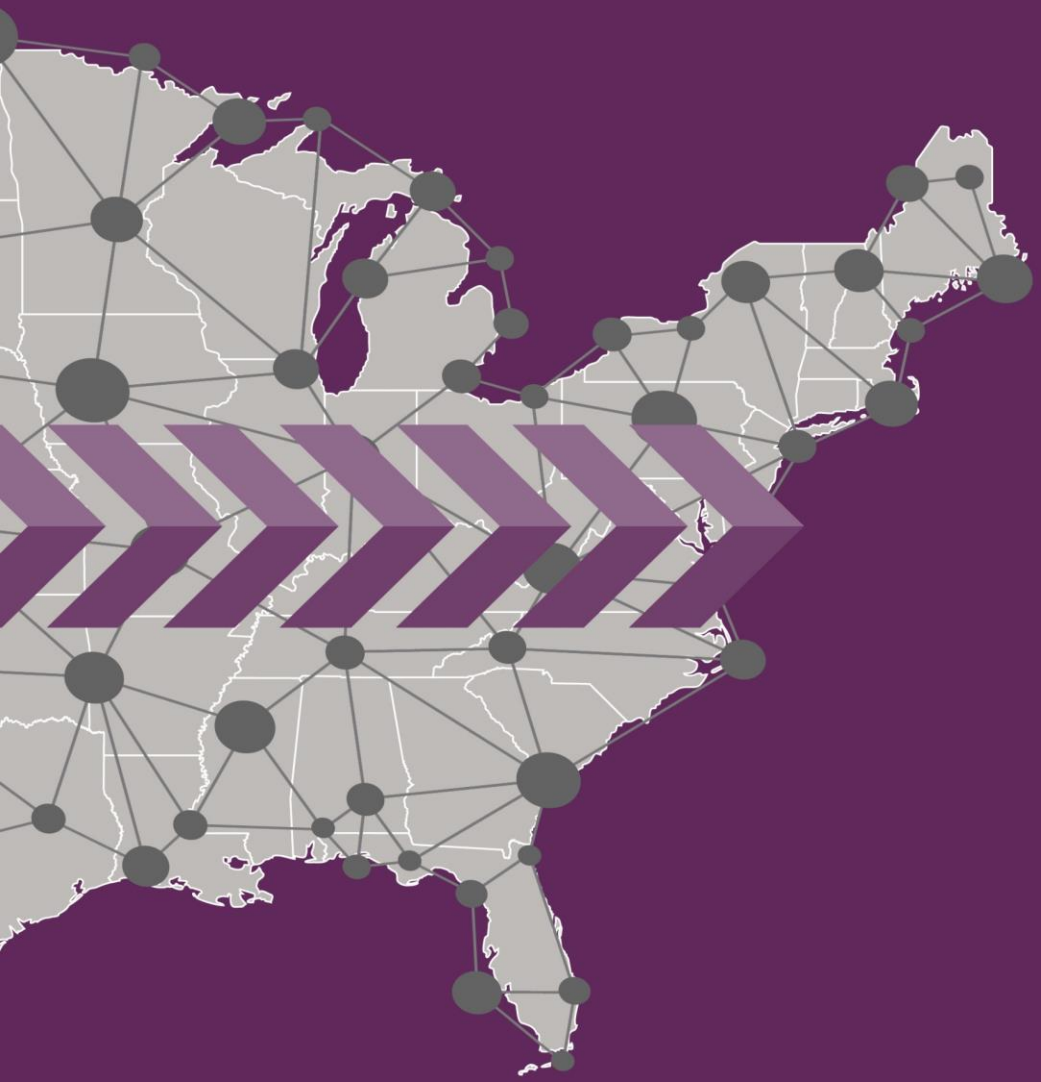


Michigan Health Policy Series

Unwinding the Public Health Emergency

Heather Howard

September 20, 2022

STATE Health & Value STRATEGIES

A grantee of the Robert Wood Johnson Foundation

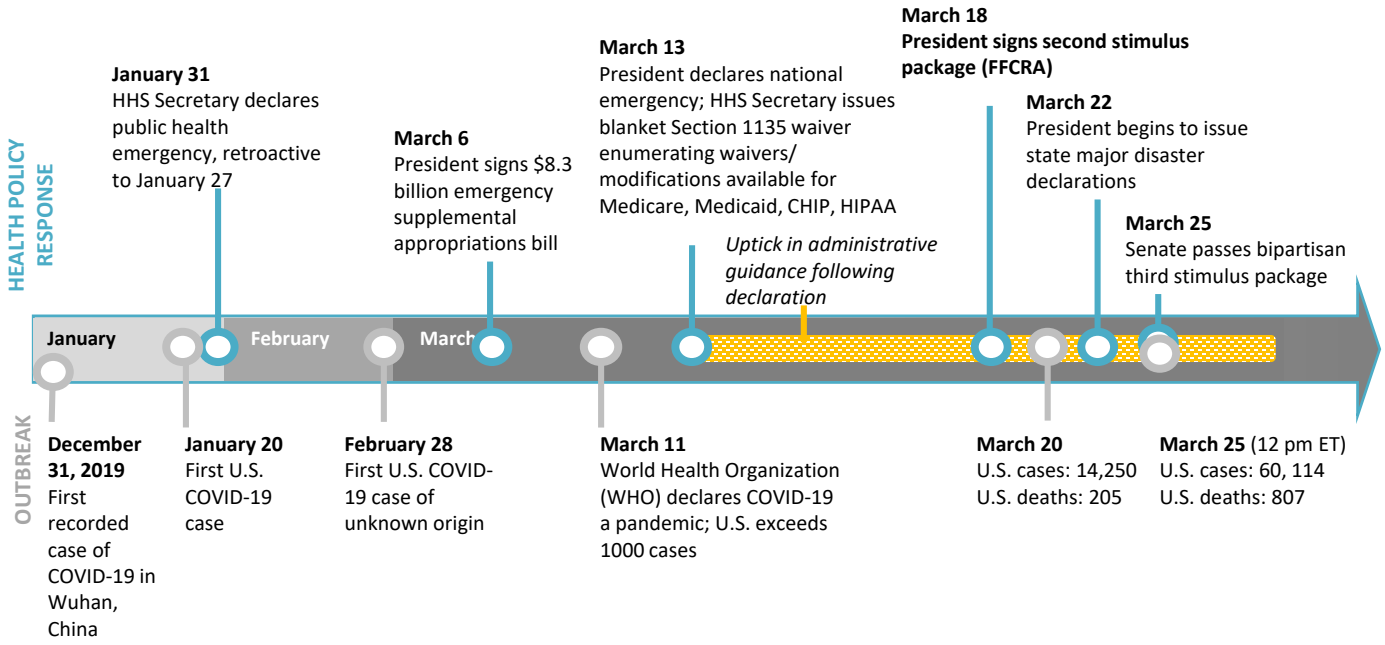
Today's Presentation

- Overview of the PHE
- What's at stake
- Issues states face
- Strategies to mitigate coverage losses
- Preserving continuity of care
- SHVS Resources

Key Points

- Stakes are high
- What are the policy goals for the unwinding?
- Partnerships and advocacy are critical
- Federal and state examples

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)*

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%; **Michigan = 70.91%,** 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

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

Medicaid Continuous Coverage Requirement

To support states and promote stability of coverage during the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) provided a 6.2 percentage point increase in the regular Medicaid matching rate, 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.

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 COVID-19 Federal Public Health Emergency

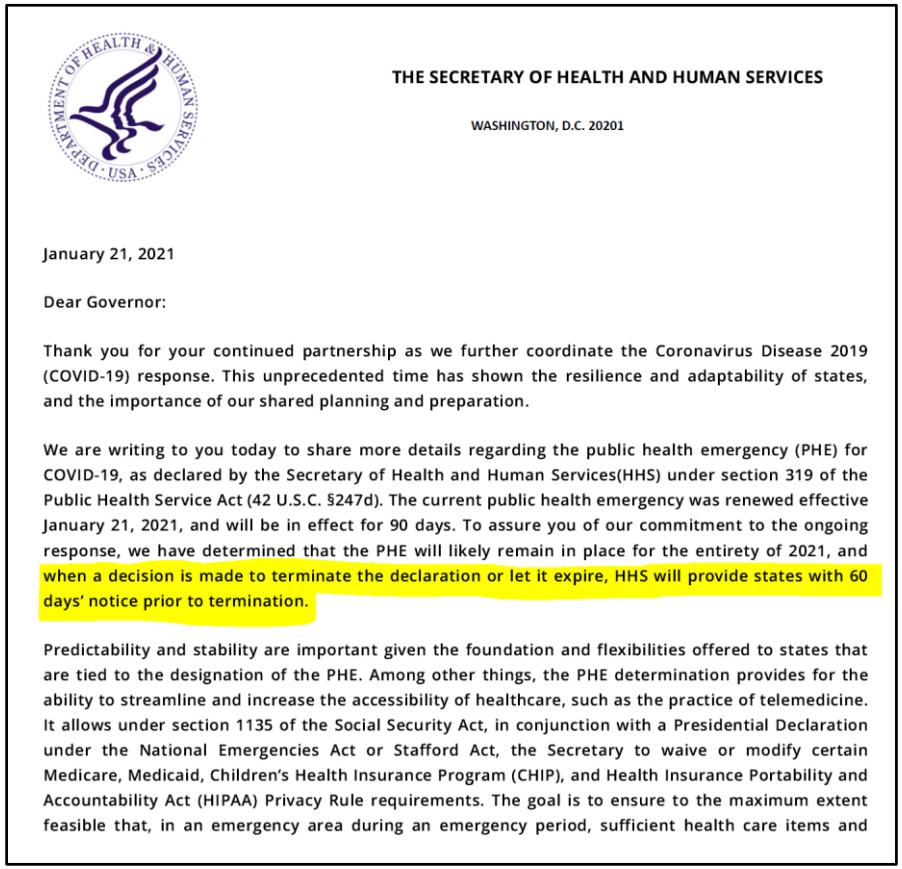
The public health emergency declaration for COVID-19 was issued January 31, 2020 by then-HHS Secretary Alex Azar.

Key Facts:

- Expires after 90 days unless renewed by HHS
- Has been renewed ten times
- Current end date is **October 12, 2022**
- 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) would be ending October 12, 2022 **was August 14**. *In the absence of such notice, we can assume that the PHE will be extended on October 13 for an additional 90 days,* ***until January 11, 2023.***

Source: Letter to Governors on the COVID-19 Response



THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

January 21, 2021

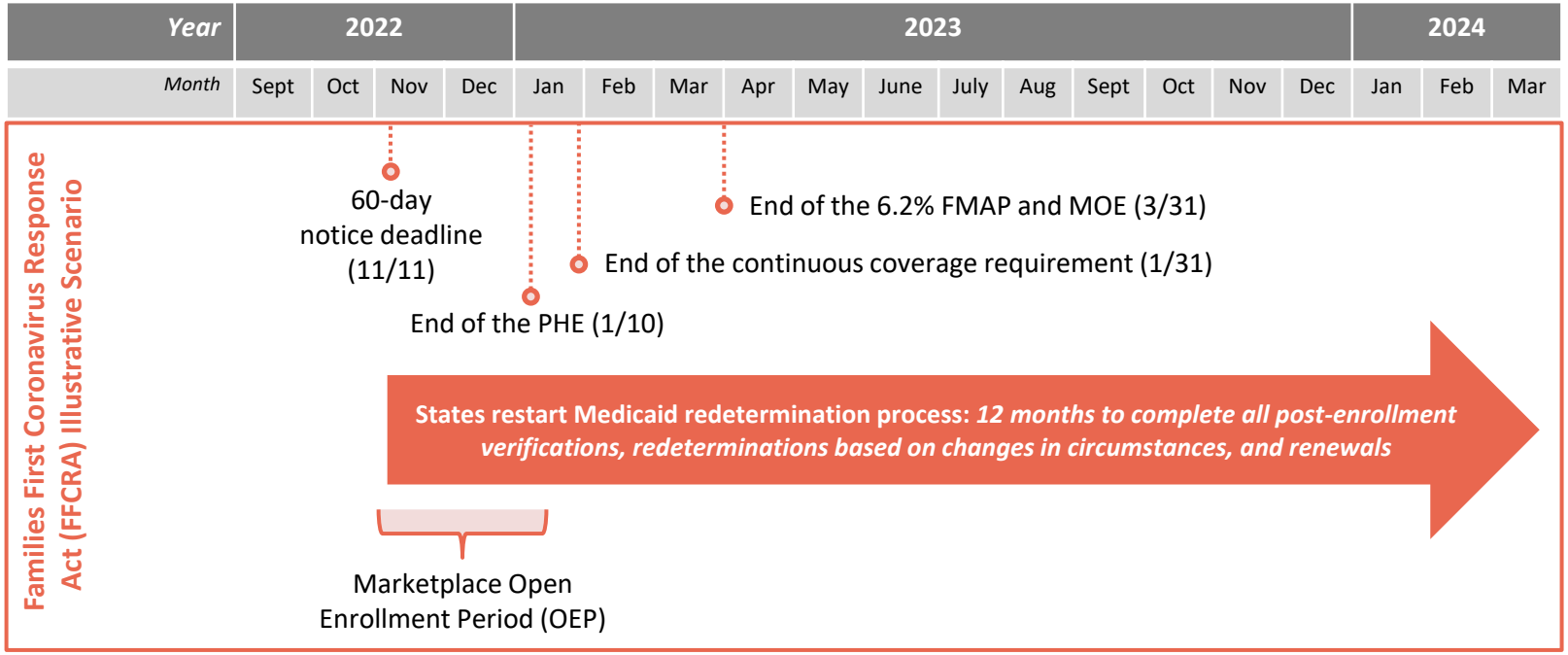
Dear Governor:

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

Illustrative Federal PHE Timeline *(Assuming PHE Extension)*



Timeline Notes: The federal PHE is currently in effect through October 12, 2022. Because the United States (U.S.) Department of Health and Human Services (HHS) has promised to provide 60 days' notice prior to termination and this 60-day mark has passed, states can assume that the PHE will get pushed out further, likely until January 2023 (as is reflected here). 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.

THE STAKES ARE HIGH

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

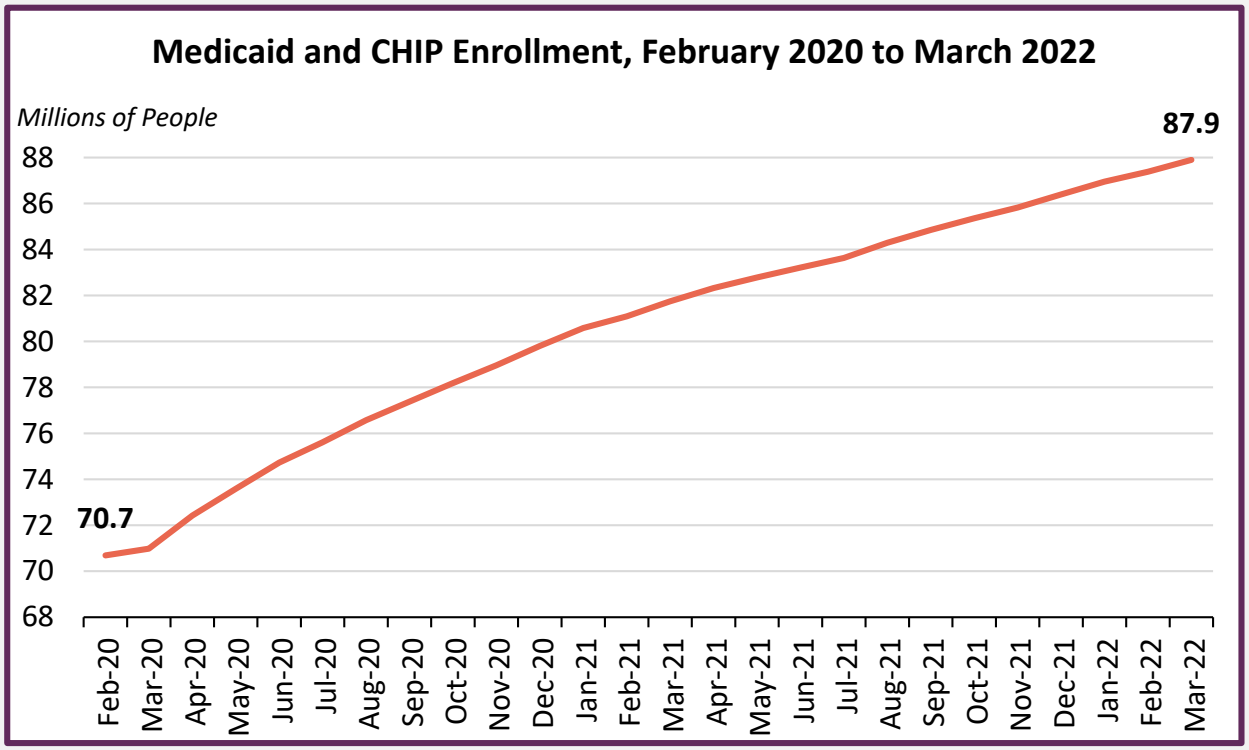
The continuous coverage provision has effectively eliminated churn in the Medicaid program and enabled people to retain coverage throughout the pandemic.

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

- Since February 2020, Medicaid/CHIP enrollment has increased by more than 17 million individuals – a 24% increase
- 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.

Preparing for the Largest Health Coverage Event Since the Affordable Care Act

At the end of the PHE, Medicaid/CHIP agencies will be faced with an unprecedented number of caseloads that must be addressed within a condensed period of time.



- 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)

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

The Stakes Are High: Uninsurance at All-Time Low

ASPE OFFICE OF HEALTH POLICY
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

DATA POINT

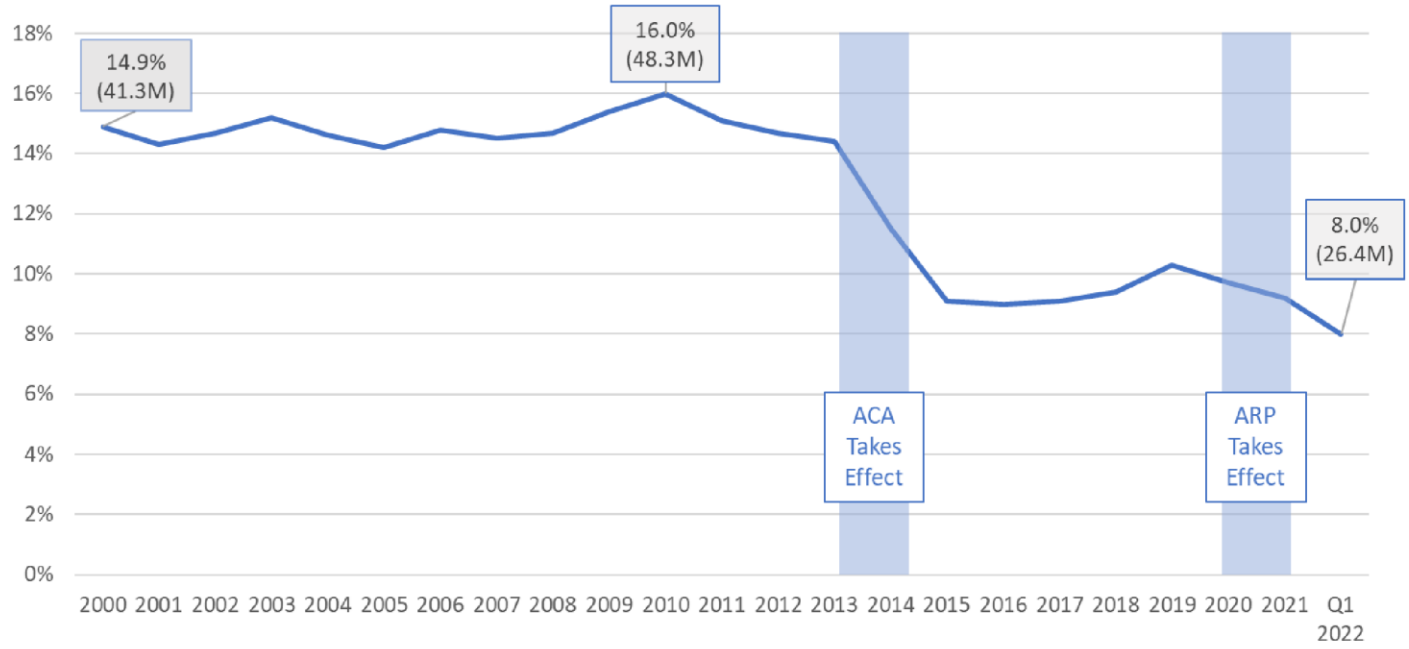
HP-2022-23

National Uninsured Rate Reaches All-Time Low in Early 2022

The uninsured rate in early 2022 has reached an all-time low of 8.0% among all U.S. residents, indicating that 5.2 million people have gained health insurance coverage since 2020.

Aiden Lee, Joel Ruhter, Christie Peters, Nancy De Lew, Benjamin D. Sommers

Figure 1. National Uninsured Rate, All Ages (2000 – Q1 2022)



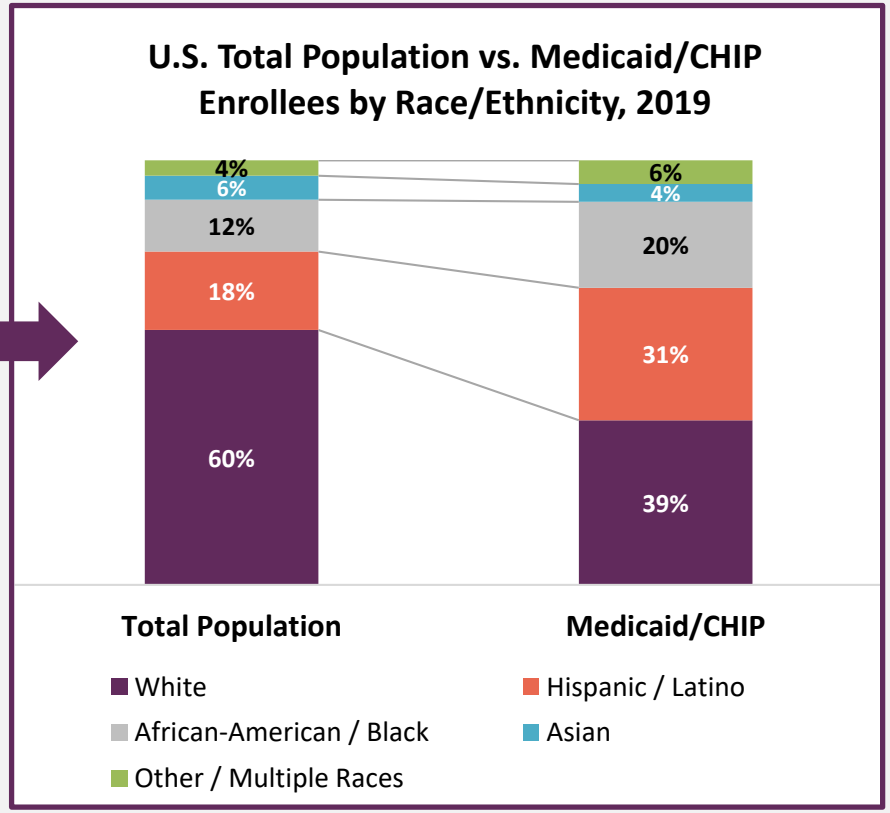
Reminder: Churn Is Common

- 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
- But we have not experienced a coverage event like this since implementation of the ACA

Implications for Equity

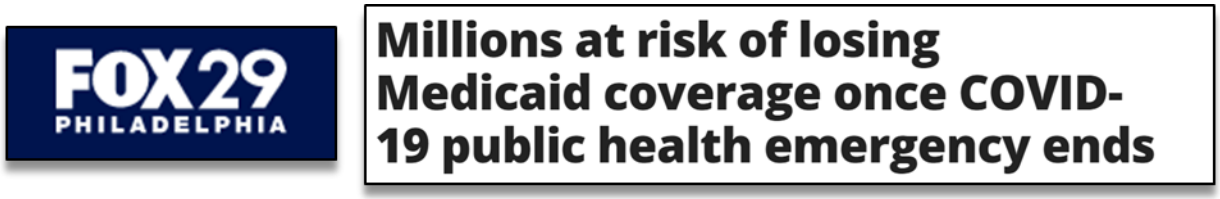
Coverage losses will disproportionately impact people of color, exacerbating already widespread racial and ethnic disparities in the healthcare system.

- 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.

Consumers Are Unaware of What's at Stake



Consumers Value Coverage

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."

Consumers Value Coverage

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."

State Health and Value Strategies Programming: Preparing for Medicaid Continous Coverage Unwinding

SHVS developed 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

Consumer Communications and Outreach

- Medicaid Communications Plan Template
- Text Messaging Strategies to Retain Coverage

Data/IT

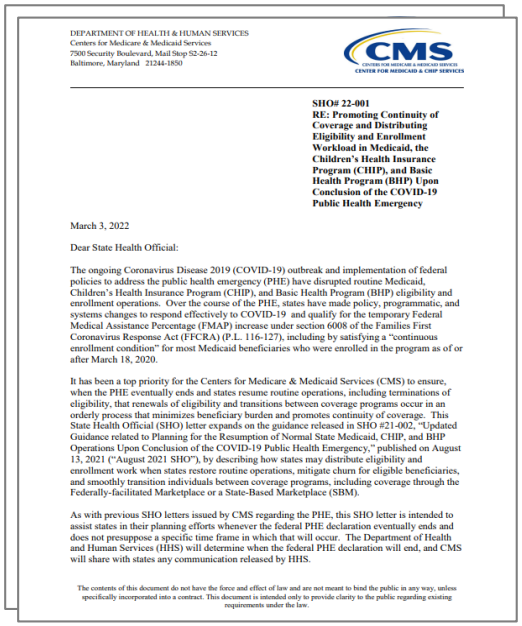
- Model Data Dashboard

Eligibility and Enrollment Policy/Operations

- Improving the Redetermination Process to Ensure Coverage Retention

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
CENTERS 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 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.

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.

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.

Challenges States Face in 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:

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

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

Challenges States Face in 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:

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

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

Challenges States Face in 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:

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.

STATE STRATEGIES TO MITIGATE COVERAGE LOSSES

- Operational strategies
  - Strengthen ex parte processes, stage redeterminations
- Enhance outreach and communications
- Stakeholder collaboration
- Smooth transitions to marketplace

Strengthening the Ex Parte 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.

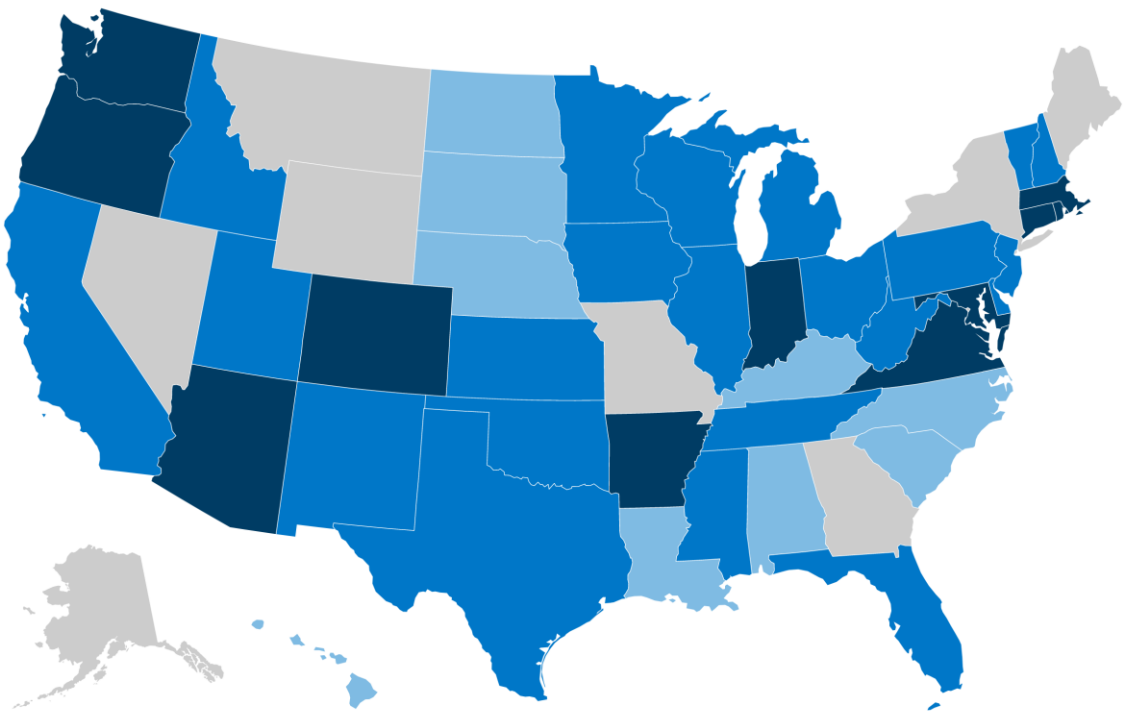
States can also streamline renewals that are unable to be completed through the ex-parte process–e.g., pre-populate renewal forms, extend the deadline for responding to requests for additional information, accept reasonable explanations of inconsistencies or to allow for self-attestation of certain eligibility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

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

Strengthening the Ex Parte Renewal Process

Figure 11

Share Of Medicaid Renewals Completed Using Ex Parte Processes, January 2022



SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

KFF

Improving Ex Parte Renewal Rates: State Diagnostic Assessment Tool

This toolkit contains a table that can be used by a state to examine current *ex parte* processes and identify and deploy additional strategies that could increase their *ex parte* rates.

Improving Ex Parte Renewal Rates: State Diagnostic Assessment Tool

Prepared by Manatt Health

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

A grantee of the Robert Wood Johnson Foundation

June 2022

Background

Improving *ex parte* rates as part of the Medicaid renewal process is one of the most effective tools available to states to mitigate coverage loss for eligible individuals when the public health emergency (PHE) ends. The current Medicaid continuous coverage requirement enacted by the Families First Coronavirus Response Act prohibits states from disenrolling individuals from Medicaid for the duration of the PHE as a condition of accessing enhanced federal Medicaid funding.[1] When the PHE ends, state Medicaid agencies will need to conduct a full redetermination for all individuals with a pending Medicaid renewal.[2] This undertaking has significant health equity implications, as communities of color are expected to be disproportionately impacted by the unwinding effort.

Federal regulations require states to attempt to renew Medicaid enrollee eligibility through an *ex parte* process using all available data sources.[3] If an individual's eligibility is able to be verified *ex parte*, states are required to extend Medicaid coverage without any additional action from the enrollee. If the state is unable to determine an individual's eligibility through an *ex parte* process, the state must send a new renewal form requesting additional information and/or documentation. Importantly, states are required to attempt an *ex parte* renewal process for both Modified Adjusted Gross Income (MAGI) and non-MAGI populations.[4]

There are tremendous benefits to enrollees and to states in maximizing eligibility redetermination through an *ex parte* process. For enrollees, they are more likely to retain their coverage; any time a state sends a request for information to an enrollee, the likelihood increases that an eligible individual will lose coverage, either because they moved or because they cannot or do not respond to the requested information in a timely way. States can reduce administrative workload on an already taxed eligibility workforce. As states develop their unwinding policies and operational plans in readiness for the end of the PHE, improving *ex parte* rates should be at the top of their priority list.

The following table can be used by a state to examine current *ex parte* processes and identify and deploy additional strategies that could increase their *ex parte* rates.

***Ex Parte* Diagnostic Assessment Tool**

Diagnostic Question	How the Answer to the Question Impacts *Ex Parte* Rates	Potential Next Steps	Potential Impact on Increasing *Ex Parte* Rates (High or Medium)
What is your Medicaid MAGI *ex parte* rate?	• If your state's *ex parte* rate is 60% or greater (as a percentage of total renewing MAGI enrollees), your state has a high-performing process in place and the potential for losing people as part of the renewal process will be relatively lower. • If your state's *ex parte* rate is 40 to 60%, there are ways your state can improve the *ex parte* process and reduce the number of people who will need to respond to renewal requests. • If your *ex parte* rate is 40% or lower, there is opportunity for improvement to reduce the large number of your enrollees who will need to respond to renewal requests, and potentially lose coverage.	• *60% or greater:* Focus resources on improving the state's process for getting enrollees to respond to requests for information including through outreach and communication. • *Lower than 60%:* Review the following diagnostic question set and identify and implement all strategies that will improve *ex parte* rates.	N/A

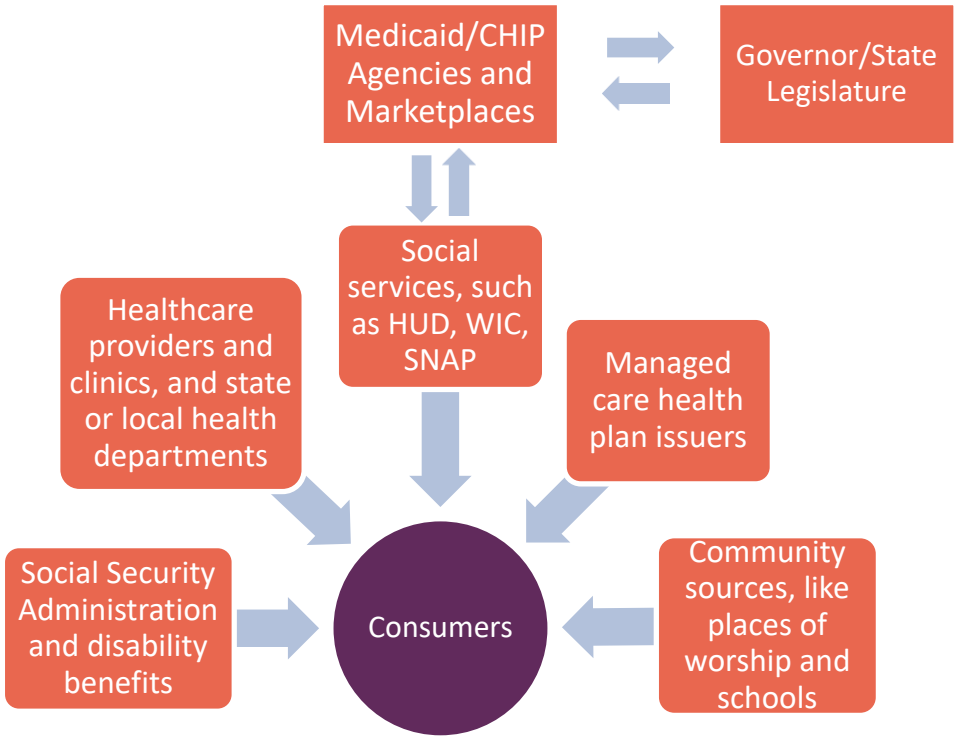
Promising State Strategies to Prepare for Unwinding: Operational

Pursuing multiple operational avenues to maximize coverage retention, including:

- ✓ Preparing the workforce to address pending eligibility and enrollment actions and the 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?

Collaboration With Stakeholders Is Key

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.



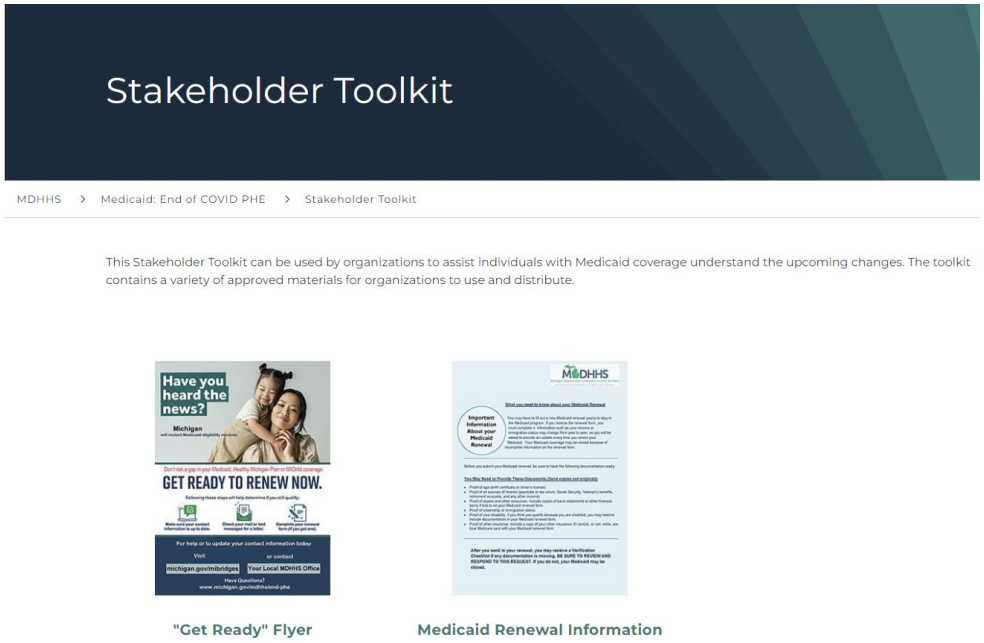
State Spotlight: Michigan Medicaid Outreach & Unwinding Plan

- The Michigan Department of Health and Human Services (MDHHS) published their unwinding operational plan as well as a presentation for stakeholders about the work they are doing to prepare for the end of the PHE, which included a summary on Medicaid enrollment during the PHE as well as an illustrative timeline to highlight a phased approach to communicating with enrollees prior to and after the end of the PHE.

Source: MDHHS, Medicaid – COVID-19 Public Health Emergency (PHE) Ending Resources

State Spotlight: Michigan Medicaid Outreach & Unwinding Plan

- The Michigan presentation also included an illustrative timeline of their proposed eligibility renewal plan at the end of the PHE, as well as a link to a **stakeholder toolkit** for communicating with enrollees about the upcoming changes.
- MDHHS also has a **website** which will be continually updated with the latest information as the department restarts processes and releases updated policies.

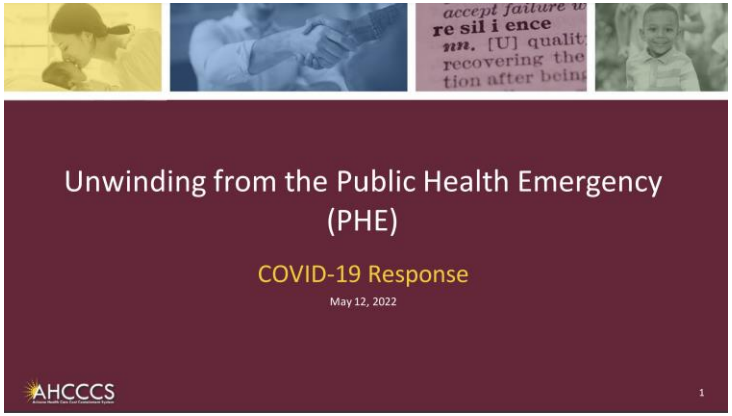


"Get Ready" Flyer

Medicaid Renewal Information

State Spotlight: Arizona Medicaid Unwinding Plan

The Arizona Health Care Cost Containment System posted their **operational plan** along with a **summary** for stakeholders, and both documents detail the specific flexibilities that are set to expire, those that have already been terminated, and those that will be extended beyond the end of the PHE.



July 26, 2022

AHCCCS Posts Summary of Operational Plan for Returning to Normal Eligibility Processes

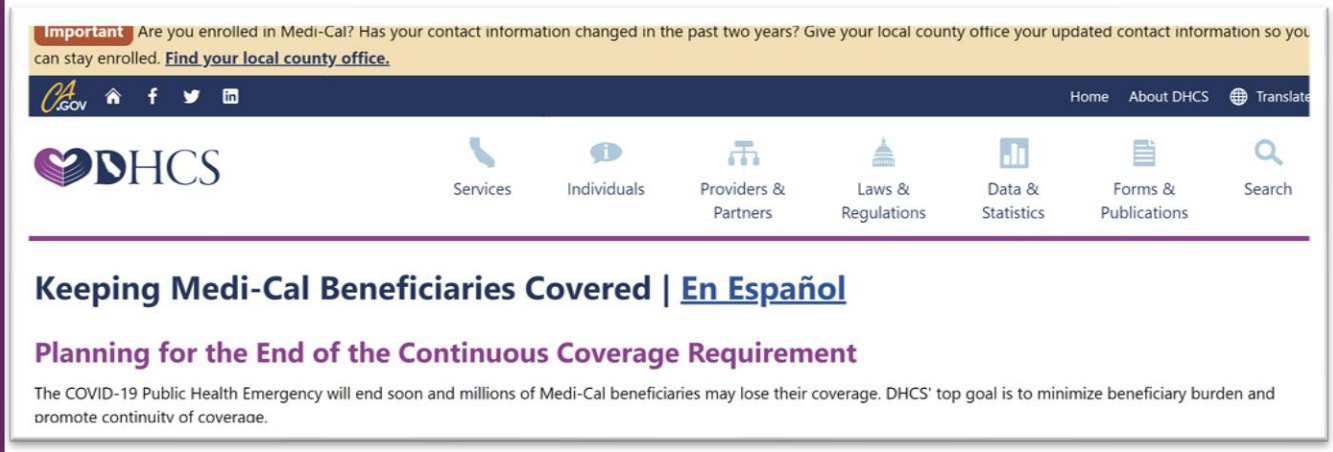
When the federal Public Health Emergency (PHE) ends, AHCCCS must reinstate many regular enrollment and operational procedures that have been suspended since March 2020. To inform stakeholders of the operational plan, AHCCCS has posted a Summary Public Health Emergency Operational Unwinding Plan.

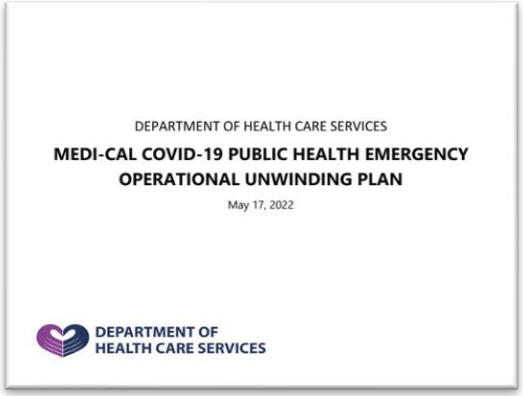
Find the plan on the Preparing for the End of COVID-19: Return to Normal Renewals web page along with fliers, messaging toolkits, and other resources to help communities prepare for the end of the PHE.

Source: Arizona Health Care Cost Containment System, Unwinding from the Public Health Emergency (PHE)

State Spotlight: California Medicaid Outreach & Unwinding Plan

- The Department of Health Care Services (DHCS) released the Medi-Cal COVID-19 Public Health Emergency Operational Unwinding Plan. The two primary purposes of this document are to: 1) describe DHCS' approach to unwinding or making permanent temporarily flexibilities implemented across the Medi-Cal program during the PHE; and 2) describe DHCS' approach to resuming normal Medi-Cal eligibility operations following the end of the PHE.





Source: CA Department of Health Care Services, Planning for the End of the Continuous Coverage Requirement

State Spotlight: North Dakota and Virginia Stakeholder Outreach

- North Dakota and Virginia publicly posted presentations for relevant stakeholders, highlighting potential 12-month redetermination timelines.
- Virginia's presentation, which was addressed to their Senate Finance and Appropriations Committee, assigns roles to specific stakeholders during each phase of their community outreach plan.
  - For example, health plans and Marketplace navigators will need to encourage members who lose coverage for administrative reason to complete necessary paperwork.
- Virginia's plan also outlines strategies for augmenting their staffing in preparation for unwinding, such as seeking funding to support payment of overtime for local agencies.

Source: North Dakota Human Services, Unwinding Federal Public Health Emergency; Virginia Department of Medical Assistance Services, Medicaid Federal Public Health Emergency Unwinding Planning

Addressing Account Transfer Data Completeness and Adding Additional Contact Fields

States have an opportunity to improve account transfer data quality across two dimensions—data completeness and contact information—both of which will reduce or better facilitate casework:

Address Data Completeness:

- Successful account transfer to the FFM requires a minimum set of completed data fields.[1]
- States can assess previously failed transfers, identify the source of failure, and prioritize fixing common inconsistencies.

Collect Additional Contact Information:

- Collect optional contact information (e.g., e-mail and mobile numbers), if not already.
- Update account transfer data files to include these optional fields.

Improving account transfer data quality could take between 3 and 5 months to implement, depending on baseline data quality and necessary IT system changes.

Source: 1. CMS Office of Information Services, Federal Data Services Hub (Federal DSH).

Data and IT System Limitations Will Impact Coverage Retention When Continuous Coverage Ends

While states continue to modernize their Medicaid Enterprise Technology, implementing strong data and IT systems strategies will be critical to maintaining or transitioning individuals to new affordable health coverage options when Medicaid continuous coverage requirements end.

Medicaid IT Systems

- Inconsistencies and failed matching cause coverage loss for eligible people, even with increased linkages between data sources.
- IT systems may not be able to support the volume of pending redeterminations post-continuous coverage period.
- IT barriers may also create upfront obstacles and impact consumer experience, e.g., non-mobile responsive websites not allowing consumers to update accounts.

Account Transfers

- Transfers to a State-Based or Federal Marketplace require complete and consistent data across multiple state or federal systems.
- Not all State-Based Marketplaces (SBMs) have integrated eligibility systems with Medicaid, forcing consumers to take additional steps and creating opportunities for data-matching errors.

Perfect Storm: The triple threat of **unprecedented volume, condensed time period, and enrollees unfamiliar with redetermination processes**–paired with existing IT and data limitations–poses a considerable risk of coverage loss following the end of COVID-related Medicaid continuous coverage requirements.

Overview of "Table Stakes" Data and IT Strategies

Effective redetermination begins with complete enrollee contact information, user-friendly pathways for individuals to update critical information, and standardized data definitions with partners. States may want to evaluate current data and IT infrastructure now and adopt table stakes strategies to be ready for the end of the federal Medicaid continuous coverage requirements.

Strategies:

- **Optimizing effective and efficient uses of eligibility data**
- **Ensuring robust and high-quality account transfer data**
- **Providing online portal functionality that meets consumer needs**

Table Stakes are the minimum strategies that states would want to have in place; they will have the highest impact for states seeking to ensure that eligible enrollees are able to keep or transition to new affordable health coverage when the continuous coverage requirements end.

Funding: **States that have not pursued these efforts already, or have more to do to enhance functionality, can undertake system enhancements now and execute in a way that enables receipt of the 90% federal match for Medicaid IT investments.**

COMMUNICATION STRATEGIES

Goals for Direct-to-Consumer Messaging

- Direct-to-consumer messaging in mail, email, and text should be:
  - **Repetitive.** Best practice calls for audiences being exposed to messaging 10 to 13 times across multiple channels to drive behavior
  - **Specific** to those who need to act at different points in time
  - **Clear,** providing specific instructions for each renewal group as their redetermination window occurs
  - **Careful to avoid overwhelming** customer service channels and confusing those enrollees who do not yet need to act



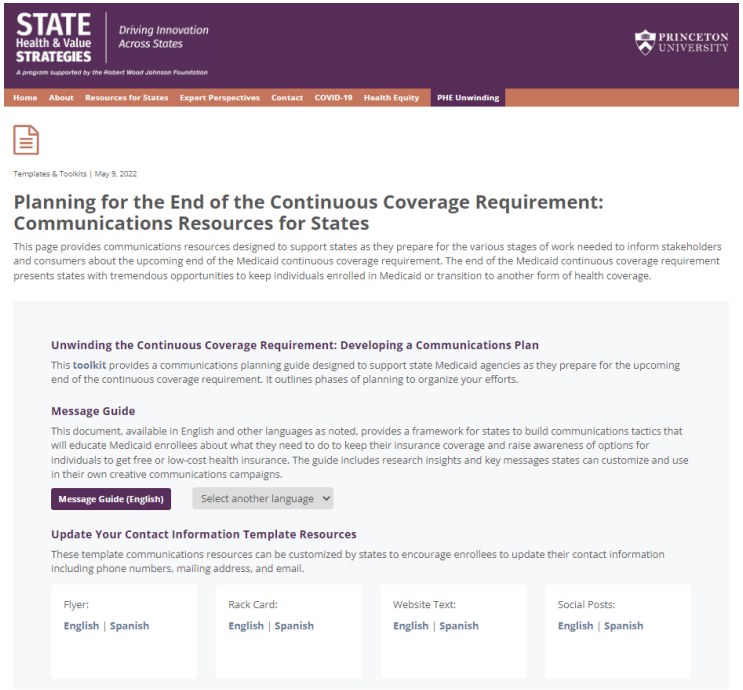

Partner Amplification

- Consumer research finds that enrollees:
  - Expect to hear about their health insurance from health plans and providers, in addition to Medicaid agencies
  - Want to receive information in a variety of ways, including text and email
- CHIP agencies and Marketplaces are important partners to ensure smooth coverage transitions for those no longer Medicaid eligible

Message Recommendations

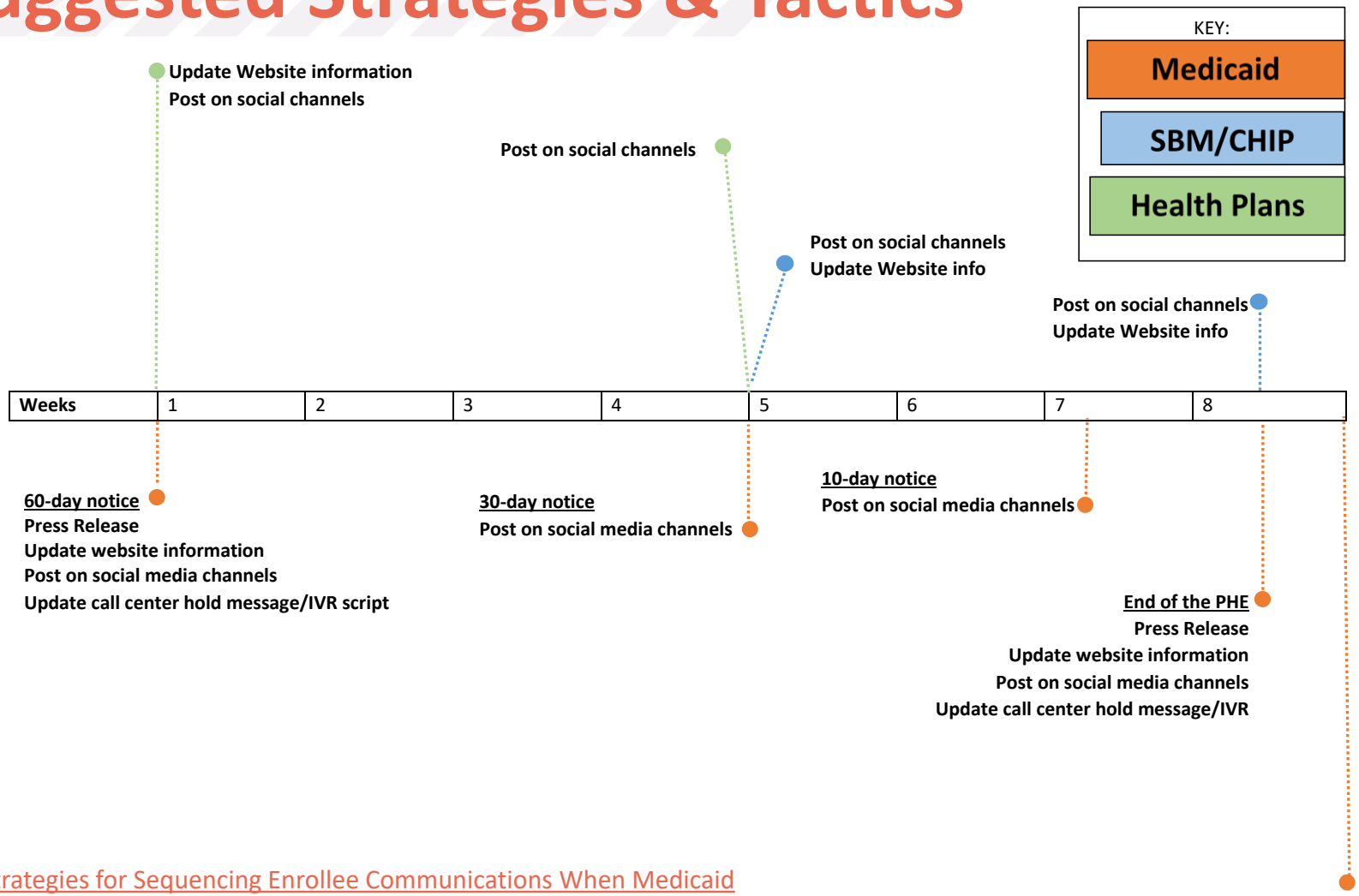
All direct-to-enrollee messaging should be short and simple. Use straightforward language to spell out:

- ✓ What is new or changing?
- ✓ Which enrollees need to act when, and what does the enrollee have to do?
- ✓ Where can the enrollee get help?



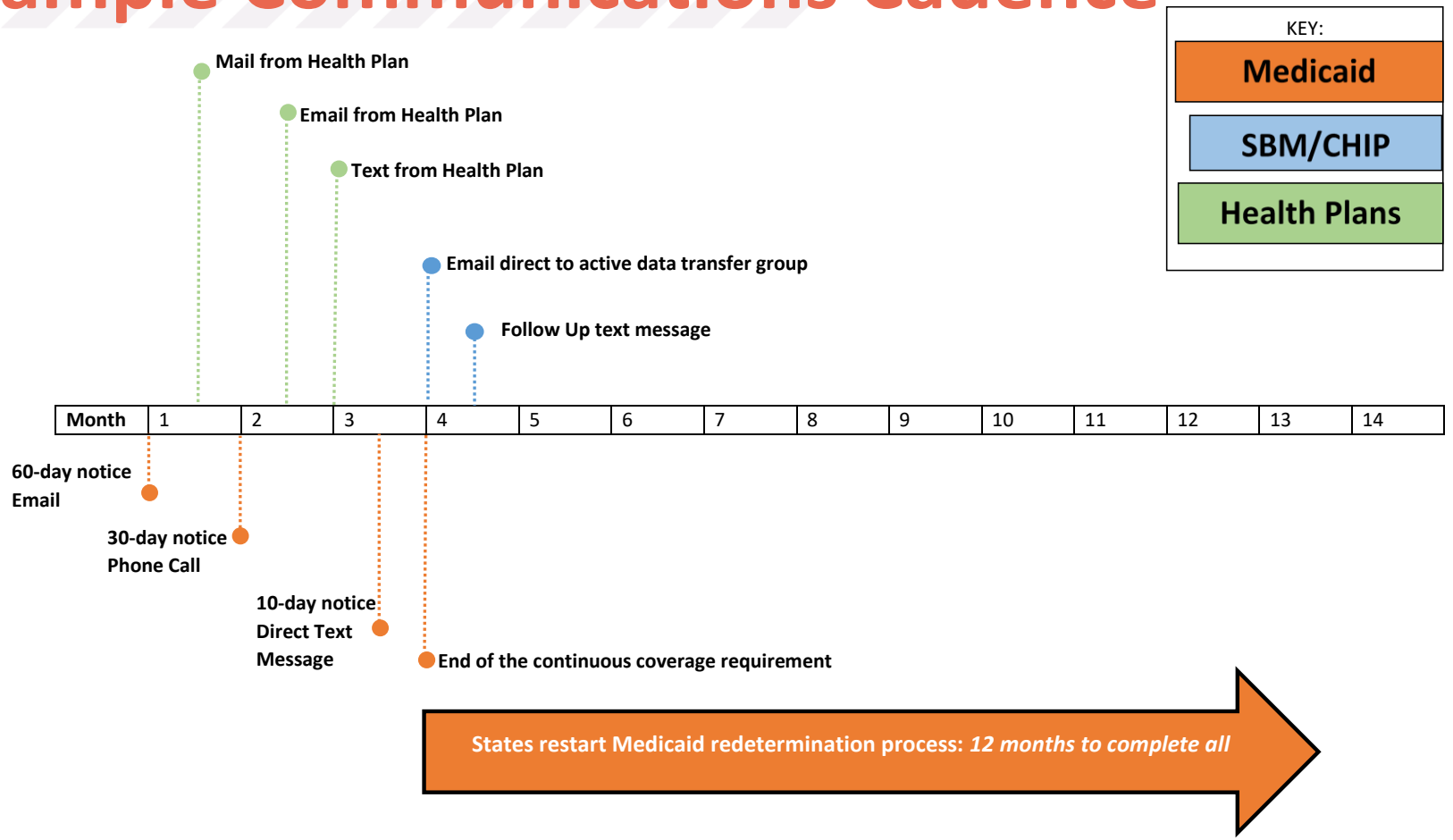
The SHVS website includes a toolkit and message guides which contain sample language for enrollee communications which states can use and customize for their own purposes.

Suggested Strategies & Tactics



State Strategies for Sequencing Enrollee Communications When Medicaid Continuous Coverage Ends, State Health and Value Strategies, August 2022

Sample Communications Cadence



Timeline Notes: This sequencing process will be recurring with each new redetermination/autoenrollment group.

Promising State Strategies to Prepare for Unwinding: Communications

Building communications into the overall approach to unwinding to ensure members get critical information and take steps to retain coverage, including:

- ✓ 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 share updated contact information and stay connected for regular updates about their coverage.

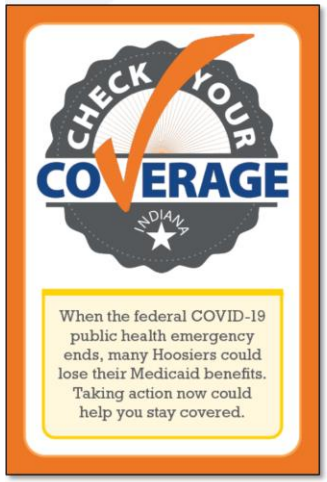
LA launched a robust phone campaign to encourage Medicaid members to update contact information.

NH created a webpage to host information on the unwinding of the federal Medicaid continuous coverage requirement, including sample member notices.

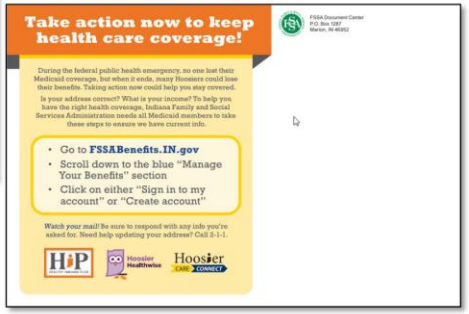
NY launched a campaign to encourage consumers to "stay connected" with NY State of Health, the state's Marketplace, by signing up for text messages and encouraging people to update their contact information. The state is working on adding the capability to (1) send and receive texts in Spanish, and (2) text members who haven't returned mail to offer customer service support.

Indiana: Communicating With Medicaid Enrollees

Member Communications



Postcard



Poster

Promising State Strategies to Prepare for Unwinding: Outreach

Expanding and enhancing outreach channels:

- ✓ 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.

CA is leveraging managed care organizations, Navigators/assisters, and providers to obtain updated consumer contact information and developed a toolkit for "Coverage Ambassadors."

MA's state legislature allocated $5 million for a community-based outreach and education campaign. Health Care for All will support the redetermination process by leveraging CBOs to conduct outreach to individuals; canvassing in communities that have the highest potential risk of coverage loss; and launching a local ethnic media campaign.

CONTINUITY OF CARE STRATEGIES

Continuity of Care: What's the Issue?

- Five to six million people are projected to be disenrolled from Medicaid but eligible for subsidies on the Marketplace, and many will have health needs requiring uninterrupted care
  - Medicaid enrollees tend to have poorer health than the general population and disproportionately likely to have diabetes, hypertension, asthma, mental illness or SUD.
  - Could be in the middle of a hospitalization, recovering from injury or trauma, or pregnant when Medicaid benefits are terminated.
  - And many will have relationships with a specific provider or rely on continued access to a particular prescription.

- Those transitioning to the Marketplace will enroll in plans with **different benefit designs**, **drug formularies**, **provider networks**, and cost-sharing policies than their Medicaid coverage
  - Services they previously received for free could come with deductibles or other cost-sharing; hospitals and doctors may suddenly become "out-of-network."
  - Patients may be required to re-submit paperwork to receive prior authorization for services that their previous plan had already approved.

- **For state health officials, helping people maintain continuity of coverage is only part of the challenge. States must also focus on ensuring continuity of care.**

Ensuring Continuity of Care: Medicaid Strategies

- Develop specific approaches to ensure coverage and care continuity for populations with high health needs
  - Identify high risk enrollees and those in the middle of a course of treatment
  - Identify particular eligibility groups that may be at higher risk for harm if they lose or experience gaps in coverage (e.g. pregnant/postpartum, those receiving HCBS through a waiver or the state plan; children with special health needs).

- Consider sequencing redeterminations in way that mitigates risk of coverage loss and access gaps
  - Allow more time for targeted (and enhanced) outreach and assistance
  - Coordinate with implementation of expanded postpartum coverage or a "bridge" program

- Ensuring Continuity of Coverage and Care for High Need Enrollees When the Medicaid Continuous Coverage Ends: Medicaid Strategies, State Health and Value Strategies, June 2022

Ensuring Continuity of Care : Commercial Insurance Strategies

- Review and update educational materials to explain commercial insurance terms for those transitioning from Medicaid benefits
  - State-based marketplaces can work with assister partners to build health insurance literacy into enrollment assistance
  - SBMs can also use claims data to "map" those transitioning to a marketplace plan that includes the providers they use regularly
- While some insurers will voluntarily adopt policies to ensure continuity of care, states can consider requiring insurers to implement measures
  - 13 states extend continuity of care laws requiring coverage of services from out-of-network provider for those in middle of treatment to when enrollee switches from Medicaid to new health plan
  - Require Marketplace plans to honor prior authorization under enrollees' prior Medicaid coverage
  - Require Marketplace plans to pro-rate deductibles and MOOPs
  - Create Special Enrollment Period allowing those with inadequate network to switch to new plan
- Departments of Insurance (DOIs) will need to monitor consumer complaints
- **State DOIs should assess their existing continuity of care laws and consider how to extend protections for those who are disenrolled from Medicaid while in the middle of treatment or with other significant health care needs.**

- Ensuring Continuity of Care for Individuals Transitioning from Medicaid to Marketplace: Post-PHE Considerations for States, State Health and Value Strategies, July 2022

Continuity of Care Strategies: Protecting Coverage for Postpartum Women

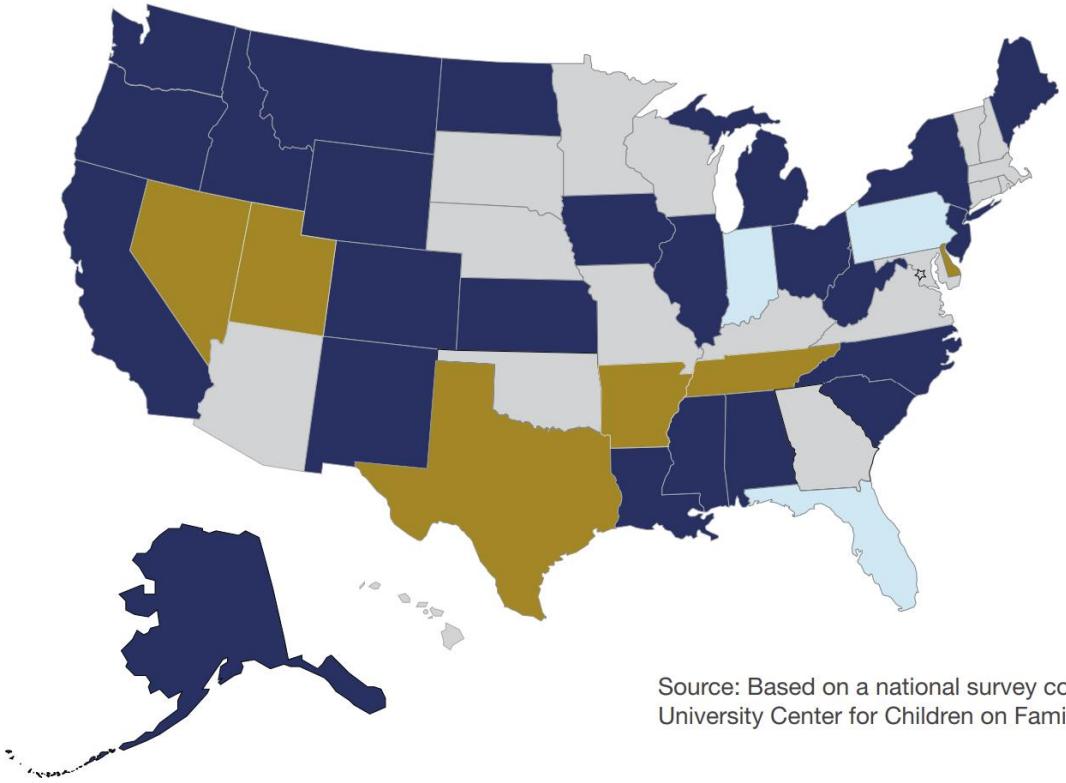
- During the PHE, Medicaid and enrollment among pregnant individuals increased by 67% or 682,000 enrollees
  - Large-scale disruptions in coverage and care at the end of the PHE would jeopardize the health and wellbeing of postpartum women and their infants
- Strategies to protect coverage and ensure access to care
  - Expand Medicaid eligibility levels, postpartum period and eligible populations
  - Strategically sequence redeterminations
  - Conduct enhanced outreach and targeted communications
  - Ensure seamless transitions to marketplace coverage
  - Mitigate procedural denials
- For more information, see the SHVS issue brief *Protecting Coverage for Postpartum Individuals at the End of the Public Health Emergency*

THE WORK CONTINUES AFTER THE PHE: STRENGTHENING THE COVERAGE CONTINUUM

Post-PHE: Continuous Eligibility for Kids

- Continuous eligibility reduces the administrative costs associated with enrollees cycling on and off Medicaid due to temporary fluctuations in income
- 24 states have adopted 12-months continuous eligibility for children
- Oregon proposed 1115 waiver to extend continuous coverage for kids from birth to age five
- Washington planning to submit a similar 1115 request, and legislators in California and New York are advancing similar legislation

State Adoption of 12-Months Continuous Eligibility for Children's Medicaid and CHIP



State Take-Up of 12-Month Continuous Eligibility for Children

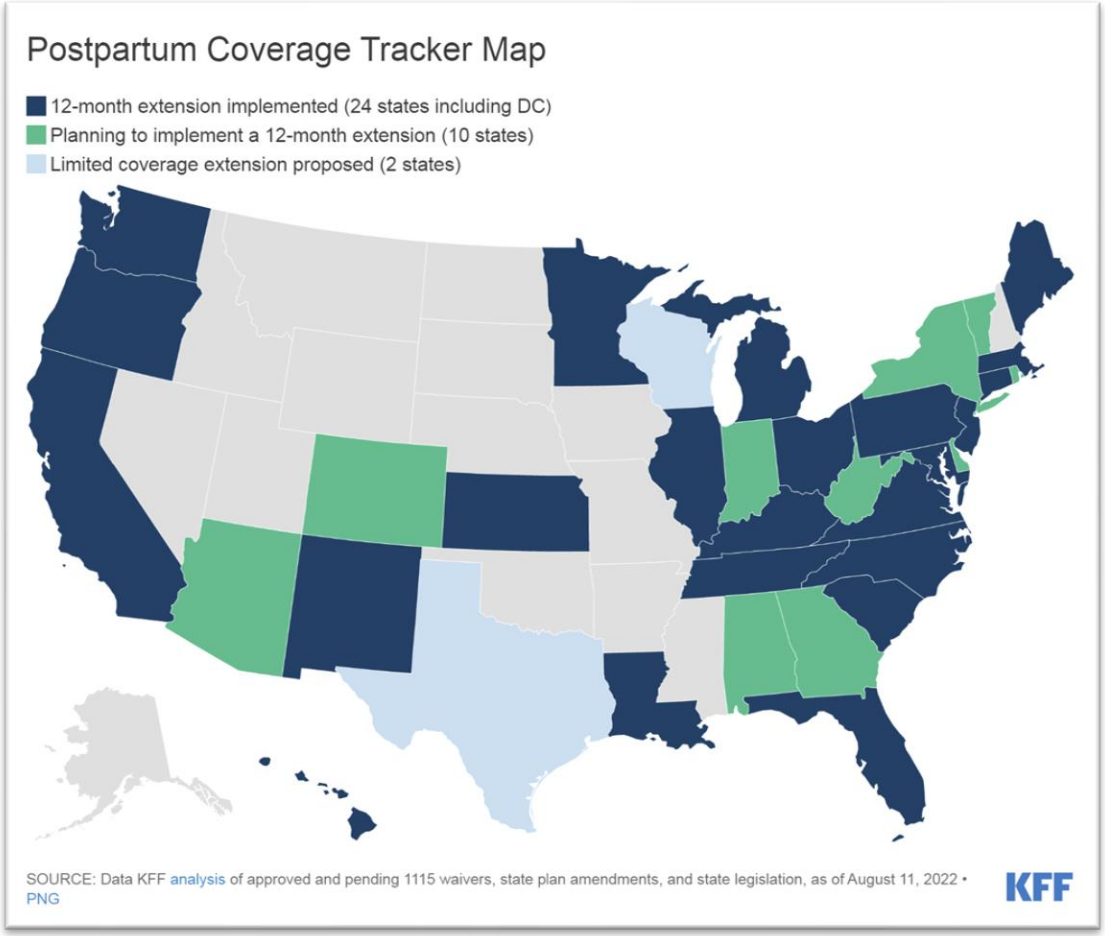
- 12-month continuous eligibility for all children under 19 in Medicaid and CHIP (24 states)
- 12-month continuous eligibility for all children under 19 in CHIP only (6 states)
- 12-month continuous eligibility for some children in Medicaid and/or CHIP (3 states)
- No 12-month continuous eligibility for any children in Medicaid or CHIP (17 states and D.C.)

Source: Based on a national survey conducted by Kaiser Family Foundation with the Georgetown University Center for Children on Families, 2020. Data on South Carolina is based on the 2019 survey.

Source: Georgetown University Health Policy Institute, Center for Children and Families, Continuous Coverage in Medicaid and CHIP

Post-PHE 12 Months Postpartum Coverage

- American Rescue Plan provides states a new option to extend Medicaid postpartum coverage to 12 months via SPA



Thank You

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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.

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.

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The views expressed here do not necessarily reflect the views of the Foundation.