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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.

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Working through the Medicaid and CHIP Learning Collaborative, the Centers for Medicare & Medicaid Services (CMS) has developed a set of policy and operational strategies that states can implement to support unwinding activities. The strategies—found on the following pages—are organized around seven topic areas, offering actionable steps that states can take to maintain continuous coverage for eligible individuals enrolled in Medicaid, CHIP, and BHP and ease the return to normal operations:

1. Strengthen Renewal Processes
2. Update Mailing Addresses to Minimize Returned Mail and Maintain Continuous Coverage
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

States can use these "punch lists" to proactively plan work.

Implementation of some of the strategies described in this document will require states to work with CMS and, in some cases, submit state plan amendments (SPAs) or BHP Blueprint revisions, updates to verification plans, or other documentation. To the extent these additional steps are required, states should make efforts to start these processes as soon as possible and before states implement their plans to restore operations. CMS is available for technical assistance.

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Strengthen Renewal Processes

Many individuals enrolled in Medicaid, CHIP, and BHP lose coverage at renewal due to procedural or administrative reasons rather than eligibility-related factors, such as not submitting information needed to complete their renewal in a timely fashion. To prevent inappropriate coverage loss among eligible individuals, states should implement actionable strategies to strengthen their renewal processes.

The more renewals that a state can complete based on available information (*ex parte*), the less often that states will need to follow-up and request additional information from individuals to complete the renewal process. Therefore, these strategies include implementing changes that will increase the percentage of successful *ex parte* renewals, reduce workload for state eligibility workers, and minimize burden on individuals enrolled in Medicaid, CHIP, and BHP for renewals that cannot be completed via an *ex parte* process. When *ex parte* renewal is not possible, states must ensure that their processes facilitate individuals' ability to provide needed information in a timely way.

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 (e.g., use both the Internal Revenue Service (IRS) and quarterly wage data; leverage unemployment income data sources)

Leverage data from other means-tested programs, like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF), for Medicaid eligibility renewals

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) and verify income when data source in the hierarchy confirms reasonable compatibility

Use a reasonable compatibility threshold (e.g., 10%) for income for MAGI and non-MAGI populations and a reasonable compatibility threshold for assets for non-MAGI populations, if not already used

☆ Denotes a strategy that will likely have the biggest impact on mitigating coverage loss.

Assess and adjust the current reasonable compatibility threshold for income (e.g., increase to 20%)

Streamline, increase levels for, or eliminate asset requirements for some or all non-MAGI populations

Automate data checks

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

Revise instructions on pre-populated form to make clear requests for additional information as well as the process and timeframe for returning documents/information

Extend the deadline for responding to requests for additional information (e.g., increase time individuals have to respond to a renewal form from 30 days to 45 days)

Provide a 90-day (or longer) reconsideration period for individuals enrolled on a non-MAGI basis who do not respond to the renewal form, as is required for MAGI populations

Implement a reconsideration period after termination due to a change in circumstances for all individuals enrolled in Medicaid and CHIP (on both a MAGI and non-MAGI basis)

Update verification plans to accept reasonable explanations of inconsistencies or to allow for self-attestation of certain eligibility criteria for which documentation may be difficult for individuals to obtain

Create specialized units to process complex/time-consuming redeterminations (e.g., renewals for households with self-employment income or individuals without a fixed address)

Additional resources:

Medicaid and CHIP Renewals and Redeterminations (January 2021).

Coverage Expansion Learning Collaborative Virtual Meeting #3 (March 2012).

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Update Mailing Addresses to Minimize Returned Mail and Maintain Continuous Coverage

It has been several years since states may have conducted a renewal or communicated with individuals enrolled in Medicaid, CHIP, or BHP, meaning 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. To prevent inappropriate coverage loss from occurring as states resume renewals and other operations, states should take concrete steps to proactively update mailing addresses and other contact information for individuals enrolled in Medicaid, CHIP, or BHP.

Implement processes to prevent and address returned mail:

Engage community-based organizations, application assisters (including Navigators and certified application counselors), and providers to conduct outreach to remind individuals enrolled in Medicaid, CHIP, and BHP 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

Identify other data sources that will be leveraged to obtain updated contact information (e.g., managed care plans, the state agency that administers SNAP or TANF, Department of Motor Vehicles records, and/or the U.S. Postal Service National Change of Address database)

Send periodic mailed notices, texts, and email/online account alerts reminding individuals to update their contact information (e.g., on a quarterly basis)

Ensure individuals are able to submit updated contact information via all modalities, including mail, telephone, and online

Ensure consumer notices and renewal forms include reminders for individuals to update their contact information

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Revise call center/Enrollment Broker scripts to include requests for updated contact information (e.g., prior to answering any question, inquire about updated contact information)

Add bolded reminders to update contact information on Medicaid/CHIP/social services websites

Provide clear guidance and update policy manuals to ensure that staff know what specific actions they should take in response to different forms of returned mail, including:

Mail that is returned with an in-state forwarding address: States should attempt to confirm the address by conducting outreach, checking data sources, and sending a request for information to the forwarding address; states may **not** terminate coverage if no response is received.

Mail that is returned with an out-of-state forwarding address: States should attempt to confirm the address by conducting outreach, checking other data sources, and sending a request for information to both the current and forwarding address; coverage can *only* be terminated if no response is received.

Mail that is returned with no forwarding address: States should attempt to confirm the address by conducting outreach and verifying data sources; coverage can be terminated if no response is received.

Create specialized and dedicated unit (either centralized or within each region/county) for processing returned mail

Additional resources:

Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Beneficiaries: Part 2 (August 2021).

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Improve Consumer Outreach, Communication, and Assistance

As states resume normal operations at the end of the continuous enrollment requirement, they will be sending consumer notices, renewal packets, and requests for additional information. Some individuals enrolled in Medicaid, CHIP, and BHP may be confused about what they must do and the timeline required to take specific actions. States that conduct robust outreach, issue clear communications, and provide consumer assistance are more likely to get better responses to requests for information. When states are unable to reach individuals via mail, they should conduct outreach using alternate modalities, such as telephone and email. States should also look to their managed care plans as essential partners in consumer communication, outreach, and assistance.

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)

Re-label envelopes to clearly indicate that the information enclosed is important and time-sensitive (e.g., in bold, add "time-sensitive urgent action needed")

Change the format of mailed notices and envelopes (e.g., use a different attention-getting color, such as yellow)

Conduct intensive outreach:

Conduct more intensive outreach via multiple modalities to remind individuals enrolled in Medicaid, CHIP, or BHP 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)

Implement a text messaging program to quickly communicate eligibility reminders and requests for additional information, as permitted

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Incentivize stakeholder partners to conduct outreach and provide education to individuals enrolled in Medicaid, CHIP, or BHP about the return to normal state operations, expectations for sending in requested information, and the importance of updating contact information. Stakeholders include:

- Managed care plans
- Community-based organizations
- Providers
- Application assisters (including Navigators and certified application counselors)
- State Health Insurance Programs (SHIPs)
- Schools
- Others ______________________________

Provide robust consumer assistance:

Develop and provide policy training, scripts, and informational materials to call center staff that emphasize the importance of providing clear information to help consumers maintain coverage

Engage application assisters (including Navigators and certified application counselors) and other stakeholders to assist individuals who need help with renewal; expand use of outstation locations for eligibility workers to provide individuals with renewal assistance

Update online account portals to display the status of renewals and what information is outstanding

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 key documents such as written notices, applications, and renewal forms are translated into multiple languages by qualified translators and reviewed for cultural competence

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- Increase number of non-English language translations of key written materials, after review of census and other local data sources

- Review and enhance access to and availability of qualified oral interpreters for individuals with LEP. Consider the following:
  - Hire or deploy multilingual staff who speak certain frequently spoken languages within the states' population (e.g., Spanish) and conduct training
  - Partner with community-based organizations with interpretation services
  - Provide qualified telephonic interpreters (some interpreter vendors offer services in over 100 languages)

- Ensure individuals with LEP know how to access available language services by updating websites with taglines in non-English languages (e.g., short statements that language services are available free of charge, including how to access those services)

- 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, consistent with the Americans with Disabilities Act (ADA) and section 1557 of the Affordable Care Act

Additional resources:

Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Beneficiaries: Part 1 (July 2021).

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Promote Seamless Coverage Transitions

Many individuals currently enrolled in Medicaid who are found ineligible once the FFCRA continuous enrollment requirement ends will be eligible for other coverage. To maintain continuity of coverage and comply with federal statute and regulations, states must ensure that systems are correctly programmed to determine eligibility for other Insurance Affordability Programs when individuals are found ineligible for Medicaid. This includes updating processes and information technology (IT) systems for facilitating seamless transfers of eligibility information between Medicaid, CHIP, and BHP, as well as the State-Based Marketplace (SBM) (if eligibility systems are not integrated), SBM on the Federal Platform, or the Federally-Facilitated Marketplace (FFM).

Ensure accounts are seamlessly transferred to the Marketplace when individuals are found ineligible for Medicaid, CHIP, or 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

Conduct regular system testing/quality assurance to eliminate glitches in sending or receiving accounts between the Medicaid or CHIP agency and the Marketplace

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

Introduce an eligibility results page following an online application that provides real-time guidance on next steps and the transition to the Marketplace

Set up regular feedback loop/information-sharing process with the Centers for Medicaid and CHIP Services (CMCS) Data and Systems Group (DSG) (Enterprise State Systems Officer) and the Center for Consumer Information and Insurance Oversight (CCIIO) to identify and troubleshoot Account Transfer issues

Additional resources:

Medicaid and CHIP Renewals and Redeterminations (January 2021).

Understanding the Consumer Experience in Transfers from the State Medicaid/CHIP Agency to the Federally Facilitated Marketplace (October 2016).

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Improve Coverage Retention

As states complete renewals in the coming months, they may want to implement additional policy and operational strategies to help the state resume normal operations. These strategies may also help to ensure that individuals in Medicaid, CHIP, or BHP easily remain enrolled in coverage that they are eligible for, minimize churn, and reduce states' administrative burden. States are also encouraged to look to their managed care plans as essential partners in improving coverage retention.

Adopt 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 to mitigate additional requests for information and manual work by state agencies)

Adopt Express Lane Eligibility for children (via SPA)

Leverage SNAP facilitated enrollment authority for adults (via SPA)

Leverage managed care plans:

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

Share list of individuals who are due for renewal in upcoming months with managed care plans to enable plan outreach

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Share list of individuals terminated for failure to return renewal form or documentation with plans to support outreach that enables re-enrollment during the 90-day reconsideration period, consistent with federal regulations

Program systems to ensure that updated contact information gathered by managed care plans can be received and integrated into the individual's record

Partner with plans to identify individuals who are enrolled in Medicaid or CHIP and are at high risk for not renewing coverage in a timely fashion

Additional resources:

Medicaid and CHIP Renewals and Redeterminations (January 2021).

Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Beneficiaries: Part 1 (July 2021).

State Health Official Letter (SHO#15-001): Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies (August 2015).

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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, including conducting renewals for their entire Medicaid, CHIP, and BHP-enrolled populations and catching up on any pending applications and verifications. The significant volume of pending work that states will need to complete is likely to place a heavy burden on the eligibility and enrollment workforce and could contribute to coverage loss related to procedural errors. To prevent inappropriate loss of coverage of eligible individuals, each state should conduct an assessment of its current eligibility and enrollment workforce capacity to determine whether the state (and regional/county offices) can continue to efficiently and accurately process its regular monthly application caseload while simultaneously moving through outstanding renewals and completing other routine functions. Based on the findings of the risk assessment, states should implement targeted strategies that help ensure adequate staff capacity to process applications and redeterminations in a timely fashion. States should also conduct training and issue guidance to the eligibility and enrollment workforce so that they stay abreast of all policy and operational changes that will occur.

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 efforts

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Create specialized units to process complex/time-consuming applications/ redeterminations (e.g., evaluating self-employment income)

Become a Medicaid and CHIP Eligibility Determination State if you are an Assessment State with an FFM or SBM on the Federal Platform to reduce workforce burden

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 resources

Communicate policy changes to other entities that partner with the eligibility and enrollment workforce (e.g., managed care organizations, Navigators, delegated fair hearing agencies) through a variety of methods (e.g., routine updates to Medicaid/CHIP agency websites, mailings, agenda items during standing meetings)

Additional resources:

Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Beneficiaries: Part 1 (July 2021).

Risk Assessment Tool for Evaluating COVID-19 Flexibilities and Waivers (July 2021).

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Enhance Oversight of Eligibility and Enrollment Operations

The significant volume of renewals and other actions that states will need to complete as they return to normal operations following the end of the continuous enrollment requirement are likely to stretch state capacity and could contribute to coverage loss related to procedural errors. To prevent inappropriate loss of eligible individuals in Medicaid, CHIP, and BHP and ensure that those who are no longer eligible for Medicaid, CHIP, or BHP are seamlessly transitioned to the applicable Marketplaces, states should establish a centralized oversight and monitoring infrastructure. A strong oversight and monitoring infrastructure will help identify processing backlogs in a timely fashion, diagnose workforce issues, and gather critical data that can inform corrective actions, address operational challenges, and mitigate unintended coverage loss.

- 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
- Conduct diagnostics and ongoing monitoring by modality
- 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
- Automate a "circuit breaker" flag based on a data review for the agency to pause and consider a change in its practices to mitigate inappropriate coverage loss
- Establish processes for reviewing data captured by tracking and management tools (e.g., cadence for reviewing data, process for sharing findings with county staff) and implementing mitigation strategies

Additional resources:

Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Beneficiaries: Part 1 (July 2021).

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