CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COVID-19 Medicaid Update
2021 National Conference on Special Needs Planning and Special Needs Trusts

October 14, 2021

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COVID-19 Public Health Emergency

- The Secretary of HHS may, under section 319 of the Public Health Service (PHS) Act, determine that: a) a disease or disorder presents a public health emergency (PHE); or b) that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists.
- PHE declarations last for the duration of the emergency or up to 90 days, at which time they must be renewed by the Secretary.
- The Secretary first declared a PHE related to COVID-19 effective January 27, 2020. The declaration has been renewed six times, most recently on July 19, 2021.
- Subsequent references and discussion are for this federal PHE unless specified.

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Supporting State Response Efforts

- Even prior to the declaration of a national public health emergency (PHE), CMCS deployed our Disaster Relief Toolkit and began technical assistance to help states ready their response efforts.
- To streamline this process, CMS developed tools and checklists to speed state applications and approvals for various flexibilities specific to the pandemic
  - 1135 Waiver Checklist ①
  - Medicaid Disaster SPA Template
  - Reissued a CHIP Disaster SPA Template
  - 1115 Demonstration SMDL and Checklist ②
  - Pre-populated Appendix K (tailored to state needs during COVID-19 PHE)

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§433.400 – Continued Enrollment for Temporary FMAP Increase

This IFC establishes a new section 433.400 in Part 433 of Title 42 of the Code of Federal Regulations, which provides that States claiming the temporary FMAP increase must maintain the Medicaid enrollment of "validly enrolled" beneficiaries, in one of three tiers of coverage (or a more robust tier of coverage). Such coverage must be maintained, with certain exceptions, through the end of the month in which the PHE for COVID-19 ends. ① ②

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Key Dates for Termination of Conditions for COVID-19 Enhanced FMAP

6.2 percentage point increase for FMAP is effective January 1, 2020 and expires the last day of the calendar quarter in which the PHE ends.

FFCRA 6008 (b) Conditions for 6.2 percentage point increase for FMAP	Termination Date
Maintenance of Effort (standards, methodologies, procedures) - 6008 (b)(1) of FFCRA	Expires the last day of the calendar quarter in which the PHE ends.
Premium Restrictions - 6008 (b)(2) of FFCRA	Expires the last day of the calendar quarter in which the PHE ends.
Continuous Coverage - 6008 (b)(3) of FFCRA	Expires the last day of the month in which the PHE ends.
Coverage of, and Cost sharing Exemption for, COVID-19-related Testing and Treatment - 6008 (b)(4) of FFCRA	Expires the last day of the calendar quarter in which the PHE ends.

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State Health Official Letter # 21-002

- ***SHO #21-002: Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency.***
- Released August 13, 2021
- Updates guidance released in the December 2020 SHO #20-004: *Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency,* in two key areas:
  - **Extends the timeframe for states to complete pending eligibility and enrollment work from 6 months to 12 months after the PHE ends**
  - **Requires a redetermination of eligibility after the PHE prior to taking any adverse action (i.e., rescinds the option to avoid repeating a redetermination for certain individuals)**

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Updated Guidance: 12 Month Timeline

- To minimize burden for both states and beneficiaries, states may take *up to 12 months* after the month in which the PHE ends to complete pending post-enrollment verifications, redeterminations based on changes in circumstances, and renewals.
- The 12 month timeline:
  - Provides more time to conduct outreach and implement strategies to maintain coverage.
  - Allows states to adopt strategies to streamline enrollment processes, such as continuous eligibility, Supplemental Nutrition Assistance Program (SNAP) enrollment strategies, and extended timeframes for individuals to respond to renewal forms and requests for information.
  - Provides the opportunity to better manage coverage transitions following the PHE and distribute workload in a manner that is sustainable in future years. ①
- States may align pending post-enrollment verifications and redeterminations based on changes in circumstances with the individual's renewal due during the 12 month post-PHE period. ②
- This policy change does not affect the timeframe in which states must resume the timely processing of all applications. States continue to have up to 4 months after the month in which the PHE ends to resume timely processing of all applications.

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Updated Guidance: Redeterminations

- A redetermination must be completed in accordance with 42 C.F.R. §435.916 prior to taking an adverse action with respect to any individual after the PHE, even if the state conducted a redetermination during the PHE.
  - Includes all individuals determined ineligible or who failed to respond to a request for information during the PHE and whose coverage has been identified for termination following the PHE.
  - Removes option in the December 2020 SHO to avoid completing another redetermination, prior to terminating coverage after the PHE ends, for actions completed within 6 months of the individual's termination.
- Medicaid redetermination requirements must be followed for the additional redetermination. ①
  - Includes checking available information and data sources to attempt a redetermination without contacting the beneficiary, and requesting documentation to obtain reliable information when eligibility cannot be renewed based on available information, as appropriate.
  - Refer to the December 2020 CMCS Informational Bulletin "*Medicaid and Children's Health Insurance Program Renewal Requirements*" for more information on processing renewals and redeterminations based on changes in circumstances. ②

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ARP Section 9817

- Provides states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for home and community-based services (HCBS).
  - Increased FMAP for HCBS for any state or territory cannot exceed 95 percent.
  - Federal funds attributable to the FMAP increase under section 9817 will not be applied to the territories' payment limits.
- State Medicaid Director Letter (SMDL) released on 5/13/2021 provides guidance on implementation of ARP section 9817, including:
  - Eligible services for which states can claim the increased FMAP, ①
  - Requirements for states to receive the increased FMAP,
  - Process of claiming the increased FMAP, and
  - Examples of activities that states can implement to enhance, expand, or strengthen HCBS. ②
- SMDL is available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf

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Requirements to Receive the FMAP Increase

1. States must supplement but not supplant state funds expended for Medicaid HCBS in effect as of April 1, 2021.
   - To demonstrate compliance, states must:
     - Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
     - Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and ①
     - Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.
   - CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP once the authority for temporary changes expires or if a state needs to implement changes to comply with other federal statutory or regulatory requirements. ②

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Activities to Enhance, Expand, or Strengthen HCBS

- States can implement a variety of activities under section 9817.
  - Examples in appendices C and D are not exhaustive.
- States have until March 31, 2024, to fully expend funds on activities to enhance, expand, or strengthen HCBS.
  - If states are making changes to an HCBS program that operates under a Medicaid authority, states should follow the applicable rules and processes that apply to the Medicaid authority.
  - CMS will do our best to process these action as expeditiously as possible, particularly if they are flagged as 9817 actions. ①
- If states provide additional Medicaid-covered HCBS, they may be eligible for the increased FMAP on those expenditures one additional time. ②
  - States should not claim the HCBS increased FMAP for subsequent expenditures between April 1, 2021, and March 31, 2022.

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Section 3(b) of the Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39

"Nothing in section 2404 of Public Law 111-148, section 1902(a)(17) or 1924 of the Social Security Act shall be construed as prohibiting a State from applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (1) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (including a disregard of the income or resources of such individual's spouse); or (2) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act." ① ②

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Questions?

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