Policy Recommendations on the Post-COVID-19 Redeterminations Period

On behalf of the Medicaid Health Plans of America (MHPA), we share the following recommendations as states proceed through the resumption of eligibility determinations following the COVID-19 Public Health Emergency (PHE).

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care organizations (MCOs) serving more than 50 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

Background

At the start of the COVID-19 PHE, Congress enacted the Families First Coronavirus Response Act (FFCRA) which included a maintenance of effort (MOE) requirement for Medicaid. This requirement provided an enhanced federal match of 6.2% in exchange for states keeping individuals continuously enrolled in Medicaid programs through the end of the COVID-19 PHE. Subsequently, Congress passed the Consolidated Appropriations Act (CAA) of 2023 on December 29, 2022, which delinked the end of the COVID-19 PHE from the MOE requirement and instead allowed states to resume eligibility determinations for Medicaid enrollees beginning April 1, 2023. The CAA also gradually reduced enhanced federal funding through December 2023. The continuous enrollment requirement from the FFCRA resulted in record numbers of enrollees for the Medicaid program, with nearly 95 million individuals enrolled by March 2023. As states have conducted redeterminations, enrollment has declined to 90 million individuals as of October 2023, and states are expected to conclude redeterminations or "unwinding" efforts in mid-2024.

During the unwinding period, CMS has offered states numerous optional flexibilities that aim to minimize procedurally related coverage losses. The adoption of these flexibilities has yielded valuable lessons learned which can be carried forward into the post COVID-19 era of Medicaid. CMS has published a list of available strategies to minimize terminations for procedural reasons during the COVID-19 unwinding period, which can be found here.

MHPA has completed a survey of Medicaid MCOs which summarizes efforts by managed care organizations to support the Medicaid renewals process, including best practices and opportunities for the future. The survey was conducted between June and July 2023 and respondents represent 103 different local MCOs across 39 unique states and the District of Columbia; nearly every state that partners with Medicaid MCOs. The results of this survey were key to the development of our policy recommendations. Our recommendations, detailed below, are as follows:

Congressional Recommendations	**Regulatory Recommendations**
State Grant Funding to Modernize Infrastructure Related to Enrollment and Eligibility Systems	Additional Support to Allow MCOs to Help Medicaid Members Complete Renewal Forms
Continuous Eligibility for the Long-Term Services and Supports Population as a State Option	Permanent Flexibility for MCOs to Conduct Outreach via Modern Modalities of Communication
Extension of Enhanced Federal Match (FMAP) for Another Quarter	Increase Use of Ex-Parte Renewals Beyond the Unwinding Period

Congressional Recommendations

State Grant Funding to Modernize Infrastructure Related to Enrollment and Eligibility Systems

Background

- The implementation of the Affordable Care Act (ACA) provided permanent 90% federal financial participation (FFP) to states to adopt streamlined Medicaid enrollment systems, which enable real-time eligibility determinations and automated renewals. However, state systems for enrollment and eligibility continue to vary significantly in their sophistication and ability to support modernized modalities of communication and outreach.
- Less sophisticated systems are sometimes unable support the adoption of new technologies, integration with other health and human services programs, adaptability in implementing new rules, efficiency and accuracy of keeping contact information up to date, and implementation of strong security measures. Additionally, they are often unable to support modernized modalities of data integration with MCOs which, consequently, can lead to unnecessary coverage losses for enrollees who are eligible for Medicaid but are unreachable via traditional mail. With numerous essential programs vying for state funding, state Medicaid agencies may not have sufficient resources available to proceed with systems modernization.

Recommendation

- We recommend that Congress provide grant funding to states in addition to the 90% FFP to allow them to modernize their enrollment and eligibility systems to streamline renewal processes and support the receipt of renewal forms that include voice-recorded signatures and electronic signatures, in order to minimize coverage losses due to procedural reasons. Modernized systems would also allow states to facilitate ex-parte renewals (further defined below) and implement automated processes for members where renewal information is available through existing data sources, minimizing the burden on states and enrollees to process renewals manually.[1]

Continuous Eligibility for the Long-Term Services and Supports (LTSS) Population as a State Option

Background

- The American Rescue Plan Act (ARPA) of 2021 gave states a new option to extend Medicaid postpartum coverage for pregnant people for up to 12 months via a State Plan Amendment. This option was rendered permanent by the CAA of 2023. As of December 2023, 40 states have adopted this option.
- The CAA of 2023 created a requirement for states to provide 12 months of continuous eligibility for children under the age of 19 in Medicaid and the Children's Health Insurance Program (CHIP), effective January 1, 2024.

Recommendations

- Given the value of reducing unnecessary churn among vulnerable populations, and the high level of state support for such options, we recommend providing a similar continuous coverage option to the LTSS population under Medicaid as a state option.

- [1] We appreciate the recent resurgence of Medicaid Information Technology Architecture (MITA), as it offers a national framework to enhance systems development and healthcare management. MITA mandates states to adhere to MITA Standards, conduct a MITA State Self-Assessment (SS-A), implement the roadmap derived from the SS-A, and continually monitor and enhance their systems and processes. Additional funding coupled with MITA guidance would help states move forward in their modernization journey.

- Continuous eligibility provisions have provided stability to children and individuals in the postpartum phase as states conduct redeterminations and have reduced pressure on states to process such a high volume of renewals. Ensuring continuity of care for vulnerable populations is critical to preventing adverse health outcomes.
- We recommend the adoption of 12 months continuous eligibility for the LTSS population in Medicaid as a state option, in order to maximize continuity of coverage and minimize churn for this subgroup, which often faces a more complex renewal process as their eligibility is sometimes based on factors besides income.
- These individuals typically qualify for Medicaid due to categorical eligibility. While financial thresholds remain, the financial fluctuation of these population categories tends to be lower, but their need for Medicaid services remains consistent.

Extension of Enhanced Federal Match (FMAP) for Another Quarter

Background

- The CAA of 2023 phased down the enhanced FMAP from the FFCRA between March 2023 and December 2023 (6.2% through March 2023, 5% through June 2023, 2.5% through September 2023, and 1.5% through December 2023).

Recommendation

- Given the likelihood that states will be processing redeterminations into April 2024 based on CMS efforts to minimize procedurally related coverage losses, we recommend that Congress approve 1.5% enhanced FMAP in the first quarter of 2024 to ensure that states continue to have the resources needed to process the high volume of renewals. A continuation of enhanced FMAP will incentivize states to continue using unwinding-related flexibilities to minimize unnecessary losses of coverage.

Regulatory Recommendations

Additional Support to Allow MCOs to Help Medicaid Members Complete Renewal Forms

Background

- As part of the strategies CMS released to minimize procedurally related coverage losses during the unwinding period, states are currently authorized to leverage Section 1902(e)(14)(A) waivers to permit MCOs to provide assistance to enrollees to complete and submit Medicaid renewal forms.[2]
- Collecting signatures via paper forms has proven to be a barrier to MCOs facilitating complete renewals for enrollees. Medicaid enrollees can be difficult to reach via mail due to the transient nature of the population and the increased frequency of individuals experiencing homelessness. In many instances, a member is reached on the phone and verbally consents to a renewal, but the renewal is not finalized because the plan is unable to obtain a physical signature for the form.
- CMS has recently indicated that there are no federal barriers to MCOs leveraging digital signature software such as DocuSign or voice-recorded signatures to process renewal forms, but states often lack the infrastructure to support such approaches.

Recommendation

- We recommend that CMS provide additional guidance and technical assistance to states to encourage them to support modernized renewal processes. This guidance should affirm to states that there are no federal barriers to leveraging voice-recorded or digital signatures to process renewal forms and should clarify that MCOs can collect an enrollee's signature.
- Rendering permanent 1902(e)(14)(A) flexibilities would provide MCOs with the stability needed to better invest in effective tools to assist with enrollee paperwork and collect signatures.

Permanent Flexibility for MCOs to Conduct Outreach via Modern Modalities of Communication

Background

- Based on a Federal Communications Commission (FCC) ruling from early 2023, state Medicaid agencies and their partners, including Medicaid MCOs, are authorized to send text messages and to make automated phone calls to individuals about enrollment-related issues.
- MCOs are leveraging texting to inform members that they are due for renewals and have indicated that texting yields the highest response rates of all modalities of communication.
- Outside of the context of redeterminations, the consensus is that plans should communicate with their state Medicaid agencies to determine what methods of outreach are permissible and in what situations, given the variation in state policies surrounding outreach to members. Generally, the TCPA requires prior express consent before "any person" makes certain phone calls (the FCC defines phone calls as including texting). While the FCC has indicated that State Medicaid agencies are not "persons" for the purposes of outreach, that same flexibility has not yet been extended to Medicaid MCOs.

Recommendations

- Allowing plans to continue to conduct outreach related to renewals leveraging modern modalities of communication (texting, automated phone calls) with implied consent outside of the redeterminations period would streamline renewals in the long-term moving forward past the unwinding period.

[2] This represents strategy 12 in the CMS document.

- Beyond renewals, given the high response rates to texting, coordination of care would be improved if plans had the flexibility to reach out to members via text with implied consent to share information such as provider networks or benefits. Furthermore, allowing bi-directional communication between health plans and members, including clinical communication, while ensuring compliance with HIPAA regulations, would further improve the effectiveness of care coordination. Plans would continue to be prohibited from conducting marketing outreach without prior express consent and members would have the ability to opt-out, but MCOs would be able to share key information more easily with their existing members.
- As a secondary option to implied consent for digital engagement, states should be encouraged to obtain member consent during the application process and subsequently share that consent with health plans through the 834 file.

Increase Use of Ex-Parte Renewals Beyond the Unwinding Period

Background

- The CAA of 2023 requires states to meet all existing renewal processing requirements to be eligible for an enhanced match, including conducting ex-parte renewals of Medicaid enrollees. Ex-parte processes seek to simplify and streamline the renewal process by requiring states to attempt to confirm ongoing eligibility by using reliable, existing data sources on individuals, such as income.
- The value of ex-parte renewals cannot be understated; based on the most recent CMS data available from March through July 2023, 59.4% of renewals nationwide have been made on an ex-parte basis.
- Ex-parte renewals can be challenging for states in some instances. Non-MAGI eligibility groups, or individuals who qualify on the basis of disability or age, have additional factors for eligibility that are more complicated to verify than for individuals who are eligible solely on the basis of their income. Further, income verification can be a barrier for individuals with zero or unstable incomes. Finally, outdated IT systems in some states can complicate the ability to overlay eligibility data with enrollees to facilitate ex-parte renewals.
- The Medicaid and CHIP Payment and Access Commission (MACPAC) has highlighted opportunities for improving the ex-parte process in a September 2023 Issue Brief, which also provides a detailed overview of the challenges surrounding ex-parte renewals.

Recommendations

- CMS should provide additional guidance and technical assistance to states, especially on renewing non-MAGI enrollees and individuals with zero or unstable income, on an ex-parte basis.
- CMS should provide robust technical assistance to states with low ex-parte renewal rates on how they can effectively leverage existing data sources, such as Supplemental Nutrition Assistance Program (SNAP) data, to support renewals.
- CMS should make Section 1902(e)(14)(A) flexibilities permanent to support the use of SNAP data and other sources of data to process ex-parte renewals.