

To: Ohio Consumers for Health Coverage
From: Marie B. Curry, Christine DiSabato
Date: August 18, 2022
Re: CMS Questions included in the Request for Information:
Access to Coverage and Care in Medicaid & CHIP

See language below for the text of OCHC comments submitted on April 18, 2022.
https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. *CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.*

1. What are the specific ways that CMS can **support states in achieving timely eligibility determination and timely enrollment** for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.

RESPONSE:

Recommendation 1 of 2: SNAP-based Renewal Capability Should be Advanced and Supported in All States

Passive renewal procedures should be implemented and expanded in every state. SNAP-based renewal is one of the optimal methods of passive renewal and should be required in each state. Recent guidance from CMS gives states the option to automatically renew Medicaid eligibility for beneficiaries under age 65 who receive Supplemental Nutrition Assistance Program (SNAP) assistance. The vast majority of SNAP participants qualify for Medicaid, and this option could prevent millions of people from losing Medicaid coverage. Ohio Consumers for Health Coverage (OCHC) recommends that CMS go further than giving states the option, by identifying and ameliorating barriers states face in taking up the option.

As OCHC knows through its partner and member organizations, many families who benefit from programs including Medicaid and SNAP tend to lack reliable means of communication due to the same socioeconomic factors that led to their enrollment in public benefits. Permanent home or mailing addresses are unreliable due to the often transient nature of renters, and some do not have access to even temporary housing in their own name. For those reasons and others, mail is likely to get lost or take far longer to reach its intended recipients, and countless eligible

beneficiaries are at risk of losing coverage due to missed notices.

With the impending challenge of resuming Medicaid redeterminations after the public health emergency, CMS should be doing everything it can to ensure that states take advantage of this opportunity to combat the overwhelming administrative burden that is to come (in the midst of a nationwide workforce shortage no less) by supporting states in developing automated systems that can identify beneficiaries who participate in SNAP and electronically renew them. During the public health emergency, Medicaid has grown to the largest number of beneficiaries in its history. Unless states are compelled to and supported in taking immediate action, Medicaid coverage losses for eligible participants could exceed any experienced before. Urban Institute researchers project that, nationally, between 12.9 million and 15.8 million people will lose Medicaid if typical pre-pandemic patterns apply, a figure which at its minimum would still be over five times the largest previous annual loss in the program's history.

(<https://www.urban.org/research/publication/what-will-happen-medicaid-enrollees-health-coverage-after-public-health-emergency>.)

In Ohio, about a quarter of the population, approximately 3.3 million Ohioans, rely on Medicaid coverage. Before the public health emergency, in February 2020, 2.78 million Ohioans were on Medicaid. The Center for Community Solutions estimates somewhere between 200,000 and 300,000 Ohioans will lose Medicaid coverage after post-public health emergency redetermination. They warn that children, elderly, and disabled Ohioans will likely be hurt the most by the redetermination process. When the federal government officially ends the public health emergency, an outside vendor will begin processing Ohio's redeterminations. The Ohio Department of Medicaid has reported that it will employ its passive renewal process "to renew as many past-due cases as possible prior to the end of the PHE," but advocates have consistently pushed for a more effective passive renewal process that will encompass more participants.

(https://medicaid.ohio.gov/static/About+Us/AdvisoryCommittee/2022/J.+TASSIE+-+ODM+Nex+Gen_Listening+Session_vF.+2-17-2022.pdf.)

SNAP-based auto-renewal can prevent disenrollment of roughly half of all beneficiaries, specifically protecting many families of color and families in rural areas. It can also significantly reduce administrative burdens facing understaffed state and local agencies that will soon undertake the largest volume of redeterminations in Medicaid's history. This auto-renewal option can also improve program integrity by preventing eligible participants from being disenrolled due simply to missing information or paperwork rather than substantive causes for ineligibility.

See Families USA: *Medicaid Programs Should Protect Health Care for Millions of Families by Implementing a New Federal Option for SNAP-Based Electronic Renewal*

(https://familiesusa.org/wp-content/uploads/2022/03/MCD-2022-48_SNAP-Issue-Brief_final.pdf
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Recommendation 2 of 2: Disaggregated Application and Denial Rates Should be Recorded and Publicly Available.

One of the most beneficial things CMS could spearhead is the collection and public release of data from each state that includes information on application and denial rates, including reasons for denials and rates of denial. Data is the most powerful tool CMS and states can provide advocates who support individuals in navigating application and renewal processes for Medicaid and CHIP. Likewise, coalitions like OCHC, as well as its member organizations, use data to identify systemic inequities in the implementation of these processes.

Useful data would include: rates of (a) application versus acceptance or denial, and (b) redeterminations versus renewal or disenrollment; reasons for rejection or disenrollment (i.e. whether rejection or disenrollment was based on procedural or substantive reasons and what those reasons are), and; demographic statistics on applicants, both accepted and denied, and redetermined beneficiaries, both renewed and disenrolled. Having reliable, up-to-date information from states will be essential to monitoring the unwinding process, determining where additional steps may be necessary to avoid coverage losses among eligible individuals. Looking forward, laying the foundation for collection and reporting of these data will also inform CMS and state operations beyond the public health emergency unwinding.

According to a recent publication from the Kaiser Family Foundation, most states are able to report the key metrics needed to monitor the unwinding process. CMS has indicated it will require states to report monthly data to monitor their progress on unwinding and compliance with current rules, but as of April 2022 there has been no indication that the data will be released to the public. While CMS is already requiring this data collection and reporting, CMS should also require data collection and public reporting of rates of denials of new applications, and rates of rejection or disenrollment of renewals.

Moreover, the reasons for those denials and disenrollments are an essential element to understanding whether state systems are functioning to best protect eligible people from losing health insurance coverage. States struggle to identify reasons for rejection or disenrollment, and are not always able to determine from an individual's lack of response whether they still need Medicaid coverage but have, for whatever reasons, not responded to notices. CMS should require states to seek and report reasons (with meaningful specificity) for rejection or disenrollment. When organizations that support individuals are made aware of the reasons that prevent individuals from receiving or maintaining coverage, they can work with state agencies to correct individual level decisions. When organizations that have expertise in identifying system-level problems have access to data, they can analyze potentially overarching problems that create or

perpetuate population-level inequities. Providing these data to the public supports targeted, data-driven advocacy efforts to assist those who are eligible for Medicaid and CHIP in securing and retaining benefits.

See Kaiser Family Foundation: *Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey*

(<https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/>.)

2. What **additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes**, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?

RESPONSE:

Recommendation: CMS and States Must Implement Modern Avenues of Communication in Order to Effectively Reach Participants

CMS and states should integrate texts, phone calls and emails into their standard communications procedures because a multifaceted approach to communicating with beneficiaries is necessary in this day and age. Particularly over the last 2+ years of COVID-19, housing instability has been a widespread issue and contact information has changed for many. The complicated circumstances of the pandemic increase the likelihood that states do not have individual beneficiaries' most up-to-date contact information. While mailing is an important mode of communication, today texting and calling should be standard forms of communication alongside mail, particularly for agencies that serve vulnerable populations that often rely heavily on cellular phones over direct mail and email for communication.

There are restrictions and requirements to be navigated in order to implement texting and calling as avenues for communication with beneficiaries, but there are ways to satisfy those requirements. The most straightforward way to obtain consent for texting would be to make it a part of the enrollment process. This forward-looking solution should be incorporated into application processes for prospective enrollees as soon as it is technically possible. To improve communications with existing beneficiaries, states should set up processes for opting-in to texting and calling capabilities. These methods of communication should be employed before, during, and after the PHE unwinding. States can set up processes to send texts to enrollees without pre-approved consent, send automated texts to individuals seeking consent for its managed care plans to send texts, or have their managed care plans or other contractors obtain

opt-in consent from enrollees directly. These methods are consistent with current Federal Communication Commission (FCC) interpretations of the Telephone Consumer Protection Act (TCPA).

State Health and Value Strategies recently reported that the FCC has interpreted the TCPA to mean that state Medicaid and CHIP agencies are not subject to TCPA text messaging restrictions. This means that state agencies can send text messages directly to their enrollees without first obtaining express consent. However, FCC guidance has also clarified that contractors of state agencies, (including Medicaid managed care organizations (MCOs) as well as counties and municipalities, are subject to the TCPA. Consequently those entities must obtain consent from enrollees prior to sending text messages if they are using an autodialer.

[\(https://www.shvs.org/text-messaging-an-important-communication-and-outreach-strategy-as-states-unwind-the-federal-medicaid-continuous-coverage-requirement/.\)](https://www.shvs.org/text-messaging-an-important-communication-and-outreach-strategy-as-states-unwind-the-federal-medicaid-continuous-coverage-requirement/)

An effective and inclusive multifaceted communication approach should include not only standardizing the use of modern means of communication, but also establishing and including multiple points of contact for beneficiaries throughout their communities. One way to achieve this is by supporting and promoting school-based community health centers as schools are one of the most stable and consistent resources community members interact with regularly regardless of the type of community they live in. This approach and other forms of direct and consistent contact with communities would likely have the most impact on those in both urban and rural communities, where, for varied reasons, healthcare can be hard to access.

See State Health and Value Strategies: *Text Messaging: An Important Communication and Outreach Strategy as States Unwind the Federal Medicaid Continuous Coverage Requirement* ([https://www.shvs.org/text-messaging-an-important-communication-and-outreach-strategy-as-states-unwind-the-federal-medicaid-continuous-coverage-requirement/.](https://www.shvs.org/text-messaging-an-important-communication-and-outreach-strategy-as-states-unwind-the-federal-medicaid-continuous-coverage-requirement/))

3. In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

RESPONSE:

Recommendation 1 of 3: CMS and States Should Recognize that Medicaid Accessibility is a Racial Health Equity Issue

CMS and states should collect data on Medicaid accessibility, including acceptance and denial rates, disaggregated by race. That data should then be made public so that individuals and advocacy organizations can access it. As a major source of health coverage for people of color, Medicaid and CHIP are essential to addressing health disparities among communities of color. The COVID-19 pandemic has highlighted and exacerbated long-standing racial and ethnic disparities in health and health care. Long before the pandemic, people of color fared worse than white people across many measures of health and health care, reflecting wide-spanning inequities within the healthcare system as well as across community conditions that are drivers of health. These disparities are rooted in racism and discrimination.

People of color statistically face increased challenges affording private health insurance coverage because they are more likely to be low-income due to a variety of factors, most notably including our nation's history of racial inequity. People of color are less likely to be privately-insured than white people even though private insurance is the largest source of health coverage for people across racial and ethnic groups. Medicaid and CHIP help to fill gaps in private coverage for people of color. The Kaiser Family Foundation has reported that as of 2020, "Medicaid covers about three in ten Black, American Indian and Alaska Native (AIAN), and Native Hawaiian or Other Pacific Islander (NHOPI) nonelderly adults and more than two in ten of Hispanic nonelderly adults, compared to 17% of their White counterparts."

(<https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/>.) Medicaid and CHIP services are essential to advancing the health outcomes of these communities.

Recently the federal government and many states have identified advancing health equity as a key priority for the Medicaid program. After taking office, President Biden issued a series of executive orders and actions aimed toward advancing equity and strengthening Medicaid. In November 2021, CMS published its strategic vision for Medicaid and CHIP that identifies equity as one of three key focus areas also including coverage and innovation.

In comments in response to Objective one part one, Ohio Consumers for Health Coverage has offered recommendations regarding data collection. However, it bears repeating in this response that improving Medicaid data collection and procedures, and publicly reporting the results, will be key in the effort to address racial health disparities. Reliable and current data is essential for identifying disparities, targeting intervention efforts, and allocating resources to address disparities, measuring progress in the effort to advance equity, and establishing accountability for achieving measurable progress. When data is lacking, inequities go unseen and unaddressed. Moreover, as we have seen in Ohio over the course of the past two years, disaggregated data, even within racial groups, is necessary to discern which groups are being left behind. For example, when Asian individuals are grouped together, it is too easy to miss the disparities faced by the various groups of people who are more recent immigrants. Whereas, if the effort is made to identify ethnicity, e.g., Hmong, Karen, Nepali, the disparities faced by Ohio's various refugee

populations are made visible.

Recommendation 2 of 3: The 5-Year Bar on Medicaid Eligibility for Immigrants is an Unjust Barrier to Health Equity and Should be Removed.

The 5-year bar for immigrants to access Medicaid promotes racial health disparities and should be removed. The Kaiser Family Foundation reported in April 2022 that in 2020, 22.1 million noncitizens in the United States accounted for nearly 7% of our total national population. The American Immigration Council reported in 2020 that five percent of Ohio residents are immigrants, while another 5 percent of residents are native-born U.S. citizens with at least one immigrant parent. That report also noted that in 2018, 555,583 immigrants (defined as foreign-born individuals) comprised 5 percent of the population. Noncitizens in all states are significantly more likely than citizens to be uninsured. The pandemic likely contributed to increased health and financial needs, and decreased access to health services among immigrant families.

<https://www.americanimmigrationcouncil.org/research/immigrants-ohio#:~:text=Five%20percent%20of%20Ohio%20residents,5%20percent%20of%20the%20population.>)

Many lawful immigrants who are eligible for coverage remain uninsured because immigrant families face a range of enrollment barriers. These barriers include fear of interacting with government entities, confusion or lack of information about available services and eligibility policies, issues navigating enrollment procedures, and language and literacy challenges. These challenges drive poor health outcomes among immigrant populations and nationwide health inequity. The five-year bar contributes to the fear, confusion and lack of information immigrants have surrounding Medicaid and other government services even once they become eligible.

Efforts to rectify the disparate treatment of immigrants, specifically with regard to the five-year bar, have gained popularity in recent years. In 2021, two pieces of legislation, the Health Equity and Access Under the Law (HEAL) Act and Lifting Immigrant Families Through Benefits Access Restoration Act (LIFT the BAR) Act, were introduced in Congress. Both acts would remove the five-year waiting period for health coverage and other assistance programs that currently apply to many lawfully present immigrants that were implemented in 1996. The acts would also expand the definition of lawfully present immigrants to include Deferred Action for Childhood Arrivals recipients and other authorized immigrants. The HEAL Act would allow undocumented immigrants to access health insurance coverage through the ACA Marketplaces and create subsidies to offset the cost of that coverage. These initiatives would be significant steps towards health equity, and align with federal goals for CMS and the Biden Administration as a whole. CMS should support efforts at both federal and state levels to advance health equity by enabling more immigrants to obtain access to health insurance.

[https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.](https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/))

Recommendation 3 of 3: Language Accessibility Must Be Improved in Order to Alleviate Health Disparities

Ohio communities have welcomed immigrants and refugees who speak many languages (e.g., Arabic, Burmese, Chinese, Creole, French, German, Hmong, Korean, Japanese, Karen, Nepali, Pashto, Polish, Portuguese, Somali, Spanish, Swahili, Susu, Tagalog, and Vietnamese). Ohio Consumers for Health Coverage interviewed several Ohio legal aid advocates who represent clients in accessing social safety net programs. Advocates describe many instances of language barrier issues across public benefit agencies. Many of their clients have encountered barriers at the outset of seeking assistance because of an inability to understand prompts when calling phone lines for various programs. These lines typically present options in English, and sometimes Spanish, but speakers of other languages are left unable to understand what is expected of them in order to even reach interpretation services. The answering message on Ohio's general state-wide phone number offers lengthy guidance in English on a number of important topics. Following that information, a short passage of information is offered in several other languages, presumably including a prompt to press a certain number for a particular language. This system is confusing and insufficient. LEP callers who need interpretation from a language other than the eight languages offered are left in the dark as to how to obtain help in their spoken language. This gap has been even more pronounced during the public health emergency, when many local agencies were not assisting people in person, making unavailable one avenue LEP people used to circumvent the phones all together.

Having said that, multiple clients have also sought assistance in person and have been met with severely lacking interpretation and translation services that greatly complicate the application and renewal processes for them. Clients that speak less common languages or dialects have an especially hard time, even when interpretation services are, in theory, readily available. Unfortunately, these obstacles can discourage individuals from seeking benefits for which they are eligible. It is lawful and essential that federal, state and local agencies be prepared to provide competent and smooth access to assistance in the language of their constituents.

Based on their experience assisting clients struggling to overcome language barriers, advocates offer practical ideas for strategies that can address these barriers. First, LEP applicants and benefits recipients need paths to speak in real time with someone who can explain what is happening in their case rather than having to rely solely on written notices. Perhaps because they arrived from countries where the culture of a safety net is vastly different than it is in the United States, LEP individuals often face greater obstacles than most people in understanding the procedures and rules of the public benefits entities they interact with, and don't understand the reasoning behind approval or denial of an application. Yet it is very difficult to reach a person at an agency to seek better understanding. These individuals need access to an individual and an

interpreter who will take the time to help them understand the application process and the outcome of an application, so they can navigate through and later assess whether any adverse outcome they have received is justified.

Second, advocates also feel that proactive outreach into the community should be prioritized, particularly among groups that are likely to need services and are at risk of not getting those services due to language barriers (or other factors). An example of this is the local Medicaid agency attending community events with an interpreter or employee who has the capability to interact with members of the community and build awareness of and trust in the agency. It is essential that state and local entities connect with the communities they serve and be prepared to provide competent and smooth services in the languages of their constituents.

Any steps that CMS can take to incentivize states and local agencies to prioritize community partnerships with immigrant communities, and to invest in more robust language access services, could significantly reduce health inequities experienced by these populations.

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. *CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income (SSI)/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).*

2. How should CMS consider setting standards for how states communicate with **beneficiaries at-risk of disenrollment** and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?

RESPONSE:

Recommendation: Texting, phone calls and email are essential standard modes of communication today (especially among impoverished populations) and should be integrated as standard practice in CMS and state Medicaid communications procedures.

Many families that benefit from programs including Medicaid and SNAP tend to lack reliable

means of communication due to the same socioeconomic factors that led to their enrollment in public benefits. Housing instability has been exacerbated by the conditions of the COVID-19 pandemic. The requirement that states not remove anyone from Medicaid rolls in exchange for receiving the increased Federal Medical Assistance Percentage during the public health emergency has allowed many eligible people to remain enrolled even if they did not update their contact information along the way. As a result, mail is more likely to get lost or take far longer to reach its intended destination and countless eligible beneficiaries are at risk of losing coverage due to missed notices. This issue can be addressed by implementing standard texting, email and phone policies throughout the states.

While these modern modes of communication are essential, mailing should not be abandoned as there are plenty of participants that do not have access to phones or computers. A blended approach is necessary to ensure inclusion and effectiveness. One size does not fit all. In addition to communication upgrades, states and the federal government should broaden their reach by partnering with organizations that have existing relationships with the community, who work directly with prospective and existing program participants.

Because of the COVID-19 emergency, recurring difficulties in reaching beneficiaries by mail have been exacerbated. Most states plan to take action to update addresses before the public health emergency expires, including: conducting data matches with the United States Postal Service (USPS) National Change of Address database; working with managed care organizations (MCOs), and; conducting outreach campaigns. These efforts should include multiple reminders using updated communication methods, including texting, email and phone calls.

See State Health and Value Strategies: *Text Messaging: An Important Communication and Outreach Strategy as States Unwind the Federal Medicaid Continuous Coverage Requirement* (<https://www.shvs.org/text-messaging-an-important-communication-and-outreach-strategy-as-states-unwind-the-federal-medicaid-continuous-coverage-requirement/>.)

See Kaiser Family Foundation: *Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey* (<https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/>).



We thank you for your time spent taking this survey.
Your response has been recorded.



Resources Reviewed in RFI Research (not part of submission to CMS)

- Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey, Kaiser Family Foundation (KFF):
<https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/>
- States Are Planning for the End of the Continuous Enrollment Requirement in Medicaid After the COVID-19 Public Health Emergency Expires, But Many Have Not Made Key Decisions, KFF:
<https://www.kff.org/medicaid/press-release/states-are-planning-for-the-end-of-the-continuous-enrollment-requirement-in-medicaid-after-the-covid-19-public-health-emergency-expires-but-many-have-not-made-key-decisions/>
- Medicaid Managed Care Plans Can Help Enrollees Maintain Coverage as the Public Health Emergency Unwinds, KFF:
<https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-plans-can-help-enrollees-maintain-coverage-as-the-public-health-emergency-unwinds/>
- Pandemic Emergency Supports Expiration Timeline December 2021-December 2022, Advocates for Ohio's Future (AOF):
<https://static1.squarespace.com/static/5dc5b0da70fe636e7866b171/t/622906d415debf24ab35581e/1646855893493/Pandemic+Emergency+Supports+Expiration+Timeline+3.2.22.pdf>
- Unwinding of the PHE: Maintaining Medicaid for People with Limited English Proficiency, KFF:
<https://www.kff.org/medicaid/issue-brief/unwinding-of-the-phe-maintaining-medicaid-for-people-with-limited-english-proficiency/>
- Streamlining Medicaid Renewals Through the Ex Parte Process, Center on Budget and Policy Priorities:
<https://www.cbpp.org/research/health/streamlining-medicaid-renewals-through-the-ex-parte-process>
- Record enrollment numbers send a clear message about health care affordability, access, The Hill (by Community Catalyst ED Emily Stewart):
<https://thehill.com/blogs/congress-blog/healthcare/592389-record-enrollment-numbers-send-a-clear-message-about-health/?rl=1>
- UPDATE: HHS and CMS Take Steps to Help Keep Families Connected to Coverage After the Eventual End of the COVID-19 Public Health Emergency, Medicaid.gov:
<https://content.govdelivery.com/accounts/USCMSMEDICAID/bulletins/30d2d19>
- Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations,

March 2022 Update, CMS:

<https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf>

- Text Messaging: An Important Communication and Outreach Strategy as States Unwind the Federal Medicaid Continuous Coverage Requirement, State Health & Value Strategies:
<https://www.shvs.org/text-messaging-an-important-communication-and-outreach-strategy-as-states-unwind-the-federal-medicaid-continuous-coverage-requirement/>
- Medicaid Programs Should Protect Health Care for Millions of Families by Implementing a New Federal Option for SNAP-Based Electronic Renewal, Families USA:
https://familiesusa.org/wp-content/uploads/2022/03/MCD-2022-48_SNAP-Issue-Brief_final.pdf
- Medicaid Enrollment Churn and Implications for Continuous Coverage Policies, KFF:
<https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>
- Medicaid and Racial Health Equity, KFF:
<https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/>
- Racial and Ethnic Disparities in Medicaid: An Annotated Bibliography, Medicaid and CHIP Payment and Access Commission (MACPAC) April 2021:
<https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf>
- Health Coverage of Immigrants, KFF:
<https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/>
- CMS: States can seek to extend postpartum Medicaid, CHIP coverage to 12 months, Fierce Healthcare:
<https://www.fiercehealthcare.com/payers/cms-states-can-seek-extend-postpartum-medic-aid-chip-coverage-12-months>
- Medicaid Postpartum Coverage Extension Tracker, KFF:
<https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>
- Ohio Department of Medicaid, *Next Generation of Ohio Medicaid's Managed Care Program*:
https://medicaid.ohio.gov/static/About+Us/AdvisoryCommittee/2022/J.+TASSIE+-+ODM+Next+Gen_Listening+Session_vF.+2-17-2022.pdf