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Streamlining Medicaid Enrollment During COVID-19 Public Health Emergency

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States facing increased demands on their Medicaid programs due to the COVID-19 public health emergency (PHE) should streamline enrollment to expedite coverage for eligible families and minimize administrative burden for overwhelmed eligibility workers.

The COVID-19 emergency is putting intense pressure on state and local agencies that administer Medicaid. They face increased demand as more people seek health coverage and more become eligible for Medicaid because they're working less or have lost their jobs entirely. Meanwhile, the PHE has severely limited state and county Medicaid agencies' operational capacity. Due to the requirements for social distancing, most states have closed their eligibility offices to the public or limited interactions to scheduled appointments only. Some are still open for staff, but only having a portion of their staff work each day. And many eligibility workers and other key staff are unable to work due to personal health issues or caregiving responsibilities. Unfortunately, states have limited abilities to allow eligibility workers to work from home and remotely access the eligibility systems. Other essential support functions including call centers and mail scanning centers face similar capacity limits.

As a result, state operational capacity to field calls, process paperwork, and make eligibility decisions is severely limited. The higher demand and less capacity could mean significant delays in processing new Medicaid applications when people need coverage the most. Therefore, it is critical to look at expedited pathways and other simplifications that can allow eligible individuals to quickly enroll in Medicaid with minimal burdens on eligibility workers and paperwork hassle, while preserving program integrity.

This paper makes recommendations on streamlining eligibility for children, pregnant women, and parents — known as MAGI groups[1] — as well for seniors and people with disabilities. States can expand presumptive eligibility, streamline account transfers from HealthCare.gov, increase real-time eligibility determinations, and minimize paperwork through various pathways (see Table 1).

[1] Financial eligibility for children, pregnant women, parents/caretaker relatives, and the newly eligible adult population is based on tax-based rules for measuring income and household size without considering assets or other resources. Eligibility is based on the household's modified adjusted gross income (MAGI).

State Pathways to Streamlined Eligibility and Enrollment

Medicaid agencies can use four pathways to streamline their eligibility and enrollment processes during the current crisis. Some of these pathways rely on authorities that are linked to the PHE declared by Health and Human Services Secretary Alex Azar on January 31 and the Stafford Act Emergency Declaration President Trump issued on March 13.

- **Medicaid state plan amendments** are usually the simplest and quickest way for states to make changes. Each state has a plan describing its rules related to Medicaid eligibility, benefits, cost sharing, and payments, and states always have significant latitude to modify these plans. Because of the presidential and secretarial emergency declarations related to COVID-19, states can temporarily change their Medicaid state plans even more easily and quickly. The Centers for Medicare & Medicaid Services (CMS) recently issued a special Medicaid state plan amendment (SPA) template that lets states change their Medicaid state plans and easily implement various eligibility and enrollment policies described in the main text.[2] The template also includes an option to make SPAs retroactive to the beginning of the PHE and to waive public notice requirements that usually apply to SPAs. (These options rely on section 1135 waiver authority, described below.)
- **Eligibility verification plans** provide details on how Medicaid agencies verify eligibility and use electronic data sources.[3] States can update their plans to reflect changes in verification policies without approval from CMS. CMS has also provided a disaster relief verification plan addendum to allow states to easily change verification procedures during the PHE.
- **Section 1135 waivers** are special waivers available only after both the President and Secretary have declared a national emergency. Section 1135 provides certain blanket waiver authorities that apply to all states and don't require CMS approval.[4] It also provides additional authority for the HHS Secretary to waive or modify Medicaid (and CHIP and Medicare) requirements or to modify deadlines to ensure that health care items and services are sufficient to meet the needs of enrollees in areas affected by a PHE. CMS has a template states can use to make additional requests using section 1135 authority and a web page with approved waivers.[5]
- **Emergency section 1115 waivers**, which are available after the Secretary has declared a national emergency, relieve states from certain requirements that usually apply to 1115 waivers, like demonstrating budget neutrality and public notice and comment procedures. Like "traditional" section 1115 waivers, emergency 1115 waivers can be used to implement policies not otherwise allowed under Medicaid law. In the past, emergency 1115 waivers

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[2] "State Plan Flexibilities – Medicaid State Plan Disaster Relief State Plan Amendments," Medicaid.gov, https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/state-plan-flexibilities/index.html.

[3] Most state eligibility verification plans are available on the Medicaid.gov website at https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans/index.html.

[4] These blanket authorities don't waive Medicaid eligibility and enrollment processes but instead are related to specific provider enrollment, certification, and other related requirements. See "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," Centers for Medicare & Medicaid Services, https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf.

[5] Section 1135 templates are available at https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html and approved waivers can be viewed at https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/federal-disaster-resources/index.html.

have been used to expand eligibility and benefits as well as streamline enrollment processes. CMS has issued a template for emergency 1115 waivers that provides an expedited way for states to make their requests.[6]

Families First Act Lets States Focus on Application Processing

The Families First Coronavirus Response Act provides an estimated $36 billion in additional federal Medicaid funding to states. To qualify for these funds, states must abide by a maintenance-of-effort provision that's designed to protect people's access to health coverage during the crisis. Among other requirements, states are barred from ending Medicaid coverage during the national public health emergency, except for individuals who voluntarily end their coverage or move out of state.

In addition to protecting people's coverage during the pandemic, this requirement allows states to free up resources to process new applications. In particular, states can free up staff time and other resources by ceasing renewals, stopping actions on periodic income checks, and ceasing implementation of restrictive waivers.

Streamlining Enrollment for Children and Families

States have numerous ways they can minimize paperwork and the need for eligibility worker intervention in determining eligibility of children and families. Some options can provide a nearly automated eligibility determination, enroll eligible individuals quickly and, in some cases, reduce state agencies' workload.

Presumptive Eligibility

Presumptive eligibility (PE) allows hospitals, clinics, and other entities to screen individuals for Medicaid eligibility, and to temporarily enroll those who appear eligible. Individuals can then submit a full Medicaid application for ongoing coverage. Given the current limits on Medicaid agencies' capacity to process applications, PE may be a valuable option to quickly enroll people when they seek care, allowing eligibility workers more time to process full applications. Further, since no client signature is required for PE, qualified entities can make PE determinations during a virtual or telephonic visit. State Medicaid agencies can take several steps to fully use PE by amending their Medicaid state plans. States should:

Expand the number and types of "qualified entities" that can conduct PE determinations. Medicaid regulations give states broad authority to designate health care providers, schools, WIC agencies, other community-based service providers, and even the Medicaid agency itself as qualified entities capable of determining PE. Designating the state agency itself as a qualified entity would allow agency staff (including non-eligibility workers and contract staff) to take an abbreviated Medicaid application and immediately approve an applicant for coverage.

As the health crisis evolves, states can identify additional points where uninsured residents are contacting organizations in the community and enlist them to conduct PE determinations.

[6] The template is available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html.

Ensure that qualified entities can determine PE for all Medicaid eligibility groups. If states provide PE for children and pregnant women, they can allow qualified entities to determine PE for parents/caretaker relatives, newly eligible adults, and former foster care children. Without a waiver, though, only hospitals can provide PE for other groups such as seniors and people with disabilities (see below).

Liberalize state rules for hospitals that perform PE to encourage them to participate. While states have the option to designate other qualified entities, they are required to give hospitals the option to perform PE. Participating hospitals must meet state standards as to the percentage of individuals approved for PE who submit full Medicaid applications and for the percentage who are determined eligible. Some states have very strict standards that discourage hospitals from conducting PE determinations. These states should consider easing their high standards to encourage more hospitals to participate during the PHE. States can temporarily revise their performance standards through a SPA.[7]

Eliminate state restrictions that delay PE determinations. Some states have additional rules around PE that require action by an eligibility worker and delay determinations. For example, some states limit individuals to a single PE period in a year. That means that, after a qualified entity submits a PE application, an eligibility worker must manually check the individual's case record for prior periods of PE before approving the PE coverage.

Ensure a full Medicaid application is submitted before the end of the PE period. Temporary Medicaid coverage through PE is valid through the end of the month following the month in which the PE determination is made if a full application is not submitted. But, if an application is submitted, coverage doesn't end until the Medicaid agency makes a decision on a full application, so submitting a full application is critical to maintaining coverage after a PE determination. States should encourage PE providers to help clients submit a full application with the PE determination or shortly after, guaranteeing that health coverage lasts until the Medicaid agency is able to process the full application. Or, if the Medicaid agency does the PE determination, it should take a full application when it determines PE; coverage would then extend until the agency has the capacity to adjudicate the full application.

Medicaid agencies can also request an extension of the PE eligibility for a longer period through an 1115 waiver.

Streamline Account Transfers From HealthCare.gov

The 38 states that use the Federally Facilitated Marketplace (FFM) to determine eligibility and financial assistance for individual-market health plans receive application information for people who apply through the FFM but appear to be eligible for Medicaid. Some states, known as determination states, accept the FFM's eligibility finding and simply enroll the applicant in Medicaid if the FFM has verified all eligibility criteria. Other states, known as assessment states, take the information from the FFM but do a full eligibility determination at the state level before enrolling the applicant. This takes eligibility worker time and may require additional information or documents from the applicant, delaying the eligibility determination.

[7] See II.E.5 in "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," updated May 5, 2020, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

The 29 assessment states could take steps to streamline account transfers or temporarily or permanently become determination states to expedite the processing of new Medicaid applications.[8] States do not need authority from CMS to make this change.[9] States could accept FFM-provided verifications and do only minimal checks, such as making sure the applicant isn't already enrolled. Or they could transition to a determination state and accept the FFM eligibility determination. This could be particularly helpful in states with a difficult online application process or limited call center capacity. Residents could be encouraged to apply online through HealthCare.gov. Medicaid agencies could then automate processing of account transfers from the FFM to quickly enroll applicants or, if they couldn't quickly make system and process changes to automate processing, they could instruct eligibility workers to accept the FFM's eligibility findings and grant eligibility.

Expand Real-Time Eligibility

Some states can automatically process applications and determine eligibility within 24 hours. Known as real-time eligibility (RTE), this is a quick way to enroll eligible applicants with little to no eligibility worker involvement.

Forty-six states report that they make RTE decisions.[10] But states vary on what percentage of applications they process in real time, with the percentage depending on rules in the eligibility system regarding who qualifies for RTE. Some states limit RTE based on factors such as whether the applicant is known to the system, how closely the information the applicant enters matches electronic data sources, and the type of income an applicant has. States should consider changing the RTE parameters to open this pathway for a larger pool of applicants. For example, states that don't currently allow cases with earned income verified through electronic data sources to be approved through RTE could opt to do so.

Minimize Paperwork

Medicaid agencies often require additional information or verification documents from applicants before they approve eligibility. This step delays enrollment and can be challenging for applicants who must obtain the required documentation and submit it back to the agency after receiving a document request. Providing documents may be nearly impossible to complete during the health crisis when clients can't obtain the documents they need, local offices are closed, and eligibility workers are overloaded.

Current regulations and options allow Medicaid agencies to significantly reduce paperwork requests by changing their verification plans. States can minimize verification requests and preserve

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[8] States that are currently assessment states and could switch to determination states to expedite enrollment are Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Michigan, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Wisconsin. "Medicaid and Health Insurance Marketplace Coordination," Kaiser Family Foundation, as of January 1, 2019 https://www.kff.org/health-reform/state-indicator/medicaid-and-health-insurance-marketplace-coordination. (Nevada transitioned to a state-based marketplace at the end of 2019 and is no longer an assessment state.)

[9] COVID-19 FAQs, *op. cit.*, II.A.8.

[10] "Medicaid Eligibility Determinations, Applications, and Online Accounts," Kaiser Family Foundation, as of January 1, 2019, https://www.kff.org/health-reform/state-indicator/features-of-online-and-telephone-medicaid-applications.

program integrity by increasing reliance on electronic data sources to verify eligibility. While there have always been good reasons to streamline processing, the need is even more compelling during the PHE considering increased applications, decreased state capacity, and logistical challenges in obtaining and submitting paperwork. Even if states are unwilling to make some of these changes permanently, they should consider them during the current PHE.

Maximize use of self-attestation. Medicaid agencies can accept the information the applicant enters on the application form — known as self-attestation — for most eligibility factors including age or date of birth, residency, and household composition. They only need to follow up on these factors if they have information that is inconsistent with what the applicant reported.[11]

Verify income. Agencies can determine eligibility based on the income information on the application and conduct post-eligibility verification. After enrolling the applicant, the agency can compare the self-attested income to electronic data sources, and request verification if needed. Alternatively, agencies can attempt to verify income information using electronic data sources before approval. If information on the application and in the data sources are both below the eligibility threshold, including if there is nothing found in the data sources, the Medicaid agency can approve the case. If the data show income over the eligibility threshold, agencies can seek a reasonable explanation for the discrepancy, such as that the client's employer closed due to the PHE. States should accept client statements for things like job loss or reduction in hours without requiring additional documentation. States can modify their verification plans to use self-attestation and not require documents verifying self-employment income. If a Medicaid agency chooses to require proof of certain income, it can accept self-attestation on a case-by-case basis where verification documents would be difficult to obtain or submit to the agency.[12]

Social Security numbers, citizenship, and immigration status through electronic data sources. States match applicant-provided information against databases including the Social Security Administration and Department of Homeland Security for Social Security numbers and citizenship or immigration status. Most applicant information can be verified through these data sources, but some requires further information. When an agency can't verify citizenship or immigration status, it must approve benefits and provide a reasonable opportunity period to allow the applicant or agency to resolve the discrepancy. While this must be at least 95 days from when the agency sends the client a notice, it can be extended — and Medicaid continued — if the individual is making a good faith effort to obtain documents or the agency needs more time. The CMS SPA template allows states to elect to issue these extensions during the PHE.

Streamlining Eligibility Determinations for Seniors and People With Disabilities

Seniors and people with disabilities are particularly vulnerable during this health crisis because they are more likely to become seriously ill from COVID-19. Meanwhile, they are likely to face particular challenges enrolling in health coverage, since they are often more dependent on in-person or phone assistance from eligibility workers. Though rules for determining their eligibility are more complex, states can simplify the process.

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[11] COVID-19 FAQs, *op. cit.*, II.F.2.

[12] 42 CFR §435.952(c)(3).

Presumptive Eligibility

States should encourage hospitals to determine eligibility for non-MAGI groups such as seniors and people with disabilities, as well as for children and adults. This may require states to submit a SPA[13] and may require a change to their PE portals to collect additional information necessary for a non-MAGI determination. But it would be worth the investment to give these vulnerable populations an expedited pathway to securing Medicaid.

The Medicaid agency and other organizations can also be a qualified entity for PE for these groups through an emergency 1115 waiver.

Minimize Paperwork

Determining eligibility for seniors and people with disabilities often requires extensive documentation of resources and sometimes medical bills. Applicants may have to visit their banks and health care providers to collect paperwork and submit it to the agency, often in person, all of which is inadvisable now given social distancing recommendations. Medicaid agencies can take several actions to streamline enrollment for seniors and people with disabilities on a permanent basis or temporarily during the PHE.

Submit a SPA to eliminate, or at least increase, resource limits. The CMS SPA template allows states to implement a less restrictive resource methodology for this population, including higher limits or eliminating the resource test altogether.

Use electronic data sources to verify resources. Where resource limits are in place, Medicaid agencies can use an asset verification service (AVS) to verify application information. The AVS checks client information against financial institutions and identifies account and balance information. As long as the applicant reports resources below the limit and the AVS results don't show resources above the limit, the applicant should be approved without requiring further documentation.

Simplify determinations for the medically needy. Seniors and people with disabilities with income above the Medicaid eligibility threshold may be eligible for Medicaid coverage if, after deducting medical expenses they incur, their income is below a medically needy threshold. This population typically must gather and submit bills to the Medicaid agency before their coverage begins and sometimes every month thereafter. States can accept self-attestation of incurred medical expenses or can amend their state plans to disregard certain amounts of income over their medically needy income levels for these individuals.[14] This would eliminate the need for seniors and people with disabilities to collect receipts and medical bills and try to submit them to the Medicaid agency. And it would save eligibility workers burdensome paperwork processing and undertaking complicated computations to determine an individual's eligibility date.

[13] COVID-19 FAQs, *op. cit.* II.E.2.
[14] COVID-19 FAQs, *op. cit.*, II.C.3.

TABLE 1

States Can Simplify Medicaid Enrollment

Simplification Strategy	Implementation
Presumptive Eligibility (PE)	
Expand the number and type of qualified entities	State plan amendment (SPA)
Allow PE for all MAGI eligibility groups*	SPA
Liberalize state rules for hospital PE	State rules
Eliminate state restrictions that delay PE	State rules
Ensure full Medicaid application is submitted	State procedures
Extend PE period	1115 waiver
Allow hospitals to do PE for seniors and people with disabilities	SPA
Allow agency or other entities to do PE for seniors and people with disabilities	1115 waiver
Streamline account transfers from HealthCare.gov	State policy
Expand real-time eligibility	State policy/system
Minimize paperwork	
Maximize use of self-attestation	State verification plan
Streamline income verification policy	State verification plan
Extend reasonable opportunity period	SPA
Eliminate or increase resource limits	SPA
Use electronic data sources to verify resources	State policy/system
Simplify determinations for medically needy	SPA

*Financial eligibility for children, pregnant women, parents/caretaker relatives, and the newly eligible adult population is based on tax-based rules for measuring income and household size without considering assets or other resources. Eligibility is based on the household's modified adjusted gross income (MAGI).