

# State Health Reform Assistance Network

Charting the Road to Coverage

A Robert Wood Johnson Foundation program

ISSUE BRIEF

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## Medicaid's Role in Public Emergencies and Health Crises

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### I. Introduction

When it comes to natural disasters and public health crises, it is not surprising—in fact it is expected—that federal agencies such as the Federal Emergency Management Association (FEMA) and the Centers for Disease Control and Prevention step in and help the victims. While less known, the Medicaid program plays a similarly essential role in responding to public health emergencies, epidemics, and natural and man-made disasters. In this issue brief, we describe Medicaid's unique and critical role in responding to events such as the opioid and HIV/AIDS epidemics, the 2001 World Trade Center attacks, the Flint, Michigan lead contamination crisis, and Hurricane Katrina.

Notably, Medicaid's role as a disaster response tool is possible because of its financing structure. Medicaid's current matching rate structure guarantees that the federal government will match state expenditures on eligible individuals for Medicaid benefits, without limitation. This open-ended federal commitment is key to Medicaid's ability to respond quickly to major disasters and public health crises, allowing states to rapidly deploy health care services and emergency health coverage, even as Congress debates providing help through other federal programs. In some instances, Medicaid 'naturally' responds, such as when already-enrolled children in Flint, Michigan began to receive lead testing and treatment through Medicaid after the water disaster was publicly identified (though the state also expanded eligibility to even more affected residents). In other cases, states take advantage of Medicaid's flexibility to modify their programs through state plan amendments (SPA) or waivers that address emerging crises.

In the context of federal legislative proposals that would cap federal Medicaid funding to states in the form of a per capita cap or block grant, it is important to review the role that Medicaid has played in several high-profile disasters and public health crises over the past four decades and to explore whether Medicaid could respond to similar disasters under alternative financing models that limit federal funding to states.

### II. Medicaid's role in public health crises and disasters

This overview begins with the HIV/AIDS epidemic and the central role that Medicaid has played in providing coverage and services to hundreds of thousands of affected people since the 1980s. We then turn to the 2001 World Trade Center attacks, Hurricane Katrina, and the Michigan lead contamination crisis, when Medicaid stepped in almost immediately to provide access to health care services

#### ABOUT STATE NETWORK

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit [www.statenetwork.org](http://www.statenetwork.org).

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for affected populations. Finally, we end with recent examples of Medicaid's role in responding to the national opioid epidemic.

## **MEDICAID AND THE HIV/AIDS EPIDEMIC**

Since the beginning of the HIV/AIDS epidemic in the 1980s, Medicaid has enabled care for hundreds of thousands of people with HIV/AIDS and today is the single largest source of health coverage for people with HIV in the United States.<sup>1</sup> During the early days of the epidemic, when thousands suddenly became sick and lost access to income and commercial health insurance, Medicaid provided a safety net. As the epidemic grew, so did Medicaid's role. By the year 2000, Medicaid covered over 100,000 people with HIV/AIDS, up from 5,300 in 1986. This number expanded to almost a quarter million people (242,000) by 2011, and subsequently, the Affordable Care Act (ACA) allowed many additional low-income people living with HIV to access coverage in states that expanded their Medicaid programs.<sup>2,3</sup>

As the cost of treating HIV has risen over time, Medicaid's matching rate structure has absorbed the expense of life-saving treatments in real time. In 2011, annual per-capita spending on HIV-positive Medicaid beneficiaries was nearly five times that of Medicaid beneficiaries overall; the lifetime cost of care for someone who acquires an HIV infection at age 35 is estimated to be over \$325,000.<sup>4,5</sup> If Medicaid funding were capped, states may find it difficult to sustain their response to the HIV/AIDS epidemic. Without Medicaid expansion, many HIV-positive Medicaid beneficiaries would lose coverage, and would need to rely on alternative programs for care, such as the Ryan White Program and its related AIDS Drug Assistance Program (ADAP). Both of these programs are designed as 'last resort' options, and require congressional reauthorization and annual discretionary appropriations.

## **MEDICAID IN THE AFTERMATH OF DISASTERS AND PUBLIC HEALTH CRISES: 2001 WORLD TRADE CENTER ATTACKS, HURRICANE KATRINA, AND THE MICHIGAN LEAD CONTAMINATION CRISIS**

In the wake of sudden disasters or public health crises over the last two decades, Medicaid has served as a valuable tool to quickly enroll affected people in temporary or permanent coverage and to allow for rapid access to medical care, including mental health services. The 2001 World Trade Center terrorist attacks, Hurricane Katrina, and the Flint, Michigan lead contamination crisis are case studies in Medicaid as an emergency response tool.

### **2001 World Trade Center Attacks and Disaster Relief Medicaid**

After the World Trade Center terrorist attacks on September 11th, many New Yorkers lost homes, businesses, jobs, and health care coverage, and suddenly found themselves in need of medical or mental health care. To make matters worse, New York state temporarily lost the ability to process electronic Medicaid applications in the attacks. Within seven days of the attack, then-Governor George Pataki announced that low-income New York City residents could immediately begin four months of Medicaid coverage in order to access medical and mental health care services by completing a one-page application. In the background, state and federal officials quickly worked to put New York's Medicaid program under special provisions through a Section 1115 Demonstration Waiver. The program was called 'Disaster Relief Medicaid,' and over the course of the four-month period, some 350,000 people enrolled in this temporary coverage. In total, the program financed approximately \$670 million in post-9/11 health care costs, without diverting emergency funding sources needed for rescue operations, debris removal, shelter, and other necessities, and without the need to await congressional action.<sup>6</sup>

### **Medicaid's Role in the Aftermath of Hurricane Katrina**

In 2005, Hurricane Katrina displaced tens of thousands of individuals across a broad swath of southern states, causing many to lose their homes, jobs, and health benefits, and driving a sharp increase in the need for medical and mental health care. The leadership within Louisiana Medicaid responded immediately by stationing Medicaid workers in FEMA shelters to enroll individuals in coverage. They also quickly changed the rules for the state's program so that out-of-state providers could treat evacuees without having to go through pre-authorization procedures.<sup>7</sup> In the weeks following the hurricane, 15 states worked with federal officials to rapidly secure Medicaid 1115 waivers to tackle many of the health coverage and access challenges caused by Katrina, including:

- Instituting a process to provide and fund temporary Medicaid or Children's Health Insurance Program (CHIP) coverage to evacuees who otherwise would have remained uninsured in their temporary communities;
- Streamlining the Medicaid application and enrollment process to ease enrollment for people who often had lost their papers in the flooding;
- Creating uncompensated care funding pools to reimburse providers for the extra work they took on to provide services to uninsured evacuees.<sup>8</sup>

### Flint, Michigan Lead Contamination Crisis

In January 2016, President Obama declared a state of emergency in Flint, Michigan in response to mounting evidence of lead contamination in the water supply. Pediatricians, parents, and community members quickly recognized the enormity of the public health crisis, particularly because of the devastating effects that lead can have on a child's lifelong development. Children under six are most vulnerable to these effects, which include decreases in IQ, learning difficulties, and a host of behavioral, hematologic, immunologic, endocrine, and cardiovascular conditions. Approximately 30,000 people in the Flint area already were enrolled in Medicaid at the time the emergency was declared, making it possible for Medicaid to provide immediate access to medically-necessary diagnostic and treatment services. In addition, within a month of declaring a state of emergency, Michigan sought and received a Section 1115 waiver to broaden Medicaid coverage and access by:

- Expanding Medicaid/CHIP eligibility for children and pregnant women served by the Flint water system;
- Waiving co-payment and premium payment requirements for Flint beneficiaries; and
- Extending Medicaid case management and community support services to all Medicaid-eligible children and pregnant women served by the Flint water system.<sup>9</sup>

In the wake of these emergencies, state and federal officials were able to leverage Medicaid to immediately expand access and coverage to the victims. Had it not been for Medicaid's matching rate structure and flexibility, the speed and scale of this response would not have been possible. By comparison, even in cases where Congress acts rapidly to appropriate funds for emergency relief, it still can take years for the money to be distributed to the affected communities. In the case of Hurricane Katrina, over 25 percent of the authorized budget appropriations had not been spent by the fifth year following the hurricane (2010).<sup>10</sup>

### MEDICAID'S RESPONSE TO THE NATIONAL OPIOID EPIDEMIC

Medicaid has been at the forefront of the country's ongoing response to a vast and deadly opioid crisis affecting an estimated 2 million Americans who are addicted to prescription pain relievers and over half a million who are heroin users.<sup>11</sup> It plays a particularly important role in the 32 states (including the District of Columbia) that have expanded Medicaid under the ACA, allowing 1.2 million individuals with substance use disorders (SUDs) to gain coverage. In these states, Medicaid has infused an estimated \$4.5 billion per year in funding for vital SUD treatment and recovery services and mental health services.<sup>12</sup> The speed and scale of that investment demonstrates Medicaid's ability to nimbly respond when a unique need for health care services arises in states. By contrast, even with the tail wind of bipartisan support, congressional efforts to address the opioid crisis have lagged. Congress spent nearly two years debating legislation leading to the 21st Century Cures Act, which appropriates \$500 million per year (over two years) in state grants to combat the opioid epidemic. While important, the 21st Century Cures Act's resources for opioid addiction represent only a fraction of the Medicaid funding invested in mental health and substance use services and, during the nearly two-year period the Act and its related legislation were under debate, an estimated 60,000 Americans died from an opioid overdose.<sup>13</sup>

As the opioid crisis has taken hold in recent years, Medicaid programs across the country have incorporated a host of strategies to enhance coverage and benefits for individuals with (or at highest risk for) SUDs. For example, Maryland, Rhode Island, and Vermont have leveraged federal Medicaid dollars to implement intensive care management and care coordination programs for individuals with opioid use disorders. In July 2015, the Centers for Medicare & Medicaid Services (CMS) announced several measures giving states the flexibility to overhaul SUD benefit packages and delivery networks and allowed states to expand access to Medicaid-funded residential treatment services. In response, many states have answered the charge, using their Medicaid programs to:

- Bolster and incentivize screening for SUDs among primary care providers;
- Expand coverage and access to the medications used in medication-assisted treatment (MAT) for SUDs;
- Add all forms of naloxone (a drug that can reverse an opioid overdose) to preferred drug lists;
- Expand the availability of recovery and peer support services; and
- Institute prior authorization requirements and other review criteria for opioid prescriptions to help prevent addiction.

A recent opioid-related public health crisis in Indiana provides a useful case study of the speed with which Medicaid can assist in addressing the repercussions of the opioid epidemic. Beginning in late 2014, 181 cases of HIV were diagnosed over the course of 12 months in Scott County, a rural area of southern Indiana with a population of only 24,000, where the typical number of new HIV cases is fewer than five per year. The cases were linked to injection of opioid drugs, and the community affected by the outbreak was largely impoverished and uninsured.<sup>14</sup> Within days of the outbreak being reported, then-Governor Mike Pence undertook a targeted campaign to enroll affected individuals into Medicaid under Indiana's newly-expanded Medicaid program (Healthy Indiana Plan 2.0, or HIP 2.0), providing immediate access to HIV treatment, substance use treatment, and other medical services to affected individuals.<sup>15</sup> The campaign included a 'one-stop-shop' in the small town of Austin, coupling assistance in HIP 2.0 enrollment with hot meals, HIV screenings, and vaccinations. As noted by Jeni O'Malley, a spokesperson for the Indiana State Department of Health, "A lack of health insurance was one of the first barriers to testing and treatment identified in Scott County. HIP 2.0 helped address that gap and opened doors to medical care and treatment that have been life-changing for people living with HIV and hepatitis C."<sup>16</sup>

### III. Conclusion

By definition, emergency disasters and public health crises are unexpected and require an immediate response from public authorities, without regard to financial cost. The Medicaid program has served as a valuable tool for states in quickly addressing the health needs of people affected by such events. As currently designed, Medicaid gives states immediate access to federal matching funds that can be used to respond to the unplanned costs and burdens associated with disasters and public health crises. The flexibility inherent in the matching rate structure combined with the option to change program rules or pursue waivers, allows states to mount rigorous responses to such disasters and epidemics without waiting until they have further spiraled out of control or Congress is able to act. Were it not for this flexible design, states may be required to rely exclusively on their own funds to respond to such crises, await congressional approval of funding, or, in the worst case, mount a weak or diminished response that fails to mitigate or even prolongs the effect of the event.

## Endnotes

- <sup>1</sup> Kaiser Family Foundation. "Medicaid and HIV." October 2016. Available at: <http://files.kff.org/attachment/Fact-Sheet-Medicaid-and-HIV>.
- <sup>2</sup> Kaiser Family Foundation. "Medicaid and HIV." October 2016. Available at: <http://files.kff.org/attachment/Fact-Sheet-Medicaid-and-HIV>. Note: 2011 is the most recent year for which national data is available on the number of Medicaid beneficiaries with HIV. This data pre-dates the expansion of coverage to this population under the ACA.
- <sup>3</sup> Prior to the implementation of the ACA, several states received Medicaid Section 1115 waivers or pursued other mechanisms that allowed them to cover low-income, childless adults diagnosed with HIV who did not meet the federal disability requirement. Twenty-five states, accounting for 52 percent of people diagnosed with HIV, provided full or limited Medicaid benefits to this population. Kates, Jennifer, Rachel Garfield, Katherine Young, Kelly Quinn, Emma Frazier, Jacek Skarbinski. "Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV." Kaiser Family Foundation. January 2014. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/12/8535-assessing-the-impact-of-the-affordable-care-act-on-health-insurance-coverage.pdf>.
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- <sup>11</sup> American Society of Addiction Medicine. "Opioid Addiction 2016 Facts and Figures." Available at: <http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf>.
- <sup>12</sup> Study results summarized in Frank, Richard and Sherry Glied, "Keep Obamacare to keep progress on treating opioid disorders and mental illnesses." *The Hill*. January 11, 2017. Available at: <http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioid-disorders>. Underlying data available at: <https://www.hcp.med.harvard.edu/sites/default/files/Key%20state%20SMI-OD%20v3corrected.pdf>.
- <sup>13</sup> The 21st Century Cures Act, signed in December 2016, funds initiatives authorized by the Comprehensive Addiction and Recovery Act (CARA), introduced in February of 2015. The number of opioid overdose deaths from February 2015 to December 2016 was estimated by multiplying the number of monthly opioid overdose deaths in 2015 (2,757, or 33,091 for all 12 months of 2015) by 22 months. Overdose rates published by the Centers for Disease Control and Prevention. "Increases in Drug and Opioid-Involved Overdose Deaths—United States, 2010-2015." December 2016. Available at: <https://www.cdc.gov/mmwr/volumes/65/wr/mm65051e1.htm>.
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