Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FOUR STATES REVIEWED RECEIVED INCREASED MEDICAID COVID-19 FUNDING EVEN THOUGH THEY TERMINATED SOME ENROLLEES' COVERAGE FOR UNALLOWABLE OR POTENTIALLY UNALLOWABLE REASONS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Inspector General

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Office of Inspector General

https://oig.hhs.gov

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: September 2023
Report No. A-06-21-09002

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Four States Reviewed Received Increased Medicaid COVID-19 Funding Even Though They Terminated Some Enrollees' Coverage for Unallowable or Potentially Unallowable Reasons

Why OIG Did This Audit

The COVID-19 pandemic was declared a nationwide Public Health Emergency (PHE) in January 2020. In March 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA), which provided States with a temporary increase of 6.2 percentage points to their regular Federal medical assistance percentage (FMAP) rates. To qualify, States must meet certain FFCRA requirements. The increased COVID-19 FMAP became effective January 1, 2020, and extends through December 31, 2023. The amount of the FMAP increase began phasing down April 1, 2023.

Our objective was to determine whether selected States met the requirements to receive the increased COVID-19 FMAP.

How OIG Did This Audit

We selected four States (New York, Florida, Texas, and Minnesota) for review. These States received an additional $12.8 billion in FMAP funding during our audit period (January 1, 2020, through June 30, 2021). For each State, we (1) reviewed the PHE eligibility policies and procedures; (2) obtained and compared a list of Medicaid enrollees on March 18, 2020, and June 30, 2021; (3) analyzed enrollee terminations; (4) analyzed cost-sharing related to COVID-19 testing, services, or treatment; and (5) reviewed premiums to verify that the States met FFCRA requirements.

What OIG Found

The four States we reviewed did not meet all of the requirements to receive the increased COVID-19 FMAP. All four States terminated Medicaid enrollees' coverage for unallowable or potentially unallowable reasons. Two States (Texas and Minnesota) terminated Medicaid coverage for 26,915 total enrollees for unallowable reasons, and three States (New York, Florida, and Minnesota) terminated Medicaid coverage for 220,113 total enrollees for potentially unallowable reasons due to a lack of support or documentation.

Additionally, Minnesota may have inappropriately charged some enrollees cost-sharing for COVID-19 testing, services, and treatment. Minnesota could not determine whether Medicaid enrollees were responsible for any cost-sharing, and enrollees may have been charged up to $951,202 for COVID-19-related testing, services, and treatment.

What OIG Recommends and CMS Comments

We recommend that CMS (1) work with the four States to determine what amount, if any, of the funding they received because of the increased COVID-19 FMAP should be refunded to the Federal Government; and (2) work with Minnesota to determine whether Medicaid enrollees were responsible for any cost-sharing for COVID-19 testing, services, or treatments and, if any cost-sharing is identified, work with Minnesota to ensure that enrollees are reimbursed for any out-of-pocket expenses incurred.

In written comments on our draft report, CMS concurred with both of our recommendations and described actions that it planned to take to address our recommendations. Specifically, CMS stated it will work with the States to determine what amount, if any, of the funding the States received because of the increased COVID-19 FMAP should be refunded to the Federal Government. CMS also stated that it will work with Minnesota to determine whether the State improperly imposed any cost-sharing for COVID-19 testing, services, or treatments and, if so, determine the appropriate remedy. CMS also provided technical comments on our draft report.

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INTRODUCTION

WHY WE DID THIS AUDIT

The COVID-19 pandemic was declared a nationwide public health emergency (PHE) in January 2020. In March 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA) in response to the COVID-19 PHE.[1] The FFCRA provided States with a temporary increase of 6.2 percentage points to their regular Federal medical assistance percentage (FMAP) rates. To qualify for the increased COVID-19 FMAP, States must meet requirements in section 6008(b) of the FFCRA. The increased COVID-19 FMAP became effective January 1, 2020, extends through December 31, 2023, and began phasing down the amount of the FMAP increase April 1, 2023. We judgmentally selected four States for review based on the amount of funding received, including three high-funded States (New York, Texas, and Florida) and one medium-funded State (Minnesota). These four States received a total of $12.8 billion in additional funding from the temporary increase in their FMAPs for the period January 1, 2020, through June 30, 2021.

COVID-19 has created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for the Department of Health and Human Services (HHS), the Office of Inspector General (OIG) oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.[2]

OBJECTIVE

Our objective was to determine whether selected States met the requirements to receive the increased COVID-19 FMAP.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program according to a CMS-approved State plan. Each State has considerable flexibility in designing and operating its Medicaid program but must comply with applicable Federal requirements.

[1] The Families First Coronavirus Response Act (P.L. No. 116-127) (Mar. 18, 2020).

[2] OIG's COVID-19 response strategic plan and oversight activities can be accessed at HHS-OIG's Oversight of COVID-19 Response and Recovery | HHS-OIG.

The Federal Government pays its share of a State's medical assistance costs based on the FMAP, which varies depending on the State's per capita income.[3] Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time. The standard FMAP varies by State and ranged from 50 percent to 78 percent during our audit period.[4]

Federal Requirements and Other Guidance

In March 2020, Congress enacted the FFCRA in response to the COVID-19 PHE. Section 6008 of the FFCRA provides a temporary 6.2-percentage-point increase to each qualifying State's FMAP under section 1905(b) of the Social Security Act (the Act), effective January 1, 2020, extending through December 31, 2023, and began phasing down the amount of funding on April 1, 2023.[5]

All States are eligible for the increased COVID-19 FMAP provided they meet the requirements of section 6008(b) of the FFCRA. To qualify for the increased COVID-19 FMAP during our audit period, States were required to:

- maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the State had in place as of January 1, 2020;
- not charge premiums that exceed those in place as of January 1, 2020;
- cover—without impositions of any cost-sharing—COVID-19-related testing, services, and treatments including vaccines, specialized equipment, and therapies; and
- not terminate individuals from Medicaid if such individuals were enrolled in the program as of March 18, 2020, or become enrolled during the emergency period, unless the individual voluntarily terminates eligibility or is no longer a resident of the State (under the continuous enrollment requirement which was set to end on March 31, 2023).[6]

[3] Social Security Act (the Act) § 1905(b).

[4] 83 Fed. Reg. 61157, 61159 (Nov. 28, 2018) and 84 Fed. Reg. 66204, 66206 (Dec. 3, 2019).

[5] The PHE ended May 11, 2023. Section 5131(a) of the Consolidated Appropriations Act amended section 6008(a) of the FFCRA to continue the temporary FMAP increase through Dec. 31, 2023, and phases down the amount of the FMAP increase beginning Apr. 1, 2023 (P.L. No. 117-328) (Dec. 29, 2022).

[6] Division FF, Section 5131, Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022). Section 5131(a)(2)(C) separates the end of the continuous enrollment condition from the end of the COVID-19 PHE by amending section 6008(b)(3) of the FFCRA to end continuous Medicaid enrollment as a condition for claiming the temporary FMAP increase on Mar. 31, 2023.

Title 42, section 433.400 of the Code of Federal Regulations (CFR), effective November 2, 2020, interprets and implements FFCRA section 6008(b)(3). This CFR section sets forth requirements for a State to receive the increased COVID-19 FMAP. Enrollees for whom a State must maintain coverage are those who: (1) qualify for minimum essential coverage; (2) are enrolled under a Medicare Savings Program (MSP); (3) qualify for coverage of testing, services, and treatments for COVID-19, including vaccines, specialized equipment, and therapies; or (4) otherwise are enrolled under a State plan or waiver. A State must maintain coverage for individuals who were validly enrolled as of or after March 18, 2020.[7]

Title 42, section 433.400(d) outlines exceptions to the continuous enrollment requirement. A State may terminate a person's Medicaid enrollment during the PHE if:

- the enrollee or the enrollee's representative requests a voluntary termination of eligibility,
- the enrollee ceases to be a resident of the State, or
- the enrollee dies.

A State may also limit coverage to services necessary for treatment of an emergency condition for an enrollee who no longer meets the definition of a lawfully residing child or pregnant person.[8]

A State must maintain coverage for those who were validly enrolled as of or after March 18, 2020 (42 CFR § 433.400(c)(2)). Under 42 CFR § 433.400(b), a person is:

> . . . not validly enrolled if the agency determines the eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility (if such last redetermination or renewal was completed prior to

[7] In *Carr v. Becerra*, No. 22-cv-0098, the U.S. District Court of the District of Connecticut issued a preliminary injunction on Jan. 31, 2023, enjoining HHS from enforcing the Interim Final Rule (42 CFR § 433.400) with respect to certain individuals. These individuals included all individuals who were enrolled in Medicaid in any State on March 18, 2020, or later and, as a result of the adoption of the Interim Final Rule on Nov. 6, 2020, either had their Medicaid eligibility reduced to a lower level of benefits and were determined to be eligible for an MSP or will have their Medicaid eligibility reduced to a lower level of benefits and be determined to be eligible for an MSP prior to a redetermination conducted after Mar. 31, 2023 (No. 3:22-cv-988(MPS)). For the purposes of this audit, we identified enrollees who were disenrolled for reasons other than voluntary withdrawal and residency, or whose termination reasons could not be supported, and did not identify in our findings enrollees whose coverage was reduced to limited benefits and determined to be eligible for the MSP as result of the Interim Final Rule. We also did not review whether States reinstated full Medicaid coverage for those determined to be eligible for the MSP whose coverage was reduced as a result of the Interim Final Rule.

[8] For States that have elected the option under section 1903(v)(4) of the Act to provide full benefits to lawfully residing children or pregnant persons, the States must limit coverage to such enrollees to emergency care (42 CFR § 433.400(d)(2)).

> March 18, 2020) because of agency error or fraud (as evidenced by a fraud conviction) or abuse (as determined following the completion of an investigation pursuant to §§ 455.15 and 455.16 of this chapter) attributed to the [person or the person's] representative, which was material to the determination of eligibility. Individuals receiving medical assistance during a presumptive eligibility period . . . have not received a determination of eligibility by the State under the State plan and are not considered validly enrolled . . . for purposes of this section.

According to CMS's FAQs about COVID-19:[9, 10]

> States that want to qualify for the increased [COVID-19] FMAP should make a good faith effort to identify and reinstate individuals whose coverage was terminated on or after the date of enactment for reasons other than a voluntary request for termination or ineligibility due to residency. At a minimum, States are expected to inform individuals whose coverage was terminated after March 18, 2020, of their continued eligibility and encourage them to contact the state to reenroll. Where feasible, States should automatically reinstate coverage for individuals terminated after March 18, 2020, and should suspend any terminations already scheduled to occur during the emergency period. Coverage should be reinstated back to the date of termination.

HOW WE CONDUCTED THIS AUDIT

We selected four States (New York, Florida, Texas, and Minnesota) for review. These four States received an additional $12.8 billion in FMAP funding during our audit period (January 1, 2020, through June 30, 2021). For each State, we: (1) reviewed the PHE eligibility policies and procedures; (2) obtained and compared a list of Medicaid enrollees on March 18, 2020, and June 30, 2021, to identify enrollees whose coverage was terminated during our audit period; (3) analyzed enrollee terminations; (4) analyzed cost-sharing related to COVID-19 testing, services, or treatment; and (5) reviewed premiums to verify that the States met the requirements of the FFCRA section 6008(b).[11]

[9] CMS, "COVID-19 FAQs for State Medicaid and CHIP Agencies," updated Jan. 6, 2021. Available online at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf. Accessed on July 28, 2021.

[10] While these FAQs were applicable during our audit period, the court found in *Carr v. Becerra,* No. 22-cv-0098, that CMS must reinstate previous guidance "Frequently Asked Questions" "Updated as of 4/13/2020," and "Last Updated June 30, 2020" with respect to individuals identified in footnote 7. The previous guidance also included language that States should make a good faith effort to identify and reinstate individuals whose coverage was terminated on or after the date of enactment for reasons other than a voluntary request for termination or ineligibility due to residency.

[11] The Mar. 18, 2020, enrollment totals were 6 million in New York, 4.2 million in Florida, 4.5 million in Texas, and 1.1 million in Minnesota.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The four States we reviewed did not meet all of the requirements to receive the increased COVID-19 FMAP. All four States maintained eligibility procedures that were no more restrictive than the procedures in place as of January 1, 2020, and the two States (Texas and Minnesota) that charged premiums as part of their program did not raise the premiums in place as of January 1, 2020. However, two States (Texas and Minnesota) terminated Medicaid enrollees' coverage for unallowable reasons. Three states (New York, Minnesota, and Florida) terminated Medicaid enrollees' coverage for potentially unallowable reasons due to a lack of support or documentation. One State (Minnesota) may have inappropriately charged some enrollees cost-sharing for COVID-19-related testing, services, or treatment.

ALL FOUR STATES TERMINATED ENROLLEES' COVERAGE FOR UNALLOWABLE OR POTENTIALLY UNALLOWABLE REASONS

FFCRA section 6008(b)(3), as amended, states that to qualify for the increased COVID-19 FMAP States must, through March 31, 2023, not terminate an individual from Medicaid who was enrolled in the program as of March 18, 2020, or became enrolled during the emergency period unless the individual voluntarily terminates eligibility or is no longer a resident of the State (continuous enrollment requirement).

None of the four States we reviewed completely complied with the continuous enrollment requirement of the FFCRA. Two States (Texas and Minnesota) terminated Medicaid coverage for 26,915 total enrollees for unallowable reasons. Three States (New York, Florida, and Minnesota) terminated Medicaid coverage for 220,113 total enrollees for potentially unallowable reasons due to a lack of support or documentation. Specifically:

- New York could not support that it had terminated coverage for 142,378 enrollees for allowable reasons;

- Florida could not support that it had terminated coverage for 62,641 enrollees for allowable reasons;

- Texas terminated coverage for 22,680 enrollees for unallowable reasons; and

- Minnesota could not support that it had terminated coverage for 15,094 enrollees for allowable reasons, had an additional 4,228 unallowable coverage terminations for enrollees who were later reinstated (but each had a lapse in coverage), and terminated coverage for 7 enrollees for unallowable reasons.[12]

Enrollees who were disenrolled for unallowable reasons went without Medicaid coverage during the PHE, and some could have had out-of-pocket expenses. Because these States did not comply with the continuous enrollment requirement, they may not have been eligible to receive some of the funding they received because of the increased COVID-19 FMAP.

New York

New York could not support that it had terminated Medicaid coverage for 142,378 enrollees (2.36 percent of total March 2020 enrollment) for allowable reasons. These terminations are potentially unallowable due to a lack of support or documentation.

New York officials stated that the "reason codes" listed for terminations in New York's enrollment system were not specific enough to easily determine the reason the coverage ended for all enrollees. New York officials stated that a manual review of the 142,378 enrollees was not feasible due to the time associated with individual reviews of the enrollees' coverage terminations.

Florida

Florida was unable to provide support that it had terminated 62,641 enrollees (1.5 percent of total March 2020 enrollment) for allowable reasons. These terminations are potentially unallowable due to a lack of support or documentation.

Florida officials stated that they did not maintain codes for why an enrollee's coverage was terminated. The State agency's system was not designed to capture reasons for termination because this was not something that was needed before the PHE.

Texas

Texas terminated Medicaid coverage for 22,680 enrollees (0.5 percent of total March 2020 enrollment) for unallowable reasons. There were two causes for these terminations.

First, prior to the PHE, Texas' enrollment system was designed to automatically terminate coverage for enrollees when certain criteria were met (e.g., when an enrollee's supplemental security income ended, Medicaid coverage was automatically terminated). During the PHE, Texas disabled some, but not all, of those automatic terminations.

[12] The seven enrollees were not reinstated during our audit period.

Second, although Texas made changes to its termination policies and procedures to comply with the FFCRA requirements, some of its employees continued to use the State's prior termination procedures due to high staff turnover and the many procedure changes.

Minnesota

For 19,329 enrollees (1.82 percent of the total March 2020 enrollment), Minnesota:

- could not support that it had terminated Medicaid coverage for 15,094 enrollees for allowable reasons, so coverage for these enrollees could potentially have been terminated for unallowable reasons; and

- terminated 4,235 enrollees' coverage for unallowable reasons, 4,228 of whom were later reenrolled but had a lapse in coverage, and 7 of whom had not been reenrolled at the time of our audit.

In Minnesota, individual counties were responsible for Medicaid enrollments and terminations during our audit period. Employees in each county manually tracked terminations in Excel spreadsheets before determining whether an enrollee's coverage termination was allowable. Due to the decentralized and manual nature of its system, Minnesota was not able to identify the reasons for all enrollees' coverage terminations or confirm that the terminations were for allowable reasons. Minnesota officials stated that it was not feasible to manually review the termination reasons for the 15,094 enrollees.

MINNESOTA MAY HAVE INAPPROPRIATELY CHARGED COST-SHARING FOR COVID-19 TESTING, SERVICES, OR TREATMENT

During our audit period, FFCRA section 6008(b)(4) stated that to qualify for the increased COVID-19 FMAP, States must cover—without impositions of any cost-sharing—COVID-19-related testing, services, and treatments, including vaccines, specialized equipment, and therapies.

Minnesota Medicaid enrollees may have been responsible for cost-sharing for COVID-19 testing, services, or treatment during the PHE. Minnesota provided documentation showing that there were 10,988 managed care encounters with a diagnosis code for COVID-19 testing, service, or treatment with patient liability amounts totaling $951,202.

Minnesota updated its provider manual in April 2020 to inform providers that any claim with a COVID-19 diagnosis code should be exempt from cost-sharing. Minnesota also provided instructions to its managed care organizations (MCOs) to bypass cost-sharing for COVID-19 testing, services, or treatment. However, when asked about the 10,988 managed care encounters with patient liability amounts totaling $951,202, Minnesota officials stated that they had done very limited quality testing of the cost-sharing field in MCO encounter data and were unable to validate the data in that field. Therefore, Minnesota cannot determine whether

Medicaid enrollees were responsible for any cost-sharing for COVID-19 testing, services, or treatment.

Because Minnesota was unable to validate the amounts in the MCO cost-sharing field, enrollees may have been charged up to $951,202 in COVID-19-related testing, services, and treatment.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- work with the four States to determine what amount, if any, of the funding they received because of the increased COVID-19 FMAP should be refunded to the Federal Government; and

- work with Minnesota to determine whether Medicaid enrollees were responsible for any cost-sharing for COVID-19 testing, services, or treatments and, if any cost-sharing is identified, work with Minnesota to ensure that enrollees are reimbursed for any out-of-pocket expenses incurred.

CMS COMMENTS

In written comments on our draft report, CMS concurred with both of our recommendations and described actions that it planned to take to address our recommendations. Specifically, CMS stated that it will work with the States to determine what amount, if any, of the funding the States received because of the increased COVID-19 FMAP should be refunded to the Federal Government. CMS also stated that it will work with Minnesota to determine whether the State improperly imposed any cost-sharing for COVID-19 testing, services, or treatments and, if so, determine the appropriate remedy. CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed whether four selected States met the requirements to receive the increased COVID-19 FMAP funding provided by the FFCRA. Those four States received a total of $12.8 billion in additional funding from the temporary 6.2-percentage-point increase in FMAP for January 1, 2020, through June 30, 2021.[13]

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. We consulted CMS officials to gain an understanding of the oversight activities CMS performs to ensure that States met the requirements of the FFCRA. However, because our review was limited to these aspects of internal control, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit. Any internal control deficiencies we found are discussed in this report.

We conducted our audit from October 2021 through March 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- met with CMS officials to discuss the steps they took to ensure that States met the requirements of the FFCRA;
- judgmentally selected four States based on the amount of funding received, including three high-funded States (New York, Texas, and Florida) and one medium-funded State (Minnesota);
- reviewed State plan amendments (SPAs) submitted by the selected States and approved by CMS; [14]
- obtained and compared Medicaid enrollees on March 18, 2020, and June 30, 2021, for the selected States;
- identified enrollees whose coverage was terminated, requested reasons for terminations, and determined whether those reasons were allowable;

[13] New York received $5.5 billion, Texas received $4.1 billion, Florida received $2.3 billion, and Minnesota received $929 million.

[14] SPAs approved by CMS are posted on the Medicaid.gov website at https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html. Accessed on Dec. 1, 2022.

- obtained and reviewed policies and procedures related to enrollee eligibility and premiums during the PHE from the four States we reviewed and compared them to the policies and procedures in place prior to the PHE;

- obtained a list of medical codes from each selected State that had cost-sharing for testing, services, and treatments related to COVID-19;

- obtained claims and encounter data for the quarter ended June 30, 2021, for COVID-19-related medical codes to determine whether enrollees were charged cost-sharing for testing, services, and treatments related to COVID-19;

- obtained Medicaid premiums charged as of January 1, 2020, and determined whether any changes were made to premiums after January 1, 2020;

- sent questionnaires and held discussions with officials from the four selected States to gain an understanding of the changes the States made to meet the requirements of the FFCRA; and

- met with CMS officials to discuss the results of this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: July 19, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Four States Reviewed Received Increased Medicaid COVID-19 Funding Even Though They Terminated Some Enrollees' Coverage for Unallowable or Potentially Unallowable Reasons (A-06-21-09002)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of the Medicaid program. Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program and work closely together to carry out these responsibilities.

In order to support both states and the federal government in responding to the coronavirus disease 2019 (COVID-19) Public Health Emergency (PHE), Congress passed the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) on March 18, 2020. As described in the OIG's report, section 6008 of the FFCRA authorized states to claim a temporary 6.2 percentage point increase in their Federal Medical Assistance Percentage (FMAP), so long as states satisfied certain conditions. CMS provided guidance to states on these conditions, including the continuous enrollment condition, through Frequently Asked Questions (FAQs),[1] all state calls,[2] and individualized technical assistance. Additionally, in November 2020 CMS issued an interim final rule with request for comment (CMS-9912-IFC) that established new regulations at 42 CFR § 433.400 implementing the continuous enrollment condition.[3]

As noted in the OIG's report, there were certain circumstances in which states could terminate an individual's Medicaid enrollment and still qualify for the increased FMAP. Further, under CMS's guidance about section 6008 of the FFCRA, in order to remain eligible for the increased FMAP, states

[1] CMS, COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies. Accessed at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
[2] CMS, Medicaid and CHIP All State Calls. Accessed at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/cmcs-medicaid-and-chip-all-state-calls/index.html,
[3] *Federal Register*: "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency"; Interim Final Rule with Request for Comments (85 FR 71142) (November 6, 2020).

needed to make a good faith effort to identify and reinstate the Medicaid eligibility of individuals whose enrollment was incorrectly terminated on or after the date the FFCRA was enacted. The Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023), enacted on December 29, 2022, later ended the continuous enrollment condition as a condition for claiming the increased FMAP on March 31, 2023. As a result, as of April 1, 2023, states claiming the increased FMAP are no longer required to maintain the enrollment of individuals for whom the state completes a renewal and who no longer meet Medicaid eligibility requirements. The increased FMAP will continue to be available to states through December 31, 2023, and the amount of the FMAP increase will phase down each quarter, starting with the quarter beginning April 1, 2023.

In addition to the continuous enrollment condition, states claiming the temporary FFCRA FMAP increase must comply with the condition in section 6008(b)(4), and cover any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies, during any quarter in which the increased FMAP is claimed. States cannot impose deductibles, copayments, coinsurance, or other cost sharing charges for any of these services. The condition at section 6008(b)(4) of the FFCRA was not changed by the CAA, 2023 and remains in effect until December 31, 2023. Additionally, from March 11, 2021 through September 30, 2024, under section 9811 of the American Rescue Plan Act of 2021 (ARP) (P. L. 117-2) (enacted March 11, 2021), all states must cover COVID-19 vaccinations for nearly all Medicaid beneficiaries and must cover the following services for many Medicaid beneficiaries: COVID-19 testing; treatments for COVID-19, including specialized equipment and therapies (including preventive therapies); and, when certain conditions are met, treatment of conditions that may seriously complicate the treatment of COVID-19. States are not permitted to charge cost-sharing for the coverage required under section 9811 of the ARP. The ARP coverage requirements apply to all states, regardless of whether they are claiming the FFCRA FMAP increase.

OIG's recommendations and CMS's responses are below.

OIG Recommendation

Work with the four States to determine what amount, if any, of the funding the States received because of the increased COVID-19 FMAP should be refunded to the Federal Government.

CMS Response

CMS concurs with this recommendation. CMS will work with New York, Texas, Florida, and Minnesota to determine what amount, if any, of the funding the states received because of the FFCRA FMAP increase should be refunded to the federal government.

OIG Recommendation

Work with Minnesota to determine whether Medicaid beneficiaries were responsible for any cost-sharing for COVID-19 testing, services, or treatments, and if any cost-sharing is identified, work with Minnesota to reimburse the beneficiaries for any out-of-pocket expenses incurred during the PHE.

CMS Response

CMS concurs with this recommendation. CMS will work with Minnesota to determine whether the state improperly imposed any cost-sharing for COVID-19 testing services or treatments, including vaccines, specialized equipment, and therapies. If so, after consultation with the state, CMS will determine the appropriate remedy.