



Medicaid Directors' Priorities for First 100 Days of the Biden Administration: Enhancing Medicaid's Ability to Respond to the COVID-19 Pandemic

Since the onset of the COVID-19 pandemic, state Medicaid Directors and the programs they administer have been critical components of state responses to the pandemic. Medicaid made immediate changes to expand coverage, enroll new providers, rapidly expand adoption of telehealth to support providers continuing to serve Medicaid members safely, and modify payment structures to ensure vulnerable provider types kept their doors open. Medicaid continues to be a key player in state strategies to manage the pandemic as we enter a new phase this winter.

As the association representing Medicaid Directors in all 50 states, the five U.S. territories, and the District of Columbia, NAMD offers the following priorities for the transition team's consideration. Each of these priorities has a clear and direct link to enhancing Medicaid's ability to respond to the ongoing pandemic.

We have bolded the most immediate priority in each section. We welcome the opportunity to discuss these requests in detail.

Prioritize the State/Federal Partnership

The state/federal partnership is the core of the Medicaid program. States co-finance and administer the program, while the federal government invests significant resources in the program, provides operational guidelines, and exercises oversight of states. NAMD has developed a set of guiding principles for the state/federal partnership in a separate document which provide more detail on how to maintain and strengthen this foundational aspect of the program. **Key aspects of the partnership include mutual accountability, consistent communication, flexibility to innovate within the program, a commitment to efficient administration, and continual process improvement.**

As the direct administrators of the program, Medicaid Directors have key operational knowledge and insights that can effectively inform ongoing federal efforts to address the COVID-19 pandemic. This is particularly true for ensuring critical safety net providers in the Medicaid program receive federal supports, via the Provider Relief Fund or other mechanisms, to ensure that current and new Medicaid members receive the services they need. Providers that have been particularly challenged in the current environment include, but are not limited to, Medicaid home- and community-based service providers, behavioral health providers, pediatricians, and non-emergency medical transportation providers, all of which are critical for maintaining Medicaid's provider network capacity.

Support Medicaid's Role in Successful COVID-19 Vaccination Efforts

The nation is thankfully on the cusp of initiating a COVID-19 vaccination campaign. Recommendations from the Centers for Disease Control and Prevention call for frontline health care workers and long-term care facility residents to be prioritized in the first wave of vaccinations. These categories will include significant numbers of Medicaid providers and members. As such, Medicaid Directors are already working to operationalize policies to ensure a successful vaccine rollout for these priority populations, including enrolling new provider types, making rate changes for vaccine administration, and

strengthening partnerships with state and local public health authorities. This work will be ongoing throughout the vaccination campaign.

We strongly recommend federal and state Medicaid experts be included in all federal planning processes for the ongoing COVID-19 vaccination effort throughout 2021. We particularly encourage solidifying policy and operational approaches as soon as possible to allow consistent communication to Medicaid providers and members on how the vaccine rollout will function for all populations. This messaging will be critical to ensuring a successful vaccination effort, particularly for populations that may be reticent to receive the vaccine.

Provide Certainty Around Future COVID-19 Public Health Emergency Declarations

The COVID-19 public health emergency declaration (PHE), which first became effective January 27, 2020, is the bedrock for a variety of Medicaid flexibilities and additional federal resources. The most notable of these are the Congressionally authorized 6.2 percentage point federal match enhancement passed in the Families First Coronavirus Response Act (FFCRA), which provides states with critical funds to support the growing needs of the program. Medicaid is a countercyclical program whose resource needs grow as economic conditions worsen and state revenues shrink, so this funding enhancement is vital as program enrollment grows. Other regulatory flexibilities, such as 1135 waivers to expedite provider enrollment and disaster State Plan Amendments to support provider rate enhancements, the rapid expansion of audio-only telehealth via discretionary enforcement of the Health Insurance Portability and Accountability Act's protected health information regulations, and other programmatic changes, are also conditioned on the PHE.

Unfortunately, statute requires the U.S. Secretary of Health and Human Services to renew the PHE every 90 days. This creates uncertainty for states around what resources and flexibilities will be available going forward. This uncertainty necessitates conservative decision-making with real-world consequences. This can be mitigated by providing certainty early in a PHE renewal cycle around future PHE renewal decisions. [**NAMD recommends convening a group of expert stakeholders to develop a set of clear, publicly available metrics which the Secretary will rely on to inform PHE renewals going forward. This will provide states with more certainty and promote stable long-term planning.**](#) Metrics to consider include national and regional COVID-19 positivity rates and the percentage of the nation that has successfully received a COVID-19 vaccination.

Advance Equity in Medicaid

The pandemic has illustrated painful disparities in the nation's health care system, including within the Medicaid program. NAMD and our members recognize the challenge these systemic inequities create and have committed to take action to address these inequities going forward. We encourage thoughtful approaches to improve Medicaid's delivery system infrastructure and provide better care to underserved populations. This includes, but is not limited to, improving Medicaid's pediatric service delivery, behavioral health and substance use disorder services, long-term services and supports including home- and community-based services, services for justice-involved populations, and services for rural populations. We recommend a specific focus on addressing the digital divide that can prevent many communities of color from effectively accessing telehealth services in the Medicaid program. We stand ready to partner with the Administration to develop and implement actionable solutions in this area.

As an immediate area of focus, we wish to call attention to the COVID-19 vaccination campaign. The Medicaid population is disproportionately impacted by COVID-19 and faces worse outcomes from the virus, driven by long-standing racial and ethnic disparities in health care systems and the higher disease burden that accompanies poverty. These populations are further challenged by comparatively low health literacy and are generally more difficult to consistently reach than non-Medicaid populations. **We encourage the Administration to leverage Medicaid Directors as partners to creatively address these concerns and implement a concerted, targeted vaccine outreach campaign to the Medicaid population.**

Provide Guidance on Expectations for End of the Public Health Emergency

The COVID-19 PHE creates specific obligations, including a requirement that, as a condition of the receipt of the federal match enhancement, states must maintain Medicaid enrollment for individuals who were Medicaid eligible prior to the PHE or who become Medicaid eligible during the PHE. As the PHE continues, Medicaid rolls are constantly increasing due to the economic decline and this requirement. While NAMD fully supports the provision of health insurance coverage during the pandemic, the increase in enrollment raises operational questions for how states should plan to conduct redeterminations, make coverage changes, and effectuate coverage terminations for ineligible individuals when the PHE expires and normal Medicaid rules apply once again.

These operational questions have significant resource ramifications for state programs. As enrollment continues to increase, states will need to invest more and more staff time and administrative resources to conducting redeterminations, managing fair hearings processes, issuing beneficiary notices, and other activities. Resolving temporary provider enrollments and completing provider credentialing processes will also be necessary. State systems may need to be modified to support these processes, which creates additional resource challenges.

HHS can support state planning for this work by rapidly issuing clear guidance on federal expectations for Medicaid member redeterminations and Medicaid provider enrollment requirements, including compliance timelines that account for the overall length of the PHE's impact on state workloads and state budget cycles. There is also a critical need to explore how longer-term supports can be provided to states as the economic challenges of the pandemic are expected to persist well beyond the end of the formal PHE declaration.

Maintain Flexibilities in FFCRA Continuous Enrollment Requirement and Create Reasonable Timeframe for State Compliance

When Congress initially passed the FFCRA with its federal match enhancement and continuous enrollment requirement, CMS's interpretation of the statute did not allow states to make any changes to Medicaid coverage for enrolled individuals. This produced some challenging situations, where states were unable to transition individuals to coverage that more accurately reflected their needs and circumstances, and also resulted in increased costs to the federal government as states were required to maintain full Medicaid coverage for Medicare-eligible individuals.

In the [fourth COVID-19 Interim Final Rule published on November 6](#), CMS revised its interpretation. NAMD supports this new interpretation of the FFCRA continuous enrollment requirement. The tiered

coverage approach allows states to make reasonable modifications to their programs to manage ongoing program needs and to correct for eligibility errors made by the state. We encourage the Administration to maintain these state flexibilities.

That said, we also recognize that states will need sufficient time to implement coverage changes required under this interpretation. The continuous enrollment requirement necessitated state eligibility system changes, which can be costly and time-consuming to modify. **States will need at least one quarter to implement these changes.**

Address Near-Term Regulatory Timelines that Challenge State Compliance Capacity

Several regulatory timelines and requirements set in place prior to the pandemic will pose near-term compliance challenges for states. Other timelines are specific to the pandemic and PHE and require reconsideration in light of the pandemic's continually evolving impact on the health care landscape. Some of these regulations include:

- **1115 Waiver Renewals:** Several states utilize large and complex Section 1115 Medicaid demonstration waivers to operate significant portions of their Medicaid programs. Such waivers are generally approved for five years. The process of negotiating renewals and modifications to these waivers can take a year or more, requiring significant planning, budget forecasting, and negotiations with federal partners. In ideal conditions, this is an intensive and demanding process. The ongoing pandemic means conditions are far from ideal for states facing an 1115 renewal in the next two years.

We encourage the Administration to consider, upon state request, allowing a short-term and streamlined renewal of one to two years under existing waiver parameters. The goal is to allow states with limited bandwidth to defer major negotiations pertaining to their demonstrations to a future time when the pandemic is contained, and all parties can devote the appropriate resources to the 1115 renewal process.

- **Retainer Payment Policy:** In Medicaid home- and community-based services (HCBS) implemented through Section 1915(c) waivers, states have the authority via the Appendix K to implement retainer payments for habilitative service providers. These payments are linked to a specific set of services the provider provides to a specific waiver services recipient in instances when the waiver recipient is unable to go to the provider or otherwise receive such services.

Since the onset of the pandemic, virtually every state implemented Appendix K retainer payment authority to mitigate the significant decrease in service utilization faced by their HCBS habilitative service providers. Without such payments, these financially fragile providers would likely significantly curtail their service provision or shut down entirely.

Unfortunately, in its [Medicaid COVID-19 Frequently Asked Questions](#) CMS limited these Appendix K retainer payments to a maximum of three 30-day episodes. Since the majority of Appendix K approvals became effective between late January to mid-March of 2020, this limit

has been reached and states no longer have this option available to bring relief to their habilitative HCBS providers. **We urge the Administration to lift this limit on retainer payment approval periods for the duration of the COVID-19 PHE.**

Further, early in the pandemic states recognized a need to provide relief to a wide array of providers via retainer payment mechanisms and to not limit payments to habilitative HCBS providers. [States would need 1115 demonstration authority to make retainer payments to other Medicaid provider types](#). To date, such demonstrations have not been approved by CMS. NAMD encourages the Administration to allow a broader application of retainer payments via 1115 authority while the PHE continues.

- **Expiration of 1915(c) Appendix K Waivers:** 1915(c) Appendix K waivers can be approved for a maximum of one year under current CMS policy, which was set pre-pandemic and was generally informed by time-limited disasters such as hurricanes or wildfires. Current Appendix K effective dates begin on January 26, 2020 at earliest. This means that states electing to make their Appendix Ks effective at this date face imminent expiration.

The duration of the COVID-19 PHE and ongoing need for Appendix K flexibilities requires reconsideration of this one-year approval period. **We urge the Administration to swiftly lay out parameters for seamless renewals of Appendix K flexibilities.**

- **Interoperability Rule:** In May 2020, CMS published a [Final Rule on health systems interoperability and patient access to their health information](#). This rule includes compliance timelines for states as early as January 1, 2021 regarding development of Application Programming Interfaces for provider directories and patient access to claims and encounter data. In recognition of the pandemic's impact on state resources, [CMS is applying a discretionary enforcement period to extend the compliance date for these provisions to July 1, 2021](#).

NAMD remains concerned that this is not sufficient time for states to comply with these requirements. [As we explained in an October 2020 letter to CMS](#), states are challenged by both available resources and the relatively high cost for vendor support to meet these requirements. **We recommend a full year of additional compliance time beyond July 2021. The additional time could be conditioned on state demonstration of good faith compliance efforts.**

- **Electronic Visit Verification:** Beginning on January 1, 2021, states which do not meet CMS's definition of compliance for an active Electronic Visit Verification (EVV) system in their Medicaid personal care services waiver programs will begin having a federal match penalty applied to their noncompliant services. We are gravely concerned that these fiscal penalties will undercut states, which are already struggling financially during the ongoing pandemic. While we recognize CMS does not have the statutory authority to delay the implementation date of this requirement as it is laid out in the 21st Century Cures Act, **we strongly encourage revisiting the**

definitions of compliance with the EVV requirement and providing as much flexibility as possible for states to continue demonstrating good-faith efforts towards compliance.

- **Fee-for-Service Access Monitoring Rule:** In January 2016, [CMS published a Final Rule on methods for assuring access to Medicaid covered services in fee-for-service \(FFS\) Medicaid programs](#). This rule requires states to develop access monitoring plans for certain Medicaid services, as well as for services subject to rate reductions or significant rate restructuring. States are required to monitor for three years the impact of the rate change on access to the service. NAMD has expressed concern with the administrative burden this rule creates for states and the relative lack of value generated by these access monitoring plans. In response, CMS in 2017 [identified some narrow exceptions for the rule](#) and in 2019 [proposed rescinding the rule](#), though the rule currently remains in effect.

As states grapple with serious budget challenges posed by COVID-19's impact on state revenues, states will face difficult decisions around rate reductions in their programs. While no state seeks rate reductions as a first resort, the magnitude of budget challenges may require states to implement them. NAMD is concerned that applying the access rule's burdensome regulatory requirements will create additional challenges for states as they grapple with these rate modifications. **We recommend a temporary suspension of the access rule's requirements for the duration of the PHE.** We also recommend moving forward with the rescission of this rule in favor of a holistic access monitoring framework applicable across Medicaid FFS and managed care, as [we indicated in our formal response to the 2019 proposed rescission](#).

We appreciate your consideration of these requests. NAMD's executive leadership team and our staff stand ready to provide additional detail on any of these priorities. We look forward to a collaborative and productive relationship with the Biden Administration.