

State Medicaid & Basic Health Programs: CMS Flexibilities to Fight COVID-19

Since the beginning of the COVID-19 Public Health Emergency, the Trump Administration has issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. These temporary changes will apply immediately for the duration of the emergency declaration.

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is funded jointly by states and the federal government, and the programs are administered by states, according to federal requirements. Medicaid provides comprehensive benefits to people who are determined eligible by states. Some benefits are required and some are optional.

An additional health coverage program that states may elect to operate is the Basic Health Program (BHP). In the states that elect to operate a BHP, the BHP makes affordable health benefits coverage available for individuals under age 65 with household incomes between 133 percent and 200 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage. The Center for Medicaid and CHIP Services (CMCS) made the following Medicaid and BHP regulatory updates in this Interim Final Rule with Comment Period (IFC):

Medicaid Mandatory Benefit Revisions

Laboratory Services Flexibility

The Families First Coronavirus Response Act (FFCRA) added a new mandatory benefit in the Medicaid statute at section 1905(a)(3)(B) of the Act, and this provision was amended by section 3717 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Section 1905(a)(3)(B) of the Act provides that, for any portion of the COVID-19 public health emergency (PHE) period that begins on or after March 18, 2020, Medicaid coverage must include certain tests for the detection of COVID-19, as well as administration of these tests.

This IFC amends the CMS regulation at 42 CFR 440.30 to provide flexibility with respect to Medicaid coverage of certain COVID-19 related laboratory tests in a greater variety of circumstances and settings. For example, the IFC provides states with flexibility to cover, under their Medicaid programs, a COVID-19 test without it being first ordered by a physician or other licensed practitioner, as well as to cover COVID-19 tests administered in certain non-office settings that are intended to minimize transmission of COVID-19, such as parking lots. Given the nature and scope of the pandemic, it is important to accommodate the evolution of COVID-19 diagnostic mechanisms. The regulatory updates would also allow Medicaid to cover laboratory processing of self-collected COVID-19 tests that the FDA has authorized for home use.

The flexibility is not limited to the COVID-19 PHE, but would also be available for any future PHEs resulting from outbreaks of communicable disease during which measures are necessary to avoid transmission and those measures might result in difficulty meeting the requirements of the rule.

The flexibility would also apply to any period of active surveillance subsequent to the declared PHE. Continued active surveillance may be part of strategies to detect recurrence of a communicable disease in individuals and populations to prevent further spread of the disease after the PHE has ended. For purposes of the changes made to 42 CFR 440.30 in the IFC, a period of active surveillance is defined as an outbreak of communicable disease during which no approved treatment or vaccine is widely available. A period of active surveillance ends on the date the Secretary terminates it, or the date that is two incubation periods after the last known case of the communicable disease, whichever is sooner.

This IFC does not change the scope of services authorized under the mandatory laboratory services benefit. CMS is providing flexibility only with respect to the location in which laboratory tests may be conducted and the requirement to first obtain an order from a physician or other licensed practitioner for the laboratory test.

Home Health Expansions

Section 3708 of the CARES Act amends both Medicare and Medicaid Home Health benefits by modifying who can order home health benefits. Specifically, the legislation allows nurse practitioners, physician assistants and clinical nurse specialists to order home health services in addition to physicians. The purpose of this regulation is to implement this statutory directive in the CARES Act within the Medicaid program.

CMS had previously allowed similar flexibility in a prior IFC, but the change was restricted to the time period of the COVID-19 PHE. In contrast, the CARES Act language is not time limited to the period of the COVID-19 PHE; rather, it permanently modifies the Medicare and Medicaid home health benefits. Therefore, CMS is incorporating these Medicaid changes into existing regulations at 42 CFR 440.70. These provisions do not change the scope of services authorized under the mandatory home health benefit, only the scope of providers who may order the service.

When the Medicaid program was signed into law in 1965, most skilled medical professional services in the United States were provided by physicians, with the assistance of nurses. Over the decades, the medical professional field has diversified and allowed for a wider range of certifications and specialties, including the establishment of mid-level practitioners such as nurse practitioners and physician assistants. These regulatory updates acknowledge the role of these other providers and expands the provider pool, which serves the acute needs of the COVID-19 PHE, and modernizes the Medicaid mandatory benefit.

It is important to note the structural differences between the Medicare home health benefit and the Medicaid home health benefit, which were both amended by the CARES Act. Durable Medical Equipment (DME) is a separate benefit under Medicare, and could already be ordered, prior to the CARES Act, by a wider pool of providers. Comparatively, Medicaid does not have a separate DME benefit and therefore was more restrictive on who could order medical supplies. Therefore, the updates in this IFC align Medicaid with Medicare with regard to DME ordering capabilities among providers.

These benefits are still restricted to what is permissible under applicable state law.

Flexibility for Basic Health Program (BHP) Blueprint Revisions

The BHP Blueprint is a comprehensive written document submitted by the state to the Secretary for certification of a BHP. Current BHP regulations require a state that implements a BHP to operate under the terms of its existing BHP Blueprint until and unless a revised BHP Blueprint that seeks to make significant changes is certified by HHS, and that all revised BHP Blueprints making significant changes be submitted on a prospective basis.

However, states operating a BHP may need to implement certain programmatic changes immediately in response to the COVID-19 PHE. This IFC revises 42 CFR § 600.125(b) and adds the new paragraph 42 CFR § 600.125(c) to permit states operating a BHP to submit revised BHP Blueprints for temporary substantial changes that could be effective retroactive to the first day the COVID-19 PHE. These changes must be directly tied to the PHE for the COVID-19 pandemic and increase access to coverage, and must not be restrictive in nature. For example, states might want to revise a BHP Blueprint retroactively during the COVID-19 PHE to implement provisions such as temporarily allowing continuous eligibility or temporarily waiving limitations on certain benefits covered under its BHP to ensure enrollees have access to necessary services. The state would need to demonstrate to HHS that the significant changes in its revised Blueprint are tied to the COVID-19 PHE and that the changes are not restrictive in nature. This flexibility is similar to the flexibility that states currently have with Medicaid and CHIP state plan amendments.

Additionally, revised BHP Blueprints submitted under § 600.125 are not subject to the public comment requirements under § 600.115(c), although they will still need to be approved by HHS. We have determined that the existence of unforeseen circumstances resulting from the PHE for the COVID-19 pandemic warrants an exception to the normal public notice procedures to expedite the certification of a revised BHP Blueprint that implements temporary significant changes to expand access to coverage. This approach is similar to the flexibility that states have with Medicaid state plan changes during the COVID-19 PHE.

Any permanent, significant changes a state wants to make to its BHP Blueprint, or that are not directly tied to the COVID-19 PHE, would need to be submitted and reviewed under the standard process under 42 CFR § 600.125(a).