Medicaid Maintenance of Effort – Summary of CMS FAQ Document

March 2021

On January 6, 2021, the Center for Medicaid and Medicare Services (CMS) released one, comprehensive FAQ document inclusive of all of the COVID-19 FAQs issued by CMS. These COVID 19 FAQs are now available at medicaid.gov (https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf).

Under the Families First Coronavirus Response Act, states receive an increase in Medicaid funding (referred to as "the temporary FMAP increase") if they agree to keep beneficiaries enrolled in Medicaid and halting most terminations during the declared COVID-19 public health emergency. These requirements are often referred to as "maintenance of effort" requirements. When advising beneficiaries, CWICs provide estimates of the effect of earnings on eligibility for Medicaid and Medicare Savings Programs and normally provide time frames for when these eligibility changes will occur. For example, a counselor may advise a beneficiary in a particular case that they will lose their QMB eligibility until after they complete their Trial Work Period and cessation occurs. With these maintenance of effort requirements, these changes in eligibility may under a different time frame. CWICs should factor this into their advisement.

Below you will find relevant answers to the COVID-19 FAQs issued by CMS. Many answers refer to 42 C.F.R. 433.400, which did make some changes to the maintenance of effort requirements. States are still required to provide continuous enrollment. However, this requirement can now be met by maintaining enrollment in the current coverage category or, in specific circumstances listed below, moving the beneficiary to another coverage category.

1. For beneficiaries whose Medicaid coverage meets the definition of MEC (minimum essential coverage) as of or after March 18, 2020, the state must continue to provide Medicaid coverage that meets the definition of MEC (minimum essential coverage), except as provided in #2 below.
2. For beneficiaries described in paragraph #1 above, whom the state subsequently determines are eligible for coverage under a Medicare Savings Program eligibility group, the state satisfies the requirement if it furnishes the medical assistance available through the Medicare Savings Program.
3. For beneficiaries whose Medicaid coverage as of or after March 18, 2020 does not meet the definition of MEC (minimum essential coverage) but does include coverage for testing services and treatments for COVID-19, including vaccines, specialized equipment,

and therapies, the state must continue to provide Medicaid coverage that includes such testing services and treatments.

4. For beneficiaries not described above, the state must continue to provide at least the same level of medical assistance as was provided as of or after March 18, 2020.

Are states required to provide continuous coverage for all Medicaid beneficiaries through the end of the month in which the emergency period ends?

Yes. To receive the temporary FMAP increase provided under section 6008 of the Families First Coronavirus Response Act, states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who are no longer considered to be residents of the state. NOTE: This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment" and the continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at § 433.400(a).

If a state receives information during the emergency period that would make a beneficiary eligible for a different eligibility group, must the state keep the beneficiary enrolled in the group in which he or she is currently enrolled?

To receive the increased FMAP under the FFCRA, states may not terminate coverage for beneficiaries enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, unless the beneficiary voluntarily requests termination from the program or is considered to no longer be a resident of the state. Further, while states may increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP. NOTE: This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; except that as of November 2, 2020: (1) references to "coverage" in this FAQ should be read as "enrollment" and the continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at § 433.400(a); and (2) states are permitted to reduce the amount, duration, and scope of benefits available in accordance with § 433.400(c)(2) and (c)(3) and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

How should a state handle Medicaid beneficiaries who are eligible based on receipt of Supplemental Security Income (SSI) in 1634 states who become ineligible for SSI? Does the state need to continue Medicaid coverage if it

receives a notification from State Data Exchange interface (SDX) that the individual was terminated from SSI?

An individual who is eligible for Medicaid based on his or her receipt of SSI as of March 18, 2020 or is determined eligible based on receipt of SSI after that date, and who becomes ineligible for SSI, may not be terminated from Medicaid prior to the end of month in which the emergency period ends if the state claims the temporary FMAP increase. If such an individual is eligible for a different eligibility group which offers at least the same benefits available to SSI beneficiaries, the state may transfer the individual to that group. NOTE: This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; except that as of November 2, 2020, states are permitted to reduce the amount, duration, and scope of benefits available in accordance with § 433.400(c)(2) and (c)(3) and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

To be eligible for the temporary FMAP increase, should an individual who is enrolled in the adult group described at 42 CFR 435.119, but who turns 65 and becomes eligible for Medicare, be retained in the adult group during the emergency period, or can the state transition the individual to a Medicare Savings Program group for assistance with his or her Medicare premiums and cost sharing?

To be eligible for the enhanced FMAP authorized by the FFCRA, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP. This means that states must continue to provide coverage to such beneficiaries in the eligibility group in which the beneficiary is enrolled if transitioning the beneficiary to another eligibility group would result in a reduction in benefits. If there is a separate eligibility group for which the individual is eligible and which provides the same amount, duration, and scope of benefits, then a state may shift the individual to that group; what is critical for ensuring eligibility for the temporary FMAP increase is that the same amount, duration, and scope of medical assistance be maintained. If, in the scenario provided, an individual turns 65 while in the adult group and becomes enrolled in Medicare and eligible for assistance with Medicare premiums and/or cost sharing under one of the Medicare Savings Program (MSP) groups (which do not provide the full benefit package available to adult group beneficiaries), and the individual is ineligible for another eligibility group which confers the same amount, duration and scope of benefits, the state must continue to furnish services available to beneficiaries enrolled in the adult group until the last day of the month in which the emergency period ends, and also enroll the individual in the MSP group. In this case, Medicare would be the primary payer, with Medicaid providing secondary coverage. NOTE: This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020 when 42 C.F.R. § 433.400 became effective because the state is no longer required to maintain the same amount, duration, and scope of benefits and therefore may transition a beneficiary to another group for which they

are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2). Note also that the response to this question effective November 2, 2020 is addressed in the regulation at 42 C.F.R. § 433.400(c)(2)(i)(B).

Can a state, consistent with the requirement in section 6008(b)(3) of the FFCRA, move an individual from one MSP group into another? For example, could a state move an individual from the qualified Medicare beneficiary (QMB) group to the specified low income Medicare beneficiary (SLMB) group?

A state must maintain, during the emergency period, an individual's eligibility for at least the same amount, duration, and scope of benefits as are covered for the group in which the individual is enrolled, including paying for Medicare Part A/B premiums through MSPs and other Medicaid categories. In the example of a QMB who is determined during the emergency period to no longer meet the QMB group eligibility requirements, the individual could not be shifted to the SLMB group, because the SLMB group offers a lesser amount of assistance with Medicare premiums and cost sharing than the QMB group. The state would have to maintain the individual's enrollment in the QMB group. NOTE: This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020 when 42 C.F.R. § 433.400 became effective because the state is no longer required to maintain the same amount, duration, and scope of benefits and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

For the working disability eligibility groups, can states suspend the requirement that eligible individuals be receiving earned income?

No. Receipt of earned income is an eligibility requirement for the working disability groups described in sections 1902(a)(10)(A)(ii)(XIII) of the Act (the “Work Incentives” group), and sections 1902(a)(10)(A)(ii)(XV) and 1902(a)(10)(A)(ii)(XVI) of the Act (respectively, the Ticket to Work and Work Incentives Act (TWWIIA) “Basic” and “Medically Improved” groups). However, we note that states seeking to claim the 6.2 percent FMAP increase under section 6008 of the FFCRA must continue to treat as eligible for benefits individuals who were receiving coverage under a working disability group as of March 18, 2020 (or determined eligible for such a group after that date) through the end of the month in which the public health emergency ends, even if the individual ceases to have earned income.

Can states suspend Medicaid and CHIP premiums and CHIP premium lockout requirements for enrollees affected by a disaster or public health emergency?

Yes. States can suspend premiums for the duration of the COVID-19 public health emergency. States can effectuate such a suspension, and other cost-sharing requirements, for the duration of the COVID-19 public health emergency….

Even if a state does not suspend Medicaid and CHIP premiums, we note that in order to be eligible for the temporary FMAP increase under section 6008 of the FFCRA, states cannot

disenroll Medicaid beneficiaries for failure to pay premiums. Section 6008(b)(2) of the FFCRA, as amended by section 3720 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, places additional restrictions on states' ability to increase premiums after January 1, 2020 in order to qualify for the temporary FMAP increase.

Can a state terminate Medicaid coverage for beneficiaries for failure to pay premiums during the COVID-19 public health emergency period and still receive the temporary 6.2 percentage point FMAP increase?

No. Until the end of the month in which the public health emergency ends, states cannot terminate Medicaid coverage for beneficiaries for failure to pay premiums and still get the temporary increase in FMAP.

For states seeking to claim temporary increased FMAP, can states bill for premiums during the emergency period?

Yes. States may still charge premiums during the emergency period without violating section 6008(b)(2) of the FFCRA. However, a state may not terminate beneficiaries' eligibility or coverage due to unpaid premiums during the emergency period or terminate individuals' eligibility or coverage due to non-payment of premiums incurred during the PHE after the expiration of the emergency period. As discussed in Question II.B.7, states seeking to claim temporary increased FMAP may not terminate individuals' eligibility or coverage for failure to pay those premiums.

Effective the month in which the emergency ends, a state may resume implementation of its premium policy under 42 C.F.R. § 447.55(b)(2), which allows for termination after 60 days of non-payment. While states cannot terminate beneficiaries' eligibility or coverage following the end of the PHE for unpaid premiums accumulated during the PHE, states can terminate beneficiaries for unpaid premiums incurred prior to the PHE. To implement this termination, states would not be able to count the PHE time period as part of the 60 days of non-payment and states would have to provide beneficiaries with advance written notice of the termination (see 42 C.F.R. §§ 435.917 and 431.206–.214) and provide fair hearing rights (see 42 CFR § 431.220(a)).

Does section 6008 of the FFCRA prohibit states from increasing premium amounts on any beneficiary even when his/her income increases during the public health emergency and his/her premiums are supposed to be charged on a sliding scale basis?

Yes. Section 6008(b)(2) of the FFCRA requires states to maintain premiums at the same or lower level as assessed on January 1, 2020 for any beneficiary.2 If a beneficiary reports an increase in income that would result in a higher premium after January 1, 2020, then assuming the individual still has an increase in income at the end of the public health emergency, the earliest date that a state could assess the increased premium would be the first day of the month following the end of the calendar quarter in which the public health emergency ends.

For an individual subject to a premium requirement who fails to pay, but whose eligibility is not terminated for failure to pay premiums on the basis of section 6008 of the FFCRA, can the state, after the end of the emergency period, seek recovery against the individual?

No. States seeking to claim the temporary FMAP increase may not collect premiums after the end of the emergency period for an individual who owed a premium during the emergency period but whose Medicaid eligibility is maintained solely on the basis of the FFCRA's enhanced FMAP provision. Effective the month following the month in which the emergency ends, a state may resume implementation of its premium policy under 42 CFR 447.55(b)(2) or other authorized policy with respect to premium non-payment, such as under an approved section 1115 waiver.

If an individual has an increase in income that would normally result in the individual becoming ineligible for his/her current eligibility group and moving to a new eligibility group that provides the same benefits but also charges a premium, can the state move forward with this change during the emergency period?

Section 6008(b)(2) of the FFCRA requires states to maintain premiums at the same or lower level as assessed on January 1, 2020, "with respect to an individual[.]" While the state could move the individual to the new eligibility group, it could not charge this individual the higher premium until the last day of the calendar quarter in which the PHE ends.