COVID-19 State of Emergency
Medicaid and WVCHIP Frequently Asked Questions (FAQs)

I. EXTENSION OF MEDICAID AND WVCHIP RENEWALS

Q: Do I need to process any Medicaid or WVCHIP renewals at this time?

A: No. From this point forward, Caseworkers are not to process Medicaid or WVCHIP renewals that have been submitted to the Department. This will ensure our clients remain covered and free up time for Caseworkers to process new applications. All Medicaid and WVCHIP renewal dates have been extended for three months:

- March extended to June 2020
- April extended to July 2020
- May extended to August 2020

Q: If a client has already provided a Medicaid Review (MREV) form that has not been processed, what should be done with this form?

A: At this time any late MREV forms for the month of March 2020 are not required. The system has extended these cases for three months. A new MREV will be issued for the modified review date. If the MREV is from before March and has not been processed, the MREV should be worked in order to restore coverage if eligibility is determined.

Q: What will happen when I have double the amount of renewals to process in June, July and August?

A: BMS and WVCHIP continue to evaluate the emergency and may need to extend renewals further. Every effort will be made to spread out the renewals over a reasonable period of time for catch up processing.

Q: I have a MWIN case with a disability reevaluation due, are those renewals extended also?

A: Yes. Disability reevaluations completed by the Medical Review Team (MRT) are included in the above three-month extension. Health care providers need to preserve time and resources to respond to those most in need during the emergency.

II. CHANGE OF CIRCUMSTANCES

Q: Do we need to act on reported or identified changes in circumstances during the COVID-19 emergency period?

A: No. You must not terminate coverage for any client currently enrolled in Medicaid or WVCHIP until the date of their next renewal, or the end of the month in which the emergency period ends. This requirement to maintain continued coverage applies to clients who might otherwise have coverage terminated after a change in circumstances, including individuals who age out of an eligibility group during the emergency period, have income that exceeds the income

limit, who lose receipt of benefits that may affect their eligibility (e.g., SSI, foster care assistance payments), and whose whereabouts become unknown. However, you may act on changes that do not affect eligibility, for example, a change in address.

Q: What are the circumstances we can close coverage during this emergency period?
A: Action may be taken to close Medicaid and/or WVCHIP coverage *only* if the client is deceased, no longer a resident of the state or requests voluntary termination.

Q: If I receive information during the emergency period that would make a client eligible for a different eligibility group, do I keep the client enrolled in the group in which he or she is currently enrolled?
A: Yes. WV BMS and WVCHIP made the decision to not process renewals or act on change of circumstances for the next three months, or until the end of the emergency period. This allows Eligibility Workers more time to process new applications. Changes may be made to a case that do not affect eligibility. Action may be taken to close coverage *only* if the client is deceased, no longer a resident of the state or requests voluntary termination.

Q: Do I close Medicaid coverage for a client if they do not cooperate with obtaining Medicare when they turn age 65?
A: No. Coverage should not be terminated for any reason except if the client is deceased, no longer a resident of the state or requests voluntary termination.

Q: Should we keep Medicaid coverage open for individuals who are receiving benefits during a period of presumptive eligibility?
A: No. Individuals receiving benefits during a period of presumptive eligibility are not eligible to receive continuous coverage. Eligibility will close at the end of the presumptive eligibility period.

Q: Are we required to keep coverage open for clients that were determined ineligible before March 18, 2020, but are in the process of a Fair Hearing, regardless of the hearing decision?
A: Yes. Individuals who continue to receive services pending an appeal of a determination of ineligibility would be considered to be enrolled for benefits, if this was their status as of March 18, 2020 and therefore should not be terminated from enrollment until the end of the month when the emergency period ends.

III. VERIFICATION FLEXIBILITIES FOR NEW APPLICANTS

Q: What verification requirements do not have flexibilities under this emergency?
A: Citizenship and Identity. The State of Emergency does not extend to the requirement to verify client's citizenship and identity.

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Q: Are the available flexibilities for verification requirements only for MAGI Medicaid?
A: No. The flexibilities for verification requirements extend to **all** Medicaid and WVCHIP programs including Pregnancy, BCC, Nursing Facility and HCB Waiver applicants, MWIN and Medicare Premium Assistance categories, etc.

Q: Are the flexibilities extended to the requirement of verification of income sources?
A: Yes. All available electronic data sources should be used to verify income of the applicant at the time of application/renewal. However, due to the State of Emergency, some applicants may not have access to records or statements received from employers. At this time, the client's statement would be considered the best available information.

Q: Should clients reach out to employers to obtain verifications for loss of employment or reduced hours due to the emergency?
A: Clients should attempt to provide as much information as possible at application/renewal. However, caseworkers are encouraged to use all electronic data sources to verify income. If the information is not available, the client's statement would be considered the best available information.

Q: Are clients required to write additional statements to replace normal verification requirements?
A: No. The client's statement documented on the application/renewal form are considered signed statements.

Q: What type of information should be documented in the case record?
A: The case comments should be as detailed as possible. At minimum the case record should provide for the usage of all available data sources prior to using the client's statement for verification due to the emergency.

IV. MWIN PREMIUMS AND ENROLLMENT FEES

Q: Will clients be required to pay the monthly premium during the COVID-19 emergency?
A: No. MWIN premiums for the months of March, April, and May will be waived, this will be for all payments including enrollment fees and late payment notices.

Q: If the client missed payment for March, will the case remain open?
A: Yes, the missed payment will not result in closure of the MWIN case.

Q. Will clients need to pay the enrollment fee if a new MWIN application is approved?
A. No, all MWIN enrollment fees are being waived at this time.

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Q: If the client is not able to work during this emergency will their Medicaid coverage close?
A: No, we understand and will not close MWIN Medicaid coverage for this reason either.

Q: Do the workers need to notify the clients about changes in monthly premiums?
A: No, HMS will be sending out notices to MWIN clients.

Q: If a client has already provided the review form for MWIN that has not been processed, what should be done with this form?
A: At this time any review forms for the month of March 2020 that have been received with the medical records, send them to the MRT Coordinator for processing. If the review form has not been received, set an alert to review the case in three months (See below). If the review form is from before March and has not been processed, the form should be worked in order to restore coverage if eligibility is determined.

Q: When do I need to start doing MWIN reviews again?
A: March occurs in June; April occurs in July; May occurs in August.

Q: What does the worker do if a new application for MRT/MWIN is received?
A: All new MRT applications are being processed as usual. However, we do not want the clients going to hospitals or doctor's office to get their medical records. If they would have records readily available, the workers could use those. The worker needs to complete the Social Summary (RT-1) with as much detail as possible.

Q: What type of information should be documented in the case record?
A: The case comments should be as detailed as possible, including documenting that the review was extended, and payments were waived. At minimum the case record should provide for the usage of all available data sources prior to using the client's statement for verification due to the emergency.

V. ERRORS

Q: What if my case is pulled for an audit, will I receive an error on the case?
A: No, you should not. The Families First Coronavirus Response Act (FFCRA), signed into law on March 18, 2020, requires States to maintain 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. Current federal regulations allow for flexibilities in the verification process during an emergency. Additionally, BMS is requesting CMS waiver approval to apply other less restrictive policies during this time.