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States Can Act Now to Keep Medicaid Enrollees Covered When the Public Health Emergency Ends

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The continuous coverage provision of the Families First Coronavirus Response Act prohibits Medicaid agencies from terminating coverage for most enrollees during the federally declared public health emergency (PHE). State Medicaid agencies should act now to prepare for the end of the PHE and develop policies to resume regular operations that ensure eligible enrollees retain crucial health coverage.

Families First, enacted in March, temporarily increased the federal government's share of Medicaid costs (known as the federal medical assistance percentage, or FMAP) to help states deal with increased enrollment and large budget shortfalls due to the COVID-19 public health and economic crises. Congress also put in place key protections for beneficiaries, prohibiting states from cutting Medicaid eligibility while receiving the additional federal funds and from terminating most people's coverage. Under the continuous coverage provision, states may not terminate Medicaid coverage during the PHE unless an enrollee requests termination, moves out of state, or dies.

The continuous coverage provision has played a critical role in preserving health coverage for people with low incomes during the pandemic. Under normal circumstances, to stay enrolled enrollees must respond to requests for information when the Medicaid agency thinks their income has changed and when they need to complete annual eligibility renewals. But enrollees often don't receive these requests or respond to them timely, and agencies sometimes fail to process responses from enrollees, so many enrollees lose coverage despite remaining eligible and have to reapply. This cycle, known as churn, can lead to gaps in coverage for enrollees and unnecessary administrative burdens for enrollees and Medicaid agencies.

The pandemic has upended the lives of many Medicaid enrollees who have lost jobs, relocated, and experienced health crises. Medicaid agencies have been thrown into chaos with office closures, eligibility personnel working from home, and staffing shortages due to illness, caregiving responsibilities, and budget cuts. Without the continuous coverage provisions, these factors would have likely led to many eligible enrollees losing coverage due to failures to complete or process paperwork. Fortunately, the continuous coverage provision has kept people enrolled and allowed state agencies to focus their limited bandwidth on processing new applications.

The continuous coverage provision is in effect through the end of the month in which the PHE declared by the Secretary of Health and Human Services (HHS) ends. The Secretary recently renewed the PHE.[1] This declaration will last through late January 2021 and will likely be further extended; the Congressional Budget Office (CBO), for example, has projected the PHE will last into early 2022.[2]

Many agencies responded to the continuous coverage provision by stopping actions on renewals and changes and will have to deal with many overdue renewals when the PHE ends. If states try to rapidly address their backlogs at the end of the PHE, notices will be sent to outdated addresses, enrollee questions will go unanswered by overwhelmed call centers, and eligibility staff will be unable to process the volume of returned paperwork. Thousands of eligible enrollees will lose coverage, prompting a barrage of phone calls, appeals, and reapplications that will further overwhelm short-staffed state agencies. But if state agencies can effectively communicate with enrollees and streamline their workloads, most eligible people will retain coverage.

Two sets of things must happen to ensure eligible people stay covered. First, states must take steps now to renew and update cases when possible, strengthen their renewal process in preparation for the end of the PHE, and improve communications with enrollees. Second, states must establish policies for the end of the PHE to conduct renewals for all cases based on current information, stagger out the renewals to effectively manage their workload, and ensure smooth transitions between different types of coverage for those whose circumstances have changed.

Well before the end of the PHE, the Centers for Medicare & Medicaid Services (CMS) needs to provide states with clear guidance on how they should restart renewals in a way that preserves coverage for eligible enrollees.[3] HHS should notify states when it expects to stop renewing the PHE well in advance of its expiration, providing agencies with time to make system changes and effectively communicate with enrollees and community organizations. Moreover, CMS' guidance must direct states to complete full renewals of the entire caseload based on current information and mandate that states spread out the workload over a manageable period. While waiting for guidance, Medicaid agencies can act now to prepare for reinstatement of renewals and develop policies for the end of the PHE that will ensure coverage for eligible enrollees.

Actions States Can Take Now

Although the end date of the PHE remains uncertain, states can act now to better situate themselves for the resumption of normal operations. The following steps will reduce confusion, loss of coverage for eligible enrollees, and administrative burden on states, including from reapplications from those who lose coverage despite remaining eligible.

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[1] U.S. Department of Health and Human Services, "Renewal of a Determination That a Public Health Emergency Exists," October 2, 2020, https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx.

[2] Congressional Budget Office, Estimate of H.R. 748, the CARES Act, April 27, 2020, https://www.cbo.gov/system/files/2020-04/hr748.pdf.

[3] Medicaid and CHIP Payment and Access Commission, Letter to Secretary Azar, March 25, 2020, https://www.macpac.gov/wp-content/uploads/2020/08/Letter-to-the-HHS-Secretary-Regarding-Notice-to-States-on-Unwinding-the-COVID-19-Public-Health-Emergency.pdf.

Renew Coverage Now When Possible

Federal regulations require Medicaid agencies to attempt to automatically renew an enrollee's eligibility using available data sources before requesting any information from the enrollee, a process known as *ex parte* renewal. To reduce the renewal backlog at the end of the PHE, agencies can conduct *ex parte* Medicaid renewals now. If an agency can confirm ongoing eligibility for enrollees using electronic data sources — such as confirming through quarterly wage data that household income is below the eligibility threshold — it can renew eligibility *ex parte* and extend it for 12 months. The case will likely then be current, rather than overdue, when the PHE ends.

If an agency can't successfully renew a case *ex parte*, it may choose not to mail a renewal notice, the next step in the renewal process, as this may cause confusion for the enrollee during the PHE. If an agency does send a renewal notice, it can renew coverage if the enrollee returns the renewal form and any required documents showing they remain eligible. But the agency may not terminate an enrollee's coverage during the PHE if the notice is returned as undeliverable, the client fails to respond to the notice, or the response suggests ineligibility. Agencies should take no action on these cases and re-evaluate eligibility once the PHE ends.

Improve the Renewal Process

Federal regulations require a streamlined renewal process which, when implemented effectively, can ensure continuity of care for enrollees and decrease the burdens reapplications cause.[4] There is great variation in how states implement these requirements and in the results, particularly the success rate of *ex parte* renewals.[5] Medicaid agencies can act now to improve the success rate for *ex parte* renewals to ensure eligible enrollees stay covered and to decrease the burden on eligibility workers.

The *ex parte* process is largely automated so modifications generally require analysis and changes to the state's eligibility system. While this is time-consuming, it can yield great dividends as even a small increase in the percentage of automatically renewed cases can mean a substantial decrease in churn and caseworker burden, prioritizing caseworker time for more complex cases. Further, states can access an enhanced federal match that offsets much of the cost of eligibility system changes. To improve *ex parte* renewals, state agencies should:

- **Examine the data.** Eligibility systems have criteria for allowing renewal of cases *ex parte*. Cases may not qualify if, for example, income can't be verified using available data sources or a caseworker action is pending on the case. By obtaining and analyzing data showing which requirements account for most cases that can't make it through the *ex parte* process, an agency can identify areas for further examination. For example, there may be additional data sources the state could access to verify income or a change in workflow that could resolve pending caseworker actions, allowing more cases to be eligible for *ex parte* renewal.

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[4] Center on Budget and Policy Priorities and Center for Law and Social Policy, "Improving SNAP and Medicaid Access: Medicaid Renewals," November 30, 2018, https://www.cbpp.org/research/health/improving-snap-and-medicaid-access-medicaid-renewals.

[5] Tricia Brooks *et al.*, "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," Kaiser Family Foundation, March 26, 2020, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/.

- **Analyze the system design documents.** Design documents, which policy staff usually develop in coordination with the eligibility system vendor, instruct programmers how the system should operate. The design documents for *ex parte* renewals outline the criteria cases must meet to go through the *ex parte* process. For many states, these design documents were created years ago during Affordable Care Act (ACA) implementation. Re-examining decisions made at that time could allow more cases to be successfully renewed *ex parte*. For example, the system may have been designed to disallow *ex parte* if the Medicaid case shows one employer but the data sources show two current employers. State agencies could modify the rules so that the case is eligible for *ex parte* renewal if the combined income from both current employers is under the eligibility threshold.
- **Leverage current information from other programs for Medicaid renewals.** Medicaid agencies can conduct *ex parte* renewals based on information from other programs, such as the Supplemental Nutrition Assistance Program (SNAP). States can use income information recorded in the SNAP case, use the "fast track" state plan option to adopt the gross income calculated for SNAP, or use Express Lane Eligibility to renew Medicaid based on children's enrollment in another program.[6] All of these options would allow an agency to complete *ex parte* renewals for individuals enrolled in both Medicaid and SNAP without requiring action by the enrollee. States can also conduct an *ex parte* Medicaid renewal in conjunction with a SNAP renewal (but can't terminate coverage during the PHE even if information provided during the SNAP renewal suggests ineligibility).[7] States can use these options to increase the success rate of *ex parte* renewals whether their SNAP and Medicaid eligibility systems are integrated or separate.

Transition Eligible Cases to Other Coverage Groups

CMS recently issued an interim final rule that allows states to transition beneficiaries to other coverage groups during the PHE, provided the new coverage group offers a similar level of coverage.[8] In particular, states can now move individuals enrolled in Medicaid coverage that is considered minimum essential coverage (MEC) to other Medicaid categories that meet MEC requirements. This allows states to update coverage for enrollees whose circumstances may have changed during the PHE. For example, states that have expanded Medicaid under the ACA can transition individuals who turn 19 and age out of children's coverage into the adult group. However, if that 19-year-old is in a non-expansion state and isn't eligible for any other category of coverage, they must remain in children's coverage until the end of the PHE.

Under this rule, states can also transition adults who turn 65 and enroll in Medicare into Medicare Savings Program (MSP) coverage if they're eligible. If the state needs additional information, such as

[6] Center on Budget and Policy Priorities, "Using SNAP Data for Medicaid Renewals Can Keep Eligible Beneficiaries Enrolled," September 9, 2020, https://www.cbpp.org/research/health/using-snap-data-for-medicaid-renewals-can-keep-eligible-beneficiaries-enrolled.

[7] Jennifer Wagner and Alicia Huguelet, "Opportunities for States to Coordinate Medicaid and SNAP Renewals," Center on Budget and Policy Priorities, February 5, 2016, https://www.cbpp.org/research/health/opportunities-for-states-to-coordinate-medicaid-and-snap-renewals.

[8] CMS, Fourth COVID-19 Interim Final Rule, October 28, 2020, https://www.cms.gov/files/document/covid-vax-ifc-4.pdf.

information on an enrollee's resources, to determine eligibility and is unable to obtain it, they must leave the individual in the prior coverage through the end of the PHE.

Update Enrollee Contact Information

The COVID-19 pandemic and spate of natural disasters in 2020 has caused housing disruptions for many Medicaid enrollees. The Aspen Institute estimates that 30 to 40 million Americans could face evictions in the coming months.[9] Many enrollees whose addresses changed during the pandemic may not have reported their new addresses to the Medicaid agency, or the agency may not have acted on reported changes due to their own disruptions in operations. These enrollees face potential loss of coverage at the end of the PHE if they don't receive and respond to notices related to renewals or other requests for information. Agencies should update contact information now, prior to restarting renewals, to minimize this loss of coverage.[10] This includes:

- Interfacing with the National Change of Address database to capture address changes reported to the U.S. Postal Service.
- Updating Medicaid records with address changes reported to other programs, such as SNAP.
- Updating Medicaid records with address changes reported to managed care organizations (MCOs).
- Public outreach (via email, text, news conferences, or other means) about the importance of providing updated contact information and how to report changes online, in person, or by mail.
- Contacting enrollees whose mail is returned via phone, email, or text message to obtain updated contact information.

Improve Communications With Enrollees

State agencies can also take proactive steps now to establish more effective communication channels with enrollees. Rather than just mailing a renewal notice or request for information to a Medicaid enrollee and terminating coverage if they fail to respond, agencies can use different forms of communication to reach enrollees and ensure they understand what steps they must take to retain coverage when the continuous coverage provision ends. Agencies can:

- Improve notices to ensure they accurately convey the steps enrollees must take to retain coverage.

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[9] Emily Benfer *et al.*, "The COVID-19 Eviction Crisis: an Estimated 30-40 Million People in America Are at Risk," Aspen Institute, August 7, 2020, https://www.aspeninstitute.org/blog-posts/the-covid-19-eviction-crisis-an-estimated-30-40-million-people-in-america-are-at-risk/.

[10] Patricia Boozang, Kaylee O'Connor, and Kinda Serafi, "Maintaining Medicaid and CHIP Coverage Amid Postal Delays and Housing Displacements," Manatt, September 29, 2020, https://www.manatt.com/insights/newsletters/manatt-on-health-medicaid-edition/maintaining-medicaid-and-chip-coverage-amid-postal.

- Send text messages to enrollees to notify them they are due for renewal or must submit documentation. Texts should include links or phone numbers that enrollees can use to take the required action.[11]
- Keep community-based organizations, health centers, health care providers, and other agencies informed so they can help people stay covered. Let them know when renewals will restart, what enrollees need to do, and how they can best assist them.

Policies for the End of the PHE

At the end of the PHE, most enrollees will likely still be eligible for Medicaid since few will have experienced a significant increase in income during the recession. States should carefully craft their policies and make operational and system decisions aimed at keeping eligible people enrolled. Taking the time to carefully review all enrollees' circumstances can avoid confusion, gaps in coverage, and a significant volume of re-applications from eligible enrollees who incorrectly lose coverage.

Conduct Renewals for All Enrollees Based on Current Information

Medicaid enrollees' circumstances have been exceptionally volatile during the pandemic, with job losses, changes in work hours, evictions, and changes in living situations. *Information received from data matches or other sources during the pandemic are unlikely to accurately reflect enrollees' current circumstances and eligibility at the end of the PHE.*

Not only is terminating coverage based on such information likely to result in loss of coverage for eligible people, it also violates statutory requirements. The Families First continuous coverage provision states that Medicaid enrollees "shall be treated as eligible for such benefits through the end of the month in which such emergency period ends…." This means that enrollees are deemed eligible through the end of the PHE, and states must conduct a full review of their circumstances when the PHE ends.

When some states have fallen behind on Medicaid renewals in the past, they have relied on data matches to identify people who may no longer be eligible. Rather than conducting full renewals for these individuals, they have sent out requests for information and required them to provide verification documents within a short time frame or be terminated. Many enrollees didn't receive the notice or were unable to timely respond with the requested information. And because the state agency sent out such large volumes of requests at the same time, they were unable to keep up with questions and responses, resulting in many eligible enrollees losing coverage.[12]

The results could be even worse if states try this approach at the end of the PHE. Some enrollees in states that conducted renewals or data matches during the PHE may not have responded to requests for information due to instability in their living situation or because they knew their coverage would continue.

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[11] For more information, see Jennifer Wagner, "Leveraging Text Messaging to Improve Communications in Safety Net Programs," Center on Budget and Policy Priorities, May 8, 2019, https://www.cbpp.org/research/poverty-and-inequality/leveraging-text-messaging-to-improve-communications-in-safety-net.

[12] See, for example, David Ramsey, "The Arkansas Medicaid verification mess: what went wrong," *Arkansas Times*, August 10, 2015, https://arktimes.com/arkansas-blog/2015/08/10/the-arkansas-medicaid-verification-mess-what-went-wrong.

States must make a fresh determination of eligibility after the PHE ends rather than relying on stale information they obtained during the PHE. This fresh determination must follow the procedures for a full renewal, which looks at current data and gives enrollees the opportunity to provide information reflecting their current circumstances. The procedures laid out in federal regulations are to:[13]

- Review available data sources to determine if eligibility can be confirmed *ex parte* before requesting any documents from enrollees;
- Send the enrollee a pre-populated renewal notice if a renewal can't be completed *ex parte*;
- Give the enrollee 30 days to return the renewal notice; and
- Reinstate coverage without requiring a new application if the enrollee doesn't complete the renewal but requests coverage within 90 days of termination.

Evaluate Enrollees for Other Coverage Groups

Some enrollees may no longer be eligible for the category of coverage they are receiving when the PHE ends. This includes enrollees who aged out of children's coverage in a non-expansion state, those who turned 65 and weren't transitioned to MSP, those who are no longer pregnant and weren't transitioned into other coverage, and those who lost Supplemental Security Income. While states may wish to prioritize these cases for renewal, they must evaluate the enrollees for other coverage groups.[14] Where the agency has sufficient information to determine eligibility, it can conduct an *ex parte* review and move the enrollee to the proper category. Where additional information is needed (such as information on resources if an enrollee is moving to a group that doesn't use modified adjusted gross income), the agency should send out a request for the necessary information. Agencies can't simply terminate coverage and direct the enrollee to reapply for other coverage if the enrollee no longer qualifies under their current group.

Coordinate With the Marketplace

Some enrollees will no longer be eligible for Medicaid. These individuals may be eligible for coverage through a state-based marketplace or the federally facilitated marketplace. States should clearly communicate with enrollees who lose coverage that they may be eligible for marketplace coverage, that they will have a special enrollment period due to loss of Medicaid, and what steps they must take to enroll.

Stagger Renewals Over a 12-Month Period

If agencies attempt to renew their entire caseload in one month or over a few months, it would likely cause massive hardship for enrollees. Community organizations and MCOs — and the Medicaid agencies themselves — would be overwhelmed and unable to help all those who need their assistance, and the agency would likely be inundated with phone calls and paperwork. Eligible people would lose coverage in large numbers.

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[13] 45 CFR §435.916.

[14] 45 CFR §435.916(f).

Instead of attempting to quickly catch up, states should stagger the renewals over a 12-month period. This will allow people in the community to provide effective assistance, help the agency timely process the renewals, and lead to a more even distribution of work in future years.

CMS Guidance Needed on Staggered Renewals

CMS guidance is particularly needed in this area so states know that phasing in renewals is allowable. Medicaid agencies will likely be hesitant to allow cases to be out of compliance, as cases with overdue renewals would appear to be, fearing repercussions from CMS or auditors. In addition, state budget pressures may drive states to terminate coverage for enrollees as quickly as possible, regardless of the accuracy of those terminations. CMS should direct states to stagger their renewals over multiple months to ensure eligible enrollees retain coverage.