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How are State Medicaid Programs Approaching the Unwinding of the Federal Continuous Enrollment Provision?

Robin Rudowitz:

Good afternoon. Thank you all for joining us for our web event looking at Medicaid and CHIP policies as states prepare for the unwinding of the continuous enrollment provision. We are thrilled that so many people were able to join us for this really important discussion. We have a lot to cover in the next hour, but before we get to the substance, I want to go over a few logistics.

First, the briefing is being recorded and a link to the recorded version will be emailed to everyone later today. Second, we have ASL interpretation available. To access it, please click on the globe icon in your Zoom control panel and select American sign language. A screen will appear and you'll be able to view the interpreter. Finally, we will be saving time for your questions. Please enter questions using the Q&A function at any time during the discussion. Let's get started.

I am finding it quite fitting that we're holding this briefing on the kickoff to March Madness Basketball, because getting ready to unwind the Medicaid continuous enrollment provision that has been in effect for the last three years definitely qualifies as a much different time for March Madness, but with very high stakes as coverage for millions of Medicaid enrollees hangs in the balance. A KFF analysis shows that by the end of March, Medicaid and CHIP enrollment will be close to 95 million people, an increase in 23 million since prior to the pandemic.

During the unwinding, estimates show that millions could lose coverage if they're no longer eligible, but also if they remain eligible and big barriers renewing their coverage. We heard during recent focus groups that many Medicaid enrollees have experienced worsening health and financial stability during the pandemic, but we also heard that Medicaid coverage is portable and has helped people access needed health care. Most enrollees in our groups were not aware that Medicaid coverage had been protected during the pandemic, and they were also not aware that disenrollments could start as early as April. These findings suggest the need for ongoing efforts to conduct outreach and communication about the upcoming renewals.

In preparation for the unwinding, a lot of activity is already underway. CMS has been working to provide guidance to states while states are working to adopt and implement policies to get ready for the unwinding. In addition, managed care plans, providers and enrollment assistors are gearing up to help people navigate [inaudible 00:02:48]. Earlier today, in collaboration with the Georgetown Center for Children and Families, CCF, we released our 21st annual survey of state Medicaid and CHIP eligibility, enrollment and renewal policies showing what policies were in place as of January 2023.

This survey also presents a snapshot of actions states are taking to prepare for the unwinding of the continuous enrollment provision. This report is a huge team effort. We really want to thank all the states who took time to participate in the survey. We are always grateful for state participation, but even more

so this year because we were in the field just as legislation ending the continuous enrollment provision was passed at the end of 2022. It was and continues to be an extremely busy time for state officials.

I also want to recognize the staff at KFF and CCF who worked on the substance of the report, but also our communications and productions teams who helped to organize this webinar and get the report posted and disseminated. Finally, I want to thank our amazing panel of experts. We are really looking forward to hearing from Jennifer Tolbert from KFF and Tricia Brooks from CCF who will walk us through some high level findings for the annual survey, and then we will turn to more of a discussion with the panel to offer a range of perspectives from the federal government, the states, and on the ground.

We are looking forward to hearing from Jessica Stephens, a senior policy advisor in the Office of the Center Director for the Center for Medicaid and CHIP services at CMS, Kate McEvoy, the executive director for the National Association of Medicaid Directors, and Tia Whitaker who is the statewide director of outreach and enrollment for the Pennsylvania Association [inaudible 00:04:33]. With that, I will turn it over to Jen and Tricia to go over some findings.

Jennifer Tolbert:

Great. Thanks, Robin. While Tricia Brooks and I are presenting findings from the report, I do want to take a minute to acknowledge the rest of the incredible team that made this work possible, Alexa Gardner [inaudible 00:04:54] at Georgetown Center for Children and Families, and Brad Corallo, Sophia Moreno [inaudible 00:04:59] here at KFF. As Robin noted, we simply could not do this work without our state partners, and we especially appreciate their participation this year. Thanks to you all.

Now, let's dig into the findings. Great. Thank you. With the continuous enrollment provision ending on March 31st, after months of preparing, states are actually beginning the unwinding process. Under CMS guidance, states had the option to initiate the first batch of the renewals, or in other words [inaudible 00:05:35] the unwinding period in February, March or April. According to our survey data as well as data from CMS, eight states started this process in February, 15 states started this month, and 28 states will begin in April.

Now, while states can begin disenrolling people as early as April, as a general rule we can expect to see disenrollments about 60 days after renewals have been initiated, given federal notice requirements. That means we'll begin to see disenrollments in April for states that started in February, but not until June for states that started the process or that will begin the process in April. Next slide, please.

CMS guidance permit states to take up to 12 months to initiate and 14 months to complete all renewals during that period. Most states, 43 in total, plan to take the full time to process all renewals. However, some states are planning to move a bit more quickly. Spreading renewals over a longer period will enable states to better balance the volume of renewals with the capacity of both staff and their systems to process those renewals. Next slide, please.

States that have continued processing renewals while the continuous enrollment provision has been in place have been able to flag individuals who appear to no longer be eligible or who did not respond to a renewal request. Importantly, states will still have to complete a full renewal on all enrollments, even if they have information suggesting that someone may no longer be eligible. However, they can use this information to prioritize renewals for these individuals earlier in the unwinding period. While over half

of states reported flagging individuals who may no longer be eligible, only 11 of the reporting states said that they will prioritize renewals for these individuals first during the unwinding period.

Most states are instead considering multiple factors in their approach to prioritizing renewals, including factors such as time since last renewal, whether individuals have been utilizing services, and the vulnerability of certain groups. I should note some states are also planning to simply process renewals based on [inaudible 00:08:10]. Next slide, please.

Federal regulations require states to attempt to renew coverage for enrollees using reliable data sources before requiring enrollees to complete a renewal form or to submit documentation. Now, these automated renewals are referred to as ex parte renewals, and 43 states reported that they have continued to process ex parte renewals during the past year. Additionally, 30 states indicated that they have taken steps to increase ex parte renewals again over the past year. That effort does seem to be paying off. 18 states reported that they are able to complete 50% or more of all renewals using ex parte processes. While that number may still be a little low, it is up from just 11 states last year. Completing higher shares of ex parte renewals can help reduce the administrative burden on both staff and enrollees. Next slide, please.

Reducing the administrative burden on staff is really important because many states are facing staffing challenges including staffing shortages. Over half of reporting states indicated their vacancy rate for frontline eligibility workers exceeds 10%, including seven states with vacancy rates greater than 20%. States face similar challenges, though slightly less severe with call center staff. In response, over two thirds of states have taken steps to boost eligibility staff capacity, including approving overtime and hiring new staff, temporary workers or contractors. Next slide, please.

States face longstanding difficulties in reaching enrollees by mail, which is still the primary method they use to send renewals and other requests for information. One important way that states can reduce disenrollments among people who remain eligible is to make sure they have enrollees' current contact information. That way, when they send out a notice through the mail, it's more likely that the enrollee will receive and act on that notice.

To that end, all states took action over the past year to encourage enrollees to update their mailing addresses and other contact information, including direct outreach to enrollees as well as checking for updated addresses and staff and other benefit programs. States have also made it easier for enrollees to update their information by creating an online change of address form, or having a dedicated [inaudible 00:10:56]. In addition, 40 states reported that they will follow up on returned mail by phone, mail and/or text to attempt to locate an enrollee before terminating coverage.

Provisions in the Consolidated Appropriations Act require states to make a good faith effort to follow up on returned mail using at least two communication modes. I will note that our survey was sent out, as Robin noted earlier, our survey was sent out in mid-December before the CAA was enacted, and many states submitted their survey responses before CMS released more detailed guidance on this issue. It is possible that more states are now taking steps to follow up on returned mail. Next slide, please.

Given the massive undertaking that states have already in some cases embarked on and others are beginning to, most states are engaging with key stakeholders, including managed care organizations to assist with outreach to enrollees. 31 states are accepting updated contact information from MCOs

without reverifying that information with enrollees, and states are also planning to send MCOs advanced lists of members who are due for renewal, members at risk of being disenrolled because they have not responded to a renewal request, as well as members who have been disenrolled that identifies whether the individual was determined ineligible, or whether they were disenrolled [inaudible 00:12:33]. Now, the goal of these efforts is to enable MCOs to do targeted outreach to their members and provide assistance to help members complete the renewal process, or transition to other coverage in the marketplace if the MCO also operates a qualified [inaudible 00:12:53]. With that, I will turn it over to Tricia to present additional findings.

Tricia Brooks:

We can go to the next slide, please. Thank you, Jen. I'd like to start with highlights of a few actions states are taking to improve the renewal outcomes. States must give [inaudible 00:13:12] based enrollees, that's kids, pregnancy and adults, 30 days to respond to renewal requests, but there's no federal requirement for states to do more than send the renewal form or the request for information. We know that sending reminder notices as 36 states plan to do via mail and through other communication modes, including phone, text, and email, can increase the renewal response rate. Follow-up reminders also help reduce the number of people who are disenrolled at the end of the unwinding period because they did not provide needed information. As you can see here, about a third of states plan to mail a reminder while about half of the states will text reminders, two out of five states will send emails or plan to make individual or automated calls. Altogether, over 29 states are planning to use multiple methods to follow up with enrollees. Next slide, please.

Online assistor portals create administrative efficiencies for states by allowing navigators, assistors and authorized partners to initiate certain administrative tasks associated with enrollment and renewal. Secure portals also provide a mechanism for states to monitor assistor performance. These portals often have many of the same features that are available to enrollees in their online accounts, which almost all states have now. We were pleased to find that 29 states have online assistor portals, and most of those states assistors are able to submit applications and review application status. Assistors can report changes in circumstances in 19 states, view notices in 15 states, view pending actions and submit renewal information in 18 states, and upload documents or update contact information in 20 states.

In the report we also show steps that states are taking to align renewal policies for the [inaudible 00:15:22] groups with people who have disabilities or dual eligible seniors. As background, many of the streaming renewal rules adopted by the Affordable Care Act did not apply to coverage for people with disabilities or seniors dually eligible for Medicaid and Medicare. CMS has proposed rules that will largely align renewal policies across these groups, but states are a step ahead with all states taking at least one action to align renewal processes. Next slide, please.

Turning now to eligibility, South Dakota will expand Medicaid to adults in July of 2023, making it the seventh state where voters have approved ballot initiatives to adopt Medicaid expansion. North Carolina is poised to become the 41st state to adopt Medicaid expansion after state legislators reached a deal that is expected to be voted on soon. However, eligibility remains extremely low in the states that have not implemented the Medicaid expansion. With the median income of eligibility dropping from 38.5% of the federal poverty level to 37%, that's just over $9,000 annually for a family of three, and this

is because eight non-expansion states based income eligibility on dollar thresholds that are not routinely updated. Over time, the equivalent FPL level decreases when the federal poverty threshold is adjusted upward to account for inflation as it did in 2023 when the FPLs rose an average of 8%. The erosion is more evident. For example, Tennessee's parent eligibility declined from 88% FPL in 2022 to 82% in 2023. Next slide, please.

Over the past year, several states have taken steps to expand coverage to immigrant children and adults. In 2022, Kentucky removed the five-year waiting bar for children and pregnant individuals. As of January of 2023, 40 states use federal funding to extend coverage to some immigrant children and/or pregnant individuals without the five-year waiting period. This includes 35 states that have adopted the option for children of Medicaid and CHIP, and 26 states that provide pregnancy coverage to lawfully residing individuals. In 2022, Connecticut and Maine adopted the unborn child option in CHIP to provide coverage during pregnancy regardless of immigration status, bringing the total count of states doing so to 20.

States are also increasingly using state funds to extend coverage or limited benefits to some immigrant children, pregnant individuals, and other adults who have no federal pathways to coverage. A dozen states now cover all income eligible children regardless of the immigration status, including Connecticut, Maine, New Jersey, Rhode Island, and Vermont that extended this coverage in 2022. 11 states use state only funds to cover immigrant adults who are otherwise ineligible, including Illinois, New Jersey, Oregon, and Vermont. That newly extended coverage to targeted immigrant adult groups in 2022. Next slide, please.

The pandemic has shown how continuous enrollment stabilizes coverage in Medicaid and CHIP. States have long had the option to provide 12-month continuous eligibility for children as 33 states do, but that includes seven states that guarantee full year coverage only in CHIP. The CAA requires states to provide 12-month continuous eligibility for all children beginning in January 2024, but some states have their sights on longer periods of continuous enrollment for children, particularly during the critical early developmental years when continuous access to care can address developmental delays and support school readiness.

In 2022, Oregon became the first state to receive section 1115 waiver approval to cover children continuously until their sixth birthday. Three other states, California, New Mexico and Washington have similar plans. Oregon also received approval to provide two-year continuous eligibility for everyone age six and older. Illinois is developing a similar proposal to provide two years coverage for all enrollees and would be remiss to not note the rapid take-up of extended coverage for 12 months postpartum in 37 states in about two years with more states considering legislation to do so. Kentucky also expanded income eligibility to cover pregnant adults through CHIP, while Oklahoma is seeking approval to increase pregnancy eligibility of Medicaid. These actions are a clear reflection of the country's increased focus on maternal health and health disparities. Next slide, please.

The impact of the unwinding will vary across states driven by differences in system capabilities, including the rate of ex parte renewals as well as communication strategies, staff capacity and adoption of operational policies that make it easier for people to stay enrolled. Even with many states taking steps to promote continuity of coverage, millions are expected to lose their health insurance. After achieving

historically low rates of uninsurance, it is likely that the uninsured rate will increase as states resume Medicaid disenrollments.

Now, we know that most people who are disenrolled for Medicaid because they're no longer eligible should have a path to other coverage options through the marketplaces or an employer, but even with zero premium ACA plans available for some, affordability and limited special enrollment periods may remain a barrier for others. Still, disenrollments for procedural reasons are expected to be high. The Office of the Assistant Secretary for Planning an Evaluation estimated that 45% of people disenrolled during the unwinding will lose coverage despite remaining eligible. This will disproportionately impact children and people of color. Boosting staff resources actively monitoring the unwinding to identify issues, and rapidly responding to systemic or recurring problems can help avoid procedural disenrollments that lead to coverage losses.

Nonetheless, after achieving historic coverage levels, it is likely the uninsured rate will rise again. Beyond the unwinding in the coming year, Medicaid agencies will continue to be stretched as the Biden administration works to finalize rules and policy to help promote and expand coverage. At the same time, congressional debate over the debt selling has given rise to talks of cuts to Medicaid and other assistance programs. Interest in putting restrictions on Medicaid enrollments such as work requirements have resurfaced as well as strategies to slow the growth in Medicaid spending that largely shifts increasing cost onto the states by putting constraints on federal funding. How serious this debate is remains to be seen. On that note, I'll pass it back to Robin.

Robin Rudowitz:

Thank you so much, Jen and Tricia, for the great overview of so much information that's included in the report. Now, as promised, I want to turn to our panel discussion and hear their perspectives on what's happening with unwinding. I want to start with a pretty high level question and going to ask our panel if they could talk about how you or your organization have been helping states or enrollees prepare for the unwinding, and maybe highlight some of the key actions that you were taking. Maybe we could start with Jessica on that one.

Jessica Stephens:

Sure. Thanks Robin and thanks to all of you for this great report. It really highlights, I think, some of the work that states have been doing and that we at CMS have been doing over the past now two plus years to prepare for the unwinding. From the CMS perspective, we really think about this as an all of government approach, and have bucketed our work in what we like to think about as three different areas. The first is minimizing churn. As we've talked about, and I think as you've highlighted, states are really thinking about all of the work that they will need to do to renew and redetermine eligibility. The primary goal is to ensure that people who are eligible retain coverage, and we've been doing that by providing policy guidance, by providing tools. If anybody has seen the medicaid.gov/unwinding page, we have put out multitude of tools over the past couple of years to help both states and stakeholders prepare for the unwinding period. That includes as well the work that we plan to do in the future around data monitoring and oversight.

Our second bucket involves transitions of coverage, ensuring that smooth transitions of coverage occur for people who are no longer eligible for Medicaid. That includes not only coverage to the marketplace, but there'll be lots of children in particular who may no longer be eligible for Medicaid and continues to be eligible for CHIP, or individuals who may no longer be eligible for Medicaid but now may be eligible for Medicare. It is critical from our perspective to ensure that those transitions happen in a smooth fashion to ensure that people who continue to be eligible aren't lost from coverage. I know there's been a lot of talk about the numbers of people who are expected to lose coverage. That does not necessarily need to equate to the number of people who become uninsured.

I think the third bucket of work that CMS and federal government overall have been focused on really has to do with outreach and engagement, both on what to expect, what can be done now, and on an ongoing basis, the targeted outreach and education work that I think we've been trying to do and will continue to do in the coming months to ensure that eligible people know what they need to do to keep their coverage and what those need to do to transition. Right now, CMS is working on their campaign referred to as Don't Wait Update. I heard Tricia talk about updated contact information, which is going to be critical. Soon, we'll have further updates including things like social media, digital campaigns, transit ads, et cetera. Some of the tools that we've released, including toolkits, are intended to help support both state outreach efforts and also the work of many community partners as well.

Robin Rudowitz:

Terrific. Thank you so much. Kate, how about we hear a little bit about what the perspective is from the states?

Kate McEvoy:

Yes. Thank you so much. Just echoing Jessica, this report is an absolute wealth of information, very of the minute, so thank you so much for Kaiser's leadership in this area. I also want to build on what Jessica said when she talked about an all of government approach that is encompassing in the framework of a federal state partnership, the longstanding partnership of state and federal actors in operating the Medicaid program. We are all in linking arms on those aspects that Jessica discussed. I would say from the NAMD lens, just amplifying a predominant focus is on raising awareness, not only of the reality and the challenges of the unwinding process, but to Tricia's point, around the foundational importance of Medicaid benefits to millions of folks nationwide at this time where there may be existential threats. Raising awareness is a key aspect I think our association is very concerned with.

We also are actively partnering with CMS to translate the guidance that it is issuing to states acting as an intermediary for not only doing that, but offering as a real-time basis feedback on the state experience with operationalizing the expectations, especially as states navigate the staged process towards compliance with all of the rules around eligibility processing. Finally, NAMD has convened and maintains very close contact with several affinity groups representing individuals across our membership in several domains that are really important to this unwinding effort. First, eligibility and enrollment leads from state programs. Second, communications officers, and also very notably chief fiscal officers. Really, the effort is to acknowledge that this is a multifaceted effort encompassing different domains of the work of

state government, really bringing folks together to synthesize the work, to improve communication, and really to drive toward that common goal of retention of coverage for all eligible folks.

Robin Rudowitz:

Great. Tia, I think you're closest to the ground in working with enrollees. Can you tell us a little perspective from [inaudible 00:29:20]?

Tia Whitaker:

From our perspective, we see that it is extremely important to share clear, concise communication, and do it often to help to prepare our Medicaid recipients, our community health centers, our patients and community organizations for the unwinding and all of the changes that are going forward. We're working very closely with the Department of Human Services in the state of Pennsylvania, and in conjunction with Pennie, our state-based marketplace, and many community organizations. We've been collaborating and working regularly, both local and regionally to ensure that we're all utilizing and saying the same message and communicating the most important information and the most important points so that we don't have folks who are slipping through the cracks.

Our messaging consists of there's no wrong door for enrollment assistance in Pennsylvania. Community health center enrollment assistors can assist with clarification of notices, renewals and enrollments directly through our Department of Human Services system, which is called COMPASS. We're making sure we're filling in the gaps going from the state and federal level right down to the boots who are on the ground, and we're highlighting the role of health insurance enrollment assistors at our network of community health centers in all of our locations, and letting folks know we're not only connecting them to quality health insurance, but we're connecting them to quality care, and that we're available during periods of insurance and uninsurance.

Robin Rudowitz:

Just to build on that a little bit, I'm wondering if we could stay with you and if you can talk a little bit about what you see the biggest challenges are on the ground in terms of what enrollees and providers are faced with in this as they start this process.

Tia Whitaker:

One of the biggest challenges we see, of course, are consumers who are not receiving their notices or understanding their notices when it comes to the renewals. Another challenge we see is the sheer number of renewals that will be coming over the next 12 months. Pennsylvania has over 3.6 million Medicaid recipients who will be renewing, and close to a million, if not over a million folks who are likely ineligible or will be deemed ineligible at the end of the public health emergency. Another challenge we see will be accessing the data to know who's actually ineligible, and providing proactive assistance.

Robin Rudowitz:

Great. I know that the Medicaid directors, of course, will have many challenges ahead of them, and I'm wondering if you could maybe highlight a few of what you think the biggest challenges are there.

Tia Whitaker:

Really, with the Medicaid directors ... Sheer volume.

Robin Rudowitz:

Kate, I'm sure you want to add on to the long list of Medicaid director challenges.

Kate McEvoy:

Tia, I absolutely resonate. Volume is a very serious challenge. Obviously, this is an unprecedented volume of work within a defined period of time. I will say Medicaid programs have actively been preparing for over a year developing very detailed multifaceted operational plans that touch on major aspects of communications, engagement with members and providers, and really the operational nuts and bolts. I do absolutely resonate with what Tia said about just the sheer numbers will definitely tax systems that are accustomed to doing this on a more stage basis.

I think also the piece on which Tia dwelled around public literacy, just playing that out a little bit, folks with very complex life circumstances who are served by Medicaid have a lot of demands in their lives tracking to those formal communications that have been the norm for Medicaid programs. Medicaid directors are very aware of a need to approach us in a different way that will meet people where they are, for instance through texting. Examining and operationalizing those different ways of connecting through text and email, and really looking at ways to intersect with how people receive information in their daily lives through their trusted partners in the community, I think that is a central challenge at this stage of the unwind ongoing. I think another major challenge is to remain vigilant about progress and emerging themes where there may be challenges that we can make observations about nationally from which states can learn best practice from their peers. Those are the areas I think we'll really be tracking.

Robin Rudowitz:

Great. I want to turn to Jessica and tack on to a little bit of what you were just saying and leads into the next question that I had, which is about monitoring of what might be happening as the unwinding begins. I think that's a great place for Jessica to talk about some of the challenges and maybe what might be happening at the federal level with monitoring of what happens as states begin the unwinding.

Jessica Stephens:

Sure. First, I completely agree with what Kate and Tia said about volume being a biggest challenge, but also to tie it into capacity at the same time. I think the survey itself shows the high vacancy rates and lots of work ahead for states at the same time that there's limited staff capacity, which is not unique to Medicaid agencies. That said, I take comfort in all the work that states have been doing over the past couple of years, and really think that we are in a place where with all of the work that states have been

doing, Medicaid is better positioned now for the work ahead than I think has ever been the case, and really also in the longer term to ensure to minimize churn and continue the focus on the enrollee.

To that point though, and going to your question about monitoring, we intend to take a really multi-pronged strategy to monitor the unwinding as we move forward using data, our ongoing state outreach and engagement in partnership with NAMD and others, as well as other information from stakeholders and those on the ground. States have been reporting data to CMS for quite a while now, almost a decade, on a number of key indicators that will continue to be helpful to help us identify where there may be issues bubbling up, whether that's call center data or enrollment application volume.

And then, the Consolidated Appropriations Act also required new requirements around things like the renewal outcomes and the disposition that CMS will continue to monitor and make public. Really just want to note that all of that work we are beginning now, and there are also new tools that the Consolidated Appropriations Act gave to CMS to follow up with states and ensure that where needed, we can implement corrective action plans where we identify potential issues. But really, the goal is to prevent that, which is why a lot of the work that is happening now is upfront to try and avoid any issues that may occur.

Robin Rudowitz:

Great. I'm wondering, do Tia or Kate have anything else on monitoring or identifying early warning signs of how unwinding might be going?

Tia Whitaker:

As far as identifying in Pennsylvania, the Department of Human Services has started sharing data like the number of COVID flagged or overdue consumers by zip code with stakeholders, which has been helpful. There's also an expectation that the data that is collected by states that is shared with CMS will be shared with stakeholders statewide for analysis and to monitor trends. Managed care organizations are also encouraged to share their data with community health centers and with providers to partner in educational outreach and efforts to make sure that those Medicaid patients don't slip through the cracks. This data should really assist in identifying any issues that are taking place over the next 12 months of the unwinding period.

Kate McEvoy:

I'll just add. This collection of data, the transparency around the data is critical to this effort as we look to roll that up nationwide. A piece that we feel that we can contribute through our association is the standing affinity groups to which I referred earlier will continue to meet on a very regular basis, often weekly. That's an opportunity for closely a held session among peers from a range of states sharing information about best practice, but also challenge areas. This will equip us to really raise up those themes, especially to convey them to our partners at CMS, and really to act on those aspects that are presenting more obstacles for states.

I'd say those affinity groups are a really important convening forum. I would also say we in the association are very much interested in remaining in direct communication and collaboration with

advocacy groups like the Georgetown Center for Children and Families to examine lived experience of members and also partners in the community around communication, the real-time experience they've had, and also how it can inform course shifts or ways of augmenting the approaches at the state level. We'd really like to partner in that respect.

Robin Rudowitz:

Great. Last question before we get to a very long list of questions coming in through the Q&A. It's a speed round on if there's one piece of advice you might give to either states or enrollees as we're about to embark on implementation of unwinding, what would that very strong piece of advice be? Jessica, we can start with you.

Jessica Stephens:

I'll say echoing our theme of Don't Wait Update as it relates to contact information, open the mail, and as it relates to both states and partners, really just continue the work that is happening to ensure that people who are eligible continue to remain eligible.

Robin Rudowitz:

Great. Kate?

Kate McEvoy:

Yeah. In that vein, let's overcommunicate. I think redundancy is not a fear in this instance. It's really trying all available channels. I would just say I hope people will understand that state officials who are responsible for operating Medicaid programs are deeply committed to retention of coverage, continuity of care for folks, and will be using every effort to ensure that that occurs. Sometimes, presuming goodwill on part of folks who are operationalizing the program, despite a lot of real challenges of the type that we have surfaced during this conversation, that would be of great benefit.

Robin Rudowitz:

Great. Tia?

Tia Whitaker:

Two bits of information. One to states, automate and share information as much as possible, and also for those who are on the ground and working with Medicaid recipients, contact community health centers and other organizations for in-person assistance for folks who are having troubles getting into or getting in contact with their Medicaid agencies or with their county assistance office, and report issues immediately.

Robin Rudowitz:

Great. Well, I want to invite Tricia and Jen back up onto the panel. We have many questions. I'm not sure if we'll get to all of the questions. A lot of state-specific questions. I'll just say the report has many

state-specific tables, so I think some folks are asking state-specific information and we might not get to answer those questions on the webinar, but there's a lot of state-specific information in the report that we can direct you to afterwards.

We are getting some questions about staffing, and certainly the report highlights the staffing shortages and some ways that states are working to expand capacity. I'm wondering if anyone has anything to add about if there are any actions that CMS, or other actions that states can do to highlight or to fill vacancies and expand staff capacity. I'll leave that one open. Maybe Jessica, if you have anything from the CMS side, and then we could see if there's any other suggestions from others.

Jessica Stephens:

Sure. I would say at the state level, states are really trying to broaden, think about it as the net of people who can support. There's the eligibility workers and then states are working with many contractors, but in thinking about capacity and what is needed, I want to make sure that we're also thinking more broadly about the role that community partners, faith-based organizations and others can play that is equally critical to helping people renew their eligibility. That includes all the work to promote, I think all the things that Tia talked about to make sure that people understand what is happening, as well as to provide on the ground one-on-one assistance through healthcare providers, community health centers. Health plans are also playing a critical role to help individuals update contact information. Even in cases where people can't necessarily serve as state staff, there are critical roles that everyone can play in order to support this work ahead.

Kate McEvoy:

Yeah. I'll just wrap around and say I think that's an excellent point about the amplifying effect of all those who are linking arms in this effort. I will say state programs are using every available tool. They are, of course, challenged as are so many other entities right now with the very low rate of unemployment and the challenge of recruiting for positions, especially with this enormous bubble of effort that they're responsible for presently.

Folks are borrowing from other divisions, they're bringing back retirees as Robin said, mentioned contracting for call center support, and that will continue. I think they're also examining the onboarding process for eligibility staff, smoothing that to the best ability using apprentice models and enabling people to become effective as rapidly as possible, even acknowledging the complexity of this work. Often, it is not cookie cutter, especially with folks who are non-MAGI members, it is complex so you really want to make sure people are equipped to handle the individualized determinations for those folks.

Robin Rudowitz:

Great. We also have a bunch of questions about transitions and coverage, some on estimates, which I'm not sure if we can cover in this call, but I think we can probably touch on if there's anything that states can be doing to, or if there's any more details that anyone wants to provide on things that states can be doing to facilitate any transition in coverage from Medicaid to marketplace coverage for those who are no longer eligible for Medicaid.

Jessica Stephens:

I can jump in there and let my colleagues add. I think yes, absolutely, and it's many of the things that we are already talking about because facilitating transitions and coverage starts with completing the renewal process, completing the redetermination, ensuring that individuals have their contact information up to date because the process is already in place for an individual who is found ineligible for Medicaid to seamlessly transition over to CHIP, if that's appropriate, or over to the marketplace or to Medicare. There's a new special enrollment period opportunity at the marketplace that will facilitate transitions to the federal marketplace for individuals who continue to be eligible, also for individuals to transition to Medicare. There are many both state-based marketplaces as well as the federal marketplace that will be doing active outreach to individuals as well. Getting information up to date, emails, phones, other contact information is critical, not only to complete the Medicaid redetermination process, but also to support the transitions to other coverage and outreach there.

Tricia Brooks:

Robin, we should note that in the survey, we did ask state-based marketplaces if they were doing anything special to ease transitions, so we would invite people to take a look at those data in the report as well.

Robin Rudowitz:

Great. There's a number of questions here asking about people with specific health conditions and what states might be doing in terms of prioritizing or deprioritizing certain redeterminations. You know that states have some flexibility in how they can ... And that's part of their plans, but I'm wondering if anyone has more insight that they might want to share about particular populations and what might be happening with the ways in which states are planning to move forward with their redeterminations.

Kate McEvoy:

Yeah. I would start by saying that I think states are very, very attuned to continuity of care matters for people with chronic conditions, folks with disabilities who are reliant on Medicaid supports to remain independent and employed. There's a lot of attention, as you said Robin, in the staging of the redetermination process, which coverage groups are renewed at which interval over the time period of redetermination. Also, states are exploring strategies, New Jersey is one of them, really to have specifically targeted outreach to those individuals through their usual source of care, and also directly with members to cue them, especially if folks are not responsive to the mailed notices and to wraparound with other means of communicating with people, notably texting. New Jersey set up a feel safe with a dedicated team around those special populations that I think is specifically oriented to maximizing the opportunity to retain coverage.

Jennifer Tolbert:

I'll just echo a little bit what Kate said with information from the survey. We did ask states how they were prioritizing renewals, and we learned that some states are planning to use claims data to identify individuals who are currently using services, and particularly people who are in the middle of treatment

or high users of services to maybe delay their renewals somewhat, or at least consider that as one factor in how they are prioritizing renewals. I think states are cognizant of this issue, and some states are really focused on trying to make sure that people who continue to need access to care are able to get that during this [inaudible 00:50:07].

Robin Rudowitz:

Great. Tia, maybe this one is for you. I think there's some specific questions here. We've talked a lot about communication, but there's some specific questions about how folks are engaging faith-based organizations, churches, other community-based organizations as well as providers. What can we tell these organizations about unwinding, and how can they help?

Tia Whitaker:

Specifically, we rely on our Department of Human Services, and again, have partnered with the Department of Human Services and with Pennie to really get information at FAQ centralized on the Department of Human Services website. We're really pointing folks to those resources and information right on the website. And then on the ground, we're connecting and providing information, webinars, providing enrollment assistors at different locations, and really maximizing the partnerships that we have on the ground to drive folks directly to that one source of information so that we can all continue to say the same thing, and folks know where to go for help and assistance.

And then of course, our state-based marketplace, which is called Pennie, short for Pennsylvania Insurance Exchange, they're collaborating also with the Department of Human Services to send out information and notices that are co-branded to those who are likely ineligible for medical assistance at the end of the PHE. It really just circles back out to folks and provides information for them to go directly to DHS's website, to go to the Pennie website to look for in-person assistance. And then again, those folks who are on the ground are reaching across to those partner organizations to provide education to them where DHS and Pennie's hands may not be able to reach.

Tricia Brooks:

We also know that a lot of states have produced communication materials and toolkits that they're making available to community partners. CCF is tracking this in our 50 state unwinding tracker, and there are links that folks can access there to get those documents. Some of it is really fabulous. It's an area that I've really been impressed with some of the state work in terms of those graphics and communications and social media messages. There are a lot of resources out there.

Robin Rudowitz:

One other question on the communication side is related to rural areas. I'm wondering if there's any efforts or specifics that anyone might be aware of that wants to talk about outreach efforts to people in rural communities that might be different to target people in those areas.

Tia Whitaker:

For the community health center aspect, we really stress, meet people where they live, work, play, pray, eat and shop. If you meet folks at those locations, that will be where they'll have the questions and where you'll be able to give them the information. That speaks to urban, but that also speaks to rural. Sometimes there's not broadband available. Telephone service may not be the greatest, but there are community health workers who are on the ground who can share information as well. Again, wrapping your arms around the folks who are in the communities that you serve is what community health centers do. We're providing them with the information that they need.

Jessica Stephens:

I was going to jump in and say Tia said it very well. These are the types of things that I think we're trying to highlight. There are really many tools available for states, and many states are taking them up to help ensure that all communities, whether it's rural, or urban, or limited English proficient, or populations that may not otherwise be reached by broad-based messaging are able to also perceive the communications that are needed to move forward. A lot of that involves partnering with local communities, whether it's the faith-based organizations, health plans or other areas where individuals access information, and using them as assistance partners to be able to get this message out, and also actually do the support to help individuals complete the renewal process.

Kate McEvoy:

I would just add, I think this is an inspired overview of the myriad touchpoints that are possible. One aspect that I think we really talked about today is just winnowing the message, the central message that we need individuals' contact information. We don't want to exacerbate the burdens on members by shifting the responsibility for the entirety of understanding the redetermination process. That squarely remains situated with the state programs, but we do want to alert them to that very, very simple proposition of making sure that their contact information is up-to-date. I think all states have striven to focus there and to really hone that message to shuck away all the other types of language that usually come with a Medicaid notice, which tends to be pretty opaque and impenetrable.

Robin Rudowitz:

Great. I think the last question that we have time for, I might just ask if there's any lessons that we think we learned from this continuous enrollment period that we might think about in going forward with the unwinding that might be important, both at implementation for enrollees and for policy as well. I think anyone could jump in to answer that kind of question, things that we might take away from these last three years of this process as we look forward to the unwinding.

Jessica Stephens:

I can start very briefly. I touched on this a little bit earlier, but really there have been so many advances that Medicaid agencies have made in both the partnerships that they've done, the adoption of strategies that they have taken, and really a focus on the individuals who are enrolled through things like contact information updates. Tricia mentioned the social media and other outreach that has historically not been so prevalent in the Medicaid space, and really think that this process has laid the

foundation for states to continue that work, which ultimately will improve continuity of coverage for eligible people, transitions of coverage for individuals who are no longer eligible, and make for a more efficient and effective management of the program.

Robin Rudowitz:

Perfect.

Kate McEvoy:

I would say we've had an absolutely fertile period of time in which to examine the myriad impacts of continuity on outcomes and experience for folks. I think that is enormously important as states will be implementing continuous coverage for children, and hopefully influence the pace of adoption of it, and also the option for postpartum coverage from others, which are non-exclusive examples of smoothing the process of the redeterminations for folks who would otherwise be highly vulnerable to discontinuity of care, and potentially worse outcomes if they are not retaining Medicaid coverage. I think this is a really important leaping off point to consider those mechanisms within the program, and potentially to build on that going forward.

Tia Whitaker:

I would also like to say that during any process, especially during this unwinding process and thinking about it for the past three years, we should make decisions and help to make decisions for consumers, but we also need to make these decisions with consumers. The consumer voice, their opinion, what works best for them is always the best sounding board to ask questions to work with the consumers and with the patients to find out what they like and what they need.

Tricia Brooks:

Robin, I would emphasize the importance of states maximizing their use of technology. We know that states that have high shares of automated renewals have less manual processing to do that goes hand in hand with staffing shortages, and in fact, by maximizing technology, we can reserve those human resources for giving the human touch to the folks that need it.

Robin Rudowitz:

Great. Thank you so much. We are out of time, but clearly there are many more questions to answer and a lot of work to do. As we begin the unwinding process and get into March Madness, I think we all learned from this briefing that there's a huge amount of work to be done, and that unwinding will be an enormous undertaking. We also know that the policy choices and the implementation of those policy choices will vary across states, but collectively have really important implications for coverage, including how well people transition and how many people remain eligible or continue to be enrolled in the Medicaid program.

I want to wrap up and thank everyone who joined the webinar, and also thank the panelists for a great discussion and sharing their time and expertise. I want to remind everyone that the slides and a

recording of the webinar will be available later today, and you should get the email about that. I think that concludes our webinar. Thanks so much.