

Emergency Medicaid Waivers during the COVID-19 pandemic

Options for states to consider as they build their emergency response

Katherine Wentworth, JD
 Carol Steckel, MPH
 Jeremy Hoffman, JD
 Michael Cook, FSA, MAAA
 Greg J. Herrle, FSA, MAAA



The COVID-19 pandemic has forced states to build emergency action plans for their Medicaid programs at lightning speed. Nearly all have begun with the Section 1135 “blanket waivers” issued by the Centers for Medicare and Medicaid Services (CMS), but as the pandemic lingers, many are seeking additional options. A variety of broader policy and expenditure options are available under emergency 1115 waivers and other federal authorities to support states with accelerated access to emergency assistance for Medicaid recipients and healthcare providers.

These are extraordinary times, not just for the Medicaid program but also the public health system and the economy. The COVID-19 pandemic is placing historic pressures on our healthcare system and coverage programs alike, and Medicaid programs are a key mechanism states are using to address these challenges.

Following President Trump’s declaration that the COVID-19 outbreak in the United States constitutes a national emergency, and Health and Human Services Secretary Alex Azar’s invocation of his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Social Security Act to mitigate the consequences of the COVID-19 pandemic, states were given the ability seek emergency waivers of the normal Medicaid program requirements in order to support their pandemic response efforts.¹

MEDICAID OPTIONS AVAILABLE FOR COVID-19

States can choose some or all of these vehicles to support their unique emergency response needs.

- **1135 waivers** –to assure sufficient healthcare items and services are available to meet the needs of Medicaid recipients
- **Emergency 1115 waivers** – to assist states in enrolling and covering beneficiaries in Medicaid as well as to enable program changes and emergency funding options

While not discussed in this paper, several other emergency authorities may also be useful to states:

- **1915(c) Appendix K** – to accelerate changes to home- and community-based waivers during an emergency
- **Emergency Medicaid and/or CHIP State Plan Amendment (SPA)** – to adjust policies like eligibility, enrollment, benefits, premiums and cost sharing, and/or payments
- Some policy changes are also possible under **existing state plan authority**, only requiring state policy updates, regulatory, or statutory changes, or managed care contract amendments.

In responding to this current crisis, CMS used its Section 1135 authority to issue a set of COVID-19 “blanket waivers” – largely focused on topics such as the temporary waiver of certain program requirements for hospitals and other healthcare facilities, provider enrollment rules, and state Medicaid options for prior authorization, nursing home pre-admission screenings, state fair hearing rules, and reporting requirements.² But states are not limited to the blanket waivers in making their requests. During past emergencies such as natural disasters, as well as within some states’ current COVID-19 requests, additional options have been approved under Section 1135 (see discussion later in this paper).

¹ Centers for Medicare and Medicaid Services. (2017, December 12). 1135 Waivers. Retrieved April 6, 2020, from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers>

² Centers for Medicare and Medicaid Services. (n.d.). Section 1135 Waiver Flexibilities. Retrieved April 6, 2020 from <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html>

As states are experiencing different needs based on local factors like the number of COVID-19 cases and provider capacity in various areas, it may be useful to consider a package of waiver options beyond those available under 1135 authority. For instance, emergency 1115 authority may be needed to waive certain program rules, or more significantly, to enable spending authority for some emergency-related Medicaid program expenses.

Waivers may be requested retroactively to March 1, 2020, under the current emergency declaration.³ In all cases with these emergency waiver and state plan options, the regulatory burdens related to submission criteria and ongoing monitoring and evaluation are reduced from the normal process. Additionally, in some cases, CMS has offered public notice options so that states can more quickly design and gain approval for waiver proposals.

Emergency 1115 funding authorities and program changes

A primary reason that states may want to evaluate emergency 1115 options is to help solve capacity needs and financial challenges currently being experienced by providers. This may be of particular concern for smaller or more Medicaid-focused provider types like long-term services and supports agencies, behavioral health providers, and critical access hospitals. Because most of these providers' revenue comes from Medicaid, they may be less able to withstand this dramatic period of change for their practices. As a result, several states have already submitted or announced their COVID-19 emergency 1115 waivers. It should be noted that none have yet been approved by CMS as of April 1, so it remains to be seen what additional requests CMS will be willing to approve.

The emergency 1115 waiver, in particular, allows states to aggressively and quickly address infrastructure, regional or provider-specific healthcare capacity needs (such as for rural communities or safety net providers), and targeted individual worker support. During federally designated public emergencies, budget neutrality is presumed to be met.⁴ While states should calculate and document expenditures and budget effects, they

are not required to submit a budget neutrality analysis in such requests, aiding in the ability to quickly address a state's needs.⁵

HARDSHIP PAYMENTS TO PROVIDERS

As states grapple with assuring continued access to care, one concern high on the list for many states is the business structure of smaller providers whose financial and staffing situations may not enable them to remain fully equipped to maintain capacity, and in some cases, may even cause them to go out of business. CMS has included several pre-approved options for temporary expenditure authorities for provider hardship payments and enhanced benefits for Long Term Services & Supports (LTSS) (see the COVID-19 1115 waiver template for additional detail⁶).

More extensive payment options may also be permissible (subject to CMS approval) to help other provider types stay open and respond to the current emergency situation. However, CMS has recently clarified that payment must be related to care provided to recipients. In the April 2 update to the COVID-19 frequently asked questions (FAQ) document, CMS noted that states can increase Medicaid payment rates as a way to offset losses to Medicaid providers, but federal financial participation "is not available under the Medicaid state plan to pay providers directly for the time when care is not provided to beneficiaries."⁷ In another example noted in the April 2 FAQ, CMS discussed that it will be left to states to determine whether facilities may continue to receive full payment when a recipient is in a residential setting but unable to receive normal treatment due to quarantine. An emergency state plan amendment may be required if the current state plan does not permit this payment methodology.⁸

As the hardest-hit states seek to borrow nurses and doctors from areas not experiencing a high level of infection, finding ways to maintain the infrastructure and workforce in states where infection rates are currently lower will be critical as protection should their number of cases increase. States may wish to pay particular attention, in building their relief packages, to provider types that might not otherwise be able to withstand the economic changes caused by the emergency.

³ Centers for Medicare and Medicaid Services. (2020, April 3). Coronavirus Waivers & Flexibilities. Retrieved April 6, 2020, from <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>

⁴ Centers for Medicare and Medicaid Services. (n.d.). Using Section 1115 Demonstrations for Disaster Response. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/section-1115-demonstrations/index.html>

⁵ Centers for Medicare and Medicaid Services. (n.d.). Using Section 1115 Demonstrations for Disaster Response. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/section-1115-demonstrations/index.html>

⁶ Centers for Medicare and Medicaid Services. (2020, March 22). SMDL # 20-002 RE: COVID-19 Public Health Emergency Section 1115(a) Opportunity for States. Retrieved April 6, 2020, from <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx>

⁷ Centers for Medicare and Medicaid Services. (2020, April 2). COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf> (see FAQ E.10, E.14, and E.15)

⁸ Centers for Medicare and Medicaid Services. (2020, April 2). COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf> (see FAQ E.22)

EMERGENCY SPENDING THAT MAY HAVE LONGER-TERM BENEFIT

Another option for states to consider is whether to request emergency 1115 spending authority for infrastructure-related payments or authority to cover new services not normally permitted under Medicaid. While relief payments have been made available through several federal options including the recently passed Coronavirus Aid, Relief, and Economic Security (CARES) Act (S. 3548)⁹, not all provider types were included in this package. For telehealth and other infrastructure investments that have the long-term ability to bolster providers' ability to respond to this emergency as well as future ones, states should consider whether a critical provider type could benefit from additional assistance under an emergency 1115 waiver.

Using an emergency 1115 waiver in addition to other funding sources (some through different federal agencies such as the Public Health Service for Federally Qualified Health Centers [FQHCs] and Rural Health Clinics [RHCs]) may provide a state an opportunity to transform its rural healthcare system, especially transportation and linkages to tertiary care hospitals in a way not possible without these resources.

EXPANDING COVERAGE DURING AN EMERGENCY

The recently enacted Families First Coronavirus Response Act (H.R. 6021)¹⁰ outlined options for states to cover COVID-19-related testing and testing-related services (only) for uninsured individuals at a 100% federal financial participation during the emergency period. States also have the option to temporarily expand eligibility for full Medicaid benefits. This can be done broadly under a state plan amendment, but if the state wishes to create a targeted eligibility expansion for individuals affected by the disaster, this can be done under an emergency 1115 waiver. States can also use an emergency 1115 waiver to make temporary adjustments to eligibility verification rules, waive retroactive coverage for applications made under a temporary eligibility period, or put in place 12-month continuous eligibility.

States may also seek emergency 1115 waiver authority to ease the Medicaid enrollment process by designing an expedited application process or permitting hospitals to make presumptive eligibility decisions for demonstration populations.¹¹ These eligibility-related options may also be of interest to states experiencing a spike in Medicaid applications or whose eligibility staffing levels have been affected during the emergency period.

Additionally, states may use emergency 1115 waivers to make temporary program changes to their existing 1115 waivers or otherwise respond to the emergency using their current waiver programs as the vehicle for response. This may be useful when the changes are specific to emergency needs because amending an existing 1115 waiver would otherwise require a state to adhere to all rules regarding public notice and budget neutrality whereas an emergency 1115 waiver can be approved more rapidly.

ENHANCEMENTS TO COVERED SERVICES

Unique circumstances during a public health emergency may cause states to consider temporarily adding new covered services to the benefit package. While some benefit changes would not require 1115 waiver authority, examples that may be useful at this time could include enhanced transportation benefits to enable delivery of services to isolated individuals or coverage of home-based services that must normally be rendered in an office or facility setting. While states can use their normal state plan authority to adjust copays (and federal law now prohibits cost sharing on COVID-19 testing), an emergency 1115 waiver could also be used to reduce or eliminate other recipient cost sharing specific to COVID-19 related treatment.

Likewise, a number of states have been searching for ways that Medicaid can more broadly support – and fund – non-medical services, similar to some supplemental benefits permitted in Medicare Advantage plans. During this current emergency, several states have requested Medicaid authority to cover benefits like food and housing, although CMS has not yet publicly determined if these requests will be granted.¹² For example, North Carolina has requested authority to cover housing-related

⁹ Centers for Medicare and Medicaid Services. (2020, March 28). Trump Administration Provides Financial Relief for Medicare Providers. Retrieved April 6, 2020, from <https://www.cms.gov/newsroom/press-releases/trump-administration-provides-financial-relief-medicare-providers>

¹⁰ Centers for Medicare and Medicaid Services. (n.d.). Families First Coronavirus Response Act – Increased FMAP FAQs. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>

¹¹ States must allow hospitals to make presumptive eligibility determinations for parents and caretaker relatives, children, pregnant women, and former foster care children, adults (in states that have adopted the adult group), individuals eligible for family planning services (if covered by the state), and individuals needing treatment for breast or cervical cancer (if covered by the state). Under current authority, states may choose to allow hospital to make PE determinations for individuals who are age 65 or older, blind, disabled, or medically needy.

¹² Existing authority to cover home-delivered meals and other social supports already exists in very limited situations for Medicaid, such as under home and community-based waiver programs. The current asks under COVID-19 waivers would appear to offer a more extensive benefit across broader population groups.

services for the homeless and healthy meals to families. Deferring its decision on items requiring 1115 waiver or other authority, CMS noted in granting the 1135 waiver approval that it “continues to work on the additional waiver or modification requests that are not currently reflected in the attached approval [per] NC request” and that some of these requests may require different authorities (e.g., an 1115 waiver).¹³

To the extent approved, these requests by North Carolina (and other states) may provide a useful opportunity for policymakers to study the value of Medicaid covering non-medical services related to social determinants of health in the longer term.

ENHANCED FEDERAL FINANCIAL PARTICIPATION

Traditional federal financial participation for Medicaid is available for expenditure authorities approved per an emergency waiver. In addition, the Families First Act has now made available an increased rate of federal financial participation (6.2% above the state’s normal rate) for states that meet certain criteria.¹⁴ Under this new law, states are eligible for temporarily enhanced Medicaid funding so long as they maintain the following through the end of the public health emergency:

- Eligibility standards that are no more restrictive than those in place as of January 1, 2020 (maintenance of effort requirement)
- Recipient premiums (if applied) that are no higher than those in place as of January 1, 2020
- Waiver of all recipient cost sharing for COVID-19 testing, services, and treatments (including vaccines, specialized equipment, and therapies)
- Continue to cover (and not terminate) Medicaid recipients currently enrolled in the program or who become enrolled during the emergency period, other than voluntarily terminations by the recipient or those who move out of state (continuous coverage requirement)

EXPENDITURE CONSIDERATIONS

As previously indicated, budget neutrality is presumed to be met for emergency 1115 waivers. Traditional 1115 waivers require significant effort regarding establishing baseline expenditures as well as expenditure projections with and without the 1115 waiver payments and other provisions, and projections of budget neutrality are required in order for the waiver to be approved.

Presuming the budget neutrality requirements are met under an emergency waiver will save significant preparation and approval time and effort as well as allow states more flexibility to design their relief packages. It should be noted, however, that while there will not be a penalty if an emergency 1115 waiver does not actually turn out to be budget neutral, retrospective evaluations of costs and waiver goals must be completed (on a consolidated basis).¹⁵

Each expenditure introduced under an emergency 1115 waiver should be structured in a manner that best matches its goal. For example, targeted improvements to provider infrastructure or training may be best achieved through a fixed payment structure. On the other hand, cash flow assistance for providers realizing significant utilization decreases in non-urgent services may be better structured as a function of employee count or percent of historical revenue.

In examining all options, states will need to keep a critical eye on expenditure levels as they evaluate how to use newly available funds or repurpose existing funds and programs to meet these new needs.

A broader look at 1135 options

States considering an emergency 1115 waiver have generally pursued an 1135 waiver as well. As of April 3, nearly all states have received approval for 1135 waivers as a first wave of emergency assistance (with more being approved at a rapid pace).¹⁶ CMS has aided quicker submission and approval of these requests by publishing a COVID-19-specific 1135 template that includes a list of “blanket waivers” which do not require individualized approval.

While many states have focused on these blanket waivers offered by CMS, a variety of other 1135 options are available and have been successfully used by states during past emergency declaration periods. However, currently some of these non-blanket waiver ideas may take longer to obtain approval. CMS is working to approve 1135 requests, but has included standard language in its approvals thus far, that it “continues to work on the additional waiver or modification requests that are not currently reflected in the attached approval.”¹⁷

¹³ North Carolina Department of Health and Human Services. (2020, March 17). 5. Retrieved April 6, 2020, from <https://files.nc.gov/ncdma/covid-19/NCMedicaid-COVID19-CMS-1135-Flexibilities-20200317.pdf>; Centers for Medicare and Medicaid Services. (2020, March 23). Section 1135 Waiver Flexibilities - North Carolina Coronavirus Disease 2019. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry/54036>

¹⁴ Centers for Medicare and Medicaid Services. (n.d.). Families First Coronavirus Response Act – Increased FMAP FAQs. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>

¹⁵ One year after the end of the demonstration, states will be required to produce an evaluation report showing demonstration implementation data, lessons learned, and best practices that can be applied to future emergency situations.

¹⁶ Current 1135 approvals to date can be found here: <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/index.html>

¹⁷ Centers for Medicare and Medicaid Services. (2020, April 1). Section 1135 Waiver Flexibilities - Georgia Coronavirus Disease 2019. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/88951>

In general, 1135 waiver purposes tend to fall into one of three categories: (1) growing capacity of providers, (2) expanding access to services, or (3) easing administrative burdens. These waivers work together to focus on serving more individuals, in an efficient and timely manner, and without the administrative burdens that often limit a provider's capacity or slow the expansion of the provider network during extraordinary times.

Looking at 1135 approvals from past healthcare emergencies as a guide, additional waiver options may include, but are not limited to:

- Temporary suspension of CMS administrative activities and procedures
- Loosened or waived prior authorization requirements
- Suspension of certain screening and enrollment procedures for providers (including use of unlicensed facilities)
- Increased access (through removal of bed limitations, etc.) on Critical Access Hospitals and skilled nursing facilities
- Waiver of CMS requirements for rehab facilities
- Temporary waivers of notice requirements related to the emergency

These options, as well as a variety of other 1135 requests, have been used by states as a complement to mechanisms like enhanced provider payments in order to address past public health emergencies. For example, following Hurricane Florence in 2018, South Carolina requested, and CMS approved, several waivers under the 1135 authority that included temporary waivers for quality reporting, flexibilities for alternative treatment facilities, and allowing out-of-state providers to practice in South Carolina.¹⁸

Capitation rate adjustments

During public health emergencies, providers may be required to perform beyond the scope of their usual and customary services. In states that have Medicaid managed care, these changes can also affect for managed care organizations (MCOs). While the Families First Act requires most insurers to cover COVID-19 tests, there has not been a requirement thus far for insurers to cover treatments or procedures related to the virus.

While services related to COVID-19 may result in material utilization and cost increases, other non-emergency and elective procedures are in most cases being placed on hold or cancelled altogether as a result of social distancing mandates as well as increased demand to address the current emergency situation. At

the same time, reduced eligibility redetermination and increases in unemployment are factors that may be likely to increase Medicaid rolls with individuals of lower acuity than assumed in capitation rate development.

This fluctuation in the services performed may significantly affect the medical loss ratio and profitability of MCOs. For example, the largest independent physician group in Massachusetts has reported a 75% decrease in utilization since mid-March.¹⁹ Many facilities are reporting that they are furloughing staff due to these types of reductions. These effects are likely to vary substantially by managed care population (elderly and at-risk populations are more likely to have higher net costs, while child populations have a greater chance of experiencing decreased net costs).

Examples of approaches states are considering to help protect the integrity of their managed care contracts and capitation rates include:

- **Minimum medical loss ratio.** Many states require existing remittances to the extent an MCO's medical loss ratio is below the contractual minimum percentage. While this provides a level of financial protection to a state in the event COVID-19 results in lower net costs to the Medicaid program, it does not protect MCO financial results if net costs are higher.
- **Risk corridor.** A risk corridor arrangement would allow for retrospective payments or recoupments in the event that program financial results vary significantly from those expected during rate development. Risk corridors provide two-sided financial risk mitigation, often with tighter limits than minimum medical loss ratios. Such mechanisms are relatively common in managed care programs where there is significant cost uncertainty (such as the first year of coverage for the Affordable Care Act expansion population).
- **Mandated sub-capitation payments.** Some states are considering requiring MCOs make sub-capitation payments based on historical payments for certain providers or hospitals that are realizing revenue strain because of the emergency. Sub-capitated payments could also be retrospectively cost settled against actual services rendered. However, such arrangements may be administratively difficult to calculate and administer, and arrangements that are not cost settled would require the completion and approval of a directed payment preprint.

An evaluation of a state's current managed care program structure and expected financial outcomes can help inform which of the above options might present the best risk mitigation strategy.

¹⁸ Centers for Medicare and Medicaid Services. (2018, September 17). CMS Response to South Carolina's Hurricane Florence Waiver Requests. Retrieved April 6, 2020, from <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry/49380>

¹⁹ Bebinger, M. (2020, April 2). COVID-19 Hits Some Health Care Workers With Pay Cuts And Layoffs. NPR. Retrieved April 6, 2020, from <https://www.npr.org/sections/health-shots/2020/04/02/826232423/covid-19-hits-some-health-care-workers-with-pay-cuts-and-layoffs>

Building a waiver package tailored for local needs

While many states have chosen to exercise the full set of “blanket waivers” under Section 1135 during the COVID-19 crisis, decisions regarding whether to request additional options – be they spending authority requests or program changes under an emergency 1115 waiver, or other options like a 1915(c) Appendix K, State Plan Amendment, or a combination thereof – must be individualized for a given state.

States should consider the unique needs of their most at-risk recipient groups and provider types in order to build a package of COVID-19 Medicaid waiver requests that will best serve their particular local situation. Consideration of the state’s budget restrictions, impacts on managed care capitation rates/contracts (if applicable), and ability to maximize all forms of funding will also be important in developing the right approach, both to support the immediate emergency response as well as any investments to improve the healthcare provider system’s ability to serve their communities no matter what emergencies arise in the long term.



Milliman is among the world’s largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Katherine Wentworth
katherine.wentworth@milliman.com

Carol Steckel
carol.steckel@milliman.com

Jeremy Hoffman
jeremy.hoffman@milliman.com

Michael Cook
michael.cook@milliman.com

Greg Herrle
gregory.j.herrle@milliman.com