Renewal Tips of the Day: March 2023

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The NHeLP Medicaid Continuous Coverage Unwinding Team started sending out a Medicaid Renewal Tip of the Day in March 2023. As the unwinding period continues, we will continue to update this document. In the interim, advocates can always find the social media version of the tips under #MedicaidRenewal.

Eligibility & Redetermination Processes

Optional COVID Group (3/8/2023) — Alicia

Did your state or territory implement the optional COVID group? Federal authority for this coverage group expires on the last day of the COVID-19 public health emergency (PHE). At that time, states are required to sunset the eligibility group and redetermine eligibility on all bases for beneficiaries enrolled in this group. However, CMS has offered some flexibility on the process for states that did not integrate the optional COVID Group into their eligibility systems. States can do something other than a full redetermination by adopting 1 of the 3 strategies outlined in CMS guidance. See CMS PPT, p. 14-16. Regardless of the option selected, states still must provide 10-day advance notice that coverage in this group is ending. States can also end coverage for this optional eligibility group before the COVID-19 PHE ends by submitting a SPA to CMS.

Change in Circumstances (3/2/2023) — Sarah

Most individuals must receive a full renewal during the unwinding period. In some cases, though, a state can use the change in circumstance process instead. The question to ask to figure out which process applies is: when was the last successful full renewal? Generally, if it was within the last 12 months, the state can use the change in circumstance process. If it was longer ago (or not successful) the state must complete a new renewal. If your state uses shorter eligibility periods for non-MAGI groups, that shorter timeframe will apply. Why does it matter which process the state uses? The change of circumstance process allows states to streamline verifications and removes two important MAGI protections: use of the pre-populated form and the 30-day timeline to return that form. No matter what, the state must evaluate for all categories of eligibility and provide notice and hearing rights before termination. Learn more!

Don't re-verify SSN/Immigration Status (3/28/2023) – Sarah

Does your state's renewal form routinely ask for Social Security numbers or immigration status? It shouldn't! Renewal forms should only request information the state doesn't already have and that is necessary to complete the redetermination. CMS has made clear that a "form that requests . . . Social Security Number, citizenship or immigration status would not satisfy

the requirement. Such information is only needed once and, thus, would not be needed to renew eligibility." (SHO 23-002, FN 20). And removing these questions is important to avoid deterring immigrant families from completing the process.

Asset Verification (3/9/2023) — Sarah

Does your state struggle to complete ex parte redeterminations for individuals with asset tests? States are required to use an asset verification system (AVS) as part of their ex parte process and face FMAP reductions if they don't. (See 42 U.S.C. 1396w). States also have options to streamline asset verification: they can rely on the prior recorded value of certain assets, consider assets verified when the total value is below the applicable threshold, and through a 1902(e)(14)(A) waiver, find assets verified if the AVS returns no information.

Income Verification (3/23/2023) — Sarah

States often struggle to complete renewals ex parte for individuals with no income. Generally, CMS has said that when the ex parte data checks return no information, the state must request additional information, such as a new attestation or explanation from the individual. During the unwinding, CMS has approved 1902(e)(14)(A) waivers to allow states to avoid requesting additional information from individuals with no income. You can find out whether your state has adopted this waiver here: https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html

Redetermination Protections for MAGI Enrollees (3/10/2023) — Miriam

The 2023 tax filing season has begun, but that is not the only reason that MAGI rules are important. During the Medicaid continuous coverage unwinding, it is important to remember that populations whose income eligibility is based on their modified adjusted gross income or MAGI have specific protections that streamline their redetermination processes, such as:

1. States must send these enrollees pre-populated forms in renewal packets;
2. For individuals found eligible following a full renewal or initial application **within the last 12 months** and for whom the state subsequently received a reported change of circumstance, states can ask for information, BUT only about information related to the specific facts that call into question the enrollee's eligibility. See 10/17/22 FAQs, Q5, Q6;
3. MAGI enrollees must have at least 30 days to return renewal information that was requested;
4. Redeterminations should be conducted at least (but no more than) every 12 months; and
5. Lastly, states must reconsider individuals' eligibility if they return the requested information w/in 90 days after termination. See 42 C.F.R. §435.916(a)(3).

Marketplace Transfers (3/16/2023) (Mara)

If a redetermination accurately determines that a person is ineligible for continued Medicaid coverage, the person's "account" should be transferred to CHIP or a health insurance marketplace to assess eligibility for that coverage. Unfortunately, the account transfers from Medicaid to marketplaces are often incomplete and individuals will have to fill out a complete application before being determined eligible for coverage or tax credits. Healthcare.gov will be reaching out to consumers in this situation so they may get calls. But they also need to know how to identify potential scams. Referring consumers in this situation to assisters for help submitting an application could promote timely coverage. In states with state-based marketplaces, advocates should check to see how the account transfer process works and what steps individuals may need to take if they are transferring to CHIP or marketplace coverage. (NOTE: Individuals found ineligible due to "procedural" reasons will not have their accounts transferred.)

Due Process & Notices

General Restart of Redeterminations Notices (3/7/2023) — Elizabeth

Is your state sending a general alert notice to beneficiaries about redeterminations? Does it include inappropriate language like "You will be losing coverage" before any individual determination has been made? The general notice should get the attention of the beneficiaries about the issue and include a clear ask, but should not provide misinformation or otherwise cause people to think they have already lost coverage. See the example from Oklahoma of a misleading notice prompting people to think they have lost coverage and potentially leading them to not respond to further requests.

Informal Appeal Resolution (3/13/2023) — Elizabeth

CMS has encouraged states to use informal resolution processes to help manage the appeal workload. While resolving appeals by allowing people to submit missing information or otherwise finding the person eligible without having to go through the hearing can be helpful, informal resolution processes can be rife with due process violations. For example, appeals staff may improperly tell a person it is not worth pursuing the appeal or otherwise discourage a person from continuing with their appeal. Due process violations are especially likely to occur if states do not have clear policies about what is and is not allowed during informal resolution, including scripts where helpful. Advocates should ask states for their policies around informal resolution and monitoring of those policies to check for potential due process issues.

Notice, Notice, Notice (3/21/2023) — Charly

"I just got this paper; I don't know what it says." If I had a dime for every time I heard that as an advocate representing individuals in Medicaid appeals, I could fund Medicaid for All. Notices of adverse action are notoriously lengthy, confusing, garbled, and yet somehow still fail to provide individuals with the information they need to understand what is going on and protect their rights. Advocates should be on the lookout for insufficient notices during unwinding. Insufficient notices:

- Give only general information about reasons for the adverse action that is not specific to the individual (*e.g.*, "over-income");
- Require an individual to reach out to a call center or log in to an account to receive more information;
- Fail to include taglines or other instructions for disability or LEP accessibility;
- Uses complex or confusing language that is indecipherable by the general public; or
- Does not explain how to access an appeal or fair hearing, or uses language that improperly limits access to an appeal or fair hearing.

Notice of adverse action must be written, and must include the following elements:

- Plain language;
- Accessible to individuals with disabilities and/or Limited English Proficiency (LEP), including taglines at a minimum;
- A statement of what action the State is taking and the effective date;
- A clear, individualized statement of the specific reasons supporting the intended action;
- The specific regulations that support/require the action;
- The right to a hearing to appeal the decision; and
- An explanation of the right to continuing Medicaid coverage if a hearing is requested.

Requesting a Fair Hearing or an Appeal (3/20/2023) — Charly

How long after an adverse action does an individual have to request a fair hearing? Some states have extended or changed the timeline for fair hearing requests during the public health emergency and unwinding period. Advocates should check three places to make sure they have the right timeline for an appeal:

- Notice of adverse action received by the individual;
- State unwinding plan; or
- State 1135 waiver (if still in effect).

Timeline given on the notice doesn't seem right? The time to request a fair hearing given on the adverse action notice should match the timing given in the state's unwinding plan or 1135 waiver. But if a notice was sent during a PHE-related extension, the person has that amount of time stated in the notice to request a hearing. For more information, see State Health Official Letter #22-001 at p. 21.

Administration, Monitoring & Compliance

Accessibility of Call Centers for LEP (3/6/2023) — Mara

Como se dice "redetermination" en Español? As unwinding begins, we expect people with limited English proficiency and people with disabilities will face additional barriers to maintaining their coverage. Call Centers should be accessible to all. LEP individuals likely will need to be connected to competent bilingual call center staff or interpreters who can assist them and transfers should not result in dropped calls or longer waiting times. People with disabilities may have someone helping who is only available for a limited period of time who cannot wait for hours to get through a long wait time. Is there capacity for the call center to make appointments for callers with disabilities? See here for more information on protecting people with disabilities and people with LEP during unwinding.

Unwinding Plan Warning Signs (3/17/2023) — Cassandra

Has your state shared its plan for redetermining eligibility during the unwinding period? Here are some things to look out for that could spell trouble ahead:

- Plans could be vague, prompting questions about what policies and processes the state will apply to meet renewal requirements and promote continuing coverage.
- Does the plan include the state's plan to increase capacity for beneficiary assistance, beneficiary information updates, eligibility determinations, and fair hearings? Are they using temporary employees or contractors who may not be familiar with Medicaid eligibility issues to help with demand? See our previous tip on the use of contractors for more information!
- Does the state have a robust plan for beneficiary outreach to update contact information? If not, the agency runs the risk of beneficiaries not receiving the information they need, leading to loss of coverage.

Use of Contractors (3/1/2023) — Elizabeth

Contractors are supposed to have only a limited role in eligibility determinations, namely to support the state's eligibility and enrollment (E&E) workforce and not to make eligibility determinations (See CMS PPT, p. 12 and Q&A, q. 32). States have matching funds available to support staffing up for the unwinding. When the state is awarding third parties (e.g., Maximus) for E&E support, check those contracts for harmful incentives. For example, are there incentives for short calls or number of calls handled? If so, that could hurt people with disabilities and people who have LEP since those calls often take longer. Or if there are not clear policies for accommodations or language services.

Outreach & Messaging (3/3/2023) — Michelle

As states begin their unwinding periods, it is important for advocates to use clear and targeted messaging to prepare enrollees to renew their coverage. Key messages on unwinding include:

1. Medicaid eligibility is being reviewed for almost everyone (accounting for changes in circumstances and renewals that happened during the PHE);
2. Get ready by updating your contact information, checking your mail, and completing any renewal forms if received; and
3. If you no longer qualify for Medicaid/CHIP, you may qualify for a Marketplace plan and can apply right away. Additional recommendations are to default to messaging consistent with and specific to your state (e.g., reference state Medicaid office and state-based exchange contact information), include specific dates and timeframes whenever possible, include information on enrollees' due process rights, and highlight that enrollment assistance is available with referrals to state-specific resources.

Mitigation Mysteries (3/27/2023) — Elizabeth

States are using a variety of mitigation strategies to meet the compliance with renewal requirements so that they may claim the temporary FMAP increase. CMS has encouraged the use of these strategies in various guidance, including the January 27, 2023 and March 3, 2022 letters, but what strategies states are using is not entirely clear as CMS only publicly tracks what states are using certain 1902(e)(14)(A) strategies, Which mitigation strategies are being used and why are important to understand because a state may be meeting a redetermination requirement not through the required mechanism, but through a combination of other means. For example, if a state cannot do ex parte renewals for non-MAGI categories, they may have adopted several other renewal strategies that should help with renewing those populations without making requests of those beneficiaries. If a state is not transparent with their mitigation strategies, advocates may need to use public records requests to ask what mitigation strategies they have been approved to use and why. This will help advocates better track areas in which states are noncompliant and are not using approved mitigation strategies, and where mitigation strategies are not working well.

Automation Red Flags (3/29/2023) — Cassandra

CMS has suggested several automations to states to streamline the redetermination process throughout the unwinding period. There are several red flags in these suggestions where tech issues could result in unnecessarily confusing and burdensome processes or even undue terminations. People with disabilities and limited English proficiency, and those with limited access to technology may be especially impacted. Advocates can reach out to NHeLP to learn more about these automations, access advocacy materials, and get ideas on how to engage with your state agency.

Unwinding Special Enrollment Period (SEP) (3/22/2023) — Michelle

For people who lose Medicaid/CHIP coverage during the continuous coverage unwinding, CMS has established a temporary Special Enrollment Period (SEP) in effect between March 31, 2023 and July 31, 2024 that allows people who have been terminated from Medicaid/CHIP during that time period to attest to a last day of coverage within that time period and then choose a Marketplace plan, if eligible, within 60 days of submitting their Marketplace application. For states with state-based Marketplaces (SBMs), check with your respective SBMs to find out if they're offering this Unwinding SEP. For more information, see CMS CCIIO's FAQ on the Unwinding Special Enrollment Period.

Returned Mail (3/24/2023) — Alicia

A large volume of people moved over the course of the 3-year COVID-19 public health emergency. As a result, there is concern that beneficiaries will not get Medicaid renewal paperwork in the mail. In order to help mitigate this issue and prevent procedural denials, the Consolidated Appropriations Act, 2023 added a new returned-mail condition. In order for states to receive the temporary FMAP increase in effect after March 31, 2023, along with other conditions, states must undertake a good-faith effort to contact an individual using more than one modality prior to terminating their enrollment on the basis of returned mail. States have discretion in the types of modalities they can use to satisfy this condition (mail, telephone, text messaging, communication through an online portal). State flexibilities for meeting this condition are outlined in SHO 23-002, p. 12. This condition does not change federal Medicaid rules regarding the steps that states are required to take upon receipt of returned mail.

Data Reporting Requirements (3/30/2023) — Skyler

States are subject to several reporting activities to help monitor their unwinding activities and ensure renewals are processed in an orderly and accurate manner. This is to ensure that the unwinding period is transparent and that corrective action can be taken to avoid missteps in processing renewal actions among the states.

For example, Baseline Unwinding Data is due to CMS on the 8th day of the month when states begin their unwinding period. Some states have already started this process and others are set to begin in April. States are also required to continue submitting this data on the 8th on a monthly basis for a minimum of 14 months. States must report the information through an already existing CMS data reporting tool. CMS outlined the specific data metrics that states must report in their most recent letter (page 19). These metrics include:

2. Total number of renewals that were initiated;
3. Total number of renewals that were successfully renewed;

4. The number of beneficiaries who were renewed via *ex parte*;
5. Total number of individuals whose coverage was terminated; and
6. Total number of individuals whose coverage was specifically terminated for procedural reasons.

This data will be made public so be sure to watch out for updates in your state! This can help you leverage existing data to work with your state Medicaid agency to course correct improper negative actions. You can refer to CMS' data reporting instruction manual for more in depth information about data reporting requirements.

State Penalties for Noncompliance Under the CAA of 2023 (3/31/2023) – Elizabeth

The Consolidated Appropriations Act set requirements for states to receive enhanced federal matching funds (FMAP) and provided for additional enforcement activities from CMS, including requiring corrective action plans, suspending procedural terminations, and imposing civil monetary penalties.

States are at risk of losing enhanced FMAP for any calendar quarter up to December 2023 in which they do not:

- Maintain eligibility standards, methodologies, and procedures;
- Maintain premium policies (they may adjust individual premiums starting 4/1);
- Comply with federal requirements;
- Maintain up to date contact information for beneficiaries; and
- Attempt to contact by at least two modalities before disenrollment due to returned mail.

States must also submit the data discussed in yesterday's Renewal Tip of the Day. Failure to meet reporting requirements from April 1, 2023 - June 30, 2024 will result in a loss of FMAP by .25 percentage point times the number of noncompliant quarters (not to exceed 1 percentage point).

In addition to any FMAP reductions, if a State fails to submit or implement a required Corrective Action Plan (CAP), the Secretary may require suspension of some or all procedural terminations and may impose a civil money penalty of not more than $100,000 per day of noncompliance.

Advocates should keep track of compliance issues and report problems. NHeLP is helping to collect and communicate issues, so advocates should reach out with problems they are seeing.

State Continuity of Care Laws (3/14/2023) — Wayne

Changing health plans can be a real hassle. However, for people undergoing treatment for a serious or life-threatening medical condition, changing health plans can lead to harmful disruptions in care. However, twelve states plus the District of Columbia have continuity of care laws that cover when a person changes plans, including from Medicaid. These laws allow certain high-needs patients, such as persons undergoing treatment for serious illness or those in the third trimester of pregnancy, to continue receiving treatment from a chosen provider, even if that provider does not participate in the patient's new health plan. The National Association of Insurance Commissioners (NAIC) has information on how to file complaints if your health insurance company fails to follow continuity of care or other requirements, as well as how to understand and use health insurance. HHS provides links to state consumer assistance programs and other resources for consumers who experience problems accessing the care they need.