

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this webinar was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at www.shvs.org.

Medicaid Continuous Coverage Unwinding Resources for States

State Health and Value Strategies has created an accessible one-stop source of information for states in unwinding after the end of the federal public health emergency (PHE) at www.shvs.org/resource/phe-unwinding-resources-for-states/.

The webpage is designed to support states in planning for this major coverage event, including developing processes that prioritize coverage retention at the end of the PHE.

Together with our technical assistance partners, we are developing on an ongoing basis resources for state officials on the unwinding of the PHE. Resources and tools will become available on the webpage once available.

About Manatt Health

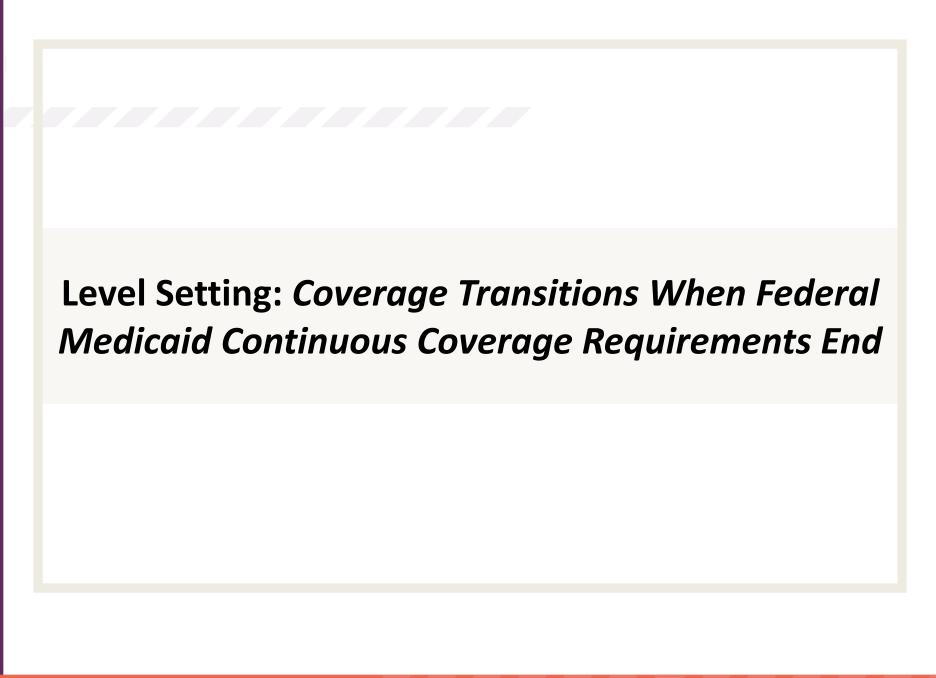
Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving health care policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

About McKinsey & Company

McKinsey & Company helps organizations across the private, public, and social sectors create the Change that Matters most to them. From the C suite to the front line, we partner with our clients to transform their organizations, embed technology into everything they do, and build enduring capabilities. With exceptional people in 65 countries, we combine global expertise and local insight to help you turn your ambitious goals into reality. For more information, visit https://www.mckinsey.com/about-us/overview.

Meeting Agenda

- Level-Setting: Coverage Transitions When Federal Continuous Coverage
 Requirements End
- Information Technology (IT) Systems and Data Strategies Overview
 - Optimizing Effective and Efficient Use of Eligibility Data
 - Ensuring Robust and High-Quality Account Transfer Data
 - Expanding Capabilities and Capacity of Online Portals
- Reactions and Next Steps
- Discussion



Medicaid Continuous Coverage Requirements

As a condition of receiving a temporary 6.2% Federal Medical Assistance Percentage (FMAP) increase, the Families First Coronavirus Response Act (FFCRA) requires states to maintain enrollment of nearly all Medicaid enrollees through the end of the month in which the COVID-19 PHE ends. Congress is currently negotiating federal Build Back Better legislation that will likely change the timeline for: (1) when the federal continuous coverage requirements end; and (2) parameters for continued receipt of enhanced FMAP.

- Continuous coverage requirements apply to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date.
- State Medicaid agencies have maintained coverage for individuals who may have become ineligible since their last eligibility determination.

When continuous coverage requirements expire, states will need to conduct a full redetermination for all enrollees who would have otherwise been subject to redetermination—approximately 80 million enrollees.

Public Law 116–127 116th Congress

An Act

Making emergency supplemental appropriations for the fiscal year ending September 30, 2020, and for other purposes.

Pamilies First
Corocarrirus
Response Act.

Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,
SECTION 1. SHORT TITLE.

This Act may be cited as the "Families First Coronavirus Response Act".

SEC. 2. TABLE OF CONTENTS.

The table of contents is as follows:

DIVISION A—SECOND CORONAVIRUS PREPAREDNESS AND RESPONSE SUPPLEMENTAL APPROPRIATIONS ACT, 2020

DIVISION B-NUTRITION WAIVERS

DIVISION C—EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT DIVISION D—EMERGENCY UNEMPLOYMENT INSURANCE STABILIZATION AND ACCESS ACT OF 2020

DIVISION E-EMERGENCY PAID SICK LEAVE ACT

DIVISION F-HEALTH PROVISIONS

DIVISION G—TAX CREDITS FOR PAID SICK AND PAID FAMILY AND MEDICAL LEAVE

DIVISION H-BUDGETARY EFFECTS

JSC 1 note. SEC. 3. REFERENCES.

Except as expressly provided otherwise, any reference to "this Act" contained in any division of this Act shall be treated as referring only to the provisions of that division.

Second Coronavirus Preparedness and Response Supplemental Appropriations

[H.R. 6201]

DIVISION A—SECOND CORONAVIRUS PREPAREDNESS AND RESPONSE SUPPLEMENTAL APPROPRIATIONS

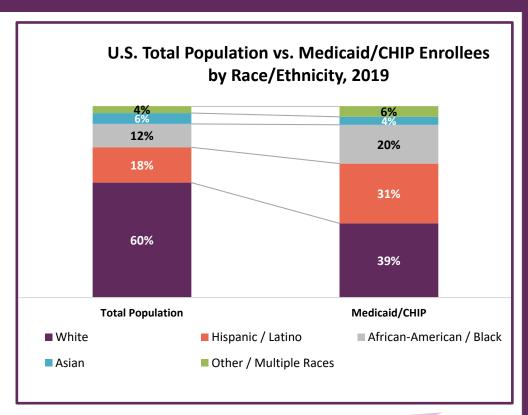
The following sums are hereby appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 2020, and for other purposes, namely:

Source: FFCRA § 6008(b)(3); SHVS, Renewal of Determination That A Public Health Emergency Exists; Centers for Medicare and Medicaid Services (CMS), Fourth COVID-19 Interim Final Rule with Comment Period (IFC-4).

Potential Coverage Losses and the Impact on Black, Latino(a) and Other Communities of Color

The end of the federal Medicaid continuous coverage requirements will present the single largest health coverage transition event since the first open enrollment of the Affordable Care Act (ACA).

- When the continuous coverage requirements end, nearly all Medicaid enrollees will need to have their eligibility redetermined, triggering a high risk of coverage losses.
- Most people will continue to be eligible for either Medicaid or subsidized Marketplace coverage, but a massive number of renewals some of which have been pending for almost 2 years—will test the system.
- Terminations of Medicaid coverage and eligibility transitions between Medicaid and the Marketplace are likely to disproportionately impact people of color.
- Black and Latino(a) populations have fared far worse during the pandemic, experiencing exacerbated housing/employment instability and facing a disproportionate burden of disease and death due to COVID-19.



Black and Latino(a) individuals are significantly overrepresented in state Medicaid/Children's Health Insurance Program (CHIP) programs.

Source: State Health Compare.

CMS Guidance on Resuming Program Operations After Continuous Coverage Requirements End

CMS released sub-regulatory guidance* to support state Medicaid/CHIP agencies in returning to normal operations when federal continuous coverage requirements expire. The current guidance includes:





Timeliness and consumer communications for redetermining Medicaid coverage for those who had their coverage continuously maintained.



Timeline for resolving all outstanding eligibility and enrollment (E&E) actions including applications, annual renewals, mid-year redeterminations, and verifications of eligibility.



CMS Administrator, Chiquita Brooks-LaSure, continues to emphasize the Administration's focus on ensuring that people remain insured—whether they are eligible for Medicaid/CHIP, Marketplace coverage or employer-sponsored coverage—when the PHE ends.

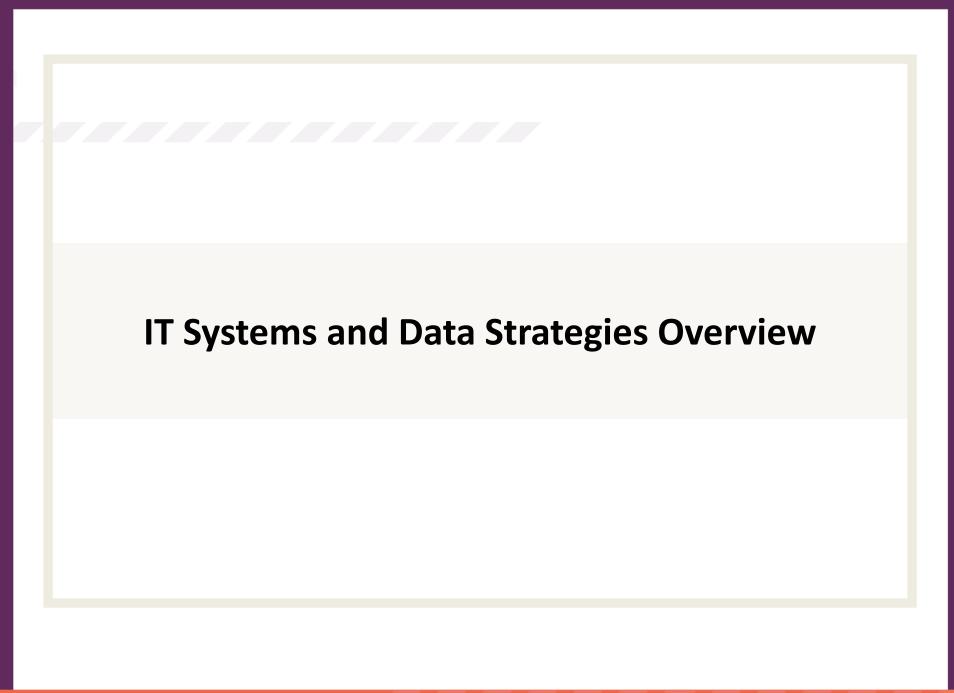
*CMS will likely issue updated guidance to clarify expectations of states upon the enactment of any federal legislation.

Source: CMS, SHO #20-004; CMS, SHO #201-004; InsideHealthPolicy, Brooks-LaSure: Don't Lose Medicaid, CHIP Enrollment Gains After PHE.

"Returned Mail" Creates Barriers to Coverage Retention

States can take action now to implement the following policy and operational strategies to help eligible individuals who may have experienced (or will experience) an address change leading up to the end of the continuous coverage period. State strategies to mitigate returned mail include:

- Communicate with Enrollees Now. States may want to communicate—via telephone, text, mail, online account, websites—in advance of the end of the federal Medicaid continuous coverage requirements to: (1) ensure consumers know about upcoming renewals; and (2) update their mailing information.
- Outreach on Returned Mail via Other Modalities. States may want to leverage other contact information, such as e-mail and text to respond to returned mail.
- **Specialized Eligibility and Enrollment Units/Processes.** States can stand-up specialized units focused on returned mail, including additional full-time equivalent (FTEs) or subcontractors.
- Leverage Managed Care Plans. Health plans can conduct outreach to update member contact information and reiterate communications from the state. States can encourage or require health plans to remind members to report changes of address during every enrollee interaction.
- Partner with Community Based Organizations (CBOs) and Application Assisters. States can look to enrollment brokers, CBOs, and Navigators to get the word out about updating contact information, provide direct assistance with obtaining updated contact information, and ensure individuals respond to requests for information and renewal forms.



Data and IT System Limitations Will Impact Coverage Retention When Continuous Coverage Ends

While states continue to modernize their Medicaid Enterprise Technology, implementing strong data and IT systems strategies will be critical to maintaining or transitioning individuals to new affordable health coverage options when Medicaid continuous coverage requirements end.

Medicaid IT Systems

Account Transfers

- Inconsistencies and failed matching cause coverage loss for eligible people, even with increased linkages between data sources.
- IT systems may not be able to support the volume of pending redeterminations post-continuous coverage period.
- IT barriers may also create upfront obstacles and impact consumer experience,
 e.g., non-mobile responsive websites not allowing consumers to update accounts.
- Transfers to a State-Based or Federal Marketplace require complete and consistent data across multiple state or federal systems.
- Not all State-Based Marketplaces (SBMs) have integrated eligibility systems with Medicaid, forcing consumers to take additional steps and creating opportunities for data-matching errors.

Perfect Storm: The triple threat of unprecedented volume, condensed time period, and enrollees unfamiliar with redetermination processes—paired with existing IT and data limitations—poses a considerable risk of coverage loss following the end of COVID-related Medicaid continuous coverage requirements.

Overview of "Table Stakes" Data and IT Strategies

Effective redetermination begins with complete enrollee contact information, user-friendly pathways for individuals to update critical information, and standardized data definitions with partners. States may want to evaluate current data and IT infrastructure now and adopt table stakes strategies to be ready for the end of the federal Medicaid continuous coverage requirements.

Strategies:



Optimizing effective and efficient uses of eligibility data



Ensuring robust and high-quality account transfer data



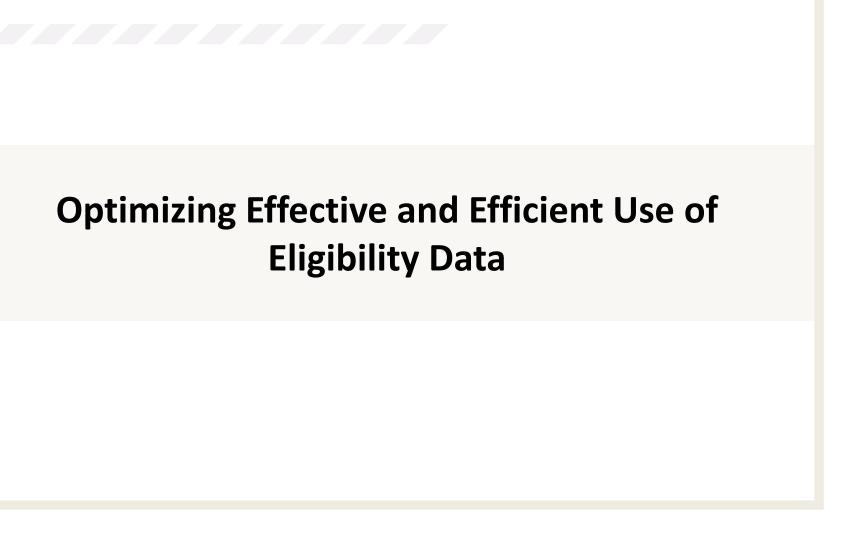
Providing online portal functionality that meets consumer needs



Table Stakes are the minimum strategies that states would want to have in place; they will have the highest impact for states seeking to ensure that eligible enrollees are able to keep or transition to new affordable health coverage when the continuous coverage requirements end.



<u>Funding</u>: States that have not pursued these efforts already, or have more to do to enhance functionality, can undertake system enhancements now and execute in a way that enables receipt of the 90% federal match for Medicaid IT investments.



Access New Eligibility Data Sources

Under federal law and regulation, state Medicaid agencies must use all available data to renew eligibility before requesting any additional information from the individual. However, given the nearly 2-year pause on redeterminations, many state Medicaid agencies will not have the most current enrollee information. Accessing data through new partners and sources can help bridge these gaps:



Create a master data management approach by aligning on minimum underlying data needed for redeterminations (first/last name, email address, phone).



Determine which systems and partners have the most up-to-date version of these data.



Prioritize importing data based on feasibility (e.g., time to set up data sharing agreement and technical complexity).



Adopting a master data management approach involves organizing data elements, data sources, data definitions, data acquisition options, operational considerations—such as cost, required resources, and timing—all of which is optimally managed through strong data governance.

Examples of Potential New Data Sources to Consider

Sourcing the most up-to-date information may require states to consider non-traditional partners and data sources within state departments, with managed care partners, or other external data.

Sources	Rationale	
Lifeline Program	Over the course of the pandemic, the Lifeline Program had nearly a 30% increase in subscribers (7 million in early 2020 compared to 9 million in 2021) and has since begun its own redetermination processes. ¹	
Immunization Information Systems (IIS)	Pre-pandemic, IIS had established connections with over 117,000 health systems, pharmacies, and other data partners. This number has grown exponentially since the pandemic began, allowing IIS to capture and consolidate administered COVID-19 vaccine doses in real-time. Consumers often registered for COVID-19 vaccines with emails and mobile phone numbers. ²	
Health Information Exchanges (HIEs)	76 HIEs cover more than 92% of the U.S. population. ³ With over 500 million COVID-19 tests reported in the last year, or via their master person index, HIEs may hold recent individual contact information.	
Mixed Coverage Families	For households that have insurance coverage split between Medicaid/CHIP and the Marketplace, it is possible that the Marketplace (and associated Navigators and assisters) may have more recent consumer contact information.	
Department of Motor Vehicles (DMV)	Amid the pandemic, DMVs had to rethink the way they operate to enable residents to conduct basic transaction. Rapid digitization of DMV processes has led to increased online transactions and may present an opportunity to gather updated mailing and email addresses.	
Department of Labor [Unemployment Insurance (UI)]	Many households that experienced loss of employment during the pandemic may have applied for and received UI. Medicaid programs could consider matching contact information against UI databases, not just for income verification purposes, but also for contact information purposes.	
Third-Party Data Enrichment Partners	Data enrichment is the process of incorporating new updates and information into existing databases to improve accuracy. Third-party data enrichment could be considered to append missing or incomplete information for populations undergoing redetermination.	

Source: 1. U.S. Federal Communications Commission, Report on the State of the Lifeline Marketplace. 2. CDC, IISAR Data Participation Rates and Maps. 3. Strategic HIE Collaborative (SHIEC), Introducing Civitas Networks for Health.

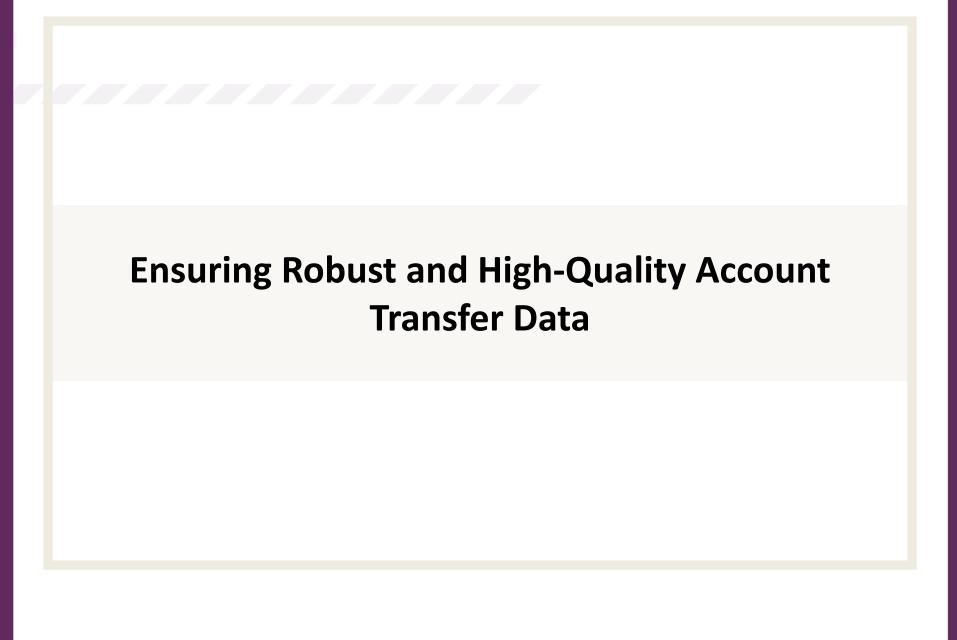
Process/Timing for Using New Eligibility Data Sources

At a minimum, the following steps may be required to use new eligibility data sources:

- 1. Identifying and establishing data sharing agreements with new partners;
- 2. Importing the data;
- 3. Refreshing Medicaid members' accounts using a hierarchical logic (e.g., prioritizing based on most recent source, or most likely to be accurate); and
- 4. Validating its effectiveness through testing.



The process of aligning on minimum data required and assessing its completeness in the existing data can take up to 9 months or more depending upon automation, dedicated staff resources, and other factors.



Account Transfers Between Marketplaces and Medicaid Will Impact Coverage Retention

Account transfers are an essential business process to help people retain coverage.

- A higher volume of redeterminations than usual will be transferred to the Federally Facilitated Marketplace (FFM) due to eligibility changes for people currently enrolled in Medicaid. SBMs that do not have integrated/shared eligibility systems and processes with Medicaid will face a similar situation.
- States will need to ensure transfers work from a technical perspective and contain sufficient information for processing. CMS guidance requires states to include all the information collected and generated by the state.¹

Account transfers must therefore:

- ✓ Have robust and accurate data;
- ✓ Populate optional fields, such as consumer email/mobile phone number; and
- ✓ Work at high volume.

Addressing Account Transfer Data Completeness and Adding Additional Contact Fields

States have an opportunity to improve account transfer data quality across two dimensions—data completeness and contact information—both of which will reduce or better facilitate casework:

Address Data Completeness:

- Successful account transfer to the FFM requires a minimum set of completed data fields.¹
- States can assess previously failed transfers, identify the source of failure, and prioritize fixing common inconsistencies.

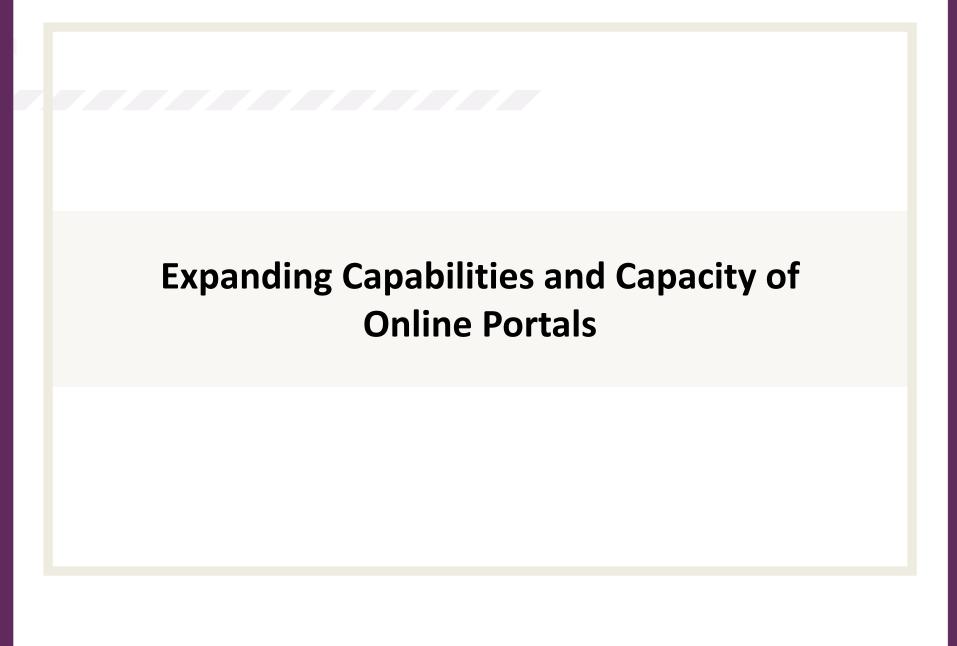
Collect Additional Contact Information:

- Collect optional contact information (e.g., e-mail and mobile numbers), if not already.
- Update account transfer data files to include these optional fields.



Improving account transfer data quality could take between 3 and 5 months to implement, depending on baseline data quality and necessary IT system changes.

Source: 1. CMS Office of Information Services, Federal Data Services Hub (Federal DSH).



Expand Capabilities and Capacity of Online Portals

Mobile access to applications and online accounts facilitates engagement with enrollees and reduces administrative workload for eligibility and enrollment staff. Portal accounts can also be a barrier if consumers have trouble accessing them.

Key criteria for online portals:

- 1. Easy for consumers to create and access.
- 2. Provide consumer access to critical eligibility and enrollment functionality.
- 3. Supported by an IT infrastructure capable of handling high volumes.



As of January 2020, 20 states have taken steps to provide a mobile-friendly design for their application, funded at least in part by Medicaid enhanced matching funds.¹

Source: 1. Kaiser Family Foundation, Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey.

Key Criteria for Online Portals

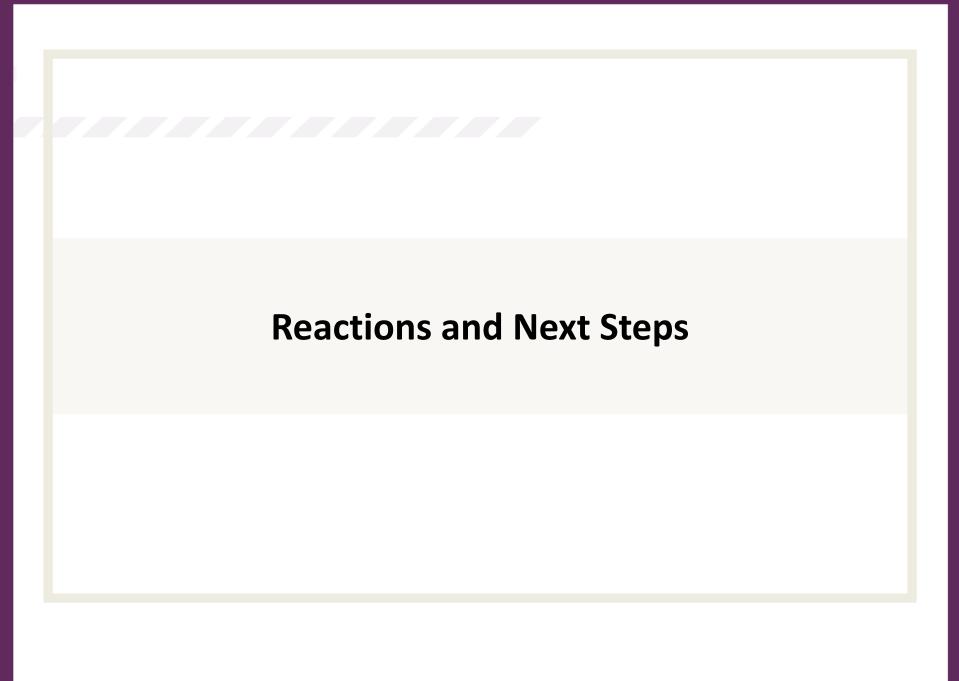
	1. Easy to Create/Access	2. Critical Functionality	3. Supported for High Volume
Purpose	Easy access averts time- consuming in-person visits, online help requests, and phone calls to call centers.	 Users must be able to: Upload verification documentation; and View member notices.* 	High volume may lead to poor performance (e.g., long load times and site crashes).
Action	Prioritize sign-in experience (e.g., reduced password complexity) and mobile access. ¹	Conduct user research and user-centered design to improve functionality (i.e., how intuitive are the steps to log-in or create an online account).	Allow for sufficient time for load testing and troubleshooting. Testing can inform the maximum capacity of the portal and highlight technical needs.

^{*} Today, 33 states' portals allow enrollees to upload verification documentation and 39 states' portals allow enrollees to view notices.²



Critical activities to meet these criteria (such as user journey mapping, building of technical specifications, and load testing) can take states between three and six months.

Source: 1. CMS, Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10) (42 CFR §433.12). 2. Kaiser Family Foundation, Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey.



Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

Patricia Boozang

Senior Managing Director
Manatt Health
pboozang@manatt.com
212-790-4523

Kinda Serafi

Partner
Manatt Health
KSerafi@manatt.com
212-790-4625

Jess Kahn

Partner
McKinsey & Company

Jessica Kahn@mckinsey.com
202.250.0872

Julie Boughn

Director
Data and Systems Group
Julie.boughn@cms.hhs.gov
443-796-5622

Heather Howard

Director
State Health and Value Strategies
heatherh@Princeton.edu
609-258-9709

Dan Meuse

Deputy Director
State Health and Value Strategies
dmeuse@Princeton.edu
609-258-7389