September 2023

Medicaid Managed Care Plan Transitions:

A Toolkit for States on Promoting Continuity of Care When Plans Enter, Leave, or Merge or are Acquired

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid Managed Care Plan Transitions:

A Toolkit for States on Promoting Continuity of Care When Plans Enter, Leave, or Merge or are Acquired

SEPTEMBER 2023

Jennifer M. Brock • Alicia Lomas • Erin Weir Lakhmani

Submitted to:

Division of Managed Care Policy
Center for Medicaid and CHIP Services
Center for Medicare & Medicaid Services
Baltimore, MD
Project Officer: Angela Jones
Contract/Task Number: HHSM-500-2010-00026I/HHSM-500-T0011

Submitted by:

Mathematica
1100 1st Street, NE, 12th Floor
Washington, DC 20002-4221
Project Director: Rebecca Lester

Suggested citation: Brock, Jennifer M., Alicia Lomas, and Erin Weir Lakhmani. "Medicaid Managed Care Plan Transitions: A Toolkit for States on Promoting Continuity of Care When Plans Enter, Leave, or Merge." Baltimore, MD: CMS, 2022.

Contents

Chapter I: Introduction 1

A. Plan transitions in Medicaid managed care 1

B. Toolkit purpose and structure 2

C. Methods 3

Chapter II: Using managed care contracts to set clear expectations for managed care plans 5

A. Requiring plans to provide state notice before a transition 6

B. Requiring plans to include specific content in transition plans 6

C. Requiring plans to share data with the state and each other 8

D. Requiring plans to notify enrollees and providers about a transition within specific timelines 9

E. Requiring plans to take steps to promote continuity of care 11

F. Requiring plans to meet specific post-transition obligations 12

G. Imposing penalties for plans that do not fulfill transition requirements 12

H. Requiring plans to protect enrollees in cases of plan insolvency 13

I. Clarifying who is financially responsible for transition-related costs 14

Chaper III: Planning for a plan transition 15

A. Strategy 1: Notify CMS and other involved partners 15

B. Strategy 2: Establish clear goals, responsibilities, and timelines for key transition activities 16

C. Strategy 3: Develop a plan for communicating with impacted enrollees about the transition 19

Chapter IV: Supporting enrollees when implementing a plan transition 25

A. Strategy 1: Notify plan enrollees about the impact of the transition and the actions they must take 25

B. Strategy 2: Use a variety of communication methods and messengers to reach enrollees impacted by the transition 31

C. Strategy 3: Implement carefully designed enrollment and disenrollment processes 35

D. Strategy 4: Exchange data to support continuity and coordination of care 39

Chapter V: Monitoring enrollment and continuity of care during and after the transition 44

A. Strategy 1: Monitor enrollment changes during and after transition 44

B. Strategy 2: Monitor data to assess access to care 47

C. Strategy 3: Assess the success of care coordination efforts during and after plan transitions 49

D. Strategy 4: Debrief on systems and processes for future transitions and close out with the exiting plan 51

Chapter VI: Summary framework to drive a successful transition 52

Appendix A: Example of managed care plan contract language supporting plan transitions 55

Appendix B: CMS notification form for Medicaid managed care plan transitions 61

Appendix C: Transition project charter template for states 63

Appendix D: Example of Ohio's internal talking points 65

Acknowledgements 68

Tables

Table III.1. Tools states can use to promote understandability and actionability of written messages 23

Table IV.1. State approaches to development of standard data templates and data sharing 41

Table V.1. Sample reporting table for monitoring enrollment changes within 90 days of a transition 47

Figures

Figure I.1. Toolkit chapters 3

Figure III.1. Example checklist for planning for a transition based on Ohio's 2020 transition 19

Figure III.2. Ohio's communications review tracker fields 21

Figure IV.1. Example of a plan comparison chart sent to enrollees in Indiana during their 2021 transition 28

Figure IV.2. Example checklist for implementing a transition based on Ohio's 2020 transition 43

Figure V.1. Example of an Ohio enrollment broker weekly report, 2019 45

Figure V.2. Example of a high-risk member movement report from Ohio, 2019 46

Figure VI.1. Transition framework 53

Chapter I

Introduction

A. Plan transitions in Medicaid managed care

Over the past decade, states have increasingly used managed care delivery systems to provide Medicaid services to enrollees. Most enrollees change their managed care plan[1] enrollment over time, and in some cases, these changes are necessary when states award new managed care plan contracts or end existing managed care plan contracts. In 2017, 13 states conducted 16 Medicaid managed care procurements that impacted more than 13 million Medicaid and Children's Health Insurance Program (CHIP) enrollees and accounted for more than $76 billion in annual spending (Allen 2017).

The term "plan transition" used in this toolkit refers to instances where a Medicaid enrollees' enrollment changes from one managed care plan to another because of one of the following reasons:

- A state Medicaid agency and managed care plan terminate their service contract prior to contract completion.
- A state Medicaid agency or managed care plan provides a notice of intent to not extend its contract beyond the current contract period.
- A state Medicaid agency enters into a new contract with a managed care plan that is not previously part of the state's Medicaid managed care market.
- A managed care plan under contract with a state Medicaid agency acquires or merges with another managed care plan.

Given that managed care requires enrollees to select provider(s) that are part of an approved network, enrollees who transition from one plan to another are at risk for disruptions in care if their new plan's network does not include providers from whom they are receiving care. Such disruptions are more likely to affect people who move from one plan to another involuntarily. Moreover, poor communication and lack of timely data exchange between an exiting plan (a plan whose contract with the state is terminating) and a receiving plan (a plan that is taking on enrollees previously enrolled with the exiting plan), increase the likelihood of disruptions in care and inappropriate billing if an enrollee mistakenly uses an out-of-network provider and becomes liable for the bill as a result. Inadequately drafted managed care plan contracts, for example those that do not contractually require receiving plans to honor prior

[1] In this Toolkit, the term "managed care plan" includes managed care organizations, health insuring organizations, prepaid inpatient health plans, prepaid ambulatory health plans, primary care case management (PCCM), and PCCM entities, as defined at 42 CFR § 438.2.

authorizations from the enrollee's previous plan, also lead to care disruption and claims problems.

Poorly managed plan transitions also present financial risks for states, plans, and providers. For example, both states and plans could incur increased costs if Medicaid enrollees cannot access the care they need and experience poor health outcomes as a result. In addition, new members dissatisfied with the transition process could provide negative feedback about the plan through an enrollee experience survey that negatively impacts a plan's quality rating. Lastly, plan transitions can confuse providers, causing those providers to spend additional time and resources to learn new policies and processes so they can obtain payment for services rendered.

Fortunately, states can prevent these risks through careful development of managed care contracts, and deliberate planning, implementation, and monitoring of plan transitions. This toolkit provides steps states can take during each phase of a transition to support successful movement of enrollees from one plan to another, clear communications with enrollees about the impact of a transition and their rights and options, and facilitation of continuity of care with established and new providers.

B. Toolkit purpose and structure

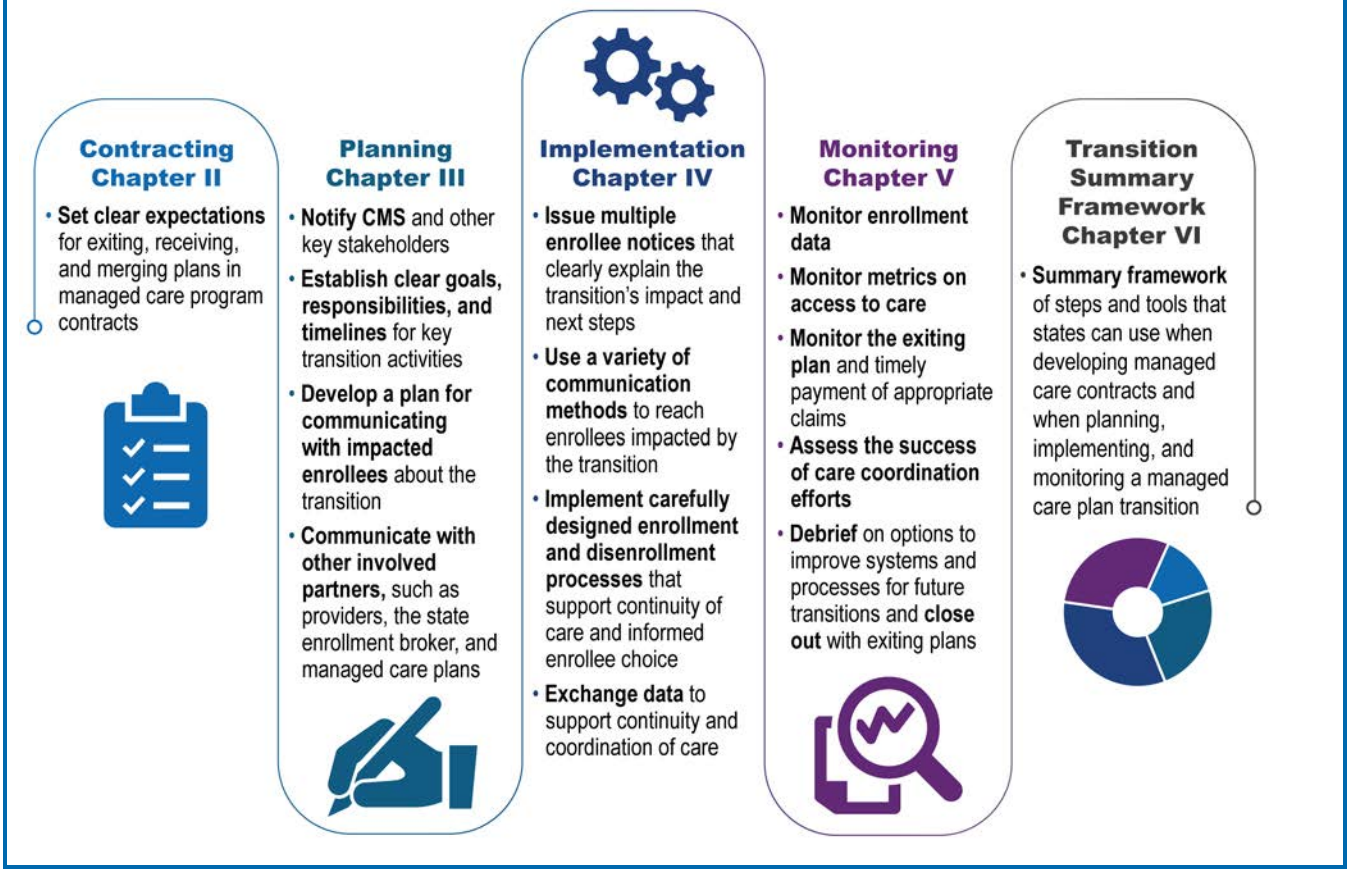
This toolkit offers practical information states can use to promote informed enrollee choices and continuity of care during Medicaid managed care plan transitions. It can also help states address the needs of enrollees during a plan transition.

Figure I.1 provides a visual depiction of the toolkit's organization and structure. Chapters II, III, IV, and V describe strategies states can use when developing contracts with managed care plans, as well as in planning, implementing, and monitoring plan transitions. Chapter VI: Summary framework to drive a successful transition, provides a printable framework of actionable strategies and tools that states can use as a checklist during future transitions.

Box I.1 Transitions to fee for service (FFS) or voluntary managed care

In states with fee for service (FFS) or voluntary Medicaid managed care, plan transitions may prompt enrollees to leave managed care for FFS. While this toolkit has been structured to describe the steps that take place within **mandatory** managed care programs, many of this toolkit's tips are applicable to voluntary managed care programs. In these cases, steps directed at the "receiving plan" would be taken by the state.

Figure I.1. Toolkit chapters



C. Methods

The state examples shared in this toolkit were drawn from a variety of sources, including interviews with state Medicaid agency and CMS staff who have overseen plan transitions in the past, recommendations from enrollee advocacy groups in **Iowa** and **Ohio** who have helped enrollees navigate plan transitions, and Mathematica review of Medicaid managed care contracts and state communication materials provided to enrollees during previous transitions. Mathematica conducted interviews between May and August 2021 with state Medicaid agency staff from **Iowa, Nebraska**, **New Mexico**, **Ohio, Puerto Rico**, and **Virginia** regarding their experiences with plan transitions that occurred between 2018 and 2021 and involved plan exits, entrances, and mergers or acquisitions. Additionally, Mathematica reviewed contract language from **New Jersey** and communication materials developed by **Illinois**, **Indiana**, and **Wisconsin** developed during their recent plan transitions.

Mathematica considered a transition strategy or tool for inclusion in this toolkit if it met the following criteria: (1) one or more states described the strategy as helpful during a transition, (2) the strategy had potential for adaptation or adoption by states with different infrastructure and resources, and (3) the strategy was consistent with the intent of federal regulation and policy. This toolkit does not provide an exhaustive list of strategies or options

states can take, but rather presents activities and approaches gleaned from the sources described above that may be applicable to states experiencing plan transitions.

Chapter II

Using contracts to set clear expectations for managed care plans

Managed care plan contracts should set requirements for plans to follow throughout their contract period, including when preparing for and undergoing changes to enrollment following an entrance, exit, or merger or acquisition. Clearly communicating transition requirements in a state's managed care plan contract enables plans to fully understand the resources and timeline requirements needed to fulfill their obligations during a transition.

It is important that transition requirements be kept current and accurate; therefore, states should **review and update transition requirements as part of each contract renewal**. Doing this will ensure that appropriate requirements are in place when a state receives notice of an imminent plan transition. Key contract requirements are listed in Box II.1 and summarized in Sections II.A through II.I.

In addition to setting clear expectations from the outset, **states can continuously improve their transition requirements over time by integrating lessons learned from past transitions**. State officials interviewed for this toolkit emphasized the value of updating contract language after a transition to incorporate lessons learned and/or address gaps identified during a transition. For example, state interviewees identified two types of contract changes made following their previous transition: (1) adding language to protect enrollees and facilitate continuity of care in the event of plan insolvency and (2) adding language to clarify who is financially responsible for transition-related costs.

Box II.1. Chapter Summary: Contracting

Successful plan transitions begin with clear contract requirements for managed care plans to follow during the transition period. Most states interviewed update their contract requirements frequently to apply lessons learned from previous procurements. This chapter highlights strategies states can use when updating transition requirements in their managed care plan contracts, including:

A. Requiring plans to provide the state with sufficient notice before specific actions such as termination or merger or acquisition with another managed care plan.
B. Requiring plans to include specific content in transition plans.
C. Requiring plans to share data with the state and each other.
D. Requiring plans to notify enrollees and providers about a transition within specific timelines.
E. Requiring plans to take steps to facilitate continuity of care.
F. Requiring plans to meet specific post-transition obligations.
G. Imposing penalties for plans that do not fulfill transition requirements.
H. Requiring plans to protect enrollees in cases of plan insolvency.
I. Clarifying who is financially responsible for transition-related costs.

A. Requiring plans to provide sufficient notice before a transition

All six state contracts reviewed for this toolkit required plans to provide notice of a contract termination at least a certain number of days before the termination. Of the state contracts reviewed, most required plans to **notify the state about a transition at least 180 days (or six months) before the date of transition**. Some states specified different time periods for notification based on the type of transition. For example, **New Jersey** requires that plans undergoing a merger or acquisition provide notice of termination 180 days before the transition takes effect, while plans have 120 days to give notice for any other type of transition. Most state contracts reviewed apply financial penalties for exiting plans that do not adhere to the contract required notice period. However, even with contractually specified timeframes and penalties for non-compliance, there may be instances in which plans do not provide timely notice of a transition. This toolkit provides suggestions for abbreviated planning and implementation periods under call out boxes labelled "Tips for states with 60 days or less until a transition."

Most state contracts reviewed **clearly define the start and end of the transition period** in their contracts. Example language might include, "the transition period starts at least 180 days before the date of transition and ends 60 days following [date] once all contract obligations are completed to the satisfaction of the state as stated in writing by the state." For example, **New Jersey**'s contract includes precise time frames for when the transition period starts and ends. **Iowa** is adding similar language into its contract after a previous transition occurred which state staff referred to as "rushed." Both the state and enrollee advocacy groups interviewed about the "rushed" transition agreed that the more recent transition ran "more smoothly" than the previous one because there was more time for enrollees to make a new plan choice. By specifying the start and end date in their contracts, states provide themselves with more time and increase transparency for both exiting and receiving plans, which can support better planning and decision-making.

"Requiring a sufficient amount of time in the contract for plans and states to prepare for transition prior to the effective transition date is a must and the only real thing preventing a plan from leaving 30 days before their contract is over." —State interviewee

B. Specifying enforcement mechanisms to ensure transition planning requirements are met

Four states interviewed for this toolkit included contract requirements specifying that exiting plans must submit a transition plan to the state for review and approval covering plan responsibilities and activities to minimize disruption of services to members and providers.[2]

[2] Across contracts reviewed, the transition plan was not officially defined but considered to be a written document describing the activities to be undertaken by the plan and the timeline for those activities during the transition period.

Contracts also included broad state authority to review and approve transition plans and to require plans to revise the transition plan as necessary until it meets state approval.

To ensure plan compliance with the transition plan, at least three states described monetary penalties for noncompliance in their contracts. Penalties included (1) withholding final capitation payment due to the plan (**Iowa**); (2) a damages clause allowing the state to seek and obtain injunctive relief and monetary damages for a plan's failure or unreasonable delay in cooperating and participating in services or efforts that affects the transition (**Virginia**); and (3) assessing refundable monetary assurance to the exiting managed care plan based on a percentage of the monthly capitation payment (**Ohio**). When using this last approach, the state will refund the monetary assurance back to the plan once the state approves the plan's final report documenting it has fulfilled all outstanding transition obligations.

States may consider specifying transition plan requirements for exiting plans using a template that includes the following information and data points (Box II.2) (1) at contract execution so it is ready to use with minimal updating, or (2) when a termination, non-renewal, or merger or acquisition triggers a plan transition. The template is intended to facilitate a timely and comprehensive transition plan by confirming an exiting plan has an acceptable transition of care plan in place; ensuring the plan's planned activities align with the state's goals, timelines, and intentions; and identifying potential risks associated with execution of transition activities in advance.

Box II.2. Adapted from Ohio's transition plan requirements and responsibilities for exiting plans

The managed care plan's transition plan shall include the following:

- State transition goals and the steps the plan will take to support those goals
- The managed care plan's agreement to comply with all duties and obligations incurred prior to the effective date of the agreement termination, including the performance of ongoing functions, and the submission of all reports and deliverables
- Contacts
  - Identify key points of contact for the plan, and their roles and responsibilities during the transition
  - Tip: The state may request the plan identify a transition coordinator, the exiting plan's single point of contact responsible for coordinating transition activities
- Timeframes for reports and deliverables
  - Proposed submission time frames for all outstanding reports and deliverables as identified by the state
- Communication plan and timeline
  - Member outreach workflow identifying the approach and timing of outreach to members impacted by the termination, if applicable
  - Proposed communication plan, including the plan's written notifications and proposed timeline to notify all impacted subcontractors, providers, and members of pending changes
    - Provider notification requirements
    - Member notification requirements

- Prior authorization redirection notification requirements
- Member transition of care plan
  - Includes the transition of care narrative, timeline, and member services workflow to support an efficient and seamless transition of members from coverage under the agreement to coverage under any new arrangement developed by the state
  - Identify at-risk populations and prioritize those members
- Data exchange
  - Describe data to be exchanged with the state and/or receiving plans, file formats, and other relevant exchange process details
- Anticipated risks to achieving milestones and goals (prioritized as high, medium, or low)
  - Describe mitigation strategies for each risk

Source: Ohio Department of Medicaid (ODM), 2021.

C. Requiring plans to share data with the state and each other

States should include language in their contracts to **specify data sharing requirements for the transition period**. Examples of data sharing requirements might include: (1) the types of data to be shared, (2) the formats in which the data should be shared, (3) whom the data should be sent to and when, (4) how often the data should be sent, (5) when the data sharing will be considered complete, (6) which metrics the state will use to evaluate the success or quality of the data transfer, and (7) any penalties that may be associated with a plan's failure to comply with the state's data sharing requirements. States may also wish to specify which entities are responsible for the costs associated with the data sharing process. The following are examples of the types of data states mentioned to be especially helpful for receiving plans or the state during transitions:

- **Claims or encounter records** showing transitioned members' prior service utilization and provider relationships
- **Care coordination data**, including data from plan assessments of enrollees' health risks, care needs, or functional status; care plan information; and information about external care coordinators who deliver support to transitioned enrollees
- **Service or prescription drug authorizations** or exceptions already granted by the exiting plan
- **Rosters of transitioning plan enrollees** whose health status or care needs may be especially complex, such as individuals who are pregnant or homeless, individuals with certain disabilities, or individuals receiving long-term services and supports (LTSS)
- **Information about open grievances and appeals** filed by transitioning enrollees

See Box II.3 for sample contract language that describes the data sharing requirements in **New Jersey**.

Box II.3. New Jersey's data sharing requirements for plan exits

New Jersey's managed care plan contract requires the exiting plan to adhere to the following data sharing activities (from Section 7.13.B):

"The Contractor shall be responsible for the provision of necessary information and records, whether a part of the MMIS [the state's Medicaid Management Information System] or compiled and/or stored elsewhere, to the new Contractor and/or DMAHS [Division of Medical Assistance and Health Services] during the closeout period to ensure a smooth transition of responsibility. The new Contractor and/or DMAHS shall define the information required during this period and the time frames for submission. Information that shall be required includes but is not limited to:

1. Numbers and status of grievances in process;
2. Numbers and status of hospital authorizations in process, listed by hospital;
3. Daily hospital logs;
4. Prior authorizations approved and disapproved;
5. Program exceptions approved;
6. Medical cost ratio data;
7. Payment of all outstanding obligations for medical care rendered to enrollees;
8. All encounter data required by this contract;
9. Information on enrollees in treatment plans/plans of care who will require continuity of care consideration;
10. Evidence of compliance with Article 7.36.7 of the Contract relating to compliance with Section 6032 of the Deficit Reduction Act of 2005;
11. Functional Assessment data gathered from the NJ Choice Assessment System."

Section 7.13.I.3 states that exiting plans must "make available and/or require its providers to make available to the Department copies of medical, behavioral, dental and MLTSS records, patient files, and any other pertinent information, including information maintained by any subcontractor or sub-subcontractor, necessary for efficient Care Management of enrollees, as determined by the Director."

Sections 7.13.D and 7.13.I.3 also note that enrollees may never be billed for the service of transferring these data to the state. However, the receiving plan may "reimburse any reasonable costs associated with the [exiting plan] providing the required information" if the plans "mutually agree" on costs and reimbursement.

Source: New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) 2020.

D. Requiring plans to notify enrollees and providers about a transition within specific timelines

To encourage transparency, clarity, and consistency in communications with enrollees and providers, states may also want to **describe how and when plans are to notify providers and enrollees about a transition**. For example, **New Jersey** requires the acquiring plan in a merger or acquisition to submit any provider and new enrollee welcome letters to the state for review no later than 30 days before the effective date of the merger or acquisition and to notify network providers no later than 90 days before the effective date of the transition of enrollees into the new plan. (See Box II.4 for New Jersey's full enrollee notice contract

requirements in the event of a plan merger or acquisition.) **Ohio** requires exiting plans to notify enrollees of the transition at least 45 calendar days in advance of the effective date.

Most states interviewed for this toolkit also mentioned the importance of sending notices early, so enough time is available to process returned notices, and some states include requirements in their contract that **identify steps that plans must follow when enrollee notices are returned**. New Jersey, for example, requires plans to "re-send any returned mail two additional times. If the mail to an enrollee is returned three times, the Contractor shall submit the name, the Medicaid/NJ FamilyCare identification number and last known address to the state for research to determine a more current address" (New Jersey DHS, DMAHS 2020, Section 7.14.C.2.c). See Chapter IV, Strategy 2 for ideas on how to notify enrollees through methods other than mailed notices.

Box II.4. New Jersey's requirements for enrollee notices in the instance of a plan merger or acquisition

In New Jersey's plan contract, under section 7.14.C.1a-i., the state requires merging plans to include the following information within enrollee notices:

"a. The basic details of the sale, including the name of the acquiring legal entity, and the date of the sale.

b. Any major changes in the provider network, including at minimum a comparison of hospitals that no longer will be available under the network, if that is the case.

c. For each enrollee, a representation whether that individual's primary care provider under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan. When the PCP is no longer available under the acquiring Contractor's plan, the enrollee shall be advised to call the HBC to see what other MCO the PCP participates in.

d. For each enrollee, a representation [of] whether that individual's MLTSS and/or behavioral health provider(s) under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan. When the MLTSS and/or behavioral health provider is no longer available under the acquiring Contractor's plan, the enrollee shall be advised to call the health benefits coordinator to determine if his or her provider participates in other contracted HMO provider networks.

e. In those cases where a primary dentist is selected under the non-surviving Contractor's plan, a representation [of] whether each individual's primary dentist under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan.

f. Information on enrollees in treatment plans and the status of any continuing medical care, as well as MLTSS being rendered under the non-surviving Contractor's plan, how that treatment will continue, and time frames for transition from the non-surviving Contractor's plan to the acquiring Contractor's plan.

g. Any changes in the benefits/procedures between the non-surviving Contractor's plan and the acquiring Contractor's plan, including for example, eye care and glasses benefits, over-the-counter drugs, and referral procedures, etc.

h. Toll free telephone numbers for the health benefits coordinator and the acquiring entity where enrollees' questions can be answered.

i. A time frame of not less than two weeks (fourteen days) for the enrollee to make a decision about staying in the acquiring Contractor's plan or switching to another MCO. The time frame should incorporate the monthly cut-off dates established by the state and the health benefits coordinator for the timely and accurate production of identification cards."

Source: New Jersey DHS, DMAHS 2020.

E. Requiring plans to take steps to promote continuity of care

States can also include requirements in their state contracts that promote continuity of care for transitioning enrollees. For example, state contracts can:

- Require receiving plans to **honor prior authorizations or prescription drug exceptions** granted by the exiting plans for a certain period after the transition. **Ohio** requires exiting plans to communicate a plan to continue authorization for services delivered to certain identified high-risk populations,[3] excluding prescribed drugs, for 90 calendar days after the contract termination date (ODM 2021, Appendix P.1.b.i.6). **Nebraska** requires receiving plans to honor all open service authorizations, regardless of provider participation network status, until 90 days after transition implementation, the end date of the authorization, or a new decision is reached with consultation from the provider on the medical necessity of the service (Nebraska Department of Health and Human Services [DHHS] n.d., Section IV.X.2.a).
- Require receiving plans to **cover any services and prescription drugs that a transitioned enrollee needs, without imposing prior authorization requirements or other utilization management restrictions**, for at least a certain time after the transition. For example, **Ohio** requires receiving plans to cover the cost of prescriptions for the "first 90 days of membership, or until a provider submits a prior authorization and the [receiving plan] completes a medical necessity review." Receiving plans must also "educate the [transitioned enrollees] that further dispensation after the first 90 days will require the prescribing provider to request a prior authorization," when applicable (ODM 2021, Appendix C.33.b.iv.4).
- Require receiving plans to **allow transitioned members to see providers who are not in the receiving plan's network for at least a certain time after the transition**. For example, **Ohio** requires the receiving plan to "reimburse out-of-network providers who provide services during the transition at 100% of the current Medicaid FFS provider rate for the specific service… [and] seek confirmation from an out-of-network provider that the provider agrees to provide the service and accepts the Medicaid FFS rate as payment" (ODM 2021, Appendix C.33.c).
- Require receiving plans to **take steps to maintain continuity of care for certain high-risk populations**. For example, **Ohio** and **New Jersey** contracts include specific coverage policies for pregnant members when interruptions to care could impact the health outcomes of the child. Ohio indicates that when a receiving plan becomes aware of a pregnant member's enrollment, the receiving plan must identify the member's maternal risk, "facilitate connection to services and supports … [including] delivery at an appropriate facility and continuation of progesterone therapy covered by Medicaid FFS or another plan for the duration of the pregnancy," and "allow the pregnant member to continue with an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital" (ODM 2021, Appendix C.33.b.ii). Similarly, Ohio requires receiving plans to cover chemotherapy, radiation, and other treatments for transitioned members with serious health

[3] Examples of "high-risk" populations can include individuals who are pregnant, homeless, or have a terminal illness; individuals with certain disabilities or comorbid conditions; or individuals who receive LTSS.

conditions without prior authorization, and **Iowa** requires exiting plans to continue to pay for ongoing courses of treatment for transitioning members "for whom a change of providers could be harmful… until [the] treatment is concluded, or appropriate transfer of care can be arranged" (Iowa DHS 2019, 15.1.1.17).

F. Requiring plans to meet specific post-transition obligations

Several states specify post-transition obligations in their managed care plan contracts to support continuity of care for transitioned enrollees. Such requirements can demand that exiting plans fulfill obligations to reimburse providers and submit state-required reports once the exiting plans' service obligations are completed. For example, **Iowa**'s contract requires exiting plans to:

- **Submit reports to the state every 30 days detailing their progress** in completing their transition period obligations, including their post-transition obligations (Iowa DHS 2019, Section 15.1.1.10).
- **Submit a final report to the state** and revise the report, if needed, until the state Medicaid agency is satisfied that the plan has fulfilled its obligations (Iowa DHS 2019, Section 15.1.1.10).
- **Resolve grievances and appeals** filed with the plan "with respect to dates of service prior to the day of contract expiration or termination, including grievances and appeals filed on or after the day of contract termination or expiration but with dates of service prior to the day of contract termination or expiration" (Iowa DHS 2019, Section 15.1.1.11).
- **Pay provider and pharmacy claims** submitted for dates of service during the time the enrollee was enrolled with the plan and that are submitted within 12 months of the date of service or other period specified by the state (Iowa DHS 2019, Section 15.1.1.13). Also, during **Puerto Rico**'s recent transition, it required the exiting plan to fund an account the territory would use to fund any service claims the exiting plan was not able to pay by the transition deadline (Administracion de Seguros de Salud de Puerto Rico (ASES) 2020, Section 23.2.2).

G. Imposing penalties for plans that do not fulfill transition requirements

Two states interviewed for this toolkit include language in their contracts that describes penalties the state will impose if a plan does not meet the specified transition requirements or timelines:

- **Virginia** includes a damages clause in its contract that specifies a predetermined amount of money that must be paid as damages for failure to perform obligations under the contract. The clause acknowledges that plans' "failure or delay to provide a smooth transition" can "cause irreparable injury to the State" and requires all contracted plans to "agree that the State may, in such event, seek and obtain injunctive relief as well as monetary damages" (Virginia Medicaid, Department of Medical Assistance Services [VA DMAS] n.d., Section 21.4.7).
- **Ohio** includes language under its Noncompliance with Transition Plan Requirements section indicating that if the exiting plan "fails to submit a proposed Transition Plan

> within 10 business days of receiving notice from ODM… ODM may impose a nonrefundable financial sanction in the amount of $5,000 per calendar day. If the MCP fails to cooperate with ODM to revise the proposed Transition Plan as necessary to obtain ODM approval additional financial sanctions may be imposed" (ODM 2021, Appendix N.27).

State Medicaid staff from **Iowa** also mentioned that they are updating their managed care contract language to incorporate penalties for plans that do not comply with their obligations, including an "authority to withhold clause" permitting the state to withhold final capitation and other payments due to the plan at the end of the transition period until the plan has met transition obligations "to the satisfaction of the state." **Puerto Rico** used a similar clause in their contract to withhold their last month's capitation payment until the exiting plan could demonstrate compliance with their transition plan (ASES 2020, Section 23.2.2).

See Appendix A for specific examples of transition-related contract language that illustrates state requirements for notice periods, transition plans, data sharing, continuity of care, post-transition obligations, and penalties.

H. Requiring plans to protect enrollees in cases of plan insolvency

Even when a state's managed care contract contains insolvency protections, plan insolvency can still occur. Therefore, in addition to requiring plans to adhere to state insolvency prevention rules, such as compliance with routine financial monitoring by the state and requirements for plans to notify states about any financial distress well in advance of actual insolvency, state interviewees encouraged their peers to **require plans and their subcontractors to take additional steps to protect enrollees to facilitate a smooth transition in the case of insolvency**.

"[Insolvency] is unfortunately becoming more of an issue for states. And, sadly, enrollees are the ones who suffer, because in this case the transition needs to be done very quickly." —State interviewee

For example, one state interviewee discussed requiring receiving plans to set aside a minimum amount of money to support transition-related costs when signing the contract. The state believes that doing this will ensure funds are available for a lengthy transition process, and thus will prevent continuity of care gaps that can occur when enrollees' transition immediately because of a plan insolvency. In addition, enrollees might need protection from plan subcontractors that become insolvent and abruptly discontinue services for plan members. Box II.5 includes an example of contract language used by **New Jersey** to protect enrollees from plan and subcontractor insolvency.

Box II.5. New Jersey's enrollee protections following plan insolvency

In New Jersey's managed care plan contract under Section J1–4 the following enrollee protections are in place following a plan's insolvency:

"J.1 [In the instance plan insolvency occurs,] the provider/subcontractor shall remain obligated to provide all services for the duration of the period after the Contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

J.2 The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the Contractor or the state, insolvency of the Contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than those provided in this section.

J.3 The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the Contractor, and shall be construed to be for the benefit of the Contractor or enrollees.

J.4 The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provision."

Source: New Jersey DHS, DMAHS 2020.

I. Clarifying who is financially responsible for transition-related costs

Because both receiving and exiting plans are involved in many transition-related activities (including post-transition activities), state officials interviewed for this toolkit noted that "things can get murky" as to who is responsible for costs, especially related to data transfer activities. Therefore, states can use contract language to **assign financial responsibility for transition-related tasks**. For example:

- **Virginia**'s contract indicates that the "Contractor shall be reimbursed [by the state] for all reasonable, pre-approved phase-in/phase-out costs (i.e., costs incurred within the agreed period after Contract termination that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this Contract. All phase-in/phase-out work fees must be approved by the DMAS in writing prior to commencement of said work." (VA DMAS n.d., 21.4.2).
- **Ohio**'s contract specifies that "the terminating [managed care plan] will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files" (ODM 2021, Appendix P.1.J).
- **Iowa** is currently updating its contract language to communicate that transition-related costs for notifying providers about a transition are the exiting plan's responsibility.

Chapter III

Planning for a plan transition

A. Strategy 1: Notify CMS and other involved partners

States should notify CMS, other managed care plans, the state's enrollment broker, and providers as soon as the state learns of an upcoming plan exit, entrance, merger, or acquisition.

Communicating with CMS

States should communicate with their CMS point of contact as soon as they learn of a potential plan transition and prior to information about the transition becoming public. By notifying CMS early, states can access federal advice about the planning process and receive help identifying risks that could impact members during transition. Because CMS staff work with multiple states, they can share experiences and lessons learned from other states that might be useful.

Box III.1. Chapter Summary: Planning

States achieve successful plan transitions with careful planning, which should begin as soon as a state is informed that a plan exit, entrance, merger, or acquisition will take place. This chapter highlights strategies states can use when planning a transition:

- **Strategy 1:** Notify CMS and other involved partners, such as other managed care plans, the state's enrollment broker, and providers.
- **Strategy 2:** Establish clear goals, responsibilities, and timelines for key transition activities.
- **Strategy 3:** Develop a plan for communicating with impacted enrollees about the transition.

To notify CMS, states are encouraged to email their CMS state lead with the following information: (1) when public announcement of the transition will take place; (2) milestones that the state and the exiting and receiving plans will meet in the upcoming 60 days as part of the transition process; (3) a summary of any existing issues, potential risks to members, and risk mitigation strategies in order of priority (high, medium, and low); and (4) the state's availability to discuss the plan for transition and strategies to address and respond to risks. CMS may request additional documentation, such as a transition and communication plan, as well.

See Appendix B for a template for states to complete and email to their CMS state lead to notify them about a potential or scheduled transition.

Communicating with other involved partners

States may also consider communicating about the plan transition with other involved partners including the state enrollment broker, providers, and managed care plans. Providing these partners with information on the termination/nonrenewal and planned transition

activities can help these entities prepare to take on new enrollees and avoid disruptions in their care.

B. Strategy 2: Establish clear goals, responsibilities, and timelines for key transition activities

In many states, multiple organizations—state agencies, managed care plans, state enrollment brokers and other entities—undertake a diverse set of responsibilities during plan transitions. For example, in most states, the exiting plan is required to notify its enrollees about an impending transition and transfer data to receiving plans or the state. The state's enrollment broker processes enrollment transactions and assists enrollees with questions about plan changes. The state Medicaid agency develops or oversees public communication strategies, configuration of IT systems to process enrollment changes within the state's Medicaid databases, and processes for monitoring enrollee access to care during the transition process. For a successful transition to occur, transparency and clear communication across all transition team members is essential.

Create a project charter

To establish clear communication, states can develop a project charter to communicate their expectations for the transition, metrics for success, and roles and responsibilities across all parties involved. Using language from project management, "project charters" document a leaderships' vision for the project (in this case the transition period). By thinking of a transition as a project, states can use the project charter as an initial step for communicating expectations, thereby ensuring that all parties have the direction needed to effectively operationalize the various workstreams involved (Box III.2).

States can review the project charter during a transition planning team discussion (for example, as part of a kickoff meeting) to give team members an opportunity to ask questions and confirm the full team's understanding of state expectations.

Box III.2. Benefits of a project charter

Project charters describe the scope, objectives, metrics for success, high-level timeline and roles and responsibilities across a project. Defining these items in a project charter before developing project management and transition plans achieves the following:

- Documents key elements of the transition process at the beginning.
- Provides clear, preset, expectations for incorporation into project management and transition plans.
- Provides information needed to start the project (for example, a governance structure, goals, and project scope).
- Serves as a reference document to ensure that all entities understand their roles and relevant timelines and all transition activities remain focused on the goals.
- Identifies the parties responsible for each step in the transition process to promote clear communication and accountability.

Key elements of a project charter include the project's scope; the state's vision, goals, and expectations for the transition process; factors and activities that will be critical for achieving the state's goals; measures of success (for example, the number of people who made an active plan choice during the choice period); roles and responsibilities; and an overarching approach for the project (for example, key phases,

corresponding outcomes, and required deliverables). See Box III.3 for a description of key elements in the project charter that **Ohio** developed for its 2020 plan transition.

Box III.3. Key elements of Ohio's transition project charter

For a recent transition, Ohio created a project charter in PowerPoint that state staff could easily present during a virtual kickoff meeting. Content in the charter was based on a collaboration between the state and an exiting plan after the plan notified the state about the need to transition. The following were key elements of the project charter:

- **Document control information:** (1) A description of updates made to the project charter during the planning process and (2) a list of team members to whom charter updates should be disseminated
- **Project overview:** (1) Background information about the situation that led to the transition; (2) state leaders' vision for the outcome of the transition; (3) the state's goals and expected benefits; (4) critical success factors—that is, conditions or outcomes necessary for the project to reach its goals; and (5) a description of the project's scope
- **Project approach:** (1) High-level information about key transition process phases and corresponding outcomes; (2) techniques used to achieve project outcomes (for example, weekly meetings, deliverables, or outputs); (3) high-level expectations for plans; and (4) planned project interactions
- **High-level visual timeline:** Visual timeline of key phases and deliverables to be achieved during the life of the project
- **Assumptions:** A list of assumptions the state is making when approaching the transition
- **Dependencies:** A list of aspects of this project that depend on other projects, initiatives, or factors that may require interaction to successfully complete the project
- **Project teams:** Leads for each transition workstream; their level of influence (high, medium, low); and their roles and responsibilities

Source: ODM, unpublished project charter from a plan transition occurring in 2020.

See Appendix C for a Microsoft Word project charter template based on Ohio's project charter.

Identify and document state, plan, and vendor[4] responsibilities

Of the three states interviewed for this toolkit that developed formal transition plans and/or charters (**Nebraska**, **Iowa**, and **Ohio**), each state allocated responsibilities across teams in different ways. For example, Nebraska assigned enrollee communications, enrollment, and data exchange activities to an enrollment broker, while state Medicaid agency staff provided project oversight. In contrast, Ohio and Iowa had a state team member oversee lateral teams under the states managed care director's oversight.

Despite these variations, the types of teams assigned responsibility during plan transitions were largely consistent. Most state officials described the need to **maintain a strong project management team at the state Medicaid agency level** to serve as the bedrock of a

[4] An example of a state vendor is a state enrollment broker; an example of a plan vendor is an organization contracted by the plan to handle its pharmacy authorizations and claims processing.

successful transition. In addition, all states created teams to manage enrollment (including default and passive assignment processes and algorithm development and testing), monitoring, tracking, reporting, communications, clinical operations (including exchange of clinical data), and legal and fiscal operations.

Develop a transition timeline

As previously mentioned, once a state creates a project charter, the project management team and workstream leads can use the information in the charter to effectively generate a detailed, centralized timeline that specifies activities for completion on a regular basis. Timelines can be incorporated into (or drawn from) the transition plan that exiting and/or receiving plans submit to the state for approval. For example, if a state's contract requires the exiting plan to complete a set of transition activities, the state may wish to view the exiting plan's timeline for completing these activities in its transition plan. States could **use a color-coded Gantt chart** to visualize deadlines, track milestone completion, and manage resources across multiple workstreams simultaneously.

Figure III.1 summarizes key steps that **Ohio** took in planning for a 2020 transition. This figure may be helpful for other states interested in creating transition planning checklists or timelines.

Figure III.1. Example checklist for planning for a transition based on Ohio's 2020 transition

Number of Days Before Transition	State Activity	Activity Description
180	Communicate About Upcoming Transition	• Notify CMS • Draft project charter and detailed transition timeline • Notify vendors of transition and provide expectations for their roles and responsibilities and talking points to use about the transition when working with enrollees • Exiting plan begins development of draft transition plan • Inform State Actuarial Contractor regarding transition so actuary can update capitation rates for receiving plans as needed
170 to 150	Establish Internal Operations and Notify Providers	• Create project management documents, communication strategies, and dashboards • Identify special populations requiring a unique approach to plan changes and update timeline and communication strategies to accommodate this plan • Train Customer Service Representatives/Enrollment Broker staff and set up queue • Remove exiting plan as a plan option for new enrollees • Develop and send provider notices
150 to 140	Communicate Data Transfer Requirements and Finalize Transition Plan	• Finalize updates to exiting plans' draft transition plan • Develop and send Data File Transfer Requirements Memo to plans with a description of the types of data exiting plans are required to share with receiving plans, as well as the required data formats and acceptable values

C. Strategy 3: Develop a plan for communicating with impacted enrollees about the transition

Box III.4. Developing an effective communications plan for enrollees

1. Set **clear communication goals** and measurable definitions of success.
2. Define **roles and responsibilities**, with a timeline for development, review, and delivery of enrollee communications.
3. **Identify the impacted enrollees** and tailor key messages accordingly.
4. Ensure that enrollment brokers and managed care plans **train and prepare call center staff** to address enrollee questions and concerns.

Prior to transitioning enrollees across plans, states should establish (1) standards for message clarity and consistency, (2) processes for development and review of enrollee communication materials, and (3) expectations for communication methods and timelines. They should also ensure that enrollment brokers and managed care plans are prepared to address questions and concerns of affected enrollees. States should consider drafting transition letters and enrollee materials in advance when there is no imminent transition. This can increase quality, reduce errors, and allow states to collect feedback from interested

organizations or groups to inform the communications plan. The state can then make any necessary updates at the time of transition, such as the plan name, dates, and contacts. States may also want to collect feedback after the transition to inform future planning. Key steps in developing an effective enrollee communications plan are highlighted in Box III.4 and described in Sections III.A to III.D. Note that all Medicaid-related communications must comply with the accessibility standards at CFR § 438.10.

Set clear communication goals and measurable definitions of success

Establishing measurable goals for achieving effective and consistent communications can facilitate a smooth plan transition for enrollees. All states interviewed for this toolkit **developed goals for communication in advance of their plan transitions**, but the specifics varied based on timelines and types of transitions. For example, **Nebraska** focused its communication strategies on encouraging enrollees to contact the enrollment broker's hotline to understand their enrollment options and make a choice. However, **Ohio** and **Iowa** wanted to provide enrollees with information about their plan options first, so the enrollees could consult their care manager or health care provider before contacting the enrollment broker to select a new plan.

States may also want to **establish and communicate measurable definitions of success** to be able to measure progress toward communication goals and objectives later. For example, three out of five states interviewed for this toolkit measured the success of their enrollee communications by the number of people who made an active plan choice rather than being default enrolled into a new plan. Other states measured success by the number of calls made to the enrollment broker regarding transition and the number of complaints received. By establishing measurable goals for enrollee communications and monitoring progress toward those goals, states can be on the lookout for slow or problematic enrollment and can intervene by pushing out communications through additional channels, like text blasts, local media or partner organizations.

Define roles and responsibilities and establish a timeline for development, review, and delivery of enrollee communications

State Medicaid agencies typically share the responsibility of communicating with enrollees and providers about plan transitions with the plans involved and, in some cases, the state's enrollment broker. For example, states may develop training materials or call scripts that enrollment broker and state call center staff use to assist enrollees with questions and plan choices related to the transition. **Setting clear expectations about who develops, reviews, delivers, and refines messages about the transition** helps to promote clear communications.

It is also important to **establish a timeline for reviewing each message or communication material, including who is responsible for tracking completion of reviews on time**. Because multiple parties can be involved in reviewing different messages and some

transitions may have to be implemented in short timeframes, states may find it helpful to use tracking tools. **Ohio**, for example, tracks the review of written enrollee materials using the tracker shown in Figure III.2.

Figure III.2. Ohio's communications review tracker fields

Document Name	
Date Received	Day, Date
Due Date	Day, Date
Final recipient	[Name] to send to [Name] (Email)

Step	Reviewer	Review Status
1	[Name]	
	[Team] (Back-up reviewer names)	
2	[Name]	
	[Team] (Back-up reviewer names)	

Included (Yes/No)?	Ad Hoc Reviewer Name	Topic
Yes	[Name]	Department of Rehabilitation and Corrections (DRC)
No	[Name]	Children's Services

Source: ODM, unpublished communications review tracker from a plan transition occurring in 2020.

Identify the impacted enrollees and tailor messages that speak to their needs

To create successful messaging for a transition, states should **identify the impacted enrollees' characteristics and their needs.** For example, care concerns, treatment needs, current providers, utilization patterns, health conditions, residential status, languages spoken, and cultural backgrounds can impact how people feel about a transition and how they interpret information about it. Identifying key concerns in advance can help states ensure that their messages reflect these issues in a way that will resonate (Box III.5). States should also create a plan to address translation and interpretation needs. This includes:

- Translating written materials into applicable languages
- Sending translated materials to the enrollees to prevent enrollees having to call and request translation or interpretation
- Preparing prewritten, translated messages (to distribute via pre-stuffed envelopes or email) for staff to use to on demand, if requested
- Ensuring sufficient interpreters who can translate information in prevalent languages.

States have taken a variety of approaches to identifying enrollees needs and create messages that respond to them. For example, **Ohio** used claims and eligibility data to identify enrollees impacted by the transition into descriptive categories based on their care needs and then

conducted targeted outreach (for example, people who had higher health care needs received more frequent communications). Other states promoted development of accessible notices by asking enrollees, advocates, health care providers, and/or accessibility experts to review communication and suggest improvement. For example, **New Mexico** engaged members from its Medicaid Advisory Committee of provider, consumer, and government representatives to provide input on message development for diverse enrollee groups during a transition in 2018. **Ohio** worked with an internal project management team to assist with overall messaging about the transition, as well as with enrollee notice language accessibility.

In developing messages, states should also **consider the tone of messaging to enrollees.** Receiving a transition letter may be upsetting and scary to enrollees, especially those that are undergoing specific treatments and or receiving HCBS. States can allay these concerns by messaging the facts of the transition using a positive tone and explaining the steps it is taking to prevent disruptions to care (for example, requiring the receiving plans to honor the exiting plan's prior authorizations for a certain amount of time) and loss of providers.

As noted at the start of Strategy 3, states should consider **drafting and revising transition communications when there are no imminent transitions on the horizon** to prevent the development of rushed communications and ensure partner input. Periods of non-transition is the preferred time to draft and review communications and engage partners.

The enrollee advocates interviewed for this toolkit suggested best practices for developing and disseminating communications. This information is applicable to all communications, not just during a transition, but a transition is when weaknesses in communications can seriously impact enrollees.

- **Organize a committee to provide input on enrollee notices**. Participants could include representatives from other state agencies or tribes; enrollees; and providers and organizations that represent Medicaid enrollees, such as legal aid organizations, immigrant rights organizations, maternal and child health advocacy groups, Area Agencies on Aging, or Centers for Independent Living.
- **Avoid language that may not translate well from English into other languages**. States should seek feedback from participants who are familiar with languages other than English to review notices.
- **Include representatives from a diverse set of populations** during notice development and review to ensure language used is clear, accessible, and culturally appropriate for all impacted enrollees.

Table III.1 shares examples of tools that states can use to ensure that the people reading the written materials understand the message and know what actions to take as a result; the table refers to these two concepts as understandability and actionability. Given the importance of these aims, states are encouraged to draft and refine key messages well in advance of any plan transitions.

Table III.1. Tools states can use to promote understandability and actionability of written messages

Tool name and link	Organization	Tool type	Function: Assesses for ...	
			Understandability	Actionability
The Patient Education Materials Assessment Tool (PEMAT) and User's Guide	Agency for Healthcare Research and Quality (AHRQ)	Self-scoring instrument with a user guide for print and audio patient education tools	✓	✓
The CDC Clear Communication Index	Centers for Disease Control and Prevention (CDC)	Research-based self-scoring instrument with a user guide for public messaging	✓	
Toolkit for Making Written Material Clear and Effective	Centers for Medicare and Medicaid Services (CMS)	Tools to help states create written messages for people to understand	✓	✓

Ensure that enrollment brokers and plans train and prepare call centers

Preparing call centers is a key task in ensuring clear and consistent messaging about the transition to enrollees. The state should ensure that its call centers, which are likely run by enrollment brokers and managed care plans, have plans to ramp up staffing if needed, prepare staff to handle a rapid influx of challenging calls, monitor call center statistics to assess hold times and abandoned call rates, and ensure access to TTY/auxiliary aids and interpreters. The state should also coordinate messaging to ensure call center staff can explain how the transition will affect the enrollee, steps the state is taking to prevent disruptions in care, and validate concerns and allay fears. Such messages should be consistent with other communications that the state may have sent via mail or email. See Box IV.7 (State approaches to mitigating barriers to care through enrollment broker training and support) for additional information on state approaches call center training and support.

Box III.5. How Ohio made consistent messaging a key communication strategy

Enrollee advocacy groups interviewed for this toolkit said that **inconsistent messaging can cause frustration**. To avoid this, states can develop and implement processes to promote message consistency as part of their enrollee communications plan. For example, **Ohio** made message consistency a performance goal in its communications plan for a 2020 transition. To achieve this goal, Ohio deployed a highly centralized communications protocol, which was monitored by a communications team for both development and dissemination of messaging. As part of the protocol, **the state created a set of consistent, leadership-approved internal talking points before the release of news about the transition.** The state published the talking points in its internal communications plan and the communications team provided training on how team members were to use the talking points. During the transition, talking points were the only information disseminated by team members (for example, to community-based organizations and in press releases, emails, newsletters, websites). When additional talking points were required (for a short text message, for example), the state communications team developed and disseminated new messages based on the previous talking points.

See Appendix D for an example of Ohio's internal talking points.

Tips for states with 60 days or less until a transition

States interviewed for this toolkit that had 60 days or less to prepare for a transition focused on two communications strategies: (1) disseminating clear internal talking points to ensure message consistency (see Appendix D for an example of Ohio's internal talking points) and (2) relying on multiple communication channels and partners, including providers, pharmacists, sister agencies, and community-based organizations. See Chapter IV, Strategy 2 for more information about the use of multiple communication methods and partnerships.

Within the first 20 days of planning for a transition, a state can develop a prioritized list of providers, community-based organizations, and enrollee representatives to provide input on draft talking points and disseminate transition messaging to enrollees through their network. If there is no time for states to gather input from these parties, then ensuring that enrollees receive accurate and consistent messaging is key. States can disseminate state-approved talking points to various organizations that interact with enrollees, and if possible, gather input on lessons learned to inform future transition communications. During a recent transition, **Ohio** presented its draft talking points during an informational webinar for providers, community-based organizations, and other priority representatives. Participants were encouraged to pose questions to a panel of state and plan representatives, which helped strengthen the state's draft messaging.

Chapter IV

Supporting enrollees when implementing a plan transition

A. Strategy 1: Notify plan enrollees about the impact of the transition and the actions they must take

Box IV.1. Chapter Summary: Implementation

This chapter highlights strategies states can use to support enrollees during a transition-related enrollment choice period and as they move into a new plan:

- **Strategy 1:** Notify plan enrollees about the impact of the transition and the actions they must take.
- **Strategy 2:** Use a variety of communication methods to reach enrollees impacted by the transition.
- **Strategy 3:** Implement carefully designed enrollment and disenrollment processes.
- **Strategy 4:** Exchange data to support continuity and coordination of care.

While enrollee communications about plan transitions can take a variety of forms—from flyers and postcards to phone calls or in-person conversations—official, written notices issued by the state and/or managed care plan are a central form of communicating the impact of an upcoming transition and informing enrollees about any specific actions they may need to take, such as selecting a new managed care plan. As with other notices issued in Medicaid managed care programs, transition-related notices sent to enrollees should be written in an easily understood language and format, use a font size no smaller than 12 point, explain how enrollees can access auxiliary aids and services or obtain the document alternative formats, include taglines in prevalent non-English languages, and provide the toll-free telephone number of the entity providing choice counseling services (42 CFR § 438.10).

Among the states interviewed for this toolkit, most developed and disseminated notices in partnership with plans involved in the transition. Some states issued an initial notice to enrollees about the upcoming transition to inform them that communications from their plan would be forthcoming. However, in instances of a plan merger, acquisition, or exit, states interviewed often required the exiting/merging plan to develop and disseminate notices to their enrollees after submitting a draft notice to the state for review. States can ensure that notices are clear by (1) plainly describing the key changes and action steps an enrollee needs to take, (2) sending multiple mailings of notices in accessible language and formats, and (3) providing ample time for an enrollee to act after receiving the notice.

Include key messaging in enrollee notices

State and enrollee advocates identified five key messag
to include in written notices to enrollees impacted by a
plan transition (see Box IV.2). States do not need to
include all this information in one notice; instead, they c
communicate these messages through multiple notices
delivered prior to the transition date.

Box IV.2. Five key messages for enrollee notices

1. What will change and when.
2. How the transition will impact an enrollees' access to care.
3. Which plans will continue to be available and enrollee plan choice considerations.
4. What legal rights enrollees are guaranteed.
5. Where enrollees can get help understanding their plan options or filing a complaint.

What will change and when

Interviewees said that transition notices should **describe the anticipated result of the transition for enrollees** in the simplest terms possible, using straightforward, accessible language. For example, in the case of a plan merger or acquisition, notices can describe only what the enrollee will experience, rather than the myriad legal and operational steps taking place within the merging organizations. During a 2021 plan merger, Nebraska focused its enrollee notices on the plan's name change and the transition date. The notices read, "Starting January 1, 2021, WellCare of Nebraska will become Healthy Blue. The name is changing, but you will still get the same Medicaid benefits, customer service, and support you expect" (WellCare of Nebraska, Inc. 2020).

How the transition will impact an enrollees' access to care

Interviewees also said that **notices should clearly address how the plan transition will affect enrollees' access to care**. For example, when the Paramount managed care plan exited the central/southeast region of **Ohio** in 2020, the plan sent letters to enrollees that addressed how the exiting plan was coordinating with the receiving plan to ensure continuity of care.

It read in part: *"Paramount will share important information about your care with your new managed care plan. Paramount will work closely with your new plan to help them get to know you and your needs. You can count on us to share: (1) Authorization information for ongoing services, such as home health care, durable medical equipment and out-of-plan provider visits (Note: All services that have been authorized by Paramount will be honored by your new managed care plan through the approved time period.) (2) Information about any recent assessments and (3) Care plans that you and your Paramount care manager have developed" (ODM 2020).*

This action-oriented information can help alleviate enrollees' fears about barriers to care in their new plan.

One enrollee advocate suggested that notices should include information describing how open appeals will be handled. Specifically, the advocate recommended **transferring decisions of recently closed appeals to the receiving plan** (such as appeals closed during

the month of the transition or up to three months before the transition date), so enrollees do not have to resubmit their appeals to the receiving plan. In addition, because enrollees may worry about being denied access to medications during a plan transition, advocates suggested that notices explicitly **address how access to prescription medications will be handled during and following the transition**.

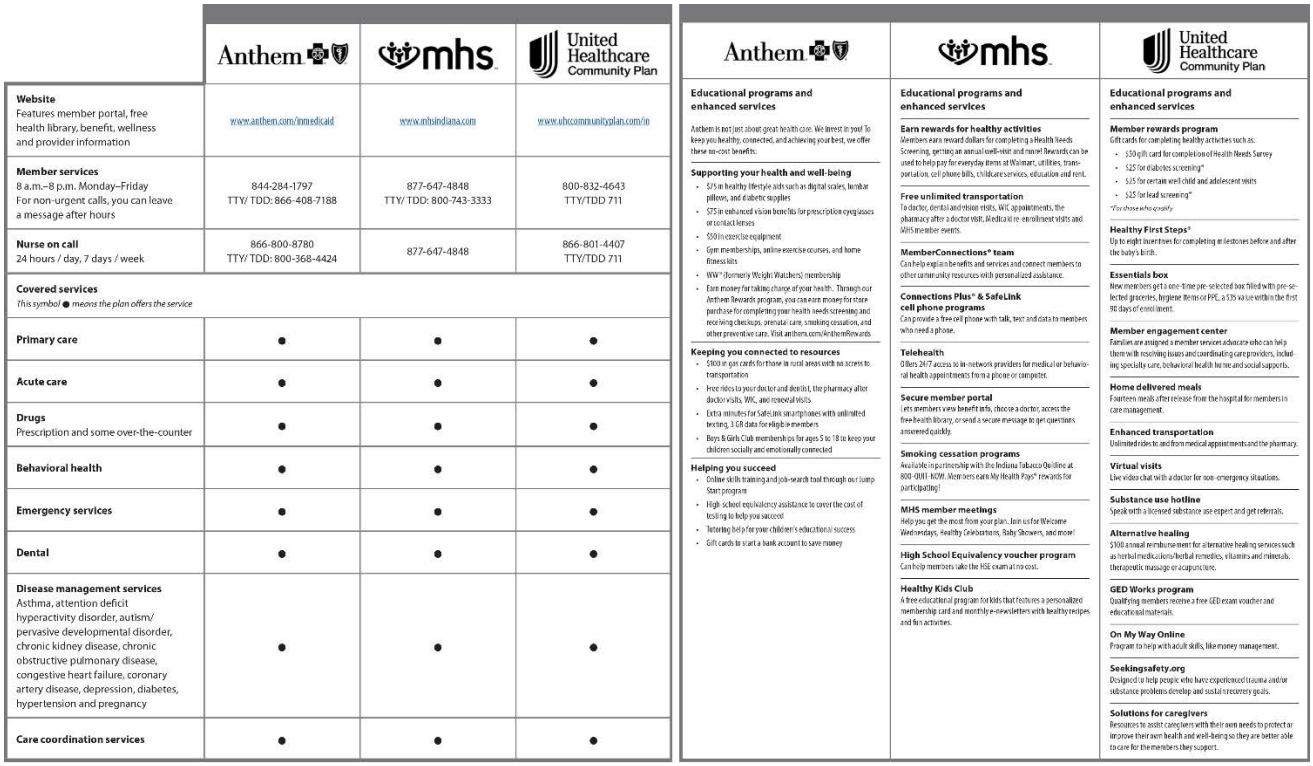
Which plans will continue to be available and enrollee plan choice considerations

When transitions require enrollees to select a new plan, notices should describe: (1) the plans that are accepting new enrollees, (2) what to consider when choosing between plans, (3) how to enroll into a new plan, (4) the deadline for choosing a new plan, and (5) what happens if an enrollee does not make a plan choice by the deadline. State Medicaid agency staff and enrollee advocates interviewed for this toolkit suggested that notices should:

- **List plan options, including where to go for more information about each plan, and remind enrollees to check that their preferred providers are in a prospective plan's network.** Some states interviewed for this toolkit enclosed additional plan information in the same envelope as the notice, such as a coverage chart and plan quality ratings. For example, **Indiana** provided a comparison table showing each plan's covered services, contact information, and value-added benefits (see. Figure IV.1).[5]

[5] "Value-added benefits" are benefits offered by managed care plans that go beyond the standard Medicaid benefits covered by all plans. This type of service is described at 42 CFR § 438.3(e)(i).

Figure IV.1. Example of a plan comparison chart sent to enrollees in Indiana during their 2021 transition



	Anthem	mhs	United Healthcare Community Plan
Website Features member portal, free health library, benefit, wellness and provider information	www.anthem.com/inmedicaid	www.mhsindiana.com	www.uhccommunityplan.com/in
Member services 8 a.m.–8 p.m. Monday–Friday For non-urgent calls, you can leave a message after hours	844-284-1797 TTY/ TDD: 866-408-7188	877-647-4848 TTY/ TDD: 800-743-3333	800-832-4643 TTY/TDD 711
Nurse on call 24 hours / day, 7 days / week	866-800-8780 TTY/ TDD: 800-368-4424	877-647-4848	866-801-4407 TTY/TDD 711
Covered services *This symbol ● means the plan offers the service*			
Primary care	●	●	●
Acute care	●	●	●
Drugs Prescription and some over-the-counter	●	●	●
Behavioral health	●	●	●
Emergency services	●	●	●
Dental	●	●	●
Disease management services Asthma, attention deficit hyperactivity disorder, autism/ pervasive developmental disorder, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, depression, diabetes, hypertension and pregnancy	●	●	●
Care coordination services	●	●	●

Source: Indiana Family and Social Services Administration, 2021 plan transition.

- **Explain the methods that enrollees can use to enroll in their chosen plan.** Methods could include: (1) calling an enrollment broker, (2) completing a paper enrollment form and returning it to the state agency by mail, or (3) filling out an online enrollment request.
- **Highlight deadlines** for making a plan choice and the date that enrollment in the new plan becomes effective.
- **Explain what will happen if an enrollee does not make a plan choice before the deadline.** For example, enrollees may be enrolled into a plan selected by the state on their behalf.

  When Paramount exited from the Central/Southeast region in February 2020, the notice included in the following language: *"What happens if I do not choose a new plan by April 30, 2020? ODM will ensure that you don't go a minute without coverage. If you haven't selected a plan by April 30, 2020, ODM will assign one to you. You'll receive a letter from ODM. It will share the name of your new plan and let you know it will be effective on June 1, 2020. If you would prefer a plan different than the one you're assigned, you will have 90 days to switch"* (ODM 2020).

What legal rights enrollees are guaranteed

Enrollees have the following rights during a plan transition:

1. **Access to information about the transition in accessible formats and prevalent non-English** languages, as well as access to an interpreter and auxiliary aids and services free of charge (42 CFR § 438.10).
2. **Access to objective, independent choice counseling** to help with understanding plan options and making a new plan selection (42 CFR § 438.71).
3. **Continued access to services to prevent serious detriment to the enrollees' health or reduce the risk of hospitalization or institutionalization**. To ensure this access during past transitions, the states interviewed for this toolkit required exiting plans to continue services for enrollees such as pregnant enrollees in their second or third trimester (depending upon the state), terminally ill enrollees, enrollees receiving inpatient services at the time of the transition, and enrollees scheduled to undergo a transplant. In addition, many states required that all enrollees entering a new plan have the right to prescription drug coverage without a prior authorization for a certain number of days following the transition. States must make their transition of care policies publicly available and provide instructions to enrollees on how to access continued services (42 CFR § 438.62).
4. The right to be **treated with respect and with due consideration for dignity and privacy** (42 CFR § 438.100).

Depending on the type of managed care program involved, enrollees may also have certain enrollment (42 CFR § 438.54) and disenrollment rights (42 CFR § 438.56) and the right to choose from at least two managed care plan options (42 CFR § 438.52).

To support enrollees in exercising their legal rights, notices can **(1) list the enrollees' rights**, including rights that are specific to certain populations, and **(2) provide instructions for how to file an appeal or grievance** (as applicable) if they believe their rights have been violated. **Puerto Rico**, for example, included a comprehensive list of enrollee rights in its notices for a recent transition, which included protections for enrollees who were pregnant and in their second or third trimester and those diagnosed with a terminal illness or receiving ongoing care during the plan transition.

Where enrollees can get help understanding plan options or filing a complaint

Choice counseling and support for filing complaints about managed care plan enrollment or access are key activities of a state's **Beneficiary Support System (BSS).** Requirements for the entities that comprise the BSS are specified at 42 CFR § 438.71. Toolkit interviewees noted that it can be helpful to include the names and contact information for state BSS entities in transition notices, along with a description of the kinds of support that the entity(ies) can provide and toll-free options for contacting them.

Use targeted language or specialized notices for certain populations

Many Medicaid plans enroll populations who use unique services or have a greater need for certain services than other enrollees, such as enrollees with intellectual and developmental disabilities, children with specialized health care needs, children in foster care, people who are pregnant, people without stable housing, and those who use LTSS. To ensure these populations receive the information they need, states may want to consider: **(1) including targeted information for certain groups in general notices and/or (2) developing population-specific notices that are mailed only to people in these groups**. Targeted information may include enhanced protections for certain populations or a description of how specialized services such as HCBS may be affected. **Ohio**, for example, developed specific, tailored communications for children in foster care that were separate from other plan transition notices. Ohio also worked closely with its sister agency, Children's Services office, to make sure that the communications were in line with that agency's processes and that the agency was aware of the transition.

Disseminate multiple, customized notices to enrollees during the choice period

Four of the six states interviewed for this toolkit indicated that they issued **a minimum of two to three mailed notices about the transition** and that issuing multiple notices to enrollees that had not responded was more effective than only sending one notice. In addition, states should consider mailing customized notices to reinforce deadlines to enrollees that have not responded can make it more likely that enrollees read a notice. For example, if the first notice stated, "You have 30 days to choose a new plan," the second notice could read, "We have not heard from you; you only have 15 days left to choose a new plan." Using phrasing such as "Urgent" on the envelope and design features like colors and font size can bring attention to important phrasing in follow-up notices (for example, "**30 days**," "**15 days**," "**5 days**").

In addition to sending multiple, customized notices, all state and enrollee advocate interviewees agreed that states should **mail initial notices at least 90 days prior to the transition effective date or enrollment choice deadline, whichever comes first**. This lead time allows the state enough time to process notices that are returned because of a wrong address.

Even if states do not have full details of an impending managed care plan transition, they can still notify enrollees that a change will be coming soon and to watch the mail for more details. For example, in **Nebraska**, when two Medicaid plans merged in 2021, the state sent a simple initial notice informing the affected enrollees of the plan merger, assuring them that nothing was changing immediately, and providing a time frame for when enrollees could expect to hear more details from the state. See Strategy 2 for more information about the importance of notifying enrollees as soon as possible about an upcoming transition.

Tips for states with less than 60 days until a transition

Even with a short time frame, states can send multiple notices to alert enrollees to an upcoming transition—for example, at 45 days and 30 days before the transition. States with less than 60 days until a transition may also want to supplement written notices with messages that are sent via other modes and messengers. For example, states can engage providers and community-based organizations to share information to their patients and clients.

B. Strategy 2: Use a variety of communication methods and messengers to reach enrollees impacted by the transition

State officials interviewed for this toolkit identified three goals for transition communications: (1) reaching enrollees with the message, (2) promoting enrollee understanding, and (3) motivating timely action (See Box IV.3). State interviewees noted that using **multiple communication methods increases the likelihood of the message reaching enrollees** (especially in instances when the state does not have an accurate home address on file for an enrollee), as well as the likelihood that the enrollee will act on the information before the transition deadline. See Box IV.4 for examples of communication methods that states have used to supplement written notices.

Box IV.3. Three key goals for transition communications

1. The message **reaches** enrollees.
2. Enrollees **understand** the message.
3. The message **motivates** timely action.

Box IV.4. Communication strategies to supplement mailed notices

Inaccurate enrollee addresses make it difficult for mailed notices to reach enrollees. Therefore, states should use multiple communication methods to disseminate information about plan transitions, including:

- **Phone-based outreach, such as phone calls, emails, or texting.** **New Mexico** noted that uses both text and email to reach enrollees, while an annual enrollee satisfaction survey conducted by a **Puerto Rico** contractor revealed that many enrollees prefer outreach by phone (text message or phone call) over mailed letters. In addition, states should ensure websites that accept enrollment requests are accessible on mobile devices.
- **Social media campaigns.** **Nebraska** conducted Facebook Live sessions to provide information about an upcoming plan transition. Other states used targeted Facebook ads to reach particular audience groups.
- **Partnerships with providers, pharmacies, patient advocacy groups, community-based organizations, and other trusted messengers.** In partnering with these entities, states can garner their buy-in for the transition process, solicit their expertise in shaping communication methods and messages, and educate them about the transition so they can educate the enrollees they serve.
- **Posting flyers at community sites.** Interviewees said that flyers with eye-catching designs and simple messages—such as "you have a new choice for Medicaid" (used by **Nebraska**)—were particularly successful. The states interviewed for this toolkit posted flyers in Veterans Affairs facilities, local libraries, YMCAs, legal aid offices, faith-based organizations, nursing facilities, federally qualified health centers, HCBS centers, and food pantries. Enrollee advocates recommended libraries and pharmacies as key places for advertisements, in addition to faith-based organizations.

Source: Mathematica state interviews conducted to inform this toolkit, 2021.

In addition to using a variety of methods for outreach, states may want to **use a variety of messengers to increase the reach of the message** and the likelihood that enrollees will trust the information. If enrollees receive a message about a plan transition from a trusted source, they may be more likely to take appropriate action after receiving the message. For example, enrollee advocates from **Ohio** indicated that Medicaid enrollees who are homeless often frequent public libraries and legal aid offices because they trust the staff, so these entities have served as critical messengers during the state's plan transitions. State interviewees identified several organization types as particularly helpful in developing and implementing enrollee communications, including the following:

- **Community-based organizations**, such as legal aid agencies, unions, social service organizations, fraternities, clubs, and cultural or ethnic organizations
- **State-based agencies**, such as state departments on aging or disability, child and family services and unemployment agencies, and departments of corrections
- **Enrollee advocacy organizations**
- **Health care providers and pharmacies** (see Box IV.5)

Box IV.5. Educating providers and pharmacies about plan transitions

Providers often serve as trusted messengers for their patients. States have informed providers about the transition and engaged their help in communicating with enrollees in a variety of ways, including:

- **Puerto Rico** created a separate web page on its website dedicated to provider education, including provider letters, educational presentations, and the territory's transition of care policies.
- **Iowa** sent providers letters regarding billing, continuity of care policies, the transition choice period, and enrollee plan options. The state also regularly communicated with providers via group meetings.
- **New Mexico** educated health care providers through regular informational email alerts sent out to provider groups, hospital associations, and primary care associations.

Enrollee advocates stressed the importance of **educating pharmacists about the transition and making sure that the systems that pharmacies use to look up enrollee coverage are up to date** during and immediately following a transition to prevent prescription access problems. States may wish to alert pharmacies, offer pharmacists mechanisms for verifying an enrollee's enrollment during the transition, and/or cover temporary prescription fills through fee-for-service Medicaid during the transition period. For example, **Puerto Rico** lifted all pharmacy network requirements and guaranteed enrollees' access to all medications prescribed by an ordering physician for the first 5 to 10 days following its last plan transition.

Source: Mathematica state interviews conducted to inform this toolkit, 2021.

Consider transition magnitude, enrollee characteristics, and timing when selecting communication methods

The following factors influenced states in their decisions regarding communication methods: (1) the magnitude of the transition, (2) the characteristics of enrollees impacted by the transition, and (3) the time available to prepare and deliver communications.

Magnitude of the transition

When considering potential communication methods, states should **contemplate the number of affected enrollees and the impact on their care**. For example, states interviewed for this toolkit tended to use more robust communication methods, such as statewide townhall meetings or TV, radio, or social media advertisements, when adding new plans to a managed care program because new plan additions often impact a large number of enrollees, some of whom may not already be connected to the new plan. In contrast, when **Virginia** experienced a plan merger in early 2021, the state only used notices to communicate about the transition because provider access did not change, and fewer people felt the effects.

Characteristics of enrollees impacted by the transition

State interviewees also said that the characteristics of enrollees impacted by a transition—for example, their health conditions, functional support needs, housing status, and languages spoken—should influence the communication methods used during a plan transition. Medicaid enrollees who lack access to stable housing, phones, or Internet access may face hurdles in receiving and responding to messages that require timely action (such as

designating a plan choice). In addition, certain enrollee populations, such as people with intellectual and developmental disabilities or limited English proficiency (LEP), may require additional support to understand and respond to plan transition messages. Moreover, certain high-risk individuals may be at an increased risk for negative health outcomes if a plan transition leads to gaps or delays in coverage. During a 2020 plan transition, **Ohio** used diagnosis codes in encounter data from its exiting plans to identify high-risk populations and target them with telephone outreach campaigns. Ohio and **Puerto Rico** also partnered with organizations that served high-risk populations to (1) obtain advice on messaging and communication methods, and (2) engage the organization as trusted messengers of key transition information. For example, Ohio disseminated talking points (see Appendix D) that other state agency partners (the Ohio Department of Developmental Disabilities, the state Department of Job and Family Services, the Department of Rehabilitation and Corrections, and the Child and Family Services Agency) communicated via newsletters, phone calls, website postings, email listservs, and public events. States may also want to consider coordinating with supportive housing providers, shelters, and food banks to train case management and other direct services staff as messengers of transition information.

"I used to work with homeless Medicaid members and every single person had a Facebook account." —Enrollee advocate

Time to prepare and deliver communications

When states had limited time to prepare for a transition, they prioritized communication methods that achieved broad reach to allow enrollees more time to react to the messages received. See Box IV.6 for examples of communication methods state interviewees recommended when time was tight and Chapter II for contract language that can provide states more time to prepare communications during plan transitions.

When states had more time to prepare, they used methods that supported enrollees' detailed understanding of their plan options, as well as dissemination of targeted messages to different enrollee populations through direct outreach. For example, when **New Mexico** used passive enrollment for a transition, the state had approximately 60 days to reach enrollees once the first set of 90-day notices were issued, leaving an additional 30 days for enrollees to react to the messaging. **During those 60 days, the state hosted 10 in-person town halls with managed care plans across nine cities.** At these events, enrollees could find out whether their existing providers had contracted with each remaining plan

Box IV.6. State communication methods used when time is limited

- Press releases.
- Flyers disseminated through provider, pharmacy, and state advocacy group email lists and posted in their communities.
- Text message notices and reminders, with enclosed website links.
- Mailings of forms for enrollees to indicate their plan choice, along with a chart comparing plan options and a pre-addressed, stamped envelope.
- Facebook Live events.

Source: Mathematica state interviews conducted to inform this toolkit, 2021.

option, ask questions related to the transition, and select a new plan.

State interviewees also described trade-offs between the rapid release of information to the public and the clarity and consistency of the messages delivered. For example, **Iowa** took time to prepare its messaging before communicating news of a plan transition, which enabled the state to be well prepared to answer questions. However, this careful preparation left limited time for enrollees to select a plan, which caused some frustration. Critics also claimed Iowa was not being "transparent" with enrollees because of the time it took for the state to release information. During a subsequent plan transition, Iowa disseminated news about the transition to the media within 24 hours. This meant that the state was not prepared to answer all questions right away, but enrollees had more time to select a plan. States approaching a plan transition may want to **consider potential trade-offs when determining the communication methods and timing** that will be most appropriate.

C. Strategy 3: Implement carefully designed enrollment and disenrollment processes

States can promote continuity of care and informed enrollee plan choice by **deploying (1) enrollment processes that provide enrollees with a variety of accessible ways to choose a plan** (including phone, Internet, in person, fax, and mail); (2) **impartial, comprehensive counseling on plan options** (§ 438.71); and (3) carefully designed **passive and default enrollment processes**, when applicable, that assign enrollees to plans that best meet their needs.

Allow enrollees to submit enrollment requests via more than one method

When states provide multiple ways for enrollees to submit a plan enrollment request, they can choose the method most convenient and accessible for their individual needs. All states interviewed for this toolkit offered enrollees a way to select their plan over the phone with an enrollment broker. In addition, each state also offered a variety of other methods to select a plan, including online enrollment, paper enrollment forms that could be submitted by mail or fax, and in-person enrollment locations or events. For example, **Puerto Rico** allowed enrollees to choose a plan in person at regional offices, while territory staff also traveled around the island to conduct in-person enrollment events.

New Mexico provided an option for enrollees to mail their plan choice to the state. However, staff interviewed for the toolkit mentioned that it took a long time to process these forms because it was hard to read the handwritten responses. Therefore, interviewees from New Mexico suggested that states minimize the need for handwritten responses on mail-in enrollment forms by pre-populating the names of plans in the form and requiring enrollees to indicate their plan selection by checking the box next to the plan name.

Provide impartial, comprehensive counseling of plan options

States are required to provide a BSS (42 CFR § 438.71) that includes choice counseling on their managed care plan options. When an enrollee makes an active plan choice, the state can reasonably assume that the enrollee was aware of the plan transition. However, an active choice does not presume that enrollees were well-informed about the transition's impact on their coverage or the plan options that would best serve them. Therefore, to promote active and informed enrollee choice, states need to offer impartial, comprehensive choice counseling that helps enrollees understand their plan options based on their health care needs.

Many states contract with independent enrollment brokers (42 CFR § 438.810(a)) to provide impartial counseling on Medicaid managed care plan options. Although state enrollment brokers are often well-versed in the state's managed care plan options and enrollment processes for enrollees who are new to the program, a plan transition generates a new set of circumstances for enrollment brokers to navigate. In particular, enrollee advocates interviewed for this toolkit cited a variety of barriers to care that stemmed from enrollment brokers' lack of knowledge about transitions and strained capacity to serve enrollees when demand increased during transitions. Therefore, states approaching a transition may want to **provide additional, targeted training and support to enrollment broker staff to make sure they are well prepared** to assist enrollees in understanding the transition, the enrollment options, and **what to do when they cannot answer an enrollee's questions during a call**. In addition to training, states can increase their enrollment broker or state hotline's capacity by employing backup call centers to fill-in when call volumes increase. See Box IV.7 for examples of ways states have mitigated barriers to care through enrollment broker training and support.

Box IV.7. Four state approaches to mitigating barriers to care through enrollment broker training and support

1. **Puerto Rico used a train-the-trainer model for training enrollment counselors.** Puerto Rico trained dedicated counselors to then train the rest of the enrollment counseling staff. If territory staff received an enrollee complaint about the enrollment counseling process, they would retrain the dedicated counselors, who would then retrain the rest of the staff, to prevent sharing misinformation. Puerto Rico also made "secret shopper" calls to assess counselors' responses and overall effectiveness of the trainings.
2. **Nebraska reviewed the enrollment broker's call scripts** to check the broker's messaging about the transition for accuracy.
3. **Iowa increased staffing at its enrollment broker call center during periods of transition** to respond quickly and effectively to the increased volume of enrollee calls. Iowa also allowed enrollees to choose a new managed care plan through an interactive voice response system that was available 24-7. Enrollees who were just making a plan choice could use that feature, freeing up counselors' time for those who needed more comprehensive enrollment assistance.
4. **Ohio** anticipated an increase in call volume to its enrollment broker during a plan transition and **hired additional staff** (also referred to as backup call centers). The state also developed a specific routing number for transitioned enrollees, so they would not have to wait in the general enrollment broker phone queue for an extended period of time. The transition-related calls also went to dedicated staff who were trained on how to counsel enrollees through the transition. Finally, Ohio set performance standards for timeliness, dropped calls, and wait times and listened to samples of counseling calls to monitor the quality of information provided to enrollees.

Source: Mathematica state interviews conducted to inform this toolkit, 2021.

In addition to providing initial training for enrollment broker staff, some states held regular check-in meetings with the broker's supervisors during the period of transition to gather information about enrollees' questions and requests and provide ongoing training to help broker staff respond effectively. Some of the enrollee advocates interviewed for this toolkit suggested that **state enrollment brokers can also document questions they receive but are unable to answer and request assistance from the state in answering those questions**—both to offer follow-up information to the enrollee who asked the question and to disseminate the answer through the counseling team. These advocates reported receiving complaints from enrollees that enrollment broker staff were unable to answer important coverage-related questions—such as whether the enrollee's preferred providers were in a plan's network and how the enrollee could maintain access to prescription medication during the plan transition—which should be easily answered with proper training and support from the state.

Use passive or default enrollment processes that assign transitioned enrollees to the plan that will best meet their needs

Each of the states interviewed for this toolkit used enrollment algorithms to determine which plan to assign enrollees to through passive or default enrollment processes. Computerized enrollment algorithms contain logic that the state and enrollment broker use to assign enrollees to plans based on factors such as the person's current primary care or family

member enrollment (42 CFR §§ 438.54(c)(6) and (d)(7). Because developing and executing such algorithms can be complex, state interviewees emphasized the importance of early preparation for automatic enrollment processes. For example, **Puerto Rico** started developing its enrollment algorithm six months prior to a plan transition and began testing and debugging the process three months before the transition.

States have integrated a variety of factors into passive and default enrollment algorithms, including:

- **Provider relationships.** Some states prioritize consideration of enrollees' current provider relationships (in comparison to plan networks), and proximity to plans' network health care providers.
- **Use of specialty services.** The number and priority of existing provider relationships may differ for people who use LTSS, behavioral health services, or are in a current course of treatment; for this reason, some states have used separate algorithms for these enrollees.
- **Family members' plan enrollment.** Another common factor prioritized in states' enrollment algorithms is family members' plan enrollments (to keep all family members in the same managed care plan). This is particularly important for children and their caregivers.
- **Existing plan enrollment.** States may also need to consider the capacity of the remaining Medicaid plans by incorporating enrollment thresholds for each plan into the algorithm to avoid creating access to care issues.

The priority of these factors may vary by state. For example, **Puerto Rico**'s overarching goal was to preserve enrollees' relationships with their primary care physicians and primary medical groups. In contrast, **New Mexico** prioritized keeping everyone in a family assigned to the same plan. **Flow charts can be helpful in describing a state's assumptions, parameters, and priorities for its plan assignment algorithm(s).**

D. Strategy 4: Exchange data to support continuity and coordination of care

When one or more plans exit a managed care program, states should assume responsibility for sharing historical utilization data (such as encounter records) and medical records, as appropriate, with the receiving plan(s) rather than relying on the exiting plan to do so (Box IV.8). States can also require the exiting plan(s) to share certain data with the state and/or the receiving plan(s), including:

Box IV.8. Key data to exchange during a plan transition

- Encounter records
- Provider information
- Assessment, care plan, and care coordination information
- Service or prescription drug authorizations and formulary exceptions granted by the exiting plan so drugs not usually covered can be covered
- Rosters of transitioning members whose health status or care needs are complex

- **Provider information.** To maintain existing provider relationships under the new plan, exiting or acquired plans can share information about enrollees' most recent provider visits, including visits to primary care and specialty providers, LTSS providers, and behavioral health providers. If the exiting plan or the state shares these data with a receiving plan, the plan can verify whether those providers are in its provider network. If they are not, the plan can reach out to the providers to solicit network participation or sign a single-case agreement to enable the providers to keep serving that enrollee.[6] Sharing these data enables care management staff in the receiving plan to **contact the transitioning member's providers** to understand their care goals and care plans and include the providers in the enrollee's newly formed care team at the receiving plan when appropriate. For example, during a recent plan transition, **Iowa** required exiting plans to share information with receiving plans about which transitioned members were enrolled with particular health homes and which providers the exiting plans held single-case agreements with for transitioned members.
- **Assessment, care plan, and care coordination information.** To promote care continuity, **exiting or acquired plans can share information from assessments of enrollees' health risks, needs, or functional status; care plans; and names of external care coordination entities** (for example, case managers associated with a state HCBS delivery system). Providing these data to the receiving plan prevents it from having to conduct new assessments and care planning processes immediately after the transition, which streamlines the transition process for enrollees and avoids disruptions in care. In addition, sharing risk assessment and care plan data for transitioned members can provide care coordinators at the receiving plan with at least some information about their new members before meeting them. Receiving plans can use that data to match care

[6] Single-case agreements are contracts between providers and managed care plans that enable the providers to receive payments from the plan for services delivered to a single plan member or a selection of plan members without signing a broader network contract with the plan.

coordinators to enrollees based on their needs and ensure that care teams include an appropriate mix of providers and other individuals involved in the enrollee's care.

- **Service or prescription drug authorizations, and exceptions granted by the exiting plan.** By **honoring authorizations and exceptions that have already been granted by the exiting plan**, receiving plans can promote continuous access to the services and prescription drugs that transitioned enrollees need to maintain their health. Arriving at a pharmacy to pick up a medication and learning that the medication has been denied or requires insurance authorization is not just frustrating, it can pose a potential health risk if the Medicaid enrollee leaves without a medically necessary prescription. The inability to obtain prescription drugs or other medically necessary services during a period of transition can also result in enrollee dissatisfaction with the receiving plan and lead to unnecessary appeals, grievances, or poor-quality ratings.
- **Rosters of transitioning members whose health status or care needs are complex.** This information helps receiving plans prioritize outreach and care coordination activities with transitioned members who may need those services most immediately. For example, exiting plans can share information about which of their transitioning members are pregnant; are homeless; have developmental disabilities, serious mental illness, or other disabilities; are actively involved in substance use disorder treatment; and are currently receiving LTSS.

Consider defining data formats and testing the exchange before sharing data across plans

States should play the lead role in facilitating successful data sharing during plan transitions. The subsections that follow summarize steps states can take to achieve successful data transfers.

Designate file layouts, fields, and values

States can facilitate data sharing during plan transitions by developing a standard data exchange file layout, as well as definitions and instructions for the data fields and values to be included. Developing standard data templates, requiring all exiting plans to use those templates, and providing written definitions or tools to help receiving plans input and ingest data correctly, promotes consistent data transfers, even if multiple plans exit a program simultaneously.

States can develop and share a standard file layout and related instructions during the planning phase of the transition. For example, **Ohio** and **Iowa** both developed detailed sets of file transfer requirements for exiting plans and established secure file transfer protocol (SFTP) sites for data transfer. Ohio conveyed its data sharing requirements in a written memo that provided high-level descriptions of the files to be shared and PDFs with specifications for the fields and values to be included in each file. Similarly, Iowa developed a detailed spreadsheet listing each of the files to be transferred, with embedded files describing the file

layout and field/value requirements. Table IV.1 summarizes the methods used by four states and **Puerto Rico** to establish data sharing expectations and processes for exiting plans during periods of transition.

Table IV.1. State approaches to development of standard data templates and data sharing

Approaches	IA	NE	NM	OH	PR
Development of data sharing template/instructions					
State/territory developed	X		X	X	X
Enrollment broker developed		X			
Transfer of data					
State SFTP site	X			X	
Exiting plan(s) sent directly to receiving plan(s)			X		X
Exiting plan(s) sent to enrollment broker and enrollment broker sent to receiving plan(s)		X			

Source: Mathematica analysis of data from state interviews.

Of the states interviewed for this toolkit, most developed data sharing templates for exiting plans themselves, while one state delegated that responsibility to its enrollment broker. When developing data transfer templates and instructions, states may wish to solicit feedback from both exiting and receiving plans. For example, **Puerto Rico** developed a data transfer template when a plan exited its managed care program, but first held several meetings with the exiting plan and each of the receiving plans to understand the information that each plan needed to execute the transition effectively. Puerto Rico noted that "staff put in a great deal of effort to establish a standardized data layout, but that ultimately it helped to ensure that each receiving plan got the information they needed to maintain continuity of care for the transitioned enrollees." Now, Puerto Rico uses this same data transfer template each time an individual enrollee switches from one managed care plan to another, in addition to using it during larger transitions.

Regardless of the data sharing approach selected or who is responsible for establishing the data sharing templates and instructions, ongoing communication between the state, the plans, and any other entities involved in the data transfer increases the likelihood of successful data transfer during the transition.

Test and evaluate data exchange

Once state staff and other decision makers have agreed on the file layouts, fields, and values, **states can require exiting and receiving plans to test the established file exchange processes in advance of the transition**. Testing ensures that the exchange processes function effectively before implementation and that both exiting and receiving plans are ready to play their respective roles in the exchange. It also allows the state and plans to identify and rectify problems or gaps in the data exchange process before the transition occurs, thereby supporting more successful data exchange when enrollees' health is at stake.

States can evaluate the quality and success of the data exchange processes during and after the plan transition as well. For example, states can request that the exiting plan share a copy of the files in advance so that the state can review the data being shared for potential errors, missing data, or other concerns. Alternatively, states can meet regularly with the exiting and receiving plans to identify and address any issues that arise in the data sharing process or any questions that receiving plans might have about the data they have received. The following are examples:

- **Ohio** initially held daily meetings with exiting and receiving plans during a recent plan transition to ensure that all required data were being exchanged and received effectively and to address any problems experienced by the exiting or receiving plans. The cadence of meetings changed to weekly as Ohio progressed through the transition.
- **New Mexico** used weekly systems calls with exiting and receiving plans to discuss any issues that arose in their file exchange so that state systems staff could help troubleshoot.

Steps used by Ohio when implementing their 2020 transition

Figure IV.3 below summarizes the steps Ohio used during a recent plan transition, which states can use an example in planning their own transition timelines. However, the "Number of days before Transition" that Ohio used may not be appropriate for every transition. For example, Ohio allowed only 40 days to "Update Federal Authorities," which is likely not long enough. States should evaluate each activity based on the unique characteristics of their program to determine the appropriate number of days for each step.

Figure IV.2. Example checklist for implementing a transition based on Ohio's 2020 transition

Number of Days Before Transition	State Activity	Activity Description
150 to 130 and 90 to 60	Send Notices	Print and mail notices to members, using mailing lists developed by the MMIS vendor
150 to 0	Prepare Outreach Plan for Special Populations	Execute processes for special population identification, analysis, and outreach plan (e.g., CallFire campaign**)
130 to 90	Systems Testing	Identify system defects which could impact the auto-assignment timeline, if any (e.g., any issues with member addresses or counties)
130 to 30	Communications Monitoring and Continuous Quality Improvement	• Develop and distribute internal and external talking points for members impacted by transition • Collect and report on queue volume, wait times, volume and methods of plan changes, and status/effectiveness of communications plan • Update communication strategies and develop additional strategies to respond to emerging needs
110 to -30*	Implementation Monitoring	• Monitor implementation issues that arise, including issues that come up at sister agencies • Monitor provider/member grievances and communicate internally among program areas to stay on top of any new concerns that might lead to new communication needs
90 to 60	Implement Additional Communication Strategies	• Conduct CallFire campaign**
40 to 0	Update Federal Authorities	• Provide list of areas/regions of the state the managed care plan is exiting from to federal authorities
30 to 0	Closing of Choice Period Activities	• Close choice period and process automatic plan assignments for enrollees who did not make an active choice • Initiate data transfer for transitioned enrollees

*Negative numbers refer to the number of days after the transition date.

**A CallFire campaign conducts direct outreach to special populations (such as to achieve a specific objective. Special populations include people with intellectual and developmental disabilities, children with specialized health care needs, children in foster care, people who are pregnant, people without stable housing, and those who use LTSS. This step is completed after states or managed care plans send notices to members so the enrollment broker can reference the notice in their discussion with the member.

Tips for states with less than 60 days until a transition

Defining extensive data sharing requirements may not always be feasible during quick transitions. In these cases, states can meet with exiting and receiving plans early in the transition process to identify the most important data elements to share and prioritize them. States should always assume responsibility for transferring historical utilization data such as claims or encounter records with the receiving plan(s).

Outside of an active transition period, states should develop contract requirements and basic expectations for data sharing when a transition occurs. Such preparatory activities can facilitate quicker and smoother data sharing, even if a transition has a short timeline.

Chapter V

Monitoring enrollment and continuity of care during and after the transition

States can work with exiting and receiving plans, as well as with enrollment brokers and other parties, to monitor enrollee experiences and continuity of care during and following plan transitions. Particularly important to monitor are: (1) enrollment changes and experiences, (2) enrollee access to care, and (3) continuity and coordination of care. Also, once a plan transition, including all monitoring steps, is complete, states can debrief with receiving plans, enrollment brokers, other parties and internal team members to identify process changes to improve future transitions.

Box V.1. Chapter Summary: Monitoring

This chapter highlights strategies states can use when monitoring effectiveness of implementing their plan transition:

- **Strategy 1:** Monitor enrollment changes during and after transition.
- **Strategy 2:** Monitor data to evaluate access to care.
- **Strategy 3:** Assess the success of care coordination efforts during and after plan transitions
- **Strategy 4:** Debrief on systems and processes for future transitions and close out with the exiting plan.

A. Strategy 1: Monitor enrollment changes during and after transition

Review enrollment reports during the transition period

States can set performance benchmarks and use enrollment data to measure progress and to determine how enrollees make an active plan selection. If data suggest that enrollees are not actively choosing a plan, the state can quickly correct course through person- or population-specific intervention strategies (such direct outreach or additional messaging through traditional and social media). Once enrollees are notified of a plan transition and asked to select a new plan, states may want to monitor the following:

- **The number of active plan selections processed, and the number of enrollees added to each receiving plan.** Capturing these data will allow states to: (1) monitor how many enrollees have received information about the transition and made an active plan choice and (2) determine whether one plan is becoming more saturated than others. In a recent transition, **Ohio** separated its data by high-risk and non-high-risk populations to assess how well different communication strategies reached different enrollee groups. See

Figures V.1 and V.2 for examples of reports that Ohio collected from its enrollment broker to monitor plan selection.

Figure V.1. Example of an Ohio enrollment broker weekly report, 2019

Enrollment Broker Reporting for Week of X/XX/XXXX
Cumulative Data

Date As Of	Cumulative Number of Incoming Calls	Cumulative Number of Plan Changes	Plan A	Plan B	Plan C	Plan D
Week 1	2,753	1,446	157	857	228	204
Week 2	3,791	1,925	227	1,107	308	283
Week 3	4,717	2,309	266	1,321	384	338
Week 4	5,465	2,629	309	1,512	436	372
Week 5	6,413	3,073	364	1,748	522	439
Week 6	7,830	3,661	440	2,090	618	513
Week 7	8,794	5,072	589	2,859	877	747
Week 8	9,429	5,575	647	3,135	967	826
Week 9	9,913	5,973	705	3,324	1,038	906
Week 10	10,633	6,788	806	3,733	1,189	1,060
Week 11	11,307	7,592	911	4,135	1,362	1,184
Week 12	11,937	5,839	1,055	4,589	1.530	1,365

Incoming calls represents the number of incoming calls to the enrollment broker where the caller selected the queue for the Transition. An incoming call may be associated with more than one plan change and plan changes include those made online or over the phone.

Source: ODM Playbook: Enrollment Broker Report Template (weekly and cumulative), obtained from ODM staff via email on May 19, 2021.

Figure V.2. Example of a high-risk member movement report from Ohio, 2019

High-Risk Member Movement Overview for Week of MM/DD/YY
Exiting Plan's High-Risk Members and Which Plan They Are Enrolled With As Of MM/DD/YY

Plan Name	Number High Risk Members Enrolled During MM/DD/YY	Percent High Risk Members Enrolled During MM/DD/YY
Total	5,201	100.0%
Plan A	3,010	57.9%
Plan B	254	4.9%
Plan C	956	18.4%
Plan D	379	7.3%
Plan E	317	6.1%
Fee-for-Service	100	1.9%
No Medicaid	185	3.6%
Number of Exiting Plan High-Risk Members Who Are No Longer Enrolled With Exiting Plan		2,191
Percent of Exiting Plan High-Risk Members Who Are No Longer Enrolled With Exiting Plan		42.1%

Source: Exiting Plan file of High-Risk members and BIAR
Data from ODM's Business Intelligence Analytic Report (BIAR) is current as of 0X-XX-XX
Report Date: 0X-XX-XX
Source: ODM Playbook: High-Risk Member Movement Report Template, obtained from ODM staff via email on May 19, 2021.

- **The number of transition-related calls made to the enrollment broker or state hotline, hold times, and average call duration compared to pre-set benchmarks.** State enrollment brokers and/or state hotlines can collect information about the reasons for an enrollee's phone call via touch-tone or voice prompts. For example, when enrollees in **Ohio** call the state's enrollment broker during a plan transition, a prompt tells them to press a specific number on their phone to ask questions related to the upcoming transition. This allows the enrollment broker and the state to track the number of transition-related calls. States can use these data to identify peak call times and changes in call volume after dissemination of notices or other enrollee outreach or communications. In addition, states can collect data on hold times to monitor enrollee access to enrollment counselors and intervene if needed (for example, by adding additional counselors during peak call periods) and call durations to check whether counseling is being provided and how long that process is taking on average. By comparing trends in these data relative to benchmarks (for example, average call volume during a previous transition), states can identify potential issues in how enrollees are understanding the transition and act quickly to remedy any issues.
- **Number of outreach calls made to inform enrollees about the upcoming transition**, including the number of successful and unsuccessful attempts to reach enrollees and the

total number of plan changes processed during enrollee outreach calls. When **Ohio** conducted outreach phone calls to high-risk and non-high-risk population groups, the state used separate reports to monitor the effectiveness of this outreach by population.

Review enrollment reports after the transition period

In addition to monitoring enrollment selections made during the choice period, states can also **monitor enrollment changes made during the first 90 days after a transition**, because changes may demonstrate that enrollees were inadequately informed about their plan choices or factors to consider when choosing a plan. By reviewing these data and identifying trends or points of concern, states can improve enrollee outreach, communications, and default or passive assignment algorithms for future transitions as well as help receiving plans improve their outreach and retention efforts with transitioned enrollees.

To monitor post-transition enrollment changes, states can ask their enrollment brokers to submit reports showing (1) the number of enrollees who were enrolled into each receiving plan via active choice or a passive or default enrollment process during the transition and (2) how many of those enrollees changed to another plan during the first 90 days after enrollment into the receiving plan. For an example reporting table, see Table V.1.

Table V.1. Sample reporting table for monitoring enrollment changes within 90 days of a transition

Receiving plan	Number/percentage of enrollees default/passively enrolled into plan	Number/percentage of enrollees who actively enroll into plan	Number/percentage of enrollees who chose a different plan	Number/percentage of enrollees who returned to fee-for-service Medicaid, total and by reason for return (if applicable)
		Data from [DATE] to [DATE]		
Plan A				
Plan B				
Plan C				

Source: Mathematica, 2021.

B. Strategy 2: Monitor data to evaluate access to care

By requesting and monitoring data on service utilization, satisfaction, and complaints, states can gauge enrollees' continued access to vital health care services and intervene when concerns arise. In addition to collecting data from exiting and receiving plans to inform their access to care analyses, states may also wish to gather feedback and reports directly from enrollees or other entities, such as ombudsman or providers. The types of data may include the following:

- **Encounter data.** States can monitor encounter data reports from exiting and receiving plans to identify changes in service utilization patterns among transitioned enrollees. By

comparing utilization trends before and after a transition, states can identify services where potential barriers to care may exist due to the transition. For example, if encounter data show significant post-transition decreases in the utilization of certain services, states may want to interview the enrollees, providers, and managed care plans to determine whether access to care issues require mitigation.

- **Appeal and grievance data from exiting and receiving plans.** States can require exiting and receiving plans to submit data to the state regarding appeals and grievances filed during and after the transition to monitor enrollee complaints and concerns, particularly those related to access to care or continuity of services. For example, changes in the number or types of appeals and grievances filed before and after the transition could indicate barriers to care or difficulties with accessing plan assistance.
- **Prior authorization data.** States should examine data that show the extent to which receiving plans honor prior authorization requests granted by the exiting plan if such practices are required under a state's continuity of care policy. For example, **Ohio** monitored these data to ensure that the receiving plan fulfilled its obligations.
- **Reports from ombudsman programs.** States can also partner with long-term care, Medicaid managed care, and other ombudsman programs to elicit feedback on complaints received by those entities during and after plan transitions. States can collect and review written reports and/or conduct regular or ad hoc meetings with ombudsman programs to identify any access issues that transitioned enrollees may be reporting. For example, Medicaid managed care ombudsman staff interviewed for this toolkit recommended that states collect qualitative and quantitative reports, including data sorted into categories of the most frequent complaints. States can also meet with ombudsmen on a regular basis to discuss barriers to care that they are spotting in real time and intervene with the appropriate receiving plans, as necessary.
- **Complaints and concerns from providers.** States should collect complaints and concerns from providers during and after the transition, as well. Observing trends in provider complaints may identify potential access concerns, exiting plans that are not fulfilling their claims payment obligations, or receiving plans that are not credentialing new providers in a timely manner. To streamline and track the collection and resolution of complaints, some states developed a provider complaint portal where providers submit concerns about enrollee access to care that remain unresolved after communication with the managed care plan. For example, **Illinois** launched a provider complaint portal after the state started a new Medicaid managed care program in 2018. Illinois developed clear procedures and timelines for submitting complaints through the portal, including a requirement that providers first submit their dispute through the plan's internal processes.
- **Reports from pharmacies.** Pharmacies can share information with the state about prescriptions that receiving plays deny in the weeks and months following the transition. States can compare this information to encounters to ensure that plans are reporting

accurate information to the states. Mismatches might signal gaps in the continuity of prescription drug coverage.

> *"A big part of the complaints that I got were from people who have been taking a prescription for 10 years, they changed plans, and they said that they have to take new steps before the plan would cover the prescription. This may be due to the records not transferring." —Enrollee advocate*

- **Enrollee satisfaction surveys.** States may also conduct (or require receiving plans to conduct) surveys with transitioned enrollees to evaluate their satisfaction in the months following a Medicaid managed care plan transition. States can design surveys solely to evaluate enrollees' experiences during the transitions or use existing surveys to assess how the transition went. For example, **Puerto Rico** conducts an annual enrollee satisfaction survey for Medicaid managed care enrollees. Territory staff were able to leverage that existing survey to monitor enrollees' experiences during a recent plan transition. Puerto Rico used the enrollee feedback in that survey to make improvements to its processes for future plan transitions.
- **Enrollee interviews and/or focus groups.** In addition to, or instead of, written or telephone surveys, states or their contractors can conduct interviews or focus groups with a selection of transitioned enrollees about their experiences during the transition. In conducting such interviews, states can oversample high-risk groups to obtain ample data on those enrollees' experiences.

C. Strategy 3: Assess the success of care coordination efforts during and after plan transitions

To ensure that new plans are providing enrollees with the same type and frequency of services they received in their previous plan, states can collect and review:

- **Reports on receiving plans' orientation and welcome activities.** States can require that plans orient new members by providing ID cards, benefits summaries, plan handbooks, as well as welcome calls that go beyond the initial screening required by 42 CFR § 438.208(b)(3). States can also require care coordinators to conduct or update health risk assessments through phone calls or in-person visits, particularly with enrollees who do not have assessment data and a plan of care on file.[7] To ensure that each of these key activities are happening on schedule, states can request that plans report the numbers of enrollees reached at various touch points. States that require plans to conduct specialized outreach activities—for example, requiring "warm handoff" calls between care coordinators in the exiting and receiving plans for high-risk enrollees, as **Ohio** has done—

[7] 42 CFR § 438.208(c)(2) directs states to require that MCOs, PIHPs, and PAHPs comprehensively assess Medicaid enrollees that need LTSS or have special health care needs for the purpose of identifying any ongoing special conditions that require a course of treatment or regular care monitoring.

can also require reports on these activities. Examples of data that could be collected in such reports include (1) the proportion of successful welcome calls completed (such as enrollees reached versus not reached, enrollees with coverage questions that are fully addressed during the call, enrollees connected to services, and enrollees who require additional follow-up to connect them to services and providers) and (2) the proportion of health risk assessments conducted and updated.

- **Enrollee satisfaction surveys, interviews, or focus groups.** As noted previously, states can use enrollee satisfaction surveys, interviews, or focus groups to understand enrollee experiences during a plan transition. States can use these tools to ask whether and when transitioned enrollees were contacted by the receiving plan's care coordinators as well as their perspectives of the receiving plan's outreach and care coordination efforts. These data can help the state and receiving plans to understand which outreach and care coordination methods have been most and least effective and to adapt their requirements and efforts accordingly.

D. Strategy 4: Debrief on systems and processes for future transitions and close out with the exiting plan

To document lessons learned from the plan transition process and adapt for future transitions, states can host meetings with transition team members and other involved parties to debrief on the transition process. States can document lessons learned in a centralized document to ensure that key takeaways inform future transitions. Most states interviewed for this toolkit suggested that states (1) hold such meetings within 30 to 60 days after a transition, so the experiences documented are fresh; and (2) document lessons learned to avoid repeating mistakes in future transitions and help retaining information that could be lost when state staff turnover.

The following suggestions can help ensure an effective debrief:

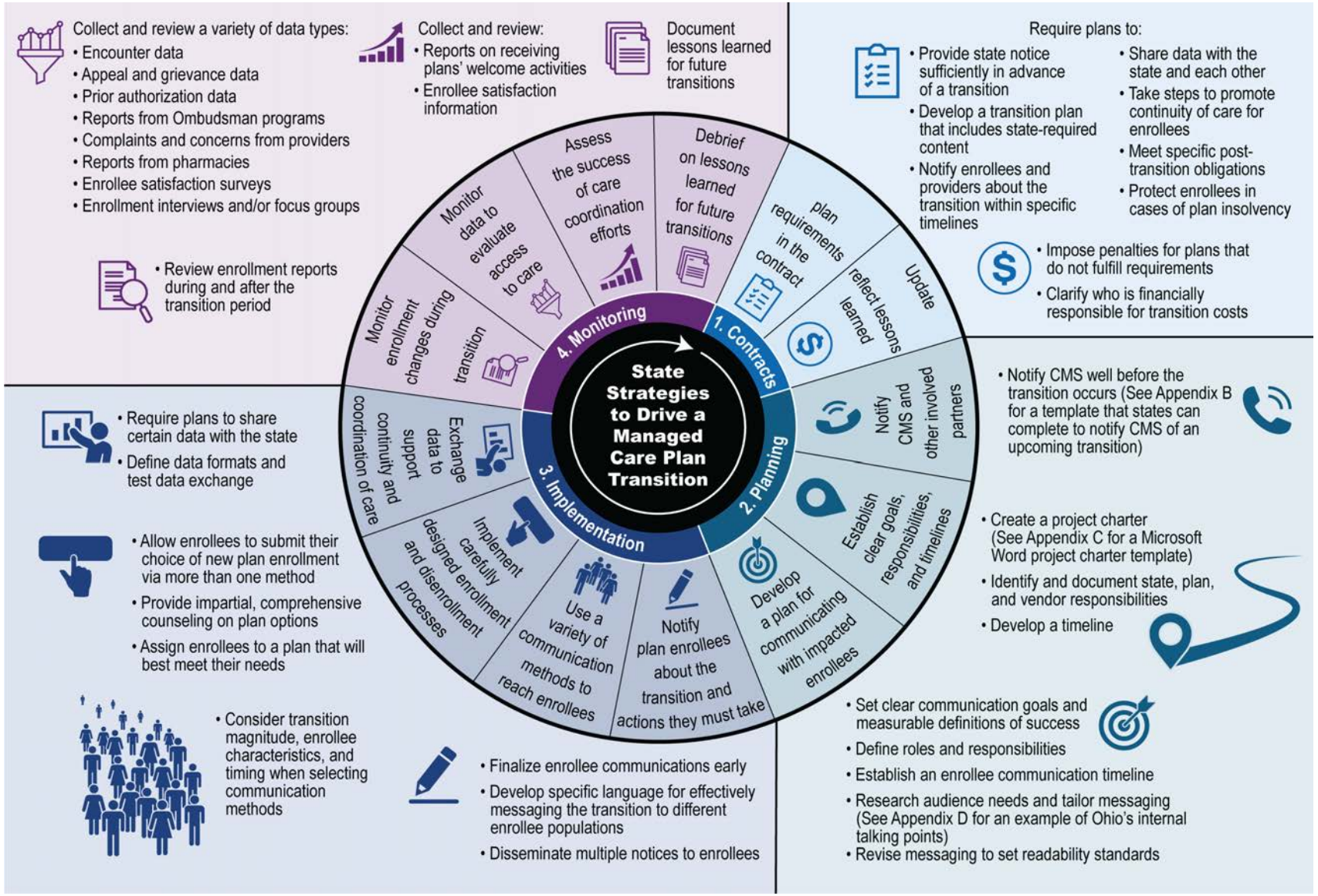
- **Determine the number of meetings and invitees** based on the kinds of feedback desired. In some instances, states may want to host multiple meetings with different organization types to solicit open feedback from each. In other cases, states may want to bring all groups to a single meeting for transparency.
- **Allow enough time** for an open discussion among all participants at the meeting. Consider the number of participants and topics for discussion when determining the length of the meeting and agenda.
- **Designate a notetaker** to document and categorize lessons learned and other key takeaways from the discussions.
- **Develop and send questions in advance**, so attendees have time to think through their responses before the discussion.
- **Frame questions to encourage constructive conversation.** For example, ask about what worked well and what participants would change.
- **Open the meeting with a message from state leaders** that encourages open discussion and feedback about improvement. Participants may be hesitant to speak up if leaders do not set the tone to encourage candid dialogue.
- **Save lessons learned in a place that is accessible to multiple state staff**, so it is easily retrievable if staff involved in the program change.

Chapter VI

Summary framework to drive a successful transition

Figure VI.1 summarizes the strategies states can use when (1) updating contracts, (2) planning, (3) implementing, and (4) monitoring a managed care plan transition. The outcomes of each phase influence the steps taken in subsequent phases, as well as the steps taken to prepare for future transitions. States are encouraged to use this as a checklist of strategies and sub-strategies when progressing through the phases of the transition framework.

Figure VI.1. Transition framework



References

Administración de Seguros de Salud de Puerto Rico. Puerto Rico Medicaid Managed Care Contract. San Juan, PR. 2020. Accessed September 2021. Available at https://www.asespr.org/proveedores-2/contratos/. Accessed September 2021.

Allen, K. "Review of Medicaid Managed Care Procurement Landscape in 2017." *Health Management Associates In Focus* blog, September 28, 2017. Available at https://www.healthmanagement.com/blog/review-medicaid-managed-care-procurement-landscape-2017/. Accessed August 2021.

Indiana Family and Social Services Administration. "Hoosier Care Connect Health Plan Summary." 2021. Available at https://www.in.gov/medicaid/members/files/Care_Center_Comparison.pdf. Accessed September 2021.

Iowa Department of Human Services. "Managed Care Organization Contract." Sioux City, IA. 2019. Accessed September 2021.

Mathematica. "Sample reporting table for monitoring enrollment changes within 90 days of a transition" Washington, DC. 2021.

Nebraska Department of Health and Human Services. "State of Nebraska Service Contract Amendment, January 1, 2017-December 31, 2021." n.d. Available at https://das.nebraska.gov/materiel/purchasing/contracts/pdfs/71164(o4)awd.pdf. Accessed September 2021.

New Jersey Department of Human Services, Division of Medical Assistance and Health Services. "FamilyCare Program Contract." October 2020. Available at https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf. Accessed August 2021.

Ohio Department of Medicaid. Notice about Paramount leaving Ohio's central/southeast region. Columbus, OH. February 2020. Accessed October 2020.

Ohio Department of Medicaid. "Ohio Medical Assistance Provider Agreement for Managed Care Plan, 2021." 2021. Available at https://medicaid.ohio.gov/static/Providers/ProviderTypes/Managed+Care/Provider+Agreements/2021_07_MMC_Final.pdf. Accessed August 2021.

Virginia Medicaid, Department of Medical Assistance Services. "Commonwealth Coordinated Care Plus MCO Contract for Managed Long-Term Services and Supports, July 1, 2021-June 30, 2022." n.d. Available at https://www.dmas.virginia.gov/media/3579/final-ccc-plus-contract-renewal-effective-july-1-2021.pdf. Accessed September 2021.

WellCare of Nebraska, Inc. Notice about the WellCare and Blue Cross plan merger. Tampa, FL. July 2020. Accessed October 2020.

Appendix A: Example of managed care plan contract language supporting plan transitions

The contract language provided in the table below was extracted from managed care plan contracts in Iowa, Nebraska, New Jersey, Ohio, Puerto Rico, and Virginia.

Transition Requirement	Example Contract Language	Plan Responsible
Duration of Transition Period	The Contractor agrees to participate in a transition period that is at least 180 days prior to the effective date of transition to ensure quality customer service, and effective continuity and coordination of care.	Exiting Plan
State Notice of Merger or Acquisition	In addition to any other information otherwise required by the State, a Contractor that intends to merge with or be acquired by another entity ("non-surviving Contractor") shall provide the following information and documents to DHS, and copies to DOBI, one hundred-twenty (120) days prior to the effective date of the merger or acquisition: 1. The basic details of the sale, including the name of the acquiring legal entity, the date of the sale and a list of all owners with five (5) percent or more ownership. 2. The source of funds for the purchase. 3. A Certificate of Authority modification. 4. Any changes in the provider network, including but not limited to a comparison of hospitals that no longer will be available under the new network, and comparison of PCPs and specialists participating and not participating in both HMOs. This shall also include an analysis of the impact on Members. 5. Submit a draft of the asset purchase agreement to DHS and DOBI for prior approval prior to execution of the document. 6. The closing date for the merger or acquisition, which shall occur prior to the required notification to enrollees, i.e. no later than sixty (60) days prior to effective date of transition of enrollees. 7. Submit a copy of all information, including all financials, sent to/required by DOBI	Exiting Plan
Written Transition Plan	Submit a written Transition Plan to the State for approval: 1. In a timeframe identified by the State following a triggering event as set forth in this contract. 2. In a timeframe identified by the State in any Notice of Termination. 3. Within 180 Days before Contract expiration. Revise the Transition Plan as necessary to obtain approval by the State. Execute, adhere to, and provide the services set forth in the State-approved plan. Obtain State prior approval for all changes to the plan. Make any updates to maintain a current version of the plan.	Exiting Plan
Transition Liaison	The Contractor shall appoint a Transition Coordinator who will serve as the primary point of contact for planning and managing all plan transition activities associated with plan termination and/or nonrenewal.	Exiting Plan

Transition Requirement	Example Contract Language	Plan Responsible
Active Prior Authorizations	Members who have active prior authorization approvals and care management with a MCO that is terminating or that are moving from fee-for-service (FFS), need to continue to receive care when they transition to their new MCO. The Enrollment Broker must establish a file exchange between the current MCOs, to receive all members' prior authorization and care management records from the existing entities and send the applicable data to the member's new MCO. The initial file must be sent to the MCOs within one business day of the initial auto-assignment run. A final file must be sent prior to 7:00 am central time on [insert date].	Exiting Plan
Data Types	[The Contractor shall] transfer all applicable clinical information on file, including but not limited to approved and outstanding Prior Authorization requests and a list of Enrolled Members in Community-Based Case Management or Care Coordination, to the Agency and/or the successor Program Contractor in the timeframe and manner required by the Agency.	Exiting Plan
Data Requirements	The Contractor shall be responsible for the provision of necessary information and records, whether a part of the MCMIS or compiled and/or stored elsewhere, to the new Contractor and/or the state during the closeout period to ensure a smooth transition of responsibility. The new Contractor and/or the state shall define the information required during this period and the time frames for submission. Information that shall be required includes but is not limited to: 1. Numbers and status of grievances in process; 2. Numbers and status of hospital authorizations in process, listed by hospital; 3. Daily hospital logs; 4. Prior authorizations approved and disapproved; 5. Program exceptions approved; 6. Medical cost ratio data; 7. Payment of all outstanding obligations for medical care rendered to enrollees; 8. All encounter data required by this contract; 9. Information on enrollees in treatment plans/plans of care who will require continuity of care consideration; and 10. Evidence of compliance with Article 7.36.7 of the Contract relating to compliance with Section 6032 of the Deficit Reduction Act of 2005. 11. Functional Assessment data gathered from the [state] Choice Assessment System.	Exiting Plan
Transition Reporting	The Contractor shall submit to the State, on a timely basis, all necessary reports concerning the operations of the Contractor pursuant to the Transition Period. In the course of the Transition Period, the State may require additional information or ad-hoc reports.	Exiting Plan
Member Notices	If applicable, unless otherwise notified by ODM, the MCP shall notify their members regarding this Agreement termination at least 45 calendar days in advance of the effective date of termination. A member outreach workflow identifying the approach and timing of outreach to the members impacted must be included. The member notification language and process shall be approved by ODM prior to distribution.	Exiting Plan

Transition Requirement	Example Contract Language	Plan Responsible
Member Notices for a Merger or Acquisition	General Requirements. Enrollee Notification. By no later than seventy-five (75) days, the non-surviving Contractor shall prepare and submit, in English and Spanish, to the state, letters and other materials which shall be mailed to its enrollees no later than sixty (60) days prior to the effective date of transfer in order to assist them in making an informed decision about their health and needs. Such letters shall not be mailed until the state has provided written approval that the provider network information meets all state requirements. Separate notices shall be prepared for mandatory populations and voluntary populations. The letter should contain the following, at a minimum: a. The basic details of the sale, including the name of the acquiring legal entity, and the date of the sale. b. Any major changes in the provider network, including at minimum a comparison of hospitals that no longer will be available under the network, if that is the case. c. For each enrollee, a representation whether that individual's primary care provider under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan. When the PCP is no longer available under the acquiring Contractor's plan, the enrollee shall be advised to call the HBC to see what other MCO the PCP participates in. d. For each enrollee, a representation whether that individual's MLTSS and/or behavioral health provider(s) under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan. When the MLTSS and/or behavioral health provider is no longer available under the acquiring Contractor's plan, the enrollee shall be advised to call the HBC to determine if his or her provider participates in other contracted HMO provider networks. e. In those cases where a primary dentist is selected under the non-surviving Contractor's plan, a representation whether each individual's primary dentist under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan. f. Information on enrollees in treatment plans and the status of any continuing medical care, as well as MLTSS being rendered under the non-surviving Contractor's plan, how that treatment will continue, and time frames for transition from the non-surviving Contractor's plan to the acquiring Contractor's plan. g. Any changes in the benefits/procedures between the non-surviving Contractor's plan and the acquiring Contractor's plan, including for example, eye care and glasses benefits, over-the-counter drugs, and referral procedures, etc. h. Toll free telephone numbers for the HBC and the acquiring entity where enrollees' questions can be answered. i. A time frame of not less than two weeks (fourteen days) for the enrollee to make a decision about staying in the acquiring Contractor's plan or switching to another MCO. The time frame should incorporate the monthly cut-off dates established by the state and the HBC for the timely and accurate production of identification cards.	Exiting Plan
Prior Authorization Redirection Notification	If applicable, the MCP shall create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination [sic]. The MCP shall utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.	Exiting Plan

Transition Requirement	Example Contract Language	Plan Responsible
Provider Notification	Provider Notification. The non-surviving Contractor shall notify its providers of the pending sale or merger, and of hospitals, primary care providers, specialists and laboratories that will no longer be participating as a result of the merger or acquisition no later than ninety (90) days prior to the effective date of transfer.	Exiting Plan
Continuity of Behavioral Health Services	The plan must work with members receiving behavioral health services from out-of-network providers as necessary to ensure a smooth transition to network providers. When a member is unable to obtain medically necessary services from a plan network provider, the plan must adequately and timely cover the services out-of-network until the plan is able to provide the services from a network provider. For continuity of care purposes, the plan will: i. Work with the service provider to add the provider to their network; ii. Implement a single case agreement with the provider; or iii. Assist the member in finding a provider currently in the plan's network.	Receiving Plan
Continuity of Services When a Member Could Suffer Detriment to Health	Upon notification from a member and/or provider of a need to continue services, the plan shall allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services.	Receiving Plan
Durable Medical Equipment Coverage (DME)	The Contractor shall provide DME for a minimum of the first thirty (30) days of the post-operations period unless other arrangements are made with the receiving Contractor and approved by the state.	Exiting Plan
Ongoing Course of Treatment	For those Enrolled Members undergoing a course of treatment for which a change of Providers could be harmful, the Contractor shall continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged.	Exiting Plan
Out-of-Network Providers & Prior Authorizations	The New Contractor shall allow members to see out of network providers for 180 days following enrollment and will send information to these providers to allow them to sign up to the New Contractor provider network during that time.	Receiving Plan
	With the exception of transplants, for which all previous authorizations will be honored, the New Contractor will honor, regardless of provider participation network status, previous authorizations for the lesser of: i. Ninety (90) calendar days from implementation; ii. The end date on the authorization from the previous entity; or iii. A new decision by the plan with consultation from the provider if determined on the medical necessity of the service.	

Transition Requirement	Example Contract Language	Plan Responsible
Prescriptions	The Contractor shall refill prescriptions to cover a minimum of ten (10) days beyond the contract termination date unless other arrangements are made with the receiving Contractor and approved by the state.	Exiting Plan
	Prescribed drugs shall be covered without prior authorization (PA) for at least the first 90 days of membership, or until a provider submits a prior authorization and the New Contractor completes a medical necessity review, whichever date is sooner. The New Contractor shall educate the member that further dispensation after the first 90 days will require the prescribing provider to request a PA.	Receiving Plan
Enrollee and Provider Customer Service Line at the Exiting Plan	The Contractor shall continue to be responsible for provider and enrollee customer service toll free numbers and after-hours calls until the last day of the [transition] period. The new Contractor shall bear financial responsibility for costs incurred in modifying the toll-free number telephone system.	Exiting Plan
Claims Payment	The Contractor shall remain financially responsible for all Claims with dates of service through the day of Contract termination or expiration, including those Claims submitted within established time limits after Contract termination or expiration. The Contractor shall remain financially responsible for services rendered through the day of Contract termination or expiration and for which payment is denied by the Contractor and subsequently approved upon Appeal or State Fair Hearing.	Exiting Plan
	The Contractor shall maintain claims processing functions as necessary for a minimum of 12 months in order to complete adjudication of all Claims for services delivered prior to the Contract termination or end date, as well as any time period beyond 12 months to the extent necessary to complete adjustments of all timely claims.	Exiting Plan
	The Contractor shall maintain at all times during the Contract Term a minimum two hundred percent (200%) of risk-based capital. The Agency reserves the right to require additional capital guarantees as the Agency deems reasonably necessary.	Exiting Plan
Closing of Contract After Merger/Acquisition	The non-surviving Contractor shall inform the state of the corporate structure it will assume once all enrollees are transitioned to the acquiring Contractor. Additionally, an indication of the time frame that this entity will continue to exist shall be provided. 2. The contract of the non-surviving Contractor is not terminated until the transaction (merger or acquisition) is approved, enrollees are placed, and all outstanding issues with DOBI and DHS are resolved. Some infrastructure shall exist for up to one year beyond the last date of services to enrollees in order to fulfill remaining contractual requirements. 3. The acquiring Contractor and the non-surviving Contractor shall maintain their own separate administrative structure and staff until the effective date of transfer.	Exiting Plan
Data Destruction	Within ninety (90) calendar days following the expiration of the transition period, the Contractors' competitively sensitive Medicaid data must be destroyed and/or rendered completely and totally inaccessible to users within the prior owner's systems (other than the prior owner's data security personnel) through archival or similar industry standard processes, except to the extent otherwise required by law or other compliance purposes, including but not limited to the records retention requirements under the HIPAA Rules.	Exiting Plan
Data Issues	[The Contractor shall] provide the Agency with all outstanding Encounter data issues and an action plan to correct the issues.	Exiting Plan

Transition Requirement	Example Contract Language	Plan Responsible
Grievance, Appeals and State Hearings	The Contractor shall resolve all provider complaints and member grievances and appeals related to the Contractors decisions and responsibilities exercised under this Agreement. The Contractor shall also provide a copy of all Grievances and Appeals decisions to the New Contractor for each member transitioned so that continuity of decisions can be considered by the New Contractor. The Contractor shall also participate in State Hearings related thereto.	Exiting Plan
	The Contractor shall be financially responsible for the resolution of enrollee grievances and appeals timely filed prior to the last day of the post-operations period	Exiting Plan
HEDIS	The Contractor shall carry out HEDIS activity for the calendar year and provide the State, or its designated entity, all pre-termination performance data, including but not limited to any State-identified survey tool and HEDIS.	Exiting Plan
Progress Reporting	[The Contractor shall] submit reports to the State every 30 Days detailing the Contractor's progress in completing its continuing obligations under the Contract. The Contractor, upon completion of these continuing obligations, shall submit a final report to the State describing how the Contractor has completed its continuing obligations. The State will advise in writing whether the State agrees that the Contractor has fulfilled its continuing obligations.	Exiting Plan
Damages	The Contractor hereby acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State which may not be adequately compensable in damages. The Contractor agrees that the State may, in such event, seek and obtain injunctive relief as well as monetary damages. Any payments made by the State pursuant to this section may also constitute an element of damages in any action in which Contractor fault is alleged.	Exiting Plan
Plan Insolvency	J.1 [In the instance plan insolvency occurs] The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the Contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility. J.2 The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the Contractor or the state, insolvency of the Contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided [in this contract]. J.4 The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.	Exiting Plan
All Transition Costs	The Contractor shall be reimbursed for all reasonable, pre-approved phase-in/phase-out costs (i.e., costs incurred within the agreed period after Contract termination that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this Contract. All phase-in/phase-out work fees must be approved by the DMAS in writing prior to commencement of said work.	Exiting Plan

Appendix B: CMS notification form for Medicaid managed care plan transitions

Instructions: The state Medicaid agency overseeing a managed care plan transition can complete this form and email it to the CMS state lead to provide notification of an imminent plan transition. CMS requests that this notification occur ***before*** news of the transition is released to the public. States should include the date of the public announcement of the transition and available times to discuss the transition with CMS in the body of the email.

<table>
<tr><th colspan="2">Section I. State Information</th><th colspan="2">Section II. Key Transition Information</th></tr>
<tr><td>State:</td><td>Estimated number of enrollees to be impacted by the transition:</td><td>Effective date of transition:</td><td>Name of transitioning plan(s):</td></tr>
<tr><td>Name of person submitting form:</td><td>Email:</td><td colspan="2" rowspan="4">Select reason for transition:
☐ Plan gave notice to state that it is not extending its contract
☐ State gave notice to plan that it is not extending its contract
☐ Change to plan's geographic coverage area
☐ Plan is merging with or acquiring another plan
☐ State to enter into a contract with a new plan
☐ Other (explain):</td></tr>
<tr><td>Title:</td><td>Phone:</td></tr>
<tr><td>Date form submitted to CMS:</td><td>CMS state lead to whom form is being submitted:</td></tr>
<tr><td colspan="2">Has the state Medicaid agency (or the transitioning plan) already notified the state Department of Insurance about the transition?
☐ Yes, date notice submitted:
☐ No</td></tr>
</table>

<table>
<tr><th colspan="3">Section III. Enrollee Communications and Choice</th></tr>
<tr><td>Number of enrollees to be impacted by transition:</td><td colspan="2">Number of enrollees whose plan enrollment must change due to transition:</td><td>Total number of days in choice period:</td></tr>
<tr><td>Select type of automatic enrollee enrollment to be used during the transition (if applicable):
☐ Passive (assignment followed by choice period)
☐ Default (choice period followed by assignment)</td><td>Date enrollee choice period will start, if applicable (mm/dd/yy):</td><td>Date enrollee choice period will end, if applicable (mm/dd/yy):</td><td></td></tr>
</table>

Please complete the table on the second page if information about milestones is available. If information for this table is not ready to be submitted or if you would like to talk through risks with CMS first, please include a date in the first row for when you anticipate being able to submit the completed table to CMS.

Transition Plan – NOT REQUIRED (Version 9.30.2021)

This form is optional. Completion of this form should not delay notifying your CMS state lead about an upcoming transition.

Add/remove rows in the table below as needed. List only high risks (or situations that are likely to occur and if they occur could prevent the milestone from happening or significantly impact the quality of the milestone). "Milestones" are actions marking a significant stage in the transition implementation. "Strategies" are steps to reduce the risks (the severity of the impact or probability of the occurrence). The first row includes an example entry. Please delete the first row before completing this form. Please note, this form is optional.

Section IV. Transition Milestones		
Milestones to be achieved in the next 60 days	**Status** (delayed, in progress, completed, or not yet started)	**List risks that could negatively impact milestone completion or quality. Describe strategies for addressing and responding to each risk.**
Milestone example: Remove exiting plan as an option for new member enrollment in enrollment broker materials.	*In progress*	*Risk: New members that want to enroll in the plan do not understand why enrolling in the plan is no longer an option.*
		Strategy: *Update new member materials to inform enrollees of upcoming plan transition. Train enrollment broker customer service staff to respond to this question and provide talking points and updated customer service scripts.*
Milestone 1:		*Risk:*
		Strategy:
Milestone 2:		*Risk:*
		Strategy:
Milestone 3:		*Risk:*
		Strategy:
Milestone 4:		*Risk:*
		Strategy:
Milestone 5:		*Risk:*
		Strategy:
Milestone 6:		*Risk:*
		Strategy:

Appendix C: Transition project charter template for states

This template is adapted from a project charter template developed by the Ohio Department of Medicaid during a recent plan transition. States can use this template to communicate high-level transition expectations to transition team members. Once complete, the charter can support development of a more detailed transition plan, work plans, or timelines to operationalize workstreams.

Background
<Describe the situation/circumstances that led to this transition. For example, MCP is leaving the central/southeast of state; the state is going through procurement of new MCPs.>
Vision
<Describe the end result of the transition at a high-level. What does success look like? For example, successful transition of members from exiting MCP to new MCP without negative implications to members' access to care.>
Goals to achieve vision
<For example, 60 percent of high-risk members make an informed plan choice.>
How goals will be measured
<For example, cumulative number of high-risk members who make a plan choice 30 days before the transition date; number of high-risk members who change plans within 90 days after the transition; feedback received from a member survey administered within 90 days after the transition.>
Benefits
<For example, decreased barriers to care for high-risk members, higher customer satisfaction, positive plan ratings.>
Critical success factors
• <Critical success factor (CSF) is the term for a condition that is necessary for a project to reach its goals and attain its expected benefits.> • <Outreach to high-risk members and X percent transitioned prior to default assignment.> • <No increase in enrollee grievances as a result of the transition.> • <No barriers or impacts to care.>

Key milestones	Milestone risks
•	• <Risks that could impact quality of milestone achievement. Categorize risks by high, medium, and low according to likelihood that the risk will occur and the level of act if risk occurs.>
•	•
•	•
•	•
•	•
•	•

Mitigation strategies for high risks
<Describe approaches to be taken to monitor and mitigate risks.>

High-level expectations of plans
<Describe high-level MCP expectations and planned project interactions or participation with MCP personnel. For example, weekly meetings, monthly MCP meetings, and any required deliverables or outputs.>

High-level timeline

Appendix D: Example of Ohio's internal talking points

The following is a series of example talking points designed to assist Ohio Department of Medicaid and Ohio Department of Jobs and Family Services staff and Jobs and Family Services county workers in responding to questions they may receive from members and providers during this transition. The goal of these internal talking points is to ensure message consistency across internal and external parties. Additional sections of the talking points not listed below include: (1) transition plan impacted regions and (2) communications already distributed to members as of X date.

Main points:

- [Name of Transitioning Plan] Medicaid will no longer be part of the Ohio Medicaid Managed Care Program in the central/southeast region.
- The managed care plan is working with Ohio Medicaid to transition members to a new managed care plan and will no longer accept new Medicaid enrollees residing in the region.
- [Name of Transitioning Plan] Members **ARE NOT LOSING MEDICAID BENEFITS.**
- For list of [counties impacted by transition], see the last page of this document.

Who is affected?

- Medicaid members who are unsure if they reside in the [regions(s) impacted by transition], should contact [Name of Transitioning Plan] member services to determine if their current address is in the affected region.
- [Name of Transitioning Plan] can confirm that their address is up to date with the county of residence records maintained by their County Department of Job and Family Services (CDJFS).
- Should there be a discrepancy, Medicaid members will need to work with CDJFS to correct.
- [Name of Transitioning Plan] member services can be contacted at the following…

What do members in the [region(s) impacted by transition] need to know?

- [Name of Transitioning Plan] members in the [regions(s) impacted by transition] can continue to see their current providers until they transition to a new managed care plan.
- Members impacted can enroll in a new plan immediately. However, they have until [date members can choose to enroll in another MCP] to make their choice.

- Members who do not select a new plan by [date members can choose to enroll in another MCP] will be automatically assigned to a new plan with an effective date of [effective date of new MCP].
- Members will have their choice among four existing plans.

Important dates:

- [Name of Transitioning Plan] members must be enrolled in a new managed care plan by <date>
- Members who do not make a choice by <date>, will be automatically assigned to a new plan with an effective date of <date> (notice of new plan will be sent <date>).
- Members who are automatically enrolled in their new plan on <date>, will have 90 days to switch plans.

How to pick a managed care plan:

- Ohio Medicaid's plans are required to provide identical, medically necessary health care services to all members. However, each has its own network of providers.
- We recommend members start by verifying that your healthcare providers are covered within the managed care plan's network.
- Ohio Medicaid also publishes a quality report card each year that shows how Ohio Medicaid's plans compare to one another in key performance areas. The Ohio Medicaid 2019 Managed Care Plan Report Card is available at…
- A comparison of plans is available online at [link]
- The Medicaid Hotline can help individuals compare plans to ensure the individual's providers remain in network with their new plan.

MEMBERS WHO MAY HAVE SPECIAL CASES

The Ohio Department of Medicaid (ODM) and Job and Family Services (ODJFS) will work with Public Children Services Agencies and IV-E Courts to ensure this change does not have a negative impact on access to health care services for children in custody, or under the supervision of state agencies who reside in the Central/Southeast region.

For children receiving adoption assistance who are enrolled in [Transitioning Plan] Medicaid plan in the affected region, legal guardians must select a new managed care plan for their adopted child(ren).

- Children in custody and those receiving adoption assistance must adhere to the same timeline provided above:
  - New managed care plan selection no later than <date>.
  - Enrollment in the new managed care plan no later than <date>.

  - Members without a plan selected by <date>, will be automatically assigned to a new plan with an effective date of <date> (notice of new plan will be sent <date>).
  - Members automatically enrolled in a new plan on <date> have 90 days to switch plans.
- ODJFS/ODM will be available to help with this process.
- Foster parents and kinship parents who do not have custody of a child do not have legal authority to change their foster child's managed care plan and should not contact the Medicaid Hotline to enroll their foster child. Only custody holders / legal guardians can change plans on behalf of the children in their care.

See the Ohio Departments of Medicaid (ODM) and Jobs and Family Services (ODJFS) memo addressing these populations and considerations needed to ensure continuity of care.

Acknowledgements

This report was prepared by Mathematica, under contract to the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Center for Medicaid and CHIP Services (CMCS), Division of Managed Care Plans. The report was prepared as part of the CMCS-funded project Providing Medicaid Managed Care and Integrated Delivery Systems Technical Assistance.

The authors wish to extend special thanks to several contributors. We are grateful for the guidance, support, and careful review by Amy Gentile, Alexis Gibson, and John Giles in the Division of Managed Care Policy. We also thank Leslie Campbell, Maria Chickering, Eowyn Ford, Cynthia Garraway, Ana Hickman, Mary McKeon, Mara Siler-Price, and Stephanie Sale from the Division of Managed Care Operations for providing insight into their experience working with states during the transition process.

We thank the following individuals and organizations for sharing their experiences with supporting Medicaid enrollees who have navigated managed care plan transitions in their states: Amy Raymond; Edanit Torres Cotto; Elizabeth Matney; Estelle Kendall; Jason Rachel; Jed Doodan; Jennifer Vigil; Jeremy Brunssen; Jessica Hawk; Joanne Bush; Julie Lovelady; Katherine Leyba; Kelsey Hiegel, Kim Carter; Kristine Radke; Lacie Ward; Lorelei Kellogg; Madeline Figueroa Rivera; Megan Pfeffer; Roxanne Richardson; Elizabeth Smith; Bryan Talbert; Rafael Vazquez; Miladis Costoso; and Marta Torres Lafront. Special thank you to Amy Raymond, Jed Doodan, and Roxanne Richardson for providing support with the development of the implementation and planning checklists based on their 2020 transitions.

Organizations: Loren Anthes of the Center for Community Solutions–Ohio; Graham Bowman of the Ohio Poverty Law Center; Linda Brundies of the State of Iowa Ombudsman, and Pamela Rupprecht of the Managed Care Ombudsman Program, Iowa; Regina Campbell of the Legal Aid Society of Greater Cincinnati; Emily Ehlers of Disability Rights Iowa, Law Center for Protection and Advocacy; Michelle Wrona Fox of Community Legal Aid, Central Northeast Ohio; Elizabeth Norris of Iowa Legal Aid; Dilynn Roettker and Ashley Socha of the Legal Aid Society of Columbus; and Rebecca Steinhauser of ABLE: Advocates for Basic Legal Equality, Inc.

We also want to acknowledge the valuable contributions to the toolkit by Mathematica colleagues Michaella Morzuch, Jenna Libersky, Rebecca Lester, and Debra Lipson.

The authors accept sole responsibility for any errors or omissions in this report. The views expressed are ours and do not necessarily represent the views or policies of HHS, CMS, or CMCS.


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES


Mathematica®