The End of the COVID-19 Public Health Emergency: Data and IT "Table Stakes" for Retaining Coverage Gains

Prepared by McKinsey & Company and Manatt Health

STATE Health & Value STRATEGIES
Driving Innovation Across States
A grantee of the Robert Wood Johnson Foundation

October 2021

Introduction

Following the expiration of the Public Health Emergency (PHE), states will resume normal eligibility and enrollment activities for all enrollees in Medicaid and the Children's Health Insurance Program (CHIP). The volume of expected redetermination activity at the end of the PHE is unprecedented. Throughout the pandemic, every state has experienced increased enrollment (totaling 10.5 million new Medicaid/CHIP enrollees, a 14.7 percent increase from 2019),[1] while having paused regular eligibility and enrollment operations for the over 70 million people that already had health coverage through Medicaid/CHIP. As a result, many enrollees have not gone through the redetermination process in nearly two years, and some have never had to redetermine their Medicaid eligibility because they enrolled during the pandemic. This issue brief reviews state Medicaid/CHIP agency data and information technology (IT) system "table stakes"—strategies that will have the highest impact for states seeking to ensure that eligible enrollees are able to keep or transition to new affordable health coverage when the PHE continuous coverage requirements end. If adopted, these strategies will also enable states to dramatically improve Medicaid/CHIP enrollment and coverage retention in the longer-term for people eligible for government subsidized health coverage.

Many states have taken steps to modernize the IT systems that determine Medicaid eligibility, making it easier for consumers to verify information through mechanisms such as prepopulated renewal forms, online portals, or automatic income verification against data from other federal and state agencies. However, even with greater use of electronic data linkages, data inconsistencies and failed matching can cause dis-enrollments of eligible people.

This consumer journey is further complicated when individuals are transferred to an insurance Marketplace, be it state or federal. On the state side, not all State-Based Marketplaces (SBMs) share an eligibility system with Medicaid; in those instances, consumers will be transferred between the two systems often with some degree of additional steps. For the federal Marketplace, which operates in 36 states, account transfers received from states are processed to determine eligibility for advanced premium tax credits (APTCs). This 'account transfer' process requires the consumer to reactively engage, relies on complete data to be provided (e.g., email addresses), and verifies information against federal systems, which may reflect different data than what is used by the individual's state, particularly around current income.

This triple threat of unprecedented volume, condensed time period, and customers unfamiliar with redetermination processes (e.g., checking eligibility, providing additional information) paired with existing IT and data limitations poses a considerable risk of coverage loss following the end of the PHE. State and federal operators and administrators have options to pursue the following set of "table stakes" strategies now to upgrade and improve data quality and IT system capacity to prepare for this major coverage event and ensure coverage retention and continuity.

State IT Table Stakes Strategies

Effective redetermination begins with complete enrollee contact information, user-friendly ways for individuals to update critical information, and standardized data definitions with partners. Three IT efforts are table stakes to meeting these needs: adopt more effective and efficient use of data, improve account transfer data quality, and expand capabilities and capacity of online portals.

States that have not pursued these efforts, or have more to do to enhance functionality, can undertake system enhancements now and execute in a way that enables receipt of the 90 percent federal match for Medicaid IT investments. Furthermore, demonstrating to the Centers for Medicare & Medicaid Services (CMS) that the IT and data work will improve the state's eligibility and enrollment processes overall (e.g., more automated verifications, fewer requests for consumer documentation, increased rate of no-touch processes) will likely assist with Advance Planning Document (APD) approvals. Given the lead time required for implementation of these strategies, states would need to launch these efforts now, before the PHE ends.

Table Stakes Strategy #1: *Adopt More Effective and Efficient Use of Data*

Under federal law and regulation, state Medicaid agencies must use all available data to renew eligibility before requesting any additional information from the individual.[2] However, given the increase in new enrollees and the nearly two-year pause on redetermination activity, it is likely that state Medicaid agencies will not have the most current information about their enrollees. Accessing data through new partners and sources can help bridge these gaps.

States can deploy a creative master data management approach prior to the end of the PHE by first aligning on the minimum underlying data that are necessary (e.g., first name, last name, email address, mobile phone number), determining which systems and partners have the most up-to-date versions of these data (see Table 1 for data sources to consider), and prioritizing the importing of this data based on feasibility (e.g., time to set-up data sharing agreements, technical complexity associated with importing). Adopting a master data management approach involves organizing data elements, data sources, data definitions, data acquisition options, operational considerations—such as cost, required resources, and timing—all of which is optimally managed through strong data governance.

Sourcing of the most up-to-date information may require states to consider non-traditional partners and data sources within departments of health or social services, with managed care partners, or other external data sources. Expanding the master data management approach in this moment leading up to the end of the PHE could allow states to broaden the aperture of where data are sourced and move toward a more modern foundation that can integrate both structured and unstructured data.

Table 1: Data Sources to Consider in Creating a Master Data Management Approach

Sources	Rationale
Lifeline Program	Over the course of the pandemic, the Lifeline Program had nearly a 30 percent increase in subscribers (7 million in early 2020 compared to 9 million in 2021) and has since begun its own redetermination processes.[3]
Immunization Information Systems (IIS)	Pre-pandemic, IIS had established connections with over 117,000 health systems, pharmacies, and other data partners. This number has grown exponentially since the pandemic began, allowing IIS to capture and consolidate administered COVID-19 vaccine doses in real-time. Consumers often registered for COVID-19 vaccines with emails and mobile phone numbers.[4]
Health Information Exchanges (HIEs)	Seventy-six HIEs cover more than 92 percent of the U.S. population.[5] With over 500 million COVID-19 tests reported in the last year,[6] or via their master person index, HIEs may hold recent individual contact information.
Mixed Coverage Families with Marketplace	For households that have insurance coverage split between Medicaid/CHIP and an insurance Marketplace, it is possible the Marketplace (and associated navigators and assisters) may have more recent consumer contact information.
Department of Motor Vehicles (DMV)	Amid the pandemic, DMVs had to rethink the way they operate to enable residents to conduct basic transactions, such as licensing renewals. Rapid digitization of DMV processes has led to increased online transactions and may present an opportunity to gather updated mailing and email addresses. For example, California saw a 22 percent increase in online transactions between 2019 and 2020.[7]
Department of Labor [Unemployment Insurance (UI)]	Many households that experienced loss of employment during the pandemic may have applied for and received UI. Medicaid programs could consider matching contact information against UI databases, not just for income verification purposes, but also for contact information purposes.
Third-Party Data Enrichment Partners	Data enrichment is the process of incorporating new updates and information into existing databases to improve accuracy. Third-party data enrichment could be considered to append missing or incomplete information for populations undergoing redetermination.

The process of aligning on minimum data required and assessing its completeness in the existing data, identifying and establishing data sharing agreements with new partners, importing the data, refreshing Medicaid members' accounts using a hierarchical logic (e.g., prioritizing based on most recent source, or most likely to be accurate), and validating its effectiveness through testing, can take up to nine months or more depending upon automation, dedicated staff resources, and other factors. For additional information on policy and operational strategies to improve enrollee communication and contact information at the end of the PHE, see our companion expert perspective, *State Policy and IT System Strategies to Prepare for PHE Unwinding: Updating Medicaid Enrollee Address Information and Responding to Returned Mail*.

Table Stakes Strategy #2: *Improve Account Transfer Data Quality*

As states redetermine eligibility, it is likely that a higher volume than usual will need to be transferred to the Federally Facilitated Marketplace (FFM) due to changes in eligibility or circumstance. To minimize gaps in coverage and better manage casework action, states will need to ensure transfers not only work from a technical perspective but also contain sufficient information for processing. Additionally, even while the data currently provided may pass the account transfer technical schema at the Federal Data Services Hub, optional fields, such as consumer email and mobile phone number, will be critically important to include where possible. In fact, CMS guidance requires states to "include all of the information collected and generated by the state."[8] In states operating their own State-Based Exchanges where Medicaid and the Exchange do not share an eligibility system and/or case management system, similar challenges may arise. Those states may want to assess if they need to implement some of the same planning as FFM/SBM-Federal Platform (FP) states to ensure smooth operations between Medicaid and the Exchange once redeterminations resume. States have an opportunity to identify and improve account transfer data quality issues across two dimensions:

1. *Address data completeness:* In order for accounts to be successfully transferred to the FFM, a minimum data set must be present.[9] States can assess outbound accounts that historically failed initial account transfer, identify the data elements that most commonly drove this failure, and prioritize fixing those inconsistencies. Given the expected volume, investing in this activity can help states minimize the number of cases requiring casework action.
2. *Update systems to include additional contact information fields:* Some states may not have updated their IT systems to include optional contact information with outbound account transfers, such as mobile phone numbers and email addresses. Resolving gaps in these fields may be simpler technical changes for states that already collect this information and could enable faster casework action by the FFM to contact individuals transferred after a determination of being over-income for Medicaid/CHIP.

Given the complexity and potential need to modify contracts, systems, data, and workflows, states would need to address these two dimensions well in advance of the end of the PHE and utilize various types of testing (e.g., technical validity testing, table-top simulations) to ensure systems and data are ready for seamless account transfers at the end of the PHE. Depending on the baseline data quality of accounts and level of effort needed to modify the outbound account transfer system logic, addressing these two dimensions could take between three and five months.

Table Stakes Strategy #3: *Expand Capabilities and Capacity of Online Portals*

Mobile access to applications and online accounts not only facilitates engagement with enrollees (e.g., enrollees can complete case maintenance functions such as uploading documents, reporting changes, and completing renewals), but can also significantly reduce the workload for state and county agencies, allowing caseworkers to focus on enrollees that need more intensive in-person/live assistance. A growing number of states offer mobile access to applications and online accounts, funded at least in part by the Medicaid enhanced matching funds. As of January 2020, individuals can submit online applications through a mobile device in 44 states compared to 28 states in 2017.[10] Recognizing the importance of this digital tool at the end of the PHE, states may want to ensure their portals meet three key criteria:

1. *Portal accounts are easy to create and access:* When an enrollee cannot easily create or access their online accounts, they may revert to in-person visits, online help requests, and phone calls to call centers. States that prioritize creating a seamless sign-in experience (e.g., reduced complexity in the data that are required to sign-in, simple password requirements) would allow enrollees to take steps to interact at a time and place that works for them. This includes portals being mobile responsive, which is considered industry standard in 2021, and is a reasonable expectation for meeting the standards and conditions for enhanced match.[11]
2. *Portal has most critical eligibility and enrollment functionality:* The upcoming redetermination effort will require two critical online portal functions—the ability to upload verification documentation and view member notices. Today, 33 states' portals allow enrollees to upload verification documentation and 39 states' portals allow enrollees to view notices.[12] States could consider not only ensuring that these functions are available in their portal, but also improving usability through user research and user-centered design (e.g., how intuitive are the steps to log-in or create an online account).

3. *Portals are supported by an IT infrastructure capable of handling high volumes:* The unprecedented volume of redetermination activity may lead to poor performance of state portals (e.g., portals take a long time to load, website crashes, memory leaks). Sufficient time for load testing (where realistic expected user loads are tested and portals are monitored for performance) and to troubleshoot identified problems will be critical. This cycle of identifying the reasons for a system crash, fixing the issue, and testing again until the cause can be fixed, can inform the maximum capacity of the portal and highlight if there is a technical need to stage redetermination activity.

Ensuring these criteria are met will help enable enrollees to access all the benefits of this digital asset while improving eligibility staff workloads. Activities such as user journey mapping, building of technical specifications, and load testing can take states between three and six months.

Conclusion

While challenging, the end of the PHE and unwinding of related policies may afford states a unique opportunity to not only address the challenge at hand and retain coverage gains experienced over the pandemic period, but also take a seismic step toward an evolved and modern Medicaid eligibility and enrollment technological approach that better serves individuals through more effective data sharing, data management, and technology solutions.

Support for this issue brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity for all in the United States. In partnership with others, we are working toward a nation that is rooted in equity, compassion, and respect. A nation that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have. We call this a Culture of Health. And it is our Foundation's vision for America. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter at *www.rwjf.org/twitter* or on Facebook at *www.rwjf.org/facebook*.

ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at *www.shvs.org*.

ABOUT MCKINSEY & COMPANY

This issue brief was prepared by Jess Kahn and Ashka Dave. We help organizations across the private, public, and social sectors create the *Change that Matters* most to them. From the C-suite to the front line, we partner with our clients to *transform their organizations*, *embed technology* into everything they do, and *build enduring capabilities*. With exceptional people in 65 countries, we combine global expertise and local insight to help you turn your ambitious goals into reality. For more information, visit *https://www.mckinsey.com/about-us/overview*.

ABOUT MANATT HEALTH

This issue brief was prepared by Patricia Boozang. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future. For more information, visit *https://www.manatt.com/Health*.

ENDNOTES

1. Kaiser Family Foundation, Analysis of Recent National Trends in Medicaid and CHIP Enrollment.
2. 42 CFR § 435.916.
3. U.S. Federal Communications Commission, Report on the State of the Lifeline Marketplace.
4. Centers for Disease Control and Prevention (CDC), IISAR Data Participation Rates and Maps.
5. Strategic Health Information Exchange Collaborative (SHIEC), Introducing Civitas Networks for Health.
6. CDC, COVID Data Tracker Weekly Review.
7. California DMV, DMV Virtual Office.
8. CMCS Informational Bulletin, Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace").
9. CMS Office of Information Services, Federal Data Services Hub (Federal DSH).
10. Kaiser Family Foundation, Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey.
11. CMS, Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10) (42 CFR §433.12).
12. Kaiser Family Foundation, Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey.