All-State Medicaid and CHIP Call

November 30, 2021

Agenda

- Strategies States and U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations
- Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations
- Open Mic Q and A

Improving Continuity of Coverage for Eligible Individuals: Background

- 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.

- States are encouraged to review:
  - Their processes and determine which strategies and options are needed to maintain continuity of coverage and create administrative efficiencies to process all eligibility work throughout the 12-month unwinding period
  - Authorities adopted during the public health emergency and determine which should be maintained during the unwinding period

- States should take any necessary steps to submit state plan amendments, update verification plans, and modify internal state policies/processes.

Punchlist of Strategies to Maintain Coverage for Eligible Individuals

CMS released "**Strategies States and U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations**"

This tool contains a comprehensive list of strategies states may adopt to ensure continuity of coverage and an orderly return to normal operations as well as links to additional resources in each section for states interested in particular strategies

Available on Medicaid.gov at [Strategies to Maintain Coverage for Eligible Individuals]

November 2021

Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations

The end of the continuous enrollment requirement for states[1] receiving the temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase under the Families First Coronavirus Response Act (FFCRA) (P.L. 116) presents the single largest health coverage transition event since the first Marketplace Open Enrollment following enactment of the Affordable Care Act. As one of several conditions of receiving the temporary FMAP increase under FFCRA, states have been required to maintain enrollment of nearly all individuals enrolled in Medicaid (this provision is commonly referred to as the "continuous enrollment" requirement). When the continuous enrollment requirement expires, states will generally have up to 12 months to return to normal eligibility and enrollment operations. This will include conducting a full renewal for all individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Program (BHP), completing processing of pending applications and resuming timely application processing, and conducting routine verifications and processing of changes in circumstances. This significant volume of work will test state eligibility and enrollment systems and staff, and necessitates immediate state action to maintain continuous coverage for individuals who are eligible for Medicaid, CHIP, BHP, or Marketplace coverage.

(Continued)

[1]Throughout this document, "states" refers to states, the District of Columbia, and the U.S. Territories.

Punchlist Topic Areas

This tool provides states a comprehensive checklist of strategies to maintain continuous coverage in **7 key areas**:

1. Strengthen Renewal Processes
2. Update Mailing Addresses to Minimize Returned Mail
3. Improve Consumer Outreach, Communication and Assistance
4. Promote Seamless Coverage Transitions
5. Improve Coverage Retention
6. Address Potential Strains on Eligibility and Enrollment Workforce
7. Enhance Oversight of Eligibility and Enrollment Operations

The following slides provide examples of the strategies presented in each key area

Strengthen Renewal Processes

Many individuals lose coverage at renewal due to procedural and administrative reasons, and states should consider strategies that allow more renewals to be completed based on available information (*ex parte renewals)* and facilitate the ability of individuals to provide information when needed.

Increase the percentage of *ex parte* renewals completed for modified adjusted gross income (MAGI) and non-MAGI populations:

- Expand the number and types of data sources used for renewal
- Create a data source hierarchy to guide verification, prioritizing the most recent and reliable data sources (e.g., leverage SNAP data that is updated every six months first, ping IRS data and if not reasonably compatible, then ping quarterly wage data)
- Assess and adjust the current reasonable compatibility threshold for income (e.g., increase to 20%)

Streamline renewals that cannot be completed via an *ex parte* process:

- Ensure that individuals can submit requested information to the agency over the phone, via mail, online, and in-person, consistent with federal requirements
- Ensure renewal forms are pre-populated for individuals enrolled in Medicaid, CHIP, and BHP on a MAGI basis, consistent with federal requirements
- Pre-populate renewal forms for individuals enrolled on a basis other than MAGI, including those that are eligible on the basis of being aged, blind, or disabled

Update Mailing Addresses to Minimize Returned Mail and Maintain Continuous Coverage

Because it has been several years since states may have communicated with beneficiaries, states may have outdated contact information. Several strategies are available to update mailing addresses and contact information.

Implement processes to prevent and address returned mail

- Engage community-based organizations, application assisters and providers to conduct outreach to remind beneficiaries to provide updated contact information
- Require managed care plans to seek updated mailing addresses and either share updated information with the state Medicaid or CHIP agency and/or remind individuals to update their contact information with the state
- Send periodic mailed notices, texts, and email/online account alerts reminding individuals to update their contact information
- Ensure individuals are able to submit updated contact information via all modalities, including mail, telephone, and online

Improve Consumer Outreach, Communication, and Assistance

States that conduct robust outreach, issue clear communications, and provide consumer assistance are more likely to get better responses to requests for information.

Improve eligibility notices

- Revise consumer notice language to ensure that information is communicated in plain language, including that it clearly explains the appeals process (also known as the Medicaid fair hearing and CHIP review process, as applicable)

Conduct intensive outreach

- Conduct more intensive outreach via multiple modalities to remind individuals of anticipated changes to their coverage and obtain needed information (e.g., require eligibility workers to make follow-up telephone calls and send an email if an individual has not responded to a request for information)

Communicate effectively with individuals who have Limited English Proficiency (LEP) or are living with a disability

- Review language access plan to provide written translation of key documents (e.g. notices, applications, and renewal forms) into multiple languages, oral interpretation, and information about how individuals with LEP can access language services free of charge, provided in a culturally competent manner
- Ensure that information is communicated to individuals living with disabilities accessibly by providing auxiliary services at no cost to the individual, including but not limited to written materials in large print or Braille, and access to sign language interpretation and/or a teletypewriter (TTY) system

Promote Seamless Coverage Transitions

Many individuals currently enrolled who are found ineligible once the state resumes routine operations will be eligible for and need to transition to other coverage.

Promote seamless coverage transitions

- Ensure accounts are seamlessly transferred to the Marketplace when individuals are found ineligible for Medicaid, the Children's Health Insurance Program (CHIP), or Basic Health Program (BHP)
- Obtain and include robust contact information (e.g., mailing address, email address, and telephone numbers) in the Account Transfer to the Marketplace so that individuals may be easily reached post-transition
- Revise notices to ensure they clearly explain the Account Transfer process and next steps and applicable deadline(s) for applying for and enrolling in a Qualified Health Plan (QHP) with financial assistance, and where to seek answers to questions at the Marketplace

Improve Coverage Retention

As states complete renewals in the coming months, states may want to implement additional policy and operational strategies to help resume normal operations.

Adopting strategies that improve coverage retention

- Adopt 12 months continuous eligibility for children (via SPA), adults (via 1115 authority), and individuals enrolled in BHP (via BHP Blueprint revision)
- Provide 12 months of postpartum coverage (via SPA, beginning April 2022)
- Consider reducing or eliminating periodic data matching to support efficient operations (e.g., reduce or eliminate periodic data checks for income changes mid-coverage year)

Leveraging managed care plans

- Direct managed care plans via contract requirements to conduct outreach and provide support to individuals enrolled in Medicaid and CHIP

Address Potential Strains on Eligibility and Enrollment Workforce

Many states will need to complete an unprecedented amount of eligibility actions as they return to normal operations, which will place a heavy burden on the eligibility and enrollment workforce.

Manage capacity

- Redistribute work across state, regional, and county staff
- Implement "overflow" workforce strategies that redirect pending applications/renewals to a centralized unit or regional/county office that has available capacity
- Identify specific roles that additional full-time employees—contractors, vendors, or other temporary workers—can play in supporting unwinding effort

Provide training and guidance

- Provide training and guidance to state workforce on changing policies
- Update eligibility and enrollment manuals so they can serve as ongoing resource

Enhance Oversight of Eligibility and Enrollment Operations

To prevent inappropriate coverage loss of eligible individuals and ensure that those who are no longer eligible are seamlessly transitioned to other coverage, states should establish a centralized oversight and monitoring infrastructure.

Enhance oversight

- Identify a centralized team responsible for tracking emerging issues and needed solutions
- Create tracking and management tools, data reports, and/or dashboards to monitor case volume, renewal rates, and workforce needs
- Implement “early warning/trigger” mechanisms that flag when a large number of individuals lose, or are slated to lose, coverage due to no response or missing paperwork

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

Background

- The COVID-19 outbreak 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 17 percent since February 2020 and, as of May 2021, nearly 83 million individuals were enrolled across the programs.

- This growth in enrollment in large part is due to the continuous enrollment requirements that states implemented 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 process renewals for all enrolled individuals and restore routine operations.

- 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 states have conducted a renewal or communicated with households enrolled in Medicaid and CHIP, 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 be confused about what they must do and the timeline required to take specific 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 Medicaid 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.
- When updated address information is received from managed care plans, states must send a notice to the address on file with the state and provide the individual with a reasonable period of time to verify the accuracy of the new contact information.

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

Requirements/Considerations:

- States are also encouraged to contact the beneficiary through other modalities, such as via telephone, electronic notice, email, or text message, and to send information to the new address, where feasible.
- If the beneficiary does not respond to verify the accuracy of the contact information provided by the managed care plan, the state may update the beneficiary record with the new contact information from the managed care plan.
- Implications for enrollees enrolled in both Medicaid and SNAP: If Medicaid and SNAP are within the same state agency and considered co-located (ex: have an integrated eligibility system), SNAP can accept Medicaid's updated address without further verification so long as it is not questionable or unclear. Note: 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.

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

Approach: States provide 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:

- Once terminated, a consumer is not considered a plan member and 42 CFR 438.104 marketing regulations may apply.
- Under the marketing rules, managed care plans generally cannot seek to influence enrollment in conjunction with the sale or offering of any private insurance (excluding QHPs), and managed care plans cannot, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.
- However, general outreach from the managed care plan on behalf of the state would not be considered marketing under 42 CFR 438.104. States and managed care plans will need to carefully balance this task with 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 managed care plans, or states may want to consider sharing standardized messaging for use by their managed care plans.

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

Approach: States encourage managed care plans that also offer Qualified Health Plans (QHP) to share information with their own 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 from providing information on a 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).
- There are no regulations governing issuers who offer QHPs through Exchanges that prohibit this type of outreach.
- Managed care plans providing information about the QHP – including helping them to enroll in the QHP, is not considered marketing. As long as states permit the plans to provide the QHP information, it is not limited to only 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 will need to carefully review their contracts to ensure clarity on this issue and consider whether any state-specific laws or contract requirements may prevent this activity.

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Questions