DHB ADMINISTRATIVE LETTER NO: 05-21, MEDICAID/NCHC PROCEDURES FOR COVID-19 – ALLOWABLE PROGRAM CHANGES AND TERMINATIONS

DATE: **June 21, 2021**

SUBJECT: **Medicaid/NCHC Procedures Due to COVID-19 Public Health Emergency – Allowable Program Changes and Terminations**

DISTRIBUTION: **County Departments of Social Services**
Medicaid Supervisors
Medicaid Eligibility Staff

I. BACKGROUND

On March 13, 2020, the President issued a proclamation declaring a national emergency concerning the Coronavirus Disease outbreak (COVID-19).

The purpose of this letter is to provide instructions and clarification for circumstances where certain program changes and/or case terminations are allowed during the COVID-19 Public Health Emergency (PHE).

As a reminder, counties should continue to follow recertification/change in circumstance procedures found in DHB Administrative Letter 09-20, Amended, Recertification Procedures for COVID-19.

DHB Administrative Letter 02-21, NC Health Choice (NCHC) Beneficiary at the Age of 19 Procedures and Reports, is now obsolete. Information from DHB Administrative Letter 02-21 that continues to be relevant has been included in this letter, see section IV, below. In addition, guidance is provided for all NCHC beneficiaries who are determined ineligible during the PHE.

II. RECERTIFICATION/CHANGE IN CIRCUMSTANCE POLICY REGARDING ALLOWABLE TERMINATIONS

Guidance provided in section III, below, is in addition to guidance previously provided in DHB Administrative Letter 09-20, Amended, Recertification Procedures for COVID-19.

During the COVID-19 Public Health Emergency (PHE), caseworkers must not terminate or reduce Medicaid eligibility. As a reminder, the following exceptions regarding terminations are still applicable, as well as the other allowable reasons for changes and terminations stated in this letter:

A. The beneficiary moves out of state

B. The beneficiary voluntarily requests termination of Medicaid/NC Health Choice benefits

C. Death of the beneficiary

D. Beneficiary no longer meets the citizenship/immigration status requirements (see DHB Administrative Letter 09-20, section III.D for more information)

III. PROCEDURES

Centers for Medicare and Medicaid Services (CMS) has issued guidance regarding programs which are considered to meet the criteria for Minimum Essential Coverage (MEC).

A. Minimum Essential Coverage (MEC)

When a beneficiary who is eligible for a Medicaid program that meets the MEC requirements has a change that results in eligibility for a different Medicaid program, the change can be made if the new Medicaid program also meets the requirements for MEC. In addition, a beneficiary is also considered to meet MEC when they are receiving Medicare and a MQB product, see Section E., for additional guidance. There are some exceptions which are outlined below. If the new program of eligibility has less coverage, the change cannot be made.

1. MAF cannot be moved to MPW

2. Medicaid cannot be moved to NC Health Choice

B. Non-MEC Programs

There are currently only two Medicaid programs that do not meet MEC requirements:

1. Medicaid for Family Planning (MAF-D) and

2. Medicaid for COVID-19 testing (MCV).

Changes allowed for these two programs are limited. The beneficiary can be moved to a program with greater coverage but cannot be moved to one with a lesser coverage benefit.

- MAF-D can move to a MEC program but cannot be moved to MCV.
- MCV can move to MAF-D or a program that meets MEC.

    - **An application for Medicaid is required when MCV beneficiaries report a change that would potentially make them eligible for a greater program, including MAF-D. Counties should make the beneficiary aware of the application process when the change is reported.**

Once the beneficiary is eligible for a program meeting MEC requirement, eligibility must continue through the end of the month in which the PHE ends unless one of the exceptions or allowable terminations included in this letter applies.

C. Allowable program changes

1. Certain changes are allowable if the new program allows the beneficiary to continue eligibility with the same level of coverage. When the beneficiary is currently eligible for a program that is considered MEC and reports a change that results in eligibility in another program that meets MEC criteria, the change can be made.

    Example 1:

    Mary and her 7-year-old son, Billy, are eligible for MAF-C. Mary reports at **recertification** that she now has a part time job which increased her household income above the MAF-C limit. Based on the new income, Billy is now eligible for MIC-N. Because MIC-N meets the criteria for MEC, this is an allowable change for Billy. Mary will move to Transitional Medicaid (TMA).

    This is an allowable change at recertification because MIC meets MEC requirements for the child and the parent will continue to receive full Medicaid through TMA, which is MEC.

    During the PHE, if Mary has a change of circumstance or her recertification must be completed that ends her TMA eligibility, the caseworker should follow the procedures found in DHB Administrative Letter 09-20, Amended, Recertification Procedures for COVID-19.

2. Changes cannot be made if the beneficiary will be moved to a lower level of coverage or to a program within the same level but with less coverage.

    Example 2:

Johnny is receiving MAF-D only. At recertification, it is discovered that he is no longer eligible for MAF-D or any other full Medicaid program but would be eligible for MCV coverage only. Both MAF-D and MCV are considered to be the same level of coverage, however, MAF-D provides a greater coverage benefit for the beneficiary, therefore, Johnny must continue MAF-D during the PHE. Follow procedures in DHB Administrative Letter 09-20, Amended, Recertification Procedures for COVID-19.

3. As noted in example 2 above, MAF-D and MCV are in the same coverage level. MCV eligible beneficiaries may be moved to MAF-D because it provides greater coverage benefit. An application is required, see section III.B. above.

Example 3:

Sally is eligible for and receiving MCV. She reports a change in circumstance and is now potentially eligible for MAF-D. An application for Medicaid is required. If Sally is determined eligible for MAF-D, authorize the MAF-D case, and close the MCV case.

D. Allowable changes for dual eligible beneficiaries

CMS has determined that dually eligible individuals receiving both Medicaid for Qualified Medicare Beneficiaries (MQB-Q/B/E) and Medicare meet the criteria for MEC.

Therefore, CMS has issued guidance that when a Medicaid beneficiary who is dually eligible for full Medicaid, Medicare, and MQB but is later determined to be ineligible for full Medicaid, the full Medicaid case can be terminated with timely notice. The beneficiary **must** remain enrolled in Medicare and **must** remain eligible for MQB to be considered MEC.

Caseworkers should take the following steps when it has been determined that the beneficiary is no longer eligible for full Medicaid:

1. At recertification:

   a. Determine if the beneficiary continues to be enrolled in Medicare.

   b. If the beneficiary remains enrolled in Medicare, determine MQB eligibility.

   c. If the beneficiary remains eligible for **any** MQB program, recertify the MQB only.

   d. Terminate the full Medicaid case following timely notice policy found in MA 2420/3430, Notice and Hearings Process.

e. If the beneficiary is **not** enrolled in Medicare **OR** is ineligible for any MQB program, continue full Medicaid coverage following guidance provided in DHB Administrative Letter 09-20, Amended, Recertification Procedures for COVID-19 and terminate the MQB case following timely notice policy found in MA-2420/3430, Notice and Hearings Process.

Example:

Tommy is receiving MAA, Medicare and MQB-Q. Tommy starts receiving a monthly pension that puts him over the income limit for MAA and MQB-Q. After reviewing the case, Tommy is still receiving Medicare and is also determined to now be eligible for MQB-B. This is an allowable change as Medicare with MQB-B is considered MEC.

2. Change of circumstance:

a. Determine if the beneficiary continues to be enrolled in Medicare.

b. If the beneficiary remains enrolled in Medicare, determine MQB eligibility.

c. If the beneficiary remains eligible for any MQB program, terminate the full Medicaid case following timely notice policy found in MA-2420/3430, Notice and Hearings Process.

d. If the beneficiary is **not** enrolled in Medicare **OR** is ineligible for any MQB program, continue full Medicaid coverage following guidance provided in DHB Administrative Letter 09-20, Amended, Recertification Procedures for COVID-19 and terminate the MQB case following timely notice policy found in MA-2420/3430, Notice and Hearings Process.

3. Loss of Medicare during the PHE:

a. When a beneficiary who was eligible for full Medicaid becomes eligible for only MQB and Medicare during the PHE but subsequently loses Medicare eligibility, full Medicaid must be reinstated beginning the month after the month Medicare enrollment ends so that MEC continues. Counties should ensure that the MQB case is closed in NC FAST. The case should be closed effective the last day of the month of Medicare eligibility to prevent the buy-in from continuing erroneously. Follow adequate notice requirements found in MA-2420, Notice and Hearings Process.

Counties should utilize and work the BENDEX report in NC FAST to determine if the beneficiary lost Medicare eligibility during the PHE. This report can be found here: **NC FAST/Reports/MA/XPTR Verification Reporting/BENDEX Detail Report**

The caseworker should authorize full Medicaid following guidance provided in DHB Administrative Letter 09-20, Amended, Recertification Procedures for COVID-19 and continue coverage through the end of the PHE. Caseworkers should use the Medicaid forced eligibility application process to reinstate full Medicaid if the beneficiary does not meet eligibility requirements for any full Medicaid program. When keying Medicaid forced eligibility, use the reason, COVID-19.

Example:

Sue was receiving Medicare, MAD and MQB-B. Sue received a lump-sum settlement that put her over the reserve limit for MAD. The caseworker terminated her MAD case May 21, 2021 however, she remained eligible for Medicare and MQB-B. In June 2021, Sue loses her Medicare eligibility. This does not meet MEC requirements therefore, full Medicaid must be reinstated effective July 1, 2021. Following guidance in Amended DHB Administrative Letter 09-20, coverage for Sue will continue with Medicaid forced eligibility as MAD.

b. In the event that an a/b with MQB-Q/B/E only who loses Medicare, please contact your OST for further guidance.

E. Evaluating and terminating cases authorized in error

Previous guidance advised counties that Medicaid could not be terminated, or benefits decreased during the PHE, even if the case was authorized in error.

New guidance from CMS states that the requirement for continuous enrollment applies only to those beneficiaries who are **validly** enrolled in Medicaid on or after March 18, 2020. This applies to initial applications or recertifications that occurred before March 18, 2020 as well as to applications or recertifications occurring during the PHE.

When it is discovered at recertification or a reported change in circumstance that a beneficiary has been authorized for Medicaid in error, the caseworker must evaluate to determine if the beneficiary would be eligible based on the beneficiary's current circumstances.

A beneficiary is **not** considered validly enrolled when one of the following applies:

1. The determination of eligibility was incorrect at the time it was made due to agency error.

2. Eligibility was erroneously given due to beneficiary fraud or abuse. Fraud or abuse is established when the beneficiary is **convicted** of fraud/abuse in a court of law. Beneficiaries convicted of fraud/abuse by a court of law are considered to be **invalidly** enrolled.

This does not apply when the applicant/beneficiary (a/b) makes a mistake or inadvertent household error, or if fraud/abuse is suspected but not convicted. If the a/b gave incorrect information by mistake and the information was verified per applicable Medicaid or NC Health Choice policy, the a/b should be considered to be **validly** enrolled.

a. Recertification:

(1) Evaluate the beneficiary for all Medicaid/NC Health Choice programs, including MCV.

(2) If the beneficiary is now eligible under the same or greater program, recertify the case. See MA-2320, Redetermination of Eligibility, MA-3420, Re-Enrollment, and MA-3421 MAGI Recertification.

(3) If the beneficiary is now eligible for a lesser benefit, recertify after timely notice requirements are met. See MA-2420/3430, Notice and Hearings Process.

(4) If the beneficiary is determined to be ineligible for all Medicaid/NC Health Choice programs, terminate the case with timely notice. See MA-2420/3430, Notice and Hearings Process.

b. Change of Circumstance:

(1) Evaluate the beneficiary for all Medicaid/NC Health Choice programs, including MCV.

(2) If the beneficiary is now eligible under the same program, continue eligibility for the remainder of the original certification period.

(3) If the beneficiary is now eligible for a greater program, certify the correct program for a new 6/12-month certification period.

(4) If the beneficiary is now eligible for a lesser benefit, recertify after timely notice requirements are met. See MA-2420/3430, Notice and Hearings Process, then certify the correct program for the remainder of the original certification period.

(5) If the beneficiary is determined to be ineligible for all Medicaid/NC Health Choice programs, terminate the case with timely notice. See MA-2420/3430, Notice and Hearings Process.

F. Excluding cases from automatic extension in NC FAST

In order to allow the termination of cases addressed in this letter, counties should continue to notify their assigned OST representative of all cases that should not be

extended via the monthly batches for COVID Extensions, Hawkins Extensions, and the End of the Month Data Fix. (See Amended DHB Administrative Letter 09-20 for more information about these extensions.) Counties should send a list of all cases that should be excluded from the extensions to their OST **no later than the third to the last workday of each month**. Failure to provide this information to your OST will result in cases being extended in error.

IV. NCHC BENEFICIARY OF ANY AGE WHO IS DETERMINED INELIGIBLE

CMS has provided guidance that **any** NCHC beneficiaries who are determined to be ineligible for NCHC either at critical age review when the beneficiary turns age 19, change of circumstance, or at recertification, are **not** protected in continuous coverage during the PHE. These beneficiaries must be evaluated for all other Medicaid programs, including MCV.

Counties should continue to work the Critical Age Report in NC FAST for beneficiaries who turn age 19 and mark the report complete so the individual falls off the critical age report.

June 2021 will be the last month that NCHC cases will be extended via the COVID extension and monthly data-fix. When the county discovers that a NCHC beneficiary no longer meets the eligibility requirements for NCHC, either at critical age review, change of circumstance, or at recertification, the caseworker should follow applicable policy found in MA-3255, NC Health Choice, and MA-3430, Notice and Hearings Process. Counties should work the pending recertification report and prioritize NCHC cases previously extended in NC FAST due to COVID-19.

Caseworkers should complete an ex-parte review following policy in MA-3421, MAGI Recertification.

As a reminder:

A. Requesting Information

1. Recertification – eligibility determination completed at the end of certification period requires NCF-20020 if continuing eligibility cannot be established with electronic matches or information in other cases.

2. Redetermination – eligibility determination completed during the current certification period when there is a change in circumstance, the DHB-5097 is used to request any needed information. The NCF-20020 is not sent.

B. Outcomes

1. If the beneficiary is determined to be eligible for a greater benefit, authorize the appropriate Medicaid program. Follow adequate notice policy found in MA-3430, Notice and Hearings Process.

2. If the beneficiary is determined to be eligible for the lesser benefit of Medicaid for Family Planning (MAF-D) or Medicaid for Coronavirus (MCV), authorize the MAF-D or MCV case and follow timely notice policy found in MA-3430, Notice and Hearings Process.

3. If the beneficiary is determined to be ineligible for all Medicaid programs, terminate the NCHC case and follow timely notice policy found in MA-3430, Notice and Hearings Process.

   Example:

   Jane, who is 10 years old, is receiving NCHC. At recertification, it is determined that the household income is now above the allowable limits for NCHC. The caseworker evaluates for all other Medicaid programs and Jane is now only eligible for MAF-D. Timely notice is sent and Jane's NCHC is terminated and she is placed in MAF-D.

C. Terminating NCHC in NC FAST

1. Caseworkers must ensure that a **timely** DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance, is generated in NC FAST.

2. Select the correct reason, outcome, and change date. Follow NC FAST job aid, MA/MAGI DSS-8110 Notice of Modification, Termination or Continuation of Public Assistance.

3. **Beginning in July 2021**, NCHC Product Delivery Cases (PDC) will not be extended via the monthly batches for COVID Extensions and the End of the Month Data Fix.

4. NCHC PDC's that the county is unable to complete the recertification or change of circumstance timely will continue to be extended one month at a time with the Hawkins extension batch.

D. Hawkins v. Cohen procedures

Policy concerning Hawkins v. Cohen continues to apply. Before taking any action to terminate or reduce benefits for these NCHC beneficiaries, the caseworker must follow procedures found in DHB Administrative Letter 03-19, Hawkins v. Cohen Procedures.

1. If it is determined that the beneficiary submitted or requested an application for Medicaid for the Disabled (MAD) within the required timeframe found in DHB Administrative Letter 03-19, the beneficiary's NCHC benefits are protected. The caseworker should follow guidance in Administrative Letter 03-19 to continue NCHC benefits until a disability decision is made.

2. Failure to complete the ex-parte review process in the required timeframe will result in the NCHC eligibility being extended by NC FAST monthly via the "Hawkins Extension" until the recertification is completed. These cases will be listed on the Hawkins Extension Report

V. IMPLEMENTATION

These policies and procedures are effective immediately for applications and recertifications. This also includes applications or recertifications currently in process. Counties will be notified of any changes to the above guidance.

If you have any questions regarding this information, please contact your Medicaid Operational Support Team representative.

DocuSigned by:
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