FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Five Innovative State Medicaid Approaches to Combat COVID-19

Congress has passed several COVID-19 relief packages in a relatively short time. These legislative measures include a number of Medicaid and state fiscal relief provisions; however substantially more is needed from the federal government to help states manage their Medicaid programs. While waiting for additional federal support, many governors, state legislators, and Medicaid agencies are finding creative ways to use their prior and new authorities to meet their residents' needs. This analysis highlights a few of the most innovative requests made by states to date and, in some cases, already approved by the Centers for Medicare & Medicaid Services (CMS).

1. Covering the Uninsured and Underinsured:

With tens of millions of people losing employer-based health insurance in the midst of a pandemic, covering the uninsured is an urgent priority. The Families First Coronavirus Response Act created a new, optional Medicaid eligibility group for uninsured individuals for the duration of the public health emergency.

States can elect to adopt this "COVID-19 testing" eligibility group, and receive a 100% federal match. Unfortunately, this state option has two major limitations. First, the new category has a limited benefit package that is narrowly restricted to testing and diagnosis of COVID-19, meaning that it fails to include any coverage for COVID treatment. Second, the new "COVID-19 testing" category needlessly excludes most documented and undocumented immigrants, an illogical approach to addressing a public health crisis.

Recent COVID legislative actions to provide cost-sharing protections for COVID-19 testing also limit testing only to people covered by commercial payers, a problem that targeted Medicaid coverage can potentially address. In response to these shortcomings, Table 1 (page 2) ohighlights select state approaches to enhance coverage for the uninsured and underinsured.

With tens of millions of people losing employer-based health insurance in the midst of a pandemic, covering the uninsured is an urgent priority.

Table 1. State Innovations to Cover the Uninsured and Underinsured in Medicaid

Approach	Description	State Example	Status
Cover Treatment	Expands new "COVID-19 testing" optional Medicaid eligibility group to cover treatment at the regular federal match. Skips 1115 budget neutrality under emergency rules; expands the optional "uninsured" eligibility group to 200% of the federal poverty level.	North Carolina	Proposed
Cover COVID via Emergency Medicaid	Deems COVID-19 testing and treatment an "emergency service" (or services) for an "emergency medical condition" for the purpose of emergency Medicaid, without regard to immigration status or care setting.	California	Proposed
Add Medicaid as a Secondary Payer for Cost-Sharing for Treatment	Adds Medicaid as the secondary payer to protect individuals from out-of-pocket costs related to COVID-19 treatment.	Illinois	Proposed
Subsidize Marketplace Coverage Below 200% of Federal Poverty Level	Creates a temporary eligibility group for individuals with incomes at or below 200% of the federal poverty level. Uses Medicaid funds to provide additional subsidies for people enrolled in qualified health plan coverage to subsidize premiums and cost-sharing.	Washington	Denied
Allow Testing and Treatment for Inmates	Allows Medicaid expenditures for COVID-19 testing and treatment for inmates for services provided in public institutions (including jails and prisons).	California	Proposed

2. Ensuring Adequate Payments to Medicaid Providers

COVID-19 is disrupting numerous components of the health care sector. Many high-volume Medicaid providers — like primary care, behavioral health, dental, and long-term services and supports providers — are seeing steep drops in utilization and, consequently, revenue. These cash flow challenges have huge implications for short- and long-term access to key health care services. Table 2 (page 3) highlights select innovative state proposals that attempt to keep many Medicaid providers financially stable.

Table 2. State Innovations to Increase Medicaid Payments to Providers

Approach	Description	State Example	Status
Make Retainer Payments to Certain Providers	Provides payments to certain Home- and Community-Based Service (HCBS) providers to maintain capacity under Appendix K of 1915(c) waivers when facilities temporarily close, utilization drops, or attendance drops; states can also use an emergency 1115 waiver, pursuant to guidance from a recent State Medicaid Director Letter.	Pennsylvania	Approved
Provide Retainer Payments to Other Providers	The National Association of Medicaid Directors (NAMD) is encouraging CMS to expand retainer payments to other essential Medicaid providers beyond HCBS providers, a step that states could propose under an 1115 waiver.	N/A	NAMD Proposed
Offer Pass-Through, Directed, or Incentive Payments	Increases managed care organization (MCO) capitation rates or offers incentive payments for MCOs to increase payments to providers to aggregate levels similar to last year's payment level. Manatt Health and State Health & Value Strategies' brief outlines these pathways.	Colorado, New Hampshire, Rhode Island, Washington	Proposed
Make Supplemental Payments for Direct Care Providers	Makes enhanced payments of $125 to $500 per week for direct care services provided to beneficiaries of long-term services and support.	Arkansas	Approved
Increase Provider Rate	Increases the Nursing Facility direct and indirect care rate by 10% through June 30, 2020, or the end of the public health emergency.	Rhode Island	Approved
Expedite Supplemental Payments	Retroactively approves supplemental payments to providers and expedites approval of proposed changes to supplemental payments.	Georgia	Proposed
Create Disaster Relief Fund	The fund would cover uncompensated care costs incurred by providers related to COVID-19 and offer payments to providers, including rural hospitals and behavioral health providers, to preserve access due to dramatic shifts in utilization.	Washington	Under Further CMS Review

3. Providing Temporary Housing for Individuals Experiencing Homelessness

Shelter-in-place requirements are important public health tools to prevent community spread of COVID-19. However, these requirements are particularly difficult for individuals experiencing homelessness. Some states are proposing to use Medicaid to finance temporary housing for the homeless, as outlined in Table 3.

4. Liberalizing Telemedicine and Technology

For years, Medicaid has provided states broad flexibility to implement telemedicine programs, but uptake has been slow. However, many states (47, according to the Kaiser Family Foundation) are quickly modernizing policies in response to COVID-19. For example, many states transitioned from only allowing office-to-office telemedicine to temporarily expand telemedicine programs into beneficiaries' homes. The Center for Connected Health Policy is tracking additional state activity. Several of these innovative approaches are outlined in Table 4 (page 5). Notably, all three examples have been implemented administratively, since new authority was not necessary.

Table 3. State Innovations to Use Medicaid Funds for Housing for the Homeless

Approach	Description	State Example	Status
Provide Up to Six Months of Temporary Housing	Provides temporary housing for a period not to exceed six months if a beneficiary is homeless or is at imminent risk of homelessness and has tested positive for COVID-19.	Arizona	Proposed
Provide Temporary Housing via Existing 1115 Coordination Entities	Provides temporary emergency housing within the state's previously approved 1115 waiver Whole Person Care program.	California	Proposed
Provide Temporary Housing and Housing Supports	Provides temporary shelter for individuals experiencing homelessness who have been diagnosed with COVID-19, have a known exposure, or live in a hotspot. Provides housing supports, including to the newly uninsured or "COVID-19 testing" eligibility group.	North Carolina	Proposed

Table 4. State Innovations to Liberalize Telemedicine and Technology

Approach	Description	State Example	Status
Institute an Originating Site Fee	Offers a $20 originating site fee for providers that host telemedicine.	Alabama	Implemented
Allow Group Therapy via Telehealth	Removes restrictions on use of telehealth for group therapy.	Nevada	Implemented
Share COVID-19 Data via Health Information Exchange	Makes COVID-19 test alerts available to providers and MCOs via the Health Information Exchange.	Washington, DC	Implemented

5. Making It Easier to Get and Keep Medicaid

People are losing and will continue to lose their job-based health insurance during this public health crisis. If our newly unemployed neighbors don't get health insurance, then they, their families — and ultimately all of us — are at risk. For this reason, states are quickly rolling out protections for beneficiaries to help them get and keep their Medicaid coverage. Select approaches are outlined in Table 5.

Table 5. State Innovations to Streamline Medicaid Coverage

Approach	Description	State Example	Status
Determine Presumptive Eligibility	Allows the state to become a qualified entity to determine presumptive eligibility, in addition to other qualified entities such as hospitals.	New Mexico	Proposed
Expand Presumptive Eligibility	Expands the hospital presumptive eligibility program to cover the newly uninsured or "COVID-19 testing" eligibility group as well as individuals 65 years or older, blind, or disabled under the income level of 138 percent of poverty.	California	Proposed
Defer Eligibility Redetermination for 12 months	Proposes that each person up for redetermination have coverage extended automatically for one year during the public health emergency.	Illinois	Proposed
Provide Continuous Eligibility for Children	Temporarily provides children with 12 months of continuous Medicaid eligibility during the emergency period.	Arizona	Approved
Suspend Premiums for Children	Temporarily suspends premiums and subsequent lock-out period for children in the Children's Health Insurance Program.	Maine	Approved

This publication was written by:
Joe Weissfeld, Director of Medicaid Initiatives, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):
Kimberly Alleyne, Senior Director, Communications
Nichole Edralin, Senior Manager, Design and Publications
Eliot Fishman, Senior Director of Health Policy
Frederick Isasi, Executive Director
Adina Marx, Communications Associate
Emmett Ruff, Policy Analyst

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

1225 New York Avenue NW, Suite 800
Washington, DC 20005
202-628-3030
info@familiesusa.org
FamiliesUSA.org
facebook / FamiliesUSA
twitter / @FamiliesUSA

MCD2020-103