



RESEARCH REPORT

How Might State Medicaid and Other Health Programs Be Affected in the Pandemic's Aftermath?

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How Might State Medicaid and Other Health Programs Be Affected in the Pandemic's Aftermath?

Shortly after the novel coronavirus appeared in the United States in January 2020, policymakers began forecasting what dire consequences would ripple through society. The number of deaths from COVID-19 was expected to be large, but few could have imagined more than half a million lives would be lost one year after the pandemic started.¹ Experts more accurately predicted the pandemic's immediate toll on the economy, understanding that social distancing would require shutting down large sectors of the economy for extended periods and would therefore lead to significant job losses.² Many believed these job losses would lead to similarly large losses of job-related health coverage and cause spikes in either uninsurance rates or Medicaid enrollment (Gangopadhyaya and Garrett 2020). Health systems would be significantly strained by the need to treat the hundreds of thousands of people stricken by the virus while also experiencing steep declines in utilization (and by extension revenue) of most health services, as consumers avoided interactions that might expose them to the virus (Cox, Kamal, and McDermott 2021). Similarly, public health systems would be forced to redeploy human and financial resources to support COVID-19 outreach, education, testing, and contact tracing (Krisberg 2020). From a fiscal standpoint, many assumed that state and federal revenues would plummet as tax collections shrank because of the pandemic, straining budgets for public services just as demands on the health and human services safety net skyrocketed (Dadyan 2020; McNichol and Leachman 2020).

Though many of these predictions have come true, a much more nuanced and variable picture of the pandemic's effects is emerging. COVID-19 infection and death rates have been devastating but have varied by state, owing, in part, to states' inconsistent efforts to enforce risk-mitigation rules surrounding public gatherings and mask wearing (Guy et al. 2021; Zhang and Warner 2020). In April 2020, unemployment spiked by 10.3 percentage points to 14.7 percent, the highest rate and largest over-the-month increase in the history of US Bureau of Labor Statistics data (available back to January 1948).³ But some sectors and workers have been hit much harder than others; those in the food and

beverage, entertainment, and hotel and travel sectors have suffered the most job losses, whereas many higher-income workers have been able to nearly seamlessly shift to remote work and remain employed. This latter effect has translated into more robust than expected income tax collections for the federal government and states with income taxes, meaning stress on state budgets varies considerably more than most predicted.⁴ Further, uninsurance rates appear not to have grown significantly in the past year, because employer-sponsored coverage losses have been largely offset by increases in Medicaid and Affordable Care Act (ACA) Marketplace enrollment.⁵ This is more true in states that expanded Medicaid under the ACA, successfully providing more Americans with coverage during the pandemic than states that opted not to expand Medicaid (Buettgens 2021).

Federal financial relief has played a massive role in mitigating harm, infusing roughly \$5.5 trillion into the economy over the past 12 months⁶—in the form of individual payments, payments to businesses, enhanced unemployment benefits, support for a range of health programs and activities, and direct aid to state, local, and tribal governments—which has certainly helped many individuals, businesses, and public-sector agencies weather the economic downturn (box 1).

In this paper, we examine the effects of the pandemic on Medicaid and other health care programs and those programs' future outlooks based on information gathered through interviews with health care stakeholders and comprehensive reviews of the literature. Our key findings are as follows:

- A year ago, many predicted the pandemic's economic effects would be devastating, but many of these predictions have not materialized. The economy has recovered better than many expected, state revenues have been higher than most expected, and huge infusions of federal assistance have bolstered individuals, businesses, and state and local governments.
- States' economic conditions vary considerably, however. State economies that depend on tourism, travel, and energy and that lack income taxes are in worse shape than those not dependent on such sectors and those with income taxes. Effects have varied dramatically across population groups as well; workers with low incomes, service industry workers, and communities of color have experienced higher unemployment, morbidity, and mortality rates during the pandemic.
- Enhanced federal matching funds and the public health emergency's maintenance-of-effort (MOE) rules initially protected state Medicaid programs and beneficiaries. Other behavioral health, public health, and maternal and child health programs also received supplemental federal funds critical to their pandemic responses. Consequently, Medicaid and other health programs did not experience significant budget cuts in 2020. Some states reduced staff and

initiated furloughs to manage costs, and non-Medicaid health programs not protected by federal legislation faced real or proposed cuts, many of which were not implemented or have been reversed.

- The pandemic has had far-reaching effects on how beneficiaries seek and how providers deliver health care services. Most Medicaid programs increased financial support and direct payments to providers experiencing steep revenue declines. And social distancing necessitated a shift to virtual operations and remote work for state program administrative staff, a transition described as smooth overall.
- Experts interviewed in early 2021 predicted continuation of the pandemic-era status quo, at least for the year ahead. Their biggest concern at the time was whether additional federal assistance would be available for states and localities. With the passage of the American Rescue Plan Act and its \$350 billion in state, local, and tribal government relief, that concern has been addressed, at least for now.
- Experts seemed to think, or hope, expansions of health insurance coverage availability and improvements to the safety net could occur as policymakers use the experience of the pandemic to reimagine safety net programs to be nimbler, more equitable, more focused on prevention, and more holistic. Whether such advances occur will be important to monitor.

In the following sections, we explore how Medicaid and other behavioral and public health programs responded to the pandemic and how the pandemic affected health care utilization and delivery systems. We then examine states' budget responses, how those responses varied in 2020, and what stakeholders predict may unfold in the coming year as governors and state legislatures work to plan and balance their budgets for fiscal year 2022. We conclude with predictions of how, as vaccine rollout continues and the economy recovers, programs may evolve to be better prepared for another public health emergency.

Research Methods

Between December 2020 and February 2021, we conducted 14 individual and small-group interviews with 31 health program stakeholders to identify and examine key concerns about the implications of state budgets for health programs during the pandemic-prompted economic downturn. The stakeholders represented governors' offices, state legislatures, and Medicaid, public health, behavioral health, maternal and child health, and long-term services and supports programs; and staff from policy

research organizations. Interview questions focused on the influence of the COVID-19 emergency on policy and practice for Medicaid and other health programs, as well as the budget-related risks and opportunities for health programs in and beyond 2021. We also conducted and periodically updated a comprehensive scan of publicly available information on state budgets during the pandemic from sources such as national policy and research organizations, professional organizations, and national and local news outlets. Our findings primarily reflect insights into and responses to the pandemic that emerged between March 2020 and March 2021.

BOX 1

COVID-19 Fiscal Relief Bills and Health Provisions Enacted during the Pandemic

The **Coronavirus Preparedness and Response Supplemental Appropriations Act**, passed March 6, 2020, provided \$8.3 billion in emergency discretionary funding primarily to the Centers for Disease Control and Prevention (CDC) for COVID-19 vaccine research. It also provided states with grants and cooperative agreements.^a

The **Families First Coronavirus Response Act**, passed on March 18, 2020, provided small and midsize employers refundable tax credits that reimbursed them for providing paid sick and family leave wages to their employees. It also gave states \$1 billion for emergency transfers to pay for unemployment benefits.

- Regarding health policy provisions, the law also authorized a 6.2 percentage-point increase to Medicaid's federal medical assistance percentage for states that agreed to maintenance-of-effort rules prohibiting disenrollment of beneficiaries who were in the program when the federal public health emergency was declared.^b It also provided \$1.2 billion to cover the costs of COVID-19 testing and required all commercial insurers, Medicaid, and the Children's Health Insurance Program to cover testing and diagnosis for COVID-19 without patient cost-sharing.^c

The **Coronavirus Aid, Relief, and Economic Security (CARES) Act**, passed March 27, 2020, provided an estimated \$2 trillion stimulus package to battle the pandemic's harmful effects. It included a \$150 billion Coronavirus Relief Fund for state, local, and tribal governments (allocated by population shares) for expenditures incurred because of COVID-19. It also expanded unemployment insurance from three to four months and provided a temporary supplemental \$600 in unemployment compensation a week; established a \$500 billion lending fund for businesses, cities, and states; and provided a \$1,200 direct payment to many Americans and \$500 for each dependent child, among many other provisions.^e The CARES Act also established the Paycheck Protection Program to provide loans to small businesses as an incentive to keep workers on payroll.^d

- The CARES Act also included the following health provisions: \$127 billion for a Public Health and Social Services Emergency Fund, which provided grants to hospitals, public entities, nonprofit entities, and Medicare- and Medicaid-enrolled providers; \$16 billion for the Strategic

National Stockpile, which supports procurement of personal protective equipment, ventilators, and other medical supplies; \$11 billion for vaccines, diagnostics, and other medical needs; \$4.3 billion for the CDC and its public health preparedness and response efforts; \$425 million to the Substance Abuse and Mental Health Services Administration to address mental health and substance use disorder needs growing from the pandemic; \$50 million for suicide prevention; \$100 million in flexible funding to address mental health, substance use disorders, youth needs, and homelessness; and \$200 million to the Centers for Medicare & Medicaid Services.^e

The Paycheck Protection Program and Health Care Enhancement Act, passed in April 2020, provided an additional \$310 billion to the Paycheck Protection Program, \$75 billion in aid to (mostly) hospitals and other health care providers, \$25 billion for COVID-19 testing capacity, and \$60 billion in small business disaster loans.^f

- The act's health care provisions included \$75 billion to support hospital and other providers via a new Provider Relief Fund and \$25 billion to enhance states' capabilities to conduct COVID-19 testing and contact tracing.

The Consolidated Appropriations Act, 2021, passed at the end of 2020, included \$900 billion in COVID-19 relief and for direct payments to individuals, an extension of the Paycheck Protection Program, education funding, and restoration of earlier enhancements to unemployment insurance payments.

- The bill's health care provisions included a one-time, one-year 3.75 percent increase in the Medicare physician fee schedule and funding for a national campaign to increase awareness and knowledge of the safety and effectiveness of vaccines for the prevention and control of diseases, including COVID-19.

The American Rescue Plan, passed March 11, 2021, provided an additional \$1.9 trillion, including money for direct payments to individuals; \$350 billion in direct aid to state, local, and tribal governments to cover increased expenditures, replenish lost revenue, and mitigate economic harm from the pandemic; extensions of unemployment benefits; expansions of tax credits (child tax credit, earned income tax credit, and child and dependent care tax credit); and additional support for K-12 schools and higher education institutions.^g

- The bill's health care provisions included \$8.5 billion to the CDC for vaccine activities; \$47.8 billion for COVID-19 testing and tracing; \$7.7 billion for state, local, and territorial public health departments to establish, expand, and sustain their public health workforce; \$7.6 billion for community health centers; \$3 billion for block grant programs under the Substance Abuse and Mental Health Services Administration; \$6.1 billion to the Indian Health Service; \$200 million to support COVID-19 infection control in skilled nursing facilities; and \$250 million for "strike teams" to assist skilled nursing facilities.^h
- One of the bill's key Medicaid provision is a new, temporary fiscal incentive to encourage Medicaid expansion in the 12 states that have not yet adopted expansion under the ACA as of this writing.ⁱ On top of the regular 90 percent federal matching rate for the Medicaid expansion

population, states that expand now can also receive a 5 percentage-point increase in their federal matching rate for two years after the expansion takes effect. The American Rescue Plan also gives states a new option to extend Medicaid coverage for postpartum women from the current 60 days following birth to a full year. States can also receive a 10 percentage-point increase in federal matching funds for Medicaid home- and community-based services from April 1, 2021, through March 30, 2022. Beginning April 1, 2021, the law provides 100 percent federal matching funds for two years for services received through Urban Indian Health Programs and the Native Hawaiian Health Care Systems Program. Finally, the new law provides \$8.5 billion in fiscal year 2021 for provider relief fund payments to rural Medicaid, CHIP, and Medicare providers (Musumeci 2021).

^a Erlinda A. Doherty, “Phases of Federal Financial Response to Coronavirus for States,” National Conference of State Legislatures (NCSL) blog, April 30, 2020, <https://www.ncsl.org/blog/2020/04/30/phases-of-federal-financial-response-to-coronavirus-for-states.aspx>.

^b Doherty, “Phases of Federal Financial Response to Coronavirus for States”; and “COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies,” Medicaid.gov, last updated January 6, 2021, <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

^c NCSL, “Summary of HR 6201—Families First Coronavirus Response Act” (Washington, DC: NCSL, n.d.).

^d NCSL, “Summary of HR 6201—Families First Coronavirus Response Act.”

^e “COVID-19 Stimulus Bill: What It Means for States,” NCSL, April 2, 2020, <https://www.ncsl.org/ncsl-in-dc/publications-and-resources/coronavirus-stimulus-bill-states.aspx>; “Unemployment Insurance Relief during COVID-19 Outbreak,” US Department of Labor, accessed April 15, 2021, <https://www.dol.gov/coronavirus/unemployment-insurance>; and Mary Williams Walsh, “Virus Did Not Bring Financial Rout That Many States Feared,” *New York Times*, March 1, 2021, <https://www.nytimes.com/2021/03/01/business/covid-state-tax-revenue.html?referringSource=articleShare>.

^f “COVID-19 Stimulus Bill: What It Means for States,” NCSL; and Teresa A. Coughlin, Christal Ramos, and Haley Samuel-Jakubos, “Safety Net Hospitals in the COVID-19 Crisis: How Five Hospitals Have Fared Financially” (Washington, DC: Urban Institute, 2020)

^g “Paycheck Protection Program,” US Small Business Administration, accessed April 15, 2021, <https://www.sba.gov/funding-programs/loans/covid-19-relief-options/paycheck-protection-program>; and Doherty, “Phases of Federal Financial Response to Coronavirus for States.”

^h “American Rescue Plan Act of 2021,” NCSL, March 9, 2021, <https://www.ncsl.org/ncsl-in-dc/publications-and-resources/american-rescue-plan-act-of-2021.aspx>.

ⁱ “American Rescue Plan Act of 2021,” NCSL.

^j “Status of State Medicaid Expansion Decisions: Interactive Map,” Kaiser Family Foundation, April 13, 2021, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

How State Medicaid and Other Health Programs Responded to the Pandemic

State Medicaid and other health programs, including those focused on public health, mental health, substance use treatment, and maternal and child health, received considerable assistance through various provisions in the six federal relief bills passed since the pandemic began (box 1). Highlights of this federal support include a 6.2 percentage-point increase in federal Medicaid matching funds in return for a maintenance-of-effort (MOE) requirement forbidding states from disenrolling beneficiaries during the public health emergency; billions of dollars in grants and direct payments to providers; large investments in public health capacity to provide COVID-19 testing, contact tracing, and vaccine distribution; billions of dollars in expansions of the Substance Abuse and Mental Health Block Grant; and new financial incentives for states to expand Medicaid coverage to single adults and postpartum women.

States also benefited from additional flexibility granted to them by the federal agencies that set policies and help administer their programs. According to our key informants, the US Department of Health and Human Services acted quickly at the outset of the pandemic to issue guidance for states that allowed health programs to respond more nimbly and effectively to the crisis. For instance, guidance for Medicaid took the form of numerous letters to state Medicaid directors and other health officials. These ranged from a March 2020 letter introducing a new waiver authority available to help states adjust their programs to pandemic conditions⁷ to, more recently, guidance issued in late December 2020 on planning for the eventual return to regular operations at the conclusion of the public health emergency (table 1).⁸ Near the start of the pandemic, the Department of Health and Human Services and the Office of Civil Rights also implemented several good faith HIPAA waivers meant to advance data sharing and telehealth while limiting provider burdens. These waivers allow HIPAA-covered providers to use audio or video communication platforms without being penalized for noncompliance with certain HIPAA rules, such as lacking a business associate agreement with the vendors running such platforms.

TABLE 1

Medicaid and CHIP Waivers and Amendments for the Pandemic Response

Waiver type	COVID-19 response	State actions as of March 2021
Medicaid disaster relief State Plan Amendments (SPAs)	CMS developed a template for Medicaid disaster relief SPAs ^a to aid states' pandemic responses. States used SPAs to make temporary changes to their Medicaid state plans to bolster access to Medicaid and covered services during the pandemic. States also used traditional SPAs to respond to the pandemic.	<ul style="list-style-type: none"> 16 states expanded coverage for testing and related services to uninsured individuals. 18 states eliminated, waived, or suspended enrollment fees, premiums, or similar charges in Medicaid.
Section 1115 waivers	CMS also developed a template for Medicaid Section 1115 demonstration waivers during the pandemic. ^b These waivers could be retroactive to March 1, 2020, and will expire 60 days after the public health emergency has ended. These waivers have predominantly been used to extend HCBS flexibilities to beneficiaries receiving LTSS.	<ul style="list-style-type: none"> 7 states received approval for waiver provisions to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency. 4 states received approval for waiver provisions to provide LTSS for affected individuals, even if services are not included in the care plan or are delivered in alternative settings.
Section 1135 waivers	During declared emergencies and disasters, the secretary of the Department of Health and Human Services can use Section 1135 authority to meet Medicaid enrollees' needs. Specifically, certain Medicare, Medicaid, and CHIP requirements may be waived or modified. CMS issued blanket Section 1135 waivers ^c for many Medicare provisions in March 2020, and states have submitted additional waivers for Medicaid programs.	<ul style="list-style-type: none"> All 50 states and DC have waivers allowing out-of-state providers with equivalent licensing to practice in their states. 44 states have waivers to allow service provision in alternative settings, like unlicensed facilities. 43 states suspended FFS prior authorizations.
1915(c) waiver Appendix K	Section 1915(c) waivers facilitate provision of states' Medicaid HCBS generally and can be used to respond to emergencies. As with the other emergency authority strategies, CMS provided guidance for Appendix K in pandemic-related waiver amendment requests. ^d Through Appendix K, states can modify or expand HCBS eligibility and services, modify or suspend certain planning and delivery regulations, and support service providers. In December 2020, CMS announced emergency authorities granted through Appendix K could be maintained up to six months after the public health emergency ends.	<ul style="list-style-type: none"> 41 states have temporarily modified processes for level-of-care evaluations. 50 states (including DC but not AK) are permitting virtual evaluations, assessments, and person-centered planning meetings. 49 states have temporarily expanded settings where services can be provided. 39 states have temporarily increased provider payment rates.

Source: "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," Kaiser Family Foundation, April 12, 2021, <https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>.

Notes: CMS = Centers for Medicare & Medicaid Services. HCBS = home- and community-based services. LTSS = long-term services and supports. CHIP = Children's Health Insurance Program. FFS = fee-for-service.

^a The template for Medicaid disaster relief State Plan Amendments is available at <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-template.docx>.

^b Calder Lynch (deputy administrator and director of the Center for Medicaid and CHIP Services), letter to state Medicaid directors, “COVID-19 Public Health Emergency Section 1115(a) Opportunity for States,” March 22, 2020, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx>.

^c “COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers,” Centers for Medicare & Medicaid Services, March 30, 2020, <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>.

^d “Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers,” Medicaid.gov, accessed April 18, 2021, <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html>.

Taken together, federal legislative changes and administrative flexibility set the stage for how Medicaid and other state health programs responded to the pandemic. In the sections below, we examine these health programs’ responses to the pandemic and experiences related to changes in health care delivery, benefits coverage, support for providers, program operations, and the extent to which health equity has become a more prominent focus.

Changes in How Health Care Is Sought and Delivered

The pandemic has prompted dramatic changes in how health care is sought and delivered, as social distancing and fears of contracting the virus caused greater discontinuities in care, limited in-person visits, and increased reliance on telehealth (Gonzalez et al. 2020, 2021b; Hill and Burroughs 2020; Smith and Blavin 2021). Consistent with other data sources (Gonzalez et al. 2021a, 2021b), our study’s key informants reported that people have avoided routine, preventive, and nonurgent care throughout the pandemic, citing decreases in childhood vaccine rates, dental visits, and follow-up care for newborn screenings. They also described how the pandemic has exacerbated health needs, particularly related to mental health and substance use disorders. In 2020, 4 in 10 adults in the US reported symptoms of anxiety or depressive disorders, up from 1 in 10 in 2019, and such rates were even higher among young adults, parents, communities of color, and essential workers (Panchal et al. 2021). The CDC also reported accelerated substance use and overdose deaths during the pandemic (Czeisler et al. 2020).⁹

When patients have sought care, they have opted for virtual care at much higher rates than were common before the pandemic. Telehealth now accounts for 6 percent of all outpatient visits, compared with 1 percent of visits before the crisis, and one in three adults used telehealth between March and September 2020 (Mehrotra et al. 2020; Smith and Blavin 2021). Key informants reported that virtual care likely mitigated preexisting barriers to care, such as lack of transportation and child care, leading to better attendance for certain types of health care visits, including prenatal and postpartum care appointments and group therapy sessions for substance use treatment. Interviewees also mentioned that preexisting provider shortages may be ameliorated by telehealth, citing implications for the

behavioral health workforce in particular. According to one stakeholder, “There are long-standing provider shortages in behavioral health. Telehealth has somewhat been able to alleviate that...[because now] they can provide services across state lines, and they are able to reach consumers that might not [otherwise] have the resources.”

Health care systems, payers, and policymakers have made many policy adjustments to accommodate the shift to telehealth. These have included expanding rules related to the site of care, such that providers can connect with patients via telephone calls and virtual platforms like Zoom, Skype, and FaceTime (Hill and Burroughs 2020). Before the pandemic, only 19 state Medicaid programs paid for telehealth services delivered to patients in their homes, and not all reimbursed these services at the same rate as in-person care. But within the last year, all 50 states and the District of Columbia have expanded telehealth for Medicaid populations. Similarly, many major private insurers have also modified telehealth policies; whether voluntarily or by state law, these insurers have waived cost-sharing for select services, expanded virtual mental health and/or substance use services, and instituted parity requirements stipulating that payers reimburse in-person and virtual care at the same level.

Though many key informants were optimistic about telehealth’s potential for improving access to care, they were also concerned about the efficacy and sustainability of telehealth-related policy changes. Some interviewees supported making permanent policies such as payment parity, whereas others disagreed and worried about the quality of virtual care. Several informants suggested that though audio-only care can reach patients unable to connect via video applications, it presents challenges because providers cannot monitor important indicators, such as a patient’s physical condition, affect, or expressions. Some key informants described the potential for increased costs related to overuse of virtual care in fee-for-service environments and noted the lack of sufficient data to determine whether telehealth access and outcomes are equitable across populations (Hill and Burroughs 2020). Key informants unanimously agreed, however, that expanded telehealth services would continue in some capacity; they expressed doubt that the US would revert to prepandemic low levels of utilization and rigid policies. One interviewee remarked, “Telehealth is here to stay.”

Though the pandemic has affected all aspects of the health care delivery system, key informants suggested some of the most notable shifts have been to long-term care services and supports (LTSS). For decades before the pandemic, Medicaid programs worked to increase the share of LTSS delivery and spending in home and community settings relative to institutional settings (O’Malley Watts, Musumeci, and Chidambaram 2020). This shift accelerated in response to the pandemic, as long-term care facilities experienced dramatically high death rates; though populations living in these facilities account for 1 percent of the US population, they accounted for 35 percent of all COVID-19 deaths in

the US.¹⁰ Providers worked to avoid these settings in favor of approaches that allow seniors and people with disabilities to remain at home and limit their exposure to the coronavirus. Indeed, key informants reported that consumer interest in home- and community-based services (HCBS) and family caregiving has increased, and hospitals are making more referrals to home health providers and fewer referrals to nursing facilities.¹¹

Policymakers have bolstered HCBS during the public health emergency, incorporating flexibilities and expanding reimbursement for these services. Medicaid altered federal rules to allow family caregivers to deliver and receive reimbursement for this care, including home health services for older adults and children and youth with special health care needs (Randi, Girmash, and Honsberger 2021).¹² As described above, most states have taken advantage of these flexibilities through Appendix K waivers, enabling temporary changes to their Medicaid programs during the public health emergency. Further, the Biden administration has proposed new supports, such as tax credits, for family caregivers providing care across the life-span.¹³

Benefit Protections and Cuts

Lawmakers commonly cut health program benefits to address budget shortfalls (Snyder and Rudowitz 2016). For example, the number of states reporting at least one benefit restriction in their Medicaid programs increased during the Great Recession. Medicaid accounts for a large portion of state budgets and, therefore, can be particularly vulnerable to cost-saving measures. However, cuts to Medicaid bring with them losses of federal matching funds. Medicaid includes mandatory benefits, but other benefits are considered optional and are therefore susceptible to being cut.

However, informants generally described cutting health benefits as counterproductive during an economic downturn that is concurrent with a pandemic. Underscoring the importance of facilitating access to services as needs increase, key informants reported that policymakers have largely protected health benefits in Medicaid. In fact, the MOE requirement enacted at the start of the pandemic initially prohibited cuts to services for Medicaid beneficiaries. Further, many states extended access to benefits by relaxing certain prior authorization, documentation, and referral requirements for services such as long-term care and HCBS (Gifford et al. 2020).

Interviewees were concerned, however, that not all benefits were protected and some programs would still be susceptible to cuts as states address budget pressures in the coming year. Adding to these fears, the Trump administration released an interim final rule in October 2020 that permitted states to cut optional benefits previously protected under the MOE requirement.¹⁴ For example, the rule allowed

states to reduce coverage of certain substance use treatment and adult oral health services.¹⁵ The National Health Law Program reported that several states were planning to implement benefit cuts in response to the rule change and submitted a letter to the Biden administration in April 2021, cosigned by 161 other organizations, requesting that it rescind the interim final rule.¹⁶ States have also made or proposed cuts to non-Medicaid health programs that are not legislatively protected; Colorado, Georgia, and Utah cut state funding for mental health and substance use disorder services in 2020 (Aron-Dine, Hayes, and Broaddus 2020). However, as some states' financial outlooks have improved, legislators may be able to restore these funds. Colorado's Governor Polis, for instance, reversed some of last year's cuts in his proposed 2021 budget.¹⁷ Federal aid from the American Rescue Plan may also help policymakers mitigate benefit cuts by relieving budget pressures.

Supporting Health Care Providers through Uncertain Times

The pandemic has had far-reaching effects on all segments of the health care industry, and supporting health care providers has been a major piece of the pandemic response for Medicaid and other safety net health care programs. Unexpected and significant shifts in health care utilization have resulted in uncertainty and strained many providers' resources. For instance, hospitals have faced significant COVID-19 testing and treatment needs, while demand for routine and preventive care provided by pediatric and family practitioners has steeply declined. And in the first few months of the pandemic, providers struggled to obtain the supplies they needed to treat patients safely, including personal protective equipment and COVID-19 tests.

Key informants suggested that early in the public health emergency, providers who no longer had the volume of patients needed to maintain solvency were particularly vulnerable, such as primary care practices, behavioral health providers, substance use treatment providers, pediatricians, dentists, adult day health centers, and other congregate community services. These providers faced threats of closure and, according to key informants, commonly looked to Medicaid for assistance. As one interviewee expressed, "I would include a third crisis on top of the public health emergency and fiscal crisis—a provider sustainability crisis."

The CARES Act included a \$175 billion Provider Relief Fund (distributed directly to providers, not through state Medicaid agencies). However, Medicaid providers often had trouble accessing these dollars, especially at first, because of how they were allocated.

Many Medicaid programs acted swiftly to maintain their provider networks and protect beneficiaries' access to care both now and after the pandemic, when demand increases. States used

State Plan Amendments (SPAs) and Social Security Act Section 1115, 1135, or 1915(c), Appendix K, waivers to modify their Medicaid programs in ways that increased financial support for providers. For instance, most states used disaster relief SPAs to temporarily increase provider payment rates.¹⁸ A majority have also used Section 1135 emergency waivers to ensure providers are reimbursed even if they cannot comply with certain requirements because of the pandemic. States' 1135 waivers, for example, allow billing by out-of-state providers, increase scope of practice for some providers, and waive requirements for quality-measure reporting so providers are not penalized for experiencing lower-than-anticipated volume. States have also employed mechanisms like interim or retainer payments to help providers stay afloat. Interim payments are made to providers in advance (addressing immediate cashflow issues) and ultimately reconciled against actual services provided, whereas retainer payments help habilitation and personal care providers (e.g., adult day health centers) maintain capacity when circumstances such as social distancing or self-quarantining prevent beneficiaries from actually receiving services.

SPAs and waivers require approval from the Centers for Medicare & Medicaid Services (CMS), and key informants suggested that CMS provided timely and useful guidance to state Medicaid agencies and worked quickly to process requests. One interviewee was disappointed CMS did not approve a state's request to extend retainer payments to providers other than those offering HCBS, noting behavioral health providers could benefit from this policy option. However, most praised the federal agency's responsiveness.

Many of the state actions described above involved direct payments from Medicaid to providers, but some Medicaid programs worked through their managed-care organizations (MCOs) to channel funds to providers. More than two-thirds of Medicaid beneficiaries are enrolled in risk-based comprehensive MCOs,¹⁹ and states pay a fixed monthly capitation rate to MCOs to provide care to these beneficiaries, regardless of utilization. Those funds may not be reaching providers facing decreased utilization, so some states have directed MCOs to bolster payments to providers in their networks; for example, they might direct MCOs to temporarily increase their provider rates or fee schedules or to make retainer payments, and MCOs may apply these directions widely or target them to specific providers (McMorrow et al. 2020). For instance, New Hampshire was one of the first states to receive approval from CMS (in April 2020) to require Medicaid MCOs to distribute a share of their capitation payments between September 2019 and June 2020 to six essential provider types: critical access hospitals, residential substance use disorder providers, home health care providers, private duty nursing providers, personal care providers, and federally qualified health centers/rural health centers (Guyer and Boozang 2020). Key informants described some situations where health plans elected to

route overpayment capitation dollars to their provider network without a state mandate, such as in California, where Medicaid behavioral health plans made supplemental payments to behavioral health care providers.

Even with state Medicaid program efforts to extend financial support to providers facing revenue declines, key informants emphasized that many providers are still struggling, and some have gone out of business or significantly reduced their capacities. This raises concerns about supply after the pandemic, when demand will presumably increase. This is especially concerning for mental health and substance use treatment providers, who key informants described as operating on very thin margins even before the pandemic and who especially needed federal fiscal relief in 2020. Interviewees reported that smaller, community-based behavioral health care facilities were most likely to have temporarily closed while they established processes for virtual care and obtained enough personal protective equipment to function. Some have since restored their capacities, but others have remained closed, possibly permanently. One interview explained, “[Behavioral health providers] are very much at risk despite the obvious imperative to expand, rather than contract, mental health care during a pandemic that leaves people isolated and has shot up overdose rates already.”

Finally, some key informants felt the public health emergency had placed a spotlight on the fundamental weaknesses of a volume-based health care delivery system. Some observed that providers in value-based systems (e.g., accountable care organizations) have been able to respond more nimbly to pandemic-related volume losses and to pivot more smoothly to virtual health care. Before the pandemic, state Medicaid programs were already moving toward value-based care, though programs’ progress varied considerably. Further, key informants acknowledged that efforts to launch or strengthen Medicaid value-based care programs had generally been paused, as Medicaid agencies, MCOs, and providers responded to the crisis. Still, several informants emphasized that one lesson learned from the pandemic was that states need to shift their Medicaid delivery systems to what one informant described as “more secure” payment models.

Adapting Program Operations to Pandemic Conditions

While officials from Medicaid and other state-funded health programs grappled with how to facilitate beneficiaries’ access to care and providers’ sustainability during the pandemic, they simultaneously transitioned programs’ administrative functions to a remote work environment and, to the extent possible, began administering benefits virtually. Most key informants felt the transition to virtual program operations had been smooth overall, though success varied by state. Some states had already

invested in the necessary technology before the pandemic. Others, however, were “completely unprepared,” according to one key informant, and were working without the appropriate technology for months (e.g., agencies that lacked laptops with cameras and microphones).

For state Medicaid agencies, several factors facilitated the shift to virtual benefits administration. The ACA had long ago prompted states to embrace modern technology in their Medicaid programs, for instance, by requiring an online application option. Key informants described these technology investments, including call centers, online beneficiary accounts, and streamlined eligibility verification, as very advantageous to Medicaid program operations during the crisis. As indicated above, Medicaid programs also used SPAs and waiver authority to adopt new policies to limit in-person interactions for applying for benefits during the pandemic. One key informant noted fewer in-person application requirements made Medicaid more like commercial coverage, which could lead to long-term changes in how the program is perceived—as health coverage rather than social welfare—if these policies are sustained after the public health emergency. Finally, the MOE requirement was helpful because it temporarily allowed states to stop processing eligibility redeterminations. Several key informants suggested states were relieved to provide continuous coverage without needing to process renewals, considering the workload associated with the pandemic.

Though they emphasized the adaptability and resilience of state health programs during the pandemic, key informants also underscored the immense pressure public health and other health program staff faced in 2020 as they, like the rest of the world, adapted to new working conditions and faced challenges related to child care or family members contracting COVID-19, all while keeping essential programs running. One interviewee emphasized the burden on state-run psychiatric facility staff, who faced mandatory overtime amid COVID-19-related staffing shortages, noting, “[We have] a lot of concern about the unmet mental health needs of our mental health workforce.”

Another interviewee focused on the highly politicized nature of the country’s pandemic response, which placed significant pressure on public health leaders, some of whom resigned or retired early. And in public health departments, staff have been transferred from their regular positions into roles related to COVID-19 (e.g., testing, contact tracing, and vaccine administration), limiting the resources available for typical public health programs and activities.

In some states, budget-related funding reductions, such as furloughs and hiring or pay freezes, compounded pressures on state health program staff. However, key informants suggested these measures were not as common as they had been in previous economic recessions. Some pointed to states that instead trimmed their Medicaid budgets by suspending contractor work (e.g., contracts with

IT companies). Several interviewees noted that states such as Washington and Wyoming implemented furloughs across all state agencies, affecting health program staff. As revenue projections improved during 2020, however, states lifted these measures.

Increased Recognition of Health Inequities

Inequities in health outcomes for communities of color, a long-standing and shameful aspect of US history, have been thrust into the spotlight over the past year. Communities of color are at greater risk of contracting and dying from COVID-19 (Dubay et al. 2020),²⁰ and Black and Hispanic people consistently receive smaller shares of COVID-19 vaccinations relative to their shares of COVID-19 cases and deaths and their shares of the total population (Ndugga et al. 2021). However, one silver lining of the pandemic is that political support for addressing racism and structural health inequities through policy change has grown. For instance, many state and local legislatures declared racism a public health crisis in 2020.²¹

Acknowledging racism as a public health crisis has prompted state legislators and governors to form working groups, task forces, and advisory councils to delineate actionable steps for addressing structural inequities. For example, as of August 2020, 18 states had created task forces to address the pandemic's disproportionate toll on communities of color.²² Several of these state task forces, such as those in California, Michigan, and New Jersey, have specifically focused on improving collection and analysis of data disaggregated by race and ethnicity.²³ By closely tracking these data, states intend to improve detection of racial disparities, increase transparency in reporting, and design targeted interventions.

Moreover, state task forces have reportedly emphasized the need for states to directly engage with communities and integrate their input in all policies and strategies, both within the context of the pandemic and more broadly.²⁴ Because myriad policies and programs shape structural and social determinants of health, key informants highlighted that state programs must use a coordinated approach to address health and social needs through a community-driven equity lens. Accordingly, a handful of states have launched strategies to incorporate community feedback in long-term policy decisions. For example, Michigan Governor Gretchen Whitmer established the Black Leadership Advisory Council, tasked with developing, reviewing, and recommending policies and state actions to address racial inequities.

Key informants also highlighted increasing interest in police reform and the intersection between public and behavioral health systems. For instance, the American Public Health Association

recommends taking a “public health approach” to combatting law enforcement violence by shifting funds to community-led health, employment, affordable housing, and violence-reduction initiatives, as well as more closely involving social workers and mental health professionals in public safety matters (Barna 2020). Interviewees underscored the importance of involving mental health professionals in emergency response procedures, as 25 percent of all fatal police shootings involve people with untreated severe mental illness.²⁵ One key informant mentioned the forthcoming 988 crisis line, a new hotline that will connect callers with mental health professionals,²⁶ as a tool for more appropriately responding to mental health emergencies, instead of relying on law enforcement.

States’ Fiscal Outlooks for 2021

Though many predicted the fiscal crisis would be deep and uniform across states, it has not been. The pandemic-created economic downturn differed significantly from recent recessions in that the economic pain was heavily concentrated in accommodation and service sectors and among lower-income workers. As such, the pandemic’s effects on revenues have been felt much worse in some states than in others.

Initially, some predicted states would collectively experience a revenue shortfall of more than \$1 trillion.²⁷ However, according to the Urban Institute’s State and Local Finance Initiative, total state tax revenues declined by 1.8 percent from April to December 2020 compared with the same period in 2019—a significant decline but not an unprecedented fiscal crisis. But, this rate masks wide variation among states. On one hand, 22 states have seen revenues increase in 2020 relative to 2019, including those that have progressive state income taxes and recently enacted tax rate increases. On the other hand, 28 states reported declines in overall state tax collections during this period, with 7 reporting double-digit declines. The hardest-hit states were those that heavily rely on fossil fuel production (e.g., Alaska and Louisiana), those relying on services and tourism (e.g., Hawaii and Nevada), and those that do not have an income tax and depend more on sales taxes (e.g., Florida and Texas).²⁸ Local governments appear to have been hurt far more than state governments because of their reliance on revenue sources, such as property taxes, including for commercial property, and taxes or fees on hotel stays and restaurant meals, which have declined sharply during the pandemic.

During our interviews in early 2021, key informants consistently said the largest unknown that would affect state and local finances in the coming year was whether federal relief might include more funds for state and local governments, and if so, how much. By early March 2021, this picture became clearer. The nearly \$1.9 trillion American Rescue Plan, described above, included \$350 billion in funds

for state and local governments. Under the law, state governments receive roughly \$195 billion, local governments receive \$130 billion, and territories and tribes get \$24.5 billion. State funds include \$25.5 billion divided equally across states and the District of Columbia and \$169 billion distributed based on states' unemployment rates at the end of 2020. Some key informants argued distributing aid based on unemployment made sense, citing recent data estimating that for every 1 percentage-point increase in unemployment, state revenues decrease by 3.7 percentage points.²⁹ With regard to local relief funds, half will be distributed based on population size and the other half based on a modified Community Development Block Grant formula. Though unemployment and local grant formulas may not be the best proxy for need, they recognize economic conditions are an important driver of fiscal need.³⁰

Several key informants remarked that the pandemic's timing was fortuitous, given that it took hold near the end of states' fiscal years. Many state legislatures had finished their planning for fiscal year 2021 by then and only needed to endure a couple of months of stress at the end of state fiscal year 2020. However, many states were forced to significantly rewrite recently enacted budgets, and 26 states convened special legislative sessions to adjust their plans in light of the pandemic, which, as described above, sometimes involved cutting budgets and putting initiatives on hold.³¹ The most significant tension facing states last year, according to key informants we spoke with, was their inability to react to growing budget and fiscal stress by cutting Medicaid or other health programs during a public health emergency. One interviewee explained, "Reductions in reimbursement rates and other cuts to providers...[have] been the go-to place in Medicaid in recessions. But we haven't had a recession with a pandemic before."

The Outlook for Medicaid in 2021

Medicaid has long been the largest or second-largest component of state budgets (alongside education), so the program is a logical target for cuts during recessions. At the same time, the generous federal matching dollars the program provides states mean Medicaid is not always the most attractive target for cuts. Smaller programs, less likely to be funded by the federal government, often suffer larger cuts.

Traditionally, budgeters focus on three Medicaid policy areas when considering cuts: program eligibility, covered benefits, and provider reimbursement. For 2021, however, eligibility cuts are prohibited during the public health emergency, because MOE rules dictate states must maintain the eligibility thresholds in place at the start of the pandemic and provide continuous coverage to those enrolled at that time to receive enhanced federal matching funds. Cuts to provider reimbursement do not seem well-advised either, according to key informants, because many providers—already operating

on thin margins because Medicaid is the lowest per capita payer in the system—suffered large revenue losses during 2020 amidst dramatic decreases in health care utilization. According to one stakeholder, some cuts to provider rates and optional Medicaid benefits for adults, such as dental care, may still be considered for 2021, depending on the state and its degree of fiscal stress.

Even as many providers experienced steep revenue declines during the crisis, Medicaid MCOs did not, because their contracts with states—which provide fixed per member per month capitation rates regardless of whether enrollees use services—were typically negotiated before the pandemic. Key informants told us that low utilization during the year upended health plans’ medical loss ratios (the proportion of dollars received that goes toward paying for services, rather than administrative costs, which CMS requires to be at least 85 percent) and resulted in large, unspent reserves. Some states worked to claw back what state policymakers considered overpayments last year, whereas others worked with health plans to negotiate direct payments from plans to providers to help providers weather the storm. Key informants told us that health plan arrangements and contracts may be key areas of focus in 2021, as states work to meet residents’ needs while balancing their budgets. As one official said, “No one wants to see Medicaid MCO dollars just sitting there, unused.” Another informant noted that 2020 MCO overpayments underscored the need to ensure accountability and transparency in Medicaid managed care and suggested states should make medical loss ratios publicly available.

Medicaid continues to be the largest payer, by far, of LTSS (CMS 2021). LTSS also constitute the largest share of Medicaid spending, accounting for 32 percent of total Medicaid expenditures in fiscal year 2019 (CMS 2020). As such, LTSS are often a target when policymakers consider Medicaid cuts and, according to key informants, they are even more vulnerable during the pandemic. Nursing facility residents suffered disproportionate COVID-19 mortality, raising numerous questions about their quality of care. More LTSS have been delivered through HCBS waivers in recent decades, and policymakers will likely consider accelerating that trend this year, as society questions the logic of continuing to care for the elderly primarily through institutions rather than in community-based settings. As part of this trend, policymakers will likely also consider more ways to reimburse family caregivers.

One large, looming question identified by stakeholders holds significant implications for state budgets: What will happen to Medicaid eligibility once the public health emergency’s MOE requirement is lifted? States could face a large backlog of eligibility redeterminations, and advocates have expressed concern over how state systems will cope with this demand, especially in states that implemented staff cuts and furloughs to balance their budgets. Medicaid enrollment may decline significantly, depending on the state of the economy when the public health emergency declaration is lifted. And if state systems are overwhelmed by the need to redetermine eligibility for their entire enrollee population in a

condensed period, stakeholders worried that the quality and accuracy of those redeterminations may suffer, leading to unintended outcomes.

Overall, stakeholders were reluctant to predict how Medicaid will fare this year and largely suggested maintenance of the status quo. That is, given the large infusion of federal support, the continuance of the public health emergency and its enhanced federal match, and a lack of policy bandwidth for dealing with much beyond the pandemic, stakeholders did not expect to see significant cuts or new initiatives. They predicted that prepandemic efforts to bring down prescription drug prices and invest in value-based payment strategies, among other priorities, will likely be paused this year.

Interestingly, however, some stakeholders were guardedly optimistic about possible program expansions this year, rather than cuts. Specifically, they hoped governors and state legislatures that have been ideologically opposed to expanding Medicaid under ACA authority might finally be persuaded that expanded coverage, facilitated by enhanced federal matching funds, is a wise way to bolster the health care safety net before the next emergency. Others mentioned more limited expansions of Medicaid postpartum coverage as another way to enhance coverage while also addressing profound racial inequities in maternal health. Informants shared these opinions even before passage of the American Rescue Plan, which, as noted, includes provisions to encourage states to adopt both expansions.

The Outlook for Behavioral and Other Health Programs in 2021

During a typical recession, non-Medicaid health programs, including those related to public health, mental health and substance use disorder treatment, and maternal and child health, can be more vulnerable to budget cuts, because they do not receive the same amount of federal matching funds as Medicaid. That is, cuts to these programs, unlike cuts to Medicaid, do not garner such large losses in federal funding while reducing state spending. But as mentioned above, key informants did not anticipate policymakers aggressively targeting these programs for cuts during the current recession. Public health programs are vitally needed to support ongoing COVID-19 testing, contact tracing, and vaccine rollout. They are also critical to supporting community and population health needs after the pandemic. Behavioral health programs are playing—and will continue to play—a crucial role in supporting people who have suffered from mental health and substance use disorders amidst pandemic-related personal and financial losses. And maternal and child health programs, which largely support preventive and primary maternal and pediatric care infrastructures, will be required to support mothers and children disproportionately vulnerable to COVID-19 and its effects.

Federal policymakers have provided new funding to safeguard these programs. As described above, the CARES Act doubled the size of the Substance Abuse and Mental Health Block Grant and included an additional 5 percent set-aside for crisis intervention (Moss et al. 2020). The Title V Maternal and Child Health Services Block Grant program also increased by \$32 million last year (March of Dimes 2020). And most recently, the American Rescue Plan builds on these investments by providing \$7.7 billion to bolster the public health workforce, \$1.5 billion for block grants for community mental health services, and \$1.5 billion for block grants for substance use disorder prevention and treatment. Still, states facing dire budget shortfalls may need to make cuts in these areas despite infusions of new federal dollars.

Longer-Term Effects and Opportunities

Perhaps what is most certain at this time is that the US faces great uncertainty in 2021 and beyond. Even as the vaccine rollout continues, some states' COVID-19 infection rates persist at levels seen during some of the worst months of 2020.³² Meanwhile, though the economy has restored more than half the jobs it lost during the pandemic, nearly 10 million fewer jobs exist now than before the pandemic.³³ Thus, economic pain and its spillover effects on population health will continue. Indeed, leading economists predict it could take until early 2024 for the economy to fully regain the 22 million jobs lost in March and April 2020.³⁴

Many of the key informants we interviewed worried that, as the country emerges from the pandemic, a secondary pandemic may be on the horizon. That is, as Americans were locked down and avoided routine preventive and primary care over the past year, they may now experience a resurgence of traditional health problems, including chronic illnesses like obesity and diabetes. Data already show childhood vaccination rates have dropped precipitously in the past year, potentially portending higher rates of avoidable childhood illnesses like measles, mumps, and rubella.³⁵

The pandemic's long-term impacts on the population's mental health and substance use are also of great concern. Millions of Americans have lost jobs, suffered through the deaths of family members, and attempted to cope with the stress and anxiety of social isolation, caring for sick family members, juggling work and children's remote learning, food insecurity, and homelessness. Rates of depression and suicidal ideation have increased during the pandemic (Czeisler et al. 2020), and stakeholders were concerned about increased intimate partner violence, homelessness, and opioid and other substance use (Czeisler et al. 2020; Evans, Lindauer, and Farrell 2020).³⁶ According to behavioral health experts, working at a job is a critical component of recovery from mental health and substance use disorder. But

in an economy that has lost millions of low-wage jobs (Kinder and Ross 2020), this aspect of recovery may not be accessible.

As noted, the pandemic laid bare stark racial inequities in the US and, by extension, in health systems. Black and Indigenous people have died of COVID-19 at 1.4 times the rate of white people, and Latinx people have died at a rate more than 1.2 times greater than that of white people.³⁷ With the vaccine rollout, these inequities have persisted. According to the CDC, as of March 1, 2021, race or ethnicity was known for just over half (54 percent) of people who had received at least one dose of the vaccine; among this group, nearly two-thirds were white (65 percent), 9 percent were Hispanic, 7 percent were Black, 5 percent were Asian, 2 percent were American Indian or Alaska Native, and 14 percent identified as multiple races or another race (Ndugga et al. 2021). These data build on myriad other well-known social inequities faced by people of color, including disproportionate rates of poverty, food insecurity, and unemployment; unequal access to health care and coverage; and adverse health outcomes, such as obesity, diabetes, and maternal morbidity and mortality (Artiga, Orgera, and Damico 2020; NASEM 2017; Odoms-Young and Marino 2018).³⁸ States are increasingly crafting policies to address health inequities, and key informants were optimistic this focus would continue, claiming such problems could no longer be ignored. As one interviewee said, “States have created new infrastructure around integrating equity into their [COVID-19] response that may be retained for future emergency responses.”

One stakeholder observed a take-away from the past year is that Medicaid is “a first responder for the nation,” citing the program’s critical role in any disaster, including the current crisis. Over the past year, Medicaid has protected millions of Americans’ health coverage, provided a safety net for people losing employer-sponsored coverage, and bolstered health systems inundated with COVID-19-related demand or struggling because of declines in routine health care utilization. Federal officials quickly issued waivers and guidance for how states could maximize the flexibility of their programs, and Congress swiftly enhanced federal financial support for Medicaid and protected beneficiaries from disenrollment during the public health emergency. Further enhancements in the American Rescue Plan, like increased financial incentives to expand Medicaid to single adults in states that have not done so, promise to further ensconce Medicaid’s role as a crucial component of the safety net.

Finally, several stakeholders were optimistic that the nation’s experience with COVID-19 could be a catalyst for reforming many aspects of the health care safety net. By analyzing both how and where US systems fell short in caring for the population and how and where they successfully adapted, stakeholders hoped that an improved US health care system would emerge. They envisioned a system that places greater emphasis on prevention and preparedness, racial and ethnic equity, social determinants

of health, value- and outcomes-based (rather than volume-based) reimbursement for health services, and safer community-based systems of long-term care. Stakeholders also hoped that this transformed health care system might more nimbly respond to health crises as they arise. Applying lessons learned during the pandemic will be important for repeating avoidable future mistakes. Key questions to monitor whether this advancement happens include the following:

- Will financial incentives included in the American Rescue Plan spur states that have not already expanded Medicaid under the ACA to do so?
- Will states maintain or reduce Medicaid eligibility when the MOE requirement is lifted?
- Will Medicaid programs, health plans, and providers point resources toward addressing gaps and inequities in care that occurred during the pandemic?
- Will states build on their COVID-19-inspired equity and data collection efforts to create more effective and comprehensive monitoring systems?
- Will states redouble their attention and investments on behavioral health systems in anticipation of increased needs for mental health and substance use treatment services after the pandemic?
- How will community-based long-term care services and investments evolve after the pandemic?
- What additional federal rule changes will occur and are needed for states to achieve more proactive, preventive, holistic, and equitable health care systems?

The questions above illustrate an initial policy framework for monitoring the country's longer-term responses to the pandemic and its fiscal aftermath.

Notes

- ¹ “Coronavirus in the U.S.: Latest Map and Case Count,” *New York Times*, last updated April 15, 2021, <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html>.
- ² Mary Williams Walsh, “States Are in a Quandary as Taxes Evaporate and Virus Spending Soars,” *New York Times*, April 15, 2020, <https://www.nytimes.com/2020/04/15/business/economy/state-tax-revenue-debt-coronavirus.html>.
- ³ “Unemployment Rate Rises to Record High 14.7 Percent in April 2020,” *TED: The Economics Daily* (blog), US Bureau of Labor Statistics, May 13, 2020, https://www.bls.gov/opub/ted/2020/unemployment-rate-rises-to-record-high-14-point-7-percent-in-april-2020.htm?view_full.
- ⁴ Lucy Dadayan and Kim S. Rueben, “Congress Needs to Understand State Tax Revenue Declines When Drafting COVID-19 Legislation,” *TaxVox* (blog), Urban-Brookings Tax Policy Center, December 10, 2020, <https://www.taxpolicycenter.org/taxvox/congress-needs-understand-state-tax-revenue-declines-when-drafting-covid-19-legislation>.
- ⁵ Daniel McDermott, Cynthia Cox, Robin Rudowitz, and Rachel Garfield, “How Has the Pandemic Affected Health Coverage in the U.S.,” *Policy Watch* (blog), Kaiser Family Foundation, December 9, 2020, <https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/>.
- ⁶ Sarah D. Wire, “House Sends \$1.9 Trillion COVID-19 Economic Relief Bill to Biden’s Desk,” *Los Angeles Times*, March 10, 2021, <https://www.latimes.com/politics/story/2021-03-10/house-prepares-to-send-1-9-trillion-covid-19-economic-relief-bill-to-bidens-desk>.
- ⁷ Calder Lynch (deputy administrator and director of the Center for Medicaid and CHIP Services), letter to state Medicaid directors, “COVID-19 Public Health Emergency Section 1115(a) Opportunity for States,” March 22, 2020, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx>.
- ⁸ Anne Marie Costello (acting deputy administrator and director, Centers for Medicare & Medicaid Services), letter to state health officials, “Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Programs (BHP) Operations upon Conclusion of the COVID-19 Public Health Emergency,” December 22, 2020, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>.
- ⁹ See also Centers for Disease Control and Prevention, “Overdose Deaths Accelerating during COVID-19: Expanded Prevention Efforts Needed,” press release, December 17, 2020, <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>.
- ¹⁰ “The Long-Term Care COVID Tracker,” COVID Tracking Project at *The Atlantic*, last updated March 7, 2021, <https://covidtracking.com/nursing-homes-long-term-care-facilities>.
- ¹¹ Anna Wilde Mathew and Tom McGinty, “COVID Spurs Families to Shun Nursing Homes, a Shift That Appears Long Lasting,” *Wall Street Journal*, last updated December 21, 2020, <https://www.wsj.com/articles/covid-spurs-families-to-shun-nursing-homes-a-shift-that-appears-long-lasting-11608565170>.
- ¹² Wendy Fox-Grage, Salom Teshale, and Paige Spradlin, “States Race to Secure Home- and Community-Based Services during COVID-19,” National Academy for State Health Policy, last updated May 7, 2020, <https://www.nashp.org/states-race-to-secure-home-and-community-based-services-during-covid-19/>.
- ¹³ Courtney Harold van Houtven and Walter D. Dawson, “Long-Term Care Reforms Should Begin with Paid Home Care Providers,” *Building Back Better* (blog), Milbank Memorial Fund, January 14, 2021, <https://www.milbank.org/quarterly/opinions/long-term-care-reforms-should-begin-with-paid-home-care-providers/>.

- ¹⁴ “Fourth COVID-19 Interim Final Rule with Comment Period (IFC-4),” Centers for Medicare & Medicaid Services, October 28, 2020, <https://www.cms.gov/newsroom/fact-sheets/fourth-covid-19-interim-final-rule-comment-period-ifc-4>.
- ¹⁵ Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 71142 (November 6, 2020).
- ¹⁶ ADAP Advocacy Organization and others, letter to Anne Marie Costello (acting deputy director for the Center for Medicaid and CHIP Services), “Rescinding the Interim Final Rule ‘Temporary FMAP Increase during the Public Health Emergency for COVID-19,’ codified at 42 C.F.R 433.400,” April 6, 2021, <https://www.lung.org/getmedia/fb8cde3f-5879-447e-978b-5a8a19a23cd7/moe-ifr-implementation-sign-on-letter-2021-04-06final.pdf>.
- ¹⁷ Matt Volz, “As Demand for Mental Health Care Spikes, Budget Ax Set to Strike,” *Kaiser Health News*, February 5, 2021, <https://khn.org/news/article/as-demand-for-mental-health-care-spikes-budget-ax-set-to-strike/>.
- ¹⁸ “Disaster Relief State Plan Amendments,” Medicaid and CHIP Payment and Access Commission, accessed April 16, 2021, <https://www.macpac.gov/subtopic/disaster-relief-state-plan-amendments/>.
- ¹⁹ “Medicaid Managed Care Market Tracker,” Kaiser Family Foundation, accessed April 16, 2021, <https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/>.
- ²⁰ “Health Equity Considerations and Racial and Ethnic Minority Groups,” Centers for Disease Control and Prevention, last updated February 12, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>.
- ²¹ Association of State and Territorial Health Officials (ASTHO), “How States Are Addressing the Public Health Crisis of Racism,” *ASTHO Experts* (blog), ASTHO, February 23, 2021, https://www.astho.org/StatePublicHealth/How-States-Are-Addressing-the-Public-Health-Crisis-of-Racism/02-23-21/?utm_source=Informz&utm_medium=email&utm_campaign=Informz; “Racism Is a Public Health Crisis,” American Public Health Association, accessed April 16, 2021, <https://www.apha.org/racism-declarations>.
- ²² Elinor Higgins, “States Launch Initiatives to Address Racial Inequities Highlighted by COVID-19,” National Academy for State Health Policy, August 3, 2020, <https://www.nashp.org/states-launch-initiatives-to-address-racial-inequities-highlighted-by-covid-19/>.
- ²³ Rebecca Cooper and Jill Rosenthal, “States Build Infrastructure to Advance Equity in Their COVID-19 Responses and Beyond,” National Academy for State Health Policy, November 30, 2020, <https://www.nashp.org/states-build-infrastructure-to-advance-equity-in-their-covid-19-responses-and-beyond/>.
- ²⁴ Elinor Higgins, “States Work to Advance Racial Equity in COVID-19 Outcomes and Beyond,” National Academy for State Health Policy, October 12, 2020, <https://www.nashp.org/states-work-to-advance-racial-equity-in-covid-19-outcomes-and-beyond/>.
- ²⁵ “People with Untreated Mental Illness 16 Times More Likely to Be Killed by Law Enforcement,” Treatment Advocacy Center, accessed April 18, 2021, <https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness/2976-people-with-untreated-mental-illness-16-times-more-likely-to-be-killed-by-law-enforcement->.
- ²⁶ National Suicide Hotline Designation Act of 2020, S. 2661, 116th. Cong. (2019–20).
- ²⁷ Timothy J. Bartik, “An Updated Proposal for Timely, Responsive Federal Aid to State and Local Governments during the Pandemic Recession,” W. E. Upjohn Institute for Employment Research, May 22, 2020, <https://www.upjohn.org/research-highlights/updated-proposal-timely-responsive-federal-aid-state-and-local-governments-during-pandemic-recession>.

- ²⁸ Lucy Dadayan and Kim S. Rueben, “Why States and Localities Need More Federal Aid,” *TaxVox* (blog), Urban-Brookings Tax Policy Center, February 22, 2021, <https://www.taxpolicycenter.org/taxvox/why-states-and-localities-need-more-federal-aid>.
- ²⁹ Allan Baumgarten and Katherine Hempstead, “Recession and Medicaid Budgets: What Are the Options?” *Health Affairs Blog*, September 10, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200908.169117/full/>.
- ³⁰ Dadayan and Rueben, “Why States and Localities Need More Federal Aid,” *TaxVox*.
- ³¹ “2020 Legislative Session Calendar,” National Conference of State Legislatures, accessed April 20, 2021, https://www.ncsl.org/portals/1/Documents/ncsl/2020_session_calendar1.pdf.
- ³² As of March 10, 2021, the seven-day average for new daily COVID-19 cases in the United States was below 58,000 for the first time since mid-October 2020. See also Julie Mack and Scott Levin, “Michigan Coronavirus Data for Monday, April 5: State’s Positivity Rate Exceeds Peak of Fall Surge,” *M Live*, April 5, 2021, <https://www.mlive.com/public-interest/2021/04/michigan-coronavirus-data-for-monday-april-5-states-positivity-rate-exceeds-peak-of-fall-surge.html>.
- ³³ US Bureau of Labor Statistics, “The Employment Situation – March 2021,” news release, April 2, 2021, <https://www.bls.gov/news.release/pdf/empsit.pdf>.
- ³⁴ Kate Duffy, “It Could Take 4 Years to Recover the 22 million Jobs Lost in the US during the Early Months of the COVID-19 Pandemic, Moody’s warns,” *Insider*, December 2, 2020, <https://www.businessinsider.com/covid-job-losses-unemployment-recovery-years-moodys-covid-2020-12>.
- ³⁵ “Global Measles Outbreak,” Centers for Disease Control and Prevention, updated April 6, 2021, <https://www.cdc.gov/globalhealth/measles/data/global-measles-outbreaks.html>; “Measles Fact Sheet,” Measles and Rubella Initiative, July 2020, <https://s3.amazonaws.com/wp-agility2/measles/wp-content/uploads/2020/09/FACTSHEET-Measles-Updated-2020-09.pdf>.
- ³⁶ “The Impact of the COVID-19 Pandemic on Homelessness in the United States,” United Way of the National Capital Area, accessed April 18, 2021, <https://unitedwaynca.org/stories/effect-pandemic-homeless-us/>.
- ³⁷ “The COVID Racial Data Tracker,” COVID Tracking Project at *The Atlantic*, last updated March 7, 2021, <https://covidtracking.com/race>.
- ³⁸ Centers for Disease Control and Prevention, “Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths,” news release, September 5, 2019, <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>; John Creamer, “Inequalities Persist Despite Decline in Poverty for All Major Race and Hispanic Origin Groups,” US Census Bureau, September 15, 2020, <https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html>; Olugbenga Ajilore, “The Persistent Black-White Unemployment Gap Is Built into the Labor Market,” Center for American Progress, September 28, 2020, <https://www.americanprogress.org/issues/economy/news/2020/09/28/490702/persistent-black-white-unemployment-gap-built-labor-market/>.

References

- Aron-Dine, Aviva, Kyle Hayes, and Matt Broaddus. 2020. "With Need Rising, Medicaid Is at Risk for Cuts." Washington, DC: Center on Budget and Policy Priorities.
- Artiga, Samantha, Kendal Orgera, and Anthony Damico. 2020. "Changes in Health Coverage by Race and Ethnicity since the ACA, 2010–2018." San Francisco: Kaiser Family Foundation.
- Barna, Mark. 2020. "Ending Police Violence Requires Public Health-Based Approach: APHA Statement Guiding Work, Outreach." *The Nation's Health* 50 (6): 1–14.
- Buettgens, Matthew. 2021. "Medicaid Expansion Would Have a Larger Impact Than Ever during the COVID-19 Pandemic." Washington, DC: Urban Institute.
- CMS (Centers for Medicare & Medicaid Services). 2021. *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018*. Baltimore: Centers for Medicare & Medicaid Services.
- Cox, Cynthia, Krutika Amin, and Rabah Kamal. 2021. "How Have Health Spending and Utilization Changed during the Coronavirus Pandemic?" San Francisco: Kaiser Family Foundation.
- Czeisler, Mark É., Rashon I. Lane, Emiko Petrosky, Joshua F. Wiley, Aleta Christensen, Rashid Njai, Matthew D. Weaver, et al. 2020. "Mental Health, Substance Use, and Suicidal Ideation during the COVID-19 Pandemic—United States, June 24–30, 2020." *Morbidity and Mortality Weekly Report* 69 (32): 1049–57. <http://dx.doi.org/10.15585/mmwr.mm6932a1>.
- Dadayan, Lucy. 2020. *State Tax and Economic Review, 2020 Quarter 2*. Washington, DC: Urban Institute.
- Dubay, Lisa, Joshua Adams, Steven Brown, and Genevieve M. Kenney. 2020. *How Risk of Exposure to the Coronavirus at Work Varies by Race and Ethnicity and How to Protect the Health and Well-Being of Workers and Their Families*. Washington, DC: Urban Institute.
- Evans, Megan L., Margo Lindauer, and Maureen E. Farrell. 2020. "A Pandemic within a Pandemic — Intimate Partner Violence during COVID-19." *New England Journal of Medicine* 383:2302–04. <https://doi.org/10.1056/NEJMp2024046>.
- Gangopadhyaya, Anuj, and Bowen Garrett. 2020. "Unemployment, Health Insurance, and the COVID-19 Recession." Washington, DC: Urban Institute.
- Gifford, Kathleen, Aimee Lashbrook, Sarah Barth, Elizabeth Hinton, Robin Rudowitz, Madeline Guth, and Lina Stolyar. 2020. *State Medicaid Programs Respond to Meet COVID-19 Challenges: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2020 and 2021*. Washington, DC: Kaiser Family Foundation.
- Gonzalez, Dulce, Michael Karpman, Genevieve M. Kenney, and Stephen Zuckerman. 2021a. "Delayed and Forgone Health Care for Children during the COVID-19 Pandemic." Washington, DC: Urban Institute.
- . 2021b. "Delayed and Forgone Health Care for Nonelderly Adults during the COVID-19 Pandemic: Findings from the September 11–28 Coronavirus Tracking Survey." Washington, DC: Urban Institute.
- Gonzalez, Dulce, Stephen Zuckerman, Genevieve M. Kenney, and Michael Karpman. 2020. "Almost Half of Adults in Families Losing Work during the Pandemic Avoided Health Care Because of Costs or COVID-19 Concerns." Washington, DC: Urban Institute.
- Guy, Gery P., Florence C. Lee, Gregory Sunshine, Russell McCord, Mara Howard-Williams, Lyudmyla Kompaniyets, Christopher Dunphy, et al. 2021. "Association of State-Issued Mask Mandates and Allowing On-Premises Restaurant Dining with County-Level COVID-19 Case and Death Growth Rates—United States, March 1–December 31, 2020." *Morbidity and Mortality Weekly Report* 70 (10): 350–54. [https://doi.org/10.15585/mmwr.mm7010e3external icon](https://doi.org/10.15585/mmwr.mm7010e3external%20icon).

- Guyer, Jocelyn, and Patricia Boozang. 2020. "New Hampshire COVID-19 Directed Payment." Princeton, NJ: Princeton University, Woodrow Wilson School of Public and International Affairs, and State Health and Value Strategies.
- Hill, Ian, and Emmy Burroughs. 2020. "Maternal Telehealth Has Expanded Dramatically during the COVID-19 Pandemic: Equity Concerns and Promising Approaches." Washington, DC: Urban Institute.
- Kinder, Molly, and Martha Ross. 2020. *Reopening America: Low-Wage Workers Have Suffered Badly from COVID-19 So Policymakers Should Focus on Equity*. Washington, DC: Brookings Institution.
- Krisberg, Kim. 2020. "Already-Strained US Public Health Workforce Grapples with COVID-19: Despite Resource Gaps, Workers Fight On." *The Nation's Health* 50 (4): 1–12.
- March of Dimes. 2020. "Summary of the 2020 End-of-Year Funding and COVID Relief Package." Arlington, VA: March of Dimes.
- McMorrow, Stacey, Dulce Gonzalez, Clara Alvarez Caraveo, and Genevieve M. Kenney. 2020. "Urgent Action Needed to Address Children's Unmet Health Care Needs during the Pandemic." Washington, DC: Urban Institute.
- McNichol, Elizabeth, and Michael Leachman. 2020. "States Continue to Face Large Shortfalls Due to COVID-19 Effects." Washington, DC: Center on Budget and Policy Priorities.
- Mehrotra, Ateev, Michael Chernew, David Linetsky, Hilary Hatch, David Cutler, and Eric C. Schneider. 2020. *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients*. New York: Commonwealth Fund.
- Moss, Kellie, Adam Wexler, Lindsey Dawson, Michelle Long, Jennifer Kates, Juliette Cubanski, MaryBeth Musumeci, et al. 2020. "The Coronavirus Aid, Relief, and Economic Security Act: Summary of Key Health Provisions." San Francisco: Kaiser Family Foundation.
- Musumeci, MaryBeth. 2021. "Medicaid Provisions in the American Rescue Plan Act." San Francisco: Kaiser Family Foundation.
- NASEM (National Academies of Sciences, Engineering, and Medicine); Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Alina Baciuc; Yamrot Negussie; Amy Geller; and James N. Weinstein, eds. 2017. "The State of Health Disparities in the United States." In *Communities in Action: Pathways to Health Equity*. Washington, DC: National Academies of Sciences, Engineering, and Medicine.
- Ndugga, Nambi, Olivia Pham, Latoya Hill, Samantha Artiga, Raisa Alam, and Noah Parker. 2021. "Latest Data on COVID-19 Vaccinations Race/Ethnicity." San Francisco: Kaiser Family Foundation.
- O'Malley Watts, Molly, MarBeth Musumeci, and Priya Chidambaram. 2020. "Medicaid Home and Community-Based Services Enrollment and Spending." San Francisco: Kaiser Family Foundation.
- Odoms-Young, Angela, and Bruce Marino. 2018. "Examining the Impact of Structural Racism on Food Insecurity." *Family and Community Health* April/June (41): S3–S6. <https://doi.org/10.1097/FCH.000000000000183>.
- Panchal, Nirmita, Rabah Kamal, Cynthia Cos, and Rachel Garfield. 2021. "The Implications of COVID-19 for Mental Health and Substance Use." San Francisco: Kaiser Family Foundation.
- Randi, Olivia, Eskedar Girmash, and Kate Honsberger. 2021. "State Approaches to Reimbursing Family Caregivers of Children and Youth with Special Health Care Needs through Medicaid." Washington, DC: National Academy for State Health Policy.
- Smith, Laura Barrie, and Fredric Blavin. 2021. "One in Three Adults Used Telehealth during the First Six Months of the Pandemic, but Unmet Needs for Care Persisted." Washington, DC: Urban Institute.

Snyder, Laura, and Robin Rudowitz. 2016. "Trends in State Medicaid Programs: Looking Back and Looking Ahead." Menlo Park, CA: Kaiser Family Foundation.

Zhang, Xue, and Mildred E. Warner. 2020. "COVID-19 Policy Differences across US States: Shutdowns, Reopening, and Mask Mandates." *International Journal of Environmental Research and Public Health* 17 (24): 9520. <https://doi.org/10.3390/ijerph17249520>.

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