Mitigating Medicaid Coverage Loss at the End of the Public Health Emergency

June 1

American Hospital Association

June, 2021

manatt

Webinar Objectives

Review Federal Medicaid continuous coverage requirements

Describe states' obligations with respect to processing outstanding eligibility and enrollment actions at the end of the public health emergency

Identify an advocacy checklist to ensure states are meeting their expectations for mitigating coverage loss

Federal Medicaid Continuous Coverage Requirements

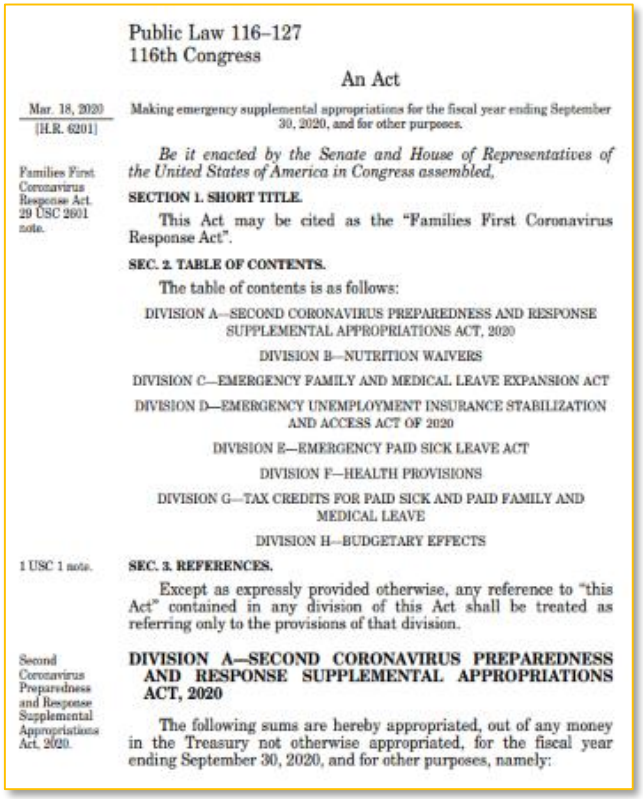
Medicaid Continuous Coverage Requirements Under Families First Coronavirus Response Act (FFCRA)

As a condition of receiving a temporary 6.2 percent FMAP increase under the FFCRA, states are required to maintain enrollment of all Medicaid beneficiaries through the end of the month in which the COVID-19 public health emergency (PHE) ends. The PHE is likely to be extend through December 31, 2021

- Continuous coverage requirements apply to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date.

- State Medicaid agencies have maintained coverage for individuals who may have become ineligible:
  - At annual renewal
  - Due to a change in circumstances mid-coverage year

When continuous coverage requirements expire, states will need to conduct a full redetermination for all enrollees who would have otherwise been subject to redetermination.



Public Law 116–127
116th Congress

An Act

Mar. 18, 2020
[H.R. 6201]

Making emergency supplemental appropriations for the fiscal year ending September 30, 2020, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Families First Coronavirus Response Act. 29 USC 2601 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Families First Coronavirus Response Act".

SEC. 2. TABLE OF CONTENTS.

The table of contents is as follows:

DIVISION A—SECOND CORONAVIRUS PREPAREDNESS AND RESPONSE SUPPLEMENTAL APPROPRIATIONS ACT, 2020

DIVISION B—NUTRITION WAIVERS

DIVISION C—EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT

DIVISION D—EMERGENCY UNEMPLOYMENT INSURANCE STABILIZATION AND ACCESS ACT OF 2020

DIVISION E—EMERGENCY PAID SICK LEAVE ACT

DIVISION F—HEALTH PROVISIONS

DIVISION G—TAX CREDITS FOR PAID SICK AND PAID FAMILY AND MEDICAL LEAVE

DIVISION H—BUDGETARY EFFECTS

1 USC 1 note.

SEC. 3. REFERENCES.

Except as expressly provided otherwise, any reference to "this Act" contained in any division of this Act shall be treated as referring only to the provisions of that division.

Second Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020.

DIVISION A—SECOND CORONAVIRUS PREPAREDNESS AND RESPONSE SUPPLEMENTAL APPROPRIATIONS ACT, 2020

The following sums are hereby appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 2020, and for other purposes, namely:

Sources: FFCRA § 6008(b)(3); State Health and Value Strategies (SHVS), Renewal of Determination That A Public Health Emergency Exists, October 2020; Centers for Medicare and Medicaid Services (CMS), Fourth COVID-19 Interim Final Rule with Comment Period (IFC 4), October 28, 2020.

Applying Continuous Coverage Requirements

Continuous coverage requirements apply to all Medicaid beneficiaries enrolled as of or after March 18, 2020. However, there are some beneficiaries who are not subject to continuous coverage requirements.

Requirements do not apply to individuals who are…

- X Determined presumptively eligible but have not received a final determination of eligibility
- X Title XXI CHIP enrollees
- X Individuals whom the state has determined are not citizens or in a satisfactory immigration status *(coverage would be limited to emergency Medicaid services)*
- X Enrolled in Refugee Medical Assistance
- X Deceased
- X Non-residents
- X Individuals "invalidly enrolled" due to agency error or enrollee fraud

Eligibility Group Transitions

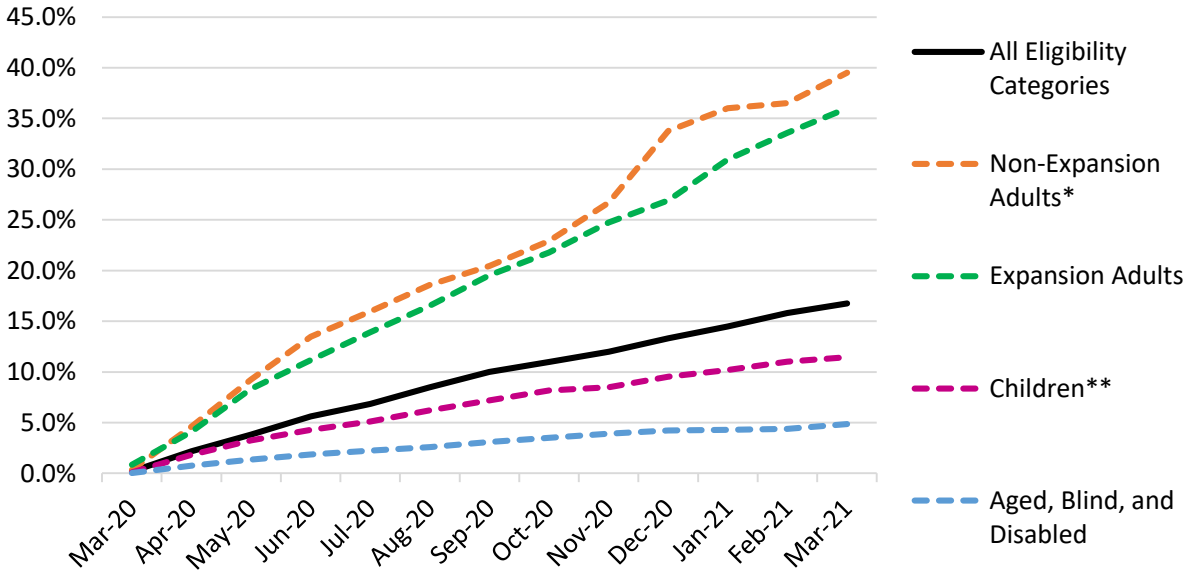
- Though states may not terminate Medicaid coverage for beneficiaries subject to continuous coverage requirements, per an Interim Final Rule, states may move enrollees to a different eligibility group in the same "tier" of coverage or to a "tier" with more robust coverage than their current group.
- *Example*: A child aging out of the children's eligibility group may be moved to the adult group but not to family planning only coverage

Source: Centers for Medicare and Medicaid Services (CMS), Fourth COVID-19 Interim Final Rule with Comment Period (IFC-4), October 28, 2020.

Backdrop for "Unwinding" Continuous Coverage Requirements

Medicaid enrollment has grown sharply due to the economic downturn as well as continuous coverage requirements. States also sought federal approval for temporary (and, in some circumstances, permanent) eligibility and enrollment flexibilities to help individuals obtain and maintain coverage.

Median Growth in State Medicaid/CHIP Enrollment, from February 2020



*E.g., parents and pregnant women
**Includes children enrolled in Medicaid and CHIP
Note: The number of states reporting data varies by month

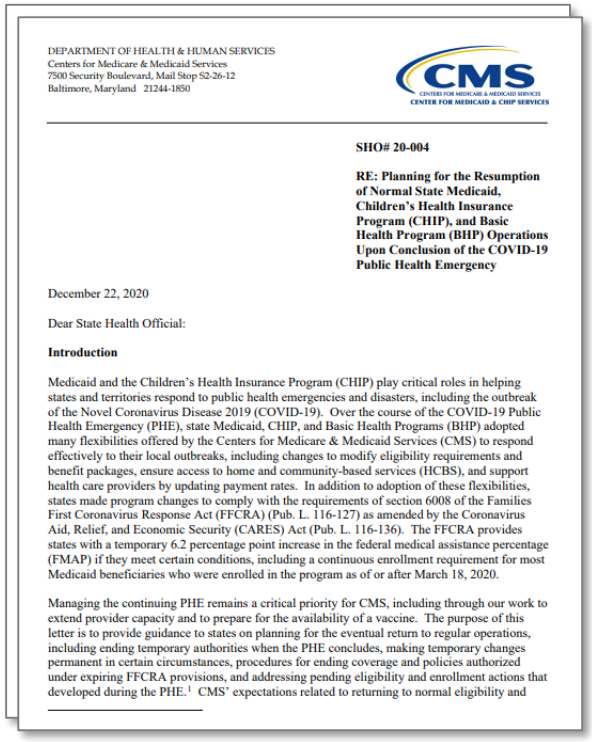
Examples of Federal Enrollment Flexibilities

- Modified verification processes (e.g., accepting self-attestation) (via Verification Plan Addendum)
- Sought CHIP flexibilities for delaying changes in circumstances and renewal processing (via CHIP Disaster Relief Spa)
- Implemented or expanded regular/hospital presumptive eligibility processes (via Medicaid Disaster Relief SPA)

Source: Manatt analysis of state Medicaid enrollment databases.

CMS Guidance on Resuming Program Operations After the PHE

On December 22, 2020, CMS released sub-regulatory guidance to support state Medicaid and Children's Health Insurance Program (CHIP) agencies in returning to normal operations after the PHE. The State Health Official (SHO) Letter sets out expectations related to:



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 20-004

RE: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency

December 22, 2020

Dear State Health Official:

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) play critical roles in helping states and territories respond to public health emergencies and disasters, including the outbreak of the Novel Coronavirus Disease 2019 (COVID-19). Over the course of the COVID-19 Public Health Emergency (PHE), state Medicaid, CHIP, and Basic Health Programs (BHP) adopted many flexibilities offered by the Centers for Medicare & Medicaid Services (CMS) to respond effectively to their local outbreaks, including changes to modify eligibility requirements and benefit packages, ensure access to home and community-based services (HCBS), and support health care providers by updating payment rates. In addition to adoption of these flexibilities, states made program changes to comply with the requirements of section 6008 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127) as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136). The FFCRA provides states with a temporary 6.2 percentage point increase in the federal medical assistance percentage (FMAP) if they meet certain conditions, including a continuous enrollment requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

Managing the continuing PHE remains a critical priority for CMS, including through our work to extend provider capacity and to prepare for the availability of a vaccine. The purpose of this letter is to provide guidance to states on planning for the eventual return to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent in certain circumstances, procedures for ending coverage and policies authorized under expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE.[1] CMS' expectations related to returning to normal eligibility and

Timeliness and consumer communications for redetermining Medicaid coverage for those who had their coverage continuously maintained

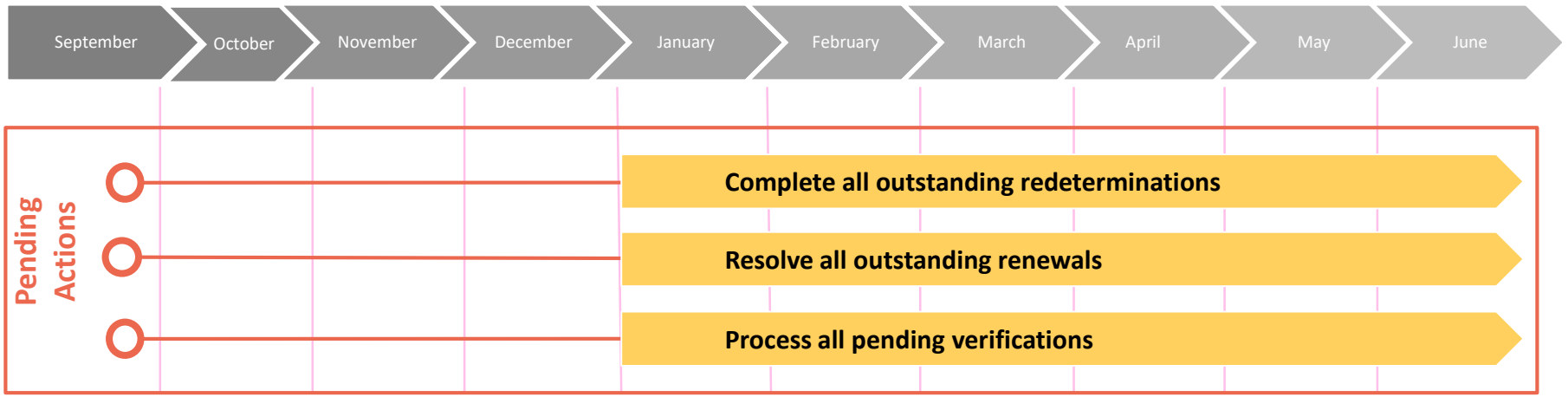
Timeline for resolving all outstanding E&E actions including applications, annual renewals, mid-year redeterminations and verifications of eligibility (up to six months following the end of the month of the PHE)

Source: The Centers for Medicare & Medicaid Services (CMS), SHO #20-004. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf.

Pending Eligibility and Enrollment Actions Timeline

The guidance lays out a timeline of "up to six months" for completing pending renewals and redeterminations for changes in circumstances once the PHE ends.

December 31, 2021*:
Continuous coverage expires (absent another renewal)



***Dates are subject to change in the event of another PHE renewal or if the new administration modifies requirements outlined in the SHO.**

Our Dynamic Policy Environment

- The duration of the public health emergency (PHE) is fluid and likely to be further extended.
- The new Biden Administration is issuing Executive Orders (EOs) related to COVID-19 and other priorities; new EOs may impact the guidance.
- The Biden Administration may also directly modify the “unwinding” guidance or issue new guidance that supersedes it.

Potential Loss for Coverage at the End of the PHE

The potential for loss of coverage as states address the backlog of pending eligibility and enrollment actions is extraordinary.

- In many states, E&E workers' ability to conduct routine actions is already limited as a result of stay-at-home orders, social distancing mandates, and transitions to telework.
- As states process pending cases, they will likely receive an influx of returned mail as the economic recession has amplified housing instability and homelessness.
- If the increase in the federal matching rate ends at the same time that states are tasked with processing delayed actions, states will have strong fiscal incentives to move quickly through redeterminations rather than take deliberate action to conduct follow-up outreach to ensure eligible individuals stay enrolled.

Federal Redetermination Requirements

Federal Redetermination Requirements Apply

State must first attempt to redetermine eligibility based on available information **without requiring information from the individual:**

- If available information is sufficient to determine eligibility, state is to continue coverage without requiring any additional action from the beneficiary (known as **ex-parte renewal**)
- If available information is insufficient to determine eligibility, state is required to send a **prepopulated renewal form** and give a reasonable amount of time to respond

If a beneficiary is no longer eligible for the category in which they have been enrolled, the Medicaid agency must consider if the beneficiary **is eligible under a different eligibility group**.

- For example, if an individual is no longer eligible based on pregnancy status, a state must evaluate if they are eligible under a different adult category.
- Coverage **must continue until a beneficiary is found ineligible under all eligibility groups or if the beneficiary does not provide information needed** to make a determination in the required timeframe.

Sources: 42 CFR § 435.916(e), 42 CFR § 435.916(f)(1), 42 CFR § 435.930(b), 42 CFR § 457.110(a), 42 CFR § 457.343

Policy and Operational Advocacy Strategy Checklist

Advocacy Checklist for Mitigating Coverage Loss

- ❑ Boost the Capacity of the Eligibility and Enrollment Workforce
- ❑ Adjust Application Pathways to Handle Crush of New Enrollment
- ❑ Evaluate Verification Processes for Streamlining Opportunities
- ❑ Conduct Outreach to Enrollees and Build in Enough Response Time
- ❑ Prepare for Returned Mail
- ❑ Remind Beneficiaries to Update Mailing Addresses
- ❑ Partner with Key Stakeholders to Reach Enrollees
- ❑ Conduct Monitoring and Oversight of Unwinding Process
- ❑ Use Program Data from Other Means-Tested Public Programs to Streamline Renewals and New Enrollments
- ❑ Adopt Other State Options for Supporting Continuity of Coverage After the PHE

Boost the Capacity of the Eligibility and Enrollment Workforce

Whether or not states have a diminished workforce—due to illness or remote work requirements—all states will need extra capacity to support the unwinding process.

Helpful Strategies

- Staffing options include temporarily increasing staffing , "borrowing" workers from other state agencies, and leveraging contractors (contractors may facilitate the application process but may not make determinations).
- States may consider establishing specialized units to support higher-intensity E&E tasks or workflows.
- Leveraging and boosting consumer assistance through navigators and application counselors and expanding the use and functionality of online assister portals will ease the burden on the state eligibility and enrollment workforce.

*States receive a 75 percent federal match for **eligibility-related activities**, including customer services relating to eligibility determination provided in call centers or by out-stationed workers.*

Sources: State Health and Value Strategies (SHVS), Considerations for State Medicaid and CHIP Agencies As they Prepare to Unwind Eligibility and Enrollment Flexibilities Obtained During the COVID-19 Public Health Emergency, August 2020; SHVS, State Strategies to Support Medicaid/CHIP Eligibility & Enrollment in Response to COVID-19, April 2020.

Adjust Application Pathways To Address New Enrollment While Managing Renewals/Redeterminations

In light of increased application volume and to address renewal/redetermination workflows at the end of the PHE, state Medicaid/CHIP agencies are developing delay mitigation strategies for each application pathway.

Potential Pathways	Description
In-Person 	• Develop messaging to direct in-person applications to telephone or online pathway for those who do not require in-person assistance; states can also direct individuals to call-center or virtual navigators for assistance
Telephone 	• Monitor call center volume • Institute mitigation strategies for long wait-times and dropped calls • Consider expanding call center capacity, including by using contractors to perform certain administrative functions or re-routing calls across regional centers
Online 	• Take steps to make the system as automated as possible to minimize need for manual processes
By Mail 	• Communicate to consumers and assisters to apply via online/telephone

For states that rely on the Federal Facilitated Marketplace (FFM), consider switching from FFM-Assessment to Determination and redirect applicants to Healthcare.gov

Evaluate Verification Processes for Streamlining Opportunities

- **Some states implemented policies during the PHE to simplify their verification processes. States can continue some of those policies to help address redetermination backlogs.**
- **These policies may increase the share of renewals conducted ex parte and the share of new applications determined in real-time, freeing up workforce capacity to address more complex cases.**

Helpful Strategies

- Accept **self-attestation** for income (with post enrollment verification), residency, age/DOB, household composition, and/or receipt of other coverage, if not already authorized.
- Increase (or adopt) a **reasonable compatibility threshold** for inconsistencies between self-attested income and the income obtained electronically.
- Accept a **reasonable explanation** of inconsistencies rather than requiring paper documentation.
- Increase the number and type of **data sources** used to verify eligibility and batch cases for **data matching** where possible.
- Review **eligibility system design** documents to identify opportunities to boost successful matches with electronic data sources.
- Suspend **periodic data checks** post eligibility determination**.** (Many states implemented these as program integrity measures in response to state and federal audits.)

Sources: State Health and Value Strategies (SHVS), Considerations for State Medicaid and CHIP Agencies As they Prepare to Unwind Eligibility and Enrollment Flexibilities Obtained During the COVID-19 Public Health Emergency, August 2020; SHVS, State Strategies to Support Medicaid/CHIP Eligibility & Enrollment in Response to COVID-19, April 2020.

Prepare for Returned Mail

State Medicaid agencies rely on mail to provide enrollees notifications, and some terminate coverage upon receipt of return mail without following up with the enrollee.

COVID-related housing displacements increase the risk for undelivered mail, which can trigger loss of coverage for those who may continue to be eligible.

Helpful Strategies

- Maximize the use of **online accounts and electronic communications**
  - States should do a push to encourage enrollees to set up online accounts
  - Going paperless should be an option, with sufficient controls for mail backup

- **Review all available data sources** to proactively identify changes of address
  - Example data sources: SNAP/TANF, housing agencies, the U.S. Postal Service's National Change of Address (NCOA) system
  - Ensure eligibility systems have a data feed for receiving updated residency information from all data sources (e.g., NCOA) and/or when a consumer reports a change to a state contractor such as a managed care plan

Source: State Health and Value Strategies (SHVS), Maintaining Medicaid and CHIP Coverage Amid Postal Delays and Housing Displacements, September 24, 2020.

Remind Beneficiaries to Update Mailing Addresses

To mitigate coverage loss for potentially eligible Medicaid/CHIP beneficiaries who have moved or have temporary housing, states may elect to adopt a variety of strategies for obtaining updated addresses.

Remind Beneficiaries Early and Frequently to Provide Updated Residency Information. States should reiterate the importance of providing updated residency information:

- In consumer notices that are clear, culturally competent, ADA-compliant, and available in numerous languages;
- Through text messages;
- On state agency websites;
- In the beneficiary's electronic account;
- During telephone outreach (e.g., incorporate into call center scripts); and
- During all interactions between an eligibility worker/providers/managed care plans and an applicant/beneficiary (e.g., incorporate into workforce training).

Conduct Outreach via Other Modalities. States should consider pursuing additional methods of outreach to beneficiaries other than mail including email, text, or phone to follow up on returned mail, non-response to renewal forms, or outstanding requests for information.

Partner with Key Stakeholders to Reach Enrollees

Leverage Managed Care Plans. Plans can conduct outreach to update members' mailing addresses, telephone numbers, and email addresses, and remind enrollees to complete the renewal process in a timely manner.

States could:

- Review existing managed care contract requirements regarding timelines and transfer processes for sharing information on residency changes (e.g., 834 transfers within one business day of learning of a change in residency).
- Take timely action and update case file based on information provided by plans.

Managed care plans could:

- Update all their consumer communications (e.g., consumer notices, welcome packet, website information) informing beneficiaries of the importance of updating their eligibility information, including residency.
- Conduct outreach via telephone and/or text messaging to solicit updated eligibility information, including residency.

Partner with Other Stakeholders (Providers, Enrollment Brokers, Community-Based Organizations, and Navigators) to:

- Provide direct assistance with obtaining updated contact information and to ensure individuals respond to requests for information/renewal forms.
- Stakeholders could ask states to invest COVID relief funds in additional consumer navigation support

Conduct Outreach to Enrollees and Build in Enough Response Time

Advance Notice. States should issue notices in advance of anticipated changes (e.g., end of PHE or prior to renewal) to alert beneficiaries that they should respond to requests for information.

Make multiple attempts to reach enrollees prior to terminating, including through email, text, phone, or electronic account, if available:

- For example, if no response is received to a mail notice, send a notice to an electronic account and/or place a telephone call.
- Text messaging should serve as a supplementary mode of communication and should not replace traditional modes of communication, including mail. Texts should include links or phone numbers that beneficiaries can use to take the required action.

Give enrollees sufficient time to respond to redetermination notices and requests for additional information. For example:

- Extend the timeframe for returning renewal forms from 30 days to at least 60 days;
- Extend the timeframes for responding to state requests for documentation or additional information (for example from 10 days to 30 days).

Source: State Health and Value Strategies (SHVS), Maintaining Medicaid and CHIP Coverage Amid Postal Delays and Housing Displacements, September 24, 2020.

Conduct Monitoring and Oversight of Unwinding Process

States should create or build on existing monitoring and oversight infrastructure to flag and quickly respond to disenrollment issues.

Helpful Strategies

- Enrollment-related data should be publicly available and updated on a current basis.
- "Eligibility and enrollment dashboards" should be implemented and should track application and redetermination timeframes by modality. Dashboards can include:
  - Dates and time lapsed between key steps in the process to identify pain points that require operational or policy interventions.
  - "Early warning/trigger" mechanisms that flags when a large number of beneficiaries are slated to lose coverage due to no response or missing paperwork.
  - States could "pause" termination based on a real-time review of data.
- Feedback loops help states keep stakeholders updated while gathering intel about redetermination challenges "on the ground." Include feedback from:
  - Providers
  - Consumer advocates, including family-led organizations
  - Consumer application assisters and navigators
  - Consumers

Sources: State Health and Value Strategies (SHVS), Considerations for State Medicaid and CHIP Agencies As they Prepare to Unwind Eligibility and Enrollment Flexibilities Obtained During the COVID-19 Public Health Emergency, August 2020; SHVS, State Strategies to Support Medicaid/CHIP Eligibility & Enrollment in Response to COVID-19, April 2020.

Use Program Data from Other Means-Tested Public Programs to Streamline Renewals and New Enrollments

States can use express lane eligibility and SNAP SPA authority to streamline enrollment for several programs for which individuals may be eligible, including Medicaid and other public benefit programs.

Children: Express Lane Eligibility

- States can enroll and renew children's coverage using findings from other public programs, like SNAP, WIC or Head Start, to determine eligibility for Medicaid/CHIP.

Adults: SNAP SPA

- States can use SPA authority to enroll certain non-elderly, non-disabled SNAP-enrolled adults into Medicaid.
- Certain MAGI-based eligibility criteria must still be verified to ensure that states are retaining or enrolling highly-likely eligible individuals.

These strategies can alleviate the burden on enrollees and enrollment staff and systems, though they may require IT systems changes and new operational processes.

Sources: Centers for Medicare and Medicaid Services (CMS), Express Lane Eligibility Option, February 2010. Robert Wood Johnson Foundation (RWJF) State Health Reform Assistance Network, Using Supplemental Nutrition Assistance Program (SNAP) Information to Facilitate Medicaid Enrollment and Renewal, September 2016.

Adopt Other State Options for Supporting Continuity of Coverage After the PHE

Promoting continuity of enrollment creates administrative efficiencies and enhances state ability to measure and improve the quality of care.

Helpful Strategies

Provide 12 months of continuous coverage for children (via Medicaid SPA) and adults (via 1115 waiver).

Extend coverage for 12 months when the state receives new information that verifies ongoing Medicaid/CHIP eligibility (e.g., when an individual renews SNAP coverage).

Adopt flexibilities for how income is counted to factor in predictable changes in income by using projected annual income at renewal to the extend coverage for current enrollees until the end of the calendar year.

Wrap Up Review of Advocacy Checklist

State-Specific Strategies

- ❑ Boost the Capacity of the Eligibility and Enrollment Workforce
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Stakeholder-Specific Strategies

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