

New State Guidance on Resuming Normal Operations After the Public Health Emergency

Manatt Health

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STATE
Health & Value
STRATEGIES
COVID-19

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About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

*Support for this webinar was provided by the Robert Wood Johnson Foundation.
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Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **www.shvs.org**.

COVID-19 Resources for States

State Health and Value Strategies has created an accessible one-stop source of COVID-19 information for states at www.shvs.org/covid19/. The webpage is designed to support states seeking to make coverage and essential services available to all of their residents, especially high-risk and vulnerable people, during the COVID-19 pandemic.

About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving health care policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx.

Agenda

- Context Setting
- Conducting Redeterminations for Medicaid Enrollees Who Were Continuously Enrolled in Coverage
- Terminating or Extending Current COVID-19 Flexibilities
- Developing A Consumer and Provider Communication Strategy
- Questions

Our Dynamic Policy Environment



The duration of the public health emergency (PHE) is fluid and likely to be further extended.



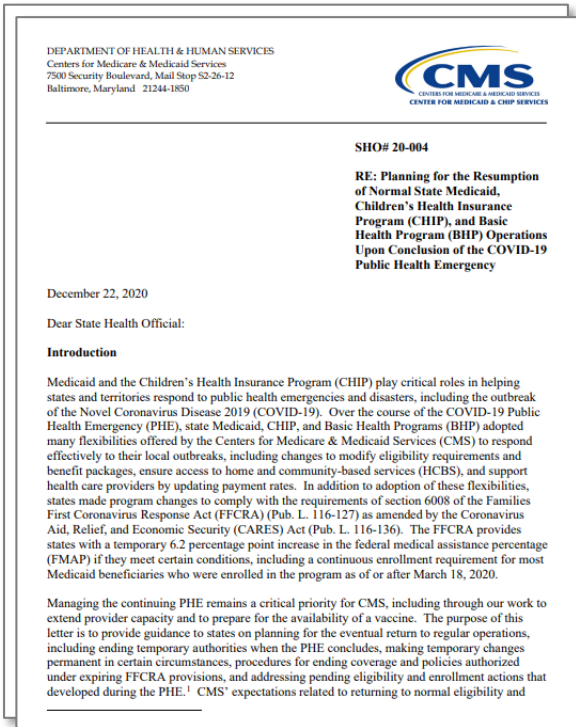
The new Biden Administration is issuing Executive Orders (EOs) related to COVID-19 and other priorities; new EOs may impact the guidance.



The Biden Administration may also directly modify the “unwinding” guidance or issue new guidance that supersedes it.

CMS Guidance on Resuming Program Operations After the PHE

On December 22, 2020, CMS released sub-regulatory guidance to support state Medicaid and Children's Health Insurance Program (CHIP) agencies in returning to normal operations after the PHE. The State Health Official (SHO) Letter sets out expectations related to:



Conducting redeterminations for Medicaid enrollees who were continuously enrolled in coverage.



Terminating or extending, where appropriate, current COVID-19 flexibilities.



Developing a consumer and provider communication strategy.

Source: The Centers for Medicare & Medicaid Services (CMS), SHO #20-004. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>.



Conducting Redeterminations for Medicaid Enrollees Who Were Continuously Enrolled in Coverage

Reminder: Continuous Coverage Requirements Under Families First Coronavirus Response Act (FFCRA)

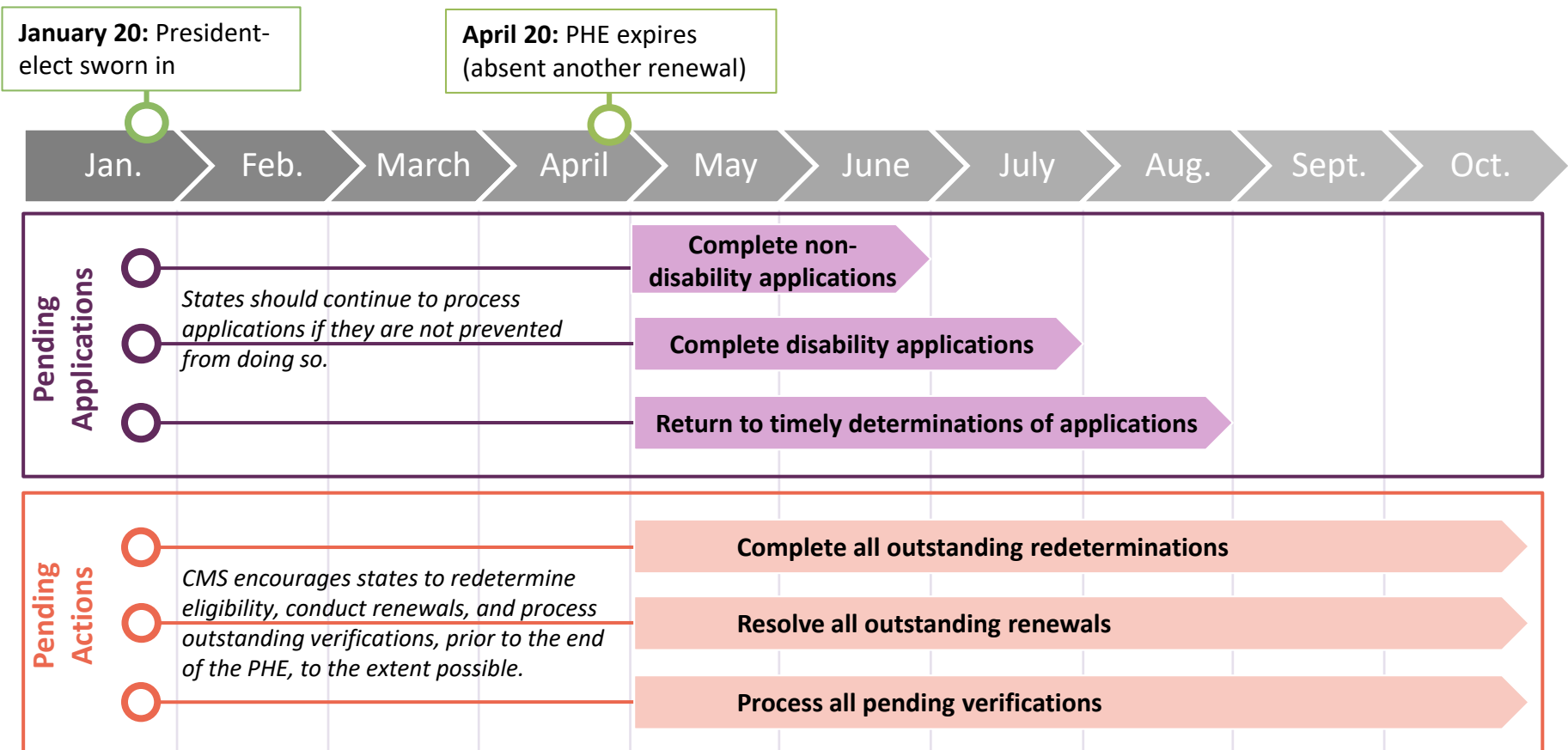
As a condition of receiving a temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) increase, states are required to maintain Medicaid coverage for enrollees through the end of the month in which the PHE ends, currently April 20, 2021.

- Continuous coverage requirements apply to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date.
- State Medicaid agencies have maintained coverage for individuals who may have otherwise become ineligible at renewal or due to a change in circumstances.
- With the rise in unemployment since March and the uncertain economic picture, states have seen an increase in Medicaid applications and expect to see continued volatility in Medicaid eligibility for those currently enrolled.

Source: FFCRA. Available at <https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf>.

Pending Eligibility and Enrollment Actions Timeline

The guidance lays out the following timeline for states to complete verifications, pending applications, renewals, and redeterminations for changes in circumstances once the PHE ends.



*Dates are subject to change in the event of another PHE renewal or if the incoming administration modifies requirements outlined in the SHO.

Requirements for Addressing Pending Redeterminations, Renewals, and Verifications Post-PHE

The SHO reminds states that they must conduct Medicaid renewals and redeterminations consistent with federal regulations.

- States will need to redetermine eligibility for changes in circumstances reported or identified during the PHE, complete outstanding renewals, and process determinations that were based on self-attestations but require verification using available data sources.
- Consistent with federal regulations, states must:
 - Redetermine eligibility based on available information without requiring information from the individual. Depending on whether the information is sufficient to determine continued eligibility, states either:
 - Proceed with an ex-parte renewal; or
 - Send a renewal form and request additional information.
 - Evaluate enrollees for other eligibility categories prior to termination and share consumer information as appropriate with the Marketplace for a review of eligibility for other insurance affordability programs.
 - Send an adverse action notice prior to termination (even if the state already sent a previous notice during the PHE advising them that their coverage will terminate at the end of the PHE).

Expectations for States that Redetermined Eligibility, Conducted Renewals, and Processed Verifications During the PHE

For a state that finds an individual ineligible no more than six months prior to the date that the enrollee's coverage is terminated, the state does not have to conduct a "repeat redetermination" or renewal if:

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The state sends advance notice at the time of the ineligibility determination during the PHE that provides information:

- ✓ About the eligibility determination;
- ✓ That enrollment will end after the month in which the PHE ends;
- ✓ That the individual can report any changes in circumstances while they remain enrolled; and
- ✓ That the state will redetermine the individual's eligibility based on such changes.

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At the end of the PHE, the state sends a second notice prior to the actual date of termination that provides:

- ✓ A minimum 10-day advance notice of termination; and
- ✓ Fair hearing rights.

States must also allow enrollees to provide information or return necessary forms/documentation through the end of the month in which the PHE ends prior to termination.

Post-COVID Eligibility and Enrollment Operational Plan

States will be required to develop a plan that describes the process for completing pending applications, redeterminations, and renewals.

- States have the option to either:
 - Use the Eligibility and Enrollment Pending Actions Resolution Planning Tool developed by CMS (*see next slide*); or
 - Develop and use their own eligibility and enrollment operational plan.
- States do not have to submit their plans to CMS for approval, but may be required to share the plans with CMS upon request (e.g., for audit purposes or if they are out of compliance with the unwinding timelines).
- States' plans must follow one of the following risk-based approaches to prioritizing their eligibility determination actions post-PHE:



Population-Based



Time-Based



Hybrid



Alternate

CMS Eligibility and Enrollment Pending Actions Resolution Planning Tool

On January 15, 2021, CMS released a tool to assist states in resolving pending applications, post-enrollment verifications, changes in circumstances, and renewals after the PHE.

Action Plan Summary

The tables below summarize the strategies and changes states should employ to restore their regular eligibility and enrollment operations. The summary tables are meant to support cross-cutting planning for states by concisely bringing together select information outlined in detail later in this tool, and to enable states to assess how the strategies adopted for each area may complement or compete with each other in order to develop an optimal overarching plan. These tables are placed first in the tool for future ease of reference, but states should return to it and complete it after completing the sections that follow.

For the cells containing checkboxes, please check all those that are applicable. No new information is required to complete this summary table after completing the rest of the tool except for any planning notes a state wishes to enter in the final column.

Risk-Based Approach

Action Area & Strategy/Change	Application Processing	Post-Enrollment Verifications	Changes in Circumstance	Renewals	Fair Hearings	Timeline	Planning Notes
Population-based approach	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	Enter timelines	Enter planning notes if applicable
Time-based approach	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	Enter timelines	Enter planning notes if applicable
Hybrid approach	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	Enter timelines	Enter planning notes if applicable
State-based approach	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	Enter timelines	Enter planning notes if applicable

Operational Strategies & Resource Plans

Action Area & Strategy/Change	Application Processing	Post-Enrollment Verifications	Changes in Circumstance	Renewals	Fair Hearings	Timeline	Planning Notes
Redistribute current staff responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enter timelines	Enter planning notes if applicable
Provide flexible work arrangements for current staff to support productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enter timelines	Enter planning notes if applicable

Source: CMS, Eligibility and Enrollment Pending Actions Resolution Planning Tool. Available at <https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-covid19-health-emergency-eligibility-enrollment-pending-actions-resolution-planning-tool.docx>.



Terminating or Extending Current COVID-19 Flexibilities

Terminating Current Flexibilities at the End of the PHE

Some of the flexibilities obtained by states are only allowable during a PHE. The new guidance lays out CMS' expectations when terminating these federal flexibilities.

Expiration Timeline	CMS Expectations of States
Section 1135 Waivers	
Generally at the end of the PHE; for some waivers, CMS has authorized grace periods post-PHE	<ul style="list-style-type: none">▪ Finalizing Provider Enrollments and Revalidation: Cease payments to providers who were not fully screened and enrolled in Medicaid within six months from the end of the PHE.<ul style="list-style-type: none">- States that paused revalidation of their providers must resume efforts upon the end of the PHE.- For revalidation due dates that occurred during the PHE, states may delay the due date by the amount of time the PHE is in place with an additional six months lead time.▪ Completing Level of Care Assessments: Outstanding assessments for 1915(c), (k) and (i) waivers should be completed within 90 days of the end of the PHE.▪ Requesting Fair Hearing Timeframes: Revert back to original requests for fair hearing timeframes or provide a longer reasonable time, not to exceed 90 days, to request a fair hearing, upon the end of the PHE.▪ Communicating with Consumers and Providers: Meet communication requirements for certain flexibilities (further detailed in the guidance).

Source: Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates. Available at <https://www.shvs.org/wp-content/uploads/2020/10/COVID-19-Emergency-Flexibility-Timelines-Product-01.08.2021.pdf>.

Terminating Current Flexibilities at the End of the PHE (Continued)

Expiration Timeline	CMS Expectations of States
COVID-19 PHE Section 1115 Demonstrations	
End of PHE + 60 days (or earlier date in the Special Terms and Conditions (STCs))	<ul style="list-style-type: none"> ▪ Reporting and Monitoring: Submit a reporting and monitoring report, consistent with the STCs, one year after the demonstration ends. (Applicable to Hawaii, Massachusetts, North Carolina, New Hampshire, Rhode Island, and Washington).
Optional Medicaid COVID-19 Testing Group	
End of the PHE <div data-bbox="57 811 517 982" style="background-color: #4a3d6a; color: white; padding: 5px; border-radius: 10px;"> <p><i>At least 17 states added the optional Medicaid COVID-19 testing group to their State Plans.</i></p> </div>	<ul style="list-style-type: none"> ▪ Communicating with Consumers: <ul style="list-style-type: none"> - Upon initial eligibility determination, inform enrollees of their termination date, and let them know that they may be eligible for more comprehensive Medicaid coverage and to submit a Medicaid application for a full eligibility determination. - At the end of the PHE, send a final letter of termination reiterating this information and the process for submitting a Medicaid application.
Regulatory Concurrence Letters	
Dependent on the language in the Concurrence Letter, as some are tied to the PHE	<ul style="list-style-type: none"> ▪ Resuming Operations: <ul style="list-style-type: none"> - Reconsider whether flexibilities that allow states to delay the processing of applications, renewals, and changes in circumstances are necessary; and resume operations as quickly as possible. - States taking more than 90 days to take final administrative action on fair hearing requests must begin processing requests when the PHE ends.

Extending Flexibilities Beyond the PHE

States may continue many flexibilities that they have obtained on a permanent basis through federal emergency authorities.

Emergency Authority	Steps to Continuing Certain Flexibilities on a Permanent Basis
1915(c) Waiver Appendix K	<ul style="list-style-type: none"> ✓ For states with Appendix Ks slated to end during the first quarter of 2021, amend the Appendix K to reflect an updated termination date that is no later than six months after the PHE. CMS will approve these changes on an expedited timeline. ✓ Provide updated notification to providers and enrollees (encouraged, but not required).
Medicaid and CHIP Disaster Relief State Plan Amendments (SPAs)	<ul style="list-style-type: none"> ✓ Submit a SPA through the regular amendment processes. ✓ Comply with appropriate tribal consultation and public notice/comment requirements. (See detailed CMS technical assistance linked in the footnotes). ✓ Make Medicaid managed care contract changes (as needed).
Verification Processes	<ul style="list-style-type: none"> ✓ Update Medicaid and CHIP Modified Adjusted Gross Income (MAGI) Verification Plans to make temporary verification flexibilities permanent.

Source: CMS All State Call. Available at <https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200616.pdf>; and <https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200623.pdf>; and 45 C.F.R. 95.624.

CMS General Transition Planning Tool

To help states return to normal operations upon conclusion of the PHE, CMS released on January 15, 2021, the General Transition Planning Tool.

Federal Authority (e.g., Section 1135 Waiver, Section 1915(c) Appendix K)


Table 1: Policy Change Strategies

Action Area and Strategy/Change	Enter Flexibility <i>(e.g., Prior Auth.)</i>	Enter Flexibility	Enter Flexibility	Enter Flexibility	Enter Flexibility	Enter Flexibility	Notes
Submit Medicaid SPA(s)	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	Enter planning notes if applicable
Submit CHIP SPA(s)	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	Enter planning notes if applicable
Submit Waiver Amendment(s)	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	Enter planning notes if applicable
Other <i>(detail or add rows)</i>	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	Enter planning notes if applicable

Table 2: Operational Strategies & Staffing

Action Area and Strategy/Change	Enter Flexibility <i>(e.g., Prior Auth.)</i>	Enter Flexibility	Enter Flexibility	Enter Flexibility	Enter Flexibility	Enter Flexibility	Notes
Evaluate and/or redistribute current staff responsibilities	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	Enter planning notes if applicable
Provide flexible work arrangements or overtime for current staff to support productivity	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	<input type="checkbox"/> Timeline:	Enter planning notes if applicable

Source: CMS, General Transition Planning Tool. Available at <https://www.medicare.gov/resources-for-states/downloads/general-transition-planning-tool-restoring-regular-medicare-chip-operations-conclusion-covid19-health-emergency.docx>.



Developing A Consumer and Provider Communication Strategy

Consumer and Provider Communication Strategy

States need to develop a robust and coordinated communication strategy that helps explain to consumers and providers in a tailored and accessible way what the changes related to continuous coverage and temporary flexibilities mean, and when they are effective.

- Manatt's new SHVS analysis of the guidance, [*CMS Guidance to States on Resuming Public Health Program Operations Post the COVID-19 PHE*](#), includes a table that summarizes the required communication related to continuous coverage requirements and unwinding COVID-19 flexibilities. States can refer to this tool (also included in the appendix) to determine when they need to provide notice to consumers and providers.
- Other Considerations:
 - The communication strategy should not create additional confusion.
 - States may choose to couple the strategy with trainings for call-center and eligibility and enrollment workforce so that they are prepared to respond to questions on the changes in policies.
 - States may wish to leverage their partnerships with managed care plans, providers, application assisters, navigators, and consumer advocates to help communicate the policy changes.

Questions

The slides and a recording of the webinar will be available at www.shvs.org after the webinar



Thank You

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Appendix

Required Communication Related to Unwinding COVID-19 Flexibilities and Federal Continuous Coverage Requirements

Unwinding Trigger	Content of Notice
<i>Medicaid Continuous Coverage Requirements</i>	
<p>Notice prior to termination of coverage (for delayed renewals, acting on changes in circumstances, post-enrollment verifications for self-attestations)</p>	<ul style="list-style-type: none"> ▪ Final termination notice: Minimum 10-day advance notice and fair hearing rights.
<p>Individuals whom Medicaid agency has determined ineligible within 6 months of the end of the month following the PHE and do not require a second redetermination</p>	<ul style="list-style-type: none"> ▪ At the time of the eligibility determination: Notice of the eligibility determination; that their coverage will end after the month in which the PHE ends; that they can and should report any changes in circumstances while they remain enrolled; and that the state will redetermine eligibility based on such changes. ▪ Final termination notice: Minimum 10-day advance notice and fair hearing rights.

Required Communication Related to Unwinding COVID-19 Flexibilities and Federal Continuous Coverage Requirements (Continued)

Unwinding Trigger	Content of Notice
<i>Unwinding Federal Flexibilities</i>	
Optional Medicaid COVID-19 Testing Eligibility Group	<ul style="list-style-type: none"> ▪ At the time of the eligibility determination: Notice that the coverage through COVID-19 testing group will be terminated at the end of the PHE; that the individual may be eligible for comprehensive Medicaid coverage; and how to submit a Medicaid application. ▪ Final termination notice: Information that the individual may be eligible for comprehensive Medicaid coverage; and how to submit a Medicaid application.
Medicaid and CHIP Disaster Relief SPA	<ul style="list-style-type: none"> ▪ Consumer communication regarding the following changes no longer in effect, if applicable: <ul style="list-style-type: none"> - Change from less restrictive methodologies; - Unsuspension of cost sharing or premiums; - Modification of benefits; - Changes in amount, duration, or scope of benefits (both state plan and Alternative Benefit Plan); - Changes in monthly prescription limits (e.g., number of prescriptions allowed per month); and - Modification of the basic personal needs allowance for institutionalized individuals.

Required Communication Related to Unwinding COVID-19 Flexibilities and Federal Continuous Coverage Requirements (Continued)

Unwinding Trigger	Content of Notice
Section 1135 Waivers	<ul style="list-style-type: none"> ▪ Consumer communication regarding the following changes no longer in effect, if applicable: <ul style="list-style-type: none"> - Prior authorizations for fee-for-service; - Times for the provision of authorized services and service authorizations in managed care; - Allowing personally responsible individuals to render personal care services; - Allowing home and community-based services (HCBS) in specified settings that have not been determined to meet HCBS settings criteria; - Allowing provision of HCBS by entities also providing case management services under a temporary waiver of conflict of interest requirements; - Allowing individual’s representative to provide Section 1915(j) and/or 1915(k) services; and - Allowing private duty nursing services to be delivered by graduate registered nurse and/or graduate licensed practical nurse. ▪ Provider communication: <ul style="list-style-type: none"> - Conflict of interest waivers allowing providers to provide both case management and to render direct care HCBS to transition to providing only one of these services.