



Making Sure Medicaid is Ready for Public Health Emergencies

Jane Perkins & Catherine McKee¹

In 2020, the COVID-19 pandemic plunged the United States into a public health crisis. This situation was not entirely unprecedented. Local crises had previously been triggered by events such as hurricanes (*e.g.*, Katrina in 2005, Irma in 2017), wildfires (*e.g.*, California in 2017 and 2018), lead contamination (Flint, Michigan in 2016), and terrorist attacks (New York City after 9/11). During these events, the Secretary of the Department of Health and Human Services (HHS) used waiver authority to allow affected states to ignore otherwise mandatory Medicaid requirements so that they could use Medicaid as part of the emergency response. These crises, and particularly the COVID-19 pandemic, have made it clear that the current statutes do not give HHS sufficient emergency waiver authority. This paper:

- Outlines legal authorities that allow HHS and states to adjust Medicaid programs during an emergency;
- Identifies deficiencies in these authorities; and
- Makes recommendations that, if implemented, will better prepare Medicaid programs for the next crisis.

The two authorities that HHS and states have turned to the most during emergencies are Section 1115 and Section 1135 of the Social Security Act.² We address each below.

¹ Many thanks to Leo Cuello for his work on this paper while serving as the National Health Law Program's Health Policy Director.

² States have also made temporary changes to section 1915(c) home and community-based services waivers as part of an emergency response. See Elizabeth Edwards, Nat'l Health L. Program, *COVID-19 Changes to HCBS Using Appendix K: Approval Trends* (Mar. 30, 2020), <https://healthlaw.org/resource/covid-19-changes-to-hcbs-using-appendix-k-approval-trends/>.

Section 1115 Demonstration Authority

Section 1115 of the Social Security Act creates authority for HHS to waive a limited set of Medicaid requirements to allow a state to engage in an “experimental, pilot, or demonstration” project that is likely to promote the objectives of the Medicaid program.³

The appeal of section 1115 to states and HHS is that it allows waiver of a relatively large number of Medicaid requirements (though there are many requirements that cannot be waived). Over the years, states and HHS have too often come to view section 1115 as a sort of Swiss-army knife that can be used to solve any problem, including a public health emergency, and HHS has sometimes ignored the requirements that section 1115 contains. For example, during the COVID crisis, HHS has issued section 1115 approvals to allow states to implement otherwise impermissible policies, such as establishing retainer payments to maintain provider infrastructure, varying services among enrollees in order to triage care, and continuing EPSDT benefits for individuals turning 21. While all of these policies clearly make vital contributions to alleviating an emergency, they have doubtful experimental or demonstration value.

At its core, section 1115 is a *demonstration* authority, making it a difficult fit as a crisis response tool.

- Section 1115 requires a valid experiment to be tested, including a well-designed experiment and a plan for evaluation. In a true emergency, there is no time to design such an experiment and evaluative framework. Yet, it would be improper for HHS to ignore the words of section 1115 to authorize waivers when states are not conducting a genuine experiment.
- During an emergency the goal is not to *innovate*, it is the opposite—to move swiftly and implement *known* solutions. Suppose during an emergency there is an action states could take with a proven, positive impact. While we would hope the 50 states, DC, and territories would all implement the change immediately, section 1115 should not be used to permit the policy because it is not experimental. In short, the policies needed during an emergency often will have nothing to do with experimentation.
- Section 1115 only authorizes HHS to approve “waivers,” *i.e.*, to allow states to ignore Medicaid provisions listed in 42 U.S.C. § 1396a of the Medicaid Act. The statute does

³ 42 U.S.C. § 1315(a).

not allow HHS to modify Medicaid Act provisions. During an emergency, HHS may need more nuanced authority than section 1115 provides, for example to modify deadlines in a Medicaid provision as opposed to waiving the provision altogether.

To sum up, section 1115 is usually inappropriate legal authority—in concept and in practice—for altering state Medicaid programs in response to a crisis.

Section 1135 Emergency Authority

In contrast, section 1135 of the Social Security Act is designed for emergencies. The purpose of section 1135 is “to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period ... that sufficient health care items and services are available to meet the needs” of Medicaid enrollees and that health care providers who are furnishing health care in good faith can “be reimbursed for such items and services and exempted from sanctions for ... noncompliance” with Medicaid requirements.⁴ To this end, section 1135 allows the Secretary “to temporarily waive or modify” Medicaid requirements for provider participation and payment during an “emergency period,” defined as a period when there is a simultaneous national emergency declared by the President and a public health emergency declared by the Secretary of HHS.⁵

There are several reasons section 1135 is well-designed for crisis response:

- Because the timeline is tied to a public health emergency, it is administratively simple for states. The authority will turn off automatically when the crisis subsides. This also helps avoid abuse of the authority, preventing the government from using an emergency waiver as a pretext for long-term redesign.

⁴ 42 U.S.C. § 1320b-5(a).

⁵ For example, the Secretary can waive or modify requirements pertaining to: conditions of participation or other certification requirements for providers, requirements that providers be licensed in the state in which they provide care, requirements pertaining to examination and treatment for emergency medical conditions and women in labor, sanctions for violating limitations on referrals, deadlines and timetables for performance of required activities (except that such deadlines and timetables cannot be waived, only modified), and sanctions for noncompliance with certain HIPAA requirements. *Id.* § 1320b-5(b).

- Section 1135 authority allows waivers to be approved retroactive to the start of the emergency period—a sensible policy as states may not understand what is needed, much less be able to instantly apply for needed waivers, in the first weeks or months of a crisis.⁶
- Unlike section 1115, section 1135 does not require the state to be implementing an experiment, and it authorizes waiver *or* modification of Medicaid Act provisions.

Unfortunately, while section 1135 is the right conceptual tool for states during emergencies, it has not been sufficient to meet all of the states' policy needs. While the stated purpose of section 1135 is broad (*i.e.*, to ensure health services during an emergency), the subsequent provisions of the statute only allow the Secretary to waive or modify requirements related to health care provider availability, payment, and retention.⁷ And in contrast to its section 1115 track record, HHS has made only some effort to apply section 1135 authority broadly.

One exception to HHS's restrictive approach to section 1135 waivers involves using section 1135 to facilitate implementation of temporary disaster relief state plan amendments (SPAs). There are in fact a number of existing SPA options that, if implemented, will be helpful during an emergency. However, the regulatory process to secure those SPAs can be time consuming and, thus, itself a problem. During the COVID pandemic, HHS has used section 1135 to relax the process to approve SPAs, for example to allow states to modify public notice requirements for SPAs and to modify tribal consultation requirements. That said, an HHS template limits this use of section 1135 to SPAs that are related to particular COVID-19 services, such as waiving otherwise applicable cost sharing requirements or allowing temporary payment increases.⁸

Recommendations for Medicaid Emergency Authorities

1. HHS should avoid using section 1115 authority to approve emergency response waivers. Section 1115 is an experimental, demonstration authority that, in most instances, will be inappropriate for crisis response.

⁶ *See id.* § 1320b-5(c).

⁷ *See supra* note 5.

⁸ *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 July 14, 2021).

2. Congress should amend section 1135 to clarify that it is the proper waiver authority to be used during public health emergencies and to authorize HHS to waive or modify a wider range of requirements that will allow states to maximize and improve Medicaid coverage and protections for applicants and enrollees during public health emergencies.
3. Meanwhile, HHS should explore opportunities to use section 1135 authority more broadly to approve emergency waivers or modifications. In so doing, however, HHS should clarify that section 1135 waivers will be approved for the purposes identified in the statute (ensuring “sufficient health care items and services are available to meet the needs of individuals”) and reimbursing providers for those. HHS should develop criteria/guidelines to ensure that section 1135 waiver requests are always tied to improving access to care during an emergency.
4. As appropriate for each branch of government, Congress and HHS should build protections into section 1135 policies to ensure that the waivers do not inadvertently worsen health equity. While the waivers are understandably intended to accelerate states’ emergency response activities, they should be approved with appropriate safeguards (*e.g.*, to avoid COVID-19 hospital discharge waivers that result in institutionalization of people with disabilities).
5. HHS should develop section 1135 resources to facilitate fast adoption when an emergency occurs (because, in contrast to section 1115 waivers, section 1135 “cookie cutter” waivers should be encouraged).
6. HHS should post a living, on-line document of the past flexibilities it has approved.⁹

⁹ See generally Medicaid & CHIP Payment & Assessment Comm’n, *Section 1135 Waivers*, <https://www.macpac.gov/subtopic/section-1135-waivers> (last visited July 14, 2021).