November 4, 2021

Mr. John Giles
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Follow-up from Q3 2021 CMCS-MHPA Quarterly Call

Dear Mr. Giles:

On behalf of the Medicaid Health Plans of America (MHPA), I would like to thank you and your colleagues from the Centers for Medicare and Medicaid Services (CMS)/Center for Medicaid and CHIP Services (CMCS) for your continued commitment to the MHPA-CMCS quarterly calls. We look forward to continuing to work with you and your team and colleagues in the best interests of Medicaid beneficiaries and in support of the stability and sustainability of the Medicaid program.

The third quarter call, held on September 30th, 2021, focused exclusively on the winding down of the public health emergency. As a follow-up to that discussion, we have compiled the key take-aways from our conversation in the attached appendix as a table. We recognize that ongoing discussions related to the reconciliation bill may impact some of these recommendations and note that the potential of an accelerated timeline for redeterminations underscores the need to address existing challenges; please know that Medicaid health plans can be a resource. We would be happy to discuss our recommendations further on our fourth quarter call, set up a separate call, or respond to any questions via email.

Once again, we would like to thank CMCS for taking the time to engage in these thoughtful discussions with our members. We look forward to connecting with you on the next quarterly call on November 18th at 3 pm. Should you have any questions in the meantime, please feel free to reach out to me directly via email at sattanasio@mhpa.org.

Sincerely,

Shannon Attanasio
Vice President, Government Relations and Advocacy

mhpa Medicaid Health Plans of America

APPENDIX

Obtain and Share Updated Beneficiary Contact Information with Medicaid Agencies

Actions MCOs Could Take	Actions Needed by State to Support MCO Action	Support CMS Could Provide to Advance Consistent Adoption
Broadly use trusted vendors to augment contact information found on 834 files	• Limit requirements that the 834 be the sole source of beneficiary contact information	• Highlight in tool kits for states the best practices for collecting and maintaining up to date modern beneficiary contact information. • Include alternative data collection resources such as EHRs from pharmacies, providers, and health systems
Share beneficiary contact information with the State	• Ensure data systems can accept information from the MCOs regarding member files • Ensure data system can maintain multiple contact numbers/emails for members and indicate the latest obtained/up-to-date information. • Support file sharing between MCO and State in preparation for the PHE outside of the 834 if such data cannot be ingested by State system • Create bi-directional data sharing, so the MCO and the state have the most current contact information	• Confirm funding available for 90/10 match to support tech enhancements to capture data. • Highlight state opportunities to quickly implement approved technology and information pathways in lieu of robust system updates. • Provide technical assistance to states focused on optimizing data on member outreach

Consistently leverage data from the 834s to support clinical and member engagement	• Leverage the ending of the PHE to build in additional data on members including but not limited to race, ethnicity, language, gender and contact information including emails, mobile numbers.
	• Additional fields that could be included to help with member data capture and improve outreach for redeterminations: (**bold** represent priority fields)
	  ○ **Email address**
	  ○ **Renewal date**
	  ○ **Phone number type – land line or cell**
	  ○ **Disenrollment reason**
	  ○ Income
	  ○ Moved to another plan
	  ○ No longer eligible
		• Develop a toolkit or standardization for 834 files particularly as it relates to race, ethnicity, language, gender, as well as capture of accurate and preferred member contact information and reason for disenrollment.

	○ Did not complete renewal form ○ Plan enrollment method ○ True self-select ○ Auto-assigned ○ Auto-assigned due to family in plan	
Use modern outreach and engagement tools that align with the members preferred communication channels	• Include member opt-in for health and Medicaid-related texting programs at the time of enrollment. Delegate the opt-in from the state to the MCOs, with an opt-out option. • Denote phones as mobile. • Limit restrictions that inhibit email outreach to members. • Allow for saving preferred mode of communication and limit restrictions for outreach using chosen modalities, including text and email.	• Support cross-agency work at the federal level to allow for Medicaid and Medicaid Health Plan outreach to engage beneficiaries through texting. This would also include support engaging cell carriers to allow targeted texting for health campaigns.

Assist Beneficiaries with Renewal Process

Actions MCOs Could Take	Actions Required by State to Support MCO Action	Support CMS Could Provide to Advance Consistent Adoption
Begin planning today for the high volume of enrollees that will need outreach	• Provide the state's detailed redetermination strategy to plans and other stakeholders as well as clear guidance on prioritization and outreach requirements as early as possible • Approve materials quickly and in advance of the end of the PHE • Allow MCOs to outreach to members prior and post disenrollment, including communicating the ability to gain coverage through the MCOs complimentary Marketplace or MA plan, if eligible.	• Toolkits and templates for planning, prioritization and communication regarding redeterminations. • Support for states to receive 60 days advance notice before HHS ends the PHE (and potentially encourage earlier advance notice – e.g., 90 days). • Support for transparency regarding the criteria the federal government will use when considering ending the PHE. • Require states to provide a detailed redetermination strategy in advance to stakeholders.
Understand when beneficiary redetermination dates are due	• Include redetermination dates on the 834 or in a supplemental file	• Establish requirement for states to include redetermination dates on 834s and/or provide supplemental files

	• Provide MCOs a list of beneficiaries who will be redetermined 60-90 days in advance of their redetermination date	
Leverage all data to help target and batch engagement with beneficiaries	• Share with MCOs a list of members who are likely to no-longer be eligible for Medicaid following the PHE and allow MCOs with footprint in the Individual Exchange to outreach for facilitated enrollment in an appropriate marketplace plan. • Clearly note which members are eligible for ex parte and who have been renewed during the PHE • Maximize ex parte renewals including efforts to automate for those over 65 and those with disabilities; Employ best practices of data sourcing and verification when conducting ex parte review (i.e. using a combination of federal and state sources) • Conduct ex parte renewals 90 days in advance of renewal dates.	• Toolkits and templates for planning, prioritization and communication regarding redeterminations; standardization of ideal ex-parte processes and procedures, including data source access and usage. • Provide clear guidance allowing for appropriate data exchange for parent companies with MCOs and Individual Exchange in the same geographic footprint for outreach to members no longer eligible for Medicaid to facilitate enrollment in an appropriate marketplace plan (e.g., allow MCO post-disenrollment communications to include information on other potential coverage options). • Allow for QHP issuers (parent company of the MCOs) to offer enhanced direct enrollment (EDE) into ACA Exchange plans in a state to allow Medicaid members determined no longer eligible for Medicaid to opt into coverage with the issuer through EDE. Individuals would be notified of their ability to utilize EDE or HealthCare.gov to view other plan options • Modify or otherwise enable healthcare.gov and state-based exchanges to seamlessly assist individuals found to be potentially Medicaid eligible during renewal process with accessing appropriate systems and enrollment.
Outreach to members via text, email, direct mail, IVR and/or live call to educate them on the end of the PHE and their need to reestablish their eligibility	• Allow MCOs flexibility in the communication channels that can be leveraged for outreach. • Ensure MCOs can text members with implied consent, rather than explicit consent messaging restrictions • Encourage multi-channel outreach.	• Provide clear guidance to states that all available channels should be leveraged for outreach at the end of the PHE

Use of case managers to discuss redetermination with members during calls and face to face visits	• Extend the timeframes within which MCOs can engage with members around redeterminations. Allow MCOs to contact members for at least 60 days post-disenrollment to better assist in maintenance of coverage	
Support members who need to be connected with someone who can support renewal activities. This includes, but is not limited to individuals over the age of 65 and those with disabilities who are ineligible for automated renewals (ex parte)	• Ensure contract language allows MCOs to outreach to members and connect them with resources (internally, vendor or state) that can support renewal activities. • Ensure beneficiaries over the age 65 and those who have disabilities have additional time to complete renewal materials • Ensure beneficiaries meeting this criteria are flagged for health plans • Provide clear guidance for care managers, care coordinators, healthcare navigators and community health workers to support members in connecting to enrollment support	• Establish partnerships with MCOs to create training, guidance, and educational materials guidance for external enrollment and redetermination support (e.g., Navigators, CHWs,)

Amplify State Messaging to Support Outreach and Communication Efforts

Actions MCOs Could Take	Actions Required by State to Support MCO Action	Support CMS Could Provide to Advance Consistent Adoption
Leverage consistent messaging	• Alignment on messaging	• Develop templates and communication toolkits
Prepare communications before the end of the PHE	• Expedited approvals of all communication outreach materials	• Encourage states to have communications approved by the end of the PHE and/or templates available to use
Give tools for community partners to help support enrollment and eligibility	• Alignment on messaging • Provide training and simplified guides that can be used by community partners to support enrollment	• Include as an example in potentially possible outreach pathways • Provide template scripts and materials
Collaborate with providers and health systems to facilitate redetermination support at facilities frequented by Medicaid members	• Allow MCOs, providers and health systems to collaborate with enrollment support. • Allow plans to conduct facilitated enrollment (one-on-one application assistance) during renewal.	• Include examples of collaborative and co-located events that are approved for outreach • Highlight targeted outreach events as a means to ease enrollment processes for underserved communities or those that would otherwise

		potentially experience barriers to digital or community access
Support public service announcements in a variety of languages and across communities	• Alignment on messaging • Allow coalition funding • Encourage collaboration among MCOs	• Include as an example in potentially possible outreach pathways

Review Managed Care Contracts

Actions MCOs Could Take	Actions Required by State to Support MCO Action	Support CMS Could Provide to Advance Consistent Adoption
Ensure contracts allow outreach and engagement around redeterminations	• Contract amendment	• Provide recommendations on the way in which MCOs can support redeterminations