
CMCS Informational Bulletin

DATE: **September 29, 2016**

FROM: Vikki Wachino
Director, Center for Medicaid and CHIP Services

SUBJECT: **Enhancing Enrollment of Individuals Transitioning from Medicaid or CHIP to Marketplace Coverage**

Since the passage of the Affordable Care Act (ACA), states have made substantial progress in enrolling and retaining eligible individuals in Medicaid and the Children's Health Insurance Program (CHIP). A key aspect of continuing this progress is making sure that individuals who have either lost Medicaid or CHIP coverage or were determined ineligible upon application are able to transition to other sources of coverage and financial assistance, if applicable, as seamlessly as possible. Over the past three years of operation of the Federally-Facilitated Marketplace (FFM), we have learned through data analysis that there is more potential to enroll in Marketplace coverage individuals who are determined not or no longer eligible for Medicaid or CHIP and who have been transferred to the FFM via account transfer. This potential can be realized through a number of enhancements to the account transfer process. This CMCS Informational Bulletin (CIB) highlights the ways states served by the FFM can help to facilitate enrollment in Marketplace coverage for people transferred to the FFM when denied Medicaid/CHIP eligibility by the state Medicaid/CHIP agency. This CIB also provides information that may be useful for State-based Marketplaces working to improve their eligibility and enrollment coordination processes with state Medicaid/CHIP agencies.

In addition, this CIB highlights ways states can make enhancements to the application and collection of data to help with successful enrollment. First, individuals are more likely to seek enrollment through the Marketplace if they have sufficient information to understand what will happen once the state has transferred their account to the Marketplace. Providing additional information to individuals found ineligible for Medicaid/CHIP regarding the transfer of their application from the state to the Marketplace will help to facilitate seamless coverage transitions. Second, enhancing the types of outreach, including the use of email outreach, to this population is essential to increasing the percentage of individuals who enroll in Marketplace coverage after being found ineligible for Medicaid or CHIP. Again, while this CIB focuses on transfers to the FFM, these improvements may be relevant to some State-based Marketplaces as well.

Adequate information and targeted outreach efforts are especially important for young adults – a group with historically high rates of uninsurance. When children become young adults, many lose eligibility for Medicaid or CHIP, or drop off of their parents' coverage. Consistent with this, prior to the implementation of the Marketplaces and other ACA coverage provisions in 2014, 19 year-olds were nearly 8 percentage points more likely to be uninsured than 18 year-olds. Recent

Census data show that, by 2015, that gap had shrunk to about 5 percentage points.¹ Nonetheless, the remaining disparities show the potential to further reduce uninsured rates by smoothing coverage transitions for young adults. Our own data indicate that young adults also account for a large proportion of the accounts transferred from states to the FFM. Improving the likelihood of seamless transitions between insurance affordability programs will help to ensure that young adults continue to receive the benefits of health coverage into adulthood. As such, this informational bulletin outlines the following strategies states should employ to expand the opportunities for increased enrollment through the Marketplace:

- Improve eligibility determination notice language for individuals found ineligible for Medicaid/CHIP so that they are aware that the Medicaid/CHIP agency will be transferring their application to the FFM, and that the FFM will be sending them a notice with information on applying for coverage and financial assistance through the Marketplace;
- Revise the manner by which states collect email addresses on the single streamlined application; and
- Gather information from multiple trusted data sources to populate the individual's application and transmit all information the state has on an individual in the account transfer to the FFM, regardless of the minimum technical requirements for such account transfers.

Improve Eligibility Determination Notice Language

As described in the CMCS Informational Bulletin *Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or “Marketplace”)* issued on July 25, 2016, Medicaid and CHIP agencies are required to transfer the electronic accounts, for both applicants and beneficiaries, to the Marketplace when they are determined ineligible for Medicaid and CHIP. To ensure that individuals found ineligible for Medicaid or CHIP understand what will happen once the state has transferred the individual's account to the FFM, states should ensure their eligibility determination notices include language that explains the transfer process and next steps for completing an application at the FFM. Outreach to individuals whose accounts have been transferred to the Marketplace will be most effective if those individuals are educated about the future communication from an entity other than the state. Effective notice language lets an individual know their information has been sent to the Marketplace, that they will be receiving a letter from the Marketplace informing them that an application has been started for them, and informs them of their ability to start a new application at the FFM, which could result in a faster path to coverage. In addition, notices should provide information about what will happen once an individual completes an application at the Marketplace, as well as Marketplace contact information.

Through the Expanding Coverage Learning Collaborative, with input from state Medicaid and CHIP agencies and consumer advocates, CMS has developed model account transfer notice

¹ https://www.census.gov/content/dam/Census/newsroom/press-kits/2016/20160913_iphi_slides_plot_points.pdf

language for use by Medicaid and CHIP programs. To demonstrate how the account transfer language can be used, we have inserted the language in a model Medicaid denial notice (see Attachment A). The key account transfer messages are highlighted in the model denial notice. In late October, the Learning Collaborative will host a webinar on the account transfer process from the consumer's perspective and tools to effectively communicate eligibility determinations, including how states can use and tailor the model notice language. Details on the Learning Collaborative meeting will be provided to all FFM states.

Revise Single Streamlined and Alternative Applications to More Easily Collect Email Addresses

Another approach to help ensure that individuals who are denied Medicaid/CHIP eligibility are able to enroll in Marketplace coverage is to enhance existing outreach to these individuals through multiple avenues, including by email. Through three years of experience at the FFM, it has become evident that email outreach is a highly effective practice that should be expanded, especially to reach out to individuals being transferred from states to the FFM, to ensure more seamless transitions of coverage. Currently, the minority of accounts transferred from states to the FFM include email addresses, which results in the Marketplace's reliance on paper outreach notices. As email increasingly becomes a primary form of communication, it is important that states and CMS take steps to increase the likelihood that individuals provide email addresses on their applications, so that their email addresses can be provided to the FFM as part of the account transfer.

In developing their single streamlined and alternative applications, most states followed the model paper single streamlined application which currently collects emails through a two-part conditional question. Individuals are asked whether they would like to get information about their application by email. Those who respond yes to this question are prompted to provide an email address. Asking the question in this format limits the number of individuals who provide email addresses to those who also want to receive information about their application by email.

In order to increase the likelihood that applicants provide email addresses, states can revise how they collect email addresses on their applications. CMS recommends that states eliminate the two-part conditional question and ask all individuals for email addresses in an optional field within the contact information section of the application, similar to how phone numbers are collected. This practice is strongly recommended for both FFM and SBM states as outreach through email should be enhanced in all states, regardless of Marketplace type. Similar changes will be made to the model paper application in the near future. States can begin making these changes now, and the costs associated with these changes are eligible for the 90 percent enhanced match.

Enhancing Robustness of Data Included in the Account Transfer

If a state Medicaid/CHIP agency determines an individual is not eligible for Medicaid or CHIP, the agency must promptly assess the individual's potential eligibility for other insurance affordability programs and transfer the individual's electronic account to the appropriate program, per the

requirements described in 42 CFR §435.1200 and §457.350. The account must include all information collected and generated by the state regarding the individual's Medicaid or CHIP eligibility. States should transmit all information the state has on an individual in the account transfer to the Marketplace, regardless of the minimum technical requirements for such account transfers.

States can enhance the information sent to the FFM and further streamline the enrollment process for individuals transitioning to the Marketplace from Medicaid or CHIP by providing in the account transfer any contact information known to its system, even if the information does not originate from the initial application. For example, many individuals apply for Medicaid or CHIP using a paper application, but create online accounts after enrollment. Individuals may provide additional contact information, such as email addresses, as part of the state online account creation process. Encouraging account creation and the provision of email addresses also benefits consumers by moving away from paper notices that rely upon individuals to open their mail. States should incorporate the information provided through the account creation process in addition to the information provided through the application process in order to fully populate an individual's information sent by the state in the account transfer to the FFM. The ability to effectively contact individuals once their account is transferred to the FFM is critical to improving the likelihood that eligible individuals successfully enroll in coverage through the Marketplace.

Additional Resources

CMS will continue to work with states to ensure transitions to the FFM for individuals found ineligible for Medicaid and CHIP are as seamless as possible. For additional information, please contact your state SOTA lead or Judith Cash, Director, Division of Eligibility and Enrollment, Children and Adults Health Programs Group, at judith.cash@cms.hhs.gov or 410-786-4473.



You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).
Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos al 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

Mary Smith
123 Any Street
Any Town, Any State 00111

Health coverage application date: May 1, 2016
Letter date: May 5, 2016
Letter number: 34567

Why you are getting this letter

We reviewed your application for health coverage. We determined that you **do not** qualify for Medicaid health coverage. To learn more, read the “How we made our Medicaid decision” section below.

You might still be able to get health coverage—and help paying for it—through the Health Insurance Marketplace (Marketplace). We sent your information to them. The Marketplace will send you a letter. To learn more, read the “Complete your Marketplace application” section below.

How we made our Medicaid determination

We calculated your household size and income based on what you told us on your application and information we got from other data sources. We found that your household size is 1 person and your income is \$1,915 each month. The Medicaid income limit for your household size is \$1,273 each month.

Since your monthly income is above the limit, you do not qualify for Medicaid health coverage. If you think we made a mistake, you can appeal our decision. To learn more, read the “If you think we made a mistake” section below.

We made our decisions based on these rules: 42 CFR 435.119, 435.603.

What is the Health Insurance Marketplace?

You can use the Marketplace to shop for and buy affordable private health insurance online, over the phone, or with in-person help. There is financial help available for people who qualify.

Complete your Marketplace application

You should complete your Marketplace application as soon as you can to see if you can get coverage now. To complete your application, you can:

1. Start a new application at HealthCare.gov. You will need to:
 - Create a Marketplace user account if you don't have one.
 - Have this letter with you to help answer questions.
 - Fill out the application. You will need to re-enter the information you gave us already.
 - Answer “yes” when asked if anyone has been found not eligible for Medicaid or the Children’s Health Insurance Program (CHIP) in the past 90 days, if this applies.

Or

2. Call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). You will need to:
 - Tell the Call Center Representative that your state Medicaid agency determined you are not



Questions? Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX). You can call Monday to Friday, 8am to 8pm. The call is free. Or, go to medicaid.state.gov. You can also find out how to meet with someone in person.

eligible for Medicaid, and that you want to apply for Marketplace coverage and help paying for coverage.

- Have this letter with you to help answer questions.
- You will need to provide the information you gave us already.

Or

3. **Wait for the letter from the Marketplace.** The Marketplace is starting a health insurance application for you. The letter will tell you how to complete your application with them.

If you have questions or need help completing your application, call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). Or go to HealthCare.gov.

After you complete your application, the Marketplace will tell you if you qualify for health coverage and financial assistance to help pay for it.

The Marketplace will also tell you whether you can get health coverage now or if you have to wait and reapply. If otherwise eligible, you can enroll in Marketplace health coverage during a certain time each year called the Open Enrollment Period. If it is not Open Enrollment when you submit your application for coverage, you will have to wait until the next Open Enrollment Period, unless you have a life event that makes you eligible for a Special Enrollment Period. Examples of qualifying life events include getting married, having a baby, or losing Medicaid or other health coverage. You usually have up to 60 days after the date of the life change to apply for coverage and qualify for a Special Enrollment Period.

Your Secure User Account

Medicaid.state.gov keeps all important information about your application and health coverage. You can choose to get letters like this online.

To create an account, go to **medicaid.state.gov** and click “Account Setup”.

If you have special health care needs

A person who has been denied Medicaid based on household size and income may still be able to get Medicaid health coverage if he or she has special health care needs. Special health care needs include if a person:

- Has a medical, mental health, or substance use condition that limits his or her ability to work or go to school
- Needs help with daily activities, like bathing or dressing
- Regularly gets medical care, personal care, or health services at home or in another community setting, like adult day care
- Lives in a long-term care facility, group home, or nursing home
- Pays a lot for health care
- Is blind
- Is terminally ill

If a person has any of these special health care needs, and wants to see if he or she qualifies for Medicaid, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX) or go to **medicaid.state.gov**. If the person has health coverage, he or she can keep it while we are making our determination about whether he or she qualifies for Medicaid based on his or her special health care needs.



Questions? Call us at **1-800-XXX-XXXX** (TTY: 1-800-XXX-XXXX). You can call Monday to Friday, 8am to 8pm. The call is free. Or, go to **medicaid.state.gov**. You can also find out how to meet with someone in person.

If you think we made a mistake

You can appeal our determination about your eligibility for Medicaid health coverage. For example, you can appeal if you think we made a mistake about your household size, income, citizenship, immigration status, or residency. You can also appeal what health services you get and how much you pay for them.

To ask for an appeal, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX). Or, go to medicaid.state.gov to get an appeals form. Or, you can write your own letter and send or bring it to us at the State Medicaid Agency, 321 Any Road, Any City, Any State 00100. You must ask for an appeal by August 8, 2016.

Once you ask for an appeal, we will see if we can fix the problem over the phone or by meeting with you. If a phone call or meeting does not fix the problem, you can have a hearing.

A hearing is a meeting between you, someone from the State Medicaid Agency, and a hearing officer. At the hearing, you can explain why you think we made a mistake.

To get ready for your hearing, you can:

- Ask for a copy of your file before the hearing.
- Bring someone with you to the hearing, like a friend, relative, or lawyer, or you can come by yourself.
- Bring documents, information, or witnesses to show us where you think we made a mistake. If a person has health coverage, he or she can keep it during an appeal.

If you have any questions, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

Sincerely,

State Medicaid Agency
321 Any Road
Any City, Any State 00100

We will keep your information secure and private.



Questions? Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX). You can call Monday to Friday, 8am to 8pm. The call is free. Or, go to medicaid.state.gov. You can also find out how to meet with someone in person.