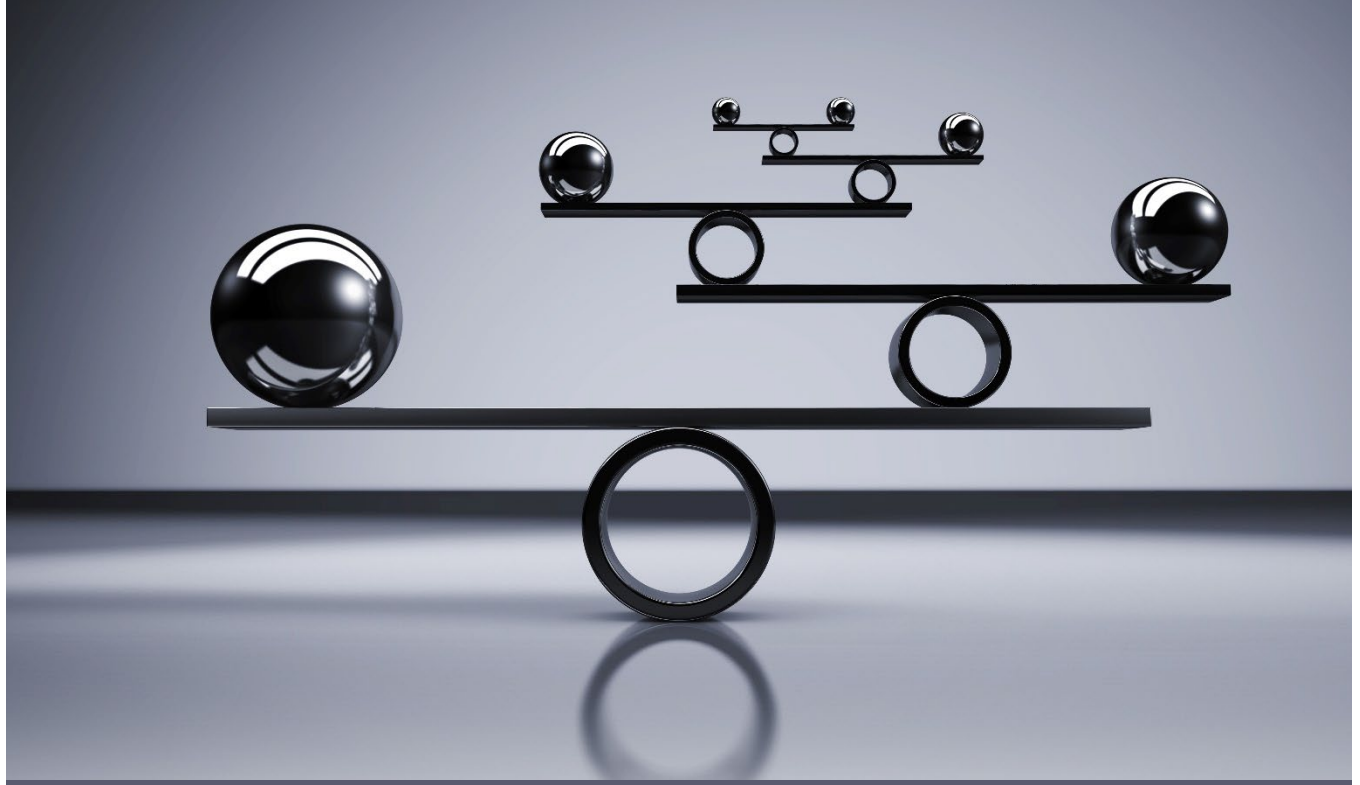
Medicaid: Unwinding from the Public Health Emergency

October 13, 2022

Achieving Affordable, Quality Health Care Systems: Health Legislative Staff Seminar

NCSL
NATIONAL CONFERENCE OF STATE LEGISLATURES



Session Overview

National Overview

Medicaid and the public health emergency (PHE)

Sally Mabon, State Health and Value Strategies

State Perspectives

Maryland

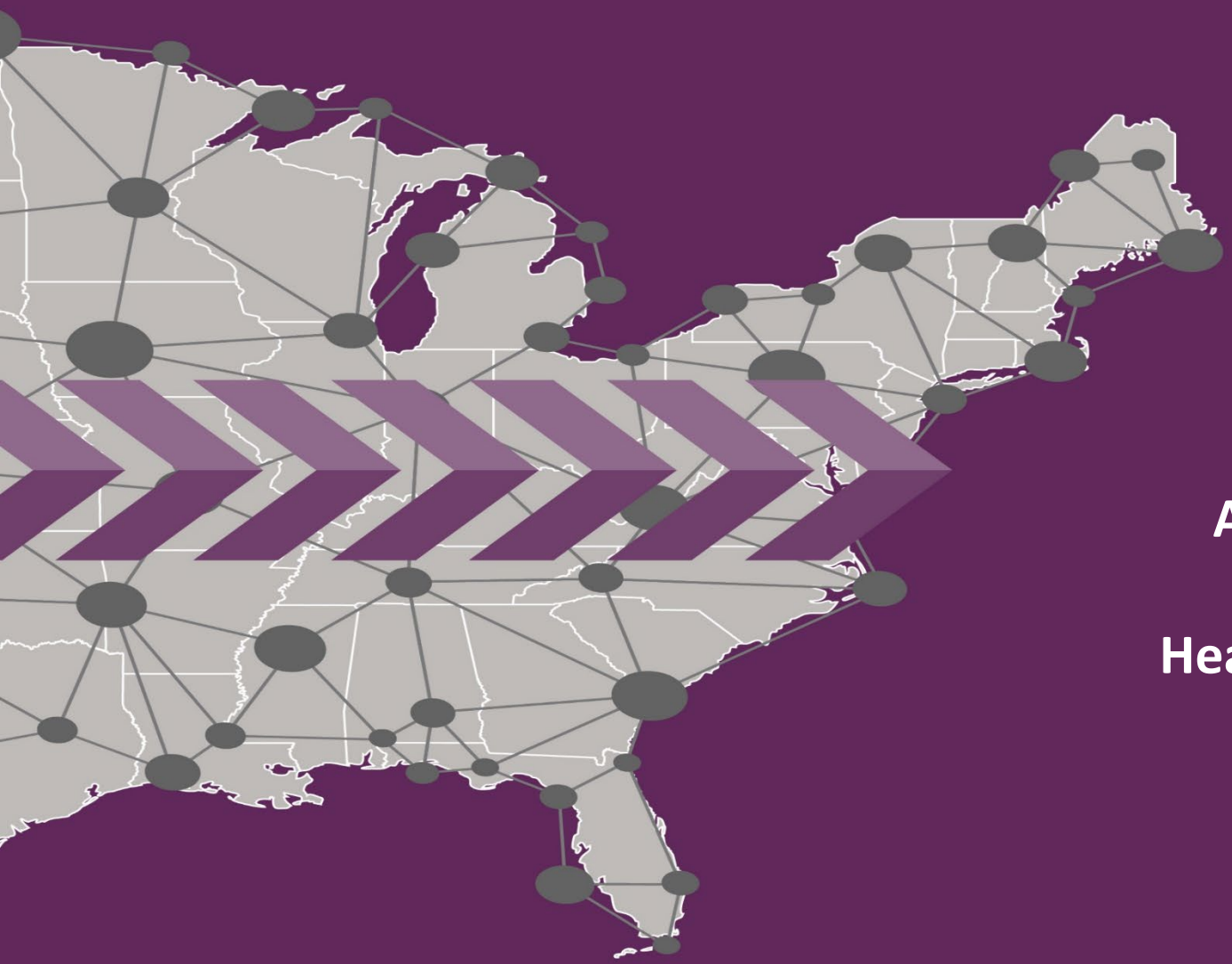
Tamara Gunter, Maryland Health Benefit Exchange

Arkansas

Dawn Stehle, Arkansas Department of Human Services

Panel Discussion

Q&A



Medicaid: Unwinding From the Public Health Emergency

Achieving Affordable, Quality Health Care Systems: Health Legislative Staff Seminar

Thursday, October 13, 2022
10:45 a.m – 12:00 p.m. EST

STATE Health & Value STRATEGIES

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Support for this presentation was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

Agenda

- ***Context: the Medicaid program***

- ***The federal public health emergency (PHE)***
- ***The Medicaid continuous coverage requirement***
- ***Consequences of unwinding the PHE***
- ***How states are preparing for unwinding***

- ***Questions and Discussion***

Context: The Medicaid Program

Overview of the Medicaid Program

Medicaid is a federal/state program that provides health coverage for lower-income Americans and individuals with disabilities.

Key Facts

- Covers **one in five** Americans
- Single **largest insurer** in every state
- Critical engine in state economies and **significant item in state budgets**

Spending on Medicaid

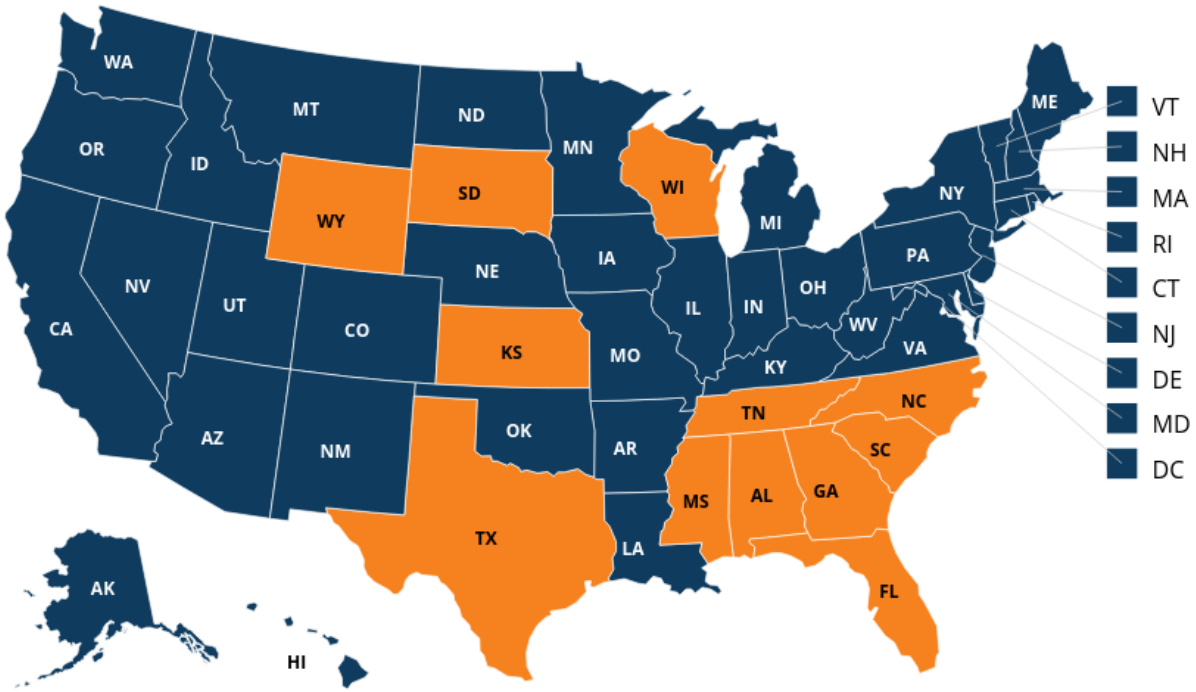
- Represents **$1 out of every $6** spent on health care in the U.S.
- Third largest mandatory spending program in federal budget
- One of the largest budget items in state budgets—in fiscal year 2021, 27.2% of state budgets were spent on Medicaid

Joint Federal-State Program

- Federal rules with state flexibility to exceed: states must provide **core benefits** to core populations without imposing wait lists or limits on enrollment.
- Guaranteed federal matching payments with no pre-set limit: states with lower per capita incomes have a higher federal matching rate for Medicaid.
- **Spending per Medicaid enrollee varies significantly** across eligibility groups and states because of **state program flexibility**

Coverage and Access: Medicaid Expansion

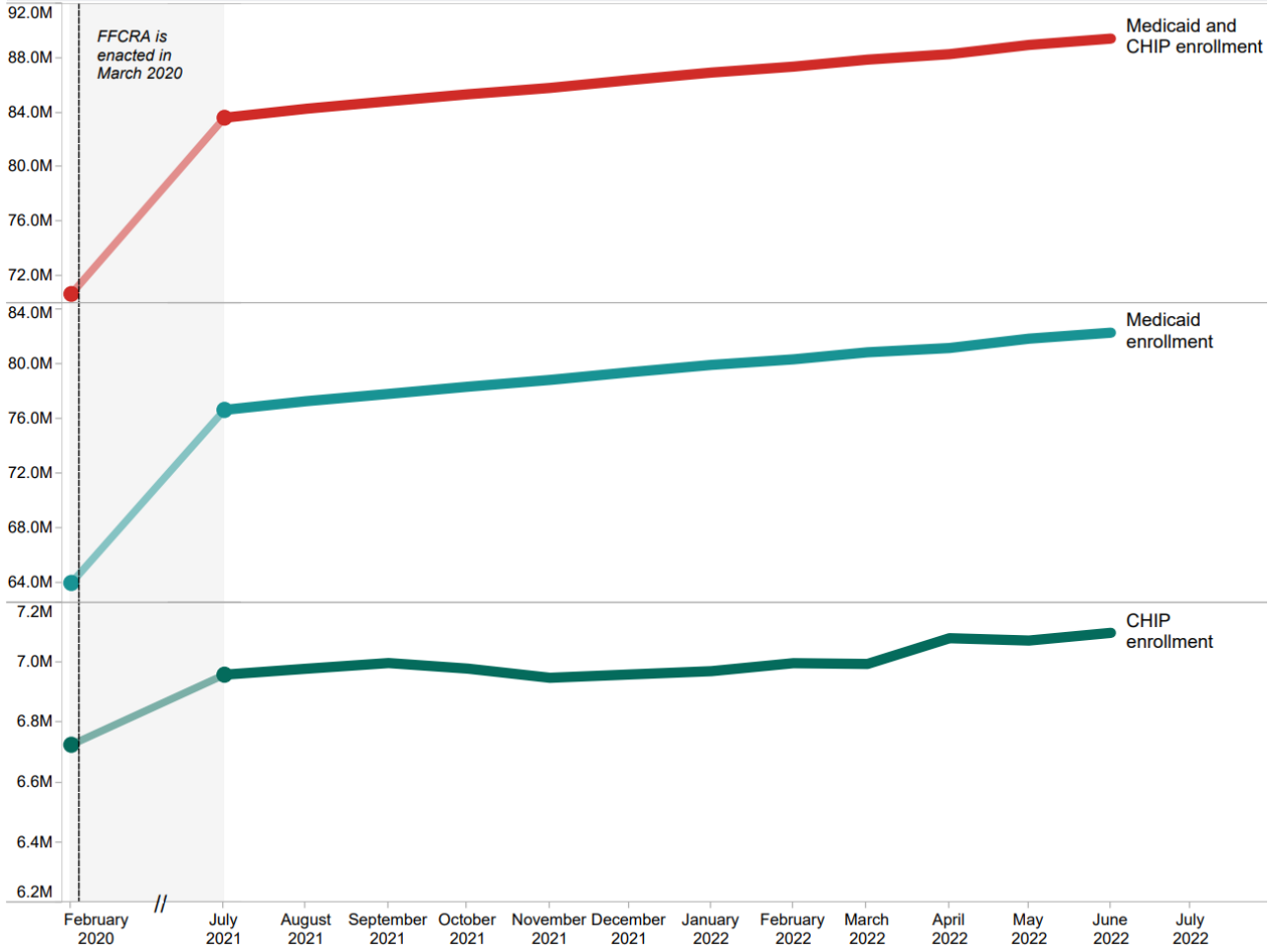
Status of State Action on the Medicaid Expansion Decision



SOURCE: Kaiser Family Foundation, kff.org

Medicaid Enrollment

Figure 1. National Medicaid and CHIP enrollment, February 2020 to June 2022, CMS Performance Indicator Data



Source: Medicaid and CHIP Eligibility and Enrollment Performance Indicator Data as of August 22, 2022.

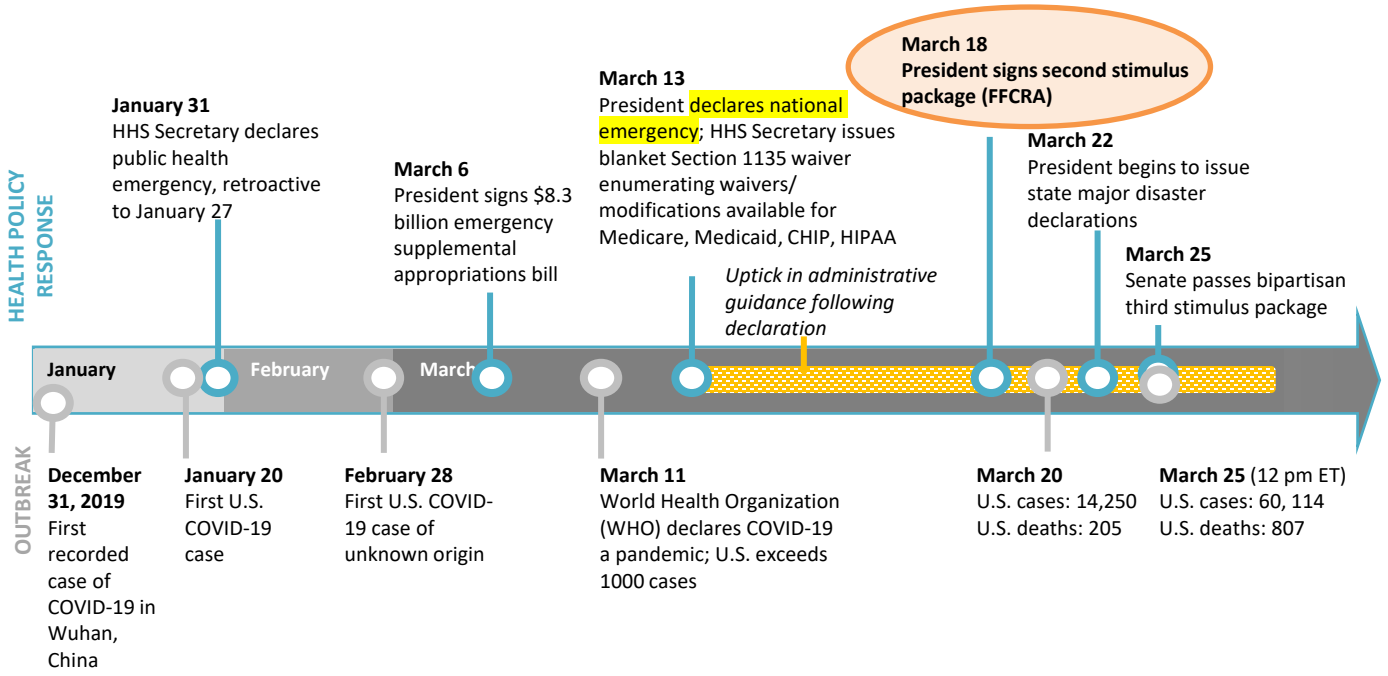
As of **Feburary 2020, 70,691,258** individuals were enrolled in Medicaid and CHIP.

In **June 2022**, **89,444,160** individuals were enrolled in Medicaid and CHIP.

Since Feburary 2020, Medicaid/CHIP enrollment **has increased by 18,752,902 individuals or 26.5%.**

The Federal Public Health Emergency

Early Federal Health Policy Actions in Response to COVID-19



Source: Johns Hopkins University, Tracking Coronavirus COVID-19

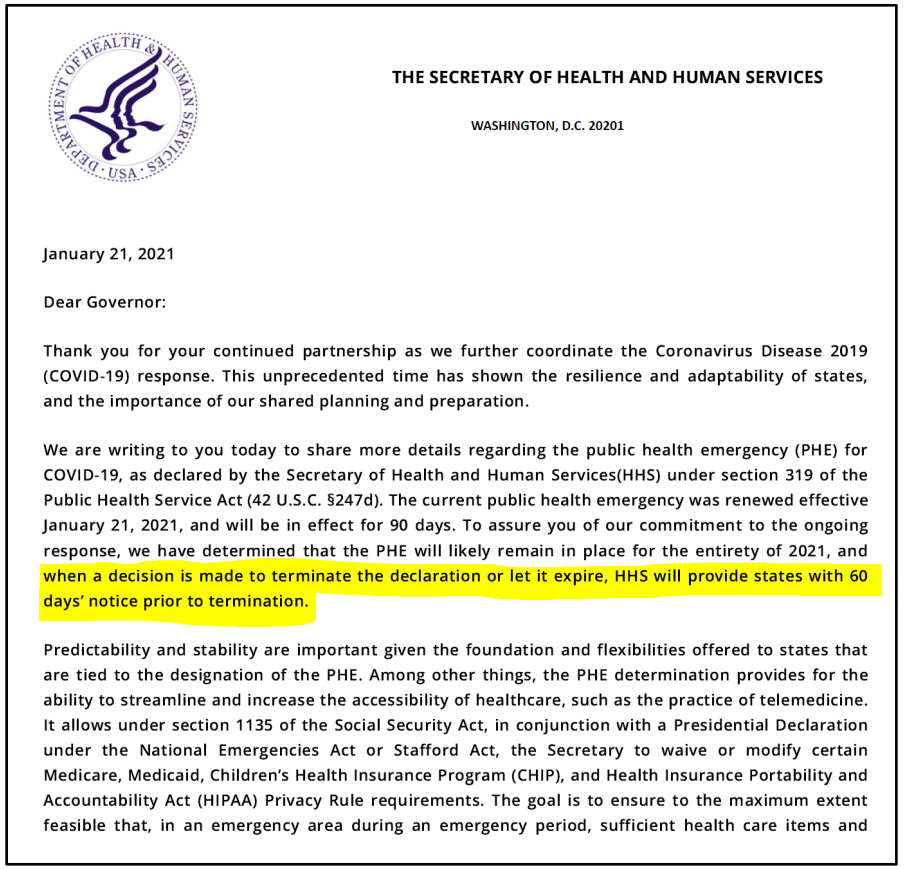
The COVID-19 Federal Public Health Emergency

The public health emergency declaration for COVID-19 was issued January 31, 2020 by then-HHS Secretary Alex Azar.

Key Facts:

- Expires after 90 days unless renewed by HHS
- Has been renewed ten times
- **The current end date is January 10, 2023**
- May be terminated at any time by HHS
- HHS committed to providing states with 60 days notice prior to termination

The deadline for HHS to notify states that the federal public health emergency (PHE) will be ending January 10, 2023 **is November 11**.



THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

January 21, 2021

Dear Governor:

Thank you for your continued partnership as we further coordinate the Coronavirus Disease 2019 (COVID-19) response. This unprecedented time has shown the resilience and adaptability of states, and the importance of our shared planning and preparation.

We are writing to you today to share more details regarding the public health emergency (PHE) for COVID-19, as declared by the Secretary of Health and Human Services(HHS) under section 319 of the Public Health Service Act (42 U.S.C. §247d). The current public health emergency was renewed effective January 21, 2021, and will be in effect for 90 days. To assure you of our commitment to the ongoing response, we have determined that the PHE will likely remain in place for the entirety of 2021, and when a decision is made to terminate the declaration or let it expire, HHS will provide states with 60 days' notice prior to termination.

Predictability and stability are important given the foundation and flexibilities offered to states that are tied to the designation of the PHE. Among other things, the PHE determination provides for the ability to streamline and increase the accessibility of healthcare, such as the practice of telemedicine. It allows under section 1135 of the Social Security Act, in conjunction with a Presidential Declaration under the National Emergencies Act or Stafford Act, the Secretary to waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP), and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requirements. The goal is to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and

Source: Letter to Governors on the COVID-19 Response

Families First Coronavirus Response Act (FFCRA)

On March 18, 2020, the Families First Coronavirus Response Act, H.R. 6201 / P.L. 116-127, was signed into law.

FFCRA Temporarily Increases Medicaid FMAP

- Temporary 6.2% point increase in the FMAP (match rate) for states and territories
- Applies to the regular Medicaid match rate so long as states meet specific conditions
- Examples: California's new rate = 56.2%; Michigan = 70.91%, and Mississippi = 84.06%

Other Medicaid and CHIP Provisions

- Covered COVID-19 testing under Medicaid and CHIP without cost sharing
- Extended Medicaid coverage to the uninsured for COVID-19 testing and testing-related services
- Paid COVID-19 testing claims for uninsured individuals through a Department of Health and Human Services (HHS) program

The Federal Medical Assistance Percentage (FMAP) determines the federal share of the cost of Medicaid services in each state – i.e. how much federal matching funds a state gets. FMAP is based on a formula that accounts for state per capita income relative to the national average, and is adjusted annually. The lower a state's per capita income, the higher the state's FMAP. It reflects states' differing abilities to fund Medicaid from their own revenues. By law, the FMAP cannot be less than 50%

The Medicaid Continuous Coverage Requirement

Medicaid Continuous Coverage Requirement

The enhanced FMAP is designed to support states and promote stability of coverage during the COVID-19 pandemic. It is tied to the condition that states maintain enrollment of nearly all Medicaid enrollees through the end of the month in which the PHE ends.[1]

The continuous coverage requirement applies 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 since their last eligibility determination.

To comply with the enhanced FMAP requirements, states have been required to make numerous changes to their eligibility and enrollment (E&E) systems, operations, and policies.

When the continuous coverage requirement expires, states will be required to redetermine eligibility for nearly all Medicaid enrollees.

Increased FMAP is available from January 1, 2020 through the last day of the calendar quarter of the end of the public health emergency declared by the HHS Secretary

1. Federal legislation, if passed, could change the timeline for when the federal continuous coverage requirement ends and parameters for continued receipt of the enhanced Federal Medical Assistance Percentage (FMAP). **Source:** FFCRA § 6008(b)(3).

The "Normal" Medicaid Redetermination Process

Under the ACA, states have streamlined eligibility processes with the goal of automating as much as possible to reduce enrollee burden and prevent churn. The end of PHE will be the largest coverage transition since ACA implementation.

Medicaid agencies redetermine enrollees *annually*

- States must use available data (e.g. state wage or IRS data, SNAP data) to determine ongoing eligibility **before** requesting an enrollee complete renewal form or provide documentation.
- The individual is provided a pre-populated form and a reasonable period of time—at least 30 days—to submit the necessary information online, in person, by telephone or by mail.
- States must also provide a reconsideration period for individuals who lose coverage due to the renewal form or information not being submitted.

Churn Is Common

- Medicaid and CHIP enrollees disenroll and subsequently re-enroll in the program within a short period of time
  - Roughly 2% of enrollees come on or leave the program in an average month (Kaiser)
  - 8% of full-benefit Medicaid and CHIP enrollees disenrolled and re-enrolled within a year (MACPAC)
- People typically enroll or disenroll from coverage for three main reasons:
  - Change in income
  - Change in circumstance other than income (e.g.: children may age out of coverage, people may move to another state or die)
  - Aspects of renewing coverage that are not based on ongoing eligibility but may result in disenrollment
    - For example, forms to renew coverage may be confusing or someone may miss a deadline resulting in disenrollment

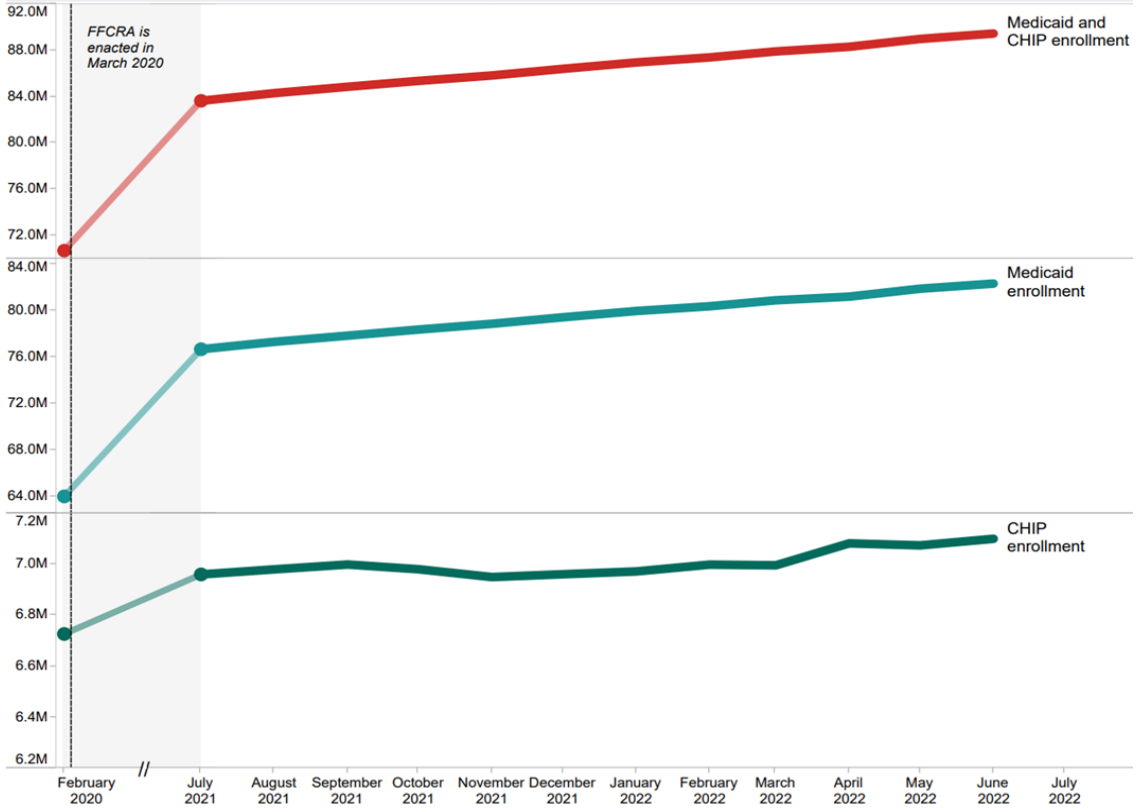
Consequences of Unwinding the PHE

Loss of Coverage

The continuous coverage provision has effectively eliminated churn in the Medicaid program and enabled people to retain coverage throughout the pandemic. Protecting health coverage during the pandemic has led to increased enrollment.

- Since Feburary 2020, Medicaid/CHIP enrollment has increased by 18,752,902 individuals or 26.5%.
- Given the dramatic increase in Medicaid enrollment during the pandemic, the **potential loss of coverage for millions of Americans is significant**.
  - A projected **13 to 16 million people will be disenrolled from Medicaid**.
  - An estimated **1/3 of those losing coverage could be eligible for subsidized Marketplace coverage**. (Urban Institute)

Figure 1. National Medicaid and CHIP enrollment, February 2020 to June 2022, CMS Performance Indicator Data



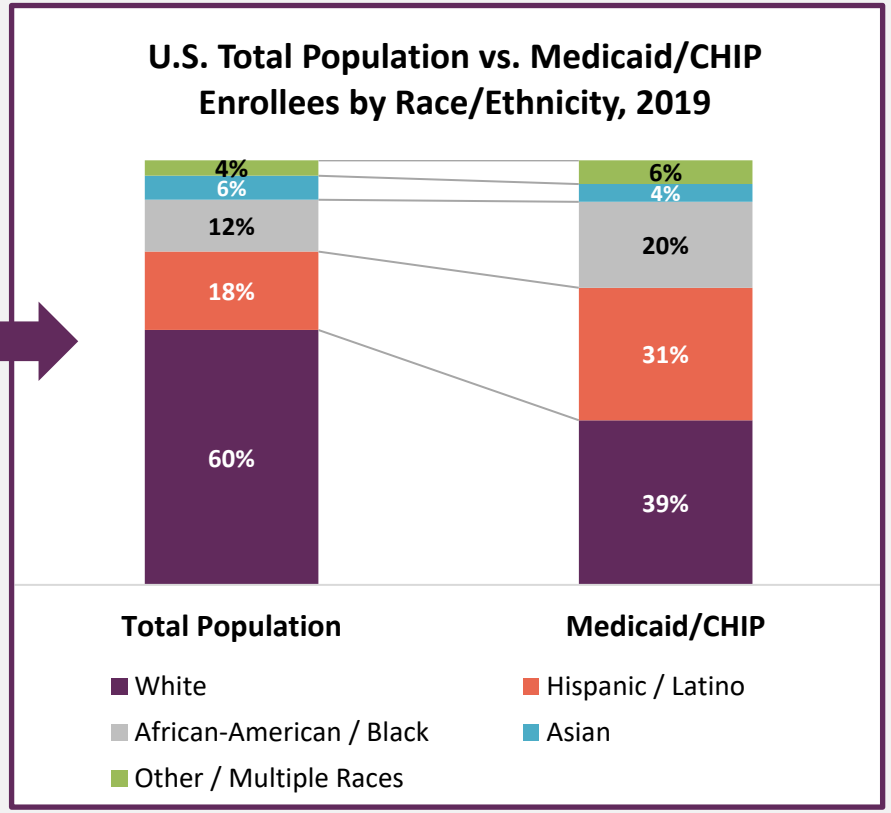
Source: Medicaid and CHIP Eligibility and Enrollment Performance Indicator Data as of August 22, 2022.

Source: CMS April 2022 Medicaid and CHIP Enrollment Trends Snapshot; Robert Wood Johnson Foundation, Biggest Coverage Event Since the Affordable Care Act; and Urban Institute, What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?

Implications for Equity

Coverage losses will disproportionately impact people of color, exacerbating already widespread racial and ethnic disparities in the healthcare system.

- The **volume of eligibility redeterminations is unprecedented** and will increase the risk that people eligible for Medicaid or Marketplace coverage lose coverage due to procedural and administrative reasons.
- Transitions between Medicaid and the Marketplace are likely to **disproportionately impact people of color**–as Black and Latino(a) individuals are significantly overrepresented in Medicaid and CHIP programs.
- People of color are more likely to experience volatility and instability in employment and housing as a result of long-standing, structural racism, increasing the likelihood that these individuals could lose coverage for administrative reasons at the end of the PHE.
- If transitions from Medicaid to the Marketplace are not well executed, **millions of people eligible for Medicaid/CHIP or subsidized Marketplace coverage could become uninsured.**



Source: Robert Wood Johnson Foundation, Biggest Coverage Event Since the Affordable Care Act; CMS, August and September 2021 Medicaid and CHIP Enrollment Trends Snapshot; and SHADAC, State Health Compare.

Loss of Access to Care

Quotes from qualitative research demonstrate how consumers value the importance of health insurance and the role it has played in their lives during the pandemic.

"When I got Medicaid, it really helped me because I was diagnosed with diabetes at that time, and I would not have been able to afford the insulin and the medications that I needed. Also, I quit worrying about being able to go to the doctor and go when I needed to go."

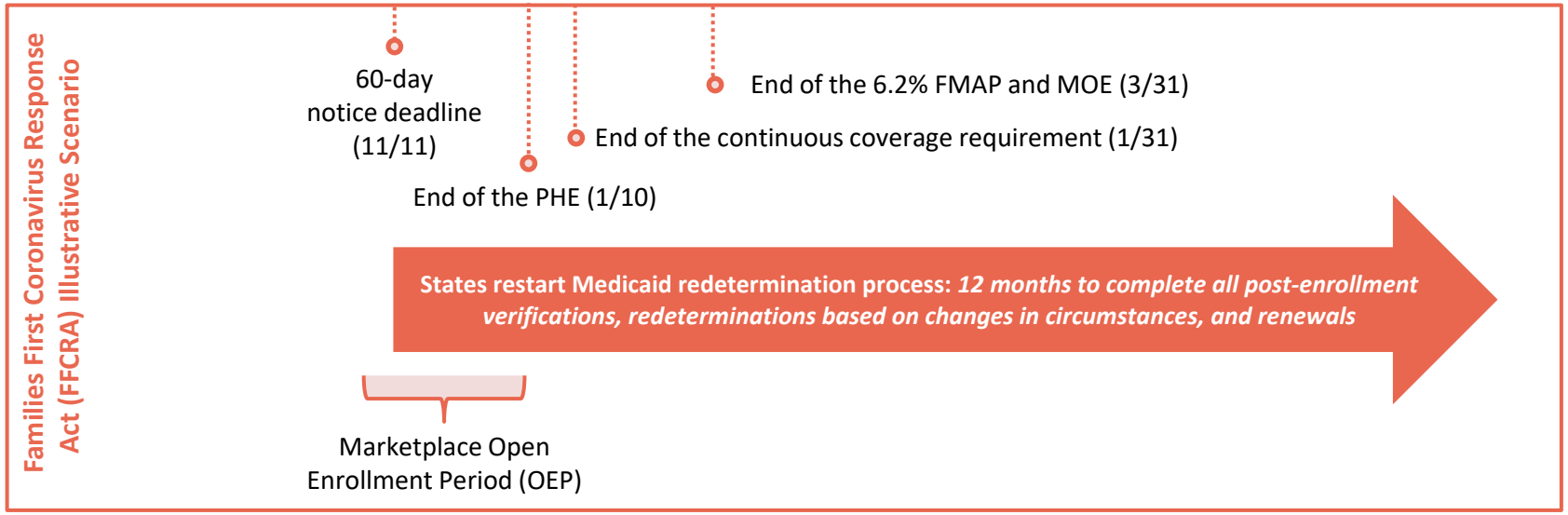
"Now I am able to see my psychiatrist and licensed clinical social workers that I've needed to see for many years. Medicaid has made it possible for that, as well as getting into a dermatologist and having my skin cancer taken care of, which is something I would have never had done otherwise. So, Medicaid is really a life changer for me."

"I changed jobs. I was working before at an after-school job with children. After the pandemic hit, it had to be closed down for health reasons. So, I lost my job due to this closure, and since it did not reopen there was no income coming in. Also, I did not have health insurance, and I felt like that was something essential that I needed. So, I decided to apply for Medicaid."

How States Are Preparing for Unwinding

Federal PHE Timeline

Year	2022				2023												2024		
Month	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar

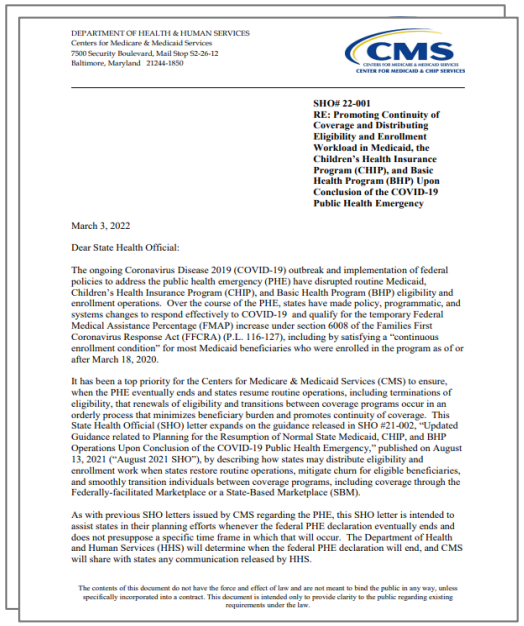


Timeline Notes: The federal PHE is currently in effect through January 10, 2023. Because the United States (U.S.) Department of Health and Human Services (HHS) has promised to provide 60 days' notice prior to termination. Federal legislation could also change the timeline for when the federal continuous coverage requirement ends and parameters for continued receipt of enhanced FMAP.

Source: FFCRA § 6008(b)(3); HHS, Renewal of Determination that a Public Health Emergency Exists; Centers for Medicare & Medicaid Services (CMS), State Health Official (SHO) Letter # 22-001.

Overview of Federal Guidance on Unwinding

Guidance issued by CMS on March 3, clarified federal expectations of state Medicaid/CHIP agencies as they prepare to process outstanding E&E actions when the continuous coverage requirement ends.



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

CMS
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 22-001
RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency

March 3, 2022

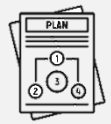
Dear State Health Official:

The ongoing Coronavirus Disease 2019 (COVID-19) outbreak and implementation of federal policies to address the public health emergency (PHE) have disrupted routine Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) eligibility and enrollment operations. Over the course of the PHE, states have made policy, programmatic, and systems changes to respond effectively to COVID-19 and qualify for the temporary Federal Medical Assistance Percentage (FMAP) increase under section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127), including by satisfying a "continuous enrollment condition" for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

It has been a top priority for the Centers for Medicare & Medicaid Services (CMS) to ensure, when the PHE eventually ends and states resume routine operations, including terminations of eligibility, that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage. This State Health Official (SHO) letter expands on the guidance released in SHO #21-002, "Updated Guidance related to Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency," published on August 13, 2021 ("August 2021 SHO"), by describing how states may distribute eligibility and enrollment work when states restore routine operations, mitigate churn for eligible beneficiaries, and smoothly transition individuals between coverage programs, including coverage through the Federally-facilitated Marketplace or a State-Based Marketplace (SBM).

As with previous SHO letters issued by CMS regarding the PHE, this SHO letter is intended to assist states in their planning efforts whenever the federal PHE declaration eventually ends and does not presuppose a specific time frame in which that will occur. The Department of Health and Human Services (HHS) will determine when the federal PHE declaration will end, and CMS will share with states any communication released by HHS.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.



Requires states to develop an **unwinding operational plan** (made available to CMS upon request) and recommends that states initiate no more than 1/9 of their total caseload of renewals per month to establish a sustainable renewal schedule.

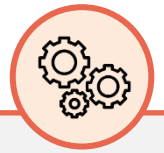
Provides clarification that states may begin their **12-month unwinding period** up to two months prior to the end of the PHE. States will need to initiate all renewals by the last month of the 12-month unwinding period and complete all actions by the end of the 14th month after the end of the PHE.

Reiterates that states **must initiate a full renewal** for all individuals, including those for whom the state already conducted a renewal during the PHE.

CMS expects states to adopt a risk-based approach when prioritizing pending E&E actions. Medicaid/CHIP agencies should consider staging redeterminations in a manner that prioritizes continuity of coverage and care–including coordinating with the Marketplace to ensure smooth transitions.

Source: CMS, SHO# 22-001; CMS, Eligibility and Enrollment Pending Actions Resolution Planning Tool – Version 2.0; and CMS, Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations.

Promising State Strategies to Prepare for Unwinding



Operational Strategies

- ✓ Preparing the workforce to address pending eligibility and enrollment actions and unprecedented volume of transitions.
- ✓ Strategically staging redeterminations for specific populations to balance priorities like maximizing coverage, smoothing transitions, and managing within limited state resources.
- ✓ Time renewals for people turning age 65 so that they can transition more seamlessly to Medicare coverage.
- ✓ Ensure continuity of care for pregnant and postpartum women.
- ✓ 12 months postpartum continuous coverage.
- ✓ 12 months continuous eligibility

Outreach Strategies

- ✓ Collaborating with navigators/assisters and other community-based organizations to help consumers with renewals, transitions, and enrollment.
- ✓ Partnering with managed care organizations.
- ✓ **HI's** federally qualified health centers train community partners to help people apply for Medicaid and Marketplace coverage.

Communications Strategies

- ✓ Developing phased communications plans to engage stakeholders and sequence member communications.
- ✓ Bolstering capabilities to engage members directly through text messaging, email, and phone outreach.
- ✓ Reaching out to members (through media campaigns, social media channels) to encourage them to stay connected for regular updates about their coverage.
- ✓ **LA** launched a robust phone campaign to encourage Medicaid members to update contact information.

Q&A

Thank You

Sally Mabon
Director of Programs
State Health and Value Strategies
Princeton University School of Public and International Affairs
smabon@princeton.edu
609-258-3596

Medicaid Continuous Coverage Unwinding Resources for States

State Health and Value Strategies has created an accessible one-stop source of information for states in unwinding after the end of the federal public health emergency (PHE) at **www.shvs.org/resource/phe-unwinding-resources-for-states/**.

The webpage is designed to support states in planning for this major coverage event, including developing processes that prioritize coverage retention at the end of the PHE.

Together with our technical assistance partners, we are developing on an ongoing basis resources for state officials on the unwinding of the PHE. Resources and tools will become available on the webpage once available.

Appendix

State Spotlight: Kansas Medicaid Unwinding Materials

KanCare posted a presentation, COVID-19 Public Health Emergency (PHE) Unwinding & Preparation, which contains graphics encouraging enrollees to update their contact information as well as a FAQ document for Medicaid members.

Preparing for the End of the PHE: Resources

Follow us on Facebook, Instagram and Twitter
Kansas Department of Health and Environment

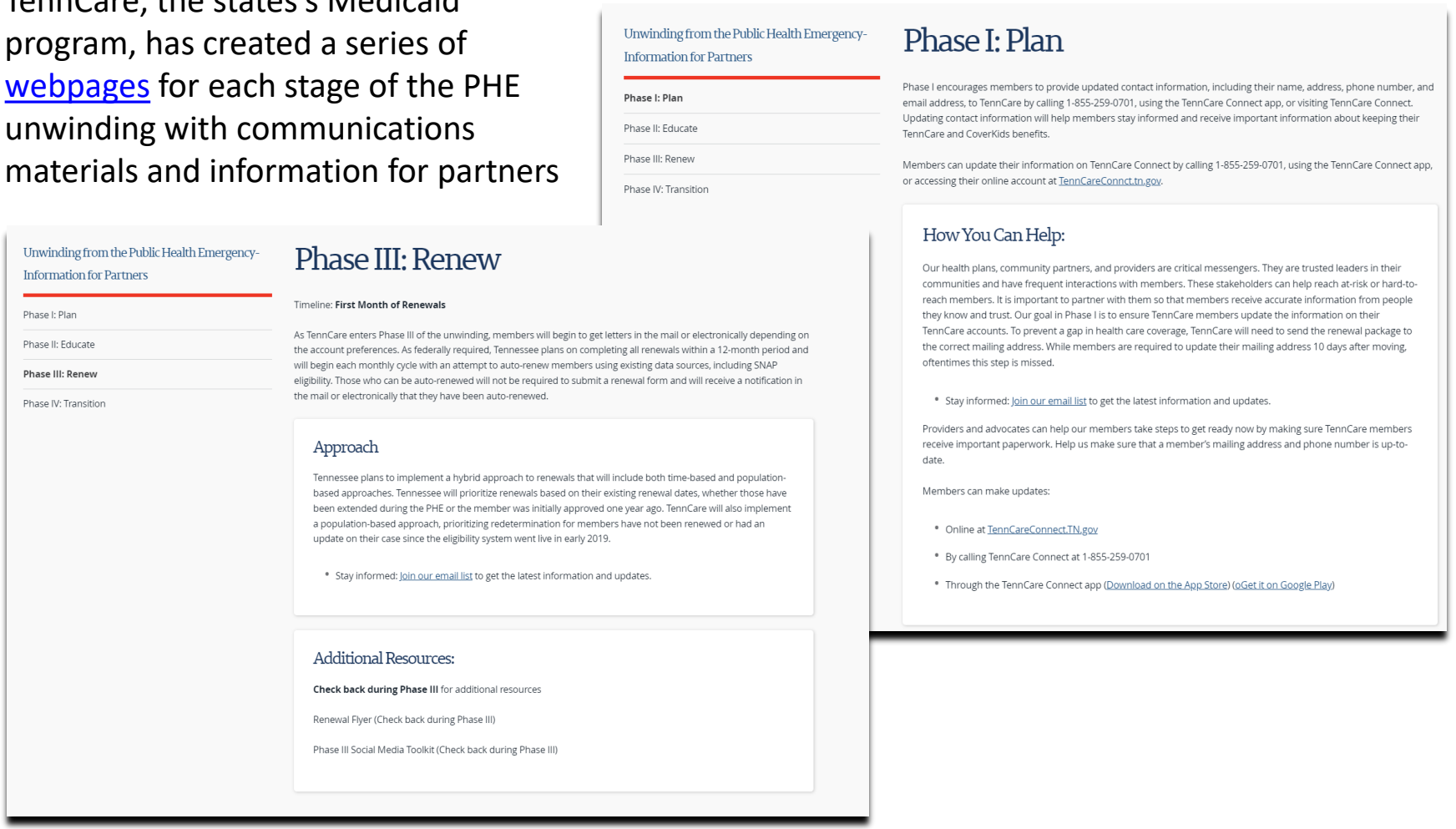
The COVID-19 PHE and Your Medicaid FAQs
the-covid-19-phe-and-your-medicaid-faqs-1-22.pdf (ks.gov)
the-covid-19-phe-and-your-medicaid-faqs-sp-1-22.pdf (ks.gov)

State Spotlight: Michigan Medicaid Unwinding Materials

- MDHHS Communication Resources: Medicaid - COVID-19 Public Health Emergency (PHE) Ending Resources
  - Frequently Asked Questions
  - Stakeholder Toolkit
  - Informational Webinar Recordings
  - Hot Buttons/links to MIBridges (application portal)

State Spotlight: Tennessee Unwinding Materials

TennCare, the states's Medicaid program, has created a series of webpages for each stage of the PHE unwinding with communications materials and information for partners



Unwinding from the Public Health Emergency-Information for Partners

- Phase I: Plan
- Phase II: Educate
- **Phase III: Renew**
- Phase IV: Transition

Phase III: Renew

Timeline: **First Month of Renewals**

As TennCare enters Phase III of the unwinding, members will begin to get letters in the mail or electronically depending on the account preferences. As federally required, Tennessee plans on completing all renewals within a 12-month period and will begin each monthly cycle with an attempt to auto-renew members using existing data sources, including SNAP eligibility. Those who can be auto-renewed will not be required to submit a renewal form and will receive a notification in the mail or electronically that they have been auto-renewed.

Approach

Tennessee plans to implement a hybrid approach to renewals that will include both time-based and population-based approaches. Tennessee will prioritize renewals based on their existing renewal dates, whether those have been extended during the PHE or the member was initially approved one year ago. TennCare will also implement a population-based approach, prioritizing redetermination for members have not been renewed or had an update on their case since the eligibility system went live in early 2019.

- Stay informed: Join our email list to get the latest information and updates.

Additional Resources:

Check back during Phase III for additional resources

Renewal Flyer (Check back during Phase III)

Phase III Social Media Toolkit (Check back during Phase III)

Unwinding from the Public Health Emergency-Information for Partners

- **Phase I: Plan**
- Phase II: Educate
- Phase III: Renew
- Phase IV: Transition

Phase I: Plan

Phase I encourages members to provide updated contact information, including their name, address, phone number, and email address, to TennCare by calling 1-855-259-0701, using the TennCare Connect app, or visiting TennCare Connect. Updating contact information will help members stay informed and receive important information about keeping their TennCare and CoverKids benefits.

Members can update their information on TennCare Connect by calling 1-855-259-0701, using the TennCare Connect app, or accessing their online account at TennCareConnct.tn.gov.

How You Can Help:

Our health plans, community partners, and providers are critical messengers. They are trusted leaders in their communities and have frequent interactions with members. These stakeholders can help reach at-risk or hard-to-reach members. It is important to partner with them so that members receive accurate information from people they know and trust. Our goal in Phase I is to ensure TennCare members update the information on their TennCare accounts. To prevent a gap in health care coverage, TennCare will need to send the renewal package to the correct mailing address. While members are required to update their mailing address 10 days after moving, oftentimes this step is missed.

- Stay informed: Join our email list to get the latest information and updates.

Providers and advocates can help our members take steps to get ready now by making sure TennCare members receive important paperwork. Help us make sure that a member's mailing address and phone number is up-to-date.

Members can make updates:

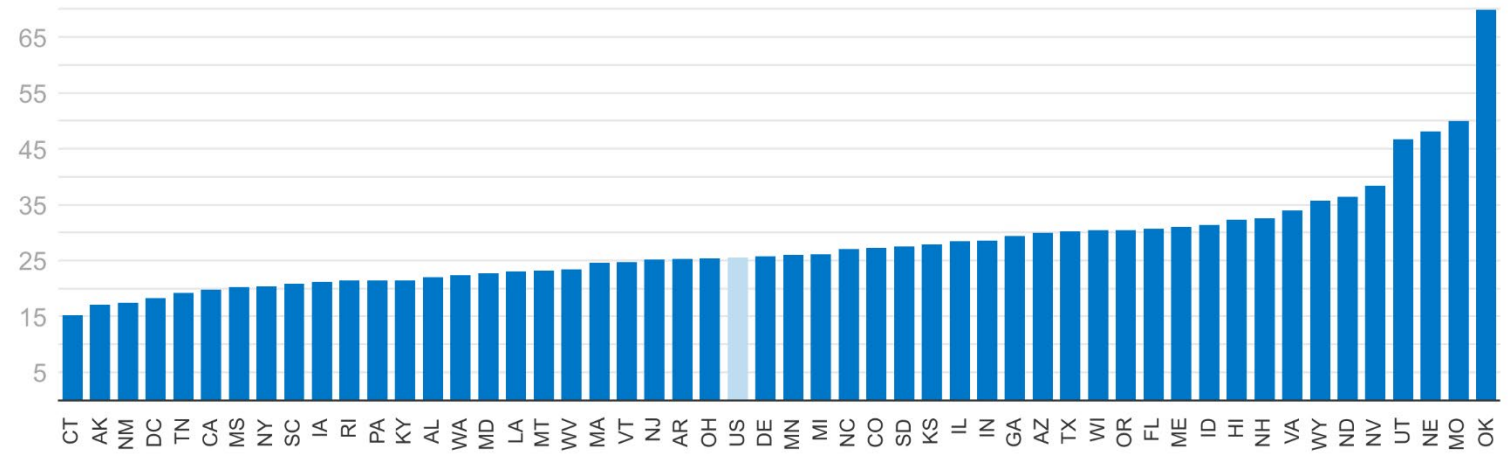
- Online at TennCareConnect.TN.gov
- By calling TennCare Connect at 1-855-259-0701
- Through the TennCare Connect app (Download on the App Store) (oGet it on Google Play)

Medicaid Enrollment

Figure 2

Enrollment From February 2020 To June 2022 Has Increased In Every State.

Cumulative Percent Change In Medicaid/CHIP Enrollment From February 2020 Through June 2022 By State



NOTE: June 2022 data are preliminary and subject to change; February 2020 (baseline) data are based on updated enrollment reports. These data differ from those reported in monthly "Medicaid & CHIP Enrollment Snapshots" published by CMS, which report preliminary data for all months. Medicaid & CHIP enrollment reports are submitted monthly by state Medicaid agencies, reflecting enrollment on the last day of the month. With each update, states often revise data for the previous month(s) to better align with reporting criteria, such as including retroactive enrollment or other criteria.

SOURCE: CMS, Medicaid & CHIP: Monthly Application and Eligibility Reports, last updated September 30, 2022.

KFF

Federal Guidance on Facilitating Coverage Transitions

The guidance also emphasizes the need for Medicaid and Marketplace coordination to facilitate smooth transitions for individuals who are no longer eligible for Medicaid/CHIP, but who may be eligible for Qualified Health Plan (QHP) enrollment through the Marketplace.

- ☑ States must have a coordinated process to send and receive electronic accounts/other information to and from the Marketplace and ensure prompt determinations of eligibility and enrollment.
- ☑ For individuals determined ineligible for Medicaid/CHIP, state Medicaid/CHIP agencies must promptly assess potential Marketplace eligibility and timely transfer the individual's electronic account (inclusive of all information collected/generated by the state Medicaid agency).
- ☑ If Medicaid/CHIP agencies have insufficient information to assess eligibility for advanced premium tax credits or cost-sharing reductions, they are *not* required to conduct individual assessments. Instead, states may implement a streamlined approach to ensure timely transfer of people potentially QHP eligible.

CMS Encourages States to:

Improve notice language on how to apply for coverage/financial assistance through the Marketplace and include contact information for Navigators/assisters.

Transmit all available eligibility and contact information to the Marketplace (e.g., email addresses, phone numbers, communication preferences).

Work with CBOs, health plans, and providers to provide consumer assistance.

Source: CMS, SHO# 22-001; CMS, Eligibility and Enrollment Pending Actions Resolution Planning Tool – Version 2.0; CMS, Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations; 42 CFR §§ 435.1200, 457.350, 600.330. CBOs = Community-Based Organizations.

Promising State Strategies to Smooth Transition to Marketplaces

States are working diligently to implement policies and practices to preserve coverage, and collaborating with Marketplaces to smooth the transition to coverage on the Marketplace.

Developing strategies to help people transition from Medicaid to Marketplace coverage during unwinding, such as:

- ✓ Ensuring account transfers work from a technical perspective by obtaining up-to-date consumer contact information, improving data completeness, and bolstering systems and technology.
- ✓ Assisting consumers found ineligible for Medicaid/CHIP to help them understand their options and transition (e.g., boosting Navigator/assister and call center capacity, partnering with trusted entities in the community).
- ✓ Paying the initial months' premium for consumers shifting from Medicaid to the Marketplace, facilitating enrollment using existing application data, and passing legislation to smooth transitions.

CA is auto-enrolling people coming off Medicaid into QHPs that best match their prior Medicaid coverage.

NM is working with their vendor to identify Medicaid/CHIP enrollees at-risk of coverage loss and sharing data (address, phone number, email, income level) with the Exchange.

VA developed an unwinding toolkit to provide community partners, stakeholders, and advocates with consistent messaging and resources to collectively support consumers with updating contact information, completing renewals, and transitioning to other coverage.

RI is planning to pay the first two month's premium for consumers shifting from Medicaid to the Marketplace, while also facilitating enrollment using existing application data.

Public Health Emergency Unwinding

October 13, 2022

MARYLAND HEALTHBENEFIT EXCHANGE

Maryland Health Benefit Exchange Organizational Structure:

Overview

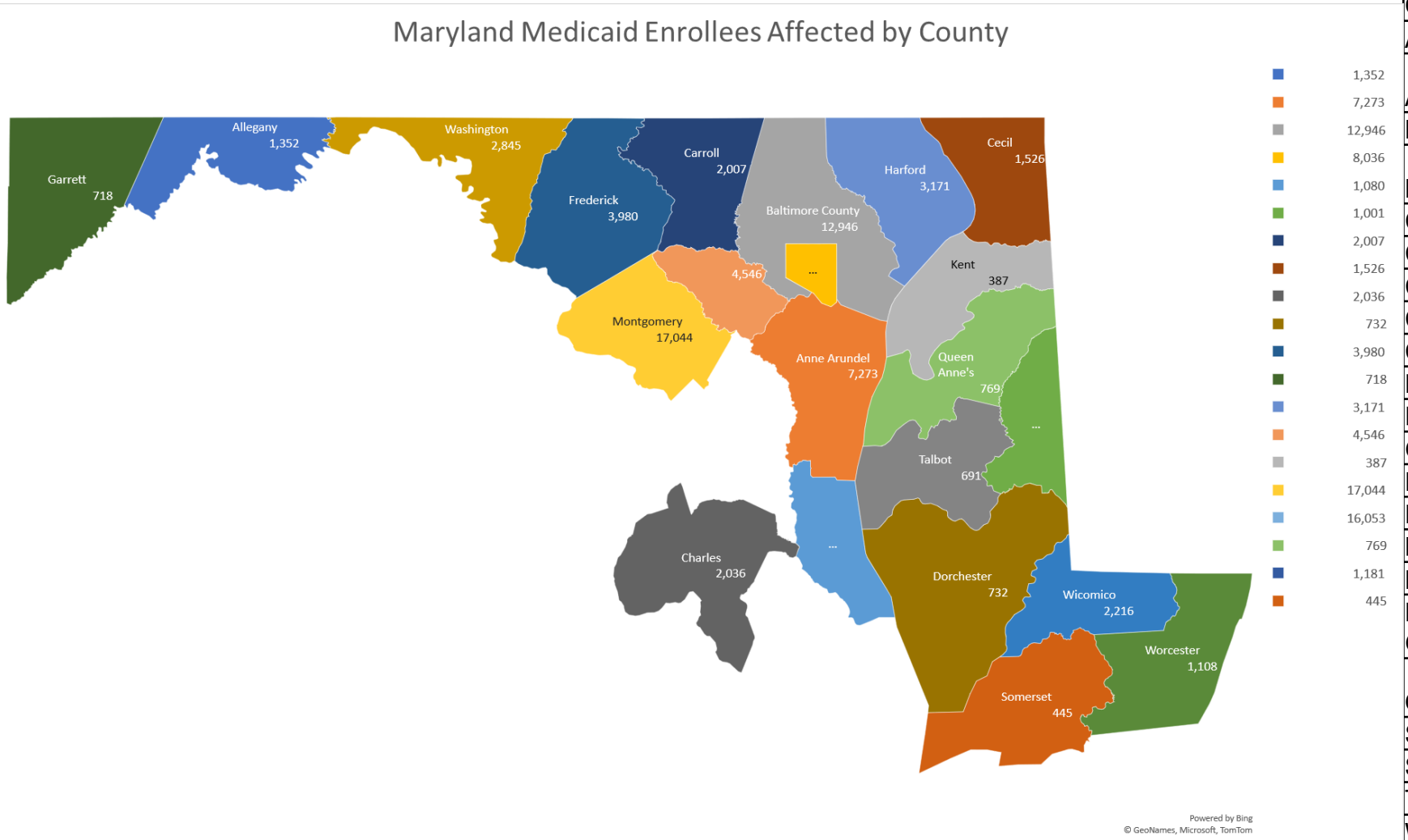
- Since the Public Health Emergency (PHE) began in January 2020, Medicaid enrollment grew significantly, as states maintained continuous enrollment of Medicaid beneficiaries in accordance with the Families First Coronavirus Response Act.

- Maryland Medicaid enrollment increased from 1.4 million to 1.7 million.

About the End of the Public Health Emergency:

- Maryland was approved for a 1902 waiver from the Centers for Medicare & Medicaid Services (CMS) to (Streamline Asset Verifications) during the PHE Unwinding period.
- Some Marylanders who had Medicaid and MCHP (Maryland Children's Health Program) coverage in 2020 may not be eligible for these programs anymore.
- Anyone who is not eligible or needs to renew their Medicaid coverage will receive a notice from Maryland Health Connection.
- The renewal period or end of Medicaid coverage will start 90 days after the federal government announces the date the public health emergency will end. Keep in mind that not everyone will be up for renewal at the same time.
- Maryland Health Connection will help those with Medicaid or MCHP keep their coverage. If they are not eligible for Medicaid or MCHP, Maryland Health Connection (MCH) will help them enroll in a private health plan.

How many Marylanders will be affected by the PHE Unwinding?



COUNTY	# CONSUMERS
Allegany	1,352
Anne Arundel	7,273
Baltimore	12,946
Baltimore City	8,036
Calvert	1,080
Caroline	1,001
Carroll	2,007
Cecil	1,526
Charles	2,036
Dorchester	732
Frederick	3,980
Garrett	718
Harford	3,171
Howard	4,546
Kent	387
Montgomery	17,044
Prince Georges	16,053
Queen Annes	769
Saint Marys	1,181
Somerset	445
Talbot	691
Washington	2,845
Wicomico	2,216
Worcester	1,108
TOTAL	**93,143**

MARYLAND HEALTHBENEFIT EXCHANGE

What will this mean for Marylanders affected by the PHE Unwinding?

- Households who have been receiving Medicaid coverage at no cost for two years under the PHE may no longer be eligible for Medicaid and MCHP.
- Families may have to pay towards their healthcare insurance premiums, copays and prescriptions.
- Households may decide not to enroll into private health plans due to cost and expenses.
- Many people in Maryland may not know they qualify for a private health plan for very low cost.
- If you are no longer eligible for Medicaid, Maryland Health Connection can help find you a private health plan that works for your life and wallet. Trained experts are available to help you sign up for a health plan from the comfort of you own home. Go to MarylandHealthConnection.gov/help to find help near you or call 855-642-8572.

Maryland's Unwinding Plan

During the first six months of the PHE unwinding, the Maryland Department of Health (MDH) will prioritize renewals for selected groups, which includes those who did a change report but would have lost coverage if not for the extension, including:

- Aged out
- Overscale income limits for Medicaid/MCHP
- Transitional Medical Assistance
- Enrollees not enrolled in MCO plans who have up to 90 days of temporary coverage
- Medicare (fee-for-service)
- Family Planning (fee-for-service)

- MDH is compiling the data on these groups and once we have the specific numbers we will distribute them over the first 6 months, while processing regularly scheduled monthly renewals.
- There continues to be an average 50% auto-renewal rate.

Communications/Outreach Plan

- MHBE sends out monthly reminders in English and Spanish via social media for consumers to log into their account and update their contact information.
- MHBE is working with MDH and Department of Human Services on coordinated messaging for renewals, which will include website, Facebook, and other public facing communications.
- MHC/MHBE will include a color flyer with all manual renewal notices (paper and electronic) that informs consumers about renewing coverage.
- MDH will continue to send renewal files to MCOs.

All Hands-On Deck Approach:

- The Maryland Health Benefit Exchange has outlined a plan of actions that includes; Navigators, Outreach Workers, and Brokers. These entities will be tasked with assisting those affected by the PHE Unwinding with enrolling into a private health plan of their choice.
- Biweekly meetings and trainings have been rolled out to Navigators, Outreach Workers and Brokers beginning in September 2022.
- Brokers who already had a connection with a customer affected by the PHE will be contacted by their Broker and helped with getting enrolled into a private health plan of their choice.
- Call Center Staff received training and will receive scripting on how to streamline those affected by the PHE. These calls will be transferred to a special queue where they can speak to a Broker to get assistance enrolling in a plan that fits the consumer's needs and wallet.

Questions?

Tamara Cannida-Gunter
MHBE Director of Consumer Assistance
tamara.cannida-gunter@maryland.gov
443 970 1379 Cell Phone

MARYLAND HEALTHBENEFIT EXCHANGE

@MarylandConnect

Medicaid: Unwinding From the Public Health Emergency

National Conference of State Legislatures
Achieving Affordable, Quality Health Care Systems:
Health Legislative Staff Seminar

ARKANSAS DEPARTMENT OF HUMAN SERVICES

humanservices.arkansas.gov

Organizational Structure

Arkansas Medicaid, CHIP, and the Marketplace

- Arkansas Medicaid and CHIP are part of a broader umbrella social services structure (Arkansas Department of Human Services) which includes:
    - Integrated eligibility for Medicaid, SNAP, and TANF
    - State mental health and substance abuse authorities
    - Intellectual and developmental disabilities services
    - Provider enrollment and claims processing
    - Regulatory oversight for skilled nursing facilities as well as Medicaid home and community-based services providers
- Overall agency also includes childcare licensing, child welfare, and youth services for individuals involved in the juvenile justice system
- Arkansas Health Insurance Marketplace (AHIM) is a state-based exchange
    - Utilizes the federal enrollment platform
    - Housed within the Arkansas Insurance Department
- Arkansas uses the Assessment Model where the Marketplace makes initial assessment of eligibility, but the state Medicaid agency has final determination

Arkansas Medicaid

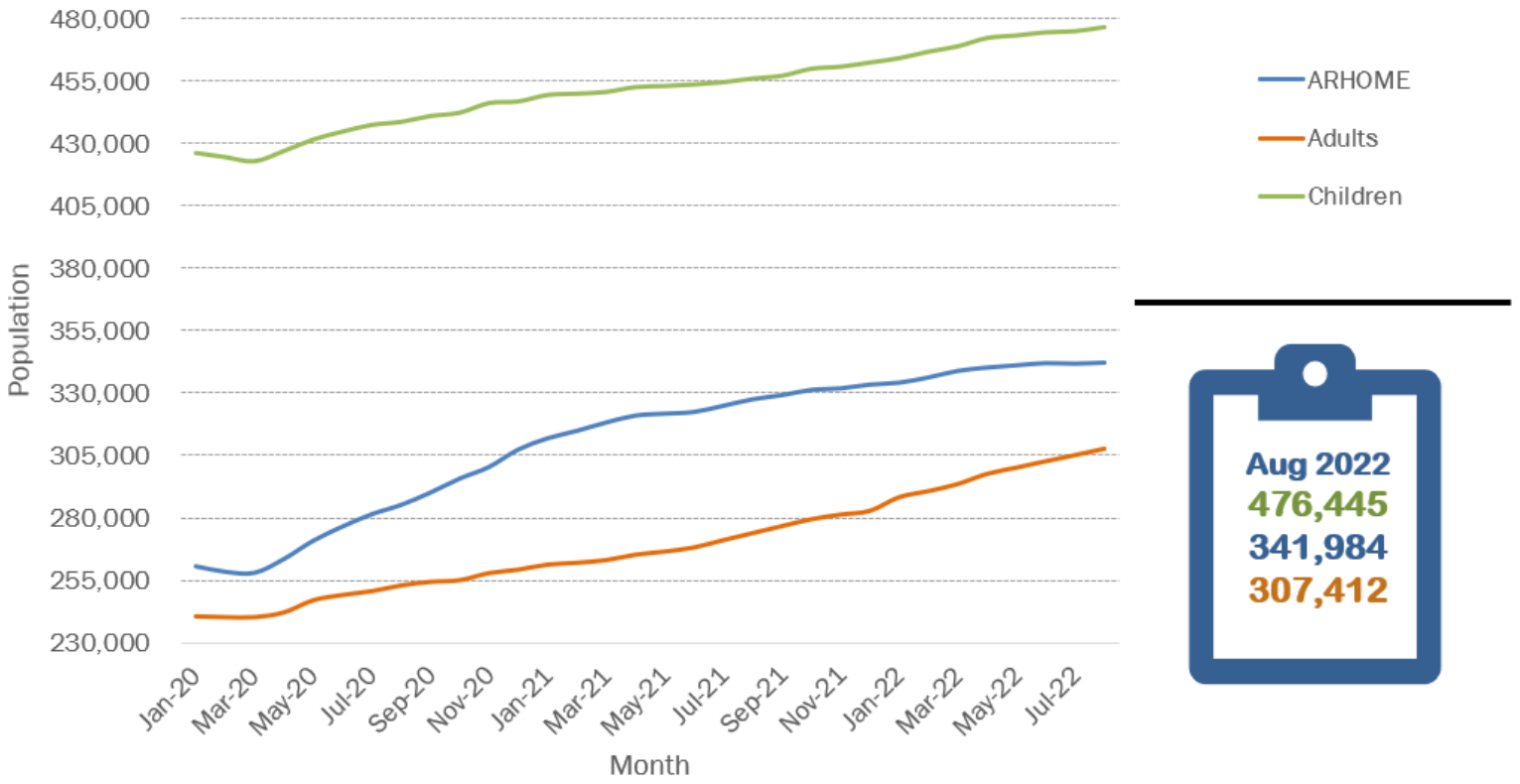
Covered Lives, Populations Served, and Overall Financing

- As of September 1, 2022, **1,121,689** Arkansas were enrolled in Medicaid
- **474,223** children and **647,466** adults
    - **339,297** in Medicaid expansion primarily using premium assistance through Qualified Health Plans (QHPs)
    - **56,953** with high needs behavioral health or intellectual/developmental disabilities served through Provider Led Arkansas Shared Savings Entities (PASSE) managed care plans
    - Majority served through Fee-For-Service (FFS) programs
- As of October 9, 2022, **346,839** enrollees have had their coverage extended due to the Public Health Emergency (PHE)
- Projected to spend $9.7B in the current State Fiscal Year (SFY) with approximately 70% federally funded

Enrollment Since Beginning of the Public Health Emergency

Monthly Enrollment Report

Since Jan 2020, Medicaid has added 198,559 individuals to the program (21% overall enrollment growth).



Aug 2022
476,445
341,984
307,412

Maintaining Operations During the PHE

- Offices remained open to provide assistance during the pandemic
- Continued processing applications, changes, and renewals for Medicaid coverage and case changes
- Implemented an integrated eligibility system for Medicaid, SNAP, and TANF
- Increased eligibility workforce through contractor support and filling vacant positions to help address a backlog of casework in advance of the unwinding
- Utilized several flexibilities in the form of waivers, rules, and rate adjustments
    - 26 Disaster State Plan Amendments
    - 28 Appendix K Waiver Submissions
    - 8 1135 Federal Blanket Waiver Provisions
- Some flexibilities will remain in place permanently and others will expire

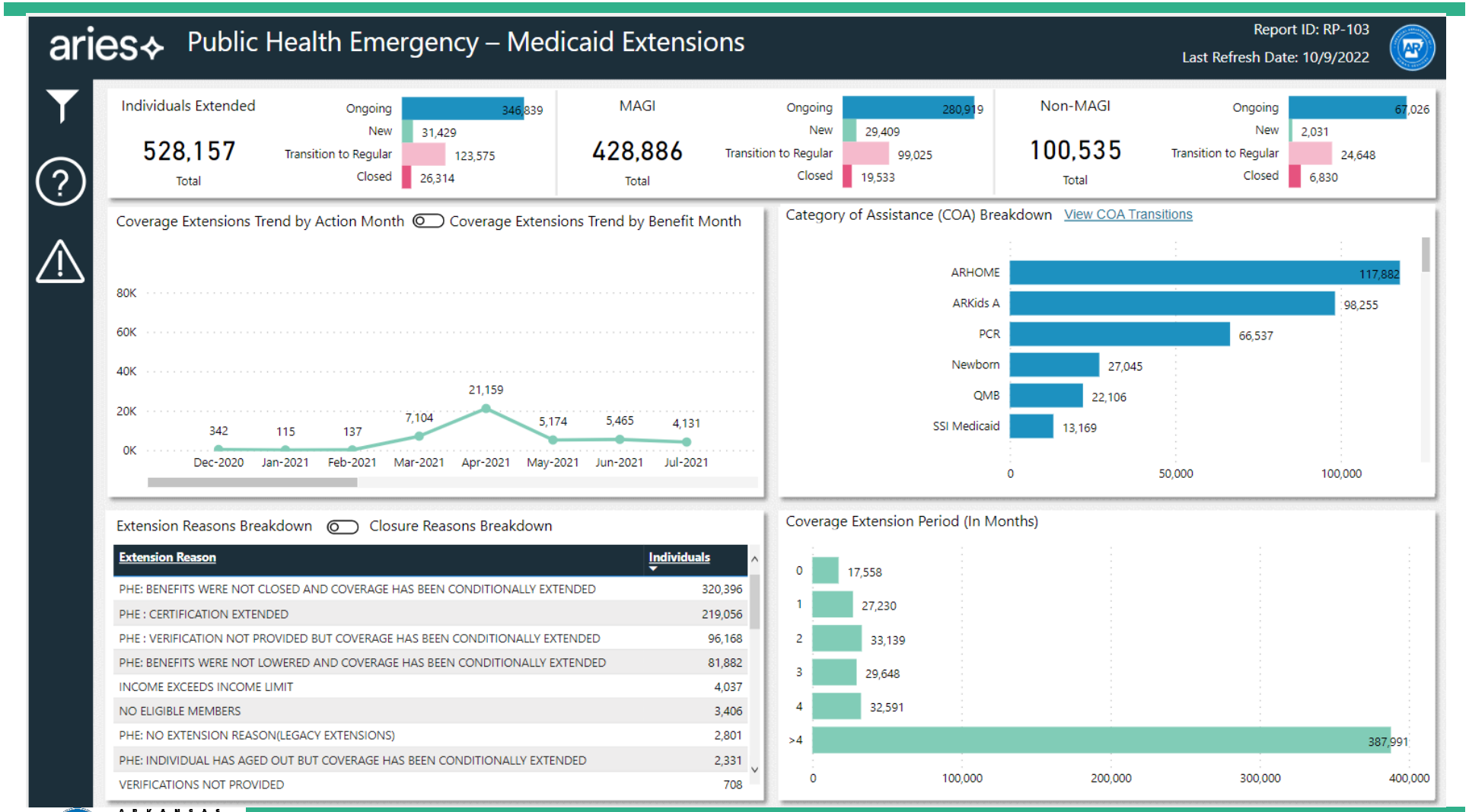
Approach to Unwinding the PHE

Current Activities

- **Client Outreach**: outbound calls to all extended clients, extended call center hours, grants to CBOs
- **Provider Engagement**: monthly reports to providers identifying clients at-risk of losing coverage
- **Program Operations**: secured additional staff and contract support for processing eligibility, medical reviews, client assessments, escalation teams for rapid review and correction of potential errors
- **Policy and Process Changes**: use of pre-populated renewal forms, accept USPS address changes and returned mail without additional client verification, and alignment of appeals process across long-term services and supports (LTSS)
- Created a Medicaid Control Center to track PHE unwinding plans and future Medicaid activities

Public Health Emergency Dashboard – Medicaid Extensions

Last Refresh Date 10/06/2022



PHE Unwinding Plan

Selected Updates

- Identified current enrollees who are at risk of losing coverage but for the PHE by each eligibility category and population group
- Discussed initial population specific PHE plans with Medicaid Client Voice Council to get their feedback
- Weekly meetings with the population owners to develop and start implementing their plans
- Developed draft renewal schedules by population group for extended clients and regular redeterminations
- Working with Qualified Health Plans, Insurance Department, and CCIIO to help individuals served through Medicaid expansion and determined ineligible to transition to the exchange for continued coverage
- Creating communication toolkits for providers, clients, and general public and tested the materials in the toolkit with a focus group of clients. Materials can be found on ar.gov/update

Update Arkansas Campaign
Website Materials

MEDICAID, ARHOME, AND ARKIDS CLIENTS
Make sure your mailing address and phone number is up-to-date. Don't miss important renewal information.
LEARN MORE

Information

- About DMS
- Get to Know Director Pitman
- Contact DMS
- Reports & Publications
- Forms & Documents
- DMS Policies
- Frequently Asked Questions
- Health Care Programs
- Helpful Information for Clients
- Helpful Information for Providers
- Provider Enrollment
- Pharmacy
- Proposed Rules

- Update Arkansas – Client Toolkit and Materials
- Update Arkansas Graphics
- Español: Update Arkansas
- Kajin Majel: Update Arkansas

ESPAÑOL | KAJIN MAJEL

It's important for clients to update their contact information now to avoid possibly losing coverage. Clients need to update their information on the phone, online, or in-person.

Here's how clients can update their contact information:

1. Call the **Update Arkansas** hotline at **1-844-872-2660**
2. Go online at **access.arkansas.gov**
3. Visit their **local DHS county office** to update their information (*find your local office here*)

Toolkits & Materials

We have created different toolkits and materials for people connected to the Arkansas Medicaid Renewal process. Click the buttons below to access the toolkit that fits you.

Clients | Partners | Friends and Family

Thank You

Dawn Stehle
Deputy Director for Health and Arkansas Medicaid Director
Arkansas Department of Human Services
Dawn.Stehle@dhs.Arkansas.gov
(501) 683-6311

We Care. We Act. We Change Lives.

ARKANSAS
DEPARTMENT OF
HUMAN
SERVICES