The End of the Public Health Emergency Is Not the End of the Story: What Happens to Health Insurance Coverage When the Medicaid Continuous Coverage Requirement Expires?

Hall Center for Law & Health
Virtual Grand Rounds Series

Indiana University
Robert H. McKinney School of Law

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Today's Presentation

- Overview of public health emergency (PHE) and Medicaid continuous coverage requirement
- What are the stakes?
- How states and the federal government are preparing for the unwinding of the PHE
- Strategies to mitigate coverage loss
- Partnerships and advocacy will be critical

The Public Health Emergency (PHE): The Basics

- Public health emergency declaration for COVID-19 was issued January 31, 2020 by then-HHS Secretary Alex Azar
  - Expires after 90 days unless renewed by HHS
  - Has been renewed nine times
  - Current end date is **July 14, 2022**
  - May be terminated at any time by HHS

The Public Health Emergency (PHE): The Basics

- When will it end?
- HHS has committed to providing states with at least 60 days' notice before termination
    - States should have received notice by May 16 if HHS planned to terminate PHE July 14
    - Therefore – absent that notice, can assume PHE will be renewed at least once more to run until mid-October

The Public Health Emergency: When Will it End?

Dear Governor:

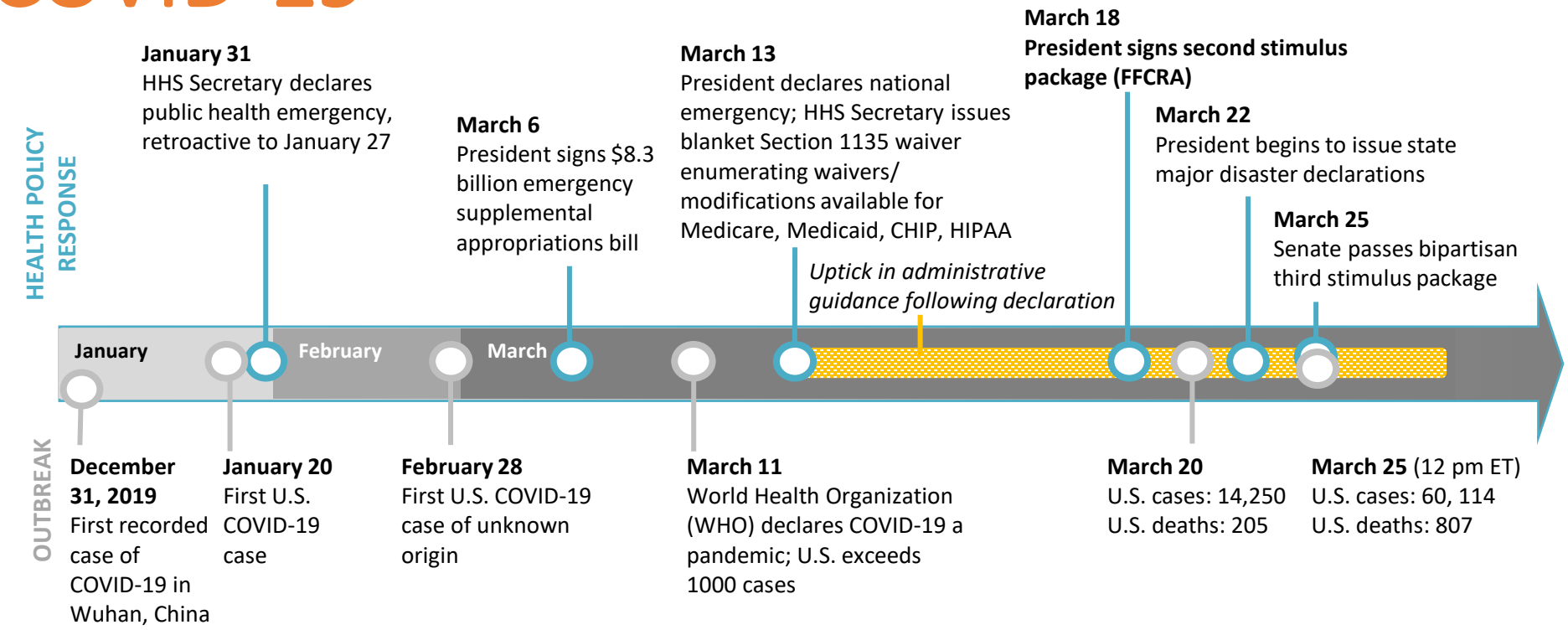
Thank you for your continued partnership as we further coordinate the Coronavirus Disease 2019 (COVID-19) response. This unprecedented time has shown the resilience and adaptability of states, and the importance of our shared planning and preparation.

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.

Polling Question

- When do you think the PHE will end?
  A. July 14, 2022
  B. October 13, 2022
  C. December 31, 2022
  D. January 14, 2023

Early Federal Health Policy Actions in Response to COVID-19



Source: Johns Hopkins University, Tracking Coronavirus COVID-19

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

In addition to the healthcare provisions—which focus largely on ensuring access to free testing across all payers as well as Medicaid fiscal relief—the law included emergency supplemental appropriations to agencies on the front lines of the response to the pandemic, $1 billion in food aid, the establishment of an emergency paid leave benefits program, and the extension of sick leave benefits

Key Medicaid/CHIP Provisions of FFCRA

Temporarily increase Medicaid Federal Medical Assistance Percentage (FMAP) *(Section 6008) – see upcoming slides*

Increase Medicaid allotments for U.S. territories *(Section 6009)*

Cover COVID-19 testing under Medicaid and CHIP without cost sharing *(Section 6004)*

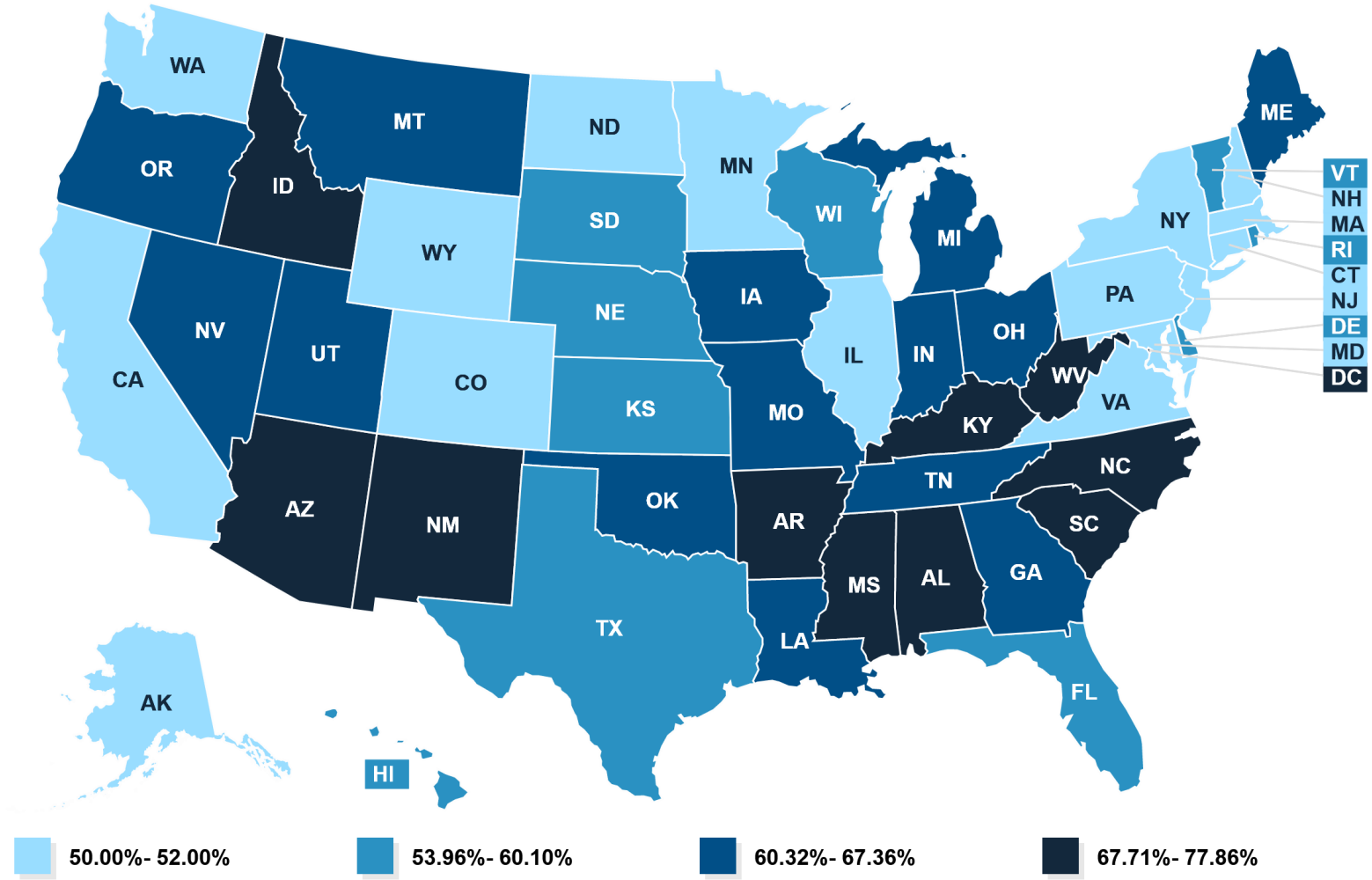
Extend Medicaid coverage to the uninsured for COVID-19 testing and testing-related services (*Section 6004)*

Pay COVID-19 testing claims for uninsured individuals through a Department of Health and Human Services (HHS) program *(Division A, Title V)*

What is FMAP?

- Reminder: Medicaid is a joint federal-state program of health and long-term care coverage for low-income Americans
- 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
  - Intended to reflect states' differing abilities to fund Medicaid from their own revenues
- By law, the FMAP cannot be less than 50%

FMAP for Fiscal Year 2023 (Current Year)



FFCRA Key Provision: Temporarily Increase Medicaid FMAP

Overview

- **Temporary 6.2% point increase** in the FMAP (match rate) for states and territories
  - Examples: California's new rate = 56.2%; Indiana = 71.86%, and Mississippi = 84.06%

Scope of Applicability

- Applies to the regular Medicaid match rate so long as states meet specific conditions

Effective Date

- 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

Polling Question

- Which state receives the highest FMAP?
  A. Alaska
  B. Indiana
  C. Mississippi
  D. Puerto Rico

Why Increase FMAP?

- Recognition that states on the front lines during pandemic incurring higher healthcare costs
  - Medicaid is countercyclical to economic growth: states have less revenue to deal with increased costs and enrollment
- Also a recognition that state budgets (and tax revenues) under stress because of drop in economic activity
  - Increased federal funding through Medicaid is efficient way to support states and prevent budget cuts
- Remember – states must balance their budgets every year!!

Temporary FMAP Increases Common During Recessions

Temporary Increases to FMAP in Response to Past Downturns

- During the past two major recessions, Congress has enacted stimulus packages that included additional FMAP
  - help support the additional demand for Medicaid
  - direct federal funds into local economies quickly via provider payments
- States did not need to make programmatic adjustments in order to access federal funds
- Need for congressional action meant stimulus funds were not available until months after recession began

Key Requirement for Increased FMAP: Medicaid Continuous Coverage Requirement

- To support states **and** promote stability of coverage during the pandemic, Congress included a "Medicaid continuous coverage requirement"

- Tied the FMAP increase to the condition that states maintain enrollment of nearly all Medicaid enrollees through the end of the month in which the PHE ends

Medicaid Continuous Coverage Requirement

- 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 must maintain coverage even for individuals who may have become ineligible since their last eligibility determination.

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

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).

What is the Normal Redetermination Process?

- Medicaid agencies redetermine enrollees annually
- Under the ACA, states have streamlined eligibility processes
- Goal is to automate as much as possible, to reduce enrollee burden and prevent churn
  - States must use available data (e.g. state wage or IRS data, SNAP data) to determine ongoing eligibility **before** requesting enrollee complete renewal form or provide documentation
  - Must then provide the individual with a pre-populated form and a reasonable period of time—at least 30 days—to provide 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

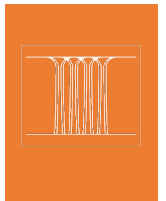
- Churn in Medicaid is common–roughly 2% of enrollees come on or leave the program in an average month (Kaiser)
- People typically enroll or disenroll from coverage for three main reasons:
  - Change in income
  - Change in circumstance other than income (for example, children may age out of coverage, people may move to another state or die); and
  - Barriers to 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

The Stakes Are High: Preparing for the Largest Health Care Event Since the Affordable Care Act

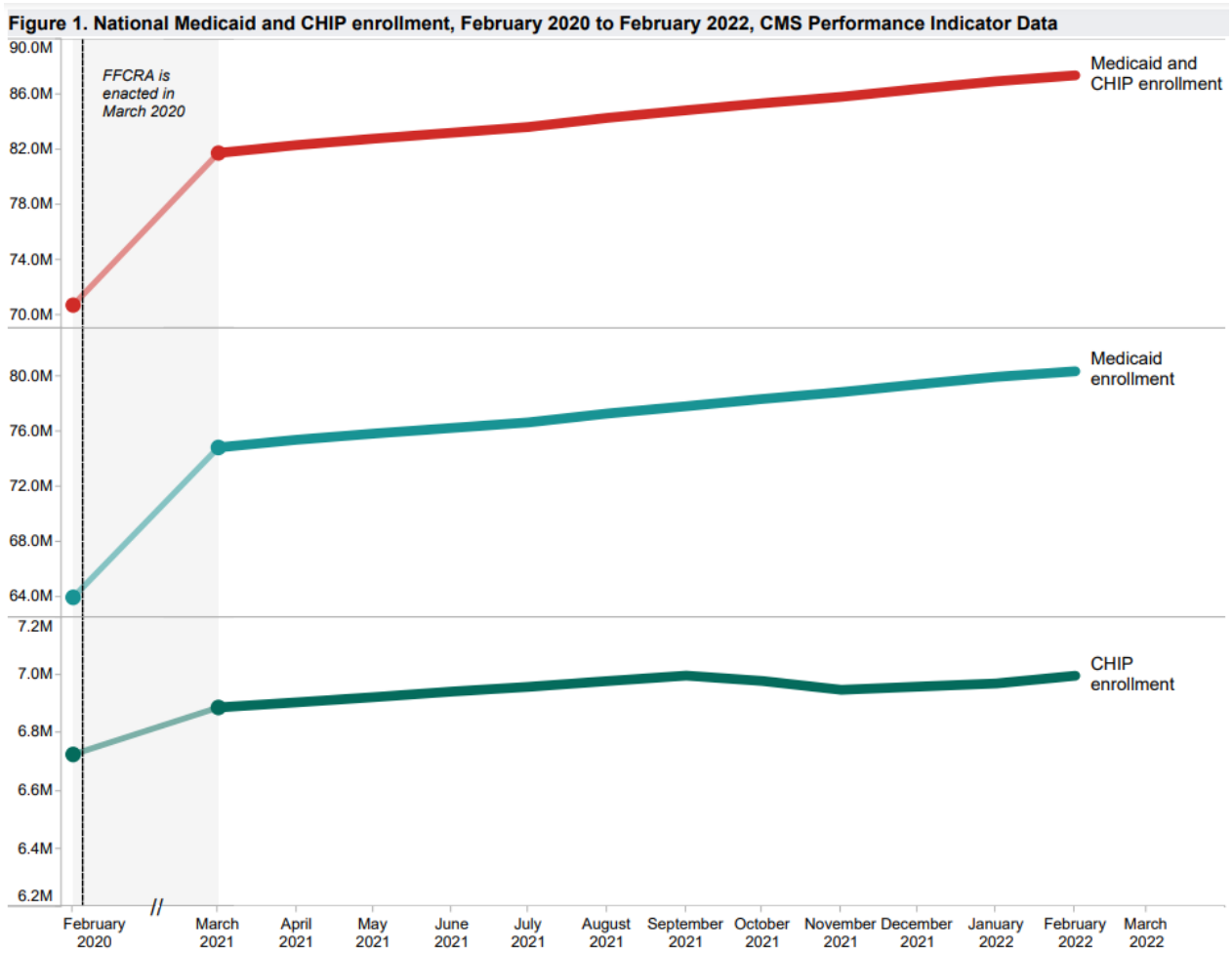
The continuous coverage provision has effectively eliminated churn in the Medicaid program and enabled people to retain coverage throughout the pandemic.

Protecting health coverage during the pandemic has led to increased enrollment:

- Since Feburary 2020, Medicaid/CHIP **enrollment has increased by just over 16 and half million individuals (23.7%).**
- At the end of the PHE, states will need to **redetermine eligibility for nearly *all* Medicaid enrollees**.
- 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)



The Stakes Are High: Unprecedented High Medicaid Enrollment

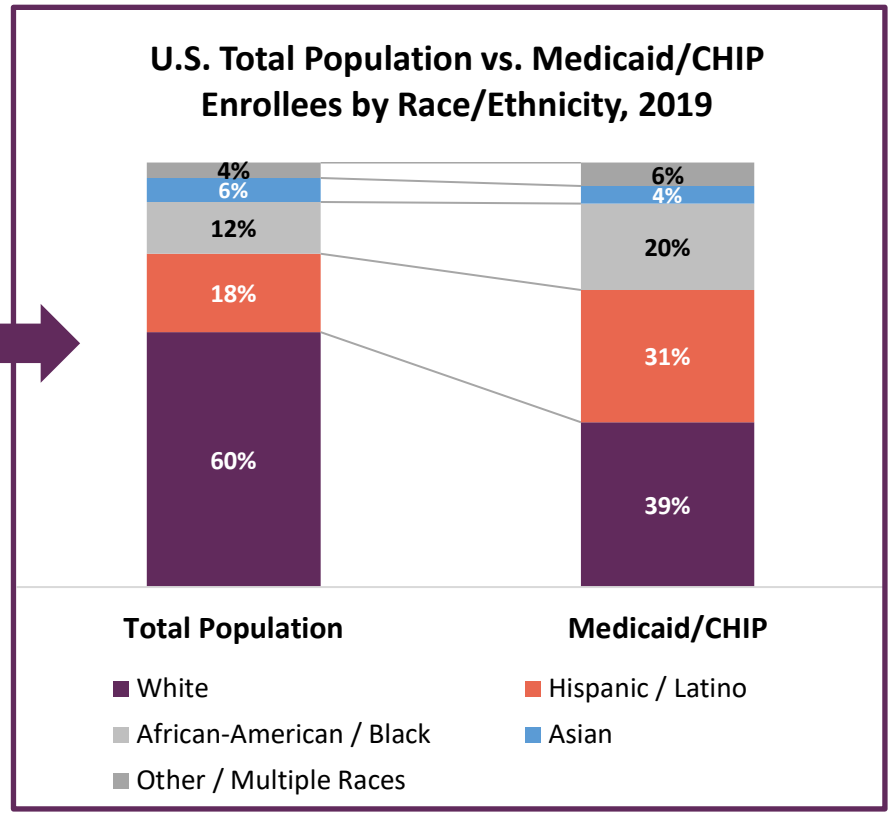


Source: CMS, [February 2022 Medicaid and CHIP Enrollment Trends Snapshot]

Medicaid/CHIP enrollment is at historic high – up 23.6% to 87 million since February 2020 – likely driven by the pandemic and the continuous enrollment requirement

Significant Equity Implications

- 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, thus increases chances that these individuals could lose coverage for administrative reasons at the end of the PHE.



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.

Policy Goals for the End of the PHE

- Ensure people **maintain health coverage** for which they are eligible and **access to care**
  - Medicaid or CHIP, or
  - Subsidized ACA Marketplace coverage, or
  - Employer-sponsored insurance
- AND **prevent exacerbating** already widespread racial and ethnic **disparities** in the healthcare system
- AND strengthen foundation of coverage to achieve more of the ACA's promise of **streamlined eligibility and enrollment**?

The Continuous Coverage Requirement: the Consumer Experience

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."

The Continuous Coverage Requirement: the Consumer Experience

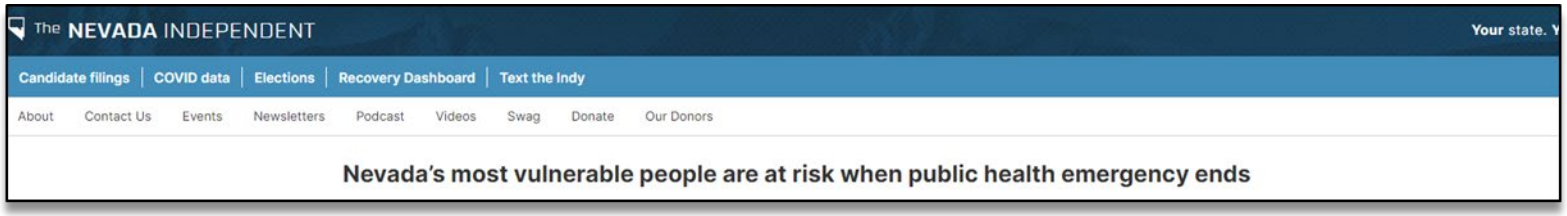
Quotes from qualitative research demonstrate how consumers value the importance of health insurance and the role it has played in their lives during the pandemic.

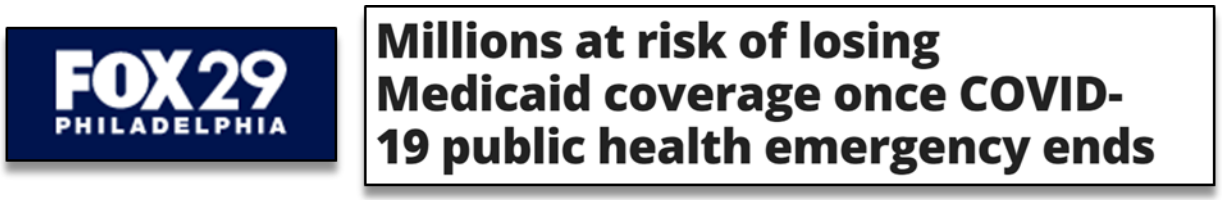
"I broke a bone, I had surgery, my husband got in a car accident, all in the same year. It was tough enough even with health insurance, it almost financially ruined us."

"I have health insurance because I have a house and I don't want to lose it over medical bills. And I am 57 and a am getting to the age where I could be diagnosed with something catastrophic."

"Certainly, I'd like good care when I need it, but I think more just about not having to start a GoFundMe page which seems to be the method in America for saving people."

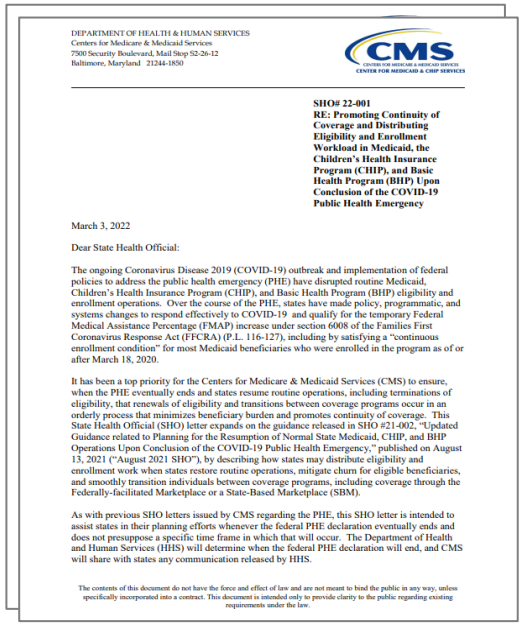
Consumers Are Unaware of What's at Stake





Overview of Federal Guidance on Unwinding

Guidance issued by CMS on March 3, 2022, clarified federal expectations of state Medicaid/CHIP agencies as they prepare to process eligibility redeterminations 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 MEDICARE & MEDICAID SERVICES
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 space out renewals (no more than 1/9th caseload a month) to establish a sustainable renewal schedule.

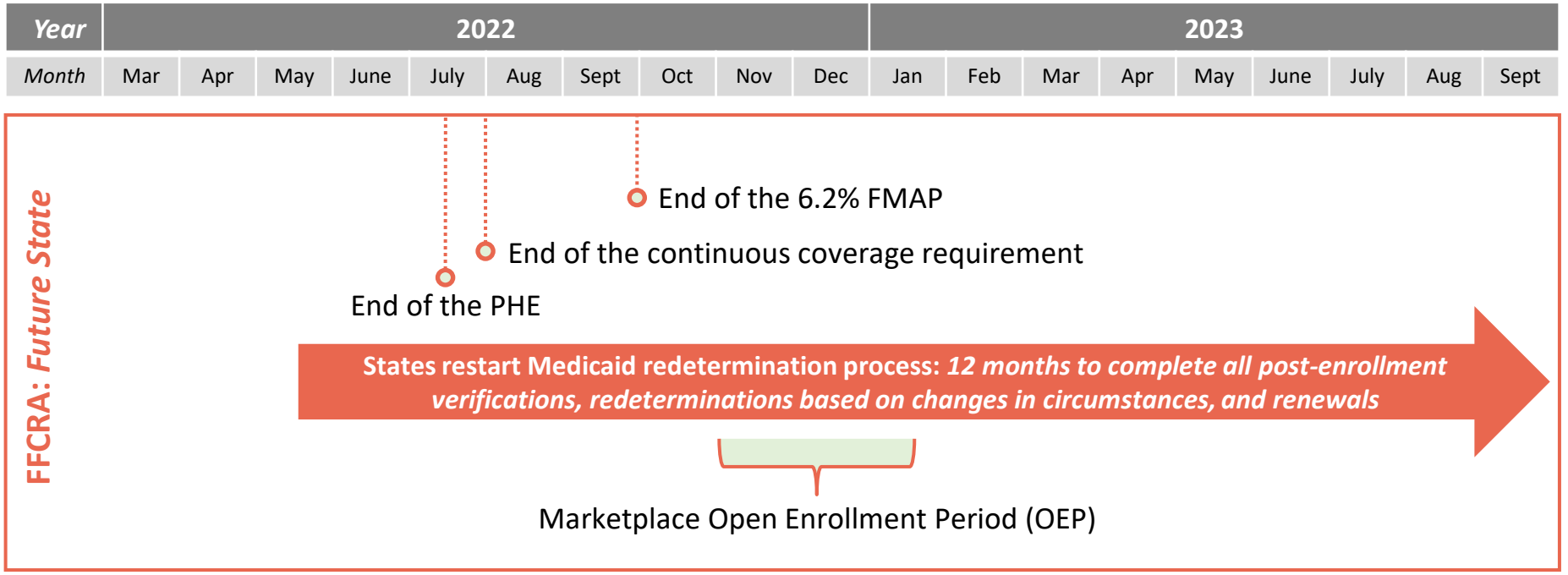
Provides clarification that states may begin their **12-month unwinding period** up to two months prior to the end of the PHE. States will need to initiate all renewals by the last month of the 12-month unwinding period and complete all actions by the end of the 14th month after the end of the PHE.

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.

FFCRA Unwinding Illustrative Timeline



Timeline Notes: The federal PHE is currently slated to end on July 14. Because the United States (U.S.) Department of Health and Human Services (HHS) has promised to provide states with 60 days' notice prior to termination, it is likely that the PHE will get pushed out until October 2022, or even further. 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); Centers for Medicare & Medicaid Services (CMS), State Health Official (SHO) Letter # 22-001; SHVS, Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates.

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.

Polling Question

- How long do states have to complete all redeterminations?
  A. Six months
  B. Eight months
  C. Twelve months
  D. Twenty-four months

Federal Actions to Prepare for Unwinding

In preparation for the end of the continuous coverage requirement, CMCS and CCIIO are working together and with federal partners to support states' unwinding needs and make sure Healthcare.gov is prepared for unwinding.

- ✓ Engaging in **regular meetings across federal agencies and with states** on unwinding.
- ✓ Providing **robust technical assistance to states**, including the development of joint guidance and resources to support unwinding.
- ✓ Exploring **temporary flexibilities** for state Medicaid/CHIP agencies and the Marketplace
- ✓ Planning to **implement a Healthcare.gov special enrollment period (SEP)** that would extend beyond 60 days for the Federally-Facilitated Marketplace (FFM).
- ✓ Developing a comprehensive **Healthcare.gov consumer and stakeholder engagement strategy**.

CMCS = Center for Medicaid and CHIP Services; and CCIIO = Center for Consumer Information and Insurance Oversight.

Renew Your Medicaid or CHIP Coverage

As COVID-19 becomes less of a threat, states will restart yearly Medicaid and Children's Health Insurance Program (CHIP) eligibility reviews. This means your state will use the information they have to decide if you or your family member(s) still qualify for Medicaid or CHIP coverage. If your state needs more information from you to make a coverage decision, they'll send you a renewal letter in the mail. Most children can still be covered through the Children's Health Insurance Program. For details, check your Medicaid notice or contact your state Medicaid office at the links below.

Get ready to renew now

Here are some things you can do to prepare for the renewal process:

1. **Update your contact information -** Make sure your state has your current mailing address, phone number, email, or other contact information. This way, they'll be able to contact you about your Medicaid or CHIP coverage.
2. **Check your mail -** Your state will mail you a letter about your coverage. This letter will let you know if you need to complete a renewal form to see if you still qualify for Medicaid or CHIP.
3. **Complete your renewal form (if you get one) -** Fill out the form and return it to your state right away to help avoid a gap in your coverage.

If you no longer qualify for Medicaid or CHIP

You may be able to buy a health plan through the Health Insurance Marketplace®, and get help paying for it. Marketplace plans are:

- 4 out of 5 enrollees can find plans that cost less than $10 a month.
- Plans cover things like prescription drugs, doctor visits, urgent care, hospital visits, and more.

Challenges States Face in Preparing for Unwinding

Beyond unprecedented enrollment growth that will result in E&E backlogs, Medicaid/CHIP agencies are confronting other barriers that amplify the risk of coverage loss post-PHE.

Key Barriers Identified by Medicaid/CHIP Agencies:

E&E, consumer support, and appeals workforce issues (related to hiring, training, and variability in processes).

Inability to reach/ communicate with members (e.g., due to moving, resulting in returned mail) and capturing members' attention.

Competing priorities (e.g., managed care re-procurement, OEP, wind down of temporary emergency authorities).

Source: CMS, Medicaid and CHIP Continuous Enrollment Unwinding: A Communications Toolkit.

Strengthening the Renewal Process

States can take additional steps to mitigate workforce constraints and prevent inappropriate coverage loss among Medicaid/CHIP enrollees by implementing changes that will increase the percentage of successful ex-parte renewals. Strategies to increase the percentage of ex-parte renewals include:

Expanding the number and types of data sources used for renewal [e.g., Internal Revenue Service (IRS), quarterly wage data]; and automating the data verification process.

Leveraging data from other means-tested programs like Supplemental Nutrition Assistance Program (SNAP) when verifying Medicaid eligibility.

Creating a data source hierarchy to guide verification, prioritizing the most recent and reliable data and verifying income when data confirms reasonable compatibility.

Using a reasonable compatibility threshold for: (1) income for MAGI/non-MAGI populations, and (2) assets for non-MAGI populations.

Increasing the reasonable compatibility threshold for income (e.g., to 20%).

Streamlining, increasing levels for, or eliminating asset requirements for non-MAGI populations.

States can also streamline renewals that are unable to be completed through the ex-parte process–e.g., pre-populate renewal forms, extend the deadline for responding to requests for additional information, accept reasonable explanations of inconsistencies or to allow for self-attestation of certain eligibility criteria.

Source: CMS, Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations..

States Are Improving Policies and Procedures

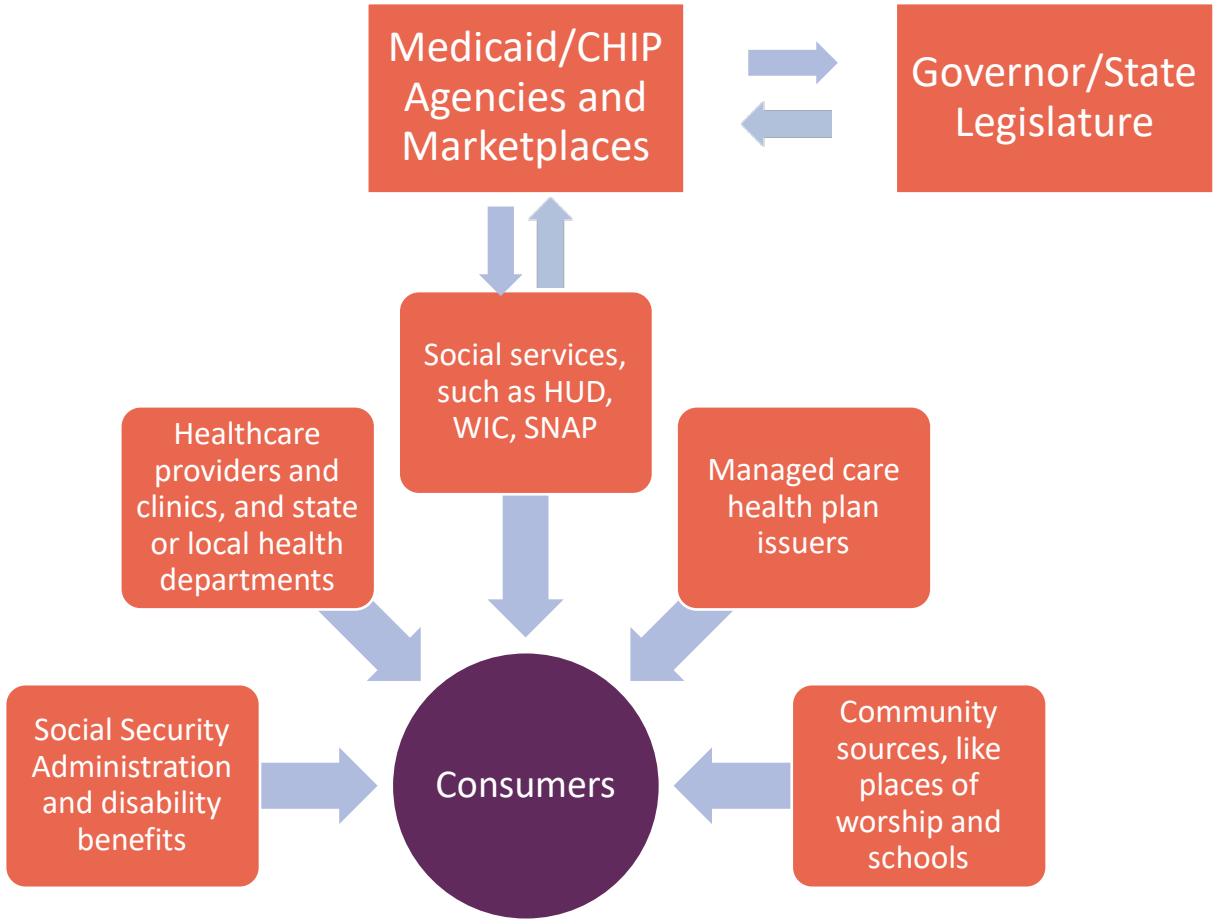
- Strengthening *ex parte* renewal processes
  - Using third party data sources reduces procedural denials and administrative workload
- Reducing returned mail (texting campaigns, “pink letter” mailings)
- Improve account transfer (to healthcare.gov or SBM)
- Developing outreach/communications plan with partners for outreach, communications and navigation assistance

States Are Improving Policies and Procedures (con't)

- 12 months postpartum coverage extensions (11 states so far)
- Phased approach by population, give people more time to complete process, smoother transitions to marketplace
- Timing renewal for people turning age 65 so that they can transition more seamlessly to Medicare coverage
- Adopt 12 months continuous eligibility
  - Reducing the administrative costs associated with enrollees cycling on and off of Medicaid due to temporary fluctuations in income

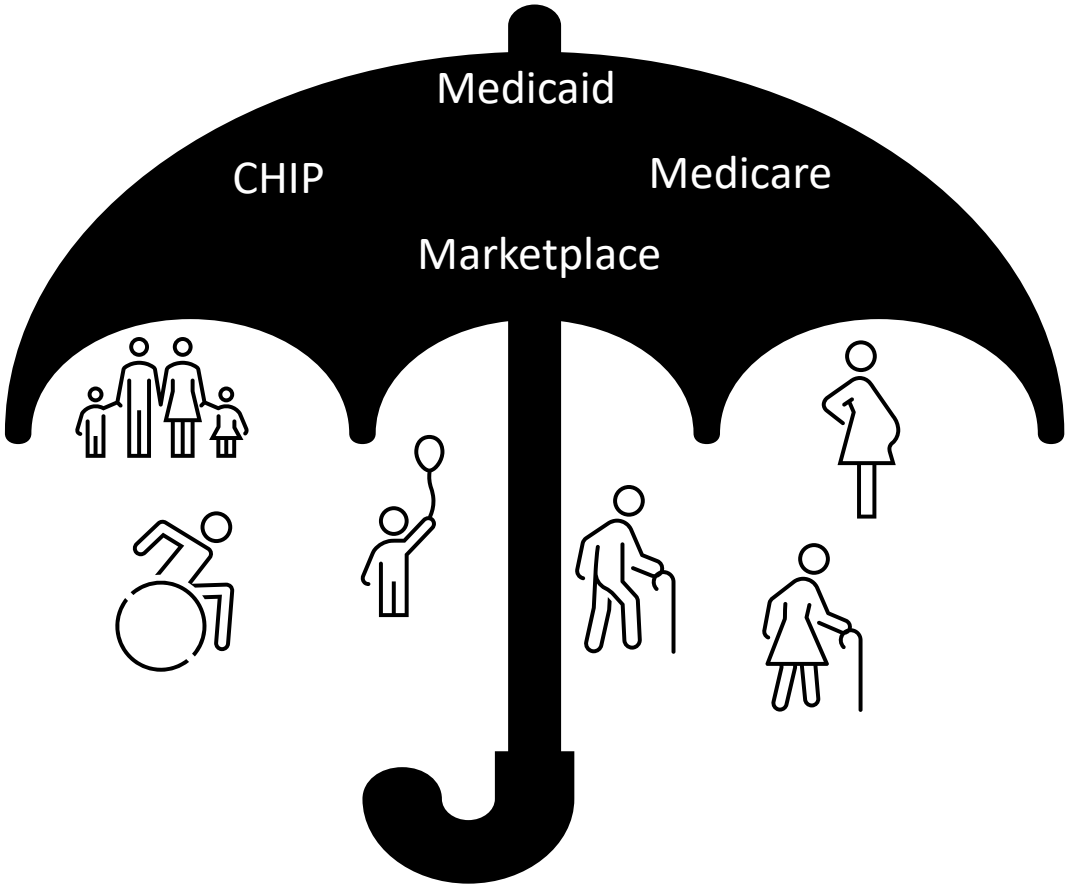
Medicaid and Marketplace Stakeholder Coordination

Medicaid/CHIP agencies and Marketplaces should collaborate with other state agencies and stakeholders to establish a feedback loop, coordinate outreach, share messaging, report progress and triage issues.



Medicaid and Marketplace Coordination to Reach Consumers

Medicaid/CHIP agencies and SBMs must recognize the various categories of consumers, the types of coverage they qualify for, and focus on transitioning those people to the appropriate coverage.



Partnerships and Advocacy Are Critical

- Partnership between federal and state governments, community-based organizations (CBOs), providers, health plans, and advocates are critical
  - Unique stakeholder alignment for maintaining coverage

AMA and other health groups lobby to extend public health emergency

May 12, 2022
Todd Shryock

Payers, Medicaid officials ask Congress for 120-day glide path to end of COVID-19 emergency

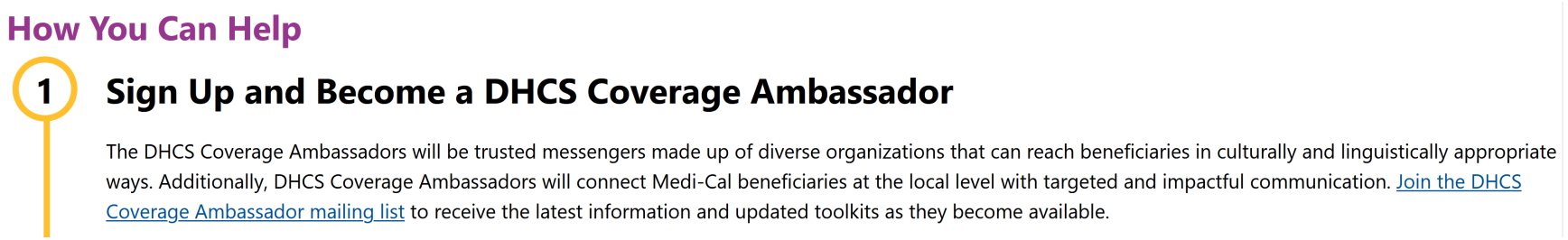
By **Robert King** • Feb 18, 2022 01:46pm

Insurance lobbying group AHIP signed on to the letter as well as Medicaid Health Plans of American and National Association of Medicaid Directors.

Other advocacy groups such as the National Association of Community Health Centers and Association for Community Affiliated Plans signed on.

States Are Collaborating With Stakeholders

- **Massachusetts:** $5 million for a community-based outreach to support redetermination process.
  - Health Care for All Massachusetts will (1) leverage CBOs to conduct one-on-one outreach in communities that have the highest potential risk of coverage loss, and (2) launch local ethnic media campaign.
- **Virginia** 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.
- **California** Department of Health Care Services – Ambassador Toolkit



How You Can Help

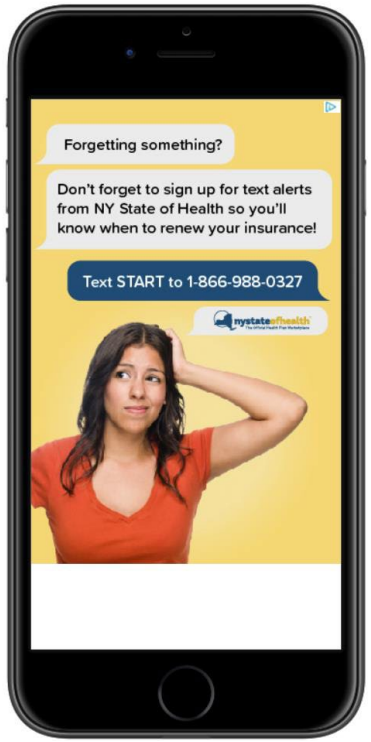
1 **Sign Up and Become a DHCS Coverage Ambassador**

The DHCS Coverage Ambassadors will be trusted messengers made up of diverse organizations that can reach beneficiaries in culturally and linguistically appropriate ways. Additionally, DHCS Coverage Ambassadors will connect Medi-Cal beneficiaries at the local level with targeted and impactful communication. Join the DHCS Coverage Ambassador mailing list to receive the latest information and updated toolkits as they become available.

NY STATE OF HEALTH "STAY CONNECTED" CAMPAIGN

DIGITAL MEDIA – Mobile Banner

Spanish



English

Chinese

nystateofhealth
The Official Health Plan Marketplace

Arkansas Medicaid Outreach

Arkansas Medicaid Clients Asked To Update Contact Information To Prepare For End Of Public Health Emergency

04/27/2022

LITTLE ROCK, Ark. — The Arkansas Department of Human Services (DHS) is preparing for the end of the COVID-19 Public Health Emergency by asking all ARHOME, PASSE, ARKids, and Arkansas Medicaid clients to update their contact information. This is the first step in the process to make sure eligible clients keep their coverage.

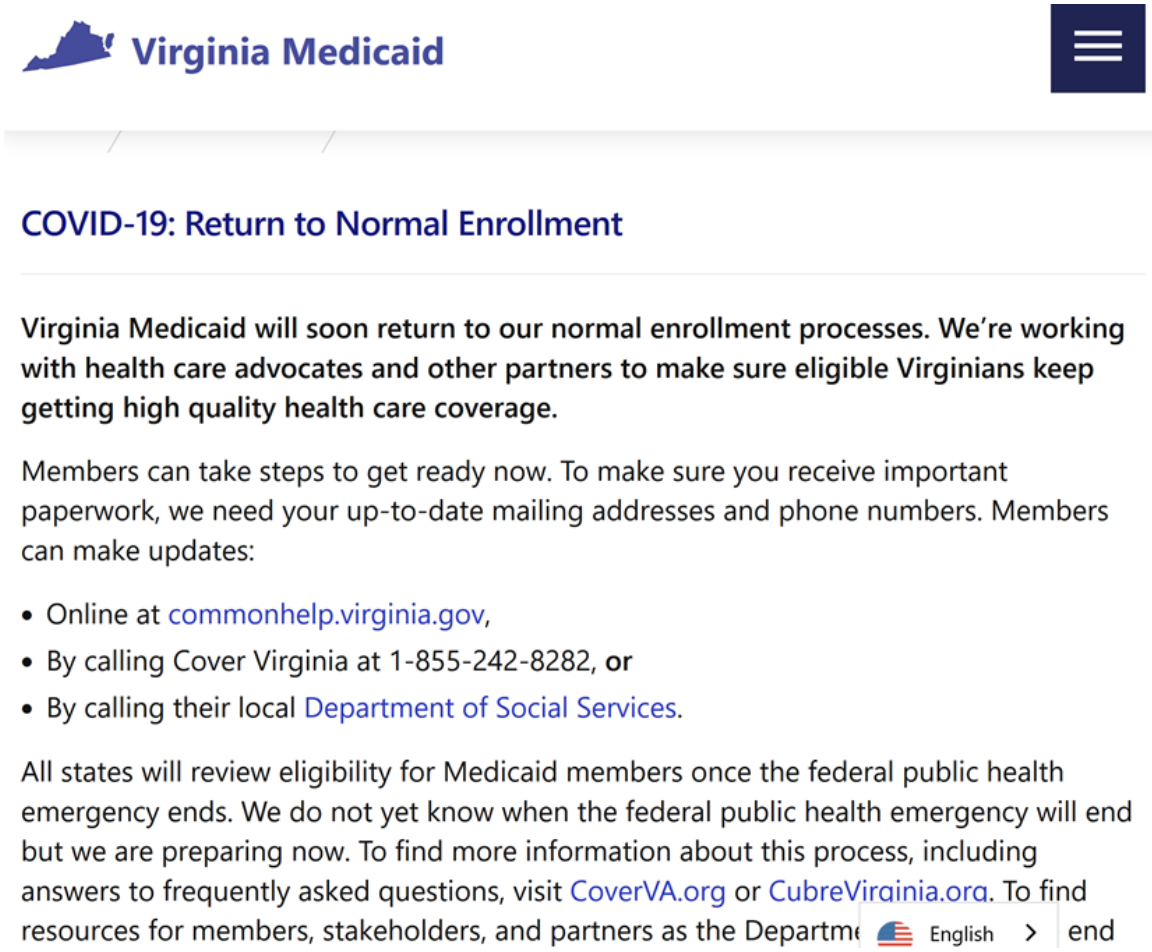
In March 2020, the federal government began allowing states to temporarily stop disenrolling Medicaid clients, even if they were no longer eligible, to help prevent people with Medicaid from losing their health coverage during the pandemic. Only clients who died, moved out of state, were incarcerated, or asked that their coverage end had their cases closed.

The Public Health Emergency was recently extended through July 15, 2022. While it could be extended again, it's important for Medicaid clients to begin preparing by making sure their correct contact information is updated on file.

"We want everyone who is eligible for Medicaid to keep their coverage," said DHS Deputy Director for Health and Medicaid Director Dawn Stehle. "Those clients who had their coverage extended due to the Public Health Emergency will need to watch for important information from DHS, so it's critical that they take time now to make sure their address is correct."

Clients can quickly and easily update their information, or verify that it is already correct, through one of several ways:

Virginia Medicaid Outreach



Virginia Medicaid

COVID-19: Return to Normal Enrollment

Virginia Medicaid will soon return to our normal enrollment processes. We're working with health care advocates and other partners to make sure eligible Virginians keep getting high quality health care coverage.

Members can take steps to get ready now. To make sure you receive important paperwork, we need your up-to-date mailing addresses and phone numbers. Members can make updates:

- Online at commonhelp.virginia.gov,
- By calling Cover Virginia at 1-855-242-8282, **or**
- By calling their local Department of Social Services.

All states will review eligibility for Medicaid members once the federal public health emergency ends. We do not yet know when the federal public health emergency will end but we are preparing now. To find more information about this process, including answers to frequently asked questions, visit CoverVA.org or CubreVirginia.org. To find resources for members, stakeholders, and partners as the Departme

English

end

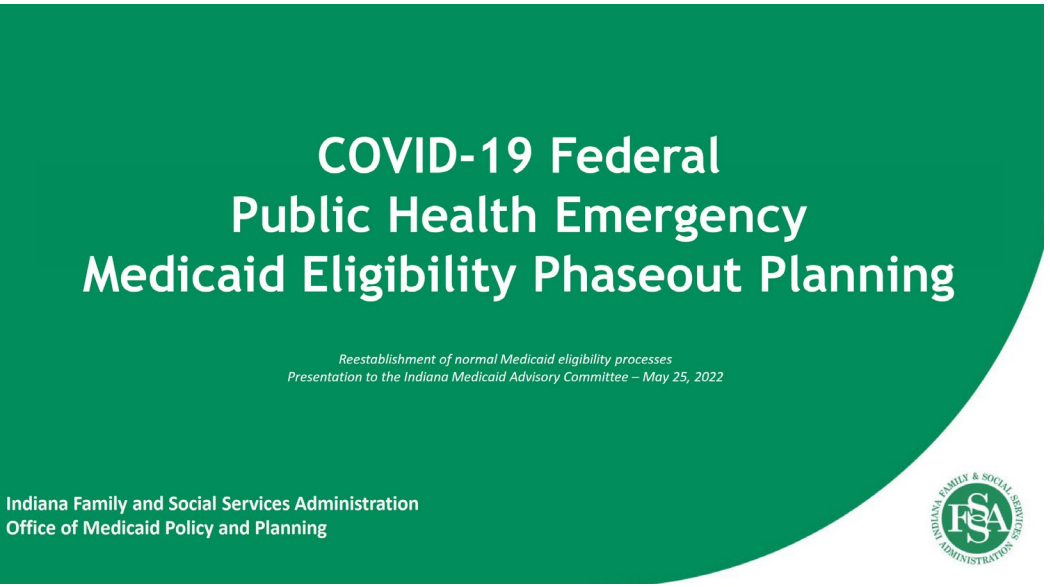
California and Connecticut Medicaid Outreach

****The Covered Connecticut Program** may provide free health coverage if you don't qualify for HUSKY Health/Medicaid. Please visit www.ct.gov/dss/accesshealthctCoveredCTProgram.

*****HAS YOUR CONTACT INFORMATION CHANGED?** Don't miss important communications regarding your benefits. Update your contact information online now! If you're a HUSKY A, B or D member, go to www.accesshealthct.com and sign in to your account. If you're a HUSKY C member, go to www.connect.ct.gov or www.mydss.ct.gov and sign in to your MyAccount.

Important Are you enrolled in Medi-Cal? Has your contact information changed in the past two years? Give your local county office your updated contact information so you can stay enrolled. **Find your local county office.**

Indiana: Transparent Planning Process



*Current Status and CMS Requirements

CMS has stated they will provide states a 60-day notice prior to the end of the federal public health emergency

- The federal PHE was most recently renewed through July 15th
  - We did not receive a 60-day notice, so we expect it will be extended again
- States have 12 months to return to normal operations; we plan to distribute our work over the full 12-month period after the federal public health emergency ends

*Subject to change by legislation and/or updated guidance

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Indiana: Timeline

Once the Federal PHE Ends…

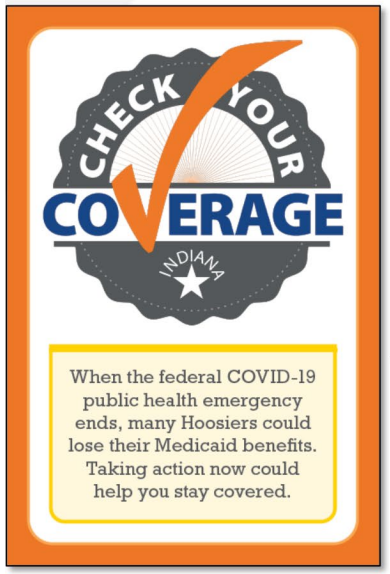
Individuals who remained open solely due to federal PHE maintenance of eligibility rules will be reassessed when their scheduled annual redetermination is due

- This is approximately 25% of our total membership
- We will process roughly 1/12 of this group each month

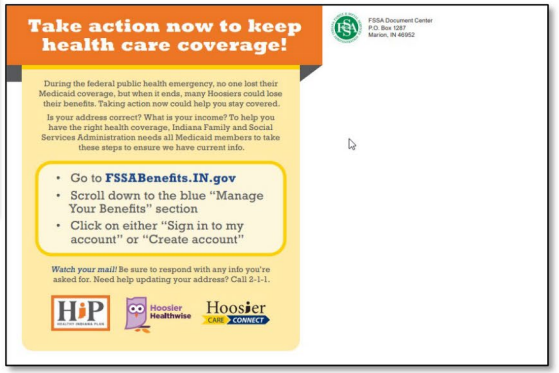
Individuals in this group cannot be closed or moved to a lesser-coverage category before their full redetermination process is completed

Indiana: Communicating with Medicaid Enrollees

Member Communications



Postcard



Poster

Indiana: Transitions to Healthcare.gov for Marketplace Coverage

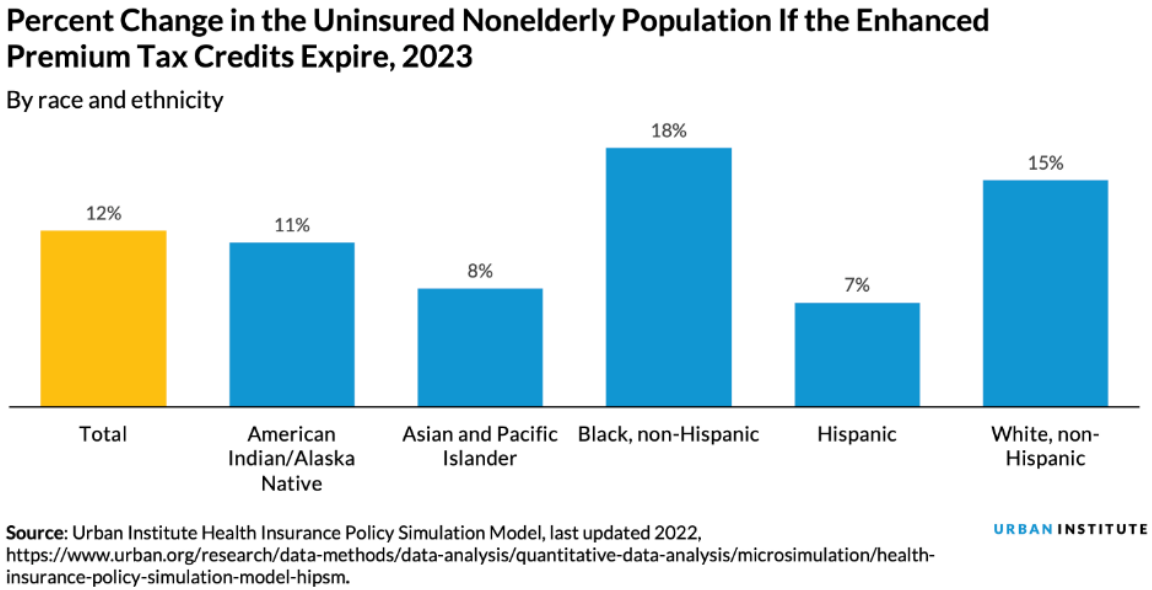
Transitions to Other Coverage

- Individuals who are over the income limit for Medicaid will have their information transferred to the federal Marketplace (Healthcare.gov) and be given a Special Enrollment Period to apply for coverage there

- Those who are closed for failing to verify their income or other eligibility factors will be eligible to apply on the Marketplace at any time during 2022 as long as their income is under 150% of the federal poverty level

What Else Will Impact the Unwinding? ARPA Subsidies in Doubt

- Will Congress extend the American Rescue Plan premium tax credits?
  - The American Rescue Plan Act (ARPA) *temporarily* enhanced and expanded premium tax credits for Marketplace plans in 2021 and 2022.
  - At the end of open enrollment in January 2022, 14.5 million people had selected a plan—**2.5 million more** than the previous year

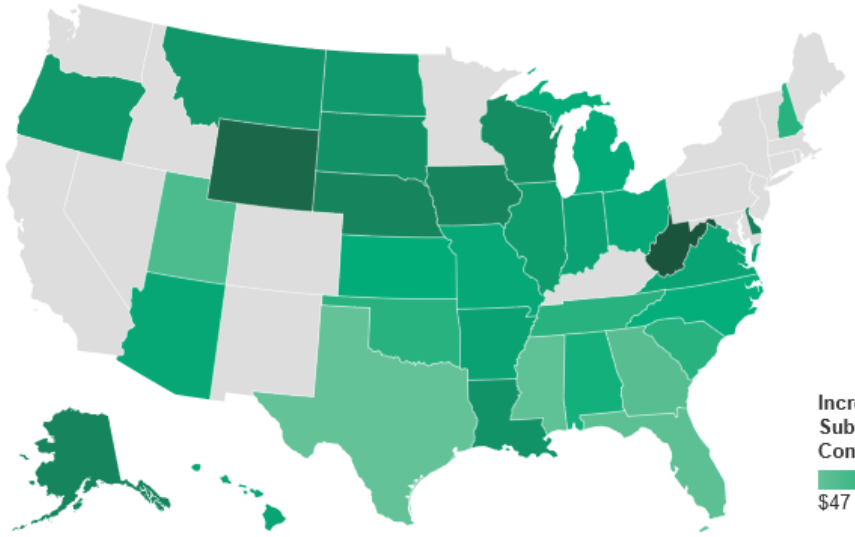


What Else Will Impact the Unwinding? (cont'd)

- What expiration could mean for premiums
  - Those who continue to purchase coverage through the Marketplace would experience much higher premiums
  - Many people facing higher out-of-pocket premiums would drop out of the Marketplace

Figure 2

Net Premium Payments on Healthcare.gov Would be 53% Higher without the American Rescue Plan Act



NOTE: Data not available for states operating their own exchange markets (shaded in gray)
SOURCE: CMS open enrollment report, 2022 • PNG

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End of PHE Lends New Urgency to Continuity of Care Issues

As many as 16 million people could be terminated from Medicaid after the end of the PHE; one-third of these are projected to be eligible for Marketplace coverage

- To what extent do Medicaid MCO and Marketplace Qualified Health Plan (QHP) networks align in your market?
  - What about behavioral health?
- Do your state's continuity of care laws protect people in the middle of treatment who transition from an MCO to a QHP?
  - 39 states have continuity of care laws but only 13 cover transitions from Medicaid
- Can QHP issuers be required to honor MCO carriers' prior authorization and/or step therapy approvals?
- Can deductibles be pro-rated for people who enroll mid-year?

Consumer education challenge: those transitioning from Medicaid MCOs may not be familiar with deductibles and other point-of-service cost-sharing.

Source: https://www.shvs.org/wp-content/uploads/2022/03/The-End-of-the-Public-Health-Emergency_How-State-Insurance-Regulators-Can-Prepare.pdf

What to Expect

- Congress could act to change timeline for when continuous coverage requirement ends and parameters for continued receipt of enhanced FMAP
  - Note: Build Back Better would have phased down the enhanced FMAP and established consumer protections
    - Passed U.S. House, stalled in Senate -- so unlikely
- Will Biden Administration set a date certain for end of PHE or keep extending?
- Will any states want to give up the enhanced FMAP in order to restart redeterminations?

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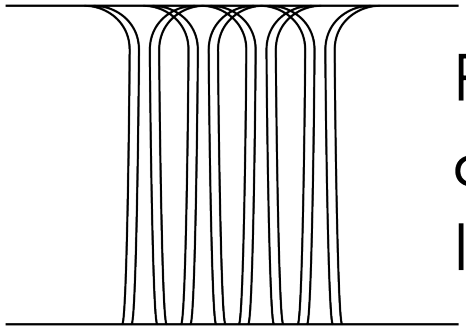

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