ClaimAid

Medicaid After COVID

Unwinding the Public Health Emergency Rules and Preparing Patients for Options to Continue Health Coverage

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Executive Summary

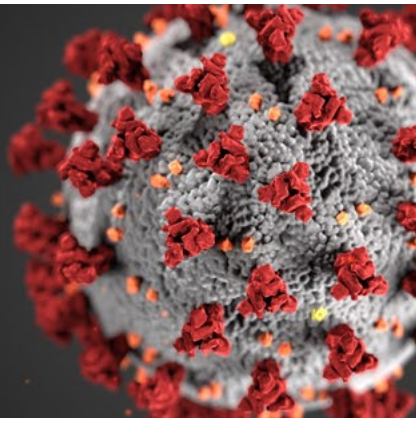
MEDICAID DURING THE PUBLIC HEALTH EMERGENCY

- Signed into law March 18, 2020, the Family First Coronavirus Response Act (FFCRA) created a "continuous coverage requirement" that has prevented states from ending or reducing the scope of coverage for most Medicaid recipients for the duration of the COVID-19 Public Health Emergency.
- During this period, states saw a 23.4% increase in Medicaid/CHIP enrollment over all in the last 25 months, with 16.7 million new enrollees. Adult enrollment grew 32.3%, with 11.1 million enrollees.

UNWINDING THE PHE

- The PHE could end in the first or second quarter of 2023. If it ends first quarter, states will begin the process of renewing member eligibility February 1, 2023. If it ends next quarter, states will begin the process of renewing member eligibility May. 1, 2023.
- Medicaid enrollees can expect requests for verification starting up to 60 days prior to the end of the PHE.
- Additionally, many enrollees will begin to be subject to small copays or premiums as part of Medicaid coverage. Estimates for loss of Medicaid coverage are up to 14.2 million when the PHE ends and the MOE provisions expire.
- Rules and transition processes will vary by state.

The **Family First Coronavirus Response Act** (FFCRA)



Introduction

Medical providers, as well as those covered under state Medicaid programs, are concerned about what will happen when the Declaration of Public Health Emergency expires. Many currently covered by state Medicaid programs may be facing the loss of health coverage and consequently may face a loss of access to healthcare services. We at ClaimAid are working to ensure that loss of health coverage is minimized for our clients and their patients. In this article, we will review the key pieces of the provisions of the Family First Coronavirus Response Act (FFCRA) and what we know about the upcoming process of unwinding those provisions.

As the Department of Health and Human Services (DHHS) announces the latest extension of the COVID-19 Public Health Emergency, it is a good time to look back at the Family First Coronavirus Response Act (FFCRA). This act suspended many of the Medicaid rules that states operated under for years to ensure coverage for the most vulnerable during the outbreak of COVID-19.

Signed into law March 18, 2020, this law provided broad economic relief to Americans who would be experiencing sudden and severe financial fallout from the COVID-19 crisis. Some of the most recognizable provisions included economic stimulus payments, expanded and enhanced unemployment and SNAP benefits, and paid sick leave for those diagnosed with COVID-19. While many of the economic provisions of this Act have expired, there remains one important provision that has allowed states to expand Medicaid eligibility. FFCRA provided states with an additional 6.2% increase in federal funding for Medicaid programs when states met certain Maintenance of Eligibility (MOE) requirements. States were required to suspend all cost-sharing requirements and cover COVID testing and treatments. These requirements have also meant that states are prevented from ending or reducing the scope of coverage for most Medicaid recipients for the duration of the federal Public Health Emergency.

These provisions provided expanded and more affordable health coverage at a time when our medical systems were being inundated with people suffering from severe illness caused by COVID-19. Now, over two years into this Public Health Emergency, COVID-19 is still with us, but the development of vaccinations and more effective treatments has resulted in a decrease of those suffering from severe illness caused by COVID. What does this mean for the MOE provisions of FFCRA?

Impact of MOE Provisions

The provisions of the MOE have disrupted regular routine Medicaid enrollment procedures for over two years. These efforts saw record Medicaid enrollment numbers.

During the COVID-19 pandemic, states saw a 23.4% increase in Medicaid/CHIP enrollment over all in the last 25 months. This increase translates into 16.7 million new enrollees. For two years prior to the COVID-19 outbreak, states experienced overall decreases in enrollment. As a result of the PHE, adult enrollment in Medicaid brought the greatest increase, with 32.3% growth, or 11.1 million enrollees nationwide.

Indiana and surrounding states saw similar increases in Medicaid enrollment, as seen nationwide, with Indiana having a 22.5% increase, translating into just over 350,000 new enrollees. Ohio and Michigan saw increases of 23.9% and 24.5%, respectively. Indiana's higher CHIP income limit prior to PHE may account for some of that difference. Kentucky, by contrast, saw a lower increase than the national average, with a 19.7% increase, representing just over 250,000 people.

Growth in Medicaid enrollment has slowed since the initial declaration of the PHE. Kaiser Family Foundation (KFF) research estimates that baseline Medicaid growth would account for about one sixth of the new enrollment, while MOE provisions are the lion's share of PHE-related enrollment increases. To date, national Medicaid/CHIP enrollment increases are 23.4%, while KFF estimates that growth in a non-pandemic environment would have been approximately 4%.

Estimates for loss of Medicaid coverage are up to 14.2 million when the PHE ends and the MOE provisions expire. Center for Medicare and Medicaid Services (CMS) has stated that the "unwinding" of the PHE rules "presents the single largest health coverage transition event since the first open enrollment period of the Affordable Care Act." For that reason, CMS has issued guidance to assist states with this transition.

ESTIMATES FOR LOSS OF MEDICAID COVERAGE ARE UP TO

14.2 million

WHEN THE PHE ENDS AND THE MOE PROVISIONS EXPIRE

Fundamentals of MOE Rules Unwinding

CHANGES FOR ENROLLEES

For Medicaid enrollees, the last 25 months brought a suspension of many enrollment and cost-sharing provisions. Requirements for verification of eligibility were relaxed; copayments and premiums were suspended. Medicaid enrollees can expect requests for verification starting up to 60 days prior to the end of the PHE. Additionally, many enrollees will begin to be subject to small copays or premiums as part of Medicaid coverage.

FEDERAL LIMITS ON THE UNWINDING PROCESS

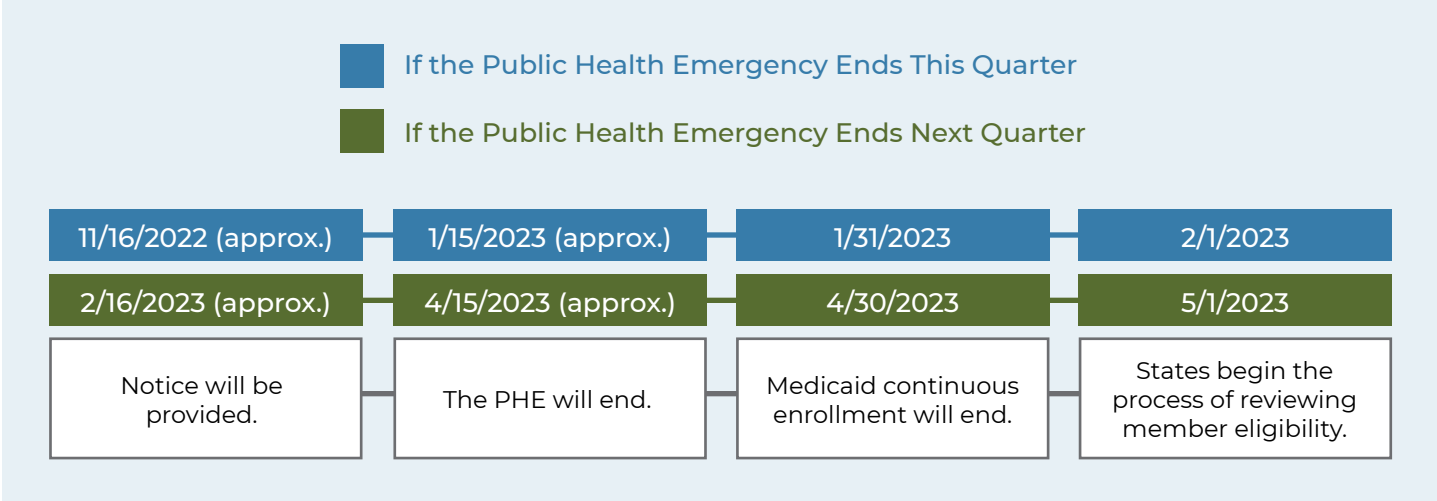
Since state Medicaid offices must maintain regular enrollment activities during the unwinding process, the Centers for Medicare & Medicaid Services (CMS) has granted states up to 14 months to complete the unwinding process. States may not review more than one ninth of their Medicaid enrollment in each month. States have been encouraged to complete eligibility reviews using electronic data resources in a process called "ex parte review."

OPTIONS FOR THOSE LOSING COVERAGE

The most prominent feature of MOE rules has been the requirement to maintain coverage for Medicaid enrollees even when there have been life changes that could make someone ineligible for Medicaid. As the anticipated end of PHE draws near, many Medicaid recipients will face the specter of a loss of health coverage. It is important to educate those losing coverage that they may qualify for Special Enrollment Periods for Marketplace coverage or employer-based coverage.

When the PHE Conclusion Could Occur

Right now, the PHE will end no earlier than 1/15/2023, with a return to normal enrollment process starting no earlier than 2/1/2023.



What States Are Planning

States will begin reaching out to Medicaid enrollees when the end of the PHE is announced by using mailers, sending text messages, posting educational material, and partnering with community stakeholders to ensure that Medicaid members are given sufficient time to prepare for the state to return to regular enrollment requirements. When states begin to review member eligibility, an emphasis will be placed on ex parte reviews to avoid requiring Medicaid members to complete any additional paperwork. State Medicaid offices will reach out to those members who are unable to renew through this process. These reviews will coincide with the renewal of Medicaid or SNAP benefits.

Indiana

While Indiana will be adhering to federal guidance in the unwinding process, CMS approval of a Medicaid waiver will launch the Workforce Bridge Program to provide additional assistance to some Hoosiers who may be losing coverage through the Healthy Indiana Plan. Outgoing HIP members will have the opportunity to enroll in the Workforce Bridge Program. This program provides up to $1,000 to help offset the out-of-pocket expenses related to enrolling in employer or Marketplace coverage.

Kentucky

Kentucky will begin the unwinding process by completing annual renewals on a passive or ex parte basis. Any Medicaid cases that cannot be renewed with that process will require an "active" renewal. This will require the completion of a renewal packet and submission of documentation. Kentucky will spread out its review of eligibility based on annual case renewal dates

Michigan

Michigan will begin the review of eligibility based on each member's annual renewal date. This allows the state to utilize the entire 14-month period allowed by CMS. The Michigan Department of Health and Human Services (MDHHS) will focus efforts on ensuring that enrolled members are made aware of the ending of PHE and ensuring that all contact information is up to date prior to the member's renewal period.

Ohio

Ohio's 3.37 million Medicaid enrollees will be reviewed for continued eligibility. While CMS has given states up 14 months for this process, Ohio BH 110 requires eligibility renewals to be completed within 90 days after the end of the PHE and 120 days for redeterminations.

Conclusion

ClaimAid Patient Advocates are partnered with providers and patients to minimize any loss of healthcare coverage. Our well-trained team will be poised to ensure those we assist have an advocate on their side communicating with state Medicaid offices to document eligibility and updated patient information as we receive it. Advocates will be available to explore other affordable health coverage options when Medicaid coverages end so patients and their families remain covered.

Healthcare organizations can confidently refer members of the patient population to ClaimAid Patient Advocates to obtain the best level of coverage at the earliest possible date.

ClaimAid's team of eligibility experts offer personal guidance to the right coverage resources for patients and their families when they need it most.

Healthcare facilities and patients alike can count on ClaimAid for current and accurate information.

Many in any given community's patient population will be subject to coverage loss when the PHE expires.

Call 800-295-4050
Visit www.ClaimAid.com

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