VIEWPOINT

Securing the Safety Net and Protecting Public Health During a Pandemic

Medicaid's Response to COVID-19

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The coronavirus disease 2019 (COVID-19) has exposed gaps in the social safety net in the US. Medicaid, which covers 71 million individuals, has an important responsibility in addressing these gaps. Medicaid programs can fund unexpected health care services that other insurance plans may exclude and are thus well-positioned to ensure that vulnerable patients have access to important health care services, and that hospitals and other health care organizations and clinicians are reimbursed for providing that care.

States can take several actions to waive federal or state requirements to accomplish the following goals: (1) improving prompt testing and treatment of patients with COVID-19, (2) mitigating the strain on the health care system and preserving capacity of hospitals and health care practitioners, and (3) limiting transmission of COVID-19 by facilitating changes in how care is delivered. Through the series of actions outlined below, Medicaid programs should have a key role in protecting enrollees, supporting public health efforts to reduce spread of the virus, and aiding the health care system to increase capacity.

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Flexibility to Maintain and Increase Enrollment and Expand Capabilities

Federal law grants states flexibility during emergencies to expand Medicaid capabilities. This authority is granted under a section 1135 waiver, which becomes available when the president declares an emergency or natural disaster, and the US Secretary for Health and Human Services declares a public health emergency.[1] With the federal government deciding to take these actions, states can pursue rapidly expanding hospital and clinician capacity by reducing standard enrollment procedures and enrolling out-of-state clinicians and staff, and by supporting care delivery in atypical settings such as shelters. This may be particularly important for COVID-19, which threatens to overwhelm existing hospital capacity.

Section 1115 waivers have also been used in times of public health emergency to increase coverage of the uninsured.[2] States should also employ strategies to ensure continuity of coverage for existing Medicaid enrollees without seeking federal approval. This includes eliminating or putting on hold eligibility redeterminations that frequently result in losses of coverage. States can also take their own steps to enroll non-Medicaid clinicians or health care centers by temporarily waiving rules to increase system capacity.

Expanding Options for Telehealth and Virtual Visits

Currently, all 50 states[3] have some form of Medicaid reimbursement for telehealth services. Many states only reimburse for select telehealth services (eg, behavioral health treatment) and many impose stringent requirements on clinicians and centers that bill for these services. By temporarily expanding coverage and lifting restrictions on telehealth, state Medicaid agencies should alleviate burden on the health system and reduce transmission of COVID-19 within health care settings.

First, state Medicaid agencies should cover telehealth and reimburse these services at parity with face-to-face visits (ie, 100% of Medicaid payment rates). Second, Medicaid agencies should relax rules on the type of clinicians, centers, and services eligible for billing under telehealth rules. Third, state Medicaid agencies should address technological barriers to telehealth by allowing clinicians and health care organizations to use billing codes for telephonic services if they cannot provide the visual technology traditionally referred to as "telehealth." This option may be particularly important in rural areas with limited broadband and where technologic platforms are limited. In the event of substantial increases in the numbers of COVID-19 cases that require care, gaps in hospital staffing, and shortages of personal protective equipment (PPE), some states are allowing health care workers to conduct virtual visits from their homes while under quarantine or other restrictions, or instituting virtual rounds in inpatient settings.

Remove Barriers to Billing for Diagnostic and Treatment Services

Agencies should change coverage and billing policy to remove access barriers for patients, including referral requirements, medical necessity requirements, and reducing administrative burdens on clinicians and health care centers for care related to COVID-19. States should also direct managed care organizations, which enroll two-thirds of Medicaid beneficiaries, to make these modifications. To remove barriers to testing and treatment, agencies should request Medicaid State Plan Amendments (SPA) to waive co-payments where they exist. They should also coordinate with public health

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agencies to communicate information to clinicians and health care organizations about procedures for testing, including providing testing guidance for centralized laboratory sites, notification on new billing of COVID-19–related tests, and proactive coverage and payment guidance for private laboratories when they are required.

To facilitate treatment, Medicaid agencies should loosen hospitalization coverage authorization and payment policies, both for patients with COVID-19 who are quarantined, and especially if hospitals with stretched censuses need to transition less ill or vulnerable patients to alternate care settings. Medicare policy changes at the federal level may be required as well. The Centers for Medicare & Medicaid Services (CMS) should consider waiving the 3-day hospitalization rule whereby under Medicare regulation a beneficiary must first have a qualifying inpatient stay of at least 3 consecutive days for coverage of skilled nursing facility (SNF) services. This could enable more timely transition of patients, freeing up needed hospital capacity.

Expand Coverage of Home-Based Care

To prevent transmission of COVID-19, Medicaid agencies should address and expand home visit policies for vulnerable populations. Twenty states[4] use Medicaid financing for home visits. In coordination with Medicaid and other state agencies, officials should provide guidance to front-line staff (nurses, personal care attendants, non-emergency medical transport personnel) on recommended infection control procedures for treatment of ill homecare patients, especially as personal protective equipment is limited in these settings and risk of transmission is increased. Some states are moving toward home visiting staff not entering the homes of all patients and waiving currently required in-person assessments while still providing triage support so patients have care continuity. In addition, states are looking to broaden telehealth services for home visits so that proper care and patient assessments can continue.

Ease Limits on Prescription Drug and Long-term Services and Supports

To ensure that all Medicaid enrollees, regardless of whether they are infected, have necessary prescriptions and durable medical equipment, agencies should ease limits on drug and long-term services and supports coverage, both for their central and managed care populations. For example, agencies could pursue an SPA to allow for a 90-day supply provision of prescription drugs and early refills. Patients should also qualify for durable medical equipment, such as oxygen, without the need for in-person assessments.

Assisting Special Populations

As the payer for nearly two-thirds of all nursing home residents, Medicaid programs have a critical responsibility in ensuring the health and safety of residents in long-term care facilities. These are individuals with functional limitations and chronic illness—those most vulnerable to the adverse effects of COVID-19 as evidenced by the high number of deaths in a single nursing home in Kirkland, Washington.[5] Medicaid programs should support this vulnerable population by encouraging robust infection control measures, reducing censuses when able, eliciting and elevating concerns to state leaders, and promoting flexibility in service delivery. For example, to limit the spread of infection, states could ease requirements on in-person visits for long-term services and support needs assessments and other services and replace them with phone calls or videoconferencing. States should promote flexibility in location of service delivery in the event of widespread infection in a nursing home. For example, through modifications to 1915c waivers, Medicaid programs could move residents out of skilled nursing facilities and assisted living facilities to stay with their families short-term, by providing financial support to family caregivers.

Individuals with end stage kidney disease, a majority of whom are dually eligible for Medicare and Medicaid, may be particularly vulnerable to COVID-19, given their frequent interaction with the health care system. Medicaid programs may transition to home dialysis when possible by removing service authorizations on equipment.

In addition, cities with large homeless populations need to be mindful of their potential vulnerability to COVID-19. Through the Medicaid program, states can offer a wide range of services and supports that can assist individuals who experience chronic homelessness. Agencies should coordinate with cities and relevant health departments to coordinate planning and response to address needs around care in atypical settings, quarantine, and necessary housing.

Medicaid agencies have a key role to play in providing access to care, creatively expanding capacity of clinicians and health care centers, and promoting infection control. By adopting these strategies state Medicaid programs should help promote an effective response to this pandemic.

ARTICLE INFORMATION

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