

What State Medicaid Agencies Can Do to Address COVID-19

States have enormous flexibility to adapt their Medicaid programs to address COVID-19. They can expand eligibility and benefits and take steps to make it easier for people to enroll and stay enrolled. While additional steps can be taken using waivers, a lot can be accomplished through state plan amendments (SPAs) or through changes in state policies and processes that don't require federal approval. Moreover, there are some things Medicaid rules already require, and all states should be doing. State advocates can play an important role in helping to ensure states are fulfilling applicable Medicaid requirements and maximizing Medicaid's flexibility to address the current public health crisis. They can also work with health care providers, social service agencies, and other community-based agencies to increase public awareness about Medicaid, including the fact that people can enroll at any time.

A few general notes:

- The Centers for Medicare & Medicaid Services released an [FAQ](#) on March 12 with some helpful information on what states can do under current rules. There also is an earlier disaster [toolkit](#) describing authorities states can use. Kaiser Family Foundation has an excellent [brief](#) describing what states can do.
- States can immediately implement changes that can be made through SPAs. SPAs are effective on the first day of the quarter an approvable amendment is submitted, which means federal match would be available as soon as the state implements a new policy. Most SPAs, including those described below, are straightforward and existing templates allow states to “check the box” to change their state plans. (42 CFR §430.20)
- The House “Families First Coronavirus Response Act,” (HR 6201) includes a temporary 6.2 percentage point increase in states’ and territories’ federal matching assistance percentages (FMAPs). Enactment of such an increase should help in advocating for state action, as this [blog](#) explains. The bill also includes a maintenance of effort provision that would prevent states from restricting eligibility during the disaster period and make it easier for people to stay enrolled. The bill has passed the House and is pending action in the Senate.
- Even if a state took up most or all these flexibilities, there would still be gaps in coverage for people who don't meet Medicaid's citizenship and immigration status rules as well as for people in the coverage gap in states that still don't take up expansion. And states may need additional funds to expand public awareness, outreach and enrollment assistance to maximize Medicaid's reach and make sure people can immediately obtain the care they need. These and other areas are where Congress needs to step in, and there will be a need for state advocates to support efforts at the federal level to fill these and other gaps over the coming months. There are also additional actions states can take under section 1135 now that a disaster has been declared and through emergency section 1115 waivers. The Medicaid and CHIP Payment and Access Commission (MACPAC) has a [brief](#) explaining how these authorities have been used in past disasters.
- Finally, state Medicaid and human services agencies are likely short-staffed and dealing with multiple aspects of COVID-19. Many of the actions listed here would simplify their processes and reduce workload, strengthening the argument for state take-up.

Eligibility: Expanding Coverage for the Uninsured

States can immediately expand eligibility by submitting state plan amendments and amendments to their section 1915 home- and community-based waivers:

- Non-expansion states can submit state plan amendments (SPA) to expand coverage for adults with incomes up to 138 percent of the poverty line with enhanced match (90 percent FMAP). (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 FMAP. (42 CFR §435.218)
- States can submit SPAs to increase eligibility for other coverage groups including pregnant women, people with disabilities, and seniors at state's regular FMAP.
- States can 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 can eliminate or decrease asset tests for seniors and people with disabilities.
- 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.

Enrollment: Ensuring that All Eligible People Can Easily Enroll and Get Coverage

- States should cease implementation of restrictive waivers including premiums, work requirements, tobacco surcharges, etc. that make it harder for people to enroll and stay enrolled.
- 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 outstation eligibility staff at FQHCs and DSH hospitals (required) and other locations. (42 CFR §435.904)
- States should minimize verification of income required from applicants 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](#).)
- States are required to 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. (See 42 CFR §435.956.)

- 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.)

Renewal: Keeping People Covered

- States can temporarily delay renewals in affected areas under authority 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.
- States can implement continuous eligibility for children (SPA) and adults (1115 waiver).
- States should suspend periodic eligibility checks during the year including quarterly wage checks, or avoid acting on mid-year checks, to avoid extra paperwork for beneficiaries and state workers and avoid potential termination of coverage for people who remain eligible. Many people who had jobs may no longer have them or may be working reduced hours.
- Under existing Medicaid rules, states should maintain coverage for people temporarily residing out of state due to the coronavirus. (42 CFR §435.403(j))
- As noted above, states should utilize SNAP data in renewing Medicaid coverage and coordinate renewals for SNAP and Medicaid.
- States should maximize the use of automated *ex parte* [renewals](#) to reduce state workload, minimize burden on beneficiaries, and keep people covered.

Benefits: Getting People the Care they Need

- States should immediately cease implementing waivers that eliminate non-emergency transportation and retroactive coverage.
- States should drop all copayments and benefit limits or at least those for prevention and treatment related to coronavirus for all adults.
- States should submit a SPA to take up the option in the Affordable Care Act (ACA) to ensure all necessary treatment and preventive services, including vaccines, are covered for all adults without cost-sharing. States that take up this option receive a one percentage point bump in the FMAP for those services under section 4106 of the ACA.
- States should cover 90-day supplies of maintenance medications, allow advance refills, and cover home delivery of prescription drugs
- States can provide expanded benefits for affected populations through 1915(i) state option for home- and community-based services.
- States should educate providers on Medicaid coverage especially the EPSDT benefit for children, guaranteeing that children receive regular screening exams and preventive care and all necessary follow-up diagnostic and treatment services.
- States should maximize the use of telehealth (See this CMS [fact sheet](#).)

- States should maximize coverage and awareness of emergency services available to people not eligible for Medicaid due to immigration status.
- States can use 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. (As noted, this would be easier if CMS made emergency 1115 waivers available.)

For questions on this list or other actions states can take in Medicaid, contact Judy Solomon (solomon@cbpp.org) or Jesse Cross-Call (cross-call@cbpp.org).