

NASDDDS COVID-19 Response

Understanding the FFCRA Enhanced FMAP Maintenance of Effort Requirements

The Families First Coronavirus Response Act (FFCRA) provides a temporary 6.2% FMAP enhancement. States are not required to submit a State Plan Amendment to be eligible for the FMAP increase.

Duration: The enhanced FMAP begins retroactively on January 1, 2020 and extends through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services (HHS) terminates.

Programs Affected: The enhanced FMAP will be applied to all parts of the Medicaid program that are currently matched at the state's standard percentage. In addition, the enhanced FMAP will indirectly enhance 1915(k) and Money Follows the Person (capped at 90%) by enhancing the state's base rate, to which these programs' already existing enhanced rates will be applied. The enhanced FMAP will not apply to activities claimed under the administrative match rates, or to Health Home Services matched at a 90% rate.

MOE: FFCRA included a four part Maintenance of Effort requirement.

- (1) States must maintain eligibility standards, methodologies, or procedures equal or less restrictive than those in effect on January 1, 2020.
- (2) States cannot raise any Medicaid premiums above those in effect on January 1, 2020.
- (3) States must commit to not disenroll any beneficiary enrolled as of March 18, 2020.
- (4) States must provide full coverage for any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies.

Considerations for State I/DD Agencies for meeting these requirements are discussed below:

- (1) Maintenance of eligibility standards, methodologies, or procedures
 - An individual eligible for Medicaid on the basis of receipt of SSI as of March 18, 2020 or later, and who becomes ineligible for SSI, may not be terminated from Medicaid. If the individual is eligible for a different eligibility group which offers at least the same benefits available to SSI beneficiaries, the state may transfer the individual to that group.

Note:

- States must maintain an individual's eligibility for a 1915(c) waiver even if they are determined to no longer meet LOC.

- If an individual’s Medicaid eligibility is connected to need for and receipt of 1915(c) waiver services (i.e., the “217” group), and they no longer meet the eligibility requirements for any group that provides the same amount, duration and scope of benefits, a state must maintain the individual’s enrollment in his or her original group and participation in the 1915(c) waiver.

Note: NASDDDS will seek further clarity from CMS on:

- The requisite obligation for service continuity, including any applicable expectations to amount, duration and/or scope of services, particularly regarding individuals who gained Medicaid eligibility by virtue of the Special Income Level group receiving services ICF/IID and nursing home services, and those in 1915(c) waivers who gained Medicaid eligibility through the eligibility group defined at 42 CFR 435.217 (“217 group”); and
- How these MOE requirements impact cost neutrality calculations for 1915(c) waivers.
- However, an individual service plan can change based on assessed need during the period of the public health emergency.

(3) Continuous coverage

- Exceptions: voluntary request for termination; ineligibility due to residency.
- In guidance, CMS has said that what it will consider “prompt” redetermination of eligibility under the current circumstances may be longer than what typically would be expected.
 - States are advised to obtain CMS concurrence that the delay is warranted via email to the CMS state lead;
 - States must document the delay in the beneficiary’s case record. If a large number of cases are affected and the state can clearly define the cohort of cases for which it seeks CMS’ concurrence, CMS will not enforce this requirement;
 - CMS guidance clearly states that “if a state is able to process a change in circumstances prior to the end of the month in which the public health emergency ends, and determines that a beneficiary no longer meets all eligibility criteria for coverage, the state must postpone taking adverse action until after the end of the month in which the emergency ends in order to qualify for the temporary FMAP increase.”
- States must make a good faith effort to identify and reinstate individuals whose coverage was terminated on or after the date of enactment. At a minimum, states are expected to inform individuals whose coverage was terminated after March 18, 2020 of their continued eligibility and encourage them to contact the state to reenroll.
- This requirement does not apply to presumptive eligibility.

Guidance:

[CMS COVID-19 FAQs](#)

[CMS FFCRA and CARES FAQs](#)

[CMS FFCRA Increased FMAP FAQs](#)