Ohio | Department of Medicaid

Medicaid and the COVID-19 PHE Unwinding Stakeholder Discussion

Ohio Department of Medicaid

May 18, 2022

HHS 60 Days Notice

- In a letter to governors dated May 10, 2022, Secretary Becerra and CMS Administrator Brooks-Lasure reiterated that HHS would provide states with 60 days' notice prior to the termination of the PHE.

If PHE is terminated/expires on:	HHS will issue 60 days' notice of non-renewal to states by:
July 15, 2022	May 16, 2022 (No notice given)
October 13, 2022	August 14, 2022
January 11, 2023	November 12, 2022

Goals & Principles: Ohio's 12-Month Plan for Medicaid Unwinding

- ODM and county JFS partners will work together to ensure eligibility for individuals is renewed as required and as quickly as possible during the unwinding period – while balancing the directives of HB 110 and federal requirements to the best of our ability
- Keep eligible individuals enrolled and reduce churn
- Identify individuals who are most likely ineligible and prioritize processing of these cases first – assist with transitions to other coverage, as appropriate
- Make efficient, accurate decisions within prescribed timelines ***and*** achieve a sustainable renewal schedule into the future
- Maintain timeliness for processing new applications, renewals, and changes in circumstances – as well as for SNAP and other county JFS responsibilities
- Comply with state and federal law and CMS requirements

Components of 12 month Unwinding Plan

- Forward date overdue renewals to the individual's anniversary **month.**
- Each month ODM run ex parte process on past-due and pending renewals.
  - » If ex parte renewal is successful, notify the individual of renewal
  - » If ex parte renewal not successful, begin manual renewal process and provide "fallouts" to data analytics vendor to test "likeliness of ineligibility"
- Each month CDJFS:
  - » Caseworker can use data from likely eligible to conduct administrative ex parte renewal
  - » If likely **in**eligible (based on vendor findings or individual previously found ineligible), caseworker will process those as priority cases (request individual's info; use PCG info as lead, but **must verify** in order to terminate)
  - » Maintain timely processing of new applications & redeterminations
- Data cannot be older than 3 months to be actionable.

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Illustration of Manual Renewal Process

Dates: "Day 1" is 60 days before the date when PHE ends.

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 incomplete 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 signed renewal by Day 31

No additional documents needed.

A determination has been made; individual is eligible.

No additional action needed.

Consumer doesn't 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.

APPEAL: 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.**
Hearing decision required within 90 days.

The Unwinding Period: CMS Requirements

- The state must develop and document a comprehensive plan to restore routine operations
- States may take up to 12 months following the end of the month in which the PHE ends to process redeterminations based on changes in circumstances, complete pending renewals, and resume timely processing of eligibility actions; with two additional months (14 months total) allowed to *complete* all pending actions initiated during the 12-month unwinding period
- States may not attempt to initiate renewal of more than 1/9 of total caseload in a given month
- Renewals of eligibility may not occur more frequently than once every 12 months
- Prior to taking adverse action based on an identified or reported beneficiary change in circumstances, the state must complete a full renewal unless one was completed in the 12 months prior to the identified change
- Consumer may appeal discontinuance of benefits – if requested by/within 15 days of notice date, they will get fair hearing benefits – Medicaid coverage reinstated until hearing. A final decision is required within 90 days
- States must distribute work in a systematic way that maintains coverage for eligible beneficiaries, manages coverage transitions, and reestablishes a renewal schedule that is sustainable in future years

1902(e)(14)(A) Waiver Options

Renewal for Individuals Based on SNAP Eligibility

- The state may renew Medicaid eligibility for SNAP participants without conducting a separate MAGI-based income redetermination when an individual's gross income as determined by SNAP is under the applicable MAGI threshold.
- Allows states to rely on SNAP data for renewals for individuals under 65 years of age, despite the differences in household composition and income-counting rules.

Ex Parte Renewal for Individuals with No Income and No Data Returned

- The state may renew households whose attestation of zero-dollar income was verified within the 12 months prior to the start of the PHE when no information is received from a financial data source at renewal.
- The state must take appropriate steps to review the non-financial components of eligibility in order to complete the passive renewal.

Partner with Managed Care Plans to Update Beneficiary Contact Information

- Temporarily permits states to accept updated enrollee contact information from managed care plans without additional confirmation from the individual.
- The state may treat updated contact information received from the managed care plan as reliable and update the beneficiary record with the new contact information without first sending a notice to the address on file with the state.

Work with Counties, MCPs and Stakeholders

- ODM has engaged with counties at leadership and line staff levels
  - » Sharing caseload estimates
  - » Funding for staffing and overtime
  - » Sharing strategies for managing work over the unwinding period
- ODM has engaged Medicaid managed care plans
  - » Address comparisons for identifying address update opportunities
  - » Outreach to members who are not renewed ex parte and are receiving renewal packets
  - » Outreach opportunities for members losing Medicaid coverage
- Partner Packet and Stakeholder input
  - » Communication toolkit
- ODM has engage with CMS to seek guidance on permissible approaches for unwinding per HB 110
  - » CMS compliance memo April 7, 2022

Appendix

The following slides were taken from the 4/7/22 presentation to JMOC

Ohio Medicaid: Preparing for the State's Unwinding Efforts

Historical Timeline

2019

- Application Backlog CAP established
- PERM Audit findings attributable to past-due renewals

2020

- Families First Coronavirus Response Act (FFCRA) enacted on March 18, 2020
- Continuous coverage provision effective March 18, 2020, through end of the month in which the PHE ends
- CMS issued initial unwinding guidance to states on December 22, 2020 – SHO #20-004

2021

- House Bill (HB) 110 passed effective July 1, 2021
- CMS issued updated unwinding guidance to states on August 13, 2021 – SHO #21-002
- Controlling Board approved third-party data vendor on October 25, 2021

2022

- CMS issued latest unwinding guidance on March 3, 2022 – SHO #22-001

Federal Guidance

- CMS has issued multiple guidance documents since the beginning of the PHE 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)
  - » *April 7, 2022 Letter from D. Tsai, CMS to Ohio (click this link to access)
  - » *May 10, 2022 Letter to Governors, Secretary Becerra and CMS Administrator Brooks-Lasure (click this link to access)
  - » *May 17, 2022, CMS Eligibility & Enrollment Processing for PHE Unwinding. Key requirements for compliance.
- 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

*Updated

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 next two slides for complete analysis.

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.

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.