

## Tools States Have Used to Address the COVID-19 Public Health Emergency

See the [NACHC Blog](#) for an accompanying Guest Post by Susannah Vance Gopalan, Esq., Partner at [Feldesman Tucker Leifer Fidell LLP](#) in Washington, DC.

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### Section 1135 waivers

Under Section 1135 of the Social Security Act, the Secretary of Health and Human Services (HHS) can waive requirements relating to Medicare, Medicaid, and CHIP during an emergency so as (1) to ensure that services are available to meet the needs of beneficiaries; and (2) to empower health care providers to provide care in good faith to the maximum possible extent during the emergency.<sup>1</sup>

The law lists eight types of federal requirements that HHS may waive—among them, requirements relating to provider conditions of participation or certification; pre-approval requirements (such as pre-admission screening in nursing homes); and requirements that health care professionals be enrolled and licensed in the state where they are providing care.<sup>2</sup>

Section 1135 waivers apply “in an emergency area and during an emergency period.” The “emergency period” is generally defined as any period when there is in effect *both* a declaration of a public health emergency, and a declaration of a national emergency. Approved waivers may be retroactive to the beginning of the emergency period (in the case of COVID-19, March 1, 2020).<sup>3</sup>

Section 1135 waivers include both “blanket” (affecting an entire health care program) and individual (provider-by-provider) waivers.<sup>4</sup> HHS has issued wide-ranging blanket waivers relating to the Medicare program during the COVID-19 emergency, and HHS has also approved Section 1135 waivers relating to the Medicaid program—for 45 states, as of April 3, 2020.<sup>5</sup>

Since the purpose of Medicaid Section 1135 waivers is essentially to temporarily lift rules that could keep providers from quickly attending to patients in an emergency, Medicaid Section 1135 waivers for the most part do not relate directly to provider payment methodologies. **The chief aspect of the so-far approved 1135 waivers of interest to health centers may be the flexibilities included in many waivers relating to provider enrollment and use of providers licensed in another state. This could be especially useful to FQHCs seeking to serve patients across state borders during the crisis.**

### Emergency state plan amendments

CMS has created a discrete State Plan Amendment (SPA) template allowing states to “establish time-limited changes to their state plan to address access and coverage issues during the COVID-19 national emergency.”<sup>6</sup> CMS invited states to

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<sup>1</sup> Social Security Act § 1135(a).

<sup>2</sup> Social Security Act § 1135(b).

<sup>3</sup> Social Security Act § 1135(a), (c), (e), (g).

<sup>4</sup> CMS, [1135 Waiver at a Glance](#).

<sup>5</sup> Kaiser Family Foundation, [Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19](#) (Apr. 3, 2020).

<sup>6</sup> CMS, [Medicaid Disaster Relief for the COVID-19 National Emergency, State Plan Amendment Instructions](#). There is a link between emergency SPAs and 1135 waivers, in that CMS has offered to waive the regulatory SPA submission requirements through an 1135 waiver, so that state plan

make wide-ranging time-limited changes to their plans—for example, relating to eligibility and enrollment, premiums and cost-sharing, covered benefits, and provider payments.<sup>7</sup>

We believe the emergency SPA will be an important tool for States to support FQHCs' continuity of operations. For example, states could use state plan authority to change provider payment methodologies in order to:

- provide for advance payments on an interim basis for a class of providers;<sup>8</sup>
- for FQHCs, provide for a temporary alternative payment methodology (APM) under Section 1902(bb)(6) of the Social Security Act, for example, to use a capitated (per-member-per month) rather than encounter-based payment methodology;
- for FQHCs, implement State plan changes aimed at accelerating full payment for services rendered under managed care—for example, accelerating the state plan schedule for managed care supplemental payments under Section 1902(bb)(5); or implementing, through an APM, a “delegated wrap” arrangement, under which the managed care organization (MCO) would assume contractual responsibility for MCOs' full cost-related rate on a temporary basis.<sup>9</sup>

Note: Any change to provider payment in an emergency SPA is subject to the same provider payment rules that CMS would otherwise use to evaluate state plan material. The methodologies presented here can also be implemented under regular, non-emergency Medicaid state plan authority. In implementing them, a state would need to make public notice of any proposed change and otherwise adhere to regular state plan effective date guidelines.

### Section 1115 demonstrations

Section 1115(a) of the Social Security Act authorizes the Secretary of HHS to waive state plan requirements in Section 1902, or to authorize federal expenditures (i.e., federal match) other than as explicitly allowed under Section 1903, provided that the demonstration project promotes the objectives of the Medicaid program and serves a valid experimental purpose.

Recent CMS guidance allows states to apply for a new Section 1115 demonstration or expand an existing demonstration on a temporary, emergency basis.<sup>10</sup> CMS' goal in issuing the emergency 1115 application template was enable states “to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.”<sup>11</sup>

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amendments may be retroactive to January 1, 2020 even if submitted after March 31, 2020. This means that the provisions of emergency state plan amendments relating to provider payment may receive quicker review and apply more retroactively than would otherwise be the case.

<sup>7</sup> Id. The recent COVID-19 legislation also authorized states to add an optional new eligibility group, comprised only of uninsured individuals, for whom medical assistance is limited to COVID-19 testing (with a 100% federal match). FFCRA § 6004(a)(3)(C), as amended by CARES § 3716.

<sup>8</sup> See CMS, [COVID-19 Frequently Asked Questions for State Medicaid and CHIP Agencies](#) (last updated Apr. 2, 2020), p. 16. Such advance payments would be subject to reconciliation.

<sup>9</sup> [State Health Official Letter No. 16-006](#) (Apr. 26, 2016), re: FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care. Such an approach would also likely require a state to amend its managed care contracts and potentially, to conduct retrospective adjustments to plans' capitation rates.

<sup>10</sup> State Medicaid Director Letter #20-002 (COVID-19 Public Health Emergency Section 1115(a) Opportunity for States), Mar. 22, 2020. CMS explained that the Section 1115(a) demonstration would expire no later than 60 days after the end of the public health emergency.

<sup>11</sup> State Medicaid Director Letter #20-002 (COVID-19 Public Health Emergency Section 1115(a) Opportunity for States), Mar. 22, 2020.

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To ease the 1115 application and approval process, CMS chose to waive the statutory notice requirements and HHS budget neutrality requirements that Section 1115 demonstration applications otherwise must meet.

An emergency 1115 demonstration could be used in various ways to facilitate additional provider payments. As one example, while we have not yet seen such a measure approved, states could seek on an emergency basis for HHS to authorize, as an expenditure authority, lump-sum supplemental provider payments that otherwise would not be permitted under Medicaid.<sup>12</sup> Post the emergency states retain the ability to facilitate additional provider payments but must make public notice in accordance with the existing statutory requirements and meet requirements surrounding budget neutrality.

### Managed care contract amendments

A State could make emergency amendments to its managed care contracts with the goal of facilitating continuity of operations for FQHCs participating in MCOs' networks. While in general, states are not allowed to direct managed care plans' methods of paying providers, the regulations now allow various exceptions. For example, the state could amend the contract to require the plans to implement "value-based purchasing models," in the form of capitated payments or other similar arrangements, in their provider agreements with FQHCs; or require the plans to provide for a dollar or percentage increase to their normal payments to FQHCs.<sup>13</sup> However, MCO payments enhanced under either of these mechanisms would likely ultimately be subject to reconciliation through the cost-related payment methodology for FQHCs under the State plan (described in Section 1902(bb)(5) of the Act), unless that methodology were also altered through an APM. The requirement to reconcile managed care payment to PPS or the APM continues after the emergency ends. States retain the ability to make supplemental payment in the form of a state directed payment after the emergency ends.

### State regulatory changes

States are free to amend their own regulations to respond to emergency conditions, so long as no amendment to the federally-approved state plan or waiver of federal requirements is required. For example, several states have recently issued emergency regulations liberalizing rules on Medicaid telehealth (including those impacting FQHCs) for the duration of the COVID-19 period, or otherwise broadening the definition of a billable "visit." Note that states have more discretion to relax their rules without seeking federal approval if specific features of provider payment (for example, the FQHC billable "visit" definition) are included only in state regulation or guidance, rather than in the State plan. If the definition is included in the State plan, then an emergency SPA would be needed in order to make changes for the duration of the COVID-19 emergency.

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<sup>12</sup> See id. (p. 5 of application template).

<sup>13</sup> 42 C.F.R. § 438.6(c)(1)(i), 438.6(c)(1)(iii)(B). Note that such amendments to MCO contracts typically require CMS regional office approval and if they involved the delegation of additional payment responsibility to plans, could also require retrospective adjustment of capitation rates.