One More Time? PHE Extension In the Cards

Flu Season, Respiratory Illness & Utilization Uptick May Push Out End Date

- **The confluence of flu season, respiratory illness uptick, new variants, and a downturn in the economy may push the PHE 90 more days (to mid-March 2022)**. While not certain, the overall macro picture may point to the administration being able to extend the cushion for three more months.

- **Interestingly, the PHE ending sooner than July 2023 results in government savings, due to CBO projections and baseline assumptions**. In May of 2022, CBO projected the PHE ends in July 2023 here. CBO estimates emergency allotments end in August 2023. This means that the PHE ending "early" actually saves the government dollars.

- **The administration is currently poised to end the PHE January 11, 2023, and Congress must be notified if this will not happen.** HHS Secretary Xavier Becerra had promised to give states 60 days' notice until the end of the PHE, which the Biden administration officially renewed until mid-October back in July. We will know in mid-November about a potential PHE extension. Additional payments to hospitals and states based on federal medical assistance percentages (FMAP) will not be required, although CBO has included them in projections.

- **As the PHE end draws closer, Medicaid redeterminations loom, Molina notes 50% of its membership will be re-verified off**. Medicaid MCOs are allowed by CMS to aid states with this onerous task, which presents a market opportunity for plans such as CNC, CVS, ELV, MOH, UNH to assess Medicaid beneficiaries and enroll into Marketplace plans. The unwinding will be the *largest* enrollment event in Medicaid history, and uniquely aligns payer, state, and beneficiary interests. Stakeholders have the shared goal of ensuring a seamless transition from Medicaid and CHIP to Marketplace plans.

- **HHS projects a coverage loss for 15 M Medicaid and CHIP enrollees.** In August 2022, HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE) released an analysis on the end of the PHE here. The *Inflation Reduction Act* (IRA) extends ARP's expanded Marketplace premium tax provisions till 2025, helping those who will lose Medicaid eligibility access alternate coverage. See IRA here.

    - ASPE projects 17.4% of Medicaid and CHIP enrollees will lose coverage in total (approximately 15 M beneficiaries).
    - 2.7 M (almost one-third of those predicted to lose eligibility) will qualify for Marketplace premium tax credits.
    - 1.7 M will be eligible for zero-premium Marketplace plans under *American Rescue Plan* (ARP) provisions.
    - 5 M are expected to find other coverage (primarily employer-sponsored). Read ARP here.

- **States are responsible for redeterminations, an arduous task given there are over 89 M Medicaid and CHIP beneficiaries.** States are allowed to start administrative work 2 months before PHE ends. CMS has given states guidance on how to conduct the volume of redeterminations (based on determining updated adjusted gross incomes, co-morbidities, etc.). Read the policy guidance here.

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- **CMS encourages states to ask plans for help with redeterminations, presenting an opportunity for managed care organizations (MCOs) to capture beneficiaries rolling off Medicaid.** Plans with both lines of business -- Medicaid and Marketplace -- could benefit from ensuring they capture lives that are rolling over. CMS has released guidance on how states can go about enlisting the help of MCOs to facilitate re-enrollment. See guidance here

- **States are recommended over 14 months post PHE to (1) spread verification cases evenly over the unwinding period and (2) prioritize seamless transitions of coverage between Medicaid and CHIP to the ACA exchanges,** among additional technical guidance. A 12-month unwinding period was initially announced in prior guidance from August 2021, but provided that the states have initiated all outstanding renewals by the end of the 12-month period, states have an additional 2 months to tie up loose ends and finish the renewals, bringing us to a 14-month deadline from the end of the PHE.

    - CMS requires states to formulate operational plans for the redeterminations process in advance. See CMS guidance here.
    - Plans are required to include (1) how states will prioritize renewals, (2) the length of time budgeted for renewals, (3) the approximate number of renewals that they attend to initiate each month, and (4) strategies to reduce inappropriate loss of coverage during this unwinding process. Unclear if these reports will be made publicly available.
    - States must submit plans to CMS by the 45th day before the end of the month the PHE ends. See CMS requirements here. NOTE: This would be mid-April 2023, if the PHE ends mid-March 2023.
    - Some states are financially incentivized, by the expected loss of FMAP and increased Medicaid costs due to continuous enrollment and an inability to disenroll beneficiaries, to rush unenrollment. For example, the Ohio Department of Medicaid has contracted with the outside vendor, Public Consulting Group, with plans to have all beneficiaries redetermined in less than 90 days, in exchange for a cut of the state's Medicaid savings. See more on state plans for unwinding below.
    - Based on a MACPAC special meeting in July, state officials at that point felt they had planned as much as they could, and that federal financial support was not necessary.

- **NEXT STEPS:** Recall that President Biden called the pandemic over on a recent 60 Minutes interview (Sept 18). However, many public health officials are concerned that the winter months will bring a COVID-19 surge, and the recent spike in respiratory illness has been concerning. We will monitor PHE end important dates(s), as well as any updated Medicaid & Redetermination guidance(s) as CMS recently extended a comment period regarding "continuous coverage." (here) See **BACKGROUND** for details on states, their (submitted) state plans, benefits expanded throughout the PHE, and the unwinding process guidance details per CMS.

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BACKGROUND: Additional relevant PHE/unwinding details.

The "big five" (CNC, CVS, ELV, MOH, UNH) with the largest Medicaid MCO business include CNC (29 states), CVS (16 states), ELV (20 states), MOH (19 states), and UNH (27 states), as of March 2022. As of July 2022, 32 states announced plans to partner with MCOs. See KFF state survey here.

Total Medicaid and CHIP enrollment skyrocketed during the pandemic, increasing by 25% (17.7 M) from February 2020, to 89 M as of May 2022 (82 M Medicaid and 7 M CHIP). This surge was likely driven by NE, MO, and OK expanding Medicaid under the ACA and the continuous enrollment provision of the *Families First Coronavirus Response Act* (FFCRA). Read the legislation here.

Minority groups will be disproportionately impacted, as 4.6 M Latino and 2.2 M Black individuals are expected to lose Medicaid coverage.
Policymakers are concerned about enrollment churn, as individuals who are still eligible but fail to fill out paperwork may be disenrolled.

States have enjoyed Medicaid benefits during the PHE due to the *Families First Coronavirus Response Act* (FFCRA) of March 2020. Read the FFCRA here.

(1) 6.2% increase in FMAP payments to states that meet "maintenance of eligibility" (MOE) requirements. Began in January 2020. Total federal FMAP funding will amount to $100.4 B by end of FY 2022 (amounting to more than twice state spending on increased Medicaid enrollment). These payments have varied by state, ranging from amounts equal to state costs in NH, NV, and OR, to about six times state costs in AL and MS. State budgets are doing well. When enhanced FMAPs end with the PHE, state Medicaid spending will likely end.

(2) The MOE requires that states adopt a 12-month continuous enrollment eligibility for Medicaid. Reverification processes must be suspended for the PHE duration. Changes in family income are disregarded.

Federal relief dollars extended to other healthcare providers can be found below.

(1) The *Coronavirus Aid, Relief, and Economic Security Act* (CARES) provided a 20% add-on payment to the diagnosis-related group (DRG) rate for Medicare beneficiaries with COVID-19 treated in inpatient prospective payment system (PPS) hospitals.

(2) $7.5 B of $8.5 B of ARP rural funds were given to hospitals and providers in rural areas.

(3) Congress gave health care providers an estimated $100 B in Paycheck Protection Program loans.

CMS Proposed Rule from September 7, 2022 would implement key changes including (1) prohibition of Medicaid eligibility categories from conducting eligibility checks more than every 12 months, (2) elimination of the requirement of in-person interviews for some populations, (3) streamlining of Medicaid and CHIP transferal processes, among others. This will likely be controversial since states would have to increase beneficiary coverage without any substantial federal funding support. See Proposed Rule here. It would result in an:

(1) Increased Medicaid and CHIP enrollment by 3 M people by 2027
(2) Increased federal and state spending on programs by $100 B over the 5 years

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(3) Increased net federal costs by $55 B

Details on CMS unwinding guidance and requirements for states. From March 3, 2022 guidance seen here.

(1) States must present CMS with a plan that considers continuity of coverage, evenly distributed renewals, and processes applications in a timely manner.
(2) States are allowed to initiate redeterminations up to two months before the end of the PHE, although no one can be disenrolled before the PHE officially ends. For enhanced federal matching funding to be retained, the unwinding period must be initiated no later than the 1st day of the month after the end of the PHE.
(3) States must detail approach to the process. Options include (1) prioritizing populations likely to no longer be eligible, (2) based on renewal month or prioritizing pending older actions, (3) hybrid of both options, or (4) a unique state-developed approach.
(4) CMS recommends that states should initiate no more than 1/9 of caseload every month.
(5) All lives who are found to be Medicaid or CHIP ineligible must be transferred to the Marketplace.
(6) CMS will monitor state progress. Monthly data will be submitted by states for 14 months. CMS is working on releasing a template with requirements.

The situation regarding states and their unwinding approaches is evolving. CMS does not require states to make these plans public.

As of October 21, 28 states (including D.C.) have posted a public state plan or summary with plans for redeterminations. See a 50-state unwinding tracker here.

States with public plans include: Alabama, Arizona, California, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Indiana, Kansas, Kentucky, Maine, Maryland, Michigan, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, and Washington. 40 states have posted unwinding information on state Medicaid or Marketplace websites. 46 states have an alert to update contact information. 33 have posted unwinding FAQ. 27 have posted communications materials or toolkits. Only 9 have an unwinding data dashboard or public posting planned.

Nevada's unwinding plan notes that the state will release a data dashboard publicly. The dashboard will be updated monthly and include enrollment by week call center information and state workload with metrics such as total applications, pending applications, and account transfers. Other states are planning on sharing the CMS-required data reports. For example, Michigan's unwinding plan notes that the state anticipates publishing the CMS-required reports to a public-facing website. The plan also notes that the state agency will create several internal operational reports to support their efforts. Arizona and Pennsylvania also noted that they will be monitoring a number of data points, including tracking call center data. See MACPAC October presentation on unwinding here.

States are allowed to acquire temporary waivers from CMS through Section 1902(e)(14)(A) of the *Social Security Act* on a limited-time basis. As of September 6, 2022, CMS has approved 84 waivers for 27 states. See CMS waiver tracker here. Approved waiver strategies include the following:

(1) Renewal for Individuals Based on Supplemental Nutritional Assistance Program (SNAP) Eligibility (Targeted SNAP Renewal) – 8 waivers have been approved
(2) *Ex Parte* Renewal for Individuals with No Income and No Data Returned (Beneficiaries with No Income Renewal) – 19 waivers have been approved

(3) Facilitating Renewal for Individuals with no Asset Verification System (AVS) Data Returned within a Reasonable Timeframe (Streamlined Asset Verification) – 13 waivers have been approved
(4) Partnering with Managed Care Plans to Update Beneficiary Contact Information (MCO Beneficiary Contact Updates) – 19 waivers have been approved
(5) Use of the National Change of Address Database (NCOA) and United States Postal Service (USPS) Returned Mail to Update Beneficiary Contact Information (NCOA and/or USPS Contact Updates) – 12 waivers have been approved
(6) Extending Automatic Reenrollment into Medicaid Managed Care Plans up to 120 Days (MCO Plan Auto-Reenrollment) – 4 waivers have been approved
(7) Extended Timeframe to Take Final Administrative Action on Fair Hearing Requests (Fair Hearing Timeframe Extension) – 8 waivers have been approved
(8) Delaying the Resumption of Premiums Until a Full Redetermination is Completed (Premium Resumption Delay) – 0 waivers have been approved
(9) Other (strategy presented by state)

The Medicaid and CHIP Payment and Access Commission (MACPAC) considered the end of the PHE in its July 2022 meeting. See presentation here. General consensus was that a more solidified end date for the PHE will help states with planning. However, some states told MACPAC that a warning of more than 60-days would not make a substantial difference in preparations.

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