

# Transition Planning Issues & Recommendations

September 2020



Administrative/Operational			
Issue	Description	Key Questions	Recommendations
<b>Eligibility</b>			
<b>Maintenance of Effort (MOE)</b>	The Families First MOE provision prohibits states from disenrolling individuals from Medicaid, and states may not reduce the amount, duration, and scope of Medicaid services that were available at the start of the public health emergency (PHE) as long as the state is receiving the enhanced match.	<p><i>What are the expectations for states related to meeting MOE requirements when the PHE has expired?</i></p> <p><i>What amount of advance notification will be provided regarding the expiration of the PHE to allow states and other Medicaid partners (MCOs/enrollment brokers/providers) to support members in ensuring access to coverage in Medicaid and/or other programs?</i></p>	<p>CMS needs to work with states and plans to make sure the timeline is smooth. We want to prevent a sudden disenrollment of members in the states, and make sure members and plans have plenty of notice to adapt.</p> <p>States should provide a minimum of 60-day notice if and when changes to the Medicaid program that were kept in place due to the MOE will be made (e.g., premium levels, eligibility levels).</p>
<b>Coverage Implications</b>	Most states received permission to extend the time frame for beneficiaries to request state fair hearings; in these states, beneficiaries disputing initial eligibility determinations were given an additional 90 days and managed care enrollees were	<p><i>Is CMS considering additional state flexibility to continue this time frame post-PHE?</i></p> <p><i>What are the expectations for notice and implementation related to transitioning to the pre-PHE timeframes?</i></p>	States should continue to have flexibility to provide members with additional timeframes to meet administrative requirements post-PHE to ensure eligibility determinations are accurate and members are given adequate time to understand their coverage options.

	<p>given 120 additional days. Medicaid beneficiaries who appeal an adverse determination must have services continue through the appeals process.</p>	<p><i>What are the expectations for managed care plans for transitions related to expiration of this policy?</i></p>	<p>Protections for plans and state partners should be developed and communicated prior to the expiration of any PHE policy changes to maximize compliance.</p>
<p><b>Communication Requirements</b></p>	<p>State communications to managed care plans related to changes in COVID-19 policy have included changes to Medicaid eligibility; MCO contractual/regulatory requirements; scope of benefits covered; and provider and/or serviced payment modifications.</p>	<p><i>Is CMS considering minimal requirements for state communications (timing, frequency, content, modality) to managed care plans related to transitioning from COVID-19-policies to pre-PHE policies?</i></p>	<p>CMS should consider streamlining the state approval processes for member communications related to member education, benefits, and marketing materials that are time sensitive in nature due to the pandemic in order to decrease the administrative burden on the states and increase timeline communication of information with members</p> <p>States should provide a minimum 30-day grace period where plans can send out communications that have been previously approved if there are no material changes made other than dates, timelines, etc. without state approval.</p> <p>CMS should also consider a temporary automatic approval process for 6 months post-PHE</p>

			that provides if a material is not approved within 5 business days by the state, plans can consider it approved.
<b>Benefit changes</b>			
<b>Telehealth</b>	<p>The pandemic has accelerated state Medicaid programs' expansion of telehealth services.</p> <p>Given the PHE, many compliance requirements have been eased temporarily. In addition, reimbursement requirements related to documentation and telehealth codes were quickly authorized by the federal government and state agencies to use during the PHE.</p> <p>Other issues related to telehealth include general availability, adoption, standards, responsibilities, and accountability of parties.</p>	<i>How will CMS help facilitate increased access to clinically-appropriate telemedicine in Medicaid post-PHE?</i>	<p>CMS should make permanent telehealth flexibilities involving delivery of home care, include waiving originating site requirements and supporting the expansion of the types of providers who can provide telehealth services for those services that are not dependent on in-person contact.</p> <p>Medicaid managed care plans should be given discretion over what is clinically appropriate for telehealth.</p> <p>CMS should work with states to develop an interstate telehealth compact to address a number of telehealth requirements and encourage greater provider and bene take up. The goal would be to harmonize state laws where possible.</p>

			CMS could support efforts/initiatives with enhanced funding for states to promote ongoing infrastructure development of telehealth capabilities with a focus on rural/frontier areas.
<b>Prior Authorization/Utilization Management</b>	Nearly all of the states have received permission to temporarily suspend some of their prior authorization and utilization management policies.	<p><i>Is CMS considering authorizing state flexibility to continue this policy for a period of time PHE?</i></p> <p><i>What are the expectations for states when the temporary suspension of prior authorization and utilization management requirements are reinstated?</i></p> <p><i>What are the expectations for managed care plans for this transition?</i></p>	<p>CMS should resume former precertification, prior authorization, and other utilization management levers after the PHE to ensure that beneficiaries receive the most cost-effective and medically necessary treatments, while preventing costs from rising due to unnecessary utilization.</p> <p>CMS could also work with MCOs to update any necessary prior authorization and/or other utilization management requirements to modernize them to allow for efficient and effective management of care.</p>
<b>Offering Out-of-Network Access for Covered Services</b>	The PHE has provided for the coverage of out-of-network services.	<i>Is CMS considering minimal requirements for the transition to pre-PHE policies on the coverage of out-of-network services?</i>	Managed care plans should be allowed to return to typical out-of-network coverage policies as soon as possible:

		<p><i>What are the expectations for managed care plans for this transition?</i></p>	<ol style="list-style-type: none"> <li>1) To reestablish incentives for providers to join networks; and</li> <li>2) To improve MCOs' and state's overall ability to manage cost and utilization via network development.</li> </ol> <p>CMS should work with states to develop an interstate compact related to out-of-network access for covered services The goal would be to harmonize state laws where possible.</p>
<p><b>Rx Drug Coverage</b></p>	<p>The PHE has allowed for flexibility in Rx drug coverage to fill quantities – 30-day vs. 90-day; generic vs. brand; and early refills.</p> <p>With a return to the pre-PHE policies, these changes raise a number of risks including the potential for member confusion, delay in refills, and a drop in medication adherence as members may have gotten used to these policies and not having to see a physician as frequently.</p>	<p><i>Is CMS considering minimal requirements for the transition to pre-PHE policies for the implementation of Rx drug coverage?</i></p> <p><i>What are the expectations for managed care plans for this transition?</i></p>	<p>CMS should encourage states to continue to allow flexibility for &gt;30-day refills and mail-order delivery for maintenance medications post-PHE.</p> <p>To minimize confusion, CMS will need to communicate about the return to pre-PHE policies to providers, pharmacists, and the plans.</p>

**IT Systems**

<p><b>Eligibility Systems</b></p>	<p>PHE-driven changes to Medicaid eligibility have required significant reconfigurations for Medicaid eligibility systems. In addition, increasing Medicaid enrollment is impacting IT systems and workflow.</p>	<p><i>Is CMS considering establishing timeframes to allow for IT reconfigurations related to post PHE policy changes?</i></p>	<p>States should be granted regulatory and operational flexibility to meet any IT standards.</p> <p>States should also be encouraged to identify opportunities to modernize and/or accelerate plans for system updates during this transition.</p>
<p><b>MMIS Impacts</b></p>	<p>PHE-driven changes have required modifications for Medicaid claims payment systems.</p>	<p><i>Is CMS considering establishing timeframes to allow for IT reconfigurations related to post PHE policy changes?</i></p>	<p>CMS should consider greater flexibility on interoperability implementation at the state level to ease any issues that may arise.</p>
<p><b>Managed Care IT Systems</b></p>	<p>PHE-driven changes have required modifications for managed care IT systems that will require additional reinstatements and modifications depending upon post-PHE transition policies.</p>	<p><i>Is CMS considering establishing timeframes to allow for managed care plans to implement IT reconfigurations related to post PHE policy changes?</i></p>	<p>CMS should encourage states to give managed care plans a minimum of 30-day timeframe to implement IT reconfigurations.</p>

**Sustainability**

**Managed Care Rates**

**Implications to Medicaid Managed Care Rates - Disenrollment Volume and Speed**

Increased Medicaid enrollment, ongoing state budget pressures, followed by potential disenrollment (upon the termination of the PHE) has implications for managed care rates based on the volume and speed of disenrollment.

*How will states adjust capitation rates and provider payments to reflect the added costs of adapting plan operations and care due to the COVID-19 pandemic?*

CMS should issue additional guidance to states affirming actuarial soundness principles in rate setting; this could include upward adjustments to capitation rates when state requirements of managed care plans results in increased costs.

**Ability to True-up Rates - Acuity/Utilization per/post Enrollment Changes**

COVID-19 has drastically changed Medicaid enrollment and health care utilization. The current underutilization of non-essential and or delayed services will impact rate setting for the next fiscal year and could lead to inappropriate changes in plan and provider reimbursements.

*How will states adjust capitation rates and provider payments to reflect the added costs of adapting plan operations and care due to the COVID-19 pandemic?*

CMS should reaffirm requirements that state rates be actuarially sound.

CMS should issue guidance that clarifies allowable actions that states can take on rates and underscores that such action must be aligned with the regulatory requirement of actuarial soundness and the principle of transparency. For example, the guidance should clarify that risk corridors should be no less than 1 full contract period and any de minimis rate cuts must be tied to a specific program change.

			<p>On a state by state basis, consider using a multi-year MLR during the PHE to account for variability in utilization due to stay at home orders.</p>
<p><b>Quality Reporting</b></p>	<p>Lack of encounters due to the pandemic has dramatically diminished the availability of critical data necessary to calculate quality measures. This has an impact on alternate payment models to providers and quality payments to MCOs.</p>	<p><i>Will CMS provide additional and ongoing guidance to states, MCOs and providers on parameters for deploying and calculating payments tied to quality, especially existing agreements contingent on 2020 reporting data?</i></p>	<p>Similar to current Medicare-Medicaid plan guidance, Medicaid MCOs should not be subject to quality withhold penalties due the inability to collection critical data during the PHE.</p> <p>CMS should encourage states to not hold managed care plans accountable for quality measures directly tied to outreach to members for 1 year post-PHE.</p> <p>It is also very likely that there will be abnormalities in care delivery, data reporting, etc. into 2021, so additional flexibilities may also be warranted. For example, CMS could consider reducing quality reporting measures to critical measures, such as immunizations, to reduce reporting burden.</p>

<p><b>Program Integrity</b></p>	<p>The COVID-19 pandemic has placed significant financial pressures on the Medicaid program that include new challenges for ensuring the proper management and function of the Medicaid program related to quality of care and the efficient use of taxpayer dollars.</p>	<p><i>Will CMS provide guidance related to various stakeholder accountabilities and program integrity?</i></p>	<p>CMS should ensure that program integrity efforts support the financial sustainability of the Medicaid program through the requirement of:</p> <ol style="list-style-type: none"> <li>1) Objective environmental assessments (e.g., requirement of third-party audits); and</li> <li>2) Transparency (e.g., clear and consistent application of rules).</li> </ol>
<p><b>COVID-19 Testing and Treatment</b></p>			
<p><b>COVID-19 screening/testing</b></p>	<p>States are required to cover COVID-19 diagnostic testing and testing-related services without cost-sharing.</p>	<p><i>What are the expectations for the states related to COVID-19 testing after the expiration of the PHE?</i></p> <p><i>What is CMS considering about Medicaid coverage/payment for testing (either during or after PHE) that might not be “medically necessary” but needed for non-clinical uses (e.g., included in back to work/school protocols)?</i></p> <p><i>Is CMS considering authorizing state flexibility to continue the policy of covering COVID diagnostic testing and testing-</i></p>	<p>In alignment with CMS guidance on commercial insurance on testing, CMS should issue guidance that affirms that Medicaid managed care plans should only be required to cover medically necessary testing and should not be required to cover testing for back to work and back to school testing</p> <p>The federal government should establish necessary codes to distinguish between medically necessary testing, public health surveillance testing, and return</p>

		<p><i>related services without cost-sharing for a period of time post-public health emergency?</i></p>	<p>school or occupational health testing.</p> <ul style="list-style-type: none"> <li>• Medically necessary: Physician-recommended testing, direct exposure or relevant symptoms and potentially result in direct patient care</li> <li>• Public health surveillance: Population-level testing, part of public health effort for contact tracing</li> <li>• Occupational health: Employer-directed testing, e.g. for return-to-work.</li> </ul>
<p><b>COVID-19 treatment</b></p>	<p>States must cover, under the state plan (or waiver), testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies, for any quarter in which the temporarily increased FMAP is claimed.</p>	<p><i>What is CMS considering to assist states in developing standards for measuring the quality of care for treatment of COVID-19 and related conditions?</i></p>	<p>Standards of care must be aligned with reimbursement and actuarial principles.</p> <p>Ongoing support should be provided to states following the end of the PHE to support access to treatment services. States should continue to have access to financial resources to pay for treatment for those covered under Medicaid or a program created to address the</p>

			<p>pandemic. Additionally, clinical guidelines and best practices should be provided to states, providers and managed care organizations to ensure the delivery of the most appropriate and effective care.</p>
<p><b>COVID-19 vaccine distribution</b></p>	<p>Vaccines are currently in development. Timing of their availability and methods for allocation and distribution remain uncertain.</p>	<p><i>If and when a vaccine becomes available, what coverage, access, network, and payment protocols will CMS require states to put in place to ensure access to immunizations?</i></p> <p><i>Who is the CMS lead for states and MCOs on the deployment of vaccines when available?</i></p>	<p>The federal government should continue its public-private partnership with stakeholders, such as payers, manufacturers, and states to determine recommendations regarding data collection, stratification of members, local and community partnerships, and strategic disbursement of initial vaccination allotment for vulnerable members.</p>