



Renewal Tips of the Day: March-June 2023

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The NHeLP Medicaid Continuous Coverage Unwinding Team started sending out Medicaid Renewal Tips 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.

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Eligibility & Redetermination Processes

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).

Application Processing Times (4/27/23) – Charly

Many of our #unwindingtips so far have focused on what happens to individuals who are at risk of losing access to Medicaid during unwinding. But what about individuals who applied for Medicaid during the PHE, who are applying for the first time, or who may be reapplying?

States will have up to four months after the end of the PHE to return to typical application processing times, depending on the type of application. See [SHO #20-004](#), pages 28-29.

For outstanding MAGI and non-disability-related applications submitted during the PHE, states will have two months after the PHE ends, or July 11, 2023, to complete processing.

For outstanding disability-related applications submitted during the PHE, states will have three months after the PHE ends, or August 11, 2023, to complete processing.

By four months after the end of the PHE, or approximately September 11, 2023, states must resume processing all applications according to the typical 45-day timeline for MAGI or non-disability-related applications, or 90-day timeline for disability-related applications.

States may not deliberately delay processing applications until the end of the given timeline or deny an application for failure to complete within the timeline. The guidelines are intended to allow states sufficient time to gradually ease away from extended processing times to the application processing times required by [law](#).

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!

[Federal Rules for Counting Income \(3/15/2023\)](#) – Wayne

What happens if someone’s current monthly income is too high for Medicaid Expansion, but the person’s annual income is too low for Marketplace coverage (less than 100% FPL)? When determining financial eligibility for most Medicaid categories, states use Modified Adjusted Gross Income (MAGI), which is also used for Marketplace subsidies. However, [MAGI rules differ](#) for Marketplace and Medicaid eligibility determinations. Medicaid has different rules for determining who is in a household, and looks at current monthly income, instead of annual income used to determine subsidies for Marketplace coverage. Because of those differences, there may be instances in which an individual seemingly is financially ineligible for either program. Federal MAGI regulations address this type of situation (see 42 C.F.R. § 435.603(i)). When differences between Marketplace and Medicaid MAGI make someone financially ineligible for either program, the state [should use](#) the Marketplace methodology to determine Medicaid MAGI eligibility.

[Verifying Self-Employment Income \(6/30/2023\)](#) – Wayne

People who are self-employed, including [gig workers](#) and freelancers, face a lot of challenges - especially when applying for, or renewing health care coverage through Medicaid or the ACA Marketplace. Income verification, usually based on wage receipts and last year’s federal income tax return, [do not always match](#) current circumstances. Self-employed people should keep a [ledger detailing income and expenses](#), which can serve as supporting documentation for both Medicaid and Marketplace eligibility determinations. [HealthCare.gov](#) offers other tips for self-employed people on [estimating unpredictable income](#), including when to [update income information](#) when it changes. Health care coverage is an important priority for everyone; and for self-employed people, it’s good for business too.

[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>

Premiums & the End of the PHE (5/23/2023) – Elizabeth

The end of the federal public health emergency (PHE) on May 11, 2023 means that all the disaster relief SPAs and Section 1135 waivers that suspended premiums also ended. Unless states have taken other action to delay or cancel their approved premiums, they have to implement their approved premiums. States can temporarily extend SPAs through a streamlined process, discussed in the [February 2023 all state call](#). Before resuming premiums, states must redetermine a person's income within the past 12 months. Before terminating someone for failure to pay premiums, states need to make sure they have provided proper notice, they are counting failure to pay correctly considering the PHE, and meet other requirements. The most recent CMS [guidance from May 12, 2023](#) answers questions about the resumption of premiums.

Unwinding Redeterminations for SSI Recipients (6/20/2023) – Miriam

How should state agencies address Unwinding redeterminations for those receiving Medicaid with SSI? CMS guidance has largely focused on [1634 states](#), rather than [209 \(b\) states](#). In a 1634 state:

1. States may rely on the SSA's State Data Exchange (SDX) transmission of eligibility for SSI and renew on an *ex parte* basis the person's eligibility. SSA does not transmit new information on the individual unless there is a change in the person's circumstances affecting SSI eligibility. [CMS FAQs May 12, 2023](#), Q 18. (Note, CMS indicated in the May 2022 All State Call that states were checking SDX monthly, but they clarified later that this was not the case and states should continue regular processes. [CMS All State Call Nov. 22, 2022](#), p.10-11).
2. If the SDX indicates a change in circumstances and the enrollee loses eligibility, the state should continue Medicaid coverage until the enrollee's eligibility for any and all possible Medicaid categories has been evaluated, including any requests for additional information or verifications. See [CMS All State Call May 3, 2022](#), p.28-29.
3. If an enrollee loses SSI for a non-disability issue, such as income, the enrollee continues to have a disability for purposes of their Medicaid eligibility, and the state should assess eligibility for all other Medicaid programs based on current information. [CMS All State Call May 3, 2022](#), p. 29-30; see also CMS October 20, 2022 presentation on [Ex Parte Renewals](#), slide 16 regarding assuming ongoing disability.

Continuing Eligibility for SSI Recipients (5/25/2023) – Skyler

While states are generally required to provide "fresh" renewals for beneficiaries during the unwinding period, one exception may involve recipients of Supplemental Security Income (SSI). [CMS' recent FAQs released as of May 12, 2023](#), clarified this point more directly under Q18. States that have 1634 agreements with the Social Security Administration (SSA) can renew via *ex parte* for those who continue to receive SSI. SSA sends information only when an individual's circumstances have changed that would impact their eligibility. This means that state Medicaid agencies can rely on the information showing that the individual still receives SSI and, thus, continue their eligibility for Medicaid.

Although, for individuals receiving SSI whose circumstances have changed, state Medicaid agencies are still obligated to redetermine eligibility on all bases, and obtain information necessary to make that determination before they can terminate coverage.

Former Foster Youth Change in Guidance (6/1/2023) – Kim

Young adults eligible for Medicaid due to their former involvement with the foster care system should more easily keep coverage during the unwinding due to recent [CMS guidance](#). CMS made it clear if a state has sufficient information to know the individual is eligible as Former Foster Care Children (FFCC) but the state has questions about eligibility under another

mandatory category of eligibility, the state does not need 1115 or other waiver authority to enroll that individual as FFCC regardless of whether the youth turned 18 prior to January 1, 2023 (see the Support Act changes discussed below). Doing so prevents FFCC-eligible youth losing coverage due to a failure to provide information that is necessary to other categories, like assets and income, but is not needed for FFCC eligibility. Covering former foster youth up to age 26 is critical during the unwinding and states should continue their coverage under the FFCC group without asking for any additional information, based on an *ex parte* review.

The 2018 Support Act, Section 1002(a), made important changes to ensure individuals do not lose coverage because of two loopholes in the category as created by the ACA. States are now required to cover those who age out in another state and no longer have to determine that the youth are not eligible for another mandatory eligibility group before being found eligible for the FFCC group if the youth turned 18 on or after January 1, 2023. CMS has determined that states can apply the same approach for those eligible as FFCC who turned 18 before January 1, 2023. CMS has also said if the state has enough information to indicate eligibility in another category (other than the adult group), then the youth should be given a “choice” of coverage groups and the state should attempt to collect any needed information.

Snapshot of California’s Optional COVID Group (5/4/2023) – Alicia

Federal authority for the Optional COVID Group expires on the last day of the COVID-19 public health emergency, May 11, 2023. If your state or territory implemented the Optional COVID Group, now is the time to check in with your state to determine if their redetermination process and notices align with requirements. See CMS [PPT](#), p. 14 -16. Now is also the time to alert enrollees and community partners about the end of your state’s program. California’s Optional COVID Group, called the COVID Uninsured Group Program, has enrolled more than 500,000 Californians, and uses state funds to cover COVID testing, testing related services, and treatment (including hospitalization). The state has developed a sunset notice and a toolkit in English and Spanish to help transition these individuals to other comprehensive coverage they are entitled to. See more info [here](#).

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.

When Can State Medicaid Agencies Process Cases BEFORE an Annual Renewal Month? (5/9/2023) – Skyler

There is a lot of information about what state Medicaid agencies CAN'T do before a beneficiary's annual renewal month. But, when CAN state Medicaid agencies process cases before a beneficiary's annual renewal month? There are a handful of events that can trigger early renewals or redeterminations even though it may be before a beneficiary's annual renewal month. Some states are treating these events differently and choosing not to pursue some of these instances over others. Below are some of the specific instances where state Medicaid agencies may process a beneficiary's case before their annual renewal month. [CMS SHO Letter #22-001](#) and [CMS FAQs dated 10/17/22](#) (Q. 5-7) detail more of these instances.

1. When a positive change occurs for another household member.
2. When a primary household member asks to cancel members no longer in the household.
3. When beneficiaries no longer qualify for Supplemental Security Income.
4. When Beneficiaries on Medicaid apply for or renew their SNAP benefits.
5. When beneficiaries report a change in circumstance within the past 12 months (or a shorter time frame selected by the state for programs other than MAGI), if the state has already completed an initial eligibility determination or renewed the beneficiary's eligibility.
6. When beneficiaries incurred unpaid premiums during the PHE.
7. When a beneficiary has remained in a "reasonable opportunity period" to verify their immigration status or citizenship.

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.)

Coverage Options for Individuals Who Lose Medicaid (5/16/2023) – Michelle

For individuals who lose Medicaid during the unwinding, there are health coverage options to stay covered.

- 1. Transition to Marketplace Coverage.** Individuals who lose Medicaid between March 31, 2023 and July 31, 2024 and live in states that use HealthCare.gov can apply for Marketplace coverage on [HealthCare.gov](https://www.healthcare.gov) at any time, without waiting for the regular open enrollment period, by using the Unwinding Special Enrollment Period. After submitting an application, individuals will have 60 days to choose a Marketplace plan, if determined eligible. See [CMS CCIIO’s FAQs](#) for more information.
- 2. Transition to Employer-Sponsored Insurance (ESI).** Employees typically must request coverage under the ESI plan within 60 days after termination of Medicaid coverage. However, individuals who lose Medicaid coverage between March 31, 2023 and July 10, 2023 have some more time and can request special enrollment in the ESI plan until September 8, 2023. See [HHS’s FAQs, pg. 12-15](#) for more information.
- 3. Transition to Medicare.** Individuals who qualify for Medicare, but did not sign up for it when they first became eligible, can sign up for Medicare Part A, Part B, or both without paying a late enrollment penalty or waiting for the usual enrollment period. Individuals have 6 months after their Medicaid coverage is terminated to sign up for Medicare. See [CMS’s fact sheet](#) for more information.
- 4. Transition to Separate CHIP Program.** States that operate CHIP as part of Medicaid should automatically check if individuals remain eligible under the state’s CHIP income limits as part of redeterminations. States that operate separate CHIP programs should transfer individuals’ accounts to CHIP to assess eligibility if they are no longer eligible for Medicaid. These individuals can apply through their state’s CHIP program at any time to see if they qualify for coverage. See [CMS’s slide deck](#) for more details on best practices for states with separate CHIP programs.
- 5. Appeal Medicaid Coverage Termination.** Individuals who believe that their state agency wrongly stopped their Medicaid coverage have the right to appeal and ask for a Medicaid fair hearing. It is important to do so as quickly as possible before the deadline in the notice. See [CMS’s SHO #22-001, pg. 21-23](#) for more information.

For more details on all these coverage options, check out our new fact sheet: [Health Coverage Options for Individuals Who Lose Medicaid During the PHE Unwinding](#).

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](#).

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.

Beware of Medicaid Scams! (4/25/2023) – Skyler

The unwinding presents an unprecedented challenge with state Medicaid agencies across the country processing renewals and determining eligibility for [approximately 92 million beneficiaries](#). Fraudsters have seized the opportunity to exploit this undertaking [by scamming unsuspecting beneficiaries](#). These scams involve trying to make money off of beneficiaries by charging bogus "fees" to enroll or re-enroll in Medicaid. Some beneficiaries receive text messages or telephone calls demanding a fee to apply or renew, sometimes up to \$500, or risk losing their Medicaid coverage.

These scams are complicating outreach and education to Medicaid beneficiaries during an already challenging time where many risk losing their coverage. It is critical that accurate

information reaches all communities on Medicaid. States across the country have already taken action to address these scam risks by issuing [press releases](#), [including anti-fraud language](#) in their outreach toolkits, and encouraging beneficiaries and community partners to report scams.

There is never a fee, and assisters are prohibited from charging fees to submit Medicaid **applications or renewals**. This is separate and apart from beneficiaries who may have a **monthly premium** to keep their Medicaid coverage. Make sure to spread the word about fraud, urge beneficiaries to look out for and report potential scams, utilize legitimate outreach toolkits and messaging from official sources like your state Medicaid agency, and encourage beneficiaries to contact their Medicaid offices if they have questions or concerns about their enrollment.

[Keeping Medicaid/CHIP is NOT Harmful for Immigration Status \(6/13/2023\)](#) – Michelle Enrolling and re-enrolling in Medicaid or CHIP does NOT have any harmful effects on [immigration status](#). Using Medicaid or CHIP to obtain health care services does not harm an individual’s chances of becoming a Legal Permanent Resident, U.S. citizen, or cause risk of deportation. Find more information on the public charge test at [keepyourbenefits.org](#) ([English](#), [Spanish](#), [Chinese](#)).

Individuals should also not need to share information about their immigration status for renewals, unless their status has changed. All personal information provided to Medicaid agencies during renewals is kept private and protected, and agencies are prohibited from sharing any information you provide with immigration enforcement.

Messaging to ease fears related to public charge is critically important during unwinding, especially as the chilling effect from the Trump rule remains. Find community outreach materials at [Protecting Immigrant Families \(PIF\)’s Connected to Coverage page](#). Materials are available in 9 languages ([English](#), [Spanish](#), [Arabic](#), [Simplified Chinese](#), [French](#), [Haitian Creole](#), [Korean](#), [Tagalog](#), [Vietnamese](#)) and include one-pagers, template community presentations, social media posts, and sample scripts. PIF partners have also worked with HHS to record videos that offer assurances that using safety net programs ([English](#), [Spanish](#)) or maintaining Medicaid coverage during the unwinding ([English](#), [Spanish](#)) will not harm immigration status.

[New CMS Guidance \(6/15/2023\)](#) – Sarah

CMS recently released guidance identifying [new strategies](#) states can adopt to prevent Medicaid terminations during unwinding. The new strategies include:

- Suspend the requirement to apply for other benefits under 42 CFR 435.608;
- Suspend the requirement to cooperate with the agency in establishing the identity of a child's parents and in obtaining medical support;
- Renew eligibility if able to do so based on available information, and establish a new eligibility period whenever contact is made with hard-to-reach populations;
- Permit managed care plans to provide assistance to enrollees to complete and submit Medicaid renewal forms;
- Delay procedural terminations for beneficiaries for one month while the state conducts targeted renewal outreach;
- Designate the state agency as a qualified entity to make determinations of Presumptive Eligibility (PE) on a MAGI basis for individuals disenrolled from Medicaid or CHIP for a procedural reason in the prior 90 days (or longer period elected by the state); and
- Designate pharmacies, community-based organizations, and/or other providers as qualified entities to make determinations of PE on a MAGI basis for individuals disenrolled from Medicaid or CHIP for a procedural reason in the prior 90 days (or longer period elected by the state).

Reinstate eligibility effective on the individual's prior termination date for individuals who were disenrolled based on a procedural reason and are subsequently redetermined eligible for Medicaid During a 90-day Reconsideration Period.

Notices & Appeals

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](#).

Keeping Hearings Fair (5/11/2023) – Miriam

Both Medicaid applicants and enrollees have long-established due process rights that ensure that they can request and receive an administrative hearing when the state Medicaid agency takes adverse actions regarding their benefits. See [42 C.F.R. § 431.220\(a\)](#). If an enrollee wants to contest a decision, he/she is entitled to a fair hearing to review that negative action. However, there is an exception to this rule, called the "Mass Change" exception:

[42 C.F.R. § 431.220\(b\)](#) provides that the agency “need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries.” This means when a change in (state or federal) law leads to across-the-board reductions or termination of services, states do not need to provide enrollees with a hearing.

At other times, a hearing might have a different format. For instance, [42 C.F.R. § 431.222 \(a – b\)](#) discusses group hearings. Group hearings may occur when state agencies are allowed to consolidate hearings in cases in which the sole issue involved is one of Federal or State law or policy; or, at times, to respond to a series of individual requests for hearing. In these instances, a state might opt to conduct a single group hearing.

Note that group hearings must follow the same policies and procedures as individual hearings, and each individual participating in the hearing must be permitted to present his/her own case or be represented by the individual’s own authorized representative.

Mass changes exceptions should happen rarely, if at all, during the Unwinding. Advocates should ensure that this limited mass change exception is used appropriately and not abused. Advocates should also monitor group hearings and verify that enrollees directed to group hearings still have an opportunity to set out the facts in each individual case.

Extending Fair Hearings & Final Action Timelines (4/20/2023) – Kim

Now that Medicaid unwinding has begun, states may face a high volume of fair hearings and become overwhelmed in processing them within the required 90 days. These states can request a temporary extension of the timeframe to process hearings and take final administrative action utilizing the waiver authority under Section 1902 (e)(14)(A) of the Social Security Act to extend hearing decisions beyond 90 days. As outlined in [State Health Official \(SHO\) Letter #22-001](#), CMS can approve such waivers as necessary to ensure states protect enrollees. Importantly, if states get this flexibility, they must provide benefits pending the outcome of the fair hearing decision (including reinstatement of benefits per 42 CFR § 431.231) and without subjecting any enrollee who appeals to recoupment of benefits if the final decision is adverse to the enrollee. Allowing additional administrative time to complete the fair hearing process ensures enrollees remain in coverage pending a decision and the state remains in compliance with the fair hearing processing timelines. Advocates in states where such [waivers](#) exist should review these Medicaid notices of actions to ensure the protections required in these waivers are clear, such as not indicating the possibility of recoupment since it would not be allowed.

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.

General Restart of Redetermination 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 attached 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. <https://healthlaw.org/wp-content/uploads/2023/03/OHCA-Purple-Letter-SoonerCare-Unwind-Notification-1.pdf>

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.

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.

[How Principles for Fair Automated Decision-Making Systems Apply to Unwinding](#) (6/22/2023) – Cassandra

Have you seen NHeLP's new resource that can help with unwinding? In May, we released our [Principles for Fairer, More Responsive Automated Decision-Making Systems](#). Many Medicaid agencies use automated decision-making systems (ADS) to make service allocation and benefit eligibility decisions. The principles outline how to build successful ADS and minimize drawbacks such as undue benefits reductions and terminations. Check out [this blog post](#) to learn more about how the principles apply to unwinding and [this resource on potential issues and questions to ask regarding unwinding automations](#).

[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.

[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.

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:

1. Total number of renewals that were initiated;
2. Total number of renewals that were successfully renewed;
3. The number of beneficiaries who were renewed via *ex parte*;
4. Total number of individuals whose coverage was terminated; and

5. 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 correct improper negative actions. You can refer to [CMS' data reporting instruction manual](#) for more in depth information about data reporting requirements.

State Unwinding Data Dashboards (4/18/2023) – Alicia

Data, data, and more data! States are required to report specific data to CMS during the unwinding, but there is a known lag time to the public release of this data. Given the intense focus on the high volume of eligibility redeterminations and anticipated disenrollments, some states have initiated state unwinding data dashboards to monitor progress. Iowa, Minnesota, Utah, Washington, West Virginia and other states have [publicly released](#) useful dashboards. For example, Iowa's interactive [dashboard](#) allows the user to filter information by county and population, and even shares the volume of renewals returned by renewal month. [Twenty-two](#) other states have indicated they plan to release state unwinding data dashboards. Is your state one of them? If so, now is the time to influence your state Medicaid agency on the contents of your state unwinding data dashboard. In combination with data reported to CMS, state unwinding data dashboards can be a critical tool for advocates and enrollment assisters to understand what is happening on the ground in their state.

Where's the Data? (6/8/2023) – Elizabeth

States are submitting data regarding coverage changes and timeliness during the Medicaid continuous coverage unwinding through longstanding performance data requirements and new data requirements from the Consolidated Appropriations Act of 2023, as described in [SHO 23-002](#). But where is this data? Some states have posted their monthly unwinding data report to their website or have shared unwinding report data in presentations. Some states also have [public dashboards](#), which may present different information. CMS has not yet [posted](#) the unwinding data required under the CAA and we do not expect to see that data until July. Some state reports show problems with [data reporting according to specifications](#) or otherwise look like they have errors. We expect that unwinding data reports will be made public after CMS addresses reporting quirks. Advocates wanting to know how their state is doing and who have not been able to find a public version of the report may need to file a public records request for the unwinding data report.

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.

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

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.

COVID is Not Over in Medicaid and CHIP (5/2/2023) – Charly

States must continue to provide COVID-19 treatment and therapies with no cost-sharing to Medicaid and CHIP enrollees. This includes vaccines, testing, treatment, specialized equipment, and, in certain circumstances, treatment for conditions that may seriously complicate COVID-19. (See [SHO #23-002](#) at page 6-7.) This requirement applies whether or not the state continues to receive the temporary FMAP increase and remains in effect until approximately September 2024 under current law.

Unwinding Plan Trends Fact Sheet (6/6/2023) – Cassandra

State unwinding plans provided general information on how they were approaching redeterminations and other unwinding requirements. While not all states included the same depth of information, we analyzed the plans for trends likely to impact coverage. This includes identifying the states that are conducting outreach and awareness campaigns in multiple languages, prioritizing redeterminations based on population, and extending their state-based marketplace special enrollment period. See [this resource](#) for more information.

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.

Population Specific Protections Used by States (5/18/2023) – Cassandra

State unwinding plans provide several examples of actions states are taking to help maintain coverage, usually for certain categories of eligibility or population. While many states are maintaining enrollees’ current renewal month, some states are de-prioritizing renewals or otherwise undertaking activities to help populations maintain coverage. Examples include:

- Colorado is maintaining 12 months of coverage for enrollees with transitional Medicaid coverage after their redetermination.
- Delaware will not automatically close cases for those with intellectual or developmental disabilities or those in long term care.
- Florida is deprioritizing those under the age of 21 with medically complex conditions, SSI institutional care enrollees, and hospice care enrollees.

In Pennsylvania, Emergency Medicaid Assistance recipients who will reach the 5-year bar during unwinding, will have their redetermination scheduled after the 5 years.