Protecting Patients' Access to Care as Medicaid Unwinding Continues:

Patient Groups Urge States to Use New Flexibilities

Our organizations, representing hundreds of millions of patients and consumers facing serious, acute, and chronic health conditions across this country, urge states to utilize all available flexibilities to help consumers during the Medicaid unwinding.

Beginning April 1, 2023, states resumed Medicaid eligibility determinations that were paused during the COVID-19 public health emergency. The data reported by states so far has shown alarming numbers of coverage terminations for procedural reasons, such as being unable to locate individuals or not receiving re-enrollment paperwork on time.[1] We are concerned coverage losses may be exacerbated by high abandonment rates at some state call centers.[2]

In June 2023, CMS provided a list of flexibilities and approaches available to states to help minimize procedural coverage terminations. Our organizations encourage all states to engage **as many of these strategies as possible** to ensure that patients have ample opportunity to respond to redetermination requests, and to minimize disruptions in their health coverage. In particular, we highlight the following approaches:

Increase *ex parte* renewal rates

[1] https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/

[2] https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-data-reporting/index.html

- States may renew eligibility based on eligibility determinations made for other programs such as the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). States may also take advantage of flexibilities that help to facilitate income verification (such as $0 income or regular income such as Title II Social Security Disability benefits).
    - States often have additional information on beneficiaries from other programs that assist people with low incomes or income information that is unlikely to change. This information can be used to renew coverage automatically and reduce red tape for beneficiaries. All states should be taking advantage of these income verification strategies.
- States may renew eligibility for beneficiaries for whom information from the Asset Verification System (AVS) is not returned or is not returned within a reasonable timeframe.
- States may renew eligibility for beneficiaries without regard to the asset test for non-Modified Adjusted Gross Income (MAGI) beneficiaries who are subject to an asset test. States also have flexibilities to ensure that asset tests do not become unnecessary bureaucratic barriers to coverage. This is particularly important for non-MAGI populations, including people with disabilities and chronic conditions. All states should utilize these flexibilities.
- States may suspend requirements to apply for other benefits and cooperate with medical support enforcement, reducing the burden on eligibility staff.

Support enrollees with submitting or completing renewal forms to reduce procedural terminations

- States may permit managed care plans to assist enrollees in completing and submitting Medicaid renewal forms. States may also send lists to managed care plans for individuals who are up for renewal or who have not responded to renewal requests to conduct targeted outreach. For many enrollees, managed care organizations (MCOs) may be their most consistent, recognized, or trusted source of contact or information regarding their coverage. Allowing MCOs to conduct outreach and assist enrollees with their renewal forms could significantly ease strain on both eligibility staff and enrollees themselves. All states should utilize this flexibility.
- States may delay procedural terminations for beneficiaries for one month while the state conducts targeted renewal outreach. We urge all states, but particularly states that are seeing high rates of procedural terminations, to implement the newly available one-month pause in procedural terminations. This additional time will allow states to conduct additional outreach, assess why the procedural termination rate is so high, and explore strategies to minimize or reduce procedural terminations based on those findings.

Facilitate the reinstatement of eligible individuals disenrolled for procedural reasons

- States can designate agencies or third-party actors such as pharmacies or community-based organizations as qualified entities who can conduct presumptive eligibility (PE) determinations for individuals who recently lost coverage.
    - Many enrollees may not realize their coverage has been terminated until they try to use it, such as picking up a prescription or seeing their doctor. Designating PE entities would also ease the burden on the state's own eligibility staff, while providing meaningful reenrollment avenues for enrollees when they learn of their coverage termination.

- States can automatically reinstate beneficiaries to the date of their procedural termination, extend the 90-day reconsideration window, and extend the automatic reenrollment in an MCO.

States should also consider deploying strategies specifically focused on mitigating coverage loss for individuals with special health care needs. First, states can identify "high-risk" enrollees such as individuals in the disabled eligibility group or individuals receiving home and community-based services. After identifying high-risk enrollees, state Medicaid agencies can distribute redeterminations later in the unwinding period (e.g., initiating renewals for high-risk individuals during months 10-12 of unwinding) to provide more time to conduct tailored outreach and provide individual assistance with the renewal process to help ensure these individuals maintain coverage. States may also adopt special redetermination processes such as providing longer timeframes for individuals to respond to requests for information to complete the renewal process and/or following up with multiple outreaches through alternate modalities for enrollees who do not respond to renewal forms.

The challenges that people with chronic conditions face when they experience gaps in coverage are well known—they are forced to go without medication or needed treatment. It is crucial that states use the above flexibilities to minimize unnecessary coverage losses, ensure lost coverage is reinstated as quickly and seamlessly as possible, and proactively notify beneficiaries of coverage reinstatements so that patients have access to the health care they need.

ALS Association
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
Cancer*Care*
Child Neurology Foundation
Chronic Disease Coalition
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Foundation for Sarcoidosis Research (FSR)
Hemophilia Federation of America
Immune Deficiency Foundation
Lupus Foundation of America
Lutheran Services in America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Bleeding Disorders Foundation
National Eczema Association
National Health Council
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society