

THE END OF THE FEDERAL CONTINUOUS COVERAGE REQUIREMENT IN MASSHEALTH: KEY STRATEGIES FOR REDUCING COVERAGE LOSS

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INTRODUCTION

Like all states, Massachusetts received enhanced federal Medicaid funding under the Families First Coronavirus Response Act (FFCRA), the first major federal stimulus package passed by Congress in response to the COVID-19 crisis in 2020.¹ As a condition of receiving these funds, Massachusetts is required to maintain continuous coverage in MassHealth (the name for Massachusetts' Medicaid program and Children's Health Insurance Program [CHIP]) during the federal COVID-19 public health emergency. Continuous coverage means that once someone has established their MassHealth eligibility, they remain enrolled in MassHealth regardless of changes in their circumstances that may otherwise impact eligibility. The continuous coverage requirement, which applies to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date, has allowed Americans with lower income to retain Medicaid coverage and get needed health care during the COVID-19 pandemic. Due in part to the continuous coverage requirement, MassHealth enrollment has grown considerably during the COVID-19 pandemic. From February 2020 through February 2022, total MassHealth enrollment grew by 24.5 percent, from 1,757,221 to 2,188,239 members.²

When the federal Medicaid continuous coverage requirement expires at the end of the month in which the public health emergency ends (which is currently slated for July 14, 2022³), MassHealth will resume updating a member's eligibility based on the redetermination process, which has been paused in most cases for almost two years. For more information on MassHealth's typical redetermination process, see the text box above. As MassHealth begins to redetermine eligibility for a considerable volume of its members, there is a high risk that some individuals who remain eligible for coverage will become uninsured. This is a particular concern for individuals whose MassHealth eligibility cannot be verified using available data sources, and they do not receive or are otherwise unable to respond to MassHealth's requests for updated eligibility information. Others may become newly eligible for coverage through the Health Connector, the Commonwealth's health insurance marketplace, but are not successfully transitioned and

OVERVIEW OF MASSHEALTH'S RENEWAL, OR "REDETERMINATION," PROCESSES

After the FFCRA continuous coverage requirement ends, Massachusetts and other states will return to their standard renewal, or "redetermination," processes. Federal rules require that states conduct a renewal of Medicaid or CHIP coverage no more frequently than once every 12 months.

Under its standard renewal process, MassHealth conducts an annual "redetermination" for each of its members. It does so first by attempting to redetermine member income eligibility based on available income data sources. If the member's income cannot be verified or if the member does not appear income eligible based on these data sources, MassHealth sends (via mail) a pre-populated renewal form for the member to complete and return, with a request for documentation. If the member does not return the form and any required documentation to establish their continued eligibility within the timeframe provided, their coverage is terminated. In addition to the annual "redetermination" process, members are expected to notify MassHealth of any changes in their income or household composition so that their eligibility can be redetermined.

enrolled. Due to federal policy changes that are unrelated to the end of the continuous coverage requirements, it is possible that premium costs will increase for many people who qualify for subsidized coverage through the Health Connector in 2023, compounding the risk of coverage loss for people transitioning from MassHealth to the Health Connector.⁴

PROCESSING THE HIGH-VOLUME OF REDETERMINATIONS WILL CREATE A COVERAGE LOSS RISK

Redeterminations have always been a source of coverage loss for some members, including for people who remain eligible for coverage. For example, an individual may continue to be income eligible for MassHealth but never reply to the state's request for documentation of such eligibility, and therefore they are disenrolled from coverage. When someone loses coverage not because they are no longer eligible but because they failed to return the required paperwork, it is called an "administrative" or "procedural" termination. Prior to the public health emergency, nationally, one in ten Medicaid/CHIP members experienced "churn," where they were disenrolled from coverage for administrative reasons and then re-enrolled in less than one year, many in less than six months.⁵

Coverage gaps have been shown to reduce access to preventive and primary care, increase unmet health care needs, and result in disruptions in continuity of health care services.⁶

Per federal regulations, upon resuming renewal processes, MassHealth will re-evaluate member eligibility based on available data sources (e.g., quarterly wage, Social Security Administration, and unemployment compensation data⁷) before requesting any information from enrollees. When a state is able to renew someone's coverage using existing data sources, without requiring paperwork or documentation from that person, it is known as an "ex-parte renewal."⁸ Massachusetts, like most states, is able to redetermine eligibility for a subset of members using the ex-parte process and, for the remaining members, must rely on a paper-based process through which the state sends members a pre-populated renewal form and requests follow-up action within a prescribed period of time.⁹ In some cases, members do not understand what is being asked of them and/or do not return the renewal forms in time to ensure continued coverage. For example, in an effort to reduce the number of renewals that it would need to process once the federal continuous coverage requirement ends, MassHealth has completed the renewal process for individuals who continue to be eligible based on available data sources (in other words, MassHealth has completed ex-parte renewals when it can, sent pre-populated renewal forms to those who could not be renewed through the ex-parte process, and, in line with federal requirements, has simply continued coverage for those who cannot be redetermined eligible based on those steps).¹⁰ In 2021, as reported by MassHealth, only an estimated 10 to 15 percent of MassHealth members whose renewal could not be completed via the ex-parte process responded to renewal notices.¹¹

MassHealth's significant enrollment growth over the past two years, together with operational challenges that include a strained enrollment workforce and a high volume of returned mail as a result of individuals who have changed addresses during the pandemic,¹² creates a "perfect storm" that puts eligible individuals at risk of losing coverage.

The risk of coverage loss at redetermination is especially acute for people of color and individuals who are homeless or who experience unstable housing. Changes in circumstances related to employment, income, and housing during the pandemic—social factors experienced disproportionately by people of color—heighten the risk of individuals losing coverage as a result of procedural terminations during redetermination. This is because MassHealth is likely to have outdated eligibility information on file; MassHealth would be checking what they have on file against available data-sources, which typically have more current information. In these cases, the data source is unlikely to match the eligibility information MassHealth has

on file, leaving MassHealth more reliant on sending paper notices requesting enrollee income information. MassHealth will also experience challenges locating individuals who have moved or are newly experiencing homelessness to make them aware of the redetermination requirements.¹³

MASSHEALTH'S STRATEGIES TO MAINTAIN COVERAGE AS IT RESUMES REDETERMINATION PROCESSES

MassHealth has already developed a multi-prong plan to increase outreach to members and work with key partners, including community-based organizations and managed care plans, to prepare for the end of the federal continuous coverage requirement and get the word out about the importance of updating eligibility information and responding to requests for information related to redeterminations.

- **Invest in Community-Level Outreach.** Leveraging federal funds from the American Rescue Plan Act, which was signed into law in March 2021 with the goal of getting money into states to start building towards recovery from the effects of the COVID-19 pandemic, Massachusetts' state Legislature allocated \$5 million in funding to support a community-based outreach and education campaign.¹⁴ This campaign, led by Health Care For All (HCFA) Massachusetts, aims to help eligible individuals keep their health insurance coverage. Committed to a linguistically and culturally appropriate campaign, HCFA intends to support the redetermination process through a three-prong approach: (1) leveraging well-established community and faith-based organizational partnerships to conduct outreach to individuals where they live and work; (2) conducting one-on-one outreach by canvassing in communities that have the highest potential risk of coverage loss; and (3) launching a local ethnic media campaign. HCFA will also be using the outreach campaign to encourage individuals to get the COVID-19 vaccine.¹⁵
- **Enhance the Renewal Verification Process.** MassHealth already embraces best practices for conducting ex-parte renewals by using robust data sources for income verification. Increasing ex-parte renewals will reduce the number of people for whom the agency needs to send requests for additional information. To further increase the number of redeterminations processed ex-parte, MassHealth is planning to adjust its income reasonable compatibility threshold—the permissible difference between an individual's attested income and available income data—from 10 percent to 20 percent. A number of states including Connecticut, New Jersey, and Illinois have also increased their reasonable compatibility thresholds to increase their ex-parte renewal rates and limit the number of touch points

with members, especially given workforce constraints and data sources that aren't always up to date.¹⁶

▪ **Partner with Medicaid Managed Care Plans.**

Partnering with managed care plans and accountable care organizations (ACOs) in supporting the eligibility redetermination process has been a long-standing practice in Massachusetts, even before the public health emergency. MassHealth sends monthly rosters of individuals who are due for redetermination to all of its managed care plans and ACOs. The managed care plans and ACOs are then encouraged to conduct outreach to individuals to remind them to complete the renewal process and update their contact information. Managed care plans and ACOs are also encouraged to obtain and share updated contact information with MassHealth on a regular basis.

▪ **Deploy Communications and Outreach Strategy.**

MassHealth is taking a number of steps to conduct outreach to its members in order to prepare them for the upcoming renewal process. The state revised its Call Center scripts to include requests for an updated mailing address and telephone number as part of any interaction when MassHealth members contact the Call Center. MassHealth is also deploying a social media strategy encouraging individuals to update their contact information if they haven't already. In addition, when notices requesting additional information for the renewal process are sent to individuals, the state plans to use blue envelopes to catch members' attention. As part of its outreach strategy, MassHealth intends to tailor its communication and messaging strategy based on linguistic and cultural needs and focus its outreach efforts in communities where there will be disproportionately higher rates of redeterminations.

▪ **Strengthen Workforce Capacity.** Like most states, MassHealth is trying to increase its workforce capacity to manage the processing of outstanding redeterminations. MassHealth has already onboarded and trained a cohort of new eligibility and enrollment caseworkers and plans to continue to bring on new workers, including those to process MassHealth appeals, in the spring of 2022.

ADDITIONAL STEPS MASSHEALTH AND STAKEHOLDERS CAN TAKE TO MAINTAIN COVERAGE FOR ELIGIBLE INDIVIDUALS

With the Medicaid continuous coverage requirement slated to end in July 2022, now is the time for MassHealth to finalize its plan for processing redeterminations and implement targeted strategies to mitigate unintended coverage loss. The following are priority strategies MassHealth can employ to maintain coverage for eligible people:

▪ **Process Pending Redeterminations Over a 12-Month Period Permitted in Federal Guidance.**

The Centers for Medicare & Medicaid Services (CMS) released guidance that describes timelines and obligations for states to “unwind” the federal continuous coverage requirement.¹⁷ The guidance attempts to help mitigate coverage disruptions and address backlogs by giving states a “12-month unwinding period” to complete pending verifications, redeterminations, and renewals.¹⁸ During this 12-month unwinding period, states can conduct redeterminations in a way that spreads the workload over a longer period of time rather than attempt to redetermine coverage in a compressed time period. The extra time will allow MassHealth to reach out to members through a robust set of modalities (text, email, telephone, plan/ACO outreach) when MassHealth receives returned mail and/or receives no response to the request for additional information. Creating a full-year plan will also allow the state to take measured steps to ensure that members for whom coverage and access are most critical—such as individuals who are pregnant, disabled, or elderly—receive the time and support they need to maintain their coverage.

▪ **Proactively Address Returned Mail.** MassHealth can deploy multiple strategies for getting updated contact information from its members such as maintaining regular communication with members, leveraging existing data sources beyond the United States Postal Service to update mailing addresses (e.g., Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Department of Motor Vehicles, Department of Labor, Immunization Information Systems), and conducting additional outreach through various communication modes such as telephone, email, texts, and/or messages on the member's online MassHealth account when returned mail is received and prior to terminating coverage. MassHealth may also wish to consider establishing a specialized unit or adding additional caseworkers (which could include increasing pre-existing eligibility and enrollment contract resources or “borrowing” caseworkers who specialize in SNAP and TANF) dedicated exclusively to processing returned mail and conducting outreach.

▪ **Implement a Text Messaging Strategy.** Similar to many other states, MassHealth is working towards, but has not yet implemented, a text messaging strategy to send reminders to members to update their contact information (mailing address, email, and phone numbers) and respond to requests for information. Some text messages are subject to the Telephone Consumer Protection Act (TCPA), a federal law designed to protect consumers from unwanted phone calls and texts. In some cases, the TCPA requires the sender of a text message to obtain the recipient's prior

consent before sending certain types of automated text messages.¹⁹ However, MassHealth, as a state Medicaid agency, has the authority to send text messages to members without obtaining their consent.²⁰ While text messaging is not a solution for every MassHealth member, it can serve as a complementary strategy to conducting telephone outreach, allowing the state to reach individuals who may have moved during the public health emergency and have not provided an updated mailing address.

▪ **Issue Guidance to Medicaid Managed Care Plans and ACOs.**

While Medicaid managed care plans and ACOs are encouraged to conduct outreach to individuals, MassHealth could issue clear guidance reminding them of the end of the continuous coverage requirement and MassHealth’s plan for restarting redeterminations. In this guidance, MassHealth could also set out expectations for plans and ACOs to obtain and update member contact information and support the renewal processes.²¹

▪ **Maintain Strong Oversight and Monitoring.**

MassHealth’s relationships with community-based organizations, its managed care plans, and its ACOs will be critical in providing bi-directional communication—whereby MassHealth provides regular redetermination process updates to community-based organizations and plans, which in turn provide real-time feedback to help MassHealth better understand where processes need to be improved (e.g., members are experiencing long wait times to speak to a Call Center representative). In addition, MassHealth may wish to create a public-facing dashboard that presents monthly enrollment and disenrollment data of terminations (based on both ineligibility determinations and procedural terminations); this would allow the state and its partners to evaluate whether coverage losses are disproportionately higher than expected. Pre-COVID historical disenrollment rates will be a good barometer for monitoring, although it may be the case that disenrollment rates in the “unwinding period” are slightly higher given how long the continuous coverage requirement has lasted. Regardless, MassHealth may want to predetermine a disenrollment rate “circuit breaker”—a disenrollment so high it would trigger a pause in redeterminations to allow the state to reassess its processes in order to stem inappropriate coverage losses.

▪ **Ensure Smooth Transitions to the Health Connector.**

When MassHealth finds an individual is no longer eligible, their eligibility information is automatically transferred to the Health Connector for evaluation for coverage without requiring an individual to submit additional information. MassHealth may want to ensure all contact information including cellphone number and email address are shared

with the Health Connector to support additional outreach and determination. The Health Connector could take advantage of its broad authority to create and expand upon Special Enrollment Periods (SEPs). For example, the Health Connector could use its “exceptional circumstances” authority to provide extended SEPs for consumers losing MassHealth coverage (beyond the normal 60 days), which could give consumers more time after the loss of MassHealth coverage to enroll in coverage through the Health Connector. The Health Connector could extend conditional eligibility for members to keep them covered while completing administrative processes. Similar to MassHealth, the Health Connector has elected to expand its reasonable compatibility threshold to 20 percent to provide flexibility to consumers and reduce unnecessary administrative follow-up. The Health Connector may wish to consider expanding this threshold to a higher percentage (e.g., 50 percent) as the Federal Facilitated Marketplace is electing to do.²² The Health Connector can also leverage its relationships with its health plans, navigators, and brokers to effectuate a smooth transition for those who are no longer eligible for MassHealth. For example, the state can collaborate with and fund navigators to provide outreach and education about the end of the public health emergency, facilitate coverage transitions, and provide materials to educate individuals about the differences between Medicaid managed care and coverage available through the Health Connector.

CONCLUSION

Medicaid continuous enrollment under FFCRA resulted in significant coverage gains in MassHealth and in Medicaid nationally.²³ These coverage gains promoted stability and continuity of health care during the pandemic. MassHealth has already developed a multi-prong plan to help reduce unnecessary coverage loss during this transition, including innovative strategies to partner with community-based organizations to conduct linguistically and culturally appropriate outreach to members at risk for coverage loss. Massachusetts has multiple opportunities to maximize coverage retention for eligible people including taking all of the time made available by CMS to implement its continuous coverage unwinding process,²⁴ and ensuring full oversight and monitoring of redetermination rates. Given the potential for significant coverage loss and widened inequities as the Medicaid continuous coverage requirement ends, it is critical for states to use all the tools at their disposal to ensure that people who remain eligible stay covered.

ENDNOTES

- 1 16th Congress, Families First Coronavirus Response Act, HR 6201, § 6008(b)(3), March 18, 2020, available at <https://www.congress.gov/bill/116th-congress/house-bill/6201>.
- 2 MassHealth, “MassHealth Enrollment Snapshot as of February 2022.”
- 3 Office of the Assistant Secretary for Preparedness and Response, “Renewal of a Determination that a Public Health Emergency Exists,” April 12, 2022. Available at <https://aspr.hhs.gov/legal/PHE/Pages/COVID19-12Apr2022.aspx>.
- 4 The American Rescue Plan Act (ARPA), a federal law passed in the wake of economic disruption because of the COVID-19 pandemic, temporarily authorized enhanced premium subsidies for purchasing health insurance through the Marketplace, or Health Connector in Massachusetts. While Massachusetts already provided additional state-based financial assistance to many marketplace enrollees prior to ARPA, ARPA enhanced subsidies for some individuals and introduced a new cap on the amount anyone purchasing through the Marketplace has to pay in premiums, effectively expanding eligibility for subsidies to purchase health insurance. Though the ARPA-enhanced subsidies are set to expire after 2022, the Build Back Better Act that passed the House of Representatives and is currently stalled in the Senate would extend these subsidies through 2025. For more information on the impacts of the ARPA enhanced subsidies on coverage and premiums in Massachusetts, please see <https://www.bluecrossmafoundation.org/publication/expanded-coverage-and-savings-effects-massachusetts-extending-american-rescue-plan-acts>.
- 5 Kaiser Family Foundation, “New Analysis of Historical Rates of Medicaid Enrollment Churn Sheds Light on the Implications for the End of the Continuous Enrollment Requirement Tied to Pandemic Funding,” December 2021.
- 6 Sugar, S., Peters C., DeLew. N., & Sommers, B. D., “Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic” (Issue Brief No. HP-2021-10), Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 12, 2021, available at <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>.
- 7 Massachusetts Medicaid and CHIP Verification Plan, available at <https://www.medicaid.gov/sites/default/files/2019-12/massachusetts-verification-plan-template-final.pdf>.
- 8 Code of Federal Regulations, Title 42, § 435.916 Periodic renewal of Medicaid eligibility.
- 9 States are required to provide at least 30 days from the date of the renewal form to respond to any requests for information. Code of Federal Regulations, Title 42, § 435.916(a)(3).
- 10 MassHealth, “Health Safety Net (HSN): Massachusetts Health Care Training Forum (MTF),” July 2021, available at https://www.masshealthmtf.org/sites/default/files/2021_July%20MTF_HSN_MassHealth%20Updates_Final.pdf; “MassHealth Renewals/RIFIs and Continuous Coverage During the Federal Public Health Emergency,” May 2021, available at <https://www.mass.gov/doc/masshealth-eligibility-update-may-2021-renewalsrfis-and-continuous-coverage-during-the-federal-public-health-emergency-0/download>.
- 11 Health Care for All, “Health Care for All Applauds \$5 Million for MassHealth Redetermination and Vaccine Outreach Campaign in ARPA Spending,” December 1, 2021, available at <https://hcfama.org/statement-health-care-for-all-applauds-5-million-for-masshealth-redetermination-and-vaccination-outreach-campaign-in-arpa-spending/>.
- 12 Based on interview with MassHealth senior leadership on January 31, 2022.
- 13 Boozang, P., & Striar, A., “The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage,” State Health and Value Strategies, September 17, 2021, available at <https://www.shvs.org/the-end-of-the-covid-public-health-emergency-potential-health-equity-implications-of-ending-medicaid-continuous-coverage/>.
- 14 Health Care for All, “Health Care for All Applauds \$5 Million for MassHealth Redetermination and Vaccine Outreach Campaign in ARPA Spending,” December 1, 2021, available at <https://hcfama.org/statement-health-care-for-all-applauds-5-million-for-masshealth-redetermination-and-vaccination-outreach-campaign-in-arpa-spending/>.
- 15 Community Catalyst, “Planning for the End of the Public Health Emergency: Massachusetts Invests in Community Outreach,” January 10, 2022, available at <https://www.communitycatalyst.org/blog/planning-for-the-end-of-the-public-health-emergency-massachusetts-invests-in-community-outreach#.YeW10nrMI2x>.
- 16 Illinois is increasing their threshold to 30 percent in response to the PHE declaration to provide “immediate relief to the amount of manual communication required when verifying income” (see <https://www.dhs.state.il.us/page.aspx?item=123618>); New Jersey is raising the reasonable compatibility standard from 10 percent to 25 percent in April 2022 (see https://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2020/20-04_COVID-19_Guidance.pdf); and Connecticut is adopting a higher standard (from 10 percent to 20 percent) to allow more individuals to enroll/auto-renew without needing to submit verifications amid the PHE (see <https://portal.ct.gov/DSS/Communications/DSS-Response-to-COVID-19>). Nevada sorts returned mail by forwarding address, out-of-state, and return to sender.

- 17 CMS, SHO# 22-001, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>; CMS, SHO# 20-004, December 22, 2020, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>; and CMS, SHO# 201-004, August 13, 2021, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>.
- 18 CMS, SHO# 22-001.; Per the SHO, CMS clarified that it will consider a state in compliance with the 12-month unwinding period if it has: (1) initiated all renewals for the state’s entire Medicaid and CHIP caseload by the last month of the 12-month unwinding period; and (2) completed all such actions by the end of the 14th month after the end of the PHE.
- 19 The Telephone Consumer Protection Act (TCPA) regulates calls, including text messages, sent via an “automatic telephone dialing system,” also known as an “autodialer.” United States Code, Title 47, § 227(b)(1)(A).
- 20 The Federal Communications Commission (FCC) has explained in guidance that state government callers making calls on official business are not subject to the TCPA’s prohibition on the use of autodialers because the TCPA only applies to a “person” and there is a presumption that states are not considered “persons.” Therefore, if an employee of a state Medicaid program is sending a text message to a Medicaid enrollee for purposes of assisting with Medicaid re-enrollment, the TCPA does not apply at all, even if the state uses an autodialer to send the message. See United States Code, Title 7, §§ 227(b); and Federal Register, Volume 86, 9299, 9300, February 12, 2021.
- 21 Manatt Health, “Leveraging Managed Care Plans to Support Medicaid Continuous Coverage Unwinding Toolkit,” State Health and Value Strategies, January 10, 2022, available at <https://www.shvs.org/wp-content/uploads/2022/01/MMC-Strategies-for-Unwinding-Toolkit-1.10.22.pdf>.
- 22 Based on information provided from the Center for Consumer Information and Insurance Oversight to state Medicaid directors on February 18, 2022.
- 23 MassHealth, “MassHealth Enrollment Snapshot as of November 2021”; Corallo, B., & Moreno, S., “Analysis of Recent National Trends in Medicaid and CHIP Enrollment,” Kaiser Family Foundation, March 3, 2022, available at <https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/>.
- 24 Some states, like Illinois, have even passed legislation authorizing continued Medicaid eligibility through the COVID-19 public health emergency and up to 12 months after the PHE expires. See Public Act 102-0043, available at <https://www.ilga.gov/legislation/publicacts/102/PDF/102-0043.pdf>.