Medicaid Restart & the End of Medicaid Continuous Coverage Provisions

Department of Health Care Finance

Division of Eligibility Policy

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Presentation Highlights

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Public Health Emergency (PHE) Overview

- The PHE was declared March 2020. The Family First Coronavirus Response Act (FFCRA) included various provisions for states such as, Medicaid continuous enrollment, that prevents disenrollment of beneficiaries in exchange for federal funds. This was necessary to ensure continuity of care and access to coverage during the first pandemic in over 100 years.

- Medicaid continuous enrollment meant that all active beneficiaries would remain on Medicaid unless, they requested closure of their case, deceased, or moved out of District. Therefore, all Medicaid renewals were postponed, and Medicaid coverage was automatically extended for all Medicaid beneficiaries.

[1]Corallo,Bradley, Rudowitz, Robin, Tolbert, Jennifer, Unwinding the PHE: What we ca learn from Pre-Pandemic Enrollment, May 10,2022, https://www.kff.org/medicaid/issue-brief/unwinding-the-phe-what-we-can-learn-from-pre-pandemic-enrollment-patterns/, July 7, 2022

Consolidated Appropriations Act, 2023

- The Consolidated Appropriations Act,2023 (CAA,2023) was enacted on December 29, 2022. The CAA, 2023, delinked the continuous enrollment condition and increased FMAP from the PHE.

- Continuous enrollment in Medicaid will end on **March 31, 2023**, and the FMAP increase will gradually reduce and phase out beginning April 1, 2023, and end on December 31, 2023.

- There are several Medicaid and Children's Health Insurance Program (CHIP) provisions included in the legislation:
  - Section 5111: Extends CHIP funding through FY 2029.
  - Section 5112: Requires 12-month continuous Medicaid and CHIP coverage for children effective 1/1/2024.
  - Section 5113: Permanency for the state option to provide 12-months of continuous postpartum coverage in Medicaid and CHIP.
  - Section 5131: Sets an end date for the Family First Coronavirus Response Act (FFCRA) Medicaid continuous coverage requirement as of March 31, 2023.

Unwinding from the Continuous Enrollment Requirement

- Unwinding from the continuous enrollment requirement is the restoration of routine eligibility, such as restarting renewals, and enrollment operations after the continuous enrollment condition ends. During the unwinding, the District will have a total of 14 months to complete renewals.
- During the unwinding, the District must:
    - **Initiate** renewals for all individuals enrolled as of the last day of the continuous enrollment condition with 12 months.
    - **Complete** renewals for all individuals enrolled as of the last day of the continuous enrollment condition within a total of 14 months.

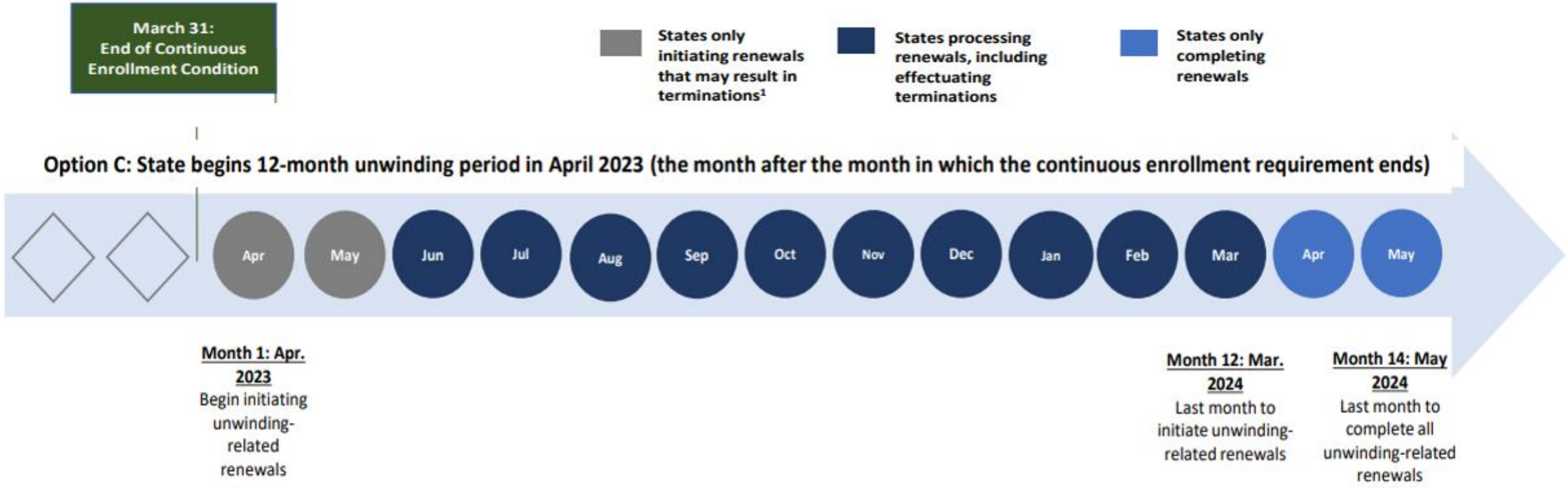
Unwinding from the Continuous Enrollment Requirement

- Beginning April 1, 2023, the District will began sending renewal forms. The District sends out renewal packets 60 days in advance for MAGI beneficiaries and 90 days in advance for Non-MAGI (including those receiving LTCSS) beneficiaries. First round of renewals will look like this:
  - On April 1, 2023, 60-Day renewal notice will be sent to MAGI populations for renewals due May 2023. If no response or beneficiary is determined not eligible, eligibility will end May 31, 2023, resulting in the first set of MAGI closures effective June 1, 2023.
  - On April 1, 2023, 90-Day renewal notice will be sent to Non-MAGI populations for renewals June 2023. If no response or beneficiary is determined not eligible, eligibility will end June 30, 2023, resulting in the first sets of Non-MAGI closures effective July 1, 2023.

- The District be allowed to terminate Medicaid enrollment for individuals who are no longer eligible, following a redetermination. This renewal cycle will continue throughout the 14-month unwinding period.

Continuous Enrollment Condition Unwinding- Defining Unwinding

The District will start unwinding the month after the month in which the continual enrollment ends. Continual enrollment ends March 31, 2023, the District's unwinding cycle will start **April 1, 2023**.



Renewal Distribution Plan

- CMS requires states to submit a report to summarize their plans for initiating the renewals for the total caseload.
- A renewal must be conducted on every beneficiary enrolled in Medicaid before taking any adverse action on Medicaid eligibility.
- The District will use a time approach strategy based on the certification date for the renewal schedule. Renewals for certain groups will be prioritize earlier in the unwinding phase (during months three (3) to eight (8) of the unwinding).
  - Beneficiaries only eligible due to the Continuous Enrollment Condition.
  - For Long Term Care (LTC), the plan is to prioritize the population still in LTC who haven't met LOC.

Upcoming Focus Areas for Unwinding Efforts

- Completed and submitted Renewal Distribution Plan to CMS.
- Medicaid Eligibility Restart Communication Plan And Communication Toolkit development.
- Revising Verification Plan and Updating transmittals.
- System Readiness and assessment of staffing and operational needs.
- DHCF Operational Unwinding Document (currently posted on our website)

Renewals Restart

- District policy requires verification of financial and non-financial eligibility factors at application, renewal, and each redetermination of eligibility pursuant to 42 C.F.R. 435.940-965 and Section 457.380.
- During continuous enrollment, CMS allowed flexibility for verifications, and the District accepted self-attestations from applicants and beneficiaries for all factors outside of citizenship and immigration status. Non-MAGI beneficiaries also continued to require verifications related to disability status and levels of care. After the continuous enrollment condition ends (March 31, 2023), self-attestation will **end** for residency, income, and resources. New applicants applying for benefits and beneficiaries in the renewal cycle must submit verification documents for residency, income and resources as requested.

Acceptable Verifications (Income)

If electronic data sources produce no results for income, it must be verified manually by the caseworker.

The following types of documents can be used to verify income:

1. Recent pay stubs(two weekly, two bi-weekly, or one monthly);
2. Completed employer verification form;
3. Statement showing retirement income, disability income, workers compensation income or pension statement;
4. Bank/Checking account statement;
5. Paper, electronic, or telephonic documentation;
6. A written statement which explains the discrepancy if other documentation is not available.

Acceptable Verifications (Residency)

If electronic data sources produce no results for residency, it must be verified manually by the caseworker.

The following types of documents can be used to verify residency:

1. An active lease agreement, certified deed, or mortgage statement with a District and their name;
2. Phone or Utility bill within the past 2 months;
3. D.C. Voter Registration Card;
4. Non-expired D.C. motor vehicle registration or D.C. DMV identification card;
5. Cancelled check or receipt of mortgage or rental payments within the past 2 months;
6. Utility bills and payment receipts with a D.C. address within the past 2 months;
7. Non-expired automobile insurance statement with a D.C. residency address;
8. D.C. One Card; or
9. Completed and signed proof of D.C. Residency Form

Acceptable Verifications (Resources)

If electronic data sources produce no results for resources, it must be verified manually by the caseworker.

The following types of documents can be used to verify resources:

1. Mortgage statements or deeds;
2. Bank statements;
3. Stock or mutual fund statements;
4. Actual bonds or bond statements;
5. Life insurance statements;
6. Lending institutions for reverse mortgages;
7. Annuity statements.

Renewal Packet Types

- Cases that migrated from ACEDS to DCAS only contain a limited amount of information. Therefore, these cases with limited information are noted in DCAS as *Converted Cases*. Cases processed initially in DCAS after 11/15/2021 will have their up-to-date level of information.
- There will be two types of renewal packets that will be sent to beneficiaries for converted and non converted cases.

Converted Cases (Cases from ACEDS to DCAS with limited information)	Change of Conversion Renewal -50B
Non-Converted Cases (Cases new to DCAS)	Shorter renewal form

Key Takeaways

1. All Medicaid beneficiaries will be sent a renewal and continual eligibility will be reassessed during that beneficiary's renewal period. First round of renewals ending June 2023, will be mailed starting April 1, 2023.

2. Beneficiaries should ensure the agency has up to date contact information (address, phone number, email address, etc.)

3. For applications, renewals and changes, beneficiaries will have to submit verifications such as income, residency and resources if the agency can not verify these items using data sources. Beneficiaries are encouraged to include verifications with applications, renewals and change submissions.

4. Converted cases (cases that originated in our legacy system ACEDS) will have to complete a conversion renewal for their **first** initial renewal cycle. In any renewals that follow, the beneficiary will receive a shorter renewal with some pre-populated information.

Questions

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