



Ending Coverage in the Optional COVID-19 Group

Preparing States for the End of the Public Health Emergency

October 2022



Agenda

- Optional COVID-19 Group Coverage
- Redetermination and Notice Strategies for Optional COVID-19 Group Beneficiaries
- Unwinding Planning, Renewal Distribution and Data Reporting for the Optional COVID-19 Group
- Questions

Optional COVID-19 Group Coverage

Background: COVID-19 PHE and Optional COVID-19 Group

- As a result of changes in federal law related to the COVID-19 public health emergency (PHE), states will have an unprecedented volume of work to complete when the PHE eventually ends.
- Some states expanded access to Medicaid coverage through a new optional COVID-19 eligibility group to ensure individuals who would otherwise be uninsured could access critical COVID-related services through the last day of the PHE.
- States that adopted the optional COVID-19 group will need to prepare to end coverage for this eligibility group when statutory authority for the group ends (i.e., on the last day of the PHE), consistent with the guidance in this deck, as part of their efforts to restore normal operations when the PHE eventually ends.

Optional COVID-19 Group Coverage

- Statutory Authority: Created under section 6004(a)(3) of the Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127), as amended, Congress added section 1902(a)(10)(A)(ii)(XXIII) to the Social Security Act to create the new optional COVID-19 Medicaid eligibility group. Fifteen states and three territories cover this group. Statutory authority for the group expires on the last day of the PHE.
- Eligibility & Benefits: To be eligible for coverage, individuals must be uninsured. Benefits covered include: COVID-19 vaccines and vaccine administration, COVID-19 testing and related services, and COVID-19 related treatment.
- Funding: The Federal Medical Assistance Percentage (FMAP) for services furnished to beneficiaries eligible under the optional COVID-19 group is 100 percent.

Payment of COVID-19 Group Claims When the PHE Ends

- Because authority for the optional COVID-19 group expires with the end of the PHE, federal financial participation (FFP) is not available for services provided for the optional COVID-19 group after the last day of the PHE.
 - This includes services provided after the last day of the PHE to individuals who are in the middle of a course of treatment or receiving services for treatment of “long COVID” when the PHE ends.
 - Note: If the PHE ends during an inpatient stay, a state should submit claims in accordance with how it normally handles a termination of eligibility in the middle of an inpatient stay per its approved state plan.
- States may continue to make claims for FFP after the PHE for covered services that were provided to beneficiaries only through the last day of the PHE, consistent with all applicable claiming requirements.
- States may, but are not required to, use state-only funds to continue to provide coverage for individuals who were enrolled in the optional COVID-19 group but are no longer eligible for Medicaid when the authority for the optional COVID-19 group ends.

Ending Coverage in the Optional COVID-19 Group

States will need to take necessary steps to ensure FFP is not claimed for services provided to beneficiaries who remain enrolled in the optional COVID-19 group after the last day of the PHE unless an individual is redetermined eligible on another basis

- Despite the fact that statutory authority for the optional COVID-19 group ends on the last day of the PHE and thus states must not claim FFP in any benefits for optional COVID-19 group enrollees after the last day of the PHE, states claiming the temporary federal medical assistance percentage (FMAP) increase authorized by the FFCRA *may not terminate enrollment* before the end of the month in which the PHE ends due to the “continuous enrollment condition.”
- Because states claiming the temporary FMAP increase must maintain enrollment through the end of the month in which the PHE ends (which will likely be after the date when authority for the optional COVID-19 group ends), states must ensure that they do not submit claims for FFP in their expenditures for services for optional COVID-19 group beneficiaries after the -last day of the PHE.
 - States may, for example, add a claims edit to ensure the state does not continue to claim FFP for services provided to individuals enrolled in the optional COVID-19 group after the last day of the PHE.
 - States may, but are not required to, use state-only funds to pay for services for optional COVID-19 group beneficiaries after the last day of the PHE
- States claiming the temporary FMAP increase must take the necessary steps, as outlined in this deck on slides 10-16, to consider eligibility on other bases and terminate enrollment for optional COVID-19 beneficiaries who are ineligible for another Medicaid eligibility group-as soon as possible when the continuous enrollment condition ends.

Advance Notice of Coverage Ending in the Optional COVID-19 Group and Fair Hearings

- States must provide beneficiaries enrolled in the optional COVID-19 group with a minimum of 10 days advance notice prior to terminating coverage of benefits under this group – i.e., a minimum of 10 days prior to the last day of the PHE.
- Any advance notice of termination must include the circumstances when a fair hearing would be granted, in accordance with 42 C.F.R. §431.210(d)(2).
- While the state need not grant a fair hearing if the sole issue raised is the end of the federal authority for the optional COVID-19 group (see 42 C.F.R. §431.220(b)), individuals retain the right to request a fair hearing if they believe the state made an error (e.g., sent the notice to the wrong person or used incorrect data in the redetermination).

Redetermination and Notice Strategies for Optional COVID-19 Group Beneficiaries

Redeterminations Based on Changes in Federal Policy

- When federal or state eligibility authorities sunset, states need to redetermine eligibility for beneficiaries who were eligible under the sunseting authority. In this case, federal authority for the optional COVID-19 group ends on the last day of the PHE.
- Impacted beneficiaries are considered to experience a change in circumstances that may affect eligibility when the authority sunsets, and the state must promptly act on such changes.
 - As part of the redetermination process, the state must consider eligibility on all bases before determining the individual is ineligible for Medicaid and terminating coverage.
 - If the state needs additional information to determine eligibility on another basis, the state must provide the beneficiary a reasonable period of time to provide information or other documentation to establish continued eligibility.

States Used Different COVID-19 Enrollment Options To Implement the Optional COVID-19 Group

- Many states faced a number of challenges in implementing the optional COVID-19 group.
- To address these challenges, CMS provided states with a number of strategies to streamline the application process and notice requirements for this group, such as:
 - Developing a simplified application that minimizes burden on applicants,
 - Enrolling individuals outside the state’s eligibility and enrollment system, and
 - Conducting outreach in advance of the end of the PHE to inform beneficiaries enrolled in the optional COVID-19 group to submit a full application if they wanted to be considered for full benefits.
- Because many states streamlined the application process for the optional COVID-19 group, they will face operational challenges to end coverage in the group when statutory authority for the group ends on the last day of the PHE.

Redetermining Eligibility in the Optional COVID-19 Group

States that implemented the optional COVID-19 group in their eligibility and enrollment system and are able to make determinations of eligibility for the group using their streamlined application will likely be able to process renewals and redeterminations for these beneficiaries as they ordinarily would for any beneficiary consistent with the guidance in the March 2022 SHO Letter #22-001.

- The state will redetermine eligibility based on the change in circumstances (anticipated expiration of the optional COVID-19 group on the last day of the PHE) and notify individuals who are not eligible on another basis that coverage of benefits will end of the last day of the PHE.
- Despite the fact that coverage of benefits under this group will end the last day of the PHE, the individual's enrollment in Medicaid may not be terminated before the end of the month in which the PHE ends due to the continuous enrollment condition.

Operational Considerations When Redetermining Eligibility

- States that adopted a streamlined enrollment process outside of a states' eligibility system to implement the optional COVID-19 group (e.g., using a separate application to facilitate enrollment), may face operational challenges because they do not have sufficient information to redetermine eligibility on all bases.
- Such states may satisfy the requirement to determine eligibility on other bases prior to terminating Medicaid eligibility for beneficiaries enrolled in the optional COVID-19 group by adopting one of three options discussed on slides 14-16.
- These options ensure that the individual understands that they are only eligible for benefits in the optional COVID-19 group through the last day of the PHE, that they could be eligible for comprehensive coverage, and how to apply for comprehensive coverage.

Strategies to Redetermine Eligibility on All Bases for Optional COVID-19 Group Beneficiaries

Option 1: Include information on how to apply for comprehensive coverage in the initial determination notice and in the advance notice of termination

- Under this strategy, states can include key information in the beneficiary's initial eligibility notice that will satisfy the requirement to redetermine eligibility on all bases and described below on this slide.
- In order to use this option, states must include the following information in the beneficiary's initial determination notice and advance notice of termination:
 - **Initial determination notices** must notify individuals:
 1. That coverage through the optional COVID-19 group ends on the last day of the PHE
 2. That they may be eligible for comprehensive Medicaid coverage; and
 3. How to submit a Medicaid application for comprehensive coverage.
 - **Advance termination notices** must meet the requirements applicable to all termination notices at 42 CFR 431.206 and 431.210 and inform the beneficiary that:
 1. A Medicaid application must be submitted to be considered for comprehensive coverage and how to submit an application; and
 2. They have the right to a fair hearing under limited circumstances, in accordance with 42 C.F.R. §431.210(d)(2) (see slide 8).
- States that did not take up this option when they implemented the optional COVID-19 group and include the information outlined above in the initial determination notice will need to implement option 2 or 3 discussed on the following slides.

Strategies to Redetermine Eligibility on All Bases (Cont'd.)

Option 2: Send notice before the end of the PHE encouraging application and include key information in the advance notice of termination

- States that did not send beneficiaries an initial determination notice that included the three required key messages outlined in option 1 may send a notice to the beneficiary that provides the messages outlined in option 1 (i.e., coverage will end the last day of the PHE, the individual may be eligible for comprehensive coverage, and how to submit an application for comprehensive coverage) before the PHE ends.
- States that send this notice may then proceed to send a final advance termination notice at least 10 days prior to the end of the PHE without first considering eligibility on other bases when the PHE ends. However, the advanced notice of termination must again clearly explain:
 - That, in order to be considered for comprehensive coverage, the individual must submit a Medicaid application for comprehensive coverage,
 - How to submit such application, and
 - That they have the right to a fair hearing under limited circumstances, in accordance with 42 C.F.R. §431.210(d)(2).
- This final advance notice must also meet the requirements at 42 CFR 431.206 and 431.210.

Strategies to Redetermine Eligibility on All Bases (Cont'd.)

Option 3: Send one combined notice 60 days prior to termination

- States that did not adopt either option 1 or 2 may send one combined advance notice of termination that notifies individuals:
 1. That coverage through the optional COVID-19 group ends on the last day of the PHE;
 2. That they may be eligible for comprehensive Medicaid coverage;
 3. How to submit a Medicaid application for comprehensive coverage; and
 4. That they have the right to a fair hearing under limited circumstances, in accordance with 42 C.F.R. §431.210(d)(2)
- This notice must be sent at least 60 days prior to ending enrollment in Medicaid to ensure time for the individual to apply for, and the state to process, an application for comprehensive coverage.
- This notice must also meet the requirements at 42 CFR 431.206 and 431.210.
- States that implement this option are encouraged to establish a process to identify optional COVID-19 group beneficiaries who submit an application for comprehensive coverage. This will enable the state (1) to notify the individual that their application has been received and (2) to pause any action to terminate enrollment until the application is processed. The prohibition on claiming FFP for services provided under the optional COVID-19 group remains in effect unless and until the individual is determined eligible for comprehensive coverage based on their application. Retroactive eligibility may be available to fill any gap in coverage.

Unwinding Planning, Renewal Distribution and Data Reporting for the Optional COVID-19 Group

Planning for Unwinding

A state's unwinding period will not be initiated solely based on the date advanced notice is sent to end coverage for optional COVID-19 group beneficiaries.

- Because advance notice for enrollees in the optional COVID-19 group is required prior to the end of the PHE, states may need to initiate work on the optional COVID-19 group before they begin initiating renewals for the rest of their Medicaid and CHIP caseload as part of unwinding.
- CMS will not consider work to end coverage for optional COVID-19 group beneficiaries and effectuate appropriate terminations when the PHE ultimately ends as renewals for purposes of determining the beginning of the state's 12-month unwinding period.

Prioritizing Eligibility Actions for Optional COVID-19 Group Beneficiaries

States do not need to include optional COVID-19 group beneficiaries in their total caseload for purposes of ensuring they are initiating renewals for no more than 1/9 of their total Medicaid and CHIP caseload in a given month.

- In the March 2022 SHO Letter #22-001, CMS provides states flexibility to prioritize work for certain populations and distribute renewals across the unwinding period.
- However, states that adopted the optional COVID-19 group will need to prioritize ending coverage under this group as of the last day of the PHE and terminate enrollment in Medicaid as soon as possible when the continuous enrollment condition ends to reduce the risk of inappropriately claiming FFP when authority for the group expires.
- Because states must initiate work on optional COVID-19 group beneficiary cases in time to send advance notice before the PHE ends, states will **not** need to include these beneficiaries in their total caseload for purposes of distributing renewals across the state's 12-month unwinding period.

Eligibility and Enrollment Unwinding Data Report & Optional COVID-19 Group Data

States do not need to include the optional COVID-19 group in their baseline and monthly data eligibility and enrollment unwinding data reports.

- During unwinding, states will report their progress initiating and completing renewals of eligibility for their total caseload to CMS through the Eligibility and Enrollment Unwinding Data Report (“Unwinding Data Report”). This Unwinding Data Report includes a baseline report and subsequent monthly reporting.
- States will not need to report on the optional COVID-19 group in their Unwinding Data Report submissions. CMS will track optional COVID-19 group enrollment numbers and application processing data through existing CMS data collection efforts rather than the Unwinding Data Report.
- As noted in the March 2022 SHO letter #22-0001, CMS will follow up with individual states if data demonstrate a state is not meeting the timelines outlined in the SHO.

Additional Resources for States

- **State Health Official Letter #22-001:** [Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Upon Conclusion of the COVID-19 Public Health Emergency](#)
- **State Unwinding Planning Template:** [Medicaid and Children's Health Insurance Program COVID-19 Health Emergency Eligibility and Enrollment Pending Actions Resolution Planning Tool](#)
- www.Medicaid.gov/unwinding

For questions and requests for further technical assistance from CMS regarding the optional COVID-19 group, please contact your state lead and cc: CMSUnwindingSupport@cms.hhs.gov

Questions?
