SPECIAL REPORT • REPORT NUMBER 22-14 • SEPTEMBER 2022

Medicaid Unwinding

Status of State Efforts to Prepare for the End of Continuous Coverage

Greg S. Griffin | State Auditor

Lisa Kieffer | Director

DOAA
Georgia Department
of Audits & Accounts

This page intentionally left blank

Performance Audit Division
Greg S. Griffin, State Auditor
Lisa Kieffer, Director

September 2022

Special Report: Medicaid Unwinding

State agencies are taking steps to prepare for the unwinding

What we found

Throughout the COVID-19 pandemic public health emergency (PHE), states have been required to suspend termination of coverage for individuals who are already enrolled or became enrolled in Medicaid. This "continuous coverage" will cease at the end of the PHE, beginning a 12-month period in which states must redetermine all enrollees' Medicaid eligibility (this is known as the "unwinding").

The Departments of Human Services (DHS) and Community Health (DCH), as well as the Office of State Administrative Hearings (OSAH), have developed strategies and already taken steps to facilitate a return to annual Medicaid renewals. The strategies are intended to increase the likelihood that eligible enrollees maintain coverage and that ineligible enrollees are transferred to the federal marketplace for other coverage options. These actions must be continually evaluated as the unwinding approaches and renewals begin.

A number of risk areas may contribute to the improper loss of Medicaid coverage for enrollees, including administrative barriers, enrollees not being contacted, enrollee confusion, staffing deficiencies, and inadequate management information and oversight. The unwinding strategies reported by DHS, DCH, and OSAH are intended to mitigate those risks. These strategies can generally be grouped into the four categories below.

Communications

DHS has taken steps to ensure Medicaid and PeachCare enrollees understand the unwinding and receive communications critical for maintaining coverage. The agency has already executed direct outreach campaigns through emails, text messages, robocalls, and a website to encourage enrollees to update their contact information and select email or text communications as a preferred method of receiving official notices.

DHS hired a public relations firm in summer 2022 to help develop a comprehensive communications plan. The plan includes a dedicated unwinding web page, unwinding logos and branding, informational videos, paid media, press releases, and materials available in multiple languages. Phase one is a continued focus on contact information and methods, while the second phase will focus on educating enrollees about their responsibilities once the unwinding begins.

Policies

DCH has requested waivers to assist with increased volume of anticipated work. Notably, waivers are expected to allow DHS to increase the use of ex parte renewals (administrative renewals that do not require information from enrollees). These waivers would provide DHS with greater flexibility to make renewal decisions based on third party data sources and use renewal information obtained for other benefit programs. Waivers will also allow DHS to send official notifications to enrollees based on the addresses provided by their care management organization (CMO) or the U.S. Postal Service. Finally, DCH has obtained a waiver allowing OSAH more than 90 days to perform any appeals of coverage termination decisions made by DHS.

Staffing

DHS is attempting to increase the number of eligibility workers who can be assigned to Medicaid and PeachCare cases. Through statewide job postings and participation in job fairs, the agency is attempting to hire approximately 500 additional eligibility caseworkers. The agency is also creating a specialized Medicaid renewal team through the reassignment of multiple supervisors and administrators and through the planned recruitment of 50 specialized caseworkers.

Both DHS and OSAH plan on utilizing temporary staff on an as needed basis. DHS has established a contract for temporary call center staffing, and OSAH plans to hire special administrative law judges if surges in hearings cannot be handled by current judges.

Technology/Automation

DHS plans to use robotic processing automation (bots) for certain unwinding-related tasks. Bots are expected to process multiple cases within minutes and generally improve processing efficiency. They can be used to automate several repetitive caseworker tasks, such as processing scanned or handwritten documents, pre-populating data from the customer portal, comparing information to third-party data interfaces, identifying red flags, and conducting certain administrative based renewals. Bots are also planned to populate some aspects of the OSAH fair hearing forms, which would otherwise be entered by DHS staff one case at a time. OSAH has also already begun utilizing an electronic case management system and unified hearing calendar to better schedule and plan hearings and communicate with outside agencies and enrollees.

DHS has already implemented a mobile-friendly website to allow enrollees to update contact information and upload document images directly through their mobile phone.

What we recommend

This report is intended to document the state's plans for the unwinding and does not contain recommendations associated with any particular risk or strategy. However, all three agencies must continue to evaluate their particular risks and refine planned strategies as the unwinding nears. Once renewals begin, the agencies must have sufficient information and management capacity to identify any problems that arise and resources and flexibility to address.

We provided a draft of the report to the agencies and made technical corrections based on their responses

Why we did this review

When the PHE comes to an end, states must reinstitute Medicaid and PeachCare renewals that were suspended in March 2020. An increase in program enrollment and the length of time since renewals were last performed will make it difficult for states to accurately complete all renewals within the required timeframes.

This report provides an overview of Georgia's preparation for the end of continuous coverage of the Medicaid and PeachCare benefits of approximately 2.6 million residents.

Table of Contents

Background 1

Medicaid Overview 1

Medicaid Eligibility Determinations 1

Public Health Emergency's Impact on Medicaid Policies 3

Public Health Emergency's Impact on Medicaid Enrollment 3

Unwinding: Return of Medicaid Renewals 4

Unwinding: Key Risks of Unwinding 5

Overview of Strategies to Address Key Risk Areas 7

Risk – Procedural/Administrative Barriers 8

Risk – Inability to Reach Enrollees 9

Risk – Consumer Confusion 11

Risk – Workforce Challenges 12

Risk – Timely Management Oversight 13

Risk – Transfers to Marketplace 14

Risk – Fair Hearings Volume 15

Appendix A – Objectives, Scope, and Methodology 17

This page intentionally left blank

Background

Medicaid Overview

Medicaid is a joint federal and state program that provides health coverage to low-income families and children, pregnant women, the elderly, and people with disabilities. The Georgia Department of Community Health (DCH) is charged with administering the Medicaid and PeachCare for Kids (PeachCare) programs, collectively known as Medical Assistance. PeachCare is Georgia's Children's Health Insurance Program (CHIP), which provides low-cost health coverage to uninsured children in families that earn too much income to qualify for Medicaid.

Eligibility for these programs is based on an applicant's financial situation and being one of the following:

- Pregnant;
- Responsible for a child 18 years of age or younger;
- Blind;
- Disabled, or has a family member in the household with a disability; or
- 65 years of age or older.

In federal fiscal year 2021, Georgia reported net expenditures of $12.4 billion for Medicaid and PeachCare. In June 2022, the programs provided health coverage to approximately 2.6 million Georgia residents.

Medicaid Eligibility Determinations

While DCH is ultimately responsible for Medicaid administration, the agency contracts with the Department of Human Services (DHS) to determine whether applicants are eligible for Medicaid or PeachCare. DHS operates the state's integrated eligibility system—Georgia Gateway—that is used for a number of social programs.[1] DHS Division of Family and Children Services (DFCS) caseworkers use information collected from applicants, as well as data collected from third-party sources, to make the following eligibility decisions:

- **Initial Determination** – Assessment at initial application as to whether the individual is eligible for Medicaid or PeachCare.

- **Redetermination** – Review of an existing enrollee's continued eligibility. Those that occur at regular intervals are known as renewals.[2] Both Medicaid and PeachCare generally require renewals every 12 months. Redeterminations may occur in the interim if the state is aware of a change in circumstances (e.g., moving out of state, marriage).

DHS attempts to conduct renewals by relying on data available through third-party sources (e.g., Georgia Department of Labor) and without contacting enrollees (called ex parte renewals). When sufficient information for a decision does not exist, DHS notifies the enrollee of the need to provide documentation. As shown in **Exhibit 1**, enrollees must submit the requested information by the end of the renewal month to prevent termination of coverage.

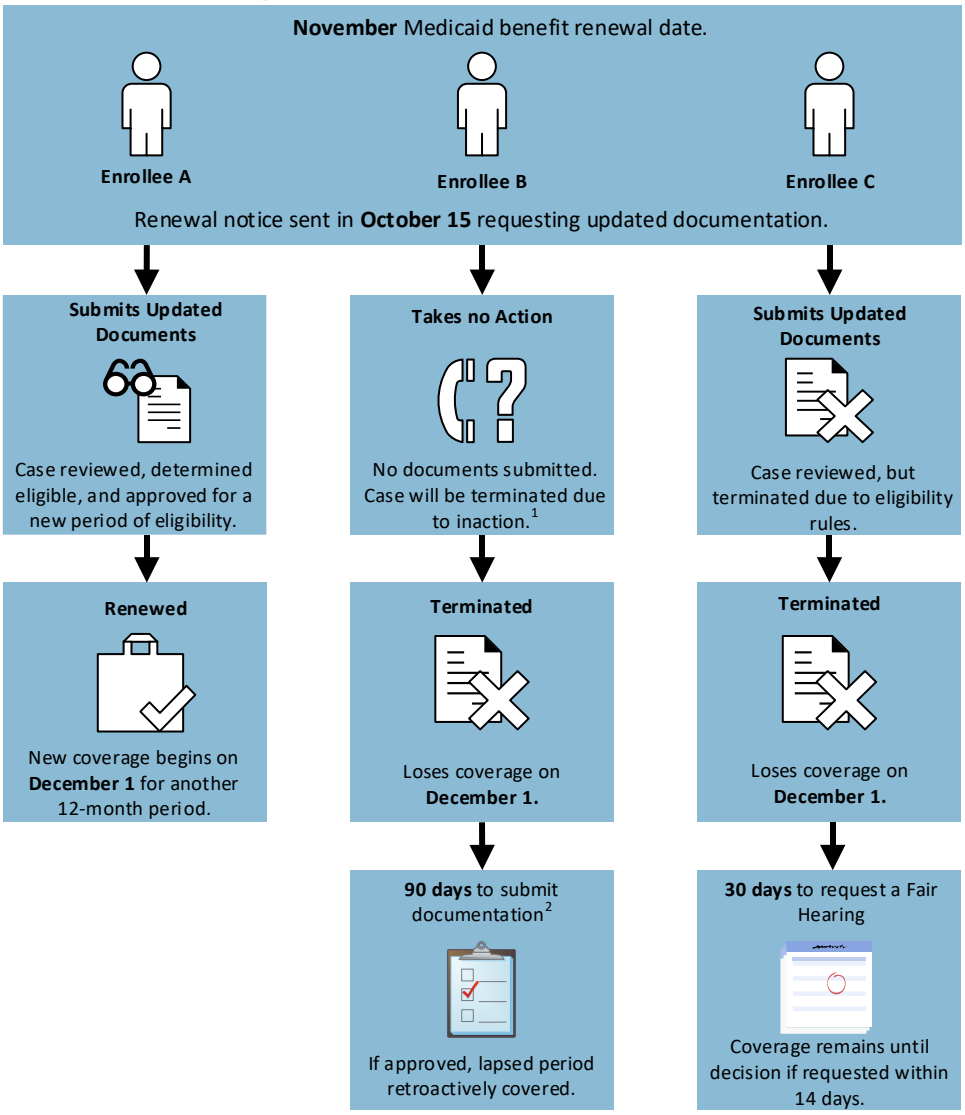
---

[1] In addition to Medicaid and PeachCare, these programs include Supplemental Nutrition Assistance Program (SNAP/Food Stamps), Temporary Assistance for Needy Families (TANF), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Childcare and Parent Services (CAPS), and Refugee Assistance.

[2] Medicaid clients may also receive benefits from other programs that have different renewal intervals. For example, federal regulations require a renewal of SNAP benefit eligibility every six months.

Exhibit 1

Renewals May Require Enrollees to Submit Documentation



[1] DHS sends a second renewal notice on the 12th of the renewal month if no action has been taken.
[2] The 90-day grace period does not apply to Qualified Medicare Beneficiaries (QMB). If the renewal is received after the period of eligibility has ended, it will be treated as an application.

Source: Centers for Medicare and Medicaid Services and Department of Human Services

If DHS determines that the enrollee is no longer eligible, the enrollee may appeal through the fair hearing process. If a hearing is requested within 14 days of the original decision, the enrollee may request that coverage continue until the final decision. If coverage is terminated because an enrollee failed to meet the original deadline, the enrollee loses coverage but is given another 90 days to submit the information and have the decision reconsidered.

Public Health Emergency's Impact on Medicaid[3] Policies

On January 31, 2020, the U.S. Secretary of Health and Human Services (HHS) declared that a public health emergency (PHE) exists as a result of the Novel Coronavirus that causes COVID-19. The PHE declaration can last up to 90 days before the secretary must extend it if its basis continues to exist.

In response to the pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA) in March 2020. Among its many provisions, the act made a number of temporary changes to Medicaid and CHIP programs. It provided states and territories with a temporary 6.2% increase in the Federal Medical Assistance Percentage (FMAP) for the PHE period (January 2020 to end of the quarter the PHE ends). To qualify for this FMAP increase, states must meet certain conditions through the end of the month in which the PHE ends. These include the following:[4]

- **No Terminations (Continuous Coverage)** – Do not terminate individuals from Medicaid who were already enrolled or became enrolled during the PHE. The only exceptions are for those who are deceased or incarcerated, voluntarily terminate, or no longer reside in the state.
- **Maintain Eligibility Requirements** – Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (maintenance of effort requirement).
- **No Premium Increases** – Do not charge premiums that exceed those that were in place as of January 1, 2020.
- **COVID-19 Provisions** – Cover testing, services, and treatments related to COVID-19 without imposing cost sharing on members. Services include vaccines, equipment, and therapies.

In addition to the changes allowed by federal law, the Centers for Medicare and Medicaid Services (CMS) provided states additional flexibility through waivers. These waivers allowed DHS and DCH to make the following changes:

- **No PeachCare Premiums** – Premiums for PeachCare were suspended instead of simply freezing at the current level.
- **Self-Attestation** – Instead of requiring third-party verifications, client statements and self-attestations could be used as acceptable verifications.
- **Email Documentation** – Email attachments instead of faxes could be accepted as secure for certain documents needed for verification.
- **Income Calculation** – Pandemic stimulus payments and pandemic unemployment compensation could not be used in client income calculations.

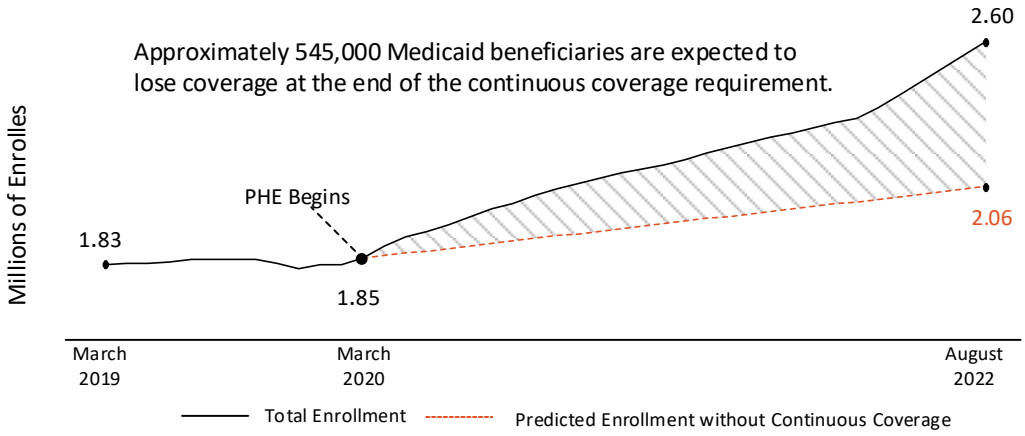
Public Health Emergency's Impact on Medicaid Enrollment

The continuous coverage requirement has contributed to a significant increase in Medicaid enrollment. In the 12 months prior to the pandemic, Georgia enrollment was relatively stable, averaging a total of 1.84 million enrollees each month. As shown in **Exhibit 2** on page 4, since the implementation of the continuous coverage requirement, Medicaid and PeachCare enrollment has increased by an average of approximately 25,000 enrollees per month. As of July 2022, total enrollment has grown to nearly 2.6 million, an increase of more than 41% since the beginning of the PHE.

---

[3] In this report, the term 'Medicaid' refers to both Medicaid and PeachCare for Kids.
[4] The enactment of the federal PHE also expanded a variety of Medicaid benefits including expanded telehealth options.

Exhibit 2
Medicaid Enrollment Has Grown More than 40% During the PHE



Source: Department of Community Health and Department of Human Services

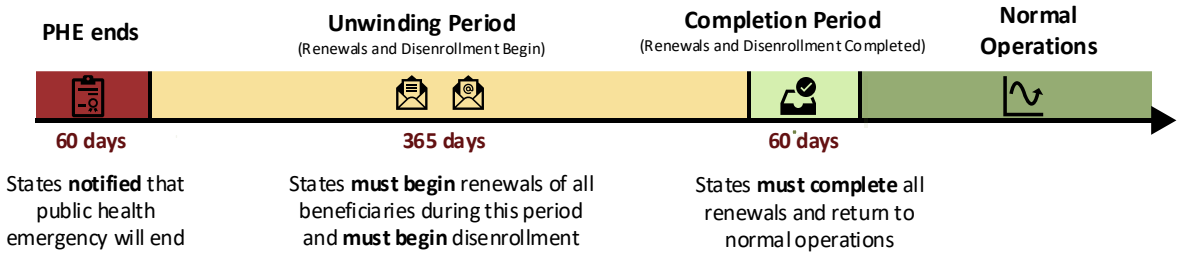
The DHS Gateway vendor estimates that when the continuous coverage requirement is removed at the end of the PHE, approximately 545,000 enrollees will no longer be eligible for Medicaid and would lose their health coverage in the year after the PHE.

Unwinding: Return of Medicaid Renewals

The return to pre-PHE Medicaid eligibility policies, commonly referred to as Medicaid "unwinding," will begin when the HHS Secretary declares an end to the federal PHE or does not extend it for another 90 days. In January 2021, HHS announced it would provide states with a 60-day advanced notice of the PHE's end.

The most notable consequence of the PHE's end will be the reinstitution of the Medicaid renewal process.[5] As shown in **Exhibit 3**, states must begin all renewals within 12 months of the PHE's end. States may begin this process when HHS provides the 60-day notice, but they may not remove members from Medicaid rolls until the month after the PHE ends. All renewals must be completed (i. e., decision made) within 60 days of the end of that one-year period.

Exhibit 3
Georgia Has 14 Months to Complete All Renewals



Source: Centers for Medicare and Medicaid Services documents

[5] *DHS conducted redeterminations during the PHE if it was reported that the client died, moved out of state, was incarcerated, or requested the coverage to end.*

Although HHS has not yet provided a notice of the PHE's end, states have begun preparing for the unwinding. In addition to the requirement that continuous coverage ends and renewals begin, CMS has announced other requirements that must be met by state Medicaid programs, and it has issued guidance intended to assist states with the unique challenges posed by the unwinding. Significant requirements and suggested procedures include the following:

- **Develop Unwinding Plan –** States will be required to create and implement an unwinding operational plan. These plans should demonstrate how states will handle eligibility determinations and renewals to reduce errors in both benefit determinations and inappropriate terminations that result in loss of coverage. Plans may include many of the items below but are likely to include other components, such as communication plans.
- **Develop Risk-Based Strategy –** States must develop a risk-based approach when prioritizing eligibility determination and enrollment tasks. CMS guidance suggests four options: prioritizing specific client populations, prioritizing renewals that have been pending the longest (i.e., originally due in April 2020), a hybrid of those two approaches, or a state specific plan. Because CMS guidance suggests that a state complete no more than one-ninth of the renewal caseload in a single month, states will also need to develop a renewal distribution schedule.
- **Align Renewal Dates with Other Benefit Programs –** While states may not shorten coverage to less than 12 months, CMS suggests that they align renewal dates for Medicaid recipients who are also on other social programs, such as SNAP.
- **Permit Targeted Enrollment Procedures –** CMS will allow additional Section 1902(e)(14)(A)[6] waivers to temporarily permit:
  - Reliance on SNAP data for renewals;
  - Ex parte renewals[7] if verification shows that the member had no income in the last 12 months and no assets;
  - Contact information provided by care management organizations (CMOs); and
  - Extension of fair hearing timeframes.
- **Submit Additional Data to CMS –** CMS will require noncompliant states to submit additional data to monitor progress related to enrollment and eligibility determinations, as well as potential corrective action plans.

Unwinding: Key Risks of Unwinding

CMS guidance includes a readiness assessment tool that allows states to self-assess their preparedness level for the return to normal Medicaid operations. The assessment tool identifies a number of risks to the proper assessment of continued Medicaid coverage for members (**Exhibit 4**).

[6] *Section 1902(e)(14)(A) of the Social Security Acts allows for waivers "as are necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries."*

[7] *Ex parte renewals, sometimes called automated or administrative renewals, allow renewal of benefits without the Medicaid enrollee completing documentation. A requirement under the Affordable Care Act, this type of renewal can be done using electronic data interfaces that provide DHS with reliable eligibility-related data, eliminating the need for the enrollee to submit information.*

Exhibit 4
Key Risks of Medicaid Unwinding

Risk	Description
Procedural/Administrative Barriers	Procedural or administrative processes create challenges for eligible individuals to maintain coverage
Inability to Reach Enrollees	State is unable to contact individuals to obtain information needed for the renewal process
Consumer Confusion	Consumer confusion about the steps and critical deadlines to retain coverage
Workforce Challenges	Insufficient and over-burdened workforce to resolve pending eligibility and enrollment actions and complete routine work
Timely Management Oversight	Lack of timely information to conduct appropriate oversight and course correct as issues arise
Transfers to Marketplace	Gaps in coverage for individuals who are no longer eligible for Medicaid or PeachCare
Fair Hearings Volume	Inability to process fair hearings timely due to a high volume of requests

Source: Centers for Medicare and Medicaid Services

Overview of Strategies to Address Key Risk Areas

While the federal government has not announced the end of the PHE, states will need to prepare to reinstitute renewals due to the end of continuous coverage. CMS mandates some strategies (e.g., a written unwinding plan), but states are largely responsible for determining what actions are necessary to ensure a successful unwinding.

The sections below provide an overview of Georgia's strategies to mitigate the risks noted in **Exhibit 4** on page 6. Some strategies are practices or actions were already established, but many have been recently implemented or remain in planning stages. DCH is ultimately responsible for Medicaid administration, but many of the strategies will be implemented by DHS staff. The Office of State Administrative Hearings (OSAH) also plays a vital role.

Across the risk areas, the strategies generally fall into four categories:

- **Communications** – DHS is utilizing multiple communication methods to encourage enrollees to update their contact information. It will later educate enrollees on additional steps necessary to maintain eligibility. The success of the unwinding will be significantly impacted by the effectiveness of these communications.

- **State Policies** – DCH has requested waivers from CMS for a number of purposes, including allowing the use of additional data sources to contact enrollees and alternate methods to facilitate renewal decisions (likely in favor of continued eligibility). In some cases, Georgia already has renewal policies consistent with CMS suggestions.

- **Staffing** – Among the strategies planned to address the significant increase in caseload, DHS is attempting to hire hundreds of additional staff and is creating a specialized unit for more complex renewal decisions. It is also planning new training, which is especially important because no caseworker hired in the last 2.5 years has conducted a Medicaid renewal.

- **Technology** – DHS has a number of recent and planned technology enhancements to assist with Medicaid renewals. These include a mobile app that allows enrollees to update information and upload documentation, robotic process automation (bots) that will perform certain tasks for caseworkers, and enhancements in usability of Georgia Gateway.

Our review is primarily a documentation of the state's plan for the unwinding; however, planned strategies do not guarantee successful implementation. DCH, DHS, and OSAH will need to continue to evaluate the risks they are facing and refine strategies as the unwinding nears. Once renewals begin, the agencies must have sufficient information and management capacity to identify any problems that arise, as well as the resources and flexibility to address.

Risk – Procedural/Administrative Barriers

While it is ultimately the responsibility of individuals to provide information necessary to maintain Medicaid coverage, states have a responsibility to ensure the process does not present unnecessary administrative challenges to its members. Potential delays in mail service, changes to contact information, and confusion about enrollee responsibilities can lead to the temporary loss of coverage during the renewal period for eligible individuals. This temporary loss of Medicaid coverage (churn) is a common, national occurrence that may cause barriers to healthcare and additional administrative costs to the state.

DHS and DCH are using a number of strategies to address potential administrative barriers to Medicaid renewals, many of which have been suggested by CMS.

- **Increase Ex Parte Renewals**[8] – Ex parte renewals require no action on the part of enrollees; therefore, they reduce the likelihood of terminations due to missed correspondence or paperwork delays. Increasing ex parte renewals is one method to reduce coverage loss by eligible individuals. DHS is implementing the following actions to enhance its use of ex parte renewals:
    - **Renewal Realignment –** DCH has requested a Medicaid waiver to allow Medicaid renewals for individuals based on their SNAP or TANF renewals. In these cases, the Medicaid renewal date will be aligned with the SNAP/TANF dates, and the data collected for those programs will be used to make the Medicaid renewal decision.
    - **No Income or Assets Documents –** DCH has requested waivers to permit renewals for households who attested to no income increases within the last 12 months if data sources do not identify income above the limit at the time of Medicaid renewal. A waiver would also permit ex parte renewals if no asset verification data is returned to the state within 12 days. This allows the state to assume no change in resources.
    - **Use of Bots –** DHS reports that caseworkers use a hierarchy of data sources when attempting to make an ex parte renewal. The agency plans to use bots to automate a portion of this verification work performed by caseworkers. Staff stated the bots can process multiple cases within minutes and will further streamline the process.

      A "bot" is a computer program that performs automatic repetitive tasks.
- **Streamline Processes for Those Not Completed Ex Parte –** Not all renewals can be completed without the enrollee providing information to DHS. In these cases, DHS notifies the enrollee to provide certain information to the agency by a specified date to continue coverage. The following actions are intended to streamline the process:
    - **Multiple Methods to Provide Information –** Enrollees can provide requested information through a number of methods, including Georgia Gateway, phone, mail, or in person. DHS recently created a mobile phone website that allows enrollees to submit documents. The mobile site will also allow enrollees to view notices and update their account information. Finally, DHS has begun to re-open nearly all offices across the state, allowing enrollees to provide renewal information and submit documentation in person.

[8] *Ex parte are considered "no touch" renewals because they do not require that caseworkers contact, or obtain documentation from, the enrollees. However, caseworkers do perform work to verify that the enrollee is still eligible, typically using verification source documents from third parties, such as wage information from the Georgia Department of Labor.*

- **Specialized Unit** – As part of its workforce strategy, DHS is creating a specialized Medicaid renewal unit to assist with complex renewals. It is currently recruiting for 50 caseworkers and will be transferring several supervisors and administrators (see page 12).

- **Pre-populated Forms** – Federal regulations require that DHS pre-populate renewal forms sent to most enrollees with information already known by the agency. DHS officials stated that the relevant form is pre-populated if mailed to the enrollee or if obtained when logging into Georgia Gateway. Pre-populated forms eliminate the need for enrollees to track down information and documentation already in DHS possession, which increases the likelihood of a timely response for information.

- **Information System Improvements** – DHS is in the process of modifying Georgia Gateway to allow the agency to align Medicaid renewals with SNAP or TANF renewals for those with benefits from multiple programs. The system changes will also include distributing the renewal workload more evenly over the 12-month unwinding, as discussed in more detail on page 12.

- **Extension of Benefits Beyond Termination –** Georgia already extends the benefits of those who are denied at renewal if the request for a fair hearing and continued benefits is received within 14 days of decision notification. Georgia also provides the required 90-day reconsideration period after coverage ends. During this time, an individual can provide documentation needed to have coverage reinstated.

- **Preparation for Renewal Notice Mailings –** DHS officials stated that they have regular meetings with the Georgia Technology Authority (GTA), which contracts with and manages the agency's mail notice vendors. DHS is monitoring expected renewal notice volume and sharing that information and any anticipated concerns with GTA. GTA is expected to work with the vendors to ensure adequate capacity and timeliness once the PHE ends.

Risk – Inability to Reach Enrollees

During the renewal process, enrollees must provide documentation to DHS to ensure continuation of coverage. DHS sends enrollees requests for the information as their renewal deadlines approach; however, correspondence likely will not reach enrollees if they have not updated their address in Gateway. The risk is particularly heightened because the Medicaid population is relatively transient with less stable housing, and some Medicaid enrollees may have had no contact with DHS since the beginning of the PHE (March 2020). Without a current address or contact method, individuals who are otherwise eligible may lose coverage if they fail to provide the required evidence of eligibility. DHS would incur additional processing time if individuals who lost coverage file a new application.

DHS has taken several steps to ensure they have the most up-to-date client contact information.

- **Communications Plan** – DHS has developed an unwinding communications plan, with phase one focused on encouraging enrollees to update their contact information and select electronic options (e.g., email, phone) as their preferred means of communications. This allows DHS to not only save on paper communications and postage, but also maintain a consistent method of communication even if enrollees relocate their physical address. The first phase of the campaign will last until the end of the PHE, at which time the focus will shift to educating enrollees on the impact of the unwinding.

DHS began delivering this message in the spring of 2022, but the campaign was expanded when the agency hired a public relations firm in the summer. The firm developed a campaign that includes branding, timelines, and multiple methods of communications, including the following:

- **Direct Outreach to Enrollees –** DHS began direct outreach to current Medicaid enrollees through text messages, emails, and robocalls prior to development of the final communications plan. Messages were also placed on Georgia Gateway, the system used by applicants and enrollees. While these messages have not been specifically related to benefits renewal or the end of the PHE, they request that the recipients provide updated information that will be needed by the agency for a successful unwinding.

- **Unwinding Website** – In May 2022, DHS created an unwinding resource page on its website. The page is linked from the agency's main page and contains recent press releases and a new unwinding planning document. The communications plan included the development of a website, recently launched at staycovered.ga.gov, which includes additional unwinding information for enrollees and providers.

- **Multimedia** – In addition to direct outreach to enrollees, the communications plan includes use of a variety of other means, including social media, paid media such as billboards and television ads, press releases, and media interviews.

- **Providers and Other Stakeholders** – DCH indicated that it has informed provider groups of why it is important that enrollees update their contact information with the state. DHS plans to work with advocacy organizations and other stakeholder groups.

- **Use of Third-Party Databases** – DCH has submitted waiver requests to CMS that would allow use of data from the National Change of Address database (NCOA) and contact information that enrollees provide to the state's CMOs.[9] Although DCH already has access to CMO data, it does not have the authority to provide the information to DHS. The waiver is expected to be approved. DHS officials did not have a definitive plan regarding use of the data but stated that it could be used to proactively confirm and correct addresses prior to sending mail related to the renewal process. The data could also be used to correct addresses for returned mail.

- **Cash Assistance Plan** – In August 2022, the Governor's Office announced a plan to provide up to $350 cash assistance to those enrolled in Medicaid, SNAP, or TANF on July 31, 2022. Potential recipients are encouraged to verify or add their email address in Georgia Gateway, which will be the source of cash assistance plan information. While not officially part of the unwinding plan, it is expected this will result in improved contact information.

- **Reopening Field Offices –** DHS has begun reopening DFCS field offices in all counties,[10] enabling enrollees to speak with caseworkers in person. Approximately 50 offices were open by the summer of 2022, and an additional 108 offices will open between August and November 2022 (the offices will have limited business hours). The offices provide enrollees (and applicants) with an additional avenue to contact the agency and an additional method for the agency to obtain updated contact information from individuals.

---

[9] As the direct insurers of certain Medicaid enrollees (pregnant women, caretakers of children), CMOs have more frequent interaction with these populations than DHS.

[10] The office in Tattnall County is currently closed for renovations performed by the county. The county will determine when DHS can move into the new space but has estimated the space would be ready in fall 2022.

Risk – Consumer Confusion

Due to the suspension of renewals, some Medicaid enrollees may have had little contact with DHS eligibility officials during the PHE (and those who enrolled during the PHE have never experienced a renewal). However, once the PHE ends, many enrollees will need to provide information to DHS to retain coverage. Confusion regarding their responsibility can contribute to loss of coverage and, as previously noted, increased administrative workload associated with reconsiderations of terminations or requests for fair hearings.

DHS is addressing the potential for enrollee confusion in the following ways:

- **Communications Plan –** DHS communications will focus on education and awareness of enrollee responsibilities once the PHE ends. This phase two of the communications strategy will use many of the same methods noted on page 10, including the unwinding website, paid media, press releases, and third-party organizations that can distribute instructional materials to their members. The communications will include the production of FAQs and informational videos, and the materials will be available in multiple languages.

- **Centralized Call Center –** DHS is reviewing its temporary staffing needs to meet the volume of anticipated unwinding calls that will be made to the call center (see page 13). The agency is also reviewing potential modifications to its interactive voice response system. Depending on the complexity of a caller's needs, information may be provided by the system or an operator.

- **Additional Notification Methods** – DHS issued a procurement solicitation in August 2022 for a technology solution that will, among other things, provide "proactive formal and informal notice functionality" to assist with the Medicaid redetermination process.

- **Reopening Field Offices –** As noted above, DHS has begun reopening DFCS field offices across the state. Enrollees with questions not addressed by other sources can meet with caseworkers by appointment.

CMS officials point to the revision of renewal notices as one method to improve consumer confusion and limit coverage loss. CMS suggests that states limit the forms to key messages with simple, clear language, clear instructions, and envelopes that indicate the presence of important, time-sensitive information.

DHS officials have not modified existing renewal forms and notices, citing the time necessary to obtain CMS approval for any changes, the programming requirements for Gateway, and the planned use of other methods to improve communications with enrollees. Two items cited above—the communications plan and notification improvement plan—are expected to mitigate confusion that might occur with a legal notification document.

Risk – Workforce Challenges

A sufficient number of well-trained staff is important to ensuring that Medicaid applications and benefit renewals are processed in a timely manner. When the unwinding begins, the significantly increased workload could overwhelm a state's eligibility caseworkers, leading to low staff morale, delayed determinations of applicant eligibility, and federal compliance issues. The unwinding is also expected to increase the work associated with Medicaid programs' mail rooms and call centers.

DHS has developed several strategies to handle workforce issues created by the unwinding.

- **Hiring Additional Eligibility Staff –** DHS is attempting to increase the number of eligibility workers who can be assigned to Medicaid cases. Through statewide job postings and participation in job fairs, the agency is attempting to hire approximately 500 permanent additional eligibility caseworkers.

  According to DHS, fewer than 900 workers could process a Medicaid case during its most recent staff count, compared to 1,200 to 1,300 with the ability prior to the pandemic. While Medicaid workloads are lower now due to the suspension of renewals, the workload will significantly increase once the unwinding begins. DHS estimates monthly renewals will total 90,000 during the unwinding, compared to approximately 60,000 prior to the PHE.

  The limits of a direct comparison of workload to caseworker counts over time should be noted. Changes in processes and technology (e.g., increased ex parte renewals, greater use of bots) are intended to achieve improved efficiency in processing. As such, the increase in workload should not require an equal increase in employees.

- **Use of Overtime –** If authorized by the Governor's Office of Planning and Budget (OPB), DHS may use additional overtime during the unwinding. DHS officials stated they have had both mandatory and voluntary overtime for eligibility staff in the past.

- **Specialized Unit for Renewals –** Currently, specialized units within DHS perform a variety of specific eligibility and enrollment tasks. Instead of being general eligibility specialists, these teams focus on specific classes of assistance or eligibility processes. To manage the increased workload during the unwinding, DHS is creating a new, statewide Medicaid renewal team. Multiple supervisors and administrators have already been reassigned to the unit, and recruiting for 50 caseworkers has begun. These teams will be deployed for surge capacity and equipped to handle complex cases.

- **Renewal Date Distribution –** DHS will distribute the renewal workload as evenly as practical over the course of the unwinding period, rather than expecting caseworkers to conduct renewals as soon as possible. This strategy is not only beneficial for the workforce during the unwinding, but it will also prevent a future "renewal bulge" with a significant number of renewals due in some months and few due in others. As previously discussed, DHS will align Medicaid renewals with the SNAP or TANF renewals for enrollees who have multiple benefits. It will then distribute the remaining members across the 12-month unwinding period.

- **Automating Certain Caseworker Activities –** DHS has been restructuring certain repetitive caseworker activities through robotic processing automation, known as bots. Bots enable caseworkers to spend less time on applications and renewals, eliminating significant manual review and allowing more cases to be processed each day. DHS has primarily used bots

in other benefit programs, such as TANF and SNAP; however, officials stated that bots will be repurposed or created to assist with Medicaid unwinding tasks. (DHS recently presented its use of bots at a national conference and provided demonstrations to CMS as part of a state technical collaborative.) Examples of tasks for new and planned bots include:

  - Conducting administrative renewals for certain Medicaid enrollees who have been approved to receive SNAP or TANF benefits;
  - Pre-populating data from the customer portal, identifying red flags, providing links to policies, and comparing information to third-party data interfaces; and
  - Processing scanned or handwritten documents.

- **Additional Caseworker Training –** DHS plans to train existing DFCS caseworkers in how to perform a Medicaid renewal. Throughout the length of the PHE, no DFCS caseworker has had to perform a Medicaid renewal because of the continuous coverage requirement, necessitating the need to train new staff and retrain more experienced staff. Due to high staff turnover, DHS has a significant number of newer staff who have not performed Medicaid eligibility renewals.

  DHS has also received a waiver from the Department of Administrative Services that will allow it to more quickly cross-train eligibility staff in a second program, such as Medicaid. Prior to the September 2022 waiver, caseworkers were trained on a single program (e.g., TANF, SNAP) for their first year of employment. That period has been shortened to six months, providing greater flexibility and capacity for DHS, as well as more rapid advancement for staff.

- **Contracted Call Center Staff –** DHS expects a large increase in the use of its customer call center during the unwinding but anticipates managing this increase through the use of temporary contractors. Although Medicaid eligibility determinations are only performed by permanent staff, temporary staff can be employed to work at call centers. DHS has already established a contract for temporary call center staffing, which it utilized during the temporary P-SNAP and P-TANF programs created by the federal government earlier in the PHE. During those programs, DHS was able to reduce contractors as the calls decreased over time.

Risk – Timely Management Oversight

Proper management oversight requires timely information about relevant outputs, outcomes, and processes. Medicaid eligibility can be a complex process with consequences for applicants' access to healthcare. Without proper oversight, employees unable to complete assigned caseloads may fall behind, or thousands of enrollees may not receive proper notifications due to an information system error. During the unwinding, risks are increased due to the higher number of enrollees whose continued coverage is dependent on proper renewal decisions.

DHS currently has in place, or plans to implement, the strategies below to ensure sufficient and timely oversight during the unwinding.

- **Existing Workload Monitoring –** DHS has a combination of specialized reports and monitoring dashboards created either within the Georgia Gateway eligibility system or by a DHS reporting team. A tracking system allows management to monitor employee workloads and

deadlines and make real-time reassignments of work. Eligibility determinations, verification of change in status, and renewals of existing benefits may be assigned to any available and trained caseworker in the state.

- **Additional Reporting** – DHS officials stated that additional reports and dashboards for leadership are being created as a result of the unwinding and the new technology used by the agency. The use of bots for case-level tasks necessitates the need for new reports to track their efficiency.

  Agency officials also pointed to management needs and CMS requirements that additional measures, such as the percentage of renewals resulting in coverage determinations, be captured in future reports. Officials indicated that reports will be created to identify an unusually high portion of renewals that result in coverage terminations. This type of reporting can warn management of a potential problem with the renewal process that should be investigated.

- **Unwinding Management Team** – Officials from DCH, DHS, OPB, the Office of Health Strategy and Coordination, and the Governor's Office meet each week to discuss preparations for the unwinding. The meetings are planned to continue until the end of the unwinding.

- **Use of Automation –** DHS officials stated that bots will not only assist caseworkers with eligibility tasks but may also be used by management to assist with reporting and testing system performance and functionality.

Risk – Transfers to Marketplace

When states determine that an individual is ineligible for Medicaid, they must facilitate a seamless transition to a qualified health plan in a state-based or federal-based marketplace. The transition includes transferring account information to the marketplace, as well as notifying the individual of the transfer and the next steps in their process of obtaining health coverage.[11] For enrollees who are deemed ineligible for continued Medicaid coverage, the transfer and communication must occur prior to the termination of Medicaid benefits to prevent a gap in health coverage.

A qualified health plan is insurance plan that meets the Affordable Care Act requirement for minimum essential coverage.

Some DHS activities will impact the likelihood of gaps resulting from the transition, including the following:

- **Obtaining Up-to-Date Information** – As previously noted, DHS is taking several steps to encourage enrollees to provide updated addresses and other contact information. If an individual is determined to no longer qualify for Medicaid benefits, up-to-date information would be needed to facilitate a successful transition to the marketplace.

- **Data Transfer to the Federal Marketplace** – DHS officials indicated that Georgia Gateway's specifications and connectivity was "heavily reviewed" in preparation for the planned

[11] *DHS also receives information from the federal marketplace for individuals who may qualify for the state-administered programs.*

transfer to a state-based marketplace.[12] They also noted that transfers to and from the federal marketplace occur on a daily basis.

- **Communication** – DHS already notifies individuals that their information has been transferred and that they should select insurance through the federal marketplace.

Risk – Fair Hearings Volume

The resumption of the renewal process will likely lead to a significant number of ineligible determinations and a proportional increase in requests for fair hearings, in which an enrollee contests the state's denial of continued coverage. A large number of fair hearing requests could challenge the state's ability to conduct timely hearings and rulings. In Georgia, members retain coverage if they request a fair hearing within 14 days; therefore, any delays in scheduling fair hearings may not result in a lack of coverage for existing member. However, new Medicaid applicants awaiting a hearing would have no coverage.

Fair hearings must be requested within 30 days of the DHS decision.

In Georgia, the Office of State Administrative Hearings (OSAH) conducts Medicaid fair hearings. Together with DHS and DCH, OSAH staff reported the following plans and strategies for managing the anticipated increase in Medicaid fair hearings:

- **Unified Calendars** – OSAH currently manages public assistance fair hearings through a unified calendar, which allows the agency to efficiently schedule the same types of hearings together. Through the use of block hearings, OSAH typically schedules days in which judges only hear public assistance fair hearings. According to OSAH staff, block hearings also allow DHS caseworkers to be present to provide expert knowledge on why renewals were denied. Block hearings also prevent staff from having to travel to a location on multiple days. These occur by "borrowing" local court rooms in centralized locations on the days scheduled for block hearings.

- **Electronic Case Management System** – OSAH staff reported that the agency's electronic case management system makes it easier to schedule and plan hearings. OSAH has been working with DCH to determine whether notices of hearings can be sent to Medicaid members electronically as well as by first class mail.

- **Use of Automation** – OSAH and DHS are planning to automate some aspects of the fair hearing forms. The agencies expect to use a DHS bot or other method to automatically enter information of those requesting fair hearings into the OSAH case management system. Currently, staff must enter this information, which could impact information accuracy and timeliness of the hearings if the volume is significant.

- **Predicting Caseloads** – DCH is providing OSAH enrollment information to estimate the volume of fair hearings; however, OSAH officials have requested additional information to allow for a more accurate estimate. The data is especially important for identifying increases in more complex classes of assistance (e.g., Medically Needy), which may require lengthier fair hearings.

---

[12] Georgia expected to implement a state-based marketplace operated by the Office of the Commissioner of Insurance in November 2022. DHS officials were to test transfers to/from the system prior to its implementation. In August 2022, HHS withdrew approval of the waiver that was to allow the use of the state-based marketplace.

- **Special Administrative Law Judges** – OSAH does not anticipate the need for additional administrative staff. Additional judges may be needed, but the agency does not know whether they will be necessary at this point. For surges in other types of hearings, OSAH has previously hired temporary contract judges and intends to do so again if the need arises.

- **Deadline Waiver** –DCH obtained a CMS waiver to the requirement that fair administrative hearings related to renewals be determined within 90 days. However, OSAH does not expect to exceed the 90-day timeline.

- **Additional DHS Staff** – DHS stated that it had hired several new staff members to assist with the increase in fair hearings.

Appendix A – Objectives, Scope, and Methodology

Objectives

This report provides an overview of the state's preparation for the termination of the continuous coverage of Medicaid benefits that has existed during the public health emergency. The elimination of this and other policies is referred to as the Medicaid unwinding.

Scope

This audit covers planning and actions related to the Medicaid unwinding that have occurred during calendar year 2022. Information used in this report was obtained by reviewing relevant laws, rules, regulations, and guidance (state and federal); interviewing agency officials from the Department of Human Services, Department of Community Health, and the Office of State Administrative Hearings; and reviewing limited agency documentation in support of specific strategies.

The scope of this report is limited to documenting the agencies' stated plans for the unwinding. We did not evaluate the sufficiency of the plan or the implementation of strategies that have already begun.

A draft of the report was provided to the Department of Human Services, Department of Community Health, and the Office of State Administrative Hearings. Revisions were made to the final report based on their responses.

Methodology

To determine the primary risks posed by the Medicaid unwinding and potential strategies to address these risks, we reviewed directives and guidance to states from the Centers for Medicare and Medicaid Services. The primary document used to identify risks and strategies was the Eligibility and Enrollment Pending Actions Resolution Planning Tool (Version 2.0). The report includes the seven major risk areas, as well as selected strategies and guidance.

To determine whether Georgia state agencies were implementing or considering these strategies, we largely relied on testimonial evidence, with requests for limited documentation of some strategies. We initially submitted a list of questions to agency leadership. We then interviewed agency staff, reviewed planning documents, presentations, press releases, websites, policy manuals, relevant news articles, and correspondence with federal agencies. From these sources, we identified actions already in place at state agencies, strategies or actions planned for implementation prior to the unwinding, and others planned for the unwinding period.

This page intentionally left blank