MassHealth Continuous Coverage

April 15, 2020

Section 6008 of Families First Coronovirus Response Act, (FFCRA), Pub.L. 116-127, (Mar 18, 2020) https://www.congress.gov/bill/116th-congress/house-bill/6201/text

Section 6008 (b) Requirement for All States.--A State described in subsection (a) may not receive the increase described in such subsection in the Federal medical assistance percentage for such State, with respect to a quarter, if--

(3) the State fails to provide that an individual who is enrolled for benefits under such plan (or waiver) as of the date of enactment of this section or enrolls for benefits under such plan (or waiver) during the period beginning on such date of enactment and ending the last day of the month in which the emergency period described in subsection (a) ends shall be treated as eligible for such benefits through the end of the month in which such emergency period ends unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State;

Eligibility Operations Memo 20-09 April 7, 2020

Effective Immediately

MassHealth will protect coverage for all individuals who have Medicaid coverage as of March 18, 2020, and for all individuals newly approved for coverage during the COVID-19 outbreak national emergency, and through the end of the month in which such national emergency period ends. These members will not lose coverage or have a decrease in benefits during this time period.

https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-applicants-and-members

NOTE: Consumer-facing information on MassHealth & Connector website describes the duration as extending for one month after the emergency period ends. See, https://www.mahealthconnector.org/covid-19 and MassHealth Frequently Asked Questions for Members and Applicants https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-applicants-and-members (both visited April 15, 2020) and March 2020 Assister Update https://www.masslegalservices.org/content/assister-updates-masshealth-health-connector

CMS, Frequently Asked Questions on Families First Coronavirus Response Act – Increased FMAP (updated as of 4/13/20)

https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf

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

Yes…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.

7. If a state has already terminated coverage for individuals enrolled as of March 18, 2020, what actions should the state take? Must those individuals have their coverage reinstated?

….At a minimum, states are expected to inform individuals whose coverage was terminated after March 18, 2020 of their continued eligibility and encourage them to contact the state to reenroll. Where feasible, states should automatically reinstate coverage for individuals terminated after March 18, 2020 and should suspend any terminations already scheduled to occur during the emergency period. Coverage should be reinstated back to the date of termination.

9. Do the requirements to provide continuous coverage during the emergency period apply to individuals who were determined ineligible prior to March 18, 2020, but who continue to receive services pending an appeal?

Yes. Individuals who continue to receive services pending an appeal of a determination of ineligibility would be considered to be enrolled for benefits, if this was their status as of March 18, 2020 and therefore should not be terminated from enrollment until the end of the month when the emergency period ends.

11. Should states continue to conduct redeterminations and act on reported or identified changes in circumstances during the emergency period?

The FFCRA does not prohibit a state from conducting regular Medicaid renewals and redeterminations or acting on reported or identified changes in circumstances. States may also continue to conduct periodic data matching between regular beneficiary renewals, consistent with states' verification plans. However, to receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid on or after March 18, 2020, until the end of the month in which the emergency period ends, unless such individual is no longer a resident of the state or requests voluntary termination. This requirement to maintain continued coverage applies to beneficiaries who might otherwise have coverage terminated after a change in circumstances, including individuals who age out of a Medicaid eligibility group during the emergency period, who lose receipt of benefits that may affect their eligibility (e.g., SSI, foster care assistance payments), and whose whereabouts become unknown.

12. 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?

…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.

13. During the emergency period, should states still terminate Medicaid coverage for deceased individuals?

Yes. Individuals who are determined to be deceased are no longer residents of the state….

Additional FAQs April 13, 2020

https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf

F. Additional Questions on the Increased FMAP Under Section 6008 of the FFCRA

22. 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.

24. 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.

25. If an individual is participating in a home and community-based services (HCBS) waiver program authorized under section 1915(c) of the Act, and the individual is determined to no longer meet the level-of-care (LOC) requirements (or other requirements) for the waiver, in order to claim the temporary FMAP increase, must the state maintain the individual's participation in the 1915(c) waiver and continue to provide 1915(c) services?

States seeking to claim the temporary FMAP increase are required to maintain an individual's eligibility for benefits (through the end of the month in which the public health emergency ends) for which an individual attained eligibility under the state plan or a waiver of the state plan. This means that the state should maintain an individual's participation in a 1915(c) waiver for which the individual is enrolled during the emergency period, even if the individual is determined to no

longer meet the LOC or other requirements for waiver participation, such as receiving a service within the last 30 days. Moreover, if a state determined after enactment of the FFCRA that an individual had not received services within the previous 30 day time period and terminated the individual, the state should reinstate the individual to ensure that the state can receive the 6.2 percentage point FMAP increase. However, states should continue to apply any criteria that is used in determining the services included in the individual's 1915(c) person-centered service plan. Services would only be provided if they arereflected in the person-centered service plan and based on an assessment of functional need, per regulations at 42 CFR 441.301(c)(2). An individual's person-centered care plan can be updated to reflect updated assessments of functional need during the period of the public health emergency. Services should not be provided that are not based on an assessed need.

26. If an individual's Medicaid eligibility is connected to his/her need for, and receipt of, section 1915(c) waiver services (i.e., the individual is enrolled in the eligibility group described at 42 CFR 435.217, or the "217" group), and the individual is determined to no longer meet the requisite level-of-care (LOC) requirement for the waiver, in order to claim the temporary FMAP increase, must a state maintain the individual in the 217 group and continue to provide coverage for 1915(c) services?

Where an individual no longer meets the eligibility requirements for the group in which he or she is enrolled and the individual is not eligible for a separate eligibility group covered under the state plan that provides the same amount, duration and scope of benefits, a state must maintain the individual's enrollment in his or her original group in order to claim the temporary 6.2 percentage point FMAP increase. In the example of a 217 group enrollee who no longer meets the LOC requirement for the relevant 1915(c) waiver (or other eligibility requirements for the group), unless the individual is eligible for a separate eligibility group which provides the same amount, duration and scope of benefits, the state would have to maintain the individual's enrollment in the 217 group and participation in the 1915(c) waiver until the end of the month in which the public health emergency ends. Covered services would be provided subject to limitations relating to assessments of functional need, as described in the question above.

27. 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 mean 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.

29. Does the requirement to continue coverage through the end of the emergency period apply to noncitizens receiving coverage of services necessary to treat an emergency medical condition?

Yes. There is no exception to the condition for states to receive the temporary FMAP increase described in section 6008(b)(3) of the FFCRA based on a limitation on the benefits for which FFP is available. The scope of such continued assistance would be limited to services necessary for treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

30. Under section 6008 of the FFCRA, can states suspend or terminate coverage of incarcerated beneficiaries and still qualify for the increase in FMAP?

Incarceration does not impact a beneficiary's eligibility for Medicaid; rather, incarceration limits the availability of FFP to inpatient services provided to the incarcerated beneficiary. (See paragraph (A) of the matter following section 1905(a)(30) of the Social Security Act, 42 CFR 435.1009–1010, and State Health Official (SHO) letter # 16-007)) (https://www.medicaid.gov/sites/default/files/Federal-PolicyGuidance/Downloads/sho16007.pdf). Therefore, in order to receive the temporary FMAP increase provided under section 6008 of the FFCRA, states must provide continuous coverage through the end of the month in which the emergency period ends to Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, if they become incarcerated. However, the FFCRA does not supersede the limitation on FFP for inmates of a public institution, and states continue to be limited to claiming FFP for inmates for covered inpatient services.

We recognize that some states are able to suspend eligibility for Medicaid beneficiaries who become incarcerated, and this practice complies with the condition in section 6008(b)(3) of the FFCRA for receipt of the temporary FMAP increase. Many states, however, currently terminate eligibility upon incarceration, and re-enroll the inmate if the inmate is admitted to an inpatient facility. These states can comply with the terms of section 6008(b)(3) of the FFCRA by ensuring

that inmates are re-enrolled in coverage when admitted to an inpatient facility and prior to release, if they are released before the end of the month in which the emergency period ends.

32. In order to comply with the condition under section 6008(b)(3) of the FFCRA for receiving the temporary FMAP increase, how should states treat beneficiaries who age out of an eligibility group – for example, adolescents who turn 19 and age out of the eligibility group for children under age 19 described in 42 CFR 435.118; individuals eligible under the group for former foster care children, described in 42 CFR 435.150, when they turn age 26; and individuals eligible under the adult group described in 42 CFR 435.119 when they turn age 65?

The answer to this question depends on the coverage options under other eligibility groups under the state plan or waiver. If a beneficiary aging out of an eligibility group is eligible for another eligibility group which covers the same amount, duration and scope of benefits, the state would transition the beneficiary to that group. For example, in a state which has expanded coverage to the adult group, a child covered under section 42 CFR 435.118 whose household income is at or below 133 percent of the Federal poverty level would be transitioned to the adult group upon attaining age 19. If, however, there is no other eligibility group for which the individual is eligible under the state plan or waiver that provides the same amount, duration and scope of benefits as those available to beneficiaries in the group under which the individual has been receiving coverage (42 CFR 435.118, 435.119 or 435.150),then the state must continue to furnish the benefits available under such group in order to qualify for the temporary FMAP increase.

33. 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.

34. Can a state, consistent with the requirement in section 6008(b)(3) of the FFCRA, move an individual from one Medicare Savings Program (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.

35. If an agency has not been able to verify an individual's declared citizenship or satisfactory immigration status during a reasonable opportunity period, must the state keep the individual enrolled in Medicaid in order to qualify for the temporary FMAP increase?

When an otherwise eligible individual has made a declaration of citizenship or satisfactory immigration status in accordance with 42 CFR 435.406(a) and the agency is unable to verify citizenship or satisfactory immigration status, the agency must enroll the individual in Medicaid for a reasonable opportunity period (ROP) under 435.956(b). Because such individuals are enrolled in Medicaid during the ROP if they otherwise meet all eligibility requirements, in order to satisfy the condition for receipt of the temporary FMAP increase under section 6008(b)(3) of the FFCRA, they must remain enrolled in Medicaid until the end of the month when the emergency period ends even if their citizenship or satisfactory immigration status has not been verified. At the end of the month in which the emergency ends, the state must terminate eligibility for any individuals whose status has not been verified prior to the end of their ROP. If and when the state determines that an individual is not a U.S. citizen or in a satisfactory immigration status, coverage would be limited to services necessary for treatment of an emergency medical condition, as defined in section 1903(v) of the Act.