Division of TennCare

MEMO

To: TennCare Managed Care Organizations (MCOs)
From: Keith Gaither, Managed Care Operations Director
Date: November 8, 2021
Subject: CMS Guidance Regarding Coverage for Covid-19 Treatment

On October 22, 2021, CMS issued new guidance on Sections 9811 and 9821 of the American Rescue Plan (ARP) Act. These sections concern (among other things) Medicaid and CHIP coverage of treatment for COVID-19. Key points are summarized below:

- The ARP requires Medicaid and CHIP to cover treatments specifically "for" COVID-19, including specialized equipment and therapies, and preventive therapies. CMS interprets this requirement to include coverage for treatment of post-COVID conditions (sometimes called "long COVID").

- As it relates to non-pharmacological treatment, CMS interprets the ARP to establish an EPSDT-like requirement. That is, CMS interprets the law to require states to cover any medically necessary treatment for COVID-19 that is coverable under Section 1905(a) of the Act in Medicaid (or under Section 2110(a) for CHIP), regardless of whether that service would normally be covered. Limits that would otherwise be applicable to a particular service should not be applied when the service is needed to treat or prevent COVID. Notably, this requirement applies to CHIP as well as Medicaid.

- As it relates to pharmacological treatments, CMS interprets the ARP to require coverage of any drug or biological that is approved (or licensed) by the FDA or authorized by the FDA under an Emergency Use Authorization to treat or prevent COVID-19.

- The ARP requires not only coverage of treatments "for" COVID-19, but also, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, treatments of any condition that may seriously complicate COVID-19 treatment. Medicaid and CHIP beneficiaries with certain underlying comorbidities are at a higher risk of progressing to severe COVID-19, or have conditions that could seriously complicate the treatment of COVID-19. Examples of these conditions include, but are not limited to, cardiovascular diseases, chronic lung diseases, diabetes, cancer, obesity, Down Syndrome, and being a recipient of a transplant or immunosuppressive therapy. Whether a beneficiary has a condition that could seriously complicate the treatment of COVID will have to be determined on a beneficiary-specific basis. As it relates to treatment for conditions that may seriously complicate the treatment of COVID-19, CMS is not requiring the coverage of any *new* services. However, when an MCO determines that a service is needed for treatment of a condition that may seriously complicate the treatment of COVID-19, that service must be exempt from cost sharing, and any limits that would otherwise apply to a covered service should not apply when the service is being covered pursuant to this ARP requirement.

- Coverage of treatment for COVID-19 (including treatment of conditions that may seriously complicate COVID-19 treatment) are exempt from any cost sharing that would otherwise apply. As discussed above, MCOs will need to make a determination about whether a particular service is "for" COVID, or for a condition that might seriously complicate COVID, in order to apply this requirement correctly.

- CMS began applying the statutory interpretations in this guidance beginning on October 22, 2021. These requirements generally end on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 public health emergency. TennCare will communicate with the MCOs when the end date of the public health emergency is known and/or when we receive additional guidance from CMS.

As you are aware, the original guidance required that states pay for Covid-19 and Covid-19 related conditions/treatment services and exempted those services from copayment obligations which we believe is in alignment with the new guidance provided above.

Please assure that your organization is compliant with the aforementioned guidance.