**MEMORANDUM**

**TO: Primary Care Associations (PCA)**

**FROM: NACHC State Affairs**

**DATE: November 9, 2020**

**RE: COVID-19 Public Heath Emergency Interim Final Rule Summary**

***Introduction***

On [October 28, 2020](https://www.cms.gov/newsroom/press-releases/trump-administration-acts-ensure-coverage-life-saving-covid-19-vaccines-therapeutics), CMS issued an [Interim Final Rule](https://www.cms.gov/newsroom/fact-sheets/fourth-covid-19-interim-final-rule-comment-period-ifc-4) (IFR) with comment period, establishing policies relating to the FFCRA passed by Congress this spring. Among other things, this IFR (1) establishes important vaccine-related coverage provisions for Medicare, Medicaid, CHIP, and private insurance and (2) alters the critical Maintenance of Effort (MOE) requirement of the FFCRA that states must follow in order to receive a 6.2% increase in FMAP . **The rule went into effect November 2, 2020 and was** [**published**](https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency) **in the Federal Register on November 4, 2020. The interim final rule will have a 60-day comment period ending on January 4, 2021.** NACHC is planning to comment on both the vaccine and MOE rules. We believe that the COVID-19 vaccine administration requirements could present additional administrative burdens and costs for health centers across the country and that the rule change relating to state Maintenance of Effort requirements could adversely impact FQHC reimbursement and coverage of optional services

**Medicaid**

On [October 2, 2020,](https://ccf.georgetown.edu/2020/10/05/secretary-azar-extends-public-health-emergency-medicaid-protections-for-beneficiaries-and-states/) the Secretary of HHS extended the Public Health Emergency (PHE) through January 20, 2021. This means that the 6.2 % Federal Medicaid Assistance Percentage (FMAP) increase remains in effect through at least March 31, 2021. This also means that state Medicaid programs must maintain enrollment through at least January 31, 2021.

**Maintenance of Effort**

Under the original maintenance-of-effort (MOE) requirements, as a condition of receiving the increased FMAP under the Families First Coronavirus Response Act (FFCRA), state Medicaid programs must not implement eligibility standards, methodologies and procedures that are more restrictive or charge higher premiums than were in place on January 1, 2020. They also must not disenroll any beneficiaries who were enrolled as of March 18, 2020, through the end of the month in which the PHE ends. CMS interpreted the continuous coverage requirements of FFCRA as barring states from cutting benefits or increasing cost-sharing for Medicaid beneficiaries while they are enrolled.

[In the Interim Final Rule](https://ccf.georgetown.edu/2020/11/02/new-cms-rule-would-weaken-families-first-continuous-coverage-protection-in-medicaid/), however, CMS provides states with more flexibility to “effectuate enrollment transitions during the PHE for COVID-19, which aims to address backlogs in redeterminations and appeals.” CMS’s proposed rule now requires states to maintain enrollment only for “validly enrolled beneficiaries” and provides that someone is not “validly enrolled” in Medicaid if:

* There was an agency error that incorrectly determined someone was eligible for Medicaid
* A Medicaid agency determines that someone has submitted fraudulent information as proof of eligibility
* An individual received coverage during a presumptive eligibility period

Additionally, CMS’ proposed rule establishes [three tiers of coverage](https://www.communitycatalyst.org/blog/cms-rule-goes-against-congressional-intent-and-risks-stripping-emergency-medicaid-coverage-guarantees#.X6WBw2hKhPZ) for beneficiaries as a way for states to maintain their temporary FMAP increase. Under its new reinterpretation, states claiming the FMAP increase are permitted to make programmatic changes, such as:

* Changes to the medical necessity criteria or utilization control procedures in determining coverage for benefits
* Elimination of certain optional benefits[[1]](#footnote-1)
* Increases in cost sharing by beneficiaries

In the IFR, CMS states its intention to provide states with flexibility to make programmatic changes to benefits and cost sharing while also establishing parameters to prevent beneficiaries from losing coverage. CMS acknowledges the challenges states face in managing budgets without cutting services or lowering provider reimbursement rates. Presumably, this rule change is intended to alleviate this financial burden. The new MOE requirements are effective immediately, as of November 2, 2020.

**Vaccine Coverage: Key elements in CMS’ new rules relating to vaccine coverage include:**

* For states to receive a temporary 6.2% increase in the FMAP, a state **must** cover COVID-19 testing services and treatments, including vaccines and the administration of such vaccines for Medicaid enrollees without cost sharing.
* States **must compensate** Medicaid providers with a vaccine administration fee or reimbursement for a provider visit during which a vaccine dose is administered, even if the vaccine dose is furnished to the provider at no cost.
* CMS does not interpret the FFCRA to require states to provide COVID-19 testing and treatment services without cost-sharing, including vaccines and their administration, to eligibility groups whose coverage is **limited by statute or 1115 demonstration**.
* After the increased FMAP[[2]](#footnote-2) requirements and the Public Health Emergency (PHE) are no longer in effect:
	+ the state **must** **cover COVID-19 vaccines**[[3]](#footnote-3), and their administration, for several populations under existing statutory and regulatory authority.[[4]](#footnote-4)
	+ the state also has the option to cover a COVID-19 vaccine and its administration for other eligibility groups. If a state elects to cover a COVID-19 vaccine and its administration for one eligibility group, it must do so for all of them.
* CMS issued three toolkits aimed at [state Medicaid agencies,](https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf) providers [who will administer the vaccine](https://www.cms.gov/covidvax-provider), and health insurance plans.
* Facility services, such as FQHCs vaccine administration, are usually included within the prospective payment system (PPS). States may set higher payment rates for vaccine administration to recognize circumstances where costs exceed the established state plan rates and are encouraged to set rates at levels that incentivize access to and availability of vaccines. For example, states could pay higher rates for the administration of a COVID-19 vaccine that requires multiple doses or based upon the qualifications of the administering practitioner or the site of service. Additionally, states may adjust or add-on to rates provided within facility settings to account for higher costs associated with COVID-19 vaccine administration that are not otherwise included within the existing state plan rates.[[5]](#footnote-5)

**Medicare, Private Insurance and Uninsured**

* Beneficiaries with Medicare will have no cost sharing for COVID-19 vaccines.
* CMS, along with the Departments of Labor and the Treasury, is requiring that most private health plans and issuers cover a recommended COVID-19 vaccine and its administration, both in-network and out-of-network, with no cost sharing. The rule also provides that out-of-network rates cannot be unreasonably low, and references CMS’s reimbursement rates as a potential guideline for insurance companies.
* The COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program (COVID-19 Claims Reimbursement program) administered by HRSA is available for reimbursement of a COVID-19 vaccine and vaccine administration costs for individuals who would not receive Medicaid coverage for a COVID-19 vaccine or its administration because their Medicaid coverage is for limited benefit packages only.
1. These optional benefits include: adult dental coverage, prescription drugs, and/ others listed at: <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html> [↑](#footnote-ref-1)
2. Section 6008(b)(4) of the FFCRA <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf> [↑](#footnote-ref-2)
3. Vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) [↑](#footnote-ref-3)
4. Some states may also elect to receive a 1% FMAP increase for covering ACIP-recommended vaccines and their administration without cost-sharing for adults under section 1905(a)(13) of Social Security Act, pursuant to section 4106 of PPACA. [↑](#footnote-ref-4)
5. CMS Toolkit, 3. Reimbursement of the Vaccine and Vaccine Administration: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf> [↑](#footnote-ref-5)