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March 30, 2020

North Dakota (ND) Medicaid
Families First Coronavirus Response Act:
Temporary Federal Medical Assistance Percentage (FMAP) Increase & Eligibility Requirements
Frequently Asked Questions (FAQ)

What is increased FMAP and when was this effective?
The FMAP is the federal government's share of most Medicaid expenditures. Section 6008 of the Families First Coronavirus Response Act provides for a temporary 6.2 percentage point increase beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency is declared over. Please note this is not a 6.2 percent increase in dollars that the State can use to fund the Medicaid program, it is a 6.2 percent increase in the federal contribution to the Medicaid expenditures; thereby, reducing the State's contribution by 6.2 percent. As of publication of this FAQ, the appropriated amounts for ND Medicaid in the 2019-2021 budget remain unchanged.

What types of Medicaid expenditures is the increased FMAP applied to?
In general, the increased FMAP is available for allowable Medicaid expenditures for which federal matching is typically paid at the standard state specific FMAP rate. The increased FMAP does not apply Medicaid expenditures which already receive an enhanced rate such as the Medicaid Expansion newly eligible adult group expenditures, family planning services eligible for 90% match, and IHS/638 expenditures that are eligible for 100% match. The increase also does not apply to Medicaid administrative expenditures such as information technology and state employee salaries.

What are the requirements for ND Medicaid to receive the increased FMAP?
To qualify for the temporary FMAP increase, ND Medicaid must, through the end of the month when the public health emergency ends:

- Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of the start of the first quarter. This is called a maintenance of effort requirement.

- Not charge premiums that exceed those that were in place as of January 1, 2020.

- Cover, without cost sharing, testing, services and treatments—including vaccines, specialized equipment, and therapies—related to COVID-19.

- Not terminate individuals from Medicaid if such individuals were enrolled in the program as of the date of the beginning of the emergency period, or becomes enrolled during the emergency period, unless the individual voluntarily terminates eligibility or is no longer a resident of the state. This is called the continuous coverage requirement.

When do these requirements start? March 18, 2020

What does "not terminate individuals from Medicaid" mean?
In order to receive the temporary FMAP increase, states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after **March 18, 2020**, regardless of any changes in circumstances or redeterminations at scheduled

renewals that otherwise would result in termination. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who move to another state.

Does continuous coverage for the emergency period apply to individuals who are receiving benefits during a period of hospital presumptive eligibility?
Individuals who have been determined presumptively eligible by a hospital under the hospital presumptive eligibility program, have not received a final determination of eligibility and are therefore not considered "enrolled". They would not be subject to the requirements for continuous coverage described under section 6008 of the FFCRA. Individuals who meet all the eligibility criteria and are "enrolled" following a period of hospital presumptive eligibility do have to be continuously covered until the end of the month when the emergency is declared over.

What if a member received a notice on or after March 18, 2020 that she/he would be terminated from Medicaid as of March 31, 2020?
These members would remain on Medicaid. The State is working with Medicaid policy, ND Information Technology and the eligibility systems vendor to not terminate these individuals. Zone eligibility workers can also change enrollment status from terminated to active if needed.

What if a member already received a letter that they need to complete redetermination paperwork during April 2020?
A follow up letter will be sent to individuals that the review forms they received do not need to be completed.

What about members who are coming up for redetermination after April 2020?
Based on the requirement of continuous coverage through the end of the quarter in which the public health emergency ends, redetermination dates will be changed. An additional 12 months will be added to the member's redetermination date. For example, redeterminations that were scheduled in the months of April, May and June of 2020 will be extended to April, May, and June of 2021.

What about members who pay a client share or a recipient liability?

- Client share, or recipient liability, will be collected in the usual manner. Whatever the recipient liability amount was determined to be in March 2020, the amount will continue to be the same throughout the emergency period, regardless of changes in income. However, if the reported change results in *increased* coverage such as a change in category of eligibility, reduced client share, etc., those changes will be implemented.
- Beginning in April 2020 if any member does not meet their 6-month client share contribution, they will not be terminated from Medicaid.

What about a member's personal needs allowance? ND Medicaid members in certain institutional settings, have a personal needs monthly allowance. They use these funds for activities such as movies, shopping, etc. Normally, if these funds are not used, and accumulate over time, they are considered an asset when redetermining eligibility criteria. However, if these funds are not used during the emergency period, they will not be considered an asset. Once the emergency is over, the State will work with facilities and members to adjust any accumulated funds as needed.

What about changes reported by households for other public assistance programs such as SNAP, TANF, Child Care, etc.?
During the emergency period, recipients cannot have Medicaid eligibility reduced to a level *lower* than they were prior to the emergency. However, if the reported change results in increased coverage such as a change in category of eligibility, reduced client share, etc., these changes will be implemented.

What if a member is enrolled in the Children's with Disabilities category? Members enrolled in this category are required to pay a monthly premium. Starting March 18, 2020 members cannot be terminated for failure to pay premiums. ND Medicaid has identified members who have been notified they were to be

terminated on or after March 18, 2020 and is working with Zone eligibility workers to ensure they will remain enrolled. Members will also be notified. However, to make this process easier for members and Zone eligibility workers, the State is currently seeking a disaster state plan amendment to waive premiums during the emergency period. This FAQ will be updated when the status of that approval is known.

What if a member is enrolled in the Workers with Disabilities (WWD) category and cannot work due to a worksite closure?
Members in this category are required to pay a monthly premium and must be gainfully employed. During the emergency period these individuals will be considered gainfully employed. Starting March 18, 2020, members cannot be terminated for failure to pay premiums. ND Medicaid has identified members who have been notified they were to be terminated on or after March 18, 2020 and is working with Zone eligibility workers to ensure they will remain enrolled. Members will also be notified. However, to make this process easier for members and Zone eligibility workers, the State is currently seeking a disaster state plan amendment to waive premiums during the emergency period. This FAQ will be updated when the status of that approval is known.

What about former foster youth who turn 26 during the emergency?
Typically, Medicaid enrollment for these members would be terminated upon turning 26. However, during the emergency the member must remain enrolled with ND Medicaid.

What about members who are enrolled in both Medicare and Medicaid?
The continuous coverage requirement applies to all Medicaid groups, including those who are also eligible for Medicare.

Are there are any changes in the processing of new applications?
No. However, potential enrollees are encouraged to use the online application which can be found at https://www.nd.gov/dhs/eligibility/index.html.