

Medicaid's Role in Disasters and Public Health Emergencies

Medicaid plays an important role in assisting states and localities respond to natural or man-made disasters and other public health emergencies. As part of routine program operations, Medicaid has provided states with matching funds to help offset unanticipated costs associated with disasters, infectious disease epidemics such as HIV/AIDS, and outbreaks such as the Zika virus. In addition, in some cases, a declaration of an emergency or disaster has allowed the program to provide a heightened response, for example by facilitating short-term changes to program rules affecting eligibility, benefits, and provider payment.

This brief describes the statutory authority under which declarations of emergencies are made and the Medicaid authorities available to respond to these crises. It concludes by discussing the role Medicaid has played in recent disasters and public health crises.

Statutory Authorities for Emergency Declarations

Medicaid's response differs depending upon the type of emergency and the needs of the state or community. The federal government has three vehicles for declaring an emergency or a disaster: the Secretary of Health and Human Services (HHS) can declare a public health emergency under Section 319 of the Public Health Service Act (PHSA, P.L. 115-96, as amended), or the President can declare a disaster or emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (P.L. 93-288, as amended) or National Emergencies Act (P.L. 94-412). In some instances, an emergency may be declared through more than one of these avenues, as the declarations provide for different types of responses.

Public Health Service Act

Under Section 319 of the PHSA, the Secretary of HHS can declare a public health emergency if it is determined that a disease or disorder presents a public health emergency, or a public health emergency—including significant outbreaks of an infectious disease or a bioterrorist attack—otherwise exists. Such a declaration does not require a formal request from state or local government. Among other things, once a public health emergency is declared, the Secretary of HHS can:

- make grants;
- modify the practice of telemedicine;
- enter into contracts;
- conduct and support investigations into the cause, treatment, or prevention of the disease or disorder;
- make temporary personnel appointments to respond to the emergency;



- grant an extension or waive requirements of certain Substance Abuse and Mental Health Services Administration grants on a state-by-state basis;
- access so-called no-year funds appropriated to the Public Health Emergency Fund; and
- grant extensions or waiving sanctions related to submission of data or reports required by statute.

An emergency declaration under the PHS Act is authorized for the duration of the emergency or 90 days (whichever occurs first), and may be extended by the Secretary.

Stafford Act

When a major disaster or emergency affects a state or tribal area, the governor or chief executive may request federal assistance under the Stafford Act.¹ This law authorizes the federal government to provide financial and other assistance to state, local, and tribal governments; certain nonprofit organizations; and individuals to support response, recovery, and mitigation efforts following a declaration of an emergency or disaster by the President (ASPE 2017). Under the Stafford Act, the Federal Emergency Management Agency (FEMA) coordinates administration of disaster relief to affected states.

National Emergencies Act

The National Emergencies Act authorizes the President to declare a national emergency without a specific request from a state. Such declarations do not provide any specific emergency authority and instead rely on emergency authorities provided in other statutes. Emergency statutory provisions are not activated automatically; the President must specify which authorities are activated in the specific emergency declaration (ASTHO 2013). For example, when declaring the H1N1 influenza pandemic a national emergency in 2009, President Obama declared that the Secretary of HHS could waive certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements using authority under Section 1135 of the Social Security Act (EOP 2009).

Response under Medicaid Authorities

Medicaid has served as an important tool in states' responses to the health care needs resulting from disasters and emergencies including hurricanes, the terrorist attacks on September 11, 2001, the outbreak of Zika, lead contamination in Flint, Michigan, and the opioid epidemic. Flexibilities under the state plan and waivers under Sections 1135 and 1115 of the Social Security Act provide states with the ability to tailor programs to respond to additional enrollment, displacement of individuals due to a natural or man-made disaster, and increased needs for medical and behavioral health services. A brief summary of the flexibilities available to states under each of these avenues is provided below.

State plan flexibilities

States may use options available under state plan authority to simplify the enrollment and renewal process for individuals. Specifically, states can elect to use presumptive eligibility in Medicaid to expedite enrollment during an emergency or disaster and the Medicaid agency may act as a qualified entity to make preliminary eligibility determinations. States may also submit CHIP state plan amendments (SPAs) that



allow for temporary adjustments to enrollment, redetermination, and cost-sharing policies during a disaster. These temporary adjustments can only be applicable for individuals living or working in a disaster area, as declared by a governor or FEMA (CMS 2017c).

Section 1135 waivers

In order to waive or modify certain Medicare, Medicaid, and CHIP requirements under Section 1135 of the Social Security Act, an emergency or disaster must be declared by the President (either under the Stafford Act or the National Emergencies Act) and a public health emergency must be declared by the Secretary of HHS. Under Section 1135, the Secretary can waive certain requirements to ensure that sufficient health care items and services are available to meet the needs of Medicaid enrollees in affected areas. For example, the Centers for Medicare & Medicaid Services (CMS) can waive the requirement that physicians and other health care professionals hold licenses in the state in which they provide services (CMS 2016a). During the period of the waiver, providers can be paid and exempted from sanctions.

Waivers under Section 1135 typically expire at the end of the emergency declaration, although the Secretary also can specify that the waiver will be granted for 60 days. The waivers can be extended for additional 60-day periods, up to the end of the emergency declaration period. In addition, waivers can be retroactive to the beginning of an emergency. Section 1135 waivers cannot be used to pay for services otherwise not covered. In addition, the waiver authority applies only to federal requirements and does not apply to state licensing or participation requirements (ASPE 2017, CMS 2016a).

Section 1115 waivers

In the event of a disaster or an emergency, a state may request a new Section 1115 demonstration waiver, or amend or extend an existing Section 1115 demonstration to provide coverage to additional populations or expedite enrollment. States are not required to demonstrate budget neutrality related to federally designated public emergencies. CMS may waive, in whole or in part, the federal and state public notice and comment procedures to expedite a decision on the state's Section 1115 request. To obtain an exemption from the public notice and comment procedures, a state must meet the following criteria: that it acted in good faith and in a diligent, timely, and prudent manner; that the circumstances constitute an emergency that could not have been reasonably foreseen; and that a delay would undermine or compromise the purpose of the demonstration and would be against the interest of beneficiaries. CMS will publish disaster exemption determinations within 15 days of approval, as well as the revised timeline for public comment or post-award processes, if applicable (CMS 2017d).



Medicaid's Response to Disasters

Flexibility in the Medicaid program has been used to assist in the response to disasters, both natural and manmade. For example, Section 1115 waiver authority was used to assist state responses following the terrorist attacks on September 11, 2001 and after Hurricane Katrina. The response to more recent hurricanes has primarily occurred through the use of Section 1135 waivers.

September 11, 2001

The terrorist attacks on September 11, 2001 increased the need for medical care stemming from air quality and other environmental hazards at the attack sites, and for behavioral health services to address the trauma associated with the attacks. In addition, the attacks disrupted the economy, with individuals losing jobs and employer-sponsored health insurance. There were also administrative disruptions as when New York City computer systems that processed applications and renewal forms stopped functioning. In addition, some displaced individuals had difficulty providing documentation to verify income or other eligibility criteria.²

Under what became known as the Disaster Relief Medicaid (DRM) Section 1115 waiver, New York offered four months of Medicaid coverage to eligible New York City residents through a simplified application process.³ A one-page application was developed and eligibility was determined manually during face-to-face interviews. Applicants attested to the information they provided, including income. If attested income was below the eligibility standards, applicants were presumed eligible and received full Medicaid benefits through the state's existing fee-for-service program for four months.⁴ Following this period, eligible participants could transition to a permanent Medicaid eligibility pathway by submitting an application and the required documentation. In addition, annual redeterminations for beneficiaries who would have had their eligibility redetermined between September 11, 2001 and January 31, 2002 were waived, allowing them to continue receiving coverage during this time frame (Cornell 2005, Haslanger 2003).

By the end of DRM, 342,362 people had enrolled in the program. Approximately 80 percent of these enrollees accessed services, about two-thirds for primary and preventive care (Cornell 2005).

Hurricane Katrina

In late August 2005, Hurricane Katrina struck the Gulf coast of Louisiana and Mississippi, leading to the evacuation of thousands of residents.⁵ In response to the immediate need for health services and to ensure the continuity of care, CMS developed a new Section 1115 waiver initiative and template application that allowed states to provide temporary coverage to evacuees for up to five months (CMS 2005a).

Similar to New York's DRM, evacuees applied through a simplified application. Between August 24, 2005 and January 31, 2006, applicants unable to provide documentation were able to self-attest to eligibility criteria, including displacement, income, residency, resources, and immigration status. After the five-month period, individuals were required to reapply under a permanent eligibility category (CMS 2005a).



Host states (the state to which evacuees relocated) could offer Medicaid and CHIP to children, parents, pregnant women, individuals with disabilities, low-income Medicare recipients, and low-income individuals in need of long-term services and supports. These states could use the eligibility thresholds of the home state (where the evacuee was from) or simplified eligibility standards developed by CMS. States also had the option to exempt evacuees from cost sharing and resource tests. In addition, states were not required to meet budget neutrality under these demonstrations, as individuals participating in the demonstration were presumed to be eligible for coverage in their home state (CMS 2005a).

Thirty-two states were approved for hurricane-related demonstration programs (OIG 2007).⁶ In addition, in eight of these states, CMS also approved provisions for uncompensated care pools that allowed providers to be paid for providing necessary services to evacuees without insurance coverage (CMS 2005b).

In February 2006, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) authorized the Secretary of HHS to pay the non-federal share of certain health care-related expenses to states with approved hurricane-related demonstration projects. Overall, the DRA made \$2 billion available for services delivered to individuals by June 30, 2006, and for uncompensated care costs incurred by January 31, 2006. Of the funds made available under the DRA, \$1.9 billion was allocated to states by CMS as of September 30, 2006.⁷ Of this amount, Louisiana received \$832 million, the largest proportion of funding (GAO 2007).

In addition, states made changes to their programs using existing authority to provide services to individuals affected by Hurricane Katrina. For example, Louisiana provided temporary Medicaid cards to enrollees who lost their cards in the hurricane. The state also allowed beneficiaries to receive services without prior authorization from any in or out-of-state provider and instituted an expedited provider enrollment procedure (Baumrucker et al. 2005).

2017 hurricanes

The 2017 Atlantic hurricane season was extremely active, with three major hurricanes making landfall: Harvey in Texas, Irma in the Caribbean and southeastern United States, and Maria in Puerto Rico and the Caribbean (NOAA 2017). For each of these hurricanes, a public health emergency was declared under Section 319 of the PHS Act and emergency declarations were made under the Stafford Act (ASPR 2017, FEMA 2017). In addition, using Section 1135 waiver authority, CMS issued blanket waivers to ensure the availability of sufficient services to meet the needs of individuals in affected areas.

Texas secured a CHIP waiver to assist with relief following Hurricane Harvey. For individuals within the disaster area between August 25, 2017 and November 30, 2017, the waiver extended eligibility, allowing enrollees to receive services beyond their renewal period; waived certain verification requirements at application and renewal; and waived co-payments and enrollment fees through November 2017 (CMS 2017a, Texas 2017). In addition, due to disruptions in mail delivery, Texas received approval for an automatic six-month extension of benefits for Medicaid, CHIP, and Healthy Texas Women enrollees living in counties where a disaster had been declared (Texas 2017).

In response to the effect of Hurricane Maria on the health systems in Puerto Rico and the Virgin Islands, the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-1892) provided these territories with an additional



\$3.7 billion in federal funding. The legislation also temporarily increased the federal matching rate for the additional funding to 100 percent for the period between January 1, 2018 and September 30, 2019.⁸

Medicaid's Response to Public Health Crises

In the event of a public health crisis, CMS has used Section 1115 waivers, state plan amendments, and other flexibilities to address events such as the water contamination in Flint, Michigan, the Zika virus outbreak in Puerto Rico, and most recently, the national opioid epidemic.

Lead contamination in Flint, Michigan

In January 2016, President Obama declared a state of emergency under the Stafford Act in Flint, Michigan in response to lead contamination in the city's water supply. Lead poisoning has severe implications for childhood development. It can lead to behavioral, endocrine, and cardiovascular conditions, as well as learning difficulties and a decline in IQ. When the water crisis began, approximately 30,000 individuals in the Flint area were already Medicaid beneficiaries, which allowed immediate access to diagnostic and treatment services for those affected (Guyer and Rosales 2017).

Within a month of the President's declaration, Michigan sought, and subsequently received approval for a five-year Section 1115 waiver to respond to the emergency. The waiver expands coverage for pregnant women and children up to age 21 with incomes up to and including 400 percent of the federal poverty level (FPL). Those with income over 400 percent FPL may buy into the program to receive full Medicaid benefits. Eligibility is limited to individuals who were served by the Flint water supply between April 2014 and a future date when the water system is deemed safe (CMS 2016b, Michigan Department of Health and Human Services 2018).

Enrollment into the Flint Medicaid waiver program began in May 2016. As of June 2017, cumulative enrollment totaled 36,027, including 33,672 children and 2,355 pregnant women. Most beneficiaries accessed primary care services. Specifically, 88 percent of pregnant women, and 77 percent of children enrolled under the waiver have visited a primary care provider (Michigan Department of Health and Human Services 2017).

The demonstration also includes targeted case management and home lead investigation and abatement services for children and pregnant women under the Michigan state plan. Lead abatement activities were approved as a health services initiative (HSI).⁹ The HSI authorizes approximately \$24 million per year for five years to reduce lead risk. Activities that are approved under the HSI include: removing lead-based paint and lead dust hazards; removing and replacing surfaces or fixtures identified as lead hazards; removing or covering soil lead hazards; pre and post-abatement testing activities; and workforce training (CMS 2016c).



Zika virus outbreak in Puerto Rico

Following the outbreak of Zika virus, which can lead to adverse birth outcomes including microcephaly and other potentially severe fetal brain defects, the Secretary of HHS declared an emergency in Puerto Rico under Section 319 of the PHS Act in September 2016. When the declaration was made, there were 10,690 confirmed cases of Zika virus in Puerto Rico, including 1,035 pregnant women. While no additional Medicaid flexibilities were granted through this declaration, Puerto Rico was able to apply for funding to hire and train unemployed workers to assist in vector control and outreach and education efforts and request temporary staff to assist in the Zika virus response. The emergency declaration was subsequently renewed three times (HHS 2016). In addition, in September 2017, CMS awarded \$60.6 million to Puerto Rico primarily for Zika virus prevention as opposed to longer-term needs arising from the disease's progression. According to the CDC, the cost of caring for a child with Zika-related birth defects is estimated to be in the millions (KFF 2016). As such, Puerto Rico will likely face ongoing costs associated with the Zika virus.

Opioid epidemic

State Medicaid programs are responding to the opioid epidemic under regular program rules. Payment and access to medication-assisted treatment (MAT) has expanded, as have strategies to reduce the prescribing of opioids, including imposing quantity limits, instituting step therapy requirements, requiring prior authorization, and requiring use of prescription drug monitoring programs. In addition, all state Medicaid programs cover at least one of the three MAT modalities—methadone, buprenorphine or naltrexone—and most cover all three. In addition, nearly all states offer at least one formulation of naloxone without prior authorization (Gifford et al. 2017).

On October 26, 2017, President Trump ordered the Acting Secretary of HHS to declare a nationwide opioid emergency under the PHS Act. The declaration was renewed through April 23, 2018 and allows for:

- expanded access to telemedicine services, including the remote prescribing of buprenorphine;
- temporary appointment of specialized personnel to address the opioid emergency;
- grants, pending additional funding, to help workers who have been displaced from the workforce because of the opioid crisis; and
- flexibility within HIV/AIDS programs to help individuals receive substance use disorder (SUD) treatment (HHS 2017).

While this declaration is not specific to the Medicaid program, provisions such as remote prescribing of buprenorphine may allow increased access to MAT for Medicaid beneficiaries.

The federal government is taking other steps to respond to the opioid epidemic outside of the emergency declaration. In November 2017, CMS announced a new Section 1115 pathway for states to receive federal funding for residential substance use disorder (SUD) treatment in institutions for mental diseases (IMDs).¹⁰ The policy was designed with the goal of accelerating states' responses to the crisis and encourages states to offer a variety of evidence-based services across the continuum of SUD care (CMS 2017b). Ten states (California, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, Utah,



Virginia, and West Virginia) have received approval to cover residential SUD treatment in IMDs and several other states (Arizona, Illinois, Kansas, New Mexico, Michigan, North Carolina, Vermont, Wisconsin) have pending Section 1115 applications or amendments seeking a similar waiver authority.¹¹

In addition, Congress included \$6 billion in new funding over two years in BBA 2018 to combat the opioid epidemic, including grants to states, prevention programs, and law enforcement efforts. Additional assistance will be targeted to states with the highest mortality rates.

Endnotes

¹ Under the Stafford Act, a major disaster is any natural catastrophe or regardless of cause, any fire, flood, or explosion, which causes sufficient damage. An emergency is defined as any occasion for which federal assistance is needed to supplement state and local efforts.

² While a major disaster declaration for New York and Virginia was issued by President George W. Bush in response to the September 11, 2001 terrorist attacks, the assistance focused largely on infrastructure, unemployment benefits, and temporary housing assistance (Lindsay and McCarthy 2016). A public health emergency was also declared under the PHSA (ASPR 2017). This declaration led to HHS funding for hospitals and other health care facilities for services provided to victims or lost revenue as a result of the disaster response (HHS 2001, 2002).

³ At the same time New York received approval for its DRM waiver, the state had begun to implement Family Health Plus, an expansion of Medicaid for parents with family incomes up to 133 percent of the federal poverty level (FPL) and other low-income adults without dependent children with incomes up to 100 percent FPL. In addition, a June 2001 court ruling required New York to extend Medicaid to all legally residing immigrants regardless of when they arrived in the United States.

⁴ Nursing facility care was offered separately.

⁵ Less than a month later, Hurricane Rita hit along the same area. Federal disasters were declared in Alabama, Louisiana, Mississippi and Florida following Katrina; and in Louisiana and Texas following Hurricane Rita (FEMA 2017). In addition a public health emergency was declared under Section 319 of the Public Health Services Act for the following states: Texas, Arkansas, Colorado, Georgia, North Carolina, Oklahoma, Tennessee, West Virginia, Utah, and Florida (ASPR 2017).

⁶ The states approved for hurricane-related demonstrations include: Alabama, Arizona, Arkansas, California, Delaware, the District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nevada, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming (OIG 2007).

⁷ Of these funds, approximately \$1.5 billion was allocated to Alabama, Louisiana, and Mississippi, the three states affected directly, for the nonfederal share of expenditures for existing Medicaid and CHIP enrollees (GAO 2007).

⁸ Of these funds, Puerto Rico was allocated \$3.6 billion and the Virgin Islands was allocated \$106.9 million. Both may be able to receive additional funds (Puerto Rico another \$1.2 billion and the Virgin Islands another \$35.6 million) if certain conditions related to data reporting and program integrity are met. Under the Social Security Act, the territories are considered states for the purposes of Medicaid and CHIP; however, rather than having an open-ended financing structure, Medicaid in the territories operates with an annual ceiling on federal financial participation (§1108(g) of the Social Security Act).



⁹ Section 2105(a)(1)(D)(ii) of the Social Security Act gives states the option to use Title XXI (CHIP) funds to develop a health services initiative (HSI) to improve the health of low-income children through direct services or public health initiatives.

¹⁰ The 2017 guidance replaces July 2015 guidance that allowed states to receive federal financial participation for SUD care in IMDs if they could demonstrate that residential service providers meet the American Society for Addiction Medicine Criteria (CMS 2015). While states are not precluded from integrating physical and behavioral health care under the new guidance, an integration strategy is not required as was the case under the 2015 guidance.

¹¹ California, Maryland, Virginia, and West Virginia have approved demonstrations under the 2015 guidance. Massachusetts also has an approved waiver under the guidance; however, the state is seeking an additional amendment to further expand its authority and this amendment is still pending approval. Indiana, Kentucky, Louisiana, New Jersey and Utah have received approval under the 2017 guidance, and West Virginia also agreed to meet the reporting and evaluation requirements under the new guidance.

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