



Strategies for SBMs to Improve Medicaid to Marketplace Coordination and Maximize Enrollee Transitions at the End of the Continuous Enrollment



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Background

- Following passage of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127), all states elected to receive a temporary Federal Medical Assistance Percentage (FMAP) increase if, along with other conditions, they maintained continuous enrollment for most Medicaid (and in some cases, the Children's Health Insurance Program (CHIP)) beneficiaries who were enrolled on or after March 18, 2020. This policy is known as the continuous enrollment condition.
- After the continuous enrollment condition ends, state Medicaid/CHIP programs must, over time, return to normal eligibility and enrollment operations, including processing eligibility renewals, changes in circumstances, and post-enrollment verifications. This process is referred to as "Medicaid continuous enrollment condition unwinding", or "unwinding".
- A recent law provides a date for unwinding to begin: Per the Consolidated Appropriations Act of 2023 (CAA, 2023), the continuous enrollment condition will end on March 31, 2023.
 - States will have up to 12 months (i.e., March 31, 2024) to initiate renewals for all individuals enrolled as of the last day of the continuous enrollment condition.
 - States will have up to 14 months (i.e., May 31, 2024) to complete renewals for individuals enrolled as of the last day of the continuous enrollment condition.
 - State renewals may begin as early as February 1, 2023, with the first coverage terminations effective no earlier than April 1.
- Many individuals will remain eligible for Medicaid, CHIP, or BHP, but a considerable number will be determined ineligible and may qualify for a Qualified Health Plan (QHP) with Advance Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSRs).

Purpose

- When the continuous enrollment condition ends, SBMs will encounter unprecedented increases in consumers gaining eligibility for QHP and APTC and will have a significant role in helping these individuals maintain coverage.
- These slides provide a “punchlist” of policy and operational strategies that SBMs and the FFM are utilizing to improve Medicaid to Marketplace coordination and maximize enrollee transitions and coverage retention. It will be updated as new ideas or strategies are developed.
- The activities described in this deck may not be practicable for every Marketplace IT system or operations and some may require further discussion with CMS, and in some cases, updates to the SBMs’ State Exchange Blueprint Applications. CMS will work with the SBMs to provide any necessary technical assistance.

Key Strategies for SBMs

1. Collaborating with State Medicaid and CHIP Agencies on Activities that Promote Seamless Coverage Transitions

2. Strengthening Medicaid to Marketplace Account Transfer Processes

3. Streamlining QHP and APTC Eligibility and Enrollment Processes

States can review this [webpage](#), which includes several useful resources for State Medicaid Agencies and the SBMs to consider in developing plans to support enrollment of consumers who are re-determined ineligible for Medicaid/CHIP but eligible for a QHP upon the end of the continuous enrollment condition.

1. Collaborating with State Medicaid and CHIP Agencies on Activities that Can Promote Seamless Coverage Transitions (1–2)

CMS previously [documented](#) the operational activities that state Medicaid and CHIP agencies can undertake in preparation for the expiration of the continuous enrollment condition. SBMs can be supportive partners with Medicaid and CHIP in a number of these strategies, including those highlighted below.

- 1. Assist with collecting updated Medicaid and CHIP enrollee contact information**, including partnering with Medicaid and CHIP agencies to collaborate with health plans, and Medicaid managed care entities who may have more updated enrollee contact information. More information on this can be found in strategy 1 of this [presentation](#). Additionally, the FCC provided guidance on how autodialed calls and texts can be used to provide individuals with information about how to maintain their health insurance coverage. Additional information can be found in this [presentation](#).
- 2. Support or supplement outreach and consumer assistance activities**, including providing in-person or telephone assistance to consumers through Navigators, certified application counselors, agents/brokers, plans/issuers, and staff to help consumers apply for coverage and provide answers to Marketplace questions. Partner with trusted entities in the community (e.g., schools, community-based organizations, faith-based organizations) that can reach consumers in culturally and linguistically appropriate ways.

1. Collaborating with State Medicaid and CHIP Agencies on Activities that Can Promote Seamless Coverage Transitions (3–5)

- 3. Ensure language and messaging to consumers is consistent across the Marketplace, Medicaid, and CHIP.** For renewal notices, include joint messaging that encourages consumers to respond even if they do not think they are eligible for Medicaid or CHIP, as they may be eligible for no- or low-cost Marketplace coverage. Coordinate on call center/enrollment broker scripts to align messaging about coverage. Link to or leverage Federally-facilitated Marketplace (FFM) messaging when available.
- 4. Jointly review available data sources used to verify Medicaid, CHIP, and APTC eligibility as part of redeterminations** and, where feasible, share verifications/verified data, or add other data sources to limit data matching issues (DMIs) and increase the number of eligibility determinations that can be completed based on available information (ex-parte). Work with Medicaid and CHIP agencies to align their reasonable compatibility thresholds for verifying income for Medicaid/CHIP eligibility with the thresholds used by the Marketplace for APTC eligibility.
- 5. Explore options and strategies in partnership with state Medicaid and CHIP agencies to identify and assist individuals whose Medicaid/CHIP coverage is terminated due to procedural reasons.**

2. Strengthening Medicaid to Marketplace Account Transfer Processes (1–3)

Some SBMs operate Account Transfer (AT) processes with their State Medicaid and CHIP agencies. Below are some ways in which SBMs can strengthen those processes.

- 1. Leverage individual-level information transferred to the Marketplace by Medicaid and CHIP agencies**, including updated household income, other eligibility data, and optional contact information, to finalize any additional QHP and APTC eligibility requirements or to conduct outreach to individuals.
- 2. Create distinct pathways online and through the SBM call center that allow individuals who may not be familiar with the Marketplace to easily access their applications** and provide any additional information required to make a final eligibility determination.
- 3. Explore sending/providing individuals pre-populated applications**, within any state or federal parameters, and using multiple communication channels, such as email, mail or through application assisters.

2. Strengthening Medicaid to Marketplace Account Transfer Processes (4–6)

- 4. Engage with health plan issuers that offer both Medicaid managed care plans and Marketplace QHPs** to provide additional outreach and education to members who are no longer eligible for Medicaid about Marketplace coverage options and to assist in the transition, within any state or federal parameters. For more information, please review this [presentation](#).
- 5. Conduct extensive outreach to anyone whose account is transferred to the Marketplace** and engage Navigators in the task of reaching out to these consumers, consistent with applicable law.
- 6. Plan for and implement AT monitoring (success and errors) and error triaging to identify/address issues early.** Conduct regular system testing and quality assurance to eliminate glitches in sending or receiving accounts between Medicaid and the SBM in anticipation of the significant volume of account transfers that may tax the system.

3. Streamlining QHP and APTC Eligibility and Enrollment Processes (1–3)

The following is a list of eligibility and enrollment flexibilities available to SBMs.

- 1. Simplify verification of certain eligibility factors** by utilizing existing regulatory flexibility under 45 CFR 155.315(h), such as: temporarily pausing the generation and/or expiration of non-Employer-Sponsored Coverage (ESC) Minimum Essential Coverage (MEC) Medicaid DMIs.
- 2. Expand the reasonable compatibility threshold** used to generate annual income DMIs in the verification of APTC eligibility. CMS recently increased the FFM’s reasonable compatibility threshold for the generation of annual household income DMIs that would require additional verification from 25% or \$6,000 to 50% or \$12,000. SBMs using their own platforms can set the same thresholds or propose different thresholds in line with the rules. Please see this [CMS guidance](#).
- 3. Accept verbal attestations of projected annual household income** where permitted by applicable regulations to improve the resolution rate for annual income DMIs, and extend the deadline for resolving an income DMI to allow consumers making a good faith effort more time to submit required documentation, as allowed under 45 CFR 155.315(f)(3).

3. Streamlining QHP and APTC Eligibility and Enrollment Processes (4–5)

- 4. Provide consumers losing Medicaid/CHIP coverage following the end of the continuous enrollment condition with a SEP during the SBM Unwinding period**, as allowed under 45 CFR 155.420(d)(9). Allow consumer attestation to a loss of Medicaid/CHIP during the SBM Unwinding period to be sufficient to qualify for the SEP without requiring further documentation. **Additionally**, consider providing consumers with additional time beyond the full 60-day SEP window to make a Marketplace plan selection, using existing authority at 45 CFR 155.420(c)(5) for loss of MEC as a triggering event and/or under exceptional circumstance authority at 155.420(d)(9).
- 5. Auto-assign eligible consumers**, or a subset of those consumers (e.g. consumers under 200% of the Federal Poverty Level), into a Marketplace plan that maximizes APTC and cost sharing support, as allowed under 45 CFR 155 410(g). Explore options, within any state or federal parameters, for obtaining the consumer’s consent to an auto-plan assignment (such as when updating their contact or eligibility information) and their affirmative agreement prior to effectuation of coverage to the chosen plan selection and receipt of APTC.

3. Streamlining QHP and APTC Eligibility and Enrollment Processes (6–8)

- 6. Provide tools that individuals can use to make the enrollment process easier**, such as providing a crosswalk between Medicaid plans to Marketplace plans.
- 7. Continue to implement outreach and assistance activities, and partner with stakeholders**, including health plans, agents and brokers to strategize on ways to assist eligible individuals with making a plan choice.
- 8. Establish data metrics and tracking of individuals who are ineligible for Medicaid and CHIP, but eligible for Marketplace coverage.** Identify early, and on an ongoing basis, trends regarding why individuals failed to transition to new coverage, and implement mitigation strategies. Obtain race and ethnicity data whenever possible to improve future data and research on health disparities.