Hello and welcome to “Our American States,” a podcast from the National Conference of State Legislatures. This podcast is all about legislatures, the people in them, the policies, process, and politics that shape them. I am your host, Ed Smith.

The states use the flexibility afforded by the PHE emergency authorities and they adopted new policies and innovations in their care models and delivery systems.

That was Andrea Maresca of Health Management Associates. She along with her colleague Jane Longo are my guests on the podcast. Maresca and Longo both have deep expertise in Medicaid policy at the federal and state level. On this episode, they focus on significant challenges for Medicaid agencies and clients in the next year. The current federal public health emergency for COVID-19 has resulted in about a 25% increase in Medicaid enrollees. Once that emergency declaration expires, probably in early 2023, experts expect millions of current enrollees will no longer be eligible. Maresca discussed the details of the changes at the federal level, the increase in the number of enrollees and how it affected care for people in the Medicaid program.

Longo explained how state Medicaid agencies responded to the increased roles, how state legislatures are helping to manage the coming changes in the scale of the challenge facing Medicaid agencies around the nation. Here is our discussion.

Andrea and Jane, welcome to the podcast.

Thank you. We appreciate the opportunity.
JL: Hi Ed. Thank you.

Ed: So, thanks first for coming on the show and discussing this big change that is going to come to Medicaid with the end of the COVID public emergency now set for October. Why don’t we start with a rundown on Medicaid and who it serves. Andrea, can you give us that background to start?

AM: So, Medicaid is a public health insurance program that provides coverage to certain low-income families and individuals. So, this will include children and parents, pregnant women, people over 65 and people with disabilities. So, a really broad range of people who have low income or no income. One of the defining characteristics about Medicaid is that it is funded jointly by the federal government and states, but each state operates its own program within the federal guidelines. And because the federal guidelines are so broad, states have a lot of flexibility in designing and administering their programs. And what this has meant in reality is that Medicaid eligibility and benefits and cost sharing and lots of other different aspects of Medicaid vary quite a bit from state to state.

Another really important aspect about the Medicaid program, especially in the context of the COVID public health emergency, is that Medicaid is a counter-cyclical program. And what this means is that when we have an economic downturn with higher unemployment, more people become eligible for Medicaid, and this is the situation we saw early on with COVID-19 in 2020. And in part, that’s what the federal legislation that we will be talking about was designed to address.

Ed: Well, let’s do that. Let’s get into some of the details about the national public health emergency or declaration rather and how that affected Medicaid programs. Andrea, can you walk us through some of the provisions such as the increased funding enrollment requirements?

AM: There are a lot of pieces to understand. I’ll try to boil it down for everyone. Going back to 2020. In early 2020 during the first few months of COVID-19, the COVID-19 Public Health Emergency or PHE, which I’ll refer to, Congress passed several major pieces of COVID relief legislation. One of those was the Family’s First Coronavirus Response Act or the FFRCA. A provision in the FFRCA increases every state’s federal Medicaid match rate 6.2 percentage points as long as the COVID-19 PHE declaration is in place. But states are eligible to receive that increase only if they meet certain conditions that are called maintenance of eligibility or MOE conditions. The most well-known of these, and I think Jane and I are on the same page about this, is arguably the most impactful MOE condition, is that states generally cannot disenroll individuals from the Medicaid program during the PHE period. So, your listeners Ed may have heard this referred to as the continuous coverage policy and so we will continue to refer to that as we go on with
the discussion. But there are also a couple other MOE conditions. For example, states can’t make their eligibility policies anymore restricted. They can’t increase premiums if they require certain Medicaid groups to pay premiums. And they have to cover all the testing and treatment services including vaccines for COVID-19 without any cost sharing. And then the final condition is that they can’t increase the financial contribution that state counties or other political subdivisions would make to the state share of Medicaid funding. So as long as they meet all of those conditions, they are eligible to get the higher federal match rate. And another important part of this is that the higher match rate and the continuous coverage policy are both really closely linked to having the PHE declaration. And the current PHE declaration is set to expire Oct. 13, 2022. Over the period of the PHE, Medicaid agencies and their partners and other stakeholders have been actually planning for unwinding these policies and the continuous coverage policy and thinking about how are we going to resume normal eligibility operations. One of the challenges with doing that planning is not knowing the exact end date of the PHE, makes outreach and education and the ramp up extremely challenging. And to help with that planning, officials at the U.S. Health and Human Services Department have promised to provide states 60 days advance notice of the end date of the PHE declaration. So, we’re in a period right now where that 60-day mark was Aug. 14 and there was no notice given so we are assuming that the PHE is going to be extended again on Oct. 13 for an additional 90 days and that would bring us to Jan. 11 of 2023 assuming that we get that full 90-day extension.

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Ed: Well, what you are describing, it sounds as though enrollment may have swelled considerably in Medicaid over this period of time, maybe something most of us were not particularly aware of. Can you talk about how much enrollment has changed and how much of an increase there was?

AM: That’s right. It’s been a very big change for Medicaid to have that continuous coverage policy in place. And what’s it meant is that very few individuals have been disenrolled from the state Medicaid programs since February of 2020. And instead, we’ve seen enrollment in Medicaid increase from about 64 million in February 2020 to more than 81 million now which is over a 25% increase in Medicaid over those 2+ years now. And this is significant relative to what we would normally have experienced on a monthly or even annual basis. As you may know, the looming issue is how to support those individuals who are going to need to take action to renew their eligibility and to support people who may need to transition to other health insurance programs like Marketplace programs or Children’s Health Insurance Programs that may be separately run in some states.
So, the impending end of the PHE is really going to be a test for Medicaid programs, for managed care plans and providers and other community-based consumer and advocacy groups who are going to need to assist individuals. We know there is going to be a tremendous need for help in navigating these processes and getting ready for this work.

Ed: If nearly 20 million people were added to the Medicaid roles, how did that affect the services for Medicaid beneficiaries? I know that during the pandemic, health care workers were stretched everywhere so how did that translate to the Medicaid agencies?

AM: Yeah absolutely. You are so right that it – its’ the challenge that everybody faced, but a particular challenge for the Medicaid program and for Medicaid members. That led states to adopt a variety of policies in response to the needs of their members and providers. And some of these are unique to Medicaid and some of these are how the health care marketplace has evolved over time. But states used the flexibility afforded by the PHE emergency authorities and they adopted new policies and innovations in their care models and delivery systems. I think one of the most well-known transformations that has occurred is the acceleration and the use of telehealth and virtual care services. States have flexibility to design telehealth policies and they used the experiences to update their Medicaid policies to reflect this change in health care marketplace and these tools which many Medicaid members and plans and providers have come to rely on a lot more.

Another thing that has helped on that provider side related to the use of telehealth is many states temporarily waived requirements for Medicaid members to do in person visits and appointments especially as it relates to mental health and substance use disorder or services. And then during this period, there was also incredible pressure on the long-term care industry particularly as it relates to the workforce. We saw many states accelerate work to expand programs where people could receive services in their homes versus having to go to a facility whether that’s a hospital or a nursing care facility. But ultimately, I think what we’ve learned is that the pandemic has shined a bright light on some of the challenges that have been present even before COVID. Inequitable access to services that disproportionately impact people of color, people of low income and rural communities as well Ed.

Ed: Andrea thanks so much. I’ll be right back after this break to talk with Jane Longo about how state Medicaid entities in state legislatures have dealt with increased enrollment and how they are preparing for the unwinding.

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I’m back with Jane Longo from Health Management Associates. Jane a lot of our audience is state legislators and legislative staff. I wonder if you could talk about how they responded as well as the Medicaid agencies to that run up in enrollment over the last couple of years.

JL: With continuous enrollment during the public health emergency, many states stopped doing annual redeterminations all together for a large number of their enrollees. This allowed state eligibility staff in some states to catch up on their work. They might have had backlogs for example in applications and large volumes of applications were received during the pandemic. Additionally, the increased enrollment impacted the financing of managed care organizations. Those are the insurers who provide and coordinate health benefits for enrollees on an at-risk basis. They are paid per member per month a dollar amount by the state to provide these services. That risk arrangement changed. The increased enrollment and then the delayed care really impacted the financial profile to the benefit of MCO’s so some of those risk arrangements changed in states.

As far as the legislatures, many passed legislation to allow the agencies to implement the flexibilities that were required for the pandemic. Some of those like the continuous enrollment were required by the feds in order to get an enhanced match. But others were to make it easier for folks to enroll during the pandemic. In some states, they started to wind down some of those nonmandatory flexibilities, so legislatures are looking at that midway through. And, of course, the key part for the legislatures is the state budget process and the pandemic, the increased federal match and the increased costs of higher enrollment changed budgets. So, they were in the middle of their fiscal year 20 budget when this all started that required adjustments and new budgets were developed trying to predict how the course of the PHE would continue. Surely legislatures are monitoring the impact on the PHE on budgets in state agency operations as we go through year three of the PHE.

Ed: Well, let’s talk a little bit more about those managed care organizations. I mean I think most of us have a general idea of what those agencies do, but can you talk about how big a role they play in providing care for Medicaid clients and the role they are going to play in this unwinding that’s going to be coming along in the new year?

JL: I think the number 70% of Medicaid enrollees get their healthcare through managed care organizations. And so, from the beginning, the MCO’s managed care organizations have been critical to getting COVID services out to their Medicaid enrollees. COVID testing, treatment, vaccines. States worked with them with the MCO’s to make changes quickly in service delivery requirements that the pandemic required. And some things like waiving cost sharing for any services that were COVID services took some quick
actions on the parts of the MCO’s. Also, the increased use of telehealth during the pandemic. States are partnering with the MCO’s whenever they need to get communications out to the members, and they did that for the availability of COVID services across the board. Now as we prepare for the unwinding, MCO’s are again key to getting the word out to members about understanding that redeterminations will come again. Right now, one of the most important messages MCO’s are assisting in getting out to members is that individuals should change their contact information with the state. They should make sure that the most recent address, phone number for texting, email address – the state has all of that. Medicaid is kind of notorious for not having the even in the best of times pre-COVID not having the most current addresses for a lot of their members. And over the three years of the pandemic, that’s probably that situation has been exacerbated. This is going to be critical because most states rely heavily on the U.S. mail to get redetermination forms out to their members. And if an individual’s address is bad with the state, they won’t get the form. They won’t know they were up for re-d’ing. They will lose coverage. They have the potential to lose coverage even though they may remain eligible. So that message of getting your best contact information updated with the state, that’s a current task that MCO’s are very involved in. But once the re-d’s start, MCO’s are going to be key in getting the word out to their individuals that they are up for redetermination, what time they are up. And also, to help them complete the process.

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Ed: It’s really interesting how critical just what seems like pretty mundane information can be to keeping a system running. You’d think it would be some huge deal, but it just shows you how difficult it is to maintain current phone number, email and that sort of thing. That’s a really great point. Something I think probably most of us wouldn’t have thought about. I wonder if you could talk a little bit about how the Medicaid agencies in the states will handle this. It will of course be different in every state. We know that, but what are the big tasks they face?

JL: Well, they’ve been unwinding for some time now and planning to unwind for some time now. And it’s been a challenge. States are kind of frustrated because not knowing when the PHE will end makes it difficult to plan. So, in addition to what we talked about contact information updates, the work that states are doing to notify folks that redeterminations will resume, but we don’t know when is undergoing. States are making sure that they are fully staffed. They will be fully staffed or the resumption of the redeterminations. There is going to be a lot of eligibility work to be done compared to what’s happening today and the job market is pretty tight especially for some of these positions. They are going to have to do eligibility determination work that is really complicated and must do it in compliance with all federal requirements including
requirements that it be done timely. There is going to be increased call volumes, so states are going to get lots of questions from their members, their enrollees and so they are going to have to make sure the staffing is on the call lines to avoid long wait times. Staffing and that folks are trained to handle questions.

There are many unwinding waivers states can ask the federal government for. Some of these are very technical, but they can simplify the renewal process, the redetermination process. So, states are looking at that and some of them continue some of the flexibilities that started in the PHE continue those past the PHE. And one area of course is like telehealth. Continuing to allow the flexibility of telehealth. Another idea is provider rates or how care is delivered. All of that. And one last thing that can be a big challenge for states is any time you do a system change. Right now, eligibility systems particularly in states are in kind of a suspense mode related to re-d’s. So, if states had to say we want to all the regular operations, but we don’t want to do re d’s so they did whatever they had to do to suspend that. Well and since then they’ve had to make other changes to update their systems for a variety of things. And now they are going to turn re-d’s back on and from a system’s perspective you can have unintended consequences of more recent system changes affecting that thing that was held at bay for a while.

Ed: Yes, our complex computer systems always sort of come back to bite us on these things. That’s a real good point. So, for our listeners, what’s the role of legislators here, legislative staff. How can they help their Medicaid agencies as they try to deal with this slow transition?

JL: This goes back to their oversight and budget responsibilities. They are going to want to understand state unwinding plans and the resources and the flexibilities that agencies, state agencies, are going to need to best perform when the unwinding begins. They are also going to want to keep up to date on what the story is when people are thinking the PHE will end. And that’s you know a very uncertain thing right now so they will want to keep an eye on that conversation. And assist and outreach activities with their constituents. They are going to be a key source of information to their constituents about what the unwinding means for those who have Medicaid, and they will probably get lots of questions too and complaints.

Ed: So, I wonder, as we wind up here, when you look around the country--you are talking to people around the country frequently about this issue-- and I wonder if you see examples of places where the people have done a great job or have taken a certain approach that other states might find useful.
It’s an interesting thing with so much guidance coming from the federal government and lots of video conferences for state agency staff to talk about how to prepare, it feels like states have not with a couple exceptions have not fully developed their unwinding plan. I think they feel like they are waiting to find out when the PHE will end and the full extent of federal guidance on it. But California has a plan out. Michigan does. Some states are moving in that direction. Generally speaking, one of the first questions about each state is how quickly will they try to get through the backlog of redeterminations? Once the PHE ends, they are going to have re-d. Not just people who are new since PHE, but their entire Medicaid population. The federal government is encouraging states to take 12 to 14 months and is saying they will look unkindly if states want to go less than nine months. But there are states who have been talking about that doing it in a quicker timeframe. The federal government is concerned that errors will be more likely if they are doing them too quickly. So, that’s one of the questions how quickly are states going to try to get through it and what kinds of issues might that bring up.

The other thing is that those unwinding waivers, some states have applied. I think my home state of Illinois has applied for every unwinding waiver that the CMS is asking for. One of the interesting things they can do is better use data matches to determine to electronically determine somebody is eligible for another year of coverage and not have to reach out to the individual. That’s called ex parte renewals and you don’t have to send the form in the mail to the individual because you are able to with wage data information and other information identify that they are still eligible. And the federal government is allowing state expansions in that to the degree states are implementing that, that requires system changes, process changes and all. All of those things that make it easier to, it gives flexibilities, to do re-d’s are important to improving health outcomes in the Medicaid program. They especially hit people who have chronic conditions hard. If they lose coverage in the middle of treatment and such or folks in long-term care facilities or long-term care programs where they get home community-based services. So, there’s lots of IT changes that have to be made. Redesigning some of their materials. Training staff. Planning communications with state marketplace. That’s the individual marketplace what’s often called the ACA marketplace. And trying to look at things like maybe not be so reliant on the U.S. mail and other kind of antiquated processes.

Well Jane, I want to thank you and Andrea so much for walking us through this. It’s not only a very complex situation, but it’s also one I think a lot of people are just not aware of. Thank you.

It’s been good to talk to you Ed. Thank you.
Ed: And that concludes this episode of our podcast. We encourage you to review and rate NCSL podcasts on Apple podcasts, Google Play, Pocket Casts, Stitcher or Spotify. We also encourage you to check out our other podcasts: “Legislatures: The Inside Story” and the special series “Building Democracy.” Thanks for listening.