

# 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 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have conducted a renewal or communicated with households enrolled in Medicaid and CHIP, which means states may have outdated contact information.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.

# Questions

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