



Use of Emergency Medicaid State Plan Amendments During the COVID-19 Pandemic

[Héctor Hernández-Delgado](#)

I. Introduction

In the past weeks, states and the federal government have recognized Medicaid's value as an essential tool in the fight to curb the spread of COVID-19. States have several paths to address Medicaid coverage for COVID, including State Plan Amendments (SPA), section 1135 authority, and other waivers. CMS released a SPA template for options related to the COVID-19 emergency.¹ The emerging use of SPA authority in six states is discussed below. While this paper is focused on SPAs, section 1135 authority is directly relevant to the CMS SPA template and approvals during the COVID crisis, so that authority is addressed first.

II. Interaction Between Section 1135 and COVID-Related SPAs

Almost all states, territories, and the District of Columbia have received approval from the Centers for Medicare and Medicaid Services (CMS) for emergency section 1135 waivers that provide states with certain flexibilities (some useful, some concerning) to facilitate Medicaid coverage and reimbursement for providers.² CMS, however, has taken a narrow view of Section 1135 waivers and has encouraged states to submit Medicaid SPA requests in order to complement these and other waivers.

In addition to approving freestanding section 1135 waivers, CMS is also using section 1135 to modify the SPA process. The CMS emergency SPA template starts with three options to use section 1135 to waive normal process requirements for SPA requests. In this paper we refer to a SPA that relies on section 1135 authority as "1135 SPAs."

Section 1135 gives the Secretary authority to waive or modify certain Medicaid requirements for the duration of a simultaneous public health emergency *and* national emergency.³ (These emergencies were declared on January 31 and March 13, respectively.) Approved 1135 SPAs will remain in effect only while both emergencies are in effect (i.e., such a SPA ends when

Use of Emergency Medicaid State Plan Amendments During the COVID-19 Pandemic

either emergency ends), unless the state requests a shorter period of duration.⁴ States may instead submit normal SPA requests if they wish to control the duration of the policy changes, including having the option to have them extend beyond the conclusion of the emergency declarations.

III. COVID-19 National Emergency Template

Below is a description of each of the categories of changes states may seek through the template:

a. Procedural Changes (Section 1135 SPAs)

Federal regulations establish that the effective date of any SPA that provides additional services to individuals, increases the payment amounts for services, or makes additional groups eligible for services may not be earlier than the first day of the quarter in which the request was submitted to CMS.⁵ This means that SPA requests submitted on or after April 1 could not be effective prior to April 1. Because the effects of the COVID-19 emergency in most states began well before this date, many states will now be interested in changes to their Medicaid program that apply retroactively prior to April 1. As a result, CMS is allowing states to use 1135 authority to waive the effective date requirement to allow SPAs submitted on or after April 1 to take effect retroactively during the first quarter of the year.

Additionally, in order to expedite the approval process, CMS is allowing states to use section 1135 authority to waive the requirement to provide notice and an opportunity to comment on the changes to the state's Medicaid plan as well as the requirement to conduct tribal consultation before submitting the request. Importantly, however, CMS has clarified that this 1135 SPA process may only be used to "provide or increase beneficiary access to items and services related to COVID-19...and [not to] restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers."⁶

The three flexibilities described above (earlier retroactivity, reduced notice and comment, and reduced tribal consultation) are only available through a section 1135 SPA and may not be approved under the normal SPA process. Most or all of the changes that follow below are standard SPA flexibilities that states could pursue outside of section 1135 authority. (Thus far, states have been using the template and requesting them as 1135 SPAs, but that may have a disadvantage, discussed below.)

b. Changes to Eligibility

The SPA template allows states to make changes to their Medicaid eligibility limits during the COVID-19 pandemic in several ways. First, states may expand eligibility for the duration of the emergency to include any optional group not currently covered in the state plan. This authority includes expanding Medicaid eligibility to childless adult who earn less than 133% of federal poverty level (FPL) for states that have yet to expand Medicaid pursuant to the Affordable Care Act (ACA). States also have the option to cover individuals who earn more than 133% FPL for the duration of the emergency and to provide COVID-19 testing services for uninsured individuals pursuant to section 1902(a)(10)(A)(ii)(XXIII) of the Families First Coronavirus Response Act.⁷ The SPA template also allows changes to Medicaid eligibility that enable states to cover non-residents and individuals who move out of the state because of the emergency. Finally, states may extend the 90-day reasonable opportunity period in which non-citizens who are eligible for Medicaid are covered while their immigration status is being verified.

c. Enrollment

States may use a SPA to simplify the Medicaid enrollment process. States may allow hospitals to make presumptive eligibility (PE) determinations for additional populations covered through the SPA or through an approved section 1115 demonstration. Hospital PE is typically limited to MAGI-based eligibility groups, but states may now extend it to any of the newly covered groups. States may also use the SPA to designate the state's Medicaid agency and/or other entities as entities qualified to make PE determinations. States may also extend the period of continuous Medicaid eligibility for children under 19 up to 12 months, extend the amount of time between eligibility redeterminations for non-MAGI beneficiaries up to 12 months, and facilitate simplified applications by paper, phone, or online.

d. Premiums and Cost-Sharing

Using the SPA process, states may suspend all or some cost-sharing charges, including deductibles, copayments, and coinsurance. This suspension must be made available to all beneficiaries and not limited to beneficiaries with particular conditions, such as COVID-19. States may also suspend enrollment fees and premiums for all beneficiaries or for some beneficiary categories. If not suspending enrollment fees and/or premiums, the state may elect to waive similar charges for undue hardship.

e. Benefits

States may also implement changes to their Medicaid benefits. Pursuant to the SPA template, states may add optional benefits or adjust current benefits to address the COVID-19 emergency. States must assure that new or modified benefits comply with statewideness,

comparability, and freedom of choice requirements. States have discretion to determine whether and to what extent new or modified benefits apply to expansion populations in Alternative Benefit Plans. States also need to submit SPAs if they want to use telehealth in Medicaid *and* use a special reimbursement rate for the telehealth services. No SPA is needed if no special reimbursement is sought and the state is merely seeking to adopt telehealth on equal terms as other services. If the state wishes to make changes to the payment rates for each of the new or modified benefits, including telehealth, such a change must be notified in the application. Finally, if the state's current plan has limits on drug benefits, the state may submit a SPA to modify day supply limit and/or quantity limit.

IV. How States are Using the 1135 and SPA Process

For the purpose of this paper, we examined the first six states that received approval for 1135 COVID-19-related Medicaid SPAs. These states, all of which received CMS approval on or before April 8, 2020, are Alabama, Arizona, Minnesota, Rhode Island, Washington, and Wyoming. Since then, several other states have received approval for SPA requests and numerous more have a request pending. Most states that have submitted SPAs for approval under section 1135 have closely followed CMS's guidance and the SPA template. Of the six states we evaluated, only one (Washington) did not formally include the template checklist specifying the changes the state sought to adopt.

Of the six SPAs we examined, five include waivers of the requirements to provide notice and a commenting period and of the tribal consultation requirements. The remaining state (Washington) did not specify changes to the procedural requirement, but it is unlikely that the State was able to meet these procedural requirements in time to submit the application on March 16, 2020. Moreover, all of the states that submitted SPAs for approval after March 31 (Alabama, Minnesota, Rhode Island, and Wyoming) also received authorization to set an effective date earlier in the year in order to ensure changes were effective at the beginning of the pandemic.

In terms of changes to enrollment, two states (Arizona and Rhode Island) received SPA approval to expand eligibility to include coverage of COVID-19 testing for the uninsured population pursuant to the Families First Act. No other SPA expands coverage to groups not currently covered. This represents a missed opportunity for states like Alabama and Wyoming that have not yet expanded Medicaid pursuant to the ACA. Similarly, for the most part, these six states did not use the SPA process to implement changes to their Medicaid enrollment process. Only two states (Arizona and Rhode Island) received approval to extend continuous eligibility for children whose families experience a change of circumstances to 12 months after the event.

Most states have sought to suspend premiums and cost-sharing for Medicaid beneficiaries. Three states (Alabama, Arizona, and Minnesota) received SPA approval to suspend all deductibles, copayments, coinsurance, and other cost-sharing charges. Alabama and Arizona suspended cost-sharing for all services for all beneficiaries, whereas Minnesota suspended cost-sharing for all testing and treatment services related to COVID-19. In addition, Arizona suspended enrollment fees and premiums for all beneficiaries for the duration of the emergency; Minnesota suspended premiums for the employed/disabled group (the only group in the state for which premiums apply); and Wyoming suspended premiums for beneficiaries enrolled in the Employed Individuals with Disabilities program.

Most states have also sought changes to the benefits covered. Alabama, for example, obtained approval to remove restrictions for emergency ambulance service destinations and to remove prior authorization requirements for nonemergency services. The state is also one of two states to receive approval for changes to their telehealth policy. Both Alabama and Minnesota used their SPAs to clarify that providers may receive reimbursement for evaluation and management services, therapies, and other medically necessary services provided via telephone. However, these states did not introduce changes to the telehealth reimbursement structure, so it is likely that they would have been able to clarify their telehealth policies without the need to submit a SPA.

Finally, three states obtained approval to modify their drug benefits during the COVID-19 emergency. Arizona and Rhode Island expanded prior authorization to include automatic renewal without clinical review and introduced exceptions to their preferred drug list in case shortages occur. Minnesota, on the other hand, now allows 90-day refills without prior authorization for certain maintenance drugs, instead of the 34-day refills allowed prior to approval of the SPA.

V. Important Trends and Opportunities for States

As expected, states are submitting COVID-19 section 1135 SPAs that address the particular necessities of their populations. However, there are important opportunities that all states could take advantage of in order to utilize Medicaid to fight the COVID-19 pandemic and that advocates should be pushing their states to adopt.

First, states should ensure that their 1135 SPAs are effective retroactively to the beginning of the pandemic. Individuals have experienced the effects of the emergency for several weeks now and it is necessary that changes are effective retroactively to include those circumstances. States not seeking to apply the changes retroactively should consider whether it is feasible to submit a normal SPA instead of a section 1135 SPA. Section 1135 requests are

tied to the emergency declarations and will expire when *either* emergency ends. This unnecessarily cedes the state's control over timing and may create problems.

For example, the President's has stated his desire to "go back to normal" and might prematurely end the national emergency. That in turn would end the approved 1135 SPA, even though the state might feel the crisis is still live and the SPA solutions should endure a while longer. The state can end a normal SPA option any time it chooses. Considering that CMS policy already allows a normal SPA to be retroactive to the beginning of the quarter, states should consider whether there is any material harm in using the normal SPA process with retroactivity. In the alternative, states using 1135 SPAs should consider a transition plan to address the possibility of a premature end to one of the emergency declarations, which would cancel any 1135 SPAs in effect.

Second, states should take advantage of the opportunities afforded to them and ensure that Medicaid is covering individuals experiencing losses or who otherwise would be eligible for Medicaid. For example, states should be utilizing the SPA process to cover uninsured individuals who have health care costs associated with COVID-19 testing. This option under the Families First Act is available to states for the duration of the public health emergency declared by the HHS Secretary, *regardless* of the duration of the national emergency declared by the President, so long as states do not use section 1135 for approval of such a SPA. In addition, states should expand eligibility to all optional groups, including childless adults in states that have yet to expand Medicaid pursuant to the ACA.

States should also utilize their SPAs to facilitate Medicaid enrollment and suspend out-of-pocket costs. For example, states should expand hospital PE to ensure that hospitals have the authority to make these determinations for people who have gained or will gain Medicaid coverage during the pandemic. This is important because many individuals will be unaware of their coverage options even when they go to a hospital for services. States not providing 12-month continuous eligibility for children, should also submit SPAs to extend this period in order to ensure that children continue to get coverage throughout the pandemic regardless of whether their family's income has changed. Also, because complicated applications and verification requirements are a major barrier to eligibility, states should take advantage of enrollment flexibilities and ensure that the application process by phone or online has been simplified. Finally, because of the impact that the COVID-19 pandemic has had on the economic stability of most low-income individuals, states should ensure that no cost-sharing is charged for any service, not only those services related to COVID-19. Similarly, states should suspend all premiums and enrollment fees for all beneficiaries throughout the pandemic.

Finally, states should take advantage of the opportunity to submit emergency SPAs to expand the services covered and ensure that all treatment services associated with COVID-19 are

covered. Similarly, states should ensure that barriers are removed for emergency and other services that beneficiaries may find it difficult to access during the pandemic. This includes removing prior authorization requirements for essential services and facilitating telehealth and telephonic services for all services that may be provided through these mechanisms when the state is unable to expand such services without the need of a SPA.

VI. Conclusion

As the COVID-19 pandemic rages on, states should consider taking advantage of all the flexibilities afforded to them by the Medicaid program. CMS has encouraged states to submit SPAs to complement approved 1135 waivers. Using these SPAs, either through 1135 authority or through the normal SPA process, states may expand eligibility to new populations, including the uninsured, simplify the enrollment process, eliminate cost-sharing and premiums, and make changes to the benefits covered. These policy changes are essential to improving access to care during the pandemic and all states would be wise to embrace them.

ENDNOTES

¹ CMS, Medicaid State Plan Amendment Template - Medicaid Disaster Relief for the COVID-19 National Emergency, <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-template.docx>.

² CMS, Medicaid News Alert, April 7, 2020, <https://content.govdelivery.com/accounts/USCMSMEDICAID/bulletins/28565e2>.

³ 42 U.S.C. 1320b-5.

⁴ CMS, Medicaid Disaster Relief for the COVID-19 National Emergency State Plan Amendment Instructions, <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-instructions.pdf>.

⁵ 42 C.F.R. § 430.20.

⁶ CMS, State Plan Amendment Instructions, *supra* note 4.

⁷ 42 U.S.C. 1396a(a)(10)(A)(ii)(XXIII).