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RI EOHHS MEDICAID POLICY

Changes to the RI Medicaid Program to Comply with New CMS Regulations Pertaining to the COVID-19 Public Health Emergency

Issue Date: December 30, 2020

Purpose

This document describes the changes that the Rhode Island Executive Office of Health and Human Services (EOHHS) is making to its Medicaid Program in the first quarter of Calendar Year 2021 to comply with new federal regulations.

Introduction

In response to the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) and the COVID-19 Public Health Emergency (PHE), EOHHS changed Medicaid Program operations to protect the benefits of the state's 318,000 Medicaid recipients. Most importantly, until the end of the federally-declared PHE, individuals that were Medicaid eligible at the start of the PHE have not been terminated and will not be terminated from coverage unless the member moved out of state, passed away, or requested the termination.

To date, EOHHS has made the following operational changes to its Medicaid program:

- delayed verifications and delayed acting on changes in circumstances to prevent adverse impacts to members' Medicaid eligibility;
- extended annual renewal dates to relieve members of providing income verification and other required documentation during the pandemic;
- prevented members' benefits from decreasing due to loss of income, while increasing benefits for those that qualify;
- accepted self-attested updates for certain criteria to determine eligibility;
- disregarded unemployment insurance income stimulus as income towards eligibility; and
- protected long-term services and support beneficiaries from increased patient share.

Since April 2020, EOHHS has been operating in accordance with the Centers for Medicare and Medicaid Services' (CMS) interpretation of the conditions specified in section 6008(b)(3) of the FFCRA, provided in the form of publicly available frequently asked questions (FAQs). On October 28, 2020, CMS published CMS-9912-Interim Final Rule (IFR) which established a new section 433.400 in Part 433 of Title 42 of the Code of Federal Regulations that reinterprets the conditions set forth in section 6008(b)(3) of the FFCRA.

Under the new regulations, state Medicaid agencies are required to make "programmatic changes to coverage, cost sharing, and beneficiary liability" and such changes can be made "without violating the requirements for receiving the temporary FMAP increase", provided that the agency maintains the Medicaid enrollment of "validly enrolled beneficiaries" in one of three tiers of minimum essential coverage (MEC). This means that EOHHS may and should make changes to the benefits that RI Medicaid members receive moving forward, but still cannot terminate members' Medicaid eligibility.

CMS has provided further guidance via weekly All State teleconference calls that they expect states to work expeditiously towards effectuating these program changes as reasonably fast as possible, adding that eligibility changes cannot be applied retroactively.[1]

Statement of Policy

In response to these new regulations from CMS, EOHHS has made provisions to implement the following changes in January and February 2021:

A. Beneficiary Liability/Patient Share/Cost of Care[2] (January 1st, 2021)

***Previous Interpretation*:** No changes in beneficiary liability / cost of care / patient share were permitted under Section 6008**.**

New Interpretation: Changes in beneficiary liability are expressly allowed.

Usually, a customer's monthly cost of care (also known as 'Patient Share' or 'Applied Income') changes when a person's income or expenses change. In 2020, EOHHS stopped any increases in cost of care for LTSS recipients. Decreases were permitted throughout the PHE and both recipient and provider were notified if this occurred.

As of January 1, 2021, in order to comply with the CMS IFR which requires implementation of cost of care changes (increase or decrease) based on members' circumstances, EOHHS will begin allowing increases to members' cost of care. Notices will be mailed to both members and LTSS providers informing them of any cost of care changes per the usual process. The cause of the increase may include any new information obtained by the Medicaid program throughout the PHE. All increases to cost of care will be effective on January 1st, 2021. Increases will not be retroactive per existing Medicaid policy.

B. Out of State Residency [3](January 1st, 2021)

Previous Interpretation: CMS did not allow termination for out-of-state benefits based solely on Public Assistance Reporting Information System (PARIS) interstate matching service match because verification required the return of additional documentation. Termination due to failure to respond to a request for additional information was prohibited.

***New Interpretation*:** State Medicaid programs can terminate a member due to not meeting state residency requirements if, 1) the state Medicaid agency receives a notice from the PARIS system that the member is currently receiving government-funded benefits in another state; 2) the beneficiary fails to respond to request for additional information; and 3) the state's alternative efforts cannot verify continued residency through other sources.

For Out-of-State terminations, EOHHS will resume PARIS matching to determine if an individual is no longer a state resident. In order to meet the CMS IFR requirement for a second point of validation, EOHHS will then take the Medicaid-eligible individuals pending for residency from PARIS and check them against a LexisNexis Address Search. Additional Documentation Requests (ADRs) will then be sent to only those individuals who are confirmed through both PARIS and LexisNexis. If the member did not respond to an ADR that was sent before the PARIS/LexisNexis match, their eligibility will not be terminated. If they fail to provide documentation of legal residency in Rhode Island as requested in the second ADR that will be sent after the PARIS/LexisNexis match is confirmed, the members' eligibility will be terminated.

C. Better Fit Benefit Maintained[4] (February 1st, 2021)

***Previous Interpretation*:** Could not reduce a Medicaid members' benefits under Section 6008.

New Interpretation: State Medicaid agencies must maintain beneficiary enrollment in an eligibility group that provides one of three tiers of minimum essential coverage (MEC) through the end of the month in which the PHE ends. Therefore, if an individual Medicaid beneficiary is moving within a tier of MEC, the state should take action to ensure that the individual benefits match their eligibility.

The new CMS IFR guidance specifies that states *must* move an individual from one eligibility group to another eligibility group but must maintain the same or better tier of Medicaid coverage.[5] EOHHS has done extensive research for several eligibility groups to ensure individual or household changes in circumstance will be correctly applied. Individuals with eligibility within the following groups and associated types of assistance may see a change in benefits if a change of circumstances is known: Complex Medicaid, Modified Adjusted Gross Income (MAGI), Community Medicaid (ABD), Long Term Services and Supports (LTSS) and Medicare Premium Payment (MPP). Of note, MPP customers transitioning from Qualified Medicare Beneficiary (QMB) to Specified Low-Income Medicare Beneficiary (SLMB), or the Qualifying Individual-1 (QI-1) programs will continue to have their Medicare Part B premiums paid as minimum essential coverage, but copays or deductibles will end under the new guidance. All individuals transitioning within a tier of MEC will receive a notice in January 2021, which will specify the changes effective on February 1st, 2021**.**

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[1] **CMS IFR Page 93** – "Section 433.400(c)(3) specifies that states may make programmatic changes to coverage, cost sharing, and beneficiary liability without violating the requirements for receiving the temporary FMAP increase, provided that such changes do not violate the individual beneficiary protections at 433.400(c)(2) or the requirements under section 6008(b)(4) of the FFCRA to cover COVID-19 testing and treatment services without cost-sharing."

[2] **CMS IFR Page 95** – "Finally, states may generally establish or increase cost sharing (consistent with sections 1916 and 1916A of the Act, implementing regulations at 42 CFR 447.50 et seq., and the state plan), and increase beneficiary obligations under the PETI rules, and still comply with FFCRA section 6008(b)(3)… For example, a state may increase the liability of individuals receiving Medicaid coverage for institutional services under the state plan through otherwise permissible reductions in their standard personal needs allowances or family allowances. In addition, they may transfer a beneficiary from one program furnishing HCBS (for example, a waiver program authorized under section 1915(c) of the Act) to another as a beneficiary's health status and level of care changes."

[3] **CMS IFR Page 97** – "Additionally, as described at § 433.400(d)(3)(ii), individuals who are identified as receiving benefits in more than one state via a data match with the Public Assistance Reporting Information System (PARIS) interstate matching service in accordance with § 435.945(d) and who fail to respond to a request for information to verify their residency in the reasonable period permitted by the state, consistent with § 435.952(c)(2)(iii), are generally considered to no longer be residents of the state for purposes of section 6008(b)(3) of the FFCRA, provided that the state takes all available reasonable measures to determine state residency prior to termination."

[4] **CMS IFR Page 86** – "This means that if a state determines a beneficiary ineligible for the group in which he or she is currently enrolled, which provides MEC, and finds the beneficiary eligible for another group that also provides MEC, the state would transition the beneficiary to the new eligibility group. In contrast, if the beneficiary lost eligibility for a group that provides MEC, but gained eligibility for coverage that does not meet the definition of MEC, the state may not move the beneficiary to the new group or demonstration but must instead maintain the beneficiary's access to coverage meeting the definition of MEC during the period in which the rule applies, except as discussed below."

[5] **MS IFR Page 87** – "if a beneficiary receiving tier 1 coverage no longer meets the eligibility requirements for the original group in which he or she was enrolled, and the beneficiary does not meet the requirements for any other eligibility groups with tier 1 coverage, the state must continue to provide the medical assistance offered under the eligibility group in which the beneficiary was eligible on or after March 18, 2020."