



Medicaid in Transitions— Monitoring COVID-Related Changes in Coverage ¹

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All 50 states and the District of Columbia have made changes to their Medicaid programs in light of the COVID-19 emergency. In most—but not all—cases, these changes maintain or expand health coverage and adapt administration of the program to maximize availability of acute and ICU beds and key equipment like ventilators; physically separate COVID patients; and support provider availability and finances.

To date, the federal Medicaid agency is approving these changes through legal authorities that allow for temporary changes during an emergency. The end dates of these measures depends on the authority being used by the state. That has consequences. For example, the current decision to tie protective measures to official emergency declarations means that states will lose this authority to continue these interventions even if they are still needed to address serious public health challenges that continue for the ensuing months or years. In addition, after the official emergencies end, states will be facing severe economic downturns that could last for years. Now is the time to begin identifying ways to maintain protections and coverage for Medicaid enrollees.

The issue brief uses a Q&A format. It summarizes the current emergency authorities being used by federal and state governments to relax state Medicaid-participation requirements. It also provides action steps that can be taken now to protect broadened Medicaid coverage with respect to three of the most frequent activities that states are taking:

- pausing premiums and cost sharing,
- relaxing prior authorization requirements, and
- expanding use of telehealth.

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It also provides action steps to address a fourth change that is popular with states: allowing care in alternative settings. Activities in this area need close monitoring now and in the months to come, as serious quality of care and service delivery issues could be implicated.

Emergency authorities

1. **What are the major federal authorities being used by federal and state governments?**

Effective January 27, 2020, the Secretary of Department of Health and Human Services (Secretary) declared a public health emergency (PHE) due to the COVID-19 pandemic. The declaration was renewed, effective April 26, 2020.² The PHE can remain in effect for 90 days, or through most of July 2020, and can be renewed multiple times.³ While currently nationwide, the Secretary can limit the PHE declaration to geographic areas. See 42 U.S.C. § 247. In a separate event, the President declared a national emergency (NE) on March 13, 2020.⁴ The President can end or limit the scope of the NE at any time.

There are five primary authorities being used, briefly summarized as:

1. **Section 1135 of the Social Security Act:** Section 1135 allows the Secretary to waive or modify certain Medicaid (Medicare and CHIP) requirements to ensure sufficient health care items and providers are available during an emergency. See 42 U.S.C. § 1320b-5. The waivers typically relax standards related to provider participation and federal licensure, preapproval requirements, and EMTALA restrictions.⁵ CMS has provided states with a template for requesting these waivers.⁶
2. **Disaster relief state plan amendments (SPAs):** States may make amendments to their state Medicaid plans using SPAs. In addition to waivers, Section 1135 can authorize temporary emergency SPAs, which allow for additional options, including extended Medicaid eligibility. CMS has issued a template for states to use to request these SPAs.⁷

² See Alex M. Azar II, Sec'y, U.S. Dept. of Health & Human Servs., *Determination that a Public Health Emergency Exists*, <https://www.phe.gov/emergency/news/healthactions/phe/pages/2019-ncov.aspx> (Jan. 31, 2020).

³ See Alex M. Azar II, Sec'y, U.S. Dept. of Health & Human Servs., *Renewal of Determination That A Public Health Emergency Exists*, <https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-21apr2020.aspx> (Apr. 21, 2020).

⁴ See President Donald J. Trump, *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak*, <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/> (Mar. 13, 2020).

⁵ Ctrs. for Medicare & Medicaid Servs., *1135 Waivers*, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers> (last visited May 7, 2020).

⁶ 42 U.S.C. § 1320b-5; see also Ctrs. for Medicare & Medicaid Servs., *Section 1135 Waiver Flexibilities*, <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html> (page with relevant links, including to downloadable document titled *Section 1135 Waiver COVID-19 State/Territory Request Template*) (last visited May 7, 2020).

⁷ See Ctrs. for Medicare & Medicaid Servs., *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> (last visited May 7, 2020).

3. Section 1915(c) Appendix K: Appendix K of the 1915(c) home and community-based services waiver can be used by states to amend approved waivers during emergencies. CMS has issued COVID-19 specific Appendix K templates and instructions for states.⁸ In contrast to the other authorities described here, Appendix K waivers must include a transition plan for participants “who might be adversely affected when the temporary changes cease and the waiver reverts back to its original form” and ensure that all applicable fair hearing rights apply.⁹
4. Section 1115 of the Social Security Act: Section 1115 authorizes the Secretary to waive certain provisions of the Medicaid Act to allow a state to implement an “experimental, pilot, or demonstration project” that is likely to promote the objectives of the Medicaid Act. 42 U.S.C. § 1315. CMS has issued a template for states seeking to implement a temporary COVID-waiver demonstration project.¹⁰
5. Section 6008 of the Families First Coronavirus Response Act (FFCRA): Section 6008(b) makes enhanced federal funding temporarily available to states. To receive this funding, the state may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020. However, “[a]n individual’s [1915(c)] person-centered care plan can be updated to reflect updated assessments of functional need during the period of the public health emergency. Services should not be provided that are not based on an assessed need.”¹¹

2. How can I track which federal authorities my state is using?

Several organizations have developed trackers. You can monitor state activities using them, e.g.:

⁸ See Ctrs. for Medicare & Medicaid Servs., *Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers*, <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html> (last visited May 7, 2020).

⁹ See Ctrs. for Medicare & Medicaid Servs., *1915(c) Home and Community-Based Services Waiver, Instructions and Technical Guidance, APPENDIX K: Emergency Preparedness and Response* <https://www.medicaid.gov/state-resource-center/downloads/1915c-appendix-k-instructions.pdf> (last visited May 7, 2020).

¹⁰ See Ctrs. for Medicare & Medicaid Servs., *1115 Application Process, COVID-19: 1115 Waiver Demonstrations* <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html> (last visited May 7, 2020).

¹¹ See U.S. Dep’t. of Health & Human Servs., *Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127; Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 Frequently Asked Questions (FAQs)*, at 9 (Apr. 13, 2020) [hereinafter FFCRA/CARES FAQs], <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>.

Georgetown Univ. Health Policy Inst., Ctr. for Children and Families, Approved 1135 Waivers and State Plan Amendments for COVID-19, <https://ccf.georgetown.edu/2020/03/24/approved-1135-waivers/>.

Kaiser Family Found., *Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19*, <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>.

You should also monitor your state's Medicaid website for COVID-specific activities.

3. How long will my state's Medicaid changes remain in effect?

The timing of your state's changes will depend on the federal provision the state used to authorize the change. Table I lists the triggering events.

Table I
End dates for state Medicaid COVID options

Federal authority	Effective end dates
Section 1135	Termination of the PHE ¹²
Disaster relief SPAs	Termination of PHE or shorter timeframe selected by the state in the SPA.
App. K	Typically effective for one year after date of approval, but see approval document
Section 1115	Will expire no later than 60 days after the end of the PHE
Section 6008	The last day of the month in which the PHE ends

¹² Section 1135 authority is available when there is both a presidential declaration of emergency and a declaration of a public health emergency. 42 U.S.C. § 1320b-5(g). The statute provides that the authority ends when either emergency is terminated. *Id.* § 1320b-5(e). However, in both the 1135 waiver approvals and other guidance, CMS has made it clear that the 1135 waivers expire at the end of the PHE, without reference to the presidential declaration. *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., All State Medicaid & CHIP Call (June 16, 2020) (PPT presentation), <https://www.medicare.gov/state-resource-center/downloads/allstatecall-20200616.pdf>.

Monitoring COVID-related changes

4. What are some actions that we can take now to lessen the impact when provisions sunset?

To date, CMS's approvals have stayed within the guardrails set forth in the various templates cited above. This means that the changes that are occurring in the states share a degree of uniformity, and there are some changes that almost all the states have adopted, such as: (1) pausing premiums and cost sharing; (2) relaxing prior authorization requirements; (3) expanding telehealth; and (4) authorizing states to provide residential long term care services in alternative settings. The remainder of this Q&A summarizes these changes and suggests action steps that advocates can take now to maintain coverage if and as the authorization for the change sunsets.

(1) Pausing premiums and cost sharing

The Medicaid Act allows, but does not require, states to impose premiums and cost sharing, such as copayments. See 42 U.S.C. § 1396o, 1396o-1. The vast majority of states have decided to implement premiums and/or copayments.

As noted above, states that accept enhanced federal funding during the COVID-19 emergency have a maintenance of effort requirement. This requirement prohibits them from terminating Medicaid eligibility for failure to pay a premium.

Also, a number of states whose approved state Medicaid plans include premiums and cost sharing have received federal approval (typically through a disaster relief SPA) to pause collection of some or all premiums and cost sharing during the emergency. CMS has issued some instructions: When suspending *copayments and similar cost sharing*, states may apply the suspension broadly to services and eligibility groups or to only specified population groups or services (e.g., doctor visits). Exempting individuals from copayments cannot be applied narrowly to only those affected by a particular diagnosis, such as COVID-19. A state cannot waive copays for beneficiaries based on how they are furnished services (e.g., fee-for-service versus managed care). And when suspending *premiums and similar charges*, states can suspend all premiums or limit suspension to only specific eligibility groups. States also have the option to waive premium payments in cases of undue hardship.¹³

Action steps:

1. Ask your state Medicaid agency for its written guidance/notices implementing the FFCA

¹³ See Ctrs. for Medicare and Medicaid Servs., *Medicaid Disaster Relief for the COVID-19 National Emergency, State Plan Amendment Instructions*, at 5 (last visited May 7, 2020), <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-instructions.pdf>.

- prohibition on terminating individuals for failing to pay a premium.
2. Determine whether your state increased premiums after January 1, 2020 but before March 18, 2020 (the date of FFCRA enactment). If so, it had 30 days (until April 17) to reduce premiums back to amounts no higher than those in effect as of January 1, 2020. Notably, the state must reimburse beneficiaries for the higher amounts charged after January 1, 2020.¹⁴ Ask your state Medicaid agency for written guidance/notices implementing this change. Verify with clients that they are not being charged (and, if applicable, that they have received a refund).
 3. Verify whether your state has suspended payment of premiums/enrollment fees. If premiums have been suspended, determine the extent of the state's action. Does it apply to all affected population groups or just some (e.g., Wyoming suspended premiums only for individuals in the Employed Individuals with Disabilities program)?
 4. If your state has not suspended payment of premiums/enrollment fees, work with your state so that COVID-related hardships will be recognized as part of an undue hardship evaluation and that federal undue hardship requirements are met, see 42 C.F.R. § 447.55(b)(4). Ask the state to send enrollees a written notice informing them that hardship exceptions are available.
 5. Verify whether your state has suspended copayments or similar cost sharing. If so, determine the extent of the state's action. Does it apply to all cost sharing? If only certain services are subject to the suspension, what are they? How are providers being informed of the policy? Verify with clients that they are not being improperly subjected to copayments.
 6. Monitor clients' experiences during the emergency period. Document instances where they have obtained Medicaid-covered services that they would have otherwise avoided due to a cost sharing requirement.
 7. States cannot recoup premiums from individuals who would have owed them during the emergency period but whose Medicaid eligibility is maintained solely on the basis of the FFCRA's enhanced FMAP provision. See FFCRA/CARES FAQs, *supra* note 10, at 8. Make sure this policy is in place in your state.
 8. Individuals qualify for Medicaid because they have limited income. The economic shut down caused by the COVID-19 pandemic has hit low-income people especially hard. When the emergency officially ends, it is likely that many of them will have had no wages during the emergency and will have little to no resources (savings) on hand. Advocate with your state not to seek recoupment of premiums and to bar health care providers from treating unpaid copayments as a legal liability of the enrollee.
 9. CMS has informed states that, when the PHE ends, they may resume implementation of premium policies.¹⁵ But states do not have to impose premiums and cost sharing, and multiple studies have documented that these practices create serious barriers to care for low income people. The suspension of premium and copayment policies during the COVID-19 pandemic is an acknowledgement by federal and state governments that these practices make care unaffordable. Seek their roll back. Inform the state of client stories. Ask the state for an accounting of revenue lost as a result of the suspension. Ask your state to forego or limit premiums and cost sharing to only those options

¹⁴ See FFCRA/CARES FAQs, *supra* note 10, at 8.

¹⁵ *Id.*

provided by the Medicaid Act. See 42 U.S.C. §§ 1396o, 1396o-1 (no premiums for individuals with incomes below 150% of the federal poverty level and limited copayments for nonemergency use of the emergency room). If the state is going to return to its previous policies, ask that they be phased in over time. For example, in the year following the end of the emergency, states should neither end an individual's eligibility due to inability to pay a premium nor allow providers to deny services because of non-payment of a copayment.

(2) Relaxing use of prior authorization requirements

The Medicaid Act allows states to implement a variety of utilization controls on the use of services.¹⁶ This includes prior authorization requiring that services be “medically necessary.”¹⁷ Prior authorization is outright prohibited for emergency services or EPSDT screens and cannot excessively delay provision of services.¹⁸ In practice, however, advocates have long complained that prior authorization does, in fact, delay service provision and even result in denial of necessary services.

Recognizing that prior authorization can be a barrier, CMS's template for applications for 1135 waivers includes an option for states to temporarily suspend prior authorization requirements in fee-for-service and to require fee-for-service providers to extend pre-existing authorizations.¹⁹ To date, CMS has approved more than 50 waivers for states and territories.²⁰ At least twenty-nine states received permission to extend existing prior authorizations, which will allow services to extend after an authorization period elapses.²¹

Action Steps:

1. Ask your state agency for documentation that they have implemented this policy and have informed providers. For monitoring purposes, determine which services are subject to prior authorization and will be affected by the waiver.
2. Given that the Medicaid Act does not require states to implement prior authorization, advocates should use this opportunity to test the need for the practice, particularly if it is used widely for routine services. Reach out early to Medicaid agency personnel and begin making the case for limiting or abolishing prior authorization after the emergency ends, particularly for routine services and ongoing service needs of people with

¹⁶ 42 U.S.C. § 1396a(a)(30); 42 C.F.R. § 440.320(d).

¹⁷ *Id.*

¹⁸ JANE PERKINS & SARAH SOMERS, NAT'L HEALTH LAW PROGRAM, AN ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM at IV.N (2011).

¹⁹ See *Section 1135 Waiver Flexibilities*, *supra* note 5.

²⁰ Ctrs. for Medicare & Medicaid Servs., *Coronavirus Waivers and Flexibilities*, <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers> (last visited May 7, 2020).

²¹ *Id.*

disabilities whose conditions will not change. Reach out to provider groups that provide affected services at intervals during the emergency for information about how lifting prior authorization has impacted service delivery. If providers report positive experiences, share those with the Medicaid agency.

3. Press the Medicaid agency to explain how it will ensure that it does not mistakenly deny payment to providers for services provided without prior authorization and will not mistakenly bill or otherwise penalize individuals who received services without prior authorization.
4. These waivers apply only to fee-for-service. Given that most state Medicaid programs largely deliver services through managed care, advocates should encourage their states to press Medicaid managed care plans to relax their requirements for prior authorization, particularly for ongoing services for people with disabilities and chronic needs. These plans should already be providing a medical home with a primary care gate-keeper, so prior authorization should already be infrequently used.

(3) Expanding use of telehealth

Prior to the COVID-19 pandemic, state Medicaid programs were already expanding coverage of telehealth. The COVID-19 pandemic has enhanced use of this modality significantly. States are expanding telehealth through state policies and also through policy changes approved by CMS, most often using disaster relief SPAs and/or the section 1915(c) App. K. According to CMS instructions for disaster relief SPAs, during the COVID-19 emergency, a state may authorize payments for telehealth services that are not otherwise paid under the Medicaid state plan, that differ from payments for the same services when provided face-to-face, or that differ from current state plan provisions governing reimbursement for telehealth. States are not generally required to describe telehealth policies in their state plans unless reimbursement for services provided via telehealth varies from reimbursement of the same services when provided face to face (note, however, that new billing codes for providers to bill a telehealth encounter may be needed). Some states have decided to include language regarding each benefit for which telehealth is available in the coverage pages of their state plans. In these states, a temporary change to expand telehealth policies during the COVID pandemic would need to be approved by CMS.²²

The Section 1915(c) App. K template also allows states to implement telehealth. Most, though not all, states, allow telehealth for certain waiver services, usually without requiring prior approval. During the COVID-19 pandemic, states have designated a range of telehealth services, including physical, occupational, and speech therapy; behavioral consultations;

²² See *Medicaid Disaster Relief for the COVID-19 National Emergency State Plan Amendment Instructions*, *supra* n. 6 at 6-8.

private duty nursing; home and vehicle modifications; delivery of Adult Day Health in the client's residence; person-centered planning and level of care evaluation.²³

Action steps:

1. Encourage your state to think creatively about using telehealth, for example to extend telehealth to the provision of home health services. CMS has provided instructions to states for using telehealth for this service. See Ctrs. for Medicare & Medicaid Servs., COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, at 8, <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf> (last updated May 5, 2020).
2. Ask the state agency for the written guidance it is giving providers/plans regarding coverage of telehealth, including coverage of electronic devices, such as tablets, as well as the broadband needed to access the range of available telehealth services.
3. Work with this state to address disparities in access to telehealth services. For in depth discussion, see National Health Law Program, *Medicaid Principles on Telehealth* (May 11, 2020), <https://healthlaw.org/resource/medicaid-principles-on-telehealth/>; Fabiola Carrión, Nat'l Health Law Program, *Fact Sheet on Telehealth and Medicaid during COVID-19*, <https://healthlaw.org/resource/fact-sheet-on-telehealth-and-medicaid-during-covid-19/> (April 14, 2020) (e-mail carrion@healthlaw.org).
4. Ask the state Medicaid agency to describe the steps it uses to authorize claims, including what sort of authorization practices are being used.
5. Ask the state Medicaid agency to begin tracking and publicizing the claims data history of claims involving telehealth.
6. Review existing Medicaid managed care contracts for provisions addressing telehealth. Where these exist, if possible, use these provisions to call for plans to use telehealth aggressively to ensure network adequacy. For example, managed care contracts in the District of Columbia provide:
In accordance with 42 C.F.R. § 438.68 Contractor shall demonstrate its ability to meet [DC Medicaid] network adequacy standards which includes: .
. . The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.²⁴
7. As noted above, states have a great deal of flexibility to use telehealth even after the COVID-19 emergency ends. Work with clients, now, to monitor its use, documenting when and how it is working well and where and why there are problems. For example, are providers of therapy services making these services available to Medicaid enrollees? If so, does the enrollee have an electronic device that allows access to the service? If not, is the state/managed care plan taking any steps to address the

²³ See Elizabeth Edwards, Nat'l Health Law Program, *COVID-19 Changes to HCBS Using Appendix K: Approval Trends*, at 5-6, <https://healthlaw.org/resource/covid-19-changes-to-hcbs-using-appendix-k-approval-trends/> (Mar. 30, 2020)

situation? How are enrollees' experiences with this modality, broken down factors such as geographic region, disability, age, race, and ethnicity.

(4) Allowing care in alternative settings

CMS has granted states permission through Section 1135 to fully reimburse care facilities including nursing homes, ICF-IDDs, PRTFs, and hospital nursing homes for services provided in an unlicensed facility. This enables facilities to relocate patients or residents and provide services in unlicensed facilities in case of evacuation due to the pandemic.²⁵ To obtain reimbursement, states must make a reasonable assessment that the transferee facility meets "minimum standards, consistent with reasonable expectations in the context of the . . . public health emergency, to ensure the health, safety, and comfort of staff."²⁶ CMS has granted this permission to more than 35 states.

Action Steps:

1. Determine whether your state is one of the many that has received permission to do this. If so, determine whether it has developed a written policy for transfers into facilities and standards for those facilities and, if so, request it. If they have not, press them to do so – perhaps drafting a model.
2. Advocate with the Medicaid agency and provider groups to document implementation of federal and state safety guidelines in facilities, such as the [CDC guidelines](#).
3. Determine whether the Medicaid agency has identified alternative facilities or whether it has required individual facilities to do so and, if so, which facilities are designated.
4. Advocate with the agency to detail procedures for informing family members of evacuations and transfers and how they will be informed of their family member's status and condition in an ongoing way.
5. Monitor for COVID-19 outbreaks in nursing homes, ICFs, and other facilities in your state for potential sites for evacuations. When outbreaks occur, contact the Medicaid agency and care facility to determine whether and when an evacuation will take place and where the patients/residents will be transferred.
6. If individuals are still housed in alternative settings as the end of the emergency nears, press for assurances that they will be promptly moved.
7. Periodically check with the agency and care facilities for plans for transferring individuals back to the originating facility. If possible, consider whether transfer to a home or community setting is possible with supportive services.

²⁵ Ctrs. for Medicare & Medicaid Servs., Section 1135 Waiver COVID-19 State/Territory Request Template, <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html>.

²⁶ See, e.g., Ohio <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/97856>

Conclusion:

It is never too early for advocates to prepare for transition during the COVID pandemic, including state activity to terminate emergency authorities and waivers. Moreover, advocates can gather information during the emergency for support in advocating for extensions of positive policies like suspending premiums and cost sharing.