Medicaid Retroactive Eligibility: Changes under Section 1115 Waivers

Federal regulation requires states to provide three months of retroactive eligibility for Medicaid, if an individual received covered services and would have been eligible at the time the service was provided (42 CFR 435.915). As of August 2019, 30 demonstrations in 27 states have been approved to make changes to the retroactive eligibility period as part of Section 1115 demonstration waivers.[1]

Historically, changes to the retroactive eligibility period were narrow in scope and applied to discrete populations, such as individuals receiving family planning or home- and community-based services (HCBS). More recently, states have sought such waivers as part of a broader strategy to adopt policies that mirror those in the commercial market. In some cases, these waivers apply to non-disabled adults, and in others, they extend to a broader group of Medicaid beneficiaries, including individuals eligible under the aged, blind, or disabled eligibility groups. The details of these policies also vary; while some states have shortened the retroactive eligibility period, others have eliminated it entirely.

This brief provides an overview of retroactive eligibility policies in states with approved waivers, including the policy goals and the features of the demonstrations. It also describes states' evaluation plans and results where available.

Policy Goals

States vary in their reasons for seeking waivers of retroactive eligibility rules. [2] Waivers that provide Medicaid coverage of specialized services for which the populations included would otherwise be ineligible (such as family planning, HCBS, and mental health services) often exclude retroactive eligibility periods because individuals would not be eligible to receive these services prior to becoming enrolled through the waiver.

States cite different rationales for reducing or eliminating retroactive eligibility period in Section 1115 waivers. Common rationales are that it encourages people to enroll in coverage prior to experiencing illness or injury; it promotes preventive care; and it better prepares beneficiaries for a transition to commercial coverage, which typically does not have a retroactive coverage period. States also argue that the policy promotes fiscal sustainability of the Medicaid program by producing cost savings. For example, a 2019 study estimated that eliminating retroactive eligibility in Florida would affect 11,500 Floridians and save $104 million in state and federal funds (Koh 2019). [3]

Critics of changes to retroactive eligibility policies have expressed concern about the effects on beneficiaries and providers. For example, they note that for individuals residing in nursing homes, filing an

application for Medicaid coverage takes an average of 71 days, and retroactive eligibility allows nursing home residents to receive services during this time (Meyer 2019). Changes to retroactive eligibility periods may also result in providers experiencing greater uncompensated care and could disproportionately affect trauma centers and rural hospitals (Meyer 2019). [4]

Features of Retroactive Eligibility Policies

The specifics of retroactive eligibility policies vary (Table 1A). While five states specifically target non-pregnant, non-disabled adults in the new adult group for retroactive eligibility changes, six states apply changes to the Medicaid population as a whole. Additionally, while many states shorten the retroactive period, several states eliminate it entirely. For example, Florida and Iowa's Section 1115 demonstrations begin eligibility the first day of the month in which the application was filed, which results in retroactive eligibility periods between 1 and 30 days (CMS 2017d, 2018c). Arkansas Works limits retroactive eligibility to 30 days prior to the date of application (CMS 2018a); two demonstrations (Massachusetts and Hawaii) restrict the retroactive eligibility period to ten days prior to the submission of the application (CMS 2018b, 2019f); two demonstrations (Kentucky and Indiana) provide coverage to individuals only after they have paid their first premium payment (CMS 2017c, 2018d).[5] Others, including demonstrations that provide family planning and HCBS, the Oregon Health Plan, and the Rhode Island Comprehensive Demonstration, eliminate the entire three-month period (Table 1A) (CMS 2018h, 2017g).

States typically exempt specific populations from the waiver and continue to allow certain Medicaid enrollees to receive coverage for a retroactive period (Table 1A). For example, demonstrations focused on the new adult group often exclude pregnant women and women within the 60 day postpartum period. States with broad waivers of retroactive eligibility generally exempt individuals eligible under the aged, blind, or disabled eligibility groups. Other groups that have been exempted from retroactive eligibility changes include infants under age 1, former foster care youth, and children under age 19.

Effects of Retroactive Eligibility Policy Changes

Little is known about the effect of changing or eliminating the retroactive eligibility period on beneficiary access to services, Medicaid spending, or payments to providers. Some states have reported data but none have conducted a formal evaluation of the effects of these policies, and there is little information on whether or how they will evaluate retroactive eligibility policies. For example, when Iowa received approval to eliminate its three month retroactive eligibility period through an amendment, it made no changes to its existing evaluation plan (CMS 2017d).

Indiana is currently the only state that has completed and made an evaluation report publicly available that mentions the effects of the demonstration's retroactive coverage policy.[6] This evaluation did not specifically measure the effects of changing the retroactive eligibility policy; rather, it noted other policies the state had implemented could remediate potential harmful effects of eliminating the retroactive eligibility period, such as gaps in coverage (CMS 2017c, Lewin 2016).[7]

In recent guidance to states on improving Section 1115 waiver evaluations, CMS suggested that states:

- use administrative data to examine whether beneficiaries subject to waivers of retroactive eligibility experience better enrollment continuity compared to those who are not, and survey data or beneficiary interviews to examine barriers to continuity of coverage;
- use a longitudinal state beneficiary survey on self-reported health status to examine whether beneficiaries subject to waivers of retroactive eligibility experience better health outcomes; and
- use data on medical debt to examine whether reduction or elimination of retroactive eligibility leads to adverse financial impacts on affected beneficiaries (CMS 2019a).

Endnotes

[1] Under Section 1115 of the Social Security Act, the Secretary of the U.S. Department of Health and Human Services (HHS) can waive almost any Medicaid state plan requirement under Section1902 to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program.

[2] Six states have applied for and received waivers that change or eliminate the retroactive eligibility period without including a rationale (CMS 2017f).

[3] During state fiscal year 2018, 3.9 million beneficiaries were enrolled in this waiver and total waiver spending was $5.8 billion (CMS 2018b).

[4] Uncompensated care is the measure for hospital care where no payment is received. It is commonly a sum of a hospital's charity care and bad debt. Charity care is defined as health care services for which a hospital determines the patient does not have the capacity to pay. Bad debt is defined as the expected payment amounts that a hospital is not able to collect from patients who, according to the hospital's determination, have the financial capacity to pay (MACPAC 2018).

[5] Retroactive eligibility changes in Arkansas, Kentucky, and New Hampshire, along with several other features of these states' approved demonstrations, were vacated by the U.S. District Court for the District of Columbia and remanded to CMS for further review in 2019. As a result, the future of these states' retroactive eligibility changes is in question; at this time, the states must continue to provide three months retroactive eligibility.

[6] Indiana's Section 1115 waiver eliminates the retroactive eligibility period. Coverage begins on the date that first premium payment is made, or, for those not subject to premiums as a condition of eligibility, 60 days following the date the premium payment would have been required.

[7] Sixty-two percent of qualifying providers made presumptive eligibility determinations, but it was not reported how many providers made presumptive eligibility determinations prior to the elimination of retroactive eligibility (Lewin 2016). In an effort to decrease gaps in coverage, Indiana introduced a simpler process for Medicaid renewals using electronic data sources for verification as compared to relying on the patient to provide verification.

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Appendix

TABLE 1A. Features of Approved Waivers of Retroactive Eligibility

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
Alabama Plan First	• Women age 19–55 with income up to 141 percent FPL who are losing Medicaid after their 60-day postpartum period and not otherwise eligible for Medicaid • Men age 21 or older with income up to 141 percent FPL	None	Date of application
Arizona Health Care Cost Containment System	All Medicaid beneficiaries	• Pregnant women (including 60 days postpartum) • Children under age 19 • Infants under age 1	First day of the month of application
Arkansas Works[1]	New adult group	None	30 days prior to the date of application

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
Delaware Diamond State Health Plan	All Medicaid beneficiaries enrolled in managed care	• Institutionalized individuals • Workers with disabilities	• For most Medicaid beneficiaries, date of application • For individuals in the new adult group, first day of the month of application
Florida 1115 Managed Medical Assistance	Adults age 21 or older enrolled in managed care	Pregnant women (including 60 days postpartum)	First day of the month in which application is filed
Florida Medicaid Family Planning Waiver	Women age 14–55 with income at or below 191 percent FPL who are losing Medicaid coverage for any reason (including after their 60-day postpartum period and those losing managed care coverage)	None	Date of application[2]
Georgia Planning for Healthy Babies	Uninsured women age 18–44 with income at or below 200 percent FPL, who are losing Medicaid after their 60-day postpartum period and are not otherwise eligible for Medicaid, (including those who delivered a very low birthweight baby)	None	Date of application[2]
Hawaii QUEST Integration	All Medicaid beneficiaries	Individuals requesting long-term care services	Ten days prior to the date of application

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
Healthy Indiana Plan	New adult group	Pregnant women (including 60 days postpartum)	• First day of the month in which the first premium payment is made • If the first premium payment is not made within 60 days of the invoice, coverage begins the first day of the month in which the 60-day period expires
Iowa Wellness Plan	All state Medicaid populations newly applying for Medicaid and new beneficiaries who join an existing household whose applications were filed or requested on or after November 1, 2017	• Pregnant women (including 60 days postpartum) • Infants under age one • Applicants who are residents of a nursing facility at the time of application	First day of month in which application is filed

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
Kentucky Health[1]	New adult group and low-income parents and caretaker relatives	• Pregnant women (including 60 days postpartum) • Former foster care youth • Individuals eligible for transitional medical assistance	• First day of the month in which the first premium payment is made • If the first premium payment is not made within 60 days of the invoice, coverage begins the first day of the month in which the 60-day period expires
Maryland Health Choice	• Women of childbearing age who have income at or below 250 percent FPL and are not otherwise eligible for Medicaid, Medicare, CHIP, or other health insurance that provides family planning services, but who had Medicaid pregnancy coverage • Optional targeted low-income children	Mandatory poverty-related pregnant women and children under age 18[3]	Date of application[2]

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
MassHealth	All Medicaid beneficiaries	• Kaileigh Mulligan-eligible children and children receiving Title IV-E adoption assistance • HCBS waiver, under age 65	• In general, 10 days prior to the date of application; • For children in Department of Children and Families custody, start date of custody • For individuals with ESI, following first month's premium payment after determination
Mississippi Family Planning Waiver	Women (including those losing Medicaid after their 60-day postpartum period) and men age 13–44 with income at or below 194 percent FPL who are not otherwise eligible for Medicaid, Medicare, CHIP or other health insurance that provides family planning services	None	Date of application
Missouri Gateway to Better Health	Individuals age 19–64 living in St. Louis County or City with income under 100 percent FPL	None	Date of application

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
Montana Additional Services and Populations	Individuals over age 18 who are not otherwise eligible for Medicaid and have been diagnosed with severe disabling mental illness, who either • have income between 133 and 150 percent FPL, or • are enrolled or eligible for Medicare with income under 133 percent FPL	None	Date of application
Montana Plan First	Women age 19–44 with income under 211 percent FPL who are not otherwise eligible for Medicaid and are losing Medicaid or CHIP (including at the end of the 60-day postpartum period), or have private coverage but meet other demonstration eligibility criteria	None	Date of application

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
New Hampshire Granite Advantage Health Care Program[1]	New adult group	• Pregnant women (including 60 days postpartum) • Children under age 19 • Parent or caretaker relatives • Individuals in aged, blind, or disabled eligibility groups	First day of the month in which application is filed
New Mexico Centennial Care 2.0	All Medicaid beneficiaries enrolled in managed care	• Pregnant women (including 60 days postpartum) • Children under age 19 • Individuals eligible for institutional care	• For 2019: one month prior to application • For 2020: first day of the month of application • For individuals subject to premiums, coverage begins the first day of the month in which the first premium payment is made

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
Oklahoma SoonerCare	All Medicaid beneficiaries who are enrolled in SoonerCare, Oklahoma's managed care demonstration program	• Pregnant women (including 60 days postpartum) • Children under age 19 • Children with disabilities living at home (TEFRA children) • Individuals in aged, blind, or disabled eligibility groups	Date of application[2]
Oregon Health Plan	All Medicaid beneficiaries	Individuals in aged, blind, or disabled eligibility groups	First day of the month of application
Oregon Contraceptive Care	Women of childbearing age and men with income at or below 250 percent FPL who are not otherwise eligible for Medicaid or CHIP	None	First day of the month of application
Rhode Island Comprehensive Demonstration	All Medicaid beneficiaries	Individuals in aged, blind, or disabled eligibility groups	Date of application
TennCare II	All Medicaid beneficiaries	None	Date of application[2]

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
Utah Primary Care Network	• Non-disabled, non-elderly individuals age 19–64 with income under 100 percent FPL who are not otherwise eligible for Medicaid • Non-disabled, non-elderly individuals age 19–64 with household income under 200 percent FPL, who are receiving Medicaid-funded premium assistance and are not otherwise eligible for Medicaid	None	Date of application[2]
Vermont Global Commitment to Health	• Individuals with incomes below 300 percent of the SSI, are not eligible for Medicaid, meet clinical standards for moderate needs group, and are at risk of institutionalization • Medicare beneficiaries age 65 and older or who have a disability, with income at or below 225 percent FPL, who are not eligible for full benefits	None	Date of application

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
The Virginia GAP and ARTS Delivery System Transformation	Uninsured non-institutionalized individuals age 21–64 with income at or below 100 percent FPL, who are diagnosed with a serious mental illness and are not otherwise enrolled in Medicaid, CHIP, or Medicare	None	First day of the month of application
Washington Family Planning Only Program	• Women losing Medicaid after their 60 day postpartum period • Uninsured women of childbearing age and men with income at or below 260 percent FPL • Teens and survivors of domestic violence with income at or below 260 percent FPL	None	Date of application
Wisconsin Senior Care	Individuals age 65 and older with income below 200 percent FPL who are not otherwise eligible for full Medicaid state plan benefits	None	First day of the month following the month in which all eligibility criteria are met, including payment of enrollment fee

TABLE 1A. (continued)

Demonstration name	Population included	Populations exempt from retroactive eligibility changes	Effective date of coverage
Wyoming Pregnant by Choice	• Women losing Medicaid after their 60-day postpartum period • Women age 19–44 with income at or below 159 percent FPL	None	Date of application

Notes: CHIP is State Children's Health Insurance Program. FPL is federal poverty level. HCBS is home- and community-based services. ESI is employer-sponsored insurance. SSI is Supplemental Security Income. TEFRA is the Tax Equity and Fiscal Responsibility Act. New adult group includes those enrollees who are newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Kaileigh Mulligan-eligible children are children with any type of disability, including medical, developmental, intellectual, or psychiatric conditions, who would otherwise require care in an institution. Moderate needs group is defined as individuals who are not otherwise eligible under the Medicaid state plan but who are at risk for institutionalization and in need of home and community-based services. Very low birthweight babies are defined as weighing less than three pounds, five ounces.

[1] Retroactive eligibility changes in Arkansas (Gresham v. Azar 18-1900-JEB (D.D.C. 2019)), Kentucky (Stewart v. Azar 18-152-JEB (D.D.C. 2019)) and New Hampshire, (*Philbreck v. Azar* 19-773-JEB (D.D.C. 2019)), along with several other features of these states' approved demonstrations, were vacated by the U.S. District Court for the District of Columbia and remanded to CMS for further review in 2019. This action leaves the future of these states' retroactive eligibility changes in question, and at this time, the states must continue to provide three months retroactive eligibility.

[2] Under the approved demonstration waiver, the state is not required to provide eligibility prior to the date of application. However, the special terms and conditions do not explicitly note the effective date of coverage.

[3] Some states have higher mandatory eligibility levels for infants and pregnant women, ranging from 150 to 185 percent FPL because they had already expanded to these levels when the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) was enacted to mandate coverage of pregnant women up to at least 133 percent FPL. States are required to maintain these higher preexisting thresholds.

Sources: CMS 2019a, 2019b, 2019c, 2019d, 2019e, 2019f, 2019g, 2019h, 2019i, 2019j, 2019k, 2018a, 2018b, 2018c, 2018d, 2018e, 2018f, 2018g, 2018h, 2018i, 2018j, 2017a, 2017b, 2017c, 2017d, 2017e, 2017f, 2017g, 2017h, 2017i, 2016a, 2016b.