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State Medicaid Changes Can Improve Access to Coverage and Care During and After COVID-19 Crisis

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Many states are taking advantage of Medicaid's flexibility and emergency authorities to make it easier for people to qualify for and enroll in coverage and obtain affordable health care during the current public health crisis. More states should consider implementing these policies, especially as the pandemic continues and more people need Medicaid coverage. Fortunately, there's still time. Health and Human Services (HHS) Secretary Alex Azar recently renewed the public health emergency (PHE) declaration through the end of October, enabling states to continue to leverage Medicaid's emergency authorities to make temporary changes to their programs to improve access to coverage and care. Secretary Azar also has the authority to continue the PHE until the crisis is determined to have passed.

But even after the PHE ends, the need for improved access to coverage and care will continue. While some of the policies states have adopted respond to specific needs driven by the pandemic, most would help beneficiaries under any circumstances by making it easier to qualify for and enroll in Medicaid coverage as well as to access and afford care. These policy changes will be especially important if the COVID-19 recession — and resulting increased need for Medicaid coverage — continues beyond the PHE. Fortunately, states can make many of their temporary improvements permanent by filing traditional Medicaid state plan amendments (SPAs) or amendments to their verification plans. States should make these changes now to ensure there are no disruptions when implementing policies that make it easier for people to qualify for, enroll in, and obtain affordable health care.

Making It Easier to Qualify for Coverage

States are making it easier for people to qualify for Medicaid coverage by expanding coverage, giving people more time to meet certain eligibility criteria, and using less restrictive eligibility standards during the crisis. States can put these policies in place using a combination of Medicaid disaster SPAs and disaster relief eligibility verification plan changes. (See box, "Medicaid Pathways to Change Eligibility, Enrollment, and Coverage.")

Medicaid Pathways to Change Eligibility, Enrollment, and Coverage

States generally use two main pathways to change eligibility, enrollment, and coverage during a disaster: Medicaid disaster relief state plan amendments and disaster relief eligibility verification plan addendums. These pathways rely on authorities that are linked to the PHE first declared by Health and Human Services Secretary Alex Azar on January 31 and the national emergency President Trump declared under the National Emergencies Act on March 13. The Secretary renewed the PHE declaration for a second time on July 23, meaning that the PHE will continue *at least* through late October.

- **Medicaid disaster relief 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) issued a special Medicaid SPA template that lets states change their Medicaid state plans and easily implement various policies through the end of the PHE.a The template also includes an option to make SPAs retroactive to March 1, 2020, and to waive public notice requirements that usually apply to SPAs.b
- **Disaster relief verification plan addendums** provide details on how Medicaid agencies verify eligibility and use electronic data sources.c States can update their plans to reflect changes in verification policies and make these changes 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.d While states have discretion in determining the time period in which these changes are in effect, the 11 states with approved disaster addendums have elected to implement these changes through the end of the PHE.

[a] "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.
[b] These options rely on section 1135 waiver authority which allows for the HHS Secretary to waive or modify certain Medicare, Medicaid and CHIP 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. These waivers expire at the end of the PHE. 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.
[c] 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.
[d] The Medicaid and CHIP MAGI-Based disaster relief verification plan addendum is available at www.medicaid.gov/medicaid/eligibility/downloads/magi-based-verification-plan-addendum-template.docx

Expanding Coverage

Ensuring people have health insurance coverage is an important tool for fighting COVID-19. Without it, people with COVID-19 symptoms may be afraid to seek testing or treatment because they worry they can't afford care. States have amended their Medicaid state plans to:

- **Cover testing for the uninsured.** The Families First Coronavirus Response Act (Families First) created a Medicaid state option to cover COVID-19 testing and testing-related services for uninsured individuals during the PHE, with the federal government paying 100 percent of the cost. While there is no income test for this optional eligibility group, people must be

uninsured and meet Medicaid's citizenship/immigration and state residency requirements.[1] Eighteen states have elected this option under approved Medicaid disaster SPAs.[2] (See Appendix Table 1.)

- **Temporarily cover out-of-state and non-state residents.** To qualify for Medicaid coverage, people generally must be residents of and living in the state in which they're applying for coverage.[3] But three states have elected to temporarily provide Medicaid coverage to individuals living in their states who are not residents. Alaska is electing to cover non-residents who are temporarily in the state and meet all other eligibility criteria, Washington is covering non-residents who are quarantined in Washington, and West Virginia is covering non-residents caring for a family member due to illness or quarantine.[4]

  States can also continue coverage for people temporarily absent from the state in certain circumstances. Recognizing that some of their residents may have had to leave the state or are otherwise absent because of COVID-19, 12 states have approved Medicaid disaster SPAs that expand their definitions of temporary absence so that these individuals remain covered while temporarily out of state.[5] (See Appendix Table 1.)

Extending Reasonable Opportunity Period

To verify Social Security numbers and citizenship or immigration status, states match applicant-provided information with Social Security Administration and Department of Homeland Security databases. Most applicants' information can be verified through these sources, but some applicants must provide further information to complete the verification process.

In those cases, states must provide benefits and provide a "reasonable opportunity period" to allow the applicant or the Medicaid agency to resolve the discrepancy. The reasonable opportunity period must last at least 90 days from when the agency sends the client a notice, and it can be extended with continuation of benefits if the individual is making a good faith effort to obtain documents or the Medicaid agency needs more time. Seven states have approved Medicaid disaster SPAs extending the reasonable opportunity period beyond the initial 90-day period to resolve any discrepancies.[6] (See Appendix Table 1.)

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[1] For individuals who meet all eligibility criteria for this optional group except for the citizenship or immigration status requirement, testing and testing services may be paid for under emergency Medicaid. For more information, see Centers for Medicare & Medicaid Services (CMS), "Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Frequently Act Questions," April 13, 2020, https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf.

[2] Kaiser Family Foundation, "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," accessed on July 2, 2020, https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/.

[3] 42 CFR §435.403.

[4] CMS, "Alaska SPA: 20-0003," May 7, 2020, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AK/AK-20-0003.pdf; CMS, "Washington SPA: 20-0014," April 24, 2020, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-20-0014.pdf; and CMS, "West Virginia SPA; 20-0004," August 13, 2020, https://www.medicaid.gov/medicaid/spa/downloads/WV-20-0004.pdf.

[5] Kaiser Family Foundation, "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19."

[6] *Ibid.*

Using Less Restrictive Eligibility Criteria

Seniors and people with disabilities are more likely to become seriously ill from COVID-19, making their health coverage especially vital. Medicaid eligibility rules for seniors and people with disabilities are more complex than for other enrollees, but states have several options to simplify eligibility and enrollment processes for this group. For example, rather than requiring beneficiaries to submit bills showing that they meet their "spenddown," states can disregard certain income above the eligibility threshold. California has elected to do this, disregarding all income up to 138 percent of the federal poverty line for seniors and people with disabilities, while Minnesota and Washington are disregarding unemployment income from their income methodologies.[7] Or, states can increase their asset limits or fully eliminate their resource tests, as Illinois has elected to do, to simplify processing and reduce the need for extensive verification documents.[8] States with resource tests can verify them through their Asset Verification Services (AVS) post-enrollment, and only require documentation if the AVS indicates resources above the resource limit.

Making It Easier to Enroll in Coverage

States have been leveraging emergency authorities to streamline the enrollment process to make it easier for people to enroll in coverage during the PHE, including by expanding the use of presumptive eligibility (PE), accepting self-attestation, verifying income and other eligibility factors after people are enrolled in coverage, and modifying standards for data compatibility.

Expanding Presumptive Eligibility

Presumptive eligibility 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. In the current crisis, PE is a valuable option to quickly enroll people when they seek care, and because PE doesn't require an applicant's signature, health care providers and other entities can make PE determinations during a virtual or telephonic visit. States have amended their Medicaid state plans to expand PE by:

- **Expanding 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. Illinois, Kansas, Kentucky, New Jersey, and Ohio have temporarily amended their Medicaid state plans to allow their Medicaid agencies to conduct PE, and Oregon has given authority to contracted community partner organizations.[9] New Mexico has also temporarily modified its Medicaid

[7] CMS, "California SPA: 20-0024," May 13, 2020, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-20-0024.pdf; CMS, "Minnesota SPA: 20-0006," May 22, 2020, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-20-0006.pdf; and CMS, "Washington SPA: 20-0014."

[8] CMS, "Illinois SPA: 20-0004," April 24, 2020, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IL/IL-20-0004.pdf.

[9] CMS, "Illinois SPA: 20-0004," April 24, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IL/IL-20-0004.pdf; CMS, "Kansas SPA: 20-0012," May 11, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/KS/KS-20-0012.pdf;

state plan to include a more expansive list of qualified entities, allowing Medicaid providers, schools, tribes, and organizations and agencies that determine eligibility for Head Start, WIC, emergency and public housing, as well as correctional facilities, to conduct PE.[10]

- **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 other groups, such as parents/caretaker relatives, newly eligible adults, and former foster care children. Illinois, Kansas, Nebraska, Ohio, and Oregon have done this through their Medicaid disaster SPAs, and California, New Hampshire, New Mexico, and Utah have extended PE to individuals these states are covering through the new uninsured option described above.[11] Some states, such as California, Iowa, Kentucky, Massachusetts, New Jersey, Ohio, Washington, and Wisconsin are allowing hospitals to conduct PE for new eligibility categories, including seniors and people with disabilities.[12]
- **Expand the number of PE periods in a given year.** Some states limit individuals to a single PE period in a year, potentially delaying coverage for some people. Expanding the number of PE periods to two per year, as California, Illinois, Kansas, Massachusetts, New Jersey, Oregon, Utah, and Washington have done, can help ensure that people, such as those who may have gained employer coverage during the year only to lose it because of the economic downturn, have timely access to care.[13]

CMS, "Kentucky SPA: 20-0003," June 22, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/KY/KY-20-0003.pdf; CMS, "New Jersey SPA: 20-0003," July 23, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NJ/NJ-20-0003.pdf; CMS, "Ohio SPA: 20-0012," May 22, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-20-0012.pdf; and CMS, "Oregon SPA: 20-0010," June 18, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-20-0010.pdf.

[10] CMS, "New Mexico SPA: 20-0004," April 24, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NM/NM-20-0004.pdf.

[11] CMS, "California SPA: 20-0024," May 13, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-20-0024.pdf; CMS, "Illinois SPA: 20-0004;" CMS, "Kansas SPA: 20-0012;" CMS, "Nebraska SPA: 20-0010," April 24, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NE/NE-20-0010.pdf; CMS, "New Hampshire SPA: 20-0034," May 22, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NH/NH-20-0034.pdf; CMS, "New Mexico SPA: 20-0007," May 13, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NM/NM-20-0007.pdf; CMS, "Ohio SPA: 20-0012;" CMS, "Oregon SPA: 20-0010;" and CMS, "Utah SPA: 20-0006," May 18, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/UT/UT-20-0006_1.pdf.

[12] Only hospitals can conduct PE for seniors and people with disabilities; a section 1115 demonstration project would be required to confer such authority to other qualified entities.

CMS, "California SPA: 20-0024;" CMS, "Iowa SPA: 20-0008," May 18, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IA/IA-20-0008.pdf; CMS, "Kentucky SPA: 20-0003;" CMS, "Massachusetts SPA: 20-006," August 18, 2020, https://www.medicaid.gov/medicaid/spa/downloads/MA-20-0006.pdf; CMS, "New Jersey SPA: 20-0003;" CMS, "Ohio SPA: 20-0012;" CMS, "Washington SPA: 20-0014;" and CMS, "Wisconsin SPA: 20-0004," May 8, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WI/WI-20-0004.pdf.

[13] CMS, "California SPA: 20-0024;" CMS, "Illinois SPA: 20-0004;" CMS, "Kansas SPA: 20-0012;" CMS, "Massachusetts SPA: 20-006;" CMS, "New Jersey SPA: 20-0003;" CMS, "Oregon SPA: 20-0010;" CMS, "Utah SPA: 20-0006;" and CMS, "Washington SPA: 20-0014."

- **Liberalize state rules for hospitals that perform PE.** 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. States can temporarily relax their performance standards to encourage more hospitals to perform PE, as Kentucky, Ohio, and Washington have done.[14]

Allowing Self-Attestation for Non-Financial Factors

States often require additional information or verification documents from applicants before they approve eligibility, which can be challenging for applicants during a crisis and can delay enrollment. To minimize paperwork during this time, states can accept the information the applicant enters on the application form — known as self-attestation — for most non-financial eligibility factors including age or date of birth, residency, and household composition. (See Table 1.) States then only need to follow up on these factors if they have information that is inconsistent with what the applicant reported.[15] The District of Columbia, Illinois, and Ohio are modifying their verification plans to accept self-attestation for non-income eligibility factors, such as receipt of other coverage (DC, IL, and OH), residency (DC and IL), household composition (DC), age and date of birth (DC), former foster care status (OH), and incurred medical expenses (IL).[16]

Conducting Post-Enrollment Verification

States can also determine eligibility based on the information on the application and conduct post-eligibility verification. After enrolling the applicant, the agency can compare the self-attested information to electronic data sources, and request verification if needed. This allows states to quickly enroll individuals in need of medical coverage and run the data checks and request verification documents (if necessary) after the individual has been enrolled.

Delaware, the District of Columbia, Indiana, Louisiana, Vermont, and Washington have modified their verification plans to conduct post-enrollment verification of income. Maine is also conducting post-enrollment verification of income, but in phases, with the first phase having started in May. States that choose not to accept self-attestation of eligibility factors, like residency and date of birth, can verify them after enrollment. For example, Indiana is verifying residency, age/date of birth, household composition, and receipt of other coverage after enrollment.[17]

Increasing Reasonable Compatibility Standards

States are required to compare electronic data sources to income information provided by the applicant to determine whether the income provided by the applicant and the electronic data are "reasonably compatible." If the information provided by the applicant and the electronic data are both below the eligibility threshold, they are reasonably compatible and no further verification is needed. In addition, states can establish a "reasonable compatibility standard," which applies when

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[14] CMS, "Kentucky SPA: 20-0003;" CMS, "Ohio SPA: 20-0012;" and CMS, "Washington SPA: 20-0014."

[15] COVID-19 FAQs, II.F.2., https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

[16] "CMS, Medicaid/CHIP Eligibility Verification Plans," accessed on July 14 , 2020, https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans/index.html.

[17] CMS, "Medicaid/CHIP Eligibility Verification Plans."

the applicant's attestation is below the eligibility threshold but data sources show income above the threshold. States may set an acceptable level of variance — either a percentage of income or a specific dollar amount — when the difference between the attestation and data sources doesn't have to be reconciled by requesting additional information from applicants.[18]

To date, three states have temporarily modified their reasonable compatibility standards using disaster relief verification plan addendums. Increasing the acceptable variance ensures that slight discrepancies around the eligibility threshold don't prevent enrollment. Colorado increased its standard from 10 percent to 20 percent, Illinois from 5 percent to 30 percent, and Ohio from 5 percent to 15 percent.[19]

[18] Jennifer Wagner, "Reasonable Compatibility Policy Presents an Opportunity to Streamline Medicaid Determinations," Center on Budget and Policy Priorities, August 16, 2016, https://www.cbpp.org/research/reasonable-compatibility-policy-presents-an-opportunity-to-streamline-medicaid.

[19] CMS, "Medicaid/CHIP Eligibility Verification Plans."

Need to Streamline Medicaid Determinations Continues

Streamlining Medicaid determinations not only allows individuals to quickly access needed health care, it also reduces the burden on Medicaid agencies so they can handle increased demand for coverage during the recession. That's critical, since state human services agencies are likely to face significant challenges in the months ahead.

Changes made during the COVID-19 crisis have helped agencies handle some increased enrollment, but agencies must prepare for additional and even greater increases in the months to come. Some individuals who lost their jobs didn't immediately lose health insurance coverage or extended it through COBRA. And many people have postponed non-essential health care, making their need for insurance less pressing and decreasing interactions with health centers that help people apply for Medicaid.[a]

In addition to a continued increase in applications, state agencies will face other workload increases. Agencies currently don't have to act on Medicaid renewals or changes during the PHE, but once the PHE ends, they will have to address a backlog of cases.[b] Further, the Food and Nutrition Service (FNS) has granted numerous waivers for SNAP processing that allowed agencies to extend certification periods, issue additional benefits, and waive interview requirements. FNS is in the process of winding down these authorities, which will increase health and human services agencies' workloads. This will particularly affect the capacity to process Medicaid applications in states with integrated administration of SNAP and Medicaid.

Unfortunately, this increase in demand is likely to occur alongside cuts to human services agencies. Many states have already announced requirements for state employees to take unpaid furlough leave, and others have imposed broad hiring freezes that will impact Medicaid caseworkers.[c] And deep budget cuts are likely to also hit information technology budgets, delaying or cancelling needed improvements to eligibility and enrollment systems.

[a] Aviva Aron-Dine, Kyle Hayes, and Matt Broadus, "With Need Rising, Medicaid Is at Risk for Cuts," Center on Budget and Policy Priorities, July 22, 2020, https://www.cbpp.org/research/health/with-need-rising-medicaid-is-at-risk-for-cuts.
[b] The Families First Coronavirus Response Act's continuous coverage provision requires that additional federal funding for states is contingent on Medicaid agencies suspending most coverage terminations for the duration of the PHE.
[c] *Ibid.*

TABLE 1

When States Can Accept Self-Attestation and When They Must Access Data Sources

Eligibility Factor	Can Accept Self-Attestation	Must Access Data Source(s): Can Do So Post-Enrollment	Must Access Data Source(s): Must Access Before Enrollment	Notes
Age/Date of Birth	X			Agency can request additional information from applicant if it has contradictory information.
Residency	X			Agency can request additional information from applicant if it has contradictory information.
Household Composition	X			Agency can request additional information from applicant if it has contradictory information.
Pregnancy	X			Agency can request additional information from applicant if it has contradictory information.
Income		X		Agency must accept applicant statement if reasonably compatible with data sources.
Resources (non-MAGI population)		X		Agency must accept applicant statement if reasonably compatible with data sources.
Citizenship or Immigration Status			X	If agency is unable to verify citizenship/immigration status, and applicant has attested to an eligible citizenship/immigration status, applicant must be enrolled for at least a 90-day reasonable opportunity period.

Making It Easier to Access and Afford Care

In addition to making it easier to qualify for and enroll in coverage, states are ensuring people can access affordable care safely during the pandemic by expanding the use of telehealth and eliminating financial barriers that may limit needed care.

Expanding Telehealth

Telehealth is a great option for people to safely access health care during the pandemic as it allows people to seek needed medical care while avoiding any risk of infection. States have considerable flexibility when expanding the use of telehealth in their Medicaid programs. Under Medicaid, telehealth isn't a service but rather a service delivery method, which means that states can expand its use without even having to submit an SPA. States are only required to submit an SPA if they intend to pay for services delivered via telehealth differently than services provided face-to-face. Additional SPAs may be needed if a state has previously included telehealth limitations in its Medicaid state

plan, such as only allowing certain services to be delivered via telehealth, and would like to remove them.[20] For example, states are using temporary Medicaid disaster SPAs to:

- **Expand provision of services.** The District of Columbia, Minnesota, and Nebraska are expanding the number of services allowed to be provided via telehealth, with Colorado, Connecticut, Kentucky, New Jersey, and Washington going even further and allowing all services to be provided via telehealth.[21]
- **Expand modalities.** Delaware, Georgia, Maryland, Minnesota, Mississippi, and Ohio are expanding telehealth modalities, including telephonic delivery of services or assessments.[22]
- **Change payment.** Illinois, Minnesota, Nebraska, North Carolina, and West Virginia are changing payment rates and methodologies, including for Federally Qualified Health Centers, Rural Health Centers, and tribal facilities.[23]
- **Expand provider participation.** Several states, such as Minnesota and Missouri, are allowing more types of providers to furnish services via telehealth, and Colorado is even allowing licensed, out-of-state providers to furnish services to its Medicaid beneficiaries.[24]
- **Suspend certain requirements.** California, Louisiana, Minnesota, and South Dakota are making it easier for services to be provided via telehealth by temporarily suspending certain requirements in their Medicaid state plans, such as face-to-face first visit requirements.[25]

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[20] For more information on Medicaid and telehealth, see CMS, "State Medicaid and CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth," April 23, 2020, https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf.

[21] CMS, "Colorado SPA: 20-0012," May 20, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-20-0012.pdf; CMS, "Connecticut: SPA-20-0015," August 13, 2020, https://www.medicaid.gov/medicaid/spa/downloads/CT-20-0015.pdf; CMS, "District of Columbia SPA: 20-0001," June 5, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/DC/DC-20-0001.pdf; CMS, "Kentucky SPA: 20-0003;" CMS, "Minnesota SPA: 20-0007," June 25, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-20-0007.pdf; CMS, "Nebraska SPA: 20-0010," *op. cit.;* CMS, "New Jersey SPA: 20-0003;" and CMS, "Washington SPA: 20-0014."

[22] CMS, "Delaware SPA: 20-0002," May 27, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/DE/DE-20-0002.pdf; CMS, "Georgia SPA: 20-0006," May 20, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/GA/GA-20-0006.pdf; CMS, "Maryland SPA: 20-0003," May 4, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MD/MD-20-0003.pdf; CMS, "Minnesota SPA: 20-0008," July 15, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-20-0008.pdf; CMS, "Mississippi SPA: 20-0015," May 7, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MS/MS-20-0015.pdf; and CMS, "Ohio SPA: 20-0012."

[23] CMS, "Illinois SPA: 20-0004;" CMS, "Minnesota SPA: 20-0007;" CMS, "Nebraska SPA: 20-0010;" CMS, "North Carolina SPA: 20-0008," May 18, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NC/NC-20-0008.pdf; and CMS, "West Virginia SPA; 20-0004."

[24] CMS, "Colorado SPA: 20-0012;" CMS, "Missouri SPA: 20-0012," June 17, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MO/MO-20-0012.pdf; and CMS, "Minnesota SPA: 20-0007."

[25] CMS, "California SPA: 20-0024;" CMS, "Louisiana SPA: 20-0004," April 20, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/LA/LA-20-0004.pdf; CMS, "Minnesota SPA: 20-

Eliminating Copayments

Although Medicaid law allows states to impose nominal copayments for certain services, research shows that cost sharing has negative effects on individuals' ability to access needed care, worsens health outcomes, and increases financial burdens for families. In fact, research has found that "even relatively small levels of [Medicaid] cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services. . . ."[26]

To ensure that people seek needed medical care during the pandemic, 11 states have approved SPAs to temporarily suspend cost sharing for all services, not just on COVID-19 testing, through the end of PHE, with West Virginia suspending cost sharing for all services except for prescription drugs.[27] Massachusetts and Vermont are suspending copayments on acute inpatient hospital stays and outpatient hospital visits, respectively.[28] (See Appendix Table 1.)

Eliminating Premiums

Premiums are generally not permitted under Medicaid state plan authority except for certain groups, such as individuals with incomes above 150 percent of the federal poverty line and employed individuals with disabilities. As with other forms of cost sharing, extensive research shows that premiums serve as a barrier to maintaining and keeping coverage and lead to greater unmet health needs and financial burdens.[29] To ensure access to care during this crucial time, 17 states are temporarily eliminating premiums in their Medicaid state plans for certain adult coverage groups and people with disabilities.[30] (See Appendix Table 1.)

States Still Have Time to Do More

With the extension of the PHE, states still have time to respond to COVID-19 by making temporary changes to their Medicaid programs to improve access to affordable coverage.[31] While progress has been made in making it easier to qualify for and to enroll in coverage as well as to access care, states can do more to help ensure people have affordable coverage during this crucial time, especially in streamlining eligibility and enrollment processes.

0008"; and CMS, "South Dakota SPA: 20-0003," May 28, 2020, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/SD/SD-20-0003.pdf.

[26] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations.

[27] Kaiser Family Foundation, "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," and CMS, "West Virginia SPA; 20-0004."

[28] CMS, "Massachusetts SPA: 20-006" and CMS, "Vermont SPA: 20-0015," May 29, 2020, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VT/VT-20-0015.pdf.

[29] *Ibid.*

[30] Kaiser Family Foundation, "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19."

[31] Rachel Roubein and Adam Cancryn, "Pence, Azar Reassure Governors Trump Won't End Virus Emergency Declaration," *Politico,* July 7, 2020, https://www.politico.com/news/2020/07/07/pence-azar-governors-coronavirus-emergency-declaration-350991.

For example, as detailed above, to date, only 11 states have completed CMS' eligibility verification plan disaster addendum templates for approval. These disaster addendums allow states to easily — and temporarily — make eligibility and enrollment changes, such as allowing self-attestation of income and non-income eligibility factors, and conducting post-enrollment verification. And while 45 states have approved Medicaid disaster SPAs, only a handful of states have implemented expanded PE, implemented less restrictive eligibility criteria, or extended reasonable opportunity periods.

CMS has made it easy for states to consider and elect various eligibility, enrollment, and coverage changes to respond the pandemic by creating Medicaid disaster SPA templates and verification plan addendums. These templates allow states to simply "check the box" of the policy they'd like to change, and for how long. States can implement these changes through the end of the PHE, or end them at an earlier date. With flexibility and additional time to act, states should leverage these options to ensure that their residents have access to affordable coverage during this crisis.

Making Temporary Changes Permanent

As noted above, most of the changes states made in response to the COVID-19 crisis are approved under Medicaid disaster SPAs or verification plan addendums, allowing states to simplify the submission and approval of their changes and adopt certain policies they may wish to make for a limited time period. But most of the underlying policy options that states have temporarily elected, such as expanding PE or eliminating premiums and copayments, are available on a permanent basis. As they experiment with these policies during the pandemic, many Medicaid agencies are finding that they simplify the enrollment process for eligible applicants while reducing burden on caseworkers. Particularly since Medicaid agencies will continue to face increased demand and decreased resources after the PHE, they should make these policies that streamline access to Medicaid permanent.

To continue implementing these changes after the PHE expires, states must submit new SPAs and verification plan addendums following traditional processes, and in some cases, comply with regulatory public notice requirements. States interested in making policies approved under their Medicaid disaster SPAs permanent, including any telehealth changes, will need to submit a new SPA no later than the end of the quarter in which the PHE ends to ensure that the new SPA's effective date coincides with the end of the PHE.[32] Before submitting the new SPA, states should ensure that they meet the necessary public notice and tribal consultation requirements. Generally speaking, most eligibility and enrollment SPAs do *not* require states to solicit public comments, but changing cost sharing, certain benefits, telehealth, and provider rates *does* require public notice.[33]

For changes to the state's verification plans, including post-enrollment verification and increases to the reasonable compatibility threshold, states would have to submit an addendum to their verification plan. The verification plan addendum submission process is straightforward, with a shorter and less complicated CMS review and approval period than for SPAs.

[32] States are allowed to submit an SPA by the end of the fiscal quarter in which it will be effective.

[33] For more information on SPA public notice requirements, see CMS, "All-State Medicaid & CHIP Call," June 16, 2020, https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200616.pdf.

APPENDIX TABLE 1

Medicaid Strategies to Improve Access to Affordable Coverage and Care

	Making It Easier to Qualify for Coverage				Making It Easier to Enroll in Coverage				Making It Easier to Access and Afford Care		
	Covering Testing for Uninsured	Temporarily Covering Out-of-State & Non-State Residents	Extending Reasonable Opportunity Period	Using Less Restrictive Eligibility Criteria	Expanding PE	Allowing Self-Attestation	Conducting Post-Enrollment Verification	Increasing Reasonable Compatibility Standard Threshold	Expanding Telehealth	Eliminating Copayments	Eliminating Premiums
Alabama	X									X	
Alaska		X	X								X
Arizona										X	X
Arkansas											
California	X			X	X						X
Colorado	X							X	X		X
Conn.	X								X		
DC						X	X		X		
Delaware							X		X	X	X
Florida											
Georgia									X	X	
Hawai'i											
Idaho											
Illinois	X			X	X	X		X	X		X
Iowa	X	X			X					X	X
Indiana							X				
Kansas					X						
Kentucky					X				X	X	
Louisiana	X	X	X				X			X	
Maine	X	X					X			X	X
Maryland									X		X
Mass.					X					X	
Michigan											

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Minnesota	X			X					X		X
Mississippi									X		
Missouri									X	X	
Montana	X										
Nebraska		X	X		X				X	X	X
Nevada	X	X									
New Hampshire	X				X						
New Jersey					X				X		
New Mexico	X				X						
New York											
North Carolina	X	X	X						X		X
North Dakota											X
Ohio			X		X	X	X	X	X	X	
Oklahoma											
Oregon		X			X						
Penn.		X									
Rhode Island		X	X								
South Carolina	X										
South Dakota											

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Tenn.											
Texas											
Utah	X				X						
Vermont							X			X	
Virginia		X									
Washington	X	X		X	X	X	X		X		X
West Virginia	X	X							X	X	X
Wisconsin			X		X						X
Wyoming						X					X
Total	18	13	7	4		15	5	7			17