2022 NCOIL Summer Meeting
Health Insurance & Long-Term Care Issues Committee

The End of the Public Health Emergency: Medicaid Redeterminations

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Today's Agenda

- **A Quick Review**: COVID-19 Authorities, Emergency Declarations, and the Public Health Emergency
- **Examples:** The Key Requirements and Flexibilities Tied to the Public Health Emergency
- **A Deeper Dive**: Medicaid Redeterminations

Authorities at Play in the COVID-19 Pandemic

- **Public Health Service Act (PHE)**
  - Declared on January 31, 2020
  - Last renewed effective April 16, 2022; extended through July 15, 2022
  - Triggers a variety of federal emergency powers
  - Remains in effect for 90 days unless the HHS secretary renews/terminates
  - Although not required, HHS has indicated it would provide states with 60 days' notice of possible termination

- **National Emergencies Act (NEA)**
  - Declared on March 13, 2020
  - Last renewed on February 18, 2022, with "beyond March 1, 2022" with no specific end date
  - Activates emergency powers contained in other federal statutes
  - Allowed temporary waiver or modification of certain Medicare, Medicaid, and CHIP Program requirements and of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

- **Stafford Act**
  - Declared on March 13, 2020
  - Enables FEMA to help deliver virus response funds to the state and local governments

Authorities at Play in the COVID-19 Pandemic

- **Public Readiness and Emergency Preparedness (PREP) Act**
  - Invoked on March 10, 2022, with 10 additional amendments as well as corrections subsequently issued
  - End date of October 1, 2024
  - Authorizes HHS to limit legal liability for losses relating to the administration for medical countermeasures such as diagnosis, treatments, and vaccines

- **Emergency Use Authorization (EUA)**
  - Declared on March 27, 2020
  - Generally, continues until terminated - Notice of termination will be published in the Federal Register
  - Allows FDA to authorize, when certain conditions are met, the emergency use of unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious or life-threatening disease or conditions

Authorities at Play in the COVID-19 Pandemic

- **Federal Legislative Changes & the PHE**
  - Families First Coronavirus Response Act (Families First Act), Coronavirus Aid, Relief, and Economic Security Act (CARES Act), American Rescue Plan Act of 2021
- **Administrative Changes that Waived or Modified Wide Range of Requirements under Medicare, Medicaid, CHIP, and HIPAA**
- **Administrative Changes that Provided Additional Flexibilities in the Commercial Health Insurance Markets**
- **State Emergency Declarations**

Pause…State Emergency Declarations

- ***State actions varied significantly, particularly with respect to the cited authority***
  - Federal PHE
  - State PHE
  - Both – Federal and state PHEs
  - General COVID-19 public health challenge
  - Silent
- **Full review of individual state actions and the authority cited is necessary** to fully understand how a termination and/or non-renewal of the PHE or national emergency issued in connection with the COVID-19 pandemic will impact the various state emergency orders, bulletins, guidance, mandates, and other actions

Key Federal Legislative Provisions Tied to the PHE

- Coverage for COVID-19 testing and testing-related services without cost sharing in commercial plans and Medicare
- Coverage, without cost sharing, for nearly all Medicaid populations for the COVID-19 vaccine and administration costs (with 100% FMAP)
- Coverage for testing and treatment, including treatment of a condition that may seriously complicate COVID-19 treatment for nearly all Medicaid populations
- ***An increase of 6.2 percentage points in a state's FMAP provided certain maintenance of effort requirements are met, including the Medicaid enrollment for certain beneficiaries is maintained through the end of the month in which the PHE ends***

The End of the PHE – Important Dates

- The end date of the PHE was most recently extended to July 15, 2022
  - Once PHE ends, most requirements/flexibilities will likely end automatically
  - Re: ***the increase of 6.2 percentage points in a state's FMAP***, if the PHE is not once again extended:
    - the continuous enrollment requirement will end August 1, 2022
    - the enhanced FMAP will conclude at the end of the quarter (September 30, 2022, or the end of federal FY 2022)
- The Administration has said that it will give states a 60-day notice before the PHE expires
- States were not notified on May 16, so PHE will likely be extended
- If the PHE is extended 90 days, the next 90-day period would end ***October 13***; 60-day notice would need to be given by ***August 14***

Medicaid Redeterminations - Overview

- ***Pre PHE:*** Before the public health emergency (PHE), states were required to annually verify Medicaid eligibility for most members.
- ***What Changed***: As a condition of receiving the enhanced Federal Medical Assistance Percentage (FMAP) under the Families First Coronavirus Response Act, states are required to maintain enrollment for their Medicaid enrollees through the end of the PHE.
  - Very narrow exceptions, including if an individual moves out of state
  - No change to Medicaid coverage throughout the duration of the PHE
- ***Post-PHE:*** When the PHE ends, states must resume the Medicaid redetermination processes.
- ***Why is this significant?***
  - The volume within the condensed time period is unprecedented
  - States will have 12 months to initiate and 14 months to complete a full renewal of all individuals enrolled in Medicaid, CHIP, and the Basic Health Program
  - States, counties, and beneficiaries have not done this in more than 2 years.

Medicaid Redeterminations – The Numbers

- Slightly more than 1 in 4 Americans rely on Medicaid for their coverage and care, making it an essential safety net for 87 million people – including women, children and veterans.
  - Total Medicaid/CHIP enrollment grew to 87.4 million, an increase of 16.1 million from enrollment in February 2020. KFF Analysis of Recent National Trends in Medicaid and CHIP Enrollment
    - Enrollment increases data by state
    - Enrollment data by state
- Increases in enrollment may be attributed to economic changes, policy changes, and the temporary continuous enrollment requirement under FFCRA.
- Between 5.3 million and 14.2 million Medicaid enrollees could be disenrolled in the months following the end of the continuous enrollment requirement.
  - KFF Analysts Find:
    - February 2022 – State officials projected that median enrollment would decline by 5% next year following the end of the PHE. This translates into decline of 5.3 million enrollees
    - January 2022 – States expected on average about 13% of enrollees to be disenrolled following the end of the MOE requirements (estimates ranged from 8% to over 30%). This translates into a decline of 14.2 million enrollees.
- State Planning: KFF 50 State Survey

Medicaid Redeterminations – The Process (in general…)

- Federal requirements and state requirements
- State processes to verify eligibility will differ (income, waiver, disability status)
- State Medicaid Agency may use the information they have through other sources to decide if individual still qualifies for Medicaid or CHIP coverage
- If more information is needed, the state will contact the individual requesting additional information
- State Medicaid Enrollment Information

Medicaid Redeterminations - The Stakes Are High

- Eligible patients will be deemed ineligible because verification was unsuccessful
- Ineligible patients will become uninsured and may not be able to “find” another source of coverage
- Providers who have been treating once-eligible patients now may not have a reimbursement source
- Individuals will lose access to health insurance coverage, thus increasing states’ uninsured rates
- Affordability of other types of coverage may be impacted due to uninsured cost shifting

10 Fundamental Actions for States to Prepare for Unwinding

1. **Create a Comprehensive State Unwinding Operational Plan** describing how the state will complete outstanding work, ensure continuity of coverage for eligible individuals, and facilitate transitions for individuals who become eligible for other forms of coverage.
2. **Coordinate with partners, including state, Tribal, and government partners.** States can:
   - engage and leverage program information from sister state agencies including human services, information technology, public health, child welfare, justice, and education agencies.
   - consult with Tribes to support strategic planning and partnerships with Tribes and Indian health care providers (IHCP).
   - Leverage government agencies, such as state or local health departments, Indian health care providers, and social services agencies that contact beneficiaries can amplify messaging around renewing coverage.
   - Coordinate with the federally facilitated marketplace (FFM) or engage their state-based marketplace (SBM) to facilitate coverage transitions. States that operate SBMs may have additional opportunities to share resources for outreach and messaging to promote continuity of coverage. For example, Medicaid agencies can share information about individuals losing coverage due to a procedural reason with SBMs (including via account transfers) as a way to sustain coverage.
3. **Implement and strengthen automated processes**, including *ex parte* renewals, increasing methods for no touch case processing (acceptance of applications and renewals online and via phone), and automated beneficiary communications.

https://www.medicaid.gov/resources-for-states/downloads/top-10-fundamental-actions-to-prepare-for-unwinding-and-resources-to-support-state-efforts.pdf

10 Fundamental Actions for States to Prepare for Unwinding

4. **Work early and closely with eligibility system vendors** to identify changes, start planning, and perform robust end-to-end testing.
5. **Establish a renewal redistribution plan** distributed across a sufficient period of time and in a manner that mitigates churn, accounts for workforce and system capacity limitations, and establishes a sustainable renewal structure for future years.
6. **Engage community partners, health plans, and the provider community** to develop and implement beneficiary outreach and communication strategies for unwinding.
7. **Obtain updated contact information** by using multiple strategies to mitigate coverage losses at renewals. Strategies could include managing returned mail, partnering with plans, using multiple modalities to reach individuals (mail, email, text) and maintaining beneficiary contact.
8. **Launch effective communication strategies**, including consumer outreach and revised notices so beneficiaries know what to expect and what is needed to maintain coverage during unwinding.
9. **Assess eligibility, enrollment and fair hearings workforce capacity and ensure adequate staffing and sufficient training.**
10. **Develop a robust monitoring strategy, including ensuring infrastructure for timely required reporting to CMS.**

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Questions?

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