NATIONAL HEALTH LAW PROGRAM

Overview on Using Medicaid to Respond to COVID-19

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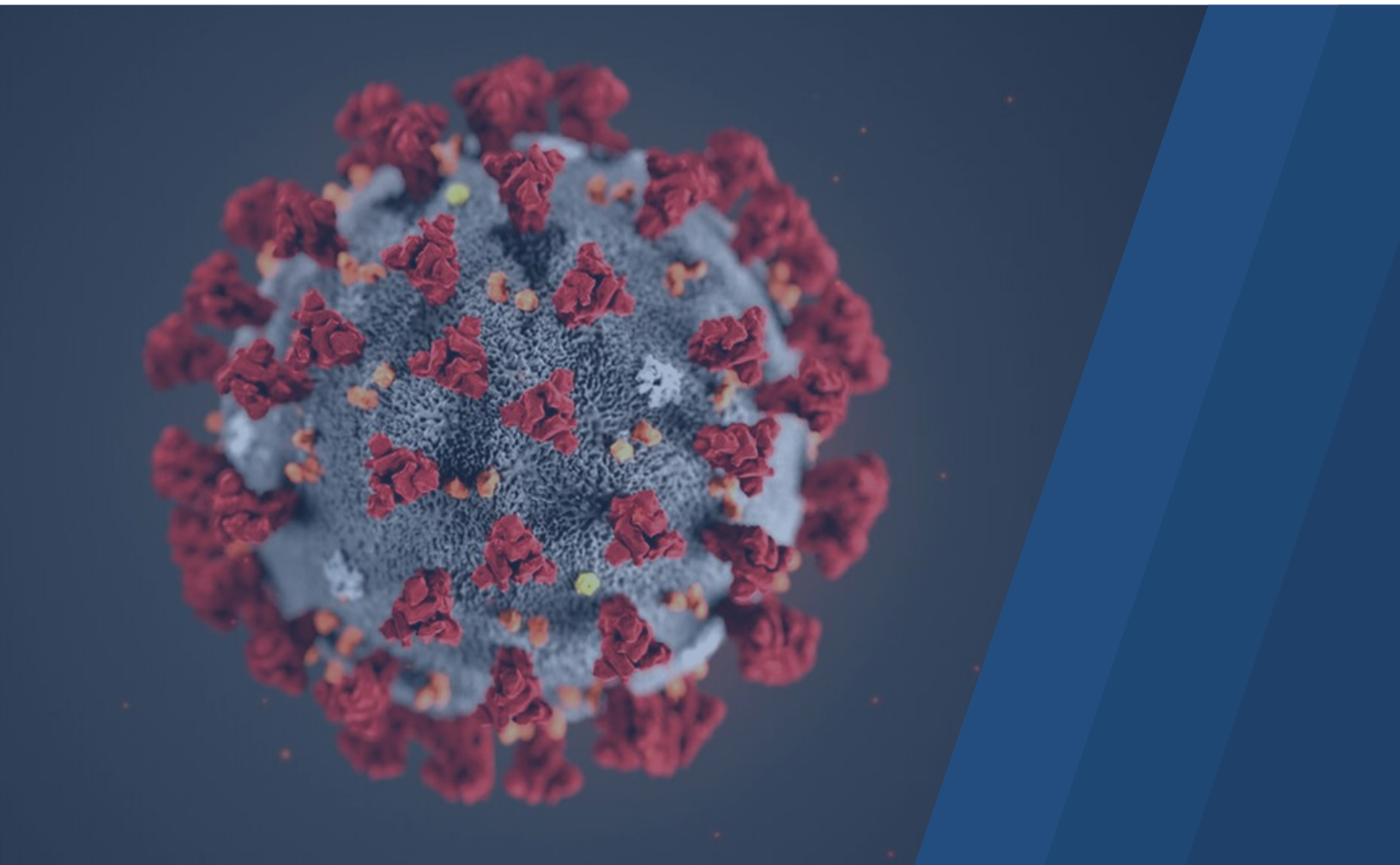

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Several major paths exist for states to respond to the COVID-19 pandemic using Medicaid. States have numerous points of discretionary authority, some special discretionary authority that arises in emergency scenarios, normal state plan amendment (SPA) options, and waiver authorities (particularly section 1135 authority). Although it can be a source of problems in other circumstances, CMS's practice is to allow SPAs to be retroactive to the beginning of the current quarter. This means SPAs filed prior to April 1 could be effective as of January 1. States can also consider filing CHIP Disaster Relief State Plan Amendments, which also may allow for retroactive applicability.[1]

Three excellent places to find more details about these options include publications by Kaiser Family Foundation, Manatt Health, and Medicaid and CHIP Learning Collaborative's Inventory of Medicaid and CHIP Flexibilities and Authorities. Below is an outline overview of ideas for state action.

Major Topics for Discretionary or SPA Action

1. **Access to Services**
    a. Suspending prior authorization and utilization management.[2]
    b. Automatically extending prior authorization.
    c. Reducing limits (e.g., quantity limits) on prescriptions and refills.
    d. Expand optional benefits and/or amount/duration/scope standard for mandatory and optional services.[3]
    e. Open managed care networks.[4]
    f. Clarify coverage of COVID-19 testing and treatment under Emergency Medicaid for immigrants. Advocate for a standard that applies to any individual receiving treatment for symptoms reasonably consistent with COVID-19.
2. **Affordability**
    a. States can eliminate cost-sharing and premiums (including in CHIP).[5] The implementation challenge is that states do not have total flexibility to pick and choose what cost-sharing to eliminate. They can target by categories of services and eligibility groups (but not disease or diagnosis).

[1] Medicaid and CHIP Coverage Learning Collaborative, *Inventory of Medicaid and CHIP Flexibilities and Authorities* at 3 (August 20, 2018), https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/medicaid-chip-inventory.pdf (hereinafter MAC Authorities).
[2] MAC Authorities at 22.
[3] MAC Authorities at 16.
[4] If needed, the state could do this by enforcing 42 C.F.R. § 438.206(b)(4), given high patient volume in plan network.
[5] *See* MAC Authorities at 14; CHIP at 15.

b. States using section 1115 to (illegally!) charge heightened copays or premiums could end these policies. This may especially important for ED use copays.

3. Eligibility

a. Implement a Medicaid expansion!
b. Optional expansion to cover adults above 133% FPL.[6]
c. Eliminate five year bar for children and pregnant women.

4. Application, Enrollment, and Retention

a. An important tactic is to reduce renewals. "States have existing authority to extend redetermination timelines for current enrollees subject to a disaster to maintain continuity of coverage. Some states have previously delayed or suspended renewals through 1115 waivers in response to emergencies. Moreover, CMS allowed states to delay or suspend renewals as a mitigation strategy when states were implementing the ACA and addressing system challenges and processing a large number of new enrollments under the Medicaid expansion."[7] States should not cut off eligibility during a redetermination delay, because a finding of ineligibility has not been made.[8] Another excellent strategy to increase retention is to suspend on-going data matching.[9] Delaying renewal is also a strategy for CHIP.[10]
b. States must accept self-attestation in some circumstances such as natural disasters.[11] Note this can include attestation of medical spending to qualify for spend-down.[12] This does not apply to immigration and citizenship verification, though there is precedent for doing it via waiver under Hurricane Katrina.[13] It can be done case-by-case or in a blanket way by updating state verification plan. No CMS approval is required.[14] Easing verification also should be considered for CHIP.[15]
c. Implement a broader "reasonable incompatibility" standard for matching self-attested income to data sources and easier methods for explaining inconsistencies.[16]
d. Increase use of presumptive eligibility for all eligibility groups.
e. Utilize 12-month continuous eligibility for children. Request the same policy for adults through section 1135 waiver.
f. "Develop a simplified paper application to support other enrollment strategies for use in affected areas."[17]

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[6] *See* § 1902(a)(10)(A)(ii)(XX); 42 C.F.R. § 435.218.
[7] Samantha Artiga, Robin Rudowitz, and MaryBeth Musumeci, Kaiser Family Foundation, *How Can Medicaid Enhance State Capacity to Respond to COVID-19?*, (March 17, 2020).
[8] 42 C.F.R. § 435.930(b).
[9] MAC Authorities at 13.
[10] 42 C.F.R. § 457.340(d)(1).
[11] 42 C.F.R. § 435.952(c);42 CFR § 435.945(a). *See also* 42 CFR § 435.952(c)(3) (similar policy for assets and spend-down expenses).
[12] MAC Authorities at 12.
[13] MAC Authorities at 11. We suggest requesting this policy under section 1135.
[14] MAC Authorities at 4.
[15] MAC Authorities 13.
[16] MAC Authorities at 11-12.
[17] MAC Authorities at 7.

5. **Other topics**
    a. **Out of state coverage**. There are numerous provisions addressing relocation related to natural disasters. While there may be less relocations for COVID-19 (compared to a flood), individuals may be trapped due to travel restrictions or get sick while on travel. There are various provisions to cover individuals who are visiting your state from out-of-state and to preserve eligibility of individuals from your state while they are out-of-state.[18]
    b. **Eligible but not enrolled/outreach**. States should be doing aggressive outreach, including informing residents about retroactive coverage. States should also be doing education for the Medicaid population (and providers), including through managed care plans.
    c. **States should consider appropriate use of telehealth**. CMS recently sent guidance reminding states that they have broad authority in Medicaid to permit coverage for telehealth services (CMS has also released information about telehealth and Medicare). This guidance establishes that states are not required to submit a separate SPA for coverage or reimbursement of telehealth services if they elect provider payment parity. At least two states have made section 1135 proposals to address telehealth: California, which asks to allow telehealth and virtual/telephonic communications for covered State plan benefits and waive face-to-face requirements, as well as Washington, which also seeks to waive face-to-face requirements and to allow reimbursement for telephone visits at the same rate as telehealth video visits.
    d. **Disproportionate share hospital payments**. States could look to increase distribution of DSH funding to hospitals treating high volumes of uninsured or Medicaid COVID-19 patients (and consider other forms of supplemental payment for other types of providers).

Waivers

Section 1135 waivers are the ideal waiver for COVID-19 response. These are waivers specifically designed for emergency scenarios, and the two statutory pre-conditions to getting these waivers have been triggered (simultaneous national emergency and public health emergency). Several states have requested waivers recently, and we recommend looking at Washington state's 1135 waiver request as a starting point.

While section 1135 is sometimes understood narrowly because it is framed around waiving conditions of participation for providers (among other provisions), in practice CMS has construed the authority broadly. For example, CMS has approved this authority to:

- "Allow[s] enrollees to proceed directly to a state fair hearing without having a managed care plan resolve the appeals; state would modify the timeline for managed care plans to resolve appeals to zero days so that the impacted appeals immediately satisfy the exhaustion requirement;"

[18] MAC Authorities at 17.

- "Allow enrollees to have more than 120 (if a managed care appeal) or 90 days (eligibility or fee-for-service appeal) to request a state fair hearing;"
- "Temporarily suspend Medicaid fee-for-service prior authorization requirements;"
- "Require fee-for-service providers to extend prior authorizations through the termination of the emergency declaration;" and
- "Extend medical necessity or level of care authorizations for 1915(c) recipients."[19]

NHeLP recommends that states use section 1135 to respond to the COVID-19 crisis to the maximum extent possible, not the 1115 demonstration authority (which should have a demonstration component to it), and that states push for aggressive policies to establish this as the standard authority for emergency scenarios. Of course, section 1135 also includes a wealth of possibilities for reducing barriers to providers treating enrollees.[20]

Advocates should also be careful to ensure state waiver requests are truly motivated by the desire to increase access to care, and not reduce accountability. CMS emergency documents invite states to use emergency waivers to excuse non-compliance with key standards around application processing timeframes, fair hearing response, etc.

Other topics

- **Section 1915(c) Waiver Appendix K**. States can modify 1915(c) waivers during emergencies pursuant to Appendix K, to allow for flexibilities around various eligibility criteria and other standards.[21]
- **Marketplace**. States should consider policies to increase Marketplace coverage, including an SEP for COVID-19.

[19] MAC Authorities at 18, 19, 21.
[20] See MAC Authorities, at 17-32.
[21] MAC Authorities at 17-19. *See also* MAC Authorities at 28.