

COVID-19 and Medicaid

POLICY SNAPSHOT

The COVID-19 pandemic has pushed the health system to its limits. Medicaid, as a major provider of health coverage, is in a unique position to help states respond to this global pandemic. Policymakers have many options to consider for using Medicaid programs and infrastructure to meet the increasing demand for health care services. Providing coverage to so many also makes Medicaid programs a major driver of state expenditures, and policymakers are grappling with how to leverage Medicaid to provide needed coverage through a pandemic with dwindling state revenues.

This policy snapshot includes state policy options for leveraging Medicaid programs in response to COVID-19, as well as relevant state examples, federal action and additional resources.

State Policy Options

The federal emergency declaration provides new options for flexibility at the state level to increase access to Medicaid services, such as [section 1135 waivers](#) and [1115 waivers](#) that waive requirements during the emergency period. The Centers for Medicare & Medicaid Services (CMS) has issued [guidance and templates](#) for states to use to facilitate faster CMS approval of COVID-related requests for waivers and modifications to Medicaid programs. Usually 1115 waivers are required to be budget neutral, or not increase costs, to the federal government; however, the requirement [will not be enforced](#) for waivers for COVID-19.

State policymakers may also consider modifying Appendix K of their [Home and Community-Based Services \(HCBS\) waivers](#) to support older adults and people with disabilities. For more information, see the “Policy Snapshot: COVID-19 and Long-Term Services and Supports.”

These waiver authorities can be used, alone or in combination, to streamline Medicaid resources in response to COVID-19 and in preparation for future pandemics in the following general categories:

- Adjusting Medicaid eligibility and enrollment.
- Providing flexibilities to increase access to health care services.
- Modifying enrollee cost-sharing requirements.
- Adding or adjusting existing [benefits and services](#).
- Supporting health care service providers who participate in Medicaid.

Most of these new flexibilities are focused on increasing access to Medicaid, which can drive additional state expenditures. With the federal maintenance of effort requirements, described in the Federal Action section below, state policymakers have fairly limited options for controlling Medicaid spending during this emergency period. With the [potential for significant revenue shortfalls](#), some policymakers may decide the additional federal funding does



not provide enough relief to offset costs, and decline the additional funds. As of July 1, no state had yet chosen the option to decline.

The primary options available for reducing spending during this emergency period include reducing provider reimbursement rates and making administrative cuts to the Medicaid agency. Some states, like Colorado and Ohio, took these steps. Colorado, along with New York, has also incorporated budget reductions by delaying implementation or assuming the emergency period ends by January 2021. With uncertainty over when the emergency period will end, states may be faced with making deep cuts to other budget items.

POLICY OPTIONS	STATE EXAMPLES
<p>Eligibility and Enrollment. Policymakers may consider expanding eligibility criteria for Medicaid to cover additional individuals, simplifying eligibility determination processes and streamlining program enrollment.</p>	
<p>Consider expanding Medicaid eligibility criteria to cover more people.</p>	<p>Thirty-seven states, Washington, D.C., and three territories have adopted the Medicaid expansion option offered under the Affordable Care Act, with some states using 1115 waivers to modify expansion to meet their specific needs. More than 20 states have expanded coverage for COVID-19 testing and treatment to uninsured individuals. Alaska and Washington allow coverage for certain out-of-state individuals.</p>
<p>Simplify eligibility requirements to gain and maintain coverage.</p>	<p>Eighteen states allow for self-attestation of eligibility criteria, particularly income. Self-attestation is not allowed for citizenship and immigration requirements.</p>
<p>Streamline enrollment using presumptive eligibility (PE) or expanding the entities allowed to determine presumptive eligibility.</p>	<p>Four states allow the Medicaid agency to determine presumptive eligibility. Illinois extended PE to the Medicaid ACA expansion population. (Illinois already provided PE for parents, former foster care youth and pregnant women.)</p>
<p>Access and Telehealth. Provide flexibilities to increase access, such as increasing use of telehealth, expanding allowable locations for services or temporarily expanding the criteria for qualified providers.</p>	
<p>Expand coverage and/or access to telehealth services by allowing more services to be delivered through telehealth and/or expanding the allowable settings and technology.</p>	<p>New York enacted SB 8416 to allow telehealth services to be provided through video-only communication or audio-only in limited circumstances. Kentucky allows for case management and most HCBS services to be delivered via telehealth.</p>
<p>Expand the allowable provider settings for service delivery. For example, states may expand settings for home- and community-based services, which are typically required to be delivered in the home or a particular facility.</p>	<p>All 50 states, Washington, D.C., and three territories have used 1135 waivers to allow health services to be delivered in alternate settings. Georgia, for example, requested flexibility to use mobile testing sites, convention centers and hotels, and other temporary residential arrangements.</p>

POLICY OPTIONS	STATE EXAMPLES
<p>Cost Sharing. States may not charge premiums or copays related to coronavirus services or increase any existing cost-sharing requirements. However, policymakers may consider temporarily eliminating or modifying existing cost-sharing requirements.</p>	
<p>Eliminate or waive deductibles, copayments, enrollment fees, premiums or other types of cost sharing.</p>	<p>At least 20 states have eliminated or waived cost-sharing requirements for Medicaid services, with 17 states eliminating cost sharing specifically for individuals with disabilities. For example, California and Maryland are eliminating cost-sharing requirements for certain low-income children.</p>
<p>Establish undue hardship waivers for cost-sharing requirements.</p>	<p>Missouri is using an undue hardship waiver to cover individuals eligible for a Medicaid buy-in for working individuals with disabilities.</p>
<p>Benefits and Services. Policymakers may consider adding new optional benefits or adjusting existing benefit limitations. Due to the maintenance of effort provisions from the Families First Act, states cannot cut optional benefits or reduce current benefit levels for the duration of the emergency period.</p>	
<p>Consider optional benefits. States can choose to include optional benefits such as dental care and laboratory services.</p>	<p>Arkansas added a management and evaluation service for individuals with serious mental illness to provide check-ins while individuals may not be able to access their regular supports.</p>
<p>Adjust existing benefits by modifying current limits or waiving certain prior authorization requirements.</p>	<p>Kentucky and New Jersey have waived prior authorization requirements for all Medicaid services. Thirty-nine states allow at least some medications to be refilled early and/or increase the allowable quantity limits for medications.</p>
<p>Service Providers. Policymakers may consider many options related to providers, including relaxing qualifications, paying retainers to providers unable to offer services due to COVID-restrictions, or increasing reimbursement to providers dealing with increased demand.</p>	
<p>Relax licensure and credential requirements, including accepting out-of-state provider credentials.</p>	<p>Fifty states and Washington, D.C., have used 1135 waivers to waive certain provider licensure requirements during COVID-19 and allow for out-of-state providers.</p>
<p>Increase reimbursement rates and/or use direct payments through managed care organizations (MCOs) to increase reimbursement to specific providers within an MCO's network.</p>	<p>Alabama allows for reimbursement to dental providers to cover needed personal protective equipment. Arkansas is providing supplemental payments to direct care workers. Rhode Island temporarily increased overall reimbursement rates by 10%.</p>
<p>Pay retainers to service providers who were unable to provide services due to social distancing or other COVID-19-related restrictions.</p>	<p>Pennsylvania is providing 75% retention payments for certain HCBS services. North Carolina used an 1115 waiver to make retainer payments for personal care and habilitation services.</p>

**Unless otherwise noted, the primary source for information in this table: [Medicaid Emergency Authority Tracker](#), Kaiser Family Foundation.*

Federal Action

The passage of the [Families First Coronavirus Response Act](#) (Families First Act), provides a temporary 6.2% increase to [regular Federal Medical Assistance Percentage \(FMAP\)](#) rates. In order to qualify for the increased federal matching funds, states must provide beneficiaries with COVID-19 testing and treatment

with no cost-sharing requirements. In addition, the funding requires “maintenance of effort.” This means states may not make changes to Medicaid eligibility, including more restrictive requirements or premium increases, and they must maintain eligibility of all individuals currently enrolled and any who enroll during the emergency period. The Families First Act also provides states with an option to cover COVID-19 testing and test-related visits for uninsured individuals, with the federal government covering 100% of costs.

The Coronavirus Aid Relief and Economic Security Act (CARES) Act established a provider relief fund, which has made general distributions to Medicare and Medicaid providers as well as distributions targeted to specific provider types, like Medicaid dental providers

Additional Resources

- [Disaster Response Toolkit: Coronavirus Disease 2019](#), Centers for Medicare & Medicaid Services
- [Blog: How States Are Leveraging Their Medicaid Programs to Respond to COVID-19](#), NCSL (2020)
- [Webinar: COVID-19: Leveraging Medicaid for Coverage, Testing and Treatment](#), NCSL (2020)
- [Understanding Medicaid: A Primer for State Legislators](#), NCSL (2019)
- [Medicaid 1115 Waivers by State](#), NCSL (2019)
- [10 State Strategies for Improving Medicaid](#), NCSL (2018)

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