CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

All-State Medicaid and CHIP Call

March 8, 2022

Agenda

- CMS Unwinding Resources and March All State Call Series
- State Health Official (SHO) Letter #22-001: *Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, CHIP and the Basic Health Program Upon the Conclusion of the COVID-19 Public Health Emergency*
  - Timelines and expectations to complete eligibility and enrollment actions
  - Distribution of renewals
- *Eligibility and Enrollment Pending Actions Resolution Planning Tool Version 2.0*
- Open Mic Q and A

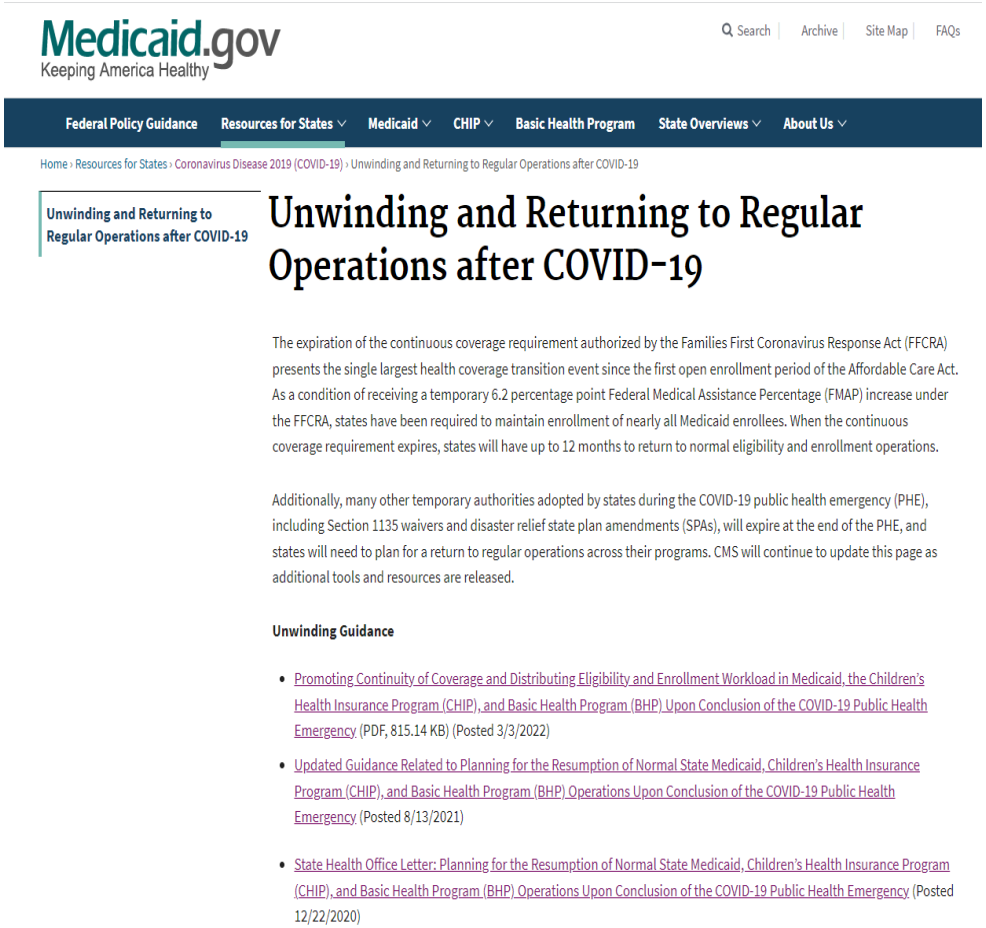
New CMS Resources to Support States

- On March 3, 2022, CMS released new guidance and tools designed to help states plan for and execute streamlined, efficient, and effective strategies to conduct redeterminations and mitigate inappropriate coverage losses when the PHE ends:
  - **Unwinding SHO #22-001**: Provides additional guidance on redetermination requirements, new flexibilities and strategies for states during the unwinding period following the PHE.
  - **Updated Planning Tool**: Provides self-assessment resources to help states highlight areas of work they may need to address in their planning efforts and identifies promising strategies. States are encouraged to use this tool to develop a plan for their unwinding activities.
  - **Communications Toolkit:** Provides insights and key messages to help states and other stakeholders plan for the renewal process and educate Medicaid and CHIP enrollees about the upcoming changes.
  - **Updated Health Plan Strategy Deck:** Provides an overview of approaches states can take to engage managed care plans as they return to routine eligibility and enrollment operations and updated strategies to help individuals re-enroll in coverage.

Medicaid.gov Unwinding Page

CMS launched a new, streamlined Medicaid.gov page for unwinding resources, including:

- **Unwinding guidance** (i.e., unwinding SHOs)
- **Unwinding Tools and Templates** (e.g., planning tools, program integrity risk assessment template)
- **Communication Tools**
- **Other Guidance and Resources** (e.g., enrollment issue briefs, CMCS Informational Bulletins on renewal requirements and coordination between health programs)
- CMCS Medicaid and CHIP **All State Calls** on unwinding



www.Medicaid.gov/unwinding

Forthcoming CMS Resources

CMS will continue to provide updated tools and resources for states. Forthcoming resources include:

- **Unwinding State Reporting Tools**
  - **Data Reporting Template**: Mandatory reporting template with specific metrics for states to provide baseline data and monthly reporting during unwinding to demonstrate progress toward restoring timely application and redetermination processing consistent with SHO guidance.
  - **State Renewal Distribution Plan Reporting Form**: Mandatory report submitted to CMS to summarize state plans for initiating redeterminations for its total caseload within the 12-month unwinding period and any strategies the state is planning or implementing to mitigate inappropriate coverage loss during these transitions.
- **Fair Hearings Strategies Deck:** Resource for states to address expected increase in fair hearing volume during unwinding period, including assessment of current capacity and strategies to address increased volume.

March 2022 All State Calls

CMS will provide an overview of the guidance and tools during calls throughout the month

March 8

- Overview of new unwinding resources
- Unwinding SHO Discussion: Part 1
- Eligibility and Enrollment Pending Actions Resolution Planning Tool Version 2.0
- State Q/A

March 15

- Unwinding communications toolkit
- Unwinding SHO Discussion: Part 2
- State Q/A

March 22

- Overview of additional unwinding resources
- Unwinding SHO Discussion: Part 3
- State Q/A

Restoring Routine Eligibility and Enrollment Operations After the PHE Ends

Background

The ongoing COVID-19 outbreak and implementation of federal policies to address the public health emergency (PHE) have disrupted routine Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) eligibility and enrollment operations.

As of September 2021, Medicaid and CHIP program enrollment has grown to nearly 85 million individuals in large part due to the continuous enrollment requirements that states implemented.

- **Medicaid**: Coverage growth is in large part due to the requirement that states maintain continuous enrollment of Medicaid beneficiaries through the last day of the month in which the PHE ends in order to receive a temporary 6.2 percentage point FMAP increase under the Families First Coronavirus Response Act ("continuous enrollment condition").

- **CHIP/BHP:** In some cases, CHIP and BHP agencies were also granted approval to delay renewals in response to the demands of the public health emergency (PHE).

Many states have not had routine contact with Medicaid/CHIP enrollees and some individuals have not had their eligibility renewed since prior to the onset of the PHE.

Source: CMS September 2021 Enrollment Trend Snapshot; Families First Coronavirus Response Act, Section 6008 (P.L. 116-127)

State Health Official Letter #22-001

CMS released State Health Official (SHO) Letter #22-001: *Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, CHIP, and the Basic Health Program Upon the Conclusion of the COVID-19 Public Health Emergency*

- The new SHO Letter*:*
  - Is part of a series of guidance and tools that outline how states may address the large volume of pending eligibility and enrollment actions they will need to take after the PHE ends;
  - Further clarifies expectations of states to restore routine operations; and,
  - Describes how states may distribute eligibility and enrollment work when the PHE ends to mitigate churn for eligible enrollees and smoothly transition individuals between coverage programs.
- The release of the SHO Letter does not signal when the federal PHE will end.

Developing a Plan to Address Eligibility and Enrollment Work

States will need to develop a comprehensive plan to restore routine operations in their Medicaid, CHIP, and BHP programs. The plan is intended to help states develop an operational approach for completing outstanding eligibility and enrollment work.

- States will have a significant volume of eligibility actions to complete following the PHE once they begin the unwinding period, including pending applications, renewals and redeterminations based on changes in circumstances.

- States' "unwinding operational plan" should include a description of how the state intends to:
  - Address outstanding eligibility and enrollment actions in an efficient manner that reduces erroneous loss of coverage for enrollees;
  - Enable a sustainable distribution of renewals in future years; and
  - Ensure timely processing of new applications and eligibility actions within specified timelines.

CMS released an updated Medicaid and CHIP planning tool that states may use to assist in their planning efforts.

Timelines to Process Pending Applications

States may use a phased approach to complete processing of pending applications that were received during the PHE and resume timely determinations of eligibility on new applications within the following timelines.

- **2 months after the month in which the PHE ends:** States should complete eligibility determinations for all pending MAGI and other non-disability-related applications (e.g., individuals determined on the basis of being age 65 or older) received during the PHE.
- **3 months after the month in which the PHE ends:** States should complete eligibility determinations for all pending disability-related applications received during the PHE.
- **4 months after the month in which the PHE ends:** States should resume timely processing of all applications.

An application is considered to be processed timely when the agency enrolls an eligible applicant or denies coverage for an individual whom the agency could not determine as eligible within the federally required application time standards.

Timelines to Process Renewals

In the August 2021 SHO, CMS announced that it would provide states **up to 12 months** after the end of the PHE to complete post-enrollment verifications, redeterminations based on changes in circumstances, and renewals.

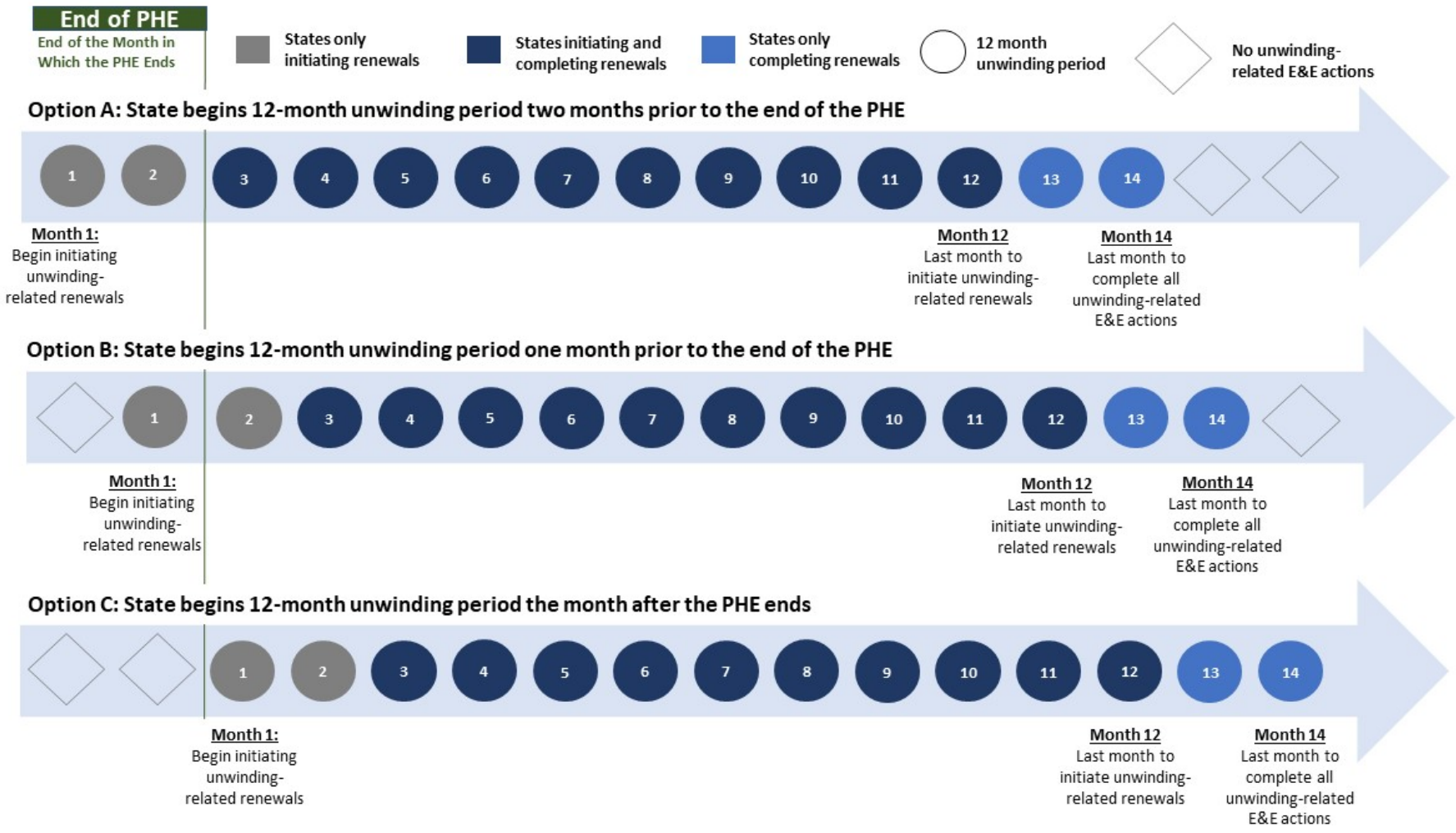
The March 2022 SHO clarifies CMS' expectations for the 12-month unwinding period.

Clarifying the 12-Month Unwinding Period

- To account for the time needed to initiate and complete renewals, CMS will consider states to be in compliance with the 12-month unwinding period provided the state has:
  - **Initiated** all renewals (as well as post-enrollment verifications and redeterminations based on changes in circumstances) for the state's entire Medicaid and CHIP population ("total caseload") by the last month of the 12-month unwinding period.
  - **Completed** such actions by the end of the 14th month from the start of the state's unwinding period.
- States may begin their 12-month unwinding period **up to two months** prior to the end of the month in which the PHE ends. This means that states may initiate a renewal that may result in termination of coverage when the continuous enrollment condition ends two months prior to the end of the month in which the PHE ends.

The 12-month unwinding period may begin no later than the first day of the month following the month in which the PHE ends.

12-Month Unwinding Timeline Options



Processing Renewals During the Unwinding Period

- States must initiate a full renewal for their total caseload in Medicaid and CHIP during the 12-month unwinding period, consistent with federal Medicaid, CHIP and BHP renewal requirements at 42 C.F.R. §§ 435.916, 457.343, and 600.340.
  - This includes enrollees the state already conducted a renewal for during the PHE and found ineligible but did not terminate Medicaid eligibility.
  - This includes enrollees who were receiving benefits pending the outcome of a fair hearing on or after March 18, 2020 and were continuously enrolled during the PHE.

- Initiating and completing a full renewal during the unwinding period will ensure that:
  - The state is collecting enrollee information that allows the state to redetermine eligibility on all bases prior to terminating coverage; and
  - Any adverse action is based on recently available, reliable information and that the state is not terminating eligibility or reducing benefits unless it has sought information from the individual.

States may refer to the December 2020 CMCS Informational Bulletin "Medicaid and Children's Health Insurance Renewal Requirements" for additional information on requirements for conducting renewals.

Guidelines for Establishing Renewal Dates During the 12-Month Unwinding Period

While states may not shorten a beneficiary's eligibility period, states have the flexibility to initiate renewals at any point within the state's 12-month unwinding period for individuals whose coverage was not successfully renewed during the PHE.

Outcome of Last Renewal Attempted During the Last 12 Months of PHE	Permissible Timing of Renewal During 12-Month Unwinding Period
Ex parte renewal attempted but not completed. No further state action taken.	Any time
Ex parte renewal attempted but not completed. State sent renewal form. Enrollee determined ineligible or did not respond.	Any time
Renewal completed based on enrollee's return of renewal form and/or additional information. Individual continues to meet eligibility requirements. New eligibility period established.	12 months after enrollee's last renewal for MAGI-enrollees; 12 months or shorter eligibility period established by the state for non-MAGI enrollees per 42 C.F.R. § 435.916(b)
Ex parte renewal attempted and successfully completed. New eligibility period established.	12 months after enrollee's last renewal or original renewal month, at state option, for MAGI-enrollees; 12 months or shorter eligibility period established by the state for non-MAGI enrollees per 42 C.F.R. § 435.916(b)
No renewal attempted in last 12 months of PHE.	Any time

Acting on Changes in Circumstances During the Unwinding Period

Consistent with federal regulations, states must promptly redetermine eligibility when they receive information about a change in circumstances that may affect eligibility. Given how long it has been since some individuals have been renewed, there is an increased risk that an individual eligible for Medicaid on another basis or for CHIP may be terminated based on a change in circumstances related to a single factor of eligibility.

Renewals When There is a Changes in Circumstances

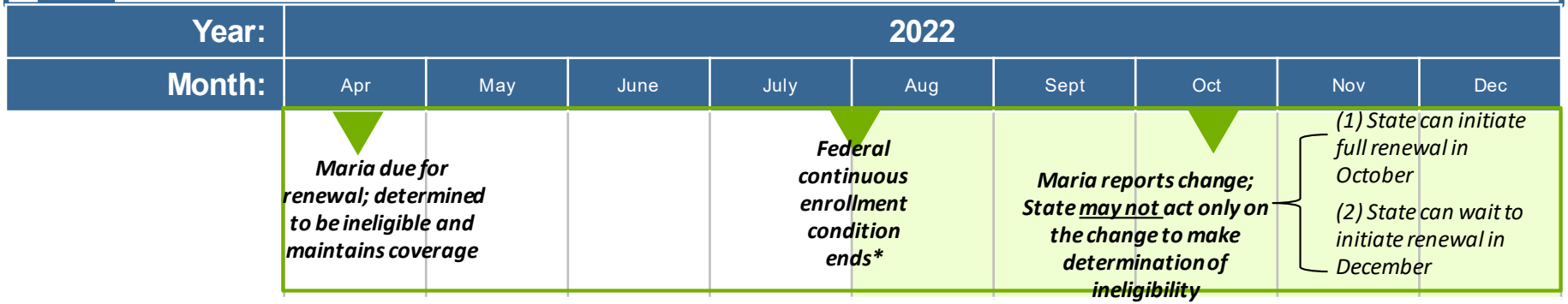
- **Determination of Eligibility or Renewal Was More Than 12 Months from the Time of the Change:** If a state identifies a change in circumstances during the unwinding period for an individual whose eligibility has not been renewed in the prior 12 months, the state may:
  - Choose to complete a full renewal at the time the change is identified; or
  - Wait to process the new information when it completes the enrollee's renewal in a subsequent month during the unwinding period.
- **Determination of Eligibility or Renewal Was Less Than 12 Months from the Time of the Change:** If the individual was successfully determined or redetermined eligible and granted a new eligibility period within the 12 months prior to the change in circumstances, the state may:
  - Redetermine eligibility based on the change in circumstances consistent with 42 CFR 435.916(d) at the time the change is identified; or
  - Wait to process the new information when it completes the enrollee's renewal in a subsequent month during the unwinding period.

Scenario 1: Last Renewal Was More than 12 Months Ago

- For illustrative purposes only, assume the federal continuous coverage condition ends July 31, 2022.
- Maria is due for a renewal April 2022. The State is unable to conduct an *ex parte* renewal using data sources, sends a pre-populated form, and Maria returns the form. State determines Maria to be ineligible based on the information Maria provided.
- Enrollment is maintained, but Maria is not granted a new 12-month eligibility period.
- The state's 12 month unwinding period is August 2022-July 2023, and according to the state's unwinding operational plan Maria's renewal during the unwinding period is scheduled to be initiated in December 2022.
- Maria reports a change in circumstances in October 2022.
- Because Maria is not within a 12-month eligibility period, the state may not act on the change in circumstances information to determine Maria is ineligible based on the particular factor of eligibility.
- The state must conduct a full renewal for Maria and determine eligibility on all bases prior to sending advance notice of termination with fair hearing rights.

Options for Timing of Renewal

- State may initiate the renewal when the change is reported in October 2022
- State may initiate the renewal at another point during its 12-month unwinding period



*Hypothetical timeline

Scenario 2: Last Renewal Was Less Than 12 Months Ago

Ava

- For illustrative purposes only, assume the federal continuous coverage condition ends July 31, 2022.
- Ava is due for a renewal April 2022.
- The State initiates renewal and determines Ava to be eligible. Ava is granted a new 12-month eligibility period (May 2022-April 2023).
- The state's 12 month unwinding period is August 2022-July 2023..
- Ava reports a change in circumstances in October 2022.
- Because Ava's eligibility had been renewed in the last 12 months, the state may promptly act on the change in circumstances as they ordinarily would in accordance with 42 CFR 435.916(d).

Options for Timing of Renewal

- State may promptly act on change in circumstances reported in October 2022.
- If the State is aligning actions on changes in circumstances with a renewal due during the unwinding period, the State does not need to act as a result of the changes in circumstances reported in October 2022 and instead may wait and complete the renewal due in April 2023.

Year:	2022								
Month:	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec

Ava due for renewal and determined eligible. Eligibility period is May 2022-April 2023

*Federal continuous enrollment condition ends**

Ava reports change in circumstances; State may act on change:

(1) State can promptly act on change

(2) State can align acting on change with the renewal due during the unwinding period

*Hypothetical timeline

Adopting a Risk Based Approach

CMS expects states to adopt a risk-based approach to prioritize pending eligibility and enrollment actions related to post-enrollment verifications, changes in circumstances, and renewals the state will conduct during the 12-month unwinding period.

Population-Based Approach
Prioritizes outstanding eligibility and enrollment actions based on characteristics of cohorts or populations who are likely to have become eligible for more expansive benefits or who are likely to be eligible for different coverage.

States may not prioritize based on eligibility group, de-prioritize based on available FFP matching rate or prioritize populations in a manner that would constitute a violation of federal law including, but not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557).

Time or Age-Based Approach
Prioritizes cases based on the length of time the action has been pending.

Hybrid Approach
Combined population- and time-based approaches. E.g., a state may adopt a time-based approach to prioritizing outstanding post-enrollment verifications and changes in circumstances and a population-based approach to prioritizing pending renewals.

State-Developed Approach
Any other approach that meets the goals of keeping eligible individuals enrolled, minimizes the extent ineligible individuals may remain enrolled, achieves a sustainable renewal schedule, and meets the 12-month unwinding timeline.

Distribution of Renewals

Once a state determines how it will prioritize its eligibility and enrollment work, the state will need to establish a distribution schedule to initiate and process renewals and other actions over the 12-month unwinding period.

- The distribution plan should ensure states maintain coverage for eligible individuals and manage transitions to other coverage for individuals determined potentially eligible for enrollment in another insurance affordability program.
  - An evenly-distributed renewal schedule will mitigate future challenges states might experience if they process a large volume of actions at the beginning of the post-PHE period (and avoid a renewal "bulge").
- States that do not make plans to distribute their work during the 12-month unwinding period run the risk of errors in processing renewals and inappropriately terminating coverage for eligible individuals (not only in the 12-month unwinding period but in future years).
  - States may not shorten a beneficiary's eligibility period in order to achieve a more even distribution of renewals, and states that process large volumes of actions during their 12-month unwinding period will not be able to shorten or extend beneficiary eligibility periods in future years to address any resulting renewal "bulges."

Distribution of Renewals: Preventing Inappropriate Terminations

Given significant increases in Medicaid and CHIP enrollment during the PHE, the disruption to operations, and the length of time that has elapsed since state agencies have had any contact with enrollees, eligible individuals are at an acute risk of losing coverage as states begin to process renewals and other actions.

- CMS recommends that states **initiate no more than 1/9 of their total caseload** of renewals in a given month to mitigate the risk of churn and establish a sustainable renewal schedule and avoid renewal bulges.
  - Total caseload includes all Medicaid and CHIP beneficiaries enrolled at the end of the month before the beginning of that state's 12-month unwinding period.
  - Total caseload calculations can be based on total number of individuals enrolled in the program or total number of households enrolled in the program.
- States that have more even distribution of renewals over the course of a year are better able to maintain a workload that is sustainable in future years, enabling the state to avoid renewal backlogs and reduce risk of inaccurate redeterminations and inappropriate terminations.
- CMS recognizes that there are natural fluctuations in the volume of renewals typically processed in different months that would prevent a state from achieving an even monthly distribution (e.g., during Marketplace open enrollment periods).

Aligning Work During the 12-Month Unwinding Period

States can use the following alignment strategies to streamline renewals initiated during the 12-month unwinding period. States may not shorten an individual's established eligibility period for the purposes of alignment. After the 12-month unwinding period ends, states must resume timely processing of periodic renewals and redeterminations of eligibility.

Align Medicaid Renewal with an Individual's SNAP Recertification

- States may schedule their Medicaid renewals to coincide with the individual's SNAP recertification, provided such recertification occurs within the 12-month unwinding period.

Align Action on Post-Enrollment Verifications and Changes in Circumstances at Renewal

- States may wait to complete pending post-enrollment verifications and act on changes in circumstances identified for enrollees with a renewal scheduled to be initiated during the 12-month unwinding period.
- Alignment strategy creates efficiencies by using information obtained at renewal to simultaneously resolve pending eligibility and enrollment actions.

Align Renewals for All Individuals in a Household

- States may align work on renewals for all members in a household during the 12-month unwinding period.
- This strategy will minimize enrollee burden by allowing families to receive one request for information from the state.
- While states may process renewals for an entire household at the same time, redeterminations of eligibility are made on an individual basis.

Aligning Work on Pending Actions: Verification and the Reasonable Opportunity Period (ROP)

- Individuals whose Medicaid benefits have been maintained during an ROP have not had an eligibility determination completed; rather, they are receiving benefits pending a determination of eligibility that rests on the verification of their citizenship or immigration status.
- States should review the verification and ROP process applied during the PHE in order to determine the appropriate action for individuals whose citizenship or immigration status was not verified during the PHE, but whose enrollment has been maintained under an ROP to comply with the continuous enrollment condition.

- If a state did not provide or fully provide an individual notice to initiate an ROP during the PHE, the agency must send the required notice after the PHE ends and provide the 90-day ROP for the individual.
- If a state already provided a fully compliant notice and ROP, states should attempt to reverify eligibility for these beneficiaries before the state's unwinding period begins, and for these individuals:
  - States are not required, but may extend the ROP for individuals who have attested to satisfactory immigration status and who are making a good faith effort to obtain any necessary documentation, or if the state needs more time to verify the individual's status or assist the individual in obtaining the necessary documents.
  - For individuals who have attested to U.S. citizenship, states may re-verify their citizenship during the unwinding period through a Disaster Relief 1115 demonstration, which would provide for an extension of the ROP beyond the 90-day timeframe.
- The ROP begins on the date the enrollee receives notice of such opportunity from the agency.

Individuals Who Missed Their Medicare Initial Enrollment Period

- States are encouraged to identify Medicare-eligible enrollees who missed their Medicare initial enrollment period and advise them to enroll in Medicare during their initial enrollment period (the 7-month period that starts 3 months before an individual is first eligible to enroll in Medicare) or during the current Medicare general enrollment period (before March 31, 2022).

- States should consider the timing of the next Medicare general enrollment period in scheduling renewals during the unwinding period for individuals who may be Medicare eligible, in order to facilitate seamless coverage transitions and avoid gaps in coverage by scheduling these individuals' renewals to coincide with the Medicare general enrollment period.

CHIP 1115 Waiver Authority for Claiming FFP

Some CHIP states, using state-only funds, have continued to cover CHIP beneficiaries found ineligible during the PHE, including young adults aging out of CHIP, pregnant individuals ending their postpartum period, and/or children found ineligible for coverage after a change in circumstance.

- States may submit a COVID-19 section 1115 demonstration application for CMS consideration requesting expenditure authority to enable the state to claim federal financial participation (FFP) for such CHIP beneficiaries through the end of the unwinding period, or until a redetermination is conducted during the unwinding period.

- States interested in pursuing a section 1115 demonstration to receive FFP for these individuals should contact their state lead or section 1115 demonstration project officer.

Eligibility and Enrollment Pending Actions Resolution Planning Tool Version 2.0

Eligibility and Enrollment Pending Actions Resolution Planning Tool – Version 2.0

CMS released an updated state planning tool, *Eligibility and Enrollment Pending Actions Resolution Planning Tool – Version 2.0* to assist states in their planning efforts to restore routine eligibility and enrollment operations and account for the anticipated volume of fair hearing requests

- The planning tool released on March 3, 2022, is an update to the *Eligibility and Enrollment Pending Actions Resolution Planning Tool* released in January 2021.
- The planning tool reflects the updated eligibility and enrollment guidance CMS released in the August 2021 and March 2022 and consists of three parts:
  - **Readiness Assessment:** Guided questions for states to assess their readiness for completing actions when the continuous enrollment condition ends
  - **State Planning Approach and Strategies**: Prompts and sample templates to: define state planning organization and structure; identify the staging and timing of activities; and anticipate potential risks and determine mitigation strategies
  - **Roll-Up Summary**: A snapshot of states' overall approach.
- States are encouraged, but not required, to use the updated planning tool in their operational planning. States may use the tool to document their unwinding operational plans or refer to the tool to update their existing plans.

Eligibility and Enrollment Pending Actions Resolution Planning Tool – Version 2.0

Medicaid and CHIP MAC Learning Collaboratives

Medicaid and Children's Health Insurance Program Return to Normal Operations

Eligibility and Enrollment Pending Actions Resolution Planning Tool – Version 2.0

I. Readiness Assessment

To help states understand their readiness for initiating and completing E&E actions when the continuous enrollment condition ends, these guided questions flag key data points and considerations for planning purposes. States should complete the questions below before moving to *Section II. State Planning Strategies*.

A. Renewals

Federal Requirements. States must renew eligibility for individuals enrolled in Medicaid and CHIP whose eligibility is determined using Modified Adjusted Gross Income (MAGI)-based financial methodologies once every 12 months, and no more frequently than once every 12 months, pursuant to 42 C.F.R. §§ 435.916(a) and 457.343. For individuals excepted from MAGI-based financial methodologies under 42 C.F.R. § 435.603(j) (non-MAGI enrollees), states must renew eligibility at least once every 12 months in accordance with 42 C.F.R. § 435.916(b). For BHP enrollees, states must redetermine eligibility every 12 months in accordance with 42 C.F.R. § 600.340.

For individuals enrolled in Medicaid who are found to no longer be eligible for the eligibility group that they were determined eligible for at application or renewal, states must consider all bases of eligibility prior to determining an individual is ineligible for Medicaid and terminating coverage in accordance with 42 C.F.R. § 435.916(f)(1). Individuals enrolled in Medicaid and CHIP who are determined ineligible must be screened for eligibility in other insurance affordability programs and their account must be transferred in accordance with 42 C.F.R. §§ 435.1200(e) and 457.350(b). For additional guidance on renewal requirements, states may refer to the *December 2020 CMCS Informational Bulletin (CIB): Medicaid and CHIP Renewal Requirements*.

State Self-Assessment Questions	State Response	Considerations for State Planning Scope
1. Did the state continue conducting renewals while the continuous enrollment condition was in effect?	***Check all that apply:*** ☐ Yes – MAGI[3] *ex parte* renewals only ☐ Yes – MAGI *ex parte* renewals and sent renewal forms ☐ Yes – non-MAGI renewals ☐ No	If the state has been conducting renewals, is the state grouping individuals who could not be successfully renewed but were retained in coverage due to the continuous enrollment condition and prioritizing them for renewal following the end of the continuous enrollment condition? If the state has not been able to conduct renewals, how is the state engaged in planning to resume renewals? How is the state planning to mitigate returned mail?

Questions