Medicaid MCO Trade Association Policy Recommendations to CMS:
Roles for Health Insurance Providers in Supporting Continuous Coverage in Medicaid

Executive Summary and Overview

The 2020 Families First Coronavirus Response Act (FFCRA) requires that states maintain people enrolled in their Medicaid programs as a condition of receiving enhanced federal matching funds through the end of the COVID-19 public health emergency (PHE). CMS has informed states they will have up to 12 months following the end of the PHE to perform required redeterminations of each person's eligibility. Nationwide, it is expected that states will need to redetermine the eligibility of most of the 82 million people enrolled in Medicaid—nearly a quarter of the U.S. population.

This document presents policy and administrative recommendations by America's Community Affiliated Plans (ACAP), AHIP, Alliance of Community Health Plans (ACHP), Blue Cross Blue Shield Association (BCBSA), and Medicaid Health Plans of America (MHPA). Our recommendations are intended to make redetermination processes run more smoothly, minimize the number of people losing coverage through eligibility redeterminations, and support transitions to other forms of coverage for individuals determined no longer eligible for Medicaid.

I. Initiatives Leveraging Medicaid Managed Care Organization (MCO) Capabilities

1. **National Awareness Campaign.** Medicaid MCOs could join CMS, state agencies, providers, advocates, and traditional and social media in a national awareness campaign to create widespread awareness of Medicaid redeterminations that will take place in every state, urging Medicaid enrollees to engage and respond to the processes in their state.

2. **Improve Process for Updating Enrollee Contact Information.** Medicaid MCOs and their network providers and contracted vendors could provide state MMIS with up-to-date Medicaid enrollee contact information through newly-established state Medicaid agency web portals to increase effectiveness of outreach to individuals whose eligibility cannot be redetermined by automatic means. If authorized by states, MCOs could contact enrollees for updated contact information and assist with responding to state requests for information.

3. **MCO Direct Outreach to At-Risk Enrollees.** If authorized by states, Medicaid MCOs could contact enrollees whose continuing eligibility cannot be verified through data matches alone and from whom more information is needed. MCOs could assist with responding to state requests for information.

4. **MCO Engagement on Transitions.** If authorized by states, Medicaid MCOs could connect enrollees who receive final adverse determinations of loss of Medicaid eligibility with navigators/assisters to review coverage options through the exchanges, employers, or other government programs. If MCOs are serving in this connection role, it will be important that all of their enrollees losing Medicaid receive equal assistance with finding other coverage and to avoid MCO marketing to select enrollees.

II. Other Initiatives Supporting Continuation of Coverage

1. **1-800-MEDICAID.** We would like to discuss an option for CMS to establish a national 1-800-MEDICAID hotline to serve as a single point of contact to assist Medicaid enrollees with information and connection to state resources.

2. **Redetermination Criteria and Prioritization.** We recommend that CMS explore streamlining of redetermination criteria or other changes such as modified presumptive eligibility processes for certain groups least likely to have lost eligibility, such as dual eligible individuals, people with intellectual or developmental disabilities, and pregnant or postpartum individuals, so that resources can be targeted at other groups more likely to have experienced eligibility changes. CMS should also increase efficiency of the redetermination process nationally by encouraging the establishment of consistent priorities for redeterminations and maximizing the number of *ex parte* redeterminations that can made automatically through use of available data on Medicaid enrollees.

3. **Medicaid-to-Marketplace Data Sharing.** We recommend improving on current Account Transfer capabilities to transfer application information between the State Medicaid agency and Health Insurance Exchanges (Healthcare.gov or the State-based Marketplace (SBM)) to initiate the Exchange application and enrollment process. This will require significant improvements to data provided by state Medicaid agencies through Account Transfers as described in I.2, and improvements to notices and the Exchange consumer experience to lower attrition rates.

4. **High-Touch Enrollment Support.** We recommend CMS and states provide needed flexibility and resources to expand the roles of navigators and assisters (including direct enrollment partners, given the likely magnitude of people affected) to provide individualized support for transitions to Exchange coverage, for example for households and families with more complex eligibility scenarios.

5. **Align End of PHE with Open Enrollment.** We recommend the end of the PHE be aligned with the annual open enrollment period for the individual market. Aligning with open enrollment would allow issuers and Exchanges to scale resources to meet the demands of increased volume of consumers applying for and enrolling in Exchange coverage. This includes website capacity, call center staffing, navigator and assister, marketing & outreach activities—all of which operate at very low levels outside of open enrollment.

6. **Provide More than 60-days Notice before Ending the PHE**. We support states and stakeholders receiving at least 60-days advance notice of the end of the PHE and encourage earlier advance notice—ideally 90 days—if possible. The federal government should provide transparency into the criteria that will be used in deciding when to end the PHE, so state Medicaid agencies, Exchanges, and issuers can better monitor and prepare.

7. **Resources for Disability Determinations.** We recommend CMS provide states with additional resources to support disability determinations to facilitate Medicaid eligibility for individuals who have COVID-related disabilities, or whose disability determinations were slowed down due to staffing shortages and safety protocols during the PHE.

Key Details of Policy Recommendations

Initiative Segment	Major Activities	Supporting Measures
How Medicaid MCOs Can Support Successful Redetermination Processes		
1. Awareness and education campaign	A. CMS, states, MCOs, providers, community advocates, and the Ad Council collaborate to produce and distribute state-specific versions of public service announcements to educate enrollees and urge response to state requests for information	• National initiative. • Include traditional and social media outlets. • Allow for flexibility in communications approaches for different communities. • Maximize lead time for planning and roll-out.
	B. States "deputize" MCOs to conduct educational outreach to enrollees using pre-approved templates (mail, email, text, website)	• Some states may need to be encouraged by CMS to enlist/engage with MCOs. • MCOs need to be authorized to conduct direct outreach, communicate with enrollees about redeterminations. • Need federal waiver or exemption from the Telephone Consumer Protections Act (TCPA) "opt-in" requirement. • Templates need to be developed and approved, determine languages. • Consider option of plans using customized messaging by population, accounting for rural/urban differences, varying levels of health literacy and access to technology. • Will feed into #3 as mail returned undeliverable.
	C. **Option for further discussion:** Create 1-800-MEDICAID enrollee assistance program	• CMS creates national 1-800-MEDICAID assistance center with adequate staffing to respond to enrollee questions, referrals to state/local resources. • 1-800-MEDICAID also could collect updated enrollee information, generate information updates to states. • Should consider separate assistance lines for states and plans.

Initiative Segment	Major Activities	Supporting Measures

2. Redetermination decision criteria	A. CMS issues redetermination playbook for states on conducting Medicaid eligibility redeterminations	• CMS issues a playbook that sets standards and expectations for states:
		  – Defined reduced criteria set/ minimum dataset elements to be considered for MAGI and non-MAGI groups
		  – Guidance on prioritization
		    ▪ elapsed time since last determination (longer time = higher priority)
		    ▪ enrollee subgroups more likely to have eligibility changes (e.g., expansion) vs. less likely (e.g., dual eligibles, children, pregnant and postpartum women)
		• Allow self-attestation/presumptive eligibility in redetermination for first post-COVID redetermination cycle for certain groups least likely to have lost eligibility, subject to verification and due process, then resume normal criteria thereafter.
		• CMS could issue emergency guidance formally designating additional entities (e.g., state unemployment/welfare offices, FQHCs, CMHCs, food pantries) as authorized to make presumptive eligibility determinations.

3. Maximize automated *ex parte* determinations	A. States leverage data exchanges with other governmental and commercial databases	• CMS requires or at least strongly encourages states to conduct MMIS data matches with available databases:
		  – State: state welfare, taxpayer systems, dept. motor vehicles
		  – Federal: SNAP eligibility, IRS, and SSA
		  – Commercial: Experian/credit reporting agencies (a resource already used by some state Medicaid agencies)
		  – Provide states with toolkits, technical assistance and best practices to improve *ex parte* renewals, covering topics such as advance action timelines, data exchange capabilities, data sources, and discrepancy resolution
		  – Potential role for enrollment broker/facilitator contractors

	B. CMS creates national Medicaid database option for *ex parte* determinations	• CMS creates national Medicaid enrollee database, invites states to send their Medicaid enrollment files for data match. • CMS brokers data match process with IRS and SSA, provides states with updated enrollment files.

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Initiative Segment	Major Activities	Supporting Measures
4. Improve quality of enrollee data	A. States permit updates of enrollee contact information in their MMIS	• CMS works with WEDI/HL7 to develop standard approach for states to create web-accessible copies of their MMIS, rules for who can update, criteria for accepting updates into system of record. • Enhance 834 file capabilities through state technical assistance and toolkits covering expanded data fields for enrollee contact information, data exchanges with other agencies and MCOs, automated updates, and enhanced administrative FMAP.
	B. Update enrollee contact information through state and plan eligibility portals	• Require/allow MCOs and their network providers and contracted vendors, to update enrollee contact information when confirming eligibility in existing state and MCO eligibility portals or through newly-established portals; provide incentives. • Encourage states and plans to assess the availability of updated information in supplemental enrollee databases maintained by some MCOs. • States need to permit updates/overrides of enrollee data subject to criteria. • Add email and cell phone numbers to data elements; less likely to change.
5. Engage MCOs, affected enrollees, and communities in redetermination processes	A. MCOs outreach and engage with members subject to manual redeterminations	• States provide MCOs with detailed information on each enrollee subject to manual redetermination with as much advanced notice as possible (e.g., at least 30-45 days advance notice prior to redetermination date, 60-90 days if possible) including contact info, reasons for loss of eligibility and action date. May be able to use existing or expanded 834 files. • States permit MCOs to engage in facilitated renewals (i.e., MCOs actively assist enrollees in responding to requests for information).
	B. States and MCOs leverage community resources to engage with enrollees	• States and MCOs partner with community agencies, churches, leaders at the local level to engage and educate enrollees on the redetermination process, the need to respond to state requests for updated information and how to contact 1-800-MEDICAID or the state for more information. Model on partnerships developed during COVID vaccination. • States and MCOs engage with Medicaid providers to engage with enrollees about updating contact information, responding to state requests for information. • May need limited waiver/exemption from HIPAA PHI disclosure rules, or clarification of uses for "treatment, payment, and operations".

Initiative Segment	Major Activities	Supporting Measures
6. For those no longer eligible, facilitate smooth transition to other coverage	A. Expand current state "no wrong door" capabilities for QHP enrollment, leverage potential navigators to assist in transitions	• Allow MCOs to contact members for up to 60 days after disenrollment to assist them in responding to any outstanding state requests for information relating to eligibility verification. • Allow MCOs to send members info on QHP enrollment, Healthcare.gov, and available coverage options if their eligibility will end. Members are more likely to open mail from their MCO than from state agency. • Key opportunity to leverage SHIPs, FFM navigators, health insurance assisters; include SSA offices, state unemployment, welfare offices as assistance sites.
Role of QHP Issuers to Facilitate Seamless Transitions to Exchange Coverage		
7. Increase awareness of coverage options through Exchanges	A. Conduct marketing, outreach, and enrollment to increase awareness	• QHP issuer marketing, outreach, and education increases awareness of the availability of QHPs and subsidies through the Exchanges. • State Medicaid agencies provide transparency—including notification to issuers offering QHP coverage in the state—of the schedule and plan for conducting redeterminations. • State shares estimate of the number of Medicaid beneficiaries who may be disenrolled and eligible for QHP coverage so issuers, their agents, and navigators can increase resources and staffing to support the increased volume of individuals needing eligibility and enrollment support.
	B. Exchange sends enrollment notice to beneficiaries losing Medicaid coverage	• Exchange develops new notice (similar to the Marketplace Open Enrollment Notice, or "MOEN") to be sent to all individuals who lose Medicaid eligibility and are disenrolled, including information on: how to apply for and enroll in Exchange coverage; how to access enrollment support via Healthcare.gov, call center, navigators, or other resources; and key differences between Medicaid and Exchange coverage (e.g., cost-sharing, potential to owe a premium, family coverage options, and, if applicable, make a binder payment to effectuate coverage). • Encourage State-based Marketplaces to develop a similar notice.

Initiative Segment	Major Activities	Supporting Measures
8. Facilitated enrollment	A. Agents and navigators provide individualized support to assist enrollment in Exchange coverage	• Allow agents employed by QHP issuers and Medicaid MCO staff to conduct outreach to all individuals disenrolled from Medicaid to complete an Exchange eligibility application and enroll in coverage as long as they are certified by the Exchange to provide members information about the full range of coverage options available. o Should include assessment of most appropriate coverage (single vs. family), also eligibility of any children for CHIP instead of QHP. • Permit Medicaid MCO employees to serve as enrollment assisters or certified application counselors to assist beneficiaries who are disenrolled to transition to Exchange coverage and mitigate coverage gaps similar to the New York state Facilitated Enrollment Program implemented under the state's 1115 waiver. Permit an expedited process for other states to apply for a waiver that mimics New York's or grant temporary authority for all states to implement such a program related to Medicaid redeterminations at the end of the PHE. • Need waiver or exemption from TCPA "opt-in" requirement and Federal Tax Information (FTI) restrictions to permit transfers and/or permit Medicaid beneficiaries to opt-in to permitting their contact information and income information for purposes of facilitating enrollment in Exchange coverage if they are determined ineligible for Medicaid.
9. **Option for further discussion:** Continue to offer opportunity for facilitated coverage transitions through Direct Enrollment (DE)	A. Leverage recognized DE partners to assist with QHP eligibility and enrollment and to alleviate the burden on exchange call centers and websites	• Allow MCO/QHP issuers to notify all beneficiaries who are no longer eligible that they can submit an application and enroll in Exchange coverage directly through the issuer's current DE website, following existing regulations requiring DE partners to be certified by the Exchange and to provide members information about the full range of coverage options available. (Note: 45 CFR § 438.104 permits QHP issuers to send marketing communications to Medicaid beneficiaries regarding issuers' QHPs.) • Additional guardrails may need to be considered to ensure individuals disenrolled from Medicaid are aware of option to shop for and enroll in coverage through a DE partner website or shop via Healthcare.gov. • Need waiver or exemption from TCPA "opt-in" requirement and Federal Tax Information (FTI) restrictions to permit transfers and/or permit Medicaid beneficiaries to opt-in to permitting their contact information and income information for purposes of facilitating enrollment in Exchange coverage if they are determined ineligible for Medicaid.

Initiative Segment	Major Activities	Supporting Measures
10. Facilitate Smooth Transitions through Account Transfer (AT)	A. Improve Marketplace Inbound ATs to facilitate transition to Exchange coverage through notification & pre-populated Exchange application	• Improve quality and completeness of demographic information from State Medicaid agency (see above) to increase percent of Medicaid disenrollment's that meet minimum data thresholds to generate an Inbound Account Transfer. • Improvements to Inbound AT Notice to meet Medicaid-specified reading level and improve application take-up rate. • Allow data sharing with navigators and assisters to conduct outreach to individuals for whom an Inbound AT Notice is generated to encourage and assist consumers to access, complete, and submit the pre-populated Exchange application. • Lower barriers to consumer take-up of prepopulated Exchange applications. Simplify the account creation and ID proofing process, even providing a QR code on notices to allow consumers to easily access and complete their application without additional steps.
	B. Modify Healthcare.gov to appropriately redirect Marketplace Outbound ATs back to State Medicaid Reenrollment	• If Healthcare.gov determines an individual who was disenrolled from Medicaid as ineligible for Exchange coverage but potentially still eligible for Medicaid (e.g., because the individual includes updated income information in an Exchange application), modify Healthcare.gov Outbound AT to a state's Medicaid renewal process rather than to the state's initial Medicaid enrollment process so that consumers are not required to provide the same eligibility information multiple times. • Urge State-based Marketplaces to take a similar approach.