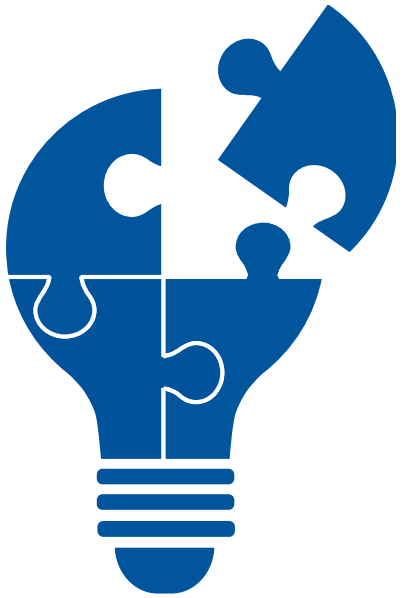
Interim Final Rule with Comment Period (IFC)
CMS-9912-IFC



COVID-19 Vaccine Coverage for Medicaid CHIP, and Basic Health Program Beneficiaries; and

Temporary Increase in Federal Medicaid Funding

Medicaid & CHIP All-State Call – 10/29/2020

Provisions Included in the IFC

On October 28, 2020, CMS issued CMS-9912-IFC jointly with the Department of the Treasury and the Department of Labor. This IFC includes the following provisions.

Provisions:
Medicare Coding and Payment for COVID-19 Vaccine
COVID-19 Vaccine Coverage for Medicaid, CHIP, and BHP Beneficiaries
Price Transparency for COVID-19 Diagnostic Tests
Medicare Inpatient Prospective Payment System New COVID–19 Treatments Add-on Payment for the remainder of the Public Health Emergency
Temporary Increase in Federal Medicaid Funding
Updates to the Comprehensive Care for Joint Replacement Model, Performance Year 5
Rapid Coverage of Preventive Services and Vaccines for Coronavirus
State Innovation Waivers Policy and Regulatory in Response to the COVID-19 Public Health Emergency.

The Families First Coronavirus Response Act: Section 6008

- Section 6008 of the Families First Coronavirus Response Act (FFCRA) authorizes states to claim a temporary 6.2% increase in the Federal Medical Assistance Percentage (FMAP) if they satisfy the four conditions described in section 6008(b).
- The four conditions for claiming the increased FMAP require that a state:
  1. Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020;
  2. Not charge premiums that exceed those that were in place as of January 1, 2020* or increase the premium charged to a given beneficiary;
  3. Keep beneficiaries enrolled, if they were enrolled on or after March 18, 2020; and
  4. Cover, without the imposition of cost sharing, testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies.

*Section 3720 of the CARES Act added a new subsection (d) to section 6008 of the FFCRA in order to provide states which have increased premiums for any Medicaid beneficiaries above the amounts in effect on January 1, 2020, with a 30-day grace period, beginning March 18, 2020, to restore premiums to amounts no greater than those in effect as of January 1 without jeopardizing the state's eligibility for the temporary 6.2 percentage point FMAP increase.

COVID-19 Vaccine Coverage for Medicaid, CHIP, and BHP Beneficiaries During the PHE

- The preamble describes current vaccine policy during and after the public health emergency (PHE). For the most part, there are no changes in the IFC to current policy or any regulatory requirements in this rule (exception noted below related to Medicaid Alternative Benefit Plans (ABP) and Basic Health Program (BHP) plans).
- Medicaid programs may receive a 6.2% increase in FMAP during PHE, and in return they are required to:
  - Cover COVID-19 testing services and treatments, including vaccines and vaccine administration, specialized equipment and therapies without cost sharing
  - Coverage is required during the period in which any state or territory receives the 6.2% increased FMAP, available through the end of the quarter in which the PHE ends
  - Coverage of the COVID-19 vaccine and its administration, without cost-sharing, is expected to be available for most Medicaid beneficiaries
- These requirements do not apply to Medicaid eligibility groups whose coverage is limited by statute or under existing section 1115 demonstration to a narrow range of benefits such as groups that receive Medicaid coverage only for COVID-19 testing, family planning, or tuberculosis-related services.
- These requirements also do not apply to the Children's Health Insurance Program (CHIP) or the Basic Health Program (BHP), but vaccine coverage is provided in both of these programs.
- Impact of IFC market-wide change: During the PHE, Medicaid ABPs and BHP plans must provide coverage for and must not impose any cost sharing for "qualifying coronavirus preventive services" including a COVID vaccine regardless of whether the vaccine is delivered by an in-network or out-of-network provider.

COVID-19 Vaccine Coverage for Medicaid, CHIP, and BHP Beneficiaries After the PHE

- After the requirements outlined in FFCRA are no longer in effect, the state must cover COVID-19 vaccines recommended by the ACIP, and their administration, for several populations including:
  - All Medicaid-enrolled children under the age of 21 eligible for the EPSDT benefit
  - Adult Populations who receive coverage through ABPs
  - Adults in states that elected to receive a 1 percentage point FMAP increase for providing vaccines under section 4106 of PPACA
- States also have the option to cover vaccines and their administration for other Medicaid-eligible groups.
- In CHIP, vaccine coverage is the same during and after the PHE.
- States must continue to provide BHP enrollees with a COVID-19 vaccine with no cost sharing.
- The requirement that Medicaid ABPs and BHP plans provide a COVID vaccine with no cost sharing regardless of whether the vaccine is delivered by an in-network or out-of-network provider is no longer in effect.

Temporary Increase in Federal Medicaid Funding: Continued Enrollment Condition

- Section 6008(b)(3) of the FFCRA requires states, as a condition for receiving the temporary FMAP increase, to maintain the enrollment and coverage of Medicaid beneficiaries who were enrolled as of or after March 18, 2020.
- CMS provided an initial interpretation of this continuous enrollment condition through FAQs issued in April, May, and June 2020.
- This interpretation required states to keep beneficiaries enrolled in Medicaid, if they were enrolled as of or after March 18, 2020, with at least the same amount, duration, and scope of benefits, including the same cost sharing and beneficiary liability (if any) through the end of the month in which the PHE for COVID-19 ends.
- The original interpretation prevented states from implementing reasonable changes to effectively manage their programs.
- This IFC reinterprets the continued enrollment condition at section 6008(b)(3) of the FFCRA.

§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.

Validly Enrolled Beneficiaries (42 C.F.R. 433.400(b))

- Beneficiaries are generally considered to be validly enrolled.
- A beneficiary is not validly enrolled if the agency determines that:
  - The determination of eligibility was incorrect at the time it was made due to agency error; or
  - Eligibility was erroneously granted due to beneficiary fraud or abuse.
- Individuals receiving medical assistance during a period of presumptive eligibility are not considered validly enrolled because they have not received a determination of eligibility.

Beneficiaries who are Not Validly Enrolled: Agency Error

- A beneficiary is not validly enrolled if the agency determines that the determination of eligibility was incorrect at the time it was made due to agency error.
- This applies only to:
  - Initial determinations of eligibility based on an application submitted on or after March 18, 2020;
  - Initial determinations of eligibility based on an application submitted prior to March 18, 2020; and
  - Renewals or other redeterminations of eligibility made prior to March 18, 2020.

Beneficiaries who are Not Validly Enrolled: Beneficiary Fraud or Abuse

- A beneficiary is not validly enrolled if the agency determines that eligibility was erroneously granted due to beneficiary fraud for which the beneficiary has been convicted or beneficiary abuse as determined by the agency in accordance with existing regulations at 42 C.F.R. § 455.16.
- This applies only to:
  - A determination of eligibility based on an application on or after March 18, 2020; or
  - A determination or redetermination of eligibility made prior to March 18, 2020.

Three Tiers of Coverage (42 C.F.R. 433.400(c)(2))

Section 433.400(c) establishes the following three tiers of coverage for the purpose of satisfying the continued enrollment condition in states claiming the temporary FMAP increase:

1. Minimum Essential Coverage (MEC): Medicaid coverage that meets the definition of MEC at 26 C.F.R. 1.5000A-2, including coverage in Medicare accompanied by Medicaid eligibility in a Medicare Savings Program group, such as the Qualified Medicare Beneficiaries group. This tier provides the most robust coverage.
2. Non-MEC with coverage of COVID-19 testing and treatment: Medicaid coverage that does not meet the definition of MEC, but does include coverage for testing services and treatment for COVID-19, including vaccines, specialized equipment, and therapies. In some states, coverage provided to pregnant or postpartum women under 42 C.F.R. 435.116 is not MEC and would meet the requirement for coverage in tier 2.
3. Non-MEC with limited benefits: Medicaid coverage that does not meet the requirements of tier 1 or tier 2 because it is not MEC and does not include testing and treatment for COVID-19; examples of such limited benefit coverage include coverage available through the eligibility groups limited to family planning or tuberculosis-related services. This tier provides the least robust coverage.

Three Tiers of Coverage: Basic Rules for Tiers 1 and 2

To satisfy the continued enrollment condition under the IFC, if a state determines a beneficiary to be ineligible for a group or section 1115 demonstration offering:

- Tier 1 (MEC coverage) –
  - The state must transition the beneficiary to another group or demonstration offering tier 1 coverage, if eligible;
  - If ineligible for other tier 1 coverage, the state must continue to provide the tier 1 coverage that the beneficiary was receiving when determined ineligible.
- Tier 2 (non-MEC coverage with COVID-19 testing/treatment) –
  - The state must transition the beneficiary to a group or demonstration offering tier 1 coverage, if eligible, or tier 2 coverage if not eligible for tier 1;
  - If ineligible for other coverage in tier 1 or tier 2, the state must continue to provide the tier 2 coverage that the beneficiary was receiving when determined ineligible.

A beneficiary may not be transitioned to a tier with less robust coverage, unless specifically requested by the beneficiary.

Three Tiers of Coverage: Basic Rule for Tier 3

- To satisfy the continued enrollment condition under the IFC, if a state determines a beneficiary to be ineligible for a group or section 1115 demonstration offering tier 3 (non-MEC limited benefit coverage):
  - The state must transition the beneficiary to a group or demonstration offering tier 1 or tier 2 coverage, if eligible;
  - If ineligible for coverage in tier 1 or tier 2, the state must continue to provide the tier 3 coverage that the beneficiary was receiving when determined ineligible.
- Coverage available in tier 3 is more limited and the services offered may vary widely from one eligibility group or demonstration to the next.
- A state may not transition a beneficiary between groups or demonstrations offering tier 3 coverage, unless specifically requested by the beneficiary.

Exceptions to the Continued Enrollment Condition (42 C.F.R. 433.400(d))

- In states claiming the temporary FMAP increase, a beneficiary's Medicaid enrollment may be terminated prior to the first day of the month after the PHE for COVID-19 ends if:
  - The beneficiary requests a voluntary termination of eligibility;
  - The beneficiary dies;
  - The beneficiary ceases to be a resident of the state; or
  - The beneficiary was not validly enrolled.
- States may only terminate the eligibility of such individuals after providing advance notice and fair hearing rights per 42 CFR Part 431 Subpart E.

Exception for PARIS Match (42 C.F.R. 433.400(d)(3)(ii))

- Data matching with the Public Assistance Reporting Information System (PARIS), may identify beneficiaries who are receiving assistance under a benefit program in more than one state.
- Such beneficiaries' Medicaid enrollment may be terminated without violating the continued enrollment condition if the state is unable to verify continued state residency because:
  1. The beneficiary fails to respond to requests for additional information, and
  2. The state makes additional efforts but cannot verify continued residency through other available sources.
- After termination, if the state subsequently obtains information to verify state residency, the state must reinstate the beneficiary's Medicaid enrollment back to the date of termination.

Permissible Changes in States Claiming FMAP Increase (42 C.F.R. 433.400(c)(3))

- States may make certain changes to their state plan, a section 1115 demonstration, or a section 1915(c) waiver without violating the continued enrollment condition in section 6008(b)(3) of the FFCRA
- States are permitted to make changes to:
  - Benefits,
  - Cost sharing, and
  - Post-eligibility treatment of income.
- Prior to reducing benefits or increasing cost sharing or beneficiary liability a state must provide proper advance notice and comply with other applicable statutory and regulatory requirements.