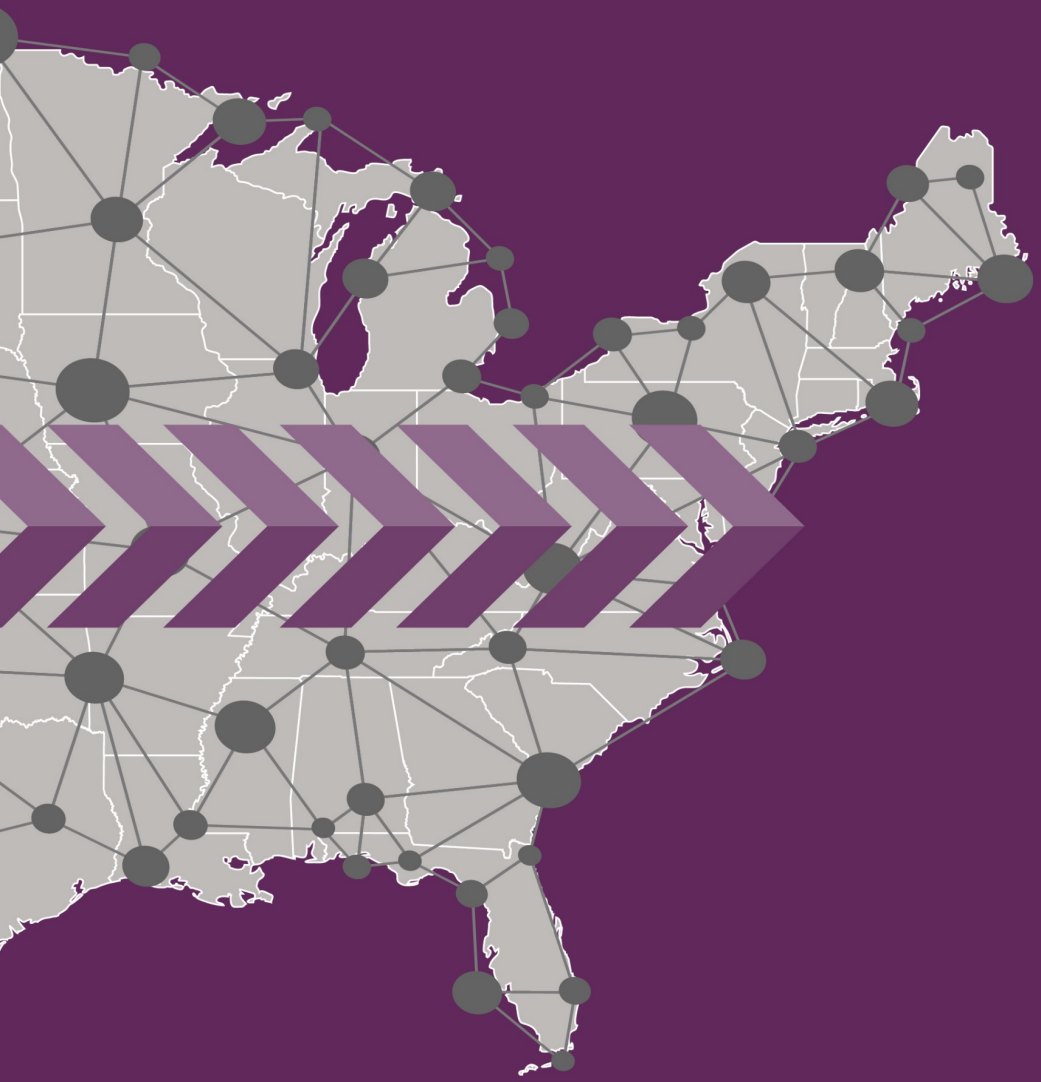

Leveraging Managed Care Plans to Support Medicaid Continuous Coverage Unwinding Toolkit

Manatt Health

Updated April 26, 2022

STATE Health & Value STRATEGIES

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

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The views expressed here do not necessarily reflect the views of the Foundation.

About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Coverage Transitions When the Federal Medicaid Continuous Coverage Requirement Ends

Medicaid Continuous Coverage Requirement

To support states and promote stability of coverage during the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) provided a 6.2 percentage point increase in the regular Medicaid matching rate, tied to the condition that states maintain enrollment of nearly all Medicaid enrollees through the end of the month in which the public health emergency (PHE) ends.[1]

The continuous coverage requirement applies to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date.

State Medicaid agencies have maintained coverage for individuals who may have become ineligible since their last eligibility determination.

To comply with the enhanced Federal Medical Assistance Percentage (FMAP) requirements, states have been required to make numerous changes to their eligibility and enrollment (E&E) systems, operations, and policies.

When the continuous coverage requirement expires, states will be required to redetermine eligibility for nearly all Medicaid enrollees.

The current federal Medicaid continuous coverage requirement ends on July 31, 2022, though it may get pushed out to an even later date.

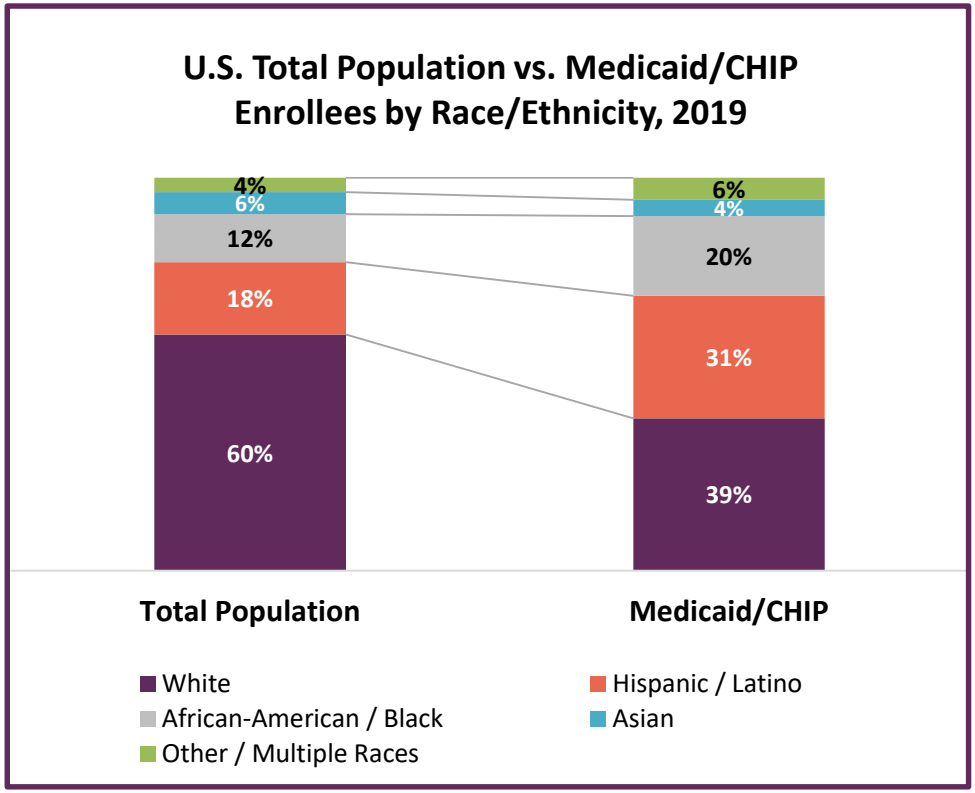
1. Federal legislation, if passed, could change the timeline for when the federal continuous coverage requirement ends and parameters for continued receipt of the enhanced Federal Medical Assistance Percentage (FMAP). **Source:** FFCRA § 6008(b)(3).

Continuity of Coverage Post-PHE

The looming end to continuous coverage will likely present the single largest health coverage event since the first open enrollment of the Affordable Care Act (ACA). States will be faced with a significant volume of eligibility actions to complete once they begin the unwinding period.

In part due to the continuous coverage requirement, **Medicaid and CHIP program enrollment has grown to nearly 85 million individuals** (as of July 2021).

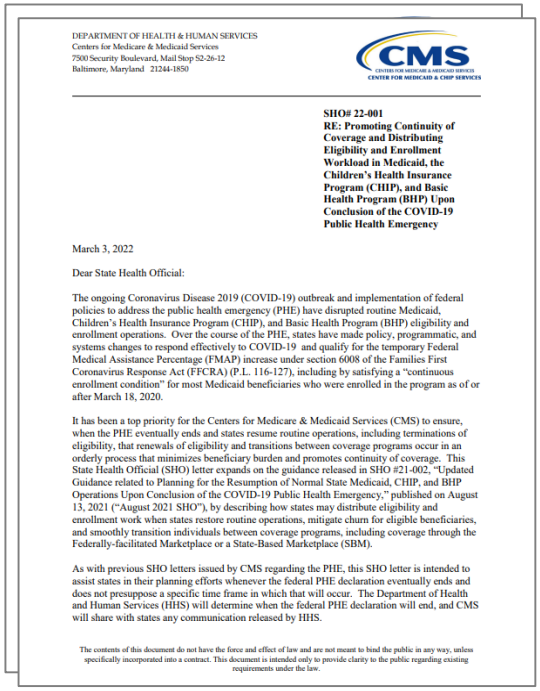
- When continuous coverage ends, **states will resume renewals and begin working through pending applications and redeterminations** based on changes in circumstances.
- **While most people will continue to be eligible for coverage, terminations of Medicaid/CHIP coverage and eligibility transitions between Medicaid and the Marketplace are likely to disproportionately impact people of color**–as Black and Latino(a) individuals are significantly overrepresented in state Medicaid/CHIP programs.



Source: SHADAC, State Health Compare; 6008(b)(3); and Centers for Medicare & Medicaid Services (CMS), March 8, 2022, All-State Medicaid and CHIP Call.

CMS Guidance on Unwinding

Guidance issued by CMS on March 3 clarified federal expectations of state Medicaid/CHIP agencies as they prepare to process outstanding E&E actions when the continuous coverage requirement ends.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 22-001
RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency

March 3, 2022

Dear State Health Official:

The ongoing Coronavirus Disease 2019 (COVID-19) outbreak and implementation of federal policies to address the public health emergency (PHE) have disrupted routine Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) eligibility and enrollment operations. Over the course of the PHE, states have made policy, programmatic, and systems changes to respond effectively to COVID-19 and qualify for the temporary Federal Medical Assistance Percentage (FMAP) increase under section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127), including by satisfying a "continuous enrollment condition" for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

It has been a top priority for the Centers for Medicare & Medicaid Services (CMS) to ensure, when the PHE eventually ends and states resume routine operations, including terminations of eligibility, that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage. This State Health Official (SHO) letter expands on the guidance released in SHO #21-002, "Updated Guidance related to Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency," published on August 13, 2021 ("August 2021 SHO"), by describing how states may distribute eligibility and enrollment work when states restore routine operations, mitigate churn for eligible beneficiaries, and smoothly transition individuals between coverage programs, including coverage through the Federally-facilitated Marketplace or a State-Based Marketplace (SBM).

As with previous SHO letters issued by CMS regarding the PHE, this SHO letter is intended to assist states in their planning efforts whenever the federal PHE declaration eventually ends and does not presuppose a specific time frame in which that will occur. The Department of Health and Human Services (HHS) will determine when the federal PHE declaration will end, and CMS will share with states any communication released by HHS.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Requires states to develop an **unwinding operational plan** (made available to CMS upon request) and recommends that states initiate no more than 1/9 of their total caseload of renewals per month to establish a sustainable renewal schedule.

Provides clarification that states may begin their **12-month unwinding period** up to two months prior to the end of the PHE. States must initiate all renewals by the last month of the 12-month unwinding period and complete all actions by the end of the 14th month after the end of the PHE.

Reiterates that states **must initiate a full renewal** for all individuals, including those for whom the state already conducted a renewal during the PHE.

Emphasizes **Medicaid/Marketplace strategies** to support coverage transitions (e.g., sharing of all available contact information, including eligibility information in the account transfer).

In addition to the State Health Official (SHO) letter, CMS continues to release additional templates and resources to support state efforts when the federal continuous coverage requirement ends.

Source: CMS, SHO# 22-001; CMS, Eligibility and Enrollment Pending Actions Resolution Planning Tool – Version 2.0; and CMS, Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations.

Managed Care Strategies to Support States' Unwinding Efforts

Engaging Plans in Supporting Coverage Retention

Close collaboration between states and managed care plans will be essential to ensuring eligible individuals retain coverage in Medicaid/CHIP and easing transitions to the Marketplace. CMS released two sets of guidance—a set of continuity of coverage strategies and a Medicaid managed care plan slide deck (updated in March 2022)—on partnering with Medicaid managed care plans. Managed care plans can support state efforts to promote continuity of coverage by:

Obtaining and Updating Enrollee Contact Information

Supporting the Renewal Process

Providing Targeted Assistance to People Terminated for Procedural Reasons

Assisting with Marketplace Transitions/ Enrollment

Source: CMS, Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations; and CMS, Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations.

Obtain/Update Enrollee Contact Information

Updated contact information will be critical to ensuring that notices, renewal packets, and requests for information reach individuals who have moved in order to avoid inappropriate coverage loss. Managed care plans can be key partners in obtaining updated contact information. States can:

Accept from managed care plans updated enrollee contact information (e.g., mailing/email addresses, telephone numbers). CMS confirmed that Medicaid/CHIP agencies may treat this information as reliable, under the following state parameters:

Contact information must be directly from or verified by the enrollee (not from a third party or other source).

When updated address information is received, states must send a notice to the address on file and provide a reasonable period of time for the enrollee to verify the accuracy of the contact information. If the enrollee does not respond, the state may update the enrollee record with the new contact information.

States facing operational or systems constraints can request temporary section 1902(e)(14) authority to forego the requirement to contact the enrollee to confirm the updated contact information prior to accepting the plan's information as verified.

If Medicaid and SNAP are within the same state agency and considered co-located, SNAP can accept Medicaid's updated address without further verification, as long as it is not questionable or unclear.[1]

Program systems to ensure that contact information gathered by plans can be integrated into the individual's record.

Require managed care plans to seek updated mailing addresses and share updated information with the state Medicaid/CHIP agency and/or remind individuals to update their contact information with the state (and, in doing so, provide assistance via online portals, the call center, and warm transfers).

Update 834 enrollment transaction fields to include contact information (e.g., email, phone number and type–landline or cell).

Source: CMS, Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations; and CMS, Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations.

Support the Renewal Process

Streamlining renewal processes will be critical to supporting eligible individuals in maintaining coverage. Plans can provide assistance to enrolled members during the renewal period. States can:

Provide to plans monthly files and leverage 834 enrollment transactions containing information about enrollees for whom the state is initiating the renewal process to enable plans to conduct outreach: (1) to assist enrollees with the renewal process; and (2) to support enrollees who have not submitted renewal forms or additional documentation and are at risk of losing coverage. States should:

- ✓ Identify and address possible systems or operational challenges now.
- ✓ Request that managed care plans use additional modalities (e.g., phone, text) to conduct outreach and encourage individuals to complete/return renewal forms.

Encourage or direct managed care plans via contract requirements to provide information and conduct outreach to individuals enrolled in Medicaid and CHIP to complete the renewal process.

Partner with plans to **identify enrollees who are at high risk** for not renewing coverage in a timely fashion, and tailor outreach accordingly.

Allow plans to engage with applicants and the state on application and renewal submission and tracking (similar to certified application assisters or enrollment brokers). Activities can include: submitting applications on behalf of the individual, troubleshooting/tracking the eligibility determination with the agency on behalf of the applicant, and managing cases between regularly scheduled redeterminations (requires Section 1115 waiver authority).[1]

1. Federal statute and regulations prohibit Medicaid health plan employees from serving as enrollment brokers or certified application counselors due to potential conflicts of interest; however, states have the ability to waive this requirement through an 1115 waiver.

Source: CMS, Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations; and CMS, Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations.

Provide Assistance to People Terminated for Procedural Reasons

To minimize churn due to loss of coverage for procedural reasons (e.g., not returning the renewal form timely), plans can conduct outreach to people who lose Medicaid eligibility. States can:

Update 834 enrollment transaction fields to include the disenrollment reason (e.g., moved to another plan, ineligible due to income, procedural denial) and plan enrollment method (e.g., auto-assigned).

Provide managed care plans with monthly termination files and leverage 834 enrollment transactions to conduct outreach to individuals terminated from Medicaid for procedural reasons.
CMS has provided the following considerations:

- 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 Qualified Health Plans (QHPs)], and plans cannot engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.
- However, general outreach from the plan on behalf of the state to prevent loss of coverage or to assist enrollees with the eligibility renewal process would not be considered marketing under 42 CFR 438.104. Additionally, materials that educate an enrollee on the importance of completing the state's Medicaid eligibility renewal process timely would not be considered marketing.
- States and managed care plans will need to review any state-specific laws and contract requirements.
- States may need to expedite review of outreach messaging to be used by managed care plans, or they may want to consider sharing standardized messaging for use by managed care plans.

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

Provide Assistance to People Terminated for Procedural Reasons (Continued)

To promote continuity of coverage, states can extend the automatic reenrollment period for individuals after a loss of Medicaid coverage for two months or less.

Medicaid managed care contracts must provide for **automatic reenrollment into an individual's original plan** for people who are reenrolled into Medicaid after a loss of Medicaid coverage for two months or less [42 CFR 438.56(g)].

States can leverage during the period of unwinding **temporary section 1902(e)(14) authority to extend the automatic reenrollment period** to between 60 and 120 days. States with systems and operational challenges should contact CMS to request a waiver.

"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." – CMS

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

Assist with Marketplace Transitions/Enrollment

States can look to their managed care plans as essential partners in supporting successful transitions for people eligible for subsidized Marketplace coverage. States can:

Encourage Medicaid managed care plans that also offer QHPs 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. CMS has established the following parameters:

- 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 (42 CFR 438.104; 81 FR 27502). 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 individuals to enroll in the QHP, is not considered marketing. As long as states permit the plans to provide the QHP information, they are 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.
- 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.

States may utilize this strategy in combination with providing managed care plans monthly termination files (see slide 12) if the plan does not have information on whether the enrollee is losing eligibility for programmatic or procedural reasons.

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

Sample Medicaid Managed Care Contract Language to Support Unwinding

Sample Contract Language to Support Unwinding

Obtain/ Update Enrollee Contact Information	The contractor shall remind members to update their contact information with the state Medicaid agency in member communication including notices, member manuals, and websites. The contractor shall provide assistance to help members with submitting updated contact information via [insert the state's online portal and call center information]. The contractor shall actively seek updated member contact information (including mailing addresses, phone numbers, and email addresses) during customer service interactions. The contractor must share any updated member contact information with the state Medicaid agency through [insert file transfer process–e.g., 834] no later than five (5) days upon receipt of an updated address.
Support the Renewal Process	The contractor shall conduct outreach to members to assist them in responding to state Medicaid agency renewal requests for additional information and submitting necessary renewal forms. The contractor shall use multiple modalities when conducting such outreach, including telephone, email, and text.
Provide Assistance to People Terminated for Procedural Reasons	The contractor shall conduct outreach to members who are terminated from Medicaid for procedural reasons and assist individuals in responding to previous renewal requests for additional information and submitting necessary renewal forms. In accordance with 42 CFR 438.56(g), individuals who have been previously enrolled with the contractor and who regain eligibility for the Medicaid managed care program within sixty (60) calendar days of the effective date of exclusion or disenrollment will be reassigned to the contractor without going through the selection or assignment process. The state Medicaid agency will send members a notice informing them of their reenrollment with the contractor.

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Appendix: Recent CMS Unwinding Resources

- CMS, **Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations**. (December 2021).
- CMS, **Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations**. (November 2021).