Medicaid Unwinding:
What you need to know

Indiana Rural Health Association

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DISCLAIMER

Connecting Kids to Coverage-Indiana is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $1,454,878 and 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

INTRODUCTION

Indiana Rural Health Association

The Indiana Rural Health Association (IRHA) was founded in 1997 as a not-for-profit corporation for the purpose of improving the health of all rural citizens in Indiana. Our mission is simple: we work to enhance the health and well-being of rural populations in Indiana through leadership, education, advocacy, collaboration, and resource development.

Connecting Kids to Coverage

CONNECTING KIDS TO COVERAGE- INDIANA (CKC-IN) is a statewide outreach and enrollment initiative with a primary goal to reach families with information about the health insurance coverage available under Medicaid and the Children's Health Insurance Program (CHIP). The Connecting Kids to Coverage Campaign works with community organizations, schools, healthcare providers, and others to ensure no eligible child goes uninsured. CKC-IN is led by the Indiana Rural Health Association (IRHA) and administered by the Centers for Medicare & Medicaid Services (CMS).

CKC-IN provides support to uninsured families in order to increase access to quality, affordable healthcare by providing free one-on-one healthcare enrollment assistance. Connecting Kids to Coverage team knows how important health insurance is to families. CKC-IN's Outreach and Enrollment Team is here to serve you and ensure all Hoosier families have access to affordable healthcare. Our team consists of licensed Indiana Navigators, Certified Application Counselors, and Community Health Workers.

CKC-IN's objective is to let families know who is eligible, what benefits are available, how to apply for coverage, understand coverage and how to use it, as well as offer continued support to maintain health insurance coverage.

Leading Indiana Families to Health Coverage

IRHA CKC-IN TEAM

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De'Janae Nash - Program Coordinator
Collette Rhoads - Program Coordinator

FROM LEFT TO RIGHT: De'Janae, Collette, April, Ann, Danielle, Shelby, and Jessica

Health Coverage Statewide Consumer Assistance Initiative of the Indiana Rural Health Association (IRHA)

IRHA Connecting Kids to Coverage – IN (CKC-IN) Representatives

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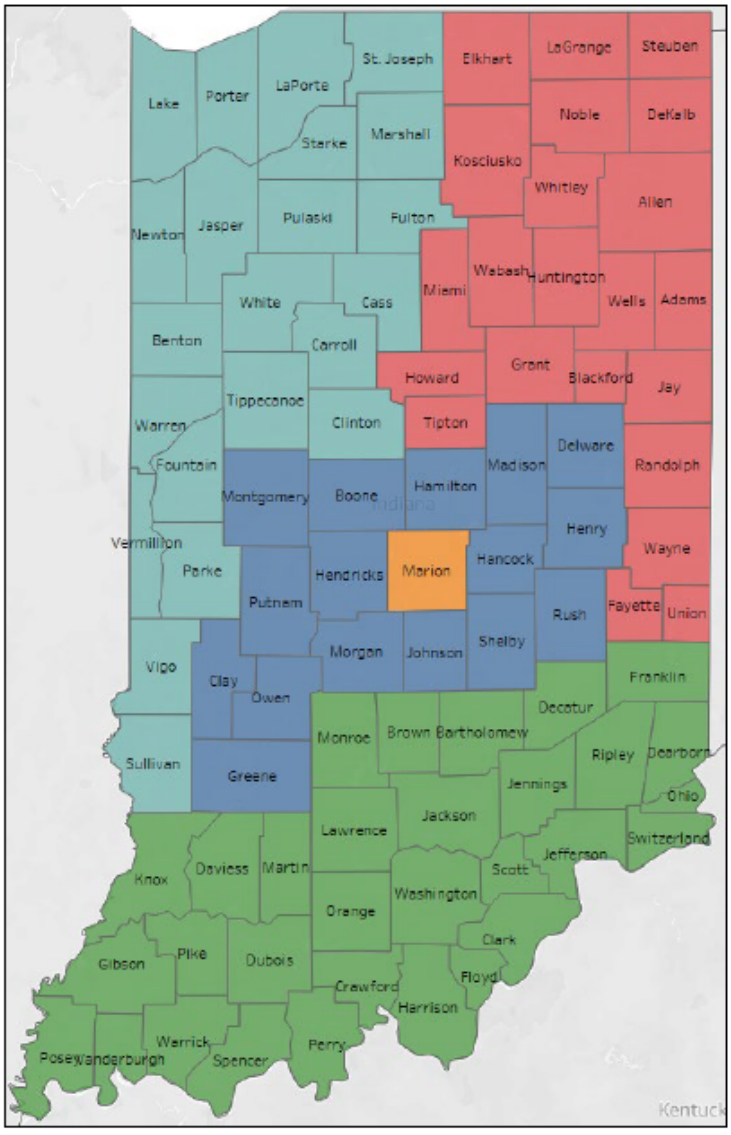


www.indianaruralhealth.org/ckc-in

SUMMARY

What is Medicaid?

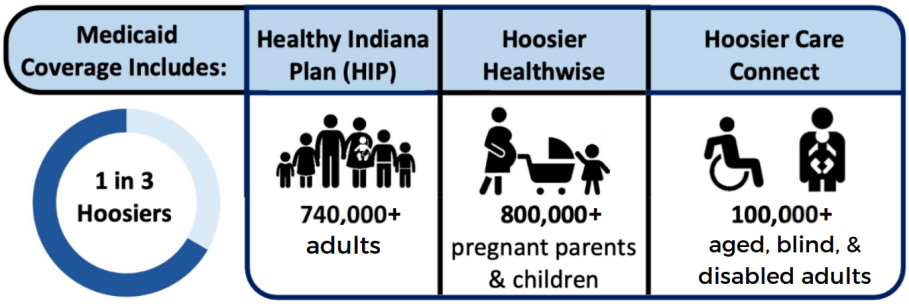
Medicaid is an essential public health insurance program that offers free or low-cost health insurance to low-income adults, children, parents, caretakers, pregnant women, aged, blind, and disabled. There are a variety of Indiana Health Coverage Programs (IHCP) available through Medicaid. Because each of these programs serves unique populations, different eligibility factors may apply. Medicaid is a program jointly funded and administered by state and federal governments. Family Social Services Administration (FSSA) is the governing state agency that administers Medicaid and other social services in Indiana. Centers for Medicare & Medicaid Services (CMS) is the federal agency within the U.S. Department of Health and Human Services that administrators the nation's major healthcare programs.

Medicaid in Indiana

There are four main types of Medicaid in Indiana:

- Healthy Indiana Plan (HIP) serves low-income adult Hoosiers.
- Hoosier Healthwise serves children up to age 19 and pregnant individuals. Children's Health Insurance Program (CHIP) falls under the Hoosier Healthwise program. CHIP is for children up to age 19 whose families have slightly higher incomes.
- Hoosier Care Connect serves aged, blind, and disabled adults. Hoosier Care Connect also serves children in Indiana foster care, as well as previous foster children.
- Traditional Medicaid serves the lowest income Hoosiers, including those with Medicare and people in nursing homes and other long-term care facilities.

Over 2 million Hoosiers adults and children rely on some form of Medicaid for their healthcare coverage.



Free Expert Assistance

Enrollment assisters like Navigators and Certified Application Counselors are health insurance experts, who offer free assistance. Assisters are trained and certified to answer consumer questions about coverage, review options, complete applications, and enroll in coverage. They offer unbiased help and are not associated with any health insurance company. Contact IRHA's CKC-IN team to get connected with your regional representative.

What is a Navigator?

An Indiana Navigator is licensed through the Indiana Department of Insurance to provide free, unbiased application assistance for Indiana Health Coverage Programs, such as the Healthy Indiana Plan, Hoosier Healthwise, and the Children's Health Insurance Program (CHIP).

What is a Certified Application Counselor?

A Certified Application Counselor (CAC) is certified through the Centers for Medicare and Medicaid (CMS) to provide free, unbiased application assistance on the ACA/Federal Health Insurance Marketplace.

What is a Community Health Worker?

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member or has a particularly good understanding of the community served. A CHW serves as a liaison between the community and health and social services to facilitate access to services and to improve the quality and cultural competence of service delivery.

IMPORTANT CHANGES

Medicaid and the Public Health Emergency

In March 2020, the Centers for Medicare & Medicaid Services (CMS) temporarily waived certain Medicaid and CHIP requirements and conditions. Under the COVID pandemic Public Health Emergency (PHE) 2020 Families First Coronavirus Response Act, states were offered increased Medicaid funding in exchange for keeping enrollees continuously on their Medicaid register for the duration of the PHE. State Medicaid agencies made policy, programmatic, and systems changes to respond effectively to the pandemic. The easing of these rules helped prevent people with Medicaid and CHIP from losing their health coverage during the pandemic.

Modifications included:

- Medicaid eligibility maintained in current or better category
- Suspended copays and premiums
- Self-attestation on application with post-enrollment verification
- Continuous enrollment condition for Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020

Under the continuous coverage requirement, individuals remained eligible for Medicaid even if they had a change in their income or family size that would have normally made them ineligible and terminated for Medicaid. The policy has kept millions of people covered during the pandemic, ensuring they have access to health care services, including COVID testing, treatment, and vaccines.

Medicaid Unwinding

While the full PHE is set to end on May 11, the Consolidated Appropriations Act of 2023 included a provision that allows states to end their continuous coverage of Medicaid enrollees, deemed “unwinding,” beginning April 1. Starting April 1, 2023, states will be resuming normal eligibility and enrollment operations, as well as terminating Medicaid enrollment for individuals no longer eligible. This means that people enrolled in Medicaid will be required to submit current information about their household, income, and meet eligibility requirements to stay enrolled in Medicaid.

Many states and other stakeholders have raised significant concerns that, due to the unprecedented nature of unwinding, Medicaid and CHIP recipients may face extraordinary challenges when transitioning from Medicaid or CHIP coverage to other forms of coverage. Medicaid and CHIP beneficiaries may be confused as to why their Medicaid or CHIP coverage is ending for the first time in several years.

Challenges

Enrollees could lose their Medicaid coverage during the unwinding process for one of two reasons:

- Eligibility: They are no longer eligible for Medicaid because their circumstances changed (income went up, household size went down, no longer pregnant, etc.).
- Procedural: They lose their coverage because of administrative errors, barriers they face during the renewal process, or other reasons not related to eligibility.

Some examples of barriers an enrollee may face include:

- They do not receive renewal letters because they moved during the pandemic or are unhoused, and the Medicaid agency does not have their current address.
- The renewal form they receive is confusing or is written in a language they don't speak, and the steps they need to take are unclear.
- They have questions about the process but can't reach the Medicaid agency's call center because of long wait times or limited access to a phone.
- They cannot readily access the documents they need to prove their eligibility.

Medicaid Eligibility Review Actions

Beginning in April, Medicaid enrollees will be subject to regular rules including responding to ongoing verification requests (i.e., an increase in income, returned mail, or household status) as well as completing the annual redetermination or renewal process.

Individuals in this group who do not respond to requests for information or who are determined to no longer qualify for coverage can be disenrolled or moved to a lesser-coverage category.

Individuals who remained open solely due to federal PHE maintenance of eligibility rules will be reevaluated when their scheduled annual redetermination is due. Individuals in this group cannot be closed or moved to a lesser-coverage category before their full redetermination process is completed.

It is anticipated that up to 500,000 Hoosiers who remained open in their current Medicaid category due to PHE policy changes will need to take action to keep their Medicaid eligibility.

FSSA Redetermination Efforts

- 12/23/22 Info postcards mailed; postcards reminding individuals to update their contact information and watch for and respond to mail from FSSA
- 02/28/23 Initial warning letters mailed
- 03/15/23 Renewal correspondence begins
- 04/30/23 First possible disenrollments
- 05/01/24 Return to normal operations complete for all members

Member Communications

- Explanation/reminder letter will be sent 60 days before the redetermination/renewal mailer is sent, including information on finding an Indiana Navigator and how to apply on the Marketplace (www.Healthcare.gov) if member is found ineligible for Medicaid.

- Redetermination mailer will be sent 45 days before redetermination due date.

- If a member is found to be ineligible during redetermination, a final warning of closure notice will be sent with appeal rights and instructions.

- Those who don't return the information can still come back into compliance within 90 days of due date and potentially regain eligibility without submitting a new application.

- Members who are subject to cost sharing (premiums, contributions, or copayments) will receive notice at least one month prior to the restart of cost sharing.

- Contribution/premium restart explanation notice will come from FSSA. Information and due date will also be sent the month before the first payment is due from the member's Managed Care Entity (for HIP) or the Premium Vendor (Children's Health Insurance Program/CHIP or M.E.D. Works).

- Cost-sharing will not resume any sooner than the first of the calendar quarter after the end of the continuous coverage requirement. The earliest cost-sharing will resume is July 2023.

TAKE ACTION

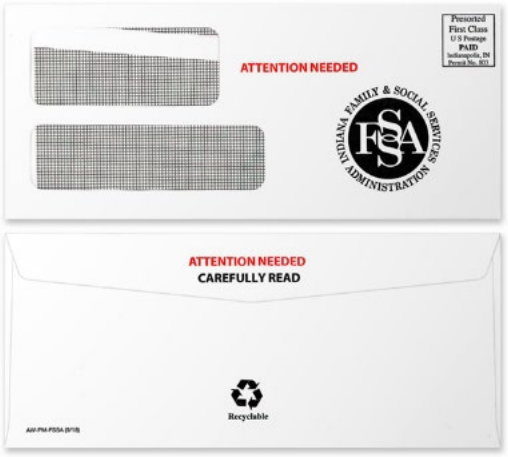
Don't Risk a Gap in Your Coverage

Anyone who is currently in one of Indiana Medicaid's health coverage programs, including the Healthy Indiana Plan, Hoosier Healthwise, or Hoosier Care Connect, should take action now to stay covered.

What You Can Do to Prepare:

- Update your contact information – Make sure FSSA has your current mailing address, phone number, email, or other contact information.

- Check your mail – FSSA will mail you a letter about your Medicaid or CHIP coverage. This letter will also let you know if you need to complete a renewal form to see if you still qualify for Medicaid or CHIP.

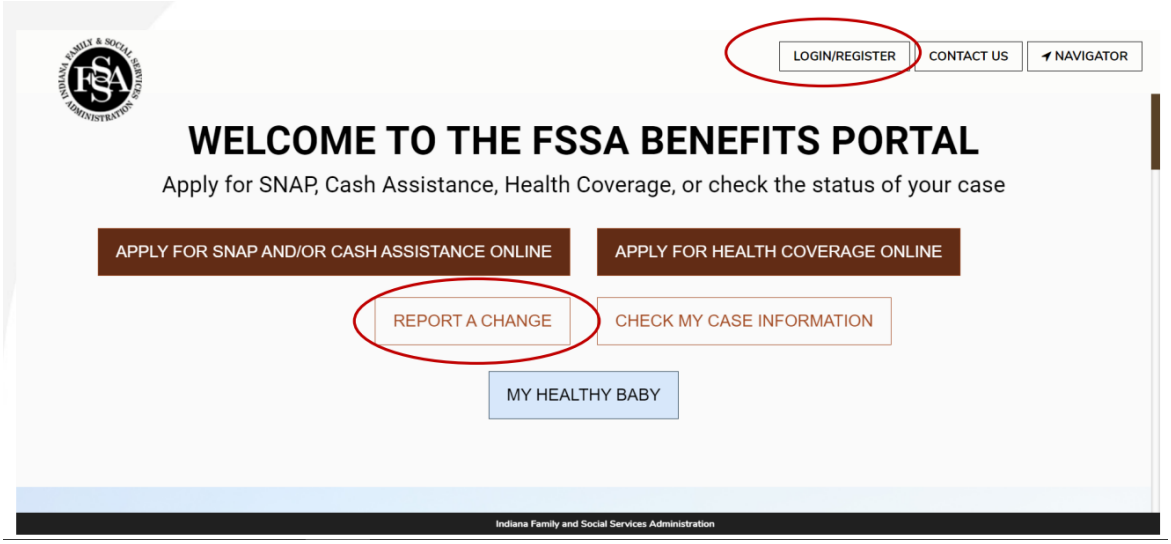


- Complete your renewal form – Fill out the form and return it right away to help avoid a gap in your Medicaid or CHIP coverage.

FSSA Benefits Portal

You can also verify or update your information online!

- Go to FSSABenefits.IN.gov
- Scroll to “Manage Your Benefits” section
- Click on either “Sign in to my account” or “Create account”



TRANSITIONING TO OTHER COVERAGE

Employer Coverage

Individuals who have an *affordable* offer of coverage from an employer that meets *Minimum Value* standards should seek out this option first. If their employer's coverage does not meet these standards, consumers should visit HealthCare.gov to review their options.

Affordable: The consumer's share of the monthly premium for the lowest-cost plan offered by the employer is less than 9.12% of their household income.

Minimum Value: A plan meets the Minimum Value standard if:

- It's designed to pay at least 60% of the total cost of medical services for a standard population.
- Its benefits include substantial coverage of physician and inpatient hospital services.

Employees should check with their employer to confirm their eligible timeframe for a special enrollment period following loss of Medicaid/CHIP. Typically, an employee will have 30 to 60 days to enroll in employer-sponsored insurance following the last day of other health coverage.

Marketplace

If an individual or family member is no longer eligible for Medicaid and does not have employer-sponsored health insurance or Medicare, individuals may be able to buy a health plan through the Health Insurance Marketplace and may also qualify for assistance with paying premiums and other cost-sharing savings.

Health Insurance Marketplace

Individuals who are over the income limit for Medicaid will have their information transmitted to the federal Marketplace (www.Healthcare.gov) and be given a Special Enrollment Period to apply for coverage there.

Those who are closed for failing to verify their income or other eligibility factors will be eligible to apply on the Marketplace at any time during 2023 as long as their income is under 150% of the federal poverty level.

Benefits of the Marketplace

- Protection. You cannot be denied or charged more for coverage based on your health history.
- Affordable. Financial assistance and cost sharing savings available. 4 out of 5 enrollees can find plans that cost less than $10 a month.
- Comprehensive benefits. All plans cover a comprehensive set of benefits, like doctor visits, emergency care, prescription drugs, maternity care, mental health, and more.

Visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596 to get details about Marketplace coverage. When you apply, don't forget to include current information about your household, income, and your state's recent decision about your Medicaid or CHIP coverage.

HealthCare.gov

MARKETPLACE SPECIAL ENROLLMENT PERIOD

CMS is announcing a Marketplace Special Enrollment Period (SEP) for qualified individuals and their families who lose Medicaid or CHIP coverage due to the end of the continuous enrollment condition, also known as "unwinding." This SEP, hereinafter referred to as the "Unwinding SEP," will allow consumers to enroll in Marketplace coverage outside of the annual open enrollment period.

CMS will update HealthCare.gov so that eligible consumers who submit a new application or update an existing application between **March 31, 2023, and July 31, 2024** and attest to a last date of Medicaid or CHIP coverage within the same time period, are eligible for the Unwinding SEP.

- Consumers will have 60 days after they submit their application to select a Marketplace plan.

- Coverage will start the first day of the month after plan selection. For example, if a consumer selects a plan on July 25, 2023, Marketplace coverage will start on August 1, 2023. If the consumer waits to select a Marketplace plan until after coverage has already ended, it would result in a gap in coverage.

Medicaid/CHIP Coverage End Date	Date of Marketplace Plan Selection	Marketplace Plan Effective Date
July 31, 2023	July 25, 2023 (before Medicaid coverage ends)	August 1, 2023
July 31, 2023	August 5, 2023 (after Medicaid coverage ends)	September 1, 2023

Consumers do not have to wait for their Medicaid or CHIP coverage to end before applying for Marketplace coverage. Consumers may report loss of coverage up to 60 days before their last day of Medicaid or CHIP coverage.

To help avoid gaps in coverage, CMS recommends that consumers submit a new application or update an existing application on HealthCare.gov as soon as possible once they are notified of loss of coverage.

Consumers will not be required to submit documentation of a qualifying life event to be eligible for the Unwinding SEP. Consumers will be required to attest to a loss of Medicaid or CHIP coverage as part of the application.

Medicare

Although HIP eligibility ends when a person turns 65, people have not been disenrolled from Medicaid due to aging out of the program during the pandemic. A person with HIP coverage who turned 65 between March 2020 and March 2023 was not disenrolled from Medicaid unless they requested disenrollment or moved out of the state. These individuals will now be able to transition to Medicare and will have a special enrollment period (SEP) that will allow them to do so without any late enrollment penalties.

The SEP begins when the person is notified that they're no longer eligible for Medicaid and continues for six months after Medicaid ends. People who use this SEP have an opportunity to have their Medicare coverage begin retroactively back to the day after their Medicaid ended, although Medicare premiums would also have to be paid back to that date.

Individuals who still are eligible for Medicaid, including a Medicare Savings Program, and have not received notice of an upcoming Medicaid termination are not eligible for this SEP.

Hoosiers over 65 should look into health coverage through the federal Medicare program at www.Medicare.gov or by calling 800-MEDICARE. Indiana's State Health Insurance Program can also help with any questions about Medicare. Find them online at www.medicare.in.gov or call 800-452-4800.

HIP WORKFORCE BRIDGE

IHCP is introducing HIP Workforce Bridge, a new program available to HIP members who lose their eligibility solely due to exceeding the HIP program income limits. This new program will be effective the month following the end of continuous enrollment provisions and return to normal eligibility review processes. The first opt-in offer letters will be sent to eligible individuals in April 2023, and the first accounts can be awarded effective May 1, 2023.

HIP Workforce Bridge is a $1,000 account that can be used for up to 12 months. The account funds can serve as a stand-alone when in the waiting period for insurance or as a payment for copays, coinsurance, and deductibles for a primary policy. HIP Workforce Bridge participants may use their account to pay for premiums for employer or individual insurance policies. When the member has other insurance, the HIP Workforce Bridge account is the payer of last resort, and all other coverage should be billed as primary.

HIP members who qualify will become conditionally eligible for HIP Workforce Bridge and will receive an opt-in letter. To participate in the HIP Workforce Bridge account, the HIP members must respond to the opt-in letter within 30 days. HIP Workforce Bridge benefits will be administered via the fee-for-service (FFS) delivery system and will only cover IHCP-covered services. After opting in, the member receives a HIP Workforce Bridge ID card; and their HIP Workforce Bridge account is active the 1st day of the month following the end of HIP benefits.

HIP Workforce Bridge accounts cannot be used to pay for Personal Wellness and Responsibility (POWER) Account contributions, HIP Fast Track payments, or Medicaid copayments.

Eligibility Verification System

In addition to the member's eligibility, the member's HIP Workforce Bridge account balance will be reported in the following systems:

- IHCP Provider Healthcare Portal
- Interactive Voice Response System
- 271 Health Care Eligibility Benefit Response transaction

A balance in the account when the claim is submitted does not guarantee payment as claims are paid on a first-in, first-out basis.

HOW YOU CAN HELP

Conduct outreach to help prepare Medicaid members and their loved ones. For many Medicaid enrollees, outreach from trusted community-based organizations may be the only way they will find out about the steps they need to take to keep their Medicaid coverage or move from Medicaid to another form of coverage.

Provide support.

- Consumers can often feel overwhelmed or confused by language used within FSSA letters and may need help with understanding next steps.
- If enrollees are no longer eligible for Medicaid, they may be eligible for free or low-cost health insurance on the Marketplace and may need specialized guidance to enroll.
- Partner with CKC-IN and our team of Indiana Certified Navigators who can offer in-depth assistance.

Indiana Rural Health Association Contact Information

Connect with a CKC-IN Navigator today!

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For additional program information and services; educational workshops, or to request a presentation for your organization or event, please contact Ann McCafferty, IRHA Program Director.