



NHeLP Webinar: Unwinding Continuous Coverage Requirements and Red Flags

February 14, 2023

Webinar Recording & Slides:

[Webinar Recording](#)

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Follow Up Answers to Questions Asked During the Webinar

This document does not use the exact questions asked during the webinar. Questions that were similar were combined and questions have also been edited for clarity. Also, we have grouped the questions together by subject rather than the order they were asked.

Please note, the answers are based on current knowledge and are intended for general application, not as answers to any individual's particular situation. The answers may change as additional guidance is issued or other changes occur. For individuals with specific questions based on your facts and circumstances, please contact your local legal aid office or Protection & Advocacy organization. Advocates can reach out to members of [NHeLP's Unwinding Team](#).

Overview of Unwinding

Q. Are state unwinding plans the same thing as the "unwinding operational plan" described in the CMS guidance? How useful are they?

- A. State unwinding plans are the same thing as the unwinding operational plans described in the CMS guidance. While some include more information than others, they are often not quite as informative as we wish they would be.

Q. Is NHeLP collecting and reviewing the unwinding plans?

A. NHeLP has started collecting and analyzing state unwinding plans that have been made public. While we would hesitate to call one plan better than another because as with any state activity regarding Medicaid there is often a mix of decisions that we see as beneficial and others that we see as less likely to maintain coverage. Some plans are longer and provide more information than others. For example, Arkansas, California, and Florida have publicly shared lengthy redetermination plans that include estimates of how many beneficiaries are at risk of losing coverage, coverage continuity plans, unwinding communication plans, staffing plans, and population priorities for redetermination.

Q. It is difficult to judge my state's verification plan without being able to compare it to what an optimal scenario would be. How useful are these plans? Is there a state that does a great job on renewals that we might compare with?

A. First, note that verification plans are different than unwinding plans and document the state's processes and data sources used to verify each eligibility criteria. Verification plans for each state, and changes made to those plans during the PHE, are available on [CMS's website](#), which may provide a useful source for comparisons. CMS has put together [recommendations](#) for how states can improve their verification processes to increase ex parte renewals both during the unwinding and after.

Q. Must the required data under the CAA be made public as it's provided to CMS?

A. CMS is required to make the data public after it is submitted by the states. Section 42 U.S.C. 1396a(tt)(1); [SHO 23-002](#) at p. 18. But how quickly CMS will post the data after states submit and what format will be used is unknown. In addition, CMS in the SHO 23-002 indicated that some data will be estimated.

Q. How will states like California, with decentralized eligibility handled by 58 counties, report call center data? There may be very different experiences by county?



A. This will depend somewhat on the state. There are about 10 states that use county based systems but not all of them will use county-based call centers. In California, NHeLP urged the state Medicaid agency to include call center data on a county/regional level but are awaiting the final version of the dashboard.

Q. Which states requested the 1902(e)(14)(A) waiver?

A. Although CMS does not post approved documents, it does keep a [public chart](#) of which states have received what type of 1902(e)(14)(A) waivers.

Q. What about Appendix K for 1915(c) waivers? We'd really like to see the changes from Appendix K be included permanently.

A. Although unwinding of services related changes are not the focus of this webinar, we can provide this brief answer. Most things a state did through appendix K it can do through an amendment to its 1915(c) waiver. Appendix Ks are only available during an emergency to make temporary changes to a 1915(c) waiver. The end of Appendix K amendments is tied to the end of the PHE and in many states the Appendix K will end 6 months after the end of the PHE. This time post-PHE should give states an opportunity to submit 1915(c) amendments to their waiver programs to keep some of the Appendix K changes permanently if they decide to do so.

Redeterminations Process

Q. If the state asks for only limited data in the renewal form they send after ex parte review fails to find the person eligible, how will they get information to indicate a person may be eligible in all of the different eligibility categories?

A. States are required to ask for additional information if it is needed to determine eligibility for all categories and must maintain coverage while it seeks that information. In the full renewal process, this should be accomplished through the renewal form, which should ask for all information necessary to evaluate for all categories of eligibility. The renewal form should include any other questions that may be necessary to solicit the information needed, such as whether the individual has a disability or



has received institutional services, etc. For MAGI populations the form must be pre-populated, and ask if any of the pre-populated information has changed. In the change of circumstances scenario (refer to slides 19-24), the quality of the notice will really matter because the state is really only asking about the eligibility factor that has changed. States may request additional information in the change of circumstance form, but may not require it. States may take the position that beneficiaries have the obligation to report other changes, but advocates should argue states are not meeting their obligation to request necessary information and consider beneficiaries for all categories of eligibility if they at least do not prompt the individual to provide information about other changes that may affect eligibility and identify what those may be generally.

Q. Change of Circumstances:

Reminder: We used 12 months in the presentation and continue to use 12 months in the Q&A as a shorthand, but the relevant timeframe may be a shorter period for non-MAGI groups, depending on a state's eligibility period for those groups.

1. Does the "last successful renewal" include an original eligibility determination within the last 12 months?
 - A. Yes. The change of circumstances process may be used if there was either a successful full renewal or successful initial application within the last 12 months.

2. If a person reports a change and is not overdue for a renewal, such as someone who was renewed in the last 12 months, can the state wait until the next 12-month renewal to process the change? What if the change would lead to a reduction in benefits, including a termination. What if the change would mean an increase in benefits, can a state still wait until the regularly scheduled renewal?
 - A. States have a lot of flexibility to prioritize work during the unwinding period and CMS expressly has said that states can decide to not act on information regarding changes and wait until the person's regularly scheduled renewal date. [CMS 10/17/22 FAQs, Q.7](#). After the unwinding period ends, the state would return to the normal obligation to process the change in circumstances within 30 days.

3. Can a state use a 1902(e)(14)(A) waiver to use addresses from MCOs and other sources to deny if data matching reports an out of state address?

A. States may use 1902(e)(14)(A) waivers to use addresses from MCOs. Such information could trigger a change of circumstances process, if the criteria are met, or a full renewal depending on the person's most recent successful renewal date. Regardless if the information indicates ineligibility, such as an out of state address, the state must contact the individual and give them a chance to dispute the information. See the [Dec. 2020 Bulletin on Redeterminations](#).

Q. If a person receives Medicaid through SSI and they remain eligible through SSI, these individuals should (in theory) be renewed through the ex parte process, correct?

A. While many people who receive SSI will be renewed ex parte, this is dependent both on whether the state ties Medicaid eligibility to SSI ([this is 34 states and D.C.](#)) and on state data matching. For most, the data matching should work. However, there are some categories that are based on receipt of Social Security benefits, such as the disabled adult child category, that we have seen some states systems struggle with. For example, a person receiving SSA benefits based on a parent's record may initially be considered by a system as over income, and the system must be able to identify that the person previously received SSI and remains eligible under categories such as disabled adult child, passalong, or pickle. Successful renewal may depend on the ex parte process and how the state's computer system and processes work, but also the renewal form and whether it asks the right questions to trigger an analysis of a person under different categories related to social security benefits.

Q. Did someone who had unpaid premiums before the start of the PHE get notices about those unpaid premiums? Are there any protections in place to allow people to pay now?

A. A person who is being terminated for unpaid premiums must be provided advanced notice with all accompanying fair hearing rights and that notice must provide the premium amount, a clear statement of the reasons supporting the premium, and the basis of the premium calculation. States may not terminate individuals for unpaid

premiums accumulated during the PHE and may not count any days that fell during the PHE as part of the days of nonpayment that would lead to termination. States have varying requirements and policies regarding payment of premiums, including how to “catch up” on unpaid premiums, and states must make those policies and requirements publicly available. 42 C.F.R. § 447.57(a)(2). So it is important to check state policies and for beneficiaries to update their information so they get any relevant notices. States must still consider all bases of eligibility before terminating an individual for unpaid premiums, including in eligibility groups that do not require premiums and follow the renewal procedures as appropriate.

Note: No notice is required to resume premiums if a state suspended them during the PHE, unless state law requires it or if the premium schedule has changed. States may delay the resumption of premiums pending a full redetermination being completed for beneficiaries subject to premiums through a 1902(e)(14)(A) waiver. [SHO 23-002](#) p. 6. [Oct. 2022 FAQ](#) p. 11-14; 42 C.F.R. § 447.55.

Notices & Fair Hearings

Q. Can the informal resolution take the place of a hearing? If someone goes through an informal resolution process, do they still get a hearing?

A. There has not been much CMS guidance about the informal resolution process, only that states may use such a process. [SHO 22-001](#) at p. 23. In states that use mediation or other informal resolution processes, a person would not have a hearing if the information resolution process resolved the appeal but would have a hearing if there was no resolution. Because of the lack of guidance on these processes, there are likely some significant risks around them, including people being discouraged from pursuing their appeals or incorrectly being told they do not have a valid appeal. Strong guardrails should be in place about how a state does information resolution, if they use it at all.



Q. Is it too late for a state to request the 1902(e)(14)(A) waiver to extend the time to provide a hearing?

A. No. CMS will likely grant 1902(e)(14)(A) waivers throughout the unwinding as issues come up.

Q. Does a termination notice have to list the alternatives the state agency considered during its ex parte review?

A. This is a really frequent question because notices really vary at how they approach the requirement of explaining the basis of the decision. The notice regarding redeterminations should explain what the state considered, including how it evaluated the other eligibility categories and what information it used about the individual to make the decision, such as income, household size, etc., but how to do this in an easy-to-understand way has been a real challenge as a practical matter. If you think your state does a great job of this, we'd definitely like to see it.

Expected Issue Areas

Q. If we see our state really messing up (i.e., making erroneous negative actions) how do we get CMS to tell them to pause all negative actions until the messing up stops?

A. If advocates are seeing systemic issues in your state, please contact [NHeLP's Unwinding Team](#) and we can consult about the best way to enforce these requirements.

Q. We received several comments about accessibility for people who need extra help and time navigating the redetermination process, including concerns about people who want to submit information online or provide electronic signatures, rather than mail or fax in documentation.

A. There are several accessibility requirements in the Medicaid regulations and through the Americans with Disabilities Act, and other non-discrimination protections. First, notices and renewal forms must be accessible to individuals with disabilities and



limited English proficiency. *See* 42 C.F.R. §§ 435.905(b); 435.916(g); 457.340(e). Second, individuals must be able to submit information, including providing signatures, online, in-person, by mail, and over the phone. And States are required to communicate with enrollees through electronic notices pursuant to an individual's election under 42 C.F.R. § 435.918. Finally, the Americans with Disabilities Act creates an independent obligation for states to ensure their processes are accessible to individuals with disabilities. If advocates are seeing problems with accessibility in redeterminations in your state, please reach out to [NHeLP's Unwinding Team](#).

