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THE VOICE FOR HEALTH CARE CONSUMERS

Case Study: Strategies for States to Maximize Medicaid Ex Parte Renewals and Limit Coverage Losses

Introduction

More than 80 million people rely on Medicaid for their health insurance. If states do not proceed carefully when the federal COVID-19 public health emergency (PHE) declaration ends, a significant number of Medicaid enrollees will be at risk of losing coverage.[1] Throughout the PHE, states have suspended the disenrollment of ineligible beneficiaries in an effort to stabilize health insurance coverage during an unprecedented and tumultuous time. When the PHE ends, states will resume terminations of those who are found ineligible or fail to respond to request for information notices and successfully renew coverage. Researchers estimate that, if past eligibility determinations are a sign of what is to come, between 13 million and 16 million people would lose Medicaid coverage, many of whom would remain eligible but lose coverage unnecessarily.[2,3]

Defining "*Ex Parte*" Renewals

States use many terms interchangeably with *ex parte*, including automated and passive. In this paper, we use the term "*ex parte*" to describe Medicaid renewals in which agencies are able to renew beneficiaries based on existing and accessible beneficiary data without having to contact beneficiaries for updated information. Ultimately beneficiaries are able to maintain Medicaid coverage without taking any actions through the *ex parte* renewal process.

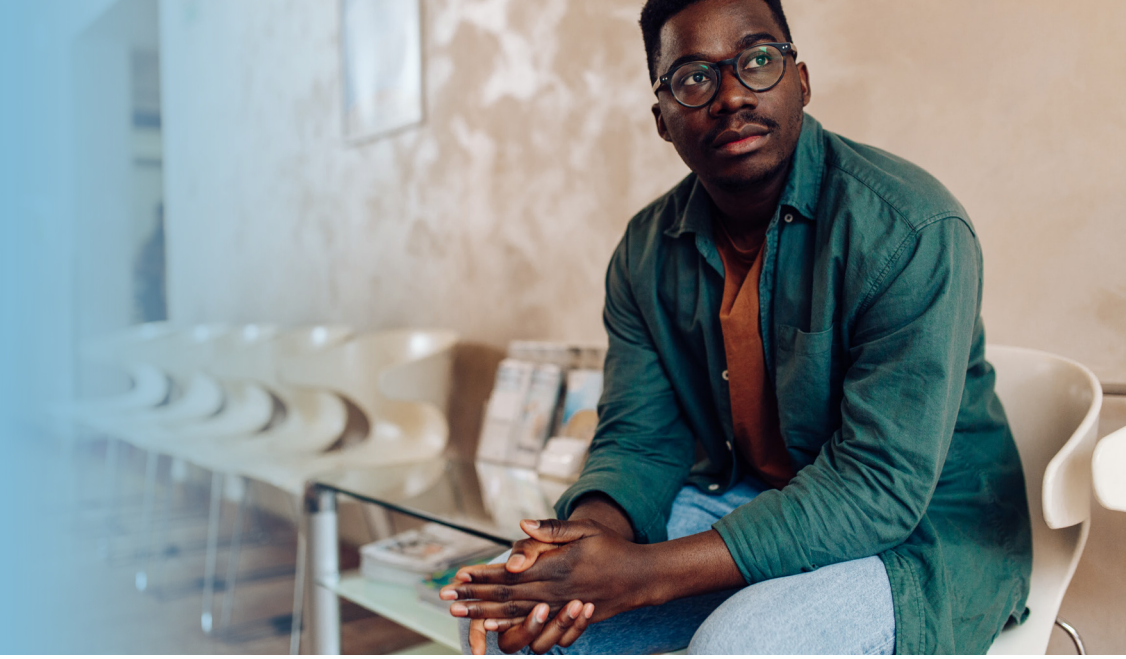
Ultimately, the number of people who maintain Medicaid coverage depends on the steps states take to ensure that eligible people maintain coverage. Perhaps the most important tool states can use to quickly process eligible beneficiaries is an "*ex parte*" renewal procedure. In this process, states use existing data sources to determine a person's eligibility rather than relying on a flawed multi-step process of mailing out notices and requiring an individual to respond with proof of their eligibility. Maximizing the use of *ex parte* renewals is a state obligation under federal law. Nevertheless, before Medicaid redeterminations were suspended, states used *ex parte* renewals in varying degrees. According to a report from the Kaiser Family Foundation, in 2020 seven states reported they used *ex parte* for less than 25% of their renewals, and nine states were leading the way by maximizing the use of *ex parte* for 75-90% of their renewals.[4]

This issue brief highlights the successes and opportunities that other state Medicaid agencies can use when preparing for upcoming redeterminations at the end of the PHE. We interviewed state Medicaid agency officials from six states, three of which had pre-pandemic *ex parte* renewal rates of 75-90%, to understand their existing redeterminations processes, including the use of *ex parte* renewals, and to share best practices for states to consider prior to resuming terminations once the PHE ends. Based on our interviews, we highlight seven strategies for states to help ensure that eligible people who rely on Medicaid for their health insurance will not lose their coverage unnecessarily in the coming months.

7 strategies for states to ensure that eligible people who rely on Medicaid will not lose their coverage unnecessarily

1. Gather beneficiary information from as many data sources as possible to renew eligibility without seeking information from beneficiaries.
2. Provide several pathways for beneficiaries to contact the agency and update their information.
3. Develop a communications plan for outreach to beneficiaries that supports language access and relies on a variety of communication channels.
4. Involve Medicaid managed care plans in the redetermination strategy.
5. Partner with enrollment assister and advocacy organizations in different communities across the state.
6. Solicit feedback from beneficiaries and advocates, and create opportunities for such feedback to be provided.
7. Connect with other states and share best practices.

When the PHE ends, more than 80 million people enrolled in Medicaid will have their eligibility redetermined.



Background

The Families First Coronavirus Response Act (FFCRA) was enacted in March 2020 and included a Medicaid continuous coverage requirement that prohibits states from terminating individuals from Medicaid during the federal PHE as a condition of accessing enhanced Medicaid funding.[5] This enhanced funding includes a 6.2% increase in the federal share of Medicaid spending for states that meet maintenance of eligibility requirements.[6] When the PHE ends, more than 80 million people enrolled in Medicaid will have their eligibility redetermined, putting eligible individuals at risk of losing coverage through a process that is administratively burdensome for both states and beneficiaries.

At the release of this publication, the PHE is scheduled to end on July 15, 2022, if it is not renewed again by the Biden administration.[7] On March 3, 2022, the Centers for Medicare & Medicaid Services (CMS) released a letter to state health officials clarifying federal expectations for state Medicaid agencies as they prepare to resume terminations when the federal Medicaid continuous coverage requirement ends. These expectations include monthly data reporting, adherence to CMS guidance on redetermination timelines, consideration of strategies to mitigate churn, among others.[8]

Federal law requires states to maximize their use of the automated *ex parte* process to consider cases quickly, and most states use such a process for at least a portion of their redeterminations. In these cases, Medicaid agencies first sift through a variety of data sources in an attempt to renew beneficiaries' coverage without the need to contact them and request further information. For some states this process is entirely electronic, while for others, the automatic renewals process still requires caseworker involvement. The ability of states to keep eligible beneficiaries enrolled will be determined by the policies and procedures used to redetermine beneficiaries' eligibility, including the use of *ex parte* renewals. Because they require less administrative effort than fully manual renewals, *ex parte* renewals are also important to states' management of what could otherwise be an unmanageable burden of an unprecedented number of redeterminations.

New research: Identifying best practices for states to maximize ex parte renewals and limit coverage losses

Families USA conducted a qualitative study in March 2022 of six states that performed *ex parte* renewals at particularly high rates prior to the pandemic. We sought to uncover the practices that led to their success, with an eye toward identifying strategies that other states can use to prepare effectively for the end of the PHE. We interviewed Medicaid agency staff members in Alabama, Arizona, Idaho, Iowa, Maryland, and North Carolina. They detailed their *ex parte* renewal processes and provided recommendations for states to limit the number of eligible beneficiaries who lose coverage when redeterminations restart.

Ex Parte Renewal Rates Prior to the Pandemic[12]

Alabama

75-90%

RENEWAL RATE

Arizona

50-75%

RENEWAL RATE

Idaho

75-90%

RENEWAL RATE

Iowa

50-75%

RENEWAL RATE

Maryland

50-75%

RENEWAL RATE

North Carolina

75-90%

RENEWAL RATE

We heard themes around data and eligibility integration, communications and outreach, language and other accessibility considerations, and stakeholder partnerships. From our interviews with state Medicaid agency staff, we have identified the strategies described below that states can employ to maximize *ex parte* renewal rates and limit coverage losses for procedural reasons once the PHE ends.

STRATEGY 1:

Gather beneficiary information from as many data sources as possible to renew eligibility without seeking information from beneficiaries

Ensuring beneficiary data gathering is comprehensive and streamlined is the number one strategy for maximizing *ex parte* renewal rates. This is because in the *ex parte* renewal process, states scan various data sources to identify the beneficiary information needed to make a redetermination, and if successful, eligible beneficiaries are renewed without being asked to provide additional information. The states we interviewed each used a variety of data sources at their disposal before deciding to contact beneficiaries, and all six states recommended others do the same. Some recommended data sources include state and federal data hubs, Social Security Administration records, Internal Revenue Service files, Unemployment Insurance information, and Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) data, if available. Arizona Medicaid staff also noted that data from their Department of Motor Vehicles has been particularly helpful for verifying state residency. State systems incorporate data from these sources using defined business rules that specify what information indicates Medicaid eligibility and whose coverage to renew.

As an overarching strategy for identifying priority data linkages, our interviewees recommended identifying the types of information beneficiaries often provide when they are sent request for information notices and determining why people are having to provide this data manually. By identifying and filling the biggest data gaps that prevent *ex parte* renewals, state Medicaid agencies will be able to increase the efficiency of the *ex parte* renewal process and maximize these renewal rates.

The gold standard is a fully electronic ex parte renewal system, where data sources are checked electronically and eligibility is automatically determined.

In addition to the breadth of data sources used, agencies should also consider automating these processes. *Ex parte* renewal processes are most efficient, and therefore most effective at renewing beneficiaries' coverage without having to contact them for additional information, when they are as automated as possible. Both federal law and good policy require states to maximize *ex parte* renewals. Thus, the gold standard is a fully electronic *ex parte* renewal system, where data sources are checked electronically and eligibility is automatically determined. Of the six states we interviewed, the following five have fully electronic *ex parte* renewal processes for at least some

of their beneficiaries: Alabama, Arizona, Idaho, Iowa and Maryland. In Alabama, children can also be automatically *ex parte* renewed to CHIP if they are ineligible for Medicaid. North Carolina, on the other hand, has an *ex parte* renewal system that is semi-automated and includes caseworker involvement at certain steps of the data matching process – although, they are working towards fully automating their *ex parte* renewal process. Ultimately, we recommend fully electronic processes as the gold standard for administrative efficiency and program retention, but North Carolina officials noted that administrative savings and increased renewals can still result from manual procedures that do not rely on beneficiary contact to establish continued eligibility.

STRATEGY 2:

Provide several pathways for beneficiaries to contact the agency and update their information

During the *ex parte* Medicaid redeterminations process, agencies must have access to beneficiaries' updated information, including income and residency, in order to make an automatic redetermination and renewal. If the agency does not have a beneficiary's updated information, the agency must ask the beneficiary to provide it – an extra communications step that creates a risk of coverage loss. There are a number of reasons why a beneficiary may not respond to a request for information, including confusion, language barriers, general paperwork burdens, or if the mailed request was not delivered and returned to the agency. It is imperative to limit the number of beneficiaries who must be contacted for a redetermination by creating several accessible pathways for beneficiaries to contact the agency and update their information.

Idaho has a one-touch integrated eligibility system, so when consumers call, the agency works to update their information and assess their eligibility for several state programs at once. Consumers in Idaho have the opportunity to call and perform their renewal by phone, which is how 70% of issues are resolved. In an integrated eligibility system, back-end processes are more efficient for caseworkers and the burden is taken off of consumers to contact each individual program for which they may be eligible or enrolled. Alabama, in addition to working with beneficiaries over the phone and in person, has an online portal where beneficiaries can update their personal information 24/7. Similarly, Maryland has a smartphone application where beneficiaries can contact the agency and update their information. In addition to providing pathways for beneficiaries to update their information, it is important that beneficiaries are actually made aware of these contact methods. We will delve deeper into this topic in Strategy 3.

There are a number of reasons why a beneficiary may not respond to a request for information, including confusion, language barriers, general paperwork burdens, or if the mailed request was not delivered and returned to the agency.

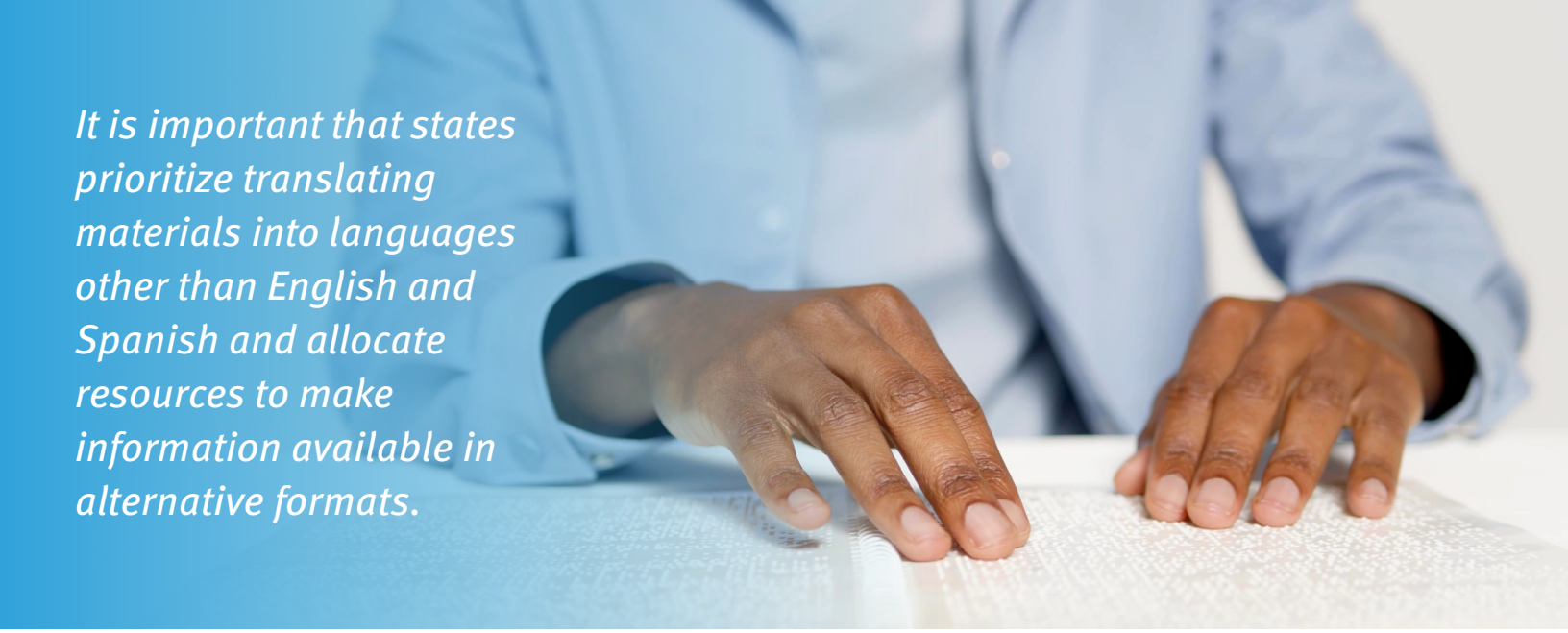
During the pandemic, many residents moved and changed addresses, and others experienced eviction when the eviction moratorium ended, both of which pose a risk of coverage loss. To reduce the high risk of erroneous disenrollments, states can proactively seek out updated beneficiary residences. Of the six states we interviewed, Arizona, Idaho, and North Carolina are taking this proactive step. North Carolina has an ongoing returned mail report and Arizona Medicaid has been using data from their DMV in addition to the U.S. Postal Service's National Change of Address (NCOA) database. According to the Kaiser Family Foundation, Arizona joins only eight other states, including Idaho, that are using the NCOA database to update mailing addresses before the end of the continuous enrollment requirement.[9] Over half of all 50 states, including Alabama, Arizona, Iowa and Maryland, are working with managed-care organizations (MCOs) to identify updated beneficiary mailing addresses. We will go more in depth into involving Medicaid health plans in Strategy 4.

STRATEGY 3:

Develop a communications plan for outreach to beneficiaries that supports language access and relies on a variety of communication channels

A major barrier to successful Medicaid renewal is confusion among beneficiaries. There have been several regulatory changes made to the Medicaid program, in addition to other programs during the pandemic, and some beneficiaries may have not had regular contact with their state Medicaid agency the last two years. To process redeterminations quickly and renew as many eligible beneficiaries as possible, states must strongly consider how they and other stakeholders are communicating to beneficiaries.

Within a communications plan, it is important that agencies be strategic about the sequencing of communication and focus on being clear about the upcoming changes, deadlines and information needed from the beneficiary. All six states we interviewed have continued outreach to beneficiaries during the pandemic, which they expect will limit general confusion around redeterminations. Our interviewees recommend states continually revise the language of letters and notices to improve clarity, reduce confusion and address outstanding beneficiary questions.



It is important that states prioritize translating materials into languages other than English and Spanish and allocate resources to make information available in alternative formats.

The Idaho Medicaid agency found that sending out notices for redetermination in a different color makes packaging notices for mail easier and draws attention to the notice, thereby encouraging responses from beneficiaries. We recommend other states consider this strategy.

Additionally, accessibility, including language, format and content accessibility, is an imperative communications consideration. In North Carolina, the state Medicaid office can translate notices from English and Spanish to about 14 other languages, and outside of those languages, an individual's local county offices can translate them further. It is important that states prioritize translating materials into languages other than English and Spanish and allocate resources to make information available in alternative formats. Beneficiaries must be given next steps that are equally accessible and feasible to respond to.

In considering how best to communicate with beneficiaries, state Medicaid agencies should identify and utilize the most effective ways to reach them. In addition to mailed notices, many of the states we interviewed are reaching beneficiaries in other ways. Maryland Medicaid staff may call their beneficiaries while Arizona, Idaho and North Carolina send text messages. Regarding mailed notices, a best practice identified by our interviewees is ensuring that any forms sent to beneficiaries are pre-populated, meaning that beneficiaries only need to fill in the information that the agency is missing and requesting. This takes some of the burden off of beneficiaries and increases the likelihood they will fill out and return any notices they receive.

In creating a communications plan, it is necessary to involve other stakeholders who can act as additional points of contact with beneficiaries. The next two strategies delve more deeply into stakeholder engagement.

STRATEGY 4:

Involve Medicaid managed care plans in the redetermination strategy

Medicaid health plans often have more direct access to beneficiaries than state agencies, and these plans can be critical partners in increasing the likelihood that beneficiaries will update their information sooner and respond to any information request notices. As our Maryland Medicaid interviewee said, redeterminations are a "joint effort of many people reaching out to the consumer." We encourage states to inform MCOs of who is up for renewal in a given month so they can perform targeted outreach to their members. In Arizona, Medicaid officials share a list of beneficiaries up for renewal each month and their MCOs make robocalls reminding their consumers that they are up for renewal and advising them to update their information and respond promptly to any notices they receive. Maryland's Medicaid agency also provides its MCOs and local health departments with monthly renewal data, and when they receive returned mail, it notifies the appropriate MCO. Idaho's Medicaid agency uses the Department of Health and Welfare's Partner Data Access Portal to share the status of beneficiaries' Medicaid coverage with providers and plans. We recommend states not only provide Medicaid health plans with useful information, but also involve them in the redeterminations planning process and solicit their feedback, given the contact they have with Medicaid beneficiaries. An additional consideration is transparency in these relationships. To ensure that advocates and community organizations understand what beneficiaries are experiencing, it is important to share information about which plans are engaging in targeted outreach, which people they are contacting and how they are supporting their members.

STRATEGY 5:

Partner with enrollment assister and advocacy organizations in different communities across the state

Medicaid agencies should partner with community groups, advocacy organizations and safety net provider organizations, including navigator and enrollment assister organizations, federally qualified health centers (FQHCs), and primary care associations . Our Maryland Medicaid interviewee offered more insights saying, "Look at everyone as a partner. It takes a village to keep people on Medicaid." Many of the states we interviewed have some type of partnership with advocacy groups that allows them to coordinate their outreach efforts and gather feedback from beneficiaries. In Alabama, Medicaid officials have reached out to about 20 advocacy and provider groups across the state, asking them to reach out to beneficiaries about updating their information prior to their redetermination. Alabama Medicaid also recently decided to partner with some of these groups as enrollment assister organizations, training them on how to enroll and reenroll beneficiaries.

It takes a village to keep people on Medicaid.

When formally and informally involving advocacy and community groups in Medicaid agency redetermination plans, it is important to eliminate any barriers to partnership. For example, Arizona has a large enrollment assister network – many of which are FQHCs – that enter into an agreement with the Medicaid agency to keep track of their Medicaid beneficiaries. Previously, there was a fee for this formal agreement, but dropping the fee led many more enrollment assister organizations to participate in the program, amplifying their joint efforts. Eliminating barriers to partnership will help agencies connect with as many groups as possible, resulting in more contact with beneficiaries ahead of the ending of continuous coverage.

Many of our interviewees noted that their partners are willing to help the agency reach beneficiaries regarding redeterminations. We have heard from these agencies that consumer groups creating and disseminating communication materials that inform beneficiaries of the upcoming redeterminations and instructions on updating their information would be most helpful.

STRATEGY 6:

Solicit feedback from beneficiaries and advocates and create opportunities for such feedback to be provided

To maximize the number of eligible Medicaid beneficiaries who maintain their coverage once the continuous coverage provision ends, it is important to solicit feedback from beneficiaries and improve the redeterminations process. Of the states we interviewed, North Carolina is proactively gathering feedback from their beneficiaries. The North Carolina Medicaid agency has held public forums where consumers can voice their concerns and ask questions, and these forums have been particularly successful when held both after work hours and at various times throughout the day to accommodate people's varying schedules.

Our interviewees said they are looking for feedback on how best to communicate with beneficiaries to limit confusion around renewals, which presents an opportunity for consumers, community groups and advocacy organizations to influence these upcoming redeterminations.

While CMS is requiring reporting from state Medicaid agencies, there is a need for transparency so that state plans align with effective implementation. We highly recommend that states make their reporting transparent to community groups and advocacy organizations so that their feedback is meaningful.

STRATEGY 7:

Connect with other states and share best practices

States have valuable information to share about their unique enrollment and redetermination experiences. Most of the states we interviewed are involved in some type of work group, such as CMS workgroups, National Association of Medicaid Directors meetings, and the National Eligibility Workers Association meetings. Beyond these formal communication forums, some states have proactively met with leaders from other states to share best practices regarding the processes of their programs. Idaho officials met with officials in other states to share best practices regarding their SNAP program, and developers of the North Carolina Families Accessing Services through Technology (NC FAST) program had conversations with officials in other states about their system. We encourage state Medicaid agencies to engage with one another in similar ways regarding their Medicaid redeterminations processes. Since every state will be facing the end of continuous coverage at the same time, Medicaid agencies can support one another through this process to increase efficiency and ensure eligible consumers do not lose Medicaid for procedural reasons.

New opportunities under CMS' latest guidance

The CMS letter to state health officials released in March 2022 includes guidance for state Medicaid agencies and stakeholders on resuming routine operations once the PHE ends. The guidance reinforces existing regulations and creates new options for states to limit Medicaid beneficiary churn. In addition to the strategies identified in this analysis, below are some additional steps states can now take at the end of the PHE to maximize the number of eligible beneficiaries who maintain Medicaid coverage.

- States can make sure redetermination outcomes data reporting is transparent. Doing so will help advocates, navigators and enrollment assisters keep track of who has been contacted and which communities require further outreach. While states are required to report to CMS, making the data public is best practice. Data reporting often leaves behind underserved and vulnerable communities, such as communities of color and those in rural areas. Transparency also keeps states accountable.
- State Medicaid programs can implement a new federal option for SNAP-based electronic renewal. When Medicaid redeterminations begin after the end of the PHE, states are allowed to automatically renew coverage for beneficiaries under age 65 who also receive SNAP benefits. Nearly all SNAP recipients qualify for Medicaid, so utilizing this option would lower administrative burden for understaffed state and local agencies.[10]
- States can adopt strategies to retain workforce capacity, which is a top concern for many states. This includes adopting workplace flexibilities, like allowing employees to telework, using third-party contractors to support case processing, increasing automation to minimize paper-based manual work, and distributing renewals across the full 12-month unwinding period to maintain a reasonable workload for staff and decrease the potential for burnout.[11]

Conclusion

Recommendations to increase efficiency and maintain eligible beneficiary enrollment

- State Medicaid agencies should streamline data processes and use as many data sources as possible to determine eligibility, which is the single best way to increase *ex parte* renewal rates. This is important because *ex parte* renewals can be processed without the agency having to contact the beneficiary.
- Medicaid agencies should create a deliberate communications plan that focuses on clarity and limiting confusion among beneficiaries. Language and other accessibility needs should be considered.
- State agencies should work with various stakeholders, including health plans, community partners, advocacy and enrollment assister organizations, and primary care associations to amplify their reach to beneficiaries, especially those who may be harder to contact and require additional accessibility considerations.

Families USA conducted this qualitative research to reveal *ex parte* Medicaid renewal best practices and inform state policymakers and advocates about strategies to limit the number of eligible individuals who lose their Medicaid coverage once the continuous coverage provision ends. With the ending of the PHE nearing and the resumption of mass redeterminations looming, eligible beneficiaries are at risk of inaccurate coverage loss for administrative reasons, but it is clear that there are steps states can take to prevent this from happening. State Medicaid agencies must be intentional about the processes they put in place to redetermine and renew beneficiaries' coverage to ensure efficiency and the maintenance of coverage for as many eligible beneficiaries as possible.

We encourage states to adopt these strategies ahead of the end of the PHE to ensure all eligible beneficiaries maintain their Medicaid coverage and others smoothly transition to other coverage options.

Endnotes

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