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CENTERS FOR MEDICARE & MEDICAID SERVICES

All-State Medicaid and CHIP Call

March 15, 2022

Agenda

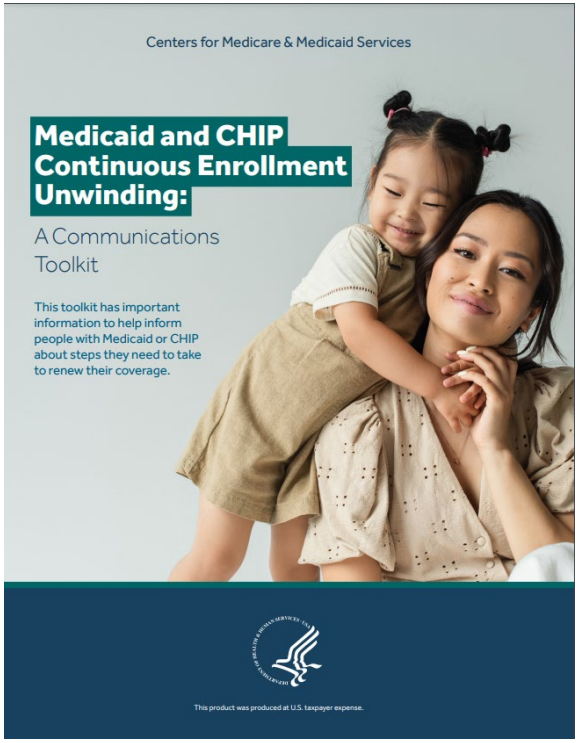
- Unwinding Communications Toolkit
- Part II: State Health Official (SHO) Letter #22-001: *Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, CHIP and the Basic Health Program Upon the Conclusion of the COVID-19 Public Health Emergency* (continued from March 8th All State Call)
  - Notices, Fair Hearings and CHIP Reviews
  - Strategies for Promoting Continuity of Coverage and Mitigating Churn
- Open Mic Q and A

Communications Toolkit

Communications Toolkit

[Unwinding and Returning to Regular Operations after COVID-19]

[Medicaid and CHIP Continuous Enrollment Unwinding]



Communications Toolkit

- Available in English and Spanish (so far)
- Contents include:
  - Research – summary and insights
  - Key messages
  - Drop-in article
  - Social media
  - Emails and text messages
  - Call center scripts
  - Graphics zip file with fillable postcard, flyer, rack card
- Living document – will iterate and add as things move forward

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

Notices, Fair Hearings and CHIP Reviews; and Strategies for Promoting Continuity of Coverage and Mitigating Churn

State Health Official Letter #22-001

- This SHO Letter*:*
  - Is part of a series of guidance and tools that outline how states may address the large volume of pending eligibility and enrollment actions they will need to take after the PHE ends;
  - Further clarifies expectations of states to restore routine operations; and,
  - Shares strategies states can utilize to mitigate churn for eligible enrollees, smoothly transition individuals between coverage programs and address the anticipated influx of fair hearing requests.
- The release of the SHO Letter does not signal when the federal PHE will end.
- The SHO Letter was introduced during the March 8th CMCS All State Call and slides can be found on the Meidcaid.gov Unwinding page: Unwinding and Returning to Regular Operations after COVID-19.
- During the call on March 8th, CMS discussed guidance in the SHO on timelines and expectations to complete eligibility and enrollment actions and distribution of renewals
- Today's call will continue to discuss the SHO Letter and focus on notices, fair hearings and strategies to protect beneficiaries and mitigate churn.
- Additionally, the CMS All State Call on March 22nd will continue to focus on SHO guidance. During that call, CMS will review scenarios related to the timeline for initiating renewals as well as provide an overview of the state information and data reporting tools that will be released.

Notices, Medicaid Fair Hearings and CHIP Reviews

Notices

- When a Medicaid or CHIP agency makes a decision affecting a beneficiary's eligibility, the state generally must send the beneficiary a notice at least 10 days prior to the date of action (e.g., termination of eligibility, increase in cost sharing).
- Even when the eligibility determination yields the same action as a determination conducted during the PHE and where the state has previously provided notice, the state must provide advanced notice.
- Advance notice must include certain information (e.g., the beneficiary's right to a Medicaid fair hearing or a CHIP review, opportunity for Medicaid benefits pending the fair hearing).

Medicaid Fair Hearings and CHIP Reviews

- States are generally required to take final administrative action on a Medicaid fair hearing request within 90 days from the date the agency receives the fair hearing request. States must complete CHIP reviews in a reasonable amount of time.
- During the PHE, a number of states were granted a regulatory concurrence that allowed a state to take more than 90 days to take final administrative action on Medicaid fair hearing requests due to an emergency beyond the state's control.
- All states, including those granted this regulatory concurrence, are expected to begin processing fair hearing requests and take final administrative action timely when the PHE ends.

See 42 C.F.R. § 435.917 and 42 C.F.R. Part 431, Subpart E (Medicaid) ; 42 C.F.R. § 457.340(e) and §§ 457.1120-1190 (CHIP)

Increase in Medicaid Fair Hearings Volume

Higher Than Normal Volume of Fair Hearing Requests

- As states develop their operational plans for the unwinding period, they should assess the anticipated volume of fair hearing requests and their operational capacity as they determine how to distribute pending actions across the unwinding period.
- States may need to adopt new fair hearing strategies and mitigations to accommodate increased fair hearing volume, and can do so without the need for additional state plan authority. For example:
  - Establish or expand an informal resolution process to resolve fair hearing requests prior to a fair hearing.
  - Hold fair hearings and reviews by telephone or video, as long as the state is providing access to the fair hearing process (including providing access to individuals with disabilities and those who have limited English proficiency).
- Some states may experience an increase in fair hearing volume which may exceed the state's capacity to adjudicate all fair hearing requests within the regulatory time limits. In these circumstances, CMS will consider providing authority under section 1902(e)(14) of the Act to provide the state with additional time to take final action provided that certain beneficiary protections are provided (see slide 11 for more details).
- CMS will provide additional resources and technical assistance to states on fair hearing processes and timeframes.

Update Enrollee Contact Information

All states should take steps during the PHE to update enrollee contact information to prevent coverage losses for eligible individuals and remind enrollees that they may report updated information online, by phone, by mail, or in person.

Working with Managed Care Plans

- States should work with MCOs to establish a process to engage in outreach to enrollees to update their contact information and use information made available to the Medicaid and CHIP agency by MCOs and/or establish processes to receive updated information on an ongoing basis from MCOs.
- State agencies may treat in-state contact information obtained from managed care plans as reliable and update the enrollee record with the new contact information, provided that the state sends a notice to the address on file with the state and provides the individual with a reasonable period of time to verify the accuracy of the new contact information.
- States should ensure that plans ONLY provide updated contact information received directly from or verified by the beneficiary, and not from a third party or other source.

Update Enrollee Contact Information

All states should take steps during the PHE to update enrollee contact information to prevent coverage losses for eligible individuals and remind enrollees that they may report updated information online, by phone, by mail, or in person.

Working with USPS National Change of Address (NCOA) Database

- States can establish agreements with USPS to gain access to the NCOA database.
- States should leverage address information received from USPS when mail is returned to the state with an in-state forwarding address.
- State agencies may treat contact information obtained from the NCOA and USPS returned mail with an in-state forwarding address as reliable and update the enrollee record with the new contact information, provided that the state sends a notice to the address on file with the state and provides the individual with a reasonable period of time to verify the accuracy of the new contact information.

Temporary 1902(e)(14)(A) Waiver Unwinding Strategies

States may seek approval to use Section 1902(e)(14)(A) authority to implement the specific targeted enrollment strategies outlined below in order to promote continuity of coverage and mitigate churn.

Renewal for Individuals Based on SNAP Eligibility

- States may renew Medicaid eligibility for SNAP participants with gross income (as determined by SNAP) at or below the applicable Medicaid MAGI standard without conducting a separate MAGI-based income redetermination.
- An approved waiver request would allow states to temporarily rely on SNAP data for renewals for individuals under 65 years old, despite differences in household composition and income-counting rules.

Ex Parte Renewal for Individuals with No Income and No Electronic Data Returned

- States can temporarily conduct *ex parte* renewals for households whose attestation of zero income was verified within the last twelve months (i.e., at the initial application or the previous renewal) when no information is received from any third-party income data sources at renewal.
- In order to complete the *ex parte* renewal, the state must take appropriate steps to review the non-financial components of eligibility.
- The renewal notice must instruct enrollees to inform the agency if any of the information used for eligibility determination is inaccurate.

Temporary 1902(e)(14)(A) Waiver Unwinding Strategies (cont'd)

Renewal for Individuals with no Asset Verification System (AVS) Data Returned within a Reasonable Timeframe

- States must attempt to make an ex parte determination at renewal and check data sources to verify assets at renewal, consistent with its verification plan.
- Generally, states must verify assets using the state's AVS for individuals excepted from MAGI-based methodologies and subject to an asset test. If the AVS does not return information from a financial institution within the timeframe established by the state, the state must attempt to redetermine eligibility in accordance with its verification process.
- Under this time-limited approach, a state could assume there has been no change in financial resources that are verified through the AVS when no information is returned within a reasonable timeframe, and therefore complete the renewal process without any further verification of the assets that are verified through the AVS.

Extended Timeframe to Take Final Administrative Action on Fair Hearing Requests

- States that experience a volume of fair hearing requests that exceeds their capacity for timely processing can request to extend the timeframe for final administrative action on fair hearing requests provided that the state agrees to:
  - Provide benefits pending the outcome of a fair hearing decision to individuals who appeal an eligibility redetermination or renewal; and
  - Not recoup the cost of benefits pending from the individual even if the fair hearing upholds the agency's decision.

Temporary 1902(e)(14)(A) Waiver Unwinding Strategies (cont'd)

Partnering with Managed Care Plans to Update Beneficiary Contact Information

- States generally are required to contact the beneficiary to confirm the accuracy of updated contact information received from a health plan prior to updating the beneficiary record.
- CMS recognizes that some states may have system or operational limitations that prevent the state for doing so.
- States may treat updated contact information received from the plan as reliable and update the beneficiary record with the new contact information without first sending a notice to the address on file with the state.

Automatic Health Plan Reenrollment

- Medicaid managed care contracts must provide for automatic reenrollment into a plan for individuals who are reenrolled into Medicaid after a loss of Medicaid coverage for 2 months or less (see 438.56(g).
- Through the end of the unwinding period, states may extend this automatic reenrollment period to between 60 and 120 days.

Example Strategies to Mitigate Churn

States are encouraged to adopt a number of strategies to maintain continuity of coverage and create administrative efficiencies when completing redetermination of eligibility.

State plan options	▪ Continuous eligibility for children ▪ 12 months continuous postpartum coverage (beginning April 2022) ▪ Express lane eligibility for children
Options to streamline renewals	▪ Expand the number and type of data sources used to attempt an *ex parte* renewal ▪ Align MAGI and non-MAGI renewal policies
Communications and outreach	▪ Actively seek to update contact information ▪ Partner with managed care plans ▪ Establish processes to address returned enrollee mail ▪ Use multiple supplemental modalities to reach individuals (e.g., mail, email, text) ▪ Make materials available in plain language and in a manner that is accessible to individuals who have limited English proficiency (LEP) and for people with disabilities

Communication Strategies to Reach Enrollees

States are required to communicate with enrollees pursuant to an individual's election and are encouraged to explore and adopt consumer communication and outreach strategies.

Utilize MCOs to Conduct Outreach

- Engage with managed care entities as they develop their unwinding operational plans and identify clear ways in which health plans can assist with outreach and enrollment efforts.

Engage Other Stakeholders

- Communicating with stakeholders regularly will help identify opportunities to leverage their support with assisting enrollees in updating eligibility information and ensure that they understand the need to respond to states' notices and complete the renewal process.

Communication Strategies to Reach Enrollees (cont'd)

Update Notices and Other Consumer Facing Messages

- Review existing applicant and enrollee notices and communications and make modifications needed to effectively convey key messages in plain language.

Review Communication Strategies for Individuals who have LEP and People with Disabilities

- Program information must be provided free of charge in plain language and in a manner that is accessible to individuals who have LEP and people with disabilities.
- Provide individuals who have LEP with translated materials and oral interpretation by hiring qualified bilingual staff, partnering with community-based organizations, or providing qualified interpreters by telephone, and utilizing qualified translators.
- Provide people with disabilities accessible information by taking appropriate steps to ensure that communications with applicants, and beneficiaries are as effective as communications with others, including providing appropriate auxiliary aids and services.

Processing Returned Mail

States should take steps during the PHE to establish procedures and update policy manuals to ensure that staff know the specific actions to take in response to returned enrollee mail.

- For all returned enrollee mail, states should attempt to contact the enrollee and send notices to both the current address on file and the forwarding address, if one is provided, requesting that the enrollee confirm the new address provided by USPS. States also should attempt to locate the enrollee by checking other data sources for updated address information.

- **In-State Forwarding address:**
  - Mail returned with an in-state forwarding address is not an indication of a change affecting eligibility.
  - States may accept the USPS in-state forwarding address and update the beneficiary's record provided that the state first sends a notice to the current address on file.
  - A state may not terminate coverage if the state does not receive a response to the request for confirmation of an in-state address change.

Processing Returned Mail (cont'd)

States should take steps during the PHE to establish procedures and update policy manuals to ensure that staff know the specific actions to take in response to returned enrollee mail.

- **Out-of-State Addresses:**
  - When an enrollee's mail is returned to the state agency with an out-of-state address, the state must send notice consistent with the enrollee's elected format and attempt to contact the enrollee to verify continued state residency. States should also send notice to the out-of-state forwarding address and/or address provided by a data source.
  - If the enrollee does not respond, or the information provided does not establish the enrollee's state residency, the state must provide advance notice of termination and fair hearing rights.
- **No Forwarding Address:**
  - States should attempt to locate enrollees whose mail is returned without a forwarding address. If an enrollee cannot be located, and there is no forwarding address, the state may terminate eligibility.

For individuals terminated on the basis of whereabouts unknown, if their whereabouts become known prior to the enrollee's originally-scheduled renewal date, the state must reinstate coverage.

Facilitating Transitions Between Medicaid, CHIP, BHP, and the Marketplace

Facilitating smooth transitions to the Marketplace for enrollees who are no longer eligible for Medicaid, CHIP, or coverage through a BHP will be critical to ensuring that such eligible individuals do not become uninsured.

- State Medicaid, CHIP, and BHP agencies are required to have an agreement with the relevant Marketplace and have a coordinated process to send/receive electronic accounts and other information to/from the Marketplace.
- For ineligible Medicaid, CHIP, or BHP individuals, the agency must promptly assess the individual's potential eligibility for Marketplace coverage and timely transfer the individual's electronic account (including all of the individual's Medicaid, CHIP, and/or BHP eligibility information collected and generated by the state) to the Marketplace.
- States can treat any ineligible Medicaid/CHIP individuals as potentially eligible for QHP enrollment, other than individuals whose coverage was denied or terminated for a procedural reason and individuals who do not attest to U.S. citizenship or eligible immigration status.

- States are also encouraged to implement additional approaches that may help with enrollees' transition to a QHP. States can:
  - Improve eligibility determination notice language for ineligible Medicaid/CHIP/BHP individuals so that they are aware that the agency will transfer their account the Marketplace and that the Marketplace will send them a notice with information on applying for coverage and financial assistance through the Marketplace; and
  - Transmit all eligibility information, to the state has, including all available contact information, in the account transfer to the Marketplace.

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Questions