Ohio Medicaid: Preparing for the State's Unwinding Efforts

The Ohio Department of Medicaid

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Agenda

- How Did We Get Here?
- Goals for Ohio's Unwinding Plan & Resuming Normal Operations
- Alignment of HB 110 & Federal Guidance
- Next Steps

A Few Key Terms & Key Provisions of FFCRA

KEY TERMS

- **Public Health Emergency (PHE)** – an official declaration by the federal Department of HHS that a disease or disorder presents a public health emergency
- **Unwinding** - the process by which states will resume annual Medicaid eligibility reviews after the PHE ends
- **Renewal** – case is up for standard annual renewal
- **Redetermination** – case is *not* up for annual renewal, but a 'redetermination' of eligibility is needed based on a "change in circumstances"
- **Ex parte renewal** – a redetermination of eligibility based on reliable verified information contained in the enrollees eligibility case or other more current info available to the agency, inc. info accessed through electronic data sources. Ex parte can be done by the enrollment system, or manually by a county case worker

FFCRA PROVISIONS

- **Temporary Increase of Medicaid FMAP: Ohio ~$300m/quarter**
  - Effective January 1, 2020, states may claim a 6.2 percentage point increase in FMAP if requirements are met
  - The increased FMAP expires on the last day of the calendar quarter in which the PHE ends
- **Continuous Coverage Provision**
  - In exchange for the temporary increase in FMAP, states must maintain the enrollment and coverage of Medicaid beneficiaries who were enrolled as of or after March 18, 2020, unless they ask to be disenrolled, move out of state, or have passed away.

How Did We Get Here?

A Timeline of Events

Historical Timeline

2019

- Application backlog CAP established
- PERM audit attributable to past due renewals

2020

- PHE starts January 2020
- Families First Coronavirus Response Act (FFCRA) – March 18, 2020
- Continuous eligibility requirement effective January 1, 2020 until the end of the PHE
- CMS issues initial unwinding guidance to states on December 22, 2020

2021

- Passage of HB 110 July 1, 2021
- CMS issues updated unwinding guidance on August 13, 2021
- Controlling Board approval for third party data vendor October 25, 2021

2022

- CMS issues latest unwinding guidance on March 3, 2022

#IN THIS TOGETHER Ohio

Public Health Emergency (PHE)

Additional Federal Match 6.2%

+

Must continue Medicaid eligibility

+

Flexibility: Appendix K, 1135, etc.

Caseload

- Significant increase
  - Redeterminations and Changes in Circumstances
  - New beneficiaries

Unwinding

- Flexibilities & rules

"VERY LIKELY THROUGH July 2022"

Disaster Related Federal Authorities:

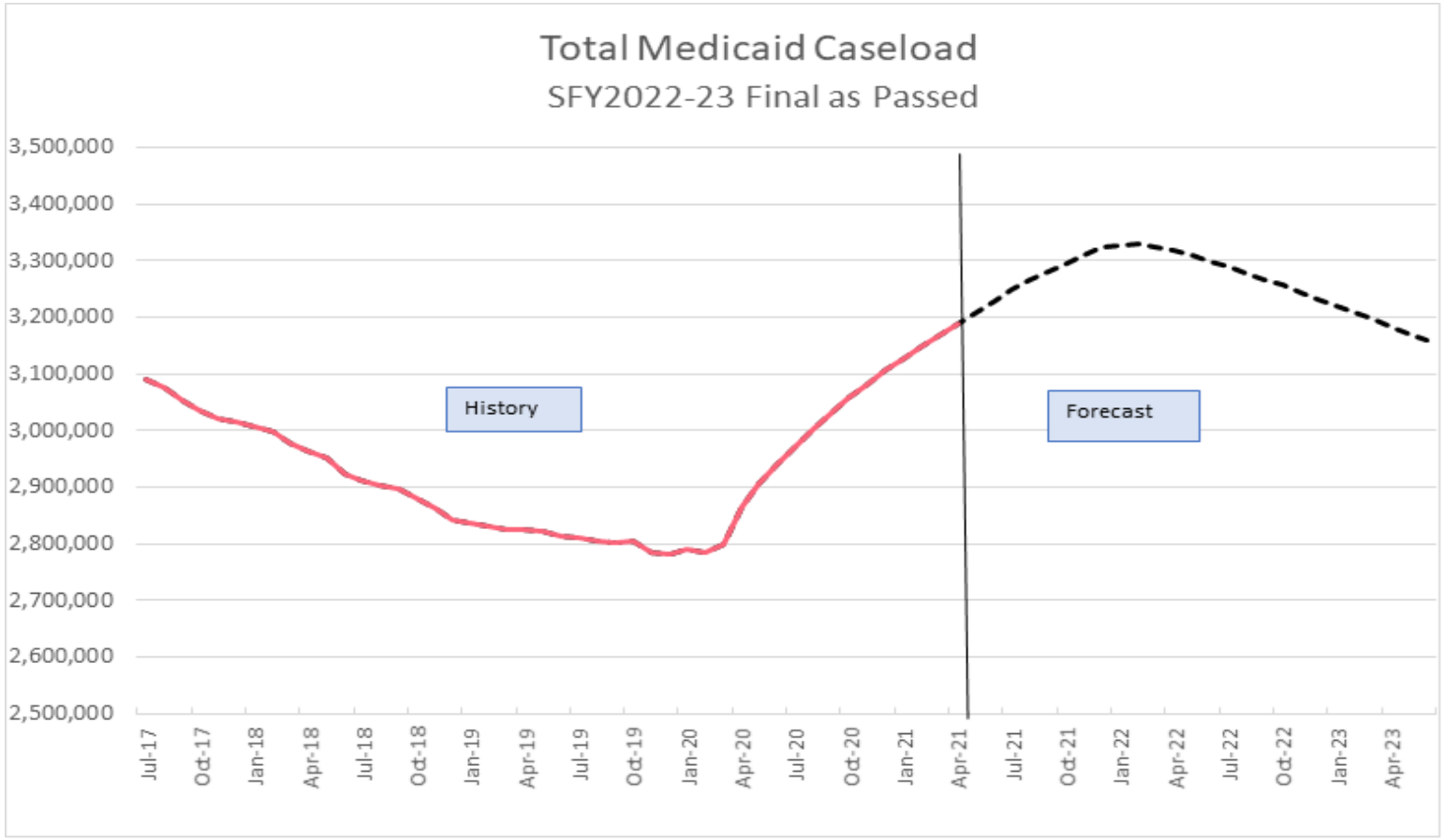
- Medicaid State Plan Amendment (SPA)
- Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum
- 1915(c) Waiver Appendix K
- 1135 Waiver

PHE Flexibilities Elected by ODM

- Increased service limits for HCBS waivers
- Provision of services in alternative settings
- Broad expansion of telehealth for services and assessments
- Temporary extension of hospital presumptive eligibility (HPE) to individuals in institutions who are eligible under a special income level (SIL)
- Suspension of copayments for services with copayments
- Addition of Health Care Isolation Centers (HCICs) as a NF benefit
- Suspension of limits on home health and private duty nursing
- Acceptance of self-attestation without additional verification for eligibility criteria
- Addition of hospital facility payments for telehealth services

Unwinding: Requirement to Maintain Medicaid Eligibility

Ohio Medicaid Caseload Projections



The Ohio Medicaid 2020 caseload increased by nearly 572,000 since Feb. 2020, the start of the COVID-19 public health emergency (PHE).

*As of February 2022

PHE: Timeframes

- Current PHE was renewed on 1/6/22. Subsequent 90-day PHE renewal dates are:

PHE Expiration or Renewal Dates	60 Day Notice of Non-Renewal of PHE & ODM Start Unwinding
4/16/22	Likely-on 4/16 states will be told that there will be one more renewal; the PHE will end on 7/15
7/15/22	5/16/22
10/13/22	8/14/22

- ODM will start eligibility unwinding activities 60 days before the PHE expiration date
- If end of PHE is 7/15, begin unwinding on 5/16

Goals for Ohio's Unwinding Plan

Goals & Principles: Ohio's Plan

- ODM and county partners will work together to redetermine individuals as required, after the PHE ends --as quickly as possible-- balancing the directives of HB 110 and federal requirements to the best of our ability.
- Keep eligible individuals enrolled and reduce churn.
- Identify those 'most likely to be ineligible; prioritize the processing of these cases and assist, as possible, the transition to other coverage.
- Make efficient, accurate decisions within prescribed timelines ***and***
- Achieve a sustainable renewal schedule.
- Maintain timeliness with new applications and change of circumstance; as well as SNAP and other county responsibilities.
- Comply with state and federal law and CMS requirements.

Unwinding: Resuming Normal Operations

Context

- Medicaid eligibility is extremely complex. This is compounded by often shifting requirements that have occurred throughout the pandemic.
- These are extraordinarily unique circumstances—ceasing disenrollment operations for more than two years followed by restarting disenrollment actions as quickly as possible
- Need for effective communication with those who will be affected, updating addresses, etc.
- Workforce challenges are significant
- Balancing competing directives in HB 110 and federal requirements
- County administration; partnership between state and counties is key
- Unwinding from the public health emergency (PHE) is one of the most important, difficult and unprecedented challenges all states and Medicaid programs will have ever to navigate

Components of Unwinding Plan

- New OB modifications have improved ex parte renewal rates
- Run ex parte process on entire past-due renewals and pending renewals
- Provide all renewed and pending cases and any other past-due cases to data analytics vendor to test "likeliness of ineligibility"
- Produce prioritized lists to counties in advance of the end of PHE based on
  - » Vendor findings
  - » Individuals previously found ineligible
- Process priority cases
  - » Data cannot be older than 3 months to be actionable
- Maintain processing of renewal fallout cases
- Maintain processing of new applications

We know that any confusion or questions causes people to ask their providers for guidance or call the counties. We need your help.

➥ ODM is committed to working with stakeholder associations to keep them appraised and get their input

Data Matching: County Prioritization of 'Likely Ineligible' Individuals

- ODM will run ex parte 2 mos. before the end of PHE (include 'current' renewals due, and past due renewals (those w/ reset renewal dates))
  - » Individuals are either **RENEWED** or fall out (fall out: could still be eligible or ineligible)
  - » If **FALL OUT**: Sent to PCG for data analysis AND renewal packet is sent to the individual
- PCG identifies individuals "likely ineligible" and returns for prioritization by counties
- ODM will provide counties with the names of those identified as “likely ineligible”, with the instruction that counties prioritize the processing of those cases first (while simultaneously maintaining the processing of new applications and redeterminations)
  - » 160,000: Avg. # of total cases per month (new applications, redeterminations and renewals)
- PCG's review will be conducted in monthly cycles to ensure data is no more than three months old when a county reviews the case as required by CMS
- The eligibility reviews of past due renewals, current renewals, pending new applications, and likely ineligible cases, will be done on **monthly cycles** to comply with requirements of 42 CFR 435.916, and to prevent backlog and concurrent violations of both the application backlog CAP and PERM CAP

Renewals

Run through ex parte

People get renewed

If they get renewed, no further action necessary

People "fall out"

Get renewal packet and simultaneously sent to PCG – this will direct the work for the counties

New Enrollments

Business as usual

Change in Circumstance

Business as usual

The process begins again

April

May 2022

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

June

Dates are for illustrative purposes only

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Day 1

Manual Renewal packet sent via USPS on May 31 by OB System

Day 18

Manual Renewal Reminder Letter sent via USPS by OB System (Second request to return renewal package)

Consumer returns <u>incomplete</u> packet on Day 31

CDJFS notifies the consumer they have 10 days to return missing information – due by Day 41.

Consumer returns the requested documents to the CDJFS within the requested timeframe and Medicaid case determination is made.

Consumer fails to return requested documents.

A 2nd request for verification is sent on Day 42. The consumer is given 10 days to return the requested document(s) – due by Day 52.

Consumer returns the requested document(s) to the CDJFS within the 10 days and Medicaid determination is made.

Consumer fails to return the requested document(s). A Pre-Termination Review (PTR) is completed on Day 53.

See NOA & appeal details below for timing

Notice of action is sent to consumer on Day 53 notifying them that their Medicaid will be discontinued on Day 62.

Consumer seeks to appeal discontinuance.

Consumer returns <u>signed</u> renewal by Day 31

No additional documents needed.

A determination has been made; individual is eligible.

No additional action needed.

Consumer <u>doesn't</u> return packet.

Auto-discontinuance initiated on Day 39.

Notice of Action mailed to consumer on Day 46 to notify them that Medicaid benefits will close effective Day 62.

Consumer may seek to appeal discontinuance of benefits – **if requested by Day 61 (within 15 days of notice date), they will get fair hearing benefits – Medicaid coverage reinstated until hearing.**

<u>Dates for illustrative purposes only.</u>

Timeline assumes individual due for renewal in July 2022 which means May 31 is "Day 1"

Assumes July 15 end date of Public Health Emergency

Alignment of HB 110 & Federal Guidance

HB 110 & Reconciling with Federal Guidance: Emphasis on areas of potential conflict

HB 110: 5163.52 & Section 333.255

• Vendor must assist ODM in identifying those enrolled in Medicaid who are deemed to be “likely ineligible” to prioritize those case when PHE ends and • Complete them within 90 days	• Data analytics vendor in place; will assist in identifying individuals who are "likely ineligible" • ODM and contractor are completing system set ups now including data sharing agreements with relevant agencies and non-state entities • ODM and the counties will prioritize the processing of those deemed “likely ineligible" • States cannot make an eligibility determination if the data being used is more than 3 months old
• ODM must conduct an expedited eligibility of newly enrolled for 3 or more months during PHE but not in the last 6 months. This must be done within six months after the PHE ends. • Request approval from CMS to conduct redeterminations on recipients enrolled for more than 3 months and act on those redeterminations within 90 days. Individual counties can request an additional 30 days	• Data analytics vendor will help identify those "most likely to be ineligible" • As required, ODM made this request to CMS. However, per 42 CFR 435.916 and reiterated in CMS’ unwinding guidance, states are not permitted to do eligibility renewals on an individual more than once every 12 months. • Per CMS guidance, states may not redetermine more than 1/9 of their total Medicaid caseload each month. • States cannot make an eligibility determination if the data being used is more than 3 months old • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two Corrective Action Plans.
• Completes and acts on redeterminations within 60 days of all individuals who haven’t had a redetermination in 12 months	• Per CMS guidance, states may not redetermine more than 1/9 of their membership every month. • States cannot make an eligibility determination if the data being used is more than 3 months old • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two Corrective Action Plans.

Emphasis on areas of potential conflict between state and federal law. See appendix for complete analysis.

Federal Guidance

- CMS has issued multiple guidance documents since the beginning of the PHE in an effort to guide states through the unwinding:
  - » December 22, 2020 (click the link to access)
  - » August 13, 2021 (click the link to access)
  - » March 3, 2022 (click the link to access)
- ODM is currently still working through the latest iteration of guidance to ensure compliance, feasibility and compatibility with other legislative requirements
- CMS Corrective Action Plan: 2019 Application backlog
- CMS Corrective Action Plan: 2019 PERM audit, inc. past due renewals

Next Steps

- ODM & ODJFS work with county partners
- Analyze the latest CMS guidance
  - »Partnering with MCOs to update beneficiary contact information
  - »Impact on hearings/ODJFS
  - »Intersection with SNAP determinations
- Finalize an unwinding operational plan for CMS--document a comprehensive plan to restore routine operations
  - »This includes new application processing, renewals, and redeterminations
- Questions re: how to coordinate with FFM for those no longer eligible for Medicaid
- Resources

Unwinding Communications Plan

Status of Unwinding communications planning

- Continue work to operationalize updates to renewal envelopes and other strategies
- In the coming weeks: Refine a phased approach for communications & stakeholder engagement between now and the end of the PHE, and post-PHE
  - » Identify communication mechanisms
    - E.g. CallFire campaign
  - » Identify key stakeholder groups
    - Members, counties, advocacy organizations, providers, legislators etc.
  - » Identify key messages for each stakeholder group
    - E.g., Update your contact information
  - » Develop strategy and plan for communicating & timelines for various activities
    - Consider frequency of communications
      - NAMD noted an average of 21 communication attempts needed to make an impact
- Leverage the CMS Unwinding Communications Toolkit available here

APPENDIX

HB 110 Implementation Efforts: Section 333.255

Seek Controlling Board approval for a 3rd party vendor by November 1st, 2021 (A)	Completed on time. Received CB approval on 10/25/21.
Vendor must have access to 8 different types of records to assist in verifying eligibility (B)	The contracted vendor will have access to these data sources.
Vendor must assist ODM in identifying those enrolled in Medicaid who are deemed to be “likely ineligible” to prioritize those case when PHE ends and complete them within 90 days (C)	• Data analytics vendor is in place; will assist in identifying individuals who are "likely ineligible". • ODM and the counties will prioritize the processing of those deemed to be “likely ineligible” while complying with federal requirements. • States cannot make an eligibility determination if the data being used is more than 3 months old.
ODM must conduct an expedited eligibility of newly enrolled for 3 or more months during PHE but not in the last 6 months. This must be done within **six months** after the PHE ends (D)	• Data analytics vendor will help identify those "most likely to be ineligible" • As required, ODM made this request to CMS. However, per 42 CFR 435.916 and reiterated in CMS’ unwinding guidance, states are not permitted to do eligibility renewals on an individual more than once every 12 months. • Per CMS guidance, states may not redetermine more than 1/9 of their total Medicaid caseload each month. • States cannot make an eligibility determination if the data being used is more than 3 months old. • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two federal Corrective Action Plans.
ODM must write a report of its findings from working with the 3rd party vendor and submit it to certain public officials no later than 120 days after the PHE ends. (E)	ODM will complete the required report.
The 3rd party vendor must be reimbursed entirely based on validated cost savings realized by the department. (F)	Reimbursement/vendor contract with ODM is compliant with the statutory requirement.

HB 110 Implementation Efforts: Section 5163.52

ODM must continue to conduct eligibility redeterminations to the fullest extent permitted under the law. (A)	The counties have continued to perform redeterminations and renewals throughout the PHE. However, because of the requirement to maintain eligibility, states are unable to disenroll, except in limited circumstances.
Within 60 days of the end of the PHE, ODM must complete an audit (B)	ODM has or will comply with the requirements for the audit.
Completes and acts on redeterminations within 60 days of all individuals who haven't had a redetermination in 12 months (B)(1)	• This conflicts with the 6-month timeline in 333.255(D). • Per CMS guidance, states may not redetermine more than 1/9 of their membership every month. • States cannot make an eligibility determination if the data being used is more than 3 months old • PCG data analytics will help identify those who are "most likely to be ineligible". Prioritization of these cases by the county will enable us to right-size the Medicaid caseload. • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two federal Corrective Action Plans.
Requests approval from CMS to conduct redeterminations on recipients enrolled for more than 3 months and act on those redeterminations within 90 days. Individual counties can request an additional 30 days (B)(2)	• As required, ODM made this request to CMS. However, per 42 CFR 435.916 and reiterated in CMS' unwinding guidance, states are not permitted to do eligibility renewals on an individual more than once every 12 months. • Per CMS guidance, states may not redetermine more than 1/9 of their total Medicaid caseload each month. • States cannot make an eligibility determination if the data being used is more than 3 months old • Data analytics vendor will help identify those "most likely to be ineligible" • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two Corrective Action Plans.
Submit a report summarizing the results of the audit to certain public officials (B)(3)	ODM will submit the required report.