MEDICAID AND CHIP ELIGIBILITY REDETERMINATIONS

MAXIMIZING RETENTION AT THE END OF THE PUBLIC HEALTH EMERGENCY

Advocacy Action Guide for AAP Chapters

Overview

Medicaid and the Children's Health Insurance Program (CHIP) have served as a critical lifeline of coverage during the COVID-19 pandemic; as of November 2021, almost 40 million, or over 53% of US children (AAP analysis), were covered by Medicaid and CHIP. Importantly, states have been prohibited from disenrolling anyone who enrolls in Medicaid or *Medicaid-expansion* (but not separate) CHIP programs during the pandemic thanks to the Families First Coronavirus Relief Act (FFCRA), which has provided a 6.2 percentage point increase in the federal medical assistance percentage (FMAP, or federal match) to state Medicaid spending. As a maintenance of effort (MOE) condition of receiving this significant federal Medicaid funding, states have, among other requirements, been disallowed from removing anyone who enrolled in Medicaid or Medicaid-expansion CHIP as of the date of FFCRA enactment (March 18, 2020) or who enrolled while the public health emergency (PHE) was in place.

The 6.2 percentage point increase will end on the last day of the quarter of the calendar month in which the PHE ends. CMS has expected states to continue processing redeterminations and renewals during the PHE, but not to act with respect to disenrollment. When the PHE ends, states can begin addressing this backlog of eligibility actions. It is during this return to normal operations—or "unwinding" period—when states will be processing these redeterminations, and when children and families are at risk of losing coverage.

Under initial guidance from the former administration, CMS had given states 6 months to complete these redeterminations of eligibility. However, CMS later issued updated August 2021 guidance that took two important steps: (1) extended the length of time to 12 months for states to complete redetermination actions; and (2) required a fresh redetermination of eligibility of everyone enrolled in the program, including those who might have already been found ineligible. This latter step will help ensure states cannot rely on previous eligibility determinations to disenroll individuals from the program when the PHE ends (whose circumstances may have since changed). CMS is also requiring states to create an "Unwinding Operational Plan." In its March 2022 guidance, CMS recommends that states include input from stakeholders in this planning process, and make such plans public. This guidance also extends the length of time for states to complete all redeterminations to up to 14 months, depending on the state's start date, and recommends states process no more than 1/9 of redeterminations in a given month following the end of the PHE.

The PHE was most recently renewed on April 12, 2022 and is currently scheduled to expire **July 15, 2022**. However, the Biden administration has committed to giving states a 60-day notice prior to the end of the PHE, and notably did not provide such a 60-day notice on May 16, 2022. This indicates the PHE is expected to continue past the current July

expiration until at least **October 13, 2022**. The AAP will continue to update chapters as to the status of the PHE as events unfold.

In the interim, AAP chapters—working together with other advocates—should seek to join state Medicaid program planning for this unwinding process, with the goal of making sure eligible children and families do not lose coverage. As we now anticipate that the PHE will not end before October 2022, our message is that states "have the time to get this process right" for children and families. The AAP has a number of internal and external tools available to help you (see more under Advocacy Tools and Other Resources, below).

Actions to Protect Enrollees During the Redetermination Process

Medicaid redeterminations at the end of the PHE are likely to result in many children and families losing coverage. However, state actions now and throughout the unwinding period will help to mitigate these coverage losses. A February 2022 Georgetown Center for Children and Families (CCF) study estimated that 6.7 million children would lose coverage at the end of the PHE. A September 2021 Urban Institute study found that of children losing coverage in that study's estimate, 57% would be eligible for CHIP, while an additional 9% would be eligible for marketplace coverage and subsidies. It will thus be important to ensure successful transitions to other coverage for any child losing Medicaid eligibility.

A recent experience in Utah may also be instructive. After initially applying a pause on redetermination actions in its *separate* CHIP program so as to prevent those children from losing coverage, CMS later determined that the state had overstepped its legal authority to take such action. As a result of restarting redeterminations for children eligible for its separate CHIP program in Utah, 41% of them lost coverage. State officials have since recommended that other states begin redeterminations in Medicaid first, particularly for children who are likely to be CHIP eligible, as many enrolled children may become eligible for CHIP upon redetermination; doing so could help mitigate their loss of coverage. Critically, this Utah example speaks to the importance of states doing as much as they can to ensure adequate protections for children.

While we do not know when the PHE will ultimately end, state Medicaid programs should have already begun planning for how the redetermination process will work. There are many steps states can take to involve relevant stakeholders such as AAP chapters, publicize the issue, maximize outreach, utilize existing data matching, and plan for streamlining enrollment into other coverage. The Georgetown Center for Children and Families (CCF)—a national partner of the AAP—has published a number of resources for advocates on these issues. CMS has also issued a number of related publications, and State Health & Value Strategies has a number of unwinding resources.

The following highlights many recommendations and steps AAP chapters can take on this important issue (for detailed recommendations on many facets on protecting children and families during the unwinding planning process, please also see the **Chapter Checklist**):

- ✓ **Get involved in state planning.** CMS is requiring states to develop a post-PHE Unwinding Operational Plan, which will detail steps they will take to operationalize redeterminations. The Kaiser Family Foundation (KFF) March 2022 annual Medicaid survey provides important insights into state thoughts on the unwinding and plans therein. CMS has expressly encouraged states to seek input from relevant stakeholders in this planning process, and to share such plans publicly. AAP chapters, together with other advocates, can encourage states to include your chapter and other relevant stakeholders at the planning table, accept your input, and make Unwinding Operational Plans publicly available. To help you, please see the **Template Letter** for chapters to customize and use to request a seat at the planning table, as well as the **Chapter Checklist** for use reviewing unwinding operational plans and/or guiding planning discussions with the state.

- ✓ **Recommend strongly that the state conduct a communications campaign to remind enrollees of the need to update their addresses/contact information. This campaign should be conducted in many languages to**

reflect the needs of different communities of the state. Such a campaign should have a public-facing component as well as direct-to-enrollee outreach, and should enlist Medicaid MCOs, partner agencies, providers, community organizations, and all Medicaid stakeholders in spreading the word about obtaining enrollee information. Components should include:

- ✓ Text/phone/email/direct mail outreach to enrollees
- ✓ Dedicated online/phone line/community-distributed forms where enrollees can easily update info
- ✓ Navigator/consumer assistance outreach that is language accessible
- ✓ Social media notices and reminders on all benefits-related notices
- ✓ Public-facing signage and notices, with instructions at hospitals, clinics, health department, and other physical sites. Consider use of a QR code to immediately link to an update page.
- ✓ Specific outreach to people and communities of color, who have borne some of the more significant economic effects of the pandemic and who may be disproportionately affected by the redetermination process

To help, please see these communication resources from State Health & Value Strategies and GMMB.

✓ **Advocate for strengthened renewals via data matching (known as "*ex parte*" renewals)**. Before asking enrollees to return a paper or other verification of eligibility, states are required to attempt renewals using existing data sources, such as that of the Supplemental Nutrition Assistance Program (SNAP) program, the federal Renewal and Redetermination Verification (RRV) service, and others. In some states, a high percentage of renewals are conducted *ex parte*, while in others, the percentage is relatively small. Increasing the usage of *ex parte* renewals is particularly important for special needs populations—such as those with serious emotional disturbance, disability, or experiencing homelessness—who may experience significant barriers to enrollment. There are many state decisions that can improve the *ex parte* process, this Center on Budget and Policy Priority (CBPP) report dives into the details. AAP chapters and advocates can work with states to improve the *ex parte* process, so that renewals are efficiently executed, and more eligible enrollees are kept in the program.

✓ **Encourage the state to *slow down* the redetermination process so that eligible children are not mistakenly disenrolled.** In its guidance, CMS has encouraged states to process no more than 1/9 of their redetermination backlog in a given month after the PHE ends. Moreover, CMS has given states 12 months to begin and up to 14-months to complete all redeterminations, depending on start date. States can maximize care in the redetermination process by taking all of this allotted time and ensuring families have every opportunity to retain Medicaid coverage or transition to other coverage. In addition, states should be able to demonstrate they have sufficient workforce to handle the case load in the timeline given and should also detail how they are going to prioritize redeterminations – by population (ie, specific groups of enrollees), by time (ie, renewals from a specific enrollment period), or a hybrid approach.

✓ **Advocate that the state update enrollee addresses using known databases.** The US Postal Service maintains a national database of change of address records; states can utilize this NCOALink database to update the addresses of Medicaid enrollees. States can also use state SNAP or TANF, Department of Motor Vehicle, and other databases to obtain and update this information. In addition, CMS has provided guidance to states on working with Medicaid managed care plans on unwinding issues. Included therein are strategies to receive updated enrollee contact information via managed care—of note, such information must have been verified by the individual. Under normal circumstances, states must then send a notice to the enrollee at the managed care organization's listed contact information, seeking to confirm this information is correct. However, CMS is allowing states to waive this requirement under a 1902(e)(14)(A) waiver through the end of

the unwinding period—this should make it easier for states to use verified managed care enrollee contact information. (See more on **1902(e)(14)(A) Waivers** below).

- ✓ **Advocate for added enrollee protections**. States can act to ensure that a failed attempt at mailing an enrollee does not simply result in another mailing attempt. States should use all available means (email, phone, text, mail) to try to reach enrollees, to ensure contact information is updated and that a redetermination of eligibility can be made. Also, states can ensure all enrollees have access to a 90-day reconsideration period (all MAGI-eligible enrollees have access to this reconsideration period, but it is not required for those eligible through other pathways), and even extend this past 90 days via a 1902(e)(14)(A) waiver. Chapters can also request that states send follow-up notices when action is required for individuals to avoid loss of coverage. In addition, states can adopt additional flexibilities via other 1902(e)(14)(A) waivers, such as allowing self-attestation of no income when this was verified within the last 12 months and no information is available via data matching (see more on **1902(e)(14)(A) Waivers** below).

- ✓ **Adopt specific flexibilities via 1902(e)(14)(A) waivers.** CMS has indicated that will allow for the time-limited use of 1902(e)(14)(A) waivers, which are special Medicaid waivers to allow states to implement strategies to protect beneficiaries during the unwinding process. States can take advantage of the strategies identified by CMS for such waivers (for more information, see page 24 of the March 3 CMS guidance):

    - **Renewal for Individuals Based on SNAP Eligibility**: this allows states to rely on SNAP data to renew eligibility for individuals, despite differences in household composition and income-counting rules.

    - **Ex Parte Renewal for Individuals with No Income and No Data Returned:** This allows states to conduct an *ex parte* renewal when household income of zero dollars was attested to, at initial application or renewal, within the last 12 months.

    - **Facilitating Renewal for Individuals with No Asset Verification System (AVS) Data Returned within a Reasonable Timeframe**: This allows states to enroll an individual if no data has been returned from the AVS within a reasonable timeframe, without additional verification required.

    - **Partnering with Managed Care Plans to Update Beneficiary Contact Information:** As previously mentioned, CMS will allow states, via this waiver, to accept Medicaid managed care plan-provided enrollee contact information as long as it has been verified to the MCO by the enrollee.

    - **Extended Timeframe to Take Final Administrative Action on Fair Hearing Requests**: This would allow states to extend the period of time for which to act on a fair hearing request for a redetermination of eligibility; during this time, states would continue to provide Medicaid benefits while final action is pending.

  Use of these strategies via waiver will help states to protect enrollees during the unwinding period.

- ✓ **Communicate with state officials as to how redeterminations will affect pediatric practices.** A significant loss of coverage will have an outsized impact on practices that see a larger number of Medicaid patients. Practices could suffer due to decreased volume and related revenue as children are disenrolled. In addition, if your state pays via capitation or if it makes an added per-member per-month (PMPM) payment for pediatric care (such as a medical home payment or other), a decrease in those payments could negatively affect practices. This only reinforces the need for states to have in place sufficient workforce to handle the increased demand in renewal activity, including increased requests at call centers, eligibility offices, and with

navigators and community assisters. Moreover, this underscores the need for successfully transition of those disenrolled to other coverage, and for policymakers to have a plan for communicating these changes.

In addition, pediatricians may have enrolled in a state Medicaid program on an emergency basis (*e.g.* from out of state). When the PHE ends, such pediatricians will need to submit a complete application to continue to remain a provider in the program. Pediatricians who enrolled as Medicaid providers under such emergency authorities should be aware of these requirements and the state's application process.

- ✓ **Strongly encourage the state to help make seamless and successful transitions to other coverage for those who are no longer deemed eligible.** Families with higher or lower incomes may become eligible for Medicaid, CHIP, or marketplace coverage and related subsidies—in particular for children, many no longer eligible for Medicaid are likely to be eligible for CHIP. States should have plans in place to make seamless account transfers to these other programs and should give families an appropriate amount of time to provide additional needed information when applying for new coverage. States should ensure data can be electronically communicated easily and without barriers between programs. Again too, states should ensure they have the workforce capacity to meet the increase in demand.

- ✓ **Advocate that the state actively monitor and report on disenrollment actions taken**. CMS is requiring states to report baseline and monthly unwinding metrics using CMS' "Unwinding Eligibility and Enrollment Data Template" (see the "Unwinding Data Report" Excel file and specifications document on this CMS page under "State Reporting")—states can also make this data publicly available. While not included in the data template, states should additionally opt to report on reenrollment call center volume, wait times, abandonment rates, disenrollment numbers (including data on those disenrolled for non-eligibility reasons), as well as the number of individuals transferred to the marketplace. States should also specifically review how disenrollment is affecting communities of color, who have been disproportionately affected by the pandemic.

  To make such data public, states can establish a data dashboard that provides a look at all of these metrics over time (for more on this, see *Tracking Medicaid Coverage Post the Continuous Coverage Requirement: Using Data Dashboards to Monitor Trends*, from State Health & Value Strategies). State monitoring and monthly reporting will help advocates ensure that processes and workforce are sufficient to meet the needs of those seeking to reenroll, and that states are properly reviewing and being held accountable for redetermining eligibility of applicants.

The importance of working in coalition

AAP chapters can play a critical role in working with the state to maximize appropriate retention in the program as the redetermination process unfolds—however, chapters need not do so alone. Almost every advocacy organization with a Medicaid constituency will advocate that the state protects enrollees and ensures the redetermination process has coverage retention foremost in mind. AAP chapters should reach out to maternal and child health partners, Group of Six state chapters, state medical societies, and others, to both advocate to the state and spread the word about the eventual end of the PHE and need for enrollees to update their contact information.

Moreover, AAP chapters need not be expert in all-things Medicaid and CHIP eligibility and enrollment and the technicalities of redeterminations to bring a critical voice to the process. What is important is that chapters and other advocates have seats at the table, ask the hard questions about how their redetermination processes will work for children, and make sure that protections are in place and messaging is spread far and wide to enrollees. While we do not yet know when the PHE will ultimately end, it is not too early to have these discussions now. AAP chapters can add this issue to standing meeting with Medicaid offices, and/or request specific meetings with their state to discuss. Alternatively, chapters can hold a meeting with other stakeholders on this issue and invite the state Medicaid office

to also join. While there is no one way to achieve doing so, raising the profile of the issue and asking for a seat at the state planning table will be important in ensuring a process that does not inappropriately result in eligible children losing coverage.

Looking ahead, AAP chapters can also continue advocacy toward state policies that will help keep children enrolled in state programs, such as presumptive eligibility, 12-months continuous enrollment, data-driven renewals, and better data transfer between programs. Such changes will help to minimize churn and maximize coverage and continuing courses of treatment.

We're Here to Help

AAP chapters stand positioned to lend expert voices to states as states plan for Medicaid redetermination actions at the end of the PHE, and the AAP is here to help. Contact AAP State Advocacy at stgov@aap.org for consultation and technical assistance.

Advocacy Tools and Other Resources

Advocacy Tools

- AAP | Template Letter Requesting Seat at Unwinding Planning Table
- AAP | Checklist and Sample Questions for AAP Chapter Engagement in and Review of State Medicaid Agency Unwinding Operational Plans
- AAP | February 15, 2022 Webinar: Medicaid Redeterminations at the End of the PHE (AAP login required)
- Georgetown Center for Children and Families (CCF) | Unwinding the COVID Continuous Eligibility Requirement at the End of the Public Health Emergency: Tips for Advocates
- Georgetown Center for Children and Families (CCF) | Webinar Series: Unwinding the COVID-19 Medicaid Continuous Eligibility Provision
- State Health & Value Strategies | Resources for States on Unwinding the Medicaid Continuous Coverage Requirement
- State Health & Value Strategies | Leveraging Managed Care Plans to Support Medicaid Continuous Coverage Unwinding Toolkit
- State Health & Value Strategies | Planning for the End of the Continuous Coverage Requirement: Communications Resources for States
- State Health & Value Strategies| Template Notices for Medicaid Continuous Coverage Unwinding
- Kaiser Family Foundation (KFF) | Key Issues for State Medicaid Programs When the COVID-19 Public Health Emergency Ends
- Kaiser Family Foundation (KFF) | Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey (contains survey data on planned state unwinding actions)

CMS Guidance and Select Resources

- CMS | Unwinding and Returning to Regular Operations after COVID-19 (CMS landing page, select items below)
- CMS | December 2020 Guidance
- CMS | August 2021 Guidance
- CMS | March 2022 Guidance
- CMS | Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations
- CMS | Connecting Kids to Coverage: State Outreach, Enrollment and Retention Strategies

- CMS | Medicaid and CHIP Continuous Enrollment Unwinding – Toolkit (English) (Spanish) and Unwinding Graphics (zip file)
- CMS | Medicaid and CHIP Unwinding Planning Efforts: Summary of Best & Promising State Practices from CMS/State Discussions
- CMS | Strategic Approaches to Support State Fair Hearings as States Resume Normal Eligibility and Enrollment Operations After the COVID-19 PHE
- CMS | Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations