MILLIMAN WHITE PAPER

Unwinding the COVID-19 Public Health Emergency: Five key considerations for Medicaid MCOs

Libby Bunzli, MPH
Zachary J Fohl, FSA, MAAA
Christopher T. Pettit, FSA, MAAA
Diane Sargent, MBA, MS, PT
Maureen Tressel Lewis, MBA

Milliman

In early March 2022, the Centers for Medicare and Medicaid Services (CMS) issued guidance providing direction to states as they prepare for the end of the COVID-19 Public Health Emergency (PHE) and resume Medicaid eligibility and enrollment activities as the continuous enrollment provision ends.[1]

This is the third state health official letter that CMS has published on this topic and focuses on the timelines and processes states must follow to resume normal functions and be compliant with the rules that were in place before the start of the PHE. At the time of this paper, the PHE is set to end July 15, 2022.[2] It is unknown whether the Secretary of the U.S. Department of Health and Human Services (HHS) will renew the PHE for another 90 day period, though the Secretary has committed to giving states at least 60 days' notice before the PHE expires.[3] While state Medicaid agencies are the intended audience of these communications, returning to normal Medicaid eligibility and enrollment operations also creates very real financial and operational implications for Medicaid managed care organizations (MCOs). As of January 2022, Medicaid enrollment has increased by nearly 16 million lives since the start of the COVID-19 pandemic as all states have complied with the continuous enrollment condition associated with increased federal Medicaid matching funding during the PHE.[4] It remains unclear whether enrollment will normalize to pre-pandemic levels after states have conducted renewals for their full caseloads.

This white paper describes five considerations for MCOs as they prepare for the unwinding of continuous enrollment and other emergency provisions put in place during the PHE. As the post-PHE landscape takes shape, MCOs should be prepared to actively engage with state Medicaid agencies, enhance member support functions, adapt financial planning, monitor member access to providers, and manage impacts to administrative functions. While this paper focuses on considerations for MCOs, state Medicaid agencies may also find these issues to be salient as they develop operational plans in anticipation of the end of the PHE.

1. Engage your state Medicaid agency

When the PHE ends, states are expected to resume normal Medicaid eligibility and enrollment activities and process backlogs in new applications and renewals that may have accumulated during the PHE. While some states continued to conduct renewal activities throughout the PHE, CMS is requiring states to process a new renewal following the end of the PHE prior to disenrolling a member. As such, states will need to conduct renewals for their entire caseload in the 12-month "unwinding period" following the end of the PHE.[5] However, CMS has indicated that each state's approach to the timing of unwinding and distribution of work is at the discretion of state Medicaid agencies. MCOs will want to gain an understanding of their states' operational plans to prepare for any activities plans will need to have in place and the financial impacts that they can expect to experience over the course of the year. Key questions MCOs will want to ask their state regulators include:

How will the state prioritize renewal activities?

CMS instructs states to adopt a "risk-based approach" to their unwinding plans. States can prioritize the workload by populations, for instance by starting with individuals who have aged out of eligibility categories while holding more stable populations until the end. States may alternatively schedule renewals based on the original redetermination date or develop their own approaches to prioritization. MCOs will want to understand the state's plans for prioritization and timing so they have a sense of the potential impact on enrollment throughout the 12-month unwinding period.

Does the state have any estimate of the timing and volume of membership that will be disenrolled?

If states have continued to process renewals throughout the PHE, they may have the capability to estimate the volume of terminations they anticipate by rate cell during the unwinding period. A recent survey found that 20 states were able to generate an estimate of anticipated disenrollment, which averaged 13% (ranging from 8% to over 30%) and was mostly attributed to changes in income.[6]

How is the state planning to communicate with members and providers?

Member communication is a key area that MCOs can support to make sure eligible individuals know what they need to do to stay enrolled. Provider communication is also critical, as providers rely on accurate enrollment information to guide their scheduling and billing operations; for instance, large-scale changes to member enrollment will have impacts on prescheduled appointments and procedures, and many providers employ assisters who can be helpful to members navigating their enrollment changes. MCOs should partner with state Medicaid agencies to coordinate with and enhance the state's outreach and communication activities.

Are there any initiatives that were put on hold due to COVID-19 that will move forward when the PHE ends?

The pandemic drastically shifted Medicaid agencies' priorities to focus on protecting members' health, safety, and access to care while preserving provider networks during the pandemic. MCOs should understand whether states are planning to return to previously planned initiatives following the end of the PHE, such as waiver demonstrations or delivery system reform efforts, and what the operational and financial implications will be for the managed care program.

2. Support your members

Due to the continuous enrollment provision that has been in effect since March 2020, Medicaid members have not been subject to disenrollment for over two years. States have varied in the amount of eligibility and enrollment activity they have conducted during the pandemic, so many members may not have had any requests for eligibility documentation since the start of the pandemic. In most cases, it is in the best interest of an MCO to retain eligible members, so MCOs should develop strategies to support communication and information sharing, help members complete renewal paperwork, and support coverage transitions for those no longer eligible.

Implement effective communications: Even before the global pandemic disrupted lives and caused mass migration across county and state lines, maintenance of accurate contact information for Medicaid members was challenging. As the PHE ends and states resume verification of Medicaid eligibility, we anticipate that the pandemic will have further disrupted the communication channels between state Medicaid agencies and their members, which will exacerbate the challenges states face when engaging members in the redetermination process and risk inappropriate coverage disruptions and lapses in care.[7]

MCOs are likely to have access to the most recent contact information for their members, particularly for those individuals who are actively engaged with the health care system. Active collaboration between the MCOs and state Medicaid agencies in sharing the most current validated contact information could stem unnecessary enrollment churn. MCOs can also leverage network providers and pharmacies who are in direct contact with members at the point of care delivery. These providers and pharmacies may also have even more recent contact information updates than the MCO. This cross-collaborative data sharing is a significant undertaking but can effectively support continued health plan coverage, access, and affordability.

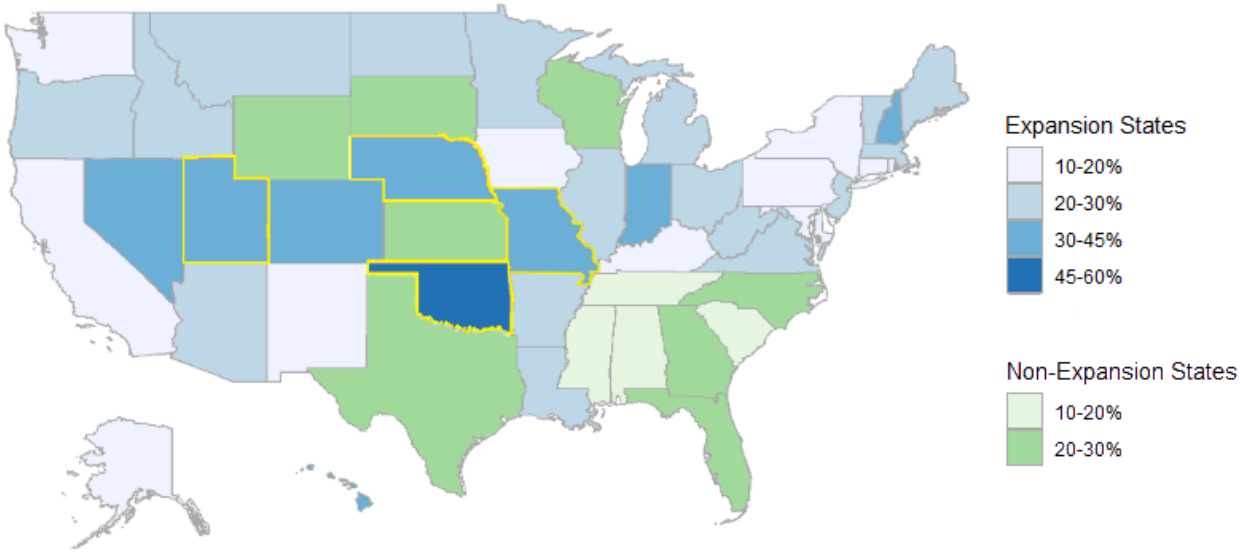
Offer member outreach and hands-on support: Because MCOs serve as direct touch-points for Medicaid members, they have an opportunity to collaborate with their state Medicaid agencies to send communications to enrolled members to proactively educate them about the reinstatement of eligibility checks and the importance of being responsive to notifications. MCOs should check with states to see what types of member communications regarding the PHE unwinding will be permitted or possibly required by the state. Even if the state prefers to send communications on its own, the MCOs should ask for copies of all communications and the planned delivery dates. Understanding the timing of state communications for different member groups will help MCOs prepare for the volume and type of phone calls likely to occur following member receipt of state notices. MCOs may also consider providing outreach to members to offer support in responding to renewal notifications. It is important to recognize the potential for the unwinding of the PHE to have a disproportionate impact on members with limited English proficiency or from communities of color, who were over-represented in Medicaid before the PHE and have experienced economic hardships at a higher rate than other demographic groups.[8,9] MCOs should engage their diversity officers and community stakeholders in planning a communication strategy to make sure they can effectively reach members in culturally and linguistically appropriate ways.

Facilitate coverage transitions: As states and MCOs brace for significant enrollment shifts once redeterminations resume, MCOs can have a role in supporting member transitions for those no longer eligible. A vast majority of individuals losing Medicaid coverage will have access to affordable coverage through the individual marketplace or through their employers. One study estimated that approximately 93% of the non-elderly adults and 90% of children losing Medicaid and Children's Health Insurance Program (CHIP) coverage would either be eligible for advanced premium tax credits available to household with incomes up to 400% of federal poverty level (FPL) or have access to employer coverage.[10] This presents an opportunity for insurers that operate across Medicaid, Marketplace, and/or commercial group lines of business to help these members find other sources of coverage. MCOs can work with their states to provide information on potential insurance options available for their members who may be determined ineligible for Medicaid coverage. This would require frontline staff at the MCOs to be trained and provided appropriate tools and resources to recognize opportunities for information sharing, navigation support, and approved messaging to direct individuals to the most appropriate resources.

3. Adapt your financial plan

Enrollment shifts will impact revenue: Enrollment grew substantially during the PHE. Since February of 2020, total Medicaid and CHIP enrollment grew by approximately 22%, to a record high of more than 87 million members in January 2022. Figure 1[11] illustrates the Total Medicaid enrollment growth percentage by state between February 2020 through January 2022.[12] The greatest enrollment growth was observed in Medicaid covered adults, at 30%, with enrollment growth of Medicaid and CHIP children at 16% and 4%, respectively.

FIGURE 1: MEDICAID ENROLLMENT GROWTH DURING THE PUBLIC HEALTH EMERGENCY



The following states were materially influenced by legislation separate from PHE changes:

- Missouri implemented Medicaid expansion July 2021
- Nebraska implemented Medicaid expansion October 2020
- Oklahoma implemented Medicaid expansion July 2021
- Utah suspended work requirement during PHE

While it is easy to understand which populations observed higher growth during the PHE, projecting what the new-normal enrollment will be after the PHE unwinding processes are completed will be far more challenging, particularly if states stopped processing renewals entirely during the PHE. Ultimately, the unwinding of the PHE is anticipated to result in enrollment reductions from current levels, which will impact MCO capitation revenue. While the timing and overall impact is not yet known, the following assumptions are reasonable based upon CMS' recent guidance to states:[13]

- A wholesale, precipitous drop in enrollment is unlikely because CMS is encouraging states to space the redetermination and eligibility verification processes out over the 12 months following the end of the PHE.
- There will be state-to-state variability in patterns of enrollment change in the months following the end of the PHE because states are permitted to take a variety of operational approaches to processing the renewal backlog.
- The timing and volume of enrollment shifts will vary by enrollment categories (e.g., age, sex, disability, eligibility criteria) and are likely to vary meaningfully between states based on each state's selected risk-based approach.

Risk-mix fluctuations: During the PHE, the overall Medicaid risk profile changed alongside enrollment increases. This was mainly driven by differences in morbidity among new enrollees (who may live in households that lost employment at the beginning of the pandemic), pre-PHE enrollees who would have lost Medicaid coverage in the absence of the pause of redeterminations because they no longer met eligibility requirements, and the remaining residual population. Risk-mix within a population will also be influenced to the extent the pause in redetermination resulted in less movement between populations (e.g., Medicaid expansion population to disabled adult population). In addition to underlying population morbidity, utilization patterns shifted during the PHE (e.g., increase in telehealth visits and decreases in office visits and emergency services).

As continuous coverage ends, MCOs should analyze subsequent shifts in morbidity levels and utilization patterns as enrollment stabilizes. Additionally, the resulting impact will vary for each population group covered under managed care programs, with the largest enrollment growth being observed among nondisabled adults. Working with the states to identify members in the population groups most likely to lose Medicaid eligibility will be key in understanding the projected risk level inherent in future time periods and appropriate capitation adjustments to account for changing morbidity levels.

There are also risk-mix considerations for insurers operating multiple lines of business. Medicaid MCOs will have better insight into the morbidity of the individuals losing Medicaid coverage, allowing these carriers to better estimate the risk profile and impact of enrollment changes on their non-Medicaid lines of business. The risk profiles of individuals returning to non-Medicaid products may not be consistent with those who may have left those markets during the PHE. Having current data on members entering the marketplace or other commercial markets can help health plans more accurately project shifts in post maintenance of effort enrollment and morbidity by line of business.

Temporary policies may end: As the pandemic created significant and sudden shifts in healthcare utilization, CMS allowed states to take measures to protect providers and MCOs alike from the associated financial disruptions and revenue uncertainty. These measures have taken the form of several strategies that directly impacted managed care revenue, including but not limited to state-directed payments to enhance rates for certain provider types, requiring the use of retainer payments to home and community based services (HCBS) providers, and adjusting capitation rates to reflect temporary changes to the fee-for-service (FFS) fee schedule.[14] While most of these Medicaid emergency authorities will automatically end once the PHE is over, there are a few flexibilities that states may extend temporarily or permanently. They might include expanded HCBS or rate increases for certain providers.[15] As states prepare to re-evaluate these temporary authorities, it would be helpful for MCOs to understand how and when their capitation rates will reflect any changes.

4. Keep an eye on members' ability to access providers and care

The United States has observed significant changes in the healthcare workforce landscape since the beginning of the PHE, as employment initially dropped significantly and has recovered at variable rates across settings.[16] These large changes have led to struggles in being able to provide adequate services for members, particularly in HCBS.[17] A shortage of critical healthcare workers exists across the continuum of care spectrum, including lower-wage healthcare workers, mental health providers, nurses, and physicians. Healthcare professionals are leaving the profession at an accelerated rate due to the aging of the professional population and also due to the exhaustion and burnout that providers have endured as essential workers during the COVID-19 pandemic.[18] Many states allowed for temporary

rate increases to help retain and recruit employees who may or may not continue after the PHE ends.[19] Should these rate changes expire and revert to pre-PHE levels, MCOs could struggle to maintain network stability and adequately provide the service level needed to ensure a quality level of care and to meet demand.

In addition, the COVID-19 pandemic and resulting shutdowns necessitated changes to how Medicaid members accessed care. States allowed, by emergency authority, members to access care virtually with telemedicine. As the PHE ends, MCOs will first need to understand the state-level regulatory parameters for continued access to services through telehealth modalities under Medicaid. MCOs can then use that information, along with telehealth utilization data, to strategize accordingly to ensure members are able to transition back to in-person care if telehealth is no longer permitted for certain services. Conversely, if telehealth flexibilities are extended, MCOs can consider how to leverage telehealth to bolster access to care, particularly for members in rural areas or members seeking providers in segments that have been acutely impacted by workforce challenges.

5. Manage impact on administrative services

Administrative costs will be impacted: MCOs should also review their administrative costs and deploy expense management initiatives where possible commensurate with anticipated changes that will impact membership levels and financial performance. Concurrent with anticipated aggregate Medicaid revenue reductions, there will be added pressure to the administrative load, as a percentage of revenue, for those MCOs that are slow to adjust to reduced Medicaid enrollment.

Administrative expenses are influenced by contractual requirements, organizational priorities, and operational efficiency. If the PHE unwinding creates new tasks for MCOs, plans need to prepare for and adjust to the short-term and long-term administrative cost implications, while facing the pressure that results from decreased economies of scale in a shrinking Medicaid business. Health plans with line-of-business diversification, including individual marketplace and commercial offerings, will fare better during this coverage shift if they are able to support members with a seamless transition to other coverage options or reallocate idled resources to support other lines of business.

Be strategic about staffing: MCOs will have to adapt staffing levels to support necessary administrative functions, balancing shifts in enrollment (and associated revenue) with managing any new activities resulting from the end of the PHE, such as the enhanced communication efforts discussed previously. The sooner that MCOs can understand how the PHE unwinding will impact their organization, the better they can effectively manage the business with informed and feasible strategic plans. Recognizing that many MCOs participate in multiple markets and each state will approach unwinding differently, these discussions will require tailored strategies across states.

Workplace dynamics continue to shift, bringing their own set of challenges, none of which are insurmountable but do require careful consideration. The pandemic reshaped the work environments for many Americans, including a shift to teleworking for those jobs when doing so was possible.[20] While the split between in-office and telecommuting is likely to continue to evolve alongside worker and employer preferences, MCOs will benefit from early and thoughtful consideration of how any hybrid work arrangements impact employee engagement and productivity, company culture and performance, and the member experience. In addition, as policy changes such as the PHE unwinding take effect, there is risk that frontline employees may not fully comprehend the changes, potential member impact, and what information should be shared with members. MCOs that plan ahead for this risk and ensure effective mitigation strategies such as comprehensive employee training, frequent recorded call audits, timely feedback loops, and performance and accountability measures will be better prepared to deliver consistent and reliable communications to members and quickly identify and address areas for improvement. States may require enhanced MCO reporting about member support activities during the PHE unwinding, so any MCO efforts in this direction have the potential to be useful for compliance purposes as well.

Conclusion

While the official end date of the PHE remains unknown, Medicaid MCOs still have time to prepare for anticipated impacts resulting from expected federal and state government decisions related to the expiration of the PHE. MCOs can seek to supplement the outreach efforts of state Medicaid agencies with the shared goal of minimizing potential health coverage disruptions and ensuring continuity of care. The decisions MCOs make now and in the coming months can improve the experience for Medicaid members, facilitate smooth coverage transitions, and support health plan financial stability during the PHE unwinding.

In addition to having a finger on the pulse of state policy approaches and operational decisions, MCOs need to continue to monitor decisions being made at the federal level. Many are calling on Congress to pass an extension of the enhanced Federal Medical Assistance Percentage (FMAP) after the end of the PHE,[21] and any additional flexibility will impact the level of budget pressure felt within the states and the urgency with which they will be inclined to process redeterminations and identify and disenroll non-Medicaid-eligible individuals. While a phasing out of the enhanced FMAP was contemplated by Congress as a part of the proposed Build Back Better bill,[22] this bill has not been passed. Under current law, the enhanced FMAP will cease at the end of the quarter in which the PHE ends unless legislation is otherwise enacted, while eligibility redetermination activities may only begin the month after the PHE ends, creating a gap where states will have some of the increased enrollment associated with continuous coverage and yet lack the additional funding intended to offset the additional costs associated with these individuals.

As previously mentioned, the Biden administration has indicated to states that the HHS Secretary will provide 60 days' notice prior to the termination of the PHE, so it will be important to monitor communications from the federal government as the current 90-day PHE extension elapses. MCOs will want to pay attention to continued communications from HHS, CMS, and their states in order to stay current with timelines and guidance that will have downstream impacts on their business.

CONTACT

Christopher T. Pettit, FSA, MAAA
chris.pettit@milliman.com

Maureen Tressel Lewis, MBA
Maureen.TresselLewis@milliman.com

ENDNOTES

[1] CMS (March 3, 2022). Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency. Retrieved May 10, 2022, from https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[2] HHS. Renewal of Determination That a Public Health Emergency Exists. Retrieved May 10, 2022, from https://aspr.hhs.gov/legal/PHE/Pages/COVID19-14Jan2022.aspx.

[3] HHS (January 21, 2021). Letter to Governors on the COVID-19 Response. Retrieved May 10, 2022, from https://aspr.hhs.gov/legal/PHE/Pages/Letter-to-Governors-on-the-COVID-19-Response.aspx.

[4] CMS. October and November 2021 Medicaid and CHIP Enrollment Trends Snapshot. Retrieved May 10, 2022, from https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-november-2021-medicaid-chip-enrollment-trend-snapshot.pdf.

[5] CMS (March 3, 2022), op cit.

[6] Brooks, T. et al. (March 16, 2022). Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings From a 50-State Survey. Kaiser Family Foundation. Retrieved May 10, 2022, from https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/?utm_campaign=KFF-2022-Medicaid&utm_medium=email&_hsmi=207006865&_hsenc=p2ANqtz-8-XHZYqhav_ZprE6uBWiQue6-ZKcH_MivS57n0qHb5Sjo09PJX_dbEIRRUVH9CYZH-KUcxSxLRy2mH-Z9f059NdvMKxFKTFu2ML57XgzVZf-tK09g&utm_content=207006865&utm_source=hs_email.

[7] National Academy for State Health Policy (December 20, 2021). States Plan for the End of the Medicaid Continuous Coverage Requirement. Retrieved May 10, 2022, from https://www.nashp.org/states-plan-for-the-end-of-the-medicaid-continuous-coverage-requirement/.

[8] Haldar, S. et al. (March 3, 2022). Unwinding of the PHE: Maintaining Medicaid for People with Limited English Proficiency. Kaiser Family Foundation. Retrieved May 10, 2022, from https://www.kff.org/medicaid/issue-brief/unwinding-of-the-phe-maintaining-medicaid-for-people-with-limited-english-proficiency/.

[9] Urban Institute (April 11, 2022). Tracking COVID-19's Effects by Race and Ethnicity: Questionnaire Two. Retrieved May 10, 2022, from https://www.urban.org/features/tracking-covid-19s-effects-race-and-ethnicity-questionnaire-two.

[10] Buettgens, M. & Green, A. (September 2021). What Will Happen to Unprecedented High Medicaid Enrollment After the Public Health Emergency? Urban Institute. Retrieved May 10, 2022, from https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf

[11] https://data.medicaid.gov/dataset/

[12] Enrollment growth for the following states were materially influenced by state-specific legislation:

- Missouri: https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
- Nebraska: https://neappleseed.org/medicaidexpansion
- Oklahoma: https://oklahoma.gov/ohca/about/medicaid-expansion/expansion.html
- Utah: https://www.healthinsurance.org/medicaid/utah/

[13] CMS (March 3, 2022), op cit.

[14] Wentworth, K., Steckel, C., Hoffman, J. et al. (April 2020). Emergency Medicaid Waivers During the COVID-19 Pandemic. Milliman White Paper. Retrieved May 10, 2022, from https://us.milliman.com/-/media/milliman/pdfs/articles/covid-19-emergency-medicaid-waiver.ashx

[15] CMS (December 22, 2020). Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency. Retrieved May 10, 2022, from https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf.

[16] Kaiser Family Foundation (December 10, 2021). Health Employment Continues Slow Recovery Since the Beginning of the Pandemic. Retrieved May 10, 2022, from https://www.kff.org/health-costs/press-release/health-employment-continues-slow-recovery-since-the-beginning-of-the-pandemic/.

[17] Medicaid and CHIP Payment and Access Commission (March 2022). State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages. Issue Brief. Retrieved May 10, 2022, from https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf.

[18] Ollove, M. (March 25, 2022). Health Worker Shortage Forces States to Scramble. PEW Charitable Trusts. Retrieved May 10, 2022, from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/03/25/health-worker-shortage-forces-states-to-scramble.

[19] Kaiser Family Foundation (July 1, 2021). Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19. Retrieved May 10, 2022, from https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/.

[20] Parker, K. et al. (February 16, 2022). COVID-19 Pandemic Continues To Reshape Work in America. Pew Research Center. Retrieved May 10, 2022, from https://www.pewresearch.org/social-trends/2022/02/16/covid-19-pandemic-continues-to-reshape-work-in-america/.

[21] Letter From State Associations to Congress (October 21, 2021). Retrieved May 10, 2022, from http://www.advancingstates.org/sites/nasuad/files/u33914/FINAL%20state%20associations%20to%20Congress%20COVID%20Medicaid%20match%20post-PHE.pdf.

[22] The full text of the proposed Build Back Better Act is available at https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-117HR5376RH-RCP117-18.pdf.