CMS-9912 Interim Final Rule with Comment Factsheet on Updated Policy for Maintaining Medicaid Enrollment during the Public Health Emergency for COVID-19

On March 18, 2020 President Trump signed the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) into law in response to the Public Health Emergency (PHE) for coronavirus disease 2019 (COVID-19). Section 6008 of the FFCRA authorizes states to claim a temporary 6.2 percentage point increase in the federal medical assistance percentage (FMAP) if they satisfy certain conditions laid out in section 6008(b).

CMS's original interpretation of the conditions specified in section 6008(b)(3) was issued in guidance, in the form of frequently asked questions, in April, May and June 2020. This interpretation prevented states from implementing certain changes to effectively manage their programs. On 10/28, CMS published CMS-9912-IFC which establishes a new section 433.400 in Part 433 of Title 42 of the Code of Federal Regulations that reinterprets the condition in section 6008(b)(3) of the FFCRA under which states claiming the temporary FMAP increase must maintain beneficiary enrollment through the end of the month in which the PHE for COVID-19 ends, and includes additional safeguards to protect beneficiaries.

Overview of New Section 42 C.F.R. 433.400

Initial CMS guidance on section 6008(b)(3) of the FFCRA required states, as a condition for receiving the temporary FMAP increase, to maintain the enrollment and coverage of all Medicaid beneficiaries through the end of the month in which the PHE for COVID-19 ends. Under this initial guidance, states were prohibited from making any changes to the benefits available to a beneficiary or to a beneficiary's required cost sharing or, in the case of institutionalized beneficiaries, to their financial responsibility for the cost of care under the post-eligibility treatment of income rules.

Under the new regulations at 42 C.F.R. section 433.400, in order to claim the temporary FMAP increase, states must maintain the Medicaid enrollment of "validly enrolled beneficiaries" in one of three tiers of coverage. Such enrollment must be maintained, with certain exceptions, through the end of the month in which the PHE for COVID-19 ends. States may terminate individuals not validly enrolled, after providing advance notice and fair hearing rights per 42 C.F.R. Part 431 Subpart E, and still claim the temporary FMAP increase. Section 433.400 permits states to make changes to beneficiary coverage, cost sharing and post-eligibility treatment of income without violating the condition in section 6008(b)(3) of the FFCRA. This includes both individual changes and changes to the state plan, a section 1115 demonstration and/or a waiver authorized under section 1915 of the Act, provided such change is consistent with other federal Medicaid requirements.

Details about the Requirements in 42 C.F.R *§* 433.400

Which beneficiaries would NOT be considered validly enrolled beneficiaries under § 433.400?

Beneficiaries generally are considered to be validly enrolled. However, a beneficiary is not validly enrolled if the state Medicaid agency determines that:

- The determination of eligibility was incorrect at the time it was made due to agency error.

- Eligibility was erroneously granted due to beneficiary fraud for which the beneficiary has been convicted or beneficiary abuse as determined by the agency in accordance with existing regulations at 42 C.F.R. § 455.16.

Individuals receiving coverage during a presumptive eligibility period are not considered validly enrolled beneficiaries for purposes of section 433.400.

What are the three tiers of coverage under § 433.400?

Section 433.400 establishes the following three tiers of coverage for the purpose of satisfying the condition to maintain coverage in states claiming the temporary FMAP increase.

1. Minimum Essential Coverage (MEC): Medicaid coverage that meets the definition of MEC at 26 C.F.R. 1.5000A-2, including coverage in Medicare with coverage under a Medicaid Medicare Savings Program eligibility group (this includes the eligibility groups for Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Individuals and Qualified Working Disabled Individuals). This tier provides the most robust coverage.
2. Non-MEC with coverage of COVID-19 testing and treatment: Medicaid coverage that does not meet the definition of MEC, but does include coverage for testing services and treatments for COVID-19 including vaccines, specialized equipment, and therapies. Some states provide tier 2 coverage under a section 1115 demonstration project, and in some states, coverage provided to pregnant or postpartum women under 42 C.F.R. 435.116 is not MEC and would also be included in tier 2.
3. Non-MEC with limited benefits: Medicaid coverage that does not meet the requirements of tier 1 or tier 2 because it is not MEC and does not include testing and treatment for COVID-19; examples of such limited benefit coverage include coverage available through the eligibility groups limited to family planning or tuberculosis-related services. This tier provides the least robust coverage.

A beneficiary may transition from one eligibility group to another eligibility group during the PHE for COVID-19, as long as the new eligibility group provides the same tier of coverage, with an exception for the non-MEC coverage in tier 3 because the benefits are much more limited and may vary widely; beneficiaries receiving tier 3 coverage generally must continue to receive the same coverage for which they have been enrolled. In addition, a beneficiary may move to a tier with more robust coverage, but may not be transitioned to a tier with less robust coverage unless the beneficiary requests such transition.

Are there any individuals whose coverage may be terminated prior to the end of the PHE?

In states claiming the temporary FMAP increase, a beneficiary's Medicaid enrollment may be terminated prior to the first day of the month after the PHE for COVID-19 ends if:

1. The beneficiary requests a voluntary termination of eligibility;
2. The beneficiary dies;
3. The beneficiary ceases to be a resident of the state; or
4. The beneficiary was not validly enrolled, as described above.

Note that a beneficiary may be identified, through a data match with the Public Assistance Reporting Information System (PARIS), as receiving assistance under a benefit program in more than one state. In such cases, if the state is unable to verify the beneficiary's continued residency in the state because the beneficiary fails to respond to requests for additional information and the state makes alternative efforts but cannot verify the beneficiary's continued residency in the state through other sources, that beneficiary's Medicaid enrollment may be terminated in accordance with 435.400(d)(1)(ii). If the individual subsequently provides information to verify state residency, the state must reinstate the beneficiary's Medicaid enrollment.

What happens when a validly enrolled beneficiary becomes ineligible or eligible only for a less robust tier of coverage?

If a validly enrolled beneficiary becomes ineligible for Medicaid under any eligibility group or demonstration project, to qualify for the FFCRA increase FMAP, the state must maintain the beneficiary's enrollment and continue to provide the same tier of Medicaid coverage that the beneficiary would have received absent the determination of ineligibility. If a validly enrolled beneficiary becomes eligible only for a group or demonstration project providing a less robust tier of coverage, to qualify for the FFCRA increase FMAP, under section 433.400 the state may move the validly enrolled beneficiary to a tier with more robust coverage, but may not transition the beneficiary to a tier with less robust coverage unless the beneficiary requests such transition.