PANEL: RESTARTING MEDICAID ELIGIBILITY REDETERMINATIONS WHEN THE PUBLIC HEALTH EMERGENCY ENDS

EXECUTIVE SUMMARY

The Medicaid and CHIP Payment and Access Commission (MACPAC) convened a panel to discuss the process for restarting Medicaid eligibility redeterminations when the public health emergency (PHE) ends. The Families First Coronavirus Response Act (FFCRA) enacted continuous coverage for Medicaid enrollees to ensure that individuals do not lose coverage during the pandemic. In turn, states took action to prevent terminations, but this resulted in the need for states to conduct redeterminations for all enrollees when the continuous coverage provision expires one month after the PHE ends.

Panelists representing the consumer perspective and state Medicaid agencies discussed how states need guidance from the Centers for Medicare and Medicaid Services (CMS) to be issued swiftly and provide the flexibility on timing to address the backlog of redeterminations. The Commissioners agreed that two related topics need to be addressed: 1) providing timely CMS guidance that allows states flexibility to conduct redeterminations over a year; and 2) extending the increased FMAP to account for a larger Medicaid-eligible population.

STAFF PRESENTATION

Ms. Jennifer Wagner, Director of Medicaid Eligibility and Enrollment at the Centers on Budget and Policy Priorities, spoke about actions states can take now to prepare for restarting eligibility redeterminations. Ms. Wagner detailed two scenarios that may occur due to the backlogged redetermination process: either states begin conducting renewals now based on current information, which results in potentially eligible individuals losing coverage; or states space their renewals overtime, which would ensure minimal loss of coverage. To address the impending backlog of renewals, Ms. Wagner recommended states conduct ex parte renewals and improve their renewal processes now to ensure accurate eligibility is determined. After the PHE, Ms. Wagner supported spreading the renewals out over a 12-month period and detailed that CMS guidance is needed for this flexibility.

Ms. Rene Mollow, Deputy Director of Health Care Benefits and Eligibility for the California Department of Health Care Services, spoke about the state's response to the COVID-19 pandemic and ways to preserve coverage for eligible enrollees. Ms. Mollow detailed how the state acted swiftly postpone terminations, leverage the ex parte process to maintain coverage, cover the uninsured, and expand the presumptive eligibility pathways. She noted how county operations have been reduced and how limited capacity exists to assist individuals with in-person applications. To address the end of the PHE and the

ensuing redeterminations, Ms. Mollow urged CMS to issue guidance with enough lead time for states to prepare appropriately. She further detailed that guidance should also include the timing needed for the backlog of redeterminations and she suggested that 6 to 12 months be allowed. Finally, to ensure that all state needs are met, she supported working collaboratively with CMS in order to establish clear expectations for the states after the PHE ends.

Ms. Lee Guice, Director of Policy and Operations for the Kentucky Department of Medicaid Services, detailed how the state agency was able to quickly modify its systems to stop terminations of coverage and reinstate coverage for inappropriate terminations. When addressing renewals for after the PHE, Ms. Lee stated that Kentucky is currently conducting ex parte renewals to carry coverage forward for the coming year. She further explained that once the PHE ends, the agency plans on spreading out the renewals as to not overwhelm staff capacity to conduct redeterminations. Additionally, Ms. Guice supported the issuance of CMS guidance 3 to 6 months in advance of the termination of the PHE in order to prepare their systems to resume normal activities.

CLARIFYING QUESTIONS

Commissioner Toby Douglas asked the panel about the fiscal implications once the PHE ends and the financial impact of working through the redetermination process. Commissioner Douglas spoke about the financial pressure of losing the increased Federal Medical Assistance Percentage (FMAP) one quarter after the PHE expires and the pressure that may put on state budgets. Ms. Mollow stated that the financial pressure is going to be significant. She detailed that the one month CMS provided to conduct redeterminations and the expiration of the FMAP does not provide adequate timing or resources. Commissioner Douglas suggested that MACPAC recommed that increased FMAP be extended through the redetermination process.

Commissioner Martha Carter referenced the 10-day time window Medicaid agencies impose when requesting additional information for redeterminations and how this timeframe is not adequate given current circumstances. She then asked if states are making efforts to expand out-stationed workers to increase staffing for redeterminations. Both state Medicaid agency panelists detailed the efforts have been made to increase telephone services but resources for out-stationed workers are limited. Ms. Lee did provide that Kentucky extended the response time to 30 days.

Vice Chair Chuck Milligan noted that how some states are already planning on sending out termination notices to enrollees detailing that coverage will end once the PHE ends. He then asked the panel if anyone was tracking state plans for terminations. Ms. Wagner replied that rumors about plans are starting to circulate, but since the policies are not formal there has been no way to track the plans. She further explained that it would be illegal to end coverage on the day of the PHE because each enrollee is to be considered eligible and therefore subject to the redetermination process. She also asserted that for states to conduct this process properly, increased FMAP needs to be maintained.

COMMISSIONER DISCUSSION

Commissioner Darrin Gordon acknowledged that increased FMAP may be needed to support the redetermination process, but expressed concern that some states may prolong the process in order to keep receiving increase funds amid the financial pressures of the pandemic. He suggested that the Commission support a recommendation for continued increased FMAP that does not create perverse incentives.

Commissioner Kisha Davis emphasized the need to build a grace period in order to accomplish the renewal process. She detailed that many patients are in the midst of receiving care and they cannot afford to lose coverage immediately following the end of the PHE. She also noted how rapid removal may impact minority individuals.

Commissioner Tricia Brooks stated that extending the redetermination process to 12 months is the only logical way to avoid uneven renewal workflow in the future. She also supported giving states increased FMAP for the duration of the renewal process. Commissioner Brooks then suggested the Commission examine the various COVID-19 regulations and their interplay.

Vice Chair Milligan stated that the ability for states to catch up on redeterminations and increased FMAP should be separate but related issues that the Commission should consider. He further detailed that a grace period to address redeterminations and resume normal operations should be assumed to be funded under normal FMAP, while increased FMAP should be viewed through the lens of greater Medicaid eligibility moving forward. He concluded that the first issue can be accomplished through guidance and FMAP will require Congressional action. Commissioner Douglas also supported the idea of two separate recommendations on this topic, but acknowledged the significant financial tension states are facing when completing redeterminations.