

**Long-Term Modernization of Medicaid Redeterminations of Eligibility: An Analysis of
State and Federal Public Policy Solutions**

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Submitted to the Graduate Faculty of the
Department of Health Policy and Management
Graduate School of Public Health in partial fulfillment
of the requirements for the degree of
Master of Health Administration

University of Pittsburgh

2022

UNIVERSITY OF PITTSBURGH
GRADUATE SCHOOL OF PUBLIC HEALTH

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2022

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University of Pittsburgh, 2022

Abstract

The negative economic effects of the COVID-19 Pandemic coupled with a state requirement for continuous enrollee coverage through the duration of the Public Health Emergency (PHE) have caused Medicaid program enrollment to swell to record levels. When states are permitted to restart Medicaid redeterminations of eligibility at the conclusion of the PHE, most enrollees will need to renew coverage, and estimates place up to 15 million at risk of coverage loss. Over the course of the pandemic, many Medicaid program enrollees experienced a positive change in income, and thus are no longer eligible for coverage. However, millions more will be at risk for improper coverage terminations due to state procedural and administrative factors, including current staffing issues and rushed processes. Medicaid is jointly run by states and the Federal Government, and states have struggled to successfully implement the provisions related to streamlining and modernizing redeterminations procedures mandated by the Patient Protection and Affordable Care Act of 2010. Because of these struggles and other state barriers to redeterminations, Medicaid enrollees have traditionally faced an uphill battle to renew coverage. Renewal difficulties disproportionately affect Black and Latino populations, causing coverage loss known as “churn” and decreasing access to care. Federal and state policymakers should consider policy implementations to mitigate the negative public health effects of churn caused by the redeterminations process. One approach could be the adoption of a state facilitated enrollment and renewal program via a CMS demonstration waiver, partnering Managed Care Organizations with

states to support enrollee outreach and information gathering efforts. A second option could involve state data infrastructure enhancements and adherence to best practices to improve initial enrollee eligibility verifications known as “ex parte” reviews. Finally, states should implement CMS-proposed policy and operational strategies to ensure streamlined renewals. Policymakers should be aware of unique state redeterminations procedures and recognize the political willingness of states to adopt improvements designed to coverage retention. The PHE “unwinding” presents an opportunity of public health significance to solve long-standing Medicaid redeterminations process issues and thus address key disparities in access to affordable preventative care and chronic condition treatment for America’s most vulnerable individuals.

Table of Contents

1.0 Overview	1
2.0 Introduction.....	4
2.1 Medicaid Program and Eligibility Basics.....	4
2.2 Program Effectiveness, Outcomes, and Public Health Successes	6
2.3 Medicaid and the COVID-19 Pandemic.....	8
3.0 Medicaid Redeterminations of Eligibility and Barriers to Renewal	10
3.1 Redeterminations Process and Implications on Coverage and Care.....	10
3.1.1 Legal Authority and State Requirements	10
3.1.2 Variation in State Redeterminations.....	12
3.1.3 CMS Guidance to States on Redeterminations and the PHE Unwinding ...	12
3.2 Medicaid Churn.....	15
3.3 Barriers to Medicaid Renewal and Continuous Coverage	17
3.3.1 Paperwork and Address-Related Barriers to Renewal	18
3.3.2 Timing, Confusion, and State Consumer Support Barriers to Renewal	20
3.3.3 Non-Seamless Program Transition Barriers	22
4.0 Policy Implementations to Improve Medicaid Redeterminations.....	23
4.1 Overview of State Policy Implementations	23
4.2 Managed Care Facilitated Enrollment and Renewal.....	24
4.2.1 Facilitated Enrollment and Renewal Authority	25
4.2.2 Demonstration Waivers	25
4.2.3 Recommended Program Structure and Key Restrictions	26

4.2.4 Facilitated Enrollment and Renewal Program Advantages	28
4.2.5 Facilitated Enrollment and Children’s Public Health Insurance in New York City	29
4.2.6 Potential CMS Actions to Encourage Models	31
4.3 State Data and Infrastructure Enhancements to Improve the Ex Parte Renewal Process	32
4.3.1 Data Source Requirements and Improvement Strategies	34
4.3.2 Principles for Ex Parte Renewal Success	36
4.3.3 Best Practices When Renewals Cannot be Completed Via Ex Parte	37
4.4 CMS Policy Proposals and Strategies to Improve Redeterminations	38
4.4.1 Strengthening the Ex Parte Renewal Process.....	38
4.4.2 Updating Mailing Addresses to Minimize Returned Mail	38
4.4.3 Improving Consumer Outreach, Communications, and Assistance	39
4.4.4 Promoting Seamless Coverage Transitions	40
4.4.5 Addressing Strains on Eligibility and Enrollment Workforces	40
4.4.6 Enhancing Oversight of Operations	41
4.4.7 Implementation Considerations.....	41
5.0 Political Issues and Considerations	43
5.1 Administrative Actions	43
5.2 State Actions and Preparation Concerns	45
5.3 Implications of Federal Legislative Proposals	50
6.0 Conclusions.....	52
Bibliography	55

List of Figures

Figure 1. Percentage of Arkansas Medicaid Enrollees Case Closure by Reason, June 2018.	
.....	19
Figure 2. States by Share of Renewals Able to be Completed Using Automated, Ex Parte	
Process.....	33

1.0 Overview

The adverse health and economic effects of the COVID-19 pandemic triggered Congressional action to safeguard health care coverage for those who faced financial difficulty during the pandemic through the Families First Coronavirus Response Act (FFCRA). In order to receive a temporary enhancement of Federal Medical Assistance Percentage (FMAP) funds during the COVID-19 pandemic, FFCRA required states to maintain the enrollment of Medicaid program beneficiaries enrolled or determined eligible on March 18, 2020 through the end of the month in which the COVID-19 Public Health Emergency (PHE) ends. Prior to this requirement, states conducted yearly evaluations of beneficiary eligibility status for the Medicaid program and were able to terminate beneficiaries from coverage due to state and federal eligibility requirements. While it is not currently known what percentage of Medicaid recipients are incorrectly removed from the program due to eligibility redeterminations policies, as compared to removals for legitimate income and asset reasons, Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of disenrollment rates in 2018 found that in states providing data, 8% of all Medicaid and CHIP beneficiaries disenrolled and re-enrolled in the program within 12 months, or approximately 10 million individuals. This may indicate improper terminations or flawed renewal processes, particularly in states with higher-than-average disenrollment and re-enrollment rates.¹

During the pandemic, the PHE has been extended continuously and quarterly since January 31, 2020.² HHS Secretary Xavier Becerra recently issued a 90-day renewal of the PHE, now set to expire in July, 2022. While the termination of the PHE may come as soon as July, the Administration has maintained that states will have at least a 60-day notice prior to PHE termination. Barring legislative intervention, at this time the enhanced federal funding will expire

as projected, and states may resume renewals and redeterminations of eligibility for almost the entirety of the Medicaid-enrolled population of 80 million Americans. States are allotted 14 months to complete all necessary and pending redeterminations, yet the pandemic-related enrollment increases present a massive task for the Medicaid agencies charged with renewal duties. Indeed, The Centers for Medicare & Medicaid Services (CMS), the government agency that works in partnership with states to regulate Medicaid programs, recently noted that, “The end of the continuous enrollment requirement for states receiving the temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase...presents the single largest health coverage transition event since the first Marketplace Open Enrollment following enactment of the Affordable Care Act.”³

Due to changing circumstances, including resumption of employment, many current enrollees have become ineligible for the income and asset requirements of the Medicaid program over the course of the pandemic. When renewals begin post-PHE, this ineligible population will be removed from state Medicaid rolls and ideally transitioned by the state (as mandated under FFCRA) to a more appropriate form of coverage for their eligibility status, including to the state’s health insurance exchange. However, policymakers, researchers, states, advocates, and others have raised concerns over coverage losses during the post-PHE redeterminations process for those who are properly eligible for Medicaid coverage.^{4,5}

While it is difficult to delineate the percentage of current Medicaid enrollees who will lose coverage due to state procedural and policy reasons compared to the percentage of those who will lose coverage due to income and asset level change during the pandemic, estimates of the total Medicaid population who is at risk to lose coverage range from 10 to 15 million individuals.^{6,7} This significant potential for coverage losses will affect the health outcomes of a vulnerable,

predominantly Black and Latino population of individuals. The potential losses are at least partly due to procedural reasons, including state administrative burden and lack of effective enrollee communications. These issues with the Medicaid redeterminations process and the barriers to successful renewal are not novel. The issues, barriers, and challenges have plagued the program for years, and without lasting and impactful policy change, each month there is an ever-present risk for many eligible individuals to lose coverage and enter the dangerous “churn” cycle of coverage loss and gain. This essay will discuss the dangers of churn and coverage loss from redeterminations barriers on the vulnerable Medicaid population.

Long-term solutions are required and will be reviewed in this essay to solve or at least mitigate many of these challenges. In addition to a variety of CMS-proposed policy solutions and state strategies, two main solutions – the implementation of a state facilitated enrollment and renewal program model and state IT and data infrastructure upgrades – will be presented and discussed. These solutions were chosen due to the ambitious and targeted nature of assistance they offer to the challenges faced by the consumers and states that must undergo redeterminations. Further, both federal and state political considerations with redeterminations improvement policy will be addressed to discuss the feasibility of lasting, impactful process change.

2.0 Introduction

2.1 Medicaid Program and Eligibility Basics

The U.S. Medicaid program is a means-tested health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). The Medicaid program represents a state and federal collaboration between a network of individual state programs that are established and administered under broad guidelines that include statutes, regulations, and policies.⁸ Although the base-level program guidelines are set by the federal government, specific requirements, program design, benefits and eligibility factors vary by state.⁹ A recent (September 2021) national estimate places over 84.8 million individuals enrolled in both the Medicaid and Children's Health Insurance Programs (CHIP), with the large majority of individuals enrolled in the Medicaid program.¹⁰ Medicaid benefits are paid either directly to providers by the state (known as fee-for-service), through state monthly payments to Managed Care Organizations (MCOs) that in turn pay providers, or through a combination of both payment methods. According to MACPAC, in 2019 about 70% of Medicaid program beneficiaries were enrolled in an MCO health plan.¹¹ Notably, Medicaid is the “single largest source of health coverage in the United States” and, “the nation’s largest payer of mental health services, long-term care services, and births.”⁸

The Medicaid program is jointly funded in a collaboration between federal and state governments. The Federal Medical Assistance Percentages (FMAPs) determine the amount of state expenditures that the federal government “matches” with payments. FMAPs are calculated by The Department of Health and Human Services (HHS) on a yearly basis.¹² For fiscal year 2022,

state FMAP percentages range from 56.20% in 12 states to 84.51% in Mississippi, figures that include the conditional 6.2% increase allocated to states for the duration of the PHE.¹³

To enroll in Medicaid services, an individual must meet strict requirements and rules set by the state in which they reside. These state-specific rules must, at minimum, follow federal laws, although states have the ability to add supplemental services and benefits, and/or to relax certain standards. For instance, states cannot cover fewer eligibility groups than are established under federal law, however they may augment these eligibility groups to provide additional coverage. Currently, the Medicaid program in each state serves the following populations and broad eligibility groups: children and adolescents, parents or caretaker relatives of minor children, certain people with disabilities or blindness, pregnant women, seniors, and youth aging out of foster care.

Within these broad eligibility groups, there are additional federal financial requirements most individuals must meet to enroll in coverage. The current financial requirements on income and asset limits were established under the Patient Protection and Affordable Care Act (PPACA) of 2010.¹⁴ The PPACA afforded states the opportunity to expand their Medicaid programs to cover significant portions of low-income individuals under the age of 65. For adults, states were given the option to receive higher levels of federal funding if they expanded eligibility to adults with income levels at or below 133% of the federal poverty line (FPL). Since the option was established, thirty-eight states have decided to expand Medicaid to cover an expanded population.¹⁵

The PPACA additionally established a methodology for calculating income eligibility for Medicaid, based on an individual's Modified Adjusted Gross Income (MAGI). MAGI determines both the program eligibility of the individual as well as the amount of premium tax credits and cost sharing reduction allotted to the enrollee to assist with the cost of health care coverage. Certain exceptions apply to the MAGI method of calculation, including those who are part of certain

disabled or age groups. Further, other groups of beneficiaries, for example young adults who have recently aged out of the foster care system, are exempt from income determinations and are eligible for Medicaid regardless of income and asset level. In addition to financial eligibility requirements, individuals enrolling in Medicaid must meet requirements for immigration status and citizenship, as well as state residency.¹⁴

2.2 Program Effectiveness, Outcomes, and Public Health Successes

The effectiveness and outcomes of the Medicaid program can be seen by comparing beneficiary data in states that expanded Medicaid under the provisions of the PPACA to those in states that did not expand. Medicaid expansion is a key component of increased access to care for low-income populations both during the pandemic and after the PHE expires. Sommers et. al. (2016) discuss the effects and impacts of Medicaid expansion under the PPACA on beneficiaries, focusing primarily on the program expansion designs of Kentucky and Arkansas.¹⁶ Kentucky's Medicaid program and Arkansas's "private option" were associated with significant increases in outpatient utilization, preventive care, and improved health care quality; reductions in emergency department use; and improved self-reported health. These beneficiary outcomes are positive when compared to Texas, a state which has not adopted Medicaid expansion.

Research has widely established that the greater health coverage and access to medical care that Medicaid affords improves outcomes for program enrollees. Literature demonstrates that beneficiaries of Medicaid in expansion states use their coverage to obtain cancer screenings, necessary prescription drugs, and treatment for chronic health conditions.¹⁷ Access to care leads to better public and population health outcomes¹⁸ including improvements in self-reported health,

decreases in the share of low-income adults screening positive for depression, and fewer premature deaths. Further, a joint study from the University of Michigan, NIH, and UCLA shows that Medicaid expansion saved the lives of at least 19,200 adults aged 55 to 64 from 2014 to 2017.¹⁹

Importantly, Medicaid expansion has helped narrow racial and ethnic disparities in health coverage and access to care. Medicaid coverage plays a role in protecting minority populations from the adverse effects of recessions and economic downturn.¹⁸ Cross-Call and Broadus (2020) note, “Racism, economic and health system inequities, limitations on immigrants’ eligibility for Medicaid and other public health coverage, and numerous other factors have resulted in longstanding, harmful racial disparities in coverage and access to care. Those disparities, while still significant, have narrowed since the PPACA’s major coverage provisions took effect in 2014.” The gap in uninsured rates between white and black adults shrank by 51% in expansion states since PPACA took effect, compared to 33% in non-expansion states. Similarly, the gap between white and Hispanic adults shrank 45% in expansion vs 27% in non-expansion states. The PPACA and associated Medicaid expansion helped narrow racial disparities in those not seeking care due to cost, a significant obstacle to accessing care.²⁰

Access to quality, affordable health care has never been more important than during the months since March 2020. Throughout the ongoing COVID-19 pandemic, infection rates and deaths in most states are higher among those who are Black and Hispanic, American Indian and Native Alaskans. Two contributing factors (but certainly not the only contributing factors) to the increased prevalence of adverse health effects and economic disruption among these racial groups are higher levels of comorbidities and living/working conditions non-conducive to social distancing.²¹ Despite the positive influences of Medicaid expansion, the pandemic demonstrates

that increased access does not eliminate disparities but can help lessen the effects of these disparities and improve health outcomes for millions of Americans.

2.3 Medicaid and the COVID-19 Pandemic

As noted, current Medicaid program enrollment stands at approximately 84.8 million low-income American adults and children. The PPACA drove many of these coverage increases and, in turn, produced positive health benefits for low-income and medically vulnerable individuals and families.⁸ The present (September 2021) level of reported enrollment represents a 19.1% increase from enrollment in February 2020, prior to the COVID-19 pandemic.¹⁰ The enrollment jump reflects economic trends during the pandemic – including widespread job and income loss, driving millions to fall into the income eligibility categories of Medicaid. Enrollment increases also reflect certain provisions in FFCRA that allow states the ability to access a temporary 6.2% increase in federal matching rates with the requirement that states offer continuous coverage to current Medicaid enrollees.¹⁰

The PPACA gave states the option to expand Medicaid, and as of 2022, 12 states have chosen not to expand Medicaid coverage. While budgetary pressures are often cited as a reason for non-expansion, state political ideologies may additionally play a role in the decision whether to expand Medicaid or not – Medicaid is a key social safety net program, and can be used as an measure to score political points with voters.²² States that previously expanded Medicaid are better positioned to respond to the health coverage losses of the COVID-19 pandemic and ensure residents have continuous, uninterrupted access to health care.¹⁸ These expansion states entered the pandemic with lower rates of uninsured individuals who may forego testing and treatment for

COVID-19 and related illnesses due to affordability concerns. Lack of access to testing and treatment may contribute to the spread of the virus throughout the state, exacerbating public health resource concerns. The Center for Budget and Policy Priorities, a nonpartisan think tank focused on budgetary policy, estimates that at least four million uninsured adults would become eligible for Medicaid coverage if the remaining 12 states that have yet to expand Medicaid under the PPACA opted for expansion. In 2018, the uninsured rate among low-income, non-elderly adults in expansion states was 17%, about half of the 32% in non-expansion states. This includes 650,000 currently uninsured frontline workers, who have higher-risk jobs and positions that often require them to attend work regardless of lockdowns or stay-at-home orders. Prior to the COVID-19 pandemic, the uninsured rate for low-income workers in frontline positions was 30% in non-expansion states (double the rate of expansion states).¹⁸

Further, a recent study examined the association of unemployment and Medicaid enrollment during the pandemic.²³ The results indicate that just 15% of unemployed people in North Carolina (a non-expansion state) gained Medicaid coverage during the pandemic. Thus, Medicaid was unable to fulfill an important countercyclical role of providing temporary health coverage during a period of economic downturn. Importantly, the study's authors contribute much of this failure to North Carolina's stringent eligibility criteria. Increasing critical access to quality, affordable health care through adoption of Medicaid expansion in holdout states and program eligibility relaxations can help prepare for next pandemic or public health crisis.

3.0 Medicaid Redeterminations of Eligibility and Barriers to Renewal

3.1 Redeterminations Process and Implications on Coverage and Care

The process of Medicaid redeterminations of eligibility itself can present a substantial barrier to sustained individual health care coverage and thus access to affordable care. The PPACA took steps to mitigate inappropriate coverage losses from redeterminations (referred to as terminations) with policies to streamline renewals via online portals and processing, as well as state mandates for enhanced communications to beneficiaries undergoing redeterminations.²⁴ Many states promptly implemented these improvements to comply with federal regulations, however, significant challenges and issues remain throughout the nation. Due to these longstanding challenges, the end of the PHE will pose a newfound threat to coverage because of the high number of individuals that must undergo redeterminations simultaneously.⁶

3.1.1 Legal Authority and State Requirements

Redeterminations, legally established under 42 CFR § 435.916 describe the periodic renewal of an enrollee's Medicaid eligibility.²⁵ These renewals pertain mainly to individuals whose eligibility is based on MAGI methods and take place once every twelve months (and not more frequently than once every twelve months) as stipulated in the PPACA. Non-MAGI populations, those who are aged or blind or disabled with Medicare, were not included in the PPACA's Medicaid expansion categories and operate under the eligibility and renewal guidelines in place prior to the PPACA. 42 C.F.R. §435.916(b) stipulates that renewal of non-MAGI individuals

requires the Medicaid agency to redetermine eligibility for circumstances that may change, at least once every twelve months. During the redeterminations process for MAGI enrollees, the state Medicaid agency first conducts an “ex parte” review of eligibility on behalf of the enrollee. These ex parte reviews are based on available data and information and do not require the state to engage with the enrollee unless there is information that is missing, incomplete, or out-of-date. If the state Medicaid agency can renew eligibility on an ex parte basis using available data, it must notify the individual of eligibility determination.

However, if the agency cannot automatically renew an individual’s eligibility with the materials at its disposal, a situation that according to KFF occurs in anywhere from below 10% to above 75% of cases, depending on the state,²⁶ it must send the beneficiary a pre-populated renewal form with all available information. Upon receipt, the beneficiary is granted at least 30 days to respond back to the state with necessary or lacking information through any mode of submission allowable, including online, paper, telephone, and in-person modalities. If that deadline is missed, the state must reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit, if the individual subsequently submits a renewal form within 90 days after date of termination or longer as allowed by the state.²⁷

The specific requirements and criteria for renewal vary by state, similarly to the requirements of initial eligibility for enrollment. In expansion states, the median eligibility income limit for all non-elderly adults is 138% FPL, and in non-expansion states, the median eligibility income limit is 41% FPL. Additionally, there are more restrictive eligibility standards for adults with disabilities regardless of income level. Restrictive eligibility criteria entails that small (frequently temporary) increases in income can lead to a loss of Medicaid eligibility.⁴ In addition to yearly renewals, enrollees must also report changes that effect their eligibility. States may also

conduct periodic checks of eligibility, outside of regularly scheduled renewals, via data sources available. In 2020, thirty states checked data periodically, however, at least five states have discontinued the practice during the PHE.⁴

3.1.2 Variation in State Redeterminations

In addition to variation in eligibility criteria, there is wide state enrollment and renewal *process* variation. A 2020 KFF survey of states, providing recent information on enrollment and renewal process variation, shows that all states have implemented more streamlined enrollment and renewal processes as required by the PPACA, regardless of expansion status. These improvements include the presence of online applications in all 50 states.²⁴ According to the survey, a majority of states have phone application capability and can complete real-time determinations within 24 hours and most can complete automated renewals (47 states). Additionally, at least 22 states are able to complete half of renewals automatically through the *ex parte* data review process, without taking the next step to verify information by engaging enrollees. Importantly, the PPACA may have accelerated the adoption of data-driven enrollment and renewal processes by providing enhanced federal funding for system upgrades.

3.1.3 CMS Guidance to States on Redeterminations and the PHE Unwinding

In August 2021, CMS released guidance to states in the form of a State Health Official (SHO) letter that addressed the timeline of the post-PHE redeterminations and imposed a mandate for states to take all necessary and available steps to transition individuals no longer eligible for Medicaid to the most appropriate form of coverage. Under the August 2021 guidance, states are

able to take up to 12 months to complete redeterminations, although states may (and many will) take a shorter time period to complete redeterminations. The August SHO letter additionally reiterated the requirement for states to transition Medicaid-ineligible beneficiaries to other insurance programs they are found to be eligible for, including Marketplace coverage.²⁸ Because of data gathering and system connectivity challenges, states will undoubtedly struggle to fulfill their mandate to provide timely and efficient transitions of coverage. The mandate to transition coverage further emphasizes the urgency of redetermination policy solutions that support IT infrastructure upgrades and stakeholder partnership to facilitate transitions.

CMS updated their August guidance in early March 2022 via the release of a new SHO letter along with other CMS resources to support state efforts during the PHE unwinding. The March SHO letter responds to state concerns around the timeline for redeterminations by extending the completion date for all state redeterminations cases to the end of the 14th month after the end of the PHE. The letter additionally adds the requirement for states to develop operational plans to address outstanding enrollment and eligibility actions based on a CMS template. While states will not be required to submit these plans to CMS, they are expected to make them publicly available to stakeholders and solicit feedback from partner organizations (including MCOs). To efficiently process renewals and mitigate risk of enrollee churn, CMS expects states to take a risk-based approach when prioritizing pending eligibility and enrollment actions and recommends several caseload distribution strategies or approaches. These include a population-based approach prioritizing cases based on the characteristics of the cohort or populations that are likely to have become eligible for more expansive benefits or eligible for different coverage during the pandemic, a time or age-based approach which prioritizes cases based on the length of time it has been pending, a hybrid approach, combining population and time-based strategies, or a different state-

developed approach that meets the goal of maintaining coverage of those eligible and supports timeframe expectations. To help ensure state timelines and strategies for conducting redeterminations are sound, CMS adds a new requirement for states to submit their timelines, risk mitigation, and renewal distribution plans to CMS and to submit monthly data reports to show progress towards completing the goals of these plans.²⁹

To aid state development of strategies and action plans, CMS released additional resources in tandem with the SHO letter, including a communications toolkit providing messaging strategies and scripts, updated guidance on state and MCO partnership during the unwinding that encourages states to allow MCO communications to enrollees undergoing redeterminations, and a state action planning tool to self-evaluate readiness to complete pending enrollment and eligibility actions and develop preparation plans.³⁰

The ability of CMS to enforce state timelines and actions during the unwinding is limited in scope. The only “requirement” CMS outlines in the March CMS SHO letter is the previously mentioned submission of monthly data on pending applications and initiated and completed renewals over the 14-month unwinding timeframe. CMS notes that it can request states provide additional data and information if they appear to be off-track or non-compliant with potentially incorrect disenrollments. If a state is found to be out of compliance, CMS can require the state to submit a corrective action plan detailing strategies the state will take to come back into compliance.²⁹

3.2 Medicaid Churn

Loss of individual health coverage can lead to a detrimental cycle known as “Medicaid churn”. Churn is defined as an individual moving in and out of Medicaid coverage temporarily.⁴ Income fluctuations are a primary driver of churn and fluctuations are more prevalent among lower income individuals, people of color, non-elderly working people, and those with less education. Even minor income increases can make individuals temporarily ineligible for Medicaid for periods of time before income changes again and eligibility is reestablished.³¹ However, income fluctuations are not the only causes of churn. Those who remain income eligible are still at risk for temporary coverage losses due to renewal barriers that may result in incorrect determinations of eligibility.

Possibly due to income fluctuations, the typical Medicaid beneficiary is covered with health insurance for less than ten months per year.³² Indeed, nearly 25% of Medicaid beneficiaries change coverage within one year, and 55% of these beneficiaries also experience a gap in coverage,³³ although churn rates are lower among children enrolled in Medicaid due in part to higher income eligibility levels and policies in some states designed to maintain continuity of coverage for children.⁴ Recent analysis of 41 states found that full-benefit beneficiaries enrolled in Medicaid at any point in 2018, 10.3% experienced a gap in coverage of less than a year, disenrolling and subsequently re-enrolling into the program within one year of losing coverage.³⁴

Medicaid churn can have serious and lasting effects on individual health.⁴ These common disruptions in Medicaid coverage lead to periods of delayed care as well as lower rates of preventative care measures. In addition, churn results in higher administrative costs, less predictable state expenditures, higher monthly health care costs from pent-up demand and less predictable medical expenditures. A 2010 study by Banerjee, Ziegenfuss, and Shah found that

losses in coverage increased the use emergency department use, physician office visits, and hospitals between 10 and 36% and decreased the use of prescription medications by 19% compared to individuals with consistent Medicaid coverage.³⁵

Further, a 2015 analysis estimated that the administrative cost of the churning cycle is between \$400 and \$600 per individual,³⁶ and a 2016 study (Sommers et. al.) found that adults with 12 full months of Medicaid coverage had lower average costs than those with only 6 months of coverage after adjusting for demographic and health characteristics.³³

Sugar et. al (2021) note that providers and MCOs are also burdened by churn as it limits their ability to provide effective care, achieve managed care quality requirements, and lower the administrative cost of processing new applications on a regular basis. Additionally, transitions of individuals between health plans lead to barriers to accessing care. Transitions often involve moves to different provider networks with unfamiliar physicians or health systems that do not have records or established relationships with the beneficiary, and certain benefits or drug formularies may also differ between health plans.⁴ As Sugar et. al note, individual churning between sources of health coverage occurs frequently for the Medicaid population and is associated with adverse health effects from a lack of access. These effects may be exacerbated by the conclusion of the PHE and continuous coverage requirements, pointing to an urgency to develop and implement public policy solutions to counteract Medicaid churn and promote effective health management.

3.3 Barriers to Medicaid Renewal and Continuous Coverage

State decision-making regarding the Medicaid redeterminations process can play a role in reducing (or exacerbating) rates of churn. Churn can readily result from difficulties of individuals navigating state renewal processes. Incorrect redeterminations of eligibility, resulting from procedural failure, can cause beneficiaries to lose Medicaid coverage and necessitate their re-enrollment in the program.³⁷ According to 2019 reports by Families USA, a health care consumer advocacy group, and KFF, faulty state renewal processes may cause drastic year-over-year Medicaid enrollment decreases and cause periods of uninsurance.³⁸ The Families USA report analyzed Medicaid program enrollment by state between December 2017 and December 2018. As state enrollment declines varied widely during this timeframe, there is indication that state-specific policy choice plays a role in enrollment variation. Because of the ties between Medicaid program enrollment and economic conditions, it should be noted that the report showed no correlation between state Medicaid enrollment trends and state job growth.

The three states with the largest percentage drops in enrollment during the time period of the study were Tennessee, Arkansas (a Medicaid expansion state at the time) and Missouri. These states noticed Medicaid enrollment declines of 9.7%, 7.3%, and 7.2% between 2017 and 2018. Faulty redeterminations processes that in some cases do not comply with federal regulations are seen as a “clear” factor of sharp enrollment decline in these three states and are described below.³⁸ Examining the renewal challenges and issues in these states can paint a general picture of the barriers posed to Medicaid beneficiaries nationwide. While barriers are not limited to the states of Tennessee, Arkansas, and Missouri, the examples these states provide capture some of the most prominent barriers and challenges to individual Medicaid renewal and continuous coverage across

all states. These barriers include paperwork and address-related barriers; timing, consumer confusion, and state consumer support barriers; and non-seamless program transition barriers.

3.3.1 Paperwork and Address-Related Barriers to Renewal

Antiquated, paperwork-related issues present one major enrollee barrier to successful redetermination of eligibility. Notably, in 2018, Tennessee, Arkansas, and Missouri all lacked online account options for use of beneficiaries to re-enroll, thus requiring beneficiaries to renew coverage via telephone or mail. These methods of renewal are subject to challenges. Medicaid beneficiaries frequently change addresses, lack permanent addresses, or otherwise miss mailings due to post office delays and other related issues. While research on the magnitude of Medicaid recipients who change addresses on a yearly (or other) basis is lacking, some states estimate that millions of letters from public assistance programs to members are returned each year. Colorado estimates about 15% of the 12 million letters sent from public assistance programs to program members are returned – a sum of approximately 1.8 million pieces of undelivered mail each year.³⁹ In July 2018, Arkansas Works, the state’s “private option” Medicaid expansion program, released the following graph breaking down the reasons for approximately 14,000 Arkansas Works recipients whose case was closed by the agency during the previous month. Almost 40% of the 14,000 case closures were attributable to an inability of the agency to locate the enrollee, and 21% of the closures from a failure of the beneficiary to return requested information to verify eligibility. In Arkansas in 2018, any returned mail automatically triggered a case closure, and notably, these statistics have nothing to do with Arkansas’ controversial work requirement for some Medicaid enrollees, which had yet to be implemented by June 2018 (and has since been rescinded).⁴⁰

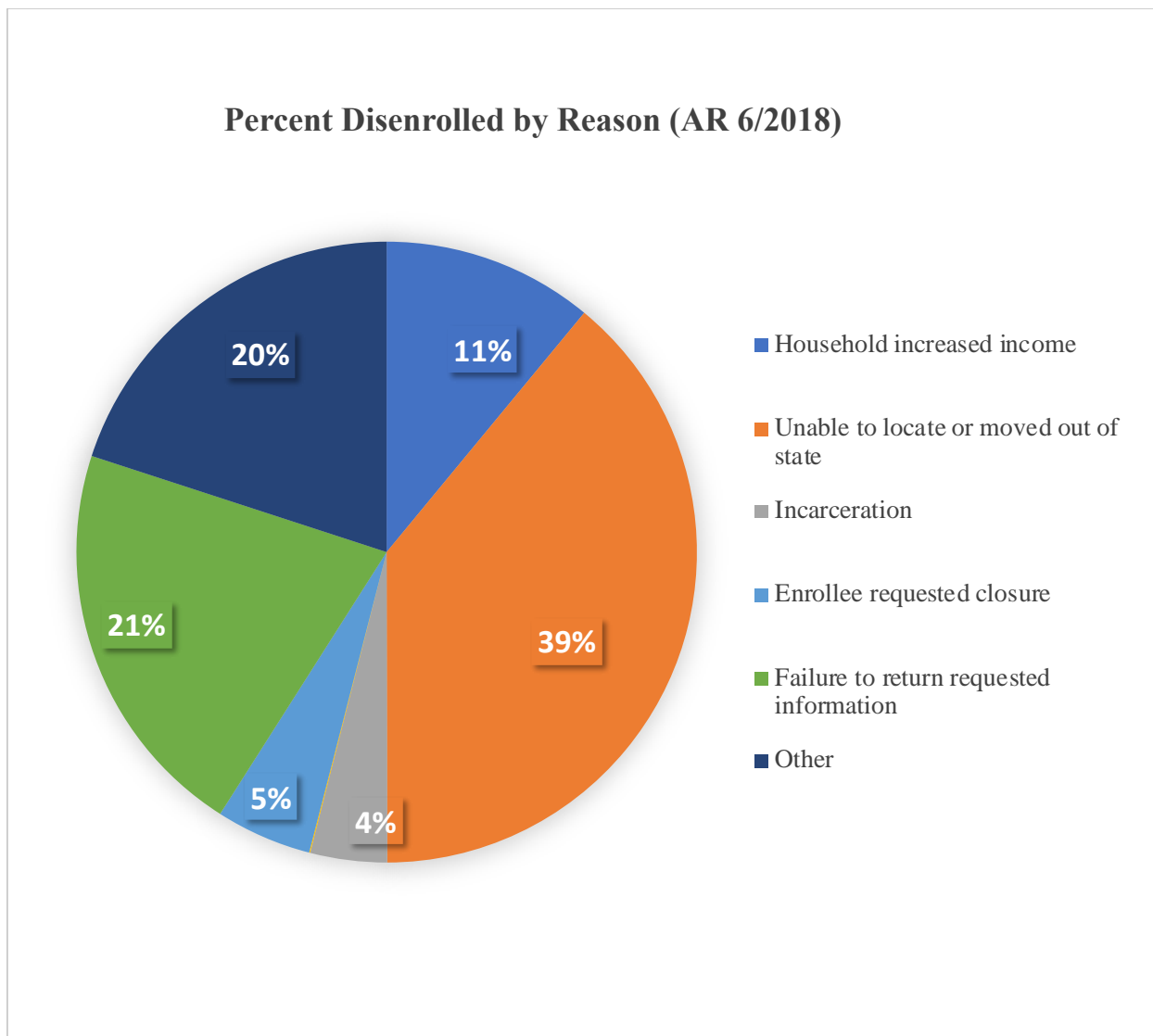


Figure 1. Percentage of Arkansas Medicaid Enrollees Case Closure by Reason, June 2018.

Data from The Arkansas Times (2018)⁴⁰

Lengthy, confusing forms and information requirements create an additional barrier to Medicaid renewal. Although states are mandated to use all available data sources to perform ex parte renewals of eligibility before engaging with an enrollee for additional verification, both Arkansas and Missouri did not send, as required, a form pre-populated with information the states had uncovered (Tennessee did not even perform the baseline data source verification). Further,

until 2019, Tennessee's process for redeterminations was highly involved, convoluted, and burdensome, including a mailed 98-page form. Anecdotal reports from Tennessee indicate that in many cases the state mailed renewal packets to incorrect addresses, never processed renewal packets despite the state receiving them, and separate packets were mailed to each individual within a family. While Tennessee implemented a new online eligibility renewal system in 2019, it remains to be seen if Tennessee's overall redeterminations success will be lifted by this improvement. Finally, language-related barriers with state renewal forms and other communications can hinder redetermination efforts. State translation services may not have the capabilities to send culturally proficient or appropriate paperwork and communications to all beneficiaries, causing difficulty to accurately complete and return forms.³⁷ While the issues in Tennessee, Arkansas, and Missouri are notable, many aspects of the redeterminations process lack automation and digitization in most states, causing millions of enrollees to be faced with mail and telephone challenges to communication and renewal.

3.3.2 Timing, Confusion, and State Consumer Support Barriers to Renewal

Despite federal requirements mandating a 30-day time period for beneficiaries to verify their eligibility during a redetermination, Arkansas historically has only allowed some beneficiaries 10 days to respond to requests for additional information or face coverage loss, a contracted timeline that is wholly uncondusive to renewal success. Likewise, Texas frequently checks the income of households of children enrolled in Medicaid, and if the state finds a change that may affect eligibility, it sends the household a letter to respond with eligibility-confirming information within 10 days. If after 10 days there is no response, the state system automatically closes the case and terminates coverage without additional review.³⁷

Further, states may provide inadequate support to beneficiaries undergoing redeterminations by failing to complete adequate ex parte data checks before engaging with a beneficiary for additional information. As recently as January 2022, health care consumer advocacy groups in Texas reported during a MACPAC panel discussion that the state only provides an adequate ex parte review during 9% of renewals.⁴¹ There are many reasons for ex parte renewal failures, and many are state-specific. For example, Missouri's automated ex parte eligibility check system does not use data from other state safety-net systems for review of eligibility. Missouri's Medicaid agency additionally suffers from an antiquated technology infrastructure, with a 2019 McKinsey assessment of the state's Medicaid program concluding that the state's system was "not positioned to meet current or future needs". The program's technology infrastructure, partly based on components from the 1970s, frequently sends incorrect messages to Medicaid applicants and enrollees and has been described by users as "dehumanizing".⁴²

As previously mentioned, both Arkansas and Missouri have failed to pre-populate renewal forms with state data when engaging with beneficiaries, adding another layer of burden to the consumer through lack of support. Additionally, because of mail processing efficiencies and the address and contact information collection difficulties outlined above, states may often lack proactive outreach capabilities to contact beneficiaries via multiple modalities (e.g., email, text, telephone, online account) upon receipt of returned mail. Telephone renewal options pose issues to beneficiaries of long wait times and confusing voice interfaces. When mailings and other communications go unanswered, coverage disruptions and loss occur, often without the beneficiary knowing they were removed from state Medicaid rolls.³⁸

3.3.3 Non-Seamless Program Transition Barriers

Many individuals deemed ineligible for Medicaid but found to have eligibility status for ACA Marketplace or Medicare coverage face barriers to program transition.⁴³ The Biden administration has taken steps to mitigate this barrier, issuing a recent executive order focused on streamlining eligibility and enrollment processes to reach uninsured individuals,⁴⁴ increasing marketing and advertising outreach to educate consumers on program availability,⁴⁵ and increasing funding for the Health Navigator program to assist consumers with transitions.⁴⁶ Despite these executive actions, state prohibitions on MCOs to market their exchange plans to enrollees who are removed from Medicaid rolls pose an issue to continuous coverage of those who are found ineligible for Medicaid.

FFCRA's continuous eligibility and enrollment requirements have helped to temporarily reduce churn during the COVID-19 pandemic. However, once the PHE ends and disenrollments resume, states will face budgetary and staffing pressures to quickly process renewals. In recent years, most states have implemented policies to reduce churn and ensure continuous coverage, thus mitigating the potential for churn during the PHE unwinding. As of January 2020, 35 states take anticipated, normal income fluctuations into account when making a renewal eligibility determination, including three quarters of Medicaid expansion states and over one third of non-expansion states. Additionally, some states have recently improved their beneficiary communications processes and procedures to employ modern methods of communication (text and email, for example) that address the returned mail and address change barriers faced by enrollees.³⁴ Despite these efforts and improvements, churn is an ever-present threat, particularly due to the pandemic-increased enrollment in Medicaid, and many individuals may indeed experience a loss in coverage within the coming months.

4.0 Policy Implementations to Improve Medicaid Redeterminations

4.1 Overview of State Policy Implementations

Finding long-lasting, impactful solutions to the renewal barriers posed by the redeterminations process presents a difficult task because of the structure of the Medicaid program. As a joint state and federal program, each state hosts a unique policy, regulatory, and administrative environment. One size does not fit all. However, there are policy interventions that can be implemented by states, with assistance available from the federal government. For states that wish to enroll and retain in coverage a higher percentage of the population and are politically comfortable with sharing a small percentage of authority with payers and local organizations, a facilitated enrollment and renewal model engages MCOs and Community-Based Organizations (CBOs) to actively participate as a state partner in the enrollment and redeterminations processes. Likewise, a state that strives to promote increased coverage and enrollment retention but is wary to cede any power or authority to MCOs and CBOs can take significant steps to modernize their state IT infrastructure and processes to enhance their ex parte renewal capabilities. A state that enhances these capabilities can, in many cases, bypass the issues of beneficiary outreach and returned mail. While these two solutions are sound levers of improvement for Medicaid redeterminations, they are by no means the only policy implementations states may undertake. CMS has recently published material outlining several state strategies and actions that may serve to improve the post-PHE renewal situation. Many of these policies can be implemented in tandem with others and work to ease the financial and administrative burden of states.

4.2 Managed Care Facilitated Enrollment and Renewal

A long-term solution to many of the prominent barriers to redeterminations could include fostering state partnerships with key stakeholders through an MCO facilitated enrollment and renewal model. A model of this nature permits a state Medicaid agency to leverage key partners, such as MCOs, CBOs, and providers and augment state resources to solve enrollment and renewal challenges. In a facilitated enrollment model, the MCO acts as a “qualifying entity” to offer enrollment (and renewal) services in tandem with the state agency. Generally, states manage the vast majority of Medicaid renewal processes, with strict contractual and statutory regulations prohibiting MCOs and other organizations from assisting beneficiaries with either initial enrollment or renewal to guard against anti-competitive practices. In a perfect world, the state would conduct an adequate level of outreach and provide the necessary levels of assistance to efficiently guide each individual through the redeterminations process. However, states face budgetary challenges, staffing issues, and procedural weaknesses exacerbated by the pandemic that demonstrate an opportunity for external partner assistance. Leveraging MCOs and other community-based partners aids the member through guided, personalized assistance. Some researchers contend that full involvement of MCOs in the redeterminations process is a key aspect of their responsibility to coordinating care and ensuring uninterrupted coverage to maintain health goals.⁴⁷

MCO redeterminations assistance can be leveraged to guide an enrollee through engagement with the state agency while taking some burden off state resources. A facilitated enrollment program appeals to MCOs, as they would favor playing an increased role in Medicaid redeterminations to reduce their own administrative costs of members churning on and off coverage. Additionally, enhanced control and involvement allows MCOs to develop and sustain

relationships with members to improve health outcomes, and therefore improve their own reported metrics of success. Currently, New York is the only state to actively employ a facilitated enrollment model. While the state model sample size is therefore limited, the program structure and lessons learned from New York are important evidence to examine the model success and feasibility in other states.

4.2.1 Facilitated Enrollment and Renewal Authority

Federal law authorizes states to utilize enrollment brokers and certified application counselors to assist residents in Medicaid and Marketplace enrollment processes (Social Security Act 1903(b)(4), 45 CFR 155.255, 42 CFR 435.908 and 42 CFR 438.810). However, federal law also prohibits Medicaid MCO employees from serving as enrollment brokers or certified application counselors out of steering and anticompetitive concerns under the Social Security Act 1903(b)(4) and 42 CFR 438.810(b)(1)-(2). CMS has established precedent to waive that prohibition and allow MCOs to employ staff dedicated to enrollment and renewals. New York was granted waiver approval in 1997 under Section 1115 authority enabling MCOs with New York state plan contracts to perform facilitated enrollment services to Medicaid enrollees, and this waiver has been continuously re-approved by CMS since that time.⁴⁸

4.2.2 Demonstration Waivers

Authorized by Section 1115 of the Social Security Act, 1115 Waivers grant state Medicaid agencies the authority to approve experimental, pilot, or demonstration projects that are found to be likely to assist in promoting the objectives of the Medicaid program. These demonstration

waivers add flexibility to states to design and improve programs and opportunity to evaluate programs before nationwide implementation. CMS reviews waiver proposals on a case-by-case basis, and the goals and objectives of each proposal must be consistent with federal policies and budget-neutral to the federal government over the course of the project (federal Medicaid expenditures cannot be more than they would have been without the demonstration).⁴⁹ Waivers are approved for an initial five year period and can be extended 3-5 years with the potential to fast-track re-approval for a five year period, if approval has been given once before.⁵⁰ Fast-tracking, which can be used to reapprove waivers indefinitely, occurs through a specific type of streamlined waiver known as an 1115(a) waiver for established demonstrations that are working successfully, not making major or complex policy changes and have had at least one full extension cycle. As previously discussed, no state other than New York has been granted authority to employ facilitated enrollment services under a similar demonstration waiver.

4.2.3 Recommended Program Structure and Key Restrictions

Facilitated enrollment program costs are included in MCO capitation rates and are partially funded under the category of MCO administrative costs through federal matching shares of service provision. CMS is therefore allowed to partially match expenditures for facilitated enrollment services.⁴⁸ Facilitated enrollers are employed by MCOs, health care providers, CBOs and “other entities” under state contract. These qualifying entities are agencies who hire and oversee facilitated enrollment staff and ensure successful program operations and compliance with monitoring, reporting, and restrictions surrounding neutrality. Qualifying entities (MCOs and CBOs) should be selected with care by the state to ensure they maintain capabilities for success, including the ability to offer multilingual and culturally appropriate assistance to prospective

applicants, experience with vulnerable populations of low health literacy, and the capacity to reach individuals residing in a certain traditionally underserved geographic areas, including both urban and rural areas.⁵¹

The role of facilitated enrollment staff is centered around initial enrollment application assistance to those applying for government sponsored health insurance programs, but in New York enrollers have traditionally assisted with yearly renewals of eligibility. Enrollers perform an initial screening of applicants for eligibility to determine the most appropriate form of coverage, provide program information to applicants, assist the applicant with all aspects of the process including filling out forms and gathering required verification materials, and coordinating and communicating with the state Medicaid agency to ensure materials have been transmitted and processed in a timely and efficient manner. It is important to note that currently facilitated enrollers do not themselves make determinations of program eligibility. That specific power remains with the New York State Department of Health.⁵¹

The state, as the program regulator, may place Special Terms and Conditions (STCs) as a protective element against the threat of system abuses by qualifying entities. First and foremost, as mentioned above, a state must retain authority for determinations of program eligibility. States are prohibited under federal law from granting this decision-making authority to qualifying entities. States may also take action to establish program restrictions over facilitated enrollers steering individuals to one MCO or another. These restrictions may additionally prove influential to CMS approval of facilitated enrollment waiver requests. One such restriction could be that of product neutrality. Because many facilitated enrollers are employed by organizations that offer Medicaid Managed Care plans in the state, enrollers can be required to equally and fairly present plan options to applicants without prejudice. Other restrictions that preserve competition and

program integrity may include limits on the number of facilitated enrollment staff an organization is permitted to employ, limits on state capitated reimbursement potential for marketing materials sent by MCOs, training and certifications to ensure customer service quality and staff competency, enrollee privacy protections and sanctions for qualifying entities that fail to adhere to the restrictions and terms outlined by the state. Further, the federal government (through CMS as well as the Department of Justice) should offer to play an active role in the prevention of steering and the investigation of potential steering activities by qualifying entities.⁵²

With similar structure and contractual guardrails, a facilitated enrollment program instituted in another state environment has the ability to impartially assist applicants with Medicaid program enrollment.

4.2.4 Facilitated Enrollment and Renewal Program Advantages

Implementing a facilitated enrollment and renewal program offers several advantages for states and individuals. Compared to state Medicaid agency staff, facilitated enrollment staff members who work for community organizations and health plans, which may have the resources to disperse staff over a wide territory, can be more decentralized and located within the communities in which they serve. This aspect of the program enables connections, involvement, and relationship development with the target population undergoing yearly renewal. Further, facilitated enrollers have the flexibility to meet members of the community where they are – in health care settings, schools, childcare settings, shopping areas, and places of worship. Facilitated enrollers can therefore share individualized information and recommendations in a face-to-face setting, establishing and building trust.⁵³

Facilitated enrollers may understand local residents and community health care systems to a greater extent than centralized state Medicaid staff. Intimate, localized knowledge of communities and their outlets for health care provision alleviate the need of individuals and families with low levels of health literacy to understand the complex differences between programs and coverage options that affect their access to care. Facilitated enrollers can additionally provide culturally and linguistically appropriate services when a state agency may not have the capabilities to provide widespread availability of these services. A facilitated enrollment program can also build trust between state Medicaid agencies and the respective MCOs and CBOs operating in their state by demonstrating enhanced value to the state of the qualifying entities who operationalize the program. Finally, facilitated enrollment provides beneficiaries a consistent partner during their time on the Medicaid program. Consistency helps ensure coverage and mitigate churn.⁵³ This advantage can be seen as a potential factor in New York's low uninsured rates. New York, a Medicaid expansion state, consistently has some of the lowest uninsured rates in the country with just 4.6% of its total population uninsured as of 2020, compared to the national average of 8.6% uninsured, an average which includes both expansion and non-expansion states.⁵⁴ While the positive impact of Medicaid facilitated enrollment and renewal in New York on churn is not significantly represented in the extant literature, it is not a stretch to consider the state's facilitated enrollment ability as a driving factor of this positive metric.

4.2.5 Facilitated Enrollment and Children's Public Health Insurance in New York City

A pre-ACA study of the impact of facilitated enrollment on Children's Public Health Insurance Enrollment in New York City shows that the program is seen to drive successful engagement and enrollment assistance with consumers. Seventy-six percent of program applicants

receive enrollment assistance, mostly regarding document provision, through facilitated enrollers. Seventy-six percent also report that they require some level of assistance with document provision, demonstrating a key barrier to enrollment that facilitated enrollers play a role in solving.⁵⁵

Additionally, the study describes the different strategies that MCOs and CBOs employ to recruit and reach populations. CBOs prefer to utilize “inreach” strategies to recruit new enrollees via families already coming to and engaging with the organization. MCOs facilitated enrollment staff, on the other hand, conduct broader outreach and traditionally have been responsible for enrolling a larger share of new program beneficiaries. Both CBO and MCO enrollers can immediately enroll members in coverage through a temporary, presumptive status while their paperwork is being processed. Overall, CBO enrollers were shown to be more successful at enrolling children whose families engaged with the CBO (80% successful enrollment) while MCOs had around a 60% success rate. Three fundamental differences are presented by the study’s authors to explain this disparity in results. First, CBOs are said to have deeper relationships and integration with the community through their multi-directionality. CBOs (examples in the New York metropolitan area include the Arab-American Family Support Center of Greater New York, BronxWorks, and Korean Community Services of Metropolitan NY, Inc.)⁵⁶ offer a variety of services to individuals and families while an individual may only engage with an MCO when they access health care services, an often burdensome and stressful experience. Second, those who seek enrollment or other services at CBOs may be more motivated to attain coverage than those who are approached by MCOs due to the nature of the engagement. Third, because MCOs can enroll individuals with presumptive eligibility prior to a final determination, parents may mistakenly believe their child has insurance while still going through the process of enrollment and lead to an ultimately unsuccessful enrollment effort. Although with these advantages CBOs are shown to

have superior enrollment results with children, MCOs do maintain a high enrollment success rate among this population. Overall, these results demonstrate that both CBOs and MCOs play a role in promoting enrollment as well as facilitating renewals through community partnership, relationship-building, and face-to-face enrollee engagement.

4.2.6 Potential CMS Actions to Encourage Models

As New York is the only state that has opted in favor of facilitated enrollment, it is worth exploring why other states have not been inclined to follow their example. Indeed, the program may have aspects that appeal to states on both ends of the political spectrum. For traditionally “liberal” states, facilitated enrollment can be seen as a method of encouraging and increasing enrollment in Medicaid, a key social safety-net program. On the other hand, for traditionally “conservative” states that aim to privatize aspects of government functions, a facilitated enrollment program gives power to private MCOs, while retaining some level of state oversight of enrollment and renewal. Despite these advantages, states may have hesitated to adopt facilitated enrollment for multiple reasons. First and foremost, states may not be aware of the opportunity to implement the program. By and large, CMS has not publicized the existence or advantages of New York’s program, and little information is readily and publicly available. Second, states may be wary of the potential for steering and anti-competitive practices, particularly if they have a managed care market dominated by a few large health plans yet have several smaller plans operating in the market. Finally, states may have interest in submitting an 1115 waiver to CMS to apply for the allowance to support a facilitated enrollment program yet may not believe in the potential success of that application.

Although a facilitated enrollment model is predicated on state and federal joint action, one option at the disposal of CMS to increase the prevalence of facilitated enrollment models among states is to create and promote streamlined 1115 waiver applications for a state facilitated enrollment program demonstration. Creating a streamlined 1115 waiver template that incorporates the basic structure and major elements and guardrails of the New York model could persuade states with similar outlooks on the Medicaid program to attempt a facilitated enrollment program model. The most recent New York waiver extension was submitted on March 4, 2021 with a simple footnote for continuation of expenditures for “enrollment assistance services provided by managed care organizations, the costs for which are included in the claimed MCO capitation rates.”⁵⁷ CMS has created similarly streamlined waivers and templates to assist states with their COVID-19 pandemic response,⁵⁸ demonstrating both their ability and motivation to encourage state 1115 demonstration program innovations.

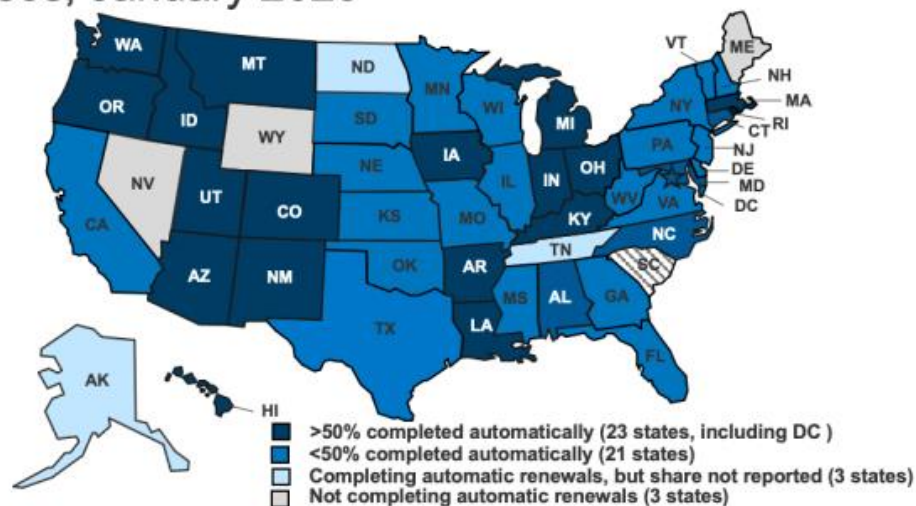
4.3 State Data and Infrastructure Enhancements to Improve the Ex Parte Renewal Process

Perhaps a less ambitious, but equally impactful policy change to spur successful redeterminations is that of state information technology and data infrastructure investments and adoption of best practices to improve the ex parte renewal process. As discussed, ex parte renewals refer to the initial data review that state Medicaid agencies undertake to renew Medicaid program eligibility for individuals. The full ex parte renewal process for Medicaid and CHIP beneficiaries is shown in the appendix. Broadly, states use a variety of available state and federally-based data sources to automatically renew coverage, and the Medicaid enrollee is not contacted to verify information, return requested forms, or take other actions to maintain coverage.⁵⁹ States vary both

in data source usage and the share of renewals completed via the ex parte process, and the ability of a state to successfully or unsuccessfully complete a large share of renewals without need for enrollee outreach plays a role in continuity of coverage. As of a January 2020 KFF survey, 47 states were completing renewals on an ex parte basis. Of the 43 states providing data to the survey, 22 states were able to successfully complete at least half of their redeterminations via automatic ex parte processes without requiring enrollee action, and 9 states were able to complete three-quarters or more redeterminations via ex parte reviews of eligibility.⁶⁰

Figure 16

Share of Medicaid Renewals Completed Using Automated Processes, January 2020



NOTE: Share of renewals for non-disabled children, pregnant women, parents and expansion adults. South Carolina not reported.

SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.



Figure 2. States by Share of Renewals Able to be Completed Using Automated, Ex Parte Process.

*Figure sourced from KFF, who stipulates their “materials may be reprinted, in whole or in part, without written permission, if they are not altered”⁶⁰

Enrollee contact and outreach abilities are a main point of failure in redeterminations success, and states are beginning to raise warning flags relating to increased administrative and staffing challenges in light of the pandemic,⁶¹ as states deal with staff transitions to telework and increased Medicaid applications due to the economic downturn and maintenance of effort provision. These challenges may impact a state's ability to successfully cope with the sheer volume of redeterminations that must occur post-PHE end. Taken together, enrollee contact and state administrative burden are driving factors to the need for state redeterminations process improvement and streamlining. Even small improvements to the ex parte process components can make cost-saving adjustments to states from a decrease in both churn and caseworker administrative burden.⁶² Finally, states can access federal matching funds to offset the cost of system changes to implement data infrastructure upgrades.⁶³ In many states, this financial incentive may be a tipping point that spurs innovative change.

4.3.1 Data Source Requirements and Improvement Strategies

States are required under federal law to utilize the following data sources to analyze information on beneficiaries undergoing redeterminations: State Wage Information Collection Agency; State Unemployment, IRS, SSA, SSI, Title I, X, XIV, XVI, SNAP, the Federal Data Services Hub, and to make verifications of non-financial information, for example the address of a beneficiary.²⁵ While diligent review of these required data sources may result in a successful ex parte renewal, the use of additional data sources may increase a state's rate of success. A collaboration between State Health & Value Strategies, a Robert Wood Johnson Foundation program, and two health care consulting practices, Manatt Health and McKinsey & Company, outlines additional sources for states to consider utilizing for optimal ex parte reviews. These

innovative sources may provide the most up-to-date information on a beneficiary and include the following: Immunization Information Systems; Health Information Exchanges; the Department of Motor Vehicles; the Department of Labor (specifically, Unemployment Insurance) and use of Third-Party Data Enrichment Partners, such as LexisNexis, to append missing or incomplete information. State Health & Value Strategies notes that use of these sources may require states to implement data sharing agreements with partners, improve data import capabilities, require hierarchical prioritization logic for accuracy and recency, and validation of effectiveness through testing.⁶⁴ Additionally, CMS has noted the value of addressing contact information difficulties through state use of the U.S. Postal Service Change of Address database to access recent enrollee information.²⁹

States should ensure they are taking advantage of all useful data sources from state, federal, and commercial sources. Many states rely on data verification services through CMS's data services hub, which includes information from the Social Security Administration and Equifax's Work Number database that provides current wage info for businesses.⁵⁹ State Medicaid agencies can additionally access IRS tax data, however this income data is often outdated and unreliable. States that have high percentages of workers working across state lines should partner with bordering states to verify and access wage and unemployment systems. Further, SNAP, TANF, other benefit programs are "exceptionally reliable" data sources for ex parte verification. In particular, the SNAP database is seen as current and highly verifiable, as it retains specific income information, including the type of income and the specific beneficiary. Additionally, the use of Express Lane Eligibility allows a Medicaid agency use of income findings from another program in determining Medicaid eligibility.⁵⁹

An additional strategy to increase the rate of state ex parte enrollments is for a state to review eligibility system data and design documents, which direct how the system is programmed. States should establish data hierarchies and use reasonable compatibility thresholds for income verification. Hierarchies help determine which information states should use when there are conflicting data or results on eligibility factors from various sources. Further, reasonable compatibility policies allow state Medicaid agencies (with approval from CMS) to accept the income and asset attestation of an enrollee if that attestation falls below a certain eligibility threshold, even if data sources show income above the threshold. For example, a state with a reasonable compatibility standard of 10% of income may determine an enrollee eligible if their income is found by state review to be above the threshold, but within 10% of their attestation.⁶⁵ The utilization of a reasonable compatibility policy reduces the need for additional verification from the enrollee, and therefore reduces the burden on the individual to take steps to maintain coverage.⁵⁹

4.3.2 Principles for Ex Parte Renewal Success

To maximize the chance of a successful ex parte renewal, states are encouraged to only verify specific eligibility factors that are generally subject to change year to year. For example, citizenship status is a factor that generally does not change between years and should not require yearly verification for program eligibility. Additionally, no changes should be assumed in household composition or tax filing status to streamline verifications. States should make attempts to “maximize the universe” of cases that are eligible to go through an ex parte process. State agencies should include vulnerable groups like seniors and individuals with disabilities in ex parte renewals. These non-MAGI groups are federally mandated to be included in the ex parte renewal

process, but according to CBPP, many states don't perform ex parte renewals for this population. Also, states should not automatically disregard data sources based on the age of the source or focus on exact matches for employer names. Finally, states should improve their approach to handling complex or uncommon scenarios. These scenarios may involve unclear or incomplete data, including situations in which Medicaid enrollees have no countable income, frequent employment change, or income that cannot be electronically verified (for example, alimony payment) and in these cases states should move towards threshold compatibility calculations rather than exact income data matches for verification. Above all, states should use caution and internal reviews when completing ex parte renewals to eliminate unnecessary enrollee contact and interview requirements.⁵⁹

4.3.3 Best Practices When Renewals Cannot be Completed Via Ex Parte

If renewals are not able to be completed via ex parte data checks, states are required by federal regulation to send renewal forms to enrollees that are pre-populated with enrollee information (information includes name, household, recently reported income if available). Subsequently, states are mandated to provide 30 days for enrollees to return necessary forms and additional verification materials required by the state. States are mandated to permit online and telephone-based renewal submissions in addition to mailed submissions, and enrollees must be granted a certain amount of leniency where the state must reopen the renewal case, without requiring a new application if the beneficiary contacts the agency within 90 days of benefit loss.

4.4 CMS Policy Proposals and Strategies to Improve Redeterminations

4.4.1 Strengthening the Ex Parte Renewal Process

By strengthening their renewal processes, states can increase the percentage of ex parte renewals completed through expanding the number and types of data sources used for renewal, as well as streamlining renewals that cannot be completed through ex parte review by pre-populating renewal forms and extending individual deadlines for response. The strategies that CMS proposes states to adopt to strengthen renewal processes are largely covered in the preceding section of this essay.

4.4.2 Updating Mailing Addresses to Minimize Returned Mail

To reduce the potential of returned mail outreach, states can adopt policies to verify address and other enrollee contact information, including engaging CBOs, enrollment assisters and Navigators, as well as providers and MCOs to collect updated information. States can additionally leverage other means-tested programs as address-confirming data sources, including SNAP, TANF, the DMV, and the U.S. Postal Service Change of Address database. Finally, states can communicate via periodic reminders, with multiple modalities, to beneficiaries up for renewal to change and update their address and contact information.

4.4.3 Improving Consumer Outreach, Communications, and Assistance

To effectively communicate and provide timely and essential information to enrollees undergoing renewals, CMS suggests that states should ensure robust outreach is made via text messaging, email, and phone calls. Also, CMS suggests partnerships with MCOs, CBOs, providers, and others to both develop materials and distribute information to enrollees. Importantly, this involves empowering MCOs to outreach before and after an individual is contacted by the state to provide information to verify their eligibility for Medicaid. Despite having the capability to do so, MCOs often face state statutory and/or state contractual restrictions to providing outreach on redeterminations status and alternative coverage options. Although the CMS guidance does not explicitly mention this barrier, states can provide MCOs with the ability to outreach to their members by sending lists to MCOs of members due for redetermination and encouraging MCOs to outreach via email and text message. MCOs often do not receive information on members who are due for renewal and have difficulty implementing texting campaigns because states do not allow texting to members via implied consent with member ability to opt-out. Many states additionally require explicit member opt-in to text message and/or email communications, a barrier that hinders the ability of MCOs to conduct outreach and share vital information.⁶⁶

Finally, CMS recommends effective communications with those who have Limited English Proficiency and/or individuals who suffer from a disability. Communications should be culturally competent, be provided in multiple languages, readily available, and supported by multilingual agency staff members.

4.4.4 Promoting Seamless Coverage Transitions

For those individuals deemed ineligible for Medicaid, but potentially eligible for another source of government-sponsored health insurance, states should attempt to make efficient transitions between programs. CMS lists several activities to support coverage transitions, including state IT system interoperability that transfers individual accounts between Medicaid and the Marketplace, real-time transition assistance and guidance, twelve-month continuous eligibility and reduced periodic data matching tests, and leveraging MCOs to conduct outreach and provide support to individuals making a program transition. This would include the timely state sharing of data lists with MCOs that include contact information both individuals due for redeterminations and individuals terminated for failure to return documentation. CMS does not federally prohibit MCOs to market affiliated Qualified Health Plans (plans that are certified to operate in the Health Insurance Marketplace) to previously enrolled individuals who have lost coverage for procedural reasons yet states often implement contractual barriers to product marketing. CMS advises states to remove any contractual and statutory barriers to post-disenrollment outreach, as well as allow plans to provide support for a certain period of time post-disenrollment to educate former enrollees about coverage opportunities.

4.4.5 Addressing Strains on Eligibility and Enrollment Workforces

As states have signaled their uncertainty with administrative ability and workforce staffing to handle the increased redeterminations workload, CMS presents strategies to manage capacity by engaging additional county and local-level resources to assist state Medicaid agencies where necessary, among other changes to address staffing needs and staff confusion. CMS has recently

released best practices related to workforce and staffing issues, a “top concern” in most states. CMS describes best practices and strategies that states are implementing to address workforce capacity, including adopting workforce flexibilities such as telework, conducting refresher trainings on redeterminations processes, and increasing automation and taking action to boost exparte success rates to minimize paper-based, manual work.⁶⁷

4.4.6 Enhancing Oversight of Operations

CMS calls for states to establish centralized oversight and monitoring processes to minimize procedure errors and backlogs. State activities in this regard may include tracking tools and dashboards to monitor agency needs and quickly catch data errors to reduce inappropriate coverage loss. To assess state progress and potential issues that may cause renewal delays or missed deadlines, CMS is requiring state Medicaid agencies to submit monthly data reports during the PHE unwinding.⁶⁸

4.4.7 Implementation Considerations

Implementing any combination of the solutions presented by CMS would provide long-term assistance to individuals undergoing redeterminations and help states to ensure continuous coverage for a vulnerable population of health care consumers. Each of the CMS strategies outlined above presents an option for states to modernize their redeterminations process, however CMS cannot mandate through guidance or rule change that states take up any or all of the options. Indeed, as CMS notes that some of these solutions may require a State Plan Amendment (SPA) revision, it is incumbent on the willingness of states, determined by their unique political, financial,

and administrative environments to make the decision to implement the strategies presented. Dedicated funding to research the impact of these strategies and their ability to mitigate Medicaid churn may result in greater awareness or adoption by state Medicaid agencies. As lawmakers debate policies to support the Medicaid population's access to care during the PHE unwinding, maintaining enhanced levels of FMAP and/or gradually reducing the enhanced FMAP post-PHE end may provide a financial enticement for states to implement some of the strategies outlined.

5.0 Political Issues and Considerations

A willing political environment must exist in both the federal executive branch and individual state governments to enable implementation of the policy proposals outlined above. First, the current administration (in this case, the Biden-Harris Administration) must be dedicated and driven to improve the redeterminations process at a national level and broadly support Medicaid enrollment among those eligible. Indeed, federal executive branch agencies with jurisdiction over Medicaid enrollment and renewal, namely CMS and its sub-agencies, Consumer Information and Insurance Oversight (CCIIO) and The Center for Medicaid and CHIP Services (CMCS), have positively signaled their awareness of the issues with the redeterminations process and barriers to renewal and have signaled their intentions to make systemic changes. Without legislation, and health care-related legislation seems unlikely in the current environment, the federal government can only go so far to regulate the PHE unwinding and enforce regulations surrounding redeterminations best practices. Therefore, individual state Medicaid agencies must also be amenable to redeterminations process improvement in order to partner with the federal government and create lasting change.

5.1 Administrative Actions

As discussed, CMS has recently published materials designed to guide state Medicaid agencies towards amenable policy and operational environments to facilitate the large-scale redeterminations that must occur at the end of the PHE. In recent months, Administration officials

have readily expressed their grasp of the issues related to renewals and their willingness to direct states (to the extent of their ability) to modernize and augment their existing procedures to support redeterminations efforts. Comments made by CMS Administrator Chiquita Brooks-LaSure at the annual Medicaid Health Plans of America (MHPA) conference in September 2021 reinforce this position. In her remarks, Administrator Brooks-LaSure acknowledged state budgetary pressures regarding redeterminations and the importance of maintaining coverage for enrollees either in Medicaid or through transitions to the best source of coverage including the Marketplace.⁶⁹ Further, Brooks-LaSure and Deputy Administrator Daniel Tsai published a strategic vision for Medicaid and CHIP in the peer-reviewed journal *Health Affairs*,⁷⁰ reiterating the present opportunity to protect, strengthen, and expand Medicaid access and coverage in the face of risk of enrollee churn. In their vision statement, CMS leadership reiterated that their main strategic priority is protecting access to coverage for those eligible after the COVID-19 continuous coverage requirement ends.

CMS strives to help states with their planning and preparation efforts to cope with the large number of eligibility redeterminations required, minimize unnecessary coverage losses, and ensure those no longer eligible can transition to Marketplace coverage. In support of this goal, CMS has, and will continue to create guidance, planning tools, and other resources for state use, as well as collaborate with state Medicaid and CHIP agencies through regular workgroups, all-state calls, and extensive and individualized technical assistance. CMS will additionally engage stakeholders like CBOs, enrollment assisters, and health systems to support individuals undergoing the renewal process and improving transitions of coverage.

Finally, CMS is focused on assisting states to remove red tape and administrative barriers to coverage loss and churn. Efforts in this regard include working with states to improve eligibility

and enrollment data collection and related systems for ex parte renewals, assisting states to modernize documentation provision and use other digital communication strategies to better reach enrollees and eliminate paper-based elements of the renewal process and paper document requirements, and facilitating and encouraging state engagement with health plans to support outreach and renewal efforts.

These encouraging efforts by CMS are proactive and reflect the recent administrative change from the Trump Administration to the Biden Administration. It is clear that CMS career staff and current political appointees are aware of the risks that the end of the PHE presents to Medicaid enrollment and health coverage, yet it is unclear the level of influence and enforcement that CMS expectation will have on state adoption of preferred redeterminations policy and operational strategies. Progressive states seem more likely to adopt these strategies as methods of ensuring Medicaid program stability and continuous enrollment. On the other hand, conservative states may have little will to accomplish more than the base level redeterminations processes required by law and will decline to take the best practices of CMS into account when establishing plans and processes for redeterminations.

5.2 State Actions and Preparation Concerns

There is significant concern among states related to the preparations that must occur prior to the PHE end date to support coverage retention. The National Association of Medicaid Directors (NAMd) expressed these state concerns in a recent blog post following the organization's 2021 annual meeting. NAMd explains that the pandemic is an "unprecedented" disaster in terms of its "scale, scope, and longevity". NAMd presents two main keys to success during the unwinding: a

nimble and flexible process design, and transparency with stakeholders. NAMD additionally lists three critical areas of focus, regulatory, with a smooth environment that allows for proactive outreach to beneficiaries and the ability to address Medicaid agency workforce issues; financial, with consistent actuarial analysis of risk to set accurate rates, and communications to ensure consistent and tested messaging to coordinate stakeholder efforts.⁷¹

Because of the joint state and federal aspects of the Medicaid program, there is wide variability in Medicaid programs across the country, and states control many processes and procedures related to enrollment and eligibility. Redeterminations processes are not immune to the political pressures and stigmas that characterize “welfare” programs in many states and regions of the United States. Many states have anecdotally telegraphed their desire to restart redeterminations as soon as possible due to the budgetary pressures of the continuous coverage mandates of FFCRA. Ohio has gone a step further and codified into law a sixty-day post-PHE expiration time limit for the state to complete all pending redeterminations, drawing the ire of organizations as far removed from the process as the American Cancer Society Cancer Action Network.^{72,73} Therefore, despite the allowance of 12 months for states to conduct and complete redeterminations post-PHE, states facing budget pressures⁷⁴ will rush to conduct as many redeterminations as possible in the first months post-PHE end. The expedited timeline can pose major administrative issues for states that have inexperienced agency staff conducting the ex parte and enrollee-engaged portions of the renewal process. Lack of adequate, experienced staff, coupled with the necessary urgency of the decisions will undoubtedly pose threats to coverage loss by procedural error. Jim Jones, Medicaid Director of the Wisconsin Department of Health Services⁷⁵ adds color to these workforce challenges. Forty percent of their Medicaid workers have never completed a renewal or terminated

coverage for any enrollee. Even those who have completed renewals in the past must be retrained on current processes and procedures.

The effects of staffing issues on redeterminations are already apparent in both Medicaid enrollment processing and enrollment into other state benefit programs. Missouri recently reported they are taking on average 70 days to process a typical Medicaid program application, almost a full month longer than the 45 days allowed by federal law to process applications. In contrast, Kaiser Health News reports that according to 2021 federal data most states were processing Medicaid applications within a week, and “many” cases took less than one day to process. Missouri’s Department of Social Services’ Family Support Division attributes these current delays to a pandemic-related worker shortage.⁷⁶ Texas, a state that has experienced Medicaid enrollment of more than 1.3 million enrollees since the beginning of the pandemic (February 2020 to December 2021)⁷⁷, shows signs of an inability to adequately and timely process redeterminations. According to a Houston Chronicle report,⁶¹ the state health agency, the Health and Human Services Commission (HHSC) cut staffing levels in 2020 by order of the Republican-led executive branch. At least 700-1000 (15%) of eligibility determination workers were lost by the state Medicaid agency in 2020, contributing to a backlog in processing food assistance sign-ups in 2021. Utilizing the same employees as Medicaid redeterminations processing, the timeliness rate for Texas food assistance application processing (application processed within 30 days) fell from 90% to 66% despite application levels holding steady. Even before the pandemic, Texas struggled with performing Medicaid and CHIP renewals, demonstrated in 2019 with 40% of children dropped from the program re-enrolling within six months, indicating possible procedural reasons for termination, rather than eligibility reasons. To note, Texas has not adopted 12-month continuous eligibility for children enrolled in the state Medicaid program.⁷⁸ Because states are permitted to

continue redeterminations for CHIP enrollees during the pandemic, children are at risk for losing coverage before PHE end. In Utah, a state which has continued to make determinations for CHIP enrollees during the pandemic, reports suggest that 41% of all program recipients lost coverage and were required to reapply in 2020. According to state health plan staff, Texas has also continued to make determinations of eligibility for CHIP recipients throughout the pandemic and has seen similar levels of redetermination failure.⁷⁹ While HHSC maintains that they are attempting to automate the process and work with health plans to prepare for renewals, these factors raise red flags in a large state that has not expanded Medicaid and already suffers with a high rate of uninsured, at 18.4%, or double the national average.⁸⁰

Concerningly, some states have indicated rushed processes of redeterminations, leading to the potential for large-scale Medicaid disenrollments post-PHE end. As the federal funding levels supporting the Medicaid enrollment increases fall off, at least one state has strongly indicated its desire to urgently complete all redeterminations. Ohio's State Legislature included a requirement in its state budget for the state to complete all necessary redeterminations within a 90-day window post-PHE end date. Authorities in larger Ohio counties have stressed the challenge of completing renewals in this timeframe with limited staffing resources. With their existing workload of applications and coordination of benefits from additional welfare programs like SNAP, it will be nearly impossible for Ohio caseworkers to adequately conduct outreach and fair renewal verifications for, presumably, many of the 3.2 million recipients of Medicaid in the state who will not have their eligibility verified via ex parte renewal.

More worrying still, Ohio has contracted with a vendor, Public Consulting Group, to process redeterminations automatically via third party data sources.⁸¹ According to Politico, the firm is to be paid by the state based on state Medicaid savings, partly due to the number of

Medicaid enrollees that the firm is able to remove from the rolls. This extreme method of processing redeterminations removes any standard of fairness, diligence, and agency from Medicaid recipients and will almost certainly result in thousands losing coverage for procedural, rather than legitimate eligibility reasons. The end result plausibly will be a higher administrative cost to the state of re-enrolling those who apply for Medicaid and dealing with the short and long-term health outcomes of coverage loss.

Overall, it is difficult to grasp the exact levels of state preparedness for the PHE unwinding. Prior to the publication of this paper, most states had not made public their plans for redeterminations, or how these plans or processes may have changed due to the unique circumstances of the PHE end. However, general preparedness conclusions can be drawn from various redetermination factors at play, including state ex parte success rates and abilities, state Medicaid agency staffing reductions during the pandemic, percentages of increased Medicaid enrollment, state restrictions on marketing Exchange plans, pre-pandemic rates of churn, and state contractual provisions with MCOs prohibiting communications by MCOs to members undergoing redeterminations. While there is little scientific evidence that these factors are predictors of redeterminations success, many states will make good faith efforts to adopt strategies to reduce disenrollments and will take cues from CMS to follow guidance as it is relayed. For example, Shawnda O'Brien, the director of Public Assistance at the Alaska Department of Health and Social Services notes that as CMS releases informational materials and offers state assistance, they intend to facilitate partnerships to help Medicaid enrollees navigate the redeterminations process.⁸²

5.3 Implications of Federal Legislative Proposals

The Build Back Better Act (BBBA), the Biden administration's legislative framework to address longstanding social concerns, includes certain Medicaid provisions designed to uncouple the end of the PHE from the temporarily increased FMAP levels and state mandates for continuous coverage.⁸³ While all indications point to the bill's inability to pass in its current, senate proposed form,⁸³ certain provisions relating to health care (and redeterminations specifically) have the potential to pass within another, smaller legislative vehicle.⁸⁴

The proposed BBBA extends FMAP but provides a gradual ramp-down rather than a "cliff" post-PHE end. Having passed the date for FMAP ramp-down proposed in BBBA, subsequent legislation would require an adjustment to this timeline. However, the uncertainty caused by the proposed BBBA provisions on FMAP in late 2021 and early 2022 impacted state timelines and resources preparations for post-PHE redeterminations. The bill additionally seeks to end the tying of FFCRA continuous coverage provisions of to the PHE end and includes the guardrail that states may not redetermine more than 1/9 of this population on a monthly basis. The 1/9 limitation for redeterminations is based on CMS recommendation to mitigate risk of churn and establish a sustainable renewable schedule for the future. CMS notes that based on their experiences working with states, an even monthly distribution of redeterminations case processing will minimize operational and procedural challenges and errors associated with attempts to process large numbers of cases in a short time period. Initiating no more than 1/9 of renewals within a given month additionally recognizes the natural fluctuations in renewal volume as well as fluctuations in staffing levels.²⁹ Further, if states change Medicaid eligibility standards, methodologies, or procedures to be more restrictive than those in place on October 1, 2021, the FMAP level for the state will be reduced by 3.1% for the quarter. This provision would remain in effect until the end

of 2025. Because the uncoupling of the PHE is meant to be a cost-saving provision, if a similar bill does pass, it likely will retain the provisions related to the uncoupling of the PHE end from the start of redeterminations.

If new legislation is indeed proposed, it would be wise for legislators to include provisions designed to strengthen the enforcement power of CMS-proposed standards related to redeterminations. Legislative enforcement tactics might include the requirement for states to provide outreach to enrollees undergoing redeterminations with multiple methods, including texting and emailing. Further, legislation has the potential to expand the number of data sources that state agencies are required to check enrollee information during an ex parte renewal.

6.0 Conclusions

The public health effects of continuous, uninterrupted access to health care services cannot be overstated, and continuous coverage requirements have been a vital source of community and individual support during the COVID-19 pandemic. The Medicaid program, which has seen enrollment gains during the pandemic, helps ensure that many of the nation's traditionally underserved individuals, including people of color, economically vulnerable individuals, children, and those with disabilities, have continuous access to long-term treatment. The continuous coverage requirements of FFCRA have supported that increased enrollment, however as life returns to normal and the PHE unwinds, states will be eager to regain fiscal stability as they lose increased federal matching for sustaining high levels Medicaid enrollment. When the requirements for continuous coverage expire, all states will resume redeterminations of program eligibility, and although states are allowed 14 months from the end of the PHE to complete all pending renewals, some states will assuredly attempt to complete the process quicker than others. In some cases, state Medicaid agencies in charge of the redeterminations may fail to adequately follow federal regulations and ignore process best-practice guidance and expectations from CMS, which has little enforcement power. Protecting the coverage and access to care of individuals in these states should be of the utmost importance to policymakers and legislators.

Historically, many program-eligible beneficiaries have been incorrectly terminated from Medicaid coverage due to procedural errors and failures during the redeterminations process. Additionally, some beneficiaries who enrolled in the Medicaid program during the pandemic are, because of income or other status change, legitimately ineligible for Medicaid, and may be eligible for coverage under the Marketplace. States are mandated to take measures to transition them to the

Marketplace if eligible. However, the sheer, unprecedented volume of redeterminations that states must complete has the potential to overwhelm the understaffed state agencies in charge of conducting redeterminations. To ensure fair and accurate assessments of program eligibility, state Medicaid agencies and governments must examine policy proposals that can solve the longstanding barriers to eligibility that Medicaid redeterminations present. States have the option to improve and augment their current abilities, required under the PPACA, to perform ex parte renewals of eligibility prior to engaging with Medicaid beneficiaries undergoing redeterminations. States can supplement the data sources utilized for ex parte renewals and make a host of other improvements designed to modernize and digitize the redeterminations process. Further, states have the option to engage with key local stakeholders through a facilitated enrollment model to support renewals. A facilitated enrollment model partners states with MCOs and CBOs to provide direct, personalized assistance to beneficiaries as they go through redeterminations, and can be established through an 1115 waiver application. Finally, states can adopt recommended CMS strategies and actions designed to maintain coverage during the PHE unwinding.

While fiscal or political pressures may inhibit some states from taking the proactive steps necessary to enhance redeterminations and guard against incorrect terminations, many states will follow CMS guidance to the best of their abilities and take measures to partner with stakeholders in accordance with the gravity of the situation. Through proactive policy implementation, states can support efforts to maintain continuous coverage of eligible Medicaid enrollees and ensure that the inevitable ending of the COVID-19 PHE does not cause widespread coverage loss and exacerbate health disparities among the nation's most vulnerable. Benefits from policy action are not limited to the ending of the PHE – states that choose to pursue forward-thinking policies can

make strides to solve longstanding issues with the redeterminations process and safeguard the health of the nation's most vulnerable.

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