

Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations

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Background

- The COVID-19 pandemic and implementation of federal policies to address the resulting public health emergency (PHE) have disrupted routine Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment operations.
- Medicaid and CHIP program enrollment has grown by 20 percent since February 2020 and, as of September 2021, nearly 85 million individuals were enrolled across the programs.
- This growth in enrollment in large part is due to the continuous enrollment requirements that states implemented in Medicaid as a condition of receiving a temporary 6.2 percentage point federal medical assistance percentage (FMAP) increase under section 6008 of the Families First Coronavirus Response Act (FFCRA).
- As described in State Health Official Letter #21-002, *Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency*, states will have a 12-month unwinding period to complete all pending post-enrollment verifications, redeterminations, and renewals following the end of the PHE.
- CMS is working closely with states and other stakeholders to ensure, as states resume routine operations, that renewals of eligibility occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage for eligible individuals, including those who no longer qualify for Medicaid or CHIP and therefore may transition to a different form of coverage, such as through a Marketplace.

Engaging Managed Care Plans to Prepare for Return to Regular Eligibility and Enrollment Operations

- It may have been several years since some beneficiaries have had to complete renewals for Medicaid, which means states may have outdated contact information. Without updated contact information, notices, renewal packets, and/or requests for additional information may not reach individuals who have moved, leading to inappropriate coverage loss among individuals still eligible for coverage.
- Additionally, as states return to normal eligibility operations, some individuals may need assistance to complete required actions such as submitting additional documentation to confirm Medicaid or CHIP eligibility, or enrolling in Marketplace coverage with financial assistance.
- Close collaboration between states and managed care plans can help ensure eligible enrollees retain coverage in Medicaid and CHIP and ease transitions for individuals eligible for coverage through the Marketplace.
- Managed care plans can support states in their efforts to promote continuity of coverage for eligible individuals by:
 - Helping individuals enrolled in their Medicaid managed care plan complete the renewal process;
 - Minimizing churning due to loss of coverage for procedural reasons; and
 - Facilitating transitions from Medicaid to the Marketplace where appropriate.
- The strategies in this presentation are permissible and consistent with federal Medicaid and CHIP policies. States need to consider whether state-specific laws or contract provisions may present barriers that prevent adoption of these strategies.

Key Strategies for Working with Managed Care Plans

1. Partnering with Plans to Obtain and Update Beneficiary Contact Information
2. Sharing Renewal Files with Plans to Conduct Outreach and Provide Support to Individuals Enrolled in Medicaid during their Renewal Period
3. Enabling Plans to Conduct Outreach to Individuals Who Have Recently Lost Coverage for Procedural Reasons
4. Permitting Plans to Assist Individuals to Transition to and Enroll in Marketplace Coverage if Ineligible for Medicaid and CHIP

Strategy 1: Partnering with Plans to Obtain and Update Beneficiary Contact Information

Approach: States accept from managed care plans updated enrollee contact information, including mailing addresses, telephone numbers, and email addresses. Medicaid and CHIP agencies may treat this information as reliable and update the beneficiary record with the new contact information from the health plan.

Requirements/Considerations:

- States should ensure that plans **ONLY** provide updated contact information received directly from or verified by the beneficiary, and not from a third party or other source.
 - Plans that receive third party address updates from providers, delegated entities, or others may transmit information to states if the plan confirms the accuracy of the information with the enrollee and receives a response. Updated contact information should not be transferred to the Medicaid agency if received by a third party, without confirmation from the member.

Strategy 1: Partnering with Plans to Obtain and Update Beneficiary Contact Information (Cont'd)

Requirements/Considerations:

- When updated address information is received from managed care plans, states must send a notice to the individual's original address on file with the agency, using the beneficiary's preferred mode of communication, and must provide the individual with a reasonable period of time to dispute the accuracy of the new contact information.
 - If the beneficiary does not respond, states may treat the updated information received from the health plan as verified and update the beneficiary's information in the case file.
 - States are also strongly encouraged to contact the beneficiary through other modalities, such as via telephone, electronic notice, email, or text message, to inform them of the updates to their contact information.
- Through the end of the unwinding period, under the authority at 1902(e)(14)(A) of the Social Security Act, CMS will approve waivers providing flexibility to states to forego the requirement to contact the beneficiary to confirm the updated contact information prior to accepting the health plan's information as verified.
 - This flexibility is available only on a temporary basis, to states with systems or operational constraints that prevent them from providing the individual with an opportunity to dispute the accuracy of the new contact information.
 - States should contact CMS for additional information and to request a waiver.

Strategy 1: Partnering with Plans to Obtain and Update Beneficiary Contact Information (Cont'd)

Requirements/Considerations (Cont'd):

- To assist members in updating their contact information, managed care plans may also instruct individuals to update their contact information directly with the state agency and provide assistance to do so.
 - Assistance may be provided to update information online through a member portal, by calling the state's call center while the member is on the line to provide updates, or via warm phone transfers to the call center.
 - Providers, managed care plans' subcontractors, or other third-parties may also provide assistance to members to update contact information directly with the state.

Strategy 1: Partnering with Plans to Obtain and Update Beneficiary Contact Information (Cont'd)

Implementation Consideration:

- States adopting this strategy should review and revise any necessary contracts and protocols to ensure successful implementation. In establishing agreements with plans, states may consider setting guidelines for the information to be shared, such as the maximum age and type of contact information received from health plans, and should ensure that any information sharing is consistent with applicable law (e.g., HIPAA privacy rules).
- Implications for enrollees enrolled in both Medicaid and SNAP:
 - If Medicaid and SNAP are within the same state agency and considered co-located (e.g., in an agency with an integrated eligibility system), SNAP can accept Medicaid's updated address without further verification so long as it is not questionable or unclear.
 - Additional action is required for SNAP after an address is updated, as the state must solicit updated shelter costs and recalculate benefits without the excess shelter deduction if the household does not respond.

Strategy 2: Sharing Renewal Files with Plans to Conduct Outreach and Provide Support to Individuals Enrolled in Medicaid during their Renewal Period

Approach 1: States provide monthly files containing information about beneficiaries for whom the state is initiating the renewal process to their managed care plans to enable plans to conduct outreach and provide assistance with the renewal process.

Approach 2: States could use a similar approach to support outreach to enrollees who have yet to submit their renewal form or additional documentation and are at risk of losing coverage.

Requirements/Considerations:

- When developing the process to share information with the managed care plans, states should identify and address possible system or operational challenges in advance of resuming normal eligibility and enrollment operations.
- States should request that managed care plans use additional modalities (e.g., phone, text) to conduct outreach to beneficiaries and encourage individuals to complete and return their renewal forms.

Strategies When Beneficiaries Are Losing Medicaid or CHIP Coverage

There are no federal regulatory barriers that prevent states and managed care plans from working together to help individuals who are terminated from Medicaid or CHIP coverage, including transitions to other sources of coverage.

- Medicaid managed care plans have flexibility to provide information and conduct outreach to beneficiaries about the eligibility renewal process when the outreach to beneficiaries is not marketing or marketing activities within the scope of the Medicaid managed care marketing regulations at 42 CFR 438.104.
- When beneficiaries are losing their Medicaid or CHIP coverage, states and managed care plans should consider utilizing the following strategies:
 - **Strategy 3:** States provide Medicaid managed care plans with monthly termination files to enable plans to conduct outreach to individuals terminated from Medicaid for procedural reasons (such as not returning their renewal form timely).
 - **Strategy 4:** States encourage Medicaid managed care plans that also offer a Qualified Health Plan (QHP) to share information with enrollees who are determined ineligible for Medicaid to assist in the transfer of individuals to Marketplace coverage where applicable.

Strategies When Beneficiaries Are Losing Medicaid or CHIP Coverage

- States and managed care plans should evaluate whether to utilize strategies 3 and 4 separately, or in combination, particularly when information may be limited regarding the reason a beneficiary may be losing coverage. For example, states and managed care plans should consider the following scenarios:
 - Managed care plan knows the beneficiary is losing eligibility for procedural reasons – Strategy 3
 - Managed care plan knows the beneficiary is losing eligibility for programmatic reasons – Strategy 4
 - Managed care plan does not have information on why the beneficiary is losing eligibility – Combination of Strategies 3 and 4

Strategy 3: Enabling Plans to Conduct Outreach to Individuals Who Have Recently Lost Coverage for Procedural Reasons

Approach: States provide Medicaid managed care plans with monthly termination files to enable plans to conduct outreach to individuals terminated from Medicaid for procedural reasons (such as not returning their renewal form timely).

Requirements/Considerations:

- Under the Medicaid managed care marketing rules at 42 CFR 438.104, Medicaid managed care plans cannot seek to influence enrollment in conjunction with the sale or offering of any private insurance (excluding qualified health plans (QHPs)). Medicaid managed care plans cannot, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.
- General outreach from Medicaid managed care plans, including outreach from Medicaid managed care plans that also offer QHPs, to prevent enrollees' loss of coverage or to assist enrollees with the eligibility renewal process on behalf of the state is not considered marketing under 42 CFR 438.104.
- As published in previous marketing guidance from CMS¹, there is no provision in 42 CFR 438.104 specifically addressing a Medicaid managed care plan's outreach to enrollees for eligibility purposes, including outreach from Medicaid managed care plans with QHPs; therefore, a plan's ability to conduct this activity depends on the Medicaid managed care plan's contract with the state Medicaid agency.

¹ <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-01-16-2015.pdf>

Strategy 3: Enabling Plans to Conduct Outreach to Individuals Who Have Recently Lost Coverage for Procedural Reasons (Cont'd)

Requirements/Considerations (Cont'd):

- If the information and outreach about the eligibility renewal process is not intended to influence a beneficiary to enroll in a specific Medicaid managed care plan—or to not enroll in, or disenroll from another specific Medicaid managed care plan—the activity is not within the scope of 42 CFR 438.104.
- Materials and information that educate an enrollee on the importance of completing the state's Medicaid eligibility renewal process in a timely fashion would not meet the federal definition of marketing.
- States and managed care plans will need to assess their outreach messaging to ensure compliance with the marketing requirements, as well as any state-specific laws or contract requirements.
- States may need to expedite review of the outreach messaging to be used by Medicaid managed care plans, or states may want to consider sharing standardized messaging for use by their Medicaid managed care plans for these purposes.
- CMS clarifies that the federal marketing rules do not differentiate between coverage termination reasons; therefore, states may use their Medicaid managed care plans to conduct general eligibility outreach to their enrollees on behalf of the state for any potential coverage termination reason.

Reenrollment Following a Loss of Medicaid Coverage

- Medicaid managed care contracts must provide for automatic reenrollment into an enrollee's original plan for enrollees who are reenrolled into Medicaid after a loss of Medicaid coverage for 2 months or less (*see 42 CFR 438.56(g)*).
- Through the end of the unwinding period, under 1902(e)(14)(A) of the Social Security Act, CMS will approve waivers providing flexibility to states to extend this automatic reenrollment period to between 60 and 120 days.
 - This flexibility is available only on a temporary basis, during the 12-month unwinding period, to support states with systems and operational challenges to ensure continuity of coverage and care.
 - States should contact their CMS state lead for additional information and to request a waiver.

Strategy 4: Permitting Plans to Assist Individuals to Transition to and Enroll in Marketplace Coverage if Ineligible for Medicaid and CHIP

Approach: States encourage Medicaid managed care plans that also offer a Qualified Health Plan (QHP) to share information about such QHP(s) with enrollees who are determined ineligible for Medicaid to assist in the transfer of individuals to Marketplace coverage where applicable.

Requirements/Considerations:

- Medicaid managed care regulations do not prohibit a managed care plan that offers a QHP from providing information on that QHP to enrollees who could potentially enroll in a QHP due to a loss of eligibility, or to potential enrollees who may consider the benefits of selecting a managed care plan that has a related QHP in the event of future eligibility changes. This was clarified in the 2016 managed care final rule (42 CFR 438.104; See 81 FR 27502 for more information²).
- There are no other Exchange regulations governing issuers who offer QHPs through Exchanges that prohibit this type of outreach.
- Medicaid managed care plans providing information about a QHP (whether before or after the loss of Medicaid eligibility) – including helping enrollees to enroll in the QHP – is not considered marketing when it is about the QHP offered by that plan. As long as states permit the plans to provide the QHP information, it is not limited to terminated enrollees.
- Managed care plans may reach out to individuals before they lose Medicaid/CHIP coverage, to allow them to apply for Marketplace coverage in advance and thereby avoid a gap in coverage. For example, someone whose Medicaid coverage will end on July 31 and is notified before that date could apply, attest to their future coverage loss with the Marketplace, and have Marketplace coverage starting August 1.
- States and managed care plans should review their contracts to ensure clarity on this issue and consider whether any state-specific laws or contract requirements prevent these activities.

² <https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf>