# Medicaid Unwinding

**Heather Howard**

Director

State Health and Value Strategies

**Lindsey Browning**

Director of Medicaid Programming

National Association of Medicaid Directors

**Kathryn Costanza**

Program Principal

NCSL

**Cheryl Roberts**

Director

Virginia Department of Medical Assistance Services

**Tara LeBlanc**

Medicaid Executive Director

Louisiana Department of Health

**Jeff Lunardi**

*Moderator*

Executive Director

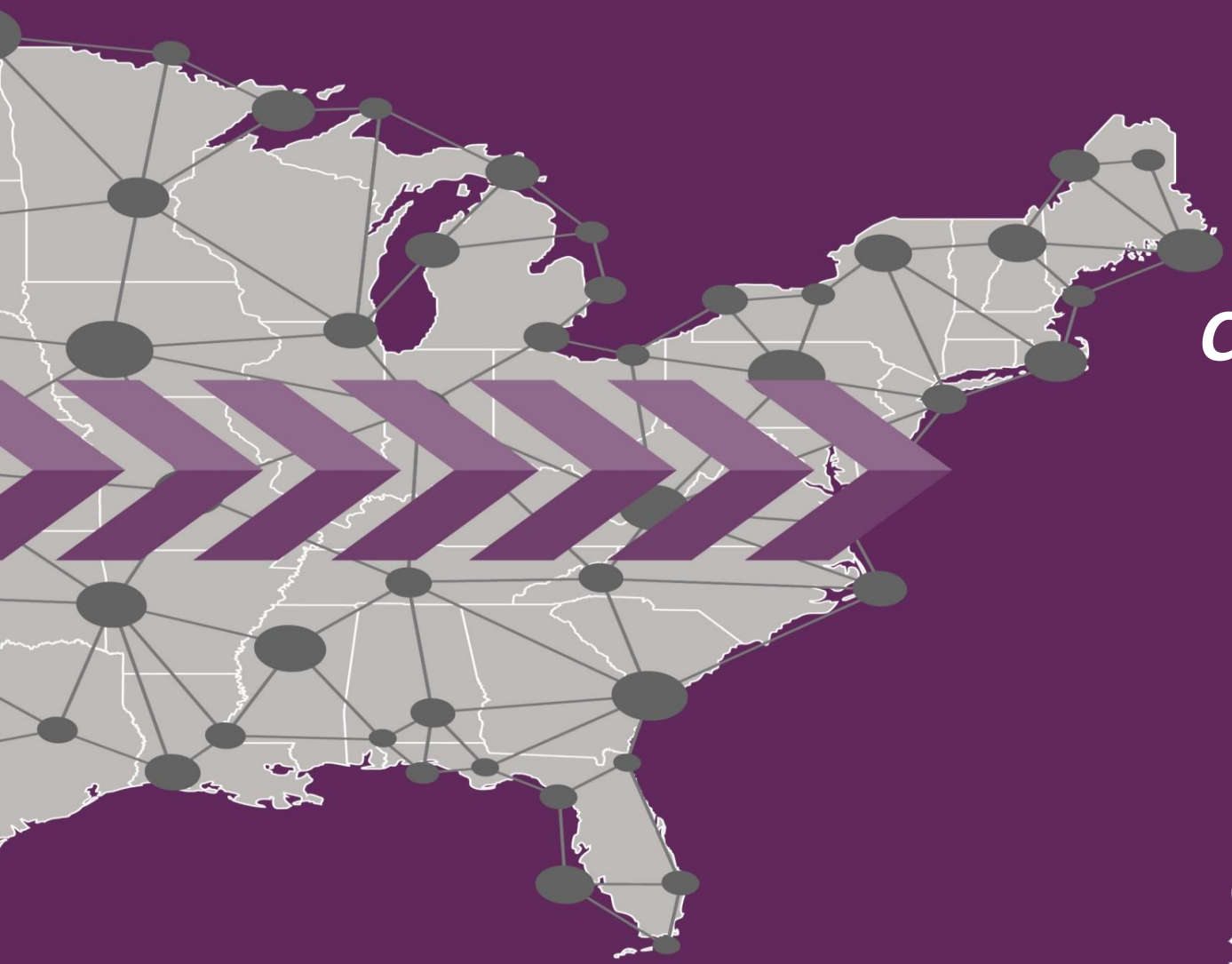
Virginia Joint Commission On Health Care

# Send us your questions!

We have a full program for you and will not have time for live Q&A.

Please put any questions in the chat ***or*** email them to lauren.kallins@ncsl.org.

We will follow up with the answers to all questions we receive.



# *Unwinding the Medicaid Continuous Coverage Requirement*

Presentation to National Conference of State Legislatures

February 17, 2023

Heather Howard

STATE Health & Value STRATEGIES

*Driving Innovation Across States*

*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.

**Questions?** Email Heather Howard at heatherh@Princeton.edu.

*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 Setting**
  - *The Medicaid Continuous Coverage Requirement*
  - *The Consolidated Appropriations Act, 2023*
- **The Return to Typical Medicaid and CHIP Operations**
  - *Timing*
  - *Outreach Process*
  - *Data Reporting*
  - *Enhanced FMAP Phase-Out/Conditions*
- **Appendix**

# The Medicaid Continuous Coverage Requirement

# 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. Includes temporary 6.2% point increase in the FMAP for states and territories.**

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.

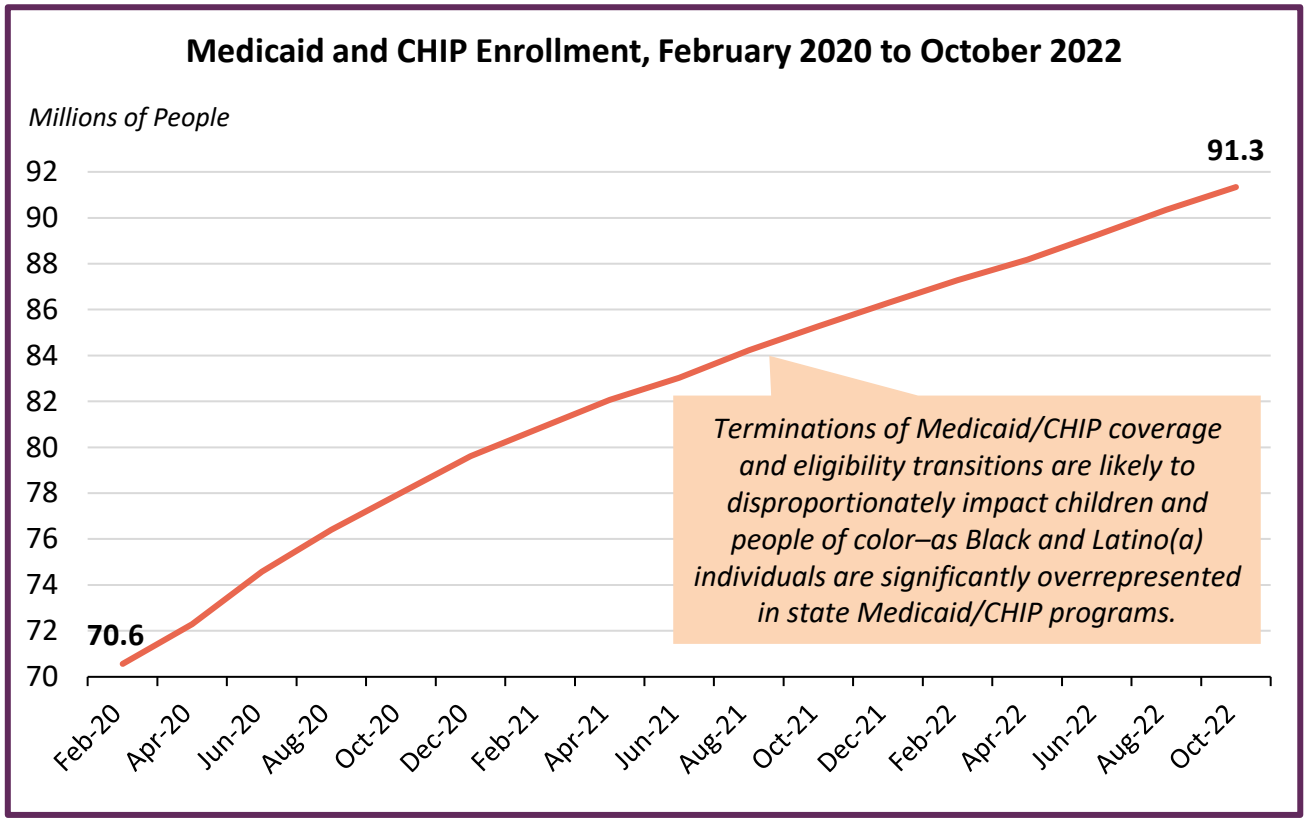
When the continuous coverage requirement expires, states must redetermine eligibility for nearly all Medicaid enrollees.

**Other Medicaid and CHIP Provisions of FFCRA**

- 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 Largest Health Coverage Event Since Affordable Care Act Implementation

**Between now and April, states will begin to redetermine eligibility for nearly all 91 million Medicaid/CHIP enrollees—threatening the historic gains in coverage achieved as a result of continuous coverage.**



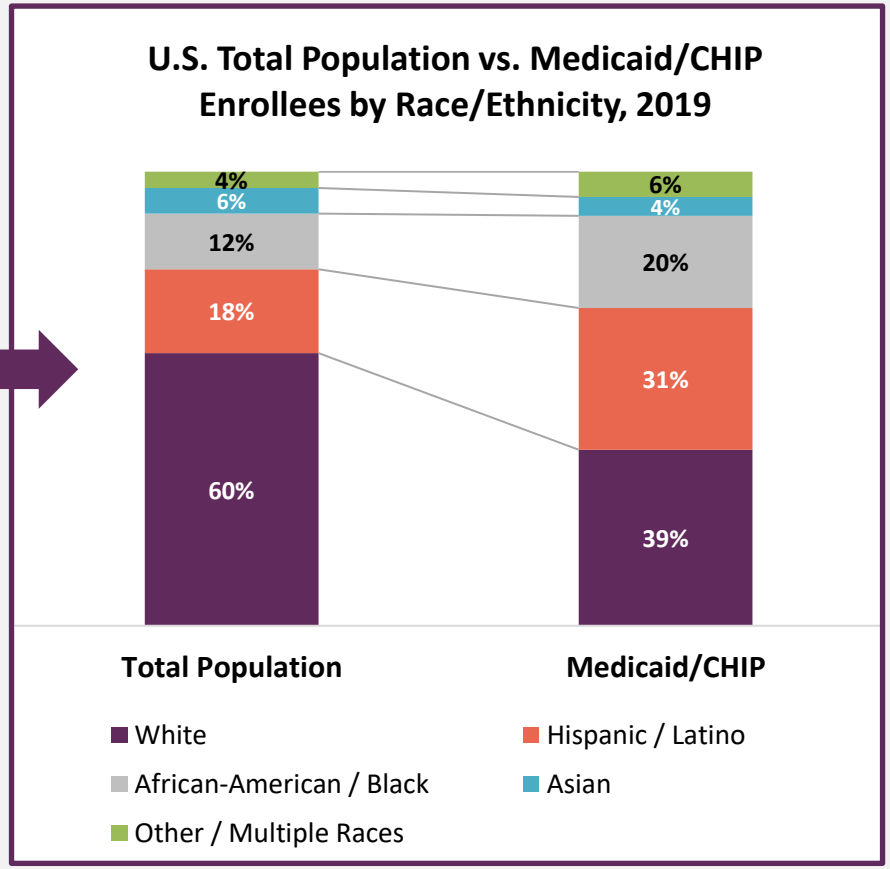

- Since February 2020, Medicaid/CHIP enrollment has increased by 20 million individuals (29%).
- A projected 15 million people, or 17% of current Medicaid/CHIP enrollees, will be disenrolled.
- 6.8 million people (7.9%) are projected to lose coverage despite still being eligible.
- Almost 1/3 of those losing coverage could be eligible for subsidized Marketplace coverage.

**Source:** CMS, June 2022 Enrollment Trend Snapshot; Assistant Secretary for Planning and Evaluation (ASPE), Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches; and SHVS/Manatt Health, The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage.

# 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 continuous coverage requirement.
- 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.

# Consolidated Appropriations Act, 2023 (CAA) Changes to Unwinding Parameters

**Section 5131 of the recently enacted CAA makes key changes to the parameters for unwinding that will ultimately support coverage retention for eligible individuals among states that are able to comply.**

Decouples the Medicaid continuous coverage requirement from the end of the COVID-19 PHE, and sets a new statutory end date of March 31, 2023, enabling states to initiate renewals as early as February 1, 2023 (though states may not terminate Medicaid enrollment until April 1, 2023).

Provides for extended enhanced federal medical assistance percentage (eFMAP) to support unwinding during a nine-month phase-down from April 1, 2023, through December 31, 2023, and establishes conditions for claiming eFMAP.

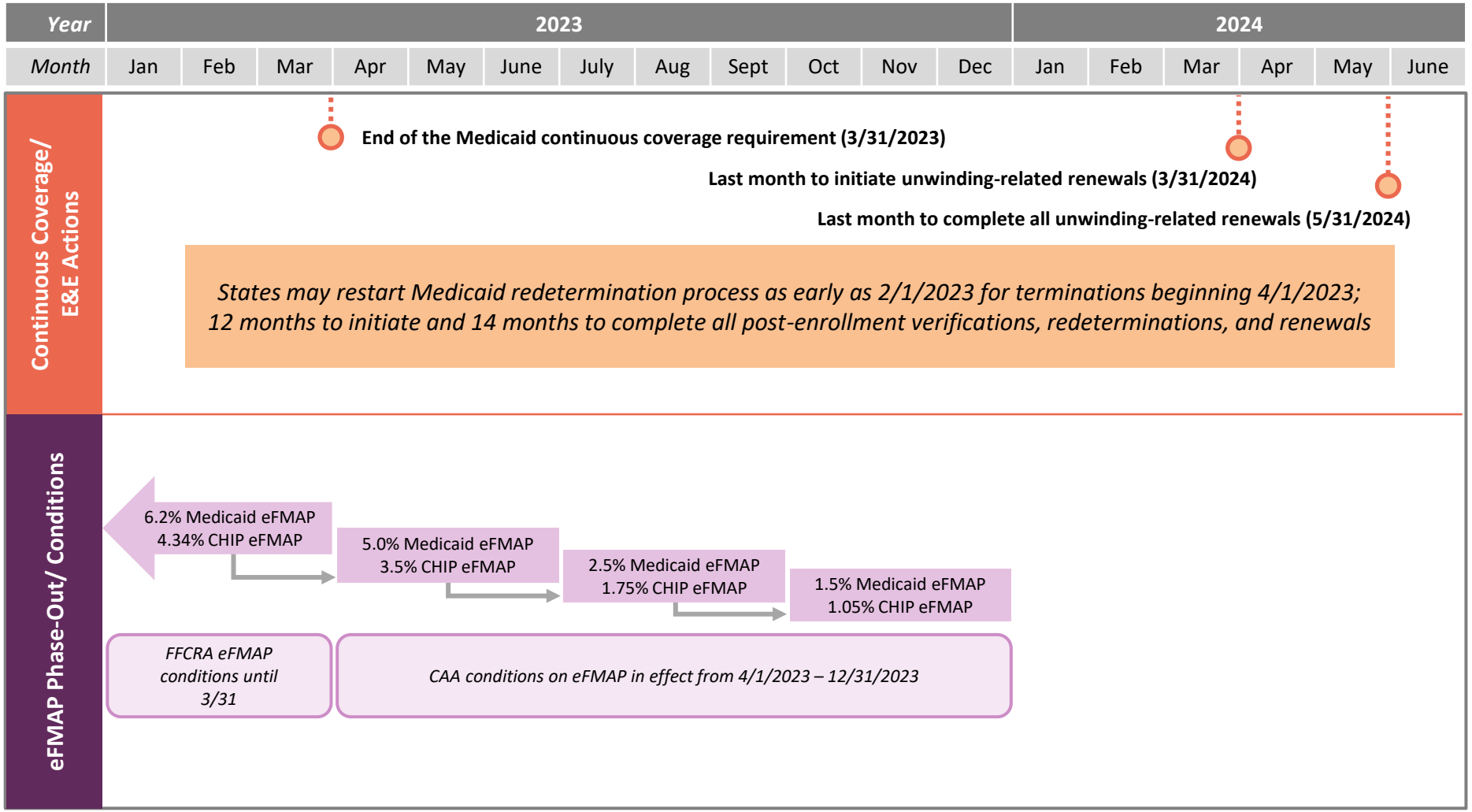
Institutes new Medicaid, CHIP, and Marketplace reporting requirements to enable oversight of unwinding and improve transparency.

Gives CMS targeted enforcement powers to reduce states' *regular* FMAP, require corrective action, suspend procedural terminations, and impose civil monetary penalties as a result of non-compliance with federal renewal and CAA reporting requirements.

**Source:** CAA Section 5131; CMCS Informational Bulletin, Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA; SHVS, Omnibus Unwinding Provisions and Implications for States; and National Association of State Medicaid Directors (NAMD), NAMD Supports Redetermination Certainty in FY 2023 Omnibus Release.

# The Return to Typical Medicaid and CHIP Operations

# Medicaid Continuous Coverage Timeline




**Source:** SHVS, Unwinding Provisions in the 2023 Consolidated Appropriations Act; and CMCS Informational Bulletin, Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA.

# Enhanced FMAP Conditions

**Receipt of the enhanced FMAP from April through December 2023, will be contingent upon certain conditions that build upon the existing conditions established by FFCRA.**

| 6.2% FMAP *(start of the PHE through 3/31)* | 5.0% FMAP *(4/1 through 6/30)* | 2.5% FMAP *(7/1 through 9/30)* | 1.5% FMAP *(10/1 – 12/31)* |
|---|---|---|---|

States **must conduct eligibility redeterminations and renewals in compliance with federal requirements**

States **must "attempt to ensure" they have up-to-date enrollee contact information**

States **must not disenroll anyone who is determined ineligible for Medicaid based on returned mail**, without first making a **good faith effort** to contact the individual using more than one modality (e.g., telephone and email).

**Note:** See 42 CFR § 435.911, 42 CFR § 435.916, and 42 CFR § 457.343 for federal *ex parte* requirements. Also see SHVS, Improving Ex Parte Renewal Rates to Support Unwinding: Q&A; CMS, COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals; and CMCS Informational Bulletin, Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA.

# Federal Renewal Requirements

**As a condition of receipt of the eFMAP and a potential trigger for corrective action/related penalties, states must conduct eligibility redeterminations and renewals in compliance with federal regulatory requirements.**

Conduct *ex parte* renewals for both Modified Adjusted Gross Income (MAGI) and non-MAGI populations.

Send renewal forms (must be pre-populated for MAGI enrollees).

Provide a reasonable timeframe (30 days for MAGI) and make available all modalities to return the renewal form.

Redetermine eligibility on all other eligibility group bases.

Provide advance notice of termination and fair hearing rights.

Assess eligibility for other insurance affordability programs and transfer account information.

Allow a reconsideration period during which terminated individuals may re-enroll without reapplying.

*Note: While procedural denials should not be sent to the federally-facilitated marketplace (FFM), states that do not use the federal eligibility and enrollment platform are encouraged to (1) identify individuals who have been terminated for procedural reasons and are highly likely for marketplace coverage, and (2) transfer those accounts to the SBM.

**Source:** 42 C.F.R. 435.916; SHVS, Improving *Ex Parte* Renewal Rates: State Diagnostic Assessment Tool; and SHVS, Leveraging Section 1902(e)(14) Waiver Authority Amid Unwinding.

# Contact Information and Returned Mail

**As a condition of receipt of the eFMAP, states must meet certain requirements to obtain up-to-date contact information for each enrollee prior to redeterminations and make a good faith effort to contact an individual before terminating enrollment based on returned mail.**

## *Contact Information*

Use multiple data sources to obtain up-to-date contact info (i.e., mailing address, telephone number, and email address) prior to redetermining eligibility. Data sources can include:

- ☑ The National Change of Address (NCOA) database.
- ☑ Other state health and human services agency information (e.g., SNAP, TANF).
- ☑ Other recent and reliable sources of contact information (e.g., DOL, DMV).

## *Returned Mail*

Make a good faith effort to contact an individual using two modalities before terminating enrollment based on mail returned to the state in response to a redetermination. The SHO letter clarifies that allowable modalities include:

- **Mail**
- **Telephone**
- **Email**
- **Text Message**
- **Online Portal Communications**
- **Commonly Available Electronic Means**

**Source:** CMS, Unwinding and Returning to Regular Operations after COVID-19; CMS, Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations; and SHVS, Leveraging Section 1902(e)(14) Waiver Authority Amid Unwinding.

# Mitigation Strategies

**For states seeking to ensure access to the eFMAP, now is the time to assess compliance with the CAA conditions. If gaps are identified, states should pursue CMS-approved mitigation strategies.**

- States that are not able to comply with eFMAP conditions may propose mitigation plans.
  - States will want to seek confirmation from CMS that their proposed mitigation strategies fulfill the expectations for receiving the eFMAP.

- States may claim eFMAP by attesting that they comply with these conditions. If CMS later determines that a state has failed to comply, ***the state may have to return federal financial participation (FFP).***

**Mitigation Plans**

- ☑ Should expressly include strategies identified in existing CMS guidance and resources.
- ☑ May include additional alternative strategies [e.g., tailored or new section 1902(e)(14) waiver flexibilities].

***Reminder:*** Regardless of whether the eFMAP is being claimed, states must comply with federal renewal requirements at all times or face corrective action.

**Source:** CMS, Unwinding and Returning to Regular Operations after COVID-19.

# New Reporting Requirements

**The CAA establishes new reporting requirements regarding eligibility and renewal processes for Medicaid, CHIP, and the Marketplace. Reporting requirements apply to *all states*, regardless of whether they comply with the conditions for enhanced FMAP during unwinding.**

From April 1, 2023, through June 30, 2024, states must submit to CMS a monthly report that will be made public

## *Medicaid & CHIP Related Reporting Requirements*

- ✓ The number of:
  - Eligibility renewals initiated.
  - Enrollees renewed.
  - Enrollees whose coverage was terminated.
- ✓ The number of individuals who were enrolled in CHIP as a result of renewals.
- ✓ Total call center volume, average wait times, and average abandonment rates.

## *Marketplace-Related Reporting Elements*

*(unless CMS reports this information on the state's behalf)*

**State-Based Marketplaces (SBM) with integrated eligibility system**

- ✓ Total # of individuals determined eligible for a QHP or BHP.
- ✓ Of these, # who selected a QHP on the Marketplace or were enrolled in a BHP plan.

**States with no integrated eligibility system**

- ✓ # of individuals whose accounts were transferred from Medicaid to the Marketplace/BHP.
- ✓ Of these, # determined eligible for a QHP or BHP.
- ✓ Of these, # who made a QHP selection or were enrolled in a BHP plan.

# New Reporting Requirements

**CMS believes that all of the reporting measures established by the CAA overlap with indicators Medicaid/CHIP agencies and State-Based Marketplaces (SBMs) are currently required to report.**

For more information on the new reporting requirements and the mode of submission for each, see the SHVS expert perspective, *Reporting Requirements Related to Unwinding Medicaid Continuous Coverage: Considerations for Medicaid and the Marketplace*.


STATE Health & Value STRATEGIES

*Driving Innovation Across States*

*A program supported by the Robert Wood Johnson Foundation*

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FEB, 09, 2023

**Reporting Requirements Related to Unwinding Medicaid Continuous Coverage: Considerations for Medicaid and the Marketplace**

*Elizabeth Lukanen and Emily Zylla, SHADAC*

# Federal Oversight & Enforcement

**The CAA vests CMS with targeted enforcement powers related to unwinding. These enforcement mechanisms extend beyond the ability for CMS to eliminate the enhanced FMAP for states that do not meet required conditions.**

## Federal Enforcement Mechanisms

| Penalty |
| --- |
| 1) Corrective Action Plan |
| 2) Loss of Enhanced FMAP |
| 3) ***Regular*** FMAP reduction |
| 4) Suspension of procedural terminations and/or civil monetary penalties of up to $100,000 a day |

**Source:** CMS, SHO Letter # 23-002.

# How States Are Approaching Unwinding

**States have been planning to implement myriad strategies to maximize coverage retention for eligible individuals and smooth transitions to other coverage programs for people who are determined ineligible when the Medicaid continuous coverage guarantee ends.**

- Update Member Contact Information
- Conduct Integrated Outreach and Education Campaign
- Develop Unwinding Plan and Monitoring Processes
- Improve the Redetermination Process
- Engage the Community and Other Key Partners
- Leverage Health Plans and Providers
- Address Workforce Constraints
- Promote Seamless Coverage Transitions

**Source:** CMS, Unwinding and Returning to Regular Operations after COVID-19; and SHVS, SHVS Resources and Tools Related to PHE Unwinding.

# Unwinding Resources for States

State Health and Value Strategies has created an accessible one-stop source of information for states on “unwinding” the Medicaid continuous coverage requirement:
Resources for States on Unwinding the Medicaid Continuous Coverage Requirement.

Together with our technical assistance partners, SHVS will update this page frequently with new resources as they become available.

# Thank You

**Heather Howard**
Professor of the Practice
Director, State Health and Value Strategies Program
School of Public and International Affairs
Princeton University
609-258-9709
heatherh@princeton.edu

# Appendix

# Unwinding Challenges & State Efforts

# Workforce Solutions

**Amid continued workforce constraints as states prepare to address pending E&E actions and the unprecedented volume of transitions, some states are deploying innovative strategies.**

- **Leverage partnerships:**
  - ✓ Use private contractors to support administrative E&E tasks.
  - ✓ Train community partners to support people in applying for coverage.
  - ✓ Work with sister agencies to find and recruit more staff.
- **Offer incentives for work** (e.g., overtime or increased pay).
- **Dedicate full-time units** to applications and/or renewals.
- **Stage redeterminations**
  - ✓ Cases that require the most assistance are evenly distributed or sequenced last.
- **Reassess staffing plans and business processes to identify efficiencies:**
  - ✓ Reassign experienced eligibility workers to focus on more complex assignments.
  - ✓ Contract with a vendor for data entry to free up eligibility worker time.
- **Develop eligibility training programs**

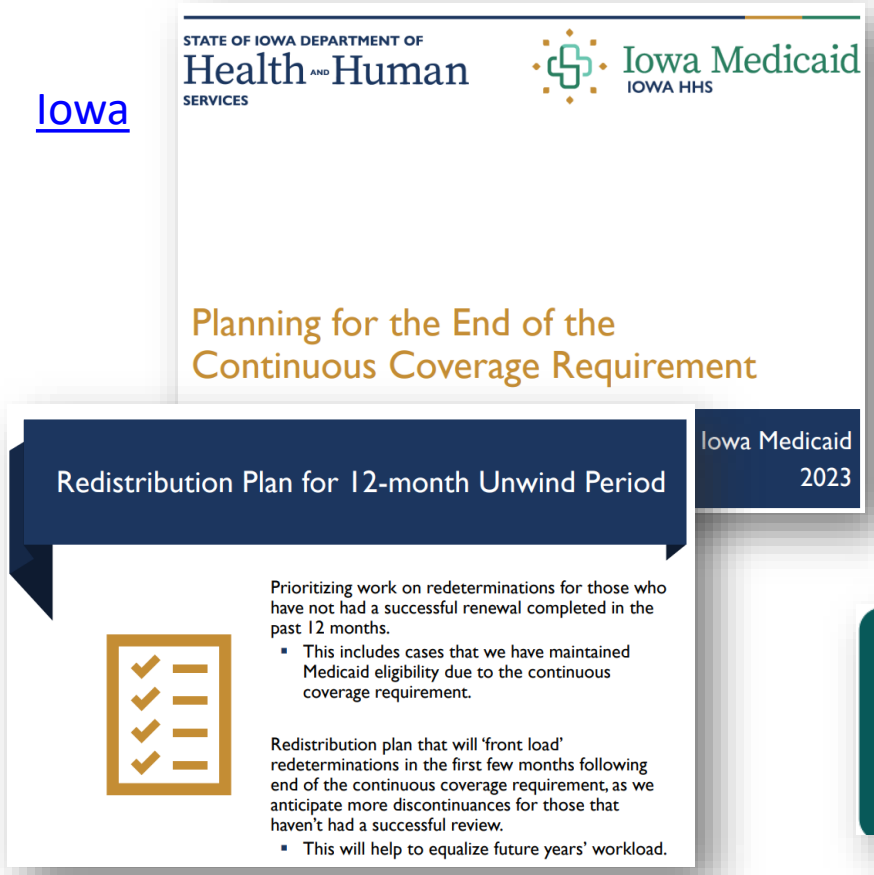
For additional information on staging redeterminations, see these SHVS expert perspectives:

- *Ensuring Continuity of Coverage and Care for High Need Enrollees When the Medicaid Continuous Coverage Ends: Medicaid Strategies*
- *State Strategies for Sequencing Enrollee Communications When Medicaid Continuous Coverage Ends*

# Unwinding Operational Plans

**One way that states are promoting transparency in their planning efforts is through the public release of their unwinding operational plans, including information on how they intend to stage redeterminations.**

Iowa




Georgia


**Georgia's Approach**

- The state-developed approach ensures pending actions are handled appropriately to prevent improper terminations, mitigate churn, and provide smooth transitions to healthcare.gov.

# Supporting Transitions to Employer-Sponsored Insurance (ESI)

**According to recent estimates from the Urban Institute, of the roughly 18 million people expected to lose Medicaid coverage when the continuous coverage requirement ends, 9.5 million are expected to enroll in ESI.**

- **These new SHVS resources highlight the role states can play in connecting people with ESI:**

- *Helping Consumers Navigate Medicaid, the Marketplace, and Employer Coverage* reviews how Medicaid agencies, State-Based Marketplaces, labor departments, and employers can play critical roles in helping people understand and navigate their coverage options.
- *Unwinding the Medicaid Continuous Coverage Requirement—Transitioning to Employer-Sponsored Coverage* discusses the proportion of individuals with an offer of ESI by income and state, and the proportion of those offers that are considered affordable based on premium cost.
- Sample messaging for state departments of labor to share with the employer community which explains the unwinding and coverage options for employees.

# Unwinding Special Enrollment Period (SEP)

**HealthCare.gov recently announced it will allow people who lose Medicaid eligibility to claim a SEP between March 31, 2023, and July 31, 2024, as the continuous coverage requirement ends.**

The "Unwinding SEP" will be available in all states using the federal enrollment platform and is optional for SBMs.

To access the Unwinding SEP, a Marketplace-eligible person must submit a new application or update an existing one between March 31, 2023, and July 31, 2024, and attest to loss of Medicaid coverage during that time period. Consumers will have 60 days after they submit their application to select a plan.

Coverage starts the first day of the month following plan selection. Consumers who are aware that their Medicaid is ending may report loss of coverage and select a plan up to 60 days prior to the event for coverage as early as the first day of the month following coverage loss.

**Source:** 45 CFR 155.420(d)(9); and CMS, Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition– Frequently Asked Questions (FAQ).

# Communications Considerations

# Communications Considerations: Immediate Priorities for States

Develop and share unwinding plan, including timeline for renewals and associated outreach and communications activities.

Create and share messaging and materials.

Enlist partners and stakeholders to complement and supplement your efforts.

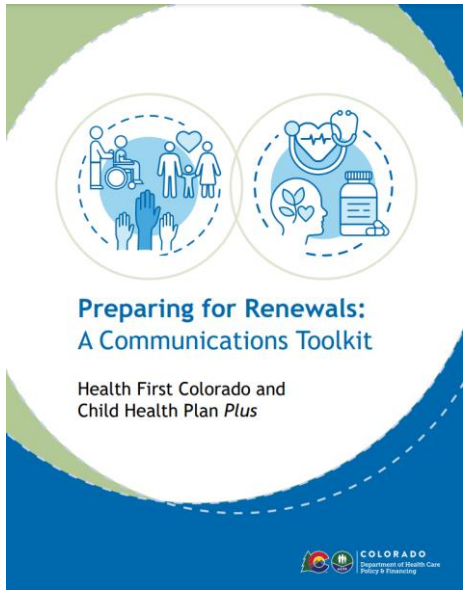
Equip navigators and assisters with information.

Establish a feedback loop process to understand and resolve issues as they arise.

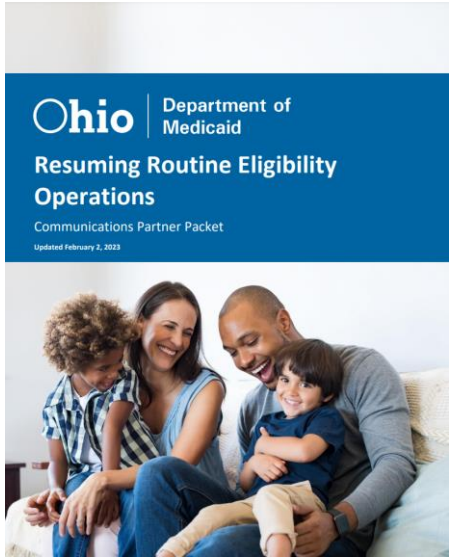
**SHVS resources related to communicating about the upcoming end of the Medicaid continuous coverage requirement are available here: https://www.shvs.org/unwinding-toolkit/**

# Examples of State Materials for Stakeholders

## Colorado




## Ohio




## North Carolina

# SHVS Resources

# State Health and Value Strategies Resources

**SHVS has created a resource page to serve as an accessible one-stop source of information for states in unwinding when the Medicaid continuous coverage requirement ends.**

https://www.shvs.org/resource/phe-unwinding-resources-for-states/

**Resource Topics**

- Health Equity
- Data/IT
- Eligibility and Enrollment Policy/Operations
- Consumer Communications and Outreach
- Oversight and Monitoring
- Medicaid and Marketplace Integration
- Federal Resources

**State Health and Value Strategies Resources**

- Planning for the End of the Continuous Coverage Requirement: Communications Resources for States
- New CMS Guidance on Unwinding Provisions in the CAA, 2023
- Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates
- Communicating the PHE Unwinding: How States Are Conducting Outreach and Planning
- Text Messaging: An Important Communication and Outreach Strategy as States Unwind the Federal Medicaid Continuous Coverage Requirement

# Medicaid Agencies' Operational Priorities in Unwinding Continuous Coverage:

*Key Insights for State Legislators*

National Conference of State Legislators
**February 17, 2023**

# Overview

About the National Association of Medicaid Directors

Operational priorities in unwinding continuous coverage

- Communications and messaging
- Capacity and workforce
- Coverage transitions
- Federal policy parameters and flexibilities

Takeaways for state legislators

# About the National Association of Medicaid Directors

# About NAMD

NAMD is the non-profit association for the 56 state and territorial Medicaid leaders

**Mission:** help Medicaid leaders deliver high value services to millions served by the program

**Core strategies:**

- Be a thought leader and convener to improve Medicaid and CHIP
- Build a strong state/federal partnership
- Provide connection and program management assistance to Medicaid leaders
- Support the development of state and territorial Medicaid

# Operational priorities in unwinding continuous coverage

# The context for Medicaid's operational priorities

- Medicaid played a key role in helping the nation respond to the pandemic
- We are entering a period of returning to normal operations
- Medicaid agencies face important challenges that will require a thoughtful and measured approach, and support and partnership
- The defined timeframe is intense. Moving too fast could have administrative costs, programmatic costs, and partner costs.

# Communications and messaging

- Reaching Medicaid enrollees and communicating actions that are needed is top priority
- This is facilitated by:
  - Ensuring contact information is up-to-date
  - Clear messaging around renewal notices
  - Using multiple modes of outreach
  - Providing information on how to access other sources of coverage
- Medicaid has statutory obligations around communications that are tied to the enhanced FMAP

**Examples of state strategies**

- Partnering with managed care plans
- Leveraging new data sources
- Engaging community-based organizations
- Using new methods of communication, like texting

# Capacity and workforce

- Ensuring state and county governments have the capacity for this work is an ongoing challenge exacerbated by labor market dynamics
- Medicaid leaders are focused on ensuring there is sufficient:
  - Eligibility workforce (state or county) to process renewals and new applications
  - Call center staff
  - Mail center staff
  - Appeals and fair hearings staff and administrative law judges
- Training is also a core component of capacity

## Examples of state strategies

- Maximizing use of automatic renewals
- Providing flexible work arrangements (remote/hybrid)
- Using contractor and vendor support, especially for call and mail centers
- Allowing weekend and overtime work
- Leveraging staff from other state agencies

# Coverage Transitions

- Up to 18 million people nationally may no longer be covered by Medicaid after unwinding continuous coverage is complete
- Helping individuals transition to other sources of coverage will minimize disruption and health impacts, including:
  - Employer-sponsored insurance
  - Subsidized commercial coverage on the federally-facilitated or state-based marketplace
  - Children's Health Insurance Program (if your state operates a separate CHIP program)
  - Medicare
- Some percentage of individuals will not ultimately make the transition to other coverage due to administrative hurdles, affordability, or other factors

**Examples of state strategies**

- Facilitating account transfers to the marketplace
- Partnering with managed care plans
- Leveraging health insurance navigators
- Engaging other community-based partners

# Federal policy parameters and flexibilities

- Congress created new compliance requirements and gave CMS more oversight authority in the Consolidated Appropriations Act (CAA)
- States must comply with new and existing requirements to receive enhanced FMAP and avoid other financial penalties
- Most Medicaid agencies will need to seek federal flexibilities to facilitate compliance (e.g., through 1902(e)(14) waivers)
- Medicaid programs continue to engage CMS to get needed clarity around federal policies and compliance requirements

**Examples of state strategies**

- Using National Change of Address Database to update addresses
- Partnering with managed care plans to update contact information
- Aligning Medicaid and SNAP renewals

# Takeaways for state legislators

# Takeaways for state legislators

- This return to normal operations in Medicaid presents important challenges for the program
- Medicaid programs continue to advance solutions around:
  - Communications and messaging
  - Capacity and workforce
  - Coverage transitions
  - Federal policy parameters and flexibilities
- Guiding the program through this work will require a thoughtful and measured approach, and the support and partnership of state legislators


# State Legislative Perspective on the End of Continuous Coverage

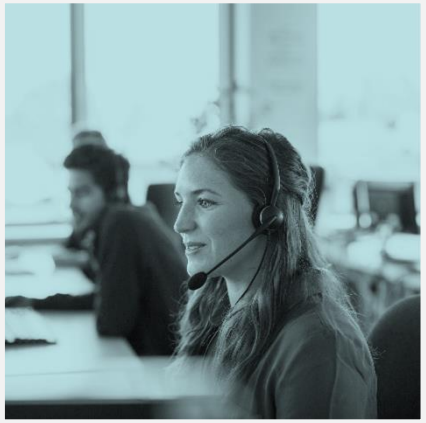
# How NCSL Strengthens Legislatures

## Policy Research

NCSL provides trusted, nonpartisan policy research and analysis

## Connections

NCSL links legislators and staff with each other and with experts



## Training

NCSL delivers training tailored specifically for legislators and staff

## State Voice in D.C.

NCSL represents and advocates on behalf of states on Capitol Hill

## Meetings

NCSL meetings facilitate information exchange and policy discussions

# Roadmap

NCSL
NATIONAL CONFERENCE OF STATE LEGISLATURES

State Budget

Constituent Services

The End of Other Federal Flexibilities

# Budget Impact

## Programs Tied to the Tapered FMAP Rate

- Medicaid Services (Regular FMAP and eFMAP)
- CHIP
- Title IV-E Foster Care Maintenance Payments
- TANF Contingency Funds
- Child Support Enforcement Collection
- Child Care Mandatory and Matching Funds of the Child Care and Development Fund
- Adoption Assistance
- Kinship Guardianship

## Other Impacts

Redetermination Timeline

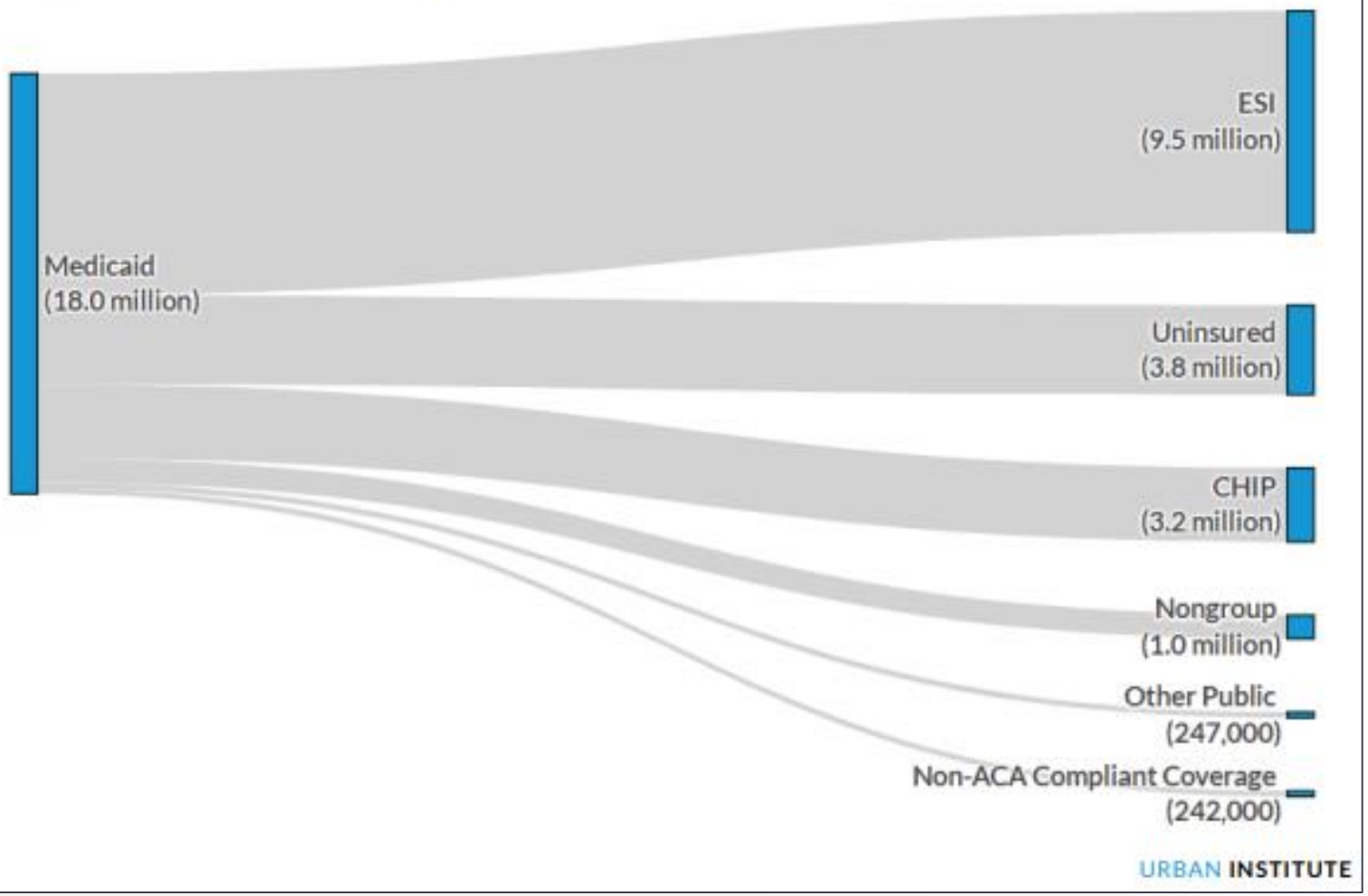
New Unwinding Penalties

Enrollment Churn

# Constituent Services

FIGURE 1

**Coverage Transitions of Medicaid Enrollees after the Public Health Emergency Expires**



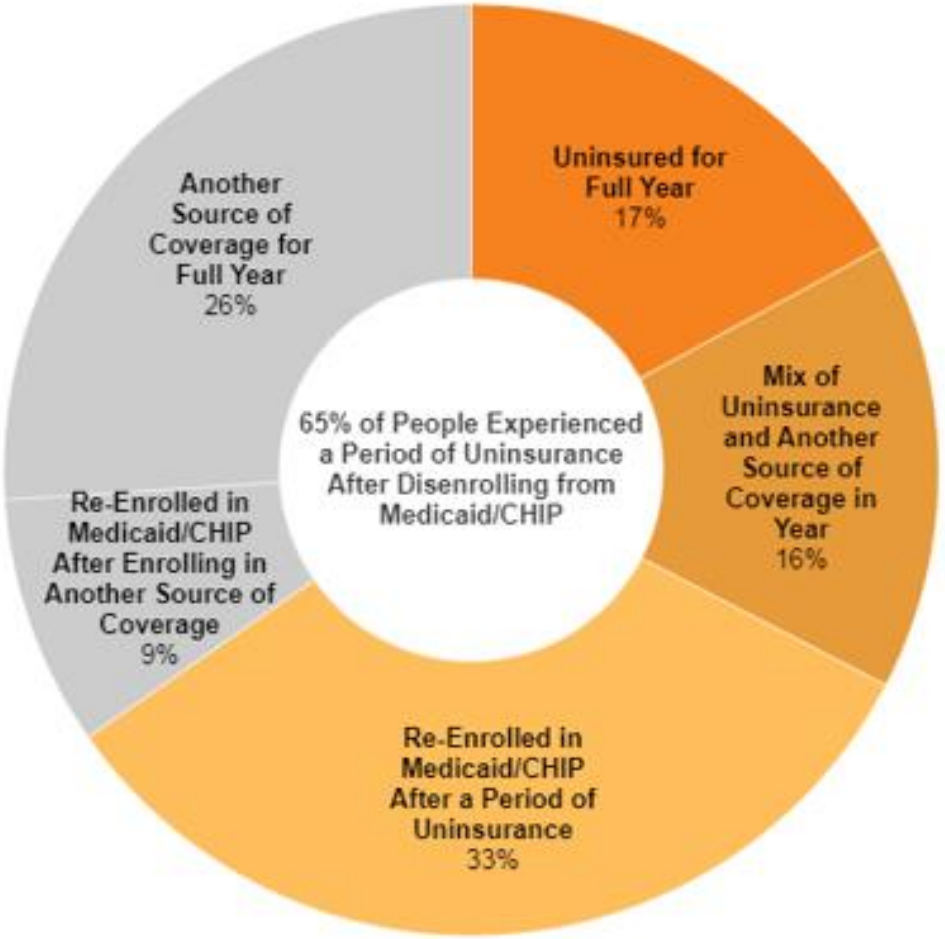

ESI = Employer Sponsored Insurance

Nongroup = Marketplace

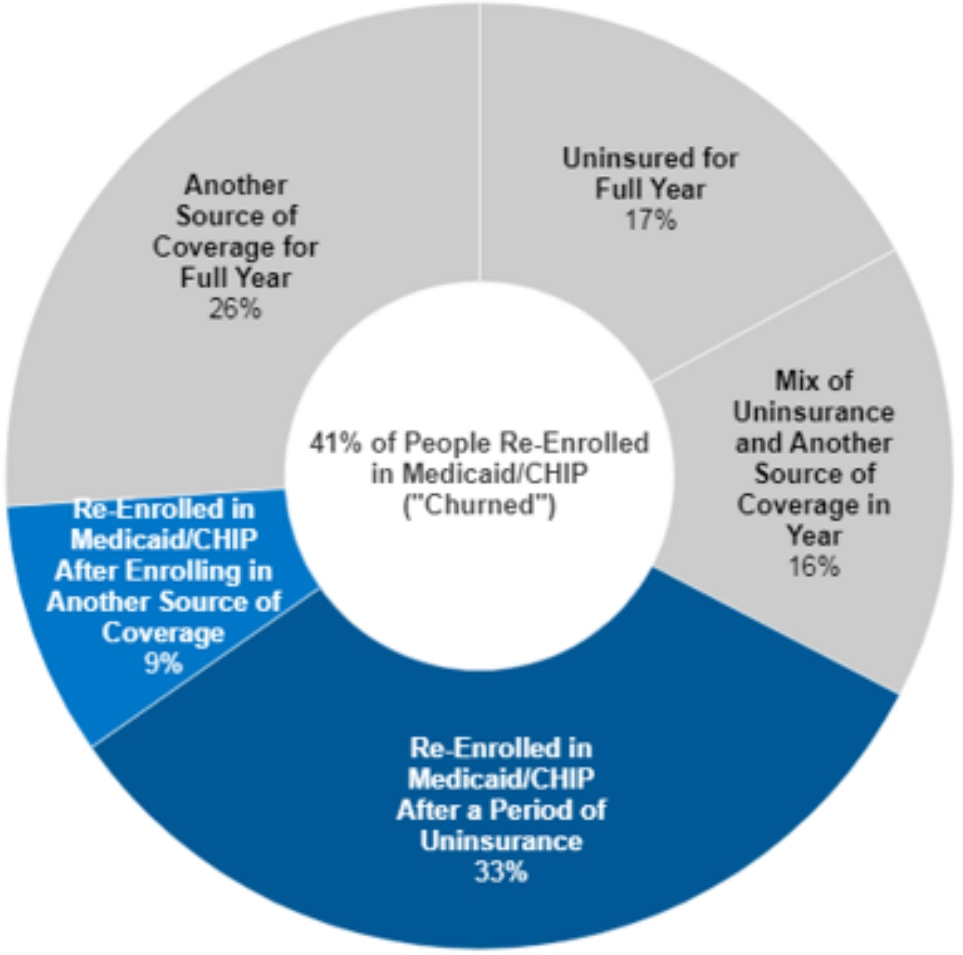
Source: The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage, Urban Institute

# Constituent Services

## Uninsurance




## Enrollment Churn



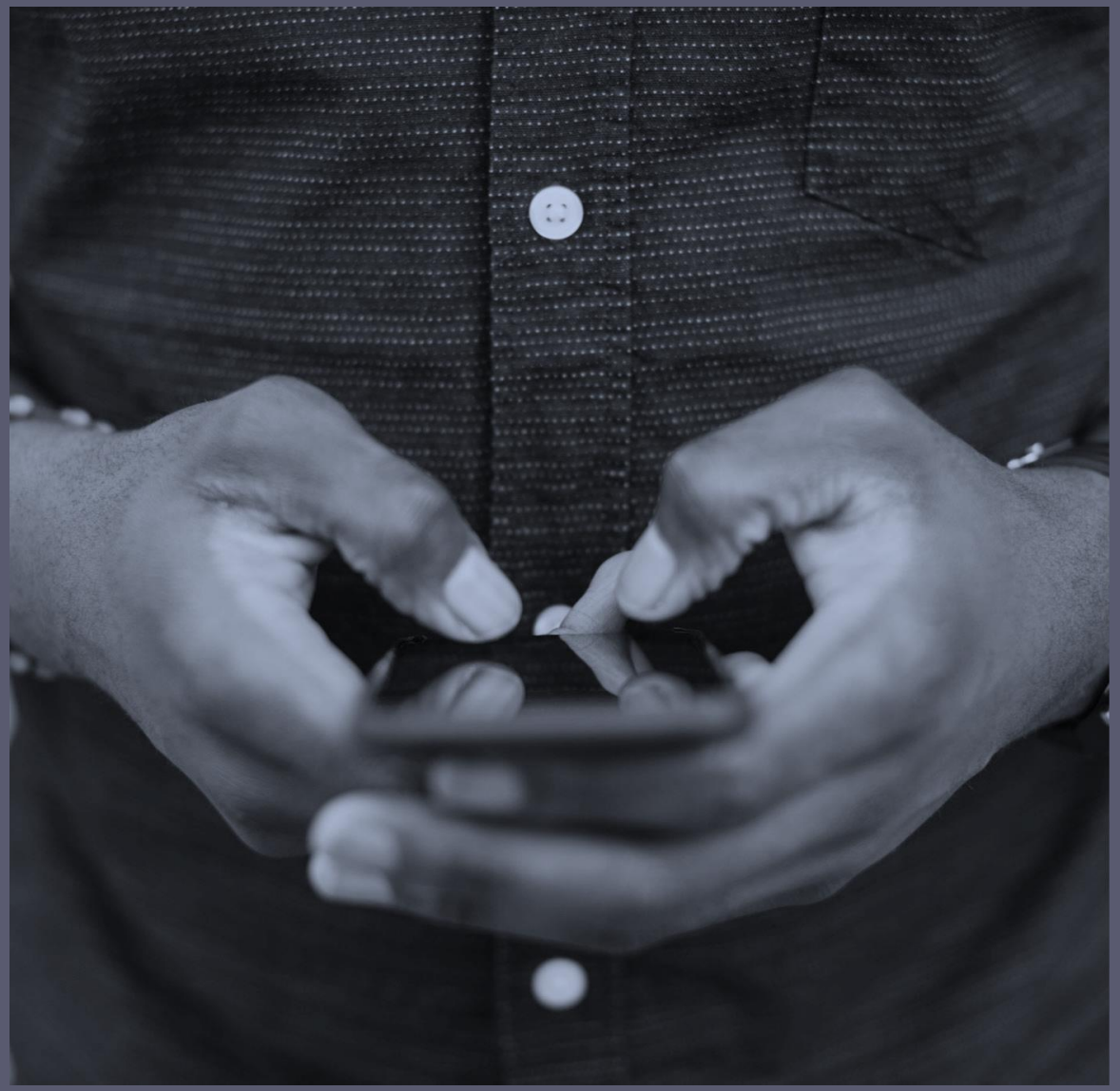

Source: What Happens After People Lose Medicaid Coverage, Kaiser Family Foundation;

# End of Other Federal Flexibilities

- Medicaid Administrative Flexibilities Related to Redeterminations (*Through June 2024*)
  - 41 states have requested these types of waivers.
- Medicaid Flexibilities Related to Operations (*End with PHE, Timing Varies*)
- Telehealth, HIPAA, Other (*End with PHE, Timing Varies*)

# Additional Resources

- Medicaid.gov/unwinding
- Unwinding Resource Center, State Health & Value Strategies
- What Happens After People Lose Medicaid Coverage, Kaiser Family Foundation
- 50-State Unwinding Tracker, Center for Children and Families
- Post-Pandemic Medicaid Changes Pose a Challenge for States, NCSL Podcast



# Kathryn Costanza
# Program Principal

## Reach out anytime!

| Email | Phone |
| --- | --- |
| Kathryn.Costanza @ncsl.org | 303.856.1388 |

# VIRGINIA'S MEDICAID PROGRAM FOR NATIONAL CONFERENCE OF STATE LEGISLATURES MEETING


Cheryl Roberts
Director, DMAS


February 2023

# Our Mission & Values

**To improve the health and well-being of Virginians through access to high-quality health care coverage**

Service | Collaboration | Trust | Adaptability | Problem Solving

# Medicaid Enrollment – February 2023
# Managed care delivery system through six health plans

Children 867,211

Pregnant Members 35,319

Older Adults 87,148

Individuals with Disabilities 153,144

Adults 875,237

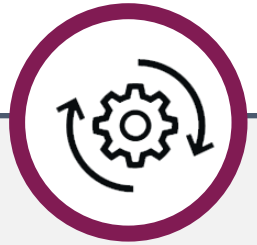
Limited Benefit Individuals 148,387



**Source**: Department of Medical Assistance Services February 2023 Enrollment Report, https://www.dmas.virginia.gov/data/enrollment-reports/

# Medicaid Enrollment in the Commonwealth

**The end of the continuous coverage requirement in the Commonwealth will present the single largest health coverage event since the first open enrollment of the Affordable Care Act (ACA).**



Historically, the Commonwealth has experienced **churn, which is enrollees who reapply and re-gain coverage shortly after being terminated**.

From March 2020 through February 1 2023, the Commonwealth experienced an **increase of 620,100 enrollees (a 40% increase in enrollment growth).**

Enrollment growth has been the **fastest among non-elderly, non-disabled adults**, and slower among children and aged, blind, and disabled (ABD) eligibility groups.

Post continuous coverage, **roughly 14% of the state's total Medicaid enrollees may lose coverage, and up to 4% of members may lose and regain coverage within 1-6 months of closure. The national average for loss is around 20%.**

# Unwinding Factors and Considerations

- Ongoing CMS guidance
- Collaboration with DSS
- Eligibility dashboard, reporting, and tracking
- Contractor impacts
- Systems changes
- MCO engagement
- Return to normal processes for TANF, SNAP, other PHE-related enhancements and flexibilities
- Appeals preparedness
- FMAP Tiering
- State exchange

**These activities, issues, and progress closely monitored by designated oversight committee**

# Community Outreach and Engagement Strategies

Phase I: March 2022

Phase II: Feb 2023

Phase III: April 2023

## Phase I Purpose:

- Encourage members to update contact information
- Campaign began in March will run throughout unwinding
- All stakeholder participation

## Phase II Purpose:

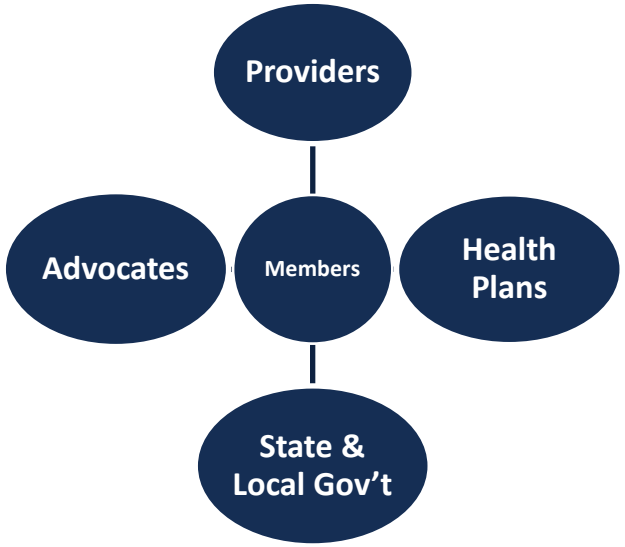
- Encourage members to complete needed paperwork
- Campaign will run Feb 2023- Jan 2024
- All stakeholder participation

## Phase III Purpose:

- Encourage members who lose coverage for administrative reason to complete needed paperwork
- Campaign will run April 2022-June 2024
- Primarily health plan participation & Marketplace navigators

# Community Outreach and Engagement Strategies

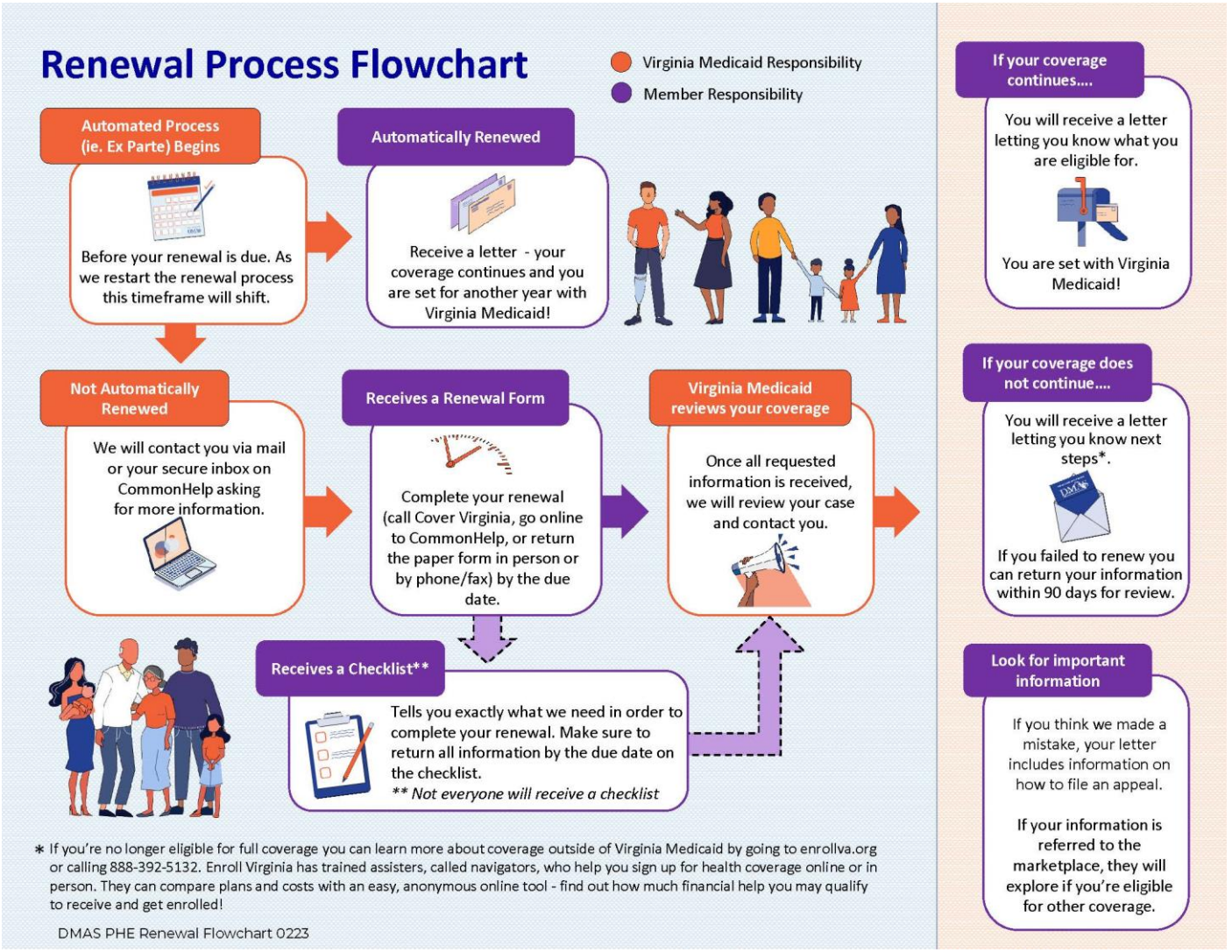
| Regularly Scheduled Meeting Cadence | | | |
|---|---|---|---|
| DMAS Community Outreach & Engagement: All Stakeholders | Bi-Monthly | Department of Education: Medicaid Coordinator & School Counseling Directors | Monthly |
| VDSS/DMAS/Local DSS Unwinding Planning | Monthly | Virginia Health Care Foundation Project Connect | Quarterly |
| HHR Secretary Report Out Meeting | Monthly | DMAS/MCO Leadership | Bi-Weekly |
| DMAS/DSS Unwinding Report Out Meeting | Bi-Weekly | Commissioner Calls with Local Leaders | Monthly |
| VA League of Social Services Executives (VLSSE) Benefits Programs Subcommittee Meeting | Monthly | VLSSE Executive Board Meeting | Quarterly |
| Local Directors Meetings | Quarterly | | |




| Stakeholder Engagement | |
|---|---|
| Non-Profit Organizations: 243 | Faith-Based Organizations: 82 |
| State & Local Gov. Agencies: 253 | Providers: 73 |
| Businesses: 81 | Committees/Taskforces: 43 |
| Public & Private Schools: 98 | Associations: 6 |
| Community-Based Organizations: 67 | Advocacy Groups: 28 |
| Social Organizations | Others: 8 |
| Members/General Public | |

# Appendix: Renewal Process Flowchart

A renewal process flowchart walks members through their process during redetermination. Find this and other resources on the Cover Virginia unwinding page at https://coverva.org/en/phe-planning. Specific unwinding documents can be found under the toolkits and materials tab.



**We are grateful  to all partners across the Commonwealth who are working to support the efforts to ensure a smooth transition back to normal processing.**

# Send us your questions!

Thank you for joining us!

Please email any questions to lauren.kallins@ncsl.org.

We will follow up with the answers to all questions we receive.