Missouri Medicaid in 2023

Missouri Foundation for Health
Manatt Health
Missouri Budget Project
Missouri Medicaid in 2023

Anam Khan
Health Policy Associate
About Us

Mission

To eliminate underlying causes of health inequities, transform systems, and enable individuals and communities to thrive.

Equity  Integrity  Humility  Commitment
The Foundation serves 84 counties and the city of St. Louis.
What is MO HealthNet?

• Missouri’s Medicaid Program, MO HealthNet, provides health insurance for low-income children and parents, pregnant women, older adults (age 65+), blind individuals, individuals with disabilities, and since implementation of Medicaid expansion, adults (age 19-64).

• This program supports the health and well-being of individuals and communities.
Fast Facts

Covers

1 out of every 5 Missourians

Covers

48% of Missouri's children

Pays for

39% of all births in the state

Covers

1 out of every 16 adults aged 19-64

Covers

1 out of every 12 older adults aged 65+

Pays for

66% of all nursing home care in the state
## Eligibility

### MO HealthNet Income Eligibility

<table>
<thead>
<tr>
<th>Covered Populations</th>
<th>Income Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (under age 19)</td>
<td>&lt;300% FPL</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>&lt;196% FPL**</td>
</tr>
<tr>
<td>Individuals with a Disability</td>
<td>&lt;85% FPL*</td>
</tr>
<tr>
<td>Older Adults (age 65+)</td>
<td>&lt;85% FPL*</td>
</tr>
<tr>
<td>Blind Individuals</td>
<td>&lt;100% FPL*</td>
</tr>
<tr>
<td>Parents</td>
<td>&lt;21% FPL***</td>
</tr>
<tr>
<td>Expansion Adults (age 19-64)</td>
<td>&lt;133% FPL</td>
</tr>
</tbody>
</table>
Missourians From Across the State Are Enrolled

• About 19% of all Missourians were enrolled in MO HealthNet in SFY 2022
Medicaid Expansion

- Enrollment began in October 2021
- Estimated 275,000 adults were newly eligible for coverage
- As of mid-January 2023, 294,437 Missourians were enrolled in the adult expansion group (including new enrollees and transferred enrollees)
- 90% of expansion costs are covered by the federal government
- During SFY 2022, adult expansion group used only 4% of the state Medicaid budget
Public Health Emergency Unwinding

- What is a public health emergency?
- HHS secretary declared a COVID-19 pandemic PHE in January 2020, and PHE has been repeatedly renewed since
- During PHE, states not allowed to disenroll Medicaid participants
- After PHE ends, state Medicaid agencies will begin unwinding process and review eligibility of Medicaid enrollees
How is MO HealthNet Financed?

- The majority of MO HealthNet is funded through the federal government.
- Less than 1/5 of funding for SFY 2023 comes from state general revenue.

Diagram:
- 63% Federal Funds
- 18% State General Revenue
- 19% Other
Families and Children Use Fewer Resources

- Enrollees: 23%, 9%, 68%
- Budget: 15%, 51%, 34%

- Families & Children: 23%
- Older Adults & People with Disabilities: 9%
- Other: 68%
Unwinding of the Medicaid Continuous Coverage Requirements

Patricia Boozang
Senior Managing Director, Manatt Health

Content used to develop this presentation was informed by work funded by the Robert Wood Johnson Foundation through the State Health and Value Strategies program.
# Illustrative Continuous Coverage Unwinding Timeline Under CAA

<table>
<thead>
<tr>
<th>Year</th>
<th>2023</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month</strong></td>
<td>Jan</td>
<td>Feb</td>
</tr>
</tbody>
</table>

**Continuous Coverage/ELIE Actions**

- End of the Medicaid continuous coverage requirement (3/31/2023)

  States may restart Medicaid redetermination process as early as 2/1/2023 for terminations beginning 4/1/2023; 12 months to initiate and 14 months to complete all post-enrollment verifications, redeterminations, and renewals

**eFMAP Phase-Out Conditions**

- 6.2% Medicaid eMAP
- 4.34% CHIP eMAP
- 5.0% Medicaid eFMAP
- 3.5% CHIP eFMAP
- 2.5% Medicaid eFMAP
- 1.75% CHIP eFMAP
- 1.5% Medicaid eFMAP
- 1.05% CHIP eFMAP

**Unwinding Reporting**

- Renewal Redistribution Plan and Systems Readiness Artifacts due 2/1/2023 for states initiating renewals in February, or 2/15 for after
- Baseline Unwinding Data Report due 8th day of the month in which renewals begin (2/8/2023, 3/8/2023, or 4/8/2023); Monthly Unwinding Data Report due to CMS the 8th day of each month thereafter through 6/30/2024

**CAA monthly reporting requirements in effect 4/1/2023 – 6/30/2024**

**Monitoring & Enforcement**

- States subject to corrective action/other penalties for failure to comply with reporting requirements or any “federal requirements applicable to eligibility redeterminations” from 4/1/2023 – 6/30/2024
- States subject to regular FMAP reduction for failure to report required information from 7/1/2023 – 6/30/2024

Source: SHVS, Unwinding Provisions in the 2023 Consolidated Appropriations Act; and CMCS Informational Bulletin, Key Dates Related to the Medicaid Continuous Enrollment Conditions Provisions in the CAA.
New Conditions on Enhanced FMAP

Receipt of the enhanced FMAP from April through December 2023, will be contingent upon new conditions.

**6.2% FMAP (start of the PHE through 3/31)**

States must conduct eligibility redeterminations and renewals in compliance with federal requirements and other strategies approved by CMS, such as temporary section 1902(e)(14) waiver flexibilities.

**5.0% FMAP (4/1 through 6/30)**

States must “attempt to ensure” they have up-to-date enrollee contact information by using the National Change of Address (NCOA) Database, state health and human services agencies, or other reliable sources of contact information.

**2.5% FMAP (7/1 through 9/30)**

States must not disenroll anyone who is determined ineligible for Medicaid based on returned mail, without first making a good faith effort to contact the individual using more than one modality (e.g., telephone and email).

**1.5% FMAP (10/1 – 12/31)**

The enhanced FMAP will also remain subject to FFCRA maintenance of effort (MOE) requirements. With the end of the continuous coverage guarantee in April 2023, states will be permitted to increase individual premiums for enrollees who have a change in circumstances and terminate coverage for individuals who fail to pay premiums.

Note: See 42 CFR § 435.911, 42 CFR § 435.916, and 42 CFR § 457.343 for federal ex parte requirements. Also see SHVS, Improving Ex Parte Renewal Rates to Support Unwinding; Q&A and CMS, COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals.
New Reporting Requirements

The CAA establishes new reporting requirements—beyond those required in the existing Renewal Distribution Report and Unwinding Data Report—regarding eligibility and renewal processes for Medicaid, CHIP, and the Marketplace.

From April 1, 2023, through June 30, 2024, states must submit to CMS a monthly report (that will be made public) detailing...

<table>
<thead>
<tr>
<th>Medicaid and CHIP-Related Reporting Elements</th>
<th>✓ The number of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>– Eligibility renewals initiated;</td>
</tr>
<tr>
<td></td>
<td>– Enrollees renewed, including a breakdown for <em>ex parte</em> renewals that would have resulted from successful completion of renewal forms/requests for information;</td>
</tr>
<tr>
<td></td>
<td>– Enrollees whose coverage was terminated;</td>
</tr>
<tr>
<td></td>
<td>✓ The number of individuals who were enrolled in CHIP as a result of renewals.</td>
</tr>
<tr>
<td></td>
<td>✓ Total call center volume, average wait times, and average abandonment rates.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marketplace-Related Reporting Elements (unless CMS reports this information on the state’s behalf)</th>
<th>For states that operate a State-Based Marketplace (SBM) and have an integrated eligibility determination system:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ The total number of individuals who were determined eligible for a qualified health plan (QHP) or the Basic Health Program (BHP).</td>
<td>Of these, the number who selected a QHP on the Marketplace or were enrolled in a BHP plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>For states that do not have an integrated eligibility determination system (including all Federally-Facilitated Marketplaces (FFM) states):</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ The number of individuals whose accounts were transferred from Medicaid to the Marketplace or BHP.</td>
<td>Of these, the number who were determined eligible for a QHP or the BHP.</td>
</tr>
<tr>
<td>✓ Of these, the number who made a QHP selection or were enrolled in a BHP plan.</td>
<td></td>
</tr>
</tbody>
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In addition to these requirements, CMS may request additional information “related to eligibility redeterminations and renewals.” Reporting requirements apply to all states, regardless of whether they comply with the conditions for enhanced FMAP during unwinding.
Updated Reporting Requirements

In light of the CAA, the January 5, 2023 CMCS Informational Bulletin updates and revises due dates for existing unwinding reports and documentation required of states.

<table>
<thead>
<tr>
<th>Submission</th>
<th>Due to CMS by...</th>
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<tbody>
<tr>
<td>Renewal Redistribution Plan</td>
<td>• February 1, 2023, for states initiating renewals in February</td>
</tr>
<tr>
<td></td>
<td>• February 15, 2023, for all other states</td>
</tr>
<tr>
<td>Systems Readiness Artifacts</td>
<td>• The 8th day of the month in which a state begins renewals (i.e., February 8,</td>
</tr>
<tr>
<td>(configuration plan, testing plan</td>
<td>2023, March 8, 2023, or April 8, 2023)</td>
</tr>
<tr>
<td>and test results</td>
<td></td>
</tr>
<tr>
<td>Baseline Unwinding Data Report</td>
<td>• The 8th day of each calendar month during the unwinding period</td>
</tr>
<tr>
<td>Monthly Unwinding Data Report</td>
<td></td>
</tr>
</tbody>
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*Note: Where a submission due date falls on a weekend or public holiday, states may submit the required document(s) on the following business day.

CMS also expects that states will continue to submit timely data submissions through the Medicaid and CHIP Eligibility and Enrollment Performance Indicator dataset on the 8th of each calendar month, and data submissions through the Transformed Medicaid Statistical Information System (T-MSIS) dataset before the end of the subsequent calendar month.

CMS notes that reporting activities are intended to “ensure that renewals of eligibility occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage, including for individuals eligible for other insurance affordability programs, and maximizes state effectiveness.”
New Federal Enforcement Mechanisms

The CAA vests CMS with targeted oversight powers related to eligibility redeterminations and reporting during unwinding. Federal enforcement mechanisms supplement and, in some cases, overlap with CMS’ existing enforcement mechanisms.

<table>
<thead>
<tr>
<th>Penalty</th>
<th>Trigger</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) FMAP reduction for failure to report required information</td>
<td>• If, in the period from July 1, 2023 through June 30, 2024, a state fails to comply with the CAA reporting requirements (see previous slides).</td>
<td>• A state’s FMAP for the quarter will be reduced by 0.25 percentage points, plus an additional 0.25 points for each prior quarter of noncompliance (not to exceed 1 percentage point).</td>
</tr>
</tbody>
</table>
| 2) CAPs and additional penalties | • If CMS determines that from April 1, 2023, through June 30, 2024, a state has failed to comply with:  
  – The CAA reporting requirements; or  
  – Any “federal requirements applicable to eligibility redeterminations.”  
  • If a state fails to submit or implement its CAP, CMS may:  
  – Order the suspension of all or some procedural terminations of eligibility until the state takes appropriate corrective action; and/or  
  – Impose civil monetary penalties of up to $100,000 for each day a state is out of compliance. | • The legislation establishes timelines for timely submission, CMS approval, and implementation of the CAP.  
• It remains to be seen how and the degree to which CMS will exercise these enforcement actions and how states will respond. |

Procedural terminations occur when potentially eligible individuals fail to respond to a state Medicaid/CHIP agency’s request for additional information as part of the redetermination process.
Stakeholders Can Plan An Important Outreach Role

Stakeholders—providers, community-based organizations and plans—can play a critical role in supporting the unwinding process including by helping individuals update their contact information and responding to renewal requests for information.

Stakeholders can:
▪ Remind enrollees about updating their contact information and help them understand how to do so.
▪ Give updates to individuals that the end of the PHE means they need to respond to requests for information from the state.
▪ Help individuals complete the renewal forms and send back in a timely way.

Stakeholders can also provide important feedback to the State on how the unwinding of the continuous coverage requirements are impacting enrollees on the ground.

Source: Centers for Medicare & Medicaid Services (CMS), Strategies States and U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations; and SHVS, Planning for the End of the Continuous Coverage Requirement: A Communications Toolkit for States.
Medicaid Budget

Amy Blouin
President and CEO, Missouri Budget Project
COVID Relief Funding for Medicaid

Temporary Enhanced Matching Rates for Medicaid

- **The first enhanced FMAP** is a temporary 6.2 percentage point increase in the federal match as part of the Public Health Emergency (PHE).

- **When Medicaid expansion is implemented on July 1, 2021**, Missouri will benefit from two enhanced match rates: in addition to the enhanced rate for the PHE, when Medicaid expansion is implemented, there will be a 5 percentage point increase in the FMAP for services for existing populations.

- **After PHE has ended**, the 5 percentage point Medicaid expansion incentive will remain for 2 years past implementation.

Permanent Federal Matching Rate for Medicaid Expansion Group

- **This is a Permanent Match Rate for the Expansion Group**.
Medicaid Expansion in the FY 2023 Budget

- **Section 11.825 To the Department of Social Services**
- For the MO HealthNet Division
- For program distributions related to Section 36(c) of Article IV of the Missouri Constitution, and provided ten percent (10%) flexibility is allowed between this section and Sections 11.700, 11.715, 11.720, 11.725, 11.730, 11.745, 11.755, 11.760, 11.765, 11.785, 11.800, 11.805, 11.815, and 11.825
- From FMAP Enhancement - Expansion Fund (2466). $236,195,649 (GR Contribution)
- From Title XIX - Adult Expansion Federal Fund (0358). $2,245,660,096
- From Pharmacy Reimbursement Allowance Fund (0144). $355,785
- From Nursing Facility Reimbursement Allowance Fund (0196). $28,411
- From Ambulance Service Reimbursement Allowance Fund (0958). $461,068
- From Federal Reimbursement Allowance Fund (0142). $12,476,846
- **Total.** $2,495,177,855
Transition from the Medicaid Continuous Coverage Requirement

<table>
<thead>
<tr>
<th>Phase-Out of the Enhanced Federal Match</th>
<th>Enhanced Medicaid Rate</th>
<th>Enhanced CHIP Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1 – March 31, 2023</td>
<td>6.2%</td>
<td>4.34%</td>
</tr>
<tr>
<td>April 1 – June 30, 2023</td>
<td>5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>July 1 – September 30, 2023</td>
<td>2.5%</td>
<td>1.75%</td>
</tr>
<tr>
<td>October 1 – December 31, 2023</td>
<td>1.5%</td>
<td>1.05%</td>
</tr>
</tbody>
</table>
➢ Requires 12-Month Continuous Eligibility for Children

➢ Extends State Option for 12-month Postpartum Coverage (Senate Bill 45)

➢ Extends Federal Funding for CHIP through FY 2029

➢ New Investments in Mental Health for Children including School Based Mental Health and Early Childhood Mental Health
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