All-State Medicaid and CHIP Call
December 5, 2023

Agenda

- **Continuous Eligibility & Premium FAQs**
- **Interim Final Rule with Comment Period (IFC)**: CMS Enforcement of State Compliance with Reporting and Federal Medicaid Renewal Requirements Under Section 1902(tt) of the Social Security Act
- **Open Mic Q & A**

Continuous Eligibility & Premium FAQs (Verbal Update)

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Interim Final Rule with Comment Period: CMS Enforcement of State Compliance with Reporting and Federal Medicaid Renewal Requirements Under Section 1902(tt) of the Social Security Act

Link to Interim Final Rule with Comment Period

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The Consolidated Appropriations Act, 2023

- The Consolidated Appropriations Act, 2023 (CAA, 2023) was enacted on December 29, 2022, ending the Medicaid continuous enrollment condition on March 31, 2023, and ending the availability of the temporary increase in the Federal Medical Assistance Percentage (FMAP) on December 31, 2023.
- The CAA, 2023, also established new state reporting requirements and CMS enforcement authorities at section 1902(tt) of the Social Security Act (Act), including:
  - New reporting requirements for all states (section 1902(tt)(1)); and
  - New enforcement authorities for CMS related to state compliance with the new reporting requirements and state renewal activities during the period from April 1, 2023, until June 30, 2024 (1902(tt)(2)), including:
    - FMAP reduction for state failure to meet data reporting requirements;*
    - Requirement to submit corrective action plans for states that fail to meet federal reporting or redetermination requirements; and
    - Requirement to suspend procedural disenrollments and imposition of civil money penalties for states that fail to submit or implement an approvable corrective action plan (CAP) for reporting or redetermination violations.

* Applies to state failure to meet the requirement to report data for one or more months during the period from July 1, 2023, through June 30, 2024

Data Reporting Requirements, § 435.927

- The rule includes new enforcement authority for CMS to use if it determines that a state is not in compliance with the reporting requirements under section 1902(tt)(1) of the Act.
- Under § 435.927(c), states must report certain data elements on renewals, operations, transitions and other information for each month in the period from April 1, 2023, to June 30, 2024 (see Appendix for the full list of data elements). States are already reporting these data to CMS.*
- States are in compliance with the data reporting requirement if:
  - They submit the required data through CMS-approved processes (or through alternative processes approved by CMS when a state is making a good faith effort as defined in the rule (as discussed on slide 8)) and
  - The data reported are timely, complete, and of sufficient quality (as those terms are defined in the rule).
- Under section 1902(tt)(1) of the Act, CMS must publish certain data and is already publishing these data monthly, to help hold states accountable for following redetermination and reporting requirements and promote transparency.

*The rule's reporting requirements generally align with previous CMS guidance (see *Frequently Asked Questions*, released June 30, 2023; and *State Health Official Letter # 23-002*, released January 27, 2023).

FMAP Reduction for Reporting Requirements, § § 435.927 and 435.928

- **Noncompliance**: A state is noncompliant in a fiscal quarter if it has failed to comply with the reporting requirements described in § 435.927 for one or more months of the quarter. This means that states that fail to report data according to the requirements in § 435.927 for a single month within a quarter will be subject to the FMAP reduction for the entire quarter.
- **FMAP Reduction**: If a state is not in compliance with the data reporting requirements in § 435.927 for a fiscal quarter between July 1, 2023, and June 30, 2024, CMS is required to reduce the state's FMAP.*
  - *Reduction Amount*: For the first quarter in which a state is noncompliant, the FMAP reduction is 0.25 percentage points.
    - The amount of the reduction grows by 0.25 percentage points for each successive quarter of noncompliance, regardless of whether the noncompliant quarters are consecutive.
    - In no case, however, would the FMAP reduction for any single quarter exceed 1 percentage point.

* The applicable FMAP is the one determined for the state for the quarter under section 1905(b) of the Act.

FMAP Reduction: Good Faith Effort for Reporting Requirements, § § 435.927 and 435.928

- Some states might encounter unusual circumstances that interfere with reporting using existing CMS-approved processes or that impede a State's ability to meet the deadlines in § 435.927(c). For example, states may experience a natural disaster.
- CMS would consider approving alternative timelines and/or processes for reporting required data if the state is making a ***good-faith effort*** to submit the required data, defined in § 435.927(b)(4) as follows:
  - The state is experiencing significant, unforeseeable, or unavoidable challenges in complying with the reporting requirements, or is experiencing significant foreseeable challenges in complying and is working to remediate these challenges but needs additional time to address them;
  - The state requested and CMS approved an alternative process for submitting the data or an alternative timeline; and
  - The approved alternative process for submitting the data or timeline is sufficient to ensure CMS can obtain and use the data to meet CMS' obligations to report the data publicly per section 1902(tt)(1) of the Act.
- CMS will work with the state to ensure that CMS has all data needed to meet its requirement to publicly report these data and will only approve alternative timelines or reporting processes that permit CMS to meet CMS's public reporting requirements.

Corrective Action Plans, Suspension of Procedural Disenrollments, and Civil Money Penalties, § 430.49

- New § 430.49 of the IFC interprets and implements section 1902(tt)(2)(B) of the Social Security Act, which authorizes CMS to take the following actions for state noncompliance with reporting and renewal requirements during the period from April 1, 2023, through June 30, 2024:

    1. **Require states to submit and implement a corrective action plan (CAP)** for noncompliance with *Federal redetermination requirements*, which CMS defines in the rule to mean requirements outlined at 42 CFR 435.916, including renewal strategies authorized under section 1902(e)(14)(A) of the Act or other alternative processes and procedures approved by CMS under section 1902(e)(14)(A) of the Act or section 6008(f)(2)(A) of the FFCRA, and the *reporting requirements* described in section 1902(tt)(1) of the Act, and

    2. **Require states to suspend some or all procedural disenrollments from Medicaid and/or impose civil money penalties (CMPs) of not more than $100,000 per day** if the state fails to submit or implement an approvable CAP in accordance with section 1902(tt)(2)(B)(ii) of the Act until the state takes appropriate corrective action.

Corrective Action Plans: Notice, § 430.49(b)(2)

- **Notice** – If, after considering mitigating circumstances (described in slides 15-16 below), CMS decides to require the state to submit and implement a CAP or to revise or resubmit such a plan, CMS will provide the state with a written notice directing the State to submit a CAP to correct the identified areas of noncompliance. The notice will:
  - Explain the violation of Federal redetermination or reporting requirements that CMS has identified and the basis for CMS' finding;
  - Inform the state of the requirement to submit and implement a CAP;
  - Include instructions on the method and deadline by which the state must submit the CAP to CMS; and
  - Explain the enforcement actions CMS may pursue if the state fails to submit or implement and approved CAP, including if CMS disapproves the state's submitted CAP or if the state fails to meet the requirements set forth in the approved CAP.

Corrective Action Plans: Content, § 430.49(b)(3)

- **Content –** To be approvable by CMS, a CAP must identify:
  - Actions the state will take immediately if needed to prevent further harm or risk of harm to beneficiaries while it implements the corrective action plan;
  - Steps the state will take to ensure compliance with Federal requirements, such as new policies, procedures, operational processes, or systems changes it will implement;
  - Key milestones and a detailed timeline for achieving compliance; and
  - A plan for communicating the steps the state will take to prevent actual harm or risk of harm to beneficiaries and to ensure compliance with Federal requirements to:
    1) CMS,
    2) state staff, and
    3) beneficiaries.

Corrective Action Plans: Approval Process and Deadlines, § 430.49(b)(4)

- **CMS Approval** – In determining whether to approve a CAP submitted by a state, CMS will consider:
  - Whether the CAP includes the required content (as described above);
  - Whether the CAP will promptly eliminate or minimize any harm or risk of harm to beneficiaries; and
  - Whether the CAP will result in the state achieving compliance in a reasonable time, taking into account systems challenges and circumstances faced by the agencies involved.
  - Systems challenges that could impact the time frame for achieving compliance could include, for example, updating eligibility system coding, creating policy manuals and/or training materials for workers, training workers, and/or creating or implementing new forms or functions to receive or track information in the renewal process

- **Deadlines –** Under the statute and rule, the following timeframes are required for submission, approval and implementation of a CAP:
  - ***Submission*** – 14 calendar days after CMS notice of noncompliance
  - ***CMS Approval*** – 21 calendar days after submission; under the rule, if CMS has not approved or disapproved by this deadline, the CAP is deemed approved
  - ***Implementation*** – must begin no later than 14 calendar days after CMS approval

Suspension of Procedural Disenrollments and Civil Money Penalties, § 430.49(c)

- If a state fails to submit or implement an approved CAP, CMS may take either or both of the following actions:

  1. **Require the state to suspend some or all procedural disenrollments** from Medicaid until the state takes appropriate corrective action.
     - If the impact of the noncompliance is limited (for example, to a specific population or geographic area), CMS may limit the suspension only to the affected population(s).

  2. **Impose civil money penalties** of not more than $100,000 for each day a state is not in compliance, according to the following formula:
     - ***Days 1-30***: $25,000/day;
     - ***Days 31-60***: $50,000/day; and
     - ***Days 61+:*** $100,000/day.

- **For CMS to lift a requirement to suspend procedural disenrollments and/or to stop accrual of additional CMPs**, a state must come into compliance with the CAP requirements at § 430.49(b).

Mitigating Circumstances, § 430.49(d)

- Under new section 1902(tt)(2)(B), the Secretary has discretion to determine whether to require CAPs, require suspension of procedural disenrollments, and impose CMPs as well as to determine the amount of any CMP, up to the statutory maximum of $100,000/day.
- Under the rule, CMS interprets this discretion to allow CMS to consider certain ***mitigating circumstances*** in determining whether to require a CAP, require a suspension of procedural disenrollments, and/or impose a CMP.
- **Requiring a CAP:**
  - *All Violations:*
    - An **emergency or other extraordinary circumstances** prevents the state's compliance (e.g., natural disaster or systems outage)
  - *Redetermination Requirement Violations Only:*
    - Noncompliance caused **no actual harm or substantial risk of harm** to beneficiaries
  - *Reporting Requirement Violations Only:*
    - CMS determines that a CAP is **not necessary to ensure that the noncompliance is remedied**

Mitigating Circumstances, § 430.49(d) (cont'd)

- **Requiring Suspension of Procedural Disenrollments and/or Imposition of CMPs:**
  - *All Violations:*
    - An emergency or other extraordinary circumstances occurred after the initial violation requiring a CAP and significantly impeded the state's ability to submit or implement such CAP, CMS may:
      - Delay or forgo imposing **CMPs** (CMS will still require **suspension of procedural disenrollments**).
  - *Reporting Requirement Violations Only:*
    - If the violation does *not* impede CMS' oversight of procedural disenrollments, CMS will:
      - Delay **suspension of procedural disenrollments** for 1 month. (CMS will still impose **CMPs** without delay, except in cases where there are also extraordinary circumstances that warrant CMS to delay or forgo CMPs [as described above]).

Appeals, § 430.49(f)(1)

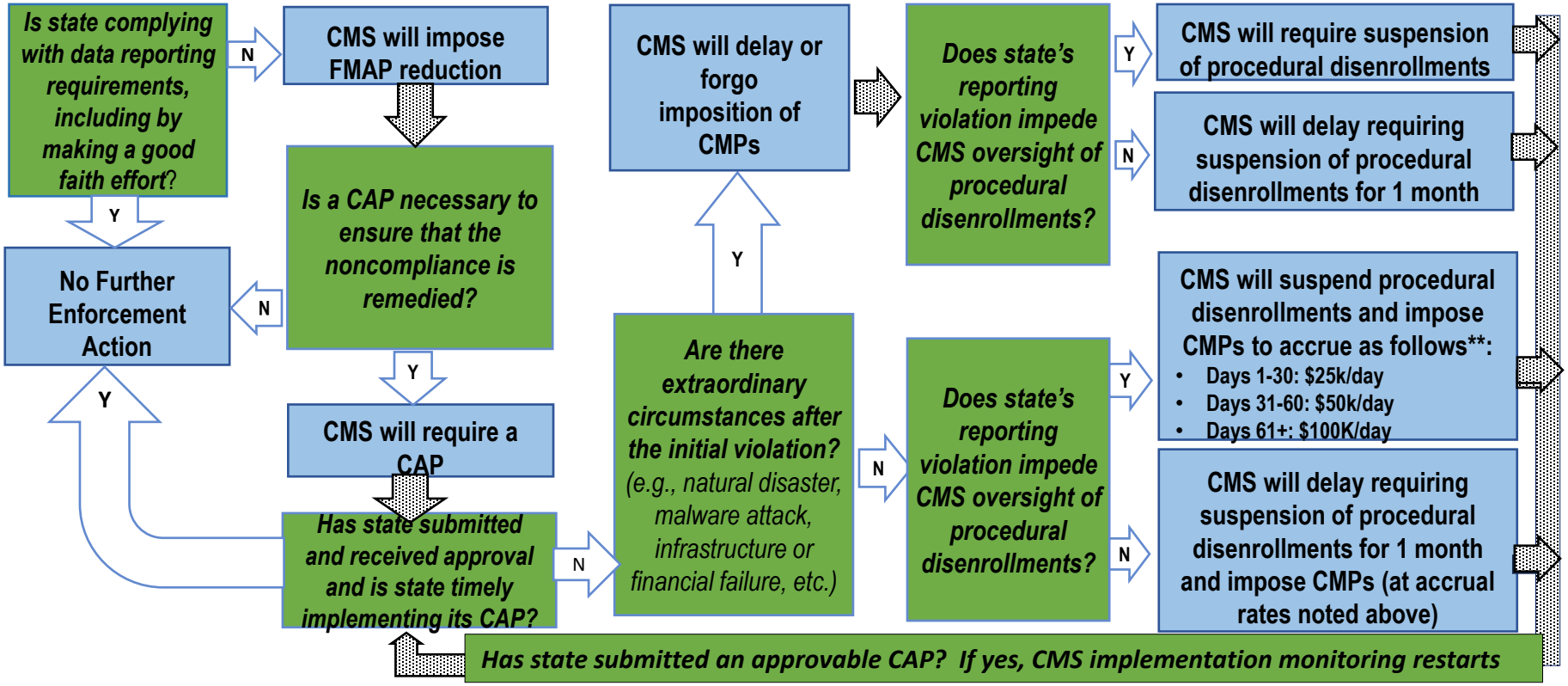
- States may appeal CMS' imposition of **FMAP reductions** under the appeals process applicable to disallowances under already existing regulations at 42 CFR § 430.42.
- States may *not* appeal CMS' decision to require a **CAP**.
- States may appeal to the HHS Departmental Appeals Board (Board) CMS' decision to require a state to **suspend procedural disenrollments** and/or **impose CMPs** under the following process:
  - A state dissatisfied with CMS' decision under § 430.49(c) will have 30 days from receipt of the notice described in § 430.49(c)(2) (as counted consistent with 45 CFR § 16.19) to appeal CMS's decision to the Board. If the state does not submit an appeal request within the 30-day time frame, then CMS' decision will be the final agency action under 5 U.S.C. 704.
  - The appeal will follow the usual Board review process under 45 CFR part 16. That means that the expedited appeal procedures outlined in 45 CFR § 16.12 might be available, if the conditions in § 16.12 are met.
  - Under amendments to 45 CFR § 16.22, any suspensions of procedural disenrollments required by CMS under 42 CFR § 430.49(c) will continue in effect and CMPs imposed on a state under § 430.49(c) will continue to accrue until the Board disposes of an appeal.

Reconsiderations, § 430.49(f)(2)

- Any party dissatisfied with the Board's decision in an appeal under § 430.49(f)(1) may seek a **reconsideration by the CMS Administrator**. The Administrator may also decide to review the Board's decision absent a request.
  - If the Administrator does not reconsider or review the Board's decision, the Board's decision is final agency action under 5 U.S.C. 704.
  - Otherwise, the Administrator's decision is final agency action under 5 U.S.C. 704.

Process Flow: Enforcement of Reporting Requirements (§§ 435.927 and 435.928)

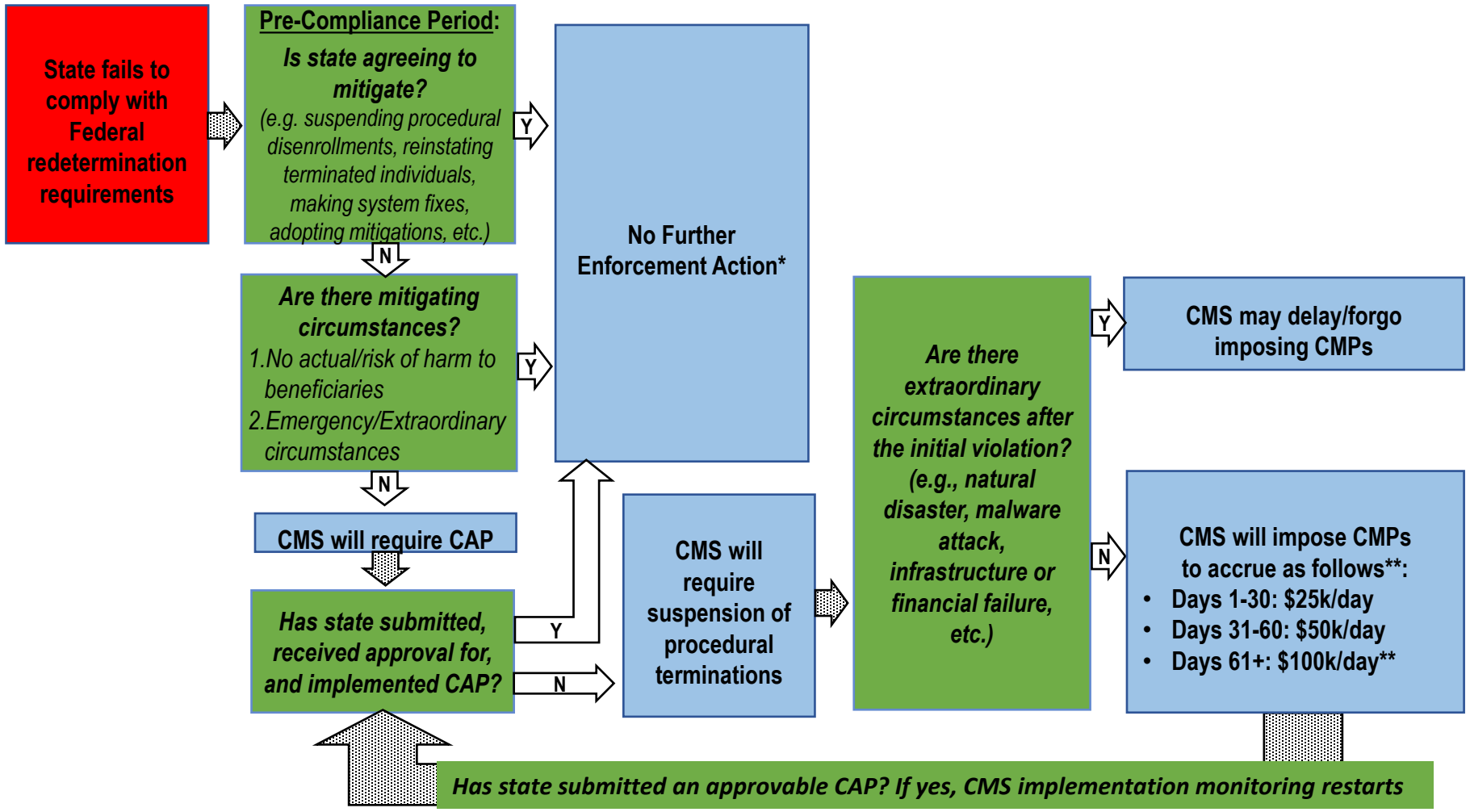
If a state is not in compliance with § 435.927 data reporting requirements for a fiscal quarter between July 1, 2023, and June 30, 2024, CMS is required to reduce the state's FMAP. CMS may also take additional enforcement action under § 430.49 if a state is not compliant with the reporting requirements during the period from April 1, 2023, to June 30, 2024.



* CMS reserves the right to request CAP later in cases where the state fails to implement/ comply with mitigations

**If CMS determines that the plan a state has submitted is approved, CMS will retroactively end the accrual of CMPs on the day the CAP was submitted and stop charging CMPs prospectively.

Process Flow: Enforcement of Redetermination Requirements (§ 430.49)



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**If CMS determines that the plan a state has submitted is approved, CMS will retroactively end the accrual of CMPs on the day the CAP was submitted and stop charging CMPs prospectively.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Questions

Appendix: Data Elements States are Required to Report under § 435.927(d)

(1) Total number of Medicaid and Children's Health Insurance Program (CHIP) beneficiaries for whom a renewal was initiated.

(2) Total number of Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed.

(3) Of the Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed, the total number whose coverage is renewed on an *ex parte* basis.

(4) Total number of individuals whose coverage for Medicaid or CHIP was terminated.

(5) Total number of individuals whose coverage for Medicaid or CHIP was terminated for procedural reasons.

(6) Total number of beneficiaries who were enrolled in a separate CHIP.

(7) For each state call center, total call center volume.

(8) For each state call center, average wait times.

(9) For each state call center, average abandonment rate.

Appendix: Data Elements States are Required to Report under § 435.927(d)…*contd*.

(10) For states with state-based Exchanges (SBEs) using a Non-Integrated Eligibility System and not using the Federal Exchange eligibility and enrollment platform:

(i) Total number of individuals whose accounts are received by the SBE or Basic Health Program (BHP) due to a Medicaid/CHIP redetermination.

(ii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or a BHP.

(iii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or a BHP, and who make a QHP plan selection or are enrolled in a BHP.

(11) For states with SBEs with an Integrated Eligibility System and not using the Federal Exchange eligibility and enrollment platform:

(i) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or a BHP.

(ii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or BHP, and who make a QHP plan selection or are enrolled in a BHP.