

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

Eligibility and Enrollment Pending Actions Resolution Planning Tool – Version 2.0

During the national COVID-19 public health emergency (PHE), states¹ implemented program changes or other emergency flexibilities and will need to take steps to reverse many of these changes when they return to normal operations. As one of several conditions of receiving the temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase under the Families First Coronavirus Response Act (FFCRA), states have been required to maintain enrollment of nearly all individuals enrolled in Medicaid (this provision is commonly referred to as the “continuous enrollment condition”).² When the continuous enrollment condition eventually ends, states will generally have up to 12 months to return to normal eligibility and enrollment (E&E) operations. This will include initiating a full renewal for all individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Program (BHP); completing processing of pending applications and resuming timely application processing; and conducting routine verifications and processing of changes in circumstances. This significant volume of work will test state E&E systems and staff, and necessitates extensive state planning to maintain continuous coverage for eligible individuals and ensure a smooth transition to resumption of normal operations.

This tool is intended to highlight the areas of work states may need to address in their planning efforts, and key state planning domains and strategies. States are encouraged, but not required, to leverage this tool to validate their readiness to complete E&E pending actions and resume normal operations, and the comprehensiveness of their planning. While states must develop and document their plans to restore routine operations, states are not required to submit their entire operational plan to CMS for review or approval. The perspectives and partnership of the Federally Facilitated Marketplace (FFM), State Based Marketplaces (SBM), Medicaid and CHIP managed care organizations (MCOs), providers, enrollee advocates, and other stakeholders are critical to the resumption of renewals and other eligibility actions in a manner that supports retention of coverage, including the successful transition to other programs. CMS encourages states to solicit input on their unwinding operational plans from these partners, and to share their plans publicly, prior to their implementation.

Under the authority in sections 1902(a)(6) and 1902(a)(75) of the Social Security Act (the Act) and 42 C.F.R. § 431.16, all states will be expected to submit data demonstrating progress in completing pending applications and initiating the state's total caseload of renewals, along with the disposition of renewals. States will be required to submit baseline data to CMS and report additional data on a monthly basis, for a minimum of 14 months. Where reported data indicate that states are not meeting timelines or in circumstances where data demonstrate other potential compliance issues, including potential erroneous disenrollment of eligible enrollees, states may be expected to report additional data and/or report information more frequently. CMS will identify the data elements to be reported and provide a mandatory reporting template for states to use.

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

¹ Throughout this document, “states” refers to states, the District of Columbia, and the U.S. Territories.

² Consistent with 6008(b)(3) of the FFCRA and 42 C.F.R. § 433.400, states claiming the temporary 6.2 percentage point FMAP increase authorized under FFCRA must ensure individuals that are “validly enrolled” remain enrolled through the end of the month in which the PHE ends unless the individual requests voluntary termination, is no longer considered to be a resident of the state, or dies.

The tool consists of three parts:

I. Readiness Assessment: Guided questions for states to assess their readiness for completing E&E actions when the continuous enrollment condition ends, highlighting areas of risk for coverage loss and delayed E&E processes.

II. State Planning Approach and Strategies: Prompts and sample templates to: define state planning organization and structure; identify the staging and timing of activities and populations for completing E&E actions when the continuous enrollment condition ends; and anticipate potential risks and determine mitigation strategies for completing E&E actions as planned.

III. Roll-Up Summary: A snapshot of states' overall approach.

In addition, CMS has developed and compiled several resources to provide additional support to states as they prepare to resume normal operations. These resources, as well as the guidance documents referenced throughout the Planning Tool, may be found in *Appendix A*.

I. Readiness Assessment

To help states understand their readiness for initiating and completing E&E actions when the continuous enrollment condition eventually 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: <input type="checkbox"/> Yes – MAGI ³ <i>ex parte</i> renewals only <input type="checkbox"/> Yes – MAGI <i>ex parte</i> renewals and sent renewal forms <input type="checkbox"/> Yes – non-MAGI renewals <input type="checkbox"/> 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?

³ MAGI renewals include individuals enrolled in Medicaid and CHIP.

State Self-Assessment Questions	State Response	Considerations for State Planning Scope
2. On average, what share of individuals can be renewed on an <i>ex parte</i> basis?	MAGI renewals able to be completed <i>ex parte</i> : [Enter percent] Non-MAGI renewals able to be completed <i>ex parte</i> : [Enter percent]	What barriers, if any, has the state identified to higher <i>ex parte</i> rates? What strategies, if any, could the state consider to increase <i>ex parte</i> rates to reduce overall manual renewal caseload volume? What policy flexibilities, operational and workforce changes, and systems changes would the state need to be addressed to adopt the strategies to support <i>ex parte</i> renewals?
3. Are notices and additional outreach and communications (i.e., flyers, social media posts, text messages) currently being provided to individuals about what to expect related to their coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If <i>yes</i> , is the language provided in the notices and other messages still accurate? When is the state planning to send additional communications? What steps are being taken to ensure the messaging is reaching Medicaid enrollees who have limited English proficiency? If <i>no</i> , what are the state's plans for outreach and messaging? Which additional stakeholders, state agencies and other partners can be leveraged to support outreach efforts?
4. Did the state extend eligibility to additional temporary eligibility groups and populations in response to the PHE?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If <i>yes</i> , how is the state prioritizing these individuals for re-determination? What plans are needed to ensure these populations are informed of any eligibility changes after the PHE ends and appropriately transitioned to other available coverage options?

B. Application Processing

Federal Requirements. 42 C.F.R. § 435.912 requires states to determine eligibility promptly and without undue delay, not to exceed the following maximum days for any given applicant: 90 days for applicants who apply for Medicaid on the basis of disability and 45 days for all other applicants. In accordance with 42 C.F.R. § 457.340, these requirements apply equally to applications for CHIP. An application is considered to be processed timely when the agency enrolls an eligible applicant or denies coverage for an individual the agency could not determine as eligible within the application processing timeliness standards.

State Self-Assessment Questions	State Response	Considerations for State Planning Scope
1. Since the continuous enrollment condition has been in effect, has the state maintained application processing timeliness standards across all application types (MAGI applications, other non-disability-related applications, and disability-based applications)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how will the state ensure that timely application processing is maintained when work resumes on renewals and other eligibility actions? If <i>no</i> , what policy, operational or staffing changes are needed for the state to ensure that it can complete pending applications and ensure continued timely processing of applications during the unwinding period?
2. If the state responded “no” to Q1: How many applications are pending processing by application type? <i>Note: This includes applications submitted during the period of the continuous enrollment condition that have not exceeded applicable timeliness standards for processing.</i>	<i>Enter the amount for each application type that the state has pending</i> MAGI Applications: [Enter number] Other Non-Disability Applications: [Enter number] Disability-Based Applications: [Enter number]	How is the state staging these applications for processing? What additional policy, operational or staffing changes are needed to ensure the state can address this backlog to minimize overall caseload volume and increase timely processing rates?

C. Medicaid Fair Hearings

Federal Requirements. Generally, states are required to take final administrative action on a fair hearing request within 90 days of receipt of the request (42 C.F.R. § 431.244(f)(1)), while states must take final administrative action on expedited fair hearings “as expeditiously as possible” (42 C.F.R. § 431.244(f)(3)).

State Self-Assessment Questions	State Response	Considerations for State Planning Scope
1. Since the continuous enrollment condition has been in effect, does the state have any fair hearing requests that were received more than 90 days ago for which the state has not taken final administrative action?	<input type="checkbox"/> Yes <input type="checkbox"/> No (<i>skip to Q3</i>)	If yes, what steps is the state planning to ensure it can conduct fair hearings on a timely basis? Are there changes that could increase the state's capacity for timely processing, including procedure updates, staffing, fair hearing venue, and involvement of Medicaid agency staff in pre-fair hearing work?
2. If the state answered "yes" to Q1: How many fair hearing requests were received more than 90 days ago, and, of those, how many were expedited the fair hearing requests?	<p><i>Enter the amount of fair hearing requests that the state has pending for 90 days or more</i></p> <p>Fair hearing requests > 90 days: [Enter number]</p> <p>Of fair hearing requests > 90 days, requests to expedite: [Enter number]</p>	Is the state planning to prioritize resolution of pending fair hearing requests, for example, based on: the length of time a hearing request or final administrative action has been pending; whether it is an expedited request; whether the individual is receiving benefits (aid paid) pending the hearing decision; or whether benefit/service has been terminated?
3. Does the state anticipate an increase in fair hearing requests following the end of the continuous enrollment condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No (<i>skip to Q5</i>)	If yes, is the state using methodologies to estimate any expected increase in the volume of fair hearing requests? For example, has the state reviewed the average number of fair hearing requests expected based on terminations in a given year by eligibility group that could be applied to the state's expected number of terminations after the continuous enrollment period?

State Self-Assessment Questions	State Response	Considerations for State Planning Scope
4. If the state answered “yes” to Q3: What is the expected increase in fair hearing requests following the end of the continuous enrollment condition?	<p><i>Enter the estimated number of additional fair hearing requests per month</i></p> <p>Increase in fair hearing requests/month: [Enter number]</p>	How is the state planning to address increases in volume? How is the state evaluating operational and workforce changes, policy flexibilities, and systems changes to support the anticipated increase?
5. What is the state’s current capacity to process fair hearings (i.e., how many fair hearings can the state process each month)?	<p><i>Describe:</i> _____</p>	How is the state planning to account for current capacity and addressing backlogs or increases in fair hearing requests after the end of the continuous enrollment condition? Fair hearing processing involves a range of actions, including: providing notice of fair hearing rights, scheduling fair hearings, performing informal resolutions, conducting fair hearings, and taking final administrative action. What changes to any of these components of the fair hearing process could help the state to reduce the risk of backlogs and increase capacity for timely reviews?

II. State Planning Approach and Strategies

To help states with their planning efforts, this section prompts states to:

- identify organization and staffing resources,
- stage and prioritize the work ahead, and
- anticipate key risks and determine mitigation strategies for completing E&E actions as planned.

A. Organization and Staffing

1. Describe how your state is organized to support planning for resolving pending E&E actions and resuming normal operations. Identify other State or local agencies that are key partners for resolving pending E&E actions and resuming normal operations (e.g., State human services agency, State-based Marketplace, local social services agencies).

Narrative Summary

2. Indicate the designated leads and supporting teams identifying changes and strategies for resolving pending E&E actions and resuming normal operations.

Area	Lead	Supporting Team(s)
Policy		
Operations (including workforce)		
Systems		
Training		
Outreach and Communications		
Fair Hearings		

Area	Lead	Supporting Team(s)
Other:		

B. Sample Planning Templates

1. Assessment and Approach: Processing Renewals

CMS Expectations. States may take up to 12 months when the continuous enrollment condition ends (“12-month unwinding period”) to initiate renewals in accordance with 42 C.F.R. §§ 435.916, 457.343, and 600.340, as well as to conduct post-enrollment verifications and redeterminations of eligibility due to changes in enrollee circumstances for its total caseload. While states will be required to initiate renewals for all individuals enrolled within 12 months, the month the unwinding period begins may vary by state but is based on the month in which the PHE eventually ends. States have the option to initiate renewals up to two months before the end of the month in which the PHE ends as long as any associated terminations occur after the continuous enrollment period ends. If a state chooses that option, it’s 12-month unwinding period would begin the month in which the state initiates renewals that may result in a termination based on a determination of ineligibility or due to failure to respond to requested information. States that have conducted renewals, but have not terminated Medicaid eligibility for enrollees who were determined ineligible or who did not respond to requests for documentation, generally may not terminate coverage for such enrollees until the state completes a new full renewal during the 12-month unwinding period. While states must initiate all pending eligibility actions (including renewals, post-enrollment verifications, and redeterminations based on changes in circumstances) by the last month of the 12-month unwinding period, states may take an additional two months (14 months total) to complete all work initiated during the unwinding period. States are expected to resume timely processing of renewals initiated after the 12-month unwinding period.

As stated in the [January 2021 COVID-19 Frequently Asked Questions \(FAQs\) for State Medicaid and Children’s Health Insurance Program \(CHIP\) Agencies](#), states are not permitted under the CHIP state plan to extend eligibility periods for separate CHIP enrollees who have been determined ineligible for coverage. If a state receives information from an enrollee, processes that information, and determines the individual ineligible for its separate CHIP, the state must process the termination and transfer the individual to Medicaid or the Marketplace, in accordance with 42 C.F.R. § 457.350(b) and (i).

Assessment and Approach. Each state’s assessment and approach should be customized for the state environment. Informed by the data provided in Section I.A., states should:

1. Assess the volume of renewals that the state will need to distribute and process, and consider factors such as the following in identifying and staging population groups for actions⁴:

- ☐ share of renewals state has been able to complete;
- ☐ length of time renewals have been pending;
- ☐ which populations may have eligibility that tends to be stable (e.g., children, individuals dually eligible for Medicaid and Medicare);
- ☐ which populations may be particularly vulnerable if they experience a loss of coverage—such as those who have ongoing health care needs (e.g., people with disabilities, people who are pregnant);
- ☐ which populations are enrolled in SNAP or other integrated benefit programs, for whom the state may be able to align renewals and recertifications; and
- ☐ which populations are likely to no longer be eligible for Medicaid coverage (e.g., individuals aging out of eligibility group, individuals who become eligible for Medicare, individuals who gained eligibility due to use of a temporary eligibility flexibility).

2. Consider the potential policy changes that may help to facilitate renewals, maintain coverage continuity, and assist with staging renewals for workload management.

3. Refer to resources in *Appendix A* for potential policy changes in the [*December 2020 SHO #20-004: Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Operations Upon Conclusion of the COVID-19 Public Health Emergency*](#), the [*August 2021 SHO #21-002: Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Operations Upon Conclusion of the COVID-19 Public Health Emergency*](#), the [*November 2021 Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations*](#), and the [*March 2022 SHO #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*](#).

4. Identify the associated operational and systems changes and summarize the state approach and timing. Example rows are provided below.

⁴ States are reminded that they may not prioritize populations based solely on the Medicaid eligibility group in which they are enrolled, de-prioritize cases based on the availability of FFP at a matching rate that exceeds the state’s regular FMAP (e.g., states may not de-prioritize completion of outstanding eligibility actions for individuals enrolled in the adult group) 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). Further, compliance with these laws includes providing reasonable accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

Assessment		Approach			
Population and Estimated Number Affected (Define populations and estimate number in each population)	Status of State Action Taken to Date	Policy Changes to Facilitate Renewal and Maintain Continuous Coverage for Eligible Individuals	Operational and Systems (E&E, MMIS, Other) Changes	State Approach Including Target Completion Date and Prioritization	Other Considerations
Example: Individuals dually eligible for Medicaid and Medicare	<ul style="list-style-type: none"> Identified individuals dually eligible for Medicaid and Medicare 	<ul style="list-style-type: none"> Use authority under section 1902(r)(2) of the Act to adopt less restrictive rules in counting income and resources and thereby effectively increase the income and resource criteria for Medicare Savings Programs (MSP) eligibility groups (Eligibility SPA) Per regulations specified at 42 C.F.R. 435.916(b), adopt 12-month renewals (Eligibility SPA) Per the options specified in 42 C.F.R. 435.916(b), provide pre-populated renewal forms and reconsideration period (Eligibility SPA and/or Update to State's Internal Procedures) 	<ul style="list-style-type: none"> E&E: Implement system change to eliminate income and resource criteria, extend renewals, pre-populate forms to duals Other: Develop notice language 	<ul style="list-style-type: none"> Approach: Streamline renewals for dual eligibles Target: Complete by end of the 12th month after the continuous enrollment condition ends 	<ul style="list-style-type: none"> Ensure any proposed targeting of populations does not 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.

Assessment		Approach			
Population and Estimated Number Affected (Define populations and estimate number in each population)	Status of State Action Taken to Date	Policy Changes to Facilitate Renewal and Maintain Continuous Coverage for Eligible Individuals	Operational and Systems (E&E, MMIS, Other) Changes	State Approach Including Target Completion Date and Prioritization	Other Considerations
Example: People who are pregnant and those who are beyond 60 days postpartum	<ul style="list-style-type: none"> Identified pregnant people and those beyond 60 days postpartum 	<ul style="list-style-type: none"> Implement the American Rescue Plan Act's (ARP) postpartum coverage option in April 2022 (effective date) and coordinate eligibility re-determinations for people who are beyond 60 days postpartum (Eligibility SPA) 	<ul style="list-style-type: none"> E&E: Implement system change to extend redetermination date to after April 2022 and before end of continuous enrollment condition + 12 months Other: Develop notice language 	<ul style="list-style-type: none"> Approach: Stage renewal actions to start April 2022 Target: Complete by end of 6th month after the continuous enrollment condition ends 	
Example: Individuals determined eligible for Medicaid during continuous enrollment condition through a temporary eligibility category	<ul style="list-style-type: none"> Identified individuals determined eligible through a temporary eligibility category 	<ul style="list-style-type: none"> Rely on SNAP recertification income determination for MAGI individuals (Facilitated Enrollment SPA) 	<ul style="list-style-type: none"> Coordinate with human services agency to identify individuals who are also enrolled in SNAP E&E: Implement system changes to align Medicaid redetermination date with SNAP redetermination date 	<ul style="list-style-type: none"> Approach: Align action on processing renewals for individuals enrolled in Medicaid, CHIP, or BHP who are also enrolled in SNAP with SNAP recertification and rely on SNAP income determination for MAGI individuals Target: Complete by end of the 12th month after the continuous enrollment condition ends 	<ul style="list-style-type: none"> Ensure accounts are transferred are for Marketplace coverage

2. Assessment and Approach: Application Processing

Use this section if the state has any pending applications.

CMS Expectations. States must make every effort to make timely determinations of eligibility for new applicants, and therefore, CMS expects states to expeditiously process applications now. However, given that states receive applications on a rolling basis, CMS anticipates that many states will have pending applications when the continuous enrollment condition is in effect that remain to be processed as states restore their E&E operations during their unwinding period. States may use a phased approach to complete processing of these applications and resume timely and accurate determinations of eligibility on new applications within the following timelines, measured going forward from the end of the month in which the continuous enrollment condition ends.

- **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.

Assessment and Approach. Each state’s assessment and approach should be customized for the state environment. Informed by the data provided in Section I.B., states should:

1. Assess pending applications and consider factors such as the following in identifying and staging population groups for actions:
 - ☐ length of time applications have been pending; and
 - ☐ type of applications that are pending (e.g., MAGI, other non-disability-based applications, disability-based applications).
2. Consider the potential policy changes that may be necessary to facilitate application processing and assist with staging applications for workload management.
3. Refer to resources in *Appendix A* for potential policy changes in the [March 2019 Coverage Learning Collaborative resource Medicaid & CHIP MAGI Application Processing: Ensuring Timely and Accurate Eligibility Determinations](#), the [December 2020 SHO #20-004: Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Operations Upon Conclusion of the COVID-19 Public Health Emergency](#), the [August 2021 SHO #21-002: Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Operations Upon Conclusion of the COVID-19 Public Health Emergency](#), the [November 2021 Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations](#), and the [March 2022 SHO #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](#).
4. Identify the associated operational and systems changes and summarize the state approach and timing. An example row is provided below.

3. Assessment and Approach: Fair Hearings

Assessment		Approach			
Pending Application Type and Estimated Number Affected <i>(Pending application type and estimated number affected)</i>	Status of State Action Taken to Date	Policy Changes to Facilitate Verification and Application Processing	Operational and Systems <i>(E&E, MMIS, Other)</i> Changes	State Approach Including Target Completion Date and Prioritization	Other Considerations
<i>Example: Other non-disability-based applications: 25,000</i>	<ul style="list-style-type: none"> Identified number of non-disability-based applications and sent notice regarding pending application. 	<ul style="list-style-type: none"> Accept self-attestation and conduct post enrollment verification Expand access to additional data sources Align MSP and Medicare Part D Low Income Subsidy criteria and leverage SSA’s LIS “Leads data” 	<ul style="list-style-type: none"> E&E – Build interface with additional data source and SSA’s leads data 	<ul style="list-style-type: none"> Approach: <i>[To be populated]</i> Target: Complete processing of applications received during the period of the continuous enrollment condition by the end of the 2nd month after the continuous enrollment condition ends 	

CMS Expectations. CMS expects that states will begin to process fair hearing requests timely when the PHE ends. In general, states must take final administrative action on a non-expedited fair hearing request within 90 days of receipt of the request (42 C.F.R. 431.244(f)(1)). However, CMS recognizes that some states may experience a substantial increase in fair hearing requests after the end of the continuous enrollment period. States should estimate their anticipated fair hearing volume to avoid delays in hearings that could have adverse effects on enrollees.

Assessment and Approach. Each state’s assessment and approach should be customized for the state environment. Informed by the data provided in Section I.C., states should:

- Estimate the volume of fair hearing requests that the state will need to distribute and process, and consider the following factors in identifying and staging fair hearing request categories for action:
 - ☐ number of requests and types of cases, including those that meet the requirements for an expedited fair hearing;
 - ☐ length of time fair hearing requests have been pending (oldest to most recent);
 - ☐ number of requests for: a) individuals who are not receiving benefits pending (e.g., initial eligibility or service/benefits denials) and b) individuals who appeal the termination of eligibility and who are receiving benefits pending;
 - ☐ staffing resources available to hear cases and usual caseload management capacity.
- Consider the potential policy and process changes to facilitate the timely resolution of fair hearing requests.

3. Refer to resources in the [December 2020 SHO #20-004: Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Operations Upon Conclusion of the COVID-19 Public Health Emergency](#), the [November 2021 Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations](#), and the [March 2022 SHO #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](#).
4. Identify the associated operational and systems changes and summarize the state approach and timing. An example row is provided below.

Assessment		Approach			
Population and Estimated Number Affected (Define populations and estimate number in each population)	Status of State Action Taken to Date	Policy Changes to Facilitate the Timely Resolution of Fair Hearing Requests	Operational and Systems (E&E, MMIS, Other) Changes	State Approach Including Target Completion Date and Prioritization	Other Considerations
Example: Estimated individuals who requested a fair hearing and are not receiving benefits pending (e.g., initial eligibility or service/benefits denials): 5,000	<ul style="list-style-type: none"> Identified number of requests and categorized by those who are not receiving benefits pending the hearing outcome Project number of requests expected in future months based on projected number of renewals processed. 	<ul style="list-style-type: none"> Accept a hearing officer’s recommended decision, as final (if applicable) 	<ul style="list-style-type: none"> Operational: <ul style="list-style-type: none"> Enhance informal resolution process, including ensuring it is available by telephone or allowing for internal administrative review. Review and revise, if needed, operational procedures including intake process for fair hearing requests, evidence submission, call center scripts Hire, reorganize, or detail new staff to support increased volume of renewals to ensure timely review System: E&E or Fair Hearing system – Build enhancements to telephonic and online user interface for fair hearing request and evidence submission Training: Train staff across multiple parts of the E&E process of the revised fair hearing processes including: eligibility 	<ul style="list-style-type: none"> Approach: [To be populated] Target: Complete processing of fair hearings received by the end of the 3rd month (or relevant state time limit, if shorter) after receipt of fair hearing request (timely processing). 	<ul style="list-style-type: none"> Structure of fair hearing process (e.g., separate agencies between eligibility, single state agency, and fair hearings

			<i>staff, call center, managed care plans, fair hearing office staff.</i> <ul style="list-style-type: none"> • Other: Assess notice language for readability and accuracy of information about the appeals process, including regarding informal resolution option, and update as necessary. 		
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C. Outreach and Communications Plan

Reflect on the ways in which information about the resolution of renewals and other E&E actions and resumption of normal operations will be communicated with appropriate stakeholders in a timely manner. Example areas to consider include:

- **Audience(s):** Who are the core audiences? Should there be targeted outreach and communication strategies for certain populations?
- **Key messages:** What is the most important information to be communicated to these audiences about resuming normal operations after the continuous enrollment condition ends?
- **Methods and tools:** What communication methods and tools are available? Are there existing communication tools and delivery methods that can be leveraged? Consider: agency websites, social media posts, blog posts, bulletin board notices, targeted e-mail correspondence, webinars, press releases, newsletters, etc., as well as potential partnerships (e.g., earned media, sister agency engagement, faith-based partnerships).
- **State agency lead:** What are the internal staff positions and departments within state agencies that will need to be leveraged in order to spread the word about upcoming renewal and E&E changes? If needed, a core communication team may be developed.
- **Communication partners:** Who are important partners that can be leveraged by that state to spread information? E.g., state and local agencies, community-based organizations, providers, managed care plans, universities, community colleges, radio stations, etc.
- **Timing:** What time frame and/or timeline will most efficiently and effectively convey the intended information to stakeholders?

For important information to help inform people with Medicaid or CHIP about steps they need to take to renew their coverage, please see the unwinding communications toolkit, [Medicaid and CHIP Continuous Coverage Unwinding Phase I: Plan & Educate](#).

Consider strategies to “Improve Consumer Outreach, Communication, and Assistance” within the [November 2021 Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations](#). Example rows are provided below.

Core Audience(s)	Key Messages	Communication Methods and Tools	Communication Partners	State Agency Lead	Timing
Example: Individuals enrolled in Medicaid or CHIP	<i>Renewals are starting</i>	<i>Web, social media, text message, direct phone call, e-mail, direct mail, paid media</i>	<i>Managed care plans, providers, community-based organizations</i>	<i>Marketing manager, public relations officer</i>	<i>2 months prior to the end of the continuous enrollment condition</i>
Providers					
Managed Care Plans					
Enrollment Brokers					
Call Center					
Navigators/Assistors					
Community-based Organizations					
Media outlets					
Sister Government Agencies					
Other:					

D. Timeline

States should be able to articulate a month-to-month work plan for meeting key milestones, including:

- completing eligibility determinations for all pending MAGI and other non-disability-related applications received during the PHE by 2 months after the end of the month in which the PHE ends;
- completing eligibility determinations for all pending disability-related applications received during the PHE by 3 months after the end of the month in which the PHE ends;
- resuming timely application processing of all applications by 4 months after the end of the month in which the PHE ends;
- initiating renewals and resuming timely renewal processing by 12 months after the state begins its unwinding period; and
- completing all pending actions by 14 months after the state begins its unwinding period.

States may find it helpful to break down key activities as well as the staging of different populations for completing E&E actions.

Activities/Populations	Staging Before the State's Unwinding Period Begins	Staging After the State's Unwinding Period Begins	+1 mo	+2 mo	+3 mo	+4 mo	+5 mo	+6 mo	+7 mo	+8 mo	+9 mo	+10 mo	+ 11 mo	+12 mo	+13 mo	+14 mo
Key Milestones																
Planning	*															
Eligibility Determinations Completed – Pending MAGI and Non-disability				*												
Eligibility Determinations Completed – Pending Disability-related					*											
Application Processing Timely						*										
Renewals Initiated														*		
Renewals Completed																*
Key Activities																
Planning																
[Enter text]																
[Enter text]																
[Enter text]																
Application Processing																
[Enter text]																
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Eligibility Determinations																
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Renewals																
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Outreach and Communications																
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Activities/Populations	Staging Before the State's Unwinding Period Begins	Staging After the State's Unwinding Period Begins	+1 mo	+2 mo	+3 mo	+4 mo	+5 mo	+6 mo	+7 mo	+8 mo	+9 mo	+10 mo	+ 11 mo	+12 mo	+13 mo	+14 mo
[Enter text]																
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E. Risk Areas and Mitigation Strategies

In order to complete E&E actions at the end of the continuous enrollment condition as planned, states will want to assess risks and consider mitigation strategies. Use this section in tandem with *B. Sample Planning Templates*. Example key risks to anticipate and mitigation strategies are included below for reference. See the [November 2021 Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations](#) for additional resources.

1. Key risk: Inappropriate coverage loss among eligible individuals due to procedural or administrative reasons

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Increase the percentage of <i>ex parte</i> renewals completed for MAGI and non-MAGI populations: <ul style="list-style-type: none"> Expand the number and types of data sources used for redetermination (e.g., use both IRS and quarterly wage data; leverage unemployment income data sources) Leverage data from other means-tested programs, like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF), for Medicaid eligibility redeterminations Create a data source hierarchy to guide verification, prioritizing the most recent and reliable data sources (e.g., leverage SNAP data that is updated every six months; first ping IRS data and if not reasonably compatible, then ping quarterly wage data) and verify income when data source in the hierarchy confirms reasonable compatibility 	<ul style="list-style-type: none"> How significant is this risk in your state? Which of these strategies will the state implement to mitigate risk? Are there other strategies the state will adopt? What steps will the state need to take to operationalize these strategies and when?

Potential Strategies to Mitigate Risk	State Approach and Timeline
<ul style="list-style-type: none"> ○ <i>Use a reasonable compatibility threshold (e.g., 10%) for income for MAGI and non-MAGI populations and a reasonable compatibility threshold for assets for non-MAGI populations, if not already used</i> ○ <i>Assess and adjust the current reasonable compatibility threshold for income (e.g., increase to 20%)</i> ○ <i>Streamline, increase levels for, or eliminate asset requirements for some or all non-MAGI populations</i> ○ <i>Automate data checks</i> 	
<p>□ Streamline renewals that cannot be completed via an <i>ex parte</i> process:</p> <ul style="list-style-type: none"> ○ <i>Ensure that individuals can submit requested information to the agency over the phone, via mail, online, and in-person, consistent with federal requirements</i> ○ <i>Ensure renewal forms are pre-populated for individuals enrolled in Medicaid, CHIP, and BHP on a MAGI basis, consistent with federal requirements</i> ○ <i>Pre-populate renewal forms for individuals enrolled on a basis other than MAGI, including those that are eligible on the basis of being aged, blind or disabled</i> ○ <i>Revise instructions on pre-populated forms to make clear requests for additional information as well as the process and timeframe for returning documents/information</i> ○ <i>Extend the deadline for responding to requests for additional information (e.g., increase the time individuals have to respond to a renewal form from 30 days to 45 days)</i> ○ <i>Provide a 90-day (or longer) reconsideration period for non-MAGI enrollees who do not respond to the renewal form, as is required for MAGI populations</i> 	

Potential Strategies to Mitigate Risk	State Approach and Timeline
<ul style="list-style-type: none"> ○ <i>Implement a reconsideration period after termination due to a change in circumstances for all individuals enrolled in Medicaid and CHIP (on both a MAGI and non-MAGI basis)</i> ○ <i>Update verification plans to accept reasonable explanations of inconsistencies or to allow for self-attestation of certain eligibility criteria for which documentation may be difficult for individuals to obtain</i> ○ <i>Create specialized units to process complex/time-consuming redeterminations (e.g., renewals for households with self-employment income or individuals without a fixed address)</i> 	
<input type="checkbox"/> Assess systems capacity for revising renewal dates and develop workaround for systems limitations	
<input type="checkbox"/> Provide benefits pending the outcome of a fair hearing to individuals who request a fair hearing prior to the date of action.	
<input type="checkbox"/> Reinstate benefits pending the outcome of a fair hearing to individuals who request a fair hearing not more than 10 days after the date of action.	
<input type="checkbox"/> Other:	

2. Key risk: Inappropriate coverage loss among eligible individuals due to being unable to reach enrollees

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Implement processes to prevent and address returned mail: <ul style="list-style-type: none"> ○ <i>Engage community-based organizations, application assisters (including Navigators and certified application counselors), and providers to conduct outreach to remind individuals enrolled in</i> 	<ul style="list-style-type: none"> • <i>How significant is this risk in your state?</i> • <i>Which of these strategies will the state implement to mitigate risk? Are there other strategies the state will adopt?</i>

Potential Strategies to Mitigate Risk	State Approach and Timeline
<p><i>Medicaid, CHIP, and BHP to provide updated contact information</i></p> <ul style="list-style-type: none"> ○ <i>Require managed care plans to seek updated mailing addresses and either share updated information with the state Medicaid or CHIP agency and/or remind individuals to update their contact information with the state (if the state's managed care contracts grant the state such authority)</i> ○ <i>Identify other data sources that will be leveraged to obtain updated contact information (e.g., managed care plans, the state agency that administers SNAP or TANF, Department of Motor Vehicle records, and/or the U.S. Postal Service National Change of Address database)</i> ○ <i>Send periodic mailed notices, texts, and email/online account alerts reminding individuals to update their contact information (e.g., on a quarterly basis)</i> ○ <i>Ensure individuals are able to submit updated contact information via all modalities, including mail, telephone, and online</i> ○ <i>Ensure consumer notices and renewal forms include reminders for individuals to update their contact information</i> ○ <i>Revise call center/Enrollment Broker scripts to include requests for updated contact information (e.g., prior to answering any question, inquire about updated contact information)</i> ○ <i>Add bolded reminders to update contact information on Medicaid/CHIP/social services websites</i> ○ <i>Attempt to contact the individual by mail and send notices to both the current address on file and the forwarding address, if one is provided, requesting that the individual confirm the new address provided by USPS</i> 	<ul style="list-style-type: none"> • <i>What steps will the state need to take to operationalize these strategies and when?</i>

Potential Strategies to Mitigate Risk	State Approach and Timeline
<ul style="list-style-type: none">○ <i>Provide clear guidance and update policy manuals to ensure that staff know what specific actions they should take in response to different forms of returned mail, including:</i><ul style="list-style-type: none">▪ <i>Mail that is returned with an in-state forwarding address:</i> <i>States are strongly encouraged to verify the information by sending notice by mail to the current address and also to the forwarding address and attempt to contact the individual using one or more other modalities, such as by phone, electronic notice, email, or text messaging as permissible. States may accept the USPS in-state forwarding address and update the individual's record provided that the state first sends a notice to the current address on file confirming the accuracy of the information. States may not terminate coverage if the state does not receive a response to the request for confirmation of an in-state address change, even if the state does not update the individual's record with the new in-state address.</i>▪ <i>Mail that is returned with an out-of-state forwarding address:</i> <i>States must send notice and attempt to contact the individual to confirm the accuracy of the information and verify continued state residency. States must send notice consistent with the individual's elected format, either electronically or by mail, to the current address the state has on file, requesting that the individual confirm the address and state residency. States are strongly encouraged also to send notice to the out-of-state forwarding address and/or other address provided by a third party, attempt to locate the individual using other electronic or telephonic</i>	

Potential Strategies to Mitigate Risk	State Approach and Timeline
<p><i>modalities, and by checking third-party data sources for more recent address information. If the individual does not respond with the requested information, or the information provided does not establish the individual's continued state residency, the state must provide advance notice of termination or other adverse action and fair hearing rights consistent with 42 C.F.R. §§ 431.206-214.</i></p> <ul style="list-style-type: none"> ▪ Mail that is returned with no forwarding address: <i>States should attempt to locate individuals whose mail is returned to the state agency without a forwarding address consistent with the steps described above prior to discontinuing coverage based on a determination that an individual's whereabouts are unknown. If an individual cannot be located, and there is no forwarding address, the state may terminate eligibility in accordance with regulations at 42 C.F.R. part 431, subpart E. If an individual's whereabouts become known prior to the individual's originally-scheduled renewal date, the state must reinstate coverage in accordance with regulations at § 431.231(d).</i> ○ <i>Create specialized and dedicated units (either centralized or within each region/county) for processing returned mail</i> 	
<input type="checkbox"/> Other:	

3. Key risk: Consumer confusion about the steps and critical deadlines to retain coverage

Potential Strategies to Mitigate Risk	State Approach and Timeline
<p><input type="checkbox"/> Improve eligibility notices:</p> <ul style="list-style-type: none"> ○ Review consumer notice language to ensure that information is communicated in plain language, including that it clearly explains the appeals process (also known as the Medicaid fair hearing and CHIP review process, as applicable), and steps to take if consumer ultimately must transition from Medicaid/CHIP to Marketplace coverage ○ Ensure the notice highlights the resources to contact if individuals have questions about the notice (e.g., bold contact information or put the information in a box to draw attention) ○ Re-label envelopes to clearly indicate that the information enclosed is important and time-sensitive (e.g., in bold, add “time-sensitive urgent action needed”) ○ Change the format of mailed notices and envelopes (e.g., use a different attention-getting color, such as yellow) 	<ul style="list-style-type: none"> • <i>How significant is this risk in your state?</i> • <i>Which of these strategies will the state implement to mitigate risk? Are there other strategies the state will adopt?</i> • <i>What steps will the state need to take to operationalize these strategies and when?</i>
<p><input type="checkbox"/> Conduct intensive outreach:</p> <ul style="list-style-type: none"> ○ Conduct more intensive outreach via multiple modalities to remind individuals enrolled in Medicaid, CHIP, or BHP of anticipated changes to their coverage and obtain needed information (e.g., require eligibility workers to make follow-up telephone calls and to send an email if an enrollee has not responded to a request for information) ○ Implement a text messaging program to quickly communicate eligibility reminders and requests for additional information, as permitted ○ Incentivize stakeholder partners to conduct outreach and provide education to individuals enrolled in Medicaid, CHIP, or BHP about the return to normal state operations, expectations for sending in requested information, and the importance of updating contact information. Stakeholders include: 	

Potential Strategies to Mitigate Risk	State Approach and Timeline
<ul style="list-style-type: none"> ▪ <i>Managed care plans</i> ▪ <i>Community-based organizations</i> ▪ <i>Providers</i> ▪ <i>Application assisters (including Navigators and certified application counselors)</i> ▪ <i>State Health Insurance Programs (SHIPs)</i> ▪ <i>Schools</i> ▪ <i>Others</i> 	
<p><input type="checkbox"/> Provide robust consumer assistance:</p> <ul style="list-style-type: none"> ○ <i>Develop and provide policy training, scripts, and informational materials to call center staff that emphasize the importance of providing clear information to help consumers maintain coverage</i> ○ <i>Engage Navigators, application assisters (including Navigators and certified application counselors), health coverage ombuds offices, and other stakeholders to assist individuals who need help with renewal</i> ○ <i>Expand use of outstation locations for eligibility workers to provide individuals with renewal assistance to increase accessibility to the renewal process based on geography and hours of operation</i> ○ <i>Update online account portals to display the status of renewals and what information is outstanding</i> ○ <i>Use technology to improve accessibility of the process of providing documentation (e.g., allowing individuals to upload documents via cell phone photos, use bar code technology on renewal notices requesting documents to ease the process of associating missing documents with an existing case)</i> 	

Potential Strategies to Mitigate Risk	State Approach and Timeline
<ul style="list-style-type: none"> ○ <i>Ensure call centers are appropriately staffed and implement mitigation strategies and call-back options to reduce wait times and call abandonment rates.</i> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>□ Communicate effectively with individuals who have Limited English Proficiency (LEP) or are living with a disability:</p> <ul style="list-style-type: none"> ○ <i>Review language access plan to provide written translation of key documents (e.g., notices, applications, and renewal forms) into multiple languages, oral interpretation, and information about how individuals with LEP can access language services free of charge, provided in a culturally competent manner</i> ○ <i>Ensure key documents such as written notices, applications, and renewal forms are translated into multiple languages by qualified translators and reviewed for cultural competence</i> ○ <i>Increase number of non-English language translations of key written materials, after review of census and other local data sources</i> ○ <i>Review and enhance access to and availability of qualified oral interpreters for individuals with LEP. Consider the following:</i> <ul style="list-style-type: none"> ▪ <i>Hire or deploy multilingual staff who speak certain frequently spoken languages within the states' population (e.g., Spanish) and conduct training</i> ▪ <i>Partner with community-based organizations with interpretation services</i> ▪ <i>Provide qualified telephonic interpreters (some interpreter vendors offer services in over 100 languages)</i> ○ <i>Ensure individuals with LEP know how to access available language services by updating websites with taglines in non-English languages (e.g., short statements that language services are available free of charge, including how to access those services)</i> </div>	

Potential Strategies to Mitigate Risk	State Approach and Timeline
<ul style="list-style-type: none"> ○ <i>Ensure that information is communicated to individuals living with disabilities accessibly by providing auxiliary services at no cost to the individual, including but not limited to written materials in large print or Braille, and access to sign language interpretation and/or a teletypewriter (TTY) system, consistent with the Americans with Disabilities Act (ADA) and section 1557 of the Affordable Care Act</i> 	
<input type="checkbox"/> Other:	

4. Key risk: Gaps in coverage for individuals who are no longer eligible for Medicaid, CHIP or BHP

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Ensure accounts are seamlessly transferred to the Marketplace when individuals are found ineligible for Medicaid, CHIP, or BHP	<ul style="list-style-type: none"> • <i>How significant is this risk in your state?</i> • <i>Which of these strategies will the state implement to mitigate risk? Are there other strategies the state will adopt?</i> • <i>What steps will the state need to take to operationalize these strategies and when?</i>
<input type="checkbox"/> Obtain and include robust contact information (e.g., mailing address, email address, and telephone numbers) in the Account Transfer to the Marketplace so that enrollees may be easily reached post-transition	
<input type="checkbox"/> Conduct regular system testing/quality assurance to eliminate glitches in sending or receiving accounts between the Medicaid or CHIP agency and the Marketplace	
<input type="checkbox"/> Revise notices to ensure they clearly explain the Account Transfer process, next steps and applicable deadline(s) for applying for and enrolling in a Qualified Health Plan (QHP) with financial assistance, and where to seek answers to questions at the Marketplace	
<input type="checkbox"/> Introduce an eligibility results page following an online application that provides real-time guidance on next steps and the transition to the	

Potential Strategies to Mitigate Risk	State Approach and Timeline
Marketplace	
<input type="checkbox"/> Set up a regular feedback loop/information-sharing process with the Centers for Medicaid and CHIP Services (CMCS) Data and Systems Group (DSG) (Enterprise State Systems Officer) and the Center for Consumer Information and Insurance Oversight (CCIIO) to identify and troubleshoot Account Transfer issues	
<input type="checkbox"/> Other:	

5. Key risk: Insufficient and over-burdened workforce to resolve pending E&E actions and complete routine work

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Create efficiencies by combining pending E&E actions: <ul style="list-style-type: none"> ○ Align pending verifications and changes in circumstances with renewals; ○ Conduct renewals for all members of a household at the same time, if currently not aligned; and ○ Align Medicaid and SNAP renewals and leverage SNAP data for Medicaid renewal 	<ul style="list-style-type: none"> • <i>How significant is this risk in your state?</i> • <i>Which of these strategies will the state implement to mitigate risk? Are there other strategies the state will adopt?</i> • <i>What steps will the state need to take to operationalize these strategies and when</i>
<input type="checkbox"/> Redistribute work across states, regional, and county staff	
<input type="checkbox"/> Implement “overflow” workforce strategies that redirect pending applications/renewals to centralized unit or regional/county office that has available capacity	
<input type="checkbox"/> Identify specific roles that additional full-time employees—contractors, vendors, or other temporary workers— can play in	

Potential Strategies to Mitigate Risk	State Approach and Timeline
supporting unwinding efforts	
<input type="checkbox"/> Create specialized units to process complex/time-consuming applications/redeterminations (e.g., evaluating self-employment income)	
<input type="checkbox"/> Become a Medicaid and CHIP Eligibility Determination State if you are an Assessment State with an FFM or SBM on the Federal Platform to reduce workforce burden	
<input type="checkbox"/> Provide training and guidance to state workforce on changing policies	
<input type="checkbox"/> Create salary increases for high performance based on training certification in new policies, high volume of case processing, or processing of more complex cases as a hiring/retention incentive	
<input type="checkbox"/> Update E&E manuals so they can serve as ongoing resources	
<input type="checkbox"/> Communicate policy changes to other entities that partner with the E&E workforce (e.g., managed care organizations, Navigators, delegated fair hearing agencies) through a variety of methods (e.g., routine updates to Medicaid/CHIP agency websites, mailings, agenda items during standing meetings)	
<input type="checkbox"/> Other:	

6. Key risk: Lack of timely information to conduct appropriate oversight and course correct as issues arise

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Identify a centralized team responsible for tracking emerging issues and needed solutions	<ul style="list-style-type: none"> • <i>How significant is this risk in your state?</i> • <i>Which of these strategies will the state implement to mitigate risk? Are there other strategies the</i>

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Create tracking and management tools, data reports, and/or dashboards to monitor case volume, renewal rates, and workforce needs	<p><i>state will adopt?</i></p> <ul style="list-style-type: none"> <i>What steps will the state need to take to operationalize these strategies and when?</i>
<input type="checkbox"/> Conduct diagnostics and ongoing monitoring by modality	
<input type="checkbox"/> Implement “early warning/trigger” mechanisms that flag when a large number of individuals lose, or are slated to lose, coverage due to no response or missing paperwork	
<input type="checkbox"/> Automate a “circuit breaker” flag based on a data review for the agency to pause and consider a change in its practices to mitigate inappropriate coverage loss	
<input type="checkbox"/> Establish processes for reviewing data captured by from the tracking and management tools (e.g., cadence for reviewing data, process for sharing findings with county staff) and implementing mitigation strategies	
<input type="checkbox"/> Other:	

7. Key risk: Inability to process fair hearings timely due to a high volume of requests

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Redistribute current staff responsibilities or hire additional staff, short or long term, to assist with fair hearing process, including informal resolution	<ul style="list-style-type: none"> <i>How significant is this risk in your state?</i> <i>Which of these strategies will the state implement to mitigate risk? Are there other strategies the state will adopt?</i> <i>What steps will the state need to take to operationalize these strategies and when?</i>
<input type="checkbox"/> Use paralegals or other staff to prepare cases for decision by hearing officers	

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Utilize contactors for administrative fair hearing functions, such as intake and processing, call center (as long as using standard operating procedures), scheduling and managing cases, issuing notices	
<input type="checkbox"/> Use hearing officers, rather than administrative law judges, to conduct and issue hearings decisions	
<input type="checkbox"/> Spread out eligibility renewals to spread out potential fair hearing requests	
<input type="checkbox"/> Identify fair hearing requests needing prioritization (e.g., expedited requests where an individual has an urgent health need, vulnerable/transient populations, individuals without benefits pending appeal – service or new application appeal)	
<input type="checkbox"/> Create or expand informal resolution processes <ul style="list-style-type: none"> ○ Models include: case workers/call center staff phone calls to address and resolve appellants’ questions, use of paralegals or senior eligibility staff review of cases, pre-hearing conferences, and mediation. ○ Target cohorts of cases which may be more suitable to an informal resolution process (e.g., procedural terminations) 	
<input type="checkbox"/> Use multiple modalities (e.g., in-person, telephone, or video conference hearings) in a manner that is accessible to individuals with disabilities and those who are limited English proficient	
<input type="checkbox"/> Accept a hearing officer/ALJ’s decision as final without further Medicaid agency review	
<input type="checkbox"/> Develop or enhance electronic appeals management processes to reduce reliance on paper files (e.g. online fair hearing requests, upload of evidence)	

Potential Strategies to Mitigate Risk	State Approach and Timeline
<input type="checkbox"/> Engage stakeholders and community organizations (e.g. Ombudsman office, legal services, providers, sister agencies): to help communicate adjustments and process changes, spot issues, and identify cases that require prioritization	
<input type="checkbox"/> Other:	

III. Roll-Up Summary

Although states are not required to submit their detailed plan or this summary tool to CMS for approval, stakeholders may benefit by viewing a roll-up summary on a state’s unwinding approach. This summary can be a tool for providing an overview to various stakeholders and the public on the approach for resolving pending E&E actions and resuming normal operations. This section provides an outline states can adapt to summarize their approach for resolving E&E actions and resuming normal operations, using the information completed in the prior sections.

Roll-up Summary
<ul style="list-style-type: none">• Overall Approach for Renewals, Application Processing, and Fair Hearings, including populations prioritized (2 paragraphs)• Organization and Staffing (1 paragraph)• Policy Changes (1 paragraph)• Operations and Systems Changes (1 paragraph)• Systems Changes (1 paragraph)• Outreach and Communications (1 paragraph)• High Level Timeline (Graphic snapshot)

Appendix A: Guidance and Resources for States

Guidance

- **CMCS Informational Bulletin (CIB), “Medicaid and CHIP Renewal Requirements** (“Renewal CIB”): Reminds states about current federal requirements and expectations codified in existing regulations at 42 C.F.R. §§ 435.916 and 457.343 for completing redeterminations of eligibility for Medicaid and Children’s Health Insurance Program (CHIP) enrollees. These requirements are intended to ease the administrative burden on states and enrollees by limiting requests for information to information needed to determine eligibility, ensuring eligibility is assessed on all bases before determining an individual is ineligible and promoting seamless transitions of coverage, and minimizing churn on and off Medicaid and CHIP coverage for procedural reasons. States may access the Renewal CIB at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>.
- **State Health Official Letter (SHO) #20-004, “Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency** (“December 2020 SHO”): Provides guidance to states on planning for the eventual return to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent in certain circumstances, procedures for ending coverage and policies authorized under expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE. States may access the December 2020 SHO at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>.
- **State Health Official Letter (SHO) #21-002, “Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program Operations Upon Conclusion of the COVID-19 Public Health Emergency** (“August 2021 SHO”): Updates guidance in the December 2020 SHO to provide states 12-months after the PHE ends to complete pending eligibility and enrollment work and ensures states renew eligibility for all enrollees prior to taking any adverse action. States may access the August 2021 SHO at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>.
- **State Health Official Letter (SHO) #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** (“March 2022 SHO”): Part of a series of guidance that outlines how states may address the large volume of pending eligibility and enrollment actions they will need to take after the PHE ends and identifies strategies to mitigate churn for eligible enrollees and smoothly transition individuals between coverage programs. States may access the March 2022 SHO at <https://www.medicaid.gov/unwinding>.

Resources

- **COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies** (“January 2021 FAQs”): States may access the January 2021 FAQs at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

- **Medicaid & CHIP MAGI Application Processing: Ensuring Timely and Accurate Eligibility Determinations:** States may access the “Medicaid & CHIP MAGI Application Processing: Ensuring Timely and Accurate Eligibility Determinations” at <https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/timely-accurate-eligibility.pdf>.
- **Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations:** Provides states a list of policy and operational strategies that states can implement to support unwinding activities at the end of the COVID-19 PHE in order to ensure continuous coverage for eligible enrollees and facilitate coverage transitions for individuals eligible for other forms of coverage. States may access the “Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations” tool at <https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf>.
- **Medicaid and CHIP Continuous Coverage Unwinding Phase 1: Plan & Educate (Unwinding Communications Toolkit):** Provides important information to help inform people with Medicaid and CHIP about steps they need to take to renew coverage. States may access the Unwinding Communications Toolkit at <https://www.medicaid.gov/unwinding>.