Medicaid Policies Expanding Access to Health Care for People Living with HIV and Viral Hepatitis During the COVID-19 Public Health Emergency

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Although the unique impacts of COVID-19 on people living with HIV or viral hepatitis are still not known, people living with chronic conditions, particularly conditions affecting the immune system, are at greater risk of developing more serious illness from the virus. Additionally, with other viral respiratory infections, we know that risk for people living with HIV is greatest if they have low CD4 counts and are not in care. People living with HIV or viral hepatitis may also have other risk factors, such as age or other medical conditions, that put them at greater risk of serious health complications from COVID-19. It is therefore important that people living with HIV and viral hepatitis maintain uninterrupted access to care and treatment for the duration of the emergency, while complying with social distancing guidelines to reduce their likelihood of exposure to COVID-19.

State, federal, and private insurance policies that expand access to COVID-19 related testing and care are critical protections for people living with HIV, viral hepatitis, and other chronic conditions who are at greatest risk of health complications from the virus. Additionally, policies that expand access to telehealth for routine visits and to triage patients who are ill, allow 90-day supplies and/or early refills of prescription medication, allow home delivery of prescriptions, relax formulary and prior authorization requirements, require coverage of out-of-network providers, provide smoking cessation benefits, facilitate enrollment in coverage, and prevent or prohibit disenrollment from coverage are especially important for ensuring that people living with HIV and viral hepatitis can continue treatment without interruption and reduce their risk of exposure to, or adverse health consequences from, the virus. The protections and services available to insured clients depend on their source of coverage. For Medicaid and private insurance, policies may also vary by state and insurance carrier.

This fact sheet describes Medicaid policies and protections that can help ensure safe and comprehensive access to health care for people living with HIV and viral hepatitis. For information about other types of coverage, refer to NASTAD's fact sheets on Medicare and private insurance policies related to the COVID-19 pandemic.

In addition to the Medicaid policies described in this fact sheet, Ryan White HIV/AIDS Program recipients and AIDS Drug Assistance Programs can consider adapting their programs in response to the COVID-19 pandemic to safely provide uninterrupted care and services to clients. Additionally, health departments can offer additional support to programs and service providers that work with people living with HIV, people living with viral hepatitis, and people who use drugs. RWHAP clinics and other medical providers can also consider expanding use of telehealth services to provide care to clients in their homes. Visit NASTAD's COVID-19 Resource Page for more information about how public health department programs and health care providers can continue to safely serve people living with HIV, people living with viral hepatitis, and people who use drugs during the COVID-19 pandemic.

Federal Protections

"Maintenance of Eligibility" Protections and Ensuring Continuous Access to Coverage

The Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security (CARES) Act provide state Medicaid programs with a 6.2% increase in federal matching funds, subject to several conditions. These "Maintenance of Eligibility" or "Maintenance of Effort" (MOE) requirements prevent state Medicaid programs from making their eligibility standards more restrictive and ensure enrollees maintain continuous access to coverage during the public health emergency.

All states are receiving enhanced federal matching funds and are therefore subject to the following MOE requirements:

1. **States may not disenroll any individual who was enrolled as of March 18, 2020 or who newly enrolls during the crisis.** Many states have provisions allowing them to suspend benefits and/or disenroll Medicaid enrollees who fail to comply with requirements such as work requirements, premiums, or annual redeterminations. States may not implement these suspension and disenrollment policies for the duration of the emergency. States must also provide continuous coverage for the duration of the emergency to individuals who might otherwise become ineligible for Medicaid due to a change in circumstances (unless the individual moves out of state or requests voluntary termination). However, states may transfer enrollees to a new eligibility group or make changes to enrollees' level of coverage under some circumstances.

2. **States may not implement eligibility requirements that are more restrictive than those in effect on January 1, 2020.** To the extent that a state requires compliance with eligibility standards, such as work requirements, before new enrollees can begin their coverage, such standards may not be more restrictive than those in effect on January 1, 2020. Existing enrollees may not be disenrolled for failure to comply with such requirements for the duration of the emergency.

3. **States may not impose new or increased premiums that exceed the amount of premiums in effect on January 1, 2020.** To the extent that a state requires new enrollees to pay a premium before their Medicaid coverage can begin, such premiums may not exceed those in place on January 1, 2020. Existing enrollees may not be disenrolled for failure to pay premiums for the duration of the emergency.

4. **States may not impose cost-sharing for COVID-19 treatment.** State Medicaid programs must cover, without cost-sharing, treatment, vaccines, specialized equipment, and therapies for COVID-19.

To find out whether your state Medicaid program has work requirements, premiums, or coverage suspension policies in place, visit NASTAD's Medicaid Waiver Map.

COVID-19 Testing, Treatment, and Vaccines

All state Medicaid and CHIP programs must cover, without cost-sharing:

1. COVID-19 testing,
2. COVID-19 test-related services, including the physician, clinic, or outpatient hospital visits to evaluate the need for and administer the test,
3. COVID-19 vaccines, and
4. COVID-19 treatment, including prescription drugs and treatment of conditions that complicate COVID-19 treatment.

State Flexibilities Under the Medicaid Program

States have several flexibilities to increase access to coverage and care in the Medicaid program during the COVID-19 emergency.

1. States can expand Medicaid to low-income adults under the Affordable Care Act (ACA). The American Rescue Plan Act, signed into law in March 2021, includes substantial new incentives for states that have not yet implemented the ACA's Medicaid expansion.

2. States can extend Medicaid and CHIP postpartum coverage for 12 months. The American Rescue Plan Act allows states to cover enrollees through pregnancy-related Medicaid and CHIP for one year after the end of pregnancy. Previously, states could only expand postpartum coverage for up to 60 days. This option will be available to states for seven years and is critical for responding to the maternal mortality crisis in the United States.

3. States can provide community-based mobile crisis intervention services. The American Rescue Plan Act provides enhanced federal funding for three years to states that opt to cover community-based mobile crisis intervention services for individuals experiencing behavioral health crises.

4. States can submit a State Plan Amendment to provide Medicaid-funded COVID-19 testing, treatment, and vaccines to uninsured individuals. The Families First Coronavirus Response Act and American Rescue Plan Act allow states to expand limited Medicaid coverage to all uninsured individuals, including those who would not otherwise be eligible for Medicaid. (However, all immigration-related Medicaid requirements remain in place.) This Medicaid coverage would be limited to COVID-19 testing and test-related services, vaccines, and treatment. "Uninsured" individuals include those who are not enrolled in federal health care programs, Marketplace or off-Marketplace plans, grandfathered health plans, employer-sponsored plans, or the Federal Employees Health Benefits (FEHB) Program. People enrolled in short-term limited duration insurance and other non-ACA compliant coverage would also be considered "uninsured."

5. States can submit an "1135 waiver" allowing for a temporary waiver or modification of certain Medicaid requirements to ensure access to services during an emergency. States can use this flexibility to facilitate enrollment of providers into the Medicaid program, increase access to out-of-state providers, suspend prior authorization requirements, increase access to Medicaid fair hearings, relax Medicaid appeals timelines, suspend certain pre-admission and screening requirements for nursing home residents, and make modifications to certain administrative deadlines. All 50 states, the District of Columbia, Puerto Rico, the Northern Mariana Islands, and the U.S. Virgin Islands have received approval for Section 1135 waivers related to the COVID-19 emergency.

6. States can submit a State Plan Amendment or "1115 waiver" to make changes to their Medicaid programs. A State Plan Amendment can allow states to provide Medicaid coverage to additional populations, expand presumptive eligibility, simplify Medicaid applications, eliminate cost-sharing for certain items or services statewide, revise payment methodologies for telehealth, or extend deadlines for providing documentation of immigration status. States can use Section 1115 waiver authority to temporarily increase eligibility levels in certain regions most heavily affected by COVID-19 or accept self-attestation for citizenship and immigration status in certain situations. States seeking Section 1115 waivers during a public health emergency are not required to complete the full public notice process.

7. States can make several changes to their Medicaid programs without seeking federal approval. States have flexibility to expand access to Medicaid coverage without federal approval. States can make changes to enrollment processes to facilitate quicker enrollment in Medicaid—for example, states can allow self-attestation of eligibility criteria (other than citizenship and immigration

status), accept applications with slight income inconsistencies, verify income post-enrollment, allow applicants to provide reasonable explanations of inconsistencies in lieu of providing documentation, or expand hospital capacity to conduct presumptive eligibility for people with a diagnosis or presumptive diagnosis of COVID-19. States can also expand telehealth services, suspend or relax prior authorization requirements, relax out-of-network requirements, eliminate physician referral requirements, and collaborate with managed care plans to communicate with enrollees about prevention, testing, and treatment. Most states can also allow for extended day supplies of medications or early refills without submitting a State Plan Amendment. For managed care programs, some of these changes may require amending the state's managed care contracts. Massachusetts is an example of one state that has made many of these changes in response to the COVID-19 emergency.

8. States can expand access to telehealth services in Medicaid. Telehealth is a cost-effective alternative to providing traditional face-to-face medical care. In an emergency such as COVID-19, telehealth allows Medicaid enrollees to receive a wide range of services from their providers without having to travel to a health care facility so that they can limit risk of exposure to and spread of COVID-19. States can implement telehealth in fee-for-service programs without seeking federal approval (although a State Plan Amendment is required to revise payment methodologies) or amend managed care contracts to extend telehealth flexibilities.

Frequently Asked Questions

My client was disenrolled from Medicaid after March 18, 2020. Can they re-enroll?

Yes. All states are receiving the temporary 6.2 percent increase in their federal Medicaid matching rate. This means all states must make a good faith effort to identify and reinstate Medicaid coverage for anyone who was disenrolled after March 18, 2020. Clients who were disenrolled after this date should contact their state Medicaid agency immediately and request reinstatement of coverage retroactive to their date of termination.

My client applied for Medicaid and is currently receiving benefits during a period of presumptive eligibility. Can their enrollment be denied?

Yes. Clients who have been determined presumptively eligible for Medicaid have not yet been "enrolled" in Medicaid and may be denied enrollment. However, once the client is enrolled in Medicaid, they cannot be disenrolled for the duration of the emergency.

My client was denied Medicaid coverage prior to March 18, 2020 and is in the process of appealing their denial, but is receiving services pending appeal. What happens if their appeal is denied?

If the client is receiving Medicaid services pending their appeal, they are considered to be "enrolled" in Medicaid. They cannot

be disenrolled for the duration of the emergency.

My client's Medicaid coverage is up for redetermination. Do they still have to comply with the redetermination requirements?

Yes. States may conduct regular Medicaid renewals and redeterminations, but may not disenroll clients if they fail to complete redetermination paperwork or if they would otherwise lose eligibility for Medicaid at the time of their annual redetermination. States also may not disenroll clients for failure to respond to notices requesting additional information.

Even though states may not disenroll clients for the duration of the emergency, clients are encouraged to complete their redetermination paperwork on time to avoid disruptions in coverage after the pandemic ends. Additionally, clients may be found eligible for a more generous Medicaid benefits package—for example, Medicaid for older adults or people living with disabilities. However, under new federal rules issued in November 2020, states may also move enrollees to an eligibility group with reduced benefits in some circumstances.

My client has had a change in circumstances that impacts their Medicaid eligibility. Are they required to report the change to the state?

Yes. However, states may not act on reported or identified changes if doing so results in termination of coverage. States also may not disenroll individuals for failure to respond to notices requesting additional information. Reporting changes in circumstances may result in the client moving to a new eligibility group with a higher level of benefits. However, under new federal rules issued in November 2020, states may also move enrollees to an eligibility group with reduced benefits in some circumstances.

A client who moves out of state may still lose Medicaid coverage in the state where they previously lived. The client should apply for Medicaid in the state where they now live.

Medicaid Resources

- Centers for Medicare & Medicaid Services (CMS) Disaster Response Toolkit
- CMS Disaster Preparedness Toolkits identifying Medicaid strategies that states and territories can deploy under different legal authorities (State Plan Amendment, Section 1135 waiver, Section 1115 waiver)
- CMS approved Section 1135 waivers
- CMS COVID-19 Resources, including information about submitting Section 1115 waivers, Section 1135 waivers, State Plan Amendments; clinical and technical guidance; billing and coding guidance; survey and certification guidance; and agency press releases
- CMS COVID-19 FAQs for State Medicaid and CHIP Agencies
- Kaiser Family Foundation Medicaid Emergency Authority Tracker
- Georgetown Center for Children and Families COVID-19 Resource Center
- CMS COVID-19 Vaccine Policies and Guidance