Medicaid Redeterminations and Transitions of Coverage Best Practices

THE REDETERMINATION PLAN

Slightly more than 1 in 4 Americans rely on Medicaid for their coverage and care, making it an essential safety net for 87 million people – including women, children, and millions of veterans. The 2020 Families First Coronavirus Response Act (FFCRA) requires that states maintain eligibility for people enrolled in Medicaid to receive enhanced federal matching funds through the end of the COVID-19 public health emergency (PHE). At the end of the PHE, States will have up to 12 months to initiate required redeterminations of each person's Medicaid eligibility.

Health insurance providers including Medicaid Managed Care Organizations (MCOs) and those offering qualified health plans (QHPs) through the Marketplace are essential partners in making the redetermination process run more smoothly, and to support transitions to other forms of coverage for people determined no longer eligible for Medicaid. State agencies are encouraged to share strategy and timing details of state redetermination plans with health plans and other stakeholders so that stakeholders are well-prepared to coordinate outreach and help ensure as many people retain access to health care as possible.

Critical Components of a State's Redetermination Strategy Plan

- **Sufficient Time.** State agencies are encouraged to consider how best to optimize the full time (14 months) allotted by the Centers for Medicare & Medicaid Services (CMS) to ensure adequate time to address the backlog of redeterminations, minimize processing errors, ensure sufficient numbers of staff are available and adequately trained, distribute the workload evenly over time, and support continuity of coverage.
- **Maximize Available Tools.** States are encouraged to utilize current tools to maximize continuous coverage and increase reliance on available data sources to verify eligibility. The greater the number of eligibility renewals that can be completed through data matches, the fewer state staff resources are needed and the chances of an eligible member slipping through the cracks are reduced.
- **Leverage MCOs.** MCOs can amplify state messages about the renewal process, help update contact information, assist members through the verification process, and help ineligible individuals transition to other coverage if needed. MCOs are a valuable resource and willing partner to help states and members.
- **Test.** States are encouraged to test components of their strategies to ensure challenges are resolved prior to the start of their redetermination processes.

- **Use Consistent and Tailored Messaging.** States are encouraged to coordinate across agencies (including Medicaid, Division of Insurance, and Exchange), with all health care stakeholders and community resources, like navigators and assisters, as well as with CMS on communications approaches. CMS recently published a communications toolkit for states, to help advance consistent messaging, develop an awareness campaign, and create training tools for navigators and assistors.
- **Initiate Outreach Now.** States should launch an outreach strategy as soon as possible to encourage individuals to update their contact information. There is a higher likelihood of enrollee response if they hear a consistent message – from multiple stakeholders and multiple times – which emphasizes the importance of providing accurate and current contact information to states.

- **Use MCOs to Obtain Accurate Contact Information.** State Medicaid agencies often do not have the most current address, phone number, or email address for Medicaid enrollees. Because MCOs have regular communication with their Medicaid members through care management programs, community outreach, and engagement initiatives, MCOs frequently receive updated contact information from their members. States are encouraged to use CMS best practices guidance that allows states and MCOs to quickly exchange updated member information. CMS recently provided additional flexibility allowing states to accept updated contact information from MCOs without the state having to "double check" the information.
- **Use MCOs to Assist Members with Renewal Process.** States are encouraged to leverage flexibility for MCOs to contact members at risk of losing Medicaid eligibility, to assist members in responding to state information requests so they can maintain coverage, or transition members more seamlessly to other coverage if they are no longer Medicaid eligible. States should provide advance monthly lists of members at risk of disenrollment as early as possible to MCOs, communicate the specific reason for potential disenrollment, and allow MCOs to communicate with members who may be at risk of losing Medicaid. This will help ensure members have completed and returned their redetermination paperwork, corrected any inaccurate information, are aware of other coverage options and have sufficient support/assistance throughout these processes.

  These types of flexibilities are allowed by federal Medicaid laws and regulations but there has not been as urgent a need to employ them in the past, so their adoption rate is low across the country. Given the unprecedented redeterminations workloads that states will face once the PHE ends, they would be best served by engaging with and enabling MCOs to perform these actions to minimize loss of health insurance coverage.
- **Improve *Ex Parte* Renewal Rates.** States are required to first attempt to redetermine eligibility based on reliable information available without requiring information from the individual (called *ex parte* renewal, a.k.a. auto renewal, passive renewal, or administrative renewal). CMS encourages states to improve their *ex parte* renewal rates by increasing data sources relied on and creating a data source hierarchy to guide verification, prioritizing the most recent and reliable data sources. Since systems changes take time to implement, these efforts should be undertaken as soon as possible. (See CMS guidance here.)

Coverage Transitions

- **Support QHP Outreach.** States are encouraged to support opportunities for additional outreach by the individual marketplace exchanges and commercial health plans to help ensure individuals losing Medicaid coverage are both aware of other coverage options and can be assisted as much as possible in transitioning to new coverage. States should review and update guidance to better allow MCOs to not only share information with members about other coverage options, but also to share member information with QHP issuers.
- **Update Marketplace Communications.** State-based individual marketplace exchanges are encouraged to develop notices that include enrollee-specific information about eligibility for coverage and subsidies; how to enroll, including information on how to access enrollment support via Healthcare.gov, call centers, navigators; and information about how individual marketplace coverage compares with Medicaid.