Top Ten List: Transitions in the Medicaid Program in Light of COVID-19

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During the emergency triggered by the COVID-19 pandemic, the federal government has offered states flexibilities to ensure that people receive the Medicaid services they need. Many of these changes can be preserved even after the emergency ends. Here are ten actions that advocates can take to minimize harm and preserve benefits during and after the COVID-19 emergency.

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1. **Monitor your state's use of federal authorities to make changes to their Medicaid programs:** When the Secretary of the Department of Health and Human Services (HHS) declared a Public Health Emergency (PHE), this opened the door for states to request permission to make temporary changes to their Medicaid programs. These authorities are Section 1135 of the Social Security Act (SSA), which allows states to modify certain Medicaid requirements through waivers or State Plan Amendments (SPAs) during an emergency and Appendix K to Section 1915(c), which allows states to amend these waivers during emergencies. States also have access to Section 1115 of the SSA, which allows waivers for experimental purposes.[1] As their first steps, advocates should monitor their state's use of these authorities, identify areas where reversion to the status quo could cause problems for beneficiaries, and determine whether the state has flexibility to keep the change in place even after the emergency ends.[2]

2. **Monitor Appendix K transition plans:** Unlike other emergency authorities, the state's Appendix K waiver must include a transition plan for protecting beneficiaries against harm when the waiver ends. Although compliance with fair hearing rights is to be specifically addressed, many (if not all) of the states fail to mention due process rights when this transition occurs.[3] Advocates should check whether their state has submitted an Appendix K and read the description of the planned transition.[4] If it does not mention fair hearing rights when services revert to lower pre-pandemic levels, press your state to commit in writing to providing those rights.

3. **Protect expansions of eligibility:** The Centers for Medicare & Medicaid Services at HHS (CMS) has given states the opportunity to expand Medicaid to cover additional eligibility groups during the PHE. Many states have taken this offer and expanded

eligibility to uninsured individuals for access to COVID-19 testing and treatment.[5] Others have temporarily disregarded income for some groups or expanded eligibility to evacuated residents.[6] When the federal Medicaid Act authorizes it, advocates should press their states to extend coverage of these groups if, when the PHE ends, there are significant numbers still displaced or needing treatment. In addition, even if the state ends a temporary eligibility category, states should determine whether the individual qualifies in another category of eligibility before terminating them. They should also provide notice and an opportunity to argue that they qualify for eligibility in another category.[7]

4. **Monitor your state's practices regarding premiums and cost sharing:** While not mandatory, states are allowed to impose premiums and cost sharing. Most do.[8] A number of states received permission to pause collection of some or all premiums during the PHE. Advocates should determine whether their state has received this permission and for which services or eligibility groups. They should ask for any written policies or directives and how they were disseminated, and monitor whether providers are aware of and following this directive. Advocates should also use this time to collect evidence to advocate against premiums and cost sharing. Suspension of premiums and cost sharing is an acknowledgement that they reduce access to services. Seek input from clients and providers and document instances when a client obtained a service that they would otherwise have skipped because of a cost sharing requirement. Use this evidence to argue against reinstitution of premiums and cost sharing when the PHE ends.

5. **Protect against recoupment of premiums:** The Families First Coronavirus Response Act (FFCRA) makes enhanced Medicaid funding available to states. As a condition of receiving the funding, states may not reduce benefits for anyone enrolled in Medicaid on or after March 18.[9] This means that states cannot terminate Medicaid eligibility for failure to pay a premium. Advocates should monitor to ensure that beneficiaries are not being terminated. When the PHE ends, advocates should remind the state agency that many beneficiaries may not have had wages for months and will likely have no savings on hand. Advocate with the state not to seek recoupment of unpaid premiums and prohibit providers from treating unpaid copayments as legal liabilities of the enrollee.

6. **Advocate for continued relaxation of prior authorization requirements:** Nearly all of the states have received permission to temporarily suspend prior authorization in fee-for-service Medicaid and to require fee-for-service providers to extend pre-existing authorizations.[10] Reach out to Medicaid agency personnel and begin making the case for limiting or abolishing prior authorization after the emergency ends, particularly for routine services and ongoing service needs of people with disabilities whose conditions will not change. Reach out to provider groups that provide affected services at intervals during the emergency for information about how lifting prior authorization has impacted service delivery. If providers report positive experiences, share those with the Medicaid agency. And, although this emergency-related relaxation of prior authorization applied only to FFS, advocates should also consider

pressing this issue in managed care. Given that managed care was designed to control utilization by coordinating services and providing a medical home, there is a good argument that prior authorization is unnecessary in that system. Advocates should also use information gathered from FFS providers during the pandemic to support their argument to eliminate or reduce prior authorization in managed care.

7. **Monitor appeals systems:** Most states received permission to extend the time frame for beneficiaries to request state fair hearings; in these states, beneficiaries disputing initial eligibility determinations were given an additional 90 days and managed care enrollees appealing determinations about services were given 120 additional days.[11] Medicaid regulations have long provided that beneficiaries who appeal an adverse determination must have services continue through the appeals process.[12] States may also, pursuant to Section 1135, ask for permission to continue benefits pending appeal even if the beneficiary did not request them within 10 days.[13] However, Medicaid agencies and managed care plans are also allowed to recoup the costs of services provided pending appeal if the beneficiary ultimately loses.[14] Advocates should press their state agency 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 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.

8. **Preserve and improve expansion of telehealth:** The pandemic has accelerated state Medicaid programs' expansion of telehealth services. States are using disaster relief SPAs and Appendix K to make this transition. Common services include physical, occupational, and speech therapy, as well as behavioral consultation, person centered planning, and level of care evaluations.[15] Advocates should encourage states to think creatively about use of telehealth, including provision of home health services.[16] States will continue to have a great deal of flexibility to use telehealth even after the COVID-19 emergency ends. Work with clients, now, to monitor its use, documenting when and how it is working well and where and why there are problems. For example, are providers of therapy services making these services available to Medicaid enrollees? If so, does the enrollee have an electronic device that allows access to the service as well as the necessary broadband? If not, is the state/managed care plan taking any steps to address the situation? How are enrollees' experiences with this modality, broken down factors such as geographic region, disability, age, race, and ethnicity? The answers to these questions can inform development of a robust service during and after the pandemic.

9. **Monitor provision of care in alternative settings:** CMS has granted states permission through Section 1135 to fully reimburse care facilities including nursing homes, ICF-IDDs, PRTFs, and hospital nursing homes for services provided in an

unlicensed facility. This enables facilities to relocate patients or residents and provide services in unlicensed facilities in case of evacuation due to the pandemic. To obtain reimbursement, states must make a reasonable assessment that the transferee facility meets "minimum standards, consistent with reasonable expectations in the context of the . . . public health emergency, to ensure the health, safety, and comfort of staff. CMS has granted this permission to more than 35 states. Advocates should determine whether their state has received permission to do this. If so, determine whether it has developed a written policy for transfers into facilities and standards (typical and COVID-related) for those facilities and, if so, request it. If they have not, press them to do so – perhaps drafting a model. If individuals are still housed in alternative settings as the end of the emergency nears, press for assurances that they will be promptly moved. Periodically check with the agency and care facilities for plans for transferring individuals back to the originating facility. If possible, consider whether transfer to a home or community setting is possible with supportive services.

10. **Chart client experiences and collect data to support changes in the best interests of recipients:** As noted above, many changes that states are making during the pandemic do not have to be lifted when the pandemic ends. Yet, regardless of the length of the pandemic, the country is certain to face difficult economic times. States will turn to Medicaid to make cuts to save money – some will be deep. Collecting data and information about people's experiences with Medicaid changes could help preserve coverage even during an economic downturn.

ENDNOTES

[1] For more discussion of these authorities, see Jane Perkins and Sarah Somers, *Anticipating Medicaid Transitions When the COVID-19 Emergency Ends* (May 2020), https://healthlaw.org/resource/medicaid-in-transitions-monitoring-covid-related-changes-in-coverage/ (Transitions); Elizabeth Edwards, *Trends in Appendix K Approvals* (March 30, 2020), file:///C:/Users/Sarah/Downloads/Trends-in-Appendix-K-Approvals-3-30-20-final%20(3).pdf.

[2] There are several trackers of state activities. *See Georgetown Univ. Health Policy Inst., Ctr. for Children and Families, Approved 1135 Waivers and State Plan Amendments for COVID-19: https://ccf.georgetown.edu/2020/03/24/approved-1135-waivers/; Kaiser Family Found, Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19: https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/;* and Medicaid.gov, Federal Disaster Resources, https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/federal-disaster-resources/index.html.

[3] Edwards, *Trends in Appendix K Approvals* at 3.

[4] For approved Appendix K documents, *see* Medicaid.gov, 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.

[5] *Georgetown Univ. Health Policy Inst., Ctr. for Children and Families, Approved 1135 Waivers and State Plan Amendments for COVID-19* supra note 2. *See also* 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXIII) (providing option for states to cover COVID-19 testing for uninsured individuals).

[6] *Georgetown Univ. Health Policy Inst., Ctr. for Children and Families, Approved 1135 Waivers and State Plan Amendments for COVID-19* supra note 2

[7] *See* U.S. Const. amend. XIV, § 1; *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970) (requiring recipient be accorded right to pre-termination hearing when welfare benefits may be terminated: "[T]he interest of the eligible recipient in uninterrupted receipt of public assistance, coupled with the state's interest that his payments not be erroneously terminated, clearly outweighs the State's competing concern to prevent any increase in its fiscal and administrative burdens."). *See, e.g., Crippen v. Kheder*, 741 F.2d 102, (6th Cir. 1984); *Mass. Ass'n of Older Ams. v. Sharp*, 700 F.2d 749 (1st Cir. 1983), *same case sub nom., Mass. Ass'n of Older Ams. v. Comm'r of Pub. Welfare,* 803 F.2d 35 (1st Cir. 1986); *Stenson v. Blum*, 476 F. Supp. 1331, 1339-42 (S.D.N.Y. 1979), *aff'd mem.*, 628 F.2d 1345 (2d Cir. 1980).

[8] 42 U.S.C. § 1396o, 1396-1.

[9] Families First Coronavirus Response Act, Pub. L. No. 116-127 (March 18, 2020).

[10] Perkins & Somers, *Transitions* at 6 *supra* note 1.

[11] Sarah Somers, *Medicaid and Due Process During the COVID-19 Pandemic* at 5 (April 10, 2020), file:///C:/Users/Sarah/Downloads/Due-Process-and-COVID-19%20(3).pdf

[12] 42 C.F.R. §§ 431.230, 438.420.

[13] Somers, *Medicaid and Due Process* at 5 *supra* note 11.

[14] 42 C.F.R. §§ 431.230(b), 438.420.

[15] Edwards, *COVID-19 Changes to HCBS Using Appendix K* at 5-6.

[16] CMS has provided instructions to states for using telehealth for this service. See Ctrs. for Medicare & Medicaid Servs., COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, at 8, https://www.medicaid.gov/stateresource-center/downloads/covid-19-faqs.pdf (last updated May 5, 2020).