The Enrollment Coalition

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

RE: Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP

Dear Administrator Brooks-LaSure:

On behalf of The Enrollment Coalition, we write in response to the Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP. The Enrollment Coalition is a group of organizations across the health care community, including consumer advocates, patient advocates, health plans, health care providers, employers, and technology and data organizations. Our mission is to collaboratively identify, develop, and advance actionable policy recommendations for federal policymakers aimed at improving enrollment data, systems, and processes to foster the enrollment of uninsured Americans under age 65 into existing health coverage plans and programs for which they are otherwise eligible.

Due to economic disruption associated with COVID-19 and the maintenance of effort requirement to which states are subject, the number of individuals enrolled in Medicaid and CHIP has increased substantially since Spring 2020. Recent estimates from CMS show nearly 10 million individuals, a 13.9% increase compared to February 2020, enrolled in Medicaid and CHIP coverage between February 2020 and January 2021 and more than 80 million people have health coverage through these programs.[1] The Enrollment Coalition supports strategies and tools which can help avoid coverage disruption or losses by identifying appropriate ways individuals can be enrolled in another source of coverage for which they would be eligible at the end of the PHE. We applaud the Centers for Medicare and Medicaid Services (CMS) for the guidance and resources it has provided to states, plans, and stakeholders on unwinding the PHE, including aligning renewals with SNAP recertification, using information from SNAP and TANF to renew eligibility, and establishing linkages with U.S. Postal Service data. Additionally, many of these strategies can be used to support regular eligibility determination and enrollment processes beyond the unwinding of the PHE. We encourage CMS to provide states and managed care plans with 120 days advanced notice about when the PHE will officially end. This will allow states to more accurately plan their workstreams, hire necessary staff, update health IT systems, and any other steps needed to minimize erroneous denials.

[1] "December 2020 and January 2021 Medicaid and CHIP Enrollment Trends Snapshot," Medicaid and CHIP MAC Learning Collaboratives, 2021, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/december-2020-january-2021-medicaid-chip-enrollment-trend-snapshot.pdf

The Enrollment Coalition also supports the goals of the RFI and has provided the following responses to Objectives 1 and 2 to help ensure everyone can access the coverage and care to which they are eligible.

Thank you again for the opportunity to provide feedback on ways CMS can improve access to care and coverage for people eligible for Medicaid and CHIP. We look forward to continuing to work together on policies to improve enrollment data, systems, and processes to foster the enrollment of uninsured Americans under age 65 into existing health coverage plans and programs for which they are eligible.

Sincerely,
The Enrollment Coalition

Alliance of Community Health Plans
American Academy of Family Physicians
Amputee Coalition
Association for Community Affiliated Plans
Benefits Data Trust
Centene Corporation
Community Catalyst
Health Care Service Corporation
Healthcare Leadership Council
March of Dimes
SameSky Health

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

1. What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.

In order to help states in achieving timely eligibility determination and timely enrollment, CMS should provide guidance and technical assistance for states on appropriate strategies for easing and improving the redetermination process, which could include using pre-printed, pre-populated, renewal forms for non-MAGI populations, allowing renewals by phone and internet, accepting self-attestations and conducting post-enrollment verification of specific eligibility requirements in a timely manner, and extending the timeframe for returning renewals forms from 30 days to 60 days, as well as extending timeframes for resolving discrepancies arising from a change in circumstances.
CMS can also encourage states to consider changes including, but not limited to, modifications to requirements for in-person and phone interviews, allowing the state Medicaid agency to determine presumptive eligibility, 12-month continuous eligibility for all children enrolled in Medicaid/CHIP, and allowing additional entities to be able to determine presumptive eligibility for certain vulnerable populations.

Managed Care Organizations (MCOs) are another key enrollment and redeterminations partner for states. CMS should continue to encourage states to share individual renewal data and fully utilize MCO support capabilities to provide outreach and communications to members undergoing redeterminations, including via text and email, prior to and post-disenrollment. CMS can additionally develop an 1115 demonstration waiver template to streamline state applications for a Facilitated Enrollment and Renewal program allowance. A Facilitated Enrollment program is currently in operation in New York State and permits MCOs and other community partners to assist individuals (with proper anti-steering guardrails) to navigate the state enrollment and renewal procedures.

These changes are critical to addressing the looming coverage crisis at the end of the Public Health Emergency, while moving forward with the goals of improving consumer experience, as articulated by President Biden's Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government.

2. What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing

arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?

In order to improve the enrollment and eligibility process, the Enrollment Coalition recommends CMS re-issue a previous exception to the cost allocation requirements set forth in the Office of Management and Budget (OMB) Circular A-87[2] to allow Federally-funded health and human services programs to benefit from investments in the design and development of State eligibility-determination systems for State-operated Exchanges, Medicaid, and the Children's Health Insurance Program (CHIP). In 2011, HHS and the U.S. Department of Agriculture issued this exception[2] to encourage states to leverage the technology investments and advances in streamlined enrollment required under the Affordable Care Act (ACA) for modernizing eligibility and enrollment for other safety-net benefits. Reviving this time-limited tool would be an important step enabling the creation of data connections between public agencies that make major contributions to enrolling the eligible uninsured and preventing coverage losses among people who are currently enrolled. Investments in enrollment systems will be critical as states prepare to conduct full Medicaid redeterminations after the end of the Public Health Emergency (PHE).

Providing an exception to the cost allocation requirements in OMB Circular A-87 would allow states to do more to integrate the eligibility determination and enrollment functions across health and human services programs, realizing efficiencies for States and serving individuals and families. Integrated eligibility systems would allow individuals and families to access critical safety-net services without having to complete multiple enrollment processes and without government workers processing the same information again and again.

States could also utilize this waiver to connect health programs to external sources of data that can verify eligibility without requiring individuals and families to complete repetitive paperwork. States could also simultaneously enroll eligible individuals into health coverage as well as other programs for which they are eligible by improving data matching, establishing more robust referral mechanisms, streamlining business processes, and notifying program participants of their potential eligibility for other benefits. By promoting more integration of IT systems across health and social services programs through the A-87 exception, HHS can assist states in implementing strategies included in the March 3 guidance related to syncing Medicaid and CHIP redeterminations with recertifications for human service programs including SNAP and TANF, and establishing linkages to the U.S. Postal Service National Change of Address database.

HHS can also use the A-87 exception to encourage states to integrate all safety-net programs, regardless of state agency. Given the millions of Americans who faced unemployment during the public health emergency and the technology challenges state unemployment agencies faced to meet the unprecedented demand, states will be looking to improve their unemployment IT

[2] "OMB CIRCULAR A-87 REVISED," The White House – President Barack Obama Archive, 5/10/2004, https://obamawhitehouse.archives.gov/omb/circulars_a087_2004

systems. This presents an opportunity for HHS to partner with the U.S. Department of Labor to leverage federal technology investments that will be made to improve access to unemployment to also improve access to health and social services. For example, creating more direct linkages between unemployment Insurance benefits and Medicaid, CHIP, and ACA-exchange plans could help consumers who may have lost employer-based coverage avoid a gap in coverage and disruption in treatment.

3. In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

Outreach to enrollees is critically important, especially for hard-to-reach communities. CMS should equip states with resources to initiate targeted outreach through community partnerships to notify enrollees of potential coverage changes, obtain updated contact information, and assist with applications or renewals. We know that plain language notices, particularly surrounding requests for information and the appeals process, will go a long way in helping enrollees maintain their coverage and furthering our joint desire for improving health literacy. These outreach strategies should be conducted with established community leaders and key stakeholders to ensure messaging is culturally competent and appropriately tailored to the above-listed groups, so it is well-received and understood by enrollees. CMS should also consider providing funding to community-based organizations that are connected with populations that may face additional barriers to enrollment. CMS could create educational materials that can be posted at health care facilities and distributed to patients directing them to update their contact information and prepare for renewals or enrollment in QHPs.

The Telephone Consumer Protection Act (TCPA) also continues to be a barrier to reaching vulnerable Americans through their preferred communication methods. Guidance is needed from CMS and the Federal Communications Commission (FCC) to ensure health care entities can effectively communicate with Medicaid-eligible individuals and enrollees, improving individuals' health care access and reducing inequities.

When used to remind enrollees of renewal requirements and health care appointments, provide assistance with navigating plan benefits, and provide fundamental health education, text messaging can be an effective method of communication for individuals with Medicaid.

92% of adults earning less than $30,000 own a mobile phone,[3] and 97% of low-income phone owners use text messaging.[4] These phone owners indicated that 89% would prefer communicating by text,[5] for reasons including more flexibility and privacy in situations like working in hourly positions that limit taking personal calls.

In limited situations, text messaging has been used effectively for non-marketing activities such as capturing and validating data related to race, ethnicity, language, gender identity, sexual orientation, social determinants, and behavioral health factors; providing health education; appointment and immunization scheduling and reminders; connection to plan benefits and resources, health risk assessments and other screenings; primary care provider selection.

Importantly, text messaging can reduce coverage churn in Medicaid. In one example, after using text messaging, retention rates improved by 15 percentage points (72% retention prior to using texting and 87% retention after implementing text messages).

Culturally and linguistically appropriate text messaging can also reduce health disparities and improve health outcomes. In some examples noted within the Coalition:

- Enrollees contacted via text were six times more likely to get a COVID-19 vaccine. This benefit was especially pronounced among historically marginalized populations.
- SMS messaging significantly reduced health disparities between racial groups for diabetes management, maternal health, preventive screenings, and recommended immunizations.
- Texting also reduced gaps in cervical cancer screening, maternal health visits, and childhood immunization rates.

Guidance from CMS and FCC clarifying that these activities are allowed under the TCPA would further advance efforts to reduce churn in coverage and eliminate health disparities. The Enrollment Coalition believes health care entities should be able to contact consumers to support the consumer's enrollment in health coverage, including critically important information on both coverage (such as when patients may be at risk of losing coverage), and medical care and health care services (such as immunization reminders).

The Enrollment Coalition supports and appreciates the existing guidance that CMS has issued promoting the use of text messaging to reduce coverage losses in unwinding the Public Health Emergency (PHE). For example, CMS recommended states use text messages to encourage consumers to apply for other health coverage if they are determined to no longer be eligible for

[3] Eileen Cianciolo, "3 Member Engagement Pitfalls Health Plans Should Avoid," Fierce Healthcare, 3/3/2019, https://www.fiercehealthcare.com/payer/industry-voices-3-member-engagement-pitfalls-health-plans-should-avoid

[4] Aaron Smith, "U.S. Smartphone Use in 2015," Pew Research Center, 4/1/2015, https://www.pewresearch.org/internet/2015/04/01/us-smartphone-use-in-2015/

[5] "Global Mobile Messaging Consumer Report," Twilio, 9/12/2016, https://www.twilio.com/press/releases/twilio-study-finds-that-9-out-of-10-consumers-globally-want-to-message-with-brands

Medicaid or CHIP.[6] CMS also encouraged states to "request that managed care plans use additional modalities (e.g., phone, text) to conduct outreach to beneficiaries and encourage individuals to complete and return their renewal forms."[7] The Enrollment Coalition supports these recommendations but is concerned the TCPA continues to be a barrier to outreach. Although texting has been successful when used in limited circumstances and is the preferred form of contact for many enrollees, many health care entities will not conduct outreach through text for fear of violating the TCPA.

The Enrollment Coalition urges CMS to work with FCC to develop guidance to provide assurance that health care entities can conduct these non-marketing outreach activities to health plan beneficiaries beyond the end of the PHE without violating the TCPA.

> **4. What key indicators of enrollment in coverage should CMS consider monitoring? For example, how can CMS use indicators to monitor eligibility determination denial rates and the reasons for denial? Which indicators are more or less readily available based on existing data and systems? Which indicators would you prioritize?**

CMS could consider monitoring denials for children, denials for those with limited English proficiency who may have not responded to renewal requests due to the lack of accessible information, and abnormally high rates of denials during a given time period, which could be an indicator of procedural issues. Encouraging states to share reasons for denials with Medicaid health plans would be useful as well and would help plans engage members with the goal of avoiding unnecessary gaps in coverage.

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income (SSI)/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

> **1. How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of**

[6] "Medicaid and CHIP Continuous Enrollment Unwinding," Centers for Medicare & Medicaid Services, 3/2022, unwinding-comms-toolkit.pdf

[7] "Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations," Centers for Medicare & Medicaid Services, 3/2022, https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf

the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?

With respect to managed Medicaid, managed care regulations do not prohibit health plans from providing information on a qualified health plan to enrollees who could potentially enroll due to a loss of eligibility, and this type of outreach is likewise not considered marketing. States should be encouraged to amend any administrative regulations or internal procedures which may prohibit the sharing of disenrollment information of members with their MCO. To enable timely and accurate communication from MCOs in tandem with states, states should provide members and MCOs with awareness of at least 60 days advance notice prior to when a redetermination will begin.

Encouraging greater cross sector collaboration should be encouraged to ensure consumers are able to seamlessly transition to appropriate forms of coverage as redeterminations commence. CMS should also consider extending the special enrollment period for individuals that lose Medicaid or CHIP coverage during the redeterminations process. This could facilitate enrollment in a QHP and avoid coverage losses.

2. How should CMS consider setting standards for how states communicate with beneficiaries at-risk of disenrollment and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?

Contacting beneficiaries solely through traditional mail has proven to be vastly ineffective, due to changes in address and delays in mail delivery. We appreciate CMS advising Medicaid agencies to use multiple forms of communication to reach enrollees to discuss their eligibility or redetermination status and/or application status, including text messages, phone calls, and emails, in addition to traditional paper mail, which is still important for enrollees who may not have access to technology. Importantly, multiple renewal notices are needed to provide enrollees enough time to complete renewal processes. With proper communication and outreach allowances, MCOs can additionally be a valuable state partner to share information with members through these modern methods. It is vital that member contact information, renewal date, and disenrollment reason (eligibility or procedural, *if applicable*) sharing between states and plans is promoted by CMS, including via the publication of a standard 834 file form template for state adoption. This template could include the requirement of data fields for the following: email address, phone number, phone type, date of renewal, and identified disenrollment reason for a beneficiary.

3. What actions could CMS take to promote continuity of coverage for beneficiaries transitioning between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for

beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

CMS should consider how to help interested states leverage navigators and other qualified partners to ensure continuous coverage. For example CMS can encourage states to develop "Community Enrollment Partnerships" where qualified partners assist in directly enrolling eligible individuals into qualified health plans. Utilized by Covered California, "Community Enrollment Partnerships" seek to supplement the enrollment activities of a state or federal exchange, but do not replace the state or federal exchange platforms. CMS could also provide funding to navigators to assist enrollees with renewing coverage or enrolling in QHP coverage if they are no longer eligible for Medicaid.

CMS should also continue to support states in preparing IT systems for eligibility redeterminations, including the implementation of electronic health record (EHR) reminder messages for patients. CMS could partner with EHR developers to facilitate the implementation of automated EHR alerts at the point of care. These alerts could equip physicians with information on how to discuss eligibility changes and coverage renewals with their patients. Alerts for patients in their EHRs can reiterate what was discussed in visits with their physicians and can include guidance and information on how to renew or transition to alternative coverage.

4. What are the specific ways that CMS can support states that need to enhance their eligibility and enrollment system capabilities? For example, are there existing data sources that CMS could help states integrate into their eligibility system that would improve ex-parte redeterminations? What barriers to eligibility and enrollment system performance can CMS help states address at the system and eligibility worker levels? How can CMS support states in tracking denial reasons or codes for different eligibility groups?

The ex parte process is a promising tool to somewhat mitigate churn following the end of the public health emergency. However, states are sometimes hesitant to maximize the use of ex parte, particularly in complex circumstances. CMS could issue detailed guidance about how to maximize ex parte to address the end of the public health emergency, along with suggested best practices and implementation guidance which reiterates the data sources that states are required to utilize under federal law and includes additional data sources that states should be expected to utilize when possible during ex parte reviews. CMS can additionally conduct individual reviews of state system design and programming structure to offer recommendations for improvement. By improving ex parte reviews , states would face reduced administrative burden, and free up resources to focus on other critical issues of enrollment.