

MEDICAID

Why and How States Must Review Eligibility



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THE BUCKEYE INSTITUTE

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INTRODUCTION

The national Covid-19 public health emergency ended in May 2023, and as the temporary rules for Medicaid eligibility lapse, states need to take quick corrective steps to remove program enrollees who are no longer eligible for benefits. Medicaid enrollment ballooned during the Covid pandemic in part because federal “maintenance of effort” rules barred states from removing ineligible enrollees as a condition placed on additional federal money. Now that those rules are no longer in place and federal funding contributions taper off, states must purge their Medicaid rolls of ineligible recipients or risk severe fiscal consequences. Implementing automated eligibility reviews, prioritizing redeterminations, and following efficient processes for managing disputes and appeals are good places for states to start.

COVID MEDICAID BACKGROUND

Medicaid is a joint federal- and state-funded program that provides health care coverage to low income and special needs populations. Washington sets broad programmatic rules and the states administer the program, exercising some flexibility with respect to eligibility and benefits. States are reimbursed according to a variable federal reimbursement rate—the federal medical assistance percentage (FMAP). Poorer states receive a higher percentage of FMAP assistance than richer states. Even in normal economic conditions, Medicaid eligibility and the ensuing costs are a chronic problem. The Affordable Care Act (ACA) expanded program eligibility and increased the FMAP to 90 percent for the newly eligible adult recipients. The expansion created incentives for states to incorrectly classify some Medicaid recipients in order to receive a higher match rate. Unfortunately, Medicaid rolls are now filled with beneficiaries who should otherwise be ineligible.¹ Government surveys have found, for example, that six percent of Medicaid recipients were enrolled in multiple states, and 14 percent reported other medical coverage, which means states often pay Medicaid insurers for coverage provided by a different party.² In 2020, Ohio’s state auditor reported that Ohio could save more than \$450 million annually by eliminating improper Medicaid payments.³ Covid-19 made this situation dramatically worse.

At the beginning of the coronavirus pandemic, President Donald Trump signed the Families First Coronavirus Act, which increased the FMAP to 6.2 percent from January 1, 2020, through the then-undetermined end of the national health emergency.⁴ Every state voluntarily accepted the enhanced funding and, in so doing, agreed to follow new federal Medicaid “maintenance of effort” (MOE) rules that prevented states from reducing Medicaid enrollment for the duration of the health emergency. Upon accepting the enhanced federal funds, states agreed: not to adopt Medicaid eligibility requirements more stringent than those in place January 1, 2020; to maintain Medicaid premiums at January 2020 levels; to maintain benefits eligibility for anyone on Medicaid until the end of the month in which the public health emergency ends; and to cover Covid-19 testing and

¹ Brian C. Blasé and Aaron Yellowitz, *The ACA’s Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments*, Mercatus Center, November 2019.

² Joel Zinberg, *Roll It Back*, *City Journal*, April 23, 2023.

³ *Ohio’s Medicaid Eligibility Determination Process*, Ohio Auditor’s Office, November 9, 2020.

⁴ U.S public law 116-127 (2020).

treatment.⁵ Maintaining benefits eligibility for anyone on Medicaid during the pandemic means that current enrollees remain eligible even if their income rises above the normal eligibility threshold.⁶

As the virus spread and government mandates shuttered businesses and restaurants, unemployment spiked nationwide to almost 15 percent—the highest level recorded since World War II.⁷ Without work, incomes plunged and eligibility for government assistance programs including Medicaid skyrocketed. Medicaid rolls swelled in 2020 and have continued to climb since. The MOE rules turned temporary Medicaid beneficiaries into long-term Medicaid participants. Lay-offs may have been temporary as the economy recovered, but the new rules kept re-hired or newly employed workers eligible for Medicaid.

In Ohio, for example, before the pandemic, Medicaid enrollment was declining. From 2019 to 2020, more than 250,000 beneficiaries left Medicaid. The trend quickly reversed when Covid-19 arrived and Ohio Medicaid enrolled almost the same number from March to July. Two years later, Medicaid enrollment has continued to climb to a projected 3.6 million enrollees despite the post-pandemic economic recovery. This 40 percent increase since January 2020, far exceeds the pandemic’s impact on the labor market. And Ohio was not an outlier. Overall, national Medicaid enrollment rose by more than 23 million from February 2020 to March 2023.⁸

⁵ Hannah Eichner, **Top Ten List: Maintenance of Effort Requirement Compliance**, National Health Law Program, June 2020.

⁶ There are some exceptions where a state can terminate Medicaid coverage such as death of an enrollee, enrollee is imprisoned, moves out of state, or request to be removed from Medicaid.

⁷ Unemployment Rate, **FRED Economic Data, Federal Reserve Bank of St. Louis**, (Last visited August 21, 2023).

⁸ Jennifer Tolbert and Meghana Ammula, **10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision**, KFF, April 5, 2023.

Table 1: Growing Number of Medicaid Enrollees⁹

Ohio	Medicaid Enrollees
1/1/19	2,650,556
1/1/20	2,398,039
7/1/20	2,626,131
7/1/21	2,874,387
7/1/22	3,040,264
12/1/22	3,117,798
3/1/23	3,167,340

Contributing to the persistently rising enrollment was the federal government's decision to extend the national emergency for more than three years, during which Washington continued making enhanced FMAP payments, and no state turned down the additional money to escape the MOE restrictions. Federal law enacted in December 2022, ended the MOE and will gradually phase out the enhanced FMAP through 2023. The Biden administration ended the national health emergency on May 11, 2023, and so ended the MOE.¹⁰ Starting July 1, 2023, the enhanced FMAP fell to 2.5 percent, and will fall another 1.5 percent on October 1, 2023. As the FMAP declines, states will receive less federal money per beneficiary, which will make once-ineligible enrollees even more burdensome to states.

⁹ U.S. Centers for Medicare and Medicaid Services, **State Medicaid and Chip Applications, Eligibility Determinations and Enrollment Data** (Last visited August 15, 2023).

¹⁰ Zeke Miller and Amanda Seitz, **President Biden to end Covid-19 emergencies on May 11**, Associated Press, January 30, 2023.

WHY AND HOW STATES MUST REVIEW MEDICAID ELIGIBILITY

As the enhanced federal contributions wind down, states have millions of previously ineligible Medicaid recipients now receiving benefits, but the states will no longer receive the extra federal money to pay for the added \$80 billion in costs.¹¹ This poses a significant fiscal problem for states. The Biden administration recognizes that many Medicaid recipients are currently ineligible and that it will be difficult for states to review recipient eligibility quickly. And although states now have a full year to determine whether a beneficiary is eligible for benefits,¹² the U.S. Department of Health and Human Services (HHS) wants to artificially limit how many eligibility cases states review each month, which is a mistake.¹³

HHS estimates that 8.2 million Medicaid enrollees are only eligible due to the pandemic-related rules.¹⁴ But even that assessment likely underestimates the real number of enrollees because the HHS study assumed a traditional unwinding impact based on previous MOE models. The HHS calculations looked at 2015-2016 as representative of the first half of the Covid-19 health emergency from March 2020 to December 2021.¹⁵ In the latter period, the unemployment rate tripled and then declined to below the March 2020 rate. In the former, the unemployment rate steadily declined. As HHS notes, its projections are based on historical data and does not account for economic differences between the two periods.¹⁶ The national labor market and unemployment rolls have recovered far faster from the Covid-19 emergency than during prior downturns and by the end of the Covid-19 health emergency the national unemployment rate was statistically the same as the pre-pandemic level of 3.5 percent¹⁷ with states seeing record lows of unemployment with many unfilled job openings.¹⁸ This relatively speedy recovery stands in sharp

¹¹ Drew Gonshorowski, Brian Blasé and Niklas Kleinworth, *The Cost of Good Intentions*, The Paragon Institute, July 19, 2023.

¹² Daniel Tsai, **State Health Official letter #22-001**, Center for Medicaid and Chip Services, March 3, 2022.

¹³ Titus Wu, **More than 400,000 Ohioans at risk of losing Medicaid coverages this summer as Covid emergency ends**, *The Columbus Dispatch*, April 18, 2022.

¹⁴ Office of the Assistant Secretary for Planning and Evaluation, **Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Evaluation**, U.S. Department of Health and Human Services, August, 19, 2022.

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ *Ibid.*

¹⁸ Courtenay Brown, **Jobs Boom at the State Level**, Axios.com, July 24, 2023.

contrast to the great recession of 2007 that took eight years for the unemployment rate to return to similar levels.¹⁹ The result: HHS undercounts the number of ineligible enrollees. More accurate Medicaid studies estimate that 9.5 million recipients will be disenrolled from Medicaid and then receive health coverage through their employer, indicating they are working and have other coverage alternatives.²⁰

To address the problem, states can pursue several corrective measures. First, states should automate eligibility review. An automated service can search, sort, and match data quickly to see if enrollees may now be ineligible due to employment or earnings changes. The Ohio Department of Medicaid, for example, expects that more than half of all Medicaid eligibility cases can be determined using the automated method.²¹ The automated process is faster than manual checks and can flag those who need a more detailed case review. Individual case workers who manually contact Medicaid enrollees should be used as a last resort. Caseworkers are slower and more expensive than machines, but they can play a vital role in more nuanced cases and appeals.

Second, states can prioritize Medicaid redeterminations and set prompt but reasonable deadlines for reviews. The Ohio General Assembly asked for a review within 90 days of the end of the national public health emergency²² and gave the Ohio Department of Medicaid \$30 million to help. State legislatures can oversee the process to ensure that taxpayer money is well spent and look for ways to make Medicaid reviews more efficient.

Finally, states should establish a clear process for handling eligibility disputes and appeals. The processes should be fast, transparent, and easy to understand. States should maintain a single office to handle appeals so that the appellate process is efficient, and the state is protected against litigation.²³ Already, a lawsuit has been filed that seeks to halt the redetermination process.²⁴ The lawsuit argue that the

¹⁹ *Ibid.*

²⁰ Matthew Buettgens and Andrew Green, *The Impact of the Covid-19 Public Health Emergency Expiration on All Types of Health Coverage*, The Urban Institute, December 2022.

²¹ Titus Wu, *More than 400,000 Ohioans at risk of losing Medicaid coverages this summer as Covid emergency ends*, *The Columbus Dispatch*, April 18, 2022.

²² *Ibid.*

²³ Dennis Smith and Nina Owcharenko Schaefer, *What States Should Do to Restore Control and Authority over Medicaid When the COVID-19 Public Health Emergency Officially Ends*, The Heritage Foundation, November 30, 2022.

²⁴ Tami Luhby, *Lawsuit seeks to halt Medicaid terminations in Florida*, CNN.com, August 22, 2023.

state's redetermination process was confusing and unclear, and some Medicaid recipients were improperly disenrolled.

CONCLUSION

The U.S. economy and a once-imperiled labor market have recovered from the Covid-19 pandemic faster than most other economic emergencies. That recovery, however, means that many Medicaid recipients who became program-eligible during the pandemic have since returned to work and are likely no longer eligible for benefits. As enhanced federal Medicaid funds dry up, states must quickly conduct eligibility reviews and purge their Medicaid rolls of ineligible members or risk significant financial shortfalls. To do this, states should adopt automated review procedures, prioritize eligibility redeterminations, and implement timely, efficient dispute and appeals processes to protect Medicaid beneficiaries and taxpayers.

ABOUT THE AUTHORS



Rea S. Hederman Jr. is executive director of the Economic Research Center and vice president of policy at The Buckeye Institute. In this role, Hederman oversees Buckeye’s research and policy output.

A nationally recognized expert in healthcare policy and tax policy, Hederman has published numerous reports and papers looking at returning healthcare power to the states, the impact of policy changes on a state’s economy, labor markets, and how to reform tax systems to spur economic growth.

Prior to joining Buckeye, Hederman was director, and a founding member of the Center for Data Analysis (CDA) at the Heritage Foundation, where he served as the organization’s top “number cruncher.” Under Hederman’s leadership, the CDA provided state-of-the-art economic modeling, database products, and original studies.

While at Heritage, Hederman also oversaw the organization’s technical research on taxes, healthcare, income and poverty, entitlements, energy, education, and employment, among other policy and economic issues. He was also responsible for managing Heritage’s legislative statistical analysis and econometric modeling.

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Hederman graduated from Georgetown Public Policy Institute with a Master of Public Policy degree and holds a Bachelor of Arts from the University of Virginia.

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