



# Medicaid and Due Process During the COVID-19 Pandemic<sup>1</sup>

Sarah Somers

The federal government has used a variety of authorities to allow states flexibility in operating their Medicaid programs during the national and public health emergency triggered by the COVID-19 pandemic. Its primary tools are waivers and State Plan Amendments (SPAs) under section 1135, Section 1115 waivers, and Appendix K to 1915(c) waivers to relieve states from various obligations and grant them the ability to expand eligibility and service. This issue brief describes potential consequences for due process rights from these authorities and the pandemic in general. It also makes recommendations for monitoring developments in this area and protection of due process rights.

## Federal Authorities in Play During the Pandemic<sup>2</sup>

### Section 1135 Emergency Waivers

Section 1135 of the Social Security Act allows the Secretary of Health and Human Services to waive or modify certain Medicaid, Medicare, and CHIP requirements to ensure that sufficient health care items and providers are available when a national disaster and public health emergency occur simultaneously.<sup>3</sup> Typical waivers or modifications granted by HHS under this authority include changes to:

<sup>1</sup>This Issue Brief was prepared through a contact with the Training and Advocacy Support Center (TASX), which is sponsored by the Administration on Disabilities (AoD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Rehabilitation Services Administration (RSA), and the Social Security Administration (SSA). TASC is a division of the National Disability Rights Network (NDRN).

<sup>2</sup> For additional discussion of Medicaid and COVID-19, see Leo Cuello, National Health Law Program, *Overview on Using Medicaid to Respond to COVID-19*, March 18, 2020, [file:///C:/Users/Sarah/Downloads/Overview-on-Using-Medicaid-to-Respond-to-COVID-19\\_Leo-Cuello.pdf](file:///C:/Users/Sarah/Downloads/Overview-on-Using-Medicaid-to-Respond-to-COVID-19_Leo-Cuello.pdf).

<sup>3</sup> 42 U.S.C. § 1320b-5. The Act provides for waivers when a president declares a disaster or emergency pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and the HHS Secretary declares a public health emergency pursuant to section 319 of the Public Service Act. 42 U.S.C. § 1320b-5(a), (g)(1).

- Conditions of participation or other certification requirements for providers,
- Program participation and similar requirements,
- Service preapproval requirements,
- Certain licensure requirements,
- Emergency Medical Treatment and Active Labor Act (EMTALA) restrictions,
- Rules to allow placement of hospital patients or institutional residents in unlicensed “alternative facilities” in case of emergencies.<sup>4</sup>

By definition, the Secretary may only grant these flexibilities under official emergencies and the waivers are limited to the emergency’s duration. States can amend existing Section 1135 waivers to request additional authorities and/or submit additional Section 1135 waiver requests.<sup>5</sup>

### Section 1135 Waivers and SPAs

The Secretary may only grant these flexibilities when there is both a national and public emergency. They are limited to the emergency’s duration.

CMS has provided a checklist for states that includes possible options for Section 1135 waivers. Among these are nearly immediate exhaustion of internal managed care plan hearings and providing extended time periods to request state hearings when an adverse determination occurs during the emergency period.<sup>6</sup>

### Section 1115 Experimental Waivers

Section 1115 of the Social Security Act gives the HHS Secretary authority to waive certain Medicaid requirements to approve “experimental, pilot, or demonstration projects . . . likely to assist in promoting the objectives” of the Medicaid Act.<sup>7</sup> The Secretary may only waive requirements contained in 42 U.S.C. § 1396a, which describe the elements of a state Medicaid plan.<sup>8</sup> Over the years, these waivers have been used for a variety of experiments, including operating managed care programs, authorizing enhanced cost sharing, and expanding coverage to non-disabled adults—all of which were eventually authorized in some form by Congress in the Medicaid Act. More recently, CMS has attempted to condition Medicaid coverage on work requirements for certain beneficiaries, actions which courts have held to be

<sup>4</sup> Ctrs. for Medicare & Medicaid Servs., *1135 Waivers*, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers> (last visited Apr. 3, 2020) (CMS, *1135 Waivers*).

<sup>5</sup> CMS, *Section 1135 Waivers*, *supra* n. 4.

<sup>6</sup> Ctrs. for Medicare & Medicaid Servs., *Section 1135 Waiver Flexibilities: CMS 1135 Waivers*, <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html> (last visited March 31, 2020) (CMS, *Section 1135 Waiver Flexibilities*).

<sup>7</sup> 42 U.S.C. § 1315(a), see also Ctrs. for Medicare & Medicaid Servs., *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>.

<sup>8</sup> *Id.* § 1315(a)(1).

unlawful.<sup>9</sup> Typically, these waivers are approved for 3-5 year periods during which the experiment is to be conducted, assessed, and reported on. There are statutory requirements for public hearings and notice and comment at the state and federal levels before a Section 1115 waiver can be approved.<sup>10</sup>

## Appendix K

States may use Appendix K during emergency situations to amend an existing 1915(c) waiver.<sup>11</sup> The application provides for states to request amendments modifying:

- access and eligibility (e.g., level of care criteria),
- scope and type of services,
- rules governing payment for services by family caregivers,
- modify provider qualifications and types,
- modify processes for level of care evaluations,
- increase payment rates,
- modify person-centered plan development,
- incident reporting requirements or other participant safeguards,
- payments for supporting waiver participants in acute care hospital or short-term institutional stays,
- expand opportunity for self direction, or
- other necessary changes.<sup>12</sup>

As of April 10, CMS has granted permission for 24 states to use Appendix K.<sup>13</sup>

---

<sup>9</sup> See, e.g., *Gresham v. Azar*, 950 F. 3d 93 (D.C. Cir. 2020).

<sup>10</sup> 42 U.S.C. § 1315(a), (d); 42 C.F.R. § 431.408; see also Ctrs. for Medicare & Medicaid Servs., 1115 Transparency Requirements, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-transparency-requirements/index.html> (last visited Apr. 1, 2020).

<sup>11</sup> For summary and discussion of how states are using Appendix K, see Elizabeth Edwards, National Health Law Program, *COVID-19 Changes to HCBS Using Appendix K: Approval Trends* (March 30, 2020).

<sup>12</sup> Ctrs. for Medicare & Medicaid Servs., *Appendix K: Emergency Preparedness and Response*, <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-template.pdf> (template) (last visited Apr. 3, 2020); Ctrs. for Medicare & Medicaid Servs., *1919(c) Home and Community-Based Services Waiver Instructions and Technical Guidance Appendix K: Emergency Preparedness and Response* <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf> (technical guidance) ) (last visited Apr. 3, 2020).

<sup>13</sup> Ctrs. for Medicare & Medicaid Servs., *Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers*, <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html> (last visited Apr. 10, 2020).

## State Plan Amendments

Each state must have a comprehensive, written plan approved by CMS that governs the structure and operation of its Medicaid plan.<sup>14</sup> The state plan must be amended to reflect changes in federal law or material changes to state policy, organization, or operation of the program.<sup>15</sup> CMS has provided instructions and a template for states to use when requesting Section 1135 State Plan Amendments (SPAs) which provides for additional options, such as expanding eligibility and coverage of services.<sup>16</sup> The SPA template includes options to expand covered population groups and presumptive eligibility, change redetermination and residency requirements, and suspend premiums and cost sharing.<sup>17</sup> As of April 3, CMS has approved SPAs for Washington and Arizona.<sup>18</sup>

## Due Process and the Pandemic

**Section 1135.** States have used this section to make many of the changes recommended by CMS in its template application, described above. In addition, CMS granted permission to numerous states to suspend the Pre-Admission Screening and Resident Review (PASSR) Levels I and II assessments for 30 days and to allow reimbursement for services rendered in an unlicensed facility, in the event of an evacuation or similar event.

As of April 10, CMS has approved section 1135 waivers to 48 states and most have made changes to their fair hearing systems.<sup>19</sup> Many states were granted permission to make two important changes. The first change concerns exhaustion of internal plan hearings. Millions of Medicaid beneficiaries are enrolled in managed care plans.<sup>20</sup> Regulations require that beneficiaries appealing adverse determinations by the managed care plan exhaust an internal plan hearing.<sup>21</sup> CMS gave most of the states applying for 1135 waivers permission to allow managed care enrollees to skip the internal managed care plan appeal and go directly to a fair hearing. The second change extends deadlines for appealing adverse actions affecting

---

<sup>14</sup> 42 U.S.C. § 1396a (listing requirements of a state plan).

<sup>15</sup> 42 C.F.R. § 205.5; see also, e.g., *Concourse Rehab. & Nursing Ctr., Inc. v. DeBuono*, 179 F.3d 38, 46 (2d Cir. 1999).

<sup>16</sup> Ctrs. for Medicare & Medicaid Servs., *Section 1135 Waivers*, *supra* n. 4; Ctrs. for Medicare & Medicaid Servs., *Medicaid Disaster Relief for the COVID-19 National Emergency State Plan Amendment Instructions*, <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-instructions.pdf> (CMS SPA Instructions) and Template, <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/state-plan-flexibilities/index.html> (CMS SPA Template) (last visited March 31, 2020).

<sup>17</sup> CMS SPA Template, *supra*, n. 17.

<sup>18</sup> Ctrs. for Medicare & Medicaid Servs., *Medicaid State Plan Amendments*, <https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html> (last visited Apr. 1, 2020).

<sup>19</sup> Gardner, *Approved 1135 Waivers and SPAs*; CMS, *Federal Disaster Resources*, *supra* n. 4.

<sup>20</sup> Ctrs. for Medicare & Medicaid Servs., 2017 Managed Care Enrollment Survey, <https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-Summary/uw3d-3r25> (last visited April 10, 2020).

<sup>21</sup> 42 C.F.R. § 438.402(c).

eligibility or service coverage. Federal regulations provide that state agencies must provide applicants and enrollees at least 90 days to request a hearing for denial of eligibility or, in a fee-for-service system, coverage of services.<sup>22</sup> In a managed care system, where exhaustion is required, enrollees have 120 days from the original action to request a state hearing for adverse actions related to services.<sup>23</sup> Through the 1135 waivers, CMS has authorized most states to provide additional 120 days for managed care enrollees and an additional 90 days for fee-for-service enrollees.<sup>24</sup>

CMS has also granted additional flexibilities with regard to due process rights. States are

### Delays in Scheduling Hearings

The federal agency has so far granted two states – Washington and Florida – permission to delay scheduling hearings and issuing hearing decisions. All states have the ability to grant themselves extensions of the deadline for issuing final hearing decisions.

required to provide at least a 10 day notice before taking an adverse action, such as denial or termination of services or eligibility.<sup>25</sup> CMS granted Washington and Florida permission to suspend adverse actions for individuals for whom a determination has been made but the state has either not sent the notice or the state determines it is likely the individual has not received the notice. CMS also granted both states permission to delay scheduling hearings and issuing decisions. To mitigate

potential problems for beneficiaries, the state Medicaid agency is required to document the reason for the delay in the record and prioritize hearing requests for the beneficiaries most likely to be impacted. The state is also authorized to continue benefits even if an appeal was not filed within the time frame set forth in 42 C.F.R. § 431.230.<sup>26</sup>

**Section 1115.** A number of states, including Arizona, Arkansas, Georgia, Illinois, Iowa, Rhode Island, and Washington, have requested Section 1115 waivers. In their applications, they have requested permission for numerous waivers, including comparability, amount duration and scope, and free choice of provider. They also requested permission for different types of enhanced payments for a variety of providers, and payments for temporary housing and meal delivery.<sup>27</sup> As of April 1, none had yet been granted.

<sup>22</sup> 42 C.F.R. § 431.221(d).

<sup>23</sup> 42 C.F.R. § 438.408(f)(2).

<sup>24</sup> See Gardner, *Approved 1135 Waivers and SPAs*, CMS, *Federal Disaster Resources*, *supra* n. 4.

<sup>25</sup> 42 C.F.R. § 431.211.

<sup>26</sup> See Ctrs. for Medicare & Medicaid Servs., *Section 1135 Waiver Flexibilities – Florida Coronavirus Disease 2019*, <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry/53995> (last visited Apr. 3, 2020); Ctrs. for Medicare & Medicaid Servs., *Section 1135 Waiver Flexibilities – Washington Coronavirus Disease 2019*, <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry/54022> (last visited Apr. 3, 2020)

<sup>27</sup> Georgia, Dep’t of Comm. Health, *COVID-19 Section 1115(a) Demonstration Application Template*, file:///C:/Users/Sarah/Downloads/2020-03-28%20State%20of%20Georgia%20COVID-

## Isolated adverse actions

Outside of the context of the emergency authorities discussed above, given that states are facing or anticipating crisis situations, Medicaid agencies or managed care organizations may take actions that deny or reduce services without providing notice or opportunity for a hearing. State agencies and providers are naturally concerned about mitigating the risk of spreading COVID-19 in facilities as well as in home and community settings. Yet, advocates will need to be vigilant to ensure that agencies or plans do not needlessly terminate home based services without ensuring that appropriate alternatives are available.

A recent example from Michigan illustrates. There, the sole behavioral health provider sent a general notice to all enrollees announcing suspension of “all but critical services” including outpatient therapy, infant mental health, homebased therapy, psychiatric evaluations, ABA therapy, occupational therapy, Community Living Supports, and respite.<sup>28</sup> Neither the managed care plan for the county nor the state agency provided no written notice to individual beneficiaries but cut a variety of services for many enrollees. The provider took this action in response to the federal government’s March 16 recommendation of a 15 day self-quarantine. The state, meanwhile had not ordered such drastic action but rather instructed plans that restrictions employed to manage the public health emergency “do not provide blanket permission to eliminate or reduce services.”<sup>29</sup>

Advocates from Michigan Protection and Advocacy Services pressed the state agency to clarify their policy and emphasize that services should not be terminated and filed for individual hearing for two clients. The internal managed care plan appeal resulted in overturning the decisions. Advocates continue to press the state to prevent similar situations and monitor for additional threats to service coverage.<sup>30</sup>

## Conclusions and Advocacy Tips

---

[1\\_1115\(a\)%20Waiver\\_Final.pdf](#); Ill. Dep’t of Healthcare and Fam. Servs., *Illinois COVID-19 Section 1115(a) Demonstration Application* (March. 26, 2020); <https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/1115DemonstrationWaiverHome.aspx>; Rhode Island Exec. Off. Of Health and Hum. Resources, *COVID-19 Section 1115(a) Demonstration Application Template*, [http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/11152nd%201115%20Waiver\\_3.27.20%20for%20web.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/11152nd%201115%20Waiver_3.27.20%20for%20web.pdf). Other section 1115 applications on file with NHeLP.

<sup>28</sup> Letter from Kerry Possehn, CEO, The Right Door, to “Persons Served” (March 19, 2020) (on file with author).

<sup>29</sup> Memo from State of Mich. Dep’t of Health and Human Servs. to Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) re: Service and Setting Concerns (Mar. 20, 2020) (on file with author).

<sup>30</sup> Discussion with Kyle Williams, Michigan Protection and Advocacy Services; see also Mich. Behav. Health and Devel. Disabilities Admin., “Clinical Guidance for Mich. Dept. of Health & Human Servs. for Community Based Mental Health Services, Substance Use Services and their Providers Practicing in Clinical Settings and Delivering Home Based Servs. (March 22, 2020) (on file with author). Administrative Hearing Decisions available from author.

The COVID-19 public health emergency creates obvious risks for Medicaid beneficiaries' due process rights. These risks arise both from the waivers and other flexibilities that CMS has granted states as well the overall crisis caused by a deadly infectious disease and the imperative to ensure that the disease does not spread further and infect vulnerable patients or health care providers. Advocates should take the following steps:

- In states that have been given permission to delay fair hearings, the Section 1135 waivers require them to prioritize hearing requests that are the most exigent, including those by individuals who are denied eligibility or initial service coverage and for those placed at risk of illness or institutionalization without services. Advocates should closely monitor the situation. While, to date, only Washington and Florida have approved Section 1135 waivers allowing them to do this, other states may already have or might in the future request this permission. And, current federal regulations allow states to grant themselves extensions to the deadline for issuing hearing decisions under "unusual circumstances" like emergencies beyond the agency's control.<sup>31</sup> If a state exercises this option, advocates should press for the same transparency and prioritization required under the Section 1135 waivers.
- It is important to note that, for individuals who have had services terminated or reduced but are receiving those services pending an appeal decision, the agency or managed care plan can pursue them for the costs of services pending the appeal.<sup>32</sup> Therefore, advocates should press their state agency to agree not to pursue the beneficiary for services covered while a hearing is delayed, and to instruct managed care plans not to do so. In states that have not received explicit permission to delay hearings, advocates also should monitor for unusual delays. Advocates can also work with their state agencies to develop alternative processes to protect beneficiaries' due process rights such as automatic grants of continued benefits, virtual hearings, or automatic extension of long term care services if an authorization period expires during the emergency.
- Advocates should watch for across the board cuts to home and community based services by providers or managed care plans, fight them when appropriate, or press for individualized determinations of whether a telehealth or other virtual option can substitute or whether an in person service is necessary to prevent illness or institutionalization. Many states have already issued guidance about how to safely provide services to beneficiaries in their homes and when telehealth or other communication methods can substitute for in person services and instructed plans to make individualized determinations of whether services must continue or be substituted.<sup>33</sup>

---

<sup>31</sup> 42 C.F.R. § 431.244(f)(4).

<sup>32</sup> 42 C.F.R. §§ 431.230(b); 438.420.

<sup>33</sup> See, e.g. Memorandum from Mich. Dep't of H.H.S., *supra* n. 29; see also Cal. Dep't of Health Care Servs., Behavioral Information Notice No. 20-009 (March 14, 2020), <https://www.dhcs.ca.gov/Documents/Covid-19-BHIN-20-009.pdf>.

- Medicaid beneficiaries are not entitled to a hearing when the sole issue is a federal or state law or policy requiring an automatic change adversely affecting them, unless there is a valid factual dispute about their eligibility for coverage.<sup>34</sup> As noted above, a number of states have requested permission to waive comparability or other important provisions impacting coverage of services in Section 1115 waivers. Advocates should work with the agency to ensure that beneficiaries receive required notice, will there be proper notice and will there be a process for requesting a hearing if they believe there is a valid argument that they may qualify for alternative services.
- In states that have been given permission to transfer patients or residents of ICF-DDs into “alternative facilities,” it is likely that no hearing rights will be given and perhaps not even notice if the state agency or facility decides the situation is sufficiently urgent. Advocates should press the state agency to publicize and, if they have not, create written protocols for such transfers that include notice to patients and their authorized representatives when such a transfer may occur.
- In states that have temporarily extended coverage to additional people or increased coverage of services, beneficiaries should receive clear notice that eligibility or services will be terminated at a specific date in a manner that is understandable to the beneficiary. Advocates should engage with their state Medicaid agencies and urge them to provide notice before terminating services and not only when extended eligibility or temporary services are initiated.
- Advocates should reach out to providers, community based organizations, and groups that have a membership of or serve Medicaid beneficiaries to monitor for problems in all of these areas.

---

<sup>34</sup> 42 C.F.R. § 431.220(b); *Davis v. Shah*, 821 F.3d 231, 253 (2d Cir. 2016); *Rosen v. Goetz*, 410 F.3d 818, 926 (6th Cir. 2005).

