A network diagram consisting of numerous grey circular nodes connected by thin grey lines, forming a complex web-like structure that fills the upper and right portions of the page.

On the Ground Enrollment: Results from a National Survey of Medicaid Managed Care Organization **Experiences** **During Redetermination**

September 2023



About MHPA

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 140+ member health plans, known as managed care organizations (MCOs), that serve more than 50 million Medicaid enrollees in 41 states, the District of Columbia, and Puerto Rico. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market.

In Acknowledgment

With deep appreciation for their insight and analysis, MHPA would like to acknowledge Vice President of Research, Quality, and Performance Michelle Proser, PhD, MPP; Director of State Affairs Stephanie Myers, and graduate student Karishma Patel, University of California, Berkeley. MHPA would also like to thank MHPA members for their participation in this research.

About this Research

This report summarizes quantitative and qualitative research completed by MHPA. It presents results of an MHPA-developed national survey conducted between June and July 2023 and completed by approximately three-quarters of MHPA member MCOs. Respondents represent 103 different local MCOs across 39 unique states and DC—nearly every state that partners with Medicaid managed care organizations. It also includes thematic analysis of qualitative data, as well as best practices shared by MHPA members during the summer of 2023. Most MCOs responded to both the survey and opportunities to provide qualitative information.

For a map showing states with at least one responding Medicaid managed care organization, please see page 15. Email research@mhpa.org for additional information on this report.



On the Ground Enrollment: Results from a National Survey of Medicaid Managed Care Organization Experiences During Redetermination

After a three-year pandemic-related hiatus, all states have resumed the Medicaid redetermination process. This is a heavy lift for states as it requires them to reassess Medicaid eligibility for every single Medicaid beneficiary. While more than 90 million individuals were enrolled in Medicaid and the Children’s Health Insurance Program (CHIP) nationally as of March 2023, an estimated 17 million people are expected to lose Medicaid coverage over the course of the 14-month redetermination timeline.¹

The high volume of Medicaid redeterminations following the end of the COVID pandemic is unprecedented for all involved. Many individuals on Medicaid are going through the redetermination process for the first time in three years, and some are experiencing it for the first time ever. Many state Medicaid eligibility workers have also never experienced redetermination.

There is much at stake. Among states reporting early data, nearly three-quarters (72%)² of those who have already lost Medicaid coverage were disenrolled because they did not complete the redetermination process. Referred to as “procedural disenrollment,” many of these individuals may in fact still be eligible for Medicaid but did not understand the redetermination process, were unable to complete it on time, or were unaware because, for example, the state did not have up-to-date contact information. Disenrolled individuals may experience gaps in coverage that can disrupt their ability to access needed care and prescriptions, and in turn experience declines in health, financial security, and ability to work. The “churning” of individuals on and off the Medicaid rolls also increases administrative costs for states. Research looking at pre-pandemic trends of Medicaid coverage loss finds that 65% of people experience gaps in insurance during the subsequent year and 41% re-enroll within the year.³

Medicaid managed care organizations (MCOs) can assist with outreach, education, and completion of complex Medicaid redetermination applications. Forty-one states, DC and Puerto Rico already partner with MCOs to serve state Medicaid beneficiaries. Medicaid MCOs routinely interact with their Medicaid members as they provide comprehensive, coordinated care for diverse communities experiencing limited resources and high risk for adverse health outcomes.

FOOTNOTES

¹ Alice Burns, et al, “How Many People Might Lose Medicaid When States Unwind Continuous Enrollment?,” April 26, 2023, [brief/how-many-people-might-lose-medicaid-when-states-unwind-continuous-enrollment/](https://www.kff.org/medicaid/issue-brief/how-many-people-might-lose-medicaid-when-states-unwind-continuous-enrollment/)

² As of September 8, 2023 from 44 states and DC reporting data. Kaiser Family Foundation, “Medicaid Enrollment and Unwinding Tracker Overview,” <https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/>.

³ Brad Corallo, et al, “What Happens After People Lose Medicaid Coverage?,” January 25, 2023, <https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage/>.

To understand the important and lasting role of Medicaid MCOs in helping states with redetermination, Medicaid Health Plans of America (MHPA) recently surveyed and collected detailed accounts of MHPA member MCOs' experiences. Key findings include:

- Medicaid MCOs are engaged in a range of activities to help those still eligible maintain Medicaid coverage. The extent and details of their outreach activities are defined by what states permit MCOs to do. They are leveraging their direct connections to members and providers, as well as their community footprint and engagements. MCOs also commonly help connect those no longer eligible to other forms of potential health coverage, particularly through the Health Insurance Marketplace.
- States can best equip MCOs to support Medicaid members through redetermination by sharing accurate and complete data throughout the redetermination process so they can effectively engage with their members. States can also grant MCOs greater flexibility in outreach activities.
- MCOs and states are actively working together to improve processes and ensure Medicaid members maintain coverage.

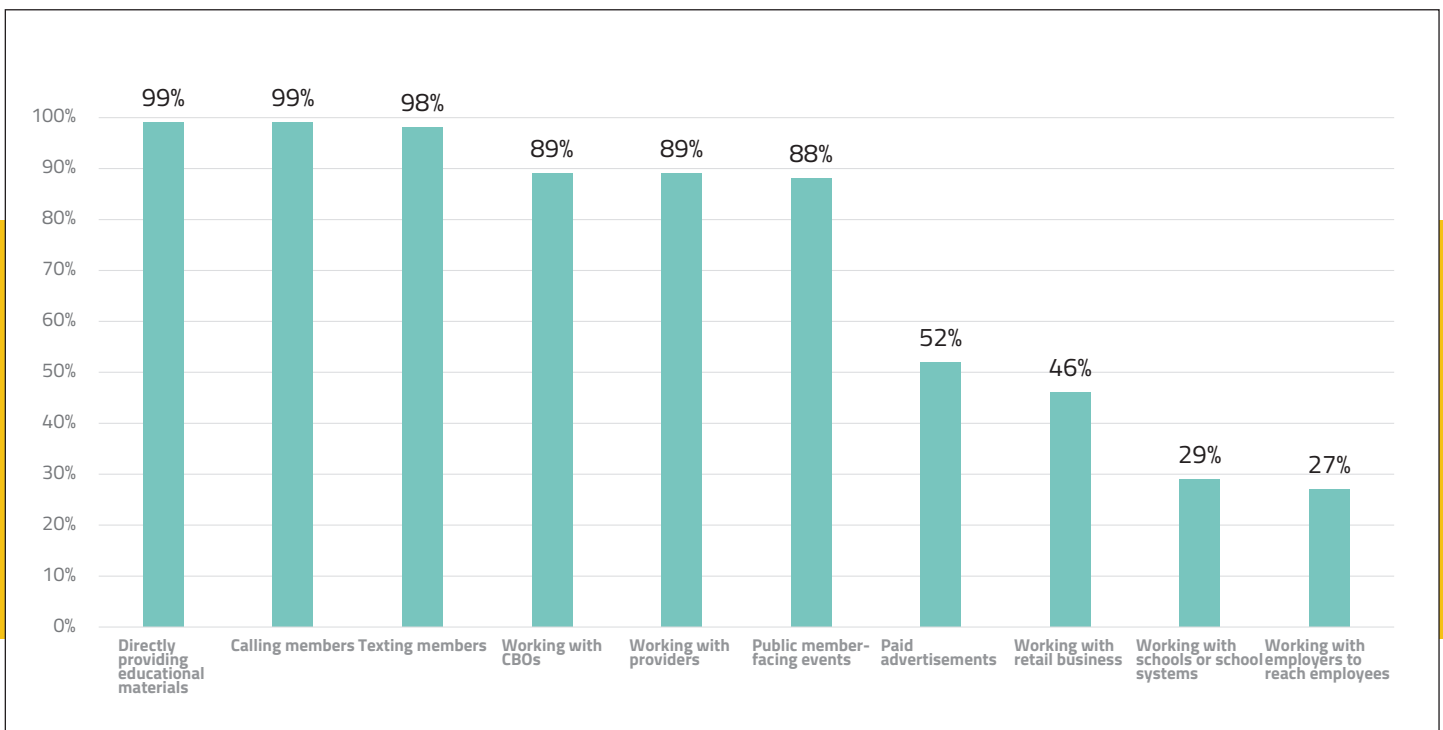
These experiences and lessons demonstrate that Medicaid MCO activities are critical for minimizing care disruptions for those who remain eligible for Medicaid, and are reliable, long-term partners as state Medicaid agencies return to normal eligibility and enrollment operations.



Redetermination Outreach Activities

Because MCOs conduct redetermination outreach in accordance with state regulations and timelines, how they conduct outreach varies by state. Every MCO conducts multiple strategies to educate members and non-members about the Medicaid redetermination process and the need to complete renewal applications (Figure 1). MCOs consistently report that multiple outreach activities and modalities are needed to reach and then engage as many members as possible. Supporting members through the redetermination process can be a multi-step, multi-method endeavor.

FIGURE 1
Plan Reported Redetermination Outreach Activities
Average Number of Outreach Activities Reported = 7.3
N = 103



THE REDETERMINATION PROCESS: A VERY BRIEF PRIMER

States are expected to reassess eligibility for every Medicaid beneficiary over a relatively short timeframe (45 days for MAGI-based eligibility and 90 days for Aged, Blind, and Disabled). State Medicaid agencies must confirm a Medicaid beneficiaries' eligibility by verifying or requesting individual and/or family information. Beneficiaries currently enrolled in Medicaid or CHIP can expect to receive a letter in the mail that will either:

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

MCOs are working to make sure members are aware of their upcoming redetermination, confirm interest in reapplying, understand what is needed to determine eligibility, and can fill out the application and submit documentation. Some are also reaching out to disenrolled members to educate them about other insurance options, and even guide them through those application processes.

When asked which outreach activities are most effective, and four common strategies emerged:

1. Direct member outreach and engagement.
2. Partnerships with local providers.
3. Partnerships with trusted community-based organizations.
4. Presence in the community.

Direct Member Outreach and Engagement

MCOs are universally reaching out to their individual members using “tried and true” direct methods and are uniquely positioned to do this. Building upon regular channels of interfacing with members, MCOs are texting, making phone calls (both live and robocalls), emailing, and providing informational materials. Direct member engagement involves both informing members of redeterminations and engaging them repeatedly to guide them through the renewal application process, which can be complex and require multiple forms of documentation.

MCOs have learned that supporting members through the redetermination process necessitates direct, multiple, and ongoing member outreach. Direct outreach is strategically spaced out to remind members and engage them through the application steps. Moreover, MCOs report coupling outreach modalities, such as text followed by live person calls to offer application assistance, further improves member engagement. Live person calls take time and often require follow up calls when members do not have time or necessary documentation on hand.

MCOs consistently report to MHPA higher call connection rates, better email open rates, and better text received rates compared to direct member outreach prior to redetermination. Tracking these metrics show which outreach efforts are the strongest driver of maintaining member engagement, but also indicate the extensive resources and time required of plan personnel and vendors. Some MCOs are also working to determine the extent to which these efforts lead to completed redeterminations.

Partnerships with Local Providers

All MCOs report working with local healthcare providers given the trust members have in them and their regular interaction with members. Primary care providers, pediatricians, care managers, pharmacists, and other clinicians and care team members are critical “touchpoints” for members. These providers are effective in raising awareness about redetermination and how to complete the redetermination process, and patients may be unaware of changes in their Medicaid coverage until they seek care or prescriptions. Many MCOs are partnering with safety net providers, including Federally Qualified Health Centers.

MCOs report working to educate providers on the redetermination process and provide information regarding which of their patients are up for redetermination. In many cases MCOs are equipping providers to directly support patients or refer them back to the MCO.

United Healthcare Community & State is partnering with Federally Qualified Health Centers (FQHCs) to engage their Medicaid patients. The MCO provided FQHCs with health navigator grants to increase outreach activities through the redetermination period while also building FQHCs’ outreach capacity over the long term.

Partnerships with Trusted Community-Based Organizations

MCOs also have extensive connections to local community organizations and institutions that directly serve members or have broader community reach (e.g., schools, libraries, religious institutions, community centers, and groups tackling social determinants). Involving these organizations as partners in Medicaid redetermination requires additional education to raise their awareness and help them guide community residents through the process.

AlohaCare in Hawaii initiated the Community Health Advisory Partnership (CHAP, <https://www.hiphi.org/chap/>) to leverage existing relationships with community-based organizations and community health centers led by and serving Pacific Islanders, COFA migrants, recent immigrants, LEP communities, unhoused individuals, and young and single mothers. CHAP outreach activities include recruiting and activating trusted local influencers, in-language collateral, coordinated social media, town halls, webinars, and community events. Partnering with member-facing organizations has ensured language competencies and familiarity and built upon existing community engagement. AlohaCare has since enlisted and received funding for the CHAP from three of the other four MCOs in Hawaii.

Aetna Better Health of Kentucky is leveraging their ongoing partnership with a network of over 100 food pantries serving rural communities across the state. The MCO has placed outreach team members at these locations and have added redetermination education and support to the health literacy classes they were already conducting at these sites.

Centene Corporation plans are collaborating with community-based organizations such as the Boys & Girls Club, local YMCAs, school districts, Salvation Army, and networks of food banks on in-person events where people and families receive information about the redetermination process.

Presence in the Community

Nearly all MCOs are attending or hosting live community events or leveraging physical locations for redetermination efforts. These broader community outreach strategies are intentionally reaching both members and non-members alike, giving MCO staff the opportunity to interact directly with community residents. Examples of community outreach events include neighborhood block parties and events hosted by community organizations such as the Salvation Army and YMCA.

Not only do these “boots on the ground” strategies provide MCO staff more opportunities to inform and assist Medicaid members, but they also help staff understand the extent to which community residents are aware of the redetermination process and the barriers they experience. This in turn better informs MCOs on how best to engage and support members.

UPMC Health Plan in Pennsylvania leverages their member resource centers located throughout the state in “high traffic areas” to provide in-person support on utilizing their plan, research insurance coverage options, and navigating insurance. Known as Connect Centers, they are currently assisting members and non-members alike with the paperwork needed to reapply for Medicaid.

Molina Healthcare Inc. reports that having a physical presence in hard-to-reach communities is key to effective outreach. MCO staff attend and directly interact with community members during live events where staff communicate clear messages about what redetermination means for their coverage and help them understand what they need to do.

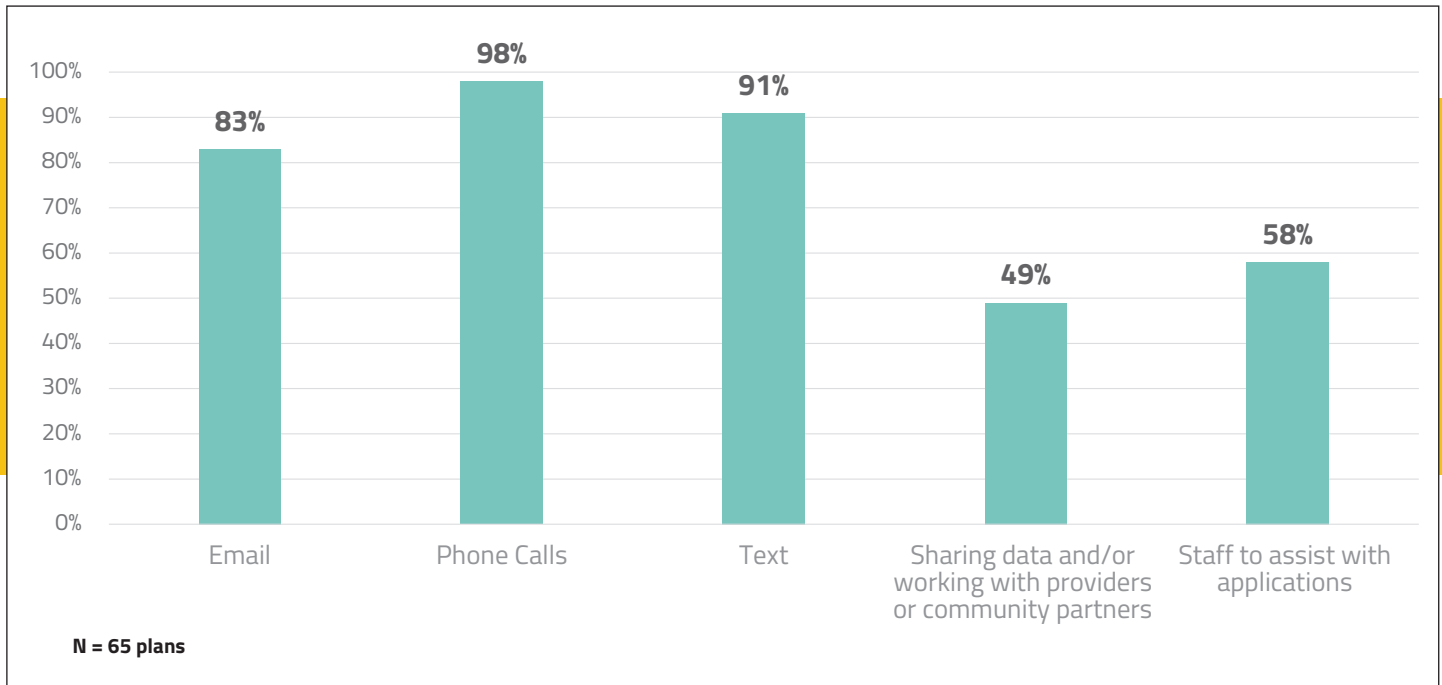
Outreach to Procedurally Terminated Members

Some states allow MCOs to conduct outreach during a reconsideration period, in which procedurally terminated members have a set period of time to submit the renewal application and necessary documentation to have their coverage reinstated. Just as they do during the redetermination window, MCOs can engage, guide, and support members in this process, or, when no longer eligible for Medicaid, assist them in identifying or even applying for other forms of insurance.

When empowered by the state to do so, all MCOs report conducting multiple outreach activities during the reconsideration period to help reenroll Medicaid eligible members who were procedurally terminated. Every MCO reports conducting direct outreach to members, with nearly all making phone calls and texting members. More than half (58%) report deploying staff to assist members with applications, and others report they would like to but need state permission to do so. Half (49%) report collaborating with providers and community partners (Figure 2).

FIGURE 2

Plan Outreach Activities during Reconsideration Period for Medicaid-Eligible Members Who Were Procedurally Terminated



MCOs Are Ready to Do More

When asked about the barriers inhibiting greater outreach and support for Medicaid eligible members, MCOs repeatedly report to MHPA their desire for more flexibility in outreach activities. States vary in their scope of approved outreach activities with much of this variation coming down to the adoption of federal waivers granting flexibility⁴ to aid the redetermination process.

In states where there are still opportunities to enhance flexibility, MCOs would like to see the following in order to enable greater action on behalf of Medicaid eligible members:

- Greater clarification on how MCOs can conduct outreach to members who are procedurally terminated through guidance from the state.
- Longer timelines to conduct outreach to members who had their coverage terminated for procedural reasons.
- Permission to help members complete and submit Medicaid redetermination forms to state Medicaid eligibility determination agencies.
- More transparency and data-sharing. For example, data on the status of member redetermination applications, data on which members enrolled for coverage through the Marketplace, and the ability to share data on members coming up for redetermination or who were procedurally terminated with providers.

FOOTNOTE

⁴ In recognition of the burden states experience with incredibly large volumes of redetermination case work while simultaneously experiencing staff shortages, the federal government designed these time-limited waivers under the authority of section 1902(e)(14)(A) to ease the operational issues and protect eligible beneficiaries from losing Medicaid.

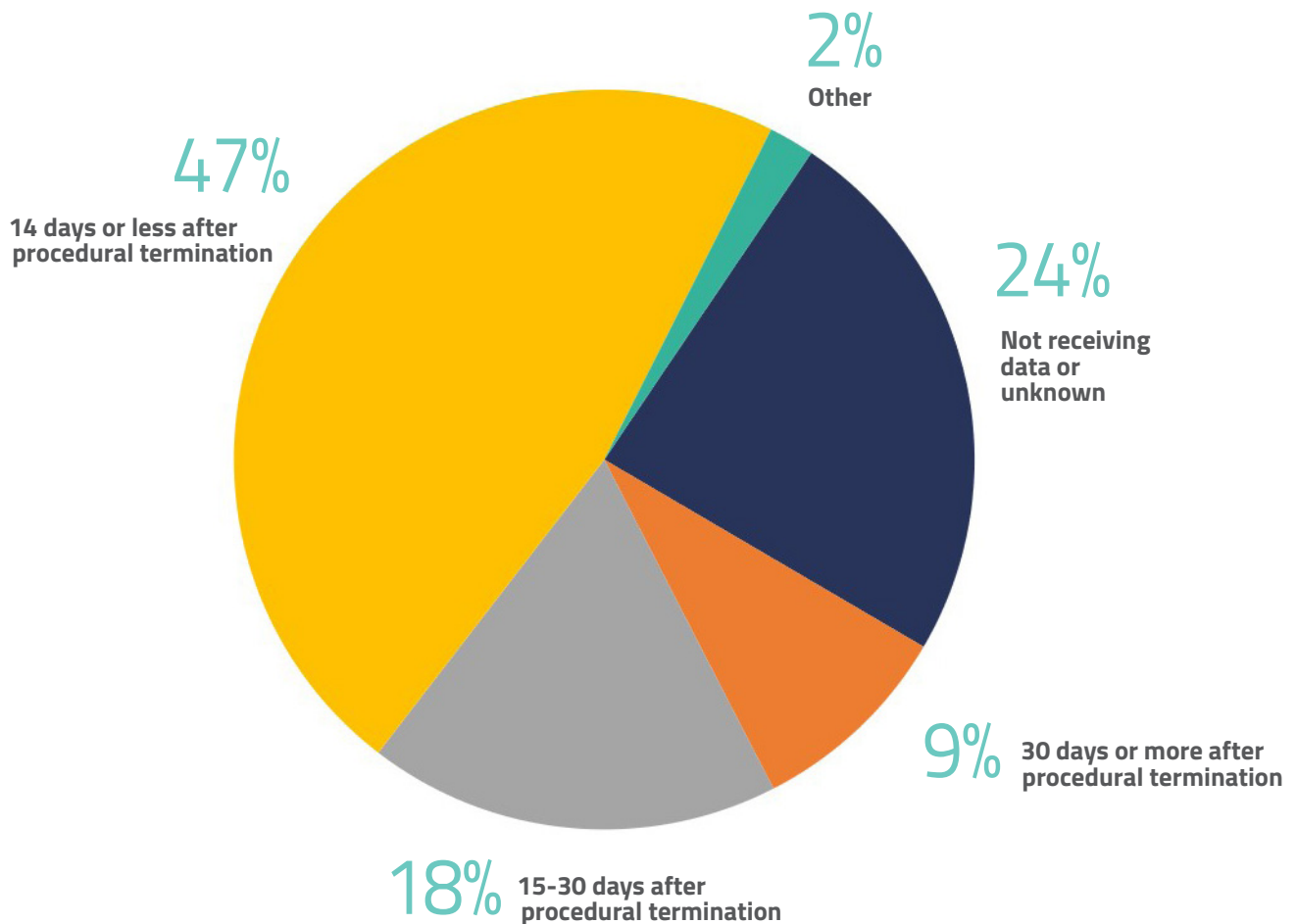
Integrity Issues with State-Provided Data Impede Outreach

For Medicaid MCOs to efficiently target their direct member outreach, they rely on timely, complete, accurate, and regularly provided data indicating which members will have their eligibility redetermined each month. Additionally, MCOs need this data with plenty of time to proactively engage members and work to prevent coverage losses.

Nearly all MCOs report receiving data from the state indicating which members will have their eligibility redetermined. Nearly all MCOs (94%) report receiving it 30 days or more before the member goes through redetermination. At least 76% of MCOs also report receiving data from the state on which members have been procedurally terminated, with the timeline of when that data is shared varying across MCOs and states (Figure 3).

FIGURE 3

How Soon Plans Receive Data on Which Members Have Been Procedurally Terminated



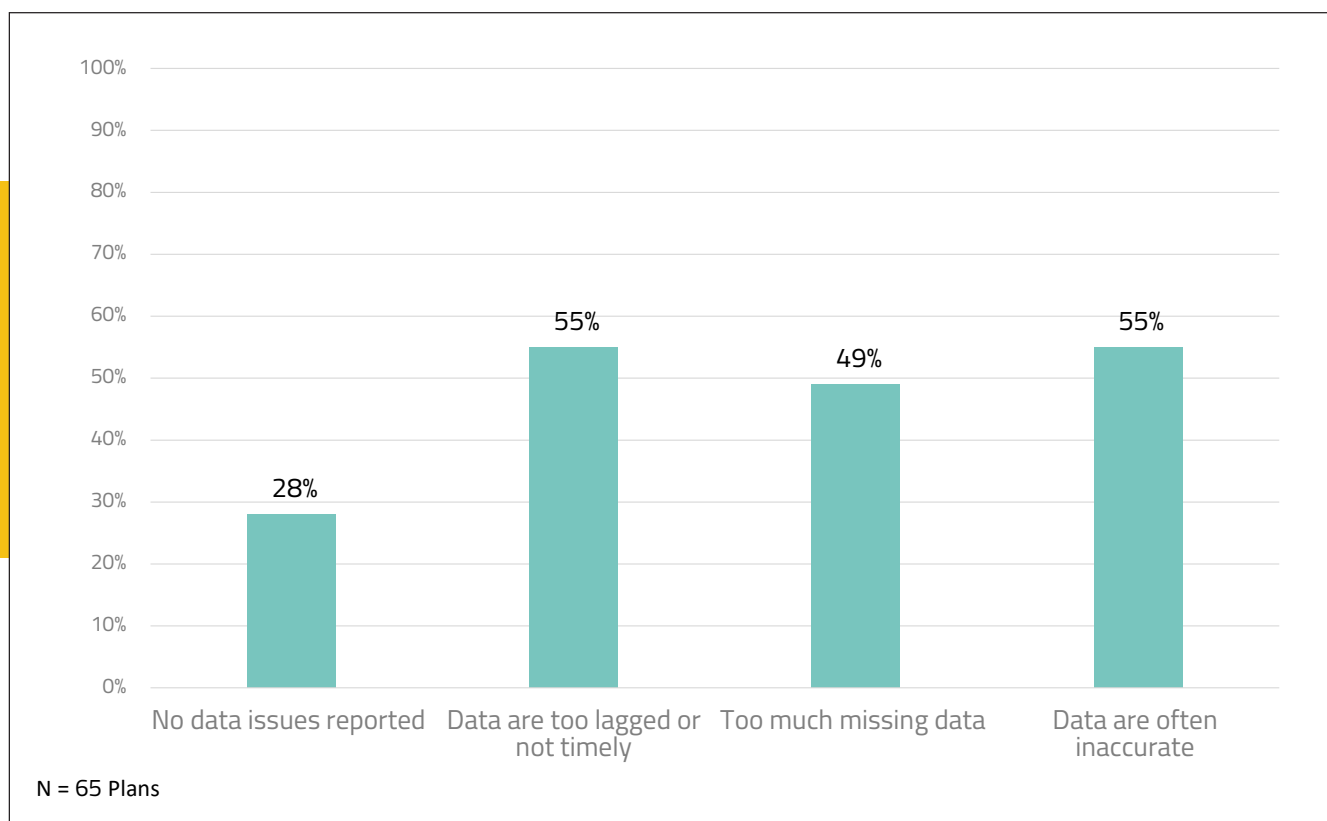
N = 66 PLANS

More than a quarter (28%) of MCOs reported experiencing no data issues with state provided member redetermination status data. The remaining MCOs report experiencing multiple data challenges (Figure 4) and are actively working with states to address data integrity issues.

More than half (55%) report data inaccuracies and 49% report that state data files are missing key information on members (Figure 4). MCOs report receiving data files with incorrect plan status, missing member contact information and/or Medicaid IDs. Some MCOs also comment that they are unable to link family members together to streamline outreach efforts, and others report that the extent of missing data varied month to month. While 76% of MCOs report getting data from the state on which members have been procedurally terminated, 39% report that the data are missing codes indicating procedural termination reasons (not shown).

FIGURE 4

Reported Challenges or Issues with State-Provided Redetermination Data



Latency, or timeliness of receiving data, is also a major concern, with 55% of MCOs reporting delays in receiving data (Figure 4). States restrict the windows of time in which MCOs are allowed to conduct member outreach for both phases of redetermination—first to complete the redetermination paperwork process and second to complete the reconsideration process for those who have been procedurally terminated. States are required to provide 90 days for reconsideration of eligibility for those individuals; however, some states allow for as many as 120 days post disenrollment, if granted by the federal Centers for Medicare and Medicaid Services (CMS) through a waiver.

Shortcomings with state-provided data impedes MCOs' redetermination and reconsideration outreach activities. They inhibit the opportunity to engage or re-engage members because data do not easily indicate who MCOs should reach out to, shorten the timeframe between outreach and completing redetermination paperwork, and make it hard to explain to members what their actual timelines are. Unreliable data also makes it more challenging to equip providers and other partners to support outreach and engagement. Subsequently, more people run the risk of preventable insurance coverage gaps, resulting in delayed needed care, higher out-of-pocket costs, and worsening health outcomes.

Some MCOs report that they are frequently utilizing their own data to augment state-provided data for completeness and usability. Even though MCO capacity to conduct outreach and education activities are limited due to this issue, MCOs are willing and able partners working with states to ensure that members continue to have coverage after the unwinding.

Policy Changes that Enable Greater Plan Action

When MHPA asked member MCOs what policies or process changes would enable broader or more effective support of Medicaid members, several key themes emerged. These themes align with state best practices MHPA previously identified in March and April 2023.⁵

1 *The use of ex parte redeterminations needs to further increase.* CMS requires states to use existing data documenting eligibility information as much as possible to automatically renew eligible beneficiaries. More than half (55%) of people who retained Medicaid coverage were renewed through ex parte renewal as of September 8, 2023. States vary in their use of ex parte renewal, ranging from 3% to 99% of all those renewed.⁶ However, process and technology issues have kept states from taking full advantage of this redetermination simplification tool, and many beneficiaries may end up losing Medicaid. Improving these issues so that states complete more ex parte redeterminations can prevent those still eligible for Medicaid from having their coverage terminated, reduces burden on outreach partners such as Medicaid MCOs and community-based organizations, and ensures providers are reimbursed for covered services.

FOOTNOTES

⁵ Medicaid Health Plans of America, "Resuming Medicaid Eligibility Redeterminations while Minimizing Coverage Disruptions: A Resource for State-level Stakeholders," March 2023, <https://medicaidplans.org/wp-content/uploads/2023/03/State-Resource-Guide-for-Medicaid-Redeterminations-3.1.23.pdf>.

⁶ Kaiser Family Foundation, "Medicaid Enrollment and Unwinding Tracker," as of September 12, 2023, <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/>.

2 *Greater flexibility to conduct outreach to members should be provided.* Some states restrict how and how many members MCOs can engage via text and phone on any given day. The restrictions make it more difficult for MCOs to contact as many of their members whose coverage is being redetermined as possible, which increases the likelihood of members not being informed of their impending redetermination and having their coverage terminated for procedural reasons. Longer timelines to conduct outreach, especially for those whose coverage was procedurally terminated, and permission to help members complete and submit forms would help more eligible members maintain coverage. Also, clear guidelines from both CMS and the states on how MCOs can conduct outreach are of import to ensure MCOs do not run afoul of state and federal laws and regulations.

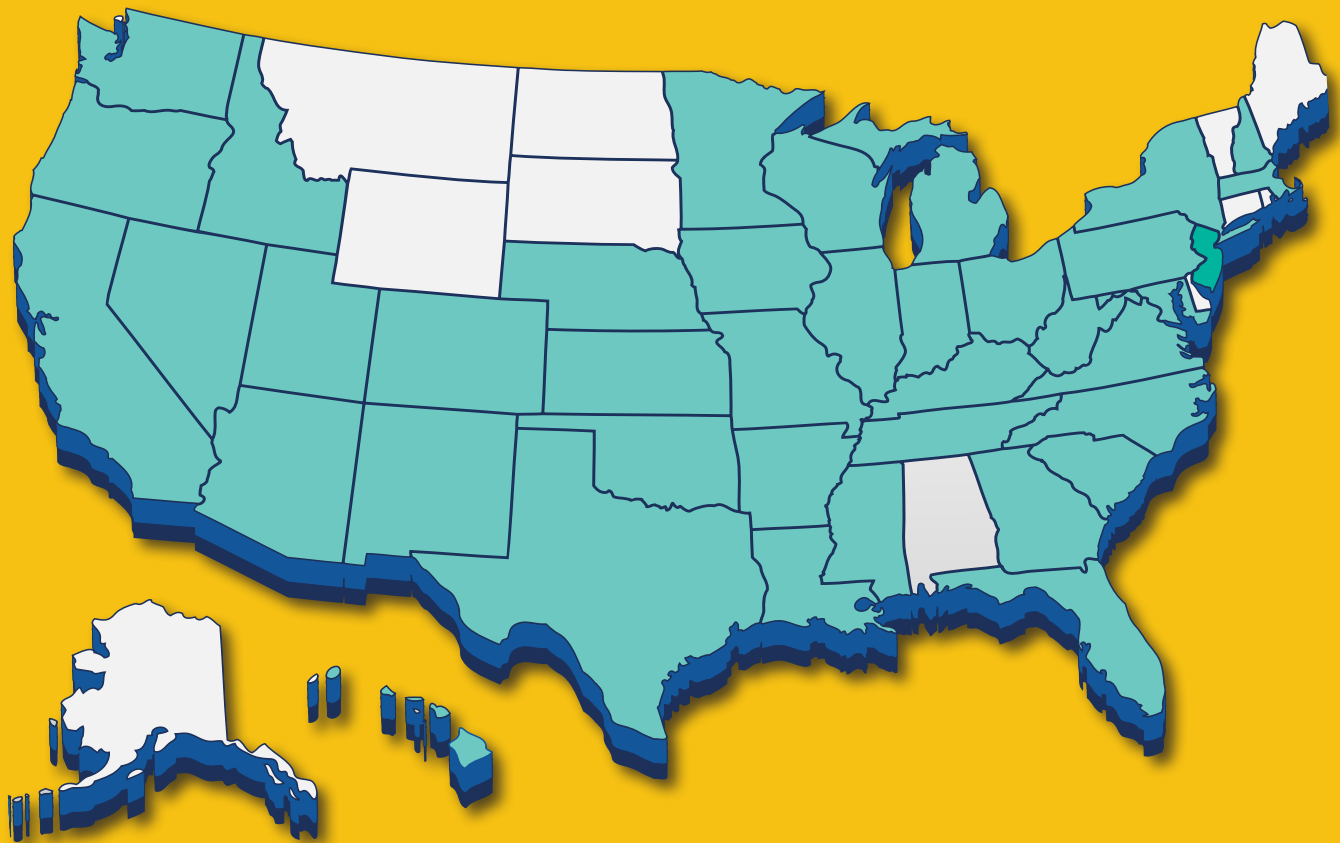
3 *States should adopt additional federal waivers allowing them to streamline the redetermination process.* These waivers are available under section 1902(e)(14) of the Social Security Act to help provide relief to states who are processing an unprecedented number of redeterminations and include flexibilities that allow MCOs to engage more successfully with members, in turn decreasing the number of Medicaid beneficiaries who are likely to fall through the cracks and become uninsured. While this recommendation is closely related to the previous, MCOs felt it was important to call out separately.

4 *Data shared by states should be timely, complete, and accurate so that Medicaid MCOs can effectively engage with members.* The higher the rate of procedural terminations, the more problematic this is for the people who are eligible for and depend on Medicaid for needed care. Sharing data sooner with MCOs, such as 60 days before redetermination, provides more time to contact members and guide them through the redetermination process. Inaccuracy and incomplete data impede outreach efforts.

In Conclusion

The lessons Medicaid MCOs are learning in this process will remain relevant as state Medicaid agencies return to normal operations and manage Medicaid eligibility and enrollment in the future. MCOs are actively engaged in a range of activities to ensure those who remain eligible can maintain their needed Medicaid coverage and, in many cases, are helping those who no longer qualify access coverage in the Marketplace. Their experiences indicate how states and MCOs can partner to minimize care disruptions that lead to worsening health outcomes for those who remain eligible. The lessons learned and policy recommendations listed above become especially pressing as states transition from redetermination to reenrollment of Medicaid-eligible individuals who have unfortunately fallen between the cracks.

Medicaid MCOs **in the USA**



Map Legend



States with at least one participating Medicaid Managed Organization



States with no participating plans



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