COVID-19 Related Medicaid Efforts
As of April 25, 2020

On March 13, 2020, the President of the United States declared the 2019 Novel Coronavirus Disease (COVID-19) a public health emergency. This declaration allows states to submit requests to the federal Centers for Medicare & Medicaid Services (CMS) to waive certain federal regulations and provide additional flexibility to address the emergency. The Illinois Department of Healthcare and Family Services has been working with the Office of the Governor, the Illinois General Assembly, our state and federal partner agencies as well as providers, advocates, and other stakeholders to mount the best possible response to the COVID-19 public health emergency through the Medicaid program.

From the beginning of the public health emergency, HFS commenced numerous efforts related to beneficiaries, eligibility, coverage, providers, and billing to work in concert with the sudden and dramatically changing healthcare needs related to COVID-19. Some policy and procedure changes HFS had the authority to immediately implement, but the majority of our processes required approval from federal Centers for Medicare and Medicaid Services (CMS), and/or state regulatory changes. Some initial federal approvals have already been received, while many other requests are under consideration. HFS has consistently communicated with our providers partners during this fluid time, largely though provider notices, guidance, FAQs, and by posting full text federal submissions on our COVID-19 Updates page on our website at https://www.illinois.gov/hfs/Pages/coronavirus.aspx. HFS thanks our healthcare provider partners, federal partners, advocates, and associations for their efforts, input, cooperation, and patience during this time.

Emergency rules related to new expansive telehealth opportunities

- HFS submitted emergency rules on March 20, 2020 and were **EFFECTIVE IMMEDIATELY**.
- Provider Notice, FAQs, Billing instructions and Codes were posted on the HFS website.
- The telehealth emergency rules were expanded to allow reimbursement for previously unapproved virtual services and includes using the patient's home or other settings, expands the provider types authorized to provide telehealth, and provides coverage in new and previously unexpected ways.

Section 1135 Waiver submission

- Submitted on March 19, 2020
- 1135 Summary – the first emergency submission, largely requests flexibilities for providers during the COVID-19 crisis. 1135 Partial Approval received on March 23, 2020.
- The partial approval only covered a handful of the state's requests, noting the remainder of the requests were still under CMS review.
- Unless otherwise specified, the section 1135 waivers are effective March 1, 2020 and will expire upon termination of the public health emergency, including any extensions.

Section 1115 Waiver submission

- Submitted on March 26, 2020 - To date no 1115 waiver requests from Illinois have been approved.
- 1115 Summary – Requested items include: Elimination of out of pocket costs for COVID-19 treatment for uninsured individuals, and authority to pay out of pocket costs as a secondary payer for insured individuals; temporary housing for individuals with COVID-19 experiencing homelessness, and home delivered meals for Medicaid beneficiaries who do not have access to meals during the social distancing period; streamlining the Medicaid application and eligibility process, and allowing presumptive eligibility for aged, blind, and disabled adults on Medicaid.

Home and Community Based 1915(c) Waiver Appendix K Submission

- Submitted on March 27, 2020. Submission is under active consideration by CMS.
- Request to extend from January 27, 2020 through January 26, 2021.
- Applies to the 9 existing waivers. These include seniors and persons with disabilities, individuals with HIV/AIDS, individuals with traumatic brain injury (TBI), medically fragile/technologically dependent children, supportive living program, and adults/children with DD.
- Appendix K submission requests cost increases for services for these populations, as well as new flexibilities for providers to serve clients in new/different ways. Allowing for services in different settings, telehealth visits, infection control supplies, and other service changes during the COVID emergency, among other requests.

Disaster Medicaid State Plan Amendment (SPA)

- Submitted on April 5, 2020, **APPROVED** by federal CMS on April 24, 2020.
- Authorities are retroactive to March 1, 2020 unless otherwise noted:
    - Coverage of testing for uninsured individuals without regard to income.
    - Elimination of the asset test for Aged, Blind and Disabled population.
    - Presumptive eligibility for most adults and expanded frequency for children and pregnant women (expanded to two times per calendar year).
    - Suspension of premiums/co-pays for Health Benefits for Workers with Disabilities.
    - Prior authorization for prescription drugs is expanded to automatic renewals.
    - ICF/DD & MC/DD facility rate increases to a uniform 20% effective March 17.
    - Reimburse encounter rate clinics FFS for virtual check-ins and e-visits effective March 9.

Disaster CHIP State Plan Amendment (SPA)

- Submitted on April 5, 2020. Federal CMS conducting an expedited review for formal approval.
- Largely the same as the above Disaster Medicaid SPA, applies the request to the Children's Health Insurance Program (CHIP).

Concurrence List

- Formal notice to federal CMS on April 13, 2020 of implementation.
- IES changes and other policy and procedure communications have been completed.
    - Allow self-attestation of income, incurred medical expenses, residency, disability status, and insured status when electronic verification is not available.
    - Exception to timeliness standards for processing Medicaid applications and renewals.
    - Permit phone applications without recording client authorization (telephonic signature).

Medicaid Blanket Waivers

- HFS received clarification from CMS that the March 30 Medicare blanket waivers for healthcare providers can also be **extended to Medicaid at the state's discretion**.
- These are provider-based flexibilities. Including: Specific flexibilities for hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), long-term acute care hospitals (LTACs), inpatient rehab facilities (IRF), inpatient psychiatric facilities, home health agencies, hospice providers, end state renal dialysis (ESRD) providers, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers.

MCO Contract Amendments

- In progress. Adjustments to contractual obligations and possibly rates for the MCO's to match the new flexibilities in the waivers and SPAs above.