STATE OF DELAWARE

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE

PLANNING & POLICY UNIT
M E M O R A N D U M

REPLY TO
ATTN. OF: Administrative Notice DMMA-A-06-2021

TO: All DMMA/DSS Staff

DATE: 3/1/2021

SUBJECT: COVID-19 Emergency Declaration – Renewals, Redeterminations, and Changes in Circumstance for Medicaid Programs

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NOTE: This update replaces Admin. Notice DMMA-A-06-2020

BACKGROUND

The purpose of this notice is to provide updated guidance regarding Medicaid eligibility determinations affected by the COVID-19 Emergency Declaration. ***Please note** – These requirements apply to Federally funded Medicaid programs only. CHIP renewals, redeterminations, changes in circumstance and terminations must be acted on per existing policy under DSSM 18000 and are not subject to the COVID-19 regulations.*

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency. As a result, states were given certain flexibilities related to Medicaid eligbility determinations and renewals. Additionally, On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Responces Act (FFCRA). Consequently, the state must comply with certain Maintenance of Effort (MOE) requirements, including continuos coverage requirements.

States were instructed to not terminate Medicaid coverage for any individuals unless the individual requested a voluntary termination of eligibility, died, or was no longer considered to be a resident of the state through which coverage was provided. Further, while states were allowed to increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, states could not move an individual to an eligibility group with less benefits.

Effective November 2, 2020, under the new regulations' CMS updated the original guidance instructing states that beneficiaries no longer have to remain in the current eligibility group and receive the same benefit package, as long as they remain in the same "tier" of coverage or move to a more robust coverage "tier".

Additionally, CMS added another exception to the continuous coverage requirements allowing states to terminate individuals that were not validly enrolled into the Medicaid program.

Finally, in a memo from CMS on December 4, 2020, CMS reminded states of their obligation to conduct timely Medicaid and CHIP eligibility redeterminations.

DISCUSSION

There are a few changes from the instructions that staff received under Administrative Notice DMMA-A-06-2020.

Eligibility Terminations:
Staff was previously instructed to not terminate individuals as a result of renewals, redeterminations, or changes in circumstance except in the following three circumstances:

1. An individual requests their eligibility to be terminated,
2. An individual is deceased, or
3. An individual is no longer a Delaware resident.

Under the new guidance, a fourth circumstance has been added to the list of circumstances that allows for Medicaid beneficiaries to be terminated. States may now terminate individuals that were "not validly enrolled" into the Medicaid program.

"Not validly enrolled" includes:

- Agency error for eligibility determinations based on applications submitted on or after 3/18/2020; initial determinations made on applications submitted prior to 3/18/2020; or renewals or redeterminations made prior to 3/18/2020.
- Beneficiaries enrolled due to fraud, as evidenced by fraud conviction or finding of beneficiary abuse as determined under existing CMS processes.

Eligibility Cascading and "Tiers" of Coverage:

Staff was previously instructed to not move any individuals to a different eligibility group in which their benefits would be reduced, regardless of change in circumstance. Now, under the new CMS rules, Medicaid coverage can fall into one of three "tiers" and an individual is only prohibited from being moved to a lesser "tier" of coverage. Although the CMS notice identifies three (3) tiers of coverage, DMMA has performed an analysis and determined that all Federally funded Delaware Medicaid programs, except for emergency Medicaid-only coverage, fall into tier 1. **Therefore, individuals may cascade between Medicaid eligibility groups, including into Medicare Savings Programs** (Qualified Medicare Beneficiaries-QMB, Specified Low-Income Medicare Beneficiaries-SLMB and Qualifying Individuals-QI1). Individuals may not cascade from a Medicaid eligibility group into CHIP.

If an individual becomes ineligible for coverage in their current group, they must be enrolled in coverage in another group for which they are eligible. If no such group exists, the individual must maintain the same Medicaid coverage that the individual would have received absent the determination of ineligibility.

Children or Women Who Lose Qualifying Immigration Status

These individuals must be moved from the full benefit group to emergency Medicaid only.

Individuals Eligible for Emergency Medicaid (Only) Per CMS, non-qualified, non-citizens receiving Emergency Medicaid-only coverage must have their coverage continued through the end of the emergency period. Note the scope of assistance provided is limited to services necessary for the treatment of an emergency medical condition.

A Question and Answer section is included below for reference.

ACTION REQUIRED

During the COVID – 19 Disaster, until further notice, staff must

- Continue to follow policy in the Delaware Social Serivces Manual (DSSM) under the following sections:
    - 14100.5 – Determination of Eligibility
    - 14100.5.1 – Timely Determination of Eligibility
    - 14100.6 – Annual Renewal of Eligibility
    - 14820 – Changes in Circumstances
- Not terminate individuals as a result of renewals, redeterminations, or changes in circumstance except in the following circumstances:
    - An individual requests their eligibility to be terminated,
    - An individual is deceased,
    - An individual is no longer a Delware resident, or
    - An individual was not validly enrolled.
- Allow individuals to cascade between Medicaid eligibility groups, including Medicare Savings Programs (Qualified Medicare Beneficiaries-QMB, Specified Low-Income Medicare Beneficiaries-SLMB and Qualifying Individuals-QI1).
- Not allow individuals to cascade from Medicaid to CHIP.
- Document the Case Comments section in Assist Worker Web and cite this administrative notice number and name if, upon renewal, redetermination, or change in circumstance, an individual was determined to be no longer eligible for Medicaid, but they were required to have eligibility maintained per the PHE.
- Document the Case Comments section in Assist Worker Web and cite this administrative notice number and name if, due to the PHE, there is a delay in acting timely on change(s) in circumstance or renewal processing, consistent with 42 C.F.R. §435.912(e) and §457.340(d), as applicable.

DIRECT INQUIRIES TO:
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3/1/2020
DATE

KD Xavier

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Question & Answer:

Q1: Does MEC include coverage in Medicare with coverage under a Medicare Savings Program (MSP) eligibility group, such as Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI-1) and Qualified Working Disabled Individuals (QDWI)?

A. Yes. Medicaid recipients who become eligible for a Medicare Savings Program eligibility group (e.g., QMB, SLMB, QI-1). can be changed to the applicable MSP group. This change is allowable because Medicare coverage is considered MEC, with or without Medicaid as a secondary coverage.

Q2. If an individual becomes ineligible for MAGI and becomes eligible for a Medicare Savings program (MSP), must staff terminate coverage in the adult group and enroll the individual in the MSP option?

A. Yes. Staff must still conduct the review of other Medicaid coverage options prior to termination, but an individual may be terminated in Medicaid if they are eligible in a Medicare Savings Program.

Q3. If an individual becomes ineligible for MAGI and becomes eligible for Medicare, but is ineligible for a Medicaid Shared Savings program (like the QMB group),may staff terminate coverage in the adult group and enroll the individual in the MSP option?

A. No. If the individual does not qualify for MSP, staff must keep the individual open in MAGI in this scenario.

Q4. While the PHE and MOE requirements are in effect, can staff move individuals to other MSPs that offer lower levels of subsidy?

A. Yes.

Q5. When staff conducts a redetermination based on a verified change in circumstances and the beneficiary does not return required documentation, may staff terminate coverage?

A. No.

Q6: Can a beneficiary transition from one eligibility group to another eligibility group within the same tier, such as from MAGI Youth Medicaid to the MAGI Adult group, or from Pregnant Women's Medicaid to the MAGI Adult group?

A. Yes. If no such group exists, staff must maintain the same Medicaid coverages that the beneficiary would have received absent the determination of ineligibility.

Q7: Are there any individuals whose coverage may be terminated prior to the end of the Public Health Emergency (PHE)?

A. 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, as described above.

   *NOTE: Note that a beneficiary may be identified, through a data match with the Public Assistance Reporting Information System (PARIS), as receiving assistance under a benefit program in more than one state. In such cases, if the state is unable to verify the beneficiary's continued residency in the state because the beneficiary fails to respond to requests for additional information and the state makes alternative efforts but cannot verify the beneficiary's continued residency in the state through other sources, that beneficiary's Medicaid enrollment may be terminated in accordance with 435.400(d)(1)(ii). If the individual subsequently provides information to verify state residency, the state must reinstate the beneficiary's Medicaid enrollment.

Q8: Can you confirm that for members who were enrolled inaccurately due to an error on their application but have not been convicted of fraud or suspected of program abuse, the state needs to maintain coverage for that individual?

A. Yes, coverage must be maintained in this scenario. An agency error in making a determination of eligibility is different than an applicant making a mistake on their application. We can still close for the individual not being validly enrolled if the agency makes the error in completing the determination of eligibility or the redetermination of eligibility, but not because the applicant made a mistake.

Q9: For standalone CHIP, if an individual ages out would they be moved to regular Medicaid coverage or be kept in CHIP?

A. Continuous enrollment does not apply to standalone CHIP. If they age out of CHIP their eligibility should be terminated unless they qualify for a Medicaid coverage group. There is no requirement to keep a child open in CHIP if they age out.

Q. Can a child move from CHIP to Medicaid or from Medicaid to CHIP under these Maintenance of Effort (MOE) requirements?

A. A child can move from CHIP to Medicaid. The statutory requirements for MOE apply only to Medicaid and are not applicable to a child losing CHIP coverage. A child may not move from Medicaid to CHIP.