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Addressing Medicaid and CHIP Procedural Terminations in States that Operate a State-Based Marketplace with Account Transfers

Background

- CMS is committed to minimizing gaps in coverage and ensuring that eligible individuals retain coverage in Medicaid and CHIP and that those who are no longer eligible are appropriately transitioned to other health insurance affordability programs.
- State Medicaid and CHIP agencies have played a critical role in responding to the COVID-19 public health emergency (PHE), and we recognize state eligibility and enrollment operations have been disrupted as states respond to the needs of their local communities.
- In addition, states also made program changes to qualify for the Federal Medical Assistance Percentage (FMAP) increase available under section 6008 of the Families First Coronavirus Response Act ("FFCRA," Pub. L. 116-127), including by satisfying the continuous enrollment condition for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020 ("continuous enrollment condition").
- States will have a large volume of eligibility and enrollment actions that they will need to complete once this continuous enrollment condition ends, and CMS will continue to work with states as they resume eligibility and enrollment

Minimizing Procedural Terminations

- Since the implementation of the continuous enrollment condition in response to the COVID-19 PHE, state Medicaid and CHIP agencies may have had limited contact with enrollees, particularly in states that have not been conducting renewals during the PHE.
  - As a result, enrollee contact information on file with state Medicaid and CHIP agencies may be outdated.
  - Without updated contact information, renewals and notices may not be received by individuals who have moved.
- CMS encourages Medicaid and CHIP agencies to conduct outreach and adopt available flexibilities to update beneficiary contact information in order to minimize the likelihood of terminations for procedural reasons, such as beneficiaries' failure to respond.
- Procedural terminations lead to gaps in coverage and access to care. Many individuals whose coverage is procedurally terminated may still be eligible for Medicaid or CHIP, but have to take action to resume coverage.
- The volume of procedural terminations may be higher than usual during the unwinding period.

Coordination between State-Based Marketplaces and State Medicaid and CHIP Agencies on Procedural Terminations

- State-Based Marketplaces (SBMs) and the Medicaid and CHIP Agencies in those states can work together to mitigate the effects of procedural terminations and minimize gaps in coverage. Such coordination could include:
  - Sharing information about individuals who have been procedurally terminated via account transfer or other means; and
  - Jointly developing messaging and conducting tailored outreach to encourage such individuals to take the necessary steps to enroll in coverage for which they may be eligible.
- CMS regulations at 42 CFR 435.1200(e) and 457.350(b) require state Medicaid and CHIP agencies to promptly and without undue delay determine potential eligibility for, and as appropriate, transfer via secure electronic interface the individuals account to other insurance affordability programs for individuals who submit an application or renewal to the agency which includes sufficient information to determine Medicaid or CHIP eligibility.
- These regulations also permit state Medicaid and CHIP agencies to send an account transfer to their State-Based Marketplace for individuals who have been terminated for procedural reasons, such as failure to submit a required renewal form or provide other information needed for the agency to complete the renewal.

CMS reminds states that, per 42 CFR 435.1200(b) and 457.348(a), the State Medicaid and CHIP agencies must enter into one or more agreements with the State-Based Marketplace delineating the responsibilities of each to effectuate a coordinated system of eligibility and enrollment between their programs. This agreement should include the responsibilities of each entity, including related data sharing.

Note: As described in a 2016 CMCS Informational Bulletin (CIB)[1], Medicaid and CHIP agencies in states that use the Federally-facilitated Marketplace (FFM) should not transfer accounts to the FFM for individuals who are denied or terminated from Medicaid/CHIP due to procedural reasons. The 2016 CIB and the FFM's Account Transfer Business Services Definitions reflect guidance based on the operational policies of the FFM.

1 – 2016 CMCS Informational Bulletin, Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace"). https://www.hhs.gov/guidance/document/coordination-eligibility-and-enrollment-between-medicaid-chip-and-federally-facilitated

Requirements for Sharing Data: Maintaining Applicant and Beneficiary Confidentiality

- CMS regulations at 42 CFR 431.302 and 457.1110 require state Medicaid and CHIP agencies to restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan including establishing eligibility, determining the amount of medical assistance, and providing services to beneficiaries.
  - State Medicaid and CHIP agencies are permitted to share information with the state's SBM for the purposes of establishing eligibility, which is a purpose directly related to the administration of the Medicaid and/or CHIP state plan.
- State Medicaid and CHIP agencies are required to obtain consent from a family or individual, whenever possible prior to release of information about applicants, unless meeting certain exceptions described at 42 CFR 431.306(d) and 457.1110(b).
  - The single streamlined application should include language that authorizes the state to share an applicant's information with the Marketplace for purposes of determining eligibility in the appropriate health insurance affordability program. Such language on the application meets the requirement to obtain consent prior to sharing the individual's information.
- The release of information directly related to the administration of the state plan concerning applicants or beneficiaries must be restricted to SBM personnel who are subject to the standards of confidentiality that are comparable to those of the Medicaid or CHIP agency. [42 CFR 431.306(b) and 457.1110(b)]

Important Guardrails and Considerations

SBMs must ensure that consumers are routed to the appropriate program, as many individuals who are terminated from Medicaid or CHIP for procedural reasons may still be eligible for those programs.

- The timing of the account transfer, or other data sharing method, should be mindful of the Medicaid/CHIP 90-day reconsideration period, as well as the availability of a Special Enrollment Period (SEP) at the SBM.
  - During the 90-day reconsideration period, individuals terminated from Medicaid/CHIP for failure to return a renewal form or necessary information can return their renewal information or other requested information and receive a determination of eligibility without submitting a new application. (42 CFR 435.916(a)(3)(iii) and 457.343)
- Outreach materials or other communication sent by the SBM should remind individuals of the Medicaid/CHIP reconsideration period.
- SBMs must have a process in place to route all consumers, including those terminated for procedural reasons, to the appropriate program, such that individuals eligible for Medicaid/CHIP are able to reenroll in Medicaid.
  - This may require careful consideration of application questions and logic, especially if the SBM has application questions/logic that mirrors or is similar the FFM's Medicaid block questions. Tailored outreach may also help individuals terminated for procedural reasons navigate such questions.

States looking to share information between the Medicaid and CHIP agencies and the SBM regarding procedural terminations should discuss their plans for implementation with CMS in order to ensure adequate guardrails are in place, beneficiary protections are maintained, and individuals are routed to the correct program based on their circumstances.

Questions