MAXIMIZING MEDICAID TO ADDRESS THE IMPACT OF COVID-19

As states deal with the impact of COVID-19 on the health and well-being of their residents, they should unleash the full power of Medicaid to address the public health emergency and the economic downturn that will likely extend beyond the public health crisis. First and foremost, all states should expand Medicaid. States can also take up Medicaid options to expand eligibility to cover more people, and they should make it easier for everyone to enroll and stay covered. States should also expand benefits and eliminate premiums and copayments to ensure people can get the care they need.

The Families First Corona Virus Response Act enacted on March 18 gives states and territories a temporary 6.2 percentage point increase in their federal matching assistance percentages (FMAPs), a significant boost in federal funds to states. It also prohibits states accepting the FMAP increase from terminating coverage or benefits or increasing cost-sharing for anyone eligible on March 18, 2020, or who becomes eligible after that date until the end of the public health emergency unless they ask to disenroll or leave the state. States also can't impose more restrictive eligibility standards, methodologies or procedures, or higher premiums than they had in place on January 1, 2020, and they must cover testing and treatment for COVID-19 without any cost-sharing. The Centers for Medicare & Medicaid Services (CMS) issued guidance on the FMAP increase and the maintenance of effort (MOE) requirement on March 24, added some questions on the MOE to its running list of FAQs on April 2, and issued further guidance on April 13. CMS issued additional FAQs on May 5 in a separate document, and also issued a 70-page compilation of all its FAQs with a table of contents.

States have begun to take advantage of Medicaid's flexibility to address the COVID-19 crisis. Many states have submitted section 1135 and section 1115 waivers to CMS. States can also make emergency changes to their home- and community-based (HCBS) waivers to include additional slots and more services, among other changes. Section 1135 authority allows the Secretary of Health and Human Services to waive or modify Medicaid and CHIP (and Medicare) requirements to make sure that health care items and services are sufficient to meet the needs of Medicaid enrollees in areas affected by a disaster or public health emergency. The Secretary can also waive or modify deadlines that would otherwise apply, including for fair hearings. Moreover, in the current crisis, the Secretary has authorized blanket 1135 waivers, which are available to all states without a waiver request. CMS has a template states can use in making their 1135 waiver requests and a web page with approved waivers.

Section 1115 emergency waivers have been used in past emergencies to broaden eligibility and benefits and to streamline enrollment. Several states have proposed emergency waivers that include support for housing and other services. CMS has issued a template for 1115 emergency waivers that provides an expedited way for states to make their requests. States don't have to show their proposals are budget neutral to the federal government or comply with the usual public notice and comment procedures. CMS approved the first 1115 emergency waiver for the

state of Washington on April 21. CMS denied the state's request to subsidize marketplace premiums for people with incomes below 200 percent of the poverty line, and deferred its requests to fund housing and nutrition supports. It approved a number of changes in how Washington determines eligibility for HCBS and authorized short-term retainer payments to HCBS providers.

The easiest way states can maximize Medicaid's power is by amending their Medicaid state plans to take full advantage of Medicaid options. Usually state plan amendments (SPAs) become effective on the first day of the quarter in which the state submits a SPA. But during the current crisis, CMS is allowing states to use 1135 waiver authority to make their disaster SPAs retroactive to March 1, 2020, even if they submit them after March 31, and CMS is waiving public notice requirements that would otherwise apply. CMS has issued a special SPA template states can use to amend their state plans for the period of the public health emergency.

The list below summarizes what states can do to maximize Medicaid's reach. We'll continue to update it with any new options and information on how states are using these authorities, including section 1115, to address the impact of COVID-19. The Kaiser Family Foundation is tracking states' use of emergency authorities. The National Academy for State Health Policy (NASHP) has an interactive map of changes states are making to their home- and community-based waivers during the public health emergency. And CBPP has a paper with helpful tables and charts compiling what states are doing to make it easier to enroll and make other improvements to coverage.

If you have questions, comments or suggestions, please reach out to Judy Solomon (solomon@cbpp.org) or Jesse Cross-Call (cross-call@cbpp.org).

Expanding Coverage for Children, Parents, Adults, and Pregnant Women

Expanding Coverage for Seniors and People with Disabilities

Making it Easier to Enroll

Making it Easier to Stay Enrolled

Expanding Benefits

Expanding Coverage for Children, Parents, Adults, and Pregnant Women

- States that haven't expanded Medicaid to adults with incomes up to 138 percent of the poverty line should submit SPAs to expand coverage and receive 90 percent federal match for services provided to newly eligible adults. (42 CFR §435.119)
- States can submit SPAs to increase eligibility for adults and children under age 65 with incomes above 138 percent of the poverty line at the state's regular federal matching assistance percentage (FMAP), which is increased by 6.2 percentage points during the public health emergency. (42 CFR §435.218) States can also increase eligibility for pregnant women also at regular FMAP with the 6.2 percentage point increase.
- States should adopt the "ICHIA" option to provide Medicaid and CHIP coverage to lawfully residing children and pregnant women. (This chart shows which states have taken up the option as of January 2019.) States can also provide prenatal care to women regardless of immigration status by extending CHIP coverage to the unborn child. (See this chart.)
- States should take up the option in the Families First Act to provide coverage for uninsured people for COVID-19 testing at 100 percent federal match. The Coronavirus Aid, Relief, and Economic Security (CARES) Act clarified that the definition of uninsured people includes people in the coverage gap in non-expansion states and people enrolled in Medicaid groups that don't provide the full scope of benefits such as covering for family planning services and supplies. April 13 guidance from CMS provides details on the benefits and eligibility requirements for this group. (FAQs 2-13) There are no income or resource requirements, but applicants do have to provide a Social Security number. Benefits include testing for antibodies, but not treatment. As of this date, Arizona, Rhode Island, Louisiana, Colorado, Puerto Rico, Maine, Illinois, Washington, Minnesota, the Virgin Islands, South Carolina, Montana, Alabama, California, and New Mexico have approved state plans for this coverage group.

Expanding Coverage for Seniors and People with Disabilities

- States can submit SPAs to increase their eligibility limits for seniors and people with disabilities at regular match with the 6.2 percentage point bump. California has expanded eligibility for these groups by disregarding all income up to 138 percent of the poverty line.
- States can eliminate or decrease asset tests for seniors and people with disabilities, and where resource tests apply, allow self-attestation with electronic verification through the automated verification systems most states are using.
- States can amend their state plans to disregard certain amounts of income over their medically needy income levels for seniors and people with disabilities, so more people can get immediate coverage without submitting proof of their medical expenses freeing state workers from complicated computations usually needed to determine the date an individual is eligible. (42 CFR 435.831.)
- States can modify their section 1915 home- and community-based services (HCBS) waivers to increase the number of slots. CMS has a template to facilitate changes in section 1915 waivers. The template can also be used to provide additional services that

are needed to address COVID-19. Note that CMS issued guidance on the MOE included in the 2009 Recovery Act that barred states from implementing more restrictive eligibility conditions. The guidance explains that the MOE bars reduction in HCBS waiver slots in certain circumstances. Given the language in Families First, the MOE should apply now as well. In addition, April 13 CMS guidance (FAQs 25 and 26) explains that people who no longer meet level of care requirements for their HCBS coverage can't lose their coverage under the MOE, but the state can modify their care plans.

Making it Easier to Enroll

- States should cease implementation of restrictive waivers including premiums, work requirements, and tobacco surcharges, which make it harder for people to enroll and stay enrolled. States receiving the Families First FMAP increase can't terminate coverage for people during the PHE, so they should suspend implementation of these restrictive eligibility conditions at least for the duration of the PHE.
- States should maximize their use of presumptive eligibility, including hospital presumptive eligibility, through expansion of qualified entities, including the state agency, community health centers, and other community sites, and adopt presumptive eligibility for all eligible populations including children, pregnant women, and other adults. States should develop a plan for follow-up to ensure eligibility of individuals beyond the PE period. (See 42 CFR §§435.1100-1110.)
- States should minimize requirements for applicants to verify their income by relying on self-attestation and electronic data sources to the maximum extent possible. States should enroll people based on their self-attestation and follow up with verification requests only when the attestation is not compatible with electronic data sources. (See 42 CFR §435.945(a) and this CBPP paper.) An FAQ (Eligibility and Enrollment Flexibilities, #6) says that states may change their verification policies to use self-attestation, adopt post-eligibility verification, or may make other changes by submitting an addendum to CMS and includes a link to a template states can use to make such changes. Note also that FAQ #5 in that section says that states using post-eligibility verification must keep people enrolled until the end of the public health emergency regardless of the outcome of post-eligibility verification. Helpful information on self-attestation and post-eligibility verification is in the May 5 FAQs from CMS, including when self-attestation is acceptable to prove an eligibility factor.
- States using the federally facilitated marketplace (FFM) should consider allowing the marketplace to determine eligibility for people who apply through healthcare.gov. This chart shows which states are already determination states and which are assessment states that currently do their own determination of eligibility based on the information transferred from the FFM. The May 5 FAQs confirm that assessment states can temporarily accept determinations from the FFM without further action if the FFM verified eligibility factors. States do not need to seek authority from CMS to take this step.

- States must provide a reasonable opportunity period of at least 90 days to individuals who attest they are citizens or have an immigration status that would make them eligible for benefits as well as to those who don't have a Social Security number (SSN). This means states should enroll people and assist them in providing any documents they need after exhausting attempts to verify citizenship or status through electronic verification. States can extend the 90-day period for good cause, including the agency's inability to complete the verification process during the PHE. (See 42 CFR §435.956 and the SPA template.) April 13 CMS guidance (FAQ 35) makes it clear that if the state can't verify an individual's status during the reasonable opportunity period, the individual's eligibility must continue through the public health emergency.
- As explained in this CBPP paper, states should take advantage of the overlapping eligibility for Supplemental Nutrition Assistance Program (SNAP) and Medicaid by using SNAP income data in determining and renewing Medicaid eligibility. States can also implement express lane eligibility (ELE) for children, which allows states to rely on findings from other programs such as SNAP, school lunch and Temporary Assistance for Needy Families (TANF) in determining eligibility at application and renewal.
- States should cease implementation of remote identity proofing (RIDP) requirements that prevent some applicants from submitting online applications. (This paper explains steps should take to ensure RIDP isn't a barrier to enrollment.)

Making it Easier to Stay Enrolled

- The MOE in the Families First Act requires that people eligible on the date of enactment (March 18, 2020) and those who enroll during the PHE "be treated as eligible" through the last day of the month the PHE ends unless the individual voluntarily disenrolls or ceases to be a resident of the state. This effectively provides continuous eligibility for people throughout the public health emergency.
- While the MOE prohibits termination of coverage for currently enrolled people and those who enroll during the public health emergency, CMS guidance leaves it up to states whether to conduct redeterminations, saying only that the MOE "does not prohibit a state from conducting regular Medicaid renewals and redeterminations or acting on reported or identified changes in circumstances," or conducting periodic data matching. To reduce unnecessary work, states should temporarily delay renewals in affected areas under authority states have to exceed time limits in emergency situations. According to the CMS Disaster Toolkit, this is authorized under existing regulations at 42 CFR §431.211, 42 CFR §435.912(e)(2), and 42 CFR §435.930. More information on this aspect of the MOE is in a recent CBPP paper.
- Given that the MOE prohibits termination of coverage, states should also suspend periodic eligibility checks including quarterly wage checks, or at least avoid acting on mid-year checks, to avoid extra paperwork for beneficiaries and state workers. The verification plan template in Eligibility and Enrollment FAQ #5 gives states an easy way

to change their verification plans to forgo periodic data matching during the public health emergency.

- Under existing Medicaid rules, states should maintain coverage for people temporarily residing out of state due to the coronavirus. (42 CFR §435.403(j)) The disaster SPA template provides an option for states to extend coverage to people living in the state who are non-residents. This could help students and others who have temporarily relocated.
- As noted above, states should utilize SNAP data in renewing Medicaid coverage and coordinate renewals for SNAP and Medicaid.
- If states continue to conduct renewals despite the MOE, they should maximize the use of automated *ex parte* renewals to reduce state workload, minimize burden on beneficiaries, and keep people covered.

Expanding Benefits

- States should drop all copayments and benefit limits or at least those for prevention and treatment related to coronavirus. The MOE makes the FMAP increase contingent on states providing "any testing services and treatments for COVID-19, including vaccines, specialized equipment and therapies," without the imposition of cost-sharing. However, CMS FAQs confirm that states can't apply exemptions from copayments just to those affected by a specific diagnosis, such as COVID-19. States could drop all co-payments through a SPA or if this isn't feasible, seek an 1115 waiver to drop co-payments just for COVID-19.
- States should immediately cease implementing waivers that eliminate non-emergency transportation and retroactive coverage to ensure people can get the care they need and, in the case of retroactive coverage, to provide financial stability for health care providers and beneficiaries.
- States should cover 90-day supplies of maintenance medications, allow advance refills, and cover home delivery of prescription drugs. The CMS SPA template includes options for adjusting any quantity limits the state imposes and allowing automatic renewals without clinical review.
- States can provide expanded benefits for affected populations through the 1915(i) state option for home- and community-based services.
- States should maximize the use of telehealth. CMS released a telehealth toolkit for state Medicaid and CHIP programs on April 23.
- States should maximize coverage and awareness of emergency services available to people not eligible for Medicaid due to their immigration status.
- States can use emergency 1115 waivers to expand services for targeted groups (see Flint waiver described in the MACPAC brief). States could also include supports for people who are quarantined such as housing supports, nutritional counseling, and physical and mental health checks. Several states have requested such authorities, but none have been approved to date. On April 21, CMS deferred requests from Washington state while approving changes affecting Washington's HCBS program.