



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

JANUARY 2023 UPDATE



This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

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 nearly 29 percent since February 2020 and, as of September 2022, nearly 91 million individuals were enrolled across the programs.
- This growth in enrollment in large part is due to the continuous enrollment condition 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 CMS’ previous guidance¹, states will have a 12-month unwinding period following the end of the PHE to initiate all pending post-enrollment verifications, redeterminations, and renewals.
- 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.

1. See: CMCS Informational Bulletin, *Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023* available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf>; and 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* available at: <https://www.medicaid.gov/sites/default/files/2022-03/sho22001.pdf>

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.

Additional strategies to support updates to contact information are available through waivers under authority provided via 1902(e)(14)(A) of the Social Security Act (see slide 6)

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 enrollees to instruct them to update information online through a member portal. Plans may also call 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.

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

Implementation Consideration (cont'd):

- Implications for enrollees enrolled in both Medicaid and SNAP:
 - Additional action is generally 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.
 - However, FNS may approve temporary waivers permitting the SNAP agency to wait to adjust the excess shelter deduction until the next certification action (recertification or periodic report), if the household does not respond with updated shelter cost information.
 - FNS may approve these waivers for implementation periods of up to 12 calendar months. Waivers approved under this rationale for extraordinary temporary situations may not continue beyond 12 calendar months after the month the federal PHE ends or up to 12 calendar months after implementation, whichever comes first.

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 as appropriate) 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.
- MCOs may share member information with the MCO's associated Marketplace QHP so that the QHP can inform the member of options to obtain Marketplace coverage

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.

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

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

Requirements/Considerations (cont'd.):

- 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.

Appendix: Scenarios & Reminders

Overview of Scenarios

- The following slides illustrate five scenarios to help clarify potential practical applications of strategies 2 through 4 above, along with reminders and tips for implementation.
- This scenarios included in this deck do not provide an exhaustive list of all the ways in which these strategies may be implemented and applied.
- Managed care plans must work closely with state Medicaid agencies to ensure a clear understanding of all state and federal laws and regulations as well as contractually permissible and prohibited activities related to enrollment outreach and marketing. Medicaid managed care plans and Marketplace qualified health plans should not interpret these scenarios as approval or permission to conduct these activities.

Contents

Scenarios:

1. Helping Individuals Complete the Renewal Process
2. Helping Individuals Found Ineligible for Medicaid/CHIP
3. Supporting Reenrollment when the Termination Reason is Unclear
4. Helping Individuals Enroll in a Marketplace QHP
5. Leveraging Marketplace Agents and Brokers

Reminders:

- Providing Application and Renewal Assistance
- Outreach and Communications
- Data Sharing

Scenario 1: Helping Plan Members Complete the Renewal Process

Scenario 1: It is June 10th. Bella is enrolled in Medicaid with a renewal due on June 30th. If Bella does not return her renewal form and missing verification information before the end of the month, she will be disenrolled from Medicaid. The state is partnering with Medicaid agency to support renewals (see strategy 2) and sends information to the MCO noting that Bella has not yet returned needed documentation to enable the state to complete her redetermination.

Permissible Actions

Bella is at risk of losing Medicaid coverage. Until Bella's termination date and subject to applicable state and federal regulations and contractual agreements, the MCO **may be permitted to:**

1. Contact Bella directly, using multiple modalities (phone, email, mail, etc.) to remind her to submit her renewal form and any missing documentation.
2. Provide Bella with information that identifies the MCO by name, including using plan letterhead and having staff identify their plan affiliation when sending messages or communicating by phone.

(continued on next slide)

Helping Members Complete the Renewal Process (cont.)

Permissible Actions (cont.)

3. Facilitate communication between member and the Medicaid agency, if the member agrees. For example, the plan can:
 - Coordinate a three-way call to the Medicaid agency call center with the member on the phone, so the member can provide needed information; or
 - Provide the member with contact information for the Medicaid agency.
4. Include QHP-branded information about a QHP that is affiliated with the MCO in outreach materials sent to Bella, to inform her of potential coverage options, if she is no longer Medicaid eligible.

Scenario 2: Helping Members Found Ineligible for Medicaid/CHIP

Scenario 2: Jacob sent updated income information to his state Medicaid agency 2 weeks ago. He just received a notice indicating that he had been found ineligible for Medicaid and that his coverage would end in 15 days. The notice states that his information will be sent to the Marketplace.

Permissible Actions

Jacob is losing coverage based on his income and may be eligible for coverage through a QHP. Subject to applicable state and federal regulations and contractual agreements, the MCO **may be permitted to:**

- Option 1: Reach out to Jacob immediately after he receives his advance notice of termination but before he loses Medicaid coverage, identify their plan affiliation, and encourage him to apply for Marketplace coverage to prevent a coverage gap.
- Option B: Provide Jacob with information about the plan's associated QHP and encourage him to go to the Marketplace and apply. The plan may use QHP-branded materials
- Either the MCO or the associated QHP may refer Jacob to an agent, broker, or other licensed assister to help him complete and submit a Marketplace application.

Scenario 3: Supporting Reenrollment when the Termination Reason is Unclear

Scenario 3: Alex and Jamie lost their Medicaid coverage 35 days ago, but they don't know why. They don't remember whether they received a renewal form. The 834 files received by the managed care plan from the state do not include termination reasons, so the MCO doesn't know why the couple no longer has Medicaid.

Permissible Actions

Alex and Jamie are no longer enrolled, but it is unclear whether they lost Medicaid eligibility for procedural reasons or because they no longer meet Medicaid eligibility requirements. **A combination of strategies 3 and 4 is appropriate.**

Subject to applicable state and federal regulations and contractual agreements, the managed care plan **may be permitted to:**

1. Facilitate communication between Alex and Jamie and the Medicaid agency, with consent (e.g. via a three-way call to the call center with the member on the phone or by providing contact information for the Medicaid agency.)
2. Remind Alex and Jamie that if they lost coverage for not returning their renewal form, they can still be reconsidered for Medicaid and should ask the agency about their status. With the 90-day reconsideration period, they may have 55 days to submit missing information and reenroll, without needing to complete a new application

Scenario 3: Supporting Reenrollment when the Termination Reason is Unclear (cont.)

Permissible Actions (cont.)

Subject to applicable state and federal regulations and contractual agreements, the MCO **may be permitted to:**

3. Identify their plan affiliation and provide information directly to Alex and Jamie about the plan's associated QHP also offered by the managed care plan.
4. Share member data with the MCO's associated QHP, so that the associated QHP may encourage them to go to the Marketplace and apply.

Scenario 4: Helping Individuals Enroll in a Marketplace QHP

Scenario 4: An MCO knows that their consumer, Susie, has been found ineligible for Medicaid and her Medicaid coverage ended 35 days ago. How can the MCO and the associated QHP help Susie enroll in a QHP?

Permissible Actions

Subject to applicable state and federal regulations and contractual agreements, the managed care plan or associated QHP **may be permitted to:**

1. Refer Susie to HealthCare.gov or to call the Marketplace Call Center at 1-800-318-2596. (TTY users can call 1-855-889-4325.)
2. Refer Susie to a registered agent or broker that can help Susie enroll in a QHP using HealthCare.gov
 - With Susie’s consent, a registered agent or broker can leverage an Enhanced Direct Enrollment (EDE) or Direct Enrollment (DE) platform that sells Marketplace QHP's to fill out an application on Susie’s behalf (the agent/broker can use any EDE or DE platform, not necessarily one associated with the issuer). Details on EDE/DE including a list of approved platforms can be found at <https://www.cms.gov/programs-and-initiatives/health-insurance-marketplaces/direct-enrollment-and-enhanced-direct-enrollment>
3. Maintain a list of active Assisters in their service area and refer Susie to the Assister closest to her. Information is available at LocalHelp.HealthCare.gov and a person can search for a local Assister by entering their zip code and filtering the type of local help to only include Assisters.

Scenario 5: Leveraging Marketplace Agents and Brokers

Scenario 5: Kevin is losing Medicaid coverage, and would like help enrolling into the Marketplace QHP that is associated with his Medicaid managed care organization. While the Marketplace QHP does not have any available captive agents or brokers (agents/brokers directly employed by the QHP), the QHP has appointments with several "non-captive" agents or brokers (agents/brokers who are not directly employed by the QHP) who are registered Marketplace assisters.

Permissible Actions

Subject to applicable state and federal regulations and contractual agreements, the Marketplace QHP **may be permitted to:**

1. Obtain Kevin's consent to share his information with an agent or broker not directly employed by the QHP (a non-captive agent/broker) to help him enroll, being mindful to explain the agent/broker(s) do not work directly for the QHP but are registered Marketplace assisters that have appointments with the QHP. As best practice, Marketplace QHPs should maintain a written record of such consent.



Reminders:

Providing Assistance with Application & Renewal

Plans can play a critical role in supporting continued enrollment of eligible people in Medicaid and CHIP or helping individuals who are no longer eligible to seamlessly transition between coverage programs. However, plans may not act on a member's behalf or in place of registered assisters.

For example, subject to applicable state and federal regulations and contractual agreements, an MCO/QHP **may not**:

- Complete and/or sign a Medicaid application or renewal form on a member's behalf, even in the presence of or on the phone with a member. Plans *may* help a member submit a form that the applicant has completed and signed (e.g. by mailing it)
- Instruct an individual recently terminated from Medicaid to enroll in the plan's associated QHP or imply that a person must enroll in the plan's associated QHP.
- Provide direct Marketplace application assistance or collect information needed to complete a Marketplace application on an individual's behalf unless performed by a registered Marketplace assister (for example, one of the QHP's registered agents or brokers).

Reminders: Outreach & Communications

MCOs and QHPs can serve a valuable role in educating members and providing important information about Medicaid, CHIP, and Marketplace coverage. However, there are important limitations in how plans can conduct outreach or market to members and other individuals, as described, for MCOs, at 42 CFR 438.104 and, for QHPs, at 45 CFR 156.225.

Subject to applicable state and federal regulations and contractual agreements, an MCO **may not**:

- Conduct direct outreach to any member who is enrolled in Medicaid instructing them to enroll in a specific QHP or implying that they must enroll in a specific QHP.
- Conduct any outreach that is inconsistent with state or federal regulations or prohibited by their Medicaid or QHP contract.

Reminders: Data Sharing

Subject to applicable state and federal regulations and contractual agreements, an MCO **may not**:

1. Share member data outside of the MCO or the MCO's associated QHP unless the member provides consent to do so, such as in the case of providing the member's information to a specific non-captive agent/broker.
For example, initially identifying only one individual agent that would be utilized, but then passing Jamie's information to a wider team of agents would not be permissible
2. Conduct any data sharing that is inconsistent with state or federal regulations or contractually prohibited.