



# All-State Medicaid and CHIP Call January 31, 2023



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# 1/31/23 All State Call Agenda

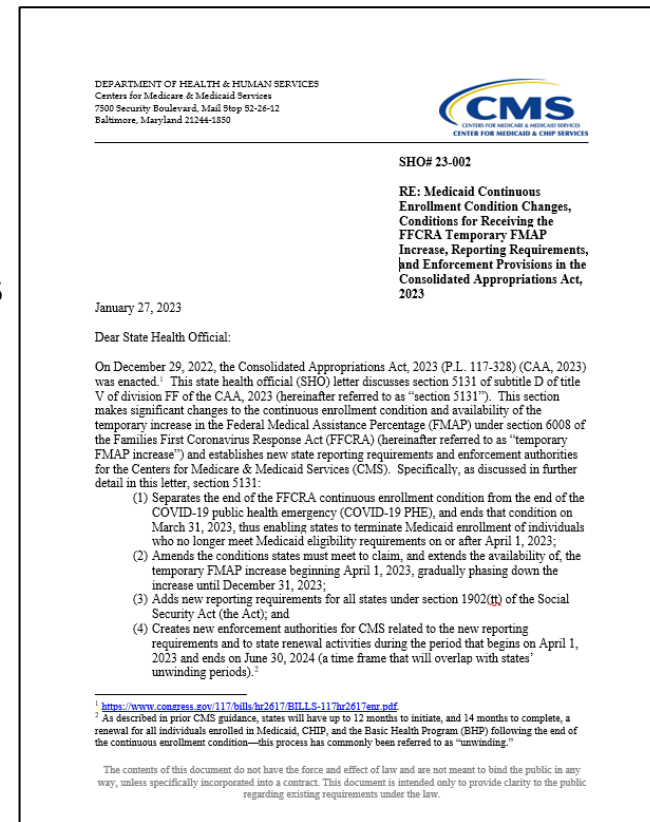
- Marketplace Updates
- Consolidated Appropriations Act, 2023, Section 5131  
Guidance: SHO #23-002
- Questions

# SHO Discussion Agenda

- State Health Official (SHO) Letter #23-002 Overview
- Changes to the Families First Coronavirus Response Act (FFCRA) Continuous Enrollment Condition and Temporary Federal Matching Assistance Percentage (FMAP) Increase
- Conditions for Receipt of Temporary FMAP Increase
- Additional Considerations & Process for Claiming Temporary FMAP
- Reporting Requirements
- Monitoring State Progress and Corrective Action
- Implications for Section 1902(e)(14) Waivers
- Questions

# Overview of SHO #23-002

- On January 27, 2023, CMS published SHO #23-002, *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023.*
- The SHO is the second in a series of guidance for states discussing section 5131 of the Consolidated Appropriations Act, 2023 (CAA, 2023),\* enacted on December 29, 2022.
- The CAA, 2023 makes significant changes to the continuous enrollment condition and availability of the temporary FMAP increase under section 6008 of the Families First Coronavirus Response Act (FFCRA).
- The CAA, 2023 does not impact the end date of the COVID-19 PHE. As of January 2023, the COVID-19 PHE is still in effect



1. SHO #23-002, available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf>
2. P.L. 117-328, enacted on December 29, 2022



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# Changes to the FFCRA Continuous Enrollment Condition and Temporary FMAP Increase

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# Changes to Medicaid Continuous Enrollment Condition and Impact for States

## Changes to Continuous Enrollment Condition:

- Section 5131(a)(2)(C) of the CAA, 2023 separates the end of the continuous enrollment condition from the end of the COVID-19 PHE
  - Amends section 6008(b)(3) of the FFCRA to end continuous Medicaid enrollment as a condition for claiming the temporary FMAP increase on March 31, 2023.
- On or after April 1, 2023, states claiming the temporary FMAP increase will no longer be required to maintain the enrollment of a Medicaid beneficiary for whom the state completes a renewal and who no longer meets Medicaid eligibility requirements

## Impact for States:

- *Beginning Unwinding:*
  - States have the *option to begin* their unwinding period as early as February 1, 2023, by initiating renewals\* that may result in terminations on or after April 1, 2023
  - For states that initiate renewals prior to April 1, 2023, terminations of Medicaid eligibility *may not be effective* earlier than April 1, 2023.
  - States *must begin* their unwinding period by initiating renewals\* no later than April 30, 2023
- *Timeframe for Unwinding Renewals:*
  - States will have up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid, CHIP, and the Basic Health Program (BHP) once the state's unwinding period begins

\* A renewal is considered to be "initiated" when the state begins the *ex parte* renewal process by accessing electronic data sources and other information available to the state in order to determine if eligibility can be renewed without contacting the individual States must comply with processes described in CMS' March 3, 2022, SHO #22-001, *RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency* and the January 5, 2023 CMCS Informational Bulletin, *Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023*

# Extension and Phase-Down of Temporary FMAP Increase

- Section 5131 of the CAA, 2023, separates the end of the temporary FMAP increase from the end of the COVID-19 PHE:
  - Continues the temporary FMAP increase through December 31, 2023 (instead of through end of the quarter in which the COVID-19 PHE ends)
  - Phases down the amount of the FMAP increase beginning April 1, 2023
  - Establishes new conditions under new section 6008(f) of the FFCRA for states to claim the temporary increased FMAP during calendar quarters 2, 3, or 4 of 2023
- The table below displays the amount of the FMAP increase available in each quarter of calendar year (CY) 2023, provided that the state claiming the FMAP increase meets the applicable conditions in sections 6008(b) and (f) of the FFCRA, as amended by section 5131 (discussed in next section):

<b>2023 Calendar Quarter</b>	<b>Temporary FMAP Increase Available</b>
Q1: Jan 1 - Mar 31, 2023	6.2 percentage points
Q2: Apr 1 - Jun 30, 2023	5.0 percentage points
Q3: Jul 1 - Sep 30, 2023	2.5 percentage points
Q4: Oct 1 - Dec 31, 2023	1.5 percentage points



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# Conditions for Receipt of Temporary FMAP Increase

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# Conditions for Receipt of Temporary FMAP Increase

Condition	Effective Q1 (Jan – Mar 2023)	Effective Q2, Q3, Q4 (Apr – Dec 2023)
<b>Prior Conditions (FFCRA Section 6008(b))<sup>+</sup></b>	Left blank intentionally	Left blank intentionally
(1) Maintenance of Effort -- No eligibility standards, methodologies, or procedures more restrictive than those in effect on January 1, 2020	Y	Y
(2) Maintenance of Premium Levels	Y	Y (with amendments)
(3) Continuous Enrollment Condition	Y	N
(4) Coverage without Cost-Sharing for COVID-19 Testing, Vaccines, and Treatment	Y	Y
<b>New Conditions (FFCRA Section 6008(f)(2))</b>	Left blank intentionally	Left blank intentionally
(1) Compliance with Federal Renewal Requirements	N*	Y
(2) Up-to-Date Contact Information	N	Y
(3) Returned Mail Contact Before Termination	N	Y

<sup>+</sup> Prior conditions for states to claim the temporary increased FMAP under section 6008(b) of the FFCRA are described in greater detail in the Appendix.

<sup>\*</sup> While compliance with federal renewal requirements is not a condition of receiving increased FMAP in Q1, *all states* must comply with federal renewal requirements at 42 C.F.R. § 435.916.

# New Condition 1: Compliance with Federal Renewal Requirements

## Section 6008(f)(2)(A) of the FFCRA

- States must conduct Medicaid redeterminations consistent with federal requirements (42 C.F.R. § 435.916), including any renewal strategies approved under section 1902(e)(14)(A) of the Act or other CMS-authorized processes and procedures
  - States unable to comply with the requirements in § 435.916 may implement renewal strategies authorized under section 1902(e)(14)(A) of the Act or other alternative policies and procedures that CMS authorizes and approves as sufficient to satisfy section 6008(f)(2)(A) and claim the temporary FMAP increase.
- Regardless of whether a state is claiming the temporary FMAP increase, *all states* must comply with federal renewal requirements. States that do not meet federal renewal requirements:
  - May be subject to corrective action under section 1904 of the Act, and
  - If the noncompliance occurs during the period that begins on April 1, 2023 and ends on June 30, 2024, may also be subject to corrective action under section 1902(tt)(2)(B) of the Act (added by section 5131).

# New Condition 1: Compliance with Federal Renewal Requirements (Cont'd. 1)

## Federal Renewal Requirements (Part 1 of 2) (42 CFR § 435.916)

Requirements	Description
<b>Ex Parte Renewals</b>	Begin the renewal process for all beneficiaries by redetermining eligibility without requiring information from the individual, if able to do so
<b>Renewal Form</b>	Provide a renewal form that requests only information needed to determine eligibility when eligibility cannot be renewed on an <i>ex parte</i> basis. The form must be pre-populated for MAGI-based beneficiaries.
<b>Reasonable Timeframe</b>	Provide MAGI-based beneficiaries with a minimum of 30 days and non-MAGI beneficiaries a reasonable period of time to return their renewal form and any requested information. Beneficiaries must be able to return their renewal form through any of the modes of submission described at § 435.907(a).
<b>Modalities to Accept Returned Forms</b>	Beneficiaries must be able to return their renewal form through any of the modes of submission described at § 435.907(a) (online, by phone, by mail, and in person).

# New Condition 1: Compliance with Federal Renewal Requirements (Cont'd. 2)

## Federal Renewal Requirements (Part 2 of 2)(42 CFR § 435.916)

Requirements	Description
<b>Eligibility Determination on All Bases</b>	Consider all bases of Medicaid eligibility prior to determining an individual is ineligible for Medicaid and terminating coverage
<b>Advance Notice and Fair Hearing Rights</b>	Provide a minimum of 10 days advance notice and fair hearing rights prior to terminating or reducing Medicaid eligibility, in accordance with § 435.917 and 42 CFR 431, Subpart E
<b>Assess Eligibility for Other Insurance Affordability Programs</b>	For individuals determined ineligible for Medicaid, assess eligibility for other insurance affordability programs and transfer the individual's account to the appropriate program
<b>Reconsideration Period</b>	Reconsider eligibility without requiring a new application for MAGI-based beneficiaries whose coverage is terminated for failure to return their renewal forms or necessary information, if the form or information is returned within 90 days (or longer if elected by the state) after coverage is terminated

# New Condition 2: Up-to-Date Contact Information

## Section 6008(f)(2)(B) of the FFCRA

- **Requirements:** A state must:
  - Attempt to ensure that it has up-to-date contact information for each individual for whom it conducts a renewal
  - Use the United States Postal Service (USPS) National Change of Address (NCOA) database, information maintained by state health and human services agencies, or other reliable sources of contact information
- **Types of Contact Information:** A state must attempt to update:
  - Mailing Address
  - Phone Number
  - Email Address
  - *States may need to use multiple data sources and/or adopt multiple strategies in order to update all types of beneficiary contact information*
- **Implementing a Robust Plan:** Implementing a robust plan to obtain up-to-date contact information for multiple modes of communication will also assist states in meeting the returned-mail condition under section 6008(f)(2)(C) of the FFCRA, described below as New Condition 3.

# New Condition 2: Up-to-Date Contact Information (Cont'd.)

- **Timing of Attempt to Ensure Up-to-Date Contact Information:**
  - States must have recent and reliable information, or have recently attempted to obtain up-to-date contact information, prior to initiating a renewal for an individual, to minimize the possibility that the information in the case record has become outdated
- **Document Strategies to Update Contact Information in Unwinding Operational Plan:**
  - States must document in their unwinding operational plan the strategies and processes for obtaining up-to-date contact information for beneficiaries in order to demonstrate compliance with the condition for claiming the temporary FMAP increase described in section 6008(f)(2)(B) of the FFCRA.

**For effective strategies to obtain up-to-date contact information:** States can review pages 36-40 of [CMS SHO #22-001](#), in which CMS discusses several strategies for states to reestablish communication with beneficiaries, including working with managed care organizations, social services organizations and other entities.

# New Condition 3: Use More Than One Modality to Contact Beneficiaries Prior to Terminating Enrollment Due to Returned Mail

## Section 6008(f)(2)(C) of the FFCRA

- States must make a *good faith effort* to contact a beneficiary using more than one modality prior to terminating enrollment whenever beneficiary mail is returned to the state agency in response to a redetermination of eligibility
- A “good faith effort” to contact an individual using more than one modality means the state:
  - Has a process in place to obtain up-to-date mailing addresses and additional contact information (i.e., phone numbers, email addresses) for all beneficiaries; and
  - Attempts to reach an individual whose mail is returned through at least two modalities using the most up-to-date contact information the state has for the individual, which could include a forwarding address if one is provided on the returned mail.
- States have discretion in the types of modalities they use to satisfy the returned mail condition.
- Modalities may include mail, telephone, email, text messaging, communication through an online portal, or other commonly available electronic means

# New Condition 3: Use More Than One Modality to Contact Beneficiaries Prior to Terminating Enrollment Due to Returned Mail (Cont'd. 1)

- **Follow Existing Requirements for Returned Mail:** States must continue to follow existing requirements for processing returned mail including confirming whether the address information on the piece of returned mail is complete and consistent with the address information the state has on file. See Appendix C of CMS SHO #22-001 for more information.
- **Returned Mail with No Forwarding Address:** States must attempt to contact the beneficiary through two modalities, including by phone, email, text, or other available modalities.
  - If the state only has one other mode of contact available, such as only an email address, the state must attempt to contact the beneficiary using that one modality.
- **Returned Mail with a Forwarding Address:** States are not required to send the returned mail to the forwarding address, but doing so would represent one attempt to contact the beneficiary. If the state does not send the notice to the forwarding address and does not have two other modes of contact, the state will need to document in their unwinding operational plan why it is unable to send notices to a forwarding address.



# New Condition 3: Use More Than One Modality to Contact Beneficiaries Prior to Terminating Enrollment Due to Returned Mail (Cont'd. 2)

- **Lack of Alternative Contact Information:** A state that has satisfied the condition described in section 6008(f)(2)(B) of the FFCRA to attempt to obtain up-to-date contact information for other modalities but was not able to obtain such alternative contact information will not violate the returned mail condition due to not reaching out to the beneficiary through another modality as long as the state has taken the recommended steps to reach the individual by mail (i.e., resending the notice to a corrected address, if applicable, and sending the notice to a forwarding address, if provided and the state is able to do so).
- **Document Returned Mail Policies in Unwinding Operational Plan:** States must document in their unwinding operational plans their process for undertaking a good-faith effort to contact individuals using more than one modality prior to disenrollment on the basis of returned mail.



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# Additional Considerations and Process for Claiming Temporary FMAP

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# State Attestation of Compliance

- **Temporary Increased FMAP Conditions:** States may claim federal financial participation (FFP) associated with the temporary FMAP increase after March 31, 2023, only if they meet the conditions described above, in slides (10-16)
- **Attestation Requirement:** When a state draws FFP associated with the temporary FMAP increase in the Payment Management System (PMS), it is *attesting that*:
  - (1) it is eligible for the temporary FMAP increase,
  - (2) the expenditures for which it is drawing FFP are those for which the temporary FMAP increase is applicable; and
  - (3) it meets the applicable conditions in section 6008(b) and (f) of the FFCRA for claiming the temporary FMAP increase.
- **Grant Award:** CMS will indicate in each grant award letter it sends to states that, by drawing down the funds, the state is attesting that it is in compliance with all federal requirements.
- **Same Attestation Process:** This attestation is the same process states have been using to draw FFP associated with the temporary FMAP increase under FFCRA section 6008 since it became available.

# Process for Claiming FFP Associated with Temporary FMAP Increase

- **How to Claim:** Qualifying states can request FFP associated with the temporary increased FMAP through the standard budget and expenditure reporting process on the CMS-37 and CMS-64 in the Medicaid Budget and Expenditure System (MBES).
  - Qualifying states should specify on their quarterly Form CMS-37 (or supplemental budget request) whether the state is requesting FFP associated with the temporary FMAP increase.
  - CMS will update the MBES and Medicaid and CHIP Financial System (MACFin) for budgeting and expenditure reporting. CMS will share more information regarding reporting instructions as soon as it becomes available.
- **Applicable FMAP:** As a reminder, the applicable FMAP is based on date of payment, not date of service. The FMAP for all prior period adjustments should be the FMAP at which the original expenditure was claimed.
- **CMS Oversight:** CMS will conduct oversight to ensure that state expenditures are allowable and accurate, including with respect to the matching rate claimed.



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# Reporting Requirements

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# Reporting Requirements: Section 1902(tt)(1)

- **Reporting Requirement:** New section 1902(tt)(1) of the Act, as added by section 5131(b), requires that, during the period that begins on April 1, 2023, and ends on June 30, 2024, states submit to CMS, and CMS makes public, certain monthly data about activities related to eligibility determinations and redeterminations conducted during that same period.
- **Required Metrics:** Data elements that states must report are included in existing Medicaid and Marketplace data sets
- **States Can Submit Through Existing Reports:** States can submit required data metrics through existing CMS data reporting tools and will not need to submit a separate report
- **Reporting Metric Table:** SHO# 23-002 includes a table that identifies each CAA-required reporting element and the data source states will use to satisfy each element

# Reporting Elements under Section 1902(tt)(1) of the Act

No.	Reporting Element: All States	Data Source
1	Total number of Medicaid and CHIP beneficiaries for whom a renewal was initiated	Unwinding Data Report, Monthly Metric 4
2	Total number of Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed	Unwinding Data Report, Monthly Metric 5a
3	Of the Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed, those whose coverage is renewed on an <i>ex parte</i> basis	Unwinding Data Report, Monthly Metric 5a(1)
4	Total number of individuals whose coverage for Medicaid or CHIP was terminated	Unwinding Data Report, Monthly Metric 5b and Unwinding Data Report, Monthly Metric 5c
5	Total number of individuals whose coverage for Medicaid or CHIP was terminated for procedural reasons	Unwinding Data Report, Monthly Metric 5c
6	Total number of beneficiaries who were enrolled in a separate CHIP	T-MSIS, CHIP-CODE
7	For each state call center, total call center volume	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 1
8	For each state call center, average wait times	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 2
9	For each state call center, average abandonment rate	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 3

# Reporting Elements Vary Based on Marketplace Status Under Section 1902(tt)(1) of the Act

No.	Marketplace with Federal Platform Reporting Element	Data Source
10	Total number of individuals whose accounts are received at the Marketplace from the state Medicaid/CHIP agency due to a Medicaid/CHIP redetermination	Marketplaces that use the Federal eligibility and enrollment platform (Federally-facilitated Marketplaces (FFM) and State-based Marketplaces (SBM) on the Federal platform); states do not need to report
11	In the accounts received at the Marketplace due to a Medicaid/CHIP redetermination, the number of individuals who apply for and are determined eligible for a QHP	Marketplaces that use the Federal eligibility and enrollment platform (FFM and SBMs on the Federal platform); states do not need to report
12	In the accounts received at the Marketplace due to a Medicaid/CHIP redetermination and who apply for and are determined eligible for a QHP, the number of individuals who select a plan	Marketplaces that use the Federal eligibility and enrollment platform (FFM and SBMs on the Federal platform); states do not need to report
No.	Non-Integrated System SBM Reporting Element	Data Source
13	Number of individuals whose accounts are received by the SBM or BHP	SBM Priority Metrics, Monthly Metrics 7a and 7b
14	Number of individuals whose accounts are received by the SBM or BHP & are determined eligible for a QHP or BHP	SBM Priority Metrics, Monthly Metric 9a and 172a
15	Number of individuals whose accounts are received by the SBM/BHP & are determined eligible for a QHP/BHP who make a QHP plan selection or are enrolled in a BHP	SBM Priority Metrics, Monthly Metric 1a and 169a
No.	Integrated System SBM Reporting Element	Data Source
16	Number of individuals who are determined eligible for a QHP or a BHP	SBM Priority Metrics, Monthly Metric 9a and 172a
17	Number of individuals who are determined eligible for a QHP or BHP and make a QHP plan selection or are enrolled in a BHP	SBM Priority Metrics, Monthly Metric 1a and 169a





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# Monitoring State Progress and Corrective Action

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# New CAA, 2023 Enforcement Authorities

## Section 1902(tt)(2)

Section 1902(tt)(2) of the Act adds three new CMS enforcement authorities:

### 1. FMAP Reduction for Failure to Comply with Section 1902(tt)(1) Reporting Requirements:

- Applies: if a state does not satisfy the reporting requirements during any fiscal quarter during the period that begins on July 1, 2023, and ends on June 30, 2024
- Penalty: the state's FMAP determined for the quarter under section 1905(b) shall be reduced by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the state has failed to satisfy such requirements.

### 2. Corrective Action for Failure to Comply with Section 1902(tt)(1) Reporting Requirements or Federal Eligibility Redetermination Requirements:

- Applies: if a state has been determined by CMS to be out of compliance with the reporting requirements in section 1902(tt)(1) and/or federal eligibility redetermination requirements during the period that begins on April 1, 2023, and ends on June 30, 2024
- Penalty: CMS may require the state to submit and implement a corrective action plan (CAP)

### 3. Suspension of Terminations for Procedural Reasons and Civil Monetary Penalties:

- Applies: If a state fails to submit or implement an approved CAP in accordance with the timelines in the CAA, 2023
- Penalty: CMS may require a state to suspend some or all terminations of Medicaid eligibility that are for procedural reasons until the state takes appropriate corrective action, and/or may impose on that state a civil money penalty of not more than \$100,000 for each day that the state is not in compliance.



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# Implications for Section 1902(e)(14) Waivers

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# Section 1902(e)(14) Waiver Authorities

- Many approved section 1902(e)(14) waivers have an effective and/or expiration date that is linked to the end of the COVID-19 PHE, not the end of the Medicaid continuous enrollment condition. As a result, these authorities may no longer align with states' unwinding timelines.
- CMS will allow states to implement modified effective dates, consistent with the guidance in SHO #23-002 and outlined below, without needing to submit a revised request to CMS.
  - States should document any change in the effective date in their records and maintain a copy of the SHO letter.

<b>Current Approval Start/Expiration Date</b>	<b>New Approval/Start Expiration Date</b>
Section 1902(e)(14)(A) waivers effective the month during or following the end of the COVID-19 PHE	Use the date of the end of the continuous enrollment condition (March 31, 2023) in lieu of the end of the COVID-19 PHE
Section 1902(e)(14)(A) waivers that expire a certain number of months after the COVID-19 PHE ends	Replace the date that the COVID-19 PHE ends with the date the continuous enrollment condition ends (March 31, 2023)
Section 1902(e)(14)(A) waivers effective when the state-specific unwinding period begins and/or expire when a state-specific unwinding period ends	Dates do not need to be adjusted

# CMS Technical Support for States

- To ensure compliance, states may
  - Need to make programmatic and operational changes to eligibility and enrollment policies, procedures, systems and operations
  - Consider adopting alternative strategies and mitigation plans
- States may also consider adopting additional strategies to streamline processes in order to maximize coverage retention and decrease procedural terminations
- CMS is available to consult with states as they prepare for and resume renewals and other eligibility determinations
- States may contact their CMS state lead for assistance

# Questions

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# Appendix

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# Maintenance of Effort Condition through December 31, 2023

## Section 6008(b)(1) of the FFCRA

- States may not claim the temporary FMAP increase for a quarter if, during that quarter, they impose eligibility standards, methodologies, or procedures that are more restrictive than those in effect on January 1, 2020
- Section 5131 of the CAA, 2023 did not change this condition, and states must continue to meet it for any quarter in which they claim the temporary FMAP increase, through December 31, 2023



# Maintenance of Medicaid Premium Levels through December 31 (Modified by Section 5131)

## Section 6008(b)(2) of the FFCRA

- Through March 31, 2023, states may not claim the temporary FMAP increase if they impose any premium “with respect to an individual” that exceeds the amount of such premium as of January 1, 2020
- Section 5131(a)(2)(B) of CAA, 2023, amends this provision to remove “with respect to an individual”
- Beginning April 1, 2023, states may increase the premium amount imposed on a given individual, subject to the following:
  - Increase must be consistent with state’s premium schedule
  - Premium schedule amounts must not have increased over amounts in effect as of January 1, 2020
  - State must comply with redetermination requirements prior to resumption of premiums

*States may request authority under section 1902(e)(14)(A) of the Act to delay the resumption of Medicaid premiums during the unwinding period until a full redetermination is completed*

# Coverage without Cost Sharing for COVID-19 Testing, Vaccines, and Treatment

## Section 6008(b)(4) of the FFCRA

- States claiming the temporary FMAP increase for any quarter ending December 31, 2023, must continue to provide coverage, without cost sharing, for any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies
- This condition was not changed by section 5131 of the CAA, 2023

**Note:** *the requirements under section 9811 of the American Rescue Plan Act of 2021 (ARP) (P.L. 117-2) generally overlap with, are in many circumstances broader than, and will extend longer than the coverage and cost sharing condition under section 6008(b)(4) of the FFCRA, and they apply even if the state is not claiming the FFCRA temporary FMAP increase*

# Resources for States

- **State Health Official Letter #23-002:** [Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023](#)
- **CMCS Informational Bulletin (January 5, 2023):** [Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023](#)
- **State Health Official Letter #22-001:** [Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Upon Conclusion of the COVID-19 Public Health Emergency](#)
- **State Unwinding Resources:** [www.Medicaid.gov/unwinding](http://www.Medicaid.gov/unwinding)

For questions and requests for further technical assistance from CMS, please contact [CMSUnwindingSupport@cms.hhs.gov](mailto:CMSUnwindingSupport@cms.hhs.gov)