U.S. Digital Service - Medicaid Renewals Playbook

Background

This playbook was created by the U.S. Digital Service as a rapid-response guide for civic technologists providing direct technical assistance to states during the COVID-19 Public Health Emergency (PHE) Unwinding. The content in this playbook focuses on strategies to rapidly decrease the burden of Medicaid renewals on members of the public and state staff.

This playbook is **NOT** a source of authoritative, legal, or regulatory guidance and has not been officially endorsed by the Center for Medicaid and CHIP Services (CMCS). It is advisory only, and should be adapted appropriately for each state and scenario. Ultimately, it is the responsibility of state Medicaid officials to ensure that implementation of any project is compliant with federal Medicaid statute and regulations. Refer to CMCS's website for up to date official guidance.

Please contribute to this repository with your questions or additions. To do so, please check out our contribution guide!

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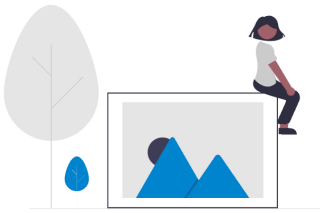
Public domain

Advice on Framing



As civic technologists jumping in to support states, it is important that teams are clear on the **framing** of their work. Without a clear well-messaged offerings state partners won't understand - and won't invest in - the team.

Close the gap between policy and implementation

Most states have adopted helpful policy postures for the unwinding period and have a broad range of flexibilities that should make renewals more seamless for beneficiaries. States are proud of and have conviction in the work that they have done to rapidly adopt these policy wins. Unfortunately, many of these policies remain on paper only and have not been implemented in systems and optimized to have the maximum impact for beneficiaries. As civic technologists, we are here to help states realize the goals of their good policy making through implementation and delivery support.

Deliver actionable recommendations

State Medicaid eligibility systems are inefficient in 100s of ways and states already have a list of existing priorities a mile long. Layered on top of these long standing challenges is the enormous task of Medicaid unwinding. Today, states are not interested in more to-dos or complex journey maps. States need analysis and recommendations that will make a big difference for them **now**. If there is long-term work to be done that is uncovered, we bring that to light when possible, but our focus is on the improvements that can be made quickly and will minimize burden on already overwhelmed state staff.

Start with the known priorities

States are reporting metrics like ex parte rate and procedural terminations, which are highly scrutinized right now. States are also hearing directly from their eligibility worker staff about the enormous workload that they are experiencing. As civic technologists, we should focus first on the data analysis and recommendations that get at the core of these well-known concerns and identify the low hanging fruit opportunities that will rapidly improve outcomes for beneficiaries, eligibility workers, and state staff. Outside of these outcomes, one state priority that civic technologists ***should not*** weigh in on (unless explicitly asked to) is system legal compliance.

Make the state the hero

In all cases, the state has the final say on what is most helpful in a crisis and civic technologists are here to surge capacity to deliver outcomes rapidly. Civic technologists can assist with rapid recommendations and steer implementation, but ultimately existing state vendors will be the ones committing lines of code. The process defined in this playbook has served previous engagements well, but ultimately we should follow the state's lead to determine what activities are best suited for the time that they're investing.

Plays and Resources

On this page:

1. Establish Trust and Urgency

It's crucial to establish a relationship of trust and clear expectations with state partners at the beginning of the project. Every stage of the process is predicated on an open exchange of details and data about how systems are performing.

In addition, all members of the team – including vendors – must understand the urgency and criticality of the project. Leadership should be engaged regularly from the beginning, and the work should be made a top priority. Common goals should be established at the beginning of the project so that everyone understands what success looks like.

- **Keep states' needs top of mind.** States are under an immense amount of pressure right now. Be mindful of the amount of work state staff have on their plates, celebrate the great work they're already doing, and focus the scope of work around the most urgent needs.
- **Orient the team towards OUTCOMES, not compliance.** Establish common goals with state partners to rapidly alleviate burden on the public and state staff. Discuss norms around confidentiality and information sharing about the project.
- **Get buy-in from senior leadership, including the State Medicaid Director and Deputy Director.** Establish this work as the top priority for the team.
- **Convene a cross functional group** of subject matter experts and decision makers, including Policy, Communications, Human-Centered Design and Technical experts across state staff and vendor teams.
- **Determine one or two North Star(s).** What goals are we specifically working towards? These should be measurable ("increase automatic renewals to XX%") but don't have to be numeric ("stand up an online renewal form").
- **Adopt terminology from the state.** For example, if a "renewal" is called a "review" in the state, this term should be used throughout the project.
- **Go where the work is.** Travel to where your state partners and their Medicaid members are. This establishes urgency for the work, builds rapport, and creates momentum around generating solutions and decision-making.

Resources

Guides

- Benefits Data Trust: Medicaid Churn Overview & FAQ: The background, causes, impacts, and mitigations of Medicaid churn.
- Benefits Data Trust: Goal Setting: Establish SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals for addressing Medicaid churn.
- Benefits Data Trust: Stakeholder Engagement: Identify who needs to be part of the process based on knowledge/expertise & capacity. Identify opportunities for engagement & establish and implement a strategy for engagement.
- Medicaid 101: A *brief and informal* overview of the Medicaid program. This presentation **should not** be taken as legal authority or advice, but used as a quick introduction to the program.

Templates

- Project Charter (docx, pdf): An example charter used to establish the goals, dates, and activities of the engagement between the civic tech organization and the state health and human services agency.
- On-Site Schedule: An example schedule for the week of the on-site engagement. Work typically begins virtually 3-4 weeks prior and 3-4 weeks following, but the on-site week is typically the most impactful and intense period of work.

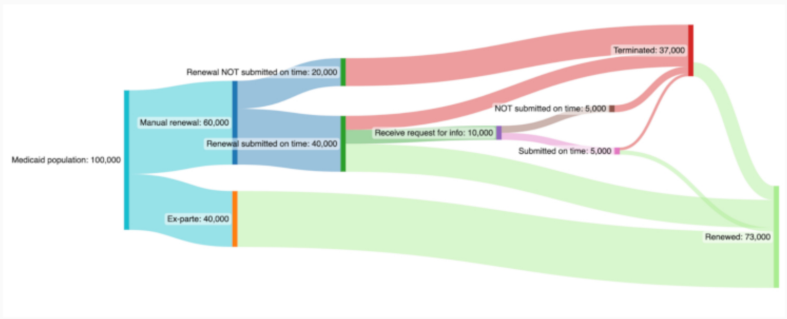
Workshops

- Kickoff Meeting: Sample agenda and materials for the project kickoff, where state staff and the full team align on goals, norms, and the work moving forward.
- Hypothesis Generation Workshop: Sample agenda and materials for a workshop focused on generating hypotheses on where the team could have the biggest impact.

2. Identify Problems

Working with the state and external partners, determine the largest sources of administrative burden and churn during renewal. Where are people being moved from automatic renewal to manual renewal? Where are people struggling or falling off when completing a renewal? What methods are most commonly utilized, and what are the biggest problems with those methods?

When determining the problems, it's important to keep the focus on the "end-to-end" renewal process. An ex parte attempt is only the first step in a person's renewal. For the millions of people manually renewing, there are vast opportunities to improve the experience and increase renewal rates.



This example funnel depicts the a population of Medicaid renewals and their various states. Full-size image here.

- **Pull the numbers.** Pull end-to-end funnel data, including where drop-offs occur at each step in the renewal process. Pull ex parte failure reasons, and organize by the number of people impacted. Pull web traffic numbers to understand how people are accessing online renewal materials.
- **Be a renewer.** Put your renewer hat on and do some Googling to figure out how to renew Medicaid in your state. Do this on mobile, record screenshots as you go, and note pain points throughout the process. Call customer support when you get stuck, take notes on the interactive voice response (IVR) and overall experience.
- **Learn from experts.** Meet with Navigators and eligibility workers to identify top challenges across the renewal process that members of their community experience. Meet in smaller groups with state SMEs and decision makers to better understand the challenges they've been dealing with.
- **Map the experience.** Map a high-level user journey of the end-to-end renewal experience, noting common pain points and workarounds. Use this journey map to target the focus of your interventions to specific and achievable areas.
- **Don't split the party.** Approach the system from a holistic, human-centered perspective; don't separate into siloed engineering, policy, design, or research teams. Those responsible for ex parte policy and systems changes may not have had the opportunity to meet with eligibility workers to understand how they process a renewal, necessary context for identifying root causes of ex parte failures. Common challenges reported by Navigators highlight not only opportunities to improve the manual renewal process, but also opportunities for ex parte logic changes.

Resources

Guides

- **Navigator Research Guide** (docx, pdf): Working with Navigators is crucial for the success of renewals work. This guide provides a set of resources for explaining, justifying, preparing, and performing work with Navigators. It includes background information on Navigator organizations, example research plans, and email templates for correspondence.

Templates

- **Data Request Worksheet** (xlsx, pdf): A worksheet that can be used by the state to begin measuring their end-to-end renewal funnel. Some states will not be able to fill out all fields in the template; that's okay! This template can and should be adapted for the particular state.
- State Renewals Funnel: A method for visualizing the end-to-end funnel of Medicaid renewals, and determining which drop-off points are the most critical to focus on.
- Renewal Journey Map: A method for mapping a member's renewal journey from start to finish. This can be used throughout the investigation and research process for determining challenges and opportunities for improvement.

Workshops

- Navigator Workshop: Typically, at the beginning of the week, we hold a convening of Navigators focused on generating potential solutions.
- Ex Parte Workshop #1: The first ex parte workshop, typically held in the week of the on-site, is focused on identifying opportunities for improvement in the ex parte renewal flow.
- Manual Renewal Workshop #1: The first manual renewal workshop, typically held in the week of the on-site, is focused on bringing the experiences and solutions from research with Navigators to the state so that solutioning can begin.

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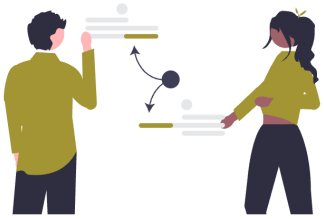
2. Generate Solutions

3. Generate Solutions



Once problems have been identified, work with the broader cross-functional team to start generating solutions. Often times there will be more problems available to solve than possible to talk through in the given time. Start with high-impact and/or low-effort problems, and present them in turn for consideration. Solutions should be high-level, but estimable. Whenever possible, rely on data or similar solutions in other states as evidence that the solution will, in fact, solve the problem.

Whenever possible, scope should be reduced towards the minimum viable solution. When implementation timelines are given, look for reasonable opportunities to reduce estimates and remove unnecessary requirements. Ask for clarity on the stages of implementation, and which are projected to take the most amount of time. Can they be reduced? For example, if a change is completely back-end, eliminate any front-end testing. If a change will only affect mobile users, eliminate desktop testing. If a website is not functional on mobile, change only the pieces to make it functional (as opposed to friendly). Keep asking "why" until the timeline is definitively as small as possible.

- **Use the lived experiences of experts.** If the team was able to meet with Navigators and case workers before a solutioning session with the state, bring their ideas and solutions to the table. Treat these as expert opinions, and champion them whenever possible.
- **Work collaboratively and let states be the heroes.** When solutions are being discussed, the decision makers and implementers should be in the room, driving the process. Give equal weight to everyone's voice, and specifically call out those with on-the-ground knowledge. Empower state policy staff to reconsider assumptions and ask questions about implementation. Pass around artifacts (like a copy of the renewal packet, if available) and let them make changes themselves.
- **Reference Medicaid rules and regulations.** Any solution MUST be palatable to state policy experts, or it cannot be implemented. Whenever possible, use rules and regulations to create a safe policy space for solutioning. If policy concerns are brought up broadly, read the policy and use it to make a risk calculation. A policy may prohibit something, but in practice that situation may never occur; use lived experiences of Navigators and case workers to make that clear. Ultimately, it is up to the discretion of state Medicaid officials to decide what changes are appropriate and it is the role of civic technologists to empower them with all of the data, evidence, and implementation clarity that they need to make well reasoned decisions.
- **Keep asking "why".** If a timeline doesn't make sense, or seems unrealistic, ask for specifics. If the explanation doesn't make sense, ask for more. We don't need to be the experts on the state systems or processes, but we do need to recognize when a solution isn't as efficient (or impactful) as it can be. "Policy" is often cited as a reason something can't be done; ask for the regulation.
- **Find the minimum viable solution.** Working with the state staff, eliminate parts of the implementation process that are unnecessary. Focus specifically on stages that may are prone to inflation: testing, for example, or administrative processes. Can these stages be reduced? Don't be satisfied until any solution is the smallest viable solution possible. Ask about the emergency release process. Strive to land changes before, rather than just after, any monthly batch run.

Resources

Workshops

- Ex Parte Workshop #2: The second ex parte workshop is focused around implementation details and aligning on potential solutions.
- Manual Renewal Workshop #2: The second manual renewal workshop is focused on determining implementation plans and assigning owners to action items.

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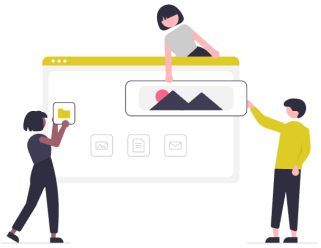
4. Prioritize and Implement



There will always be more problems to solve than there are resources available to solve them. State Medicaid teams are overwhelmed with priorities and ongoing work, and providing clarity through data-driven prioritization is critical. Driving clear prioritization with stakeholders allows the implementation teams to focus correctly on areas with the highest impact and quickest timelines.

The two most important metrics to consider when prioritizing are impact and speed. Impact is typically measured in number of successful renewals per month, while speed is measured in time to implementation. Importantly, these numbers are almost always estimates, and can be very rough; for example, improving the design of a renewal notice may increase the number of successful renewals based on the number of people receiving the notice, but it is difficult to estimate.

Once a set of solutions is prioritized, the state and vendor work together to schedule implementation and begin work. If helpful, play a part in that process as well, taking on roles ranging from advisor to individual contributor.

- **Let the state drive implementation.** States should own and manage the implementation work, and use the civic technology team as much (or as little) as they see fit. Ensure stakeholders are aware of the team's availability, strengths, and connections. If they don't need any extra help, let them do the work!

- **Meet regularly if needed.** If helpful, meet with stakeholders on a regular basis after the engagement. Gauge how well the work is progressing, and where potential roadblocks could occur. Providing basic project management of the priorities that you have agreed to can be a powerful tool. In particular, more junior vendor teams may require coaching if they are being asked to deviate from their usual process.
- **Ask for metrics.** Measuring the impact of the engagement is crucial to ensuring the state and civic technology team's time was well spent. If possible, utilize rigorous methods like A/B testing, pilots, and randomized trials to gather quality data of the effectivity of solutions.

Resources

Templates

- Example Recommendations Document(docx, pdf): At the end of the on-site week, all recommendations agreed upon by *both the state and the civic technology team* are documented in this recommendations report, which is then delivered to the state Medicaid leadership.

Guides

- Benefits Data Trust: Prioritization Tool: Determine what policy and process solutions are feasible by analyzing the risk, value, cost and effort of implementation and establish action steps for implementing proposed policy & process changes.
- Technical System Overview provides a general overview of the system components you should expect to find supporting a Medicaid program, as well as some common shortfalls and limitations.

Workshops

- Closing Meeting: This meeting is typically held at the end of the on-site week. It is an opportunity to present recommendations to the state senior leadership, and re-affirm the agreed upon actions.
- Prioritization Session: This session can help the state determine which recommendations require immediate action versus long-term changes.

Logistics

These pages deal with **how to run a USDS-style state engagement**, including what type of skills we bring and how we operate day-to-day. Consider this a reference for how to plan and execute, but adapt and modify to your team's needs!

- Team Competencies: These are the competencies we feel make us effective in a state engagement.
- Example Schedule: This is an example schedule of a full state engagement, from aligning with the state to supporting implementation.
- Workshops and Meetings
  - Hypothesis Generation Workshop
  - Kickoff Meeting
  - Navigator Workshop
  - Ex Parte Workshop
  - Manual Renewal Workshop
  - Closing
  - Prioritization Workshop

Common Ex Parte Challenges

The state eligibility systems that process ex parte renewals have not been closely scrutinized for many years. As a result, they may not be fully optimized to move all eligible individuals successfully through ex parte renewal and may not reflect the most up to date policy, guidance, and flexibilities available to states.

The value civic technologists bring to states on ex parte renewals is the ability to "look under the hood" of these state eligibility systems and identify opportunities to rapidly optimize them - maximizing the number of eligible individuals that are successfully ex parte renewed. Increasing ex parte rates reduces procedural disenrollments as well as administrative burden on both beneficiaries and state staff. Below are a few key areas where the USDS has found opportunities for optimization across several state systems. This list is not exhaustive as each state system presents unique challenges and opportunities for improvement.

Income data hierarchy

Description

Generally, states have a "hierarchy" indicating what income data sources are used in which cases to electronically verify an individual's income. Good income hierarchy rules query as many income data sources as needed to renew an individual or case; poor income hierarchy rules may not query as many income data sources as possible, leaving valuable data on the table.

The data sources that often yield the most successful renewals are:

- Quarterly wage data
- State tax data
- Social Security
- Private databases
- Other program data
- IRS data

Quarterly wage data

*Quarterly wage data is generally considered to be of **HIGH** usefulness for Medicaid!*

Sometimes referred to as State Wage Information Collection Agency (SWICA), this refers to data reported by employers on a quarterly basis for the purposes of paying unemployment taxes. **NOTE**: This is NOT the same as unemployment income!

Quarterly wage data **MUST** be reported by most employers. There are some exceptions; for example, employers with less than ten employees are exempt in most states. But the majority of employers do report, and as a result, most "W2" employees will have data in these databases. This data source may contain Individual Taxpayer Identification Numbers (ITINs), and could potentially be a good source of information for recipients without a Social Security Number (SSN).

This data is generally collected and maintained by the state's Department of Labor (or equivalent). Getting access generally requires setting up a data sharing agreement between the two agencies, and then implementing the data exchange.

State tax data

*State tax data is generally considered to be of **HIGH** usefulness for Medicaid!*

State tax data is income data gathered by the state's Department of Revenue (or equivalent). Often this data is very similar to IRS data, but with much less stringent security requirements. This data source *is very likely* to contain ITINs, and could potentially be a good source of information for recipients without an SSN.

Note that not all states have an income tax, therefore this data will not exist for all states.

Getting access to this data generally requires setting up a data sharing agreement between the two agencies, and then implementing the data exchange.

Social Security

*Social Security data is generally considered to be of **HIGH** usefulness for Medicaid!*

Income from the Social Security Administration (SSA) must be take into account for calculating an income for Medicaid. However, because SSA benefits are paid out for specific circumstances, *they often don't tell the full story*. SSA information is essential to calculating income for Medicaid, but it should be seen as a *supplement* to other data sources.

SSA information is available through the Federal Data Services Hub (FDSH). Most states should already have access and be using this data.

Private databases

*Private databases are generally considered to be of **MEDIUM** usefulness for Medicaid.*

States may use private income databases for the purposes of validating a person's income on renewal. These databases are, in general, of varying quality with respect to coverage across states; some states may have high coverage (meaning a large portion of the population has data present in the database), while others may have low or nonexistant coverage.

The data contained within private databases are often paystub-level, including precise details like hours worked, deductions, etc.

Cost can be a prohibitive factor in incorporating private databases. Some private data is available through the Federal Data Services Hub (FDSH).

Other program data

*Data from other programs is generally considered to be of **MEDIUM** usefulness for Medicaid.*

Other benefit programs like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) collect and verify income data. Once collected and verified, this data can be used in two ways to facilitate a Medicaid eligibility

collect and verify income data. Once collected and verified, this data can be used in two ways to facilitate a Medicaid eligibility determination:

1. **Use the raw gross income** - In this case, Medicaid uses the gross income collected by another program to make a Medicaid eligibility determination. This is generally easier with a state that has an integrated eligibility system, but can be acheived without one. Note that the incomes must be utilized for *individuals*, not households! Household definitions may be different between programs, so a person's SNAP household income will not be the same as their Medicaid household income.
2. **Use Express Lane Eligibility (ELE) or a waiver** - In this case, simply being on one of these programs qualifies a person for Medicaid; no income data needs to be exchanged, but the person's enrollment must be confirmed. Express Lane Eligibility applies to children only. For adults, an (e)(14)(a) waiver can be utilized to acheive the same result.

Utilizing data from other programs generally requires a data sharing agreement between the two agencies and a data exchange implementation.

IRS/FTI data

*IRS/FTI data is generally considered to be of **LOW** usefulness for Medicaid.*

Tax data collected by the Internal Revenue Service (IRS), also referred to as Federal Tax Information (FTI), is a potential data source for performing Medicaid renewals. FTI is generally older than other data sources, often up to 16 months old. In addition, there are strict requirements around the usage and storage of FTI. These factors can make FTI a difficult data source to incorporate into an eligibility system.

That said, many states can, and do, use IRS data for Medicaid determinations. If a state is interested in using FTI, work with their policy team to determine the circumstances under which they feel comfortable incorporating it.

CMS guidance indicates that states should use a **"get-to-yes" strategy** when testing income. This means that if *any* income data source provides an income that is under the qualifying threshold, then the state should consider the income verified. Some states have chosen to use a more restrictive definition, where multiple (or all) income data sources must agree before determining someone eligible.

Even if the system is described as stepping through data sources one at a time, often the data is queried separately, in the week before the ex parte process is due to be run. Make sure to have a precise understanding of when and why data sources are queried or skipped. Note that some sources charge on a per-query basis: this may be the reason why a system seems to be attempting to optimize for fewer queries over maximum information.

What this looks like

The state has a large number of people or cases failing ex parte renewal each month for the following reasons:

- "No income data available"
- "Skipping income check"
- "Not querying X for data"
- "Income source mismatch"
- "Indeterminate income"
- "Income data conflict"

Potential solutions

Describe to the state how best-in-class income verification systems query *all income data sources available*. Question and challenge any logic that excludes certain types of people from certain types of income checks. If the state is not using a "get-to-yes" strategy, cite the October CMS guidance indicating best practices. Once policy aligned, determine an implementation path forward.

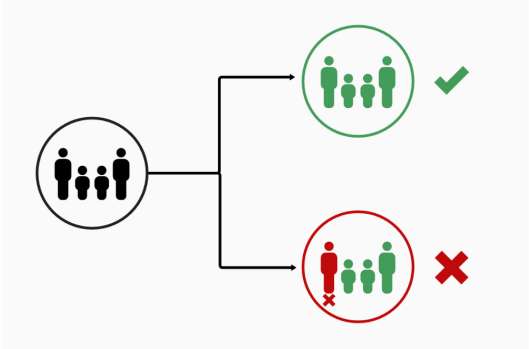
Resources

- CBPP: Streamlining Medicaid Renewals Through the Ex Parte Process (Step 2)

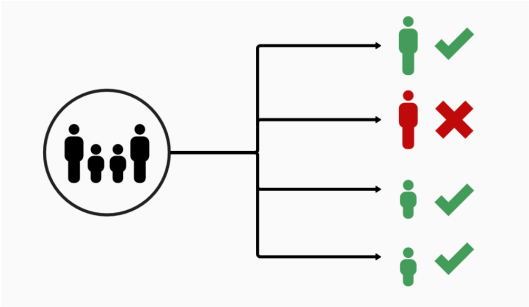
Individual/household determinations

Description

Medicaid determinations should be made at the *individual* level, meaning that individuals within the same household may have different determination statuses. Unfortunately, many state systems are configured to determine ex parte eligibility at the household level, meaning individuals who may be eligible are "swept up" in the determination of the household as a whole.



*Household-level eligibility; this logic is **incorrect**.*



*Individual eligibility; this logic is **correct**.*

The USDS first identified this defect across several state systems while providing technical assistance, and in August 2023 CMCS notified all state Medicaid agencies that they needed to urgently identify and fix this defect. By September 2023, 29 states self-attested to being afflicted by the defect. As of October 2023, all of these states are actively working to resolve this issue and have a mitigation plan in place. You should speak with your state partners to understand if they need assistance executing on their mitigation plans.

What this looks like

Some signs this may be happening:

- The state you are working with has self-attested to having the issue and has indicated to you that they need help resolving it.
- Ex parte data is only available at the case or account level.
- A flag on one person in the case blocks (or excludes) an entire case from moving forward through ex parte renewal.
- A case uses the lowest income threshold available for MAGI determinations (e.g., applies the adult threshold to children on the case).
- Mixed cases (MAGI and non-MAGI) are excluded from ex parte.
- Watch for two-stage systems where over-broad filters knock out entire cases before the eligibility rules are run in an attempt to mitigate perceived risks or defects in the rules engine.

Potential solutions

Sandbox solution:

- Prior to a month's renewal run, setup a sandboxed environment
- Load production data to simulate the current production environment
- Run eligibility for a month of data
- Using a script or query, determine individuals who were incorrectly terminated during that run
- In the *real* production environment, pre-emptively renew these individuals before running that month's eligibility

Notice solution:

- Run ex parte as normal. If anyone in the household fails renewal, send the household a renewal packet

- If the packet DOES NOT come back:
  - Renew anyone on the case who would have been successfully renewed at ex parte
  - Terminate anyone on the case who needed more information
- If the packet DOES come back:
  - Use the packet to renew (or terminate) members of the household based on the new information

Social Security Number challenges

Description

States are required to ask for an individual's social security number when they apply for Medicaid, but individuals are **not** required to supply it. In addition, there are large groups of people who may not have social security numbers on file with the Medicaid agency:

- Children under the age of 3
  - When a child is born, they do not have a social security number right away. Most new births during the public health emergency were not followed up on in order to obtain an SSN.
- Immigrants and non-citizens
  - These people may have an ITIN, which is not the same as an SSN.

SSNs are required to perform electronic income checks. However, many of these people may not need to have an electronic income check performed for the following reasons:

- Anyone under the age of 14 cannot legally make an income, and therefore do not need an income check run on them individually. These children should not be excluded from ex parte renewal if they do not have an SSN on file.
- If the state is verifying income via categorical eligibility (SNAP, for example), they do not need to perform an additional income check

Despite these considerations, many state eligibility systems exclude **all** individuals without an SSN from being run through the full ex parte before eligibility logic.

What this looks like

The following failure reasons may be symptoms of SSN challenges:

- "No SSN"
- "Missing SSN"
- "Cannot query income data sources"
- "SSN required"
- "SSN requested"

Potential solutions

Citing CMS waivers or labor laws, reiterate that there are automatic eligibility pathways for members without SSNs. Work with the state to determine a set of people who can be passed to the ex parte process, despite having a missing SSN. Work with the vendor team to ensure a missing SSN *alone* does not cause a person to be excluded from ex parte at *any* stage of the process.

Unnecessary reverifications

Description

When renewing Medicaid coverage, states only need to reverify *information subject to change*. While there is no authoritative list of items "subject to change", a combination of CMS guidance, regulation, research, and common sense has determine a list of items that do (or do not) fall into these categories.

Items that **are NOT considered subject to change**:

- SSN
- Birthday (and by extension, age)
- Citizenship/Satisfactory immigration status (October Guidance, page 16)
- Blindness status (42 CFR 435.916(b)(1))
- Disability status (42 CFR 435.916(b)(2))
- Medicare status
- Household composition (CBPP Step 4)
- Tax filing status (CBPP Step 4)
- State residency
- Anything verified in the last six months

Items that **are considered subject to change**:

- Income
- Assets
- Pregnancy status (if previously determined pregnant)
- Immigration status if not satisfactory

However, states may be over-verifying items that are not subject to change unnecessarily. This can result in people failing out of ex parte due to data unavailability, or data source errors. It's also been observed that some states consider certain types of verifications "better" than others; an electronic verification is considered more reliable than a paper verification, for example, and paper verifications are re-verified on renewal. This is not grounded in any policy or regulation, and simply results in more work for both eligibility workers and clients.

What this looks like

Some signs a state may be verifiying unnecessarily:

- Verification errors for anything in the list above NOT subject to change
- Verification errors for data older than six months
- Verification errors for data verified manually or on paper

Potential solutions

Rely on policy, regulation, guidance, and the examples of other states to get policy alignment on what needs to be re-verified (and what doesn't). After alignment is obtained, the checks can simply be removed.

Wage matching

Description

Wage matching is the process in which an person's income is compared against external data sources for verification. This process includes using the reasonable compatibility test, and incorporates any reasonable compatibility threshold the state is using.

While the regulations and guidance are fairly clear around reasonable compatibility, states may be taking an unnecessarily strict stance. The process should be:

- Compare the existing income on the account to the person's income threshold
- Compare the income returned from the electronic data source to the person's income threshold.
- If BOTH are *below* the threshold: the two incomes are reasonably compatible, and the person should be renewed.
- If BOTH are *above* the threshold: the two incomes are reasonably compatible, and the person should be sent a renewal packet.
- If ONE is above and one is below the threshold:
  - If the two values are *within the reasonable compatibility threshold of each other*: the two incomes are reasonably compatible, and the person should be renewed.
  - If the two values are NOT within the reasonable compatibility threshold of each other: the two incomes are NOT reasonably compatible, and the person should be sent a renewal packet.

Within in this process, there are flexibilities. Some states may choose to ignore the stored income completely; this is a reasonable implementation choice because the stored income will **always** be below the threshold anyway (since they qualified previously).

However, some states may be taking overly-restrictive strategies like:

- Requiring that the incomes are within a certain distance of each other BEFORE comparing to the threshold
- Requiring that the incomes have matching employer names CBPP Step 3
- Requiring that the case have an income from within the past X months
- Requiring that all income data sources confirm a source of income

What this looks like

The following signs may indicate a wage match issue:

- Errors like "Employer name mismatch"
- Large numbers of people failing for "reasonable compatibility" errors
- Errors related to multiple sources of income
- Errors indicating the stored income data is too old

Potential solutions

The first step in diagnosing a wage match issue is to ask the state to describe *in detail* how their wage match process is implemented. Ask the following questions:

- Do you use stored income when doing wage matching?
- How old can stored income be?
- What data sources do you compare against?
- When do you compare against each data source?
- How is reasonable compatibility implemented?
- What's your reasonable compatibility threshold? When does it come into play?

Describe to the state how best-in-class income verification processes do wage matching in the simplest way possible. Question and challenge any logic that strays outside of these bounds. Cite the October CMS guidance indicating best practices, and the regulations for definitions of technical terms.

Resources

- CBPP: Streamlining Medicaid Renewals Through the Ex Parte Process (Step 3)

Policy implementation challenges

Description

When presented with a policy, states are saddled with the burden of turning that policy into code. This translation is not always clean, and isn't always updated when the policy itself is updated. As a result, logic can often reflect old, outdated, or misunderstood policies, resulting in people being improperly failed during ex parte.

What this looks like

The following are signs that the implementation logic may not match policy:

- Unintelligible error codes
- Failure reasons that no one can explain
- Very old/outdated documentation
- References to old policies
- Mismatches in estimates compared to live measurements
    - For example, if a change was estimated to impact X people, but only impacted 1% of that, it may be a policy implementation issue

Potential solutions

Bring policy staff together with vendors and clarify:

- What does the policy *actually instruct*?
    - Explain it in the plainest language possible and verify with experts.
    - Cite regulation and statute if necessary.
    - Call experts whenever anything is unclear.
- How is this logic *currently implemented*?
    - Is the implementation correct?
    - Are there people who are being missed by the implementation?
    - Could the implementation be more efficient?
    - Could the implementation be less strict?

Caretaker relative challenges

Description

Family makeup, including the presence of **caretaker relatives**, is often a source of confusion and errors. It's common for states to exclude families with unclear family makeups.

However, family makeup is not subject to change without notification. While family makeup can, in theory, be verified against IRS data sources, it very rarely results in a "true positive". Regardless, states may filter out cases aggressively based on the presence of unclear caretaker relative relationships.

What this looks like

Large number of people or cases being excluded or failing ex parte renewal based on reasons like:

- "Caretaker Relative"
- "Parent Caretaker Relative"
- "No IRS data available"
- "IRS data mismatch"

Potential solutions

Leverage the October 2022 guidance to reinforce that many attributes on a case are not subject to change, and thus not required to re-verify on every renewal. Once policy aligned, define a strategy to remove unecessary parent caretaker relative checks.

Waiver implementation challenges

Description

CMS has provided flexibility for states to perform ex parte renewals through the 1902(e)(14)(a) process. However, many states may have struggled with the implementation of these waivers, or may not have the most efficient implementation possible.

Waivers that states may be struggling with:

- ***100% FPL Waiver***: Anyone with a verified income less than 100% FPL can be renewed if there's no data available from electronic sources. A person can be ex parte renewed if: *(1) the most recent income determination (either at initial application or most recent renewal) was no earlier than 12 months prior to the beginning of the PHE (i.e., March 2019) and was based on verified income at or below 100% of FPL; and (2) state has checked financial data sources in accordance with its verification plan and no information is received.*
- ***0% FPL Waiver***: Anyone with a verified income at 0% FPL can be renewed if there's no data available from electronic sources. A person can be ex parte renewed if: *(1) the most recent income determination (either at initial application or most recent renewal) was no earlier than 12 months prior to the beginning of the PHE (i.e., March 2019) and was based on verified income at or below 0% of FPL; and (2) state has checked financial data sources in accordance with its verification plan and no information is received.*
- ***SNAP/TANF Categorical Eligibility***: Anyone receiving SNAP or TANF is not subject to an income test.
- ***Removal of asset test***: Assets are no longer a consideration for eligibility.

What this looks like

In some states, the implementation of these waivers may be manual (meaning that eligibility workers are determining who falls under these rules). This process is often inefficient and can lead to a backlog of individuals to be verified.

When the implementation is automatic, the new logic may be at the *end* of the renewal, meaning that there are logic and checks being run prior to the waiver logic being run. This may result in a person being excluded before they get the chance to be considered for the waiver logic.

A key sign that the implementation may be inefficient is a mismatch between estimates and measurements. Ask the state: how many people did we estimate to be caught by this logic? Ask the vendor: how many actually were? Are the numbers close?

Potential solutions

In states where waivers are implemented manually, explore the opportunity to automate.

In states where waivers may be implemented inefficiently, recommend they be optimized by moving them up in the renewal process or expanding them to the largest group possible.

Consent requirements

Description

Consent is not required in order to renew an individual for Medicaid on an ex parte basis. Consent *is* required, however, to use IRS data in a renewal, and consent may be given from an individual for no more than five years. However, if a state does not have consent to use IRS (or the consent has "expired"), states **are still required** to attempt an ex parte renewal on an individual without IRS data. This may mean using other sources of income data, like quarterly wage data, state taxes, and/or private sources.

Despite this, some states will not attempt an ex parte renewal without the consent of the individual or their family members. This consent *is not required*, and the state *must* attempt an ex parte renewal.

What this looks like

If a state is excluding individuals from ex parte renewal for any of the following failure reasons, it may indicate a consent issue:

- "Consent not received"
- "Consent to use IRS data not received"
- "Consent expired"
- "Consent older than five years"

Check the Medicaid application of the state. Does it ask for consent? If it does, ask the state: how is this value being used? Does it prevent an ex parte renewal?

Potential solutions

Reference federal regulations that indicate that a state *must* attempt an ex parte renewal *regardless* of whether or not an individual has given consent. Once policy aligned, determine if the state is using IRS data. If they are, find a solution where consent allows the usage of IRS data, but otherwise has no effect on the renewal. If they are not using IRS data, remove any logic related to consent completely.

Resources

- October Guidance from CMS (page 19)

Worst case scenario challenges

Description

There are many pieces of information that could be utilized (and verified) during an eligibility determination. Some of these pieces of information are not able to be verified. A good example is tax deductions:

- If a person has a tax deduction on their case, their MAGI should be *lowered* by the deduction listed
- However, there may not be a way to verify the deduction
- The state may then choose to exclude the person from ex parte because of this

However, there's another option: ignore the deduction, and run the person against ex parte anyway with the *higher* income.

- If they're under the limit *without* the deduction, then we know they'll be under the limit *with* the deduction!
- If they're over the limit, they'll get a packet anyway; they're no worse off than before.

The goal is to test them at the "worst case scenario" instead of excluding them altogether. Many states do not opt for this strategy, and exclude anyone with an attribute that cannot be verified.

What this looks like

This most often comes up in MAGI calculation rules. This may look like "X cannot be verified", or "Unverified X on case".

Potential solutions

Explain the "worst case scenario" option to the state. Gain policy alignment that, by ignoring these unverified attributes, the state (and person) are at *no greater risk* than they were before.

Common Manual Renewal Challenges

While there is a large focus at the moment on ex parte renewals and the benefit that they can bring to states, a majority of the Medicaid population will still have to complete a manual renewal. Populations required to complete a manual renewal include people with income that cannot be verified electronically, non-citizens, and newborns. Filling out and completing a manual renewal form is complex and time-intensive for many to complete. This can result in vast losses of coverage as members struggle to navigate the manual process of renewing their coverage.

Human-centered design can bring large improvements to this process, and result in coverage retention for the most vulnerable populations. Measurement is an important part of this, but not one that is mandated at the current moment. Improving the manual renewal process can mean helping a state understand where the roadblocks are and helping them overcome them with best practices or innovative pilots.

*This playbook is **NOT** a source of authoritative, legal, or regulatory guidance and has not been officially endorsed by the Center for Medicaid and CHIP Services (CMCS). It is advisory only, and should be adapted appropriately for each state and scenario. Ultimately, it is the responsibility of state Medicaid officials to ensure that implementation of any project is compliant with federal Medicaid statute and regulations. Refer to CMCS's website for up to date official guidance.*

Outreach and Messaging

Members of the public face many challenges in learning how and when to renew their Medicaid, from general awareness that renewals have resumed to accessing and understanding more targeted messaging about their own renewal date. In many instances, the first time a member learns that they have missed their renewal date is when they try to use their coverage to fill a prescription or visit the doctor and get denied.

General Awareness

Challenges

States are struggling to get the word out to their members that renewals have resumed. Members have not needed to submit a renewal in 3 years, and many signed up during the PHE and have never needed to submit a renewal. Some states have engaged in ad campaigns and have a coordinated comms strategy while other states lack the budget or resources to do so.

Confusing messaging

As states engage in various outreach methods, they often use terminology that is unfamiliar to their members. Phrases like “public health emergency” and “unwinding” do not have broad familiarity and can cause confusion and invoke feelings of panic. In an attempt to avoid these terms some states may have gone too far in the other direction, using language that is too generic and doesn’t make it clear why people should pay attention or take action.

Getting the word to the right place

The Medicaid community is extremely diverse, which can make it challenging to reach all of them. States may or may not have the resources to place ads or the resources to put together a thoughtful comms strategy. It’s important to meet members where they are, meaning placing ads in multiple languages in key TV and radio markets as well as doctors offices, pharmacies, and on public transit.

SEO

While states are offering information about renewals on their websites, this information is not always easy to find. In some states, particularly those that are county-run, city, county, and state websites may compete with each other for search rankings. This makes it difficult for members to know where to go. Additionally, states are having to compete with scam websites that are placing ads in search results to trick members into providing their information or sell them a different insurance plan.

Plays:

- Review the state’s comms strategy, if they have one
- Put yourself in the member’s shoes and try common google search terms to see what comes up
- Work with navigator orgs to understand the messaging that resonates with their communities

Targeted Messaging (Notices / Renewal Packets)

Challenges:

When it is time for an individual to complete their renewal, states often struggle to get that message to the member.

Out of date contact information

Official notices and reminders about renewal dates are not reaching participants who have moved, or changed their phone number or email address over the course of the pandemic. This is particularly challenging for recipients without permanent addresses or stable living conditions, and those who rely on pay-per-minute phones.

Phone & texting access

Even if a member has kept the same phone number, calls and text messages from the state may not get through if they have run out of minutes, if their plan doesn’t allow texting, or if they live somewhere with poor reception.

Distinguishing official notices from spam

If the notice is successfully delivered to the participant, it may still be ignored. Mail, texts, and email from the state can often be hard to distinguish from spam. Often, letters are thrown away unopened and people may be hesitant to click links in texts or email. In some instances people may recognize the mail is from the state but still throw it away unopened. Some states have continued sending mail to participants throughout the PHE to keep them informed of their continuous coverage which has unintentionally conditioned people to think mail from the state is not important or actionable. In other instances, people may throw away mail unopened out of avoidance, because they have a fear of the government or because they find it overwhelming.

Plain language

Once people look at their notices, they may struggle to understand them. Notices often include confusing legalese that is not relevant or understandable to the average medicaid participant. These notices can do more harm than good, as confused recipients may not take the necessary action, or may take the wrong action based on them.

Language access

Many states support multiple languages, and translations of notices can also be a common issue. Notices may be translated word-by-word

rather than interpreting the entire sentence to make the most sense in that language, leading to nonsensical instructions. In other cases, they may use antiquated or uncommon dialects, which do not reflect the language being commonly spoken. In these instances members may seek help from friends, family, or a navigator. However, if an English copy is not also provided then the original intent of the notice may be impossible to trace back.

Timing

The timing of notices can also be a challenge. Given inconsistencies in mail delivery timelines, multiple notices can sometimes arrive out of order, creating confusion. If states are sending texts/emails in addition to mail, the mail may arrive after the member has already taken action.

Plays:

Use quantitative and qualitative research to understand if this is a challenge in the state you're working with and measure the baseline.

- Quantitative data: mail bounce/return rates, undeliverable rates for text messages, open rates for texts or emails
- Qualitative data: Navigators report that their clients are often throwing away their mail, and the first time people realize they have lost their coverage is when they try to use it (e.g. to fill a prescription) and get denied.

Design envelopes to make them stand out amongst other mail and make it clear that action is needed

Printing text on the outside of the envelope in key languages is a low-lift intervention that helps make it clear to members what the contents are and why it's important to open it. Using a unique color or design can also be effective when paired with strategic advertising so members recognize the envelope before it arrives.

Example: New York renewal notice envelope redesign

Full size image available here

Example: Hawaii's pink evelope campaign

Full size image available here

Ad campaigns encouraging people to update their contact information.

Ads should be placed in places where Medicaid participants are most likely to see them, such as TV, Radio, bus ads, doctor's offices, and pharmacies. Navigator's should be leveraged to spread the word in their communities.

Working with the National Change of Address (NCOA) database or MCOs to update recipient's addresses

Utilizing web-based messaging services like WhatsApp for outreach

Memers who run out of minutes may still connect to wifi, making web-based messaging a critical link to reach that population

Completing a renewal

Members who are not ex parte renewed for Medicaid must complete and turn in an annual renewal form. States are required to offer multiple modalities for completing and turning in the form, including a paper form mailed to the member's house, an online renewal form, or an over-the-phone option. Regardless of the path, completing a renewal form can be burdensome and time-intensive for members.

Paper form

Challenges

Not receiving the renewal packet

Some members never receive their renewal packet in the mail. Most often, this is a result of states not having an up-to-date address. Alternatively, some members do receive the packet in the mail, but perceive the envelope as spam or unimportant and throw it away without opening it. See Outreach and messaging for more on this topic.

Size of the renewal packet

The size of the renewal form is daunting, averaging 15-20 pages. After opening their renewal packet in the mail some decide not to complete it.

Lack of plain language

It's challenging to understand what's required across each section of the renewal form due to use of complex terms, lack of plain language, or unclear visual hierarchy.

Language access

Many have limited English proficiency and require translated materials to complete their renewal. However, not all languages are supported and members report variable quality across translated materials.

Income reporting

Understanding how to report current income and provide documents to prove it is one of the largest pain points across renewal forms, especially for non-W-2 earners. Words like "gross income" and the difference between "bi-weekly" and "semi-monthly" are unfamiliar to many. It's intimidating to provide documents without assurance that the document will be accepted.

Plays

Ask for data

Many states track data on renewal form *return rates.* This is the percentage of people who were sent a renewal form that successfully returned it. If this number is low, chances are that people are struggling to turn in the forms. For online forms, ask for drop off rates across the form, password reset attempts, identity verification success rates, and duplicate accounts created. For over-the-phone renewals, ask for average wait times, average call times, and issue resolution rates.

Talk to Navigators

Navigators provide 1:1 support to members of their community who need help completing their renewal form. They know *where* and *how often* people are getting stuck completing their renewal form, and the top questions people have about the form.

Usability test the form

Usability test the form with members of the public. Focus on people who face the greatest barriers to understanding the renewal form and completing it, including those who are new to the U.S., people with limited English proficiency, people with disabilities, and people with limited technology experience.

Co-design improvements

Co-design improvements to the form with end-users, including members of the public, Navigators, and eligibility workers. Establish a Member Advisory Council to provide ongoing feedback on proposed changes to the form. Include members in the iterative design process; ask for feedback and ideas early and often.

Explore options to drastically reduce the burden of renewing

For example, including a cover page on the paper form which highlights specific questions on the form in need of attention or providing an options for renewers to return a single signature page if the information on their pre-filled form is still accurate. For renewing online, explore options to upload or renew online without requiring members to create an account or login (e.g. through providing other unique identifiers).

Example: Colorado's Renewal Form Signature Page


Renewal Form Signature Page

Health First Colorado Case Number:

Read and sign this attachment (This page MUST be returned).

Please refer to What I Should Know - Rights & Responsibilities before signing.

Check the box that applies:

☐ I have read all parts of the Renewal Form and Rights and Responsibilities for Health First Colorado/CHP+. All information in the Renewal Form is correct. I do not need to make any changes or corrections to the information.

☐ I have read all parts of the Renewal Form and Rights and Responsibilities for Health First Colorado/CHP+. I need to make changes or corrections to the information. I will return the Renewal Form with the changes and corrections.

Signature of household contact or Authorized Representative Date (MM/DD/YYYY):

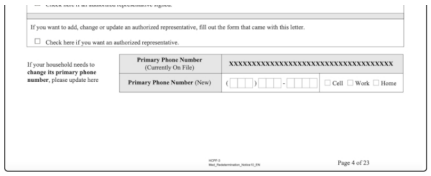
Example: Cover Page Exploration


Renewal Form Signature Page

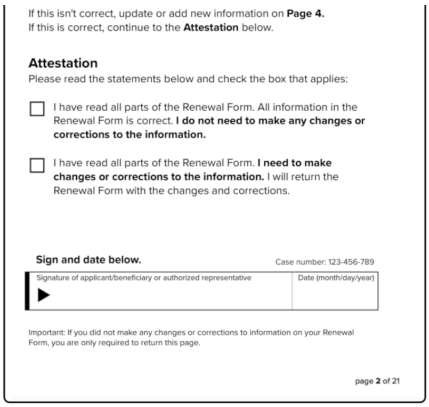
We weren't able to automatically verify the following information.
Please review the information below.

Current income

Amaya Smith - $15/hour at Starbucks



Full size image available here



Full size image available here

Online form

Challenges

Multiple platforms

Some states advertise multiple online portals to renew online, creating confusion and frustration for some members. It's unclear which is the "official" route to renew online or which is the easiest path for them.

Account access

Most states encourage members to renew online. However, members face challenges creating an account, logging in, and retrieving their password in order to renew. Many renewers don't have access to a device to complete the online renewal, have no email account, and limited internet experience.

Identity verification

Many eligible Medicaid members are unbanked or underbanked and, as such, are not represented in common identity verification databases. Furthermore, some states use Knowledge-Based Identity Verification which requires members to recall obscure facts that many do not remember. In many states, when a member's identity cannot be verified, they are not able to renew online or view submitted documents.

Navigator permissions

Navigators play a crucial role in helping Medicaid members who cannot complete their renewal without assistance. However, across online portals, Navigators typically only have access to a limited view of client information. As a result, Navigators are required to call county or state-run Medicaid hotlines for basic information such as when a client is due for renewal or whether an eligibility worker has received the client's documents.

File size limits

Many online renewal document upload portals have small file size limits which require members, Navigators, and eligibility workers to manually reduce the size of images or PDF documents before uploading them. This is a time intensive, burdensome process for those with experience on how to do it and impossible for some to figure out.

Plays

Ask for data

Ask for drop off rates across the form, password reset attempts, duplicate accounts, and identity verification success rates.

Usability test the online renewal experience

Directly observe users try to complete their renewal online, from creating an account and logging in through to submitting their form. Focus on people who face the greatest barriers to understanding the renewal form and completing it, including those who are new to the U.S., people with limited English proficiency, people with disabilities, and people with limited technology experience. Note the time it takes to complete each task, where people struggle or have questions, and whether or not each user was able to complete their online renewal successfully.

Co-design improvements

Co-design improvements to the form with end-users, including members of the public, Navigators, and eligibility workers. Establish a Member Advisory Council to provide ongoing feedback on proposed changes to the form. Include members in the iterative design process; ask for feedback and ideas early and often.

Possible solutions

Clarify communications around where to renew online

Develop a clear path for online renewals by clarifying the quickest and easiest way to renew online among multiple existing platforms. Ensure communications are consistent across mediums (e.g. renewal packet, notices, official government websites, outreach campaigns).

Simplify the account creation process

Many members do not have an email address at the time of renewal, and Navigators report spending hours with members walking through the process and familiarizing members with email before creating their online renewal account account. Additionally, complex username

and password requirements make it hard for members to successfully complete account creation. States should consider removing the requirement of an email address for members to complete their renewal online and review account creation policies to ensure ease of use for members.

Simplify account retrieval

Many members have duplicate accounts with their state, as it's often easier to create a new account than retrieve their old one. States should review the user experience of retrieving a lost username, password, or locked account to identify opportunities to simplify the process and increase success rates. Additionally, states should consider passwordless authentication options (e.g. through a Magic Link) which don't require users to remember a password to complete their renewal.

Explore login-less ways to renew online

Some states provide paths for members to upload documents without requiring them to create an account or log in, including proof of income or a completed renewal packet. Additionally, states could explore alternative paths and "guest login" options for members to complete their entire renewal online by providing personally identifiable information that links the member to their account (e.g. first and last name, DOB, SSN or ITIN, case number) as an alternative to login credentials.

Enable Navigator access

Navigators have the full trust of their clients, but often lack the permissions to view their client's renewal date, prepopulated renewal packet, case status, and confirm that documents have been successfully submitted. States should explore Navigator online access policies to ensure that they can sufficiently support their client's through the renewal process.

Expand file size limits

Members and Navigators are sometimes faced with the burden of having to resize files themselves or upload multiple different documents due to restrictive file size limits. States should expand file size limits to support the standard documents they accept (e.g. multi-page PDFs for the renewal packet) and high-resolution defaults across commonly used devices to share photos of documents (e.g. iPhone and Android smartphones).

Phone-based renewals

Challenges

Long call center wait times

Call center wait times across the nation are high for help with Medicaid renewals. However, some counties reported experiencing more burden than others. Those living in a high-density urban areas are typically met with longer wait times than those living in rural areas.

Confusing IVR options

In some states, the option to renew over the phone is not an available option in the state's interactive voice response (IVR) menu. In some states, language options that are available in the are not actually hooked up to a representative who speaks that language.

Language access

Many states use Language Line for translations when bilingual agents are not available. However, this results in additional wait time for members with limited English profiency. Through the use of an interpreter as in Language Line, context is missed and key details get lost in translation.

Plays

Listen in

Listen in while a member attempts to renew over the phone and document the experience. Note the time it takes to complete each task, where people struggle or have questions, and whether or not the member was able to complete their renewal successfully.

Ask for data

Ask for average wait times, average call times, containment rates, and issue resolution rates across the state. Compare state baseline data to data across regions (e.g. urban vs rural counties) and populations (e.g. English vs non-English speakers) to identify challenges across the phone-based renewal experience.

Review IVR menus

Review Interactive Voice Response (IVR) menus to ensure callers can easily and efficiently get routed to an agent who can help them complete their over the phone renewal.

Ensure language lines are usable for non-English speakers

In some states, language options that are available in the are not actually hooked up to a representative who speaks that language.

Getting help and troubleshooting

When members have a question or challenge with their Medicaid renewal, states provide multiple options to get support. These include in-person support at local eligibility offices, over-the-phone support, and support from Navigators. However, not all members experience the same level of support.

General

Challenges

Knowing what support is available

It's not always clear to members what support options are available. When searching online for help renewing Medicaid, official state websites don't always rank towards the top. Furthermore, not all members are familiar with Navigators or aware that individualized support is avaialbe to help them through the renewal process.

Increased demand

With the public health emergency ending, members need to take action to renew their Medicaid for the first time in several years. Some members are renewing for the first time. Navigators report that the return to annual renewals has resulted in fear, confusion, and questions among members. More members are reaching out for support than any time in the past few years.

Staff shortages

During the public health emergency, annual renewals paused. This meant less work for eligibility worker staff and call center agents. As such, many states downsized staff during this time. After the public health emergency ended, states struggled to fill vacant seats across call centers and eligibility staff. Many states report continued staffing shortages and high attrition rates, as well as an influx of new hires with minimal experience in their state's Medicaid policies and programs.

Variable support experiences

Members and Navigators report having to call in or go in person to an eligibility office multiple times to try to speak with someone who can help them. It's a roll of the dice on who will pick up the phone, or who will get assigned to your case. Sometimes members are connected to a tenured eligibility worker. Other times, they are connected to a new hire who is unfamiliar with their state's Medicaid policies and programs.

Unclear escalation paths

When a member or Navigator is assigned an agent or eligibility worker who is unable to resolve their issue, it sometimes results in a dead end. Members and Navigators report that there is not always the option to speak to a manager or supervisor to resolve an issue. Navigators in some states fall back to a formal appeals process when they cannot resolve an issue otherwise.

Plays

Be a renewer

Put your renewer hat on and try to find out where to get help on a particular Medicaid renewal topic in your state. Document the experience as you go, capturing screenshots and notes. Mark areas of confusion or frustration.

Review escalation paths

Review escalation paths to ensure members can efficiently get routed to someone who can resolve their issue when an entry-level eligibility worker or agent can't help.

Call center

Challenges

Long call center wait times

Call center wait times across the nation are high for help with Medicaid renewals. However, some counties reported experiencing more burden than others. Those living in a high-density urban areas are typically met with longer wait times than those living in rural areas.

Confusing IVR options

In some states, the option to renew over the phone is not an available option in the state's interactive voice response (IVR) menu. In some states, language options that are available in the are not actually hooked up to a representative who speaks that language.

Language access issues

Many states use Language Line for translations when bilingual agents are not available. However, this results in additional wait time for members with limited English proficiency. Through the use of an interpreter as in Language Line, context is missed and key details get lost in translation.

Plays

Call in

Call in to the customer support line as a renewer and document your experience. Note areas of confusion or frustration, record your wait time, take notes on the IVR, and highlight areas for opportunity.

Ask for data

Ask for average wait times, average call times, containment rates, and issue resolution rates across the state. Compare state baseline data to data across regions (e.g. urban vs rural counties) and populations (e.g. English vs non-English speakers) to identify challenges across the customer support experience.

Review IVR menus

Review Interactive Voice Response (IVR) menus to ensure callers can easily and efficiently get routed to an agent who can answer their questions and resolve their issues. Ensure top caller questions are reflected in IVR menus (e.g. “Renewing” should be included).

Review hand-off procedures

When callers are transferred to another department, ensure they keep their spot in line and don’t go to the back of line in a second queue.

Review escalation paths

Review escalation paths to ensure callers can efficiently get routed to someone who can resolve their issue when an entry-level eligibility worker or agent can’t help.

Ensure language lines are usable for non-English speakers

In some states, language options that are available in the are not actually hooked up to a representative who speaks that language.