Testing Administrative Frictions in the Medicaid Eligibility Redetermination Process: A Field Experiment in Louisiana (Layton, Wallace, McIntyre, Callison, & Frenier)

Policy Problem & Significance

Take-up of Medicaid benefits among people eligible for the program is in complete, a key factor in explaining part of why the uninsured rate remains high in the US.[1] The number of people *eligible for but not enrolled* in Medicaid is three times higher than the number who are uninsured because their state has not expanded Medicaid under the Affordable Care Act.[2]

Incomplete take-up has two dimensions: (1) failure to *enroll* eligible individuals and (2) failure to *retain* individuals in coverage who remain eligible for benefits. **Administrative hassles associated with enrolling and proving eligibility can affect both pathways, but barriers to *retention* are particularly understudied.** Even short spells of uninsurance have been associated with adverse health outcomes.[3]

Medicaid eligibility is typically "redetermined" on an annual basis and beneficiaries can face onerous administrative hurdles to remain enrolled. When states are not able to use internal data to "automatically" renew beneficiaries—a process called "*ex parte* renewal"—enrollees must provide documentation to their state. **These administrative hassles are acutely burdensome for older, dual-eligible enrollees who face more complex eligibility standards.**[4]

There is scant empirical evidence on: (1) the extent to which failure to maintain Medicaid coverage at redetermination is due to administrative frictions; (2) how specific administrative frictions (e.g., inadequate contact information vs. enrollee awareness vs. hassle costs) contribute to attrition during redetermination; and (3) the effects of the resulting churn on health care use and health. We also know little about how such burdens are impacting disadvantaged populations and contributing to health disparities. Our team is already engaged in research to investigate these frictions in the context of "unwinding", the end of the continuous enrollment provision that paused disenrollments from Medicaid during the public health emergency. But it is unclear how these findings will generalize to future years, when less media attention and fewer resources are focused on outreach and education related to redeterminations.

Specific Aims

We propose to study the role of three types of frictions in the eligibility redetermination process: (a) inaccurate or outdated contact information for beneficiaries; (b) lack of awareness and literacy about the redetermination process among enrollees; and (c) challenges completing complex applications. States rely on the contact information in their enrollment system to outreach enrollees during the redetermination process and these data may be out-of-date or inaccurate if enrollees do not self-report changes. Medicaid agencies often lack the resources to engage in outreach, requiring enrollees to approach the state for help. Redetermination paperwork is complex and enrollees may not know how or where to find assistance in proving their eligibility. To our knowledge, there is no research assessing how these low- to medium-cost interventions impact Medicaid renewal rates.

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[1] Einav L, Finkelstein A. The risk of losing health insurance in the United States is large, and remained so after the Affordable Care Act. Proc Natl Acad Sci USA. 2023;120(18):e2222100120. doi:10.1073/pnas.2222100120

[2] Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured. KFF. Published April 7, 2021. https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/

[3] Sugar S, Peters C, Lew ND, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; 2021.

[4] Using Asset Verification Systems to Streamline Medicaid Determinations. Center on Budget and Policy Priorities. June 23, 2021. https://www.cbpp.org/research/health/using-asset-verification-systems-to-streamline-medicaid-determinations

Our specific aims are:

> **Aim 1:** Measure the degree to which administrative hassles are a barrier to Medicaid renewal and assess the cost-effectiveness of using tracking databases, enhanced outreach, and application assistance to improve renewal rates.
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> **Aim 2**: Identify sub-groups for whom the interventions are most effective so the state can efficiently target resources to continue these interventions in the future. Assess "targeting" properties of interventions.
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> **Aim 3:** Estimate the effect of retaining Medicaid on persistence of health insurance coverage, health care use, and health.

Approach

Our state partner(s) conduct *ex parte* redeterminations monthly. They will maintain a list of enrollees who fail this automatic process and will need to be manually redetermined. Each month, these enrollees will by randomized by the study team to one of two primary arms (with cross randomization to assess the value of contact information verification):

Comparison Arm: The state will conduct redetermination outreach using their standard procedure. They will use the contact data already on file for the enrollee to target materials.

Treatment Arm 1 - Enhanced Outreach: The study team will provide the enrollee's name and contact information to a team of "application assisters," who will outreach the enrollee using phone, text message, email, and social media channels. Outreach will include standardized messages reminding enrollees of their redetermination deadline, the need to submit paperwork to maintain their Medicaid coverage, and information about the resources enrollees can access if they need additional help or clarification.

Treatment Arm 2 - Application Assistance: Enrollees randomized to Treatment Arm 2 will receive the same outreach intervention as those randomized to Treatment Arm 1, but the application assisters will also offer personalized assistance to enrollees to help them complete the redetermination process. This assistance will include guidance in filling out the forms with the enrollee over the phone, verifying that enrollees understand and possess the necessary documentation for certifying eligibility, and (where permissible by law) completing and submitting redetermination paperwork on behalf of the enrollee.

Cross randomization - Address Verification: We will cross-randomize half of enrollees in each treatment arm (both 1 and 2) to receive address and contact information verification via the LexisNexis Accurint Database Services. This service uses credit reports and public records to match people to updated contact information, including phone and email. Cross-randomizing allows us to assess the utility of low-cost, updated contact information in the outreach process.

To maximize power and our ability to test for treatment effect heterogeneity by sub-group, we will block randomize participants based on: (a) Medicaid eligibility group (MAGI vs. non-MAGI);[5] (b) race and/or ethnicity; (c) age (children/adults/elderly); and (d) county of residence.

[5] The Modified Adjusted Gross Income (MAGI) population in Medicaid includes pregnant women, dependent children under 19, parents/caretaker relatives of children under 19, and childless adults. Non-MAGI population primarily consists of those 65 and older or individuals who are blind or have disabilities.

State Collaborator: Our primary partner for this evaluation is the Louisiana Department of Health (LDH), the agency that oversees Medicaid. The study team is engaged in regular meetings with LDH to coordinate another study on redeterminations during unwinding. Should LDH decide this project does not align with state priorities, the study team is confident the project can shift to another state where we have relationships with Medicaid staff (Connecticut or Virginia).

Outcomes & Data: Our outcomes of interest are: (1) successful renewal, (2) ambulatory care visits, (3) hospitalizations, (4) emergency department visits, and (5) medical spending.

LDH will provide the study team access to individual-level enrollment data to implement the study interventions and evaluate post-intervention enrollment. For studying long-run effects of the interventions on Medicaid renewal, enrollment, and health care utilization, LDH will also provide the study team with de-identified Medicaid enrollment and claims data for 2022-2026. We will augment these data sources with electronic health record (EHR) data from REACHnet, an all-payer EHR system linked to LDH Medicaid claims. REACHnet allows us to observe health care use and insurance coverage for enrollees who retain Medicaid *and* those who exit the Medicaid program. For dual-eligible enrollees, we will also use linked Medicare-Medicaid claims data maintained at Harvard Medical School. The study team will work with LDH and CMS to develop a crosswalk permitting linkage of de-identified LDH data to de-identified CMS data.

Randomization Schedule, Expected Sample Size, and Power Calculations: As of January 2020, Louisiana reported Medicaid enrollment of 1.5 million people and that the state could complete 50-75% of redeterminations automatically. Assuming redeterminations are spread equally over the year, we expect that roughly 31,000 enrollees per month will fail *ex parte* and be eligible for randomization. The primary constraints on our ability to randomize enrollees to the treatment arms are (a) the cost of the interventions and (b) the number of enrollees that can be contacted in a month. We estimate an application assister can contact 600 enrollees/month and anticipate hiring 3 application assisters, for a total of 1,800 contacts/month. We plan to randomize participants over twelve months, targeting 900 enrollees/month in Arms 1 and 2, with the other 29,200 participants randomized to the comparison group. This will yield a final sample size of 10,800 participants in Arm 1 and Arm 2 and 350,400 people in the comparison group. We will cross-randomize half the participants in each of Arms 1 and 2 to contact information verification to assess whether a low-cost, co-intervention increases the effectiveness of Medicaid outreach.

Outcome	Baseline Mean	MDE
Medicaid Renewal (%)	12.80	0.92pp
E&M Visits (PMPM)	0.326	0.0053
ED Visits (PMPM)	0.069	0.00055
IP Stays (PMPM)	0.00623	0.00011
Medical Spending (PMPM)	$558.00	$162.50

The table above shows the minimum detectable average treatment effect for Arms 1 and 2 for Medicaid retention and the minimum detectable local average treatment effect (LATE) for health care use outcomes, assuming a twenty percentage point increase in the renewal rate in the treatment arms. These power calculations are conservative as they do not incorporate the rich set of covariates we will include in regression models evaluating the effects of the interventions.

Anticipated Budget: *We anticipate requiring $235,000 to cover the costs related to this study.*