**379.7**	189.8	**4,432.3**	2,216.2	**1,840.4**	920.2
New Jersey	**1,526.7**	763.3	**2,175.7**	1,087.9	**912.7**	456.4
New Mexico	**32.9**	24.2	**156.8**	115.2	**45.6**	33.5
New York	**3,809.3**	1,904.6	**3,765.7**	1,882.8	**798.9**	399.4
North Carolina	**519.0**	349.8	**437.9**	295.2	**176.8**	119.1
North Dakota	**21.6**	11.3	**411.1**	215.4	**138.2**	72.4
Ohio	**757.1**	481.7	**981.3**	624.4	**250.5**	159.4
Oklahoma	**63.2**	42.9	**111.6**	75.9	**51.9**	35.3
Oregon	**88.2**	53.7	**290.5**	176.8	**82.9**	50.4
Pennsylvania	**1,274.9**	665.5	**1,717.0**	896.3	**441.3**	230.4
Rhode Island	**142.5**	77.1	**3,280.7**	1,774.5	**632.4**	342.1
South Carolina	**549.8**	388.3	**988.8**	698.4	**376.6**	266.0
South Dakota	**22.5**	13.1	**249.0**	145.1	**102.8**	59.9
Tennessee	**80.3**	53.1	**116.5**	77.0	**41.0**	27.1
Texas	**1,834.5**	1,133.9	**343.8**	212.5	**216.4**	133.8
Utah	**34.5**	23.3	**110.8**	74.8	**46.2**	31.2
Vermont	**48.9**	26.7	**1,741.2**	950.2	**370.4**	202.1
Virginia	**207.8**	103.9	**308.1**	154.1	**119.3**	59.7
Washington	**438.7**	219.4	**873.0**	436.5	**272.4**	136.2
West Virginia	**106.7**	80.0	**888.9**	666.6	**190.8**	143.1
Wisconsin	**188.8**	112.1	**568.9**	337.8	**146.2**	86.8
Wyoming	**0.5**	0.3	**7.5**	3.8	**4.1**	2.0

Notes: FY is fiscal year. DSH is disproportionate share hospital. Non-elderly low-income individuals are defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. Totals reflect a federal medical assistance percentage (FMAP) with no Families First Coronavirus Response Act (P.L. 116-127) adjustment for FY 2021.

Sources: MACPAC, 2021, analysis of state plan rate year 2016 as-filed Medicaid DSH audits and the CMS Medicaid Budget Expenditure System. Keisler-Starkey and Bunch 2020, and Census 2020.

TABLE 5A-8. FY 2021 Unreduced DSH Allotments as a Percentage of Hospital Uncompensated Care, by State, FY 2018

State	FY 2021 unreduced federal DSH allotment (millions)	FY 2021 unreduced federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2018	FY 2021 unreduced DSH allotment (state and federal, millions)	FY 2021 total unreduced DSH allotment as a percentage of hospital uncompensated care in the state, FY 2018
Total	**$13,007.8**	**32.0%**	**$22,764.0**	**56.0%**
Alabama	364.6	50.9	502.4	70.2
Alaska	24.2	41.4	48.3	82.9
Arizona	120.1	26.5	171.5	37.9
Arkansas	51.2	21.0	71.8	29.4
California	1,299.9	52.0	2,599.8	104.1
Colorado	109.7	28.4	219.4	56.8
Connecticut	237.2	60.0	474.3	119.9
Delaware	10.7	11.9	18.6	20.5
District of Columbia	72.6	114.0	103.8	162.8
Florida	237.2	6.3	382.8	10.1
Georgia	318.7	14.2	475.4	21.1
Hawaii	11.6	4.2	21.8	8.0
Idaho	19.5	10.0	27.7	14.2
Illinois	254.9	14.6	500.3	28.7
Indiana	253.5	29.8	385.0	45.2
Iowa	46.7	20.6	75.6	33.3
Kansas	48.9	14.2	82.0	23.8
Kentucky	171.9	51.4	238.6	71.3
Louisiana	813.0	196.6	1,205.9	291.6
Maine	124.5	55.1	195.5	86.5
Maryland	90.4	18.6	180.8	37.1
Massachusetts	361.7	73.7	723.3	147.5
Michigan	314.2	51.3	490.4	80.1
Minnesota	88.6	25.4	177.1	50.8
Mississippi	180.8	30.6	232.5	39.3
Missouri	561.8	47.1	864.8	72.6
Montana	13.5	16.1	20.5	24.6
Nebraska	33.6	11.6	59.4	20.6

TABLE 5A-8. (continued)

State	FY 2021 unreduced federal DSH allotment (millions)	FY 2021 unreduced federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2018	FY 2021 unreduced DSH allotment (state and federal, millions)	FY 2021 total unreduced DSH allotment as a percentage of hospital uncompensated care in the state, FY 2018
Total	**$13,007.8**	**32.0%**	**$22,764.0**	**56.0%**
Nevada	54.8	22.5	86.6	35.6
New Hampshire	189.8	134.3	379.7	268.7
New Jersey	763.3	82.5	1,526.7	165.0
New Mexico	24.2	15.9	32.9	21.7
New York	1,904.6	74.5	3,809.3	149.0
North Carolina	349.8	19.5	519.0	29.0
North Dakota	11.3	10.7	21.6	20.4
Ohio	481.7	42.3	757.1	66.5
Oklahoma	42.9	5.9	63.2	8.7
Oregon	53.7	16.1	88.2	26.4
Pennsylvania	665.5	82.1	1,274.9	157.3
Rhode Island	77.1	102.6	142.5	189.8
South Carolina	388.3	38.5	549.8	54.6
South Dakota	13.1	9.7	22.5	16.6
Tennessee	53.1	4.9	80.3	7.5
Texas	1,133.9	16.9	1,834.5	27.3
Utah	23.3	6.3	34.5	9.3
Vermont	26.7	47.8	48.9	87.6
Virginia	103.9	7.4	207.8	14.7
Washington	219.4	41.2	438.7	82.5
West Virginia	80.0	43.4	106.7	57.8
Wisconsin	112.1	26.2	188.8	44.2
Wyoming	0.3	0.3	0.5	0.6

Notes: FY is fiscal year. DSH is disproportionate share hospital. Excludes 61 DSH hospitals that did not submit a FY 2018 Medicare cost report. Uncompensated care is calculated using 2018 Medicare cost reports, which define uncompensated care as charity care and bad debt. Because of recent changes in Medicare cost report definitions that changed uncompensated care reporting for 2015 and subsequent years, these data are not comparable with data for prior years. Totals reflect a federal medical assistance percentage (FMAP) with no Families First Coronavirus Response Act (P.L. 116-127) adjustment for FY 2021.

Source: MACPAC, 2021, analysis of state plan rate year 2016 as-filed Medicaid DSH audits, the CMS Medicaid Budget Expenditure System, FY 2018 Medicare cost reports, and AHA 2020.

TABLE 5A-9. FY 2021 DSH Allotment per Deemed DSH Hospital Providing at Least One Essential Community Service, by State

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,764.0**	**$13,007.8**	**$29.7**	**$17.0**	**$32.4**	**$18.5**
Alabama	502.4	364.6	62.8	45.6	71.8	52.1
Alaska	48.3	24.2	48.3	24.2	48.3	24.2
Arizona	171.5	120.1	4.5	3.2	5.5	3.9
Arkansas	71.8	51.2	23.9	17.1	23.9	17.1
California[1]	2,599.8	1,299.9	173.3	86.7	260.0	130.0
Colorado	219.4	109.7	36.6	18.3	36.6	18.3
Connecticut	474.3	237.2	158.1	79.1	237.2	118.6
Delaware	18.6	10.7	9.3	5.4	9.3	5.4
District of Columbia	103.8	72.6	17.3	12.1	20.8	14.5
Florida	382.8	237.2	12.3	7.7	13.2	8.2
Georgia	475.4	318.7	20.7	13.9	29.7	19.9
Hawaii[2]	21.8	11.6	–	–	–	–
Idaho	27.7	19.5	3.5	2.4	4.0	2.8
Illinois	500.3	254.9	27.8	14.2	29.4	15.0
Indiana	385.0	253.5	35.0	23.0	35.0	23.0
Iowa	75.6	46.7	10.8	6.7	10.8	6.7
Kansas	82.0	48.9	9.1	5.4	10.2	6.1
Kentucky	238.6	171.9	6.0	4.3	7.0	5.1
Louisiana	1,205.9	813.0	36.5	24.6	40.2	27.1
Maine	195.5	124.5	65.2	41.5	65.2	41.5
Maryland	180.8	90.4	12.1	6.0	12.9	6.5
Massachusetts[3]	723.3	361.7	–	–	–	–
Michigan	490.4	314.2	21.3	13.7	22.3	14.3
Minnesota	177.1	88.6	13.6	6.8	13.6	6.8

TABLE 5A-9. (continued)

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,764.0**	**$13,007.8**	**$29.7**	**$17.0**	**$32.4**	**$18.5**
Mississippi	232.5	180.8	15.5	12.1	16.6	12.9
Missouri	864.8	561.8	36.0	23.4	39.3	25.5
Montana	20.5	13.5	6.8	4.5	6.8	4.5
Nebraska	59.4	33.6	5.0	2.8	5.0	2.8
Nevada	86.6	54.8	21.7	13.7	21.7	13.7
New Hampshire	379.7	189.8	63.3	31.6	63.3	31.6
New Jersey	1,526.7	763.3	69.4	34.7	69.4	34.7
New Mexico	32.9	24.2	3.3	2.4	4.1	3.0
New York	3,809.3	1,904.6	82.8	41.4	82.8	41.4
North Carolina	519.0	349.8	28.8	19.4	28.8	19.4
North Dakota	21.6	11.3	21.6	11.3	21.6	11.3
Ohio	757.1	481.7	47.3	30.1	50.5	32.1
Oklahoma	63.2	42.9	3.9	2.7	4.5	3.1
Oregon	88.2	53.7	5.9	3.6	5.9	3.6
Pennsylvania	1,274.9	665.5	32.7	17.1	36.4	19.0
Rhode Island	142.5	77.1	47.5	25.7	71.2	38.5
South Carolina	549.8	388.3	36.7	25.9	39.3	27.7
South Dakota	22.5	13.1	1.9	1.1	1.9	1.1
Tennessee	80.3	53.1	4.2	2.8	5.7	3.8
Texas	1,834.5	1,133.9	25.8	16.0	26.6	16.4
Utah	34.5	23.3	5.7	3.9	6.9	4.7
Vermont	48.9	26.7	48.9	26.7	48.9	26.7
Virginia	207.8	103.9	41.6	20.8	41.6	20.8
Washington	438.7	219.4	31.3	15.7	36.6	18.3

TABLE 5A-9. (continued)

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,764.0**	**$13,007.8**	**$29.7**	**$17.0**	**$32.4**	**$18.5**
West Virginia	106.7	80.0	7.6	5.7	8.2	6.2
Wisconsin	188.8	112.1	9.9	5.9	9.9	5.9
Wyoming	0.5	0.3	0.3	0.1	0.3	0.1

Notes: FY is fiscal year. DSH is disproportionate share hospital. Excludes 61 DSH hospitals that did not submit a FY 2018 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our definition of essential community services includes the following services based on the limits of available data: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, primary care services, substance use disorder services, and trauma services. For further discussion of the methodology and limitations, see Appendix 5B. Totals reflect a federal medical assistance percentage (FMAP) with no Families First Coronavirus Response Act (P.L. 116-127) adjustment for FY 2021.

– Dash indicates that the category is not applicable.

[1] Analysis excludes 12 hospitals that received funding under California's Global Payment Program demonstration waiver under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[2] Based on available data on Medicaid inpatient and low-income utilization rates, no DSH hospitals in Hawaii appeared to meet the deemed DSH criteria in FY 2016.

[3] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act allows it to use all of its DSH funding for the state's safety-net care pool instead; for this reason, no hospitals in the state can be categorized as DSH or deemed DSH hospitals.

Source: MACPAC, 2021, analysis of the CMS Medicaid Budget Expenditure System, state plan rate year 2016 as-filed Medicaid DSH audits, Medicare cost reports for FYs 2016–2018, and AHA 2020.

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APPENDIX 5B: Methodology and Data Limitations

MACPAC used data from several different sources to analyze and describe Medicaid disproportionate share hospital (DSH) payments and their relationship to factors such as uninsured rates, uncompensated care, and DSH hospitals with high levels of uncompensated care that provide access to essential services. We also modeled DSH allotment reductions and simulated DSH payments under a variety of scenarios. Below we describe the data sources used in this analysis and the limitations associated with each one, and we review the modeling assumptions we made for our projections of DSH allotments and payments.

Primary Data Sources

DSH audit data

We used state plan rate year 2016 DSH audit reports, the most recent data available, to examine historic DSH spending and the distribution of DSH spending among a variety of hospital types. These data were provided by the Centers for Medicare & Medicaid Services (CMS) on an as-filed basis and are subject to change as CMS completes its internal review of state DSH audit reports.

Overall, 2,648 hospitals receiving DSH payments are represented in our analyses of DSH audit data. We did not include DSH audit data provided by states for hospitals that did not receive DSH payments. (Sixty hospitals were excluded under this criterion.) Some hospitals received DSH payments from multiple states; we combined the data for duplicate hospitals so that each hospital would only appear once in the dataset.

Medicare cost reports

We used Medicare cost report data to examine uncompensated care for all hospitals in each state. A hospital that receives Medicare payments must file an annual Medicare cost report, which includes a range of financial and non-financial data about hospital performance and services provided. We excluded hospitals in U.S. territories, religious non-medical health care institutions, and hospitals participating in special Medicare demonstration projects. (Ninety hospitals were excluded under these criteria.) These facilities submit Medicare cost reports but do not receive Medicare DSH payments.

We linked DSH audit data and Medicare cost report data to create descriptive analyses of DSH hospitals and to identify deemed DSH hospitals. Hospitals were matched based on their CMS certification number. A total of 2,648 DSH hospitals were included in these analyses. We excluded 61 DSH hospitals without matching 2018 Medicare cost reports.

When using Medicare cost reports to analyze hospital uncompensated care, we excluded hospitals that reported uncompensated care costs that were greater than hospital operating expenses. Two hospitals were excluded under this criterion.

When using Medicare cost reports to analyze hospital operating margins, we excluded hospitals with operating margins that were more than 1.5 times the interquartile range above the highest quartiles or below the lowest quartile. (Under this criterion, 465 hospitals were excluded from our analysis of FY 2018 margins.) Operating margins are calculated by subtracting operating expenses (OE) from net patient revenue (NPR) and dividing the result by net patient revenue: (NPR – OE) ÷ NPR. Total margins, in contrast, include additional types of hospital revenue, such as state or local subsidies and revenue from other facets of hospital operations (e.g., parking lot receipts).

Definition of Essential Community Services

MACPAC's authorizing statute requires that MACPAC's analysis include data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education and the continuum of primary through quaternary care, including the provision of trauma care and public health services (§ 1900 of the Social Security Act (the Act)).

In this report, we use the same definition to identify such hospitals that was used in MACPAC's 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*. This definition is based on a two-part test:

- Is the hospital a deemed DSH hospital?
- Does the hospital provide at least one essential service?

Deemed DSH hospital status

According to the Act, hospitals must meet one of two criteria to qualify as a deemed DSH hospital: (1) a Medicaid inpatient utilization rate greater than one standard deviation above the mean for hospitals in the state or (2) a low-income utilization rate greater than 25 percent (§ 1923(b)(1) of the Act). Because deemed DSH hospitals are statutorily required to receive DSH payments, we excluded from our analysis hospitals that did not receive DSH payments in 2016.

Calculation of the Medicaid inpatient utilization rate threshold for each state requires data from all hospitals in that state, and we relied on Medicare cost reports to make those calculations and to determine which hospitals exceeded this threshold. A major limitation of this approach is that Medicaid inpatient utilization reported on Medicare cost reports does not include services provided to Medicaid enrollees that were not paid for by Medicaid (e.g., Medicare-funded services for individuals who are dually eligible for Medicare and Medicaid). However, the Medicaid DSH definition of Medicaid inpatient utilization includes services provided to anyone who is eligible for Medicaid, even if Medicaid is not the primary payer. Thus, our identification of deemed DSH hospitals may omit some hospitals with high utilization by dually eligible beneficiaries and overstate the extent to which hospitals with low utilization by dually eligible beneficiaries (e.g., children's hospitals) exceed the threshold.

The low-income utilization rate threshold for deemed DSH hospitals is the same for all states (25 percent), so we were able to use Medicaid DSH audit data to determine whether hospitals met this criterion. However, about 17 percent of DSH hospitals did not provide data on the rate of low-income utilization on their DSH audits, and these omissions limited our ability to identify all deemed DSH hospitals.

Both California and Massachusetts distribute DSH funding through waivers authorized under Section 1115 of the Social Security Act. Consequently, Massachusetts does not have any hospital that submits Medicaid DSH audits, while California has some public hospitals which do not submit Medicaid DSH audits. For these two states, MACPAC used Medicare cost report data to estimate deemed DSH status for the purposes of calculating margins for deemed DSH hospitals. Twenty-three additional hospitals were included from California and Massachusetts using this methodology.

Provision of essential community services

Because the term essential community services is not otherwise defined in statute or regulation, we identified a number of services that could be considered essential community services using available data from 2018 Medicare cost reports and the 2018 American Hospital Association (AHA) annual survey (Table 5B-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the AHA annual survey.

TABLE 5B-1. Essential Community Services, by Data Source

Data source	Service type
American Hospital Association annual survey	Burn services
	Dental services
	HIV/AIDS care
	Neonatal intensive care units
	Obstetrics and gynecology services
	Primary care services
	Substance use disorder services
	Trauma services
Medicare cost reports	Graduate medical education
	Inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital)

For this report, for the sake of inclusiveness, any deemed DSH hospital providing at least one essential community service was included in our analysis. For deemed DSH hospitals, we also included certain hospital types if they were the only hospital in their geographic area to provide certain types of services. These hospital types included critical access hospitals because they are often the only hospital within a 25-mile radius.

Projections of DSH Allotments

DSH allotment reductions from FY 2024 were calculated using projections provided by CMS based on its DSH allotment reduction methodology, which was finalized in September 2019. DSH allotments for FY 2024 were calculated by increasing prior year allotments based on the Consumer Price Index for All Urban Consumers and applying an $8 billion reduction, consistent with the current schedule of DSH allotment reductions in statute. Unreduced allotments increase each year for all states except Tennessee, whose DSH allotment is specified in statute (§ 1923(f)(6)(A)(vi) of the Act). Per the final rule, DSH allotment reductions are limited to 90 percent of each state's unreduced DSH allotment (CMS 2019). This reduction cap limits the reductions for two states in FY 2024, and their excess reduction amounts are proportionately allocated among the remaining states that do not exceed the reduction cap.

Uninsured Rate

Each year the Census Bureau releases its annual report on health insurance coverage in the United States. The report presents statistics on coverage based on information collected in the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) and the American Community Survey (ACS). The two surveys differ in the timing of data collection, the reference period, the time frame of the resulting health insurance coverage estimates, and the uses of the data.

The 2019 CPS collected data in February through April in 2020; the survey asks whether respondents had health insurance coverage at any time during the previous year. The CPS 2019 insurance questions measure whether a person was insured on any day in 2019. In contrast, the 2019 ACS provides a rolling sample of households, with data collected throughout 2019; the survey asks whether a person is currently covered at the time of the interview. Therefore, the ACS presents a point-in-time profile of the population's health insurance coverage status.

TABLE 5B-2. Differences in the Uninsured Rate for American Community Survey and Current Population Survey, 2018–2019

Characteristic	American Community Survey			Current Population Survey		
	2018	2019	Percentage point change (2018–2019)	2018	2019	Percentage point change (2018–2019)
All uninsured	**8.9%**	**9.2%**	**0.3%***	**8.5%**	**8.0%**	**-0.5%***
Age group						
Under age 19	5.2	5.7	0.5*	5.5	5.2	-0.3
Age 19–64	12.5	12.9	0.4*	11.7	11.1	-0.6*
Over age 64	0.8	0.8	0.0	0.9	1.1	0.2*
Race and ethnicity						
White, non-Hispanic	6.0	6.3	0.3*	5.4	5.2	-0.2
Black, non-Hispanic	10.1	10.1	0.0	9.7	9.6	-0.1
Asian, non-Hispanic	6.3	6.6	0.3*	6.8	6.2	-0.6
Hispanic (any race)	17.9	18.7	0.8*	17.8	16.7	-1.1*
Income-to-poverty ratio						
Below 100 percent	15.5	16.0	0.5*	16.3	15.9	-0.4
100–199 percent	14.6	15.2	0.6*	13.6	14.1	0.5
200–299 percent	11.3	12.2	0.9*	10.8	11.0	0.2
300–399 percent	7.9	8.6	0.7*	8.1	8.3	0.2
At or above 400 percent	3.6	3.9	0.3*	3.4	3.0	-0.4*

Notes: Uninsured rates by Medicaid expansion status are based on the American Community Survey. Medicaid expansion status reflects state expansion decisions as of January 10, 2019. In past years, we reported national data on uninsured individuals using the Current Population Survey (CPS) Annual Social and Economic Supplement. However, due to complications related to data collection for CPS 2019 estimates during March–June of 2020 due to COVID, we are reporting ACS numbers to align with how the Census Bureau reports 2018–2019 trends. Numbers do not sum due to rounding.

* Indicates change is statistically different from zero at the 90 percent confidence level.

Sources: MACPAC, 2021, analysis of Keisler-Starkey and Bunch 2020.

We show the results of two different surveys meaning the 2018–2019 uninsured rates because each survey tells a different story (Table 5B-2). With the ACS, the total uninsured rate increased significantly from 8.9 percent to 9.2 percent. With the CPS ASEC, the total uninsured rate declined significantly from 8.5 percent to 8.0 percent. Comparing the surveys by age group, in the ACS, both groups in the under-65 category saw a significant increase in the uninsured rate. By contrast, CPS estimates found a significant decrease in the uninsured rate for individuals age 19–64 and a significant increase in the uninsured rate for individuals over the age of 64. The ACS found a significant increase in the uninsured rate for all race and ethnicity groups except individuals who are Black, non-Hispanic. The CPS ASEC found that the uninsured rate went down significantly for

Hispanics of any race. The ACS found a significant increase in the uninsured rate for all income-to-poverty ratios, while the CPS found a decrease in the uninsured rate for households that earn above 400 percent of the federal poverty level.

The COVID-19 pandemic affected survey collection for the 2019 CPS ASEC. Although the Census Bureau went to great lengths to complete interviews by telephone, the response rate for the CPS basic household survey was 10 percentage points lower in March 2020 compared to the same period in 2019. For the CPS ASEC specifically, the Census Bureau estimates that the unweighted combined supplement response was 61.1 percent in 2020, down from 67.6 percent in 2019. Furthermore, Census found that high-income families were more likely than low-income families to respond to the 2019 CPS ASEC (Rothbaum 2020, Rothbaum and Bee 2020, DOC 2019). As a consequence, Census used the ACS to measure most insurance trends between 2018 and 2019 in their annual report on health insurance coverage because ACS represents a more consistent data collection methodology for 2018–2019 than the CPS. MACPAC has followed suit.

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Appendix

Authorizing Language (§ 1900 of the Social Security Act)

Medicaid and CHIP Payment and Access Commission

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as "MACPAC").

(b) DUTIES.—

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

(A) review policies of the Medicaid program established under this title (in this section referred to as "Medicaid") and the State Children's Health Insurance Program established under title XXI (in this section referred to as "CHIP") affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees

of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

(A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term "appropriate committees of Congress" means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as "MedPAC") established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Melanie Bella, MBA (Chair), is head of partnerships and policy at Cityblock Health, which facilitates health care delivery for low-income urban populations, particularly Medicaid beneficiaries and those dually eligible for Medicaid and Medicare. Previously, she served as the founding director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services (CMS), where she designed and launched payment and delivery system demonstrations to improve quality and reduce costs. Ms. Bella also was the director of the Indiana Medicaid program, where she oversaw Medicaid, the State Children's Health Insurance Program (CHIP), and the state's long-term care insurance program. Ms. Bella received her master of business administration from Harvard University.

Charles Milligan, JD, MPH (Vice Chair), is the chief operating officer of Health Management Associates, a research and consulting firm specializing in publicly funded health care and human services policy, programs, financing, and evaluation. Previously, he was the national dual eligible special needs plans executive director for UnitedHealthcare Community & State and, prior to that, CEO of UnitedHealthcare's Community Plan in New Mexico, a Medicaid managed care organization with enrolled members in all Medicaid eligibility categories. Mr. Milligan is a former state Medicaid and CHIP director in New Mexico and Maryland. He also served as executive director of the Hilltop Institute, a health services research center at the University of Maryland at Baltimore County, and as vice president at The Lewin Group. Mr. Milligan directed the 2005–2006 Commission on Medicaid and has conducted Medicaid-related research projects in numerous states. He received his master of public health from the University of California, Berkeley, and his law degree from Harvard Law School.

Thomas Barker, JD, is a partner at Foley Hoag, LLP, where he specializes in Medicaid and Medicare regulatory, coverage, and reimbursement issues and is a member of the executive committee. He also has a pro bono law practice focusing on health care issues facing immigrants. Previously, he held numerous positions within the U.S. Department of Health and Human Services (HHS), including acting general counsel, counselor to the Secretary of HHS, chief legal officer for CMS, and senior health policy counselor to the administrator of CMS. Mr. Barker received his law degree from Suffolk University School of Law.

Tricia Brooks, MBA, is a research professor at the McCourt School of Public Policy at Georgetown University and a senior fellow at the Georgetown University Center for Children and Families (CCF), an independent, non-partisan policy and research center whose mission is to expand and improve health coverage for children and families. At CCF, Ms. Brooks focuses on issues relating to the policy, program administration, and quality of Medicaid and CHIP coverage for children and families. Prior to joining CCF, she served as the founding CEO of New Hampshire Healthy Kids, a legislatively created non-profit corporation that administered CHIP in the state, and served as the Medicaid and CHIP consumer assistance coordinator. Ms. Brooks holds a master of business administration from Suffolk University.

Brian Burwell is vice president, health care policy and research at Ventech Solutions, where his work includes research, consulting services, policy analysis, and technical assistance in financing and delivery of long-term services and supports, and data analysis related to integrated care models for dually eligible beneficiaries and managed long-term services and supports. Previously, Mr. Burwell was a senior executive in the government health and human services unit at Watson Health in Cambridge, Massachusetts. He received his bachelor of arts degree from Dartmouth College.

Martha Carter, DHSc, MBA, APRN, CNM, is an independent consultant. She is the founder and former CEO of FamilyCare Health Centers, a community health center that serves four counties in south-central West Virginia. Dr. Carter practiced as a certified nurse-midwife in Kentucky, Ohio, and West Virginia for 20 years and is a member of the West Virginia Alliance for Creative Health Solutions, a practice-led research and advocacy network. Dr. Carter was a Robert Wood Johnson Foundation Executive Nurse Fellow from 2005–2008 and received the Robert Wood Johnson Foundation Community Health Leader award in 1999. She holds a doctorate of health sciences from A.T. Still University in Mesa, Arizona, and a master of business administration from West Virginia University in Morgantown, West Virginia.

Frederick Cerise, MD, MPH, is president and CEO of Parkland Health and Hospital System, a large public safety-net health system in Dallas, Texas. Previously, he oversaw Medicaid and other programs for the state of Louisiana as secretary of the Department of Health and Hospitals. Dr. Cerise also held the position of medical director and other leadership roles at various health care facilities operated by Louisiana State University. He began his career as an internal medicine physician and spent 13 years treating patients and teaching medical students in Louisiana's public hospital system. Dr. Cerise received his degree in medicine from Louisiana State University and his master of public health from Harvard University.

Kisha Davis, MD, MPH, is vice president of health equity for Aledade. Previously, Dr. Davis was Maryland medical director for VaxCare Corporation; worked as a family physician at CHI Health Care in Rockville, Maryland; and served as program manager at CFAR in Philadelphia, Pennsylvania, where she supported projects for family physicians focused on payment reform and practice transformation to promote health system change. Dr. Davis has also served as the medical director and director of community health at CHI and as a family physician at a federally qualified health center (FQHC) in Maryland. As a White House Fellow at the U.S. Department of Agriculture, she established relationships among leaders of FQHCs and the Women, Infants, and Children nutrition program. Dr. Davis received her degree in medicine from the University of Connecticut and her master of public health from Johns Hopkins University.

Toby Douglas, MPP, MPH, is senior vice president, national Medicaid, at Kaiser Permanente. Previously, Mr. Douglas was senior vice president for Medicaid solutions at Centene Corporation, and prior to that, a long-standing state Medicaid official, serving for 10 years as an executive in California Medicaid. He served as director of the California Department of Health Care Services and was director of California Medicaid for six years, during which time he also served as a board member of the National Association of Medicaid Directors and as a CHIP director. Earlier in his career, Mr. Douglas worked for the San Mateo County Health Department in California, as a research associate at the Urban Institute, and as a VISTA volunteer. He received his master of public policy and master of public health from the University of California, Berkeley.

Leanna George is the parent of a teenager with a disability who is covered under Medicaid and a child covered under CHIP. A resident of Benson, North Carolina, Ms. George is the chair of the North Carolina Council on Educational Services for Exceptional Children, a special education advisory council for the state board of education. She also serves as the secretary of the Johnston County Consumer and Family Advisory Committee, which advises the Board of the County Mental Health Center, and on the Client Rights Committee of the Autism Society of North Carolina, a Medicaid provider agency.

Darin Gordon is president and CEO of Gordon & Associates in Nashville, Tennessee, where he provides health-care-related consulting services to a wide range of public- and private-sector clients. Previously, he was director of Medicaid and CHIP in Tennessee for 10 years, where he oversaw various program improvements, including the implementation of a statewide value-based

purchasing program. During this time, he served as president and vice president of the National Association of Medicaid Directors for a total of four years. Before becoming director of Medicaid and CHIP, he was the chief financial officer and director of managed care programs for Tennessee's Medicaid program. Mr. Gordon received his bachelor of science degree from Middle Tennessee State University.

Christopher Gorton, MD, MHSA, was formerly president of public plans at Tufts Health Plan, a non-profit health plan in Massachusetts, Rhode Island, and New Hampshire, as well as CEO of a regional health plan that was acquired by the Inova Health System of Falls Church, Virginia. Other positions held include vice president for medical management and worldwide health care strategy for Hewlett Packard Enterprise Services and president and chief medical officer for APS Healthcare, a behavioral health plan and care management organization based in Silver Spring, Maryland. After beginning his career as a practicing pediatrician in FQHCs in Pennsylvania and Missouri, Dr. Gorton served as chief medical officer in the Pennsylvania Department of Public Welfare. Dr. Gorton received his degree in medicine from Columbia University's College of Physicians and Surgeons and his master of health systems administration from the College of Saint Francis in Joliet, Illinois.

Stacey Lampkin, FSA, MAAA, MPA, is an actuary and principal with Mercer Government Human Services Consulting, where she has led actuarial work for several state Medicaid programs. She previously served as an actuary and assistant deputy secretary for Medicaid finance and analytics at Florida's Agency for Health Care Administration and as an actuary at Milliman. She has also served as a member of the Federal Health Committee of the American Academy of Actuaries (AAA), as vice chairperson of AAA's uninsured work group, and as a member of the Society of Actuaries project oversight group for research on evaluating medical management interventions. Ms. Lampkin is a fellow of the Society of Actuaries and a member of the AAA. She received her master of public administration from Florida State University.

Sheldon Retchin, MD, MSPH, is professor of medicine and public health at The Ohio State University in Columbus, Ohio. Dr. Retchin's research and publications have addressed costs, quality, and outcomes of health care as well as workforce issues. From 2015 until 2017, he was executive vice president for health sciences and CEO of the Wexner Medical Center. From 2003 until 2015, he served as senior vice president for health sciences at Virginia Commonwealth University (VCU) and as CEO of the VCU Health System, in Richmond, Virginia. Dr. Retchin also led a Medicaid health maintenance organization, Virginia Premier, with approximately 200,000 covered lives. Dr. Retchin received his medical and public health degrees from The University of North Carolina at Chapel Hill, where he was also a Robert Wood Johnson Clinical Scholar.

William Scanlon, PhD, is an independent consultant working with West Health, among others. He began conducting health services research on the Medicaid and Medicare programs in 1975, with a focus on such issues as the provision and financing of long-term care services and provider payment policies. He previously held positions at Georgetown University and the Urban Institute, was managing director of health care issues at the U.S. Government Accountability Office, and served on the Medicare Payment Advisory Commission. Dr. Scanlon received his doctorate in economics from the University of Wisconsin, Madison.

Peter Szilagyi, MD, MPH, is professor of pediatrics, executive vice chair, and vice chair for research in the Department of Pediatrics at the Mattel Children's Hospital at the University of California, Los Angeles (UCLA). Prior to joining UCLA, he served as chief of the division of general pediatrics and professor of pediatrics at the University of Rochester and as associate director of the Center for Community Health within the University of Rochester's Clinical Translational Research Institute. His research has addressed CHIP and child health insurance, access to care, quality of care, and health outcomes, including the delivery of primary care with a focus on immunization delivery, health care financing, and children with chronic disease. From

1986 to 2014, he served as chairman of the board of the Monroe Plan for Medical Care, a large Medicaid and CHIP managed care plan in upstate New York. He is editor-in-chief of *Academic Pediatrics* and has served as the president of the Academic Pediatric Association. Dr. Szilagyi received his medical and public health degrees from the University of Rochester.

Katherine Weno, DDS, JD, is an independent public health consultant. Previously, she held positions at the Centers for Disease Control and Prevention, including senior advisor for the National Center for Chronic Disease Prevention and Health Promotion and director of the Division of Oral Health. Dr. Weno also served as the director of the Bureau of Oral Health in the Kansas Department of Health and Environment. Previously, she was the CHIP advocacy project director at Legal Aid of Western Missouri and was an associate attorney at Brown, Winick, Graves, Gross, Baskerville, and Shoenebaum in Des Moines, Iowa. Dr. Weno started her career as a dentist in Iowa and Wisconsin. She earned degrees in dentistry and law from the University of Iowa.

Biographies of Staff

Kirstin Blom, MIPA, is the contracting officer and a principal analyst. Before joining MACPAC, Ms. Blom was an analyst in health care financing at the Congressional Research Service. Before that, Ms. Blom worked as a principal analyst at the Congressional Budget Office, where she estimated the cost of proposed legislation on the Medicaid program. Ms. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office (GAO). She holds a master of international public affairs from the University of Wisconsin, Madison.

James Boissonnault, MA, is the chief information officer. Prior to joining MACPAC, he was the information technology (IT) director and security officer for OnPoint Consulting. At OnPoint, he worked on several federal government projects, including projects for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonnault holds a master of arts in Slavic languages and literatures from The University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

Caroline Broder is the director of communications. Prior to joining MACPAC, she led strategic communications for Steadfast Communications, working with health policy organizations and foundations to develop and implement communications strategies to reach both the public and policymakers. She has extensive experience working with researchers across a variety of disciplines to translate and communicate information for the public. She began her career as a reporter covering health and technology issues. Ms. Broder holds a bachelor of science in journalism from Ohio University.

Kacey Buderi, MPA, is a senior analyst. Prior to joining MACPAC, she worked in the Center for Congressional and Presidential Studies at American University and completed internships in the office of U.S. Senator Ed Markey and at the U.S. Department of Health and Human Services (HHS). Ms. Buderi holds a master of public administration and a bachelor of arts in political science, both from American University.

Moira Forbes, MBA, is a policy director focusing on payment policy and the design, implementation, and effectiveness of program integrity activities in Medicaid and the State Children's Health Insurance Program (CHIP). Previously, she served as director of the division of health and social service programs in the Office of Executive Program Information at HHS and as a vice president in the Medicaid practice at The Lewin Group. She has extensive experience with federal and state policy analysis, Medicaid program operations, and delivery system design. Ms. Forbes was elected to the National Academy of Social Insurance in 2019. She has a master of business administration from The George Washington University and a bachelor's degree in Russian and political science from Bryn Mawr College.

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