

# Planning for the Resumption of Normal Medicaid and Children's Health Insurance Program (CHIP) Operations upon Conclusion of the COVID-19 Public Health Emergency (PHE)

DSS Presentation to the Medical Assistance Oversight Council

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# PHE Winddown – Planning Overview

- CMS provided planning guidance in December 2020 with additional clarifications in August 2021 to support states in planning for the end of the PHE and to ensure states can transition back to normal operations efficiently and limit coverage disruptions in a manner that minimizes the burden for both states and individual enrollees.
- The guidance addresses the timeframes and way states have to sunset the various flexibilities that were adopted to respond to the COVID19 pandemic, supporting beneficiaries' access to coverage and services. It also includes compliance with the requirements of section 6008 of the FFCRA as amended by the CARES Act which requires states provide continuous enrollment.

# PHE Winddown – Review of CT Flexibilities

## Examples of CT Eligibility and Enrollment Flexibilities:

- DSS extends renewals
- DSS is not acting on certain changes that result in the loss of eligibility or a lower level of benefits, in accordance with CMS guidance
- DSS increased the income compatibility standard from 10% to 20% for MAGI-based programs
- DSS implemented the Medicaid COVID-19 Testing Group for the Uninsured

# PHE Winddown – Expiration Dates of Various Authorities

- Each temporary authority or flexibility adopted by states to respond to the COVID-19 PHE is scheduled to automatically sunset upon termination of the PHE or another specified date.
- Most provisions expire the first day of the month following the month in which the PHE ends. This includes the new coverage group, Medicaid for the Uninsured COVID-19 testing (plus vaccine coverage) which will sunset at the same time.
- The maintenance of effort/continuous enrollment provision will expire on first day of the month following the month in which the PHE ends. Increased FMAP is available through the end of the first quarter in which the PHE ends.

# CMS PHE Unwinding Requirements

- As a result of the general disruption to state operations during the PHE as well as the impact of the continuous enrollment requirements, CMS understands states are faced with a significant number of eligibility and enrollment actions that will need to be completed after the PHE ends.
- States, including CT, have identified potential challenges with completing the volume of renewals, redeterminations and post-enrollment verifications that will need to be processed. These volumes continue to grow the longer the PHE is extended.

# CMS PHE Unwinding Requirements

*Extended timeframe for states to complete pending eligibility and enrollment actions up to 12 months after the month in which the PHE Ends*

- In December 2020, CMS proposed a 6-month timeframe to complete pending eligibility and enrollment work. States expressed fear that this would cause a “renewal bulge” in future years. This would be an administrative burden to states but also potentially to individuals in future years if renewals weren’t processed timely. Rushed timeframes to complete or respond could lead to errors and inappropriate terminations or denials. Access to care could also be directly impacted.
- In August 2021, CMS recognized these challenges and are now allowing states up to 12 months to process necessary work. This will allow states to reestablish renewal schedules which will be sustainable for all in subsequent years.

# CMS PHE Unwinding Requirements

## *Timely Processing of All Applications*

CMS provided states with up to 4 months after the month in which the PHE ends to resume timely processing of all applications. CT did not request any flexibility with the timely processing of new applications during the PHE. Ensuring timely access to health coverage by processing applications timely remains our priority. The implementation of other flexibilities that reduced processing burdens supported efforts as more resources were available to concentrate on new applications.

## CMS PHE Unwinding Requirements

*Completing an additional redetermination for individuals determined ineligible for Medicaid during the PHE*

- CT continues to process eligibility and enrollment actions such as renewals during the PHE. This allows individuals to be granted ongoing coverage for 12 months if they qualify rather than being extended in 90-day increments.
- If individuals do not qualify or do not complete the renewal process, they are automatically extended.



# CMS PHE Unwinding Requirements

## *Completing an additional redetermination for individuals determined ineligible for Medicaid during the PHE*

- After the PHE ends, CMS requires states complete redeterminations for all individuals who were continuously covered during the PHE before taking any adverse action.
- States must redetermine eligibility without requiring the information from the individual if they are able to do so based on reliable information in their case record or more current information that may be available to the agency, e.g., electronic data sources. If the state is not able to redetermine eligibility, the state must request information from the individual.

# CMS PHE Unwinding Requirements

## *Completing an additional redetermination for individuals determined ineligible for Medicaid during the PHE*

- States are required to promptly evaluate information received. States cannot deny, terminate eligibility, or reduce benefits based on information received through electronic data sources unless the state has reached out to the individual and provided a reasonable opportunity period for the individual to respond.
- Individuals enrolled in a MAGI-based program must be given a minimum of 30 days to respond. Non-MAGI beneficiaries must be given a reasonable time to respond. A minimum of 10 days advance notice and fair hearing rights must be provided prior to termination or other adverse action.

# CMS PHE Unwinding Requirements

## *Transition Ineligible Individuals to Other Insurance Affordability Programs*

As part of this process, states are also required to take steps to smoothly transition individuals who are ineligible to other insurance affordability programs, as appropriate. This includes assessing eligibility for marketplace programs. CT is well-positioned to support this due to the integrated eligibility system and shared rules engine with Access Health CT. If an individual is determined ineligible for Medicaid, they are simultaneously assessed and offered enrollment in a marketplace plan.

# State Winddown Options

*CMS requires states to adopt one of 4 risk-based approaches to prioritize completion of the pending work as they plan to return to routine operations. These include the following:*

- Population-based – prioritizes completing outstanding eligibility and enrollment actions for individuals in groups who are most likely to be no longer eligible (e.g., no longer categorically eligible by age, individuals who gained eligibility only by state's use of a temporary authority, e.g., 20% income threshold)
- Time-based – prioritizes based on length of time an action has been pending, working oldest actions first
- Hybrid – includes combination of population and time-based approaches
- State-developed – States may develop their own approach focusing on those who are most likely to be ineligible or for which there is greater risk that ineligible individuals may remain enrolled longer

## CT's Approach to PHE Winddown

- CT's risk-based approach options are still being developed.
- Pivotal to the decision will be understanding when the PHE is going to end.
- Throughout the year, CMS has signaled 12/31/21 as the potential end to the PHE. They have also indicated that states would be provided 60 days' notice. However, many states have concluded that 60 days is not enough time to properly outreach to individuals or complete the numerous eligibility system related changes necessary to return to normal operations.
- No matter the PHE end date, DSS will provide the opportunity for **ALL** individuals to update information and have their enrollment passively renewed.
- Outreach initiatives are being explored but at minimum will include a special mailing.

# Stay Tuned!

- The current PHE period ends on 10/17/21 and will require a subsequent declaration by the Secretary of HHS.
- The Secretary may authorize up to 90 additional days.
- More information will be available soon!