April 29, 2020

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

The Honorable Steny Hoyer
House Majority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Anna Eshoo
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone Jr.
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The undersigned fifteen local public health plans serve nearly 6.5 million Medicaid beneficiaries throughout California. Established over 25 years ago, these plans collectively cover approximately 70% of the state's managed care beneficiaries, making the local health plans' delivery system the largest community-based, not-for-profit, and publicly accountable one in the nation.

As a result of the extraordinary consequences of the COVID-19 national emergency, we know the impacts of the pandemic will most certainly result in a significant increase in Medicaid enrollment, further straining every state's budget over the next two years, if not longer.

Our experience during the financial crisis of 2008-2011, where over the two-and-a half-year period, the American Recovery and Reinvestment Act provided for $98 Billion in direct fiscal relief, leads us to believe that the following steps, taken in concert will help Managed Care Organizations, Medicaid beneficiaries, and safety net plans across the country.

Stable Medicaid Funding

Increase the federal share of Medicaid spending and to commit to at least a two-year period of federal Medicaid funding for states.

Because of COVID-19, states will experience large declines in revenue as the needs for services, including Medicaid, will significantly increase. As we learned from the last recession, state revenues dropped significantly while spending growth continued, resulting in large budget gaps. Not surprisingly, states are already estimating significant revenue declines and unemployment estimates that could easily exceed those experienced during the last recession.

Based on analysis of the provisions included in the 2009 American Recovery and Reinvestment Act (ARRA) to fund a temporary increase in the Federal share of Medicaid costs, as well as Medicaid enrollment trends, we calculated an inflation-adjusted, per-enrollee amount of funding currently needed. We then applied this to recent estimates from Health Management Associates (HMA) that predict a national increase in Medicaid enrollment from the current 71 million beneficiaries to 82 to 94 million beneficiaries as a result of growth in unemployment[i]. We found that between $167.6B and $192.1B in funding is needed to sustain the Medicaid program at the state level in the midst of the COVID-19 pandemic and the resulting recession.

The COVID-19 health crisis will increase demands on Medicaid. By picking up a larger share of the costs of Medicaid, the federal government can make sure that state budget decisions do not constrain the health response by the states and ensure that increased Medicaid costs do not force states to cut spending in other areas (e.g.,

education or public safety) in ways that could contribute to a further economic downturn or even cause a delay of economic recovery.

Medicaid Fiscal Accountability Proposed Rule (MFAR)

The Medicaid Fiscal Accountability Proposed Rule must not be finalized during the COVID-19 crisis. In fact, due to the devastating financial impact on states that the Rule would have, we contend the proposed rule be suspended until more analysis is done by CMS to understand the policy and financial impacts the proposed rule would have on states and in particular, the Medicaid delivery system and beneficiaries.

In November, 2019 CMS released the MFAR which would reduce the amount of funding provided to states as part of their Medicaid matching funds when the funding is generated through various supplemental means (e.g., provider taxes, intergovernmental transfers). Many states use supplemental funding mechanisms to provide the non-federal share of some of its Medicaid funding.

Moving forward without this information is dangerous to the efficiency and operation of any Medicaid program, and jeopardizes beneficiary services. Prior to the COVID-19 crisis, it was estimated that millions of patients could lose access to care in public health care systems alone, and project that many public health care systems could not be financially stable and thus would have to close.

For nearly all states, the reductions that would result from MFAR could unquestionably mean cuts in Medicaid program enrollment and covered services. The impact in some states could be catastrophic on state Medicaid funding and ultimately reduce access to critically needed health services for Medicaid beneficiaries.

Cease Implementation of the Public Charge Rule (Rule)

The Public Charge Rule should be fully suspended until the COVD-19 emergency has subsided.

On February 23, 2020 the U.S. Supreme Court removed the remaining Public Charge injunctions, allowing the policy to go into full effect on February 24, 2020. As you know, the Public Charge rule makes immigrants who receive non-cash public benefits, such as Medicaid, food assistance, and housing assistance potentially ineligible for green cards and visas.

Not surprisingly, the Public Charge has created an environment of fear throughout immigrant communities who were already wary of accessing health care coverage, long before the Rule went into place. In December 2018, the Urban Institute conducted a survey on non-elderly adults in immigrant families and found that one in seven did not participate in non-cash government benefit programs because of their fear of harming their or their families green card application.

As an effective public health response, it is vital that the federal government fully suspend the Public Charge rule for the duration of the emergency, at a minimum.

Presumptive Eligibility

Extend Presumptive Eligibility (PE) to all applicants that appear to be Medicaid eligible (based on initial income screening by a qualified entity); expand the types of entities qualified to perform PE screening; allow qualified entities to utilize online/telephonic applications and online/telephonic signatures for PE applications; and disallow any maximum limitation amounts that would prohibit a person from applying for PE more than once in a twelve-month period.

Presumptive Eligibility (PE) is a Medicaid policy option allowing states to authorize specific types of entities (e.g., federally qualified health centers, hospitals, and schools) to screen eligibility based on income and temporarily

enroll them in Medicaid coverage while their full enrollment application is being considered. The goal of PE is to provide short-term coverage of health care services for those with limited incomes, who appear to be eligible for Medicaid, but not currently enrolled. This allows those individuals to receive much needed medical care, while they complete the full Medicaid application and allow counties to conduct the enrollment process. Because of the potential Medicaid application backlog, we believe counties may experience challenges with processing all of the applications in a timely manner. Thus, we are asking that the federal government allow PE for a period of 90 days while counties and the Medicaid applicants complete the enrollment process, and to allow for extensions if counties are experiencing delays in processing Medicaid applications.

Presumptive Eligibility is a powerful tool in ensuring that, as people lose individual or employer coverage during this pandemic and appear to be income-eligible, they are able to receive services via Medicaid without having to wait weeks or even months to complete the Medicaid enrollment process before receiving services.

As they have since the earliest days of Medicaid managed care, the local health plans continue to serve Medicaid beneficiaries in close partnership with their community safety-net partners. The undersigned public plans are prepared to provide expertise, data and ideas as you consider various issues to be addressed in the next relief package. We stand ready to work with you to craft solutions that will ensure the solvency of the Medicaid program during and after this national emergency. These are trying and uncertain times for all Americans, and more so for our most vulnerable. Taking the above steps will result in better health care outcomes for the members of our communities and for the nation as a whole.

Sincerely,

Scott E. Coffin
Chief Executive Officer
Alameda Alliance for Health

Gregory Hund
Chief Executive Officer, CalViva Health
Fresno-Kings-Madera Regional Health Authority

Bob Freeman
Chief Executive Officer
CenCal Health

Stephanie Sonnenshine
Chief Executive Officer
Central California Alliance for Health

Norma Diaz
Chief Executive Officer
Community Health Group

Sharron Mackey
Chief Executive Officer
Contra Costa Health Plan

Margaret Tatar
Interim Chief Executive Officer
Gold Coast Health Plan

Michelle Tetreault
Interim Chief Executive Officer
Health Plan of San Joaquin

Maya Altman
Chief Executive Officer
Health Plan of San Mateo

Jarrod B. McNaughton
Chief Executive Officer
Inland Empire Health Plan

Douglas A. Hayward
Chief Executive Officer
Kern Health Systems

John Baackes
Chief Executive Officer
L.A. Care Health Plan

Elizabeth Gibboney
Chief Executive Officer
Partnership HealthPlan of California

John F. Grgurina, Jr.
Chief Executive Officer
San Francisco Health Plan

Christine M. Tomcala
Chief Executive Officer
Santa Clara Family Health Plan

[i] https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf