

## Trump Administration Reverses Course on Medicaid Maintenance of Effort Provisions, Clearing the Way for Devastating Cuts in the Midst of the COVID-19 Pandemic

In a reversal of its own guidance, on November 2 the Trump Administration released an interim final rule that would weaken protections for millions of Medicaid beneficiaries during the COVID-19 pandemic. According to this new [regulation](#) from the Centers for Medicare and Medicaid Services (CMS), effective immediately states are permitted to make Medicaid benefit cuts during the national public health emergency without losing enhanced federal matching funding.

This means that state legislatures and/or Medicaid agencies can reduce or eliminate optional benefits (e.g., oral health, home health care, or substance use treatment), increase cost sharing, and/or reduce benefit packages. These cuts would be devastating for the more than 70 million children, families, elderly, disabled individuals, and other low-income adults who rely on Medicaid for their health coverage.

### Overview of Medicaid Maintenance of Effort Included in the Families First Coronavirus Relief Act

The Families First Coronavirus Response Act (FFCRA) (PL-116-127) passed by Congress on March 18, 2020, provided a temporary enhancement in federal funding for state Medicaid programs. Each qualifying state and territory receives a 6.2 percentage point increase in its Federal Medical Assistance Percentage (FMAP) effective January 1, 2020 through the last day of the calendar quarter of the public health emergency. As with Medicaid match increases in earlier recessions, to qualify for this funding a state must abide by a Maintenance of Effort (MOE) provision that prohibits

it from imposing more restrictive eligibility standards, methodologies, or procedures than those that were in place as of January 1, 2020. In sub-regulatory guidance over the spring, CMS interpreted the MOE as protecting benefits from cuts, on the principle that a benefit cut is effectively a reduction in eligibility for coverage.

### Changes to MOE Included in New Interim Final Rule

On November 2, however, CMS reversed its prior guidance with the release of an interim final rule. This new rule reinterprets the MOE provision to allow for fewer protections for Medicaid enrollees during the public health emergency. According to this rule, CMS permits states to make:

“changes to the medical necessity criteria or utilization control procedures in determining coverage for benefits; elimination of optional benefits coverage; increases in cost-sharing responsibilities...; or changes to the post-eligibility treatment-of-income (PETI) methodology.”

## Box 1

**Previous CMS Guidance on the MOE (June 30, 2020)<sup>2</sup>*****“Are states prohibited from increasing cost-sharing during the emergency period as a condition of receiving the FFCRA enhanced FMAP?”***

Yes. A state is not eligible for the temporary FMAP increase authorized by section 6008 of the FFCRA if it reduces the medical assistance for which a beneficiary is eligible and if that beneficiary was enrolled as of March 18, 2020, or becomes enrolled after that date but not later than the last day of the month in which the emergency period ends.”

This policy reversal, which is effective immediately, enables states to make the following changes to their Medicaid programs:

**1. Cuts to Optional Benefits**

In addition to mandatory benefits under federal Medicaid law, states can cover a number of optional benefits for their Medicaid enrollees. Although technically optional, these benefits are a critical part of comprehensive insurance coverage. They include adult oral health services, substance use treatment, and select other behavioral health and most home- and community-based long-term care services. Historically, when states face tight budgets, these optional benefits are at grave risk. Unfortunately, this reversal by CMS now gives states the ability to cut optional benefits during the public health emergency, jeopardizing the health of tens of millions of Americans.

**2. More Premiums and Cost-Sharing**

Some Medicaid enrollees are required to pay premiums and cost-sharing for their Medicaid

coverage. However, as a condition of the enhanced 6.2 percentage point increase, CMS told states they could not increase cost-sharing or premiums during the public health emergency (see Box 1 above). With this rule, CMS is reversing its own guidance and now allows states to increase premiums and cost-sharing. This reversal will place another financial strain on families that already struggle to make ends meet during the economic downturn.

**3. Cuts to Coverage within New Tiers**

Medicaid benefit packages can vary based on an individual’s eligibility group. However, as a condition of the enhanced 6.2 percentage point increase, CMS informed states on April 13 that they are not permitted to move an individual into a new eligibility group that would result in a reduction of benefits (see Box 2 on page 3). In order to justify reducing an individual’s benefits package, this rule creates three new and confusing coverage tiers for Medicaid enrollees. These tiers lump Medicaid enrollees into three categories based on whether

## Box 2

**Previous CMS Guidance on the MOE (April 13, 2020)**<sup>3</sup>

“To be eligible for the enhanced FMAP authorized by the FFCRA, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP. This mean [sic] that states must continue to provide coverage to such beneficiaries in the eligibility group in which a beneficiary is enrolled if transitioning the beneficiary to another eligibility group would result in a reduction in benefits.”

they are receiving “minimum essential coverage” (MEC)<sup>1</sup> and/or coverage for COVID testing and treatment. The three tiers of coverage are:

- » **Tier 1:** Coverage that meets the definition of MEC
- » **Tier 2:** Coverage that is not MEC but includes COVID-19 testing and treatment
- » **Tier 3:** Coverage that is not MEC and does not include coverage for COVID-19 testing and treatment

Within these tiers, there are big differences in the benefits packages enrollees receive. This new rule says states cannot move enrollees into a lower tier of coverage, but can move them into a more limited benefits package within their existing tier. This gives states another way to cut benefits. For example, a woman enrolled in Tier 1 pregnancy-only Medicaid (MEC coverage) may receive additional benefits like case management, parenting education, and breastfeeding support services. If she is transferred to a different Tier

1 group, such as the expansion group, these additional benefits may not be covered. Under the new rule, however, the state can reduce her benefits by moving her from pregnancy-only coverage into Medicaid expansion coverage because it is in the same coverage tier.

#### **4. Termination of Coverage if “Not Validly Enrolled”**

FFRCA prohibited states from terminating Medicaid eligibility, except in two instances: (1) voluntary termination by the beneficiary; or (2) when an individual is no longer a resident of the state. This rule expands permissible coverage terminations to include individuals “not validly enrolled” during the public health emergency. That is, states can now terminate coverage for an enrollee who was initially determined eligible and received coverage but has since been determined ineligible due to agency error, fraud, or abuse. While “fraud” (evidenced by a fraud conviction) or “abuse” (determined following an investigation) is defined in the rule, “agency error” is not. The absence of a definition of “agency error” will give states broad discretion and could lead to widespread

## Box 3

**CMS Interim Final Rule Reinterpreting the MOE (November 6, 2020)**<sup>4</sup>

“Under the enrollment interpretation, individuals who lose eligibility for a group that offers MEC may be transitioned to a limited benefit eligibility group, in a state that offers such coverage, in which they would no longer have access to the benefits needed to manage their chronic conditions. Not only would this negatively impact the beneficiary who loses comprehensive Medicaid coverage as a result of this interpretation, but it could also undermine states’ COVID-19 response efforts during the public health emergency.”

terminations. Terminations based on “agency error” could translate into a decrease in Medicaid enrollment similar to that in [2018](#), when states such as Missouri and Texas used administrative barriers to terminate beneficiaries from Medicaid before their regular annual eligibility redetermination dates.

### **This Interim Final Rule is Substantively and Procedurally Bad Policy and Must Be Rescinded**

CMS’s Interim Final Rule gives wide latitude to states to cut Medicaid eligibility and benefits during a massive economic and public health crisis. The rule is a dramatic departure from CMS’s original interpretation of the MOE provision, in which it recognized that Medicaid coverage is integral to keeping our communities safe and healthy during the COVID-19 pandemic. CMS’s November 2

reinterpretation, which allows states to cut benefits, add premiums, and increase cost-sharing, will have a devastating impact on millions who rely on Medicaid. In fact, the Trump administration acknowledges that its reinterpretation could “undermine states’ COVID-19 response efforts during the public health emergency,” (see Box 3 above).

Further, by implementing this rule change without first opening a public comment period, the Trump administration is deliberately avoiding procedures designed to give the public an opportunity to understand and influence decisions that affect us directly. While the Interim Final Rule is effective immediately, public comments are due on January 4, 2021. We encourage all Medicaid stakeholders to [submit comments](#) and contact their congressional delegations, urging CMS to rescind this guidance and ensure that Medicaid coverage remains stable and strong throughout the COVID-19 pandemic.

## Endnotes

<sup>1</sup> 5000A(f) of the Internal Revenue Code of 1986, <https://www.law.cornell.edu/uscode/text/26/5000A>.

<sup>2</sup> Centers for Medicare & Medicaid Services, “COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies,” June 30, 2020, <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

<sup>3</sup> Centers for Medicare & Medicaid Services, “Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 Frequently Asked Questions (FAQs),” April 13, 2020, <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>.

<sup>4</sup> Federal Register, “Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency,” November 6, 2020, <https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

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