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Reforming Medicaid Reimbursement before the Next Pandemic

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On March 18, Congress enacted the Families First Coronavirus Response Act, the first economic relief bill in response to the pandemic.[1] It mandates that state Medicaid programs cover diagnosis and testing for COVID-19 at no cost to beneficiaries and includes a temporary, conditional 6.2 percentage point increase in federal Medicaid reimbursement rates.[2] This bill is an appropriate response to emergency conditions, during which delivering these necessary health services is the highest priority, while also providing states with desperately needed financial relief. Throughout this crisis, the federal government should do everything within its power to protect the safety of healthcare workers and patients alike, to keep hospitals open, and to compensate medical staff appropriately and in a timely manner.

However, the effectiveness of this temporary reimbursement increase is less than it could or should be, in large part because federal reimbursement rates were already inflated and distorted before the crisis as a result of provisions of the Affordable Care Act (ACA). These provisions have increased the cost of caring for individuals on Medicaid, especially in states that expanded Medicaid coverage to individuals who were ineligible for the program before enactment of the ACA. Before the next crisis hits, the federal Medicaid reimbursement structure needs to be rationalized.

INCENTIVES TO EXPAND MEDICAID

Medicaid has long been designed to provide free and subsidized healthcare coverage to low-income individuals, families and children, pregnant women, elderly individuals, and people with disabilities. The ACA expanded eligibility criteria such that, starting in 2014, state Medicaid programs could extend Medicaid coverage to individuals with higher incomes, without dependents,

and without disabilities. Before enactment of the ACA, states could use waivers to cover childless adults above the poverty line, but they rarely sought such waivers.[3] The ACA incentivized states to cover these individuals by providing far higher reimbursement rates for expansion beneficiaries than for Medicaid's original beneficiaries. An underappreciated consequence of this elevated expansion rate is that the federal government was providing states more generous support for less needy individuals and comparatively less generous support for those who are most vulnerable and in greatest need of care.

The ACA brought about this differential treatment through changes to Medicaid's system of Federal Medical Assistance Percentages (FMAP). These rates are the proportion of each state's Medicaid spending that is funded by the federal government. Before the ACA, states each had their own FMAP that applied to spending on all their beneficiaries without distinction. Each state's FMAP was primarily determined by comparing the average personal income within the state with the national average. Variance in FMAP rates between states was limited by statute so that a state with a lower-than-average per-person income could not have an FMAP exceeding 83 percent.[4]

Before the ACA's Medicaid expansion, the federal share of Medicaid spending generally hovered around 57 percent.[5] After the enactment of the ACA's preferential reimbursement rate for the expansion population, the federal government's share rose to 62 percent of total Medicaid expenditures by 2017, about where it is now and is projected to roughly remain.[6] But this increase in the federal share of total Medicaid spending is matched in importance by the fact that federal reimbursement to states for the expansion population has been made much more generous than for the more vulnerable pre-expansion population.[7]

Under the ACA, expansion states benefited from a 100 percent federal reimbursement rate applied specifically to their Medicaid expansion population,[8] as well as a temporary additional 2.2 percent for all enrollees if the state enacted expansion legislation before the end of 2015.[9] Between 2016 and 2020, the Medicaid expansion FMAP gradually phased to 90 percent, where it is scheduled to stay for the foreseeable future.[10]

CONSEQUENCES OF MEDICAID EXPANSION

The inflated federal reimbursement rates for the expansion population considerably reduce incentives for states to invest in effective eligibility verification systems. The higher rates also deliver additional federal support whenever previously covered individuals are misclassified as newly eligible.[11] An independent analysis suggests that between 18 and 27 percent of the expansion population receiving benefits earns more than the maximum income permitted for Medicaid eligibility.[12]

This federal favoritism toward coverage of the expansion population was problematic and inequitable long before COVID-19 hit. The expansion population is healthier and financially better off

than the original Medicaid population, but the ACA caused the federal government to cover the former much more generously than the latter. Today, the federal government reimburses states 90 percent of healthcare costs under Medicaid for an adult with a minimum-wage job, but only 57 percent for that adult's disabled neighbor with no income. It was already costlier for states to provide care for the disabled person than the able-bodied adult, and this asymmetry has been exacerbated by the more generous federal support for the latter under the ACA.

By admitting a new class of beneficiaries at virtually no cost to the states, the ACA ushered in intentional growth in Medicaid spending. However, flaws in the design of the expansion led to this spending far exceeding previous projections. In 2014, the Centers for Medicare and Medicaid Services (CMS) projected that spending on the expansion population would be less than $4,000 per capita in 2018.[13] By the time of the 2018 report, this number had been revised upward to more than $6,000 per capita.[14]

In addition to these problems of financial stewardship, the ACA's differential reimbursement rates also shift resources away from those who need it the most. To understand why, recall that fewer providers accept Medicaid compared with other insurance types—70.8 percent for Medicaid compared with 85.3 percent for Medicare and 90 percent for private insurance.[15]

The ACA's Medicaid expansion added beneficiaries to the rolls without providing for increases in health system capacity. The ACA did include a temporary increase in physician fees under Medicaid, but that increase ended at the end of 2014.[16] This combination of more beneficiaries with long-standing supply limitations inevitably leads to longer wait times and other disruptions in access to care.[17] The resulting disruption of access has reinforced a tendency for patients to seek treatment from urgent care services instead of primary care doctors, which is more costly and increases patients' exposure to diseases in hospitals.[18] It is thus unsurprising that the ACA's Medicaid expansion has been identified as a primary cause of a shortage in "the supply of primary care physicians in some areas of the country relative to the demand."[19]

The recently enacted temporary 6.2 percentage point increase in the FMAP applies to the original Medicaid population and not to the expansion population.[20] This policy is designed to neither reward nor penalize states for their expansion decisions. However, it also signifies that the ACA's inflated expansion match rate leaves the federal government less room to offer additional aid wherever it is being used. Simply put, wherever FMAP rates have been pushed up by the ACA's inflated match rate, the federal government is no longer in a position to offer much additional help in a time of crisis.[21]

TOWARD A FAIRER POST-PANDEMIC FMAP

Once the crisis ends, FMAPs are scheduled to fall back to their former levels, restoring the recent relative disadvantage of Medicaid's pre-expansion population compared with the favored expansion population. When the United States is again at that point, lawmakers should review the current FMAP rate structure to make it more sustainable and equitable; this review will ensure that Medicaid is in a better position to respond when the next crisis hits. A fair FMAP going forward would reimburse states at the same rate for all Medicaid beneficiaries.

The COVID-19 crisis will leave millions of Americans in a dire financial position. In 2018, 55.1 percent of the US population received healthcare coverage through an employer.[22] With unemployment claims at a historical high as a result of the crisis, many are losing their health insurance. This change is expected to lead to a natural increase in the number of individuals eligible for Medicaid. It will be important to reform Medicaid to preserve access to timely care for those in greatest need.

Instead of paying a 90 percent reimbursement rate for the ACA expansion population and an average 57 percent rate for Medicaid's most vulnerable participants, it would be more equitable for the federal government to reimburse the states at the same rate for everyone—which, under current projections, would be 62 percent on average, with the specific percentage varying by state.

Equalizing Medicaid's reimbursement rate across populations would not address Medicaid's larger problems of cost growth and financial stability, for it would leave average federal reimbursement rates exactly where they are now. It would, however, remove inequities from the current match formulas and better position Medicaid to serve the most vulnerable Americans in the next crisis.

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NOTES

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