Section 1115 Waivers of Retroactive Medicaid Eligibility

Lack of Evidence Raises Flags and Warrants Caution

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Medicaid's retroactive eligibility provision covers health care services received up to 90 days before the date a beneficiary applied for Medicaid coverage, provided the beneficiary would have been eligible for the program when the services were received.[1] These protections underscore Medicaid's function as a health care safety net program providing assistance when it is needed most. Congress envisioned retroactive eligibility as protecting people unaware of their Medicaid eligibility or unable to apply in a timely way because of the sudden onset of disease or injury.[2] Since retroactive eligibility became part of federal Medicaid law in 1972, this mechanism has served many purposes; it has covered medical bills when an uninsured person experiences a major health event or accident, facilitated long-term institutional placements for people being discharged from the hospital who have not yet applied for Medicaid, and covered hospital charges for Medicaid-eligible newborns before their enrollment has been processed. Retroactive eligibility helps people avoid medical debt, which can negatively affect the physical and mental health—as well as the financial well-being—of low- and moderate-income people (Hamel et al. 2016). Retroactive eligibility plays an important role in hospitals and long-term care institutions, too, allowing providers to begin care as soon as needed, regardless of a patient's date of application.

Section 1115 of the Social Security Act authorizes the US Department of Health and Human Services to waive certain parts of Medicaid law and allows states to undertake demonstration projects

promoting Medicaid objectives.[3] Beginning in the 1990s, the department authorized Medicaid Section 1115 demonstrations waiving retroactive eligibility for certain populations, typically as part of experiments to expand eligibility and exclude traditional enrollee groups (MACPAC 2019). The nature of these experiments changed with the Trump administration; between 2017 and 2020, the executive branch approved six retroactive eligibility waivers that were not part of eligibility expansions and that applied broadly to Medicaid populations, including seniors and people with disabilities.[4] In more recent Section 1115 waiver applications, state officials have asserted that waiving retroactive eligibility will familiarize beneficiaries with commercial insurance (that provides prospective coverage only), incentivize them to obtain and maintain health coverage even when healthy, and encourage them to apply for coverage as soon as they believe they meet eligibility criteria (MACPAC 2019).

Despite retroactive eligibility's long-standing role in Medicaid, little is known about how its absence affects beneficiaries and providers. Using qualitative and quantitative approaches, this study examines the effects of retroactive eligibility waivers to fill this research gap.

Methods

We first conducted an environmental scan of academic literature, policy briefs and reports, waiver applications and approval letters, and media coverage to identify national experts, states with current waivers, and key stakeholders. We conducted seven interviews with nine national experts between November 2019 and January 2020. Between January and August 2020, we then conducted virtual case studies in Arizona, Hawaii, Iowa, New Mexico, and Oklahoma. We focused on these states because they had an active waiver at the time or had had one recently and because they agreed to participate in our study. We conducted 18 interviews with 39 state-level stakeholders, including Medicaid officials, health care provider representatives, consumer advocacy organizations, and state policy experts. Our discussion guides addressed the purpose, design, implementation, and impacts of retroactive eligibility waivers. We recorded, transcribed, and analyzed interviews to uncover insights and common themes. Table 1 shows effective dates and other features of each study state's waiver.

TABLE 1

Design Features of Medicaid Section 1115 Waivers of Retroactive Eligibility in Study States

State	Effective dates	Affected and exempt populations	Retroactive coverage period	Changes after implementation
Arizona	7/2019–present	▪ Expansion and nonexpansion enrollees affected ▪ Exemption for pregnant/postpartum women, infants, and children younger than 19	▪ Coverage begins on the first day of the month of application	▪ None
Hawaii	1994–98/2019	▪ Expansion and nonexpansion enrollees affected ▪ Exemption for beneficiaries eligible for long-term care services	▪ Coverage begins 10 days before the date of application	▪ In 2012, the period of retroactive eligibility was extended from 5 to 10 days before the date of application
Iowa	11/2017–present	▪ Expansion and nonexpansion enrollees affected ▪ Exemption for pregnant/postpartum women, infants, children younger than 19, and nursing facility residents	▪ Coverage begins on the first day of the month of application	▪ Exemption for those residing in nursing facilities at the time of application took effect in 2018 ▪ Exemption for children younger than 19 took effect in 2020
New Mexico	12/2018–2/2020	▪ Expansion and nonexpansion managed-care enrollees affected ▪ Exemption for pregnant/postpartum women, children younger than 19, Native Americans (unless they opt into managed care), and people eligible for institutional care	Phase-out approach: ▪ In 2019, coverage began one month before the date of application ▪ Starting in 2020, coverage begins on the first day of the month of application	▪ Waiver reversed by governor via amendment request to CMS in June 2019 ▪ Second phase never implemented
Oklahoma	At least 2010–present[a]	▪ Nonexpansion enrollees affected ▪ Exemption for pregnant/postpartum women, infants, and children younger than 19, Tax Equity and Fiscal Responsibility Act enrollees, and aged, blind, and disabled populations	▪ Coverage begins on the date of application	▪ Exemption for pregnant women and children took effect in August 2018

Source: Urban Institute interviews with Medicaid officials, health care provider representatives, consumer advocacy organizations, and state policy experts.

Notes: CMS = Centers for Medicare & Medicaid Services. Expansion enrollees are people made eligible for Medicaid through expansion of the program under the Affordable Care Act; nonexpansion enrollees were eligible for Medicaid before the state expanded the program.

[a] The exact date Oklahoma implemented a Section 1115 waiver is unknown.

For the quantitative analysis, we used data on fiscal years 2011–18 from the Centers for Medicare & Medicaid Services (CMS) Healthcare Cost Report Information System (HCRIS) to assess waiver effects on hospitals' uncompensated care costs as a percentage of total costs and on Medicaid revenue as a percentage of total revenue. We compared hospital outcomes in states that have expanded eligibility under the Affordable Care act (hereafter Medicaid expansion states) and had retroactive eligibility waivers that took effect between 2014 and 2018 (Arkansas, Indiana, Iowa, and New Hampshire) with outcomes in Medicaid expansion states that did not have retroactive eligibility waivers. We restricted our sample to hospitals in Medicaid expansion states because the implementation of retroactive eligibility waivers coincided with Medicaid expansion. We did not assess the effects of retroactive eligibility waivers that took effect before the Affordable Care Act because these waivers were much more limited in scope than recent waivers. See the data and methods section for additional details (e.g., construction of comparison group and parallel trend tests).

Limitations

Though the information we gleaned from national experts is based on knowledge of retroactive eligibility across the country, our case studies were limited to five states and may not represent the broader set of states with waivers. To assess the effects of retroactive eligibility waivers on Medicaid enrollment and costs, we requested aggregate data on retroactive eligibility claims from five states with waivers and five states without waivers. However, we could not obtain these data, because states declined to participate upfront, were unable to provide data because of competing demands related to the COVID-19 pandemic, or were unable to identify retroactive claims in their data systems. For example, one state reported that because the Department of Social Services handles eligibility determinations, the Medicaid agency did not have access to data showing whether someone had requested or been deemed eligible for retroactive coverage. Additionally, all study states' Medicaid applications include a question about needing help paying for medical services in the prior three months; this could allow states to track how many beneficiaries who need retroactive coverage are not receiving it, but none of the study states were analyzing these data at the time of our study.

In addition, the quantitative HCRIS analysis had limited power to detect statistical differences between hospitals in the retroactive eligibility states and those in the comparison states. This is most problematic in New Hampshire, where only 25 hospitals on average were represented in the data each year. The average sample sizes for Arkansas (67), Indiana (106), and Iowa (115) were larger but still limited the analysis.

Key Findings

Many stakeholders believed the premise for retroactive eligibility waivers is faulty. In the study states' waiver applications, officials commonly suggested that restricting or eliminating retroactive eligibility would promote beneficiaries' "personal responsibility" to enroll in or renew Medicaid when they are healthy, rather than during a health crisis. However, national experts rejected the notion that waiving retroactive eligibility would encourage beneficiaries to enroll in or renew coverage in a timely manner;

instead, they argued few Medicaid-eligible individuals are even aware of the provision. As one key informant explained, "The baseline assumption of most people is that you get Medicaid coverage when you apply. And if that's what most people think, and they're still not applying, taking [retroactive eligibility] away isn't going to be a motivating factor." Most stakeholders believed cost savings were a key driver of waivers, even if not publicly acknowledged. Officials from some states identified additional motivations for implementing retroactive eligibility waivers; those in Hawaii suggested their waiver was implemented to encourage hospitals and health care providers to promptly enroll eligible people in Medicaid.

The populations affected by the waivers and the extent to which retroactive eligibility was restricted varied across the five study states. Except for Oklahoma, which implemented the ACA's Medicaid expansion after our analysis,[5] all study states included both Medicaid expansion and nonexpansion enrollees in their retroactive eligibility waivers (table 1). However, the waivers had some exemptions; CMS required exemptions for pregnant and postpartum women, infants, and children under 19. Except for Arizona, the study states also opted to exempt the aged, blind, and disabled Medicaid population or those receiving long-term care services and supports.

Oklahoma eliminated the full retroactive eligibility period, whereas other study states retained some coverage but reduced the applicable period. In Arizona and Iowa, for instance, Medicaid coverage begins on the first day of the month in which the application was submitted (i.e., the retroactive coverage period could be between 1 to 31 days versus the standard 90 days).

Stakeholders shared concerns about the waivers' effects on beneficiaries and providers, but impact data are limited because of lagging and insufficient evaluation efforts. Many speculated that the waivers increased uncompensated care costs for providers and medical debt for beneficiaries. But no interviewees could share evidence of this, and some expressed frustration over the lack of relevant data. Several referred to Indiana Medicaid data collected from 2015 to 2016 that indicated beneficiaries had an average of $1,561 in health care costs during the retroactive eligibility period.[6] When asked about the waivers' effects on Medicaid enrollment or renewal rates, stakeholders noted difficulty distinguishing waiver effects from those of other policies, such as restrictive renewal processes (box 1).

In early 2019, CMS released evaluation design guidance for Section 1115 demonstrations with specific recommendations for retroactive eligibility waivers. The design guidance's recommended hypotheses were that the waivers would increase the likelihood of enrollment (particularly when people are healthy) and increase coverage continuity, improve health outcomes, and have no adverse financial impacts on consumers (CMS 2019). Some experts we spoke with were concerned about lacking or weak evaluation designs. None of the study states reported monitoring the effects of their waivers at the time of our interviews, and some did not have formal evaluation plans. Since then, however, Arizona officials have released an evaluation plan using CMS's recommended hypotheses.[7] Oklahoma's evaluation plan (also public) includes examining the effects of restoring retroactive eligibility for pregnant women and children and how the waiver affects beneficiaries still subject to it (Oklahoma Health Care Authority 2019).

BOX 1

Florida's Retroactive Eligibility Waiver Evaluation Findings

In January 2021, Florida published findings from an evaluation of the retroactive eligibility waiver the Statewide Medicaid Managed Care program implemented in 2019. Evaluators found the waiver had minimal effects on renewal rates and no clear positive or negative effects on the provision of uncompensated care. The state also reported that hospitals and nursing facilities increased Medicaid enrollment assistance for patients after the waiver took effect, and most beneficiaries were unaware of how retroactive eligibility worked or that Florida's policy had changed.

Source: *Final Report: The Impact of the Waiver of Retroactive Eligibility on Beneficiaries and Providers*, University of Florida College of Medicine, Florida State University College of Medicine, and University of Alabama at Birmingham, January 11, 2021.

Long-term care stakeholders had unique concerns about eliminating retroactive eligibility. In states where long-term care recipients were included in waivers, stakeholders' most significant concerns were that access to long-term care would be reduced for Medicaid-eligible patients and uncompensated care costs would increase for nursing facilities. Beneficiaries and their families may need weeks to gather the necessary documentation to apply for Medicaid, during which costly nursing facility charges accumulate. In Arizona and Iowa, representatives from the long-term care community suggested that their retroactive eligibility waivers would reduce access to nursing home care for Medicaid-eligible patients and increase uncompensated care costs for nursing facilities. In Iowa, these stakeholders estimated the waiver would lead to $7 million in lost revenue for long-term care providers. Long-term care advocacy efforts reportedly factored into the state's decision to reinstate retroactive coverage for nursing facility residents in 2018.

Study states usually amended retroactive eligibility waivers after they were implemented. Similar to Iowa, other states expanded exemptions, most often to pregnant and postpartum women and children, considering that CMS required this for waivers renewed in recent years. When CMS officials asked for these populations to be exempt in Hawaii in 2018, state officials ended the waiver rather than implement such a large exemption. Finally, though New Mexico had begun phasing in implementation of its retroactive eligibility waiver in January 2019, a change in state leadership resulted in the end of that state's waiver in early 2020.[8] None of the study states with effective waivers considered or implemented any changes to retroactive eligibility in response to the pandemic.[9]

Medicaid eligibility and enrollment policies may mitigate the negative impacts of the waivers, but such policies are not a substitute for full retroactive-eligibility protections. State-level stakeholders identified several policies in their Medicaid programs that facilitated beneficiaries' access to care (e.g., presumptive eligibility) or coverage continuity (e.g., automated renewal and 90-day redetermination grace periods). Stakeholders believed these policies and others that had not been implemented in our study states, such as 12-month continuous eligibility for adults, could alleviate harmful effects on beneficiaries' access to care and providers' finances. However, multiple stakeholders cautioned that such policies do not equate to the full 90 days of retroactive eligibility included in Medicaid statute.

Hospitals' uncompensated care costs did not significantly change following the implementation of retroactive eligibility waivers. We find no significant changes at the 5 percent level in uncompensated care costs as a percentage of total costs among hospitals in Arkansas, Iowa, and New Hampshire, relative to hospitals in their respective comparison groups (table 2). We also find no significant changes in Medicaid revenue as a percentage of total revenue among hospitals in each treatment state relative to those in comparison groups. Further, we find no evidence that average uncompensated care costs increased in high-Medicaid-revenue hospitals relative to low-Medicaid-revenue hospitals following implementation of retroactive eligibility waivers (table 3).

TABLE 2

Estimated Changes in Hospitals' Mean Uncompensated Care Costs and Medicaid Revenue before and after Implementation of Retroactive Eligibility Waivers, by State

	Percentage of Hospital Revenue			Difference-in-Differences	
	Prewaiver	Postwaiver	Difference	Coefficient (%)	*p* value
Arkansas					
Uncompensated care costs					
Treatment	5.5	5.0	−0.5		
Comparison group	3.8	3.6	−0.2	−0.3	0.507
Medicaid revenue					
Treatment	11.0	11.0	0.0		
Comparison group	15.1	15.5	0.4	−0.4	0.736
Indiana					
Uncompensated care costs					
Treatment	5.7	5.0	−0.7		
Comparison group	2.7	2.5	−0.2	−0.5	0.053
Medicaid revenue					
Treatment	8.1	8.8	0.7		
Comparison group	8.8	10.6	1.7	−1.0`	0.127
Iowa					
Uncompensated care costs					
Treatment	2.7	2.4	−0.3		
Comparison group	3.7	3.7	−0.1	−0.3	0.507
Medicaid revenue					
Treatment	10.0	10.9	1.0		
Comparison group	15.3	15.1	-0.2	1.2	0.321
New Hampshire					
Uncompensated care costs					
Treatment	4.9	3.5	−1.4		
Comparison group	4.0	3.5	−0.5	−0.9	0.184
Medicaid revenue					
Treatment	6.4	6.9	0.5		
Comparison group	14.7	15.6	0.9	−0.4	0.857

Source: 2011–18 Centers for Medicare & Medicaid Services Healthcare Cost Report Information System.

Notes: For New Hampshire, Arkansas, and Iowa, the comparison group consists of hospitals in states that expanded Medicaid in 2014 but did not implement a waiver. For Indiana, the comparison group consists of hospitals in Pennsylvania, the only other state that expanded Medicaid in the beginning of 2015 but did not implement retroactive eligibility waivers. The before/after

periods for New Hampshire, Arkansas, Indiana, and Iowa are 2014–15/2016–18, 2014–16/2017–18, 2011–14/2015–18, and 2014–17/2018, respectively.

TABLE 3

Changes in Mean Uncompensated Care Costs in Hospitals with High versus Low Medicaid Revenue before and after Implementation of Retroactive Eligibility Waivers, by State

		Percentage of Revenue			Difference-in-Differences	
	Average number of hospitals per year	Prewaiver	Postwaiver	Diff.	Coefficient (%)	*p* value
Arkansas						
High Medicaid	33	6.5	5.9	−0.6		
Low Medicaid	34	4.5	4.2	−0.3	−0.28	0.815
Indiana						
High Medicaid	52	6.5	5.3	−1.2		
Low Medicaid	54	4.8	4.6	−0.2	−0.96	0.05
Iowa						
High Medicaid	57	3.2	2.6	−0.6		
Low Medicaid	58	2.1	2.1	0.0	−0.64	0.077
New Hampshire						
High Medicaid	13	5.2	3.8	−1.4		
Low Medicaid	12	4.6	3.3	−1.3	−0.12	0.875

Source: 2011–18 Centers for Medicare & Medicaid Services Healthcare Cost Report Information System.
Notes: Diff. = difference. The high Medicaid group includes hospitals with Medicaid revenue (as a percentage of total revenue) above the median within the state. The before/after periods for New Hampshire, Arkansas, Indiana, and Iowa are 2014–15/2016–18, 2014–16/2017–18, 2014–17/2018, and 2011–14/2015–18, respectively.

Discussion and Policy Implications

State Medicaid programs have been using Section 1115 authority to waive retroactive eligibility protections for several decades, and the scope of the waivers has grown significantly in recent years. Yet, little is known about their effects on beneficiaries, providers, and Medicaid programs. Our quantitative analysis of data from the HCRIS had a limited sample of states and sample size and excluded institutional long-term care facilities. A future study examining the impacts of retroactive eligibility on nursing facilities could be instructive, given stakeholders' concerns about waiving retroactive eligibility for this population. Qualifying for long-term care Medicaid coverage is a complex process, and retroactive eligibility waivers could disrupt an essential source of revenue for nursing facilities and make it more difficult for beneficiaries to access long-term care.

Medicaid officials have suggested that restricting retroactive eligibility will encourage beneficiaries to enroll in and renew coverage promptly, and CMS approved waivers using this rationale. But, to our knowledge, no evidence shows waivers have had this effect, which is predicated on beneficiaries' awareness of retroactive eligibility protections and the consequences of its elimination.

The state Medicaid officials we spoke with could not specify how they planned to evaluate retroactive eligibility waivers. Though some states have since released their plans, evaluations are often years behind waiver implementation. Even in states where retroactive eligibility waivers were in place for decades, state officials were unable to provide any information about the policy's impact. Some national experts expressed that the lack of evaluation data and weak federal enforcement of evaluation requirements undercut the purpose of Section 1115 waivers as experimental demonstrations meant to improve Medicaid.

The effects of Medicaid demonstrations must be properly documented and analyzed by early-implementation states before new states are granted permission to implement similar provisions, especially if people are concerned that a demonstration will adversely affect beneficiaries and providers. To appropriately protect beneficiaries and providers, CMS could consider requiring that states have a detailed evaluation plan prepared by an independent evaluator for their Section 1115 waivers to be approved. Further, CMS might stop the demonstrations if evaluations are not being conducted or if evaluation findings indicate negative effects in violation of the Social Security Act.

Additional Information about Data and Methods for the HCRIS Analysis

The HCRIS, which is updated quarterly, contains annual cost reports submitted by all Medicare-certified hospitals and provides hospital financial information for constructing key outcome measures. The HCRIS has known limitations with item nonresponse and data quality, though it is widely used by the federal government and other entities to track critical components of hospitals' finances. To improve the quality of these data, we coded some erroneously reported values as missing, as we have done in prior analyses (Blavin 2016; Blavin and Ramos 2021).

Our sample is limited to nonfederal, general medical and surgical hospitals. We use descriptive difference-in-differences models to estimate changes in outcomes associated with the retroactive eligibility waivers. We also estimate multivariate models that yield findings consistent with the descriptive estimates. Multivariate models control for hospital fixed effects, a set of fiscal-year-specific dummy variables, and hospital-level controls that could vary over time and influence each financial outcome. The key right-hand side variable in these models is a dummy variable set to 1 in the years a hospital was exposed to the retroactive eligibility waiver. Because fiscal and calendar years do not overlap, this variable may be specified as the share of the fiscal year that the hospital was exposed to the retroactive eligibility waiver. Robust standard errors are clustered at the hospital level to correct for possible heteroscedasticity and autocorrelation.

We do not assess the effects of retroactive eligibility waivers that took effect before the Affordable Care Act, because these were more limited in scope than recent waivers. In addition, many of these early waivers were in effect before 2011, and we cannot compare hospital cost report data before 2011 with subsequent years because the cost report forms have changed.

For New Hampshire, Arkansas, and Iowa, the comparison group consists of hospitals in states that expanded Medicaid in 2014 but did not implement a waiver. For Indiana, the implementation of the retroactive eligibility waiver coincided with Medicaid expansion in 2015. Our Indiana comparison group therefore consists of hospitals in Pennsylvania, the only other state that expanded Medicaid in the beginning of 2015 but did not implement retroactive eligibility waivers. In this instance, we compare the combined effect of Medicaid expansion and retroactive eligibility waivers in Indiana with the effect of Medicaid expansion alone in Pennsylvania. The periods before and after states implemented waivers vary to account for when the Medicaid expansion and waivers took effect in each treatment state, as shown in table 4.

TABLE 4

Medicaid Expansion and Retroactive Eligibility Waiver Implementation Dates and Comparison Groups, by State

State	Implementation Date		Comparison group	Prewaiver period	Postwaiver period
	Medicaid expansion	Retroactive eligibility waiver			
Arkansas	01/2014	01/2017	Hospitals in states that expanded Medicaid in 2014 but did not implement a waiver	2014–16	2017–18
Iowa	01/2014	11/2017		2014–17	2018
New Hampshire	08/2014	01/2016		2014–15	2016–18
Indiana	02/2015	02/2015	Hospitals in Pennsylvania	2011–14	2015–18

Source: Urban Institute analysis of data from the Healthcare Cost Report Information System.

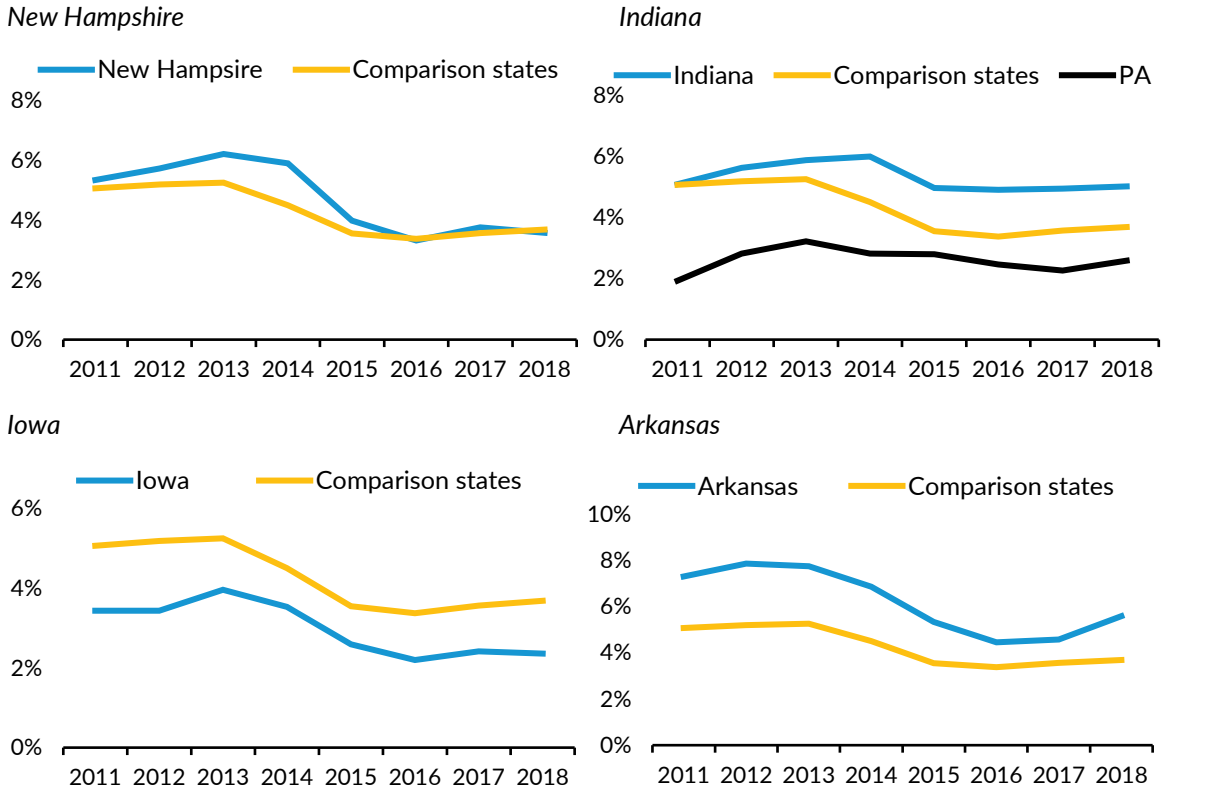
We conducted tests to determine if average uncompensated care costs in the treatment and comparison groups had parallel trends before retroactive eligibility waivers were implemented. We also assessed whether hospitals that served a higher share of Medicaid patients (i.e., those with Medicaid revenue as a percentage of total revenue above the state median) experienced a larger increase in uncompensated care costs than hospitals that served a lower share of Medicaid patients. As noted, we find no evidence that high-Medicaid-revenue hospitals experienced a larger increase in average uncompensated care costs than low-Medicaid-revenue hospitals following implementation of retroactive eligibility waivers (table 3).

Additionally, figure 1 shows that trends in uncompensated care costs were similar among hospitals in each treatment state and their comparators leading up to the implementation of retroactive eligibility waivers (and after Medicaid expansion). For Indiana, we find that that prewaiver trends were similar to those in Pennsylvania but differed from those in all other Medicaid expansion states. For each state-specific model, we do not reject the null hypothesis of parallel trends at the 1 percent level. (The *p* value for the Arkansas test is 0.048. For all other models, the *p* value exceeds 0.10). However,

differential pretrends could be present but undetected because of our small sample size, limited years of prewaiver implementation data, or both.

FIGURE 1

Trends in Mean Annual Uncompensated Care Costs as a Share of Total Expenses for Hospitals in Study and Comparison States, Fiscal Years 2011–17



URBAN INSTITUTE

Source: Urban Institute analysis of data from the Healthcare Cost Report Information System.
Note: PA = Pennsylvania.

Notes

[1] See 42 U.S.C. § 1396a (a) (34) (2010). The provision says, "A state plan for medical assistance must provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished."

[2] Senate Report No. 92-1230, at 209 (Sept. 26, 1972) (discussing section 255 of H.R. 1).

[3] "About Section 1115 Demonstrations," Medicaid.gov, accessed June 23, 2021, https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html.

[4] "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," Kaiser Family Foundation, accessed June 23, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

[5] Oklahoma expanded Medicaid via a June 2020 ballot measure and coverage became effective July 1, 2021. See "Status of State Medicaid Expansion Decisions: Interactive Map," Kaiser Family Foundation, June 24, 2021, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

[6] These data come from Indiana's prior claims program, which was created as a condition of implementing the state's retroactive eligibility waiver and required providers to be reimbursed for services received up to 90 days before the effective Medicaid coverage date for low-income parents not determined presumptively eligible. Nearly 13.9 percent of Medicaid beneficiaries in 2016 were eligible for the program. See Vikki Wachino (director, Center for Medicaid and CHIP Services), letter to Tyler Ann McGuffee (insurance and healthcare policy director, Office of Governor Michael R. Pence) regarding issues related to the Healthy Indiana Plan 2.0 Section 1115 demonstration, July 29, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[7] Danielle Daly (director, Division of Demonstration Monitoring and Evaluation, Centers for Medicare & Medicaid Services), letter to Jami Snyder (director, Arizona Health Care Cost Containment System) regarding approval of evaluation design for Arizona's Arizona Health Care Cost Containment Section 1115 demonstration, November 19, 2020, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-appvd-eval-des-2016-2021.pdf.

[8] Angela D. Garner (director, Division of System Reform Demonstrations, Centers for Medicare & Medicaid Services), letter to Nicole Comeaux (director, Medical Assistance Division, New Mexico Human Services Department) regarding approval of New Mexico's Centennial Care 2.0 Section 1115 demonstration, July 21, 2020, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf.

[9] At least one state not in our study, Massachusetts, has reinstated retroactive eligibility in response to the COVID-19 public health emergency. See "Medicaid Waiver Tracker," Kaiser Family Foundation. Most of our case study data were collected before the public health emergency, when the Medicaid maintenance-of-effort rule was not in effect. That rule stipulates that states cannot disenroll Medicaid beneficiaries while the public health emergency is in effect in order to receive enhanced federal matching dollars to support their Medicaid programs. The rule influences beneficiaries' rates of disenrollment and churn in and out of the program, which in turn influences the proportion of beneficiaries who could be affected by retroactive eligibility waivers. However, we did not explore the effects of the maintenance-of-effort rule during our interviews.

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Errata

This brief was corrected July 12, 2021. The period covered by retroactive eligibility is the 3 months before the month in which a Medicaid application is submitted. A previous version said the period covered is 90 days before the date on which an application is submitted.

About the Authors

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