mhpa Medicaid Health Plans of America

Resuming Medicaid Eligibility Redeterminations while Minimizing Coverage Disruptions

A Resource for State-level Stakeholders

As the leading association representing Medicaid managed care organizations (MCOs), Medicaid Health Plans of America (MHPA) has developed this resource to provide state-level stakeholders – including legislators, providers, advocates, and the general public – with key information to support Medicaid enrollees, promote best practices, and limit disruptions in coverage during this historic Medicaid redetermination process. Founded in 1995, the Medicaid Health Plans of America (MHPA) represents the interests of the Medicaid managed care industry through advocacy and research to support innovative policy solutions that enhance the delivery of comprehensive, cost-effective, and quality health care for Medicaid enrollees. MHPA works on behalf of its 130+ member health plans, known as managed care organizations (MCOs), that serve nearly 49 million Medicaid enrollees in 40 states, the District of Columbia and Puerto Rico.

The Issue: As of September 2022, over 90 million individuals are enrolled in Medicaid and the Children's Health Insurance Program (CHIP).[1] As a result of recent congressional action, tens of millions of Americans currently enrolled in the Medicaid program will go through the process of "redetermination" to assess whether they are still eligible for Medicaid or if they must transition into another form of coverage (e.g., Marketplace, employer-sponsored health coverage) for the first time since March 2020.

How we got here: The redetermination process normally occurs, at a minimum, on an annual basis to confirm if Medicaid enrollees are still eligible for coverage. With the passage of the Families First Coronavirus Response Act (FFCRA), this regular review was halted and nearly all enrollees retained their Medicaid coverage during the pandemic. As outlined in the recently passed Consolidated Appropriations Act, 2023 (CAA, 2023), states may resume Medicaid disenrollments effective April 1, 2023, and may take up to a full year to initiate renewals as outlined in CMS guidance. As a result of this activity, Medicaid enrollees may begin receiving information and notices about what is required of them for renewal as early as February 1, 2023.

The Process of Redeterminations: States are expected to confirm enrollees' eligibility for Medicaid coverage by verifying or requesting individual and/or family information. Constituents currently enrolled in Medicaid or CHIP can expect to receive a letter in the mail that will either:

a. Confirm that the state is renewing their coverage.
b. Inform them that they no longer qualify, and their coverage is ending.
c. Ask them for more information via a "renewal form" to see if they still meet the income eligibility requirements and qualify for coverage.

REDETERMINATION CHALLENGES	WHAT'S AT STAKE
» State health and human services departments and Medicaid agencies may be overwhelmed by the volume of work due to insufficient technology or staffing shortages.	» The Urban Institute estimates that more than 16 million people could lose Medicaid coverage following the end of the PHE[2]
» Enrollees may have moved addresses and state Medicaid agencies may not be able to contact them.	» The Centers for Medicare and Medicaid (CMS) has provided guidance to states and Medicaid MCOs to ensure this process is as smooth as possible, but given the breadth and complexity of this process, many challenges are likely.
» Enrollees could lose Medicaid coverage for which they are eligible because of not completing their renewal form, never receiving a renewal form, or a wide variety of other administrative issues.	» Gaps in coverage will be detrimental to enrollees' health, and would lead to disruptions in accessing preventative care, timely diagnosis, treatments, medication, and care coordination.
» Enrollees could be left without any form of coverage due to not successfully being transferred to employer sponsored health coverage or Marketplace plans.	

Managed Care Organizations as a Resource

Currently 40 states and the District of Columbia utilize managed care as the primary delivery system for their Medicaid programs. Managed Care is a health care delivery system organized to manage cost, utilization, and quality. The managed care model is a public-private partnership that aligns with federal and state requirements to deliver a higher standard of care. Managed care organizations (MCOs) partner directly with states to administer Medicaid benefits. Now more than ever, it's critically important to provide continued access to quality care to a growing Medicaid population, and to help states better plan and manage their budgets.

By contracting with various types of MCOs to deliver Medicaid program health care services to their Medicaid enrollees, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.[3]

As state Medicaid agencies prepare for the process of redetermination, it is important that they consider their MCOs as partners and resources for ensuring a thoughtful and deliberate approach that avoids unnecessary coverage losses. Listed below are several effective objectives and best practices that states can embark on to achieve this goal.

Objective 1:
Ensuring Continuity of Care for Disenrolled Medicaid Enrollees

MCOs can play an integral role in helping enrollees retain their Medicaid eligibility or transition to other forms of coverage if they lose programmatic eligibility. This includes acquiring Marketplace coverage through a Qualified Health Plan (QHP). MCOs are already known to go above and beyond for their members to ensure continuity of care during standard periods of transition, and that will be no different during the impending redetermination period. However, to do this effectively they need to be given the most up to date information regarding their members' eligibility status, with as much advance notice as possible. For example, some states have already begun updating their enrollment files with disenrollment information and are sharing these files with MCOs so they can help enrollees correct deficiencies or transition to other coverage. Some research has shown that Medicaid members who lose coverage on a temporary basis end up costing more due to pent-up demand following re-enrollment, and even more so for persons with chronic conditions.[4]

Objective 2:
Ensuring the Accurate and Timely Sharing of Information

MCOs are also an excellent resource for information sharing between state Medicaid agencies and Medicaid enrollees. Due to their robust case management and call center frameworks, MCOs interact with members on a much more routine basis than state Medicaid agencies and can disseminate information swiftly and effectively through the channels they've have found most effective for eliciting member responses. While traditional mail may be effective for certain demographics, MCOs have access to technology and resources that can deliver critical messaging about redeterminations that reach members where they are, including but not limited to the distribution of collateral materials, text message campaigns, and outbound call campaigns. By utilizing MCOs in this manner Medicaid agencies such as the Department of Medical Assistance Services (DMAS) in the Commonwealth of Virginia are working to ensure that their Medicaid enrollees receive consistent and timely information from their MCOs as a primary source of contact and communication. DMAS has established and distributed a communications toolkit for MCOs to assist in these efforts and the development of content for members.

Objective 3:
Serving as Navigators to the Newly Uninsured

As MCOs best understand the health care needs of their members, they are prime candidates to serve as "navigators" to assist members at risk of losing health coverage. Serving as navigators, MCOs can help enrollees whose eligibility cannot be renewed through data sources (called Ex Parte renewals) or automatic renewal processes to complete and submit their renewal information, or in the case of individuals who are terminated for procedural reasons, reapply

for Medicaid benefits. To effectively do this work, MCOs need to be granted the necessary authorities to contact members slated for disenrollment, effectively conduct disenrollment surveys, and assist Medicaid enrollees with the application process to maintain coverage if possible. Several MCOs also offer plans on the federal and state-based marketplaces and can provide critical information and resources to Medicaid enrollees losing coverage to help them navigate the Marketplace as well. To assist in these efforts, states like California have established programs such as the DCHS Coverage Ambassadors, where MCOs and other stakeholders can become trusted partners in a coordinated, phased communication campaign to reach Medicaid enrollees with messages across multiple channels about how to maintain coverage after redeterminations begin.

Best Practice 1:
Public Release and Distribution of Unwinding Plans.

Federal guidance from the past two years requires that states develop an "unwinding operational plan" and submit it to CMS for review, and over 35 states have released those plans publicly. These unwinding plans include critical information that details planned changes that directly impact all stakeholders – including Medicaid enrollees. To ensure transparency, allow stakeholders to prepare, and encourage proper planning to avoid coverage loss, it is considered a best practice that Medicaid agencies publicly release their operational plans. The State of California has released a very comprehensive unwinding plan which can be found here. The Georgetown University Health Policy Institute has released a 50-state unwinding tracker where stakeholders can access critical unwinding information that can be found in the public domain, including but not limited to: unwinding plans, public dashboards, and communication toolkits.

Best Practice 2:
Communication and Information Sharing

States can provide flexibility to their MCOs to communicate with their members about the redetermination process and assist them with renewals. Arizona and Maryland are two states sharing renewal information with their MCO partners so they can conduct appropriate outreach. Maryland is also notifying its MCOs when they receive returned mail.

States should strive to provide MCOs and relevant stakeholders with the necessary information to assist and support Medicaid enrollees as early and as often as possible. The State of South Carolina provides all MCOs with a monthly listing of its Medicaid managed care members who were mailed an Eligibility Redetermination/Review Form during the month in an effort to minimize disenrollments due to loss of eligibility. MCOs can then reach out to the members directly to provide assistance. MCOs are also allowed to reach out to members after they have been disenrolled.

28 of the 35 states that have released public unwinding plans have also released communications and messaging toolkits for key stakeholders. Pennsylvania , for example, has put forth a variety of message campaign tools including radio scripts, website banners, call center and text campaign scripts.

Best Practice 3:
Increased Transparency and Flexibility

CMS has issued guidance to states requiring them to submit monthly data on eligibility and enrollment activity, including renewals confirmed through Ex Parte data. States should consider sharing this and other pertinent redetermination data in their public facing enrollment dashboards. States that do not have public facing dashboards should consider developing them and publicly disseminating this information. These dashboards will allow MCOs, and other relevant stakeholders, to coordinate with their state partners to identify and address any problems with the eligibility determination processes in place. Utah and Colorado are examples of states that have expressed their intention to establish a public facing dashboard to provide transparent tracking data throughout the unwinding period. Utah will produce, monitor, and publish a monthly, public facing dashboard that will include key metrics beginning with the initial 60-day notice and throughout the unwinding review period.[5] Likewise, Colorado is planning to share a monthly public report leveraging existing reporting to CMS.

TO HELP

State legislators, Medicaid providers, and other healthcare stakeholders can play an invaluable role in ensuring continued access to affordable health care for Medicaid recipients across the country by linking them to the correct health care coverage resources, staying informed on the redetermination process, and communicating with state officials and other local stakeholders engaged in this process. A good starting point is familiarization with the details of the Medicaid redetermination issue and each state's specific requirements and resources by visiting Medicaid.gov/renewals, which provides a wealth of information for supporting Medicaid enrollees throughout the process.

When you receive calls or questions, you may...

✓ **Direct Medicaid enrollees to MEDICAID.GOV/RENEWALS – a resource-hub that includes:**

- State-by-state links to Medicaid enrollment information, including state contact information.
- Additional information on the Medicaid redetermination process.
- Resources to transition to other forms of health coverage.

✓ Encourage Medicaid enrollees to update their contact information (phone, address, email, etc.) with their state's Medicaid program and their MCOs. They can do this by calling the Medicaid agency directly for direction on how best to update their information, and by confirming their contact information directly with an MCO case manager or other staff in any state that has a waiver allowing its MCOs to perform this function.

✓ Encourage Medicaid enrollees to check their mail for any important correspondence or documents. They may need to fill out and sign a renewal form to maintain Medicaid coverage. They should complete and return the form as soon as possible.

✓ Encourage state Medicaid agencies to provide their MCO partners with as much flexibility and information as possible to assist with updating enrollees' contact information, filling out renewal documents, and transitioning to other health care coverage if they are determined ineligible for Medicaid for programmatic reasons.

✓ Encourage state Medicaid agencies to make their redetermination and PHE operational unwinding plans public so that affected constituents and stakeholder groups can properly plan and better understand how redeterminations will impact in your state.

Additional Resources

- Georgetown CCF 50 state unwinding tracker: https://ccf.georgetown.edu/2022/09/06/state-unwinding-tracker/
- CMS Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf
- CMS Ex Parte Renewal Slide Deck: https://www.medicaid.gov/resources-for-states/downloads/ex-parte-renewal-102022.pdf
- CMS Section 1902(e)(14) waiver approvals: https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html
- CMS Medicaid Unwinding Communications Toolkit: https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf

1. Centers for Medicare and Medicaid Services (CMS), "September 2022 Medicaid and CHIP Enrollment Trends Snapshot,".

2. Matthew Buettgens & Andrew Green, "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?", Urban Institute, March 2022.

3. https://www.medicaid.gov/medicaid/managed-care/index.html

4. Anthem Public Policy Institute (2018). Continuity of Medicaid Coverage Improves Outcomes for Beneficiaries and States. https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/13/13_Report_Continuity-of-Medicaid-Coverage-Improves-Outcomes-for-Beneficiaries-and-States.pdf

5. Narrative of Utah's Plan for the Resumption of Normal State Medicaid Eligibility upon Conclusion of the COVID-19 Public Health Emergency, last modified December 5, 2022.