Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

Center on Budget and Policy Priorities

Unwinding the COVID Public Health Emergency Continuous Eligibility Maintenance of Effort Provision

Tricia Brooks, Judy Solomon, and Jennifer Wagner

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Today's Agenda and Speakers

- What the guidance says
- What states can do
- What advocates can do
- Monitoring the process

- Georgetown CCF
  - Tricia Brooks
- CBPP
  - Judy Solomon
  - Jennifer Wagner

WHAT THE GUIDANCE SAYS

Tricia Brooks

Key Dates

	Timeline	Date if PHE is in place for entirety of 2021
Medicaid and CHIP 1135 Emergency Waivers	End of PHE	January 2022
Medicaid Disaster SPAs	End of PHE or earlier date selected by the state	January 2022
CHIP Disaster SPAs	End of PHE or date selected by the state (can be later if state has later state declared emergency)	January 2022
PHE-related Section 1115 Demonstrations	No later than 60 days after the end of the PHE	March 2022
MAGI Verification Plan Addendum	Date selected by the state	
MOE Continuous Eligibility Provision	End of the month in which the PHE ends	January 2022
FMAP Bump	End of quarter in which the PHE ends	March 2022

Planning for the End of PHE

- Guidance issued 12/22/20
  - Expect high level changes soon with detail to follow
- General Transition Plan
  - Delivery system changes (e.g., telehealth, prior authorizations)
  - Other disaster SPA or waiver provisions (e.g., suspension of premiums)
  - Optional CMS General Transition Planning Tool
- Post-COVID Eligibility and Enrollment Operational Plan
  - Comprehensive plan for states to achieve compliance with post-PHE timelines
  - Not required to submit to or be approved by CMS
  - Optional CMS tool
    - Eligibility and Enrollment Pending Actions Resolution Planning Tool
  - Stakeholder engagement strongly advised

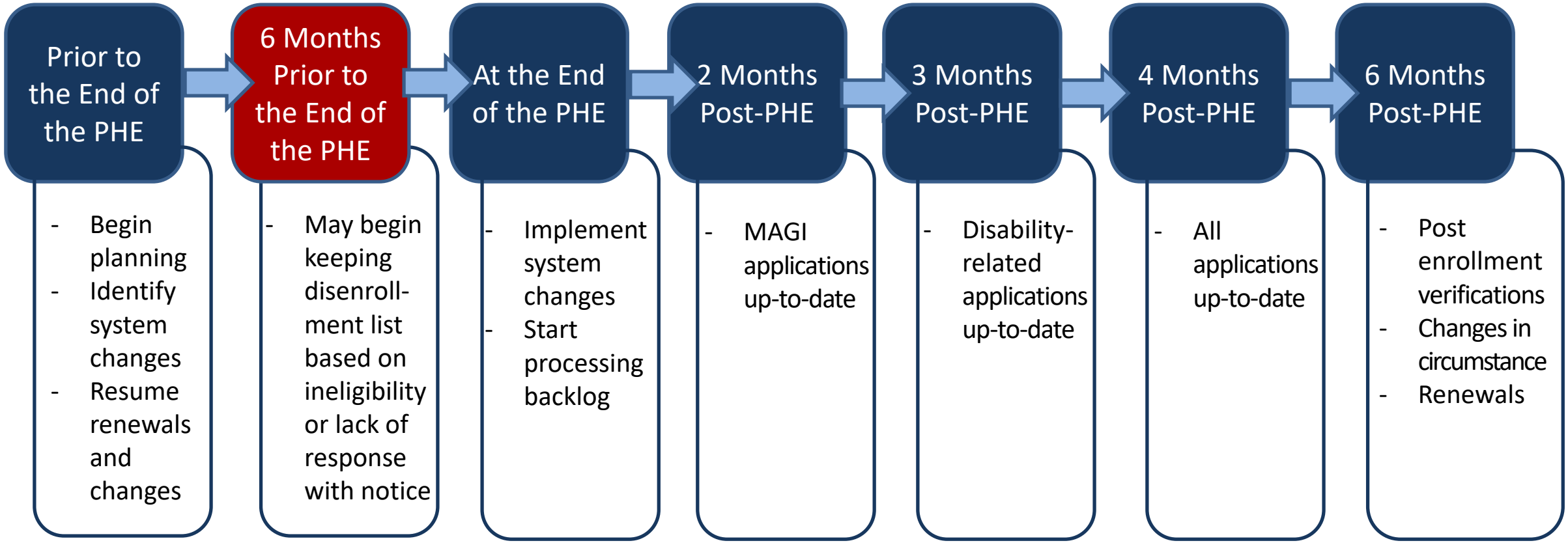
Current Guidance

- Overall, states have 6 months to return to normal operations
- Allows states to move forward with disenrollments if processed within 6 months of the end of the PHE with final 10-day advance notice
  - Individuals determined ineligible during PHE (based on ineligibility determination date)
  - Individuals who did not respond to a request for information during PHE (based on date of notice)

Change Wish List

- Extend the period of time to return to normal operations
- Require states to conduct a fresh review of eligibility for individuals on a pending adverse action list for procedural reasons (e.g., missing verifications or returned mail)
- Shorten or eliminate the look-back period
- Require states to take proactive steps to update mailing addresses

Resuming Normal Eligibility & Enrollment Operations



6-Month Lookback

Assuming PHE expires Mid-January
MOE continuous eligibility ends January 31, 2022

Any enrollee determined ineligible with pre-closure notice

Any enrollee who did not respond to a RFI sent

States must send final/second notice of termination at least 10 days in advance (1/21/22)

Potential Mass Disenrollments

Examples

8-1-21 – 1/21/22 determined ineligible

- Pre-closure notice
- 10-day advance/ final notice

8/1/21 – 1/21/22 No response to RFI sent

- 10-day advance/ final notice

Sent RFI in July, no response

- Must redetermine before taking action

Sent RFI in July; responded August, determined ineligible

- Pre-closure notice
- 10-day advance/ final notice

Starting a Disenrollment List

Individuals determined ineligible

- Based on date of determination
- Pre-closure notice must inform enrollees:
  - Eligibility determination
  - Coverage will end after the month in which the PHE ends
  - That they can and should report changes

Individuals not responding to RFI

- Based on date of the notice
- No requirement for more than a single notice
- No requirement for a new review of eligibility using electronic data sources

In either circumstance, states must review submitted information regardless of when received in the 6-month period

Risk-based Strategy
Post-PHE E&E Operational Plan

- Prioritizes actions for enrollees who are most likely to be no longer eligible
- Minimizes the extent to which coverage is provided to ineligible individuals
- Approach may vary based on transaction type
  - Post-enrollment verification
  - Changes in circumstances
  - Renewals

Risk-based Strategy

Risk-Based Approach	Details/Examples
Population-based	• Individuals who became categorically ineligible (e.g., turning 19 or 65) • Determined ineligible during PHE • Individuals enrolled due to temporary eligibility flexibility (e.g, COVID-uninsured) • Not stable groups (kids, foster youth, duals)
Time-based	• Processes oldest cases first based on length of time the action has been pending
Hybrid	• Combination of population- and time-based approaches (e.g., population-based first; then switch to time-based)
State-based	• Still must prioritize likely ineligibles

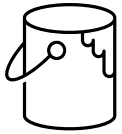
Various Aspects of Planning

- Risk-based approach
- Operational strategies and resource (capacity)
  - Redistribute current staff responsibilities
  - Using contractors or support staff
  - Hiring
  - Staff training
- Policy change strategies
  - Express lane eligibility
  - Facilitated enrollment
  - Continuous eligibility
- Verification plan changes
- System changes
  - Eligibility and enrollment systems
  - MMIS
- State policy changes
  - State code or regulations
  - Policy manuals
- Communications
  - Providers
  - Enrollees
  - MCOs
  - Internal staff
  - Enrollment broker
  - CBOs

WHAT STATES CAN DO

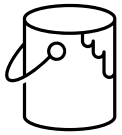
Jennifer Wagner

Before the End of the PHE



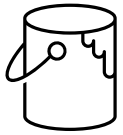
Catch up

- Application processing
- Post-enrollment verification
- Allowable moves between categories of coverage
- Renewals



Communication

- Addresses
- Email/Texting
- Outreach



Streamline processes

- Verifications
- Renewals
- Coordination with SNAP
- Non-MAGI population
- Transitions

Renewals

- Improve *ex parte* process
  - Data sources
  - Rules (design documents)
- Pre-populated forms
- Non-MAGI population

- *Now* – lessens the backlog of "overdue" at end of PHE
- *End of PHE* – retain eligible enrollees

Coordinate with SNAP

- Update addresses
- “Push forward” Medicaid when completing SNAP renewal
- Use information in *ex parte* process
- Implement express lane eligibility and/or facilitated enrollment state plan option
  - Applications
  - Renewals

Streamlining

- 12-month continuous eligibility
- No premiums/waiting periods
- Great reliance on self-attestation
- Post-enrollment verification
- Presumptive eligibility
- Transitions between categories
- Coordination with the Marketplace

Non-MAGI

- Annual renewals
- *Ex parte* renewals
- Pre-populated renewal notices
- Reconsideration periods
- Income disregards
- Self-attestation
- Presumptive eligibility

Communication

- Update addresses
  - National change of address database (NCOA)
  - MCOs
  - SNAP
- Improve communication
  - Email
  - Text message outreach
  - Draw on lessons from pandemic!
- Outreach
  - Community partners
  - Providers
  - MCOs
  - Media

Update contact info

What to expect

WHAT ADVOCATES CAN DO

Judy Solomon

What Advocates Can Do: Step 1

- Get as much information as possible on your state's plans for unwinding
  - Request state planning documents
  - Request baseline data and updates (see guidance)
  - Request notices and other communications such as provider bulletins
  - Determine what actions state has been taking during PHE (e.g. ex parte reviews, data matches)

What Advocates Can Do: Step 2

- Review state plan for PHE unwinding and other policies:
  - How long is state planning to take?
  - Is state using risk-based approach and if so, what are the details?
  - Is state planning to renew all cases or provide 10-day notices based on prior determinations?
  - Has state been doing ex parte reviews and pushing renewal dates forward?
  - Is state correctly following the six-month rule?
  - What plans for communications, monitoring and oversight are in place?

What Advocates Can Do: Step 3

- Based on review, advocate for:
  - "Fresh" renewals based on current circumstances;
  - Take full six months to unwind
  - Policy changes to make it more likely eligible people stay covered
    - Express lane eligibility
    - Continuous eligibility
    - Facilitated enrollment (SNAP option)
    - Verification plan changes
  - Robust and effective notices and communications plan

What Else Advocates Can Do

- Monitor enrollment data and enrollee's experiences
- Outreach campaign to get people to update their addresses
- Develop communications plan to raise awareness that renewals are starting
- Enlist providers and other groups that have regular contact with beneficiaries
- Establish ongoing two-way communication with Medicaid agency and advocate for mid-course corrections

MONITORING THE UNWINDING

Tricia Brooks

Performance Indicator Data

- Required as a condition of enhanced federal match for eligibility IT systems since 2014
- Few data published
- Need transparency and timely reporting on all indicators
- Performance Indicator Resources
- Performance Indicator Data Dictionary

- Types of data include:
  - Call center statistics
  - Applications
  - Account transfers
  - Renewals
  - Enrollment
  - Eligibility and Ineligibility Determinations
  - Pending work
  - Processing times

Monitoring Enrollment

- CMS enrollment data lags by several months
- At least 2/3 states post enrollment directly and more timely
- Some states provide demographic breakdowns

- Ask state to provide weekly enrollment updates as timely as possible
- Ask for disaggregation:
  - Gender
  - Age
  - Race/ethnicity
  - Geography
- Trend out the data to identify spikes or other concerns

Individuals Determined Ineligible

- Performance indicator data stratifications:
  - By program
    - Medicaid
    - CHIP
  - By determination type
    - MAGI, non-MAGI
    - At application, renewal, or other time (processing change)
  - By determination reason
    - Ineligibility established
    - Eligibility cannot be established
- States should be collecting and submitting additional data on enrollment through T-MSIS

Disenrollment Reasons

- Stratified by:
  - Triggering event (Medicaid performance indicators)
    - At renewal
    - Other determinations
  - Outcome
    - Ineligibility established
    - Eligibility could not be established

T-MSIS Eligibility Change Reason Codes	
Code	Description
01	Excess income
02	Excess assets
03	Income reduced
04	Aged out of program
05	No longer in the foster care system
06	Death
07	No longer disabled
08	No longer institutionalized
09	No longer in need of long-term care services resides
10	Obtained employer sponsored insurance (ESI)
11	Gained access to public employees health plan
12	Obtained other coverage (not ESI or public employees health plan)
13	Failure to respond
14	Failure to pay premium or enrollment fees
15	Moved to a different state
16	Voluntary request for termination
17	Lack of verifications
18	Fraud
19	Suspension due to incarceration
20	Residence in an Institution for Mental Disease (IMD)
21	Suspension/Termination with reason unknown
22	Other

Call Center Statistics

- Call center volume
- Call center wait times
- Call center abandonment rates

- Need on weekly basis
- Early warning of overwhelming access to consumer assistance

Gather Field Intel

- Facilitate sharing among key stakeholders
  - Assisters and navigators
  - Providers
  - Community-based organizations
- Collect lived experiences if possible
- Assess common themes and potential causes
- Identify possible solutions

Provide Feedback to State

- Have mechanism in place to share intel from the field frequently
- Discuss possible solutions

Tying it Altogether