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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NASTAD

Overview

- Discussion of state, federal, and insurer policies expanding access to health care and services in:
  - Medicaid
  - Medicare
  - Private Insurance
- Discussion of Ryan White HIV/AIDS Program Part B and ADAP policies that can expand access to services during the COVID-19 emergency

Medicaid Policies

FEDERAL

- Increased federal matching funds (FMAP) for states that meet certain requirements during the emergency
- No cost-sharing for COVID-19 testing (incl. test-related services)

STATE

- State Plan Amendment, including providing testing for all uninsured people
- 1135 waiver
- 1115 waiver
- State policies that do not require federal approval
- Telehealth

Federal Medicaid Policies – Increased FMAP

States may be eligible for 6.2% increase in federal matching funds, subject to certain conditions (NOT applicable to expansion group):

- **No disenrollments.** States may not disenroll anyone who is enrolled as of Mar. 18, 2020 or who newly enrolls after that date.
- **No new eligibility restrictions.*** Eligibility requirements such as work requirements may be no more restrictive than those in place on Jan. 1, 2020.
- **No new or increased premiums.*** Premiums may not exceed those in place on Mar. 18, 2020.
- **No cost-sharing for COVID-19 care.** This includes treatment, vaccines, specialized equipment, and therapies.

* Most relevant for new enrollees who may have to comply with premiums or eligibility requirements to begin coverage.

Federal Medicaid Policies – COVID-19 Testing

ALL states, regardless of whether they are seeking the enhanced federal funding, must cover without cost-sharing:

- COVID-19 testing
- The physician, clinic, or outpatient hospital visit during which patient is evaluated and test is administered

State Medicaid Policies – State Plan Amendments

State Plan Amendments (SPAs). States can temporarily modify certain Medicaid policies to expand access to services. States can use SPAs to:

- Cover additional populations
- Expand presumptive eligibility
- Simplify applications
- Increase provider payments
- Eliminate cost-sharing or premiums
- Extend deadlines for documenting immigration status

States/territories with approved COVID-19-related SPAs: AR, AL, AZ, CO, HI, IL, KY, LA, ME, MD, MN, MO, NE, NM, ND, OR, RI, SC, VA, WA, WY, Guam, U.S. Virgin Islands, Puerto Rico

State Medicaid Policies – Expanded Testing

Testing for all uninsured individuals. States can submit a State Plan Amendment (SPA) to cover testing for all uninsured individuals, regardless of Medicaid eligibility. "Uninsured" includes anyone:

- not enrolled in a federal health care program, ACA-compliant coverage (on or off Marketplace), employer coverage, FEHBP
- enrolled in a non-ACA compliant product, such as short-term limited duration insurance

States with approved SPA to expand testing to uninsured: AZ, CO, IL, LA, ME, MN, RI, WA

State Medicaid Policies – 1135 Waivers

1135 Waivers. States can temporarily modify certain Medicaid requirements to expand access to services. States can use this flexibility to:

- Facilitate enrollment of providers into Medicaid
- Increase access to out-of-state providers
- Suspend or relax prior authorization in fee-for-service
- Increase access to fair hearings and relax appeals timelines
- Waive SPA notice requirements and certain deadlines

States/territories with approved 1135 waivers: 50 states, D.C., Puerto Rico, Northern Mariana Islands, U.S. Virgin Islands

State Medicaid Policies – 1115 Waivers

1115 Waivers. States can make temporary changes to their Medicaid programs to expand access to services. States can use this flexibility to:

- Increase eligibility levels in most affected regions
- Target services on a geographic basis
- Target services based on population needs
- Accept self-attestation for citizenship and immigration status in certain situations

States are exempt from state public notice and comment requirements for COVID-19-related 1115 waivers.

States/territories with approved COVID-19-related 1115 waivers: WA

State Medicaid Policies – State-Level Flexibilities

State-level policies. States can adopt policies expanding access to Medicaid without seeking federal approval. States have flexibility to:

- Change enrollment processes to facilitate quicker enrollment
- Suspend or relax prior authorization
- Relax network requirements
- Eliminate physician referral requirements
- Allow extended medication supplies and early refills

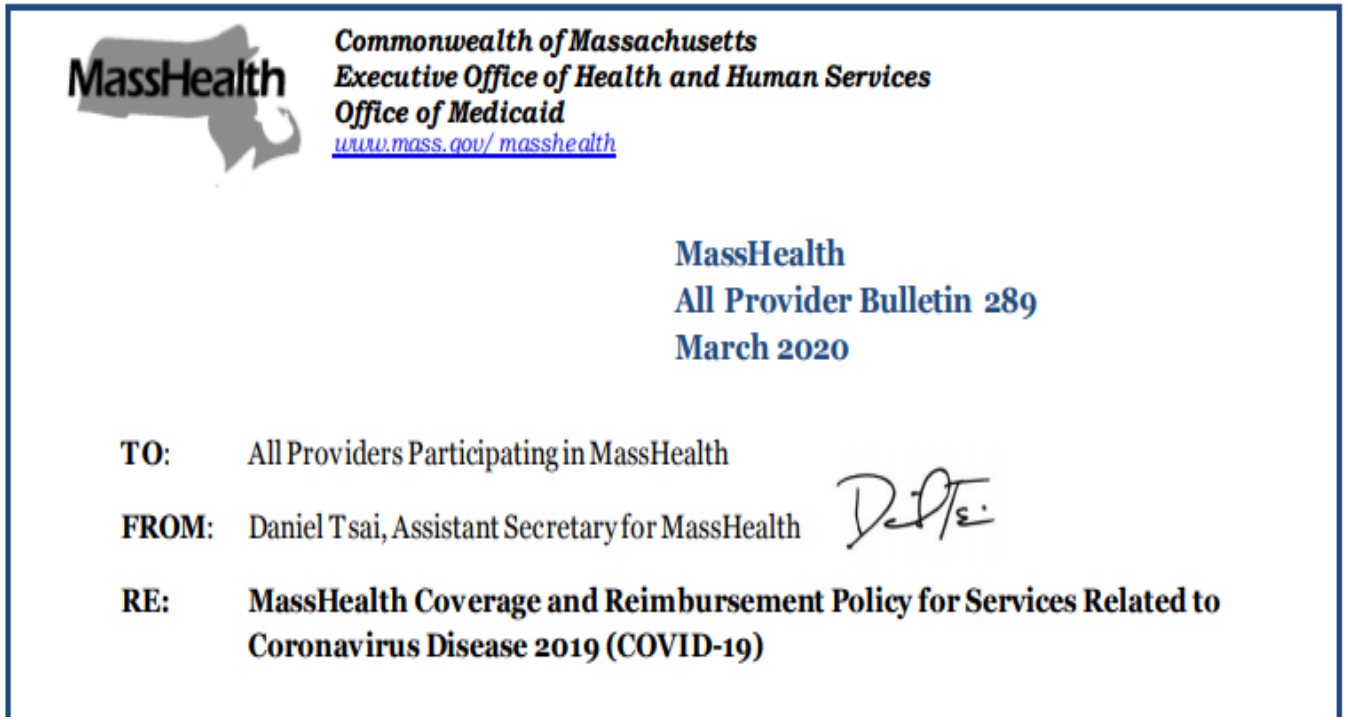
All 50 states and DC have taken some state-level action to address Medicaid access during the COVID-19 emergency.

State Medicaid Policies – Telehealth

Telehealth. States can take several actions to expand access to telehealth, including:

- Implementing telehealth in fee-for-service (federal approval not required)
- Amending managed care contracts to extend telehealth flexibilities (federal approval not required)
- Revising telehealth payment methodologies (requires SPA)

State Medicaid Policies – MassHealth (FFS)



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
All Provider Bulletin 289
March 2020

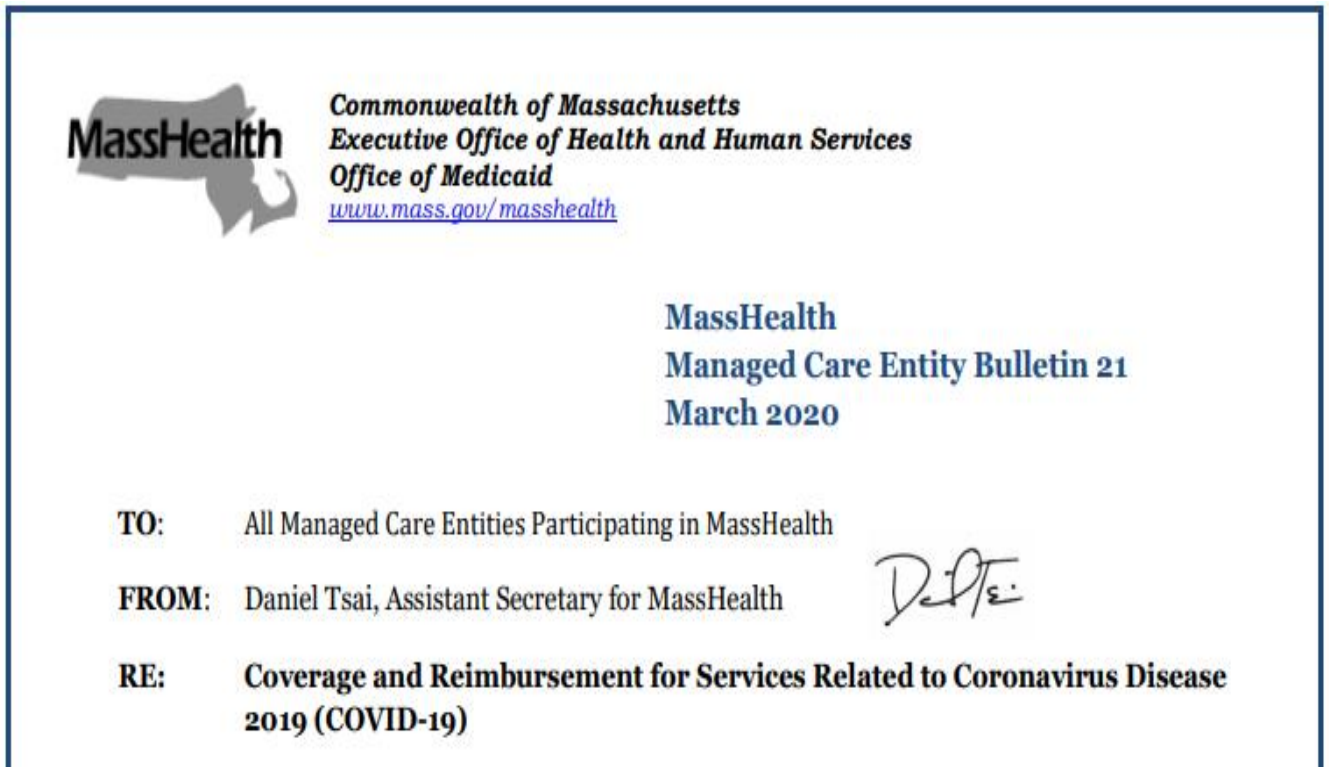
TO: All Providers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: **MassHealth Coverage and Reimbursement Policy for Services Related to Coronavirus Disease 2019 (COVID-19)**

- Presumptive eligibility for people with diagnosis or presumptive diagnosis of COVID-19
- Expansion of telehealth
- Payment for patients requiring quarantine
- 90-day supplies
- Early refills
- No referrals required for COVID-19 testing and treatment

State Medicaid Policies – MassHealth (MCOs)



MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Managed Care Entity Bulletin 21
March 2020

TO: All Managed Care Entities Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: **Coverage and Reimbursement for Services Related to Coronavirus Disease 2019 (COVID-19)**

- Expansion of telehealth
- 90-day supplies
- Early refills
- Relaxed referral, PA, and network requirements for COVID-19 testing and treatment
- Coverage of COVID-19 testing, treatment, and prevention at parity with FFS

Medicare Policies

FEDERAL

- No cost-sharing for COVID-19 test-related services
- No utilization management for COVID-19 testing (incl. test-related services) in Medicare Advantage plans
- 90-day medication supplies

Federal Medicare Policies – Testing

- COVID-19 **testing** is covered under Medicare Part B and Medicare Advantage without cost-sharing as a preventive service (this is true year-round)
- COVID-19 **test-related services** (including a visit to a provider, facility, or emergency room to evaluate the need for and/or administer a test) must be covered without cost-sharing, but only if a test is actually ordered
- Medicare Advantage plans **may not impose utilization** management for COVID-19 testing and test-related services

Federal Medicare Policies – Rx Access

Medicare Advantage Prescription Drug (MA-PD) and Part D plans must:

- Cover up to 90-day supplies of medications
- Cover medications dispensed at an out-of-network pharmacy if the enrollee cannot reasonably be expected to obtain drugs at an in-network pharmacy due to the emergency

Medicare Advantage Prescription Drug (MA-PD) and Part D plans may:

- Impose utilization management requirements for covered drugs
- Relax restrictions on early medication refills and home delivery

Other Federal Medicare Policies

Medicare Advantage plans must:

- Allow enrollees affected by the emergency to receive Medicare-covered services at out-of-network facilities at in-network cost-sharing rates; facilities must participate in Medicare program

Medicare Advantage plans may:

- Impose cost-sharing and utilization management requirements for COVID-19 treatments

Medicare Provider Flexibilities – Telehealth

- Providers may be reimbursed for broader range of Medicare-covered services furnished via telehealth
  - Permitted in broader circumstances
  - No geographic or location restrictions
  - Providers and patients may be in their homes
  - Flexibility around types of technology used
- Flexibility for providers to reduce or eliminate cost-sharing (not required) without sanctions
- Some services still require established patient-provider relationship
- Not limited to COVID-19-related services

Private Insurance Policies

FEDERAL

- No cost-sharing for COVID-19 testing (incl. test-related services)
- No utilization management for COVID-19 testing (incl. test-related services)

STATE

- Special Enrollment Period
- State regulations

OTHER

- Insurer-specific policies

Federal Private Insurance Policies – Testing

Requirements for ACA-compliant plans (including grandfathered plans) and group health plans:

- COVID-19 testing must be covered without cost-sharing
- COVID-19 test-related services (including a visit to a provider, facility, or emergency room to evaluate the need for and/or administer a test) must be covered without cost-sharing, but only if a test is actually ordered
- COVID-19 testing and test-related services must be covered if provided by an out-of-network provider
- Private plans may not impose utilization management for COVID-19 testing and test-related services

NOTE: Insurers may still impose cost-sharing and utilization management for COVID-19 treatment

Private Insurance Policies – SEPs

Special Enrollment Periods (SEPs). Consumers may change plans or enroll in coverage outside of the annual Open Enrollment Period (Nov. 1 – Dec. 15 in most states) if they experience a "qualifying life event" such as:

- Loss of coverage, including job-based coverage
  - consumers may, but are not required to, enroll in COBRA when they lose job-based coverage
- Change in income that affects eligibility for financial assistance
- Moving out of Medicaid gap
  - applies in non-expansion states
- Release from incarceration
- Permanent move to a new coverage area

State Private Insurance Policies – SEPs

COVID-19 Special Enrollment Periods (SEPs). States with state-based exchanges may create an SEP allowing uninsured residents to apply for health coverage.

CA: June 30

~~CO: April 30~~

~~CT: April 17~~

DC: June 15

MD: June 15

MA: May 25

~~MN: April 21~~

NV: May 15

NY: May 15

~~RI: April 30~~

VT: May 15

WA: May 8

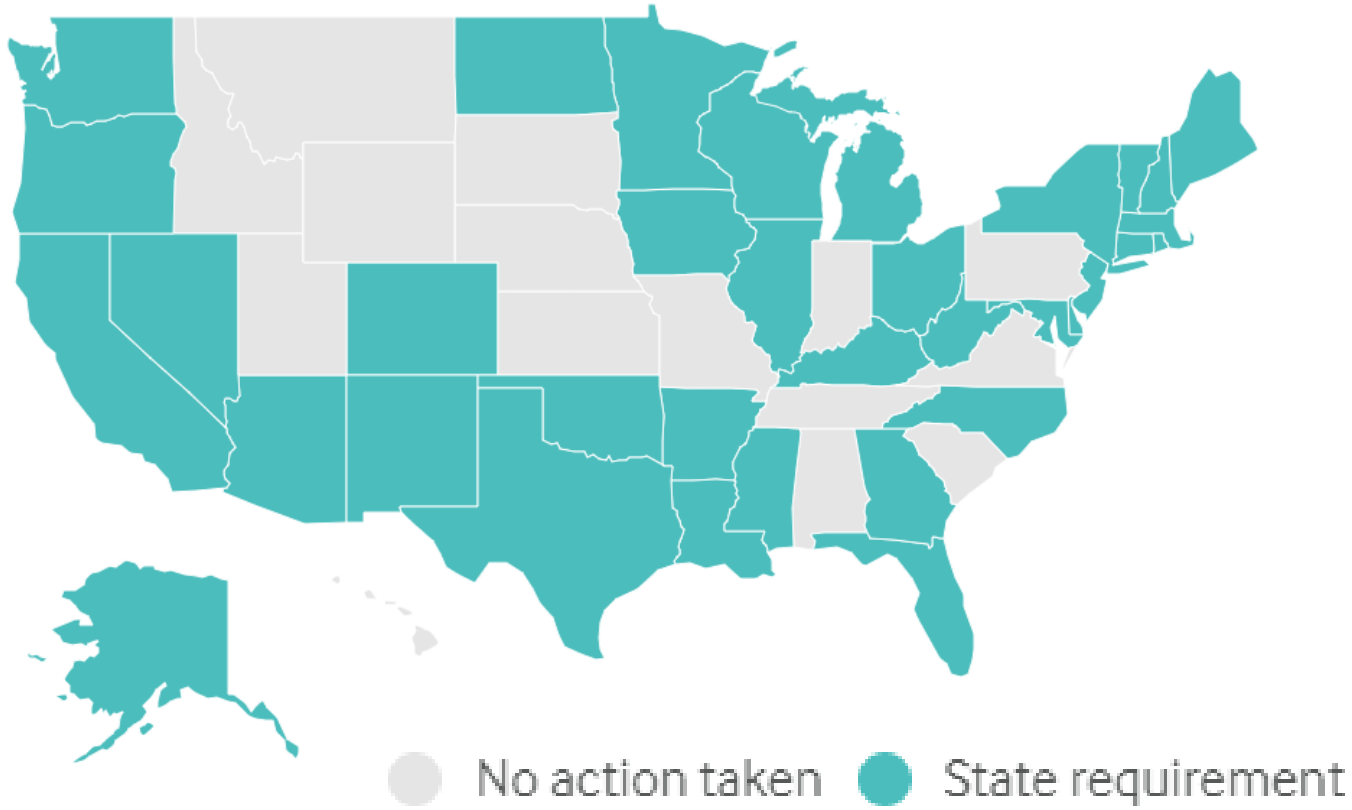
No SEP: Idaho + 38 states using federally-facilitated Marketplace (FFM)

However, consumers in Idaho and FFM states can still become eligible for an SEP for another reason.

State Private Insurance Policies – State Actions

State regulations. Many state insurance regulators have imposed additional requirements on private insurers, such as

- cost-sharing protections for COVID-19 testing and treatment
- allowing early medication refills
- off-formulary drug coverage
- expansion of telehealth
- relaxing prior authorization
- relaxing network restrictions
- premium payment relief



Source: Center on Health Insurance Reforms, Georgetown University McCourt School of Public Policy. https://www.commonwealthfund.org/publications/maps-and-interactives/state-action-related-covid-19-coverage-critical-services-private

Insurance Company Policies

- Many insurance companies have chosen to expand coverage for COVID-19-related services beyond what is required by state or federal law
- Many insurance companies have made other changes to enable enrollees to access non-COVID-19-related care safely during the emergency, such as expanding access to telehealth, relaxing early refill limits on medications, allowing formulary flexibilities, expanding home deliveries for medications, and providing supplemental food boxes for seniors

Enrollees should contact their insurance company to learn about policies in place during the emergency.

Additional Federal Funding and Policies

TAX REBATE/STIMULUS PAYMENT

- One-time payment up to $1200 for single filers / up to $2400 for married filers(amount depends on income) plus $500 per child
- Tax-free
- Not included in Medicaid income
- Not included in Marketplace income
- ADAP eligibility criteria may vary

ENHANCED UNEMPLOYMENT INCOME (UI)

- $600 per week UI increase, plus additional 13 weeks of benefits (total of 39 weeks in most states)
- Taxable
- Not included in Medicaid income (NOTE: only the $600 increase is excluded)
- Included in Marketplace income
- ADAP eligibility criteria may vary

ADDITIONAL COVID-19 FEDERAL FUNDING

- HRSA grant funds for RWHAP recipients
- HRSA grant funds for community health centers and other providers

RWHAP Part B/ADAP Program Considerations

- Streamline enrollment/recertification processes to allow for social distancing
- Assist clients losing job-based coverage and evaluate coverage options and insure uninterrupted access to care
- Assist full-pay and insured clients to access medications safely to allow for social distancing

HRSA/HAB COVID-19 FAQs: https://hab.hrsa.gov/coronavirus/frequently-asked-questions#aids-drugs

RWHAP Part B/ADAP Program Policies

Medication access

- Early refills for full-pay and/or insured clients
- 90-day supplies for full-pay and/or insured clients
- No refill denials for full-pay clients
- Extended prior authorization for full-pay clients

Streamlined enrollment and recertification processes

- Recertification deadline extensions
- Relaxed requirements for supporting documentation (e.g., waiver, deadline extensions)
- Verbal or written self-attestation
- Conducting enrollments and recertifications electronically or by phone (e.g., fillable PDF forms, secure email systems)
- Verbal client consent

RWHAP Part B/ADAP Program Policies

Client services

- Conducting client meetings and assessments by phone
- Extended deadlines for client assessments
- Waiver of client signature requirements for completed assessments and service plans
- Reimbursement for routine visits and evaluations conducted via telehealth for patients who are ill

Other

- Increased budget for support services (e.g., emergency financial assistance, housing, nutrition)
- Policies and/or funding to accommodate incarcerated or recently incarcerated clients
- Emphasis on insurance assessment for clients losing coverage

Additional Resources

- NASTAD COVID-19 Updates & Resources
  - https://www.nastad.org/resource/covid-19-updates-and-resources
- OnTAP Resource Bank COVID-19 resources
  - https://ontap.nastad.org
  - Share materials from your state via email directly to Mahelet Kebede (mkebede@NASTAD.org)
- HRSA/HAB COVID-19 Frequently Asked Questions:
  - https://hab.hrsa.gov/coronavirus/frequently-asked-questions#aids-drugs
- HRSA/BPHC COVID-19 Frequently Asked Questions:
  - https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions.html#covid-19
- Examples of CARES Act Supplemental Funding Uses and RWHAP Service Categories
  - https://hab.hrsa.gov/program-grants-management/coronavirus-covid-19-response/funding-use-examples
- ACE TA Center
  - https://targethiv.org/ace

Messages for providers and clients

When people lose coverage, case managers and benefits staff can help.

Help people explore eligibility for expanded coverage.

- Many life events and special circumstances create **Marketplace** Special Enrollment Periods (SEPs), including “Loss of coverage.”
  - Some states have COVID-19 SEPs
- Medicaid and CHIP enrollment are open throughout the year for newly eligible clients.
  - In Medicaid expansion states, some clients may be newly income-eligible for Medicaid coverage.
- Assess age-based Medicare eligibility.
- COBRA can be expensive and may not be the best fit for a person’s coverage needs

Remember: The Ryan White HIV/AIDS Program is not health insurance.

ACE
ACCESS, CARE, & ENGAGEMENT

Special Enrollment Periods

Can I enroll in a Marketplace health insurance plan outside of Open Enrollment?

Sometimes you experience a big life change that also changes your health coverage needs—like having a child, losing your job, or losing your health coverage. Usually Open Enrollment is the only time you can sign up for a new health insurance plan through the Health Insurance Marketplace (e.g., HealthCare.gov) or change your current plan. But if you have a big life change—or **"life event"**—you may qualify for a **Special Enrollment Period.**

A Special Enrollment Period lets you enroll in a new health plan or change your plan outside of Open Enrollment. You may also qualify for a Special Enrollment Period if something happened during Open Enrollment that prevented you from getting the right coverage. This is called a **"special circumstance."** See the full list of life events and special circumstances on the next two pages.

TIP

If you think you may be eligible for a Special Enrollment Period, or if you have any changes to your income, household size, or health coverage, you should report this information as soon as possible. Talk with an enrollment assister or Ryan White Program case manager, or contact the Marketplace Call Center at 1-800-318-2596.

Special Enrollment Period Fact Sheet

Stay Covered All Year Long

Now that you've enrolled in health insurance, make sure you keep it.

Health insurance is important because it covers all your health needs, such as HIV medications and care, free preventive care, hospital stays, and substance use and mental health services. This guide covers what you need to do to stay covered throughout the year.

TIP

Even if you have health insurance, stay in touch with your Ryan White Program case manager. S/he can help make sure you stay enrolled in ADAP and have access to financial help for insurance and Ryan White Program services like transportation and housing support.

STAY COVERED ALL YEAR LONG

Pay premiums on time

Make sure your premium is paid in full by the due date. Talk to your case manager or enrollment assister to make sure you know the following:

How is the premium paid?

Premiums are paid monthly. Your insurance company will send you the bill. You may need to pay the bill yourself. In some cases, ADAP or another Ryan White Program provider will pay the bill. Talk to your case manager about who is responsible for paying the bill.

- If you do not receive a bill within a month of signing up, call your insurance company. Log in to your Marketplace account to find the insurance company's phone number.

WHAT DOES PREMIUM MEAN?

The amount you pay for a health insurance plan. A premium is paid monthly.

TIP

Your insurance company will send you the premium bill even if the Ryan White Program will be paying it.

What do I need to do if the Ryan White Program is paying my premium?

- Send a copy of your first bill to the Ryan White Program as soon as you receive it at the beginning of each year. The Ryan White Program will pay the insurer directly.
- Send a copy of the bill any time the amount due changes.
- Bring a copy of your latest bill when you meet with your case manager to re-certify for ADAP or Ryan White Program insurance assistance.

How much is my premium?

- Your insurance company will send you a bill with the pre
- Make prem in yo

STAY COVERED ALL YEAR LONG

When is my premium due?

Most premiums are due by a certain day each month.

You must pay your first premium by the end of your first month of coverage each year. For example, if your insurance starts on February 1, your first monthly premium must be paid by the end of February.

What happens if I miss a payment?

If a premium is not paid on time, you will receive a notice from your insurance company, and your insurer can end your coverage. If your coverage ends, the insurance company must send you a letter to let you know.

Your Marketplace plan may offer a grace period before ending your coverage, but do your best to pay your premium on time each month.

WHAT IS A GRACE PERIOD?

A short period of time after the premium is due when you can make a payment without losing coverage. Each state has different rules about grace periods. Contact your insurance company to learn about their grace period.

Special grace period for individuals who received an Advance Premium Tax Credit (APTC)

- An APTC is a tax credit to reduce your monthly premium on coverage through the Marketplace. The Marketplace sends money directly to your health insurance company, and you pay a lower monthly premium.
- To find out if you received an APTC or if you are eligible for one, log into your Marketplace account and view "My Plans".
- If you receive an APTC and you have paid at least one full month's premium, you have a special three-month grace period in which to pay the premium in full. The grace period begins on the first day of the month that the premium was due.

ACE TA Center | Stay Covered All Year Long | Page 3

QUESTIONS?