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States, Medicaid, and Economic Hard Times

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Table of Contents

Introduction

The COVID-19 pandemic has had an unprecedented impact on America. COVID has impacted public health, the economy, health coverage, and state budgets. State Medicaid programs sit at the intersection of many of these challenges. As Baumgarten and Hempstead (2020)[1] note, the Medicaid program is inherently countercyclical, in that the demand for the program increases as the economy gets worse. Unfortunately, states' budgets and their ability to fund the Medicaid program are cyclical. In other words, when people have the greatest need for the Medicaid program, a state's ability to pay for Medicaid is weakest.

Medicaid is part of the social safety net, with a goal to ensure that individuals lacking income can still receive needed health care. Prior to the Affordable Care Act (ACA) of 2010, many states did not offer Medicaid coverage to low-income childless adults and offered limited coverage to low-income parents. That led to a muted relationship between the change in Medicaid enrollment and changes in the unemployment rate. The current recession is the first true test of the new ACA-based insurance safety net, and evidence to-date suggests that this recession has led to the largest and fastest Medicaid enrollment change in history.

This analysis will examine two crucial questions: 1) how much strain will state Medicaid budgets be under over the next few years and 2) what types of state characteristics and what types of policy options will allow states the ability address budgetary challenges.

Overall, our analysis arrives at the following conclusions:

1. State budgets are bad now, and could continue to deteriorate
    - While states are seeing significant increases in Medicaid enrollment, the associated new spending will largely be covered by increased federal matching funds during the public health emergency (PHE). While the long-term impact on projected Medicaid enrollment is likely to be moderate, the more significant budget pressure will likely be the result of decreased state tax revenues.
2. States have limited ability to reduce budgetary shortfalls
    - Environmental factors, or factors outside of a state's immediate control, have a far greater impact on a state's Medicaid spending than policy choices under a state's control. Absent additional federal support, states are likely to be left with few options to address ongoing budget challenges.
3. Federal decisions will matter

[1] https://www.healthaffairs.org/do/10.1377/hblog20200908.169117/full/

- The duration of the federally declared PHE will have profound impacts on 2021 state budgets.

4. Long-term federal help is likely needed

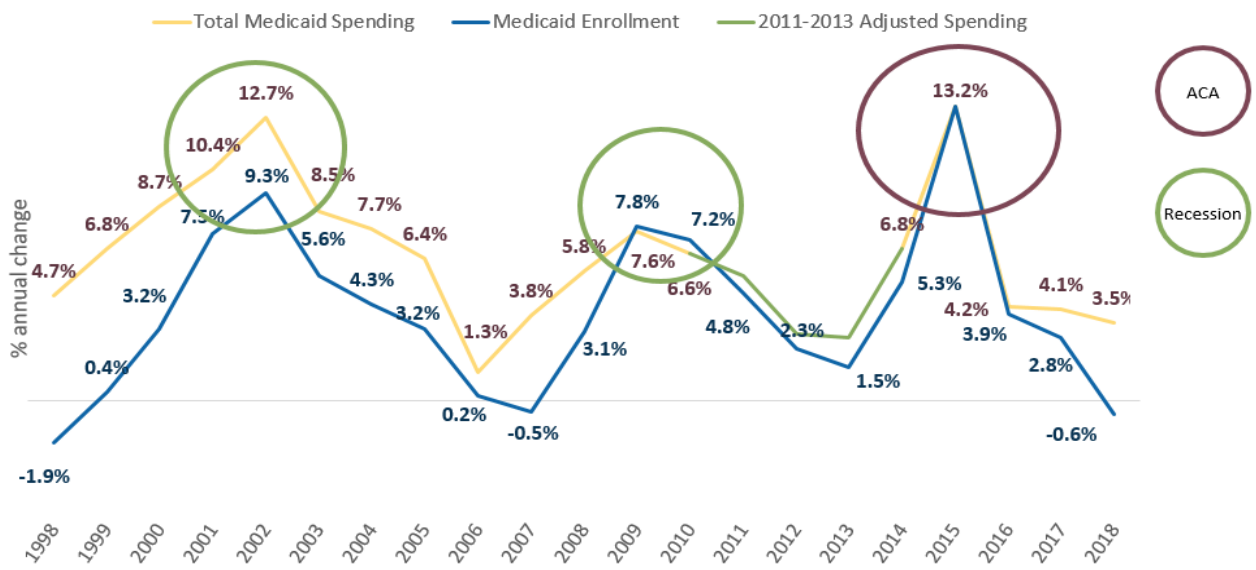
    - Without additional federal funds, states are likely to confront a situation in which they will need to rapidly reduce and restrict Medicaid enrollment and/or adjust provider payment levels and member benefits or face dire budget considerations once the PHE ends.

HMA and Wakely worked collaboratively to analyze the available data and model the impact of the various economic factors and federal and state policy decisions described in this report. Additional information regarding each entity's role is included at the end of this report.

The Economy and Medicaid Enrollment

Medicaid is a countercyclical program that historically experiences rising enrollment and spending during economic downturns, as illustrated in Figure 1. These increases in spending can significantly strain state budgets, which already face significant revenue reductions during these periods.

Figure 1: Annual Change in Medicaid Expenditures and Enrollment, 1998-2018

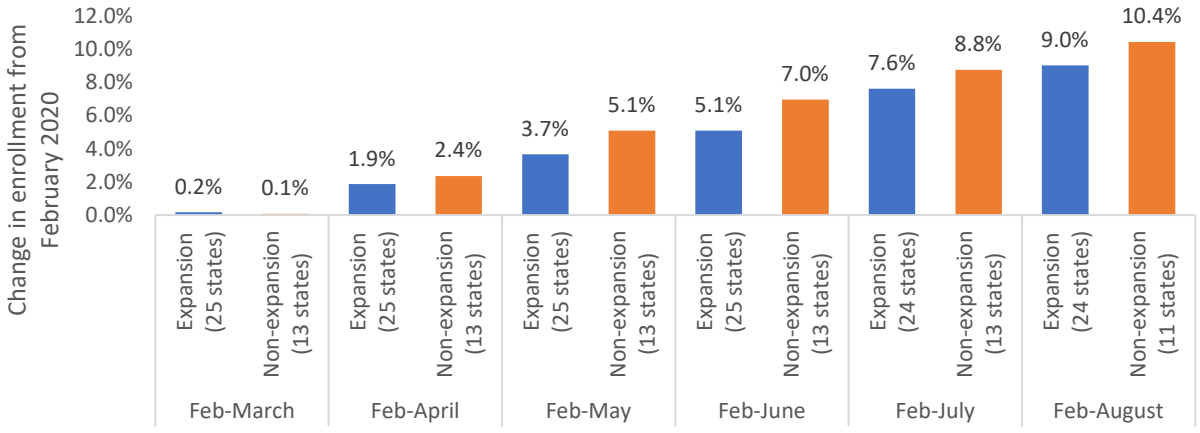


Source: CMS-64 Spending Reports; CMS Monthly Enrollment & Eligibility Reports; Kaiser Family Foundation; HMA

To support Medicaid and provide fiscal relief to states during the current economic downturn driven by the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA),[2] amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act,[3] authorized a 6.2 percentage point increase in the Federal Medicaid Assistance Percentage (FMAP)[4] for states that meet certain maintenance of effort (MOE) requirements. The enhanced FMAP was applied retroactively to January 1, 2020, and extends through the end of the quarter in which the PHE ends. To qualify for the enhanced funds, states must maintain coverage for current enrollees and may not increase premiums or make eligibility standards, methodologies, or procedures more restrictive than those in place as of January 1, 2020.

Since the beginning of the COVID-19 pandemic, national Medicaid enrollment has grown by **has grown by more than 10 percent, driven largely by the FFCRA MOE requirements.** While a portion of the enrollment increase since March 2020 can be attributed to new Medicaid applicants who gained Medicaid eligibility as a result of the pandemic, a larger share is likely a result of the MOE requirement that prevents states from terminating Medicaid eligibility for any enrollee during the PHE, eliminating the normal enrollment "churn" that occurs when states conduct eligibility redeterminations. Current enrollment growth for non-expansion states exceeds growth in states that have adopted the ACA Medicaid expansion (Figure 2), generally consistent with differences in pre-pandemic disenrollment rates. Prior to FFCRA, states that had adopted the ACA Medicaid expansion terminated eligibility for approximately 2 percent of their members every month while non-expansion states disenrolled closer to 3 percent per month.

Figure 2: Medicaid Enrollment Growth since February 2020, Expansion vs. Non-Expansion States

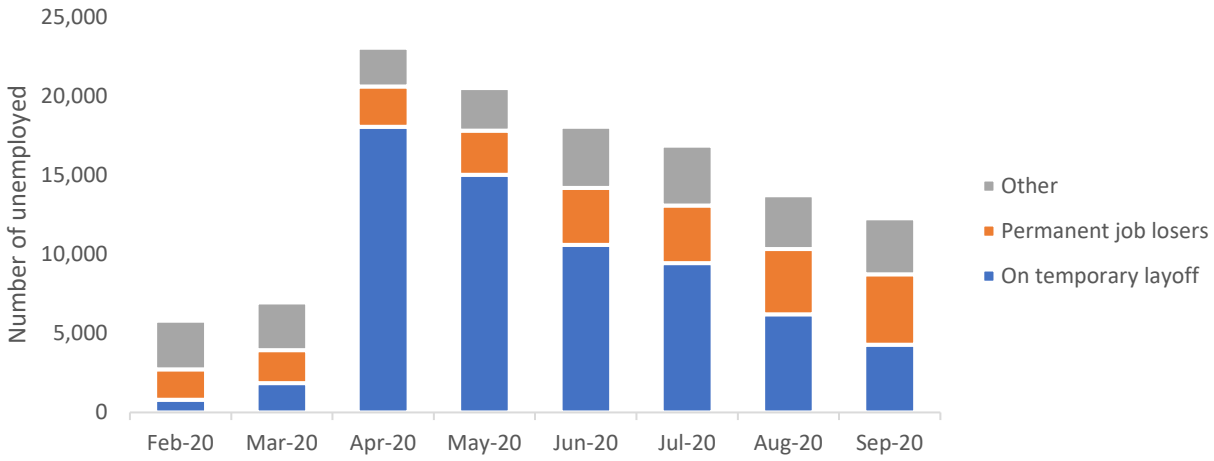


Source: HMA tracking of 38 State monthly enrollment reports

[2] Pub. L. 116-127 (March 18, 2020), https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf.
[3] Pub. L. 116-136 (March 27, 2020), https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf.
[4] FMAP = Federal Medical Assistance Percentage

Although unemployment rates have dropped since the early months of the pandemic, many states could see continued growth in new Medicaid applicants for the through the first quarter of 2021. In April and May of 2020, most unemployed individuals reported being on a temporary layoff (Figure 3), and therefore may not have had an incentive, or felt the need, to apply for Medicaid. In more recent months, a larger share of unemployed individuals report permanent job loss as opposed to temporary layoff, suggesting that states might expect to see continued growth in new Medicaid applicants for the through the first quarter of 2021 even as unemployment rates improve.

Figure 3: Reason for Unemployment During COVID-19 Economic Crisis



Source: U.S. Bureau of Labor Statistics Monthly Jobs Reports

Medicaid Enrollment Projections

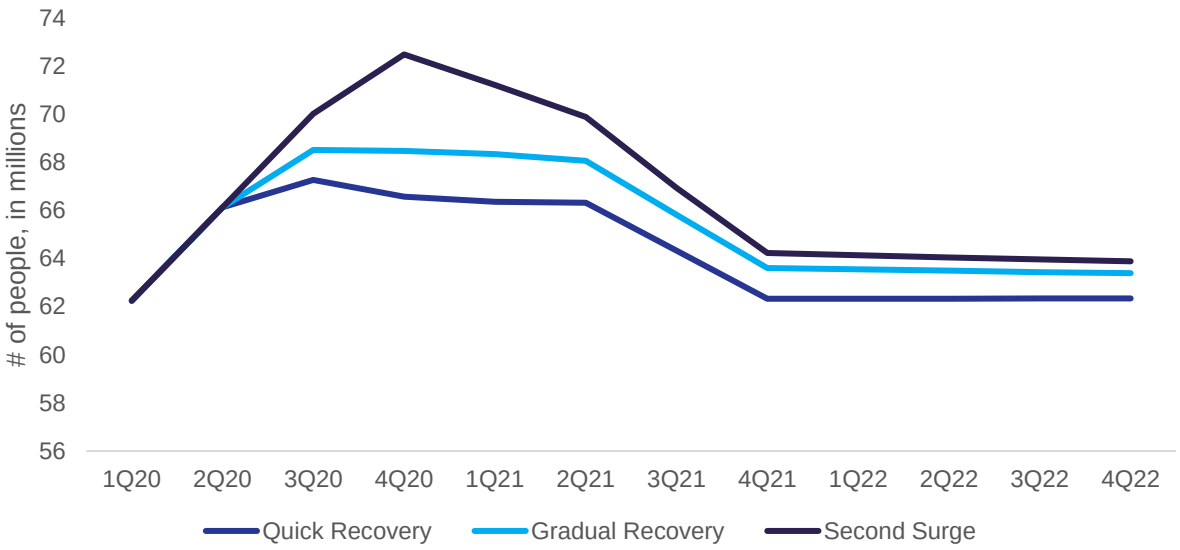
Overall there are two key factors that will influence Medicaid enrollment over the next several years. The first is when the PHE ends and Medicaid redeterminations resume, although the pace of redeterminations will vary by state. The FFCRA MOE prohibition on involuntary Medicaid disenrollment extends through the end of the PHE, which has currently been renewed through January 21, 2021. At that time (or at a later date, if the PHE is further renewed), all states will face a backlog of redeterminations to process but will also need time to unwind the eligibility system and process changes made to comply with the FFCRA MOE requirements. The second factor influencing Medicaid enrollment over the next several years is the overall state of the economy, particularly the nature of the jobs recovery. The slower the recovery, the longer Medicaid enrollment will remain high.

We explored three potential recovery scenarios to explore how Medicaid enrollment might change within each state and nationally. For modeling purposes, we also assumed the PHE would remain in effect until June 2021.

- **Quick Recovery Scenario** - Under a quick recovery, where the vast majority of jobs have returned by the end of 2020, we estimate that Medicaid enrollment will generally stabilize and then drop rapidly once the PHE is lifted.
- **Gradual Recovery Scenario** - In a more gradual recovery, where jobs slowly come back and reach pre-pandemic levels by the end of 2024, we estimate that enrollment will remain elevated after the PHE for several years.
- **Second Surge Scenario** - If the economy slows in the first quarter 2021, we estimate higher sustained total Medicaid enrollment.

Figure 4: Projected Medicaid Enrollment under Various Employment Recovery Scenarios

Note: excludes individuals enrolled in both Medicare and Medicaid



As can be seen above, under all scenarios, enrollment is above pre-pandemic enrollment throughout most of 2021, dropping to relatively stable levels beginning in the fourth quarter of 2022, with the absolute level of enrollment in each scenario dependent on the pace of the recovery. As mentioned previously, increased enrollment is highly predictive of increased Medicaid spending (and, therefore, state costs). Given the likelihood of ongoing financial pressures, how are state budgets positioned to weather the increase in costs?

The Economy and State Budgets

The economic slowdown caused by the pandemic has had a profoundly negative impact on state revenue collections leading virtually all states to forecast budget shortfalls for the current and upcoming fiscal years. Most states rely heavily on individual income and sales taxes to fund their state budgets, and both of these revenue sources have been severely impacted by the economic downturn and associated increases in unemployment. States have projected an average FY 2021 state revenue decrease of more than 10 percent, with five of the six largest states by population — California, Texas, [5] Florida, New York, and Illinois — all reporting FY 2021 revenue shortfalls of 10 percent or greater.[6] To put these shortfalls into perspective, Table 1 compares 2019 general fund spending for the five states with estimates from Moody's Analytics and as reported by the states. These projected revenue shortfalls are extraordinary in comparison to revenue drops in past recessions.

[5] Texas reflects biennium shortfall.
[6] National Conference of State Legislators (NCSL*), Coronavirus (COVID-19): Revised state Revenue Projections,* September 10, 2020; accessed at: https://www.ncsl.org/research/fiscal-policy/coronavirus-covid-19-state-budget-updates-and-revenue-projections637208306.aspx

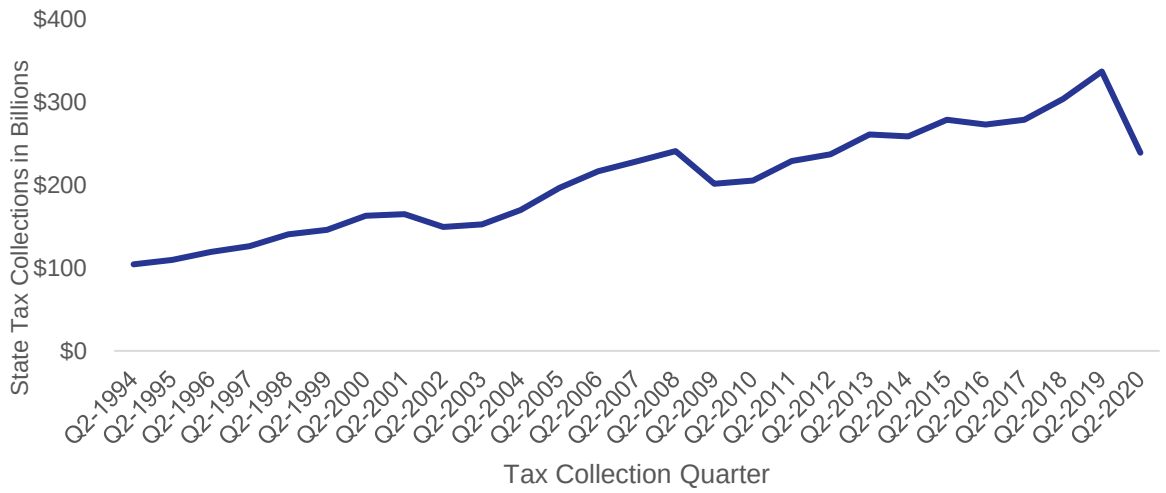
Table 1: Projected State General Fund Revenue Impacts for Selected States *(dollars in millions)*

State	General Fund 12 mo. Spend (estimated 2019)	General Fund Tax 12 mo. Impact (Moody's March 2020)	General Fund Revenue Impact (NCSL accessed October 2020)
California	$ 142,693	$ (26,124)	$ (42,000)
Texas	$ 52,054	$ (11,988)	$ (14,297)
Florida	$ 32,849	$ (8,138)	$ (3,400)
New York	$ 72,783	$ (23,823)	$ (14,516)
Illinois	$ 35,678	$ (6,920)	$ (4,233)

Source: Moody's March 2020 Report; HMA Tracking

Figure 5 further illustrates the profound state revenue decrease that began in the second quarter of 2020 — the largest second quarter drop in at least 25 years.

Figure 5: Second Quarter State Tax Collections, 1994-2020



Source: U.S. Census Bureau Quarterly Summary of State and Local Taxes

Since almost all states are required to have balanced budgets, in the absence of additional federal fiscal relief, many states are facing the need for tax increases, expenditure cuts, or both. As the second largest component of state general fund budgets behind elementary and secondary education, [7] many states working to balance their budgets will find it difficult to exclude the Medicaid program from required budget reductions.

[7]NASBO - https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2019_State_Expenditure_Report-S.pdf

It is never politically or logistically easy to reduce Medicaid expenditures, especially in a short period of time, and the ongoing effects of the COVID-19 pandemic make the Medicaid cost containment approaches used in past recessions even more challenging to implement and further suggest that future years will warrant attention as well. During the pandemic, the cancellation of elective procedures and utilization decreases for non-urgent care generally have resulted in significant revenue losses for many providers. While most states implemented provider rate cuts in response to the Great Recession, doing so in response to the current economic downturn would add to the financial strain many providers are already experiencing, especially providers that serve a disproportionate number of Medicaid beneficiaries, potentially leading to access concerns. A number of states have increased or are planning to increase selected provider rates to provide some financial relief during the PHE.[8] Nevertheless, many states have already announced or are considering Medicaid provider rate cuts. For example, Colorado, Nevada, and Wyoming implemented across the board provider rate cuts for FY 2021 of 1 percent,[9] 6 percent,[10] and 2.5 percent,[11] respectively. In recognition of the utilization decreases observed early in the pandemic, a number of states have also adjusted their Medicaid managed care organization (MCO) capitation rates or have implemented new risk corridors to limit MCO profits and losses.

In prior recessions, most states also increased their reliance on Medicaid provider taxes and intergovernmental transfers (IGTs) to help finance the state share of Medicaid and may choose to do so again in response to the current downturn. However, because all states (except Alaska) have at least one provider tax in place and many states have more than three,[12] opportunities for further leveraging of these revenue sources may be more limited during the current economic downturn.

Experience from prior recessions also suggests that Medicaid programs frequently take several cycles to show the effects of budget issues. Rate increases and rate restrictions in the previous recession indicated a multiple year effect on the major providers. So, just as the recovery may take some time, state budget and Medicaid cuts could very well be deeper in future years given the number of factors in play, including the federal and state revenue variables, managed care reconciliations, and direct program adjustments to Medicaid.

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[8] https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2020-2021/

[9] Colorado Department of Health Care Policy & Financing, Provider Bulletin B2000450, July 2020; accessed at https://www.colorado.gov/pacific/sites/default/files/Bulletin_0720_B2000450_v2.pdf.

[10] Megan Messerly, *Medicaid pushed ahead with 6 percent rate decrease proposed during budget-slashing session,* Nevada Independent, August 13, 2020; accessed at https://thenevadaindependent.com/article/medicaid-pushes-ahead-with-6-percent-rate-decrease-proposed-during-budget-slashing-special-session.

[11] Jim Angell, *Budget Cuts Could Reduce Medicaid Providers, Wyoming Health Department Says,* Cowboy State Daily, August 31, 2020; accessed at https://cowboystatedaily.com/2020/08/31/budget-cuts-could-reduce-medicaid-providers-wyoming-health-department-says/.

[12] Kathleen Gifford et al., *A View from the States: Key Medicaid Policy Changes* (Washington, DC: KFF, October 18, 2019), https://www.kff.org/medicaid/report/a-view-from-the-states-key-medicaid-policy-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2019-and-2020/

Analysis of Key Levers and State Environmental Factors for States

The budgetary impact of COVID-19 on individual state budgets is likely to vary significantly, according to a variety of factors. Some of these factors are environmental (e.g., a state's existing FMAP, expansion status, economic conditions, etc.), others factors are federally driven (e.g., the duration of the PHE), while others are dependent on state policies and decisions (e.g., state approach to member redetermination, changes in state fee schedules or provided benefits). The following sections address some of the key considerations likely to impact state budget situations in upcoming years. In particular, we will examine:

- Timing of the ending of the PHE
- The impact of state FMAP levels
- Medicaid expansion v. non- expansion states
- Changes in enrollment levels and potential changes in member acuity
- State policy choices
    - Redetermination
    - Provider Payment Reductions
    - Other Options

Duration of the PHE and State Characteristics

As noted earlier, FFCRA authorized a 6.2 percentage point increase in the FMAP retroactive to January 1, 2020, and extending through the last day of the calendar quarter in which the PHE terminates. As of this writing, the timing for the end of the PHE is highly uncertain. While the additional FMAP funding available through FFCRA is not likely to fully offset the budgetary challenges faced by states due to the pandemic, the additional funding does significantly dampen the adverse impacts that states will experience during the pandemic. However, the medium-term health of state budgets will be significantly impacted by the duration of the PHE and associated FFCRA funding.

One key question is what happens when the PHE and resulting additional federal funding ends. The table below provides an illustrative scenario of how the enhanced FMAP impacts two theoretical states. For purposes of this illustration, State A is a non-expansion state with a 70

percent FMAP for traditional Medicaid populations, while State B is an expansion state with a 50 percent traditional FMAP.[13] This example assumes no increase in enrollment.

Table 2 – Illustrative Impact of Enhanced FMAP by Traditional FMAP and Expansion Status[14]

	State A		State B		
	Non-Expansion Costs	Expansion Costs	Non-Expansion Costs	Expansion costs	Total Costs
Programmatic Cost Distribution	100.0%	0.0%	70.0%	30.0%	100.0%
Pre-FFCRA FMAP	70.0%	n/a	50.0%	90.0%	62.0%
State Funding Liability	30.0%	n/a	50.0%	10.0%	38.0%
State Funding Liability w/ FFCRA[15]	23.8%	n/a	43.8%	10.0%	33.7%
% Change in State Liability	-20.7%	n/a	-12.4%	0.0%	-11.4%

As shown in Table 2, the enhanced FFCRA funding represents a 20.7 percent reduction in non-expansion population state expenditures for a state with a traditional FMAP of 70 percent (State A). At 12.4 percent, the reduction in non-expansion population state expenditures is significantly lower for a state with a traditional FMAP of 50 percent. This differential is driven by the disparate initial state funding between States A and B (e.g., State A covers 30 percent of the cost of their non-expansion population, while State B covers 50 percent).16 In the illustration above, State B is also an expansion state. Expansion population FMAP funding is 90 percent as of 2020, and this percentage is not subject to the 6.2 percent enhanced FMAP provided by FFCRA. As a result, the proportional impact of the FFCRA enhanced funding is further diluted for State B since their Expansion costs are unchanged under FFCRA.

In total, State A can expect the enhanced FFCRA funding to reduce expenditures by 20.7 percent during the PHE, while State B receives a proportionally smaller benefit of 11.4 percent. While this structure provides a greater proportional benefit to State A during the PHE, State A

[13] FFY 2021 FMAP percentages vary by state, ranging from 50% to nearly 78% (https://www.govinfo.gov/content/pkg/FR-2019-12-03/pdf/2019-26207.pdf)
[14] The FMAP represents the portion of costs that are borne by the federal government, while individual states are responsible for the complement percentage (i.e., a FMAP of 70% indicates the state is liable for 30% of costs, which we have referred to as "State Funding Liability" in Table X). Expansion population FMAPs are 90%, and are not impacted by the enhanced FMAP under FFCRA.
[15] "State Funding Liability w/ FFCRA" is calculated as one less the enhanced FMAP percentage. In the case of State A, this is 1 – (70% + 6.2%) = 23.8%. This figure represents the proportion of programmatic costs that will be borne by the state during the PHE.
[16] (30% - 6.2%) / 30% - 1 = -20.7%; (50% - 6.2%) / 50% - 1 = -12.4%

will also face a more significant reduction in federal funding at the conclusion of the PHE. As a result, State A's budget is likely to be more sensitive to the duration of the PHE. While the above example is illustrative, it does highlight that, all things equal, states that have not expanded their Medicaid program have received a proportionally larger benefit from the enhanced FMAPs and consequently will have proportionally larger changes to their budget when the PHE ends compared to states that have expanded their Medicaid programs. Given the enrollment increases driven in large part by the halt to disenrollments associated with eligibility redeterminations, there will be increases in spending that offset some or all of the decrease in effective state match. Nonetheless, the point remains that non-expansion states and those with higher FMAPs will experience a proportionally greater impact when the enhanced FMAP goes away.

Given that the ending of the PHE could have major impacts on state budgets, especially in non-Medicaid expansion states or states generally with lower state matching rates, what are some policies states could employ to reduce budget strain?

Changes in Medicaid Enrollment and Population Acuity Driven by Redetermination Pause

As indicated in Figure 2, Medicaid enrollment has increased more than 10 percent during the pandemic due to a combination of states pausing redetermination activities and a worsened economy resulting in higher unemployment (and by association, Medicaid enrollment), with the former cohort having a larger impact on programmatic enrollment levels than the latter.

While the additional enrollment associated with each of these cohorts will certainly increase total Medicaid costs, it is possible that they will also reduce per-member costs relative to baseline levels. In general, members who lapse due to redetermination may be expected to have a lower average cost than other individuals enrolled within the same population group. This is due to a number of contributing factors, which may include members becoming employed and losing Medicaid eligibility (which suggests a certain level of functional health) and the healthiest enrollees disproportionally choosing not to go through the redetermination process even if they may be likely to be deemed eligible. Similarly, individuals who become eligible due to job loss associated with a worsening economic environment may be healthier than average due to their functional ability to work.

State Policy Decisions

States appear to have relatively few tools to limit Medicaid expenditures in light of expansive pandemic-related budgetary challenges. The following sections explore some Medicaid-related policy options that states may consider to partially offset the significant budget-related challenges arising from the pandemic.

APPROACH TO MEMBER REDETERMINATION

One policy decision under state control is how quickly states undertake member redeterminations after the PHE period ends. Individual states' approaches to redetermination at the conclusion of the PHE are likely to impact how quickly enrollment levels decline, which will have a downstream impact on the state's budget (i.e., less enrollment results in lower Medicaid expenditures). While the variance in states' approaches to member redetermination at the conclusion of the pandemic will impact their budgetary situations, restarting redeterminations is unlikely to be a panacea for their budget challenges, particularly if the redetermined members exhibit a lower acuity than the overall Medicaid population.

CHANGES TO MEDICAID FEE SCHEDULES OR MEMBER BENEFITS

In light of the budgetary challenges posed by the pandemic, states may choose to modify their fee schedules to reduce payments to providers, thus reducing state expenditures. While some states have enacted fee schedule changes in relatively narrow circumstances, the ability of such changes to materially reduce state expenditures are limited. Many providers have experienced dampened utilization during various stages of the pandemic, and states may find it impractical to reduce provider payments during this difficult economic time. Additionally, any provider payment reductions primarily reduce federal expenditures – this is particularly true during the pandemic due to increased state FMAPs under FFCRA.

States may also consider adjusting member benefits to reduce costs. Such actions would presumably be limited in scope, as various Medicaid benefits are federally mandated, others may be required by state statute, and others likely cannot be practically removed (for example, pharmacy benefits). Similar to fee schedule changes, adjustments to member benefits are not particularly cost efficient from a state perspective, as the bulk of the benefit would accrue to federal expenditures.

Modeling of Variables on Programmatic and State Costs

We developed a model to evaluate the potential impact of the various items discussed above on CY 2020 and CY 2021 state Medicaid expenditures, and by extension, state budgets. The modeling estimated monthly state and federal expenditures for January 2020 through December 2021 and allowed for testing of numerous scenarios to evaluate the relative impact of the various input variables.[17] The table below summarizes the variables included in our modeling as

[17] Our modeling allowed for the evaluation of various state-specific characteristics (FMAP levels, expansion/non-expansion, enrollment levels, approach to member redetermination, potential state policy changes) along with environmental factors largely outside of states' control (duration of the PHE, economically-driven enrollment changes, potential changes in population acuity).

well as the relative impact of each on calendar year 2020 and 2021 state Medicaid expenditures.

Table 3 – Summary of Modeled Variables on CY 2021 State Medicaid Expenditures

Category	Variable	Modeled Impact
Environmental	Existing state non-expansion FMAP	Significant
Environmental	State expansion status	Significant
Environmental	Monthly member redetermination impact during pre-pandemic period	Significant
Environmental	Emerging economic conditions and associated new enrollees to Medicaid	Moderate
Environmental	Acuity of non-redetermined members and new Medicaid enrollees	Minor to Moderate
Federal	Duration of the PHE	Most significant individual driver
State Policy	Approach to member redetermination following PHE	Minor to Moderate
State Policy	Fee schedule changes	Minor to Moderate
State Policy	Adjustments to provided benefits	Likely Minor

Below is a summary of the key CY 2021 budgetary findings associated with each modeled variable:

Existing State non-expansion FMAP

Our modeling indicates that all else equal, a state's pre-pandemic FMAP for non-expansion populations had a significant impact on its expected CY 2021 budget status under the various modeled scenarios. As indicated in Table 2, states with higher pre-pandemic FMAPs receive a proportionally larger benefit under FFCRA, a benefit that will last through at least March 2021. The longer the PHE lasts beyond this timeframe, the greater the budgetary benefit that will accrue to all states, particularly those with higher pre-pandemic FMAPs.

State expansion status

We found that state expansion status had a significant impact on expected state-level budgetary variance in our modeled scenarios. Because expansion populations (which do not receive a higher FMAP under FFCRA) are expected to represent a significant proportion of PHE enrollment increases, the federal relief provided to expansion states during both CY 2020 and CY 2021 will be proportionally smaller than for non-expansion states. Similarly, expansion

states are likely to have larger excess enrollment at the conclusion of the PHE that will need to be processed through redetermination activities.[18] In general, we found that while non-expansion states will face larger budgetary adjustments when the PHE ends (due to the loss of a proportionally larger enhanced FMAP), overall, expansion states are likely to face greater budgetary challenges during CY 2021 as the result of increased expansion population enrollment during a significant portion of this period.

Monthly member redetermination impact during pre-pandemic period

Our modeling suggests that the monthly percentage of members that a state removed due to redeterminations prior to the pandemic is likely to have a significant impact on a state's budgetary status during CY 2021. This is because states that typically remove a higher percentage of members due to redeterminations are likely to experience larger enrollment growth during periods where redetermination activities are foregone.[19]

As a result, we found that states with higher pre-pandemic levels of disenrollment due to redeterminations are likely to face larger budgetary challenges during CY 2021, as their enrollment is likely to grow more materially during the PHE than states that typically remove lower proportions of members due to redeterminations during non-PHEs.

Emerging economic conditions and associated new enrollees to Medicaid

The available data suggests that the volume of economic joiners represents a minority of the increased Medicaid enrollment observed nationally (with the lack of disenrollments due to redeterminations representing the larger share of enrollment gains).

Our modeling suggests that the ongoing rate of new Medicaid enrollment has the potential to significantly impact state budgets during CY 2021. States are likely to face greater budget challenges under scenarios if levels of new enrollees increase beyond volumes observed to date during the pandemic.

Acuity of non-redetermined members and new Medicaid enrollees

It is possible that emergency-period Medicaid enrollees will exhibit lower per-member costs than would have been anticipated absent the pandemic. Whether the additional enrollment exhibits

[18] As previously noted, non-expansion states have experienced proportionally larger enrollment increases since the beginning of the pandemic. However, expansion states have experienced larger total enrollment increases due to higher pre-pandemic enrollment levels resulting from Medicaid expansion.
[19] e.g., the difference between a typical monthly redetermination of 3% and an PHE impact of 0% is larger than the corresponding impact for a state that typically only redetermines 1% of its members each month

lower acuity, and the magnitude of that lower acuity, has the potential to materially impact programmatic costs and CY 2021 state budget status.

Our modeling indicates that lower member acuity has the potential to moderately reduce programmatic costs (relative to no acuity change) but that the impact is considerably smaller than many of the previously discussed variables. In general, our modeling found that assumed changes in acuity were likely to have a greater downward impact on expenditures in expansion states, as Medicaid expansion populations were likely to exhibit larger acuity shifts than some non-expansion populations such as Aged, Blind, and Disabled and Long-Term Services and Supports.

Duration of PHE

Our modeling suggests that the duration of the Federally-declared PHE is likely the single most significant variable impacting state Medicaid expenditures during CY 2021. The enhanced FMAP has a significantly favorable impact on state expenditures for both non-expansion and expansion states. Each additional CY 2021 quarter of enhanced federal funding has a materially favorable impact on estimated state budgets for this period, making the duration of the PHE a key variable in estimating CY 2021 state budget status.

Approach to member redetermination following PHE

A state's approach to redetermination activities following the end of the PHE (i.e., how quickly the activities are resumed and how rigidly they are applied) has the potential to notably impact CY 2021 state budgetary status. All else equal, states that more quickly resume redetermination activities to address elevated enrollment levels are likely to experience more favorable budgetary situations during CY 2021.

The effect of post-PHE redetermination activities may also be significantly impacted by employment rates affected by the rate of economic recovery. The deterioration of economic conditions relative to the pre-pandemic environment may result in very low volumes of Medicaid members experiencing improved incomes during this period. As a result, states may experience a lessened impact of redetermination following the end of the PHE despite their increased Medicaid rolls.

Fee schedule changes

We modeled various fee schedule changes to evaluate the impact on CY 2021 state budget status. In general, the impact of such adjustments is relatively straightforward (i.e., a 2 percent reduction in provider payments will generally reduce state expenditures by around 2 percent). The impact of these adjustments on state budgets are largely dependent on the level of fee schedule adjustment applied. Given the challenging current economic environment, we

anticipate that fee schedule changes will have a minor to moderate impact on most states that choose to pursue them.

Adjustments to provided benefits

Similar to fee schedule changes, we anticipate that changes in provided benefits will likely not be a game-changer for many states in limiting their expenditures during the pandemic. In general, we anticipate such changes to have a minor impact on state expenditures due to various federal and state requirements on offered benefits, and due to the challenges associated with reducing member benefits during a difficult economic period.

Conclusion

The COVID-19 pandemic, accompanying economic slowdown, and federal efforts to support the health care system and the economy have created a complex set of dynamics affecting state Medicaid programs. The economic slowdown has caused many states to predict budget shortfalls at least for the current fiscal year and potentially into the future. These projected shortfalls are on a scale rarely seen before. Most states are required to balance their budgets, and all states will likely be hesitant to raise taxes in a recession. These dynamics, combined with Medicaid's status as one of the largest state expenses, suggest it is likely that states will seek to find ways to reduce Medicaid spending.

State Medicaid enrollment is up significantly since the beginning of the pandemic, but contrary to what one might expect, it does not appear to be primarily driven by individuals losing their jobs and the employer sponsored insurance that came with them. Rather, the majority of the increased Medicaid enrollment appears to be due to the halt in disenrollments based on eligibility redeterminations included as a requirement for accepting the enhanced FMAP authorized through FFCRA. In many states, the enhanced FMAP will likely be adequate to cover programmatic costs associated with increased enrollment for the duration of the PHE, which is likely to be extended at least into the middle of 2021.

Interestingly, we find that states that expanded Medicaid under the ACA and those that did not are experiencing significantly different levels of increased enrollment. Expansion states are seeing lower levels of enrollment growth due to stopping disenrollment compared to non-expansion states, but they also proportionally benefit less from the enhanced FMAP since it only applies to traditional Medicaid spending and not Medicaid expansion expenditures. Under slower recovery scenarios, enrollment levels will still fall, but will remain elevated compared to pre-pandemic levels throughout 2021 and 2022, requiring higher state Medicaid expenditures during these periods compared to pre-pandemic levels. Whatever the pace of recovery, some new applicants will likely be those who initially thought their job loss would be temporary but eventually come to acknowledge that they are, in fact, permanent.

As shown above, the biggest determinants of states' abilities to balance their budgets are outside of their control, namely the ending of PHE and the states' pre-existing Medicaid matching rates (FMAP). While states will have some moderate control over state Medicaid costs, namely through increasing redetermination efforts, they are unlikely to be sufficient to eliminate state budget shortfalls in the near term. Furthermore, increasing redetermination efforts may result in an increase in the number of uninsured. To avoid difficult state-level decisions, the PHE may need to consider state budget challenges in addition to COVID-19 infection rates, or some additional federal funds may be needed as states attempt to transition back to normalcy. Ultimately, if Congress fails to pass another relief bill that includes meaningful fiscal support for states, the states will be left with few good options for reducing Medicaid spending.

HMA and Wakely collaborated to produce this analysis. HMA analyzed and compiled data on Medicaid enrollment growth during the COVID-19 pandemic and developed Medicaid enrollment projections under various employment recovery scenarios. Wakely developed modeling to analyze the potential impact of key variables on state Medicaid expenditures. HMA and Wakely worked collaboratively to analyze the available data, and both entities reviewed all components of this analysis for reasonability.