September XX, 2021

Name
Title
Address
Address

Re: Recommendations for STATE Medicaid Program Regarding the COVID-19 Public Health Emergency

Dear NAME:

The undersigned organizations, representing thousands of patients and consumers across STATE who face serious, acute and chronic health conditions, are committed to ensuring that the Medicaid program provides quality and affordable healthcare coverage. The COVID-19 pandemic and its economic impact have highlighted the importance of the Medicaid program and its robust healthcare coverage for low-income children, adults, seniors and people with disabilities. Our organizations urge you to ensure patients who remain eligible for Medicaid coverage maintain their access to care at the end of the COVID-19 public health emergency (PHE).

As you know, under the Families First Coronavirus Response Act, states receive increased funding from the federal government for their Medicaid programs for the duration of the PHE but must comply with maintenance of effort requirements limiting the circumstances in which people can be removed from Medicaid coverage, amongst other requirements. The federal government has said that the PHE will last at least through the end of 2021 and that states will have 60 days' notice before its termination or expiration.[1]

On August 13, 2021, the Centers for Medicare and Medicaid Services (CMS) issued a letter to state health officials updating previously issued guidance from December 2020 regarding the resumption of routine state Medicaid operations at the end of the COVID-19 PHE. Our organizations strongly support the changes in the August 2021 guidance, which take important steps to protect individuals against erroneous terminations of coverage. These include:

1. *Providing states with up to 12 months after the month in which the PHE ends to complete pending eligibility and enrollment actions.* This flexibility will help ensure that state systems, call centers and eligibility workers are not overwhelmed and are able to be responsive to the needs of enrollees in a timely manner. It will also ensure that future eligibility review workloads are more evenly distributed over the course of the year.

2. *Conducting a new review of eligibility for individuals determined ineligible for Medicaid during the PHE.* Many individuals' circumstances have changed rapidly and/or multiple times during the pandemic, so conducting a fresh review of eligibility will help protect eligible individuals, especially those in underserved populations, from a gap in or a loss of coverage. States can (and should) currently use renewal processes to extend eligibility for enrollees on an on-going basis, and thus reduce the number of fresh reviews needed when the PHE period ends. The guidance also encourages states to allow enrollees 30 days to respond to a communication and provide any necessary information needed to verify eligibility following a change in circumstances.

In addition to implementing the important steps outlined in the new guidance, our organizations believe there are additional steps that states can and should take to ensure patients who remain eligible for Medicaid coverage maintain their access to care at the end of the PHE, as well as support the state's workforce and economy. As your office moves forward with planning for the end of the PHE, we urge you to consider the follow recommendations.

Streamline enrollment and renewal processes
Streamlining enrollment and redetermination processes benefits states and Medicaid enrollees by reducing administrative burden and churn. States can improve their *ex parte* renewal processes to make sure they are relying on electronic data sources when possible, as well as improve coordination with other safety net programs to ensure they are sharing information that could help process renewals of Medicaid coverage when appropriate. States should also consider extending temporary policies that streamlined enrollment during the pandemic, such as expanding presumptive eligibility and allowing enrollee self-attestation for certain eligibility information.

Improve communications with enrollees
The PHE has been an enormous and unprecedented disruption for households. Families have lost jobs, loved ones, and in many cases, their homes. Indeed, states are reporting an increase in returned mail due to the pandemic.[2] To ensure states fully recover, states should take steps to proactively update mailing addresses and expand the use of other forms of communication, like texting and emailing, to ensure enrollees receive the information they need to maintain coverage. States should also use their website, social media and other platforms to conducting a public awareness campaign to educate enrollees and other stakeholders, including providers, managed care organizations, consumer groups and other advocates, about enrollment and renewal processes. Communication plans should provide support for non-English speakers and those who may need in person or additional consumer assistance.

Implement continuous eligibility
Continuous eligibility reduces gaps in coverage that prevent patients from accessing the care that the need. For example, research has shown that individuals with partial coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[3] Continuous eligibility also reduces churn and therefore reduces the administrative burden on states. States should use a state plan amendment to implement 12-month

continuous eligibility for children and apply for a section 1115 waiver to implement 12-month continuous eligibility for adults if they have not already done so.

Strengthen transitions to marketplace coverage
Some enrollees who no longer qualify for Medicaid coverage at the end of the PHE may be eligible for marketplace coverage. States should strengthen their processes for connecting Medicaid enrollees with information and resources to enroll in marketplace coverage, including Navigators and other trusted community partners.

Track terminations of coverage and monitor impact on underserved populations
Allowing states additional time to resume normal operations means that underserved populations are more likely to get the necessary assistance to stay enrolled in coverage. States should also set up processes now to closely track any terminations of coverage at the end of the PHE and ensure there is flexibility to adapt their plans if terminations of coverage disproportionally impact certain populations, including communities of color or people with disabilities. States should post disaggregated disenrollment data as well as other performance indicators like call center statistics on public-facing websites weekly so that patient and consumer advocates and other stakeholders can closely monitor the situation as well.

Our organizations are committed to working with you to navigate the end of the PHE and ensure that patients who remain eligible for Medicaid coverage maintain their access to care. If you have any questions about these recommendations or other related issues in STATE, please contact ACS CAN CONTACT at CONTACT INFO.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
American Kidney Fund
ALS Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Muscular Dystrophy Association
National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The Leukemia & Lymphoma Society

[1] https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf
[2] https://www.shvs.org/maintaining-medicaid-and-chip-coverage-amid-postal-delays-and-housing-displacements/
[3] https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.