

COVID-19

CMS Guidance to States on Resuming Public Health Program Operations Post the COVID-19 Public Health Emergency

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Overview

On December 22, 2020, the Centers for Medicare and Medicaid Services (CMS) released long-awaited guidance to state Medicaid and Children's Health Insurance Program (CHIP) agencies on resuming normal operations following the end of the COVID-19 public health emergency (PHE).¹ The CMS State Health Official (SHO) letter sets out expectations related to timelines and consumer communications for redetermining Medicaid eligibility for those who have had their coverage continuously maintained during the PHE as a condition of receiving a temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) increase under the Families First Coronavirus Response Act.² The guidance also lays out the expected processes for terminating, or making permanent where allowable, temporary federal flexibilities obtained during the PHE through Section 1135 and 1115 Waivers, Section 1915(c) Waiver Appendix Ks, Disaster Relief State Plan Amendments (SPAs), and Disaster Relief Modified Adjusted Gross Income (MAGI)-Based Verification Plan Addendums.³

The PHE is now extended to April 20, 2021, providing states additional time (which could further be prolonged in the event of another PHE renewal) to implement the necessary operational processes for unwinding the Medicaid continuous coverage requirements and other federal flexibilities. The incoming Biden Administration may also seek to modify some of the requirements outlined in the guidance, such as the expectation that states resolve all of their pending renewals and redeterminations within six months of the end of the PHE, as described in further detail below. This issue brief provides a high-level summary of the CMS guidance related to: (1) conducting redeterminations for Medicaid enrollees who were continuously enrolled; (2) terminating, or extending where appropriate, temporary flexibilities; and (3) developing a consumer and provider communication strategy.

¹ CMS, "[SHO # 20-004: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Operations Upon Conclusion of the COVID-19 Public Health Emergency](#)," December 22, 2020.

² [P.L. 116-127](#), Families First Coronavirus Response Act, March 18, 2020.

³ State Health and Value Strategies, "[Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts: Effective and End Dates](#)," January 8, 2021.

Conducting Redeterminations for Medicaid Enrollees who were Continuously Enrolled in Coverage

As a condition of receiving enhanced FMAP, states are required to maintain Medicaid coverage through the end of the month in which the PHE ends, which is currently April 20, 2021. CMS encourages states to redetermine eligibility, conduct renewals and process pending verifications, to the extent possible, for its Medicaid enrollees prior to the end of the PHE; those who are found ineligible, however, may not have their coverage terminated.

After the month in which the PHE ends, states and territories will need to redetermine eligibility for changes in circumstances reported or identified during the PHE, complete outstanding renewals, and process determinations that were previously based on self-attestations but still require verification using available data sources. Understanding the backlog states face, the CMS guidance provides up to six months following the end of the month of the PHE for states to resolve all outstanding renewals, redeterminations, and verifications of eligibility.⁴

States must conduct Medicaid renewals and redeterminations consistent with federal regulations, which require states to first attempt to redetermine eligibility based on available information, without requiring information from the individual.⁵ If that information is sufficient to determine continued eligibility, the state agency shall proceed with an ex-parte renewal. If available information is insufficient to determine continued eligibility, the state must send a renewal form (pre-populated for MAGI populations) and request additional information from the individual.⁶ Consistent with federal regulations, enrollees must be evaluated for other eligibility categories prior to termination and have their information shared with the state-based or federal Marketplace for an eligibility determination. States must also send an adverse action notice prior to termination.

CMS will permit states to rely on a previous eligibility determination (conducted during the PHE less than six months prior to the date coverage is slated to be terminated after the PHE) without conducting a second redetermination. This is only permissible if the state sends a detailed notice at the time of the ineligibility determination during the PHE. At the end of the PHE, states and territories must provide a minimum 10-day advance notice of termination, fair hearing rights, and the ability to provide additional information with regard to their eligibility.

States are also required to develop a post-COVID eligibility and enrollment operational plan that describes the process for competing pending applications (which must be completed within four months of the end of the PHE), renewals, and redeterminations. On January 15, 2021, CMS released two tools to assist states and territories in their planning efforts to transition back to regular operations and resolve eligibility and enrollment actions: (1) the

⁴ CMS cites the regulatory timeliness exception at 42 C.F.R. 435.912(e)(2), 457.340(d), and 600.320(b) as the legal basis for allowing this extended timeline.

⁵ 42 C.F.R. 435.916.

⁶ Id.

[General Transition Planning Tool for Restoring Regular Medicaid and Children’s Health Insurance Program Operations after Conclusion of the Coronavirus Disease 2019 Public Health Emergency](#); and (2) the [Medicaid and Children’s Health Insurance Program COVID-19 Public Health Emergency Eligibility and Enrollment Pending Actions Resolution Planning Tool](#). States will have to provide data to CMS to demonstrate their progress on plan implementation.

The guidance outlines several risk-based approaches for states to address pending eligibility and enrollment actions, all of which prioritize redetermination of individuals who are most likely no longer eligible for coverage. States may select among four risk-based approaches: (1) a population-based approach (e.g., new adults turning 65); (2) a time-based approach (e.g., prioritizing March to June 2020 pending renewals first and then turning to July to September 2020 pending renewals); (3) a hybrid population and time-based approach (e.g., prioritizing individuals who turned 65 who were up for renewal in March 2020); or (4) an alternate state-developed approach.

When redetermining eligibility for those who were previously enrolled in coverage, the guidance provides states with flexibility for determining an enrollee’s renewal eligibility periods.

Table 1: Required Timelines for Completing Pending Eligibility Actions Post-PHE

PENDING ACTIONS	REQUIRED TIMEFRAME POST PHE
Non-disability-related applications	2 months
Disability-related applications	3 months
Timely determinations of applications resume	4 months
Verifications for individuals enrolled based on self-attested information (that require verifications)	6 months
Changes in circumstances	6 months
Renewals	6 months

Terminating or Extending, where Appropriate, Current COVID-19 Flexibilities

The CMS guidance also reviews expectations of states related to timelines and operational processes for extending flexibilities obtained and terminating flexibilities that were granted to states under the PHE.

Terminating Current Flexibilities Upon the End of the PHE. Some of the flexibilities obtained by states, such as those authorized under Section 1135 and 1115 Waivers, are only allowable during a PHE and may not be continued. The guidance lays out CMS timelines and consumer and provider communication requirements for terminating these federal flexibilities.

- **Section 1135 Waivers.**
 - *Finalizing Provider Enrollments and Revalidation:* States will have up to six months from the end of the PHE to end payments to providers who were not fully screened and enrolled in Medicaid. States that have temporarily paused revalidation of their providers must resume those efforts at the end of the PHE.
 - *Completing Level of Care Assessments:* Outstanding assessments for Section 1915(c), (k) and (i) Waivers should be completed within 90 days of the end of the PHE.
 - *Requesting Fair Hearing Timeframes:* States received flexibility through Section 1135 Waivers to provide more than 90 days to request a fair hearing. Upon the end of the PHE, states may revert back to their original request for fair hearing timeframes or provide a longer reasonable time, not to exceed 90 days, to request a fair hearing.
- **COVID-19 PHE Section 1115 Waivers.** Six states—[Washington](#), [New Hampshire](#), [Hawaii](#), [North Carolina](#), [Rhode Island](#), and [Massachusetts](#), received approval for limited preset Section 1115 flexibilities⁷ that will end no later than 60 days after the conclusion of the PHE.
- **Terminating Coverage in the Optional Medicaid COVID-19 Testing Group.** As of July 2020, 17 states have added the Optional Medicaid COVID-19 Testing Group to their state plans,⁸ and this optional eligibility group terminates at the end of the PHE. States are obligated to 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.
- **Flexibilities Granted via Regulatory Concurrence.** Some states sought concurrence from CMS that, due to operational process challenges as a result of the COVID-19 pandemic, they will be delayed in processing their applications, renewals, and changes in circumstances. The CMS guidance encourages states to revisit the utilization of this flexibility and to resume operations as quickly as possible. States that are taking more than 90 days to take final administrative action on fair hearing requests under this flexibility must begin processing the requests when the PHE ends.

Extending Flexibilities Beyond the PHE. States may continue many flexibilities they have obtained on a permanent basis through federal emergency authorities as described below.

- **1915(c) Waiver Appendix K.** Many states' approved Appendix Ks are slated to end during the first quarter of 2021. The CMS guidance allows states to amend, through an expedited

⁷ M. Lipson, "[CMS Approvals of COVID-19 1115 Waivers Are Limited to Date](#)," Manatt, July 31, 2020.

⁸ S. Rosenbaum, R. Morris, and M. Valesquez, "[States Can Test for COVID-19 Under the Uninsured Medicaid Eligibility Option, But Why are So Many Opting Out?](#)" The Commonwealth Fund, August 13, 2020.

process, their Appendix Ks to reflect an updated termination date to be no later than six months after the PHE. The guidance also reminds states that many, but not all, flexibilities obtained through an Appendix K can be made permanent through an amendment to an existing Section 1915(c) Waiver.

- **Medicaid and CHIP Disaster Relief SPAs.** States seeking to make permanent the temporary flexibilities obtained through Medicaid and CHIP Disaster Relief SPAs are required to submit a SPA through the regular amendment processes and comply with appropriate tribal consultation and public notice comment period requirements. CMS has developed for states detailed technical assistance materials that walk through these processes.⁹
- **Verification Processes.** Some states availed themselves of temporary verification flexibilities through Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendums. The guidance reminds states that such flexibilities can be made permanent through their Medicaid and CHIP MAGI Verification Plan.

Developing a Consumer and Provider Communication Strategy

Finally, the guidance requires states to develop a robust and coordinated communication strategy to explain to consumers and providers, in a clear and accessible way, what the changes related to the end of the PHE mean, and when they are effective. The guidance notes that state communications should be tailored to individual enrollees, to the maximum extent possible.

The communication strategy should be coupled 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 also wish to leverage their partnerships with managed care plans, providers, application assisters, navigators, and consumer advocates to help communicate the policy changes. Table 2, below, provides a summary of required communications for consumers and providers.

⁹ CMS All State Call, June 16, 2020 available at <https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200616.pdf>; CMS All State Call, June 23, 2020 available at <https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200623.pdf>.

Table 2: 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"> • <i>Final termination notice:</i> 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"> • <i>At the time of the eligibility determination:</i> 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. • <i>Final termination notice:</i> Minimum 10-day advance notice and fair hearing rights.
<i>Unwinding Federal Flexibilities</i>	
<p>Optional Medicaid COVID-19 Testing Eligibility Group</p>	<ul style="list-style-type: none"> • <i>At the time of the eligibility determination:</i> 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. • <i>Final termination notice:</i> Information that the individual may be eligible for comprehensive Medicaid coverage; and how to submit a Medicaid application.
<p>Section 1135 Waivers</p>	<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;

UNWINDING TRIGGER	CONTENT OF NOTICE
<p>Section 1135 Waivers (cont.)</p>	<ul style="list-style-type: none"> ○ 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.
<p>Medicaid and CHIP Disaster Relief SPA</p>	<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.

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