

Centers for Medicare & Medicaid Services COVID-19

Medicaid & CHIP All State Call

March 15, 2022

3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the Q&A session, if you'd like to ask a question, you may press star 1 on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time. I'd like to turn the call over to (Jackie Glaze). You may begin.

(Jackie Glaze): Thank you. And good afternoon and welcome everyone, to today's all state call and webinar. I'll now turn to Anne Marie Costello, our Deputy Center Director, for opening remarks. Anne Marie?

Anne Marie Costello: Thanks, (Jackie). And hi, everyone. And welcome to today's all state bonus call. I wanted to start by acknowledging that this is the second anniversary of our all state call series. When we started the series in March of 2020 we never would have thought that we'd still be meeting regularly, two years later. We really appreciate your partnership and continued attendance at all of these meetings. So, thank you.

Moving on to today's agenda - today we will continue discussing the package of guidance and tools that CMS released on March 3rd, to support states in their planning efforts related to unwinding the continuous coverage requirements. First up, we'll be joined by Erin Pressley, from our Office of Communications, who will provide an overview of the unwinding communications toolkit that CMS released on March 3rd.

Then we'll continue our overview of the Safe Health official letter. Suzette Seng, Mark Steinberg, and Sara O'Connor from our Children and Adults

Health Programs group, will present on the sections of the SHO letter that focused on notices, fair hearings, and strategies for promoting continuity of coverage and mitigating churn. Then we'll take your questions. We'll use the webinar for today's presentation. So if you're not logged into the webinar platform, I suggest you do so now.

Before we jump in, I want to point out that the time for next week's call has shifted slightly. Instead of our usual 3:00 to 4:00 pm Eastern time slot, the call will take place from 3:30 to 4:30. The invitation will be sent out later this week. With that, I'll turn things over to Erin, to start her presentation. Erin?

Erin Pressley: Great. Thank you so much, Anne Marie. And thanks for having me here today. I am Erin Pressley. As Anne Marie said, I am the Director of Creative Services in our Office of Communications at CMS. And I'm so happy to be here today to talk to you about a package of materials, a toolkit of sorts, that we have been able to develop. First off, before we get into the details of it, I just want to note that this is a living document for us. This is something that we have released with an initial set of tools and information available.

But we absolutely expect for this to expand over the coming months. And to be adding and updating to it over time. And so we welcome your feedback as you begin to get into these communications and start talking with consumers and using some of these tools and tools of your own, to get more feedback about what is most helpful to you, as things move forward. Can we move to the next slide? I may have lost my webinar connection. So the first slide, we wanted to give you some resources.

This is where you can find a number of communications resources that are available to you I'm sure you're familiar with the new unwinding page on Medicare.gov. But we included the URL here as well. You can find this

toolkit on that page and you can also find some other communication tools as well. We've sort of included some screenshots of some of the covers here.

We wanted to point out that the toolkit itself, is available currently in English and in Spanish. We also have a number of other tools in a downloadable Zip file, mainly fillable types of tools so that you can add your own state or local information. And use those tools that are ready to print, with your additional personalized details.

And then we also included on that unwinding page, a copy of a PowerPoint presentation from early consumer research that we've done. So all of those are available at the first URL. The second URL is a direct link to the English toolkit that I wanted to talk about today. We can go to the next slide, slide number 5, I believe.

Just again, wanted to reiterate, we do intend to produce some of these documents and some of the additional tools that we plan to create, in languages beyond English and Spanish. We do have English and Spanish available so far, for these. But we also intend and know that there's a need for additional languages as well. We are continuing to research and are hoping to get some feedback about what's most helpful.

For example, we've found that oftentimes if we translate social media posts into other languages. They're not as useful for folks if you don't have for example, a Chinese Facebook account that you're keeping up to date. So we want to make sure that when we're investing in additional translated materials that they are things that are useful to folks. If that means things like call center scripts or drop in articles that you could use in local newsletters or things like that, that's absolutely on the table.

We do intend to do some of those things. But we are researching what additional languages will be most helpful, and then what of the tools we should translate additional languages in. The content so far as I mentioned, includes some of the early research that we've done with consumers, and overall summary as well as some key insights that we have found with folks.

I will be perfectly honest, I don't think anybody on this call will be surprised by any of those findings or insights. But a lot of it is good to reiterate and keep in mind as you're developing your own communications moving forward. We used a lot of that research to develop our own key messages, and really hone in on the kinds of things that we think is important for people to know and for people to do, and broken that into two different phases - one, to just start to build awareness that something is coming, that there will be changes and actions that people have to pay attention to; actions that they have to take.

And then when we have more information with the end of the public health emergency, we'll move into phase 2 where we can create materials and create messages that have a lot more specificity. Along with those key messages, we have a number of things that you can use today. There's a drop in article template and any of these things are also available to be customized, tweaked to your own individual messages, and your own needs in your areas.

There are some social media posts that we will use and other available for you to use as well. These could be Facebook, Twitter, other kinds of social media, wherever you think your audience is most likely to keep in touch with you. We have some email and text messages as well; a little bit more traditional way of communicating with people, if you do have email addresses or SMS or text ability, to reach out to them and share information.

We have some call center script samples of things that you might use if you're getting calls into a local number or an 800 number with some general calls and questions from people as things start moving forward. And then as I mentioned, separate from the toolkit itself, there is a Zip file available for download on the main unwinding page.

And there we have an English and Spanish fillable postcard, what we call a conference card, a flier and a (RAC) card that has the ability to be a fillable PDF so that you can add your information and then print from there. And I'll mention again, this is a living document. That's a toolkit and the graphic files. We do intend to expand; certainly we'll create more for the second phase of communications as we move forward and have more specifics to be able to add and reach out to people.

So I think I will stop there. I think we're holding questions until the end, Anne Marie. Is that right?

Jackie Glaze: Yes. So if you're finished with your presentation, Erin, we want to thank you. And then we'll just move onto the next agenda item. And the CMCS team will continue its discussion from last week, on the unwinding SHO letter that was released on March the 3rd. So I'll now to Suzette Seng, and she can begin her presentation.

Suzette Seng: Hi, (Jackie). Thanks so much. We're so excited to join this bonus episode to continue talking through the state health official letter we put out now almost a couple of weeks ago. So next slide, please. So just as a reminder of what we talked about last week on the all state call last week, the SHO letter we put out is a part of a series of guidance and tools that outline how states may address the large volume of pending eligibility in a known action they will need to talk after the PHE ends.

This SHO letter further clarifies expectations of states to restore routine operations. And we also share strategies states can utilize to mitigate churn for eligible enrollees, smoothly transition individuals between coverage programs, and address the anticipated influx of their hearings. We just want to remind states as we did last week, that the release of the SHO does not signal when the federal public health emergency will end.

Just a little recap here - so again, we put out the SHO letter on March 8th - I'm sorry, no. We discussed it during the March 8th CMCS call and the letter itself, can be found on our new unwinding page on Medicaid.gov. And the link is included here. During the March 8th call, we discussed the guidance in the SHO on timelines and expectations to complete eligibility in enrollment actions and distributions of renewal.

Today we will continue to discuss the SHO letter with a focus on notices, fair hearings, and strategies to protect beneficiaries and mitigate churn. And then we will also continue the series of calls on March 22nd, where we will have a review of scenarios we put together to talk through with states, a timeline for initiating renewals. We will also provide an overview of state information and data reporting tools that will be released shortly.

So with that next slide, please, I am going to turn it over to my colleague, Mark Steinberg, who's going to talk about notices and fair hearings.

Mark Steinberg: Thank you, Suzette. Good afternoon, everyone. So first, on notices, I want to spend a few minutes giving some context around notices during the unwinding period. Now initially, just to remind everyone of the general rule, when a Medicaid or CHIP agency, makes a decision affecting a beneficiary's eligibility, the state has to send the beneficiary notice at least ten days prior to

the date of the action. There's nothing new about that. That's always been the rule under our Federal Rules, for quite a long time.

In the context however, of an eligibility determination that's conducted during the unwinding period, we want to make clear that even when the eligibility determination yields the same action as the determination conducted during the PHE, and when the state has already previously provided notice, the state still must provide a new advanced notice. So a notice provided during the PHE period is not sufficient. There needs to be a new notice.

And this advanced notice has to have all the elements that an advanced notice normally has to have, which is the information about the beneficiary's right to a fair hearing, or CHIP review, the opportunity to have benefits pending during the fair hearing process. So what are these fair hearing process considerations and the CHIP review, to take into consideration?

So the basic rules I think most of you will be familiar with, again in general, states are required to take a final administrative action on a Medicaid fair hearing request, within 90 days from the date the agency gets the fair hearing request. Now states have to complete CHIP reviews within a reasonable amount of time under our rules. That's the federal regulation. Nothing has changed there.

However, during the public health emergency, a number of states have been granted a regulatory concurrence that allowed them to take more than 90 days, to take final administrative action on Medicaid fair hearing requests. This was because we all mutually recognized this was in fact, an emergency beyond the state's control. If there ever was an emergency, this was one of them.

However, when the PHE expires, all states including those granted this regulatory concurrence, are expected to begin processing fair hearing requests timely, and to take administrative action timely. Now we understand that some states have expressed concerns about the volume of fair hearing requests they're going to see, and that's going to - it may in fact exceed their capacity to adjudicate within time limits. So we're going to talk about what we can do about that. Next slide, please.

So as states develop their plans for this unwinding period, we are strongly encouraging everyone to take a minute to assess what their anticipated volume of fair hearing requests will be and what their operational capacity will be, in order to determine how they can distribute pending actions across the entire unwinding period. It may well be that states need to adopt some new fair hearing strategies and mitigations to accommodate an increase in fair hearing volume. These do not require the use of additional state plan authority.

There are things that states can do right now. The concept is to reduce the need for fair hearings to begin with and then to streamline the fair hearing process. A couple of examples in the letter, states can establish or expand an informal resolution process to resolve fair hearing requests prior to the fair hearing, so they don't need to have the hearing at all. Or in order to streamline the process, use different modalities, like hold a fair hearing or review by telephone or video.

Those are very - can be very effective just to make sure that access is equal for everyone, including people with disabilities and those who have limited English proficiency. We will see a longer set of strategies that we at CMS, are working on. So stay tuned, more is coming soon in this area.



We do recognize however, that even with the adoption of these strategies to reduce fair hearing requests, to spread them out, and just streamline the process, some states may experience an increase in fair hearing volume, which may exceed their capacity to adjudicate within the regulatory time limits.

These circumstances CMS will consider providing authority under Section 1902 E14 of the Act, to provide the state with additional time to make - to take final action. However, this will only be provided if certain beneficiary protections are provided. And we're going to talk later on slide 11, about what some of those details are. We understand this is an area of concern for states. It's an area of concern for CMS as well. We take it very seriously.

We will be providing additional resources and technical assistance to states on these issues. And that is all. I think I'm passing it - I don't know if it is back to Suzette Seng, or to Sara.

Suzette Seng: Yes. Back to me. Thanks so much, Mark.

Mark Steinberg: Okay, Suzette. Thank you.

Suzette Seng: Thank you. So what we'd like to continue talking about, the different strategies we lay out in the SHO letter, to protect beneficiaries and mitigate churn. Thank you. Okay. Next slide. This one, thank you. So the SHO letter outlines strategies states may use during the public health emergency to prepare for unwinding. One of the important ones is updating enrollee contact information. So we know that many states have lost contact with beneficiaries during the public health emergency.

And as we prepare for unwinding, all states should take steps during the public health emergency to update contact information to provide coverage

losses for eligible individuals, and to remind enrollees that they may report updated information to all modalities, which would be online by phone, by mail, or in person. One method states can employ to reach beneficiaries, is to work with managed care plans.

So states should work with MCOs to establish processes to engage in outreach to enrollees to update their contact information. And then use that information to update addresses in their eligibility systems. States may also want to consider establishing an ongoing process to continue working with MCOs to update contact information.

So when the state receives information from an MCO, the state may treat in state contact information obtained from managed care plans, as reliable and update the enrollee record with 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.

I will apply that we also have come up with an E14 strategy to address many concerns from states that we've heard, on the ability for the eligibility system and the processes, to do that additional outreach.

So we will talk about that a little later but want to establish that our guidance to states is that they may use the information if they first reach out to the individual to confirm the information. We also note that 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. Next slide, please.

Another strategy for updating enrollee contact information, is the use of the United States Social Services national change of address service. States can establish agreements with USPS to gain access to the NCOA database and update contact information based on information in the database. This is similar to the way states leverage address information received from USPS when mail is returned to the state within an in state forwarding address.

State agencies may treat contact information obtained from the NCOA and USPS return mail, with an in state forwarding address, as reliable and update the enrollee record with the new contact information, again just like the MCO guidance, provided that the state send a notice to the address on file with the state, and provide the individual with a reasonable period of time to verify the accuracy of the new contact information. Next slide, please.

We are very excited - I'm not sure that's a typo (unintelligible) but we're very excited about this new set of strategies on these next slides. We are setting forth some strategies using temporary 1902 E14(a) waiver authority, for states to implement some specific targeted enrollment strategies to promote continuity of coverage and mitigate churn.

So to talk a little bit about the authority itself, 1902 E14(a) of the Social Security Act, provides CMS the ability to waive certain requirements for the intended purpose of protecting beneficiaries' access to coverage by providing administrative relief to states facing operational issues and navigating serious challenges with eligibility systems. And so as states address the challenges of the unwinding period and a high volume of renewals, we set forth the set of strategies for states to consider.

The first is renewals for individuals based on (SNAP) eligibility. This is a strategy states used when implementing the Affordable Care Act and we think

is very useful. States may renew Medicaid eligibility for (SNAP) participants with both income as determined by the (SNAP) agency at or below the applicable Medicaid MAGI standard, without conducting a separate MAGI-based income determination.

An approved waiver request for the last states, temporarily rely on (SNAP) data for renewals for individuals under 65 years old despite the differences on household composition and income counting rules. The next strategy allows the states to conduct an ex parte renewal for individuals with no income and no electronic data returned.

So what this means is that states can temporarily conduct ex parte renewals for households whose attestation of zero income, was verified within the last 12 months that is either through the initial application or a previous renewal for change of circumstance, when no information is received from any electronic third party income data source at renewal. States who elect this option would still need to complete an ex parte - I'm sorry. Would still need to take the appropriate steps to review the non-financial components of eligibility.

And must instruct enrollees to inform the agency if any of the information used for the eligibility determination, is inaccurate. So the notices would have to contain language that the individual must inform the state of any inaccuracy. Next slide, please. The next strategy we'd like to talk through, is streamlining the use of the state's asset verification system data. So currently, states must attempt to make an ex parte determination at renewal and check data sources to verify assets at renewal, consistent with the state's verification plan.

Generally, this includes using the state's asset verification system, to verify assets for individuals subject to the 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 based on the state's verification plan, which could include collecting a new attestation or documentation to verify resources. This limited authority allows a state to assume no change in financial resources, if no information is returned within a reasonable timeframe.

The next strategy Mark alluded to, which is extended timeframes to take final administrative action of their hearing requests, the states that experience a volume of fair hearing requests that exceed their capacity for timely processing, can request to extend the timeframe for final administrative action on the fair hearing requests provided that the state agrees to providing benefits pending the outcome of a fair hearing decision to the individual who appeals an eligible data redetermination renewal, and that the state not recoup the cost of benefits pending from the individual even if the fair hearing upholds the agency's decision. Next slide, please.

We have two more E14 strategies to talk through. So as we just talked through the use of MCO contact information to update contact information in the beneficiary record as we - as I said before, in, you know, we talked to many states who had concerns about their eligibility system's ability to reach out to the beneficiary after receiving the MCO information.

So through this E14 strategy which states would have to request, states generally - states would may treat the 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. So again, states would - if a state elects the E14 option they would

not have to send that additional outreach to the state to confirm the new address. And again, would have to submit an E14 request.

The last strategy we put forth is automatic health plan re-enrollment. So currently, part of the regulation Medicaid managed care contracts must provide for automatic re-enrollment into a plan for individuals who are re-enrolled into Medicaid after loss of Medicaid coverage for two months or less. Using E14 authority states may choose to amend that to allow for the re-enrollment of individuals into their managed care plans for between 60 and 120 days.

And I want to note that if states are interested in any of the options we just talked through, they should reach out to the state lead and our team will follow up and provide technical assistance on the options that they may want to elect. The formal process would be to submit a letter to CMS for us to provide approval of the strategies. And we are happy to through our technical assistance, provide sample language for states to elect a new deduction. Next slide, please.

So here we talk more about existing strategies that may help states mitigate churn, that states may elect. The state - list state plan options including continuous eligibility for children, 12 months continuous postpartum coverage beginning in April of 2020 even though a lot of states are beginning to submit state plan amendments for that option and express lane eligibility for children just as an example.

Options to streamline renewals as states may expand the number of types of data sources used to attempt an ex parte renewal. And states may also want to align under MAGI and non-MAGI renewal policies. Some examples of this

are electing to use pre-populated renewal forms for non-MAGI populations and also offering a 90 day reconsideration period.

As states plan for unwinding, they also may want to think about communications and outreach, and employing different strategies to reach beneficiaries including actively seeking updated contact information as we've talked about; partnering with managed care plans; establishing processes to address returned (unintelligible) mail which we will talk about later on in the presentation; using multiple supplemental modalities to reach individuals, such as mail, email, and text. And making materials available in plain language and in a manner that is accessible to individuals who have limited English proficiency, and for people with disabilities. Next slide, please.

And here we talk a little bit more about the communication strategies to reach enrollees. So states should continue to communicate with enrollees based on their chosen method of communication.

In addition to that ongoing communication, states are also encouraged to utilize MCOs to conduct outreach and engage with managed care entities as they develop their unwinding and operational plans to identify clear ways in which the health plan can assist with outreach in enrollment efforts, also engaging with other stakeholders who regularly help identifying opportunities to leverage their support with assisting enrollees in updating eligibility information and ensuring they - that they understand the need to respond to states' notices, and complete the renewal process. Next slide, please.

States may also want to consider updating the notices to effectively convey key messages in plain language. And they may want to review communication strategies for individuals who have limited English proficiency and people with disabilities. And as a reminder, program information must be provided

free of charge in plain language, and in a manner that is accessible to individuals who have limited English proficiency, and people with disabilities.

States must 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. States must also provide people with disabilities accessible information, by taking appropriate steps to ensure that communication with applicants and beneficiaries are as effective as communication with others, including providing appropriate auxiliary aids, and services.

So with that, next slide, please, my colleague Sara O'Connor, is going to talk through processing return mail. It's a little reminder of how states should process return mail when they receive it.

Sara O'Connor: Thanks, Suzette. As you mentioned, another important strategy relates to the treatment of beneficiary mail returned to state agencies. States should take steps during the public health emergency, 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 individual 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 the US Postal Service.

States should also attempt to locate beneficiaries by checking other data sources for updated address information. And are encouraged to attempt to contact the beneficiaries through other modalities as permissible. Mail



returned with an in state forwarding address is not an indication of a change affecting eligibility. Nonetheless, it's important for the state to confirm the accuracy of the information to ensure an ability to contact the beneficiary in the future.

States may accept the in state forwarding address and update the beneficiaries record, provided that the state first sends a notice to the current address on file and gives the individual a reasonable period of time to dispute the information. The state may not terminate coverage for the beneficiary if no response is received to a request for confirmation of an in state address change. Next slide.

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 individual's elected format and attempt to contact the individual to verify continued state residency. States should also send notice to the out-of-state forwarding address and/or any different address provided by a third party data source. If the enrollee does not respond or the information provided does not establish state residency, the state must provide advance notice of termination and fair hearing rights.

States should attempt to locate individuals whose mail is returned without a forwarding address. If the individual cannot be located and there's 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 originally scheduled renewal date, the state must reinstate coverage. Next slide, please.

Another critical strategy to ensuring that eligible individuals do not become uninsured, will be facilitating smooth transitions to the marketplace, for

enrollees who are no longer eligible for Medicaid, CHIP, or coverage through a basic health plan. State Medicaid, CHIP and BHP agencies, are required to have an agreement with the relevant marketplace, and have a coordinated process to send and receive electronic accounts and other information to and from the marketplace.

For individuals ineligible for Medicaid, CHIP or BHP coverage, the agency must promptly assess potential eligibility for marketplace coverage and timely transfer the individual's electronic account to the marketplace, including all of the individual's eligibility information collected and generated by the state. States can treat any ineligible Medicaid or CHIP individual as potentially eligible for QHP enrollment, other than an individual whose coverage was denied or terminated for procedural reasons, and individuals who did not attest to US citizenship or eligible immigration status.

States are also encouraged to implement additional approaches that may help with enrollees' transition to a QHP, by improving eligibility determination notice language for ineligible individuals, but that they are aware that the agency will transfer their account to the marketplace, and that the marketplace will send them a notice with information on applying for coverage and financial assistance, and by transmitting all eligibility information the state has in the account transfer, to the marketplace including the enrollee's contact information.

And (Jackie), now I'll turn it back to you.

(Jackie Glaze): Thank you, Sara, Mark, and Suzette, for your presentations. So thank you for that. We're ready to begin the questions now. So we'll follow the format that we have in the past, by asking that you submit your questions through the chat

function, and then we'll follow by taking calls over the phone line. So, (Ashley), I'll turn to you. I see a few questions now.

Ashley Setala: Thanks, (Jackie). So the first question is, does the notice have to have specific language that the PHE is ending, or can we resume using our notices that we have that give specifics on the determination, regulation citation, and appeal rights giving 10 days' notice?

Mark Steinberg: This is Mark. Hello?

(Jackie Glaze): Yes. Go ahead, Mark. Go ahead, Mark.

Mark Steinberg: Yes. There's no specific requirement that mentioned the end of the PHE. Certainly if you have the capacity to tailor your notice, it's a great idea. But the standard information about the basis for determination, the rate of expectation, advanced notice, the right to (unintelligible) but that's what has to be required. We've not added any requirements to the notice, although certainly the clearer you can make it the better.

Ashley Setala: Okay. The next question is also on notices. And that is, are the exemptions to 10 day notice still allowed as per 42 CFR 431.211, 213, and 214?

Mark Steinberg: Yes. Yes, they would - to the extent there are circumstances which they apply, they would apply during the unwinding period as well.

Ashley Setala: Okay. The next question says, can you clarify what is meant by states can conduct ex parte renewals for households whose attestation was verified in the last 12 months? Many states have not conducted renewals in the last 12 months. If the beneficiary attested to zero income on their last renewal or

application and electronic data sources do not return any income or income below the Medicaid income standard, could this case be passively renewed?

Suzette Seng: Hi. This is Suzette. And maybe I will kick off and let anyone else who wants to mix in. But so we - when we thought about the strategy we wanted to balance program integrity with mitigating churn. And so that is why we have the guardrail of the 12 months, the household having to have had an attestation of zero income within the last 12 months. And we understand that some states have not been processing renewals, but point out that it could also be based on the last application.

So, you know, the strategy may assist part of the state's population, but also, you know, if the states wants to reach out to us directly, we can talk through the strategy and how it may work for your particular state. But let me also say though, in the example that was given, the person - the state would not be able to accept the zero income based on no return of information.

Ashley Setala: Okay. Thanks, Suzette. The next question is around ex parte for zero income populations. And it says, does this mean only cases approved in the past 12 months may be considered? We hoped to be able to include the whole zero income population in ex parte, assuming that electronic data did not find anything to the contrary.

Suzette Seng: Thanks, (Ashley). So same answer as the question before it. The strategy we lay out does include again, the guardrail that the household will have had to have an attestation of zero income within the last 12 months. So again, we are happy to talk to states - talk through the option with states as well.

Ashley Setala: Okay. Another ex parte question - why is a waiver needed to process ex parte redetermination for individuals who report no income and there's no

conflicting information from data sources? What information would be expected to be collected from such an individual if a paper form is sent and the individual continues to report no income and data sources continue to show no conflict?

Suzette Seng: Sure. So at - when a state is attempting to verify income at renewal, and there is no return of information from an electronic data source, then the state must reach out to the household, the individual, to (unintelligible) a renewal form to verify income. At that point, you know, the state would follow its verification plan and collect any documentation or new attestation that the person has zero income.

Sarah DeLone: Suzette, this is Sara. I can just jump in. I think in the (unintelligible) of the question that a renewal form had been sent. And so if the - and if the person has attempted to zero income on the renewal form and your verification plan, you know, you've done the data pings and then there's nothing that you require in your verification plan and there's nothing that's incompatible with the zero attestation of income, then that would be fine, if the E14 strategy is needed as far as the ex parte renewal process before you've actually sent the renewal form to get that additional attestation.

((Crosstalk))

Ashley Setala: The next question says, when a state completes a distribution plan for their caseload prior to the PHE ending, is there flexibility for those beneficiaries whose eligibility was successfully renewed during the PHE? We understand it would not be allowed to initiate these renewals less than 12 months after their last successful renewal, but can these renewals be initiated any time after that 12-month period, prior to the unwinding period?

(Shannon): Hi, this is (Shannon). And I can jump in to address this question. So yes, during the unwinding period there are some additional flexibilities that states would not ordinarily have to help redistribute the work. As noted in the example, for individuals who the state was able to successfully renew, the state needs to make sure that as (unintelligible) the distribution plan they aren't doing anything to shorten that beneficiary's eligibility period.

However, if for example, they wanted to pick up the case a little bit after that 12 month eligibility period, as long as it's within that 12-month unwinding period, they can do so. So for example, if an individual's renewal would have ordinarily been due six months into the state's 12-month unwinding period, the state could choose to pick up that case and its distribution plan, after that six-month period, but before the individual unwinding period.

Ashley Setala: Thanks, (Shannon). The next question says, we would like to clarify what to do when we receive an in state forwarding address. Are states unable to terminate coverage for someone who does not respond to the request for information regarding the forwarded address, or is it that states may not terminate coverage at all, for anyone who we receive returned mail for with an in state forwarding address, including terminations for no response to the pre-populated renewal packet?

Sara O'Connor: This is Sara. I can start and see if I understood the question correctly. I think the question is whether the state may terminate based on no response. And the answer to that is no. But if the person has not provided the information needed to conduct the renewal, then the state may proceed through its normal course of business.

Sarah Delone: But Sara, if the returned mail was in response - like the state sent the renewal, pre-populated renewal form and then it got a bounce back saying this person had moved to a new address, what's the answer? Can a state terminate?

Sara O'Connor: So not based on the mail being bounced back, if I'm understanding the question correctly. When the state receives an in state address we outlined in the SHO if the returned mail contains an in state address that in and of itself, is not an indication of a change in circumstance affecting eligibility. However, failure to complete the renewal form is - and provide the information needed to conduct the renewal, is sort of a separate issue, if that makes sense.

Ashley Setala: Okay. Thank you. The next question says the new SHO letter references an unwinding operational plan. And states that a template will be made available. When will that template be distributed?

(Shannon): This is (Shannon). So we released a planning template on March 3rd along with the state health official letter. So that planning template is available now on the unwinding landing page. This template is an update to the template we released back in January of 2021. So this updated template really accounts for the updates to the policy guidance and some of the new guidance that was released in this recent state health official letter. So that template is available now. States can use it to work through and think through how they want to develop their operational plan.

They can use it to document their plan if they would like, or just use it as a reference for the different considerations to assess how they want to, you know, stage out their workflow. But that is available on the new unwinding page on [Medicaid.gov/Unwinding](https://www.Medicaid.gov/Unwinding).

(Jackie Glaze): Thank you, (Shannon). I think we'll move to the phone lines now, to see if we have any calls there. So Operator, can you please provide instructions to the participants, and then open the phone lines, please?

Coordinator: Yes. The phone lines are now open for questions. If you'd like to ask a question over the phone, please press star 1 and record your name. If you'd like to withdraw your question, press star 2. Thank you. There is a phone question in the queue, from (Pat). Your line is now open.

(Pat Curtis): Hello? Did you say (Pat)?

Coordinator: Yes. Your line is open.

(Pat Curtis): Okay. Yes. This is (Pat Curtis) from Illinois. I had a question from the SHO letter and the discussion today on a managed care issue. If a state submits the 1402(a) E14 I think, waiver, to allow us to use data from the managed care organization to update our information about a beneficiary who may have moved or whatever, the SHO letter also uses the word temporary when it talks about the waiver. Can you define what temporary means? How long can we use this information?

Is it something we can continue to use from the managed care organization?  
Or is this a one time option?

Suzette Seng: Hi, (Pat). Thank you for the question. So as laid forth in the SHO letter, the E14 - the 1902 E14(a) strategies, are temporary and would last until the end of the unwinding period.

(Pat): Okay. So like we could use the managed care data initially to promote, you know, renewals that we try to get updated information to conduct our



renewals. And then at the end of the unwinding which if we go by the 14 months where we have compiled all processing, any additional information for managed care would require confirmation from the applicant and we couldn't use...

((Crosstalk))

(Pat): Okay. Thank you.

Coordinator: The next question is from (Alyssa Cohen). Your line is now open.

(Alyssa Cohen): Hi. Thank you. This is (Alyssa Cohen) from New Hampshire. I have a question that's a little bit tangential to what we discussed today. But can CMS confirm if the announcement today from the Administration that funding for COVID testing and treatment for the uninsured will be discontinued, if that applies to the HRSA fund that was established, and not the COVID optional group under (FICRA) that some states, including New Hampshire, implemented?

Sarah DeLone: Hi. This is Sarah Delone. I think that we can come back and confirm with HRSA that that relates to HRSA. We don't have any - there's no reason that we know of, Anne Marie jump in, to think that the funding for the optional testing group, that was not contingent upon funding that sort of as a new option group added to the state plan option. So I think you're safe to assume that the funding for the optional COVID testing group continues. But we can confirm on the HRSA.

(Alyssa Cohen): Great. Thank you very much.

Anne Marie Costello: (Sarah), I was going to say the same thing. We can circle back next week.

(Alyssa Cohen): Great. Thank you, Anne Marie.

Coordinator: The next question is from (Timothy). Your line is now open.

(Timothy): Thank you. I wanted to get a little clarification on the returned mail policy as it relates to review. Did I understand correctly that if a review form that we send out to someone is returned, we can't close them specifically for having returned mail? However, if we fail to get the review form as a part of normal review processing, we are allowed to close a member because they didn't complete the review process, independent of whether or not there was returned mail, even after we tried outreach to them. Is that a true statement?

Sara O'Connor: So perhaps I could ask you a question. I think what we're saying is that if there is any kind of ask us for closing a case based on the fact that the returned mail was returned, that is not permissible. However, if you do not have enough information to conduct a renewal, if that's what you're saying, if you don't have enough information in order to determine eligibility at that point then perhaps that's your - I'm not sure if that's your normal review process if we're - if that's a different...

(Timothy): It is. That's exactly correct.

Sara O'Connor: Okay. So if you don't have enough information after sending in, you know, the renewal form to the individual and on that basis, then I think the point of the returned mail guidance that we provided, was to sort of explain how to treat the various buckets, you know, the in state, out-of-state, and no forwarding address. And the requirements and the options that are available to states in the same vain as contacting, finding beneficiaries who may continue to be eligible.

However, at the point of renewal if you - you would follow your normal process. And if you can't - you don't have enough information to do that, then that would be the basis.

(Timothy): Thank you.

Coordinator: I'm showing no further phone questions at this time.

(Jackie Glaze): Thank you. We'll turn this back to you, (Ashley), for a few more questions.

Ashley Setala: Okay. Thanks, (Jackie). So the next question says how do these requirements - notices, redeterminations, etc., apply to 1915(c) waiver participants? They of course will have a medical redetermination, but should there be a waiver redetermination also?

Sarah DeLone: Hi. This is Sarah DeLone. I think maybe we should take that one back and I think we've probably got a crosscutting team that needs to get together. So if we could (Ashley), get that one offline, as well as the person's ask that the teams have follow-up questions, that would be great.

Ashley Setala: Sure. The next question says, has CMS issued a template for the ARP extension of postpartum coverage that begins on April 1st? And if so, is it available in MACPRO or elsewhere?

(Shannon): Hi. This is (Shannon). I can jump in. Yes, there is a (SPA) template in both for Medicaid and CHIP. The Medicaid template is available in MACPRO and the CHIP (SPA) template is available in MMDL.

Ashley Setala: Thanks, (Shannon). The next question says if the state is sending a notice that we have a new address to the address on file, what is a reasonable amount of time to wait on response that presumably won't be delivered unless the state pays for the forwarding service? Is the state able to send a notice to the address on file while simultaneous sending - using the NCOA for other notices?

Sara O'Connor: Yes. Well, the state may conduct all of the outreach described in the SHO at the same time. It's not necessary that everything be, you know, in terms of trying to locate the beneficiary, checking other data sources, beneficiary outreach. The notice is typically a minimum of ten days. But I'm not sure if that answers the question.

Ashley Setala: Okay. Thanks, Sara. Then we have a question that says, for individuals who applied and were determined eligible for Medicaid during the PHE, who continued to be eligible during the PHE, and became ineligible based on a change in circumstances, during the unwinding period, does the state need to complete a renewal if the individual did not have their first renewal yet?

(Shannon): This is (Shannon). I could start. So if the individual is within an eligibility period, meaning they've had their eligibility renewed and they are within, you know, (unintelligible) but the 12 month eligibility period. If they're within that 12 month eligibility period and at that point in time a change in circumstance is reported, the state may act on the change in circumstance as they ordinarily would, for that individual.

We do offer some flexibility during the unwinding period where states can align, work on a change in circumstance with the renewal that is due. If this was a beneficiary whose eligibility had not been renewed, so that they are not within an eligibility period, for those individuals the state would need to

conduct the full renewal rather than only acting on the one particular factor of eligibility.

(Jackie Glaze): Thank you, (Shannon). In closing, I'd like to thank the team for their presentation today. As Anne Marie mentioned, our next all state call will take place next week on Tuesday, March the 22nd, from 3:30 to 4:30 pm Eastern Standard Time. We will continue our discussion about the unwinding SHO letter on this call. And the invitation is forthcoming. Of course, if you have questions that come up between the next call, please feel free to reach out to us, your state lead, or bring your questions to our next call.

We thank you all for joining us today. And we hope everyone has a great afternoon. Thank you.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time.

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