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Recommendations for HHSC When Resuming Medicaid Redeterminations & Disenrollments

Background: States are receiving a 6.2 percentage point increase in their federal Medicaid matching rates (FMAP) during the duration of the COVID-19 Public Health Emergency (PHE). The PHE started March 18, 2020, and has been officially extended through April 16, 2022. As a condition of the federal funding increase, states cannot cut eligibility or make it harder for eligible families to enroll. States must also provide continuous coverage: they cannot disenroll any Medicaid beneficiary who was already enrolled or has newly enrolled during the PHE.

State health agencies must develop their plans for the many policy and process changes needed once the PHE eventually expires. In support of these efforts, in August 2021, the Centers for Medicare & Medicaid Services (CMS) issued a state health official letter that sets out expectations for how states should transition back to normal operations in Medicaid and the Children's Health Insurance Program (CHIP) after the end of the PHE.

We appreciate HHSC's continued partnership and offer the recommendations below as the state develops its plan for resuming routine eligibility determinations and Medicaid disenrollments. Ultimately, we share the common goal to ensure eligible clients stay enrolled in their Medicaid coverage and to help transition ineligible people to other coverage options, like CHIP, Healthcare.gov, or Healthy Texas Women.

The approach that HHSC takes over the next several months is critical. The stakes are high. We are concerned that resuming routine Medicaid renewals and disenrollments without careful planning and execution by HHSC would cause widespread harm to Texans, Texas' health care system, and HHSC's eligibility system.

- Medicaid continues to be a vital health program that children, pregnant women, Texans with disabilities, and seniors rely on for medical and mental health care, including during an unprecedented national emergency such as the pandemic. Yet, when Medicaid disenrollments resume, the more than 4 million Texans who rely on Medicaid will become highly vulnerable to the loss of coverage and care.
- Poor planning or execution in Texas could trigger a mass disenrollment of *eligible* individuals from Medicaid. For example, Utah suspended renewals for its Children's Health Insurance Program (CHIP) at the beginning of the pandemic; but, once the state resumed renewals, an unprecedented 41% of children in CHIP lost coverage, the vast majority (around 89%) because of a procedural issue, and not because the state determined they were no longer eligible.
- Widespread coverage loss among eligible people would not only be devastating for the low-income children and families who rely on Medicaid, it would also wreak havoc on Texas' health care system. When

individuals lose Medicaid coverage, have a gap in coverage, and then re-enroll, their health care costs are often higher. Safety net providers, already reeling from pandemic-related disruptions and demands, would face increased uncompensated care.

- We have significant concerns about the impact of restarting Medicaid disenrollments will have on an already overloaded eligibility and enrollment system and workforce. In late 2019, the high turnover of eligibility workers led to significant delays in processing applications. SNAP and Medicaid timeliness was far lower than the norm even before the pandemic. Average timeline from client application to eligibility determination for SNAP and Medicaid is *already* more delayed – with average decision time increasing by *an extra week* for SNAP and an *extra two weeks* for Medicaid (HHSC data, from 2019 to early 2021). Clients are reporting *multiple-hour-long* wait times for Maximus operators at 2-1-1, which is often the only route for a Medicaid client to address a problem, ask a question, or update their contact information.

Recommendations for HHSC

1. Limit the Number of Renewals Processed Each Month to Promote Manageable Staff Workloads and Ensure Redeterminations are Based on Current Circumstances

- As required by CMS' September 2021 guidance, HHSC should conduct eligibility determinations based on enrollees' current circumstances and ensure eligibility for Medicaid is assessed under all categories.
- We strongly urge HHSC to adopt the recommended 12-month timeline for processing all of the workload of necessary renewals. Specifically, we urge HHSC to initiate renewals or process changes in circumstances for Medicaid clients for *no more than* 1/12th of the population in any given month.
- Texas should prioritize renewals for enrollees who are most likely to be found ineligible based on data matches and the type of assistance they receive.
    - For example, children, people with disabilities, and seniors are most likely to remain eligible and should be reviewed last.
    - In contrast, young adults who turned 19 or 20 during the PHE may be more likely to be found ineligible. Or, women enrolled in Medicaid for Pregnant Women during the PHE may be more likely to be found ineligible for comprehensive Medicaid -- although they are likely still eligible for Healthy Texas Women.

2. Strengthen Renewal Processes as a Key Way to Increase Efficiencies

- Increasing efficiencies in the administrative renewal process will go a long way to reducing workload for HHSC eligibility and enrollment staff, call center workers, and community-based assisters. To increase efficiencies, HHSC should:
    - **Allow the use of Texas Workforce Commission (TWC) quarterly wage data from the two quarters prior to the current quarter**. HHSC has stated that the largest constraint on the current administrative renewal process is that the system will not allow the use of any financial information that is more than 60 days old to verify income. This policy is simply part of the system's Texas HHS-generated design, not required by CMS. In practice, this

system design means that HHSC is unable to verify earned income using TWC data in *at least 8 months* out of the year. Allowing for broader use of TWC wage data means the state could confirm income data more often – thereby re-verifying a client's eligibility more efficiently.

- **Stop the use of the New Hire Report data during the automated administrative renewal process.** The automated system requests paper verification from a client any time a New Hire Report includes an employer name and start date that does not match *exactly* with the employer name and date included in TIERS. There are many cases where the employer name and hire start date do not match *exactly* on the two forms. This automated matching process is fraught with errors, leading to many cases where families have to submit redundant information even though their income or circumstances have not changed.

- To streamline renewals for clients that cannot be administratively renewed, HHSC should:
  - Ensure renewal forms are pre-populated for individuals enrolled in Medicaid and CHIP, consistent with federal requirements.
  - Update the state's verification plans to accept reasonable explanations of inconsistencies or to allow for self-attestation of certain eligibility criteria for which documentation may be difficult for individuals to obtain.
  - Increase the time individuals have to respond to a renewal form from 30 days to 45 days.
  - As required by federal regulation, HHSC must not require clients to submit a new application if they provide requested information within 90 days after coverage is denied at renewal. HHSC's written policy follows this requirement; *however*, clients are routinely directed by 2-1-1 customer representatives to submit a new application after a denial.
- For individuals who are no longer eligible for Medicaid or CHIP, federal law requires HHSC to transfer their account information to the Federally Facilitated Marketplace (FFM). Email addresses should be included in the account transfer whenever possible as this is the primary means of contact used by the FFM.

3. Implement Proactive Steps to Get Updated Contact Information and Mailing Addresses for Medicaid Clients, Including Making Improvements to 2-1-1

- It may have been months or over a year since HHSC has communicated with a Medicaid client, meaning HHSC may have outdated contact information. Without up-to-date information, the chances of notices, renewal packets, or requests for information not reaching a person who has moved is high – possibly resulting in an eligible client losing coverage. A critical step that can be done now – before disenrollments resume – is to get up-to-date mailing addresses and contact information from all Medicaid clients.
- HHSC should accept contact information changes submitted by enrollees to their Managed Care Organization (MCOs). CMS guidance points to this step as a best practice. We urge HHSC to collaborate with Medicaid MCOs on a plan to ensure that each health plan contacts its members

to update member mailing addresses, telephone numbers, and email addresses. As part of this outreach, health plans should reiterate to their members that they need to complete the renewal process in a timely manner.

- Engage community-based organizations, application assisters (including Navigators and certified application counselors), and providers to conduct outreach to remind Medicaid clients to provide updated contact information.

- The current avenues for Medicaid clients to update their information is burdensome and relies heavily on 2-1-1 (option 2). We are *already* seeing clients struggle with extremely long wait times for Maximus operators at 2-1-1 and seeing clients and assisters struggle with technological and logistical barriers to updating their information via YourTexasBenefits. HHSC should make fixes to make it much easier for Medicaid clients to update their contact information.

    - **By phone:** 2-1-1 option 2 has long wait times, drops calls, and is hard to navigate. Clients wait for 45 minutes and then the line just drops. Reports of wait times exceeding an hour are common.
        - HHSC should revise 2-1-1 option 2, create an expedited route, or otherwise provide a direct toll-free number, to allow clients to *quickly* report a change to their contact information that bypasses persistently long wait times for operators at 2-1-1. HHSC should set high standards for short hold times and low call-abandonment rates, which will require staffing resources by the vendor.
    - **Online:** Many clients cannot update their addresses online via the YourTexasBenefits website and app.
        - People forget usernames and/or passwords. If a person needs to retrieve a user name or reset their password, they often need to call 211 (option 2). There is no way to reset a password over email.
            - HHSC should devise a process for clients to reset their YTB passwords that bypasses persistently long wait times at 2-1-1 option 2, enabling more clients to directly update their own contact information.
        - Even if a client knows their password, they need a "full case access" account to report changes or update contact info via the YourTexasBenefits app or website. Full case access account is hard for many people to set up. Without full access, this means they then need to call 2-1-1 to update contact info. We do not know the percentage of clients who have “full access” accounts.
            - HHSC should devise a process to help clients quickly and easily obtain full case account access at YourTexasBenefits. Many clients lack this access, which prevents them from reporting changes using the YourTexasBenefits website and mobile app.
    - **In-person consumer assistance:** If consumer assisters helping clients do not have "Level 3" access (a status set by HHSC), they can't help consumers look up user names, reset their password, upgrade a client’s account to “full case access,” or directly update contact information for clients. In many cases, assisters without Level 3 access end up having to call 211 (option 2) and wait on hold with a client for hours.

- HHSC should implement a process allowing smartphone submission of change forms even for clients without full case access at the YourTexasBenefits site or app.

4. Address Potential Strains on Eligibility & Enrollment Workforce

- As HHSC resumes disenrollments, there will be a significant increase in eligibility actions and workload for eligibility and enrollment staff and call center workers, especially as Texas families may be confused about forms they receive and what the end of continuous coverage means for them. HHSC eligibility and enrollment workforce is already stretched thin. In addition to routine monthly application caseload, staff will be burdened with significant renewal processings and questions from clients.

- We encourage HHSC to assess its current eligibility and enrollment workforce capacity and we support an HHSC agency request for additional staffing. Additional workforce capacity is critical given recent HHSC statistics on significantly reduced timeliness of SNAP applications, longer numbers of days from application to decision, and a substantial need for additional staff made challenging by high first-year eligibility staff turnover. The average timeline from client application to eligibility determination for SNAP and Medicaid already got longer and more delayed between 2019 and 2021. The average decision time increased by an extra week for SNAP and an extra two weeks for Medicaid comparing 2019 to 2021 average decision times (from HHSC data request).

- The state's staffing plan should anticipate the additional time and staff resources needed to process verifications and time needed to be responsive to questions and the need for assistance.

    - Assess staffing needs and IT capacity using data on current caseloads
    - Identify PHE Medicaid workload for outstanding renewals
    - Assess staff needs based on anticipated workload
    - Assess whether or not IT capacity needs to be improved based on anticipated workload

- Update infrastructure for the YourTexas Benefits online portal and mobile app to handle high volumes of traffic.

- Implement "early warning/trigger" mechanisms that flag when a large number of individuals lose, or are slated to lose, coverage due to no response or missing paperwork.

- Monitor, report to CMS, and publish regular and timely reports of performance indicator data, including:

    - Call center statistics (i.e. call volume, wait times, and abandonment rates), and
    - Outcomes of redeterminations processed. HHSC should report the share of individuals whose coverage is renewed versus those who are disenrolled. And of those disenrolled, the share of individuals who were disenrolled for procedural reasons.

5. Improve Consumer Outreach, Communication & Assistance

- Conduct more intensive outreach via multiple modalities to remind Medicaid clients of anticipated changes to their coverage and to obtain needed information. For instance, HHSC could require

eligibility workers to make follow-up telephone calls and send an email if an individual has not responded to a request for additional information.

- Encourage more clients to opt-in to text reminders so they receive timely information about renewal requirements and requests for additional information.
- Engage application assisters and other stakeholders to assist individuals who need help with renewal.
- Expand use of outstation locations for eligibility workers to provide individuals with renewal assistance.
- Allow Medicaid health plans to use multiple channels, including text messages, telephone, social media, and mail to communicate with clients about updating their contact information.
- Ensure key documents such as written notices, applications, and renewal forms are translated into multiple languages by qualified translators and reviewed for cultural competence.
- Ensure individuals with limited English proficiency know how to access available language services by updating websites with taglines in non-English languages (e.g., short statements that language services are available free of charge, including how to access those services).
- Ensure information is communicated in an accessible manner to individuals living with disabilities by providing auxiliary services at no cost to the individual, including but not limited to written materials in large print or Braille, and access to sign language interpretation and/or a teletypewriter (TTY) system, consistent with the Americans with Disabilities Act (ADA) and section 1557 of the Affordable Care Act.

For questions about these recommendations, please contact:

- *Diana Forester, Texans Care for Children, dforester@txchildren.org*
- *Melissa McChesney, UnidosUS, mmcchesney@unidosus.org*
- *Anne Dunkelberg and Stacey Pogue, Every Texan, dunkelberg@everytexan.org and pogue@everytexan.org*