

Omnibus Unwinding Provisions and Implications for States

January 11, 2023

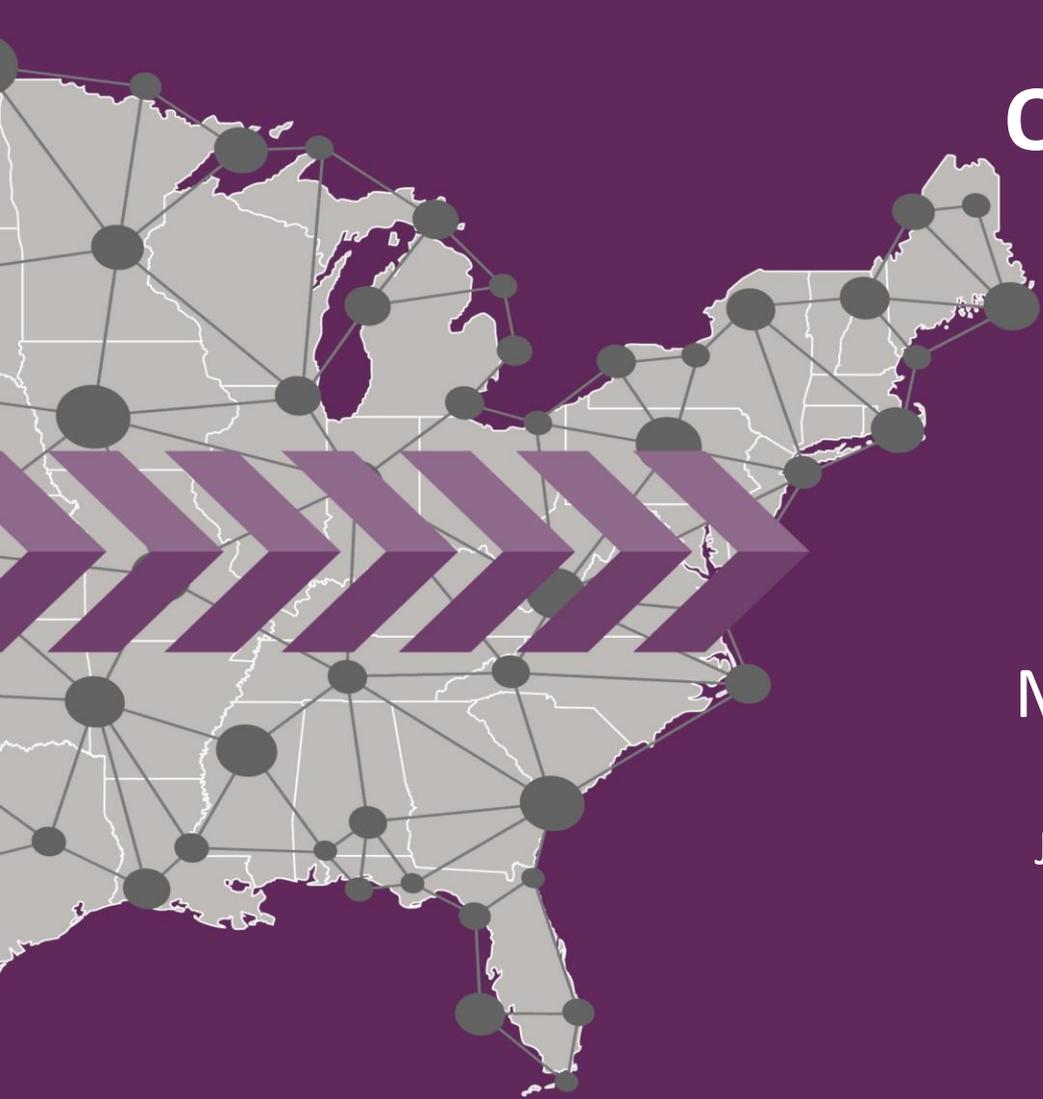
2:00 to 3:00 p.m. ET

Please stand by, this webinar will begin shortly

STATE
Health & Value
STRATEGIES

*Driving Innovation
Across States*

A grantee of the Robert Wood Johnson Foundation



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Manatt Health and GMMB

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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.

*Support for this webinar was provided by the Robert Wood Johnson Foundation.
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About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

About GMMB

GMMB is a full-service communications firm dedicated to creating real and lasting positive change in the world. We work across the health care sector and have expertise developing communications at the intersection of policy development and program implementation. For more than 30 years, we have been on the front line of issue-based communications, earning a reputation for shaping public opinion by developing research-based communications strategies that achieve real results. Our work has helped enroll millions of individuals in affordable health coverage and increased access to needed care and services.

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Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **www.shvs.org**.

Agenda

- **Level Setting**
- **Review of Consolidated Appropriations Act, 2023 (CAA) Medicaid Continuous Coverage Provisions**
- **Considerations for States**
- **Discussion**



Level Setting

Key Healthcare Provisions Included in the CAA

On December 29, 2022, President Biden signed into law the \$1.7 trillion omnibus legislation that includes government appropriations through September 30, 2023, and several notable health policy provisions.

Public Health Emergency (PHE) Unwinding

Fixed end date for Medicaid continuous coverage, gradual phasedown of enhanced federal match, and new guardrails.

Extension through 2024 of several Medicare telehealth flexibilities authorized under the PHE.

U.S. Territories

Extension of higher federal Medicaid match rates for Puerto Rico, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the U.S. Virgin Islands.

Children and Adolescent Health

Requirement to provide children with 12 months continuous Medicaid/CHIP eligibility.

Extension of CHIP funding through fiscal year (FY) 2029.

Enhancements to the provision of Medicaid/CHIP services while a youth is incarcerated in a public institution.

Maternal Health

Permanent state option to extend 12-months postpartum coverage in Medicaid/CHIP.

Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting Program and new virtual home visiting option.

Behavioral Health

Reauthorizes behavioral health programs and expands access to opioid/substance use disorder (SUD) prevention, treatment, and recovery support services.

Requires the United States Department of Health and Human Services (HHS) to issue guidance on crisis response.

Home and Community-Based Services (HCBS)

Extended funding for the Medicaid Money Follows the Person Rebalance Demonstration program.

Extended protections against spousal impoverishment for recipients of HCBS.

★ Today's Focus

Source: [CAA](#); and Manatt Health, [Congressional Omnibus Legislation Includes Robust Year-End Health Policy Package](#).

Reminder of FFCRA Parameters for Unwinding

To promote stability of coverage, the Families First Coronavirus Response Act (FFCRA) provided a 6.2 percentage point increase in the regular Medicaid matching rate, which prohibited states from terminating Medicaid coverage until the final day of the month in which the COVID-19 PHE ends.



Under the continuous coverage requirement, states must maintain enrollment of nearly all Medicaid enrollees (enrolled as of March 18, 2020, or determined eligible on or after that date) through the end of the month in which the PHE ends.



The enhanced Federal Medical Assistance Percentage (FMAP) is conditioned on states not charging Medicaid premiums exceeding those in place on January 1, 2020, and not imposing cost-sharing for COVID-19 testing and treatment.



As a result of these conditions, states have been required to make numerous changes to their eligibility and enrollment systems, operations, and policies.



At the end of the continuous coverage guarantee, states will return to regular eligibility and enrollment operations (“unwinding”)—including redetermining eligibility for nearly all 84 million Medicaid enrollees.



The high volume of pending eligibility and enrollment actions threaten the historic gains in coverage achieved as a result of continuous coverage. Coverage transitions and terminations are likely to disproportionately impact people of color.



States have implemented myriad strategies to prepare for unwinding, but, until recently, lacked certainty around the end date and stable federal resources to address the significant workload at the end of continuous coverage.

Source: FFCRA § 6008(b)(3); SHVS, [CMS Issues Guidance About New Increased Medicaid and CHIP Matching Rate](#); and CMS, [September Enrollment Trend Snapshot](#).

CAA Changes to Unwinding Parameters

With enactment of the CAA, Congress has responded to states' requests for certainty on timing for the end of continuous coverage requirement and stability of enhanced federal funding to support unwinding. Section 5131 makes the following key changes to the parameters for unwinding.



Decouples the Medicaid continuous coverage requirement from the end of the PHE and provides a new statutory end date of March 31, 2023.



Permits states to initiate Medicaid renewals as early as February 1, 2023 (though states may not terminate Medicaid enrollment until April 1, 2023).



Maintains the timeline of 12 months to initiate and 14 months to complete renewals (as previously established in Centers for Medicare & Medicaid Services (CMS) guidance).



Provides for continued federal funding during unwinding through a nine-month phase-down of the enhanced FMAP.



Makes receipt of the enhanced FMAP during the phase-down period contingent on certain conditions.



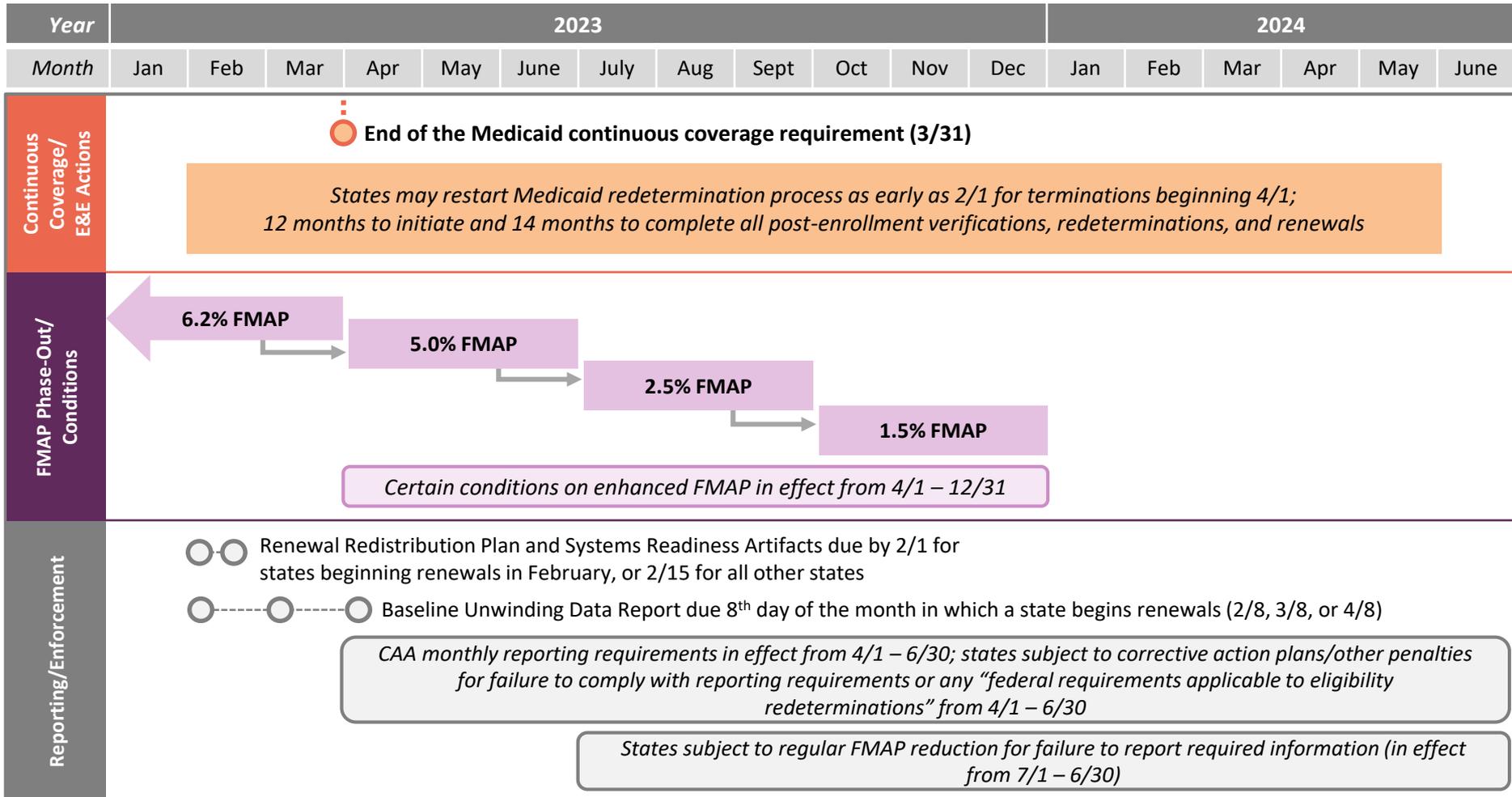
Institutes new reporting requirements to enable CMS oversight of unwinding and improve transparency.



Gives CMS targeted enforcement powers to reduce states' regular FMAP, require corrective action plans, suspend procedural terminations, and impose civil monetary penalties.

Source: [CAA Section 5131](#); [CMCS Informational Bulletin, Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA](#); and [NAMD, NAMD Supports Redetermination Certainty in FY 2023 Omnibus Release](#).

Illustrative Continuous Coverage Unwinding Timeline Under CAA



Source: SHVS, [Unwinding Provisions in the 2023 Consolidated Appropriations Act](#); and CMCS Informational Bulletin, [Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA](#).



Review of the CAA Medicaid Continuous Coverage Provisions

Enhanced FMAP Conditions

Receipt of the enhanced FMAP from April through December 2023, will be contingent upon certain conditions that build upon the existing conditions established by FFCRA.

6.2% FMAP
(start of the PHE through 3/31)

5.0% FMAP
(4/1 through 6/30)

2.5% FMAP
(7/1 through 9/30)

1.5% FMAP
(10/1 – 12/31)



States **must conduct eligibility redeterminations and renewals in compliance with federal requirements** and other strategies approved by CMS, such as temporary section 1902(e)(14) waiver flexibilities.



States **must “attempt to ensure” they have up-to-date enrollee contact information** by using the National Change of Address (NCOA) Database, state health and human services agencies, or other reliable sources of contact information.



States **must not disenroll anyone who is determined ineligible for Medicaid based on returned mail**, without first making a good faith effort to contact the individual using more than one modality (e.g., telephone and email).

CMS has (1) committed to providing states with guidance on how federal partners will interpret sufficient state compliance with these conditions and how the conditions will be implemented; and (2) offered to provide states with technical assistance as they implement these changes and prepare for the end of continuous coverage.

Note: See 42 CFR § 435.911, 42 CFR § 435.916, and 42 CFR § 457.343 for federal *ex parte* requirements. Also see SHVS, [Improving Ex Parte Renewal Rates to Support Unwinding: Q&A](#); CMS, [COVID-19 PHE Unwinding Section 1902\(e\)\(14\)\(A\) Waiver Approvals](#); and CMCS Informational Bulletin, [Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA](#).

New Reporting Requirements

The CAA establishes new reporting requirements—beyond those included in the existing reports—regarding eligibility and renewal processes for Medicaid, CHIP, and the Marketplace.

From April 1, 2023, through June 30, 2024, states must submit to CMS a monthly report (that will be made public) detailing...

<p>Medicaid and CHIP-Related Reporting Elements</p>	<ul style="list-style-type: none"> ✓ The number of: <ul style="list-style-type: none"> – Eligibility renewals initiated. ★ – Enrollees renewed, including a breakdown for <i>ex parte</i> renewals that would have resulted from successful completion of renewal forms/requests for information. ★ – Enrollees whose coverage was terminated. ★ ✓ The number of individuals who were enrolled in CHIP as a result of renewals. ★ ✓ Total call center volume, average wait times, and average abandonment rates.
<p>Marketplace-Related Reporting Elements <i>(unless CMS reports this information on the State’s behalf)</i></p>	<p>For states that operate a State-Based Marketplace (SBM) and have an integrated eligibility determination system:</p> <ul style="list-style-type: none"> ✓ The total number of individuals who were determined eligible for a qualified health plan (QHP) or the Basic Health Program (BHP). ✓ Of these, the number who selected a QHP on the Marketplace or were enrolled in a BHP plan. <p>For states that do not have an integrated eligibility determination system [including all Federally-Facilitated Marketplaces (FFM) states]:</p> <ul style="list-style-type: none"> ✓ The number of individuals whose accounts were transferred from Medicaid to the Marketplace or BHP. ✓ Of these, the number who were determined eligible for a QHP or the BHP. ✓ Of these, the number who made a QHP selection or were enrolled in a BHP plan.

★ = Reporting requirement overlaps with requirement included in the Unwinding Data Report.

In addition to these requirements, CMS may request additional information “related to eligibility redeterminations and renewals.” Reporting requirements apply to all states, regardless of whether they comply with the conditions for enhanced FMAP during unwinding

Updated Reporting Requirements

In light of the CAA, the January 5, 2023 CMCS Informational Bulletin updates and revises due dates for existing unwinding reports and documentation required of states.

Submission	Due to CMS by...
Renewal Redistribution Plan	<ul style="list-style-type: none">February 1, 2023, for states initiating renewals in FebruaryFebruary 15, 2023, for all other states
Systems Readiness Artifacts <i>(configuration plan, testing plan, and test results)</i>	
Baseline Unwinding Data Report	The 8 th day of the month in which a state begins renewals (i.e., February 8, 2023, March 8, 2023, or April 8, 2023)
Monthly Unwinding Data Report	The 8 th day of each calendar month during the unwinding period

CMS also expects that states will continue to submit timely data submissions through the Medicaid and CHIP Eligibility and Enrollment Performance Indicator dataset on the 8th of each calendar month, and data submissions through the Transformed Medicaid Statistical Information System (T-MSIS) dataset before the end of the subsequent calendar month.

**Note: Where a submission due date falls on a weekend or public holiday, states may submit the required document(s) on the following business day.*



CMS notes that reporting activities are intended to “ensure that renewals of eligibility occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage, including for individuals eligible for other insurance affordability programs, and maximizes state effectiveness.”

Source: CMCS Informational Bulletin, [Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA](#).

Additional Federal Enforcement Mechanisms

The CAA vests CMS with targeted oversight and enforcement powers related to unwinding. These enforcement mechanisms extend beyond the ability for CMS to eliminate the enhanced FMAP for states that do not meet required conditions.

Penalty	Trigger	Notes
1) <u>Regular</u> FMAP reduction for failure to report required information	CMS determines that for the period from July 1, 2023 through June 30, 2024, a state fails to comply with the CAA reporting requirements (see previous slides).	A state’s FMAP for the quarter will be reduced by 0.25 percentage points, plus an additional 0.25 points for each prior quarter of noncompliance (not to exceed 1 percentage point).
2) Corrective Action Plan	CMS determines that for the period from April 1, 2023, through June 30, 2024, a state has failed to comply with: <ul style="list-style-type: none"> – The CAA reporting requirements; or – Any “federal requirements applicable to eligibility redeterminations.” 	The legislation establishes timelines for timely submission, CMS approval, and implementation of the CAP.
3) Suspension of procedural terminations* and/or civil monetary penalties of up to \$100,000 a day	CMS determines that a state has failed to submit or implement its corrective action plan.	It remains to be seen how and the degree to which CMS will exercise these enforcement actions and how states will respond.

**Procedural terminations occur when potentially eligible individuals fail to respond to a state Medicaid/CHIP agency’s request for additional information as part of the redetermination process.*



Considerations for States

Continuous Coverage Timeline Considerations

In light of the CAA's conditions for receipt of the enhanced FMAP and new reporting requirements, states may want to revisit their timelines for unwinding.

In determining whether to initiate renewals in February, March, or April, states may want to...

Reconsider state goals in the context of unwinding (e.g., ensuring access to the enhanced FMAP, avoiding penalties), and reprioritize work accordingly.

Evaluate the level of readiness to meet all conditions and reporting requirements, and take more time (if needed) to focus on meeting the requirements established by the CAA.

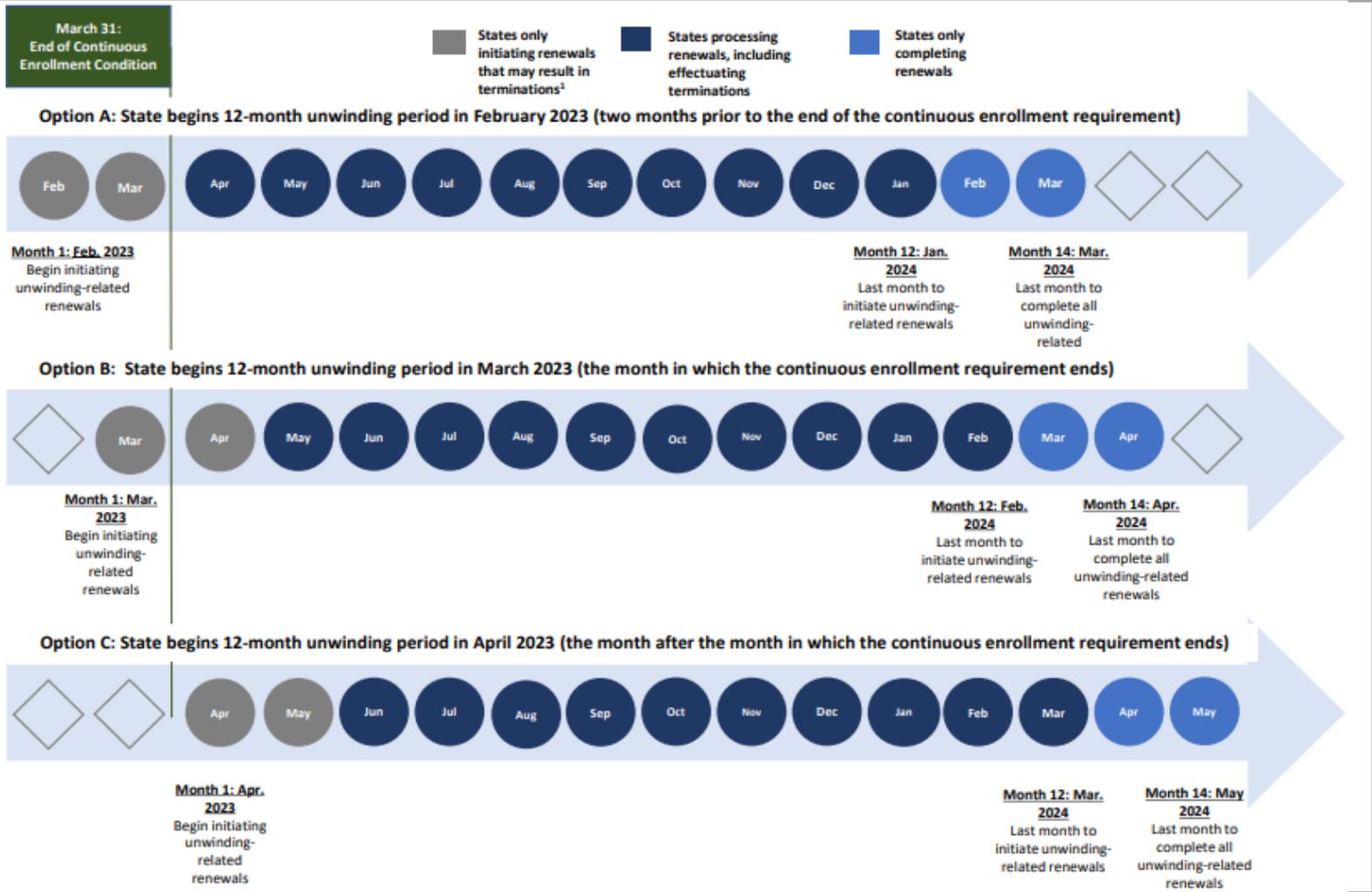
Take workforce capacity into account when distributing and planning for timely completion of renewals.

Consider triggering a redetermination process for children that comes later in the year to account for the CAA requirement that provides children with 12 months continuous Medicaid/CHIP eligibility (effective 1/1/24).

Continuous Coverage Timeline: CMS Example

Unwinding Timeline for States With a 60-Day Renewal Process

(See CMS guidance for a 90-day renewal process)



Source: CMCS Informational Bulletin, [Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA](#).

Considerations for Enhanced FMAP Conditions

To ensure they receive the enhanced FMAP, states will have a new imperative to assess compliance with existing federal redetermination requirements; where there are gaps, states can devise mitigation strategies during unwinding—and plan for correcting compliance issues long-term.



Conduct Renewals Consistent with Federal Requirements

- States may consider conducting a self-assessment diagnostic to determine compliance with federal requirements (e.g., *ex parte*, pre-populated forms, multiple modalities for renewal).
- To mitigate potential gaps, states may consider developing and proposing to CMS a mitigation strategy, including the adoption of temporary flexibilities (e.g., 1902(e)(14) Targeted SNAP Strategy, Beneficiaries with No Income Strategy) to support unwinding, as well as long-term solutions.



Obtain Updated Contact Information

- States may consider deploying strategies they have not already taken up (e.g., adopting section 1902(e)(14) waiver authority for the NCOA/United States Postal Service (USPS) Contact Updates Strategy, developing text messaging and email strategy).



Conduct Outreach to Individuals With Returned Mail Prior to Termination

- States will want to ensure a process is in place to conduct outreach via multiple modalities upon receipt of returned mail (e.g., email, text messaging).

Forthcoming CMS guidance will need to address how the agency will identify, define, and enforce non-compliance with the existing eligibility and enrollment requirements; what it means to “attempt to ensure” to have up-to-date enrollee contact information; and the amount of time a state should wait before contacting an enrollee using a second modality.

Reporting Considerations

Medicaid/CHIP agencies and the Marketplace, alike, will need to take proactive steps to coordinate and ensure they are able to meet the new reporting requirements, or face potential penalties.

- State Medicaid/CHIP agencies might consider reviewing performance indicator data to ensure the state can (or will be able to) submit robust and accurate data that meets new reporting conditions.
- Marketplaces that do not have integrated eligibility determination systems in place will need to prepare for new reporting of account transfer.
- SBMs, in particular, will need to prepare for new reporting of plan selection data for both Modified Adjusted Gross Income (MAGI) and non-MAGI enrollees.
- Given the high stakes tied to reporting, CMS intends to provide technical assistance.



CMS has indicated that it will provide guidance about the new reporting requirements and how they intersect with the requirements described in CMS' existing unwinding guidance, including the Unwinding Data Report. The guidance may also discuss:

- ✓ The timing for data collection.
- ✓ The way in which the data will be presented publicly.
- ✓ How CMS will adapt existing data/reporting requirements tied to the PHE.

Communications Considerations: Immediate Priorities



Develop and share unwinding plan, including timeline for renewals and associated outreach and communications activities.



Create and share messaging and materials.



Enlist partners and stakeholders to complement and supplement your efforts.



Equip navigators and assisters with information.



Establish a feedback loop process to understand and resolve issues as they arise.

Communications Considerations: Messaging Imperatives



Delink any references to “public health emergency” with the unwinding of the continuous coverage requirement.



Emphasize the urgency of actions needed and relay the timeline that enrollees must act.



Let enrollees know what’s at stake and the consequences of not providing updated contact information. Not completing renewal packets could mean loss of coverage and access to the needed benefits and services it provides.



Create messaging that is your “source of truth.” Describe the process in your state, what enrollees should expect and when they should expect them. Leverage this across multiple communications channels and tactics—there is no one-size-fits-all approach.

Discussion

The slides and a recording of the webinar are available at www.shvs.org. For more information, see SHVS' unwinding page, [Resources for States on Unwinding the Medicaid Continuous Coverage Requirement](#).

Thank You

Patricia Boozang

Senior Managing Director
Manatt Health
pboozang@princeton.edu

Kinda Serafi

Partner
Manatt Health
kserafi@manatt.com

Julie Bataille

Senior Vice President,
Managing Director
GMMB
julie.bataille@gmmb.com

Daniel Meuse

Deputy Director
State Health and Value Strategies Program
dmeuse@princeton.edu

Heather Howard

Director
State Health and Value Strategies Program
heatherh@princeton.edu