Leveraging Managed Care Plans to Support Medicaid Continuous Coverage Unwinding Toolkit

Manatt Health
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About State Health and Value Strategies

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About Manatt Health

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Coverage Transitions When Federal Medicaid Continuous Coverage Requirement End
Medicaid Continuous Coverage Requirement

As a condition of receiving a temporary 6.2% Federal Medical Assistance Percentage (FMAP) increase, the Families First Coronavirus Response Act (FFCRA) requires states to maintain enrollment of nearly all Medicaid enrollees through the end of the month in which the COVID-19 PHE ends. Congress is continuing to negotiate federal Build Back Better legislation that will likely change the timeline for: (1) when the federal continuous coverage requirement ends; and (2) parameters for continued receipt of enhanced FMAP.

- 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.

When the continuous coverage requirement expires, states will need to conduct a full redetermination for all enrollees who would have otherwise been subject to redetermination—approximately 80 million enrollees.

Source: FFCRA § 6008(b)(3); SHVS, Renewal of Determination That A Public Health Emergency Exists; Centers for Medicare and Medicaid Services (CMS), Fourth COVID-19 Interim Final Rule with Comment Period (IFC-4).
When the continuous coverage requirement ends, nearly all Medicaid enrollees will need to have their eligibility redetermined, triggering a high risk of coverage losses.

Most people will continue to be eligible for either Medicaid or subsidized Marketplace coverage, but a massive number of renewals—some of which have been pending for almost 2 years—will test the system.

Terminations of Medicaid coverage and eligibility transitions between Medicaid and the Marketplace are likely to disproportionately impact people of color.

Black and Latino(a) populations have fared far worse during the pandemic, experiencing exacerbated housing/employment instability and facing a disproportionate burden of disease and death due to COVID-19.

Black and Latino(a) individuals are significantly overrepresented in state Medicaid/Children’s Health Insurance Program (CHIP) programs.

Source: State Health Compare.
CMS Guidance on Resuming Program Operations After the Continuous Coverage Requirement Ends

CMS released sub-regulatory guidance* to support state Medicaid/CHIP agencies in returning to normal operations when the continuous coverage requirement expires. The current guidance includes:

- Timeliness and consumer communications for redetermining Medicaid coverage for those who had their coverage continuously maintained.

- Timeline for resolving all outstanding eligibility and enrollment actions including applications, annual renewals, mid-year redeterminations, and verifications of eligibility.

- CMS Administrator, Chiquita Brooks-LaSure, continues to emphasize the Administration’s focus on ensuring that people remain insured—whether they are eligible for Medicaid/CHIP, Marketplace coverage or employer-sponsored coverage—when the PHE ends.

*CMS will likely issue updated guidance to clarify expectations of states upon the enactment of any federal legislation.

Source: CMS, SHO #20-004; CMS, SHO #201-004; InsideHealthPolicy, Brooks-LaSure: Don’t Lose Medicaid, CHIP Enrollment Gains After PHE.
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—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
- Conducting Outreach 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*. 
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 the individual with a reasonable period of time to verify the accuracy of the contact information. |
| If the enrollee does not respond to verify the accuracy of the contact information, the state may update the enrollee record with the new contact information. |
| 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 |

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.

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

¹ 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. SNAP = Supplemental Nutrition Assistance Program.

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 (Continued)

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:

**Update 834 data fields to:**

- Improve the capture of enrollee contact information through revisions to/additions of additional data fields and requirements on 834 Medicaid application forms. Critical data fields (via 834 forms or another transfer method) include:
  - Email addresses.
  - Phone number and type (i.e., landline or cell).
  - Income.
  - Demographic data.
  - Renewal date.
  - Disenrollment reason (e.g., moved to another plan, no longer eligible, did not complete renewal form).
  - Plan enrollment method (e.g., auto-assigned).²

- Ensure plans are transmitting to the state necessary information for updating contact information (e.g., email addresses, phone numbers).

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² Plan enrollment method is not considered critical; however, it is helpful for managed care plans to have.
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** 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 system 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.

- **Direct managed care plans via contract requirements to conduct outreach and provide support** 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.

- **Allow plans to engage with an applicant and the state on the status of applications and renewals** (similar to certified application assisters or enrolment 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).  

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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*. 

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Conduct Outreach 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:

Provide managed care plans with monthly termination files to conduct outreach to individuals terminated from Medicaid for procedural reasons. CMS has provided the following 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 Qualified Health Plans (QHPs)], and plans cannot, directly or indirectly, 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 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 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.

Incentivize managed care plans to conduct outreach and provide education to individuals enrolled in Medicaid, CHIP, or Basic Health Plan (BHP) about the return to normal state operations, expectations for sending in requested information, and the importance of updating contact information.

Source: CMS, Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations.
States can look to their managed care plans as essential partners in both ensuring that eligible individuals can keep their coverage and supporting successful coverage transitions.

Encourage 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). 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, 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.

Source: CMS, 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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Appendix: Recent CMS Unwinding Resources
