Center on Budget and Policy Priorities

1275 First Street NE, Suite 1200
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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Build Back Better Legislation Makes Major Medicaid Improvements

By Jennifer Sullivan, Anna Bailey, and Jennifer Wagner

In addition to creating a permanent pathway to coverage for more than 2 million people in the Medicaid coverage gap,[1] economic recovery legislation being considered by the House would strengthen Medicaid and Children's Health Insurance Program (CHIP) coverage for parents and children, people returning to their communities from jails and prisons, and people with disabilities and older Americans who need home- and community-based services. These policies would narrow racial and ethnic inequities in coverage and access to health services and promote long-term health and well-being among Medicaid enrollees at all stages of life.

The package approved by the House Energy and Commerce Committee would:

- Ensure all pregnant people enrolled in Medicaid and CHIP can maintain coverage for 12 months after the end of their pregnancy;
- Provide 12 months of continuous coverage to children and youth enrolled in Medicaid and CHIP;
- Provide Medicaid coverage of health care services for people within 30 days of leaving jail or prison, which could connect them to the care they need in the community;
- Increase access to and quality of Medicaid home- and community-based services (HCBS) and support transitions from institutional settings to the community for seniors and people with disabilities;
- Make the successful Money Follows the Person program and spousal impoverishment protections permanent;
- Make CHIP permanent.

12 Months of Postpartum Coverage Would Improve Maternal Health

The legislation the House Energy and Commerce Committee approved would require that *all* states cover pregnant people enrolled in Medicaid and CHIP for 12 months following the end of a

[1] For more on this provision of the legislation, see Judith Solomon, "Build Back Better Legislation Would Close the Medicaid Coverage Gap," CBPP, September 13, 2021, https://www.cbpp.org/research/health/build-back-better-legislation-would-close-the-medicaid-coverage-gap.

pregnancy. Currently, states are required to provide just 60 days of postpartum coverage. In states that have expanded Medicaid under the Affordable Care Act (ACA), people with incomes up to 138 percent of the federal poverty line remain eligible for Medicaid after their postpartum period ends. However, people with incomes above that threshold often become uninsured. And in states that have not expanded Medicaid, people with much lower incomes lose coverage 60 days after giving birth, and those with incomes below the poverty line have no affordable pathway to coverage, because they are not eligible for subsidized coverage in the ACA marketplaces.

The American Rescue Plan, enacted in March, created a temporary option — which starts in April 2022 and is available for five years — for states to offer up to 12 months of postpartum coverage in Medicaid or CHIP. However, only about half the states have passed legislation or taken other steps to take advantage of this option, and of these, not all would extend coverage for 12 months.[2]

Medicaid plays a key role in financing prenatal and postpartum care. In 2019, Medicaid paid for more than 42 percent of all births in the United States, 65 percent of births to Black mothers, and more than 59 percent of births to Hispanic mothers.[3] Medicaid coverage significantly improves pregnancy-related health outcomes by increasing access to care — particularly during the postpartum period, research shows.[4] Postpartum health coverage is particularly important because life-threatening conditions during and after pregnancy are distressingly common in the United States. People with low incomes and people of color — especially Black people and American Indians and Alaska Natives — are disproportionately likely to face these conditions.[5] Ensuring that all pregnant people enrolled in Medicaid can get a full year of postpartum coverage is an evidence-based strategy to improve maternal and child health and reduce disparities that have driven this country's Black maternal health crisis.

Continuous Coverage for Children Would Reduce Unnecessary Gaps in Coverage

Under the legislation approved by the Energy and Commerce Committee, all states would provide 12 months of continuous eligibility to children enrolled in Medicaid and CHIP, a change from what is now a state option adopted by 23 states for children in Medicaid and 25 states for children enrolled in CHIP.[6] While coverage for all children is authorized for 12 months upon approval of their application or renewal, they may lose benefits during that period if their families experience an

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[2] Wisconsin plans to extend coverage for 90 days and Georgia and Texas for six months. Maine will begin with six months and ramp up to 12 months by July 2023. See "Medicaid Postpartum Coverage Extension Tracker," Kaiser Family Foundation, September 9, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

[3] Joyce A. Martin, Brady E. Hamilton, and Michelle J.K. Osterman, "Births in the United States, 2019," Centers for Disease Control and Prevention, NCHS Data Brief No. 387, October 2020, https://www.cdc.gov/nchs/data/databriefs/db387-H.pdf.

[4] Centers for Medicare & Medicaid Services, "Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health," December 2020, https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-beneficiary-profile.pdf.

[5] Judith Solomon, "Closing the Coverage Gap Would Improve Black Maternal Health," CBPP, July 26, 2021, https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.

[6] Kaiser Family Foundation, "State Adoption of 12-Month Continuous Eligibility for Children's Medicaid and CHIP," as of January 1, 2020, https://www.kff.org/health-reform/state-indicator/state-adoption-of-12-month-continuous-eligibility-for-childrens-medicaid-and-chip.

income change or don't respond to a notice from the Medicaid agency. Keeping children enrolled for the full 12 months increases continuity of care and reduces administrative costs.[7]

Income volatility is particularly common for low-income households. One study tracked low- and moderate-income households over a year and found that on average, their income fell more than 25 percent below average for 2.5 months of the year, and their income rose more than 25 percent above average for 2.6 months.[8] Another study found the majority of individuals in the bottom income quintile experienced more than a 30 percent month-to-month change in total income.[9] These fluctuations often raise family income above the eligibility threshold for some months of the year, putting them at risk of losing Medicaid even though their income has not significantly increased and may soon drop below the eligibility threshold.

In addition to requiring that households report changes in their incomes and other circumstances that may make them ineligible, many states match enrollee information against data sources, usually quarterly wage reports from their state workforce agencies. Though this information is outdated and doesn't include detailed monthly income, many Medicaid agencies flag cases with discrepancies and mail a notice to enrollees requiring information — such as a pay stub or letter from their employer — to verify their ongoing eligibility. Many families don't receive these notices, are unable to gather the required documentation, or don't respond. Children then lose coverage, even though they may remain income-eligible for Medicaid.

Gaps in coverage resulting from income volatility, missed notices, and paperwork requirements lead to higher health care costs due to skipped medications, fewer screenings, or delayed care. Further, many individuals who lose coverage reapply, increasing administrative costs. About half the states have adopted continuous eligibility for children. Making it mandatory would extend the benefits of this policy to all children covered by Medicaid or CHIP.

Providing Medicaid Coverage Would Bolster Efforts to Improve Continuity of Care for People Preparing to Leave Jail or Prison

The legislation would allow Medicaid to pay for health care services for people in jail or prison during their last 30 days of incarceration by partially lifting the statutory exclusion on Medicaid reimbursement for services provided to people who are incarcerated. Medicaid payments would be available for this population one year after the legislation's enactment, giving the Centers for Medicare & Medicaid Services and states time to prepare.

People in jail and prison have high rates of chronic physical and behavioral health conditions but often go without needed health care while incarcerated and return home without adequate access to

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[7] Jennifer Wagner and Judith Solomon, "Continuous Eligibility Keeps People Insured and Reduces Costs," CBPP, May 4, 2021, https://www.cbpp.org/research/health/continuous-eligibility-keeps-people-insured-and-reduces-costs.

[8] Anthony Hannagan and Jonathan Morduch, "Income Gains and Month-to-Month Income Volatility: Household evidence from the US Financial Diaries," U.S. Financial Diaries, March 16, 2015, https://www.usfinancialdiaries.org/paper-1/.

[9] JPMorgan Chase & Co., "Paychecks, Paydays, and the Online Platform Economy," February 2016, https://www.jpmorganchase.com/institute/research/labor-markets/report-paychecks-paydays-and-the-online-platform-economy.

medications or care coordination.[10] Once home, health care often falls by the wayside as people face competing demands, including securing housing, finding work, filling prescriptions, connecting with family, and fulfilling court-ordered obligations. These gaps in care contribute to a litany of poor health outcomes[11] and compound the harmful effects of mass incarceration and the over-policing of people of color, particularly for Black and Hispanic people.[12]

Many states and localities have taken steps to enroll eligible people leaving jail or prison in Medicaid. While states should continue these steps, many people need help beyond enrollment to get care. One solution is "in-reach" services where case managers, clinicians, or peer support professionals visit people in jail or prison to help them prepare to return home.[13] In-reach services enable providers to assess people's health, establish rapport, develop an individualized care plan, and schedule future appointments. But these services are severely underfunded and underutilized.

The reentry provision would give states additional, reliable funding that they could use to expand in-reach and other care coordination services to connect people to community-based health and social service providers upon reentry. These services would be especially beneficial for people with significant behavioral health or chronic physical health conditions.

The services could also connect people to housing and employment resources. People leaving incarceration report that finding work and housing are among their most urgent needs, making it difficult to prioritize their health care.[14] Stable employment and housing greatly improve people's chances of staying out of jail and prison, but people who were formerly incarcerated experience homelessness at nearly 10 times the rate of the general public and face an unemployment rate of over 27 percent.[15]

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[10] Kamala Mallik-Kane and Christy A. Visher, *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*, Urban Institute, February 2008, https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF.

[11] Laura M. Maruschak, Marcus Berzofsky, and Jennifer Unangst, "Medical Problems in State and Federal Prisoners and Jail Inmates, 2011-12," U.S. Department of Justice, Bureau of Justice Statistics, https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf.

[12] Wendy Sawyer and Peter Wagner, "Mass Incarceration: The Whole Pie 2020," Prison Policy Initiative, March 24, 2020, https://www.prisonpolicy.org/reports/pie2020.html; Wendy Sawyer, "Visualizing the Racial Disparities in Mass Incarceration," Prison Policy Initiative, July 27, 2020, https://www.prisonpolicy.org/blog/2020/07/27/disparities/.

[13] See National Reentry Resource Center, "Best Practices for Successful Reentry for People Who Have Opioid Addictions," November 2018, https://csgjusticecenter.org/wp-content/uploads/2020/01/Best-Practices-Successful-Reentry-Opioid-Addictions.pdf.

[14] Kamala Mallik-Kane, Ellen Paddock, and Jesse Jannetta, "Health Care after Incarceration: How Do Formerly Incarcerated Men Choose Where and When to Access Physical and Behavioral Health Services?" Urban Institute, February 2018, https://www.urban.org/sites/default/files/publication/96386/health_care_after_incarceration.pdf.

[15] Lucius Couloute, "Nowhere to Go: Homelessness Among Formerly Incarcerated People," Prison Policy Initiative, August 2018, https://www.prisonpolicy.org/reports/housing.html; Lucius Couloute and Daniel Kopf, "Out of Prison & Out of Work: Unemployment among formerly incarcerated people," Prison Policy Institute, July 2018, https://www.prisonpolicy.org/reports/outofwork.html.

Increased Federal Funding Would Improve Quality of and Access to Home- and Community-Based Services, Support Transitions to Community

The legislation creates a financial incentive for states to improve quality of and access to Medicaid HCBS. First, states could apply to receive planning grants from the Department of Health and Human Services (HHS) to develop robust HCBS improvement plans. After the Secretary of HHS approves a state's plan, the state would get a 7 percentage-point increase in its federal matching rate (FMAP) for Medicaid HCBS. In addition, states would get an 80 percent FMAP for administrative costs associated with implementing the plan, significantly greater than the regular 50 percent FMAP states receive for administrative costs. These financial incentives would be available as long as states meet certain requirements:

- **Maintenance of effort.** Maintain eligibility levels, amount, duration, and scope of Medicaid HCBS, as well as HCBS payment rates that are in place as of the date the state is awarded a planning grant.
- **Enhanced access to services.** Adopt policies to reduce barriers to accessing HCBS; provide coverage for personal care services; adopt "no wrong door" and other policies to streamline HCBS eligibility and enrollment; expand access to behavioral health services; improve coordination between Medicaid HCBS programs and programs focused on employment, housing, and transportation; provide supports to family caregivers; and take other steps to expand Medicaid HCBS eligibility or benefits.
- **HCBS workforce improvements.** Adopt policies to ensure HCBS payment rates are sufficient to provide the care and services described in the state's implementation plan; update qualifications and training opportunities for direct care workers and family caregivers; and review, update, and increase (as appropriate) payment rates for HCBS providers to support workforce recruitment and retention and to ensure that rate increases are appropriately passed through to direct care workers.

This ambitious plan builds on the HCBS investments included in the American Rescue Plan, which made additional federal funding available (also through an FMAP increase) for one year beginning in April 2021 for states to bolster their efforts during the pandemic to help seniors and people with disabilities live safely in their homes and communities rather than in nursing homes or other congregate settings. This funding is helping states shore up HCBS and prevent an erosion of services that could undermine future efforts to expand HCBS to all people who need them.

But even before the pandemic, people already encountered considerable barriers to accessing Medicaid HCBS — which are optional services that states don't have to cover — with over three-quarters of states reporting wait lists for some services, workforce shortages, and lack of affordable, community-based housing.[16] The HCBS provisions in the House legislation would allow states to continue the critical work they are beginning with the Rescue Plan investments and make long-term,

[16] MaryBeth Musumeci, "How Could $400 Billion New Federal Dollars Change Medicaid Home and Community-Based Services?" Kaiser Family Foundation, July 16, 2021, https://www.kff.org/medicaid/issue-brief/how-could-400-billion-new-federal-dollars-change-medicaid-home-and-community-based-services/.

systemic changes to improve access to HCBS, including through unprecedented actions to bolster the direct care workforce, composed primarily of low-income women of color.[17]

The new legislation also makes the Money Follows the Person (MFP) program and Medicaid HCBS spousal impoverishment protections permanent, important improvements that would reduce uncertainty and help more people receive services in their homes or communities.

- **Money Follows the Person:** MFP provides one-time funding to help people transition out of institutions and receive services in the community. Since 2007, MFP has helped more than 100,000 Medicaid beneficiaries who need long-term services and supports transition from institutions back to their own homes and communities.[18] It was most recently extended through September 2023 as part of a 2021 spending bill, but state participation has waned in recent years due to uncertainty about future funding.[19] Making it permanent would provide the stability needed to ensure more people are able to successfully transition from institutions to home- and community-based settings.
- **Spousal impoverishment protections:** These protections, originally enacted in 1988, changed Medicaid eligibility for married couples when one spouse needed care in a nursing home and the other spouse remained at home, to let the spouse at home keep a share of the couple's income and assets to meet their needs when the state decides how much the couple can pay toward nursing home care. States can also apply spousal impoverishment protections to some married couples when one or both spouses receive HCBS, but this state option only applies to one of the multiple pathways that states can use to provide Medicaid HCBS to seniors and people with disabilities.

  The ACA required states to extend spousal impoverishment protections to all married couples receiving HCBS, regardless of their eligibility pathway, but this provision expired in 2018. It has been temporarily extended several times since, but this has created uncertainty for couples when one or both people need services; if the provision is not extended, people could be forced to get care in a long-term care facility rather than at home, depending on state choices.[20] Making spousal impoverishment protections permanent is the best way to avoid further disruption and confusion for beneficiaries and increased work for states, and to continue to address Medicaid's bias toward institutional care.

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[17] Tyler Cromer *et al.*, "Modernizing Long-Term Services And Supports And Valuing The Caregiver Workforce," Health Affairs Blog, April 13, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210409.424254/full/.

[18] Kristie Liao and Victoria Peebles, "Money Follows the Person: State Transitions as of December 31, 2019," Centers for Medicare & Medicaid Services, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2019-transitions-brief.pdf.

[19] MaryBeth Musumeci, Priya Chidambaram, and Molly O'Malley Watts, "Medicaid's Money Follows the Person Program: State Progress and Uncertainty Pending Federal Funding Reauthorization," Kaiser Family Foundation, November 25, 2019, https://www.kff.org/medicaid/issue-brief/medicaids-money-follows-the-person-program-state-progress-and-uncertainty-pending-federal-funding-reauthorization/.

[20] Judith Solomon, "Married Couples With Medicaid Home- and Community-Based Services Could Lose Critical Protections," CBPP, March 13, 2019, https://www.cbpp.org/blog/married-couples-with-medicaid-home-and-community-based-services-could-lose-critical.