

# Unwinding Medicaid Continuous Coverage: Requirements & Red Flags

February 14, 2023



*Thanks for spending your  
Valentine's Day with NHeLP!*



# Housekeeping

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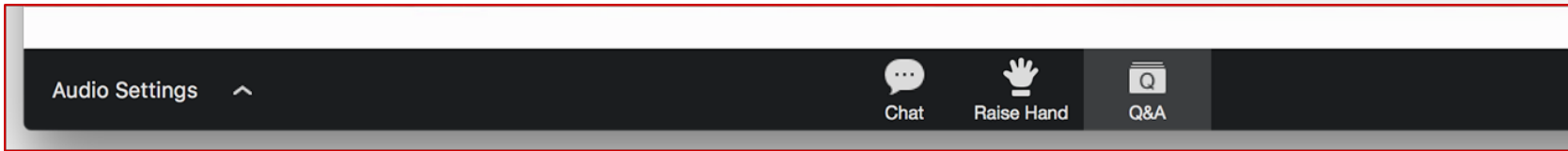
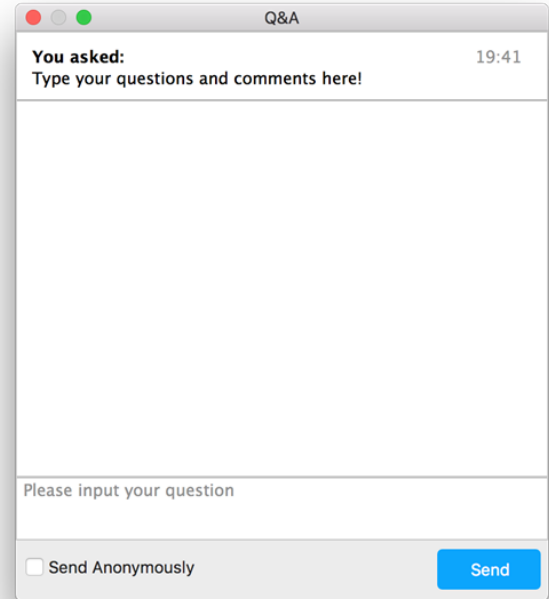
- Webinar is being recorded.
- All attendees are in listen-only mode.
- Slides were sent in advance via a link in the Zoom reminder email.
- A follow-up Zoom email will be sent after the webinar with a link to the slides and a link to the recording.
- Transcript for this webinar is enabled.
- For technical issues, please use the chat.

# Q&A and Chat

Please use the Q&A box for all questions to the panelists

- Click on the Q&A icon at the bottom of the screen
- We encourage questions!
- We will mostly answer questions at the end

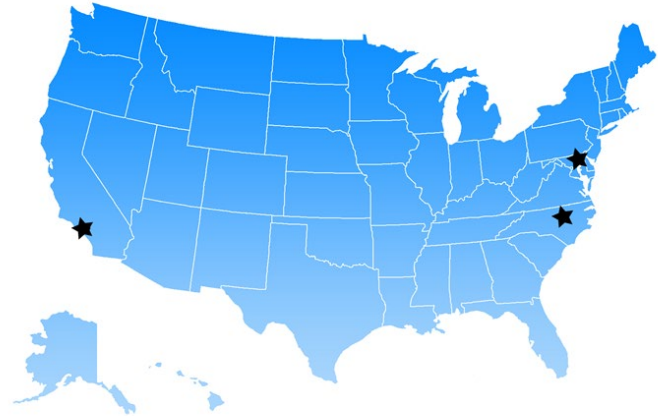
Please **do not** use the chat box for questions



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- National non-profit law firm committed to improving health care access, equity, and quality for underserved individuals and families
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# Outline for Today

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- Overview of Coverage Unwinding: what it is, how long, etc.
- Redeterminations
  - Federal requirements review
  - Who receives a full renewal and not
  - Exceptions
  - Red flags
- Notices & Fair Hearings
  - Requirements
  - Unwinding changes
  - Red flags
- Expected issue areas
- Resources
- Q&A

# State Unwinding Processing - Workload

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- 91 million enrolled; termination of an estimated 15 million
  - 6.8 million who are likely still eligible
- States must process:
  - Pending redeterminations and annual renewals
    - Many states have continued redeterminations through PHE
  - Post-enrollment verifications
  - Pending Applications

## Reminder:

- Timely application process is 45 days, unless disability based and then 90 days (42 C.F.R. § 435.912)
  - Timelines can be delayed because waiting on doctor's information, but not because of State administrative difficulties

# Consolidated Appropriations Act (Sec. 5131)

Consolidated Appropriations Act of 2023 added protections for the coverage unwinding, changed enhanced FMAP rules, and set the continuous coverage end date.

To receive enhanced FMAP, which steadily decreases quarterly until December 2023, states must:

- Not restrict eligibility standards, methodologies and procedures\*
- Not increase premiums (may adjust individual premiums 4/1)\*
- Comply with federal requirements
- Maintain up to date contact information for beneficiaries
- Attempt to contact by at least two modalities before disenrollment due to returned mail

**Note:** many states will unwind through Spring 2024; 1902(e)(14)(A)

# Consolidated Appropriations Act: Monthly Data

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Number of:

- Eligibility renewals initiated;
- Enrollees renewed on a total and ex parte basis;
- Individuals whose coverage for medical assistance, child health assistance, or pregnancy related assistance was terminated;
- Procedural terminations; and
- Children enrolled in separate CHIP.
- Total call center volume, average wait times, and average abandonment rate for each call center.
- Such other eligibility and renewal information as identified by the Secretary.

SBM info on QHP/BHP transfers, eligibility, and enrollment

- Depends on type of system

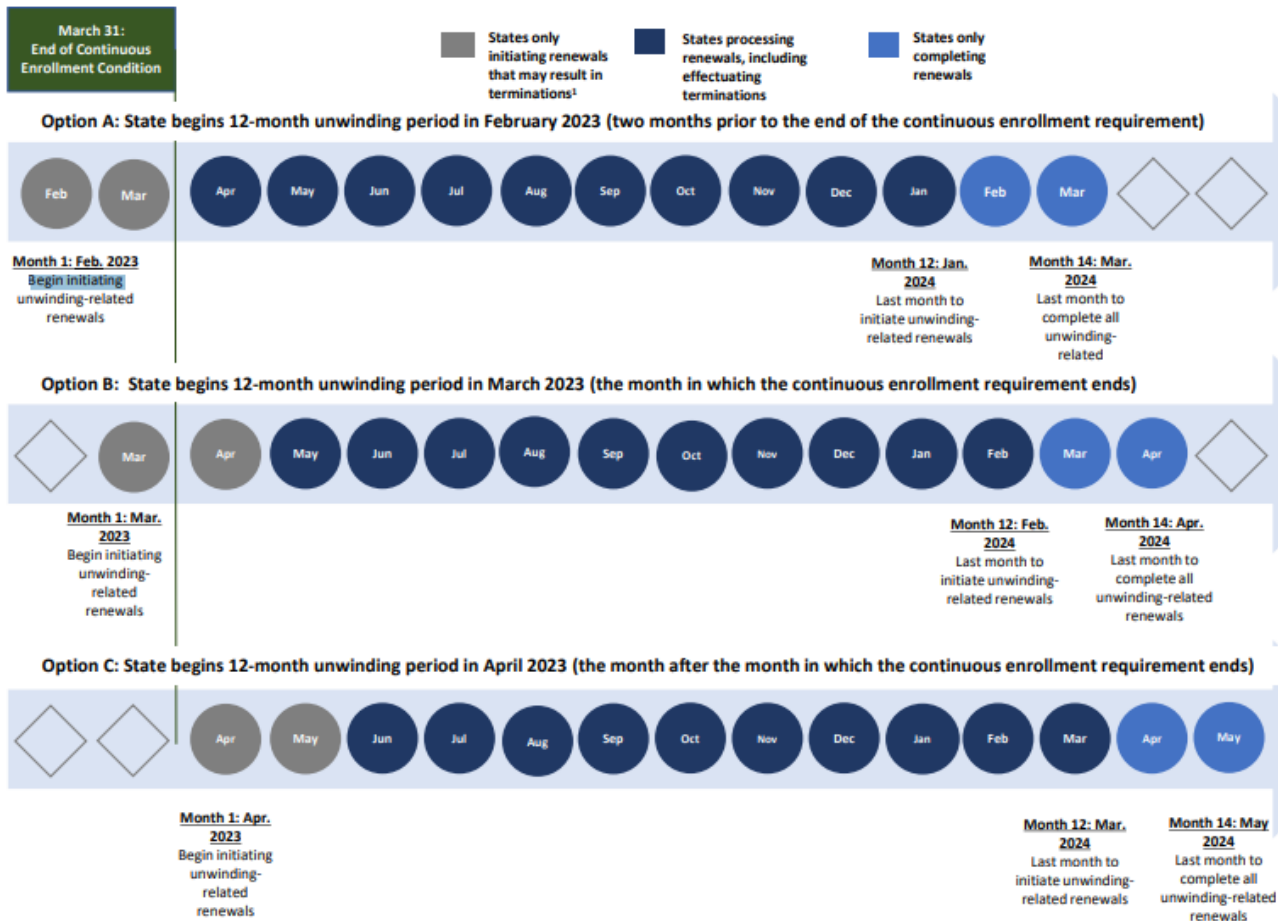


# CAA Set Continuous Coverage End Date!

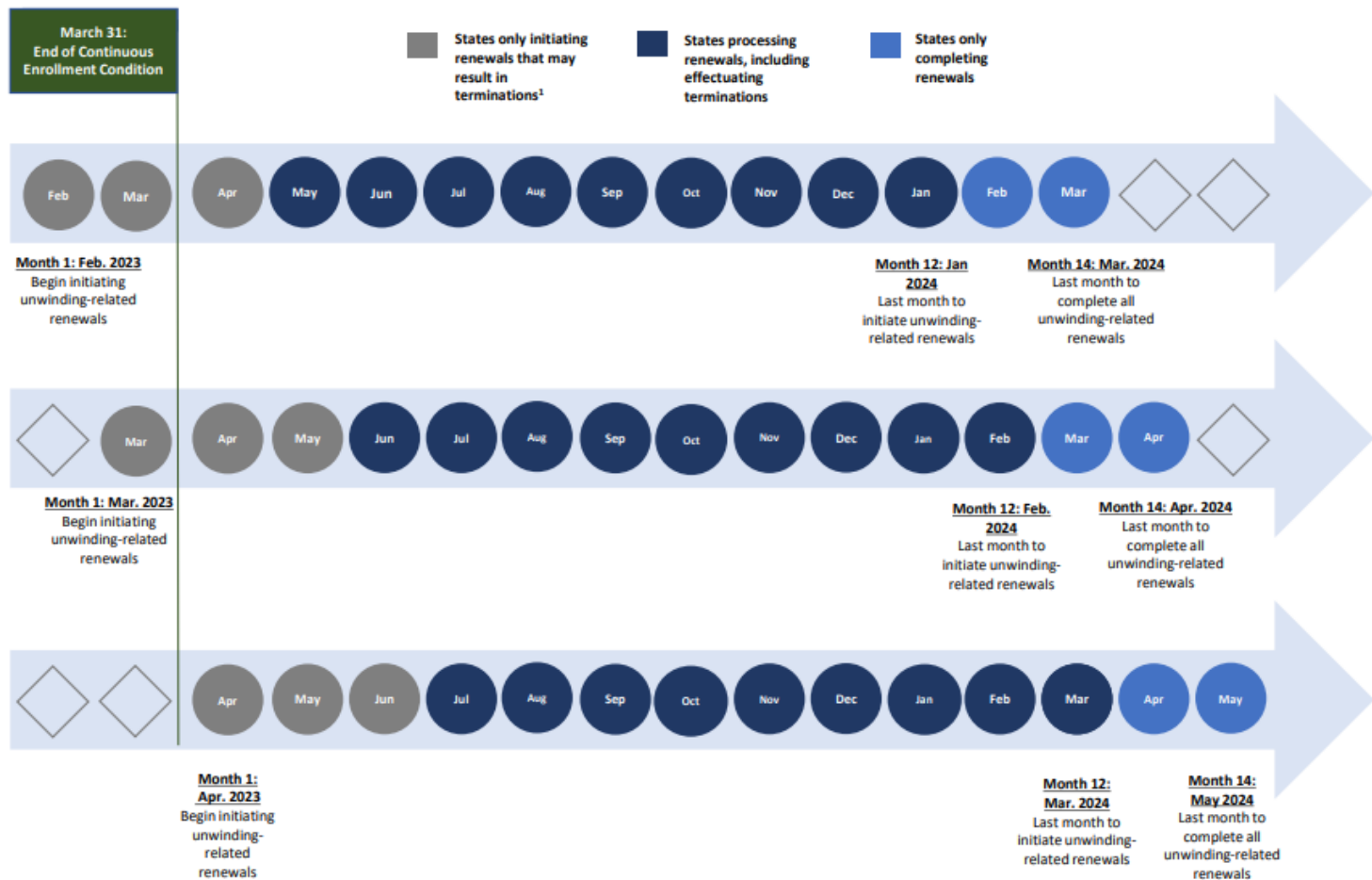
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- End of continuous coverage previously tied to the PHE, but NO MORE! Now ends **March 31, 2023.**
- Terminations **may** begin as early as April 1, 2023.
  - States have 12 months to initiate all redeterminations pending at the end of the continuous enrollment period, and 14 months to complete them. This is what CMS is referring to as a state's "unwinding period."
    - A state's unwinding period begins when the state initiates the ex parte process for renewals that could result in termination.
  - States can begin unwinding in February, March, or April 2023.
  - This means that states may start terminations anywhere between **April and July** of this year.

## Appendix B1 – Example 1: Unwinding Timeline for States with a 60-day Renewal Process



## Appendix B2 – Example – Unwinding Timeline for State with a 90-Day Renewal Process



# Required Docs Before Beginning

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Renewal redistribution plan ([Jan. 5th CMCS Bulletin](#)):

- States can choose different approaches, such as population based or time, but cannot prioritize based on eligibility group
- Encourage to adjust workload, align households, use SNAP, etc.
- **Note:** MAGI renewal limitations; [mitigate coverage losses](#)

System readiness artifacts

Baseline unwinding data

## Timeline:

- Redistribution Plan and Artifacts are due February 1, 2023 for Feb. states
  - States beginning after February are due February 15, 2023
- Data due the 8th of the month in which the state begins renewals

# Review: Redeterminations

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**Ex Parte:** For all populations, including non-MAGI, state must use recent & reliable info it has and has access to before requesting from enrollee ([Oct. 2022 FAQs](#), Q8)

- State's "[verification plan](#)" lists data sources and compatibility requirements for data match. Some states made PHE-related changes, which may be ending, so look up your state's specifics.
- **Income rules:** If attestation and data match are both above or below threshold, information "shall be considered reasonably compatible." 42 C.F.R. § 435.952(c).
- CMS Guidance on asset verification and \$0 income in [Oct. 2022 FAQs](#)

CAA also requires states to seek updated contact information prior to attempting redetermination. (§ 6008(f)(2)(B), [SHO #23-002](#))

# Ex Parte Red Flags

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- State requires consent to conduct ex-parte renewal
- State excludes a particular population from ex parte renewals
- State requires all household members to complete renewal form when some could be renewed ex parte
- Ex parte numbers are generally pretty low, especially in certain states, despite long-standing requirements
  - Encourage state to seek 1902(e)(14)(A) waiver to adopt unwinding-specific ex parte strategies (using SNAP data, limited verification of \$0 income or asset value)

CMS resource on improving ex parte rates: [Oct. 2022 PPT](#)

# Review: Redeterminations (cont.)

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**Renewal Form:** If ex parte unsuccessful, state must send a renewal form that

- Asks only for information needed to complete redetermination (MAGI: pre-populated)
- Is accessible to persons with LEP and with disabilities
- Gives individuals a reasonable time to respond (30 days for MAGI populations)
- Enables individuals to submit information requested through any of the authorized avenues: online, in person, by mail, or telephone

# Renewal Form Red Flags

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- Long, complicated forms
- Forms don't ask the right questions or ask confusing questions
- Forms are not accessible to persons with disabilities & LEP
- Can be complicated to submit information, e.g., states using QR codes, bar codes, etc. to help with document processing
- All modes of submission are not available
- Technical issues with relevant technology
- Burdensome and confusing verifications.
  - E.g., State requires proof of employment income or an asset's value but does not explain what kind of information to submit
- Relatively limited time to respond, especially for non-MAGI



# Review: Redeterminations (cont.)

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## **Consider Other Eligibility** (42 C.F.R. § 435.916(f)):

- State must consider for all categories of Medicaid eligibility and must seek information regarding other categories if needed to evaluate eligibility
- For individuals determined ineligible, state must assess for insurance affordability and transfer account.

## **Reconsideration Period for MAGI**

- State must reconsider an individual's eligibility if they return the requested information w/in 90 days after termination. 42 C.F.R. § 435.916(a)(3)

# Review: Redeterminations (cont.)

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## Termination for Returned Mail

- CAA § 6008(f)(2)(C) requires states make a good faith effort to contact individuals through multiple modes before terminating for returned mail
- States **may not terminate** for returned mail if there is an in-state forwarding address, as this is not an indication of ineligibility.
- CMS guidance: [SHO #23-003](#); [SHO #22-001](#), Appendix C

# Review: Change of Circumstance Process

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**Background:** States must have procedures for individuals to report changes and may run periodic data checks (e.g., against wage indexes) between annual renewals.

**Procedure for evaluating changes** (See [Renewal CMCS Informational Bulletin](#), Appendix A)

- States must send notice of the change and provide an opportunity to dispute or explain the information
- State may only require information about the eligibility criteria at issue.
- If the change could impact eligibility, generally state should redetermine eligibility using the new information w/in 30 days. States have more time during unwinding.

# Key Differences from a “full renewal”

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**1. Scope of verifications required:** in a change of circumstance process, the state only evaluates the eligibility factor at issue and relies on the previously provided and verified information from the last renewal (or initial application)

**2. Some MAGI protections do not apply:**

- there is no pre-populated form required in the change of circumstance process
- state only has to provide a “reasonable” time, not 30 days for individual to respond

# Unwinding: Who Must Receive a Redetermination?

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States **may not** simply send advance notice of termination for individuals found ineligible during the PHE. This includes individuals who failed to respond to a request for information sent during the PHE. [10/17/22 FAQs, Q5](#); [March 2022 SHO](#) at 10.

Individuals generally must receive a “full renewal” prior to adverse action.

Important exceptions to the full renewal requirement:

- (1) Recent “change of circumstance” cases
- (2) Individuals with unpaid premiums incurred prior to PHE
- (3) Optional COVID-19 group
- (4) Individuals who remained in a “reasonable opportunity period” to verify their immigration status or citizenship

# Exception: Change of Circumstance

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States may use the change in circumstance process, rather than a complete a full renewal if:

- (a) the individual was found eligible following a full renewal or initial application **within the last 12 months** (or shorter eligibility period for non-MAGI groups, if selected by the state); and
- (b) the state subsequently received a reported change of circumstance during the continuous enrollment period.

If the individual is **not within** their eligibility period, or was previously found **ineligible** at their last renewal, the state must complete a full renewal

Cite: [10/17/22 FAQs](#), Q5, Q6.

# Examples

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Rory was in the expansion group at the start of the pandemic. In January 2022 the state completed an annual renewal and determined they were over-income. The state set aside the case and kept them enrolled due to the continuous coverage requirement.

- State must complete a full renewal during unwinding

Kennon came up for annual renewal in October 2022, and did not respond to a request for information.

- State must complete a full renewal during unwinding

Tyler is enrolled in the children's eligibility group. He was successfully renewed in October 2022. He ages out in May 2023.

- State may use change of circumstance process.

# Examples

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Fiona is enrolled as a parent/caretaker. She was renewed ex parte in June 2022. The state's quarterly data match in December 2022 shows she is over income. Fiona did not respond to the RFI.

- State may use change of circumstance process during unwinding.

Same as above, but Fiona confirmed her new income in December 2022 and the state processed the change, concluding she was ineligible in all categories. Fiona remained enrolled due to the continuous coverage requirement.

- State must conduct another change of circumstance process during unwinding.



## Exception: Unpaid Premiums (Oct. 2022 FAQs, Q30)

Only terminate for unpaid premiums incurred **before** the PHE.

- States may not count days during the continuous coverage period towards required 60 days.
- States may not terminate for unpaid premiums accumulated during the continuous coverage period.

Prior to terminating states must consider all bases of eligibility:

- If there is a successful renewal within the last 12 months (or initial application), then state can rely on that information;
- If not, the state must conduct a full renewal.

# Exception: Optional COVID-19 Population

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**Background:** eligibility group for uninsured individuals with limited benefits covering COVID-19 testing, treatment & vaccines

- Expires on last day of the PHE (May 11)
- Some states used applications not integrated in eligibility system

**Process:** If the state did not integrate this group in its eligibility system, it can use one of three strategies that requires providing notice that:

1. the optional group ends on the last day of the PHE
2. individual may be eligible for comprehensive Medicaid coverage
3. how to submit an application
4. advance notice of termination and a right to a fair hearing under limited circumstances (42 C.F.R. § 431.210(d)(2))

CMS Guidance: [SHO #23-002](#); [Oct. 2022 PPT](#)

## Review: Notice Requirements, 42 C.F.R. § 431.210

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Must provide notice, regardless if full or procedural termination

- Plain language and accessible
- Provide relevant dates
- Clear statement of specific reasons supporting decision
- Cites specific regulations that support the action
  - Cannot just be chapter of Medicaid eligibility regulations
- Can be multiple notices
- Cannot fulfill notice obligations by telling the person to call or talk to someone
- *Goldberg v. Kelly*

Note: eligibility notices are often...not great

# Likely Notice Issues

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- Confusing notices & communications
- BAD Notices
  - Insufficient information
    - Failure to include sufficient information on income or basis of eligibility
  - Wrong information
  - Failure to provide notice: bad addresses, bad systems
  - Wrong dates on notices
    - Ex: Notice date is incorrect or totally off from mailing date

# Fair Hearings - Requesting

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## **Time for Medicaid enrollee to request a Fair Hearing:**

- Reasonable time, not to exceed 90 days from mailing of the notice (42 C.F.R. § 431.221(d))
- 1135 waivers extended timeline
  - Must continue to provide time promised to the individual in their notice after PHE ends, even if the state stops providing additional time going forward. ([March 2022](#) SHO at 22)

States may hold fair hearings and reviews by phone or video as long as providing access as required by 42 C.F.R. pt. 431 subpart E

- Must be accessible to individuals with disabilities and LEP
- May use informal resolution process

# Fair Hearings - Final Action

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**Time to Provide a Fair Hearing:** States must take final action on fair hearings within 90 days. 42 C.F.R. § 431.244(f). Some states got extensions of this time during the PHE.

**Unwinding:** States must begin processing fair hearings timely when continuous coverage ends. ([Mar. 2022](#) SHO at 22-23).

- States may seek a 1902(e)(14)(A) waiver to extend the time to provide a hearing, but only if the state:
  - (a) provides benefits pending regardless of whether the enrollee makes a request
  - (b) foregoes recoupment from beneficiaries if the agency ultimately wins the fair hearing
- CMS has granted [this waiver in 13 states](#) (as of 2/9/23)

# Likely Hearing Issues

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- Wrongful denials
- States may use informal resolution and could result in discouragement
- Hearing delays
- Failure to continue benefits pending appeal
- Hearing administration issues:
  - Overuse of group hearings (§ 431.222) and “mass change” exception (§ 431.220(b))
  - Not providing in-person hearings as needed
  - Disability and LEP access issues

# Expansion v. Non-Expansion

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Coverage gap in non-expansion states creates huge risk of harm

- People under 100% FPL in non-expansion are in the gap

State based marketplace v. Federal Marketplace

Transfers to Exchange for APTCs often loses people

Associated with good v. bad state



# Expected Issues w/ Coverage Unwinding

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- Failure to renew via ex parte
- Numbers
  - Overwhelmed eligibility systems and workers
    - Bad systems and [untested changes](#); new [automations](#)
    - Many “newer” workers in many states; understaffing
  - Long wait times on help center lines & in-person
    - Limited assistance available
    - Bad information

## Expected Issues w/ Coverage Unwinding (cont.)

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- Accessibility and language access
  - Notices, outreach
  - Call-centers
  - Automations that aren't accessible/in non-English languages
  - Failure to accommodate
  - A bad system for everyone can still discriminate
- High number of people who have moved since March 2020
  - CAA requirements regarding up to date contact information & 2 modalities of contact before termination due to returned mail

# CAA Compliance: FMAP

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- **Enhanced FMAP Requirements:**
  - Through Dec. 31, 2023
  - Failure results in a state losing the enhanced FMAP for the calendar quarter
  
- **CAA Reporting Requirements**
  - April 1, 2023 - June 30, 2024
  - Failure results in a .25 percentage point multiplied by the number of noncompliant quarters (not to exceed 1 percentage point)

# CAA Compliance: Corrective Action Plan Process

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- Secretary determines a state is not in compliance with all federal requirements related to eligibility redeterminations and CAA reporting requirements
- Secretary may require the State submit and implement a corrective action plan:
  - Secretary sends written notice to State;
  - State must submit a corrective action plan within 14 days of receiving notice;
  - Within 21 days of CAP submission, receive Secretary approval; and
  - Begin implementing CAP no later than 14 days after approval

# CAA Compliance: Corrective Action Plan Compliance

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If the State fails to submit or implement a CAP, the Secretary may, **in addition** to any FMAP reduction and any other available remedy:

- Require suspension of all or some procedural terminations until the Secretary determines the State has taken appropriate corrective action;
- Impose a civil money penalty of not more than \$100,000 for each day of noncompliance.

# Section 1902(e)(14)(a) Waivers

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- “As needed” waivers that are supposed to ensure states have eligibility systems that protect beneficiaries. [SHO #22-001](#)
- Time limited authority to facilitate renewals
- [Examples:](#)
  - Enroll based on SNAP and/or TANF eligibility
  - Ex parte for those w/ no income and no data returned
  - Partner with MCOs to update beneficiary contact information
  - Use National Change of Address Database
  - Extend automatic reenrollment into MMC up to 120 days
  - Extend timeframe to take final administrative action on fair hearing
  - Delay resumption of premiums

Red Flag: Compliance through these waivers [SHO #23-003](#) at p. 8

# End of PHE - Emergency Flexibilities

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- Section 1135 – end with the PHE
- 1915(c) Appendix K – end at most 6 months after the end of the PHE
- Emergency State Plan Amendments – end at PHE or earlier date selected by State
- Emergency Section 1115 Amendments – at most 60 days after end of PHE
- BHP Blueprint Revisions – no later than end of PHE, unless CMS approved later
- MAGI Verification Plan Addendums – date selected by State
- Eligibility for COVID-19 group
- Premiums due to FFCRA and disaster SPAs/amendments
- Chart in [Dec. 2020 Guidance](#)

# Guidance & Resources: “Must Reads”

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- NHeLP’s [NHeLP PHE Unwinding Landing Page](#)
  - [Unwinding Checklist](#)
  - [Resource List](#)
- CMS:
  - Jan. 31, 2023: [SHO 23-002](#)
  - Jan. 5, 2023: [Letter re CAA](#)
  - Oct. 17, 2022: [FAQs](#)
  - Mar. 3, 2022 [SHO 22-001](#)
  - Aug. 13, 2021 [SHO 21-002](#)
  - Dec. 22, 2020 [SHO 20-004](#)
  - Dec. 4, 2020 [Bulletin on Redeterminations](#) (reviews basic requirements)
- Georgetown CCF [50-State Unwinding Tracker](#)



Questions?

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