Medicaid Eligibility & Enrollment and the Unwinding

June 12, 2024

Skyler Rosellini (he/him)
Jules Lutaba (he/him)

About the National Health Law Program

- National non-profit law firm committed to improving health care access, equity, and quality for underserved individuals and families
- State & Local Partners:
  - Disability rights advocates – 50 states + DC
  - Poverty & legal aid advocates – 50 states + DC
- National Partners
- Offices: CA, DC, NC
- www.healthlaw.org
- Follow us on Twitter @NHeLP_org
- Like us on Facebook @NHeLProgram
- Read NHeLP's Equity Stance

Health Equity Stance

Every member of our staff defends the fundamental right of all individuals to health. Staff in every role strive to approach their work—internal and external—with an equity lens.

Our goal is to continuously examine the health care system and to advocate for health laws and policies that counteract structural barriers, institutional power dynamics, and examples of overt discrimination and implicit bias that create health inequity.

Outline for Today

- Medicaid during the Public Health Emergency
- Overview: Medicaid Continuous Coverage Unwinding
- Medicaid Eligibility Process & Unwinding
- Eligibility & Enrollment Final Rule
- Q&A

Medicaid During the Public Health Emergency

Medicaid During the Public Health Emergency

- COVID-19 public health emergency led to numerous Medicaid flexibilities
- Changes to 1915(c) requirements, provider requirements, services, telehealth, hearings, etc.
- Families First Coronavirus Response Act increased federal Medicaid funding, but with “maintenance of effort” reqs., including **continuous eligibility** effective March 18, 2020.

Continuous Coverage Requirement

- States were prohibited from terminating Medicaid coverage during the PHE with certain exceptions since **March 2020**
  - Deceased
  - Voluntary cancellation
  - Moved to reside in another state
  - Fraud or improperly enrolled
  - Loss of immigration status

- States could send out renewals, but could not terminate if information indicated the person was ineligible or if they failed to return the request for information

Overview: Medicaid

Continuous Coverage Unwinding

Consolidated Appropriations Act of 2023

- CAA 2023 de-linked and sunset the PHE from the continuous coverage requirement on March 31, 2023

- Added protections for the continuous coverage unwinding, changed enhanced FMAP rules, and set the continuous coverage end date.

- To receive enhanced FMAP, which decreased quarterly until December 2023, states required to:
  - Not restrict eligibility standards, methodologies and procedures
  - Not increase premiums (may adjust individual premiums 4/1)
  - Comply with federal requirements
  - Maintain current contact information for beneficiaries
  - Attempt to contact by at least two modalities before disenrollment due to returned mail

Consolidated Appropriations Act 2023; SHO# 23-002

Medicaid “Unwinding Period”

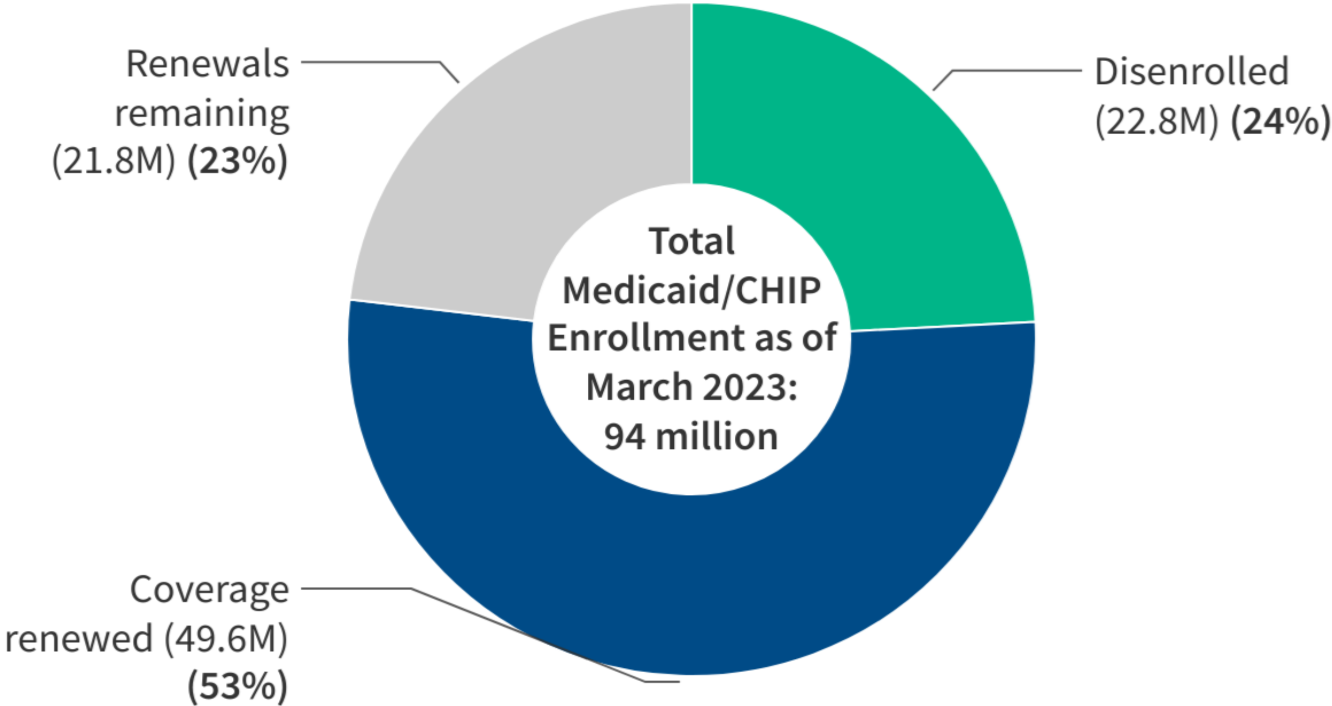
- Terminations could begin as early as **April 1, 2023**
- States had 12 months to **initiate** all pending redeterminations and 14 months to **complete** them
- Could begin unwinding in February, March, or April 2023
  - This means that states started terminations between **April and July of 2023**

SHO# 22-001

Additional Unwinding Requirements

- States required to create operational unwinding plans
- Required to collect and report on eligibility and enrollment data metrics
  - Certain enrollment and renewals data required post-unwinding (SHO# 24-002)
- CMS has issued several guidances throughout the PHE and unwinding, and has encouraged using flexibilities!

Cumulative Medicaid renewal outcomes reported as a share of March 2023 Medicaid/CHIP enrollment:



Source: KFF Analysis of State Unwinding Dashboards and Monthly Reports to CMS. CMS Performance Indicator Data (March 2023 Medicaid/CHIP Enrollment).

KFF

Medicaid Enrollment & Unwinding

- At start of unwinding period, 93.8 million enrolled
  - 32.4% increase from February 2020

- Most recent data shows 83.4 million enrolled (Feb 2024 data)
  - 11.2% decrease since March 2023

- Of those disenrolled, 69% were for procedural reasons (didn’t receive renewal forms, can’t update their contact info, etc.)

- 53% of individuals have been renewed

Medicaid Eligibility Process & Unwinding

Renewals & Redeterminations

Renewals Process

- State must use available information **before** requesting more information ("ex parte" or "passive renewal")
- Must send a renewal form or request for information if insufficient information to complete ex parte (MAGI: Pre-populated form)
  - State can only ask for information needed to complete termination
- Review for **ALL** categories of eligibility before termination
- If enrollee does not return information or complete renewal, state sends advance written notice of proposed termination (procedural)
- **MAGI**: Must reconsider eligibility if requested information is returned within 90 days after termination

42 C.F.R. § 435.916(a); 42 C.F.R. § 435.916(f)

Top Redetermination Rights

- Must seek updated contact information before attempting redetermination using reliable sources
  - Determination must be based on current information
- Cannot terminate based on ineligibility identified during PHE or the unwinding period (with some exceptions to the latter)
- Must receive renewal form or notice accessible to persons with LEP and with disabilities
- Submit information requested through any of the authorized avenues: online, in person, by mail, or telephone
- All denials receive advance notice and opportunity for hearing, including continuation of benefits

Change of Circumstance (Redeterminations)

- States must have procedures for individuals to report changes and may run periodic data checks between annual renewals

- Must send notice of the change and provide an opportunity to dispute or explain the information

- May only require information about the eligibility criteria at issue

- If the change could impact eligibility, state should redetermine eligibility using the new information within 30 days

42 C.F.R. § 435.916(c) & (d)

Full Renewals During Unwinding Period

- Enrollees got a **full renewal** during unwinding while Medicaid protected until their first renewal, including:
  - Those found ineligible during the PHE
  - Changes in circumstance reported during PHE

- Important **exceptions** to the full renewal requirement:
  - Recent "change of circumstance" cases
  - Individuals with unpaid premiums incurred prior to PHE
  - Optional COVID-19 group
  - Individuals who remained in a "reasonable opportunity period" to verify their immigration status or citizenship

Notice Requirements

- Must provide notice regardless if full or procedural termination
  - Plain language and accessible
  - Provide relevant dates
  - Clear statement of specific reasons supporting decision
  - Cites specific regulations that support the action
- Can be multiple notices
- Cannot fulfill notice obligations by telling the person to call or talk to someone
- Explain when benefits may continue during appeal
- *Goldberg v. Kelly*

42 C.F.R. § 435.917; 42 C.F.R. §§ 431.206(b), 431.210, 435.912, 435.919

Fair Hearings Rights

- Gets reasonable time, not to exceed 90 days from mailing of notice
- States may hold fair hearings and reviews by phone or video as long as providing access as required under law
- Must be accessible to individuals with disabilities and LEP
- Must provide time promised in the notice **after PHE ended**
    - Even if the state ended the extension (1135 waivers extended timeline)
- Some states also opted for extension for final administrative decision

42 C.F.R. §§ 431.220 - 431.224; SHO# 22-001

Section 1902e(14)(a) Waiver

- Time limited (and optional) authority to facilitate renewals

- Examples:
  - Enroll based on SNAP and/or TANF eligibility
  - Ex parte for those with no income and no data returned
  - Partner with Medicaid health plans to update beneficiary contact information
  - Use National Change of Address Database
  - Extend timeframe to take final administrative action on fair hearing
  - Delay resumption of premiums

Extension of Waiver Flexibilities

- 1902(e)(14)(a) waivers can be extended through June 2025
  - Certain flexibilities made permanent as of 6/3/24
  - Can use more than once on enrollee
  - Don't have to request approval again

- State verification plans can be extended through June 2025

[CMS Information Bulletin, 5/9]

CMS Eligibility & Enrollment Final Rule

CMS Final Rule

- Published by U.S. Dept. of Health and Human Services (HHS) in April 2024
  - Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.
- Effective June 2024
- States must implement most rules within 36 months, by June 2027

Stated goals

- Simplify eligibility and enrollment processes for Medicaid and CHIP applicants and enrollees
- Align enrollment and renewal requirements for most individuals in Medicaid
  - More renewals, ex parte
  - Fewer procedural disenrollments
- Address underutilization
  - Address low enrollment in cost-saving programs, e.g. Medicare Savings Program (MSP)
  - States' underutilization of data to enroll/renew

Aligning MAGI & non-MAGI enrollment and renewal

- ACA expanded Medicaid eligibility to lower income individuals
- Final Rule aligns enrollment rules for Medicaid's two main pathways MAGI (new) and non-MAGI (previous)
  - MAGI enrollment and redetermination rules are generally more favorable for applicants/enrollees
- MAGI versus non-MAGI
  - MAGI: income-based determination
  - Non-MAGI: broadly speaking, for aged (65+) and/or disabled individuals
  - Majority of Medicaid enrollees are MAGI based, approx. 80%

Timeline changes to non-MAGI

- Application: Applicant has 15 calendar days to respond to requests for additional information
- Renewal: Enrollee has 30 calendar days to respond to requests for information or return a renewal form
- Post-Termination: Enrollee has 90 calendar days after termination to renew enrollment, state reconsiders their eligibility
- Aligned with MAGI timelines

- Code: 42 C.F.R. §§ 435.916(a)–(b) and § 435.907(d)

Process changes to non-MAGI

- Renew eligibility every 12 months, and not more frequently
- Accept information through any modality available, including phone, e-mail, mail, in-person, etc.
- Not require an in-person interview
- Provide a pre-populated application or renewal form
- Review information from other sources (i.e. *ex parte*)
- Not require individual apply for other gov't benefits
- Aligned with MAGI rules

Code: 42 C.F.R. §§ 435.907, 435.916, 435.608, and 436.608

Income-based eligibility changes

- Over-income MN Medicaid applicants/enrollees can spend income on medical expenses to gain eligibility
  - Known as a "spend-down"
  - E.g. homecare services, prescription drugs, and other uncovered medical expenses
- Can now **project** spend-down
  - Can project spend-down into future months, enrollee not reestablishing eligibility
  - Code: 42 C.F.R. §§ 435.831(g)(2) and 436.831(g)(2)
- Will increase or maintain enrollment

Change in circumstances verifications

- State receives information that enrollee's information has changed
  - Change may affect eligibility
  - State reviews enrollee's eligibility
- New protections for enrollees
  - State first reviews *ex parte*, based on available information
  - Limit scope of information requests to the change in circumstances
  - Enrollee has 30 days to respond to request for information
  - State accepts information from any modality permitted (e.g. phone, online)
  - If change would benefit enrollee, state cannot terminate enrollee for failure to respond
  - 90 day reconsideration period
- Code: 42 C.F.R. §§ 435.919 and 457.344

Transitions between Medicaid and CHIP

- CHIP eligibility
  - Higher income limits for CHIP than MAGI Medicaid
  - Children who become income-ineligible for Medicaid may be eligible for CHIP
- Information sharing
  - Medicaid makes eligibility determinations on behalf of CHIP
  - CHIPs must send information to the Medicaid agency to complete the eligibility determination
  - Combined notice sent by Medicaid and CHIP

- Code: 42 C.F.R. §§ 431.10 and 435.1200; 457.65, 457.340, 457.348, 457.350, and 600.330.

Summary

- Unwinding and Final Rule goals
  - Maintain enrollment, decrease procedural terminations
  - Ease administrative burden on applicants and enrollees
  - Increase utilization of cost-saving plans, services, and information
- Strategies
  - Align non-MAGI time standards with MAGI
  - Facilitate information sharing and paperwork requirements between applicants/enrollees and Medicaid
  - Facilitate information sharing between Medicaid agencies and CHIP

Resources

Guidance & Resources: "Must Reads"

- NHeLP: NHeLP PHE Unwinding Landing Page
  - Unwinding Checklist
  - Unwinding Issue Spotting Video
  - Renewal Tips of the Day
  - Unwinding Litigation in Florida
  - Resource List
  - Preorder new edition of Advocate's Guide to the Medicaid Program!
- Georgetown CCF 50-State Unwinding Tracker
- KFF Unwinding Data Tracking

Questions?

Jules Lutaba, lutaba@healthlaw.org

Skyler Rosellini, rosellini@healthlaw.org

Connect with National Health Law Program online:

www.healthlaw.org

@NHeLProgram

@NHeLP_org

WASHINGTON, DC OFFICE
1444 I Street NW, Suite 1105
Washington, DC 20005
ph: (202) 289-7661

LOS ANGELES OFFICE
3701 Wilshire Blvd, Suite 750
Los Angeles, CA 90010
ph: (310) 204-6010

NORTH CAROLINA OFFICE
1512 E. Franklin St., Suite 110
Chapel Hill, NC 27514
ph: (919) 968-6308