



## Medicaid During and “After” the Pandemic: Changes that Should Become Permanent Policies

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### Introduction

The Medicaid program has been critical to the response to COVID-19 in the United States. Even before COVID-19, Medicaid was providing health insurance to over 70 million individuals—creating a baseline of health and economic security for families and individuals across the country. The United States was better prepared for the arrival of COVID-19 thanks to Medicaid. As the country begins to dismantle COVID-19 related policy changes, many of the Medicaid changes should be preserved to strengthen access to health care.

During the COVID-19 crisis, Medicaid has been an important tool for the federal government and states to battle COVID-19. The program’s infrastructure and flexibility were leveraged to react quickly and effectively to COVID-19. Since the early days of the pandemic, Medicaid emergency flexibilities were used to move the program into high gear to protect and streamline access to care for Medicaid enrollees, expand access to health care (including COVID-19 testing and treatment) for individuals who are uninsured, support struggling health care providers, and increase state funding to make up for state budget shortfalls during the recession. And while we may now finally be able to envision the end of the pandemic, there is no certainty that it will not take years for the fire to be effectively put out. As such, Medicaid policies to deal with COVID-19 should be continued indefinitely. More careful analysis shows that most, if not all, of them make sense as *permanent* policies.

In addition to COVID-19, individuals in the United States are battling historic unemployment and economic collapse that may also take years to recover from. This brings with it an explosion of challenges and insecurities, for example in food and housing. Access to health care is always foundational, but simplifying and securing access to health care is especially critical during this pandemic and as other insecurities abound. This matrix of problems, from

COVID-19 infections to job loss to social risk, has disproportionately harmed individuals who are Black, Indigenous, and People of Color. Therefore, the continuation of Medicaid policies responsive to COVID-19 is also critical to reduce the backsliding on health equity that COVID-19 has triggered.

Federal and state legislators and policymakers must recognize the improvements leveraged through Medicaid as essential for the coming years, and should consider making these policies permanent features of the program across the country. Depending on the policy, this may be as simple as a state issuing guidance, but may require new federal legislation. For many of these policies the path to permanency is far simpler and can be pursued through state plan amendments (SPAs). Continuing and expanding these policies will be essential to fight COVID-19 and would improve Medicaid if preserved when and if COVID-19 goes away.

Below we identify temporary policies to address COVID-19 implemented in the past months, as well as other steps taken by states that should be made permanent Medicaid policies for the sake of fighting COVID-19 in the short-term, improving access to health care in the long-term, and addressing new and on-going disparities in health equity. We have organized the COVID-19 policies to keep by the following topics:

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## Eligibility

In states that have not expanded Medicaid, expanding Medicaid is the single most important thing those states could do to be responsive to COVID-19. States that have expanded Medicaid have seen unsurprisingly stronger increases in coverage during the COVID-19 crisis.<sup>1</sup>

Federal legislation also gives all states the option to provide Medicaid coverage for testing and related services to individuals who are uninsured and otherwise ineligible for Medicaid.<sup>2</sup> This coverage option—which has been taken by eighteen states—should continue indefinitely.<sup>3</sup> Currently, the option would expire when the public health emergency ends, even if there continues to be significant need for testing. Federal policymakers should consider making this a permanent and required coverage policy for all states, and expand the testing criteria to a broader range of communicable diseases. As a matter of health policy and fiscal responsibility, it makes little sense to wait for a pandemic to spread to provide inexpensive testing for communicable diseases.

Medicaid enrollees have always faced great challenges in dealing with state Medicaid programs that only work within their own state. This can create a problem for individuals who are seasonal workers, individuals who live in or near state lines, and even individuals simply on vacation. These problems are greatly exacerbated during pandemics, natural disasters, and other crises, where individuals may be subject to travel restrictions and evacuations, have medical provider closings, have travelled to take care of family members, or face other challenges. States have used multiple authorities during COVID-19 to pursue strategies to address these problems.<sup>4</sup> These policies have helped respond to COVID-19 but should not be limited to crisis situations, since these problems impact many individuals even where there is no crisis.

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<sup>1</sup> Jesse Cross-Call & Matt Broaddus, *States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession*, Ctr. on Budget & Policy Priorities (2020), <https://www.cbpp.org/research/health/states-that-have-expanded-medicaid-are-better-positioned-to-address-covid-19-and>.

<sup>2</sup> 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXIII).

<sup>3</sup> Kaiser Family Found., *Medicaid Emergency Authority Tracker: Approved State Action to Address COVID-19* (2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>.

<sup>4</sup> Centers for Medicare and Medicaid services (CMS), Medicaid State Plan Amendment Template - Medicaid Disaster Relief for the COVID-19 National Emergency, <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disasterrelief-spa-template.docx>; Kaiser Family Found., *supra* note 3.

States have also used 1915(c) Appendix K authority to temporarily extend eligibility for individuals in waiver programs who might otherwise lose coverage due to a pause in their service use (for example due to hospitalization, temporary relocation, fear of having home attendants with COVID-19, etc.).<sup>5</sup> While COVID-19 certainly exacerbates these types of issues, they are not unique to the pandemic, and the harms to individuals with disabilities losing their waiver slots are immense. There should be a permanent Medicaid policy to create flexibility for individuals to maintain critical services during routine life fluctuations.

Another coverage strategy that several states adopted during the pandemic is extending the postpartum coverage period after labor and delivery, from the federal minimum (which is 60 days after the end of the month of the last day of the pregnancy) to a full year.<sup>6</sup> This would promote continuity of coverage, thereby reducing maternal mortality and related health disparities. States can use current flexibility to implement this policy, and federal authorities should consider making it a permanent Medicaid option or standard.

States should also pursue strategies to increase coverage for immigrants. Many lawfully residing immigrants do not have coverage because they are subject to a five-year waiting period before their Medicaid (or CHIP) coverage can start. States already have the option to eliminate the waiting period for children and pregnant women (thirty-five states do for children, twenty-five for pregnant women).<sup>7</sup> More states should take up this option, and CMS should consider making the option a mandatory policy and extending the policy to all lawfully residing immigrants. States can also expand coverage to pregnant immigrants under the state's CHIP program. These policies would help respond to COVID-19 and support public health long-term.

Finally, in the Marketplace, states should consider leveraging flexibility, and HHS and Congress should create more options for states, to create Special Enrollment Periods (SEPs) for COVID-19 and other health crises.

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<sup>5</sup> Kaiser Family Found., *supra* note 3.

<sup>6</sup> Compare 42 U.S.C. § 1396a(e)(5) with § 1396(e)(16).

<sup>7</sup> Kelly Whitener, *COVID-19 and Immigrant Health*, Georgetown Ctr. for Children and Families (CCF) (2020), <https://ccf.georgetown.edu/2020/04/10/covid-19-and-immigrant-health/>; Amy Chen, *Q&A on Pregnant Women's Coverage Under Medicaid and the ACA*, NAT'L HEALTH LAW PROG., (2018), <https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/>.

## Retention

The pandemic has highlighted the importance of ensuring that people maintain coverage for sustained periods of time, particularly during a public health emergency. To this end, states have taken advantage of several opportunities to retain Medicaid and CHIP beneficiaries that either were available to them before the COVID-19 pandemic, or that CMS made available at the beginning of the emergency. Many of these opportunities will remain available after the conclusion of the emergency and states can continue reaping the benefits of implementing them. At the same time, the federal government should consider extending the availability of retention policies slated to end once the HHS Secretary ends the emergency declaration.

### Maintaining and expanding continuous eligibility

One of the key policies to ensure retention of eligible individuals is continuous eligibility for children in Medicaid and CHIP. This policy was included in CMS's Disaster Relief SPA Template in response to the COVID-19 pandemic, but in fact was available for states before the current emergency.<sup>8</sup> Under this option, states may provide for continuous eligibility of beneficiaries under nineteen for a period not to exceed twelve months from the date of the individual's effective eligibility or the date of the most recent redetermination or renewal of eligibility.<sup>9</sup> When continuous eligibility is implemented, the beneficiary's eligibility may not be terminated regardless of changes in circumstances unless the child attains the maximum age for eligibility, termination is voluntarily requested, the child ceases to be a resident of the state, the state determines that eligibility was erroneously granted, or the child dies.

Making sure that children are continuously enrolled is essential for protecting the health of this population at all times, and it becomes even more important in the middle of a public health emergency. As such, states should take advantage of the option and submit a SPA to adopt continuous eligibility if they have not yet done so. Importantly, states that adopted the policy through the COVID-19 special SPA process (Arizona, Missouri, Oklahoma, and Rhode Island), will need to submit a standard SPA to implement continuous eligibility beyond the public health emergency period, as COVID-19-specific SPAs are time-limited and will expire when the HHS Secretary decides not to renew the declaration of public health emergency.

Under the Medicaid Act, the continuous eligibility option is currently limited to beneficiaries under nineteen.<sup>10</sup> However, there is no reason why the policy should not be expanded to

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<sup>8</sup> CMS, *supra* note 4.

<sup>9</sup> 42 U.S.C. § 1396a(e)(12); 42 C.F.R. § 435.926.

<sup>10</sup> *Id.*

adults. This is particularly true in the middle of public health emergencies and economic downturns when people may have a heightened need for health services and greater fluctuation in their monthly income. Under these circumstances, rampant coverage “churning” (cycling on and off coverage) may take place for the duration of the emergency and/or downturn, which is why it is so important that individuals have access to stable Medicaid coverage. Congress should amend the Medicaid Act to extend continuous eligibility to those over nineteen. Even if Congress fails to amend the statute, states could submit 1135 waivers seeking to expand continuous eligibility for twelve months to all beneficiaries, including those over nineteen, whenever the Secretary of HHS has declared a public health emergency.<sup>11</sup>

## Delaying eligibility redeterminations

Beyond establishing continuous eligibility, states currently have authority to limit redeterminations of eligibility for non-MAGI beneficiaries to once every 12 months, although some do so more frequently.<sup>12</sup> As part of the COVID-19-specific SPA process, CMS allowed states to change their redetermination periods in order to delay redeterminations during the pandemic. Under both federal Medicaid regulations and the COVID-19 SPA template, states may elect to only conduct redeterminations for non-MAGI groups once every twelve months. However, for this policy to be in effect after the declaration of emergency ends, states that rely on a COVID-19 SPA will need to submit a standard SPA because COVID-19-specific SPAs expire at the conclusion of the emergency. Currently only one state (Pennsylvania) has extended redetermination timelines through the COVID-19 SPA process.<sup>13</sup> Because of the importance of minimizing redeterminations even after the conclusion of the pandemic, when states will need to address considerable renewal backlog, all states should limit redeterminations to once per 12 months, and advocates in Pennsylvania and other states who decide to delay redeterminations through the COVID-19 SPA process should push their states to transition to a standard SPA as soon as possible.

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<sup>11</sup> The COVID-19 1135 checklist does not explicitly provide for expansion of continuous eligibility for twelve months for beneficiaries over nineteen. However, a provision in the checklist allows states to include “any additional flexibilities that the state/territory is requesting under the Section 1135 waiver authority.” See CMS, Section 1135 Waiver COVID-19 State/Territory Request Template, <https://www.medicaid.gov/state-resource-center/downloads/1135-checklist-template.docx>.

<sup>12</sup> 42 C.F.R. § 435.916(b); CMS, *supra* note 4.

<sup>13</sup> CCF, *Approved 1135 Waivers and State Plan Amendments for COVID-19* (2020), <https://ccf.georgetown.edu/2020/03/24/approved-1135-waivers/>.

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## Suspending ongoing data matching processes

Another excellent strategy to increase retention is to minimize ongoing data matching processes, which seek to identify individuals erroneously enrolled in Medicaid. Data matching efforts unequivocally lead to decreases in Medicaid enrollment, and while they may serve an oversight purpose, they are particularly problematic during public health emergencies when people need continuous access to health coverage *and* may have temporary fluctuations in eligibility criteria. For that reason, states should use flexibility to minimize periodic data matching between initial application and regular renewals. At the beginning of the COVID-19 public emergency, CMS encouraged states to suspend periodic data matching for MAGI-based beneficiaries for the duration of the emergency by submitting a Medicaid Disaster Relief MAGI-Based Verification Plan Addendum.<sup>14</sup> However, states have considerable authority to limit data matching outside of the declared public health emergency, and they should take advantage of the opportunity as a tool to retain individuals enrolled for a sustained period of time. While the PHE has increased fluctuations in household status and income, lower income individuals already have less stability in housing and income that causes real-time Medicaid data matching, based on monthly eligibility standards, to trigger many unfair terminations (for example, an individual is terminated because they are data matched just after the one holiday month of the year that they pick up a few extra shifts at their job.)

## Application and Enrollment

Because efforts to mitigate the spread of COVID-19 have had a direct impact on the economy and job stability, the number of people who are eligible for Medicaid has significantly increased. As a result, most states have resorted to temporary policies that make it easier for newly eligible individuals to apply for Medicaid coverage. While these policies are particularly relevant during emergencies like the COVID-19 pandemic, there is no reason to limit them to emergency situations. In fact, permanently adopting some of the flexibilities in the Medicaid application process would allow states to capture populations who are eligible for coverage, but are not currently enrolled because of lack of information, which at the same time, would likely lead to a reduction in costs associated with uncompensated or charity-based care.

## Expanding presumptive eligibility policies

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<sup>14</sup> CMS, Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum, <https://www.medicaid.gov/medicaid/eligibility/downloads/magi-based-verification-plan-addendum-template.docx>.

One of the most important strategies to facilitate Medicaid enrollment is the expansion of presumptive eligibility (PE) policies. Medicaid PE allows hospitals (in all states) and other qualified entities (in states adopting the option) to make preliminary eligibility determinations that allow individuals who are likely to qualify for Medicaid to begin receiving services before a full application is submitted and approved. States may extend PE to children, pregnant women, Modified Adjusted Gross Income (MAGI)-eligible individuals, former foster care children, and individuals in need of family planning services or, in the case of hospital PE, to any eligible population under the state plan or an 1115 demonstration.

For the duration of the COVID-19 emergency declaration, CMS has allowed those states that had yet to adopt large scale PE measures to submit emergency SPAs to expand the categories of individuals for which hospitals and other qualified entities can make PE determinations as allowed by federal law. In addition, states can submit SPAs to expand the number of entities designated as qualified entities for PE and make the State Medicaid agency a qualified entity, thus allowing the agency to fast track eligibility during the emergency while a full application is reviewed. Finally, states may submit SPAs to extend the period of PE for children under 19 to up to 12 months.

As of January 2021, CMS has approved SPAs from thirteen states to extend PE to additional groups that were previously not eligible. Eleven of those states expanded hospital PE to additional groups eligible for Medicaid under the state plan or under an 1115 demonstration. Several states, such as California, submitted SPAs to allow hospitals to make PE determinations for almost all non-MAGI populations, including the COVID-19 uninsured testing group. The remaining two states expanded PE policies in non-hospital settings. In addition, eight states have increased the number of PE periods allowed within twelve months, and eight states expanded the number of qualified entities that may make PE determinations, including the state Medicaid agency in five states.<sup>15</sup>

Approval of these SPAs has resulted in states being able to enroll eligible individuals more quickly during the pandemic, at a time when obtaining and maintaining coverage is essential in order to protect the public's health. However, expansion of PE in normal circumstances would be equally beneficial for different populations that are eligible for Medicaid in one way or another, but have yet to enroll and who may instead be receiving uncompensated care. Maintaining expanded PE at all times would also eliminate the need to submit new SPA requests every time the HHS Secretary declares a public health emergency.

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<sup>15</sup> Although PE for pregnant individuals is limited to one period per pregnancy, states may determine the number of periods of PE for children in a given time frame. *Compare* 42 C.F.R. § 435.1103(a) *with* 42 C.F.R. §435.1102(c) (the provisions for PE for other individuals references those for children).

Expansion of PE policies in emergency and non-emergency circumstances could also help states address health disparities by improving access to reproductive and sexual care and by streamlining the process for immigrant populations. PE has traditionally been used as a vehicle to expand access to prenatal care. Hospitals and other qualified entities in states that allow it, including the state Medicaid agency, can make PE determinations for pregnant individuals for the purpose of providing prenatal care. States that have yet to expand PE to include pregnant individuals should not wait until the next emergency and should instead facilitate access to prenatal care through PE at all times.

States should also consider facilitating access to care for immigrant populations through expansion of PE policies. States can choose not to ask about immigration status or may accept self-attestation of immigration status for purposes of the PE determination and can make that decision outside of the public health emergency period.<sup>16</sup> While the state will still need to verify immigration status to process full application, permitting individuals to access care through PE without verifying immigration status will improve access to care for vulnerable populations while the full application process is ongoing. This, in turn, will improve the health of this population, reduce disparities in general, and likely lead to improved outcomes during public health emergencies.

### Continuing the use of self-attestation prior to enrollment

In addition to expanding PE policies, states have resorted to making it easier for individuals to enroll in Medicaid by permitting applicants to self-attest certain required information during the public health emergency. Under the Medicaid Act, states must verify citizenship and qualified immigrant status prior to enrollment and must verify income prior or after enrollment. States, however, have the option of accepting self-attestation for non-financial eligibility criteria such as age and date of birth, household size, and state residency. Because states do not need CMS approval for introducing self-attestation changes, many have taken advantage of this flexibility during the pandemic, but those changes are not restricted by law to the emergency period. In addition, CMS amended the Verification Plan Addendum to allow states to accept self-attestation for income during the pandemic as well as to conduct income verification post-enrollment.

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<sup>16</sup> See 42 C.F.R. § 435.1102(d).

A total of eighteen states have made changes to self-attestation.<sup>17</sup> Several states are now accepting self-attestation of income for the duration of the emergency. Others have made changes to self-attestation as allowed under the Medicaid Act and these policies may extend beyond the emergency declaration. For example, a handful of states have said that they will conduct post-enrollment income verification by self-attestation once the emergency has concluded and several others are now accepting self-attestation for most eligibility criteria other than citizenship and immigration status. These actions are important to streamline the Medicaid application process and are particularly relevant during the COVID-19 emergency marked by an increase in the number of people eligible for coverage, the barriers and delays in obtaining and submitting verification documentation, and by Medicaid agency worker shortages.

States have the option of expanding these application flexibilities beyond the emergency period to allow populations to access services and encourage individuals who are likely eligible to apply even if they do not have documentation certifying the selected criteria. In the case of self-attestation of non-income eligibility criteria (outside of citizenship and immigration status), states may simply submit an amended Verification Plan Addendum. Regardless of the specific policy and the vehicle used to implement it, states should take a closer look at expansion of self-attestation and realize the benefits that adopting permanent expansion of this policy presents in a post-pandemic world.

While self-attestation does not apply to citizenship and immigration status, which states must continue to verify, states have the option of extending the “reasonable opportunity” period for beneficiaries to submit proper documentation for verification to beyond the usual period of 90 days. This option is available to states during the emergency declaration through submission of an emergency SPA. Pursuant to HHS regulations, this reasonable period may be extended beyond 90 days if the state determines that “the individual is making a good faith effort to obtain any necessary documentation or the agency needs more time to verify the individual’s status through other available electronic data sources or to assist the individual in obtaining documents needed to verify his or her status.”<sup>18</sup> States may continue the extension of the reasonable opportunity period through its processes around “good faith effort” to allow individuals more time to submit the necessary documentation. Doing so would enable immigrant individuals who are eligible for Medicaid coverage to continue receiving needed services for an extended period of time, while the verification process is ongoing.

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<sup>17</sup> See Kaiser Family Found., *Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19* (2021), <https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19>.

<sup>18</sup> 42 C.F.R. § 435.956(b).

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## Maintaining additional changes to simplify the Medicaid application process

Finally, there are several technical fixes states can make to the application process that facilitate enrollment during the emergency, but that may be equally beneficial post-pandemic or that should be replicated in future emergencies. For example, federal regulations allow states to implement their own streamlined or simplified application as long as those processes are not more burdensome than the application developed by HHS. To date, three states have submitted emergency SPAs to implement simplified online, paper, and/or telephone applications during the emergency. Such simplification can make it easier for individuals to apply for and enroll in Medicaid during the COVID-19 pandemic. This has been particularly true for those applying under the COVID-19 uninsured testing group, since the states that have introduced additional streamlined processes tend to focus on this new eligibility group. Additionally, post-pandemic, states should work to simplify access to telephonic and online enrollment and recertifications and should extend the number of days applicants typically have to complete applications.

## Access to Services

### Continuing expanded access to Medicaid services as long as necessary

First and foremost, even after the Public Health Emergency has ended, it is likely that we will be living with COVID-19 in our midst for months or years to come. Thus, it is particularly important that state Medicaid programs continue to cover COVID-19 testing and treatment, without cost-sharing or prior authorization. In addition, state Medicaid programs should continue to make clear that COVID-19 testing and treatment are considered emergency services, covered for all Medicaid beneficiaries, regardless of immigration status.

In addition, some states have temporarily added other “optional” benefits to their Medicaid programs during the pandemic, or adjusted existing benefits (by, for example, eliminating or relaxing service limits).<sup>19</sup> These changes have given people access to important services, and

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<sup>19</sup> See Kaiser Family Found., *supra* note 3. For example, Washington added additional care coordination and triage services for beneficiaries seeking dental services during the pandemic. See Wash. State Health Care Auth., *Apple Health (Medicaid) Dental Emergency Coverage Related to COVID-19 Pandemic 1-2* (2020), <https://www.hca.wa.gov/assets/billers-and-providers/apple-health-dental-emergency-coverage-COVID-19.pdf>. Arkansas expanded its non-emergency medical transportation (NEMT) benefit to allow NEMT providers to deliver medicines and groceries to beneficiaries during the pandemic. See Ark. Dep’t Health Servs., *COVID-19 1115 Waiver Application 10* (2020),

have made it easier for beneficiaries to access existing services during the pandemic. As the Public Health Emergency comes to an end, states should consider permanently adding the expanded benefits it covered during the pandemic, and continuing adjustments to service rules. In some cases, these expanded benefits and changed rules may not be needed after the pandemic ends, but states may consider adopting them again in future emergency situations.

States also used the Appendix K authority to expand services based on pandemic changes, including adding meal services, lifting service limits, and adding emergency-specific services. Nearly one-third of states took CMS's suggestion from the Appendix K COVID-19 template and added or expanded home-delivered meals to their waivers.<sup>20</sup> For some states, the changes around home-delivered meals included an expansion of who could deliver meals, including non-traditional providers. Many states added meals to replace the meals that people would have otherwise received at congregate day programming sites, such as adult day programs, and the expansion of meal providers meant that some adult day programs shifted to providing remote services, such as wellness checks, and meals. States should consider keeping some of these changes to the adult day program model to move away from congregate services.

States also recognized that the requirements of the pandemic, including social distancing requirements, and potential increased need for in-home nursing services or respite services meant that services would need to change for many people and existing service limits may be insufficient. Although not many states increased the overall cost limit for a waiver, almost all states allowed individuals to temporarily exceed service limits.<sup>21</sup> This allowed people to replace group or congregate services with individual services that may have otherwise been too limited to replace those other services and allowed people to generally change the mix of services and add services where needed. This additional flexibility and move away from congregate services towards more independent services and additional choice is important to retain to support the

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[https://humanservices.arkansas.gov/images/uploads/resources/AR\\_1115\\_COVID\\_Waiver\\_Application-3.26.20-FINAL\\_.pdf](https://humanservices.arkansas.gov/images/uploads/resources/AR_1115_COVID_Waiver_Application-3.26.20-FINAL_.pdf).

<sup>20</sup> CMS, COVID-19 Specific Sample Appendix K Template, Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers, <https://www.medicaid.gov/state-resource-center/disaster-responsetoolkit/hcbs/appendix-k/index.html>; Kaiser Family Found., *supra* note 3 (citing AL, AZ, CT, DE, IA, KS, LA, MA, MO, MS, NC, NJ, OK, SC, WI for at least some of the states' waivers); *see also generally* Elizabeth Edwards, *COVID-19 Changes to HCBS Using Appendix K: Approval Trends*, 5-6, Nat'l Health Law Prog. (Mar. 30, 2020), <https://healthlaw.org/resource/covid-19-changes-to-hcbs-using-appendix-k-approval-trends/>.

<sup>21</sup> Kaiser Family Found., *supra* note 3 (45 states allowed service limits to be exceeded while only 10 allowed temporary increase in cost limits, in some waiver of those states' waivers). Some of the cost-limit authorizations were based only in specific COVID-related circumstances, like if a primary caregiver was quarantined. *Edwards, supra* note 20, at 4.

range of choice of settings required under waivers and the requirements of *Olmstead*. As another way to increase choice, a few states increased self-direction opportunities, largely by allowing additional services to be self-directed, like transportation and respite.<sup>22</sup> Such expansions of self-direction should be retained to expand individual choice and control over their services.

The ability of individuals to adapt their plan of care to their needs under COVID-19 was also helped by some of the COVID-19-specific services that states added under Appendix K. For example, some states included consultation or training services regarding COVID-19 health and safety or preparedness.<sup>23</sup> Although relatively common in HCBS waivers, some states added personal emergency response systems.<sup>24</sup> Several states added services for “specialized medical equipment and supplies” and “participant goods and services” that would allow people to purchase necessary supplies, often with expanded purchasing options, to help keep them safe during the pandemic, including supplies for life support (including ancillary supplies), nutritional supplements, additional diapers, pads, and gloves, PPE generally, and other items to support disease control.<sup>25</sup> States also used Appendix K to add nursing services or allow nursing services in setting not typically allowed.<sup>26</sup>

## Eliminating and reducing prior authorization requirements

During the pandemic, CMS has encouraged state Medicaid programs to eliminate prior authorization requirements in fee-for-service Medicaid programs. For Medicaid managed care programs, CMS has encouraged states to require managed care plans to temporarily suspend prior authorization requirements, extend existing prior authorizations through the COVID-19 emergency, expedite processing of new prior authorization requests, and allow providers greater flexibility in documentation related to prior authorization. States that have implemented these flexibilities have streamlined access to services when prior authorization requirements slow down the process to life-saving care. Too often, beneficiaries encounter delays or forego medically necessary care due to bureaucratic prior authorization requirements. These barriers result in increased health risks and disparities. CMS has similarly

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<sup>22</sup> See, e.g., Appendix K Approvals for IA, CA, GA, ME, OK *available at* CMS, Emergency Preparedness and Response for Home and Community Based 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>.

<sup>23</sup> Edwards, *supra* note 20, at 5; see, e.g., CMS, *supra* note 22, for WA.

<sup>24</sup> See, e.g., CMS, *supra* note 22, for DC.

<sup>25</sup> See, e.g., *id.* for CO, MS, WA, PA, NC.

<sup>26</sup> See, e.g., *id.* for HI, PA.

encouraged states to reduce provider documentation requirements for services to allow providers to spend more time delivering care instead of completing paperwork.

While CMS provided states with flexibilities to eliminate or reduce prior authorization and documentation requirements during the pandemic, states are not ordinarily required to impose prior authorization on Medicaid services, as long as they have procedures in place to ensure that services provided are medically necessary. Before the COVID-19 emergency ends, states should re-evaluate whether prior authorization and documentation requirements are necessary for all services on which they were applied before the pandemic, and remove or simplify prior authorization requirements throughout Medicaid, including fee-for-service and managed care delivery systems, to the extent possible.

### Easing access to prescription and over-the-counter drugs

State Medicaid programs have significant discretion, within the bounds of federal and state laws covering prescription medication, to determine the quantity, frequency, and duration limits on and prior-authorization requirements for prescription medications. State Medicaid agencies and managed care organizations often impose restrictive access policies on many prescription medications, including preferred drug lists, prior authorization, frequent refill requirements, and other policies that steer individuals toward some drugs over others or limit access.<sup>27</sup> For example, before COVID-19, forty-one states required enrollees to use generic drugs that are equivalent to brand names, and others imposed quantitative limits on the number of prescriptions an enrollee can access per month, or limits on the frequency of refills.<sup>28</sup> These restrictions have often harmed people with disabilities and chronic conditions,

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<sup>27</sup> See 42 C.F.R. § 440.230(d). All states opt to provide prescription outpatient drugs. 42 U.S.C. § 1396d(a)(12). 42 C.F.R. §§ 440.120(a), .90, .100. Once a state elects to cover outpatient prescription drugs, it must cover all drugs approved by the U.S. Food and Drug Administration (FDA) that are offered by any manufacturer that agrees to provide rebates. 42 U.S.C. § 1396r-8(k)(2)(A). A preferred drug list is a list of drugs that the state encourages providers to prescribe over other medications, and prior authorization is a requirement that you receive approval from your insurer prior to obtaining a medication. Abbi Coursolle, *Utilization Controls for Medicaid Prescription Drugs*, Nat'l Health Law Prog. (2016), <https://healthlaw.org/wp-content/uploads/2016/12/113016-Rx-Guide-Utilization-Requirement-for-Covered-Rx-FINAL.pdf> (detailing covered outpatient drug utilization controls).

<sup>28</sup> Prior to March 2020, most state Medicaid programs commonly used several drug benefit utilization controls. Almost all states used preferred drug lists and prior authorization. See generally Kathleen Gifford et al., *How State Medicaid Programs Are Managing Prescription Drug Costs Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020*, Kaiser Family Found. (2020). <http://files.kff.org/attachment/How-State-Medicaid-Programs-are-Managing-Prescription-Drug-Costs.pdf>; see also Coursolle, *supra* note 27.

by making it harder for them to maintain a continued medication regimen. For example, for individuals with psychiatric conditions such as schizophrenia and bipolar disorder, prior authorization requirements have been associated with medication discontinuation, reduction in visits to community mental health centers, and increases in emergency room visits.<sup>29</sup>

The pandemic has affected supply chains for many prescription drugs.<sup>30</sup> Furthermore, at a time when access to medication to manage chronic conditions has been more important than ever, people are trying to limit their interactions, including visits to stores and pharmacies. To address these issues, during the pandemic, CMS has encouraged states to temporarily relax limits on quantity, frequency, and duration, by allowing beneficiaries to access a longer lasting supply of most medications, and refill their prescriptions earlier. Many states have taken advantage of these flexibilities.<sup>31</sup> Further, as discussed in more detail below, approximately half the states have eliminated cost sharing, with some specifically limiting this change to prescription medications, and others doing so across the board.<sup>32</sup>

In addition, many states have taken advantage of flexibilities that allow them to provide for mail and home delivery of prescription drugs, supplies, and equipment at no additional cost, and without a signature, to make it easier for beneficiaries to get what they need without requiring contact with another person.<sup>33</sup> Many states have encouraged pharmacies to offer home delivery services by adding temporary supplemental payments to existing dispensing

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<sup>29</sup> Christine Y Lu et al, *Association Between Prior Authorization for Psychiatric Medications and Use of Health Services Among Medicaid Patients with Bipolar Disorder*, 62 PSYCHIATRIC SERVS. 186, 192-93 (2011),

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3053119/pdf/nihms273544.pdf>.

<sup>30</sup> Lovisa Gustafsson, *COVID-19 Highlights Problems with Our Generic Supply Chain*, Commonwealth Fund (2020), <https://www.commonwealthfund.org/blog/2020/covid-19-highlights-problems-our-generic-supply-chain>.

<sup>31</sup> For example, D.C. has allowed extended fills and early refills for many medications. See Melissa Byrd, DC Medicaid Director, *DC Medicaid Transmittal # 20-11: Novel Coronavirus 2019 (COVID-19): Emergency Authorization of a 90-Day Supply for Maintenance Medications and 30-Day Supply for Nonmaintenance Medications* (2020), [https://providers.amerigroup.com/Public%20Documents/DCDC\\_CAID\\_PU\\_Pharm9030DayRXDispensEmergAuth.pdf](https://providers.amerigroup.com/Public%20Documents/DCDC_CAID_PU_Pharm9030DayRXDispensEmergAuth.pdf). During the pandemic, Massachusetts is allowing for 365 day fills of drugs prescribed for family planning. MassHealth, *Pharmacy Facts No. 157* (2020), <https://www.mass.gov/doc/pharmacy-facts-157-december-1-2020-0/download>. For a general overview of the different Medicaid emergency authorities and charts of state changes under each, see CCF, *supra* note 13.

<sup>32</sup> Kaiser Family Found., *supra* note 3.

<sup>33</sup> See CMS, *COVID-19 Frequently Asked Questions (FAQ) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies 144-145* (2021), <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

fees to account for costs of delivery.<sup>34</sup> Finally, states have also taken advantage of the flexibilities around prior authorization described above to relax prior authorization requirements for prescription and over-the-counter medications, particularly for medications like contraceptives, anti-retroviral therapy, PrEP, and PEP.<sup>35</sup>

Where allowed under federal law and state licensing laws, some state Medicaid programs also relaxed rules to make it easier for beneficiaries to obtain some prescription drugs directly from a pharmacy, rather than a provider's office, including Depo-Provera.<sup>36</sup> In addition, some states have expanded their coverage of over over-the-counter medications during the public health emergency.<sup>37</sup> These flexibilities have greatly improved access for beneficiaries and should be continued to the greatest extent possible after the pandemic.

## Maintaining and expanding increased access for substance use disorder (SUD) services

Medicaid enrollees who receive SUD treatment, including medication, face an additional set of barriers related to access to treatment during COVID-19. SUD treatment is a mandatory service under Medicaid, and medication is an integral part of treatment for some substance use disorders, particularly medications for opioid use disorder (MOUD).<sup>38</sup> States must cover the three of the main types of MOUDs: buprenorphine, naltrexone, and methadone.<sup>39</sup> Despite this

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<sup>34</sup> See e.g., MassHealth, *Pharmacy Facts No. 145* (2020), <https://www.mass.gov/doc/pharmacy-facts-145-april-28-2020-0/download> (Massachusetts policy).

<sup>35</sup> See, e.g., Truvada (emtricitabine and tenofovir DF) and Descovy (emtricitabine and tenofovir alafenamide) Medicaid Fee-for-Service, N.Y. Dep't Health, <https://www.health.ny.gov/diseases/aids/general/prep/truvada.htm> (last visited Jan. 11, 2021) (NY policy for PEP and PrEP).

<sup>36</sup> See, e.g., Cal Dep't Health Care Servs., *Information Regarding the Use of Subcutaneous Depot Medroxyprogesterone Acetate During the 2019 Novel Coronavirus Public Health Emergency* (2020), <https://www.dhcs.ca.gov/Documents/COVID-19/Medi-Cal-FFS-Depo-Provera-SQ-Temp-Policy.pdf> (California policy).

<sup>37</sup> See, e.g., Cal. Dep't Health Care Servs., *Fee-for-Service Temporary Reinstatement of Acetaminophen, and Cough and Cold Medicines for Adults* (2020), <https://www.dhcs.ca.gov/Documents/COVID-19/Coverage-of-Acetaminophen-and-CC-051320.pdf> (California policy).

<sup>38</sup> The mandate to cover methadone is only for five years. See 42 U.S.C. §§ 1396a(10)(A); 1396d(a)(29) 1396d(ee). Buprenorphine and naltrexone will likely continue to be covered by all states beyond the five-year mandate because they are also classified as an outpatient drug pursuant to 42 U.S.C. § 1396-r8.

<sup>39</sup> *Id.*

mandatory coverage, layers of additional laws and regulations circumscribing access to MOUDs have created high barriers to treatment. COVID-19 has made already difficult barriers even more challenging.

Prior to the pandemic, the majority of states subjected MOUDs to prior authorization requirements and quantity limits.<sup>40</sup> Many states also limit naloxone—a medication that reverses the effects of an opioid overdose and can save lives.<sup>41</sup> Therefore, state Medicaid emergency waivers to make prescription drugs easier to obtain and disaster SPAs to relax utilization controls have increased access to buprenorphine, naltrexone, and naloxone, which are included in the definition of outpatient medications covered by Medicaid.<sup>42</sup>

Unlike other medications, MOUDs are subject to additional federal controls. These regulations and restrictions exist apart from whether an individual uses private insurance, Medicaid, or other sources of payment for these services. For example, health professionals must receive a federal “waiver” to prescribe buprenorphine at all, and even with a waiver they may only treat a limited number of individuals.<sup>43</sup> Additionally, providers generally must conduct a face-to-face visit with a patient before they can prescribe buprenorphine—a significant barrier in normal times, particularly for individuals in rural areas and those without reliable transportation.<sup>44</sup>

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<sup>40</sup> According to a study by the Substance Abuse and Mental Health Services Administration (SAMHSA), for buprenorphine during 2016-2017, all states covered the medication, but 21 states did not have it on the preferred drug list, and 40 states required prior authorization. U.S. Substance Abuse & Mental Health Servs. Admin., *Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose* 91-92 (2018), <https://store.samhsa.gov/product/Medicaid-Coverage-of-Medication-Assisted-Treatment-for-Alcohol-and-Opioid-Use-Disorders-and-of-Medication-for-the-Reversal-of-Opioid-Overdose/SMA18-5093>.

<sup>41</sup> Kaiser Family Found., *Medicaid Behavioral Health Services: Naloxone Available in at Least One Formulation Without Prior Authorization*, (2018), <https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-naloxone-available-in-at-least-one-formulation-without-prior-authorization/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (noting that while at least 46 states cover at least one formulation of naloxone without prior authorization, at least 9 states impose other utilization limits on the drug); U.S. Surgeon Gen., *Advisory on Naloxone and Opioid Overdose* (Apr. 5, 2018 ed.), <https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html> (citing the life-saving importance of access to naloxone by users of opioids and those around them).

<sup>42</sup> 42 U.S.C. § 1396d(ee)(3).

<sup>43</sup> 21 U.S.C. § 823(g).

<sup>44</sup> 21 U.S.C. § 829(e); see also Pew Charitable Trust, *Opioid Use Disorder: Challenges and Opportunities in Rural Communities: Thoughtful strategies can improve access to high-quality*

Such limitations combine to reduce the number of providers who can prescribe the medication and contribute to racial treatment disparities: “despite similar prevalence of OUD among Black and white adults, from 2012 to 2015 white patients were almost 35 times more likely to have a buprenorphine-related office visit compared to Black patients . . . ”<sup>45</sup> During the pandemic, the Drug Enforcement Agency (DEA) has permitted buprenorphine initiation via telephone, and has waived the requirement for providers to obtain a separate registration in each state in which they practice.<sup>46</sup>

Methadone’s federal restrictions may be even more pronounced. Generally, only licensed, certified “opioid treatment programs” (OTP) may administer methadone.<sup>47</sup> Unlike buprenorphine, initiation during the public health emergency cannot be done via telehealth.<sup>48</sup> Nor can states simply amend their Medicaid state plans to provide a larger supply of

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*care* (Feb. 7, 2019), <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2019/02/opioid-use-disorder-challenges-and-opportunities-in-rural-communities> (describing the shortage of buprenorphine prescribers in rural areas and the increased need for individuals with SUD to travel for treatment and rely on friends and family for transportation); Stacey C. Sigmon, *Access to Treatment for Opioid Dependence in Rural America Challenges and Future Directions*, 71 JAMA PSYCHIATRY 359 (2014), <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/1819581>.

<sup>45</sup> Corey S. Davis & Amy Judd Lieberman, *Access to Treatment for Individuals with Opioid Use Disorder*, in *Assessing Legal Responses to COVID-19* 133, 134 (Scott Burris et al. eds., 2020), <https://www.publichealthlawwatch.org/covid19-policy-playbook>. [https://static1.squarespace.com/static/5956e16e6b8f5b8c45f1c216/t/5f445d4ff0e1b42d8e2bfcad/1598315855348/Chp17\\_COVIDPolicyPlaybook-Aug2020.pdf](https://static1.squarespace.com/static/5956e16e6b8f5b8c45f1c216/t/5f445d4ff0e1b42d8e2bfcad/1598315855348/Chp17_COVIDPolicyPlaybook-Aug2020.pdf).

<sup>46</sup> 21 U.S.C. § 802(54)(D); 21 C.F.R. § 1307.03; Letter from Thomas Prevoznik, Deputy Assistant Admin’r, Diversion Control Div., U.S. Dep’t of Justice, to DEA Registrants (Mar. 31, 2020), [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-022\)\(DEA068\)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20\(Final\)%20+Esign.pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf); Letter from William McDermott, Assistant Admin’r, Diversion Control Div., U.S. Dep’t of Justice, to DEA Registrants (Mar. 25, 2020), [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-018\)\(DEA067\)%20DEA%20state%20reciprocity%20\(final\)\(Signed\).pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf); see also Corey S. Davis & Elizabeth A. Samuels, *Continuing Increased Access to Buprenorphine in the United States via Telemedicine After COVID-19*, INT’L. J. DRUG POL’Y, Aug. 15, 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7428767/#bib0019> (discussing treatment via telehealth).

<sup>47</sup> 42 C.F.R. § 8.

<sup>48</sup> U.S. Substance Abuse & Mental Health Servs. Admin., *FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency* 1 (Apr. 21, 2020), <https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf>.

medication.<sup>49</sup> “Take home” doses are permissible, but prior to the pandemic, two weeks’ worth of methadone was limited to people enrolled in an OTP for at least a year, and one month of take home medication was limited to those enrolled two years.<sup>50</sup> In response to the pandemic, federal guidance now permits 28 days of take-home doses for all stable patients, and 14 days for those who are less stable, but the OTP deems able to safely handle take-home doses.<sup>51</sup> This flexibility allows many more individuals to avoid daily travel to a clinic. Though temporary, these changes could be made permanent via legislation or regulatory changes.<sup>52</sup>

In addition to taking advantage of new federal rules, many states implemented several other measures to enhance SUD services in Medicaid during the pandemic, some of which they should now consider extending or making permanent. For example, several states significantly extended the availability of reimbursement for SUD services provided via telehealth.<sup>53</sup> States should continue to allow services to be provided by telehealth in this way after the pandemic ends to the greatest extent they can.

## Access to Providers and Network Adequacy

Federal authority contains numerous provisions addressing relocation related to natural disasters. Medicaid programs are generally required to cover services for beneficiaries when they travel out of state in limited circumstances.<sup>54</sup> While beneficiaries are generally less likely to relocate for COVID-19 compared to other types of disasters such as floods or wildfires, some individuals become temporarily stuck out-of-state due to travel restrictions or get sick during travel. State Medicaid programs have adopted flexibilities to allow beneficiaries who are temporarily out-of-state to obtain services beyond the situations where out-of-state coverage is already required in Medicaid.<sup>55</sup> States should consider strategies to maximize interstate

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<sup>49</sup> 21 C.F.R. § 1301.74(k); 42 C.F.R. § 8.12(h).

<sup>50</sup> 42 C.F.R. § 8.12(i).

<sup>51</sup> U.S. Substance Abuse & Mental Health Servs. Admin., Opioid Treatment Program (OTP) Guidance 1 (Mar. 16, 2020 updated Mar. 19, 2020), <https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf>.

<sup>52</sup> Davis & Samuels, *supra* note 46, at 2-3 (discussing permanently reducing barriers to buprenorphine).

<sup>53</sup> See, e.g., Cal. Dep’t Health Care Servs., *DHCS COVID-19 Frequently Asked Questions: Narcotic Treatment Programs (NTPs)* 3-4 (2020), <https://www.dhcs.ca.gov/Documents/COVID-19/COVID-19-FAQ-NTP.pdf> (California policy).

<sup>54</sup> See 42 C.F.R. § 431.52 (enumerating the circumstances where Medicaid programs must cover care out of state: emergencies, situations where travel would pose a danger to health, and where the usual practice in an area is to obtain care out-of-state).

<sup>55</sup> See CMS, *supra* note 33; see also Jessica Schubel, *States Are Leveraging Medicaid to Respond to COVID-19* at Tab. 2, Ctr. on Budget & Policy Priorities, (Sept. 2020 ed.),

eligibility on an on-going basis and also develop systems to quickly implement the emergency provisions in future disaster situations.

Retainer payments can be critical to maintaining Medicaid providers, particularly those who provide home and community-based services for beneficiaries with disabilities.<sup>56</sup> These payments to waiver-based HCBS providers when participants are temporarily hospitalized or otherwise unavailable to receive services allow the participant to ensure the same providers will be available to support them upon their return. If an individual is not using their HCBS, direct care workers typically do not receive any payment and may have to look for other work or ask to be reassigned to new clients. Given the dearth of direct care workers, it may difficult to find another person to fill that role when the participant is discharged and this means an individual may miss necessary services during an important transition back to home. A lack of services could lead to a greater burden on natural supports and for many could sharply increase their risk of institutionalization.

Although long identified as an important practice to keep people in the community, prior to COVID-19, retention payments were uncommon in HCBS waivers. Under the pandemic, however, most states have authorized retainer payments in some form or fashion for 1915(c) waiver services.<sup>57</sup> Like other changes, the specifics vary by service and payments are time limited. Individuals have used retainer payments in situations where the individual was forced to limit interpersonal contacts to protect their own health and thus had to limit paid services while they temporarily relocate to stay with family or others, or while they are hospitalized.

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<https://www.cbpp.org/sites/default/files/atoms/files/5-7-20health.pdf> (listing states that have taken up this option).

<sup>56</sup> See Letter from the U.S. Health Care Finance Admin. to State Medicaid Directors, Olmstead Letter No. 3 att. 3-c (July 25, 2000), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf>; CMS, *Application for a 1915(c) Home and Community-Based Waiver: Instruction, Technical Guide and Review Criteria 52*, 158-60 (Jan. 2019), [https://wms-mmdl.cms.gov/WMS/help/35/Instructions\\_TechnicalGuide\\_V3.6.pdf](https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf).

<sup>57</sup> One study found 38 states using Appendix K, five states using section 1115, and three states using section 1135 (with overlap of states between authorities), who include retainer payments to address emergency related issues. See MaryBeth Musumeci, Kaiser Family Found., *Options to Support Medicaid Providers in Response to COVID-19* (2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/options-to-support-medicaid-providers-in-response-to-covid-19/>. Retainer payments typically reflecting the limited time allowed by Medicaid for a nursing facility bed hold, which refers to the practice of paying the facility to keep the person's spot at the facility while they are elsewhere. During COVID-19, state authority to allow HCBS retainer payments have been allowed to be consecutively renewed several times.

During the pandemic, many states have reviewed scope of practice limitations in their Medicaid programs that are narrower than those imposed by state law, to allow more providers to practice to the full extent permitted by their license. CMS encouraged these changes by, for example, making a permanent change to regulations that allows state Medicaid programs to be reimbursed when physician assistants, nurse practitioners, and clinical nurse specialists (as opposed to only doctors) certify the need for home health services and order services.<sup>58</sup> In addition, during the pandemic, some states have offered flexibility with respect to licensing and scope of practice requirements to improve access to services, particularly sexual and reproductive health services. For example, in the area of reproductive and sexual health care, some states have waived scope of practice limitations for midwifery services, birth center services, and home births.<sup>59</sup> These changes have been particularly important to improving outcomes for Black and Indigenous people, who are more likely to rely on Medicaid during pregnancy and birth, and are also more likely to experience adverse health outcomes, including death, during pregnancy, birth, and the postpartum period.<sup>60</sup> When the emergency ends, states should review the impact of these changes and reduce or eliminate licensing and practice requirements that are overly burdensome and impede timely access to health care.

### Increasing provider payment rates for Home and Community Based Services (HCBS)

Another basic strategy to improve workforce retention is to increase wages, particularly in hazardous situations. As many of the federal relief efforts have focused on supporting institutions, most support for community-based providers has come from states, via the emergency Medicaid authorities. This is especially true for providers of community-based services through 1915(c) waivers.<sup>61</sup> Over half of the states used Appendix K amendments to

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<sup>58</sup> See 42 C.F.R. § 440.70(a)(2).

<sup>59</sup> For example, Alaska has allowed direct entry midwives to provide some services using telehealth during the pandemic. See Alaska Dep't Health & Hum. Servs., *Telehealth Coverage during COVID-19 Public Health Emergency Frequently Asked Questions* 4 (Dec. 8, 2020 ed.), [http://manuals.medicaidalaska.com/docs/dnld/Update\\_COVID-19\\_Telehealth\\_FAQs\\_20201208.pdf](http://manuals.medicaidalaska.com/docs/dnld/Update_COVID-19_Telehealth_FAQs_20201208.pdf).

<sup>60</sup> See, e.g., Samantha Artiga et al., Kaiser Family Found., *Medicaid Initiatives to Improve Maternal and Infant Health and Address Racial Disparities* (2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/medicaid-initiatives-improve-maternal-infant-health-address-racial-disparities>; Amy Chen, *Routes to Success for Medicaid Coverage of Doula Care*, Nat'l Health Law Prog. (2018), <https://healthlaw.org/resource/routes-to-success-for-medicoid-coverage-of-doula-care>.

<sup>61</sup> Kaiser Family Found., *supra* note 3.

allow temporary increases to HCBS provider rates.<sup>62</sup> Increases varied by waiver, service, and conditions under which a higher rate would be paid. Some Appendix Ks were approved to increase rates across the range of waiver services up to a cap, which was usually a percentage of the current rate, while others tiered their increases.<sup>63</sup> States have also included rate increases up to a certain amount in areas determined by the state to have provider shortages or tied the increased rate to the COVID status of the HCBS participant.<sup>64</sup> In comparison to the large number of states that have used Appendix K to address rates, only a minority of states have requested SPAs and even fewer have done so for behavioral health services.<sup>65</sup>

Several states explicitly mentioned PPE, cleaning supplies, and other COVID-related needs as part of the reason for the rate increase, although sometimes only for specific providers.<sup>66</sup> Some states also addressed the need for PPE through increases in services or changes to service definitions related to medical supplies.<sup>67</sup> States also increased rates to specifically

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<sup>62</sup> *Id.*

<sup>63</sup> *Compare, e.g., CMS, supra note 22, for AR (tiered rates), AK (mix of rate adjustments) & TN (percentage increases).*

<sup>64</sup> *See, e.g., id.* for TN (providing a general rate increase of 10% or 30% depending on service, but also a per diem add-on payment to existing rate for specific services when those services are provided to a confirmed COVID positive individual).

<sup>65</sup> *See, e.g., CA SPA (#20-2025) (increase interim payments and waive limitations of “usual and customary charge” or “statewide maximum allowance” for non-narcotic treatment programs and specialty mental health services); MA SPA (#20-0008) (increase rates for Applied Behavioral Analysis).* States that provide behavioral health services via managed care could use directed payments to temporarily increase rates for specific services, but states are generally not pursuing this option for community-based behavioral health services. *See CMS, Informational Bulletin, Medicaid Managed Care Options in Responding to COVID-19, May 14, 2020, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf>; see also Musumeci, supra note 57.* SPAs for other services include: WA SPA (#20-2021) (private duty nursing); AR SPA (#20-0014) (NF, home health, personal care, hospice, assisted living facilities, residential care facilities, psychiatric residential treatment facilities, day habilitation); & CA SPA (# 20-2024) (IHSS).

<sup>66</sup> *CMS, supra note 22, for AL, HI, IL, MA, MN, MT (residential settings), NM, NY (respite and community habilitation providers), TN & WY Appendix Ks.*

<sup>67</sup> *Id.* for AL; CO (use the specialized medical equipment and supplies service to purchase PPE) (DE, HI, MS, PA, WA same); MI (MI Choice: expanded good and services to include purchase of PPE, disinfection supplies and purchase of delivery service membership or monthly fees such as grocery delivery membership; MI Health Link: added PPE to adaptive medical equipment and supplies); MS (added PPE as a service); NC (allows on-demand quick procurement of PPE through case management and purchase of sanitation and other COVID related supplies through individual goods and services); UT (operating agency may provide PPE); MD (self-directed budget modification; individual and family directed goods and services) & WY (added PPE as a service) Appendix Ks.

address overtime pay in instances where overtime was required because of staff shortages.<sup>68</sup> While some states specified the use of the increased rate, other states implemented general increases.<sup>69</sup>

## Permitting HCBS Providers in Acute Care Settings

Most states also used Appendix K to authorize waiver-based HCBS staff to provide support in acute care settings, thereby permitting DSPs (Direct Service Providers) or other companions to accompany a person with a disability when they enter a hospital.<sup>70</sup> Having a familiar DSP in a hospital setting can reduce stress and help ensure the individual's needs are met. This has been particularly relevant for individuals with needs not easily met by hospital staff, such as specialized communication and behavioral needs. This significant access gap existed before COVID-19, but became even more visible during the pandemic.

Although a majority of states are allowing HCBS providers in acute settings during the pandemic, many of these states limited the flexibility to certain services or set strict parameters about when it was allowed. States should consider keeping this permission for HCBS providers in acute care settings as it not only helps people in these settings, but it helps retain providers who may otherwise not be paid while the person is in the hospital setting. Importantly, during the pandemic, the CARES Act amended 42 U.S.C. §1396(h) to allow states to pay for some kinds of HCBS in acute care settings as long as those services met certain conditions.<sup>71</sup> While this change does not require states to provide for services in acute

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<sup>68</sup> CMS, *supra* note 22, for AL, AR, CT, DE, DC, IL, IN, KY, ME, MD, NE, NM, OH, PA, UT & WY Appendix Ks.

<sup>69</sup> *Compare* CMS, *supra* note 22, for MN (requiring at least 80 percent to be used to increase wages, salaries, and benefits for direct care workers as well as any corresponding taxes with the remaining additional revenue to be used for activities and items need to support compliance with CDC guidance on sanitation and PPE) *with* TN (silent) Appendix K.

<sup>70</sup> At least one state, Oregon, has also amended its state plan temporarily to allow for behavioral health HCBS services in acute care settings. OR SPA (#20-0011), *supra* note 21.

<sup>71</sup> Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116-136, § 3715, 134 Stat. 281 (2020) (amending 42 U.S.C § 1396a(h) to allow 1915(c) services in acute settings); *see also* ELAYNE J. HEISLER, CONG. RESEARCH SERV., R46334, SELECTED HEALTH PROVISIONS IN TITLE III OF THE CARES ACT 50-51 (P.L. 116-136) (2020),

<https://crsreports.congress.gov/product/pdf/R/R46334>. It is not clear that CMS has operationalized this change yet in the 1915(c) waiver application, which is also the amendment mechanism. CMS, Waiver Applications, 1915(c) Waiver Application and Accompanying Materials, HCBSWaiverApp-v.3.6January2019 § 6.B, Application p. 10, <https://wms-mmdl.cms.gov/WMS/faces/portal.jsp> (last visited Nov. 8, 2020) (reflecting the current waiver application required assurance from states that waiver services are not

settings, it permits it outside of the limited realm of Appendix K amendments during emergencies.

## Paying Family Members as Caregivers for HCBS

Many states have long allowed family caregivers to be paid caregivers for at least HCBS waiver services and to a lesser extent state plan HCBS.<sup>72</sup> In response to the pandemic-related pressures put on the direct service provider network and the need of many people with disabilities to restrict the risk of exposure to an outside worker, all but eleven states used Appendix K to temporarily permit or expand permission for family members or other legally responsible relatives to be paid caregivers.<sup>73</sup> Thirteen states used section 1135 to allow paid family caregivers for state plan services, including some 1915(k) services.<sup>74</sup> Depending on a state's rules, particularly its nursing scope of practice and delegation rules, family members can sometimes also provide services with higher levels of care that non-licensed DSPs may not be allowed to do.<sup>75</sup> Some states also expanded self-direction to allow individuals who hire their own employees to hire family caregivers.<sup>76</sup>

The expansion of provider availability by allowing relatives to be paid caregivers broadened the choices for people who use HCBS to stay safely in their communities during the pandemic. For many, allowing family members to be paid caregivers allowed them to use individuals within

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furnished in institutional facilities thus not showing the CARES Act option for HCBS in acute care settings).

<sup>72</sup> Elizabeth Edwards, Nat'l Health Law Prog., *Q&A Relatives as Paid Providers* 2-6 (Dec. 5, 2014), <https://healthlaw.org/resource/qa-relatives-as-paid-providers/>; see also MaryBeth Musumeci et al., *Key State Policy Choices About Medicaid Home and Community-Based Services* 7, 15, 35, 39 (2020), <https://www.kff.org/report-section/key-state-policy-choices-about-medicare-home-and-community-based-services-issue-brief/> (showing only a few states allow relative providers for state plan personal care and thirty states allow certain legally responsible relatives to be paid providers under waiver services).

<sup>73</sup> Thirty-nine states used Appendix K to temporarily permit payment for services rendered by family members or legally responsible relatives. CMS, *supra* note 22, for AK, AL, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, KS, LA, MD, ME, MN, MO, MS, MT, NC, ND, NH, NJ, NM, NV, OH, OK, PA, RI, SC, SD, UT, VA, VT, WI & WV; see also Kaiser Family Found., *supra* note 3.

<sup>74</sup> See section 1135 waivers for AK, GA, IA, LA, MD, MT, NH, NJ, NM, NY, ND, PA & VT.

<sup>75</sup> Edwards, *supra* note 20, at 3-4; Letter from the U.S. Health Care Finance Admin. to State Medicaid Directors, Olmstead Letter No. 3 att. 3-c (July 25, 2000), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf> (regarding nurse delegation); see also Musumeci, *supra* note 72, at 53 n. 68.

<sup>76</sup> See, e.g., CMS, *supra* note 22, for OK, KY.

their “bubble” as providers. This helped people who lost direct support workers during the pandemic due to a variety of circumstances, including those working in nursing facilities and hospitals, and those who needed to severely limit exposure risks from people outside their household.<sup>77</sup> Allowing paid family and legally responsible caregivers can be incredibly helpful in ensuring access to providers, service stability, and provider choice, and should remain an option. However, many HCBS systems exploit unpaid family labor to fill gaps in services and paying family caregivers may lead to increased stress on those informal networks of support.<sup>78</sup> States should not rely on paying family caregivers to fill service needs, but the option should exist for people who use HCBS.

## Affordability

In order for the above reforms to continue being meaningful, they must be tied to affordability protections for Medicaid and CHIP beneficiaries. States have resorted to many of these policies during the pandemic, but beneficiaries would greatly benefit from their continuation beyond the emergency period.

## Eliminating cost-sharing requirements for COVID-19 preventive and treatment services

The Families First Act requires Medicaid plans to cover COVID-19 testing without cost-sharing for the duration of the public health emergency (PHE) declaration.<sup>79</sup> CMS has stated, however, that “states can continue to cover COVID-19 testing under the...mandatory laboratory services benefit after the emergency period ends.”<sup>80</sup> Because COVID-19 represents a dangerous disease and the risk of contagion will remain even after the culmination of the PHE, states

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<sup>77</sup> See Emma Cott, Ben Laffin & Ellie Khadra, *Low Pay, High Risk: Nursing home workers confront Coronavirus dilemma*, N.Y. TIMES, Mar. 31, 2020, <https://www.nytimes.com/video/us/10000007046988/nursing-home-coronavirus.html?action=click&module=video-series-bar&region=header&pgtype=Article&playlistId=video/coronavirus-news-update> (nursing assistants employed at nursing facilities discussing risks, dual employment as home health aides, their own risks, and risk of spreading to others including between patients).

<sup>78</sup> Edwards, *supra* note 20, at 3 (discussing 42 C.F.R. § 441.301(c)(2)(v), which prohibits states from compelling natural supports in lieu of paid 1915(c) services); see generally Susan C. Reinhard et al., *Valuing the Invaluable: 2019 Update*, AARP Public Pol’y Inst. (2020), <https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path-forward.doi.10.26419-2Fppi.00082.001.pdf>.

<sup>79</sup> Families First Coronavirus Response Act, Pub. L. No. 116-127, § 6001 (2020).

<sup>80</sup> CMS, *supra* note 33, at 67.

would be wise to fully and explicitly incorporate COVID-19 testing (or a broader disease testing policy) into their state plan benefits under the mandatory laboratory services category. To make it easier for beneficiaries to access testing services, Medicaid coverage should extend to all diagnostic tests (PCR and antigen tests), as well as antibody tests to detect past coronavirus infections, and should be offered without prior authorization and regardless of the presence of symptoms or known or suspected exposure. Permanently covering COVID-19 testing without cost-sharing would particularly benefit those populations that are at higher risk of serious consequences from the disease and those who, because of disability or pre-existing conditions, will be unable to receive a vaccine against COVID-19.

As a condition for increased Medicaid FMAP under the Families First Act, states are required to provide coverage for “treatments for COVID-19, including vaccines, specialized equipment, and therapies.”<sup>81</sup> This requirement applies until the end of the public health emergency declaration. However, states should ensure that COVID-19 vaccines and treatment services are available, without cost-sharing, to all beneficiaries beyond the end of the PHE. States are already required to cover vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) for Medicaid expansion populations and children, but coverage becomes murkier outside of those populations.<sup>82</sup> Once the COVID-19 PHE ends, states should maximize access to COVID-19 vaccines, including vaccine administration, for all Medicaid populations, using SPA filings.<sup>83</sup> Extending coverage of COVID-19 vaccination may be particularly important if periodic shots of the vaccine are ultimately required to maintain immunity.

Similarly, states should extend coverage of all services when medically necessary to treat a person who has tested positive for COVID-19 beyond the public health emergency. Most COVID-19 treatment services are already covered or coverable under the Medicaid Act. For example, inpatient and outpatient hospital services are mandatory benefits and those extend to hospitalizations and other hospital services related to COVID-19. Additionally, while prescription drug services are an optional benefit, Medicaid programs in all states and territories currently offer coverage for prescription drugs. Nonetheless, once the public health emergency declaration is over, states should ensure that there are not any gaps in coverage

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<sup>81</sup> Families First Coronavirus Response Act, Pub. L. No. 116-127, § 6008 (2020).

<sup>82</sup> See Karyn Schwartz et al., *Vaccine Coverage, Pricing, and Reimbursement in the U.S.*, Kaiser Family Found. (2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/vaccine-coverage-pricing-and-reimbursement-in-the-u-s/>.

<sup>83</sup> Under the American Rescue Plan Act of 2021, states are required to cover COVID-19 vaccines for individuals in non-full-scope Medicaid. But this authority only lasts for the duration of the emergency and states may need to submit a SPA or Medicaid waiver to continue such coverage after that point. See American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9821 (2021).

by, for example, eliminating prior authorization and cost-sharing requirements for services to treat a COVID-19 diagnosis, to the maximum extent practically and legally feasible.

## Eliminating cost-sharing for COVID-19 services in CHIP

States have more flexibility to impose premiums, cost-sharing, and other fee requirements on CHIP beneficiaries than children enrolled in Medicaid because, in general, CHIP beneficiaries tend to belong to families with comparatively higher incomes. Nonetheless, CHIP beneficiaries are still considered low-income and research has shown that premiums and other cost-sharing and enrollment fees create barriers to obtaining, maintaining, and accessing care.<sup>84</sup> Even modest levels of cost-sharing have been shown to have negative effects on the health status of lower income CHIP enrollees and are associated with reduced care, including medically necessary care.<sup>85</sup>

The hardship imposed by these premiums and cost-sharing requirements on CHIP enrollees led several states to request CHIP SPAs to eliminate cost-sharing requirements for the duration of the COVID-19 pandemic. Nine states eliminated deductibles, copayments, coinsurance, and/or other cost-sharing charges, and twenty-three other states eliminated, waived, suspended, or delayed enrollment fees, premiums, or similar charges in CHIP.<sup>86</sup> Undoubtedly, the economic hardship caused by the pandemic made these policies all the more necessary. But given the wealth of research around the negative effects of premiums, cost-sharing, and other fees on the health of low-income children enrolled in CHIP, the end of the public health emergency will present the perfect opportunity for states to evaluate the use of CHIP charges moving forward and consider adjusting them to facilitate access to necessary services for this population.

## Establishment of undue hardship waiver for enrollment fees and premiums

While states should (and most did) use all the tools at their disposal to eliminate or waive premiums, cost-sharing and enrollment fees for all beneficiaries or groups of beneficiaries during and after the pandemic, some states resorted to a case-by-case approach instead or in addition to those policies. Three states (Massachusetts, Missouri, and Washington) created undue hardship waivers to cover enrollment fees and premiums when evidence is presented

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<sup>84</sup> See Samantha Artiga et al., *The Effects of Premium and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, Kaiser Family Found. (2017), <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

<sup>85</sup> *Id.*

<sup>86</sup> Kaiser Family Found., *supra* note 3.

that economic hardship exists.<sup>87</sup> States that continue to impose premiums, cost-sharing, and enrollment fees on certain Medicaid populations could also consider adopting or expanding their existing undue hardship waiver programs beyond the public health emergency period so that beneficiaries could easily access them and avoid disenrollment for missed payments, particularly during economic downturn events.

## Telehealth

The COVID-19 pandemic has highlighted the importance of telehealth in delivering critical health care when patients are unable to receive services in person. Medicaid beneficiaries and other underserved populations deserve to benefit from telehealth's promises. While telehealth is not the only solution for limited access to health care, it should be part of a long-term, complementary, and sustained strategy to address gaps in access to care.<sup>88</sup> Both CMS and state Medicaid agencies have a critical role to play in advancing telehealth access to Medicaid enrollees.

Before the COVID-pandemic, all fifty states and the District of Columbia provided reimbursement for some form of live video visits in Medicaid Fee-For-Service.<sup>89</sup> Yet, telehealth policies varied by state, including their definitions of telehealth, how they covered services, and which providers they reimbursed.<sup>90</sup> In the wake of the public health emergency, states have aggressively increased telehealth coverage in Medicaid.<sup>91</sup> It is clear that telehealth will be a routine modality of care in the future, and telehealth access should be normalized and streamlined.

One of the most significant changes that should be made permanent is Medicaid reimbursement of audio-only phone services. When enrollees lack access to high-speed internet, digital devices, and have limited digital literacy, audio-only interactions are a good alternative in many circumstances. A recent study shows that audio is an appropriate modality

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<sup>87</sup> *Id.*

<sup>88</sup> See Fabiola Carrión, *Medicaid Principles on Telehealth*, Nat'l Health Law Prog. (May 11, 2020), <https://healthlaw.org/resource/medicaid-principles-on-telehealth/>.

<sup>89</sup> See Ctr. for Connected Health Policy, *CCHP's comprehensive assessment and compendium of state Medicaid telehealth policies and laws covers all fifty states and the District of Columbia*, Fall 2020, <https://www.cchpca.org/telehealth-policy/state-telehealth-laws-and-reimbursement-policies-report>.

<sup>90</sup> *Id.*

<sup>91</sup> See Ctr. for Connected Health Policy, *COVID-19 Related State Actions*, <https://www.cchpca.org/covid-19-related-state-actions> (last visited Mar. 12, 2021).

for patients receiving certain services that do not require a physical or visual exam.<sup>92</sup> Although all 50 states and the District of Columbia have allowed audio-only phone services during the public health emergency, only a few states have moved to permanently reimburse for telephone/audio-only delivered health care services.<sup>93</sup>

CMS should require payment equity between services delivered in person with the same services when they are delivered through telehealth. Since 2019, California's Telehealth Medi-Cal Policy has guaranteed payment parity between services provided in-person versus those offered via telehealth.<sup>94</sup> New Hampshire enacted a law in July 2020, requiring Medicaid and private payers to reimburse for services delivered through all telehealth modalities, including video, audio and other electronic media, on the same basis as in-person care. Connecticut moved to do the same in 2020.<sup>95</sup> These decisions make sense as a matter of policy to ensure there is not a disincentive to provide telehealth.

CMS should also ensure that States remove unnecessary barriers to telehealth access like requiring in-person visits. States have already moved to remove some of these barriers. Colorado enacted a law in 2020 barring insurance carriers from requiring pre-established patient-provider relationships prior to a telehealth encounter.<sup>96</sup> Nor should telehealth interactions undergo additional barriers that are not required for the in-person delivery of the same services such as prior authorization, referrals, or higher cost-sharing payments. Massachusetts has introduced a bill in 2021 prohibiting prior authorization requirements in

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<sup>92</sup> See Lori Uscher-Pines et al., *Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic*, JAMA NETWORK (Feb. 2, 2021), [https://jamanetwork.com/journals/jama/fullarticle/2776166?questAccessKey=1cbe677e-5cda-4394-9933-078d1fcfecaf&utm\\_source=For The Media&utm\\_medium=referral&utm\\_campaign=ftm\\_links&utm\\_content=tfl&utm\\_term=020221](https://jamanetwork.com/journals/jama/fullarticle/2776166?questAccessKey=1cbe677e-5cda-4394-9933-078d1fcfecaf&utm_source=For%20The%20Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=020221).

<sup>93</sup> See Ctr. for Connected Health Pol'y, *State Telehealth Laws and Reimbursement Policies: At a Glance* (2020), <https://www.cchpca.org/sites/default/files/2020-10/StateTelehealthLawsandReimbursementPolicies%20FALL%202020%20.pdf> [hereinafter *State Policies at a Glance*]; see also, Mannatt, *Audio Telehealth Services Post-Pandemic—An Update on Emerging Policy Trends* (Feb. 16, 2021), <https://www.manatt.com/insights/newsletters/manatt-on-health/audio-telehealth-services-post-pandemic>.

<sup>94</sup> California Dep't of Health Care Services, *Medi-Cal Telehealth Policy* (Aug. 2019), <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf>.

<sup>95</sup> H.B. 6001, Gen. Assem., Spec. Sess. July (Conn. 2020).

<sup>96</sup> S.B. 212, Gen. Assem., Reg. Sess. (Colo. 2020).

Medicaid managed care for services delivered via telehealth that would not apply if those same services were provided in-person.<sup>97</sup>

CMS should also issue guidance allowing Medicaid enrollees to receive telehealth services from any location, including their home. Twenty-seven states and the District of Columbia now explicitly and permanently allow the home to be an eligible originating site under certain circumstances.<sup>98</sup> Additionally, twenty-six states and the District of Columbia explicitly note that their Medicaid program will reimburse telehealth delivered services in a school-based setting.<sup>99</sup> Allowing flexibility of locations is critical to ensuring access in Medicaid, considering factors like travel time and other personal considerations.

Services delivered through telehealth should be culturally congruent and linguistically appropriate. To this end, CMS should encourage the reimbursement of as many providers as possible, including those who offer peer-assistance, interpretation, or anything that helps the patient with the telehealth experience. Massachusetts's 2021 telehealth bill includes Medicaid reimbursement for interpreter services for patients with limited English proficiency as well as those who are deaf or hard of hearing.<sup>100</sup>

States have also moved to reimburse telehealth services in home and community-based services settings. Medicaid agencies are using emergency authorities, such as 1135 waivers, state plan amendments, Appendix K amendments, and other mechanisms, to support the use of telehealth. This includes using telehealth for in-home habilitation, monitoring, and medication management. Some states made changes through Appendix K to support telehealth usage by covering the purchase of tablets and other monitoring equipment.<sup>101</sup> CMS should formally evaluate the impact of these efforts and encourage other states to repeat successful policies.

The federal government, including CMS, and states should dedicate resources to improve beneficiaries' access to broadband, connectivity, and adequate devices for telehealth interactions, as well as digital literacy. For instance, the Federal Communications Commission should continue to enroll eligible individuals in the Lifeline program, which subsidizes phone

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<sup>97</sup> S.D. 2099, 2021 Gen. Court, 192nd Sess. (Mass. 2021)

<sup>98</sup> See Ctr. for Connected Health Policy, *State Policies at a Glance*, *supra* note 93. <https://www.cchpca.org/sites/default/files/2020-10/StateTelehealthLawsandReimbursementPolicies%20FALL%202020%20.pdf>.

<sup>99</sup> *Id.*

<sup>100</sup> S.D. 2099, 2021 Gen. Court, 192nd Sess. (Mass. 2021).

<sup>101</sup> See Daniel Young et al., *Expanding Telehealth Under COVID-19: Supporting Access to Care*, Nat'l Health Law Prog. (Apr. 22, 2020), <https://healthlaw.org/expanding-telehealth-under-covid-19-supporting-access-to-care/>.

and internet services for low-income households. States should also think about ways to reimburse devices for Medicaid enrollees, including, smartphones, computers, and tablets in the ways that a few states have done through Appendix K authority.

Lastly, CMS should incentivize additional research and data collection on the utilization and benefits of telehealth for underserved populations, including Medicaid beneficiaries. This research should include detailed demographic data like race, age, geographic location, existence of a disability, etc. The rise of telehealth use during the COVID-19 pandemic offers such an opportunity.

## **Conclusion**

The COVID-19 pandemic has been and continues to be one of the worst public health emergencies our country has faced in recent memory. The situation, however, has highlighted the importance of the Medicaid program not only in responding to crises, but also in ensuring access to necessary care on a regular basis for low-income individuals. Many of the improvements to Medicaid coverage that were implemented during the pandemic would be equally beneficial if maintained and/or expanded after the conclusion of the emergency. States should continue working closely with the federal government to ensure that the gains achieved amid all the pain during this past year are sustained beyond the pandemic.