COVID-19 Public Health Emergency (PHE): Post-PHE Frequently Asked Questions (FAQ) for Providers of Long-term Services and Supports

Document purpose

As the federal public health emergency related to the COVID-19 pandemic comes to an end, the DC Medicaid agency, the Department of Health Care Finance (DHCF), and its partners are beginning the process of returning to normal, pre-pandemic operations. Over the next several months, DHCF and its partners will roll back a number of flexibilities implemented during the pandemic. This document provides details on those changes, dates, and responses to questions we anticipate from providers and beneficiaries.

What changes are coming first?

- Effective November 1, 2022: In-person assessments conducted by Liberty resumed.
- Effective March 1, 2023: Required in-person activities by EPD Waiver providers resumed, including collection of "wet" signatures and in-person monthly visits by case managers.
- Effective April 1, 2023: Eligibility redeterminations resumed. Long-term care eligibility renewals are required. Adverse actions resumed. Notices of renewals will be issued beginning April 1 (for MAGI populations, those with eligibility ending May 31, 2023; for non-MAGI populations, eligibility ending June 30, 2023). ***For our long-term care providers, renewals completed for long-term care beneficiaries with an eligibility end date on or after June 30, 2023 must be completed through the District Direct Partner Portal using the 50B conversion renewal form and the LTC Supplemental application.***
- Effective May 11, 2023: Federal PHE declaration formally ends. Some flexibilities end on this date.
- Effective July 11, 2023: PHE enhanced payment rates for nursing facilities and intermediate care facilities end.
- November 11, 2023: All remaining EPD Waiver-related flexibilities end, six months after the end of the PHE. These flexibilities are also described in the District's unwinding plan and transmittals.

What does this mean? What is changing?

Beneficiaries are already being assessed in person by Liberty staff and visited in person by case managers. Activities that were allowed to be delivered either remotely or in person during the pandemic, including obtaining actual signatures instead of attestations of consent, are generally required to occur in person once again

The District has resumed Medicaid renewals effective April 1. This means that notices regarding required renewal applications – sent 60 days in advance for MAGI populations and 90 days for non-MAGI beneficiaries – will be issued beginning April 1, and such notices will continue for each cohort until all Medicaid beneficiaries have been notified and completed a full renewal or disenrolled from the program. Enrollments that are not renewed on a timely basis will lapse. Adverse actions resulting from assessment findings will resume.

When will an adverse service authorization take effect?

For fee-for-service beneficiaries, an adverse service authorization will occur after a recent assessment. A notice will be issued after the assessment and it will describe the individual's appeals rights. Operationally speaking, the start date of a new prior authorization for services will vary, but will generally adhere to the expected start date of the subsequent or new level-of-care date span.

Regardless, a reduction can only be effectuated after the notice is issued. For terminations of benefits unaffected by Medicaid eligibility, both DHCF and its enrolled providers must provide 30 days' advance notice before it is effectuated. Authorization processes will follow existing protocols to ensure that providers have sufficient prior authorization to continue services while complying with notice requirements.

If a fee-for-service beneficiary elects to appeal a change in services and they or a provider submits to DHCF or its vendors proof of receipt of an appeal filed on a timely basis with the Office of Administrative Hearings (OAH), services will be stayed for the duration of the pending appeal, consistent with beneficiary appeal rights. For example, providers can upload and view fair hearing filing documents within DC Care Connect. Case managers should include proof of OAH-received appeal in submissions of PCSPs to DHCF's QIO in order to continue services at current levels.

For beneficiaries with lapsed Medicaid coverage, their notice of termination from the program is the controlling notice, and providers cannot be reimbursed for services provided to individuals without Medicaid coverage.

For beneficiaries enrolled in other delivery systems, such as DC Healthy Families managed care plans, Dual Choice, or PACE, the organization responsible for their care issues authorizations, notices, and handles initial appeals of any changes to services for enrollees with continuing Medicaid eligibility. Beneficiaries must exhaust the appeals process within their care organization prior to appealing the organizational determination at OAH.

A beneficiary I serve has not completed his renewal and his Medicaid eligibility lapses in a few days. Should I file a fair hearing?

The beneficiary's appeal rights are described in the 30-day notice of termination he received, and he may exercise those rights. However, during the unwinding period, DHCF is exercising certain mitigation practices to ensure Medicaid beneficiaries who truly remain eligible for Medicaid coverage have every opportunity to renew and retain their coverage. Prior to the public health emergency, if a beneficiary submitted his or her renewal late but within the 30 days following a lapse and was approved, coverage would be reinstated to the first of the month and remain continuous. During the unwinding period, this "reconsideration period" is now 90 days. That means individuals with a lapse in coverage may still submit a renewal application any time within the following 90 days and, if approved, retain retroactive and continuous Medicaid eligibility throughout the lapsed period. DHCF recommends beneficiaries, their case managers, and other caregivers take advantage of this reconsideration period for those who initially miss the deadline to recertify.

A beneficiary my direct care provider organization serves has not completed his renewal and his Medicaid eligibility lapses in a few days. Should I issue a discharge notice?

Medicaid cannot pay for services for individuals without Medicaid coverage. While DHCF notices and communications, along with the mitigation described in the prior section, are designed to offer our beneficiaries ample time and support to complete their renewals, some beneficiaries' coverage will lapse during the unwinding period and they may actively choose to not renew or they may simply fail to renew, despite the best efforts of the supports around them.

Direct care providers are very strongly encouraged to monitor beneficiaries' eligibility information, ideally at the census and monthly cohort level, and to verify eligibility for beneficiaries frequently to ensure they are aware of upcoming changes in advance and not after the fact. Providers may choose to

issue discharge notices to Medicaid beneficiaries, consistent with regulatory requirements, in order to ensure they have done their due diligence in providing notice and protecting against the risk of unpaid services. Such notices may have the additional effect of ensuring beneficiaries are aware of the service-related implications of non-renewal, which may not be top of mind after three years of PHE policies.

Notices issued and then not effectuated – for example, a notice of discharge that is not effectuated after a person completes their renewal and continuous coverage is reinstated – must be rescinded.

How will beneficiaries learn more about these changes?

All beneficiaries subject to changes in their services or coverage receive legal notices about those changes prior to their implementation. For other process changes, DHCF has developed informational materials our providers can share with beneficiaries when they meet with them or provide care. These informational materials will also be shared with advocacy organizations and other community partners.

My beneficiary didn't receive a notice.

Prior to changes in services – whether a reduction or termination of services – a notice will be issued. If a beneficiary you serve did not receive a notice, contact LTCA, UHC, or the entity that issued the notice to confirm it was sent. If a notice was, in error, not sent, a new notice will be issued.

When eligibility redeterminations resume, notices will be issued 90 days prior to the end of each beneficiary's certification period. Beneficiaries, their caregivers, and case managers should respond promptly to requests for information about recertifications.

Finally, beneficiaries, families, and providers should take care to ensure that beneficiaries' address information is up to date with the Medicaid program. Beneficiaries can update their information with their case manager, through any service center, or online via District Direct.

What if my beneficiary refuses something that is now required?

Beneficiaries will need to participate in required activities consistent with Medicaid regulations. For beneficiaries enrolled in the EPD Waiver program, case management activities are required, including in-person case manager visits. Until Medicaid redeterminations are in effect, beneficiaries will not be terminated from the Medicaid program for non-compliance with their own roles and responsibilities, but after the PHE, refusal to participate may result in disenrollment, pending appropriate notice.

More information

- DHCF's Medicaid Renewal – The Restart of Normal Medicaid Eligibility Operations guidance document is available on DHCF's website: https://dhcf.dc.gov/page/medicaid-covid-19-updates
- Contact DHCF through dedicated email boxes:
    - Medicaid.Restart@dc.gov for general questions about Medicaid Restart (including eligibility, operations, and authorities related to the PHE)
    - Medicaid.Renewal@dc.gov for specific questions about Medicaid eligibility renewals and the return to normal eligibility operations
- COVID PHE-related Informational Bulletins and Billing & Documentation Guidance: https://dhcf.dc.gov/publication/informational-bulletins-ltc-providers
- COVID PHE-related Health Guidance: https://coronavirus.dc.gov/healthguidance
- Latest DC Medicaid Director Letters: https://dhcf.dc.gov/page/medicaid-director-letters
- Latest DC Medicaid Transmittals: https://dhcf.dc.gov/page/dhcf-medicaid-updates