July 30, 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 16 local public health plans serve over 7.3 million Medicaid beneficiaries throughout California. Established more than 25 years ago, these plans collectively cover over 70 percent of the state's Medicaid managed care beneficiaries, making the local health plans the largest community-based, not-for-profit, and publicly accountable delivery system in the nation.

We applaud the efforts of Congress to date to support low-income Americans and the health systems that serve them during the COVID-19 pandemic. We write now to encourage you to take additional needed actions to ensure these same individuals, often from low-income communities of color, continue to receive access to the health care they need and deserve.

As a result of the extraordinary consequences of the national emergency, the impacts of the pandemic are expected to increase Medicaid enrollment throughout the country, further straining every state's budget over the next two years, if not longer.

During the financial crisis of 2008-2011, the 2009 American Recovery and Reinvestment Act (ARRA) provided for $98 billion in much-needed direct fiscal relief over the two-and-a half-year period. We believe that the following steps, taken in concert, will help Managed Care Organizations, Medicaid beneficiaries, and safety net plans across the country maintain stability during this recession.

Stable Medicaid Funding

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

Because of the pandemic, states will experience large declines in revenue just as the need for services, including Medicaid, will significantly increase, 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 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 $167.6 and $192.1 billion in funding is needed to sustain the Medicaid program at the current level in the midst of the pandemic and the resulting recession.

The national health crisis also will increase demands on Medicaid utilization. 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 needed by the states to address the pandemic. It will also 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

Suspend the proposed Medicaid Fiscal Accountability Proposed Rule (MFAR) during the COVID-19 pandemic, and wait for further analysis from the Centers for Medicare & Medicaid Services to understand the devastating impact MFAR will have on millions of Americans.

In November 2019, the Centers for Medicare & Medicaid Services (CMS) released the Medicaid Fiscal Accountability Proposed Rule (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.

MFAR must not be finalized during the pandemic. 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. It is vital that the policy and financial impact the proposed rule would have on states and in particular, the Medicaid delivery system and beneficiaries be fully understood. Moving forward without this information is dangerous to the efficiency and operation of any Medicaid program, and it jeopardizes beneficiary services. Prior to the pandemic, it was estimated that the enactment of MFAR would cause millions of patients to lose access to care in public health care systems alone, and it was projected that many public health care systems would not be financially stable and thus would have to close.

For nearly all states, the reductions that would result from MFAR would unquestionably mean cuts in Medicaid program enrollment and 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.

Telehealth Services

Make permanent the temporary changes to the telehealth provisions implemented in response to the pandemic that expanded access to critically needed care to hundreds of thousands of patients.

Under your leadership, the pandemic response packages have made important strides toward ensuring patients can access covered services via telehealth technology. In part, because of these regulatory and statutory changes, telehealth usage has increased significantly. Although provider visits dropped dramatically at the beginning of the stay-at-home orders, the quick conversion to telehealth and telephonic visits allowed providers, particularly health centers, to rebound quickly – keeping providers and their office staff safe and leaving no gap in care. The increased use of telehealth video and telephone calls have proven to be key in limiting the spread of the virus by keeping people at home, when appropriate, and providing access to those with mobility issues.

It is important that patients do not lose access to telehealth services after the pandemic ends and to ensure our nation is truly prepared for any future public health emergencies. We encourage Congress to advance telehealth and telephonic policies and payment reform in both Medicaid and Medicare programs. It is also evident that telehealth has removed barriers to treatment for our members, especially in behavioral health.

Suspend Implementation of the Public Charge Rule

Fully suspend the Public Charge Rule (Rule) 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. The Public Charge rule makes legal 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 Rule 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 it would impact their green card application.

As an effective public health response, it is vital that the federal government fully suspend the 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 who appear to be eligible for Medicaid but are not currently enrolled. This allows those individuals to receive much needed medical care while they complete the full Medicaid application and counties to conduct the enrollment process. The expected influx of Medicaid applications could prove challenging for counties to process 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 allow for extensions if counties are experiencing delays in processing Medicaid applications.

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 California 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 vulnerable 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

Michael Schrader
Chief Executive Officer
Health Plan of San Joaquin

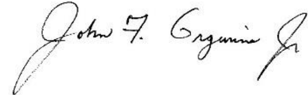
Maya Altman
Chief Executive Officer
Health Plan of San Mateo

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

Richard Sanchez
Interim Chief Executive Officer
CalOptima

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