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Medicaid Coverage Protections in Families First Act: What They Require and How to Implement Them

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The Families First Coronavirus Response Act temporarily increased the federal government's share of Medicaid costs (known as the federal medical assistance percentage, or FMAP) to help states deal with the impact of the COVID-19 public health and economic crises. States accepting the additional funds agree to "maintenance of effort" (MOE) protections that prohibit them from making their Medicaid eligibility standards and eligibility determination procedures more restrictive, and from terminating people's coverage until the Secretary of Health and Human Services declares an end to the official public health emergency.

Congress has increased federal Medicaid funds in prior economic downturns, and similarly prohibited states from restricting eligibility. The prohibition on terminating coverage (the "continuous coverage" provision) is a new addition intended to prevent people from losing Medicaid coverage during the pandemic. This paper explains the MOE's requirements and recommends how states can best implement continuous coverage.

No New Restrictions on Eligibility

The MOE restricts states from making their Medicaid eligibility standards, methodologies, and procedures more restrictive than those in effect as of January 1, 2020, and prohibits states from imposing new or increased premiums different from any premiums in place on that date.[1] States can still change their rules to make it easier for people to qualify and enroll in coverage.

This part of the MOE is straightforward, preventing states from increasing their income and asset standards, changing how they determine countable income and assets, and changing the procedures they use to determine eligibility if those changes make it harder for people to qualify, get enrolled, and stay enrolled.

[1] The MOE doesn't apply to the Children's Health Insurance Program (CHIP), although a separate MOE generally preventing states from restricting eligibility for CHIP remains in place through September 30, 2027. Section 2105(d)(3) of the Social Security Act.

Guidance from the Centers for Medicare & Medicaid Services (CMS) on an identical MOE provision in the American Recovery and Reinvestment Act (ARRA) of 2009 states that "CMS would consider changes in State eligibility policies to be more restrictive if the changes result in determinations of ineligibility for individuals who would have been considered eligible as of July 1, 2008."[2] That same test should apply to the current MOE with an operative date of January 1, 2020.

Applicable ARRA guidance also provides that reducing the number of slots in state home- and community-based services (HCBS) waivers would violate the MOE, because fewer people would be eligible. Similarly, making it harder for people to qualify for HCBS by increasing the level of care they need to qualify would also be an MOE violation.

Continuing Coverage Throughout the Public Health Emergency

To receive the enhanced FMAP, states must maintain Medicaid coverage for anyone who was enrolled on March 18, 2020, or who enrolls after that date, through the end of the month when the public health emergency ends. The only exceptions are for individuals who voluntarily terminate their coverage and those who no longer reside in the state or die. A CMS FAQ addresses multiple situations implicating the continuous coverage provision.[3]

When the Continuous Coverage Requirement Applies

Under the Families First MOE, Medicaid coverage continues during the public health emergency regardless of changes in enrollees' circumstances. This requirement will prevent unnecessary churn and coverage disruptions during the public health crisis. Particularly with widespread job and income losses due to the recession, most of those protected by the MOE will likely be eligible for coverage, but the MOE will keep them from losing it due to eligibility checks against outdated data or if they are unable to produce documentation establishing their continued eligibility.[4] Moreover, because the MOE requires that people enrolled "for benefits" on March 18 or during the public health emergency "shall be treated as eligible for such benefits" through the end of the public health emergency, states can't reduce enrollees' benefits or increase their cost-sharing while they remain eligible.

States still may transition enrollees who are no longer eligible in their current coverage pathway to a different pathway that provides the same benefits or additional benefits. But states generally must maintain current benefits for enrollees who no longer qualify for Medicaid or qualify for a pathway with lesser benefits. This means that the continuous coverage requirement applies to:

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[2] Centers for Medicare & Medicaid Services, State Medicaid Director Letter #09-005, August 19, 2009, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD081909.pdf.

[3] "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," May 5, 2020, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

[4] See Judith Solomon, Jennifer Wagner, and Aviva Aron-Dine, "Medicaid Protections in Families First Act Critical to Protecting Health Coverage," Center on Budget and Policy Priorities, April 17, 2020, https://www.cbpp.org/research/health/medicaid-protections-in-families-first-act-critical-to-protecting-health-coverage.

- **Enrollees who turn 19 and are no longer eligible as a child**, both in states that have expanded Medicaid under the Affordable Care Act and those that haven't.
- **Enrollees who lose Supplemental Security Income (SSI) benefits** and whose Medicaid coverage derived from their SSI eligibility.
- **Enrollees receiving HCBS who no longer need the services in their care plan.** States may reduce their services based on a new assessment of their needs, but their coverage can't be terminated.
- **Pregnant women who reach the end of the 60-day post-partum period** applicable to their coverage pathway.
- **Enrollees who turn 65 and are no longer eligible for adult coverage** but may remain eligible as a senior. If the individual enrolls in Medicare and is eligible for payment of Medicare cost-sharing through the various Medicare Savings Programs (MSPs), the state must continue benefits under the adult group and enroll the individual in an MSP. Medicare will be the primary payer and Medicaid the secondary payer for health care the enrollee receives.
- **Newborns who turn 1**. They can be moved out of the newborn group, which is based on their mother's eligibility as a pregnant woman, and into children's coverage but cannot lose coverage.
- **Enrollees in a working disability eligibility group** who are no longer working.

Other circumstances when coverage must continue include:

- When an individual is **enrolled in Medicaid based on their attestation of income or other eligibility factor**, regardless of whether post-eligibility verification is successful.
- When **an enrollee fails to pay premiums**. After the public health emergency ends, states cannot collect premiums for those who owed but didn't pay premiums during the emergency.
- When a **"reasonable opportunity period" for the enrollee to provide verification of eligible citizenship or immigration status ends**.[5]
- When **medically needy individuals** who must spend a share of their income on medical costs to establish eligibility for a set period **can no longer meet the "spenddown" requirement**.
- **When mail for enrollees is returned as undeliverable,** which can occur for people with unstable housing situations.
- **When enrollees enter jail or prison.** These enrollees remain eligible for Medicaid, but federal Medicaid funds can only pay for inpatient care they receive. States can either suspend Medicaid benefits while the individual is incarcerated or end benefits and re-enroll the individual when they need inpatient treatment or prior to release.

[5] If the state determines the individual does not have an eligible citizenship or immigration status, coverage may be limited to treatment of emergency medical conditions.

When the Continuous Coverage Requirement Doesn't Apply

The continuous coverage requirement does not apply to individuals who are not enrolled in Medicaid or are only enrolled temporarily, including:

- Individuals covered during a period of presumptive eligibility that ends without a determination that they are eligible for coverage.
- Children and pregnant women covered under the Children's Health Insurance Program (CHIP).
- People receiving refugee medical assistance.

Continuous Coverage for Lawfully Residing Children and Pregnant Women

States have the option to provide full Medicaid coverage to all lawfully residing children and pregnant women regardless of whether they have a specific immigration status that would qualify them for Medicaid.[6] Eligibility for these children and pregnant women is broader than for other lawfully residing immigrants who must have a specific immigration status to qualify for full coverage. If they do not have such a status, federal funds are only available to pay for treatment of emergency medical conditions. For example, many lawfully residing immigrants aren't eligible for Medicaid during their first five years in the United States.

CMS has issued guidance saying that the Families First MOE does not allow children and pregnant women receiving comprehensive coverage under the state option to retain that coverage when they no longer qualify as a child or a pregnant woman if their immigration status doesn't qualify them for full Medicaid coverage. Instead, they would only retain coverage for treatment of an emergency medical condition.

Best Practices for States

The continuous coverage provision allows Medicaid agencies to suspend certain activities and redirect resources to focus on new applications. States should take advantage of that flexibility, particularly given the increased need for coverage due to the economic crisis and the challenges facing state eligibility workers because of the public health emergency and associated social distancing measures.[7] This flexibility is temporary, though, and states should also prepare for an orderly transition back to regular activities when the current provisions end.

Renewals and Periodic Data Matching

While the Families First Act clearly prohibits ending coverage for most enrollees during the public health emergency, states have flexibility on how they deal with their Medicaid caseloads during this period. CMS guidance allows states to continue renewals and periodic data matching, but a far better course is to suspend these activities and direct all available resources toward processing new applications.

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[6] States can choose whether to continue coverage for children until they turn 19, 20, or 21.

[7] Jennifer Wagner, "Streamlining Medicaid Enrollment During COVID-19 Public Health Emergency," Center on Budget and Policy Priorities, May 13, 2020, https://www.cbpp.org/research/health/streamlining-medicaid-enrollment-during-covid-19-public-health-emergency.

States can push forward renewal dates in their systems to avoid triggering notices, forms, or other renewal actions. States may continue automated *ex parte* renewal processes and renew coverage for those whose continuing eligibility is confirmed through electronic data sources, but to avoid confusion, states shouldn't send renewal forms to enrollees whose coverage can't be automatically renewed since their coverage can't be ended. States should also suspend all actions based on periodic data matches. Not only does the MOE prevent them from acting on the information in the matches, but the information will often be outdated and inaccurate with so many enrollees experiencing job loss or drops in income during the economic downturn.

If a state continues to conduct renewals or periodic data matching, it must ensure its eligibility system doesn't end coverage for enrollees due for renewal, including for failing to respond to a renewal notice or request for information. Similarly, states must not end coverage for enrollees due to information from periodic data matches, including for failure to respond to a request for information based on the data match.

After the Public Health Emergency

The continuous coverage provision requires states to maintain Medicaid coverage for enrollees through the end of the month in which the public health emergency ends. In implementing the provisions, states should consider how they will transition to regular operations after the continuous coverage provision or any replacement expires.

States will face a large backlog of renewals and other case actions at the end of the public health emergency. If the state attempts to deal with the backlog all at once, it will likely be overwhelmed and unable to timely process renewal forms, leading eligible people to lose coverage. Moreover, compressing renewals into one or a few months will lead to an ongoing, disproportionate distribution of work in future years, causing challenges for workload management.

Similarly, if a state attempts to process all cases that had a change in circumstance during the public health emergency immediately after the continuous coverage provision expires, it will likely have trouble keeping up with responses, appeals, and new applications.

States should therefore stagger renewals over a 12-month period following the public health emergency. This will allow them to keep up with renewals and other changes while ensuring an even distribution of work across months for that year and into the future.

In addition, as state Medicaid agencies prepare for the end of the continuous coverage provision, they should consider the following:

- States should not create lists of cases to be automatically terminated at the end of the public health emergency, particularly due to non-response to requests for information or periodic data matches. States can't assume information they received during the public health emergency will be accurate when the emergency ends. A data match showing unemployment benefits in April, or a quarterly wage match from the first quarter of 2020, will likely not reflect an enrollee's circumstances months later. States must determine whether an enrollee remains eligible based on their current circumstances before ending their coverage.

- Under Medicaid rules, states must consider whether enrollees who are no longer eligible for their current coverage pathways are eligible under another pathway before terminating their coverage. For example, a child who aged out of coverage in a non-expansion state may be eligible under a disability pathway or as a low-income parent. So when the MOE ends, states should send notices and allow enrollees ample time to provide information about eligibility under other pathways before terminating anyone's coverage.

CMS hasn't issued guidance on how states should transition to normal operations. When it does, it should require states to both carefully assess eligibility for current enrollees and stagger renewals to ensure that procedural issues don't lead to massive coverage losses.