Free Webinar: Unwinding of COVID Medicaid Continuous Coverage Requirements—What Advocates for Older Adults Need to Know
Webinar Transcript
March 3, 2023

Gelila Selassie: I'm so sorry everyone. I realized I was on mute. Hello, this is Gelila Selassie from Justice in Aging. And if you're joining us, it's for a webinar on the Unwinding of COVID Medicaid Continuous Coverage Requirements. My name is Gelila Selassie, as I said. I'm a senior attorney at Justice in Aging. I'm joined by Georgia Burke, our Director of Medicare Advocacy, and Tiffany Huyenh-Cho, another senior attorney on our health team. Just a quick overview about Justice in Aging. We are a national organization that uses the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. We've been doing this since 1972, primarily focusing on groups that have been excluded from justice such as women, people of color, LGBTQ individuals and individuals with limited English proficiency. To achieve Justice in Aging, we have a commitment to advance equity, including advancing equity initiative, which is available at that link on the top of the slide for low-income older adults in all of our priority areas.

We attempt to address the enduring harms and inequities of systemic racism and other forms of discrimination. We strive to recruit, support and retain a diverse staff across all identities. And now just first, some housekeeping questions or some housekeeping points. Everyone is on mute except for the speakers. You can use the Q&A function for any substantive questions or if you're having any technical concerns. If you have problems with getting onto the webinar, you are able to email trainings@justiceinaging.org. The materials for this training and other trainings are available on our resource library with a link there. And then there will be a recording as well as the slides. And then you can enable closed captioning by selecting CC from the Zoom control panel. And if you want to receive information, you're welcome to join our Listserv, just go to justiceinaging.org to sign up or email our Justice in Aging info email address. So to provide a quick overview of what we'll be discussing today, first we're going to provide a timeline of the unwinding of the public health emergency and the continuous coverage protections.

We'll also discuss some recent litigation called the Carr v. Becerra case, which most significantly impacts dually-eligible individuals. We'll also look into the obstacles particularly facing duals during the unwinding. And then we'll discuss some practice tips for advocates to mitigate the challenges duals may face and provide some specific examples of state actions being done in California. So just to provide a quick overview, we're going to go through this through sort of timeline. I feel like that's one of the easiest ways to keep all the moving parts of the unwinding in check. So, we start where it all began in 2020. In January of that year, the then President and Health and Human Services Secretary declared...
a public health emergency due to COVID-19. And with that declaration, it
enacted a series of emergency waivers and authorities under the Medicare and
Medicaid programs to respond to the pandemic.

Later that year in March, Congress passed the Families First Coronavirus
Response Act or FFCRA or Families First, which gave states an enhanced federal
funding, which is also called their FMAP. So gave them this enhanced FMAP for
their Medicaid program. And to receive the enhanced funding of 6.2%, states
had to meet four requirements. First, they cannot impose more restrictive
standards, methodologies or procedures and was in effect on January 1st. And
this is also called Maintenance of Effort. Second, they couldn't increase any
premiums. Third is the big one that we'll dive into a lot, and that's what we refer
to as continuous coverage. And it required states to keep individuals enrolled in
Medicaid during the public health emergency, even if their eligibility changes,
unless the beneficiary either voluntarily disenrolled in Medicaid or moved out of
state.

And so, because of this continuous coverage requirement, states either were
not conducting redeterminations or were not acting on the redeterminations for
this period. And then on the slide, we starred PHE and underline that line
because this changes with later legislation. But I wanted to point out that it was
continuous coverage was initially tied to the public health emergency. And then
lastly, states cannot impose any cost sharing for COVID-19 related services.
Later in 2020, in November of that year, the Trump administration issued an
Interim Final Rule that made changes to continuous coverage while still giving
states the enhanced 6.2% FMAP. And so there is many changes to various
Medicaid populations, but in particular the IFR did require redetermination for
people who are full duals or people enrolled in Medicaid and Medicare, dual-
eligibles for receiving full scope Medicaid. And in doing so, during these
redeterminations, if they were deemed ineligible for full scope Medicaid, then
they have their benefits reduced usually to a Medicare Savings Program.

And so there is some. And so with that, the Interim Final Rule didn't exactly
completely undo those continuous coverage protections, but it did provide
some carve out to significantly reduce those protections. And so there's been
some recent litigation that we'll touch on later that Georgia will touch on. And
we also recognize that a lot of other things happen in 2020, but again, we really
want to focus it on the continuous coverage unwinding that we're experiencing
right now. And then moving on, in 2021 through 2022, in January of that year,
the Biden administration entered office and continues renewing the public
health emergency on a quarterly basis. In March of that year, Congress passes
the American Rescue Plan Act or ARPA, which provides states with an enhanced
10% FMAP just for their Home and Community-Based Service program or HCBS.
And so ARPA also added an MOE protections with respect to this 10% FMAP for
HCBS that restricted the standards, methodologies, procedures, or that
prevented more restrictive methodology standards and procedures. But it did
not add continuous coverage language, so the FFCRA rules are still in effect.
And then since April 2021 to now, CMS has continued to issue unwinding guidance and materials, most critically is that the initial unwinding period was set to be 12 months, a 12-month period at the end of the PHE or at the end of the continuous coverage protections expire. And during that time, CMS has given states an extra two months to unwind. So they must begin redeterminations within 12 months, but they have another two extra months to at least complete all redeterminations. And then moving into this year, which a couple months in has already seen a lot of action. Early this year, the president signed the Consolidated Appropriations Act of 2023, which uncoupled the continuous coverage requirements from the PHE. So it’s no longer tied to the PHE. Instead, under the CAA, states do not have to keep individuals enrolled and can complete redeterminations after that March 31st date regardless of when the PHE ends. However, in order to encourage states to take their time with unwinding and not to have some mass disenrollment as of April 1st, there is a phase down enhanced FMAP that begins from April 1st of this year through December 2023.

And so what that means is that right now states are still receiving that 6.2% from the Families First legislation and then it dips down to 5% in the second quarter of this year, 2.5% in the third quarter of this year, and 1.5% in the fourth quarter of this year. And in order to continue receiving that 1.5 to 5% enhanced FMAP for the year, the states do have certain conditions to meet, which we’ll discuss later. Also under the CAA, states could begin redeterminations as early as February of this year, so as early as last month, if they were to begin terminations for April. But again, states can still take that entire 14-month period. And then moving on to some of the actions the administration has taken this year, excuse me, early this year, the administration also announced unwinding special enrollment periods for marketplace and Medicare coverage if individuals lose Medicaid during the unwinding period.

So looking specifically at the Medicare SEP, if an individual loses Medicaid anytime after January 1st, they can enroll in Medicare without a late enrollment penalty and they can also choose the effective date for their Medicaid coverage, including any retroactive coverage up to January 1st if applicable or if they were eligible. One quick link to note is for anybody who is not on a Medicare Savings Program, they may have to pay the premiums for any retroactive coverage. So that is something to consider. And then later in January, the Biden administration did announce that the PHE will end on May 11th. So even though it’s not tied to the continuous coverage protections, there are still several emergency waivers and flexibilities for both Medicare and Medicaid that are going to be impacted by that date. We’re not going to talk about this in this webinar. That is definitely something that we’re interested in and advising folks to keep an eye on moving forward.

So as I mentioned, there’s several conditions for that enhanced FMAP under the CAA, including that states at least through December 2023, states must maintain those maintenance of effort protections. They cannot increase
premiums through 2023. And again, they cannot require cost sharing for any COVID testing related services, COVID testing or COVID related services or treatments. Oops, I'm sorry, I don't know what's happening with my computer. Okay, there we go. And so then there are also a great many redetermination-based conditions under the CAA for states to receive that enhanced FMAP. And so these are conditions that say when you do start redeterminations this year, here's exactly what you have to do. One is making sure that contact information is updated, making a good faith efforts to contact individuals using more than one modality before they terminate because of return mail. So if they send out a notice, it comes back undeliverable, then they can't immediately terminate that individual. They have to find another method of communication before beginning termination process.

States must conduct ex parte renewals, which means that the state is using existing data sets available to them to determine eligibility before reaching out to the individual. And then they must provide reasonable timeframes and methods to return forms. Some additional requirement. States also have to determine eligibility for all Medicaid programs before terminating. They must provide a minimum of 10 days’ notice prior to termination as well as a notice and right to fair hearing. They must assess eligibility and then transfer eligible individuals to other insurance programs like the Medicare or the marketplace coverage. And then another one is that they must reconsider eligibility for MAGI Medicaid enrollees without requiring a new application if they’re terminated for failure to return form, so they can reconsider their eligibility. Now unfortunately, this is only an option for states for non-MAGI populations, which does include a lot of older adults and people with disabilities. So that's one thing to consider moving forward.

And then the other big requirement is in respects to the reporting, to some reporting requirements. So again, to receive that enhanced FMAP through the end of this year, states must submit monthly reports to CMS and then CMS is obligated to publish that information for everyone to see. And those reports must contain the total number of initiator renewals, the number of renewals completed ex parte, total number of terminations, number of terminations that were done for procedural reasons like failure to respond or return mail. And then call center data, which also has to include the total volume of calls, average wait times and average call abandonment rate. And states that are not in compliance with any of these requirements do have an opportunity to rectify and become in compliant by submitting corrective action plan to CMS and working with them. However, if after submitting corrective action plan, they're still not in compliance, CMS does have the authority under the CAA to levy penalties against the state. And so with that in mind, I will go ahead and turn it over to Georgia to discuss some exciting litigation.

Georgia Burke: Thanks Gelila. Hello everyone. The most recent development in the unwinding is the issuance of a preliminary injunction in the case called Carr versus Becerra. As Gelila set out a couple slides ago, just in the months before the changes in
administration, CMS issued an Interim Final Rule, an IFR, which allowed states, and CMS actually told states they must do this to redetermined people who had Medicaid and then became eligible for Medicare during the public health emergency. If the state found that the individual no longer qualified for full scope Medicaid but did qualify for a Medicare Savings Program, then under the IFR, the state was supposed to end their full scope Medicaid and then move the individual to the MSP. According to CMS, this complied with maintenance of effort requirements and states could still get their 6% match. So the Carr lawsuit basically said that there's no way that taking away an individual's access to all Medicaid services and just giving them Medicare Savings Program coverage is compliant with the maintenance of effort requirement that's in the statute. And the judge agreed with us.

Next slide please. So the injunction that the judge issued required that any dual eligible terminated from full Medicaid needs to be reinstated before March 31. Advocates can and should insist that their states comply with this. We have a model letter here that you can use to send to your state. We’re also hearing that some states are waiting, saying that they need more precise in information and instructions from CMS before proceeding. CMS should be giving more guidance. There's actually a hearing before the judge this afternoon on this very issue, but states in any case should not be waiting. The injunction is really very simple. States should stop doing this immediately, and for everyone they moved, they should move them back to full Medicaid retroactive to the date that they transferred them in the first place to the MSP and they should do it right away. Next slide please. So just to be clear about what kinds of individuals are affected by this car injunction, here's a hypothetical of one group, which is probably the largest group involved.

So there's Mary, she's 66. She's been enrolled in MAGI adult Medicaid since she was 60. A year ago, Mary turned 65. So the state redetermined her and decided that she was over income for aged, blind, and disabled Medicaid, but that she did meet the requirements for the qualified Medicare beneficiary program and MSP. So the state moved Mary to QMB and dropped her from full Medicaid. Under the Carr injunction, the state has to reinstate full Medicaid for Mary retroactive to the date that they dis-enrolled her. So what does this mean for Mary? It means that she can submit bills, once she's reinstated, she can submit bills for the services that she paid for while she was in this gap where her Medicaid was dropped. So things that Medicaid would have covered like her dental or her eyeglasses, things like that. Also, because Mary's been reinstated, she'll be able to stay on full Medicaid until she's redetermined during the course of this whole unwinding.

And during that time, she'll be able to continue to use her Medicaid benefits to go to the dentist, to get home health aids, all the other things that she needs and lost because her Medicaid had been dropped. Now the injunction covers other scenarios, and if you look at our unwinding fact sheet, which is in the resources section of this slide deck, which you've got a copy of the deck, you can
look at it and there's a fully description of the whole scope of the injunction and of other types of individuals who might benefit. Next slide. So that's the history and where we are now. Let's look at some obstacles and solutions for dual eligibles as they go through this whole unwinding process. Next slide. First, there are all the logistical obstacles of getting through the unwinding. Can the state find the individuals? Will the individuals recognize the notice as important and not throw it away? Is the notice clear? There's also all the usual issues of translation for people with limited English proficiency and accessibility for people with disabilities. And with so many people being redetermined and so many computers involved, things are going to go wrong even with the best of plans.

Leaving aside logistics, the big substantive challenge of all this is that many people, either because of an administrative termination because they didn't respond or whatever, or because they really are not going to meet the income and asset limits for aged, blind, and disabled Medicaid, they're going to lose their Medicaid. And that means loss of all the Medicaid services that aren't available through Medicare, home and community-based services, transportation, dental, all of that. Unless they qualify for a Medicare Savings Program, they're also going to lose the state payment of their Medicare premiums, which is significantly going to affect their monthly budget. And if they're enrolled in a D-SNP, they're going to have to change because you can't be in a D-SNP if you aren't a dual. Note one thing though, that if you lose Medicaid, you won't immediately lose your low income subsidy status. This is extra help.

Definitely carries on until the end of the year and often beyond that. Next slide. So this is a very big deal. What can advocates for low income older adults be talking to their state about to make this whole process as accurate and painless as possible with the least impact on older adults? So first of all, timing. Encourage your state to take the entire 14-month timeline that's available for the unwinding. Doing anything shorter, moving faster, there's so many people involved, it just increases the possibility of improper terminations. Also, encourage your state to deprioritize older adults, particularly the non MAGI population, which includes older adults who are on aged, blind, and disabled Medicare, Medicaid. Older adults typically have fixed incomes. They're more likely to remain financially eligible, less likely to be pushed off actually based on criteria, so leave them until the end. Next slide. Now let's look at process issues you can raise with the state. All of those obligations that the state has during the unwinding which Gelila discussed, what exactly is your state doing and is it in compliance with those obligations?

Ex parte review, is your state only asking enrollees for information? It can't get through other data sources. Talk to your state about what they're really doing and ways that they can minimize the burden on individuals. Mail, if the state's notice to an individual is returned by the post office as undeliverable, exactly what steps is the state planning to take? Are they planning to make phone calls?
Are they trying to find ways to run down alternative addresses? How are they going to do it? Compatibility standards. States are also supposed to apply reasonable compatibility standards, which means that if an individual attested to income and that attestation is within a certain percentage of the data that the state got from another source like from social security, then Medicaid should be able to move forward with the renewal without asking the individual for clarification about something that was a minor discrepancy. Is your state doing that? What are they considering a minor discrepancy?

And then appeals, with the entire Medicaid population being redetermined, the appeal system is going to be really strained. So look especially at timeframes in terms of when individuals are supposed to be returning information, timeframes for filing appeals. Some states during the pandemic extended timeframes. So one thing to talk about with your state is whether they’re considering extending timeframes during the redetermination process. Next slide. Then there’s transparency. Has your estate posted its redetermination plan? If so, what groups are going to go first? What’s the timeline? What is their outreach plan for return mail? Is all of this publicly available on the state’s website? What’s the state planning to do to hand off people who no longer qualify for Medicaid and get them connected to other resources for coverage? And when the state determines that a dual is no longer eligible for full Medicaid, does their process really review them for Medicare Saving Program eligibility? Now, this is not something that’s unique to the unwinding.

In some states, there’s been an issue even before the pandemic of whether states are really doing it right in terms of reviewing people for MSPs. So it’s particularly important now that the state get this right and get things in order. Next slide. And just to repeat, what is your state doing about implementing the Carr injunction? And even foundationally to that question, what had your state been doing before the injunction? Many states aggressively moved many of their duals into MSPs, but then some states did less. So one question to your state is, what did they do in implementing the IFR? What didn’t they do? So that you really know what you’re dealing with. So there are plenty of things to talk about with your state. Now what I’m going to do is turn things over to Tiffany and she’ll start out talking about ways to work with your partners and reaching individuals who are going to be affected by the unwinding. So there you go, Tiffany.

Tiffany Huyenh-Cho: Thank you, Georgia. My name is Tiffany Huyenh-Cho. First, like Georgia said, in addition to working with your state, developing partnerships with partner agencies will help raise awareness of the unwinding the renewal process itself and to help troubleshoot issues that pop up. These include partners across the aging network, medical providers, health centers, AAAs, the area agencies on aging, SHIP counselors, the State Health Insurance Program counselors or high caps, as well as partners that serve hard to reach populations like limited English proficient individuals and those with housing instability. Now, it’s important that awareness of the unwinding is known so that everyone that does serve older
adults and people with disabilities on Medicaid know what is happening and can help prepare their patients or clients for their renewals that are about to restart. So reaching hard to reach populations are important, such as those that are LEP or have housing instability because contact information may have changed.

And this group may have not received notice of the unwinding and the renewal advocates can develop partnerships with agencies that serve these populations to alert them to the need to complete that renewal and troubleshoot issues as they arise. It's also important to update information throughout the unwinding process. This may be the first time a person has gone through a redetermination if they began receiving Medicaid benefits during the public health emergency, or it may be the first time someone has gone through a redetermination in three years. So it's important to educate individuals on eligibility rules and the process. States can provide specific and updated information about these notices and materials. Next slide please. So these next few slides I'll discuss or provide a state specific lens of the unwinding with California. So this will include actions that California is taking to protect coverage as well as challenges that California faces as we move into the unwinding. Some of these pieces might be implemented in other states as well. First, just a snapshot of California itself. California is a large state.

It has approximately 15.2 million individuals on Medicaid. Of that 15.2 million, approximately 15% are older adults and people with disabilities, 1.5 million are dually eligible for Medicare and Medicaid, and 700,000 are older adults and people with disabilities on Medicaid only. I'll just note that the 15.2 million individuals, that is the highest total Medicaid enrollment California has seen to date. California has created a operational plan for the unwinding and publicized it. It is public posted on California State Medicaid website. The plan is quite comprehensive. California is taking the full 14 months to unwind. Renewals will begin in April 2023, so next month. The April 2023 renewal activities will be for individuals that have a June 2023 renewal month. Although CMS, the Center for Medicare and Medicaid Services permits states to deprioritize renewals for specific populations, California's not deprioritizing older adults during the unwinding. Like Georgia mentioned, older adults typically have fixed incomes and are more likely to remain financially eligible for Medicaid. California will not be deprioritizing older adults.

They've cited the complex nature of de-prioritization and system capacity, but we feel that this is a missed opportunity since older adults are more likely to remain financially eligible for Medicaid. The unwinding plan also maintains past renewal month timelines in California. So for example, in pre-pandemic, if your Medicaid renewal month was August, your renewal month during the unwinding will be August 2023. Next slide please. So other state actions, California has put in place proactive protections and flexibilities to protect coverage to the extent possible. So a valid and significant concern of the unwinding is that eligible individuals will be discontinued or terminated from
Medicaid benefits because they did not complete a renewal even though they remained financially eligible. Life changes may have happened these past three years and addresses might be outdated. Medicaid county offices might have incorrect and outdated telephone and address information on file. So if a person’s address has changed, how will they know they need to renew their Medicaid to avoid losing coverage?

So one flexibility that California has taken is to update contact information using the National Change of Address database and the United States Postal Service in-state forwarding address. What that means is if a piece of mail is returned, but the USPS has an in-state forwarding address, counties can then update their contact information using that forwarding address. They can treat that updated contact information as valid and they do not have to verify with the individual itself. That saves time and administrative burden. Medicaid managed care organizations or health plans who’ve received, verified and updated contact information can also share this with the local county agencies. California’s also put in place two flexibilities to streamline renewals. These flexibilities will also reduce or eliminate the need to provide additional proofs of financial eligibility. They include the asset verification program. Here, California can verify assets electronically without asking for additional information from the individual for income.

If the county finds inconsistencies between the income reported in the case file and with electronic data sources, an individual can then provide a brief reasonable explanation to explain that inconsistency. That can be done in person or over the phone. So a reasonable explanation of an inconsistency could be as simple as citing a reduction in hours for employment or a change in household size. For outreach, California has developed a really comprehensive and targeted outreach program. There is an ambassador program to help with outreach and communications around the unwinding. This program alerts stakeholders about key unwinding updates so that they in turn can outreach with Medicaid enrollees, including the importance of updating contact information. California’s in the early stage of a robust outreach and communications program. Just last month written notice was sent to all Medicaid individuals or learning them to the restart of renewals. California is also using a paid media outreach campaign using billboards or ads, and this also includes broadcast radio outreach.

Radio is an important source of information for some racial or ethnic groups such as Spanish or Chinese language radio stations, and especially so for some populations that receive their news and information through the radio instead of digital outlets. One other key piece is that renewal packets will be mailed in colored envelopes. They will be yellow, so all renewal forms that a person may receive will be distinguished from other mail because the envelopes will be yellow. Like Georgia mentioned, it’s important to distinguish renewal packets from other forms of mails so they’re not overlooked. So one way was California is now sending out renewal forms in colored envelopes itself. Next slide please.
All right, so state challenges. So while California is taking steps to mitigate the effects of the unwinding and returning to regular operations, California also has significant challenges when renewals resume. Some of these challenges may be seen in other states as well. I know first, California is a big state. Medicaid enrollment in California grew by approximately 19% during the public health emergency. This means that there is also now a large number of Medicaid renewals to process during the unwinding.

Another challenge is that the success rate for automated ex parte renewals has dropped to 25% in California. So with ex parte renewals, a Medicaid agency can redetermine a person's eligibility for Medicaid independently. They don't have to first contact the Medicaid individual by using information in federal and state data sources. If that ex parte renewal process is not successful, paper renewal forms are sent to the individual to complete. So in California, the success rate for automatic ex parte renewals was about 41% pre-pandemic and that has dropped to 25%. Part of that is due to inconsistencies with state level and federal data sources itself. But what that means is California will now have to process more paper renewal packets if the ex parte renewal process doesn't have a high success rate. This means increased administrative burden for both Medicaid staff and individuals itself. And to add to that challenge, there is also substantial workforce shortages in some California Medicaid county offices.

The workforce shortages also means there may be longer wait times for telephone or in-person assistance because the county does not have enough staff on hand to handle the increased volume of calls or questions that may come in when renewals resume. So individuals with questions about their renewals may not receive timely answers to their questions or may give up. This is where community-based organizations are also important and critical resources because they can often answer common questions about income and eligibility criteria. So community-based organizations that work with Medicaid individuals and older adults will be a critical resource during the unwinding if counties are understaffed. California also will be publicizing a public health emergency data dashboard that includes a number of renewals that are due that month, data on renewals that resulted in terminations as well as the reasons for termination if it's due to a change in income, a change in residency, or a failure to cooperate, including a failure to return the renewal packet.

So this dashboard will provide valuable information, but it will not be broken down by race or ethnicity or language spoken. So that might make it difficult to discern if some groups are losing Medicaid at rates that are higher than others. And this concludes the substantive portion of today's webinar. This is an unprecedented time and new information is being released every day. We've compiled some resources that could be helpful. First are a couple from Justice in Aging itself. We have a fact sheet that follows some of the content that we covered in today's webinar. There is also the advocate resource fact sheet that Georgia mentioned in the Carr versus Becerra case, what that preliminary injunction means for Medicaid employees. There's also resources from CMS.
There is guidance and communications toolkit in the unwinding and returning to regular operations guidance that they have put out. Next slide please.

And then lastly, there's also additional resources from the National Health Law Program. There is a unwinding Medicaid continuous coverage checklist for redeterminations. This is helpful for advocates. It's a checklist of things to look out for during redeterminations, as well as a resource for protecting people with disabilities and people with limited English proficiency. During the unwinding itself, the Georgetown Center for Children and Families, they have an unwinding Medicaid continuous coverage resource page, but also includes a 50 state tracker. So you could go on to that website and see some of the actions that your state might be taking during the unwinding itself. I think that concludes the portion of our webinar and we can turn to some Q&A.

Gelila Selassie: Thank you so much Tiffany and Georgia. We have plenty of questions and plenty of time. I tend to rush through things because I know we have so much material to get through that during the chat, I realized that there were some foundational questions that I apologize for not addressing regarding the many acronyms that we used. One big question was MAGI Medicaid versus non MAGI. MAGI is the Modified Adjustable Gross Income. And typically the reason why that's important is that certain Medicaid populations, their eligibility is determined using the MAGI rule. So the way which income is counted, who's all included in the household. And then critically MAGI typically does not include asset determinations. So that's why that differentiation is there. And that will typically include children's Medicaid programs, pregnant women expansion populations as well. Non MAGI Medicaid is they don't use those special MAGI rules to determine income, they're their own rules regarding income and who's considered in the household.

And they're very long and complicated, but it's relatively easy to look up. And then critically, those non MAGI programs do require asset determinations depending on your state's asset limits, if it follows the federal governments rules or if the state has increased asset limits. So that's why there's that differentiation there. Another sort of foundational question was about ex parte, which we used a lot. And so what that means with ex parte review is that the state before they try to contact the individual to say, Hey, what's your income? What's your household? What's this? They're using the existing data sets that's available to them. So for example, if someone who's subject to renewal is also receiving SNAP benefits or food stamps from the county office that's also managing Medicaid renewals. Well, they have that data for their food stamps that shows their income and their housing and things like that. So to the extent that that data is available to them and is sufficient enough to answer all their questions they had about a Medicaid renewal, they can use that instead of submitting these forms out there.

And then before I turn it over to my panelists for questions, there's a lot of really good questions about this whole process because we're still very early
days, so we're going to do our best to answer these questions. But there's a lot of moving parts, a lot of confusion. So we'll do our best to answer and then we encourage you to email us to join our Listserv to look out for any other information that the administration does share where we're more than happy to share it with you. And so one question I think is probably best geared for Georgia was if you're aware of anything regarding the unwinding impacting individuals with Medigap policies or supplemental Medicare?

Georgia Burke: I was afraid you'd ask that. I am not aware of guidance on Medigap. I know it's an issue and it's not an issue that is as big for low income older adults because most of them really couldn't afford a Medigap policy. But we will keep an eye out on that. And if there is guidance that I haven't seen, I will be sure to share it so that it can go out to the group. But to my knowledge, there has been a gap there in terms of guidance for that, a gap in Medigap. I did want to also in terms of these foundational questions, just to clarify that this MAGI Medicaid, particularly for the adult expansion group, the income limit is 138% of poverty and there is no asset limit. So you have a lot of people who have been on MAGI Medicaid and then turn 65. And when they turn 65, then you're talking about a different standard using the SSI rules, which are the rules that are used for aged, blind, and disabled, totally different in terms of household definitions, all sorts of things.

And also, the state level in most cases is below 138%, often well below 138%. So some of those people who turned 65 during the pandemic, some of those people were in the class affected by the Carr decision and they ended up getting their full Medicaid dropped and ended up with only MSPs, Medicare Savings Program, which just pays for their Medicare premiums and really not much else. Or some of those people didn't qualify for MSPs or their state didn't really follow the Trump era rule and just let them be. They're there with full Medicaid and with the state if it was done right with the state paying their Medicare premium, and when they get redetermined, either they might have administrative problems or they just don't meet those income limits and they're going to be dropped. So for older adults, this is a big chunk of the people that are most likely to be adversely affected when the unwinding happens.

For others, obviously lots of people, older adults too who are on Medicaid, their circumstances may have changed, their income may have gone up, their assets may have gone up, things like that. But the population we help, the population generally is relatively stable, but this population, they've got a cliff there. So we expect a lot of them will get caught in that.

Gelila Selassie: Thank you Georgia. And on this Medigap policies, I'll also add that I haven't seen anything either. And on CMSs unwinding page, they do have a fair amount of fact sheets on the Medicare unwinding and some of the emergency waivers there. I hadn't seen anything on supplemental policies, but of course early days. So that's really helpful. Another question that I think might be best geared for
Tiffany was if you're aware if any local Medi-Cal offices have fact sheets available as of right now.

Tiffany Huyenh-Cho: Our Medicaid agency has put out some consumer friendly fact sheet as part of the ambassador program. So counties should, and I believe there are some taglines or short snippets of information that counties can use. I'm not sure if there's say like a stack of paper versions of that at the county office, but that's a good question. I can look into that and follow up after if that's part of the requirement that counties have more available pieces of information within the office. And there was one question I just wanted to quickly address that I saw in the chat that if a person has regularly renewed during this time, will they still have to go through the renewal process during the unwinding? And generally, yes. For some states, Medicaid renewals did continue and renewals were sent out and individuals could return them, but counties or states could not take negative actions based on those renewal packets. But even if someone has completed renewals during the past three years, they will have to go through the renewal process again in order to make any discontinuance or termination of Medicaid, states have to conduct a fresh renewal for persons. So for example, in California, renewals were sent out during the public health emergency but they were not acted on, unless it resulted in a positive outcome such as an increase in benefits or something along those lines.

Gelila Selassie: That's really helpful, thank you. Another question that we can sort of round-robin is this recognition that many individuals and particularly dual eligibles receiving Medicaid and Medicare are unaware of what kind of health coverage they have or if they have either or both. And so I want to highlight that because one point with that is that we've been hearing from some advocates that individuals, like in one state for example, some individuals have been referring to their Medicaid as COVID Medicaid. One really unique thing about the time period we're in is that not only was healthcare impacted by the pandemic, but there was enhanced unemployment benefits and eviction moratoriums and a variety of other benefit programs. And so during this unwinding, some people, especially if they're newer to Medicaid, may not realize that Medicaid is an ongoing benefit, an ongoing program that exists outside of PHE. And so there's that thing to throw up in the air. And then related to that question was if folks have been hearing any practices by Medicare reps or SHIP counselors to provide guidance or transfer individuals who come to the Medicare folks about Medicaid, any kind of streamlined efforts to make sure that they're directed to their Medicaid offices?

Georgia Burke: Well, I guess I'd say that we certainly hope that maybe some of the folks that are on this call can be working to do that because it's really true that people just don't know what they've got. I think in terms of 1-800-MEDICARE, if people call them, they can at least tell them whether they are a dual eligible or not, whether they have Medicaid and they can tell them if they're a qualified Medicare beneficiary if they're on a Medicare Savings Program. I think they can probably generically refer them to their state Medicaid office. But I don't think
they're really set up for a warm handoff. It would be nice if they could, but I just don't think that's going to happen.

Gelila Selassie: Great, that's really helpful. There was also one question going back to the PHE, why it was declared in January if the crux of the pandemic began in March. And just to clarify that, the president and the secretary can declare public health emergencies outside of a global pandemic. There's an ongoing one for the opioid crisis. There's often state-based or region-based ones for natural disasters and so it doesn't necessarily have to be a full-blown lockdown and the extent of a global pandemic for a declaration to be made. I will say that the bulk of the guidance and what we talked about with respect to the legislation did happen in the spring of 2020 and onward. So just to clarify that for a bit. Another question was just to clarify a bit about the Carr v. Becerra case. One question was, if anyone would be impacted would be able to get their premiums back if they've lost their MSP during the unwinding period? Are those folks subject to the Carr v. Becerra class action?

Georgia Burke: Well, Carr v. Becerra, the impacted people are those who had one kind of Medicaid and they qualified for a Medicare Savings Program. So they qualified for another kind of Medicaid, a Medicare Savings Program, which is not equal, it doesn't really meet the continuity of coverage requirement but CMS said it did. So those people are being moved to a Medicare Savings Program. And also within the Carr v. Becerra group, there are people who were in one Medicare Savings Program like QMB and it was determined that they didn't really qualify for QMB anymore, but they qualified for SLMB, Specialized Income Medicare program or QI, Qualified Individual. Those people, if they needed Part A premiums paid and QMB paid it because they didn't have free Part A, they lost that free Part A premium payment. And for those people under Carr v. Becerra, they would be restored to QMB and QMB would be paying and they should get retroactively get those Part A premiums back or retroactively get the Part A coverage if they didn't pay the premiums out of their own money, which they probably didn't but they retroactively get it covered by the state.

But Carr does not cover people who, if you had Medicaid and you didn't qualify for any other Medicaid program, you didn't qualify for QMB, SLMB or QI, then the state was not allowed to drop you, so you would've kept your Medicaid. So there really aren't people who were dropped and lost their Part B premium. Sort of a long way of saying, those people don't exist. The only people who would've lost their Part B premium coverage in all of this would be people who lost their Part A premium coverage because they lost QMB and went down to either SLMB or QI. I think that's how it's going to work.

Gelila Selassie: That's really helpful, thank you. There were a couple questions about how this process impacts individuals in long-term care facilities as well as the look back period. I can take a stab at that and just say that that is a very good question that we're actually not very clear of. One of the benefits of this webinar is not just for us to provide you all information, but we do want to keep in contact
with what you're hearing from and seeing on the ground and hearing from your clients and your partners so that we can collaborate and elevate those issues for more specific guidance from CMS and from other agencies as well. As far as I know, the biggest kind of threat for residents long-term care facilities on Medicaid is some of those general problems that Georgia addressed with respect to just how confusing this process is. And particularly some facilities, especially if they’re bad actors, could be using the unwinding process to not necessarily help out their residents as well as they should with these renewals and use that as an excuse to potentially evict individuals.

So if they are getting their forms and the resident doesn’t understand what’s going on, a facility, even though they’re obligated to help them may have an incentive not to. But then again, they may have an incentive to keep them and keep those Medicaid dollars. So it’s a little bit up in the air exactly how residents will be impacted, but it is an issue that we’re very interested in. And so we’d love folks to reach out to us if they have questions or any best practices that their state is undergoing. And then trying to figure out if you have any questions, last minute questions. I think there’s a lot of really good questions here. We’ll reach out to you all via email. There doesn’t seem like a lot that can be answered within a minute. So I think it’s appropriate for us to end now. Please feel free to reach out to us if you have any questions. Georgia or Tiffany, if you have any final thoughts or anything.

Georgia Burke: Also, just reach out to us if you find things that are happening that are going badly. This is such a complex situation. Kaiser came out today saying that there are 95 million people enrolled in Medicaid and most of those people are going to be redetermined. So this is going to be huge and things are going to go wrong. And to the extent that they can be caught early and identified and brought forward to the states and to CMS and all, it may really help to avoid as many problems and make things go as smoothly as it can.

Gelila Selassie: That’s really helpful. Thank you. I did see that there was one good question about how to find out what your state is doing if there’s nothing available on your states like Medicaid website. Georgetown Tracker, that’s in the resources page, has a lot of information of what states are doing. And then at some point, CMS is supposed to have an unwinding, another unwinding page that has the state’s redetermination plans. Although that hasn’t been up yet, so that’s another way to stay tuned. But with that, I think we’re good to go. Thank you all very much for participating. Thank you Georgia and Tiffany for your wonderful input, for your wonderful materials. And we will adjourn.