MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

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Director
AMY CARLSON

DATE: JUNE 4, 2024

RE: MEDICAID RENEWALS AND THE PUBLIC HEALTH EMERGENCY

CHANGES FROM THE PUBLIC HEALTH EMERGENCY[1]

In March 2020, the Families First Coronavirus Response Act granted states an additional 6.2% to the federal medical assistance percentage (FMAP) for traditional Medicaid. To get the increased federal match rate, states were required maintain continuous enrollments for all individuals during the span of the public health emergency (PHE). Though the additional funding was for traditional Medicaid, the continuous enrollment condition applied to expansion as well. Changes to the normal eligibility process included:

- suspending annual redetermination process of checking if individuals qualified for continued healthcare
- Not processing reported/discovered changes in circumstances
- Not ending an individual's coverage unless the individual requested it or moved out of state

Montana implemented the same policy changes for Healthy Montana Kids (CHIP) enrollment.[2]

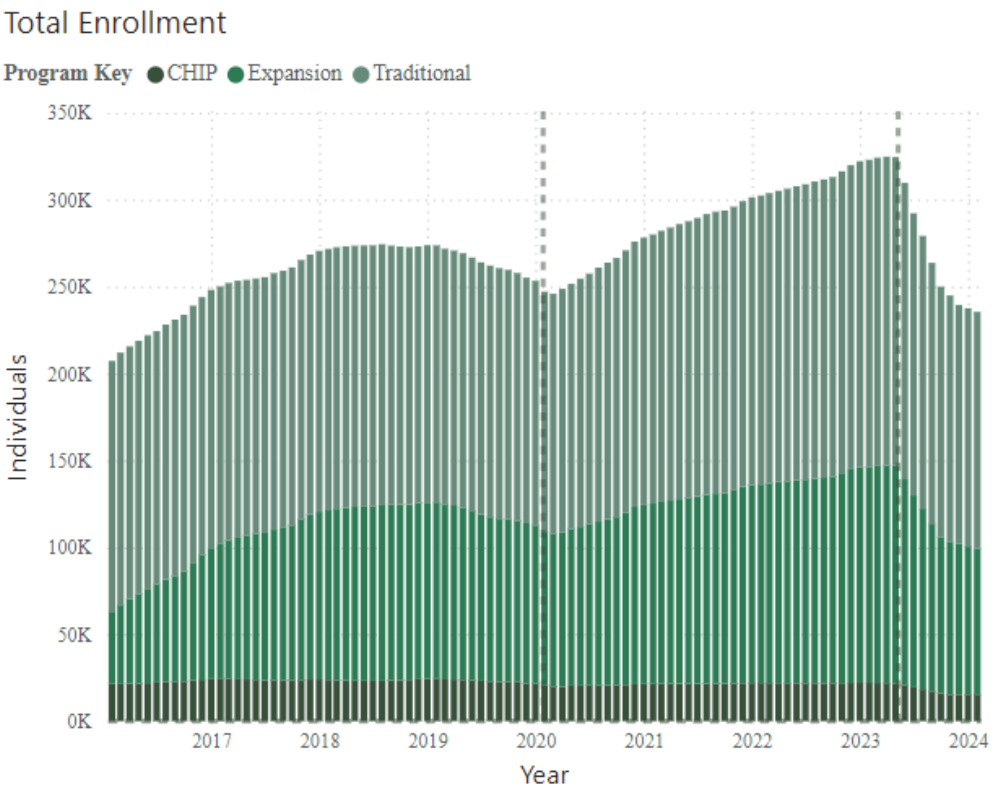
Federal legislation in December 2022 set April 1, 2023, as the end date for the continuous enrollment requirements at which time, states were to begin redeterminations.

REDETERMINATION

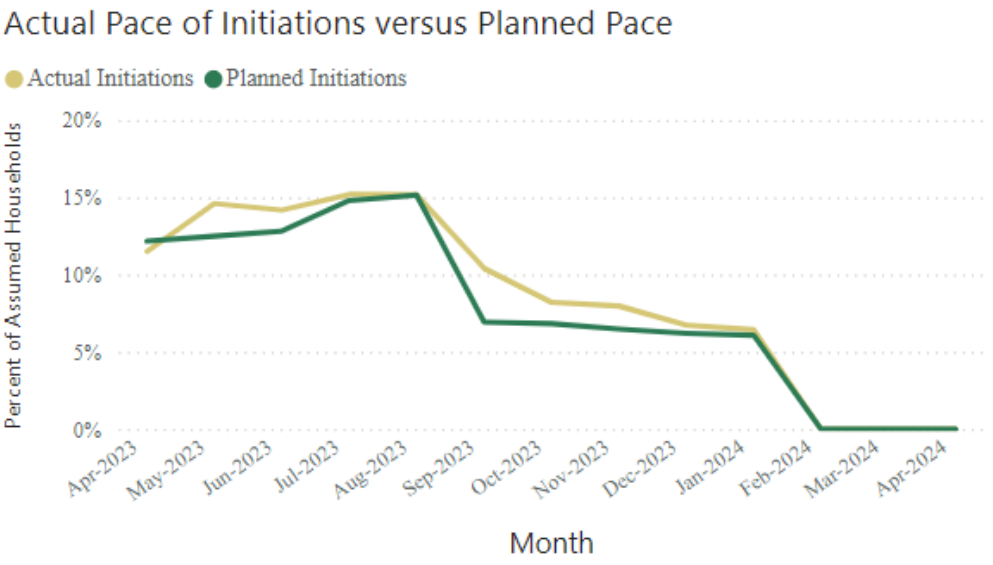
THE BIG PICTURE

At the start of redetermination in April 2023, Medicaid enrollment (Traditional, 177,777 individuals; Expansion 125,034 individuals; CHIP, 21,937 individuals) reached an all-time high of over 324,000 individuals enrolled. Before COVID, enrollment capped out around 274,000 individuals in 2018 and had been trending downward since that time reaching a low around 246,000 individuals enrolled.

[1] https://dphhs.mt.gov/hcsd/medicaidupdates/
[2] https://dphhs.mt.gov/assets/hcsd/MedicaidRenewals/WebsiteMedicaidChangesCommunityDeck.pdf

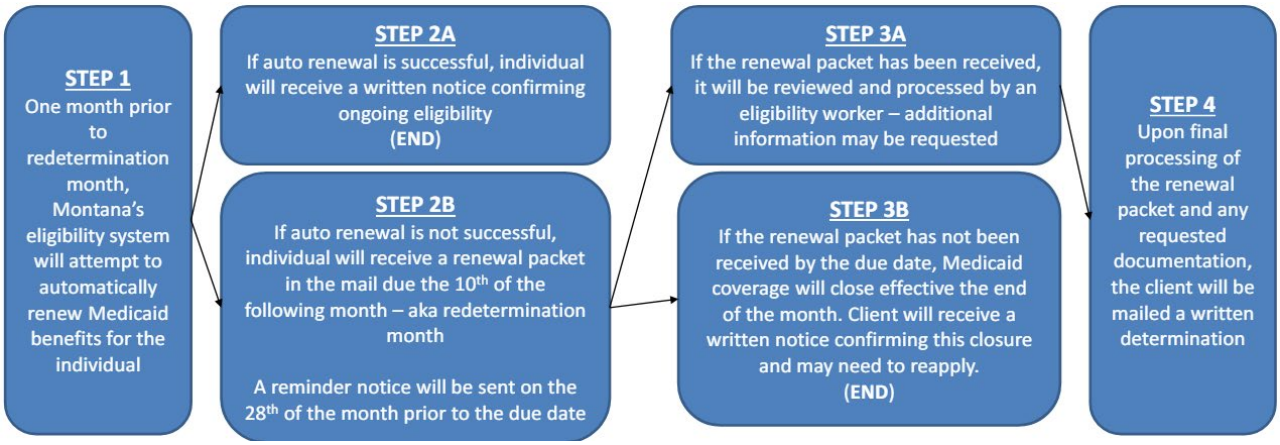


The department finished the redetermination process in January 2024. The department opted for a 10-month plan to complete all eligibility redeterminations. CMS allowed for longer unwinding timeframes. This plan was sent to the Centers for Medicare and Medicaid Services in February 2023. They had originally projected having to complete 160,000 household case initiations. Actual initiations at the end of the unwinding period totaled over 176,000 households.



The Process

The graphic below[3] was created by the department to show the process that they have been following for renewals.



If an individual has been through this process and it was determined that they are no longer eligible, through the state plan, they are allowed to appeal that decision through the fair hearings process if they believe the loss in benefits was incorrect. They have 90 days to submit a fair hearing request in writing to the Office of Public Assistance (OPA) in DPHHS.

There are many possible reasons an individual may not have their coverage renewed:

- Procedural termination for failure to return information needed to redetermine eligibility
- Determined ineligible (Change in circumstances such as an increase in income or assets above the eligibility threshold)
- A member is now deceased or no longer in the household (primary reasons for closure in the "Other reason" category on the department redetermination dashboard)
- Returned mail without a new address
- Requested closure

ELIGIBILITY

Retroactive Eligibility

Due to the nature of Medicaid eligibility determinations, if someone applies for Medicaid in December 2024, their coverage starts in September 2024 so any services they received in that timeframe are billable to Medicaid. This is called retroactive eligibility. In terms of redetermination, this means that if someone's coverage is terminated, and they either went through the fair hearings process and their coverage was restored, OR they end up returning missing paperwork, etc. within three months after that coverage termination, they never actually leave the Medicaid rolls and that individual is treated as if coverage was never terminated rather than being treated as a new applicant.[4]

The department has been maintaining a dashboard tracking redetermination data month to month. Because of 90-day retroactive eligibility, the total closures on this dashboard will not tie out with the actual changes to the Medicaid rolls. The dashboard is a static snapshot so closures may come up again in later months as "Processing".

[3] https://dphhs.mt.gov/assets/hcsd/MedicaidRenewals/WebsiteMedicaidChangesCommunityDeck.pdf
[4] Section B IBC Meeting, *Departmental Updates: Medicaid Redetermination*. December 13th, 2023.

The 90-day retroactive eligibility is also the primary reason the enrollment data that LFD received from the department has a 90-day lag.

CONTINUOUS ELIGIBILITY

Montana's Medicaid program had a policy of continuous eligibility since the start of Medicaid expansion in 2016. This meant that even if an individual/family experienced a change that would otherwise impact eligibility, continuous medical coverage was provided for a full 12 months. The 2021 Montana Legislature removed funding for and directed the DPHHS to change this policy. This change could not go into effect until the end of the PHE and the end of the federal period for continuous enrollment. This change does not apply to all populations:

Group	Continuous Eligibility PRIOR to April, 2023	Continuous Eligibility POST April, 2023
Children (under age 18)	Yes	Yes
Adults (19+)(Medicaid Expansion, PCR)	Yes	No
Adults (18+)(SDMI)	Yes	Yes
Aged, Blind, Disabled	No	No
Post-partum women*	Yes	Yes

* Continuous eligibility for post-partum women was changed in the 2023 legislature from 60 days to 12 months for women enrolled in Montana's Medicaid and CHIP.

NON-COVID YEARS

During non-covid years, individuals are granted 12 months of Medicaid coverage. Within that 12-month period, if the department receives information that indicates the member has had a change in their circumstances, DPHHS is required to re-assess if the member still qualifies. The Department may send a request for further information to the member and that existing enrollee does not need to reapply, but they may need to provide additional information to retain coverage. If the new information makes them ineligible, DPHHS must terminate their coverage. After that 12-month period of coverage, the individual is reassessed for eligibility and granted a further 12 months or deemed ineligible.[5]

[5] http://dphhs.mt.gov/hcsd/medicaidupdates/