Medical Care Advisory Committee: COVID-19 Public Health Emergency Unwinding

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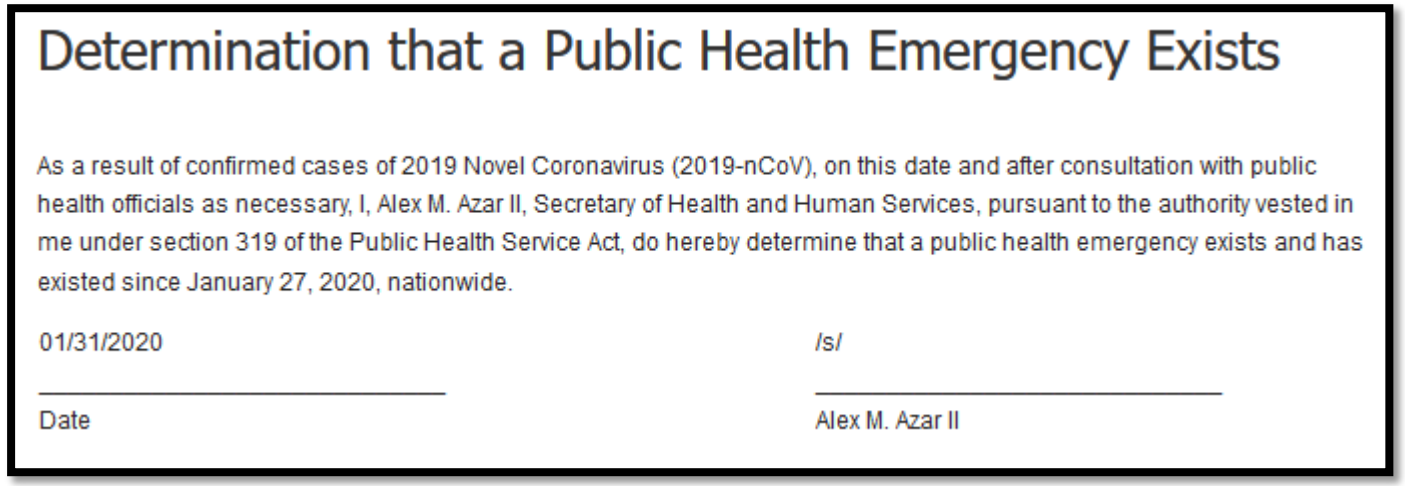
COVID-19 Public Health Emergency (PHE) Declaration

Public Health Emergency Declaration

- Under section 319 of the Public Health Service (PHS) Act, the Secretary of the Department of Health and Human Services (HHS) can declare a public health emergency (PHE)
- On January 31, 2020, Secretary Azar issued a declaration stating that the PHE had existed since January 27, 2020, nationwide



Determination that a Public Health Emergency Exists

As a result of confirmed cases of 2019 Novel Coronavirus (2019-nCoV), on this date and after consultation with public health officials as necessary, I, Alex M. Azar II, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby determine that a public health emergency exists and has existed since January 27, 2020, nationwide.

01/31/2020 — Date

/s/ — Alex M. Azar II

Public Health Emergency Duration

- The PHE declaration lasts for the duration of the emergency or 90 days, whichever is longer, but may be extended by the Secretary
- Following his original PHE declaration, the Secretary has issued four PHE renewals:

Signature Date	Effective Date	Expiration Date
April 21, 2020	April 26, 2020	July 24, 2020
July 23, 2020	July 25, 2020	October 22, 2020
October 2, 2020	October 23, 2020	January 20, 2021
January 7, 2021	January 21, 2021	April 20, 2021

- In a letter to governors dated January 22, 2021, Acting HHS Secretary Cochran indicated the COVID-19 PHE will likely remain in place for the entirety of 2021, and that HHS will provide states with 60 days' notice prior to termination when a decision is made to terminate the declaration or let it expire

Families First Coronavirus Response Act (FFCRA)

Temporary Increase of Medicaid FMAP

- Effective January 1, 2020, states may claim a 6.2 percentage point increase in FMAP if they meet certain requirements:

FFCRA 6008(b) Conditions for 6.2 Percentage Point Increase in FMAP	Termination Date of the Condition
Maintenance of Effort (standards, methodologies, procedures) - Section 6008(b)(1) of FFCRA	Expires on the last day of the calendar quarter in which the PHE ends
Premium Restrictions - Section 6008(b)(2) of FFCRA	Expires on the last day of the calendar quarter in which the PHE ends
Continuous Coverage - Section 6008(b)(3) of FFCRA	Expires on the last day of the month in which the PHE ends
Coverage of, and Cost-sharing Exemption for, COVID-19-Related Testing and Treatment - Section 6008(b)(4) of FFCRA	Expires on the last day of the calendar quarter in which the PHE ends

- The increased FMAP expires on the last day of the calendar quarter in which the PHE ends

Continuous Coverage Provision

- Section 6008(b)(3) of the FFCRA requires states to maintain the enrollment and coverage of Medicaid beneficiaries who were enrolled as of or after March 18, 2020
- CMS provided an initial interpretation of the continuous coverage provision through a series of FAQs issued in April, May, and June 2020
- CMS's initial interpretation required states to keep beneficiaries enrolled in Medicaid, if they were enrolled as of or after March 18, 2020, with at least the same amount, duration, and scope of benefits, including the same cost-sharing and patient liability (if any) through the end of the month in which the COVID-19 PHE ends
- In November 2020, CMS issued an interim final rule with request for comments (IFC) that reinterpreted the continuous coverage provision

42 CFR §433.400 – Continued Enrollment for Temporary FMAP Increase

- The IFC established a new section 433.400 in Part 433 of Title 42 of the Code of Federal Regulations, which provides that:

> States claiming the temporary FMAP increase must maintain the Medicaid enrollment of validly enrolled beneficiaries in one of three tiers of coverage (or a more robust tier of coverage). Such coverage must be maintained, with certain exceptions, through the end of the month in which the COVID-19 PHE ends.

- Three tiers of coverage:
  - » Minimum Essential Coverage (MEC)
  - » Non-MEC with coverage of COVID-19 testing and treatment
  - » Non-MEC with limited benefits

Ohio Medicaid COVID-19 PHE Response

Disaster-Related Legal Authorities

- Medicaid State Plan Amendment (SPA) - In response to a disaster, states may revise Medicaid eligibility, enrollment, and benefit requirements in their State Plan
- Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum - States may change their Medicaid and CHIP verification processes in response to a disaster and must document those changes in an amended Verification Plan
- 1915(c) Waiver Appendix K – States may submit an Appendix K to document necessary changes to waiver operations in order to respond to an emergency
- 1135 Waiver – Under Section 1135 of the Social Security Act, the Secretary has the authority to temporarily waive or modify certain Medicaid requirements

PHE Flexibilities Elected by ODM

- Increased service limits for HCBS waivers
- Provision of services in alternative settings
- Broad expansion of telehealth for services and assessments
- Temporary extension of hospital presumptive eligibility (HPE) to individuals in institutions who are eligible under a special income level (SIL)
- Suspension of copayments for services with copayments
- Addition of Health Care Isolation Centers (HCICs) as a NF benefit
- Suspension of limits on home health and private duty nursing
- Acceptance of self-attestation without additional verification for eligibility criteria
- Addition of hospital facility payments for telehealth services

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Public Health Emergency (PHE)

Additional Federal Match 6.2%

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Must continue Medicaid eligibility

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Flexibility: Appendix K, 1135, etc.

Caseload

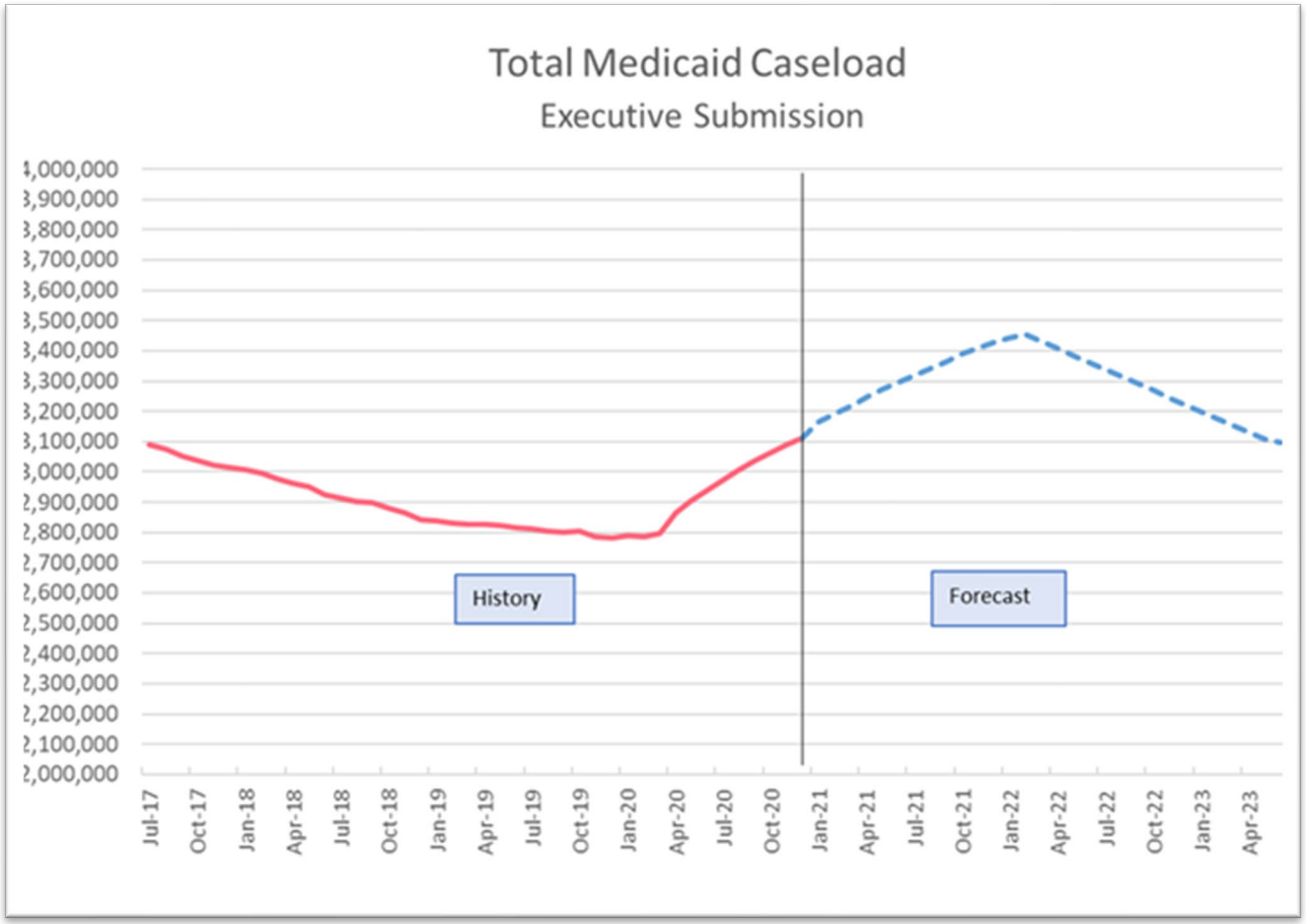
- Significant increase
  - Redeterminations and Changes in Circumstances
  - New beneficiaries

Unwinding

- Flexibilities & rules

"VERY LIKELY THROUGH 2021"

Ohio Medicaid Caseload Projections



The Ohio Medicaid 2020 caseload increased by nearly 330,000 since the start of the COVID-19 public health emergency (PHE).

Resuming Normal Operations

State Health Official Letter #20-004

- On December 22, 2020, CMS issued a State Health Official (SHO) Letter which provides guidance regarding the resumption of normal state Medicaid operations upon conclusion of the COVID-19 PHE
- Temporary authorities adopted by states to respond to the PHE are scheduled to automatically sunset upon termination of the PHE or another specified date

Authority/Provision	Effective Date	Termination Date
Medicaid Disaster Relief SPA for the COVID-19 PHE	March 1, 2020 or any later date elected by the state	Expires at the end of the PHE or any earlier approved date elected by the state.
Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum	Any date elected by the state	Expires on a date selected by the state.
1915(c) Waiver Appendix K	January 27, 2020 or any later date elected by the state	For Appendix K submissions in response to the COVID-19 PHE, the termination date will be no later than six months after the expiration of the PHE.
Medicaid 1135 Waiver	March 1, 2020	Expires at the end of the PHE

Eligibility and Enrollment

- After the PHE ends, the state will need to process the backlog of pending COVID-related eligibility and enrollment actions
  - » Applications
  - » Redeterminations based on changes in circumstances
  - » Renewals
- States may take up to **four months** following the end of the month in which the PHE ends to process pending applications received during the PHE and resume routine operations
- States may take up to **six months** following the end of the month in which the PHE ends to process redeterminations based on changes in circumstances, complete pending renewals, and resume routine operations
- States must develop and document strategies to achieve the timelines outlined in CMS guidance via the Post-COVID Eligibility and Enrollment Operational Plan

Eligibility and Enrollment Considerations

- Identify discrete eligibility populations and potential for automated processing to reduce burden on CDJFS caseworkers
- Prioritize actions that ensure eligible individuals are able to enroll and remain enrolled in Medicaid
- Encourage processing of pending applications, verifications, redeterminations based on changes in circumstances, and renewals during the PHE to limit the backlog of pending actions that will need to be addressed when the PHE ends
- Adopt or continue existing authorities to streamline eligibility and enrollment processes
- Create efficiencies by aligning work on pending Medicaid actions with upcoming recertifications for other benefit programs such as SNAP
- State hearings

Policy, Operations, and Managed Care

- Long-term Services and Supports (LTSS)
  - » Enrollment, case management, and service authorizations
  - » Alternative settings
- Care/case management emergency protocol
- Provider revalidation pause
- Federal reporting
- Managed care
  - » Contracts
  - » Rate recertifications
- Copayments, telehealth, and prior authorization waivers
- Provider site visits
- Payment rates for COVID-related services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