Top 10 List of Key COVID-19 Flexibilities for Medicaid and CHIP Providers

The Texas Health and Human Services Commission (HHSC) has implemented multiple flexibilities to support patients and providers in response to COVID-19. The following summarizes the top 10 flexibilities for Medicaid and CHIP providers.

This is not a comprehensive list, and guidance is subject to change. For the most up-to-date information, visit the TMHP provider-facing website or the HHSC Medicaid/CHIP Services COVID-19 provider-facing website.

1. Texas Health Steps Checkups and Telemedicine

To allow for continued provision of THSteps checkups during the period of social distancing due to COVID-19, HHSC is allowing remote delivery of certain components of medical checkups for children over 24 months of age (i.e. starting after the "24 month" checkup). Because some of these requirements, like immunizations and physical exams, require an in-person visit, providers must follow-up with their patients to ensure completion of any components within 6 months of the telemedicine visit.

For details, see the TMHP bulletin issued on May 12, 2020.

2. Teleservices

Medicaid and CHIP health plans have flexibility to provide teleservices, including in a member's home. HHSC has encouraged the use of teleservices when responding to COVID-19. Efforts are underway to expand the use of telemedicine for patients in both managed care and fee-for-service programs.

For details on teleservices, see the TMHP bulletin issued April 24, 2020.

3. Testing and Treatment for COVID-19

Medicaid and CHIP covers COVID-19 testing for Medicaid and CHIP clients. No prior authorization is required for COVID-19 lab testing by Medicaid and CHIP health plans or by traditional Medicaid.

The Centers for Medicaid & Medicaid Services (CMS) issued a guidance for COVID-19 treatment services covered by Medicaid.

4. Coding for COVID-19

For information on coding for COVID-19 refer to the following:

- New COVID-19 Diagnosis Code U071 to Be a Benefit of Texas Medicaid and the CSHCN Services Program Effective April 1, 2020
- Grouper Version 37.1 for Dates of Discharge on or after April 1, 2020

5. Prior Authorizations

HHSC has directed TMHP and health plans to extend prior authorizations (PAs) that require recertification and are set to expire March 1, 2020, through May 31, 2020, for 90 days.

This extension does not apply to current authorizations for one-time services or pharmacy PAs.

This extension applies to all state plan services, including acute care and long-term services and supports such as personal assistance services, personal care services, community first choice, private duty nursing, physical, occupational, and speech therapies, and day activity and health services. This extension also applies to clinician administered drugs, when clinically appropriate.

Refer to the TMHP bulletin posted on April 9, 2020 for more details.

6. Possible Drug Shortages

Visit the VDP website for any temporary changes made to the preferred drug list due to reported drug shortages.

Providers should complete the Drug Shortage Notification Form to inform HHSC of potential shortages impacting prescribing choice or pharmacy claim processing.

7. Medication Refills

On March 19, 2020, the Texas State Board of Pharmacy authorized pharmacists in Texas to dispense up to a 30-day refill supply of medication for patients in Texas in the event a prescriber cannot be reached in response to the state of disaster declaration for COVID-19. This excludes Schedule II medications.

For additional information, visit the Texas State Board of Pharmacy website.

8. Provider Enrollment

HHSC has made certain changes designed to increase and retain available providers. Additional information can be found on the TMHP website.

In addition, The Texas Medical Board has extended the due dates for license renewals during this period. See the Texas Medical Board website for additional information.

9. CHIP Co-Payments Waived

Office visit co-payments for all CHIP members for services provided from March 13, 2020, through May 31, 2020 are waived. Co-payments are not required for covered services delivered via telemedicine or telehealth to CHIP members.

The member's health plan will reimburse the provider the full rate for the service, including what would have been paid by the member through cost-sharing. Providers must attest that the office visit co-payment was not collected by using the attestation form and submit an invoice to the appropriate health plan. Health plans have 30 calendar days to pay an invoice received from a provider.

For details on telehealth services, see the TMHP bulletin issued April 24, 2020.

10. Appeals and Fair Hearings

Appeals

HHSC has required health plans and dental plans to extend the timeframes for the following through May 31, 2020:

- *Appeal requests:* Number of days a member, legally authorized representative (LAR), or other authorized representative can request an appeal is now 90 days (normally 60 days for a health or dental plan internal appeal)
- *Continuation of benefits requests*: Number of days a member, LAR, or other authorized representative can request continuation of benefits is now 30 days (normally 10 days from receipt of notice of adverse benefit determination)
- *Standard appeal resolutions:* Number of days health plans and dental plans have to resolve a standard member appeal is now 60 days (normally 30 days)

HHSC has also required all health plans and dental plans accept oral requests for appeals without the member having to provide a written request through May 31, 2020.

Fair Hearings

HHSC has also extended the timeframes for the following through May 31, 2020:

- *Fair hearing requests:* Number of days a member, LAR, or other authorized representative have to request a fair hearing is now 150 days (normally 120 days)
- *Fair hearing determinations*: Number of days HHSC has to make a fair hearing determination is now 120 days (normally 90 days)