KEEPING INFANTS COVERED AND CONNECTED TO MEDICAID

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Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

MISSING BABIES IN EPSDT: KEEPING INFANTS CONTINUOUSLY ENROLLED IN MEDICAID

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Webinar hosted by Georgetown University Center for Children and Families

June 21, 2021

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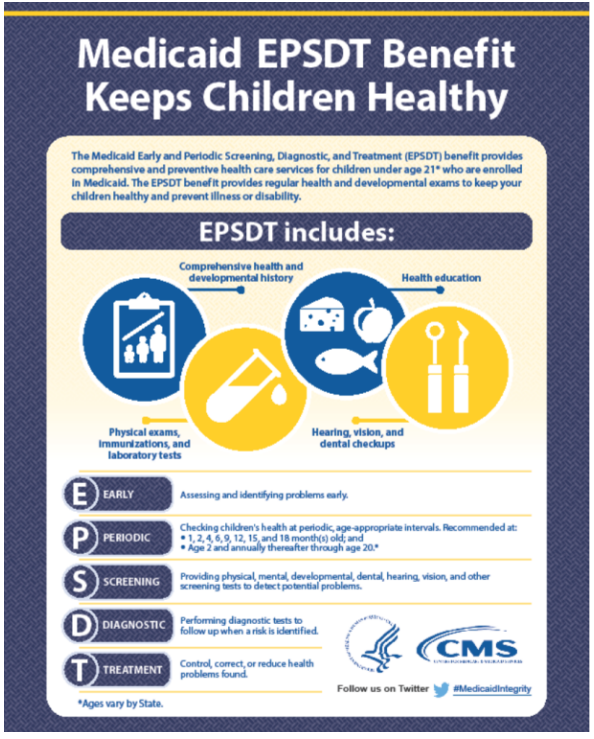
- Appreciation to Elisabeth Burak of the Georgetown University Center for Children and Families for her continued support of dissemination of this work.

Project Design

- **Phase 1** (January – June 2019)
  - Analyzed CMS 416 data for period 2009-2017
  - Conducted scan of documents
    - Review of publicly available state documents (e.g., provider manuals, websites, regulations, etc.)
    - Review of literature and reports (e.g., CMS, journal articles, media)
  - Interview key stakeholders
- **Phase 2** (July – December 2019)
  - Engaged 6 states to discuss opportunities and challenges
  - Updated analysis of state 416 data and vital statistics
- **Phase 3 – COVID era** (October – December 2020)
  - Updated review of state documents and literature
  - Scan of Medicaid managed care contracts database

Medicaid coverage and EPSDT benefit matters to infant health and survival

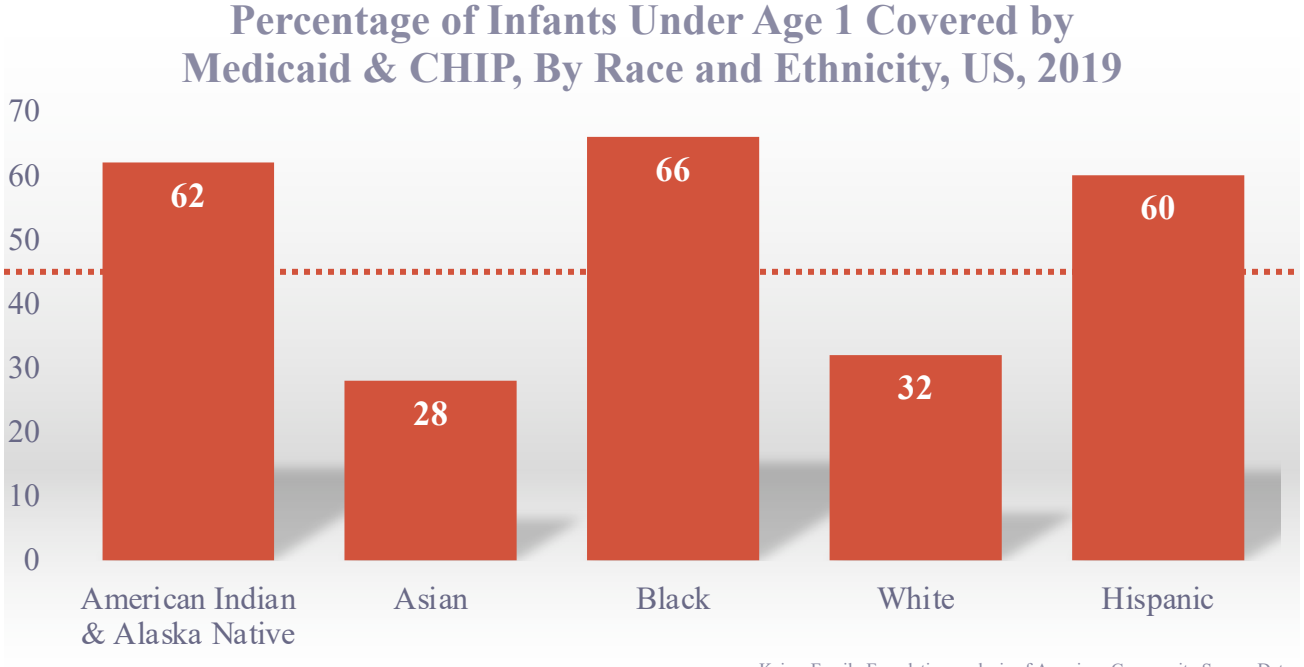


- AAP schedule calls for newborn visit in hospital and 6 more well-baby visits in the first year of life.
- Developmental screening due at 9-month well child visit.
- Newborn screening follow-up may depend on Medicaid coverage.
- Immunizations due at 5 well-baby visits.
- Maternal depression screening in well-baby visits.
- Infants are more likely to suffer from life threatening conditions (e.g., respiratory).

Source of infographic: US HHS Centers for Medicare and Medicaid Services (CMS).
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html and
http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf

Performance of Medicaid and CHIP Matter for Babies & Equity

- More than half of all babies—2.2 million infants enrolled in Medicaid.[1]
- 6 in10 Black, Indigenous, and Latinx infants.[2]
  (46% of total)



Kaiser Family Foundation analysis of American Community Survey Data.

Sources: 1. Johnson Group analysis of EPSDT 416 data from Centers for Medicare and Medicaid Services, 2018.
2. Artiga et al. *Medicaid Initiatives to Improve Maternal and Infant Health and Address Racial Disparities*. Kaiser Family Foundation, 2020.
Also see: Brooks & Gardner. *Snapshot of Children with Medicaid by Race and Ethnicity, 2018*. Georgetown University Center for Children and Families, 2020.

Deemed Infant Eligibility

- Since 1984, Medicaid law has required automatic newborn and continuous infant enrollment and changes in 2009 strengthened the law. [1,2,3,4,6,7]

- Since April 1, 2009, "*all newborns born to women covered by Medicaid for the child's birth…* [labor and delivery] *are now covered as mandatory categorically needy deemed infants*." CMS [5]

1. Deficit Reduction Act of 1984, P.L. No. 98-369;
2. Omnibus Budget Reconciliation Act of 1987, P.L. No. 100-203;
3. Omnibus Budget Reconciliation Act of 1990, P.L. No. 101-508;
4. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), P.L. No. 111-3
5. Deemed Newborn Eligibility (Section 435.117 and 457.360). SHO Letter 09-009 https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109b.pdf
6. MACPAC https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-deemed-newborns.pdf
7. Statute: 1902(e)(4) and 2112(e) Regulation: 42 C.F.R. §435.117

Current Federal Policy

- Nearly all newborns whose birth was financed by Medicaid or CHIP are deemed eligible until age 1. States are required to:
  - Provide coverage for newborns born to a woman covered by Medicaid for the birth.
  - Not require separate eligibility application and determination (i.e., "automatic").
  - Not use an income test
  - Not rule that infants must live with mother or mother remain eligible for Medicaid.
  - Use the mother's Medicaid identification number for up to a year and/or issue a separate number/card to the baby for mothers who lack a Medicaid number.
  - Not require proof of citizenship for the first year of an infant's life.
  - Continue infant eligibility until the first birthday unless the child dies, moves out of state, or a family requests voluntary disenrollment.
  - Conduct redetermination of eligibility and notify the family prior to first birthday.

Sources: Deemed Newborn Eligibility (42 CFR Sections 435.117 and 457.360). https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-sec457-353.pdf. SHO Letter 09-009 https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109b.pdf
Also see: 86382 Federal Register / Vol. 81, No. 230 / Wednesday, November 30, 2016
Also see: https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-deemed-newborns.pdf

CMS Form 416 Data

- Centers for Medicare and Medicaid Services (CMS) Form 416 for EPSDT data reported annually by states.
- States' reporting requirements include:
  - Total unduplicated number of individuals enrolled in Medicaid or M-CHIP and eligible for EPSDT services, by age (Line 1)
- In 2009-2010 eligibility rules for infants and EPSDT reporting procedures were both revised.
  - Line 1b was added to show the number of eligible and enrolled children who were eligible for at least 90 days.

Sample from CMS 416 Report, US, FFY 2018

Annual EPSDT Participation Report*
Form CMS-416 (National)
Fiscal Year: 2018

Description	Cat	Total	< 1	1-2	3-
1a. Total Individuals Eligible for EPSDT	CN	40,297,544	2,091,557	4,492,095	6,4
	MN	2,028,775	133,952	183,946	1
	Total	42,326,319	2,225,509	[illegible]	6,6
1b. Total Individuals Eligible for EPSDT for 90 Continuous Days	CN	38,107,699	1,586,720	4,289,433	6,1
	MN	1,896,014	121,644	170,566	1
	Total	40,003,713	1,708,364	[illegible]99	6,3
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN	4,174,351	28,375	234,197	4
	MN	5,542	6	128	
	Total	4,179,893	28,381	234,325	4

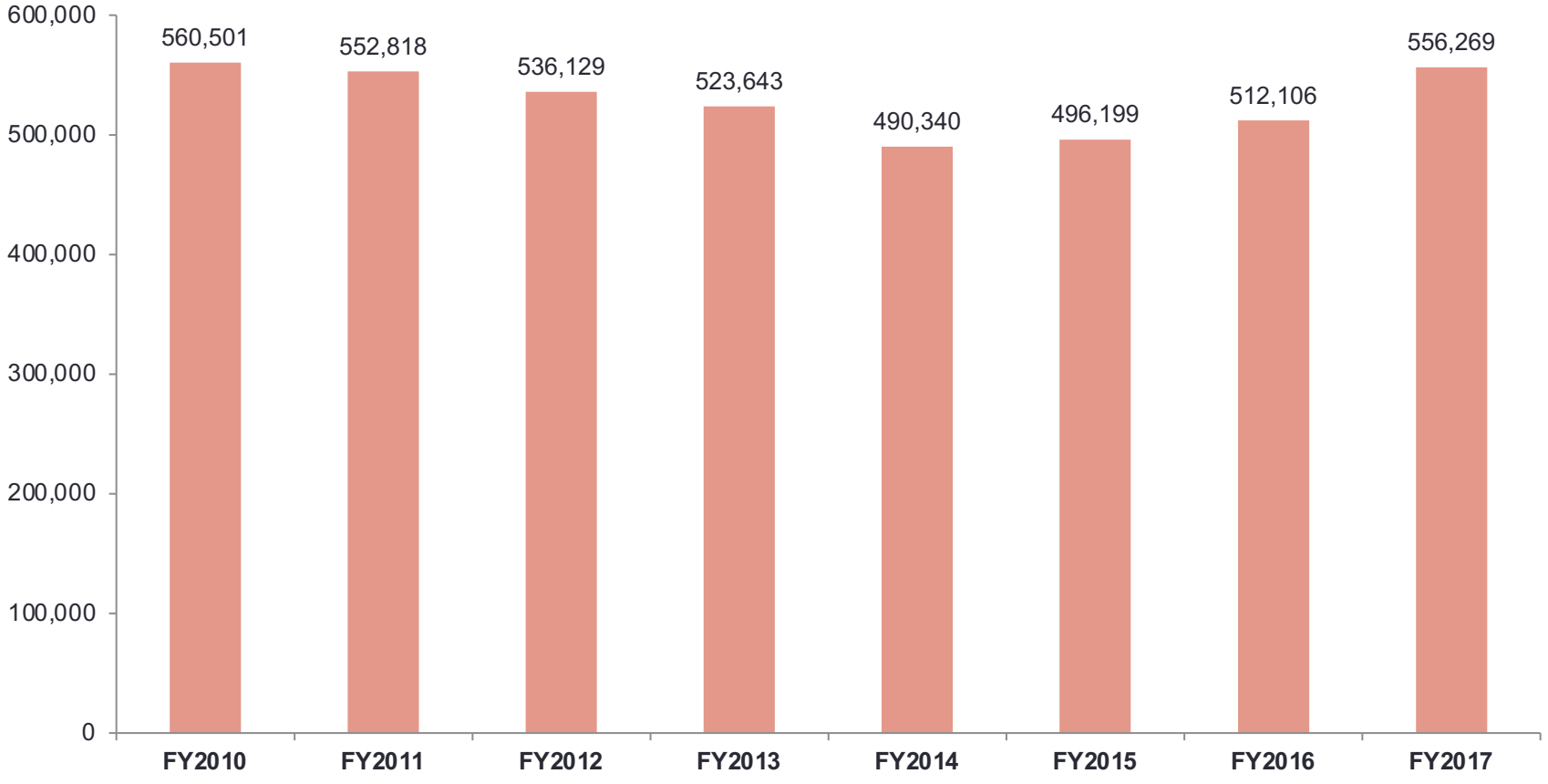
A long history of challenges with 416 data

- Performance goal of 80% for participation ratio set in 1990 rarely achieved by states.
- Quality assurance activities and oversight not routinely done by states or CMS.

- However, it is the only source of direct, comparable state information on Medicaid/EPSDT enrollment.

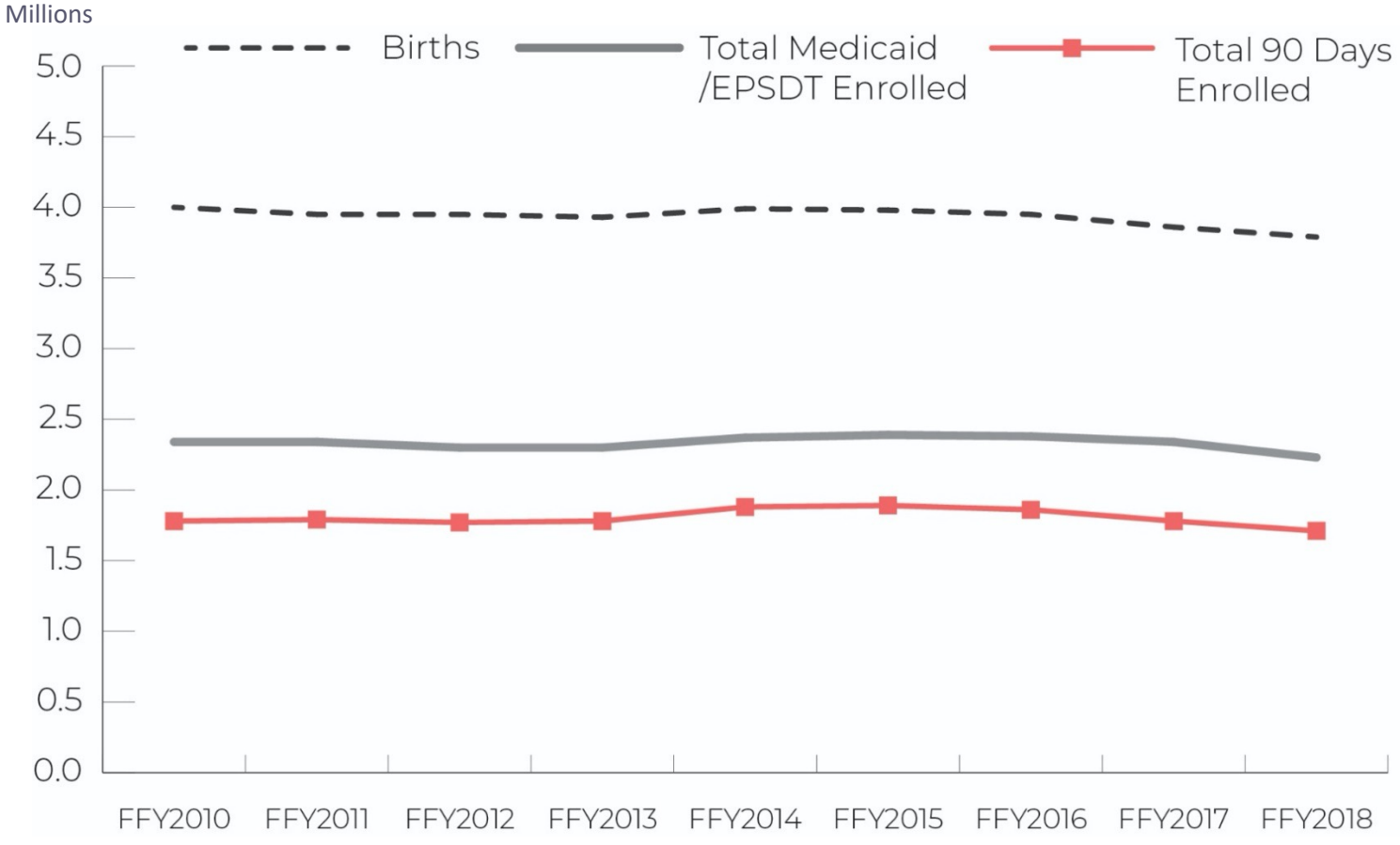
Find out more: US Government Accountability Office. *Medicaid: Additional CMS data and oversight needed to help ensure children receive recommended screenings*. GAO-19-481. August 2019. Also see: GAO-09-578. August 2009; and GAO-01-749. July 2001.

Number of Medicaid/EPSDT Infants Not Eligible 90 Days (Form 416 line 1a-1b), US, FFY 2010-2017

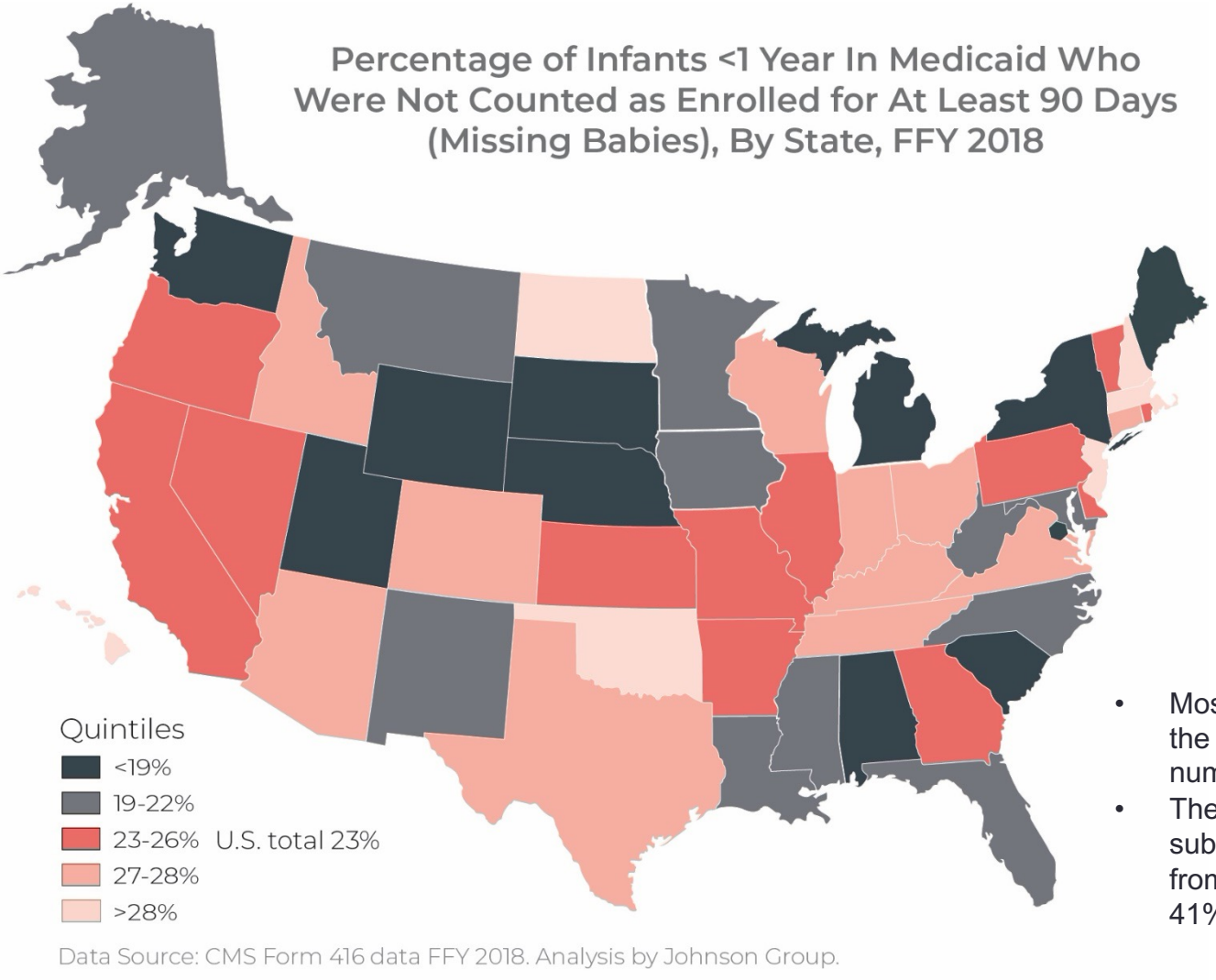


Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

Births, Infants in Medicaid, and Infants Counted 90 Days Continuously Eligible for EPSDT, US, 2010-2018



Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021



- Most states show a gap between the number of infants eligible and number continuously enrolled.
- The percentage varied substantially by state, ranging from a low of 6% to a high of 41% in FFY 2018.

Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

State Best Practices

Prenatal

- Inform during prenatal visits
- Preassign number for baby
- Give cards with preassigned numbers
- Use outstationed eligibility workers, navigators, home visitors and others to assist and inform families

Birth

- Inform family
- Notice of birth by providers or health plans
- Use mothers number until infant number / card received
- Provide tools for families and providers to verify enrollment
- Establish effective methods to auto-enroll, whether birth financed by managed care or fee-for-service

Infant

- Require no action by family before time of first birthday
- Use mothers number until infant number / card received
- Continue enrollment throughout year
- Use technology to flag when any infant is disenrolled
- Develop a data dashboard item for deemed infants

First birthday

- Inform and remind family prior to first birthday
- Conduct redetermination process automatically
- No wrong door approach (e.g., in person, online, email document submission)
- Conduct data quality reviews of CMS 416, T-MSIS, and other data

Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

State Action Related to Eligibility Rules & Protocols

- Aim to have every baby with a Medicaid/CHIP financed birth leave the birth facility with a card or printed document that shows eligibility number.
- Assure that state rules and regulations are aligned with federal law.
- Set up enrollment procedures that are streamlined and have check points.
- Include clear, specific language in Medicaid contracts with MCOs & ACOs.
- Develop specific procedures for women not enrolled in MCOs.
- Develop procedures for births to mothers with emergency labor and delivery coverage only.
- Use a State Plan Amendment (SPA) to adopt all options for coverage for CHIP financed births, and thereby expand automatic newborn coverage.

Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

State Action Related to Communication

- Clarify communications for providers and health plans (e.g., rules, guidance, provider manuals, websites, billing procedures).
- Clarify communications for families about Medicaid eligibility for infants (websites, benefits booklets, letters, etc.).
- Put information about deemed infants in **both** communications related to pregnancy and to children.
- Train and involve health navigators, outstationed eligibility workers, home visitors, staff in WIC programs, and others in the process.

Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

State Action Related to Data and Analysis

- Review CMS 416 data annually and improve quality.
- Use electronic systems for matching and verification of data (e.g., vital statistics).
- Use linked birth data and Medicaid data to assess the percentage of covered births, maternal and infant outcomes, and automatic and continuous infant enrollment.
- Use opportunities in the Transformed Medicaid Statistical Information System (T-MSIS).

Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

State Action Related to Aligning Maternal and Infant Eligibility

- Adopt Medicaid policies to extend Medicaid postpartum coverage for 12 months following the end of pregnancy.
- Set process for year of joint maternal and infant coverage.
- Increase focus on prenatally informing families.
- Use prenatal approaches for designating a Medicaid identification number to the infant, which can be quickly validated when the agency receives notice of the birth.

Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

Not so promising practices

- Out-of-date information on websites.
  - e.g., "infant must live with mother" (*incorrect*)
- Process run through managed care with no mechanisms for births paid on fee-for-service basis.
- Older fax form process with hospital.
- Requirements for family to report within 10-30-60 days for newborn to be eligible.
- Requirements for reapplication around time of first birthday to be filed in person.

Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

Conclusions

- The nation cannot afford to miss the opportunity to provide preventive and other needed health services to 500,000 babies.
- More action is needed by states to ensure automatic newborn and continuous infant (and maternal) enrollment.
- Use of promising practices can help.
- The first year of life sets a foundation for health and well-being; a time when both preventive care and early identification of special health needs are critical to ensure optimal health and developmental trajectories.

Source: Johnson K. *Missing Babies: Best Practices for Automatic and Continuous Enrollment in Medicaid and Access to EPSDT*. 2021

To download more content

Full Report

https://ccf.georgetown.edu/wp-content/uploads/2021/03/missing_babies_EPSDT_Medicaid_finalJan2021_Johnson.pdf

Executive summary

https://ccf.georgetown.edu/wp-content/uploads/2021/03/missing_babies_EPSDT_Medicaid_exec_summ_jan2021_final_Johnson.pdf

Georgetown Say Ahhh! blog

https://ccf.georgetown.edu/2021/03/10/too-many-babies-miss-out-on-medicaid-infant-coverage/

Health Affairs blog

https://www.healthaffairs.org/do/10.1377/hblog20191230.967912/full/

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES: PATH TO INCREASING NEWBORN ENROLLMENT AND DECREASING CHURN

Sarah Hatton

Deputy of Administration

Virginia's Background

- As of June 1, 2021, Virginia has 1,836,756 members in state health coverage
- Virginia provides coverage to the following pregnant individuals:
  - Individuals with income less than 143% FPL in Medicaid
  - Individuals with income less than 200% in CHIP (FAMIS MOMS)
  - Individuals who meet MN requirements
  - Note: Virginia is a CHIPRA 214 state and the postpartum period is 60 days
- Pregnant individuals are placed in managed care; managed care placement takes 30-60 days

Governor's Initiatives

On January 1, 2019, Virginia officially expanded Medicaid. As of June 1, 2021 Virginia has 555,193 members enrolled in expansion coverage

Virginia's Governor has announced several goals during his tenure, including reducing racial disparity, and combating maternal and infant mortality rates by 2025

As more individuals gain access to health coverage, Virginia has focused on enrolling as many individuals as possible and reducing churn within households

Virginia's Plan

Virginia has determined that in order to ensure newborns are enrolled and maintain enrollment, this starts with ensuring the pregnant individual and other family members have access to timely and quality care.

Virginia's Medicaid is processed through the VaCMS (Virginia Case Management System), managed by DMAS' sister agency Department of Social Services (DSS); Medicaid and FAMIS went live in this system 10/01/2013, and since DMAS and DSS have collaborated to enhance functionality and introduce several automated processes to serve both internal and external customers.

We continue to research and implement initiatives to expand access to health coverage and reduce churn by increasing the use of automated processes.

Path to Enrollment

Currently individuals can apply by phone, paper, on online

- Virginia's eligibility system has a self direct process which can automatically determine eligibility and enroll the pregnant individual

Children born to women eligible for Medicaid or FAMIS MOMS are reported by:

- Providers and managed care plans: while Virginia has an electronic process to report the birth, we still accept fax reports as well
- The mother: she can report the birth via phone to the Cover Virginia Call Center, her local Department of Social Services, or by reporting the birth online

Newborns are enrolled by either the newborn unit at Cover Virginia or the local Department of Social Services worker

- Deemed newborns receive birth month +2 managed care automatically under mom's plan

Progress to Date

- Virginia implemented an automated ex parte process in 2016; improvements made over several years post implementation have resulted in a 80% success rate for cases eligible for ex parte review
- In November of 2020, an automated re-evaluation process used for pregnant and foster care members was expanded to include individuals turning 19 and 65, as well as expansion individuals who gain Medicare (Note: while this process was put into the eligibility system, the functionality will not go live until after the end of the Public Health Emergency (PHE) due to the Maintenance of Effort (MOE)
- As of 01/01/2021 Virginia reduced processing timeframe for applications for pregnancy coverage from ten business days to seven calendar days
- On 04/01/2021 Virginia removed the 40 work quarter requirement, providing expanded coverage options for pregnant members after they reach the end of their postpartum period

Upcoming Initiatives

On 07/01/2021, Virginia will implement its Unborn Child option (FAMIS Prenatal Coverage or FAMIS PC); newborn processes will be different for this group however reporting methods stay the same

CMS is currently reviewing our CHIP 1115 Waiver Application to extend the postpartum period to 12 months for members not eligible for other full coverage post birth

In November of 2021, additional programming will be added to the automated re-evaluation batch for members turning 1

Looking at ways to automate newborn enrollment to combine the electronic, phone, and online reporting processes with a self direct process through the eligibility and enrollment systems

Virginia's Partnership with Managed Care Organizations

- Virginia holds weekly calls with managed care organizations (there are six in Virginia: Aetna, Anthem, Magellan, Optima, United, Virginia Premier) to discuss new initiatives and keep plans up to date on current affairs
- Plans meet with DMAS staff on a regular basis to discuss communication strategies (e.g. – messaging during the PHE and processes for new coverage such as FAMIS PC)
- Managed care organizations provide a live birth report which DMAS uses to match against newborn enrollment

Virginia's Collaboration with Agency Partners/Advocates

- DMAS collaborates with different stakeholders through groups such as the Children's Health Insurance Program Advisory Committee (CHIPAC), Project Connect, and directly with stakeholder groups such as Virginia Poverty Law Center and Virginia Health Care Foundation
- DMAS' Health Care Services holds monthly meetings with other state agencies, managed care plans, and other partners and advocates to discuss trends and solicit collaboration to meet the Healthy Birthday Virginia initiative
- Health Care Services also sends weekly resource emails to staff and advocates and a monthly newsletter highlighting accomplishments of the Maternal Health Stakeholder Engagement and Baby Steps VA groups

Questions and Thanks!

thank you!

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Cracking the Code on the Newborn Transition Issue in Missouri

June 2021

Background

Medicaid Advisory Group – anecdotes about newborns losing coverage at age 1

Enrollment decline data demonstrating 0-1 as a disproportionately affected age group

Started working with the state on this issue and realized some gaps in the process

Pre-Pandemic

- Worked with state to develop a process to address this issue
  - Every month run a report to identify 10 month olds on newborn coverage
  - Complete ex parte reviews – match to family case where possible
  - For those who can't be matched, begin contacting them – the state proposed mailing an application

Where We Are Now

- Additional ~30K children over 1 on newborn coverage
- Up to 15K kids at risk of losing coverage when the PHE ends
- Working with the department to reach these families early
  - Dedicating staff to look at these cases
  - Analyzing data to identify any geographic patterns
  - Engaging partners, including homevisiting, child care, pediatricians, hospitals, nurses, primary care, etc. in the effort
  - Using it as a model for outreach around annual renewals

Questions?

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What Advocates Can Do….

Tricia Brooks
June 21, 2021

Know the rules	Recruit partners	Ask for better data
Map out enrollment process	Review beneficiary communications	Examine eligibility policy manuals and websites
Pinpoint bottlenecks and problem areas	Identify best practices and potential solutions	Advocate for improvements and monitor trends

Identifying the Right People and Partners

- Your state's EPSDT coordinator
- Eligibility policy and systems experts (may not be the same)
- Eligibility workers
- State Medicaid data folks
- Medical care advisory committee
- Legislative champions
- Community health centers
- Pediatric providers
- Home visitors
- Managed care plans
- Maternal and child health coalitions
- Navigators and application assisters

Getting Better Data

- Number of births for specified period
- Unduplicated count of infant enrollment for same period in the following year
  - Deemed newborns vs new enrollees
- Number of infants disenrolled in same enrollment period by reason
  - Moved out of state
  - Voluntary request
  - Deceased
- Number of infants losing coverage at age 1 for procedural reasons (i.e. did not complete renewal)
- Average length of enrollment for infants
- Request that data be publicly available on a regular basis

Advocating for Improvement

- Look at Kay's promising practices to identify ways other states address the problems
- Make it simple for plans and providers to complete the enrollment (take burden off families)
- Ensure that families understand their infant's eligibility and what to do at renewal
- Monitor data to make sure that eligible one-year-olds transition for ongoing coverage
- Create an ongoing feedback loop

For More Information:

Medicaid Learning Lab (Session 3, Medicaid Eligibility and Enrollment):
https://ccf.georgetown.edu/2021/02/05/medicaid-learning-lab/

Website/Say Ahhh! blog ccf.georgetown.edu

Our Early Childhood work:
https://ccf.georgetown.edu/subtopic/early-childhood/

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