Continuous Medicaid Coverage During the Public Health Emergency

Background

- Federal law (the Families First Coronavirus Response Act (FFCRA), Public Law 116-127) requires states to maintain Medicaid coverage for most people active or certified for Medicaid as of or after March 18, 2020, until the end of the month in which the federal public health emergency (PHE) ends in order for the state to qualify for a temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase.
  - To date, HHSC has received approximately $4.17 billion General Revenue (GR) due to increased match rates in Medicaid, CHIP and Healthy Texas Women.
- HHSC implemented the federal directive effective March 18, 2020. Due to the complexities, automation, and integration of the Texas Integrated Eligibility Redesign System (TIERS), HHSC modified and implemented several processes to sustain Medical coverage for individuals determined to be eligible for Medicaid as of March 18, 2020:
  - Reinstated coverage terminated after March 18;
  - Suspended Medicaid renewals and administratively adjusted renewal dates;
  - Suspended automatic and manual termination processes;
  - Limited transfers between Medicaid coverage groups; and
  - Implemented a modified renewal process.
- HHSC suspended disenrollments (including all activities that could result in disenrollment) and sustained level of coverage for all members in all Medicaid programs with records scheduled to end March 31, 2020, unless the recipient has:
  - Moved out of state;

- Voluntarily withdrawn from coverage; or
- Passed away.

- Activities occurring after initial operational changes to sustain coverage for Medicaid recipients in March 2020 include:
  - HHSC resumed Medicaid renewals using a modified process in September 2020 in alignment with the Centers for Medicare & Medicaid Services (CMS) guidance.
  - CMS released guidance in November 2020 resulting in the state's ability to (starting February 2021):
    - ◊ transfer Medicaid recipients to different types of assistance while continuing to maintain their overall tier of Medicaid coverage,
    - ◊ resume age out transitions for members who qualify for another Medicaid program in the same tier of coverage, and
    - ◊ resume waiver terminations when members no longer meet functional criteria. Members will maintain Medicaid state plan services.

CMS Guidance

- Federal guidance regarding FFCRA's continuous coverage requirements has evolved over the pandemic. To date, the following guidelines have informed HHSC's efforts to maintain continuous coverage and plans for resuming normal Medicaid operations at the end of the PHE.
  - Compliance with the FFCRA is contingent upon a PHE declaration by the federal government, which can only be declared for 90 days at a time. The current PHE declaration expires April 16, 2022.
  - Continuous coverage requirements expire the last day of the month in which the PHE ends.
  - States will continue to receive enhanced FMAP for the duration of the calendar quarter in which the PHE declaration ends.
  - CMS recommends that states begin to prepare for the end of the PHE utilizing a phased approach.
- In January 2021, the Biden administration provided notice to states promising to give states at least 60 days advanced notice of when the PHE will expire. Under the current PHE declaration, states would have been informed the PHE will end by February 15, 2022. As of March 3, states have

not received that notification. CMS has verbally indicated states should assume the PHE would be renewed beyond April, but could not guarantee the length of the extension.

- CMS guidance issued in August 2021 significantly altered assumptions for HHSC's efforts to plan for ending continuous coverage. The updated guidance made the following revisions to December 2020 guidance:
  - Extended the timeframe for states to complete pending eligibility and enrollment actions, providing states up to 12 months to complete all pending verifications, redeterminations, and renewals (up from six months). [Note: based on current law, the enhanced FMAP still ends on the last day of the calendar quarter that the PHE ends.]
  - Prohibits states from terminating coverage for individuals determined ineligible throughout the PHE (whose coverage is being maintained under FFCRA) until after the PHE ends and a redetermination has been made.
  - Requires states to conduct a full redetermination (as outlined in 42 CFR 435.916), including checking all available information and data sources without contacting the recipient to request documentation and requesting renewal packets.
  - Prohibits states from using information obtained from an eligibility determination completed prior to the end of the PHE to determine their ineligibility.
  - Requires states to complete redeterminations after the end of the PHE and allow members a minimum of 30 days to respond to renewal packets or requests for information.
- CMS issued additional guidance on March 3, 2022, that provided states with additional clarification and directions on ending continuous Medicaid coverage at the end of the PHE. Key impacts included in the March guidance include:
  - States may initiate their 12-month unwinding period up to two months prior to the end of the month in which the PHE ends, so long as terminations do not begin until the month after continuous coverage ends.
  - States that choose to end continuous coverage prior to the end of the PHE can no longer claim the temporary FMAP increase. States must still follow the timelines and expectations of CMS guidance in their unwinding.
  - CMS will allow states to request temporary flexibilities under a 19029(e)(14(A) waiver to implement certain strategies to protect

recipients during the unwinding period. Strategies states may use under this waiver authority include:

- ◊ Renew Medicaid eligibility for SNAP participants without conducting a separate MAGI-based income redetermination.
- ◊ Accepting recipient contact information from Medicaid MCOs without additional confirmation.
- ◊ Extending timeframes to take final administrative action on fair hearing requests.

- CMS recommends (but does not require) states initiate eligibility redeterminations for no more than one-ninth of the total Medicaid caseload per month of the unwinding.
- HHSC will need to complete a comprehensive "unwinding operational plan" to reflect how Texas will restore routine operations for Medicaid eligibility and enrollment actions. The plan does not have to be submitted to or approved by CMS, but it must be made available upon request.
- CMS will require states to submit certain information – including how each state plans to distribute renewals – and use the information to identify states at greatest risk of inappropriate coverage loss. CMS will follow up with states as appropriate to ensure mitigation strategies are in place to avoid inappropriate terminations.

HHSC Plan to End Continuous Coverage

Based on the most recent data, HHSC estimates as many as 3.7 million members will need to have their Medicaid eligibility redetermined when continuous coverage ends, with 2.97 million of these individuals extended due to the requirements to provide continuous Medicaid coverage until the end of the PHE. This number continues to grow based on members continuing to reach the end of their current eligibility periods.

To comply with federal guidance for completing redeterminations and manage capacity for eligibility operations, HHSC plans to take a population based, phased approach to end continuous coverage. This approach prioritizes redeterminations in three groupings.

- The first group includes individuals most likely to be ineligible or transitioned to another program (i.e. CHIP, pregnant women who may transition to Healthy Texas Women, members who aged out of Medicaid, or adult recipients who no longer have an eligible dependent child in their household.).
- The second group includes individuals transitioned to a different Medicaid eligibility group, pending populations in Medicaid children, parent/caretaker and waiver groups, and certain MAGI population groups (i.e. children, people under Transitional Medical Assistance).
- The final group includes everyone remaining from the previous groups, including those most likely to remain eligible when continuous coverage ends.

- Based on December 2021 estimates, approximately 880,000 people would be processed in the first group[1]; 280,500 in the second; and 1.81 million in the third group. These numbers are constantly changing and serve as HHSC's best estimate at the point in time the data was pulled.
  - If the PHE ends in July, HHSC would complete processing for redeterminations by February 2023, based on current projections for estimated workload and staffing capacity.
    - Disenrollments for the first group would begin effective August 1, 2022 and be completed by November 2022.
    - Disenrollments for the second group would begin effective November 1, 2022 and be completed by December 2022.
    - Disenrollments for the third group would be effective by February 1, 2023.
  - Members will maintain coverage on a month-to-month basis while their redetermination is processed.
- This staggered approach provides the following benefits for the state's efforts to return to normal eligibility operations after continuous coverage ends:

[1] Two populations not subject to the Medicaid renewal process – individuals who no longer qualify for SSI and children who have aged out of DFPS conservatorship – will be disenrolled effective August 1. They are counted in the first group for consistency with the total number to be processed, but they will not follow the same process as the Medicaid renewal population. Approximately 86,400 individuals would be processed in these populations, with approximately 794,000 individuals in the first group processed through Medicaid renewals.

- It lessens confusion and abrasion for members who are most likely to maintain coverage, including older adults and people with disabilities.
- It concentrates state resources to prioritize redeterminations for those most likely to be ineligible.
- It reduces the risk of overwhelming the eligibility system by phasing eligibility work over several months.
- It allows HHSC to resume normal operations in future years by staggering renewal dates to avoid an unusually high number of renewals for certain months.

Constraints

- Unwinding the PHE is coming on top of existing eligibility challenges that are driven by a combination of increased workload and staffing challenges.
  - Eligibility operations staff are operating at maximum capacity. In addition to regular processing of new applications, staff must balance additional work to return to normal operations for SNAP, Medicaid, and CHIP.
  - Pandemic EBT and other declared disasters (e.g. hurricanes, the 2021 winter freeze) create additional workload for eligibility staff.
  - HHSC is struggling to maintain current staffing levels for eligibility operations and attrition is offsetting new hiring efforts.
  - Eligibility staff is already working mandatory overtime hours.
  - New hires do not have institutional knowledge to handle all cases, so hiring efforts may not impact workload for more complex cases such as Medicaid for the Elderly or People with Disabilities.
- Workforce challenges exist across the system that impact planning efforts and preparation. This includes hiring and retention challenges for contract partners, including call centers. HHSC is developing strategies to ensure and enhance capacity to handle increased volume of work and calls when continuous coverage ends.
- CMS continues to provide guidance about unwinding continuous coverage. New or updated guidance could impact HHSC plans and require further changes to assumptions and implementation timelines.
- The Build Back Better Act, which has significant implications for how states process redeterminations after the end of the PHE, is unlikely to pass. HHSC

is considering its impact on the current plan in the event the bill, or portions of the bill in separate legislation, passes. Significant impacts include:

- Allowing states to begin disenrolling individuals who are ineligible on April 1, 2022; however, states can disenroll no more than one-twelfth of the accrued renewal backlog per month between April and September 2022.
- Sunsetting the continuous coverage requirement on October 1, 2022.
- Phasing out the enhanced FMAP over three quarters in 2022.
- Applies a 3.1 percentage point FMAP penalty on any state that applies more restrictive eligibility standards between September 1, 2022 and December 31, 2025 than those that were in effect as of October 1, 2021.

Workload/Workforce Strategies

HHSC continues to evaluate additional strategies to reduce workload necessary to end continuous coverage and increase the eligibility workforce capacity. Some strategies have already been implemented while others may take time to see results.

Workforce Strategies

HHSC is taking all possible actions to enhance the eligibility workforce and increase capacity to process eligibility workload. These strategies include:

- Augmenting the eligibility operations team with other staff who are qualified to process eligibility.
- Leveraging virtual training for Basic Skills Training.
- Conducting job fairs in high retention areas to boost recruitment.
- Reducing the time between hire and start date by 50 percent.
- Hiring temp staff to assist with workload.
- Promoting a non-traditional/flexible work schedule.

Workload Reduction Strategies

Some strategies identified by HHSC will reduce the workload on eligibility staff by automating or streamlining processes to maximize staff time spent processing cases. Strategies implemented or underway include:

- Assigning regions specific types of workload for extended period to increase worker proficiency.
- Prioritizing specific changes in the Eligibility Workload Management System (EWMS) that have faster processing times or are considered critical and bundling tasks in EWMS for an individual case.
- Automating scheduling of SNAP appointments.
- Automating MAGI alerts.
- Using nudges in Your Texas Benefits to remind members to answer needed questions and upload any verification needed.
- Allowing clerical staff to perform data entry tasks and assist with interview scheduling.

Communications/Outreach

- HHSC is preparing a proactive communications campaign to help members, providers, health plans, and advocates prepare for the end of continuous coverage.
  - Messaging provided to health plans, providers and advocates to share widely will remind members that their eligibility will be redetermined at the end of continuous coverage and promote actions they can take now to prepare. These actions include:
    - Return renewal packets or requests for information as soon as possible.
    - Sign up for the YourTexasBenefits account and mobile app.
    - Report any changes to contact information to ensure members receive important HHSC notices when needed.
  - The outreach campaign will include tailored messaging for contract partners (e.g., health plans, enrollment broker, TMHP), internal staff, other state agencies, legislative staff, community partners, providers, associations, and advocacy groups.
- A similar campaign is in development to be deployed when continuous coverage is confirmed to be ending and HHSC implements the staggered approach to redetermine eligibility.
  - Messaging in this campaign will inform members and stakeholders that continuous Medicaid coverage is ending, and members will be

redetermined. Any renewal packets or requests for information from HHSC must be returned timely.

- Members will also receive a final notice letting them know of their eligibility. If they are determined ineligible, the notice includes information about fair hearing rights to appeal the termination.

Major Milestones and Key Dates

Below are key dates for significant milestones in the plan to end continuous Medicaid coverage. These dates assume the PHE will end on July 15, 2022, and are subject to change based on additional federal action or guidance.

- February 15, 2022 – Estimated date for CMS to confirm to states that PHE is ending on April 16, 2022, based on the January 2021 letter to states promising at least 60 days' notice before end of PHE. CMS did not confirm the end of the PHE on this date. CMS has indicated the PHE is likely to be renewed but has not indicated the duration of the renewal.
- March 2022 – Engage with key stakeholders to help members, providers, health plans, and advocates prepare for the end of continuous coverage.
- April 16, 2022 – End of current declaration of federal PHE. HHSC assumes PHE will be renewed beyond this date, based on indication from CMS.
- June 2022 – HHSC runs mass update to identify target populations based on the three groupings of the staggered approach.
- July 15, 2022 – HHSC working assumption of the end of PHE for purposes of FFCRA compliance and continuous Medicaid coverage. The federal government could extend the federal PHE beyond this date.
- August 2022 – TIERS will begin processing the first group and send renewal packets or requests for additional information to members, as appropriate.
- August 1, 2022 – Earliest effective date for disenrollments for members no longer eligible at the end of continuous coverage.
- September 30, 2022 – Estimated date for end of enhanced FMAP, based on current law.
- January 1, 2023 – Latest disenrollment effective date for most individuals most likely to be ineligible at the end of continuous coverage.
- February 1, 2023 – Estimated completion of redeterminations due to the end of the PHE.