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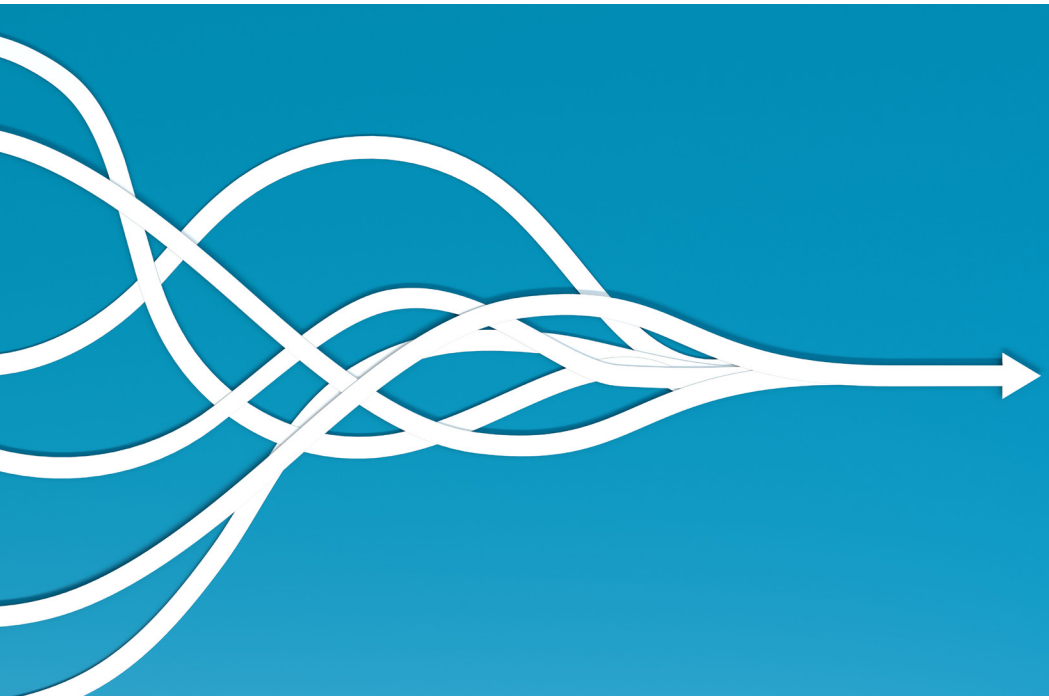
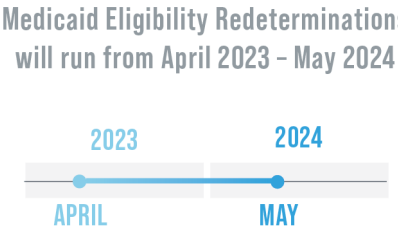


Medicaid Redeterminations Are Here: States Still Have Options to Pave the Way Toward Greater Government Efficiency

On April 1, 2023, states began to redetermine tens of millions of people's eligibility for health care benefits through Medicaid for the first time in three years — and millions of people are likely to lose health coverage as a result. To avoid unnecessary coverage losses, states can take immediate steps to make enrollment and eligibility processes more efficient during this critical time. Keeping people covered means that more families can access the care they need, hospitals have less uncompensated care, and people are more likely to be healthy and able to participate in the workforce.[1]

Procedural changes that enable state governments to work more efficiently are essential during this time of unprecedented administrative burden and widespread labor shortages. Some states have already taken steps to streamline eligibility and enrollment practices in anticipation of this moment. Other states are still working to plan for likely challenges posed by the redeterminations process that will run from April 2023 to May 2024. It is not too late for state policymakers to make improvements to their systems — changes that will help keep people covered and protect state budgets.



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States should maximize ex parte (also known as passive) renewals, auto-enroll or pre-populate applications for beneficiaries in qualified plans, and use tax return information to minimize health coverage disruptions. Some of these changes can be conducted administratively, such as ex parte renewals, while others will require legislative changes that will take more time to implement. Depending on their legislative calendars, some states might need to call for special sessions to pass new laws while others have to wait until 2024. Whether the redeterminations process is streamlined by administrative changes or by legislative action, the advantages are clear: State Medicaid agencies, people who rely on Medicaid, and the communities in which they live will see benefits and efficiencies from these improvements that will outlast the yearlong pandemic-era redeterminations process as renewals return to an annual cadence.

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Background

The 2023 Consolidated Appropriations Act decoupled the continuous Medicaid coverage requirement from the COVID-19 public health emergency declaration, effective April 1, 2023. This means that over the next year, states will have to redetermine Medicaid eligibility for over 91 million people who rely on the program for their health insurance, for the first time since early 2020. As a result, states will begin disenrolling people they deem no longer eligible for Medicaid. Using history as a guide, it is clear that some of the people deemed ineligible may no longer meet income eligibility, but others will be disenrolled simply because they did not respond to a piece of mail notifying them of the redetermination process.[i]

[i] As a part of the Families First Coronavirus Response Act, enacted at the beginning of the COVID-19 pandemic, Congress required that states maintain specific eligibility requirements, including continuous coverage for current Medicaid enrollees through the duration of the public health emergency. In exchange, states received a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP). As a result of these changes, an additional 20 million people gained Medicaid coverage since February 2020, and now over 91 million people are enrolled in Medicaid and the Children's Health Insurance Program.

In December 2022, Congress passed the 2023 Consolidated Appropriations Act, an omnibus spending bill that detached the continuous enrollment provision from the public health emergency and set March 31, 2023, as the end date for the provision, with a phase-down of the enhanced FMAP through the end of 2023. With the end of the continuous enrollment provision, states will begin redetermining the eligibility status of current enrollees and disenrolling those deemed no longer eligible.

Estimates show that anywhere from 5.3 million to 14.2 million people will lose Medicaid coverage because of the resumption of redeterminations, including an estimated 6.8 million people who will be disenrolled — due to administrative barriers — despite still being eligible for Medicaid. Disenrolling eligible people for bureaucratic reasons is a drain on the system because it means millions of people will have to restart the application process, which requires significant staff resources. It also means people who are eligible for Medicaid will be less likely to access timely medical care and less likely to afford hospital or medical care. In states that have not expanded Medicaid, many people will lose their health coverage entirely, while others will lose it temporarily as they wait to be reenrolled in Medicaid, or as they enroll in health coverage from other sources, including Medicare, the private market or their employer. These lapses and changes in health coverage, known as churn, occur frequently in the United States health care system. Historically, it has affected Medicaid enrollees the most — particularly people of color and children — and may lead to longer periods of uninsurance, delayed care and worse health outcomes.[ii]

NEARLY **7 MILLION** people who qualify for Medicaid will be disenrolled due to administrative barriers.

At the same moment that state Medicaid agencies are undertaking this monumental redetermination task, they are facing staffing hurdles that could exacerbate these challenges. Changes in the economy have led to employee shortages and high turnover of experienced eligibility and enrollment workers throughout the pandemic.[2] For the redeterminations process to go smoothly, it takes a robust, well-trained staff. Yet the average staff vacancy rate across all state Medicaid agencies in fiscal year 2022 was 17%, with one in four agencies having a vacancy rate over 20%.[3] Many agency directors are working to fill positions, but it takes time to train new and existing eligibility workers. Only one in five existing members of state Medicaid agencies' workforces have been through a Medicaid renewal process in the past.[4]

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[ii] Bradley Corallo et al., "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies," Kaiser Family Foundation, December 14, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies.

Despite all the challenges of Medicaid redeterminations, it also presents an important opportunity.

Despite all the challenges of Medicaid redeterminations, it also presents an important opportunity: States can seize this moment to improve the enrollment process in a way that will alleviate some of the burden caused by staff shortages, reduce unnecessary disenrollments and more seamlessly connect people to health coverage. To do this, states should:

Make the most of passive, or ex parte, renewals to protect Medicaid coverage for people who are still eligible.

Utilize auto-enrollment to support the transition to other sources of health coverage for people who are no longer eligible for Medicaid.

Use tax return information to connect people to appropriate health coverage based on their qualifications.

Ex parte renewals: Keeping people who remain eligible for Medicaid enrolled in the program

Ex parte renewals — also referred to as auto-renewals, passive renewals or administrative renewals — occur when states use data from available sources to confirm eligibility for people enrolled in Medicaid coverage, and automatically renew coverage when applicable, before contacting beneficiaries directly.[5] Under the Affordable Care Act, states are required to maximize ex parte Medicaid renewals,[6] but there is wide variation in the rate of ex parte renewals across states, with only 11 of the 42 states that process ex parte renewals (for people eligible from their modificed adjustied gross income) completing completing 50% or more via this process.[7] This is likely because states have not made the upfront system investments to determine eligibility passively. Yet if more states conducted most of their renewals through the ex parte process, it would minimize coverage gaps and ensure people retain health coverage over time, while also minimizing the administrative burden on state Medicaid offices. **Importantly, states already have the necessary authority to more efficiently use ex parte renewals, enabling them to protect health coverage and conserve resources immediately.**

Income data taken from benefit programs like the Supplemental Nutrition Assistance Program (SNAP) can be utilized during the ex parte process. Many Medicaid enrollees receive SNAP benefits, and SNAP provides current and verified income information.[8] Other information sources include the federal Renewal and Redetermination Verification service, a data services hub run through the U.S. Centers for Medicare & Medicaid Services for the purpose of eligibility

determinations. This hub contains information from the Social Security Administration as well as tax data from the Internal Revenue Service. State databases are also helpful to verify income of residents who may work in a neighboring state.[9]

Millions of people have faced housing instability throughout the pandemic and may not receive renewal applications by mail.[10] States should capitalize on existing databases from SNAP and the IRS to access income information and verify eligibility without requiring additional outreach or applications from beneficiaries. It will help eligible enrollees maintain coverage while preserving limited staff time and resources.[11]

Rates of Ex Parte Medicaid Renewals by State in 2020

States & D.C. with 75-90% of renewals completed ex parte	States with 0-25% of renewals completed ex parte
Alabama	Missouri
Arkansas	Nebraska
Colorado	New Hampshire
District of Columbia	New Jersey
Idaho	Texas
Michigan	West Virginia
North Carolina	Wisconsin
Ohio	
Rhode Island	

Note: The data is presented as a range and is only for the share of renewals for nondisabled children, pregnant women, parents and the Medicaid expansion population. Tricia Brooks et al., Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings From a 50-State Survey (San Francisco, CA: Kaiser Family Foundation, March 2020), https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf.

Auto-enrollment: Smoothing transitions to other sources of coverage

The U.S. assistant secretary for planning and evaluation estimates that redeterminations will result in approximately 9.5% of current Medicaid enrollees (roughly 8.2 million people) being deemed no longer eligible. They will need to transition to another source of coverage.[12]

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8 MILLION

people will lose Medicaid and will need to transfer to another coverage source — this is more difficult than redetermining Medicaid eligibility.

Transitioning people from one source of health coverage to another is more difficult than redetermining eligibility and continuing their enrollment in the same program. To make the transition easier, the Biden administration announced a special enrollment period for people losing Medicaid coverage and enrolling in marketplace coverage. Rather than the usual 60 days, enrollees will now have until July 2024 to make that transition. However, that does not fully alleviate the challenges of transitioning from Medicaid to coverage available on the health insurance marketplace. In 2018, only 3% of beneficiaries enrolled in a marketplace plan within 12 months after being disenrolled from Medicaid or the Children's Health Insurance Plan.[13]

Further complicating matters, people with incomes close to the Medicaid eligibility threshold are likely to churn between Medicaid and marketplace eligibility, as their income goes up and down. This underscores the importance of creating a streamlined process to assist those who may fluctuate between coverage groups.[14]

States can improve these transitions by passing legislation to enact auto-enrollment systems. If states have income information that shows a person is no longer eligible for Medicaid coverage but is eligible for free or low-cost coverage through the marketplace, they should either transfer that person's account to the state-based marketplace or pre-populate applications to the federal exchange to assist the beneficiary in the enrollment process. Until states have integrated eligibility systems, they can provide pre-populated applications for marketplace coverage. Once eligibility information is fully available to states, they could auto-enroll people in fully subsidized marketplace plans they are eligible for. In either approach, reducing administrative burdens and processes would help more people stay covered.[15] Information is readily accessible for states with state-based marketplaces but can also be shared by account transfer from other state programs.[16]

Reducing administrative burdens and processes would help more people enroll in health coverage.

Auto-enrollment is best fitted for states with state-based marketplaces that integrate Medicaid and marketplace eligibility systems and can share information, allowing for a seamless transition. During the early years of **Massachusetts**' health care reform, sometimes referred to as "RomneyCare," the state would automatically enroll eligible people in a plan rather than requiring that consumers select their plan. Data shows that with auto-enrollment, 48% more people signed up for coverage each month, reducing the overall uninsured rate.[17]

More states are now implementing auto-enrollment programs. For example, **Rhode Island** is rolling out a new program that will automatically enroll those who are no longer eligible for Medicaid into a qualified health plan through the state marketplace, HealthSource RI.[18] HealthSource RI will automatically enroll individuals with incomes at or below 200% of the federal poverty level into a qualified health plan and provide financial support to cover premium costs for the first month. HealthSource RI estimates that this automatic process will keep 4,000 to 12,000 Rhode Islanders covered following the end of the public health emergency.[19] Lawmakers in New Jersey are debating a bill that would do something similar.

Additionally, **California** plans to start its highly anticipated auto-enrollment process, initially enacted in 2019 but delayed in implementation due to the onset of the COVID-19 pandemic. The state has authorized Covered California, the state's marketplace, to auto-enroll former beneficiaries transitioning from Medi-Cal, starting in June 2023. Beneficiaries who are no longer eligible for Medicaid will be placed in the lowest-cost silver plan available to them given their income level, while maximizing premium tax credit and cost sharing, and will then have one month to decide if they wish to opt in or out of coverage.[20]

Utilizing tax return data: Minimizing the burden of determining coverage options

There are other ways states can connect eligible people to health coverage — including using tax return information. Right now, some states allow uninsured tax filers to indicate on their tax forms that they would like to be connected to health coverage. States then reach out to connect people to either Medicaid coverage or marketplace coverage depending on their incomes. Filers are required to complete additional eligibility forms to be enrolled in health coverage.

For example, **Maryland** implemented its Easy Enrollment program in 2019, using the state tax filing process to identify uninsured people and help them get health coverage.[21] Marylanders can indicate their health insurance status and income on their tax form and receive an eligibility determination for Medicaid or marketplace plans. If eligible, the marketplace will notify and offer individuals the chance to enroll in a plan outside of the open enrollment period.[22] The state comptroller submits household income data to the state's health insurance exchange for applicable enrollment. In the second year of this program, the state saw a 10% increase in eligible enrollees.[23] Maryland's program also includes a provision to automatically enroll Medicaid-eligible

taxpayers in a Medicaid managed care organization, with the option to opt out or select another plan. Additional states — **California, Colorado, Illinois, Maine, Massachusetts, New Jersey, New Mexico, Pennsylvania** and **Virginia** — have followed Maryland's program and are in the process of establishing their own tax filing enrollment programs.[24]

This process could be further streamlined to make it easier for people to enroll. Right now, people attest to whether or not they have health coverage on their tax forms. If they indicated they were uninsured, an additional form could be pre-populated with their income and household information and then be used to determine their eligibility for Medicaid or marketplace coverage.[25] Final eligibility, including citizenship information, would be verified through other information sources to eliminate additional outreach to verify income and determine eligibility, given the income on the tax return would be sufficient.

It is important to note that this enhanced process would require legislative changes at both the state and federal level. First, eligibility rules would need to be modified to allow eligibility to be determined by income from the previous year, rather than current or projected income, which is how programs like Medicaid currently determine eligibility. Second, the open enrollment period would need to move to April/May after the tax filing deadline. Finally, states would need to be able to confirm immigration status without discouraging noncitizens from filing taxes. This could be done through that secondary form with an attestation question where applicants confirm they or their dependents are eligible for the program. If they make a mistake, they would need to be disenrolled promptly without penalties. Federal legislation to help pave the way for these improvements may be introduced in the 118th U.S. Congress.

Conclusion

With an end to the continuous enrollment provision of the COVID-19 public health emergency, millions of Americans are at risk of losing their Medicaid coverage. Some of these people may still be eligible for Medicaid while others will need a seamless transition to marketplace plans. States should take advantage of this moment to update their eligibility systems and streamline their enrollment processes for Medicaid and marketplace plans by maximizing ex parte renewals, auto-enrolling or pre-populating applications to ease the transition to marketplace plans, and using tax data to determine eligibility and maintain coverage. Some of these changes will take time to enact. While increasing ex parte renewals can be done administratively, some of the other changes will require legislation. But the short-term investment in these changes will increase efficiency and preserve the resources of already strained state Medicaid offices, while improving the beneficiary experience and minimizing health coverage gaps for years to come.

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This publication was written by:
Arielle Kane, Director, Medicaid Initiatives, Families USA
Marina Thornton, Health Policy Intern, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):
Sara Brandenburg, Communications Associate
Justin Charles, Digital Media Associate
Nichole Edralin, Senior Manager of Design and Publications
Lisa Holland, Senior Communications Manager
Jude McCartin, Chief of Staff

The following professionals contributed:
Erin Pinkerton, Editor

1225 New York Avenue NW, Suite 800, Washington, DC 20005
202-628-3030 info@familiesusa.org FamiliesUSA.org facebook / FamiliesUSA twitter / @FamiliesUSA

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