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August 25, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar:

As you know, your declaration of a public health emergency (PHE), coupled with the President's declaration of a national emergency, has enabled state Medicaid programs to exercise regulatory flexibilities to ensure beneficiary access to services and support safety-net providers during the ongoing COVID-19 pandemic. We appreciate your recent decision to extend the PHE as it allows states to continue using these tools as they respond to the pandemic.

In the months ahead, you will face the decision regarding whether to extend the PHE once again. While we cannot predict conditions on the ground two months from now, we wanted to bring to your attention concerns that will face state Medicaid programs at that time:

- First, states cannot simply turn Medicaid policies on or off with the stroke of a pen. Reverting to prior practices and policies or making permanent changes absent emergency authority will require substantial lead time to prioritize and plan, confer with stakeholders, and implement.
- Second, states will need guidance from the Centers for Medicare & Medicaid Services (CMS) that makes clear the agency's expectations regarding timelines and priorities for a return to routine operations.
- Third, states will be undertaking this work at a time of declining revenue and growing Medicaid enrollment.

Unlike Medicare, which is a fully federal program, Medicaid operates as a partnership between the states and the federal government. State Medicaid programs cannot act alone in determining what their programs look like post pandemic. They may need state legislative approval, which may be challenging if state legislatures are not in session, and they need their federal partners to act. In keeping with the Medicaid and CHIP Payment and Access Commission's statutory role of providing advice and recommendations to you and the states:



- We urge you to commit to providing states with sufficient advance notice as to when the PHE will end. For example, providing states with at least 90 days' notice would ensure that states would have a minimum of one fiscal quarter of notice prior to the loss of enhanced federal matching assistance percentage (FMAP) for budget planning purposes. We note that the two renewals of the PHE in April and July occurred just a few days before the PHE would have expired.
- We also urge that you provide early and clear guidance on requirements for returning to normal operations for states well in advance of actions that would terminate Medicaid flexibilities.

These assurances would be extremely helpful in ensuring transitions out of the PHE in the manner that best protects and minimizes disruption for Medicaid beneficiaries, providers, plans, and states. In addition, greater transparency regarding the factors you will consider in determining whether to extend the PHE would help to guide state planning and forecasting.

To provide context, below we describe how we expect the end of the PHE to affect Medicaid operations. Next we describe the need for early CMS guidance on expectations for returning to normal program operations. We also highlight the time required to develop and submit requests for state plan amendments (SPAs) and waivers they wish to extend beyond the PHE. Finally, we note states will be doing all this (and managing the other non-COVID 19 aspects of their programs) under increasing resource constraints.

Effect of the PHE on Medicaid operations

The PHE declaration, along with national emergency proclamations under the Stafford Disaster Relief and Emergency Assistance Act and the National Emergencies Act, have provided important tools for states to meet the health care needs of enrollees in Medicaid and the State Children's Health Insurance Program (CHIP) (Appendix A). Each of the disaster authorities—Medicaid and CHIP state plan authorities, Appendix K for modifying Section 1915(c) waivers for home- and community-based services, Section 1115 waivers, and Section 1135 waivers—provide several options for flexibility (Appendix B). All states are using some combination of the available authorities and flexibilities during the PHE (NGA 2020a).

The end dates for the Medicaid and CHIP disaster flexibilities and waivers are generally aligned with the period of the PHE. When it ends, states will have to take steps to either extend policies (to the extent possible) or return to pre-pandemic policies, depending on state needs. Specifically:

- Medicaid and CHIP disaster flexibilities authorized through state plans and Section 1135 blanket and state waivers end with the PHE;
- Section 1115 waiver authority ends no later than 60 days from the end of the PHE;
- authority for coverage of the optional COVID-19 related testing Medicaid eligibility group ends when the PHE ends; and
- the 6.2 percentage point increase in the FMAP expires at the end of the quarter in which the PHE ends (Appendix B).



States will face challenges in returning to normal operations while minimizing disruptions in coverage and access to care. Returning to pre-pandemic policies and operations poses challenges due to both the number and scope of flexibilities implemented to respond to COVID-19, but also because of the many steps required to do so. For example, all states and the District of Columbia have Section 1135 waivers of multiple requirements related to provider enrollment and revalidation, and most have waived requirements pertaining to settings of care, fee-for-service prior authorizations, and certain screening requirements for admission to nursing facilities (KFF 2020a). In addition, nearly all states and the District of Columbia have implemented temporary program changes under Medicaid and CHIP SPAs (KFF 2020a). These include, for example, actions to expand coverage for COVID-19 testing and testing-related services for uninsured individuals; delay renewals of eligibility; modify benefits; or eliminate, waive, or suspend premium and cost sharing requirements (KFF 2020a).

Need for guidance on how to return to normal operations

States will need guidance as to whether they will be required to fully return to typical operations immediately upon the end of the PHE, or if there will be an option for phased-in or gradual return.¹ So far, CMS has not publicly indicated expectations for states in returning to normal operations although we understand that the agency is in conversation with states about these issues and is beginning to develop guidance for states in some areas.

Eligibility determinations and provider validations illustrate the kind of work facing states as they unwind emergency authorities. Once the PHE ends, states will have to resume beneficiary eligibility redeterminations using newly collected information. They will have to begin acting on findings of changes in beneficiaries' circumstances that make them ineligible for Medicaid and evaluate, using current information, the status of beneficiaries who remained enrolled due to the continuous coverage requirements associated with the enhanced FMAP (CMS 2020a).²

States must have sufficient time to ensure beneficiaries are aware of the requirements, the steps needed to satisfy requirements, and the consequences if requirements are not met. In returning to typical redetermination policies, states will be required to take several actions such as checking available data for information needed to determine eligibility, generating and verifying prepopulated renewal forms, and checking for eligibility through other pathways (42 CFR 435.916). States will need to make systems changes, develop and disseminate policy notices, and notify plans and providers of changes.

Similarly, when the PHE ends, states may also face a large number of in-state provider revalidations, which under Section 1135 waiver authority, have been postponed.³ Once the PHE ends, states and providers will need to resume validation activities. Depending on the provider risk level, revalidations involve:

- verifying that providers meet applicable and federal requirements based on the provider type;
- verifying provider licensure;
- conducting database checks before and after enrollment to ensure the provider meets enrollment criteria for the provider type;



- conducting site visits to verify information submitted to the state Medicaid agency is accurate and compliant with state and federal requirements;
- conducting criminal background checks; and
- requiring the submission of fingerprints (42 CFR 455.50).

States will also have to obtain disclosures related to provider ownership or controlling interest, ownership of certain subcontractors, and provider or owner affiliations with current or former Medicaid or CHIP providers with a disclosable event (42 CFR 455.104–106, CMS 2018).⁴ States will need to communicate these requirements to providers, as well as set up a process for working their way through the list of providers requiring revalidation.

Delayed guidance, unrealistic expectations, or short implementation timeframes for eligibility redeterminations and provider revalidations could disrupt state operations, result in beneficiaries churning on and off of Medicaid coverage, and jeopardize access to care.

Timeframes for converting policies authorized under disaster flexibilities to other authorities

Some of the policies permitted under disaster flexibilities could be continued under other authorities at state option.⁵ Doing so will require that states conduct certain analyses or engage stakeholders under specified time frames. This may be particularly relevant to telehealth, which states have widely expanded during the PHE. Although the Medicaid statute gives states considerable latitude to cover telehealth under the state plan, states wishing to retain expanded telehealth coverage after the PHE ends may have to take steps to convert policies authorized under disaster flexibilities to permanent policies under state plan authorities. To make these and other changes permanent, states will need to:

- estimate the effects on program spending including state and federal Medicaid spending;
- consider and address the effects of the policy on beneficiaries, providers, and health plans;
- consider downstream effects on other aspects of their program if necessary;
- seek state legislative and budgetary approval (we note the timing of state legislative sessions may not align with the ending of the PHE);
- provide public notice or comment period;
- engage in tribal consultation (where required); and
- prepare and submit appropriate SPA templates any accompanying materials (e.g., responses to the five funding questions required for SPAs) and waiver applications.

States wishing to extend Section 1115 waiver authorities beyond the PHE will also have to:

- provide budget neutrality assessments;
- provide for public hearings; and
- allow for a federal comment period.



These steps and the submission of SPA or waiver requests will need to occur within authority-specific timeframes to prevent lapses in authority (Appendix B). For example, states must submit Medicaid SPAs by the end of the fiscal quarter in which the SPA takes effect (42 CFR 430.20) while they must submit CHIP SPAs by the end of the state fiscal year in which they become effective (42 CFR 457.65).⁶ Public notice is required for Medicaid SPAs related to premiums and cost sharing and alternate benefit plans, and this must occur prior to submitting a SPA (42 CFR 447.57 and 42 CFR 440.386), and prior to the effective date for Medicaid SPAs related to payment (42 CFR 447.205, CMS 2020b). Public notice is also required prior to the proposed effective date for CHIP SPAs that restrict eligibility or benefits (42 CFR 457.65).⁷

In addition to gaining approval to retain the flexibilities, states will also need to take numerous steps to implement the policies. These include making systems changes; amending contracts; developing policy notices; and educating beneficiaries and providers.

Constrained state resources

As noted above, states will be undertaking all of these tasks under considerable resource constraints. The economic crisis resulting from the pandemic has led to declining revenues and increased Medicaid enrollment (NASHP 2020, NCSL 2020, KFF 2020b). Some states are already cutting their Medicaid budgets and implementing hiring freezes; additional measures such as layoffs and furloughs may soon follow (Raman 2020, White 2020). The increased FMAP is providing additional fiscal support but is only available through the end of the quarter in which the PHE ends. Revenue constraints are likely to extend much longer (NAMD 2020, NGA 2020b).

State administrative capacity will be further stretched as staff address other effects of the pandemic (e.g., pent-up demand for services and possibly consequences of delayed care) and resume other program and administrative functions that may have been deferred during the pandemic (e.g., quality reporting, submission of CMS-416 data on early and periodic screening, diagnostic and treatment benefits).

In conclusion, as you consider the timing for the eventual end to the PHE, we ask that you take into account the operational realities facing states and the potentially negative consequences for beneficiaries, providers, and plans from an abrupt transition back to routine operations. While CMS has provided some guidance to states on steps to extend certain disaster flexibilities during its weekly stakeholder calls (CMS 2020b–d), a more deliberate and transparent process would promote efficient program administration and prevent disruption of critical health services for Medicaid and CHIP enrollees.

Sincerely,



Melanie Bella, MBA
Chair



cc: The Honorable Charles Grassley, Chair, Senate Finance Committee
 The Honorable Ron Wyden, Ranking Member, Senate Finance Committee
 The Honorable Frank Pallone, Chair, House Energy and Commerce Committee
 The Honorable Greg Walden, Ranking Member, House Energy and Commerce Committee
 The Honorable Seema Verma, Administrator, Centers for Medicare & Medicaid Services
 Calder Lynch, Deputy Administrator and Director of the Center for Medicaid & CHIP Services

Endnotes

¹ We note that in 2013, as states were implementing modified adjusted gross income (MAGI)-based income rules and new eligibility systems required under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), CMS provided flexibility so states could delay Medicaid redeterminations within certain parameters. For example, CMS permitted states to implement staggered redetermination schedules to distribute the workload associated with the renewals. CMS made these options available in order to help states manage the transition to new systems (CMS 2013).

² The Families First Coronavirus Relief Act (FFCRA, P.L. 116-127) prohibits states from disenrolling individuals from Medicaid coverage as of March 18, 2020 until the end of the month in which the PHE ends, if they wish to receive the 6.2 percentage point increase to the Medicaid federal medical assistance percentage (FMAP).

³ Typically, states must complete revalidation of enrollment for all providers at least every five years, or more frequently at state discretion (42 CFR 455.414).

⁴ A disclosable event means having uncollected debt to Medicare, Medicaid, or CHIP; having been or is currently subjected to payment suspension under federal care programs; having been or is excluded by the Office of the Inspector General from participating in Medicare, Medicaid, or CHIP; or having had Medicare, Medicaid, or CHIP enrollment denied, revoked, or terminated (42 CFR 455.101).

⁵ CMS has recently described the key administrative steps for extending flexibilities through Medicaid and CHIP state plan amendments and Section 1915(c) Appendix K modifications (CMS 2020a, 2020b, 2020c).

⁶ States wanting to extend Medicaid SPA flexibilities with an effective date of October 24 would need to submit a SPA by December 31, 2020. States submitting a CHIP SPA taking effect October 24, 2020 would need to do so by June 30, 2021; most state fiscal years end on June 30.

⁷ We note the maintenance of effort (MOE) requirement for children prevents states from implementing more restrictive enrollment standards, procedure, or methodologies than were in place on March 23, 2010 for children enrolled in Medicaid or CHIP in families with income under 300 percent of the federal poverty level. The MOE is in place through FY 2027.

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APPENDIX A: Time Frames for COVID-19 Emergency Declarations, as of August 25, 2020

Federal emergency declaration authorities and timeframes	Summary ¹
<p>Public health emergency (PHE, § 319 of the Public Health Service Act)</p> <ul style="list-style-type: none"> • Duration is 90 days, may be extended • On January 31, 2020 the Secretary declared a PHE effective January 27, 2020 (ASPR 2020a) • Renewed on April 26, 2020 through July 25, 2020 (ASPR 2020b) • Renewed on July 23, 2020 through October 23, 2020 (ASPR 2020c) 	<ul style="list-style-type: none"> • The Secretary of the U.S. Department of Health and Human Services (the Secretary) can declare when a disease or disorder poses a public health emergency. • A PHE declaration permits the Secretary to <ul style="list-style-type: none"> – waive or modify certain Medicare, Medicaid, CHIP, and HIPAA requirements according to Section 1135 of the Act – permit prescribing of controlled substances via telehealth without requiring an in-person visit first – respond to the emergency by making grants, entering into contracts, and investigating the cause, treatment, and prevention of the disease or disorder – access PHE funds to support response efforts – grant extensions or waive sanctions related to submission of required reports – other specified actions
<p>Stafford Disaster Relief and Emergency Assistance Act (Stafford Act, P.L. 93-288, as amended)</p> <ul style="list-style-type: none"> • On March 31, 2020, the President declared a national emergency under Section 501(b) effective January 20, 2020 and continuing (CRS 2020, WH 2020a). • The President approved major disaster declaration requests for all states, the District of Columbia and the territories effective January 20, 2020 and continuing (CRS 2020, FEMA 2020). 	<ul style="list-style-type: none"> • Governors may request federal assistance for their emergency responses. The President may also make an emergency declaration (§ 501 of the Stafford Act), or he may make a major disaster declaration (§ 401 of the Stafford Act).² • A declaration under the Stafford Act permits the federal government to provide financial and other assistance to state, local, and tribal governments, certain nonprofit organizations, and individuals to support response efforts. It authorizes FEMA assistance to supplement state efforts.

Federal emergency declaration authorities and timeframes	Summary ¹
<p>National Emergencies Act (NEA, P.L. 94-412)</p> <ul style="list-style-type: none"> On March 13, 2020, the President proclaimed a national emergency beginning March 1, 2020 (WH 2020b). The President may terminate the emergency by proclamation. Congress may terminate the emergency if it passes and the President signs a joint resolution (50 USC § 1622(a)). The national emergency terminates automatically on the anniversary of the declaration if it is not terminated sooner, or if the President does not extend it (50 USC § 1622(d)). 	<ul style="list-style-type: none"> Emergency proclamations apply nationally and invoke emergency authorities in other statutes, such as Section 1135 of the Social Security Act. The NEA declaration directs the Secretary to exercise authorities under Section 1135 of the Social Security Act to waive or modify certain Medicare, Medicaid, and CHIP requirements.

Notes: CHIP is State Children’s Health Insurance Program. HIPAA is the Health Insurance Portability and Accountability Act of 1996. FEMA is Federal Emergency Management Agency.

¹ The summary highlights key features or examples of flexibilities under the emergency declarations. It is not meant to be exhaustive.

² The assistance available under a national emergency declaration is more limited than that available under disaster declarations. Under an emergency declaration, states may be eligible for assistance with activities such as emergency center operations, emergency medical care, or medical sheltering (CRS 2020). Under a disaster declaration, states may be eligible for assistance with emergency protective measures such as emergency shelter and medicine, hazard communications, and provision and distribution of necessities (CRS 2020).

Sources: ASPR 2020a, ASPR 2020b, ASPR 2020c, CRS 2020, FEMA 2020, WH 2020a, and WH 2020b.

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APPENDIX B: Medicaid and CHIP COVID-19 Disaster Authorities

Authority, timeframes, and flexibilities ¹	
Section 1135 blanket waivers	
Current approval timeframes	<ul style="list-style-type: none"> Effective March 1, 2020 through the end of either of the emergency declarations unless ended earlier by CMS² (CMS 2020a, Polaris 2020) Flexibilities under Section 1135 of the Social Security Act (the Act) can be invoked when a public health emergency (PHE) under Section 319 of the Public Health Service Act and emergencies under the Stafford Act or the National Emergencies Act are declared
Timing and required steps to retain flexibility	Waivers under Section 1135 could be extended with extensions of the PHE. Statutory or regulatory changes could also be made to permanently change provisions temporarily waived under blanket waiver authority.
Summary of flexibilities <p>CMS issued numerous blanket waivers, which apply nationally, primarily to Medicare providers (CMS 2020b). Examples of providers and types of blanket waivers include:</p> <ul style="list-style-type: none"> Medicare telehealth waivers of: <ul style="list-style-type: none"> restrictions on eligible practitioners (e.g., FQHCs and RHCs are now eligible) prohibition on audio-only services restrictions on services eligible for reimbursement when provided via telehealth restrictions for use of telehealth in nursing homes and hospice geographic restrictions, i.e., permitting telehealth in non-rural areas, permitting the home as the originating site (temporary changes made by FFCRA) 	

Authority, timeframes, and flexibilities¹

- Waivers for hospitals of:
 - enforcement of EMTALA violations
 - discharge planning requirements
 - requirements that Medicare patients be under physician care (so hospitals can use other practitioners to the fullest extent possible)
 - utilization review requirements for hospitals participating in Medicare and Medicaid, CAH personnel qualifications and staff licensure, and length of stay, CAH bed and length of stay
- Waivers for rural health clinics and federally qualified health centers of:
 - requirements that an NP, PA, or CNM be available to provide care at least 50 percent of the time an RHC operates
 - requirements for physician supervision of NPs
 - certain rules to allow existing RHCs/FQHCs to expand service locations even if they have not been independently considered for Medicare approval
- Waivers for long-term care facilities, SNFs and NFs of:
 - requirements for a three-day hospitalization before a SNF stay
 - requirements for renewing SNF benefits without having to start a new benefit period
 - required minimum data set reporting timeframes
 - PASRR requirements
 - training and certification requirements for nurse aides
 - staff data submissions
- Waivers for home health agencies of:
 - on-site home health aide supervision requirements
 - restrictions on initial and comprehensive assessments for all patients by occupational and physical therapists, and speech and language pathologists
 - required training deadlines
- Waivers for providers of durable medical equipment of:
 - requirements for face-to-face encounters, new physician orders, and new medical necessity documentation to replace lost or destroyed DME

Authority, timeframes, and flexibilities¹

- Waivers related to practitioners:
 - requirements that out-of-state practitioners be licensed in the state where they are providing services if licensed in another state
 - certain provider screening requirements (states may request similar waivers for Medicaid under Section 1135 authority, see below)
- Waivers of sanctions under the physician self-referral (i.e., Stark Act)
- Waivers of sanctions for noncompliance with certain HIPAA requirements

Section 1135 state waivers

Current approval timeframes

- Effective March 1, 2020 through end of the PHE (CMS 2020c)³
- Flexibilities under Section 1135 of the Act can be invoked when a PHE under Section 319 of the Public Health Service Act and emergencies under the Stafford Act or the National Emergencies Act are declared

Timing and required steps to retain flexibility

Waivers under Section 1135 could be extended with extensions of the PHE. Statutory or regulatory changes could also be made to permanently change provisions temporarily waived under blanket waiver authority.

Summary of flexibilities

Under Section 1135, states may:

- waive FFS prior authorization requirements
- extend pre-existing prior authorizations in FFS
- suspend PASSR Level I and II assessments for 30 days
- extend MDS authorizations for SNF/NF residents
- allow managed care enrollees to move to state fair hearing without the managed care organizations first resolving the appeal
- allow enrollees in managed care more than 120 days and those in FFS more than 90 days to request state fair hearing
- waive certain provider enrollment requirements (e.g., payment of application fees, criminal background checks, and site visits) for temporarily enrolled providers
- waive in-state licensure requirements for providers licensed in another state
- permit out of states providers to deliver emergency care to Medicaid beneficiaries
- postpone deadlines for provider enrollment revalidations
- waive conditions of participation to allow delivery of services in alternate settings

Authority, timeframes, and flexibilities¹	
<ul style="list-style-type: none"> • streamline provider enrollment requirements • modify deadlines for OASIS and MDS assessments • suspend home health and hospice aide supervision requirements 	
Medicaid disaster state plan amendments (SPAs)	
Current approval timeframes	Effective March 1, 2020 (or later date selected by state) through the end of the PHE including any extensions, or an earlier date elected by the state (CMS 2020c)
Timing and required steps to retain flexibility	<p>Submit SPA</p> <p>States must submit a SPA by the end of the fiscal quarter in which the SPA will be effective.</p> <p>Provide public notice</p> <p>Public notice required prior to submission of SPAs related to:</p> <ul style="list-style-type: none"> • Establishing or substantially modifying premium and cost sharing or the consequences of non-payment • Changing alternative benefit plans <p>Public notice must occur prior to the effective date of SPA related to payment policy changes.</p> <p>Conduct tribal consultation</p> <p>In states where tribal consultation is required, it must occur prior to submitting the SPA (§ 1902(a)(73) of the Act).</p> <p>CMS</p> <p>Has 90 days to make a decision on the SPA. CMS can stop the clock to obtain additional information.</p>

Authority, timeframes, and flexibilities¹

Summary of flexibilities

Examples of Medicaid SPA flexibilities approved in states include:

Eligibility

- Coverage of the COVID-19 testing eligibility group
- Use of less restrictive financial methodologies to non-MAGI populations
- Consider individual absent from state due to public health emergency as a resident
- Coverage of non-state residents
- Extension of reasonable opportunity period for non-citizens
- Post eligibility treatment of income (basic personal needs allowance for institutionalized individuals)

Enrollment

- Hospital presumptive eligibility for additional populations
- State Medicaid agency to perform presumptive eligibility
- Addition of qualified entities or populations subject to presumptive eligibility
- Adoption of continuous eligibility for children
- Changes to frequency of redeterminations to non-MAGI populations
- Use of simplified applications

Premiums and cost sharing

- Suspend out-of-pocket cost sharing
- Suspend premiums, enrollment fees
- Waive premiums and enrollment fees for undue hardship

Benefits

- Add optional benefits
- Changes to benefits
- Application of benefit changes to alternative benefit plans
- Changes to telehealth
- Drug benefit: supply or quantity limits
- Drug benefit: automatic renewal

Authority, timeframes, and flexibilities¹	
<ul style="list-style-type: none"> • Drug benefit: dispensing fees • Drug benefit: exceptions to preferred drug list in the event of a shortage <p>Payment</p> <ul style="list-style-type: none"> • Optional benefits added • Increased payment for certain services • Telehealth payment policies • Other payment 	
CHIP disaster SPAs	
Current approval timeframes	From the start of the state or federally declared emergency (as specified in the SPA) through the end of the PHE including any extensions, or earlier at state discretion (CMS 2020c).
Timing and required steps to retain flexibility	<p>Submit SPA</p> <p>In general, states must submit non-restrictive SPAs by the end of the state fiscal year in which they become effective. Restrictive SPAs (related to eligibility, benefits, cost sharing, or enrollment) must be submitted within 60 days of implementation (42 CFR 457.65).</p> <p>Public notice</p> <p>Public notice is not required to extended CHIP disaster-related flexibilities. Public notice is only required for CHIP SPAs that restrict eligibility or benefits (42 CFR 457.65).</p> <p>Public notice must be provided prior to the proposed effective date for restrictive SPAs (42 CFR 457.65).</p> <p>Tribal consultation</p> <p>In states where tribal consultation is required, consultation must occur prior to submitting the SPA (§ 2107(e)(1)(F) of the Act). These are the same as Medicaid requirements.</p>

Authority, timeframes, and flexibilities ¹	
	CMS Has 90 days to make a decision on the SPA. CMS can stop the clock to obtain additional information.
Summary of flexibilities Examples of CHIP SPA flexibilities approved in states include: Eligibility and enrollment <ul style="list-style-type: none"> • Delay acting on circumstances affecting eligibility, delay renewals • Temporarily provide continuous eligibility • Temporarily provide presumptive eligibility • Waive timely processing of applications and renewals • Provide families additional time to submit a renewal or verification information • Extend reasonable opportunity time to verify immigration status • Waive verifications of eligibility requirements, accept self-attestation • Waive waiting periods Out-of-pocket costs <ul style="list-style-type: none"> • Waive cost sharing • Waive or delay premiums and enrollment fees • Waive consequences of failure to pay (e.g., waive lock out period for failure to pay premiums) Other <ul style="list-style-type: none"> • Waive prior authorization requirements 	
Section 1915(c) Appendix K modifications	
Current approval timeframes	<ul style="list-style-type: none"> • Effective as early as January 27, 2020, with effective dates ranging from a few months up to one year • One year from effective date or earlier date if elected by state. End date cannot extend beyond March 31, 2021 (CMS 2020d)

Authority, timeframes, and flexibilities¹

Timing and required steps to retain flexibility

Not all Appendix K flexibilities approved during the PHE can be approved via the standard waiver amendment process under Section 1915(c) of the Social Security Act (CMS 2020e). For those that can, states must use the standard Section 1915(c) waiver amendment process.

Submit waiver amendment

To continue Appendix flexibilities after March 31, 2021, states must submit an amendment to its Section 1915(c) waiver application.

Public notice

States must provide public notice for substantive changes (e.g., provider qualifications, rate methodologies, quality improvement system, addition of services) (CMS 2020e). Public notice must be completed at least 30 days prior to implementation of the changes (42 CFR 441.304(f)).

Tribal consultation

Public notice must include tribal consultation in accordance with ARRA Section 5006(e) (42 CFR 441.304(f)).

Effective dates

Effective date for substantive changes is on or after the date CMS approves the amendment (42 CFR 441.304(d)).

CMS

States should consult with CMS regarding 1915(c) quality review processes and costs estimates that may be affected by waiver amendments (CMS 2020e).

Has 90 days to make a decision on the SPA. CMS can stop the clock to obtain additional information.

Authority, timeframes, and flexibilities¹

Summary of flexibilities

Eligibility

- Temporarily increase cost limits for entry into waiver
- Temporarily modify additional targeting criteria
- Imminent needs of individuals in the waiver program
- Temporarily modify processes for level of care evaluations or re-evaluations
- Extend reassessment and reevaluation due dates
- Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually
- Increase factor C (i.e., the projected unduplicated number of beneficiaries that can be served under the waiver)

Covered services

- Temporarily modify service scope or coverage
- Temporarily exceed service limits or requirements for amount, duration, and prior authorization
- Temporarily add services to address the emergency
- Temporarily institute or expand opportunities for self-direction
- Add home-delivered meals
- Add medical supplies, equipment, and appliances
- Add assistive technology

Service planning and delivery

- Temporarily modify person-centered plan development process and responsible individuals
- Add electronic method of service delivery to continue services remotely in home
- Adjust assessment requirements
- Add electronic method of document signing

Settings

- Temporarily expand settings where services may be provided
- Temporarily provide services in out-of-state settings (if not already permitted in waiver)
- Temporarily allow payment for services to support waiver participants in acute care hospital or short-term institutional stay when necessary supports are not available in that setting or when individual requires those services for communication and behavioral stabilization and services are not covered in such settings

Authority, timeframes, and flexibilities¹

- Not allow visitors at any time to minimize spread of infection
- Not comply with HCBS settings requirement to minimize spread of infection
- Temporarily permit payment for services rendered by family caregivers or legally responsible relatives (if not already permitted in waiver)

Providers

- Temporarily modify provider qualifications
- Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers
- Temporarily modify provider types
- Temporarily modify licensure or other requirements
- Allow case management entities to provide direct services

Payment

- Temporarily include retainer payments to address emergency related issues
- Temporarily increase payment rates

Oversight

- Temporarily modify incident reporting requirements, medication management, or other participant safeguards to ensure individual health welfare and account for emergency circumstances

Section 1115 waivers

Current approval timeframes

- New waivers can take effect March 1, 2020 through no later than 60 days after the end of the PHE including any extensions
- Appendix K modifications to existing waivers under Section 1115 of the Social Security Act use the Appendix K timeframes (CMS 2020f)

Authority, timeframes, and flexibilities¹	
Timing and required steps to retain flexibility	<p>Public notice</p> <p>States must provide at least a 30-day public notice and comment period before submitting a Section 1115 waiver application to CMS (42 CFR 431.408). Once CMS determines a complete application has been submitted, there is a 30-day federal comment period.</p> <p>Public hearing</p> <p>At least 20 days before submitting an application, states must conduct at least two public hearings regarding the demonstration (42 CFR 431.408).</p> <p>Tribal consultation</p> <p>States must conduct tribal consultation prior to submitting waiver requests (42 CFR 431.408).</p> <p>Submit application</p> <p>States will need to submit a complete Section 1115 waiver application including budget neutrality calculations, estimates of expected increase or decrease in annual enrollment and aggregated expenditures, and research hypothesis related to the demonstration.</p> <p>Federal comment period</p> <p>CMS will notify the state and open a 30-day federal comment period once a complete waiver application is received (42 CFR 431.416).</p> <p>The earliest CMS can issue an approval for a waiver is 45 days after the agency notifies the state that the application is complete and the start date of the federal public comment period.</p>
<p>Summary of flexibilities</p> <ul style="list-style-type: none"> As of August 12, 2020, Hawaii, New Hampshire, North Carolina, Rhode Island, and Washington had received approval for COVID-19 related Section 1115 waivers CMS waived a relatively narrow set of requirements related to eligibility and enrollment for beneficiaries receiving LTSS and HCBS and payment for HCBS and LTSS providers Other states have modified existing Section 1115 demonstrations using Appendix K 	

Authority, timeframes, and flexibilities¹	
6.2 percentage point increase to FMAP	
	<ul style="list-style-type: none"> • Available for expenditures incurred on or after January 1, 2020 through the end of the quarter in which the PHE (including any extensions) ends (CMS 2020g) • To qualify for the FMAP increase, states, the District of Columbia, and the territories must comply with MOE requirements (see below) (CMS 2020c)
Maintenance-of-effort requirement	
	<ul style="list-style-type: none"> • MOE in effect January 1, 2020 through the end of the quarter in which the PHE ends (CMS 2020e)⁴ • States, the District of Columbia, and territories may not impose eligibility standards, methodologies or procedures that are more restrictive than those in place on January 1, 2020; charge premiums exceeding those in place as of January 1, 2020; or impose cost sharing for COVID related to testing, services, and treatment (including vaccines).
	<ul style="list-style-type: none"> • Continuous coverage requirement is in effect as of the date of enactment (March 18, 2020) through the end of the month the PHE ends (CMS 2020e). • The continuous coverage requirement prohibits states from terminating individuals from Medicaid during the specified timeframes.
Optional COVID-19 testing group	
	<p>March 18, 2020 through end of the PHE⁵</p> <p>States choosing to cover uninsured individuals for COVID-19 testing-related services receive 100 percent FMAP.</p>

Notes: ARRA is American Recovery and Reinvestment Act Of 2009 (P.L. 111-5). CAH is critical access hospital. CHIP is State Children’s Health Insurance Program. CMS is the Centers for Medicare & Medicaid Services. CNM is certified nurse midwife. DME is durable medical equipment. EMTALA is the Emergency Medical Treatment and Labor Act. FFCRA is the Families First Coronavirus Response Act (P.L. 116-127). FFS is fee-for-service. FMAP is federal medical assistance percentage. FQHC is federally qualified health center. HCBS is home and community-based services. HIPAA is the Health Insurance Portability and Accountability Act of 1996. LTSS is long-term services and supports. MAGI is modified adjusted gross income. MDS is minimum data set. MOE is maintenance of effort. National Emergencies Act is P.L. 94-412. NF is nursing facility. NP is nurse practitioner. OASIS is Outcome and Assessment Information Set. PA is physician assistant. PASSR is Preadmission Screening and Annual Resident Review. RHC is rural health clinic. SNF is skilled nursing facility. SPA is state plan amendment. Stafford Act is P.L. 93-288, as amended. Stark Act is 42 USC 1395nn.

¹ The summary highlights key features or examples of flexibilities under the disaster-related Medicaid and CHIP flexibilities. It is not meant to be exhaustive.

² Guidance from CMS indicates that COVID-19-related Section 1135 blanket waivers are effective through the end of the emergency declaration but does not reference which emergency declaration (CMS 2020a). However, since Section 1135 flexibilities can only be invoked when both a public health emergency and an emergency under either the Stafford Act or National Emergencies Act have been declared, we assume that blanket waivers will end if either of the declarations is terminated. In general, Section 1135 waivers typically end at the end of the emergency declaration but the Secretary may specify 60-day approval periods, in which case they can be extended for additional 60-day periods up to the end of either of the emergency declarations (CMS 2020b, Polaris 2020).

³ CMS guidance on COVID-19-related state-specific Section 1135 waivers for Medicaid and CHIP indicates that the waivers terminate with the end of the public health emergency (CMS 2020c).

⁴ FAQs issued by CMS on April 13, 2020 indicated that both MOE and continuous coverage requirements are in effect through the end of the month the PHE ends (CMS 2020g). On June 30, CMS clarified that the MOE expires on the last day the calendar quarter in which the PHE ends, and that the continuous coverage requirement expires the last day of the month in which the PHE ends (CMS 2020e).

⁵ To qualify for the 6.2 percentage point increase to the FMAP, states may need to keep this group enrolled until the end of the month in which the PHE ends to comply with the maintenance of effort requirement. However, CMS FAQs state that coverage for this group terminates at the end of the PHE so states are not required to provide this group any coverage after that time even if they keep individuals enrolled to comply with the maintenance of effort requirements (CMS 2020c).

Sources: CMS 2020a, CMS 2020b, CMS 2020c, CMS 2020d, CMS 2020f, and CMS 2020g.

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