



Top Ten List: Maintenance of Effort Requirement Compliance

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On March 18, the [Families First Coronavirus Response Act](#) (FFCRA) was signed into law. The law offers a significant increase in Medicaid funding for states – a 6.2 percentage point increase in states' [Medicaid Federal Medical Assistance Percentage](#) (FMAP) rate for expenditures that are normally paid at the states' regular FMAP rate. The increased FMAP provides essential fiscal relief to states, shoring up state budgets and ensuring states can continue to operate strong Medicaid programs. This enhanced matching rate is available through the end of the last quarter that the federal COVID-19 public health emergency is in effect.

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In exchange for the additional funds, states must agree to comply with strong maintenance of effort (MOE) protections. This ensures that states do not cut their Medicaid programs while receiving the enhanced federal funds, and that individuals are able to get and stay covered during the crisis. To receive the enhanced FMAP, states [must](#):

- Not implement "eligibility standards, methodologies, or procedures" that are more restrictive than those the state had in effect on January 1, 2020;
- With very limited exceptions that are discussed below, treat anyone "enrolled for benefits" on March 18 or who enrolls during the public health emergency "as eligible for such benefits through the end of the month in which" the public health emergency ends;
- Cover – without cost-sharing – testing services and treatments for COVID-19 for Medicaid enrollees; and
- Not impose premiums higher than the state had in effect on January 1, 2020.

States must [attest](#) to their compliance with the MOE to draw down the enhanced FMAP, but the Centers for Medicare and Medicaid Services (CMS) does not verify each state's compliance before releasing the funds. Therefore, it is particularly important for advocates to pay attention to how their state is implementing the MOE. Below are ten steps advocates can take to make sure the MOE is implemented as the law requires, and in ways that fully protect enrollees.

- 1. Confirm your state intends to take up the increased FMAP.** The Congressional Budget Office [estimates](#) that the increased funding from the FMAP boost is far

greater than the costs of the MOE, so taking up the enhanced FMAP helps both states and enrollees. However, as this is ultimately a state option, advocates should confirm their state plans to receive the extra funds (and comply with the MOE).

2. **Ensure individuals are not terminated from Medicaid.** The MOE prohibits the state from disenrolling an individual from Medicaid, with very limited exceptions. The statute states that the MOE applies except in the cases of death, a move out-of-state, or an individual's request to be disenrolled. CMS has also [identified](#) what they interpret to be a few additional situations where termination is acceptable under the MOE:
 - a. If a lawfully residing child or pregnant woman covered under the [CHIPRA option](#) ages out of eligibility or their post-partum period ends, and they have not obtained a "qualified" status;¹
 - b. If an individual becomes incarcerated, so long as the state re-enrolls the individual for inpatient hospital stays and prior to release;
 - c. If an individual was covered under presumptive eligibility, but not determined eligible for full coverage by the time presumptive eligibility ends; or
 - d. If an individual's eligibility for Refugee Medical Assistance ends.

Individuals who fall into these exceptions are still entitled to due process protections. Other than those specific exceptions, the MOE prohibits disenrollment of all Medicaid enrollees (notably, the MOE does not apply to the Children's Health Insurance Program). For a non-exhaustive list of examples of situations where an individual cannot be disenrolled under the MOE, see Appendix A. Advocates should confirm that individuals in each circumstance listed in the appendix are not being terminated.

3. **Work with state agencies to ensure state computer systems are correctly programmed to comply with the MOE, and stay alert for any violations.** Many state agencies are having difficulty making these changes to their eligibility systems. Additionally, many states were unable to stop terminations from occurring that had already been scheduled when the MOE took effect. Advocates should verify with their state and consumers that the state has modified their eligibility systems to not terminate enrollees, and should stay alert for any violations noticed while working with consumers.
4. **If wrongful terminations do occur, ensure individuals' coverage is quickly and automatically reinstated.** In the event that an individual has been terminated after March 18 who should not be, CMS states that at a minimum, the state must notify the individual of their continued eligibility and encourage them to reapply. However, CMS [requires](#) that states "make a good faith effort" to automatically reinstate the individual's coverage. Advocates should urge states to pursue automatic reinstatement, as some states are doing – for example, [Virginia](#) is working to

¹ These individuals are still eligible for emergency Medicaid.

reinstate all cancellations of eligibility that occurred after March 31. Individuals will be re-enrolled in the same health plan and will receive a letter to notify them. [Arizona](#) is automatically reinstating individuals who were terminated in March for failure to pay premiums. These reinstatements should be a high priority for state Medicaid agencies, to ensure individuals are held harmless for the mistakes of the states' eligibility system. Advocates should verify that these reinstatements are automatic and conducted rapidly.

5. **Encourage your state to suspend redetermination processes.** Given the freeze on disenrollment in the MOE, the rise in the number of new Medicaid applications, and the strain on state workforces due to the pandemic, state Medicaid agencies should spend their limited resources ensuring that new applicants are covered promptly. States can [delay](#) renewals by obtaining CMS concurrence. This permits states to prioritize processing new applications, reduces confusion for enrollees, and makes sure states are not collecting information that will likely be outdated by the time the public health emergency ends. For example, [Vermont](#) has suspended renewals until the emergency ends. Texas has suspended [renewals](#) until further notice. Providing individuals additional peace of mind and ensuring states don't have a deluge of work once the MOE ends, [New York](#) is extending all cases with coverage dates ending in March through June by 12 months.
6. **Encourage your state to suspend periodic data matching, if your state conducts it.** Some states conduct periodic data checks to identify potential changes, such as fluctuations in income, between renewals. Periodic data matching results are often a trigger for eligibility changes or terminations. Just as states should suspend redetermination processes, they should also suspend these periodic data checks, as [Texas](#) has done.
7. **Make sure your state is waiving copays for the full range of services related to COVID-19 testing and treatment – or is eliminating copays entirely.** Under the MOE, states must cover all “testing services and treatments for COVID-19” without any cost-sharing. Recent research has made clear that COVID-19 can cause a [wide range](#) of symptoms, including everything from respiratory problems, to blood clots, to kidney damage. Since an extremely broad range of services may be required to treat the many manifestations of COVID-19 – from inpatient hospital services to physical therapy to prescription drugs – this is an area where advocates should work to make sure their states are fully implementing the statute. Notably, unless states receive an 1115 demonstration waiver, they [cannot](#) apply an exemption from copays for only people with COVID-19 – the exemption must apply for all enrollees using a particular service.

Thus, advocates should confirm that the state is not charging copays for all services that are related to COVID-19 testing and treatment, and that this exemption is applied to all enrollees. For example, states should suspend copays for a range of medications that may be used for treatment of symptoms of COVID-19 for all enrollees, as [Pennsylvania has done](#). Services such as non-emergency medical transportation should also be considered related to COVID-19 testing and treatment.

Further, in addition to verifying state policies, advocates should make sure providers are being informed and that the policy is working on the ground.

The ideal solution is for advocates to push for the state to waive copays for all services, as states like [Nebraska](#) and [Indiana](#) have done. This eliminates the need for determining which services are related to COVID-19 testing and treatment – a complex endeavor, given the ever-growing list of COVID-19 symptoms and the many types of services enrollees may need to treat them. A [robust](#) body of research also finds that copays harm Medicaid enrollees health and financial stability; the burdens of copays are likely to be elevated even further during this time of increased economic hardship, so it is particularly important to do away with copays now.

8. **Make sure your state is compliant with requirements for cost-sharing and premiums.** Under the MOE, states cannot [increase cost-sharing](#) for enrollees, or, for individuals receiving long term services and supports, modify states' [post-eligibility treatment of income](#) (PETI) rules in a way that increases individuals' costs. Further, states are not permitted to increase premiums any higher than they were on January 1, 2020. Given the [overwhelming harms](#) of Medicaid premiums, states that already require premiums should suspend them during the public health emergency or eliminate them altogether.
9. **Stay alert to changes in your state's eligibility procedures.** If the state makes any [changes](#) to their "eligibility standards, methodologies, or procedures" that are more restrictive than what is in effect on January 1, 2020, they run afoul of the MOE. As CMS noted in [guidance](#) about a previous MOE, some changes to eligibility procedures can be made without CMS approval, which can make it particularly difficult for CMS to detect any violations. Therefore, it is especially important for advocates to stay abreast of whether their state is putting in place any new procedural hurdles to eligibility.
10. **Consider saving stories and data about the impact of the MOE.** Currently, aspects of the MOE may be [under threat](#) in Congress. Information about the MOE's beneficial impact on enrollees may help continue to inform policymakers about why the MOE is needed during these unprecedented times. Moreover, as states eventually transition out of the public health emergency, this information can help in advocating for continuing changes like the elimination of cost-sharing.

Appendix A: Example situations where an individual's coverage cannot be terminated

- a. Individuals who experience a [change](#) in circumstances, such as change in income, that would typically make them ineligible for Medicaid
- b. Individuals who fail to pay [premiums](#)
- c. Individuals who [age out](#) of an eligibility group
- d. Individuals determined eligible for Medicaid based on [self-attested information](#), even if the individual may not be eligible based on verification conducted post-enrollment

- e. Individuals who have declared citizenship or qualified immigration status, but who the state was unable to verify that status before the end of an individual's [reasonable opportunity period](#)
- f. [Noncitizens](#) receiving coverage of services necessary to treat an emergency medical condition
- g. Individuals who were [determined ineligible](#) prior to March 18 but who continue to receive services pending an appeal
- h. Participants in home and community-based services (HCBS) [waiver programs](#) who no longer meet the waiver's level-of-care requirements
- i. Individuals who have met the [medically needy](#) spenddown and reach the end of their budget period
- j. People eligible based on receipt of Supplemental Security Income (SSI) who then become [ineligible for SSI](#)
- k. People eligible under [working disabled](#) eligibility groups who stop working