CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

All-State Medicaid & CHIP Call

January 19, 2021

State Health Official (SHO) Letter #20-004: Table of Contents

Resuming Normal Eligibility and Enrollment Operations: **Timelines**

- After the public health emergency (PHE), states will need to complete any backlog of COVID-related pending eligibility and enrollment actions and resume routine operations in four key areas:
  - Applications,
  - Verifications for individuals enrolled based on self-attested information, as applicable (post-enrollment verifications),
  - Redeterminations based on changes in circumstances, and
  - Renewals.

- States should take steps <u>now</u> to limit the volume of pending actions they must work through at the end of the PHE to the extent possible. In particular, states should process applications as expeditiously as possible during the PHE, including disability-related applications or applications for other vulnerable populations. States should also begin processing renewals, redeterminations based on changes in circumstances and post-enrollment verifications to the extent possible.

- States may take up to **<u>4 months</u>** following the month in which the PHE ends to resume routine application processing while meeting interim milestones.

- States may take up to **<u>6 months</u>** following the month in which the PHE ends to complete pending verifications, changes in circumstances, and renewals and resume routine operations.

Resuming Normal Eligibility and Enrollment Operations: Applications

- States may use a phased approach to complete eligibility determinations for pending applications received during the PHE
  - **2 months:** Complete eligibility determinations for all pending MAGI and other non-disability applications received during the PHE.
  - **3 months:** Complete eligibility determinations for all pending disability applications received during the PHE.
  - **4 months:** Resume timely and accurate determinations of eligibility for all new applications.

- Pending applications received during the PHE that must be processed within the interim milestones include:
  - Applications submitted to the Medicaid or CHIP agency during the PHE that are not processed, and
  - Account transfers received from the Exchange during the PHE.

- An application is considered to be processed when the agency enrolls an eligible applicant or denies coverage for an individual the agency could not determine as eligible.

- After 4 months, states must timely process all applications received after the PHE ends. In accordance with 42 C.F.R. §§ 435.912(c) and 457.340(d)), determinations of eligibility must be completed within:
  - 90 days for applications on the basis of a disability
  - 45 days for all MAGI and other non-disability related applications

Resuming Normal Eligibility and Enrollment Operations: Verifications

- States may elect to enroll applicants based on self-attested information and access relevant data sources, consistent with their verification plan, to verify eligibility criteria for beneficiaries after they are enrolled (post-enrollment verifications). Election made through:
  - State verification plan, or
  - Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum for temporary election of this option during the PHE.

- States should complete post-enrollment verification processes during the PHE to the extent possible. Individuals validly enrolled based on self-attested information may not be terminated in states claiming the 6.2 percentage point FMAP increase authorized under FFCRA.

- Within 6 months after the PHE ends, states that enrolled individuals based on self-attested information during the PHE must complete outstanding verifications for individuals.
  - Begin verifications the state has not initiated (e.g. check the data sources consistent with the state's verification addendum/plan),
  - Request additional information from beneficiaries, as needed, if available information cannot verify continued eligibility, and
  - Provide advance notice and terminate coverage for beneficiaries determined ineligible but who are still enrolled.

- No later than 6 months after the PHE ends, states that continue to enroll individuals based on self-attested information must complete verifications of eligibility for all beneficiaries enrolled within a reasonable timeframe after initial enrollment. States may not wait to conduct required verifications until the beneficiary's renewal.

Resuming Normal Eligibility and Enrollment Operations: Changes in Circumstances

- States must complete redeterminations of eligibility based on changes in circumstances identified, reported, or anticipated during the PHE within 6 months after the month the PHE ends. This includes:
  - Changes that may affect eligibility identified, reported, or anticipated during the PHE, but the state has not contacted the beneficiary to redetermine eligibility.
  - Redeterminations that resulted in a determination of ineligibility, but the state was unable to terminate coverage.
  - Redeterminations based on changes in state eligibility and enrollment processes that take effect when the PHE ends (e.g., elimination of temporary eligibility group, the expiration of an income or resource disregard applied during the PHE).

- After 6 months, states must promptly act on all newly identified, reported, or anticipated changes in circumstances that may affect eligibility in accordance with 42 C.F.R. §§ 435.916(d) and 457.343.

Resuming Normal Eligibility and Enrollment Operations: **Renewals**

- States must complete pending renewals due during the PHE and resume timely and accurate redeterminations of eligibility for renewals due after the PHE within 6 months after the month the PHE ends. This includes:
  - Renewals due during the PHE that the state was not able to initiate.
  - Renewals for which the state could not determine eligibility continues based on available information, but for which the state has not sent the beneficiary a renewal form.
  - Renewals that resulted in a determination of ineligibility, but the state was unable to terminate coverage.

- After 6 months, states must meet requirements at 42 C.F.R. §§ 435.916 and 457.343, to renew eligibility once every 12 months (and only once every 12 months) for MAGI beneficiaries and at least once every 12 months for non-MAGI beneficiaries.

- CMS is available to provide technical assistance to states seeking to evenly distribute renewals over the course of a year to ensure a manageable and sustainable renewal workload in future years.

Resuming Normal Eligibility and Enrollment Operations: Expectations During the PHE

- States should take steps now to prioritize actions that ensure eligible individuals are able to enroll and remain enrolled in coverage and make timely determinations of eligibility for new applicants.

- Given the volume of work that will need to be completed when the PHE ends, states are encouraged to process as many pending verifications, renewals and redeterminations based on changes in circumstances during the PHE as possible to limit the backlog of pending actions the state will need to complete when the PHE ends. At a minimum, states should:
  - Complete renewals for beneficiaries whose eligibility can be determined based on available information (*ex parte* renewals),
  - Complete verifications of all eligibility criteria for individuals enrolled based on self-attested information
  - Act to redetermine eligibility based on changes in circumstances

Eligibility and Enrollment Strategies:
Risk-Based Approach

- States should use a risk-based approach to prioritize work to complete pending verifications, redeterminations based on changes in circumstances, and renewals.

- A risk-based approach prioritizes actions for individuals who are most likely to be no longer eligible for coverage and minimizes the extent to which coverage is provided to individuals who no longer meet eligibility criteria.

- States may select from one of four risk-based approaches to address pending cases.

Eligibility and Enrollment Strategies:
Risk-Based Approach (cont.)

- **Population-based approach**: Prioritize completing outstanding eligibility and enrollment actions for individuals in groups who are most likely to be no longer eligible.

- Examples of populations states may prioritize include:
  - Individuals who became categorically ineligible for the group in which they are enrolled during the PHE (e.g., individuals who, during the PHE, exceeded the maximum age permitted for their eligibility group or individuals enrolled in the adult group who became eligible for Medicare).
  - Individuals determined ineligible for Medicaid during the PHE, but not terminated in order to comply with the continuous enrollment requirement under the FFCRA in order to claim the temporary FMAP increase.
  - Individuals who gained eligibility due to states' use of a temporary eligibility flexibility.

- Populations whose eligibility tends to be stable, such as children, former foster youth, or individuals dually eligible for Medicaid and Medicare, are not among the types of populations CMS would expect states to prioritize in a population-based approach.

Eligibility and Enrollment Strategies:
Risk-Based Approach (cont.)

- **Time-based approach**: Prioritize cases based on the length of time the action has been pending and complete oldest pending actions first.

- **Hybrid approach**: Combine the population and time-based approaches (e.g. use a time-based approach to prioritize completion of pending redeterminations for older changes in circumstances first and a population-based approach to prioritize pending renewals for certain populations first).

- **State-developed approach:** Develop a state-specific risk-based approach that prioritizes actions for individuals who are most likely to be no longer eligible or for which there is greater risk that ineligible individuals may remain enrolled longer.

Eligibility and Enrollment Strategies:
Authorities and Efficiencies

- States should inventory each flexibility implemented to address the COVID-19 PHE to determine whether the flexibility should end prior to the end of the PHE, be maintained for the duration of the PHE, or be extended on a temporary or permanent basis after the PHE concludes, as allowable (to be determined on a case-by-case basis).

- States may adopt or continue existing authorities to streamline eligibility and enrollment processes, such as:
  - Adopt Express Lane Eligibility for children at application and/or renewal,
  - Continue use of income or resource disregards for eligibility criteria initially adopted during the PHE,
  - Update verification policies, or
  - Apply required MAGI renewal processes for non-MAGI beneficiaries (e.g., use prepopulated renewal forms, offer a reconsideration period).

- States can create efficiencies by aligning work on pending actions with an upcoming renewal and/or with a renewal or recertification conducted by another benefit program, such as Supplemental Nutrition Assistance Program (SNAP), as long as states can complete work on pending actions within the timeframes outlined in the SHO.
  - For example, identify beneficiaries with SNAP recertifications due within 6 months after the end of the PHE and conduct pending verifications or redeterminations at the same time.

- Consider and request the authorities necessary to adopt or maintain an existing strategy (SPAs, Updated verification plans, Internal state policies/process).

Eligibility and Enrollment Strategies:

Avoiding Repeat Redeterminations for Ineligible Individuals

- States must repeat redeterminations after the PHE for individuals determined ineligible during the PHE, if the beneficiary's initial redetermination is conducted more than 6 months prior to the scheduled termination date.

- States may send advance notice of termination and fair hearing rights in accordance with 42 C.F.R. Part 431, Subpart E and terminate a beneficiary's coverage after the PHE, without repeating a redetermination, if:

  - **For individuals determined ineligible during the PHE**
    - The redetermination conducted during the PHE was completed no more than 6 months prior to the date of termination AND
    - The state provides an initial notice at the time of the determination that informs beneficiaries

      1) of the determination of ineligibility,

      2) that enrollment will end after the month in which the PHE ends, and

      3) that the individual can and should report changes in circumstances to have their eligibility redetermined

  - **For individuals who fail to respond to a request for information during the PHE**
    - The renewal form was sent no more than 6 months prior to the date of termination
    - The state must allows beneficiaries to provide information or return necessary forms/documentation at least through the end of the month in which the PHE ends.
    - An initial notice is not required.

Eligibility and Enrollment Strategies:
Avoiding Repeat Redeterminations Example 1

January 2021

- State processes James' renewal and determines he is no longer eligible for Medicaid on all bases
- State sends James a notice stating that he is 1) determined ineligible 2) that his enrollment will continue until after the PHE ends, and 3) that he can report any changes in circumstances

April 2021

- Public health emergency ends

May 2021

- State picks up James' case. James has not reported any changes in circumstances since the state determined him ineligible for Medicaid in January.
- State intends to terminate coverage by the end of May, which is within 6 months from the date of his determination in January
- State sends the required minimum 10-day advance notice with fair hearing rights and terminates coverage based on the determination made in January

Note: If the state is unable to terminate James' coverage until August, which is more than 6 months after the determination of ineligibility, the state would be required to repeat the renewal based on available data sources at that point, and request new information from James, if needed, to complete a determination.

Eligibility and Enrollment Strategies:
Avoiding Repeat Redeterminations Example 2

January – February 2021

- Amelia's renewal is due in February.
- In January, the state initiates Amelia's renewal and sends her a renewal form in January because the state was unable to renew Amelia's eligibility based on available information
- Amelia does not return her form before the end of eligibility period at the end of February. State takes no action but will allow Amelia to return her renewal form at least through the end of the month the PHE ends.

April 2021

- Public health emergency ends
- Amelia has still not returned her renewal form even though the state would have accepted the form

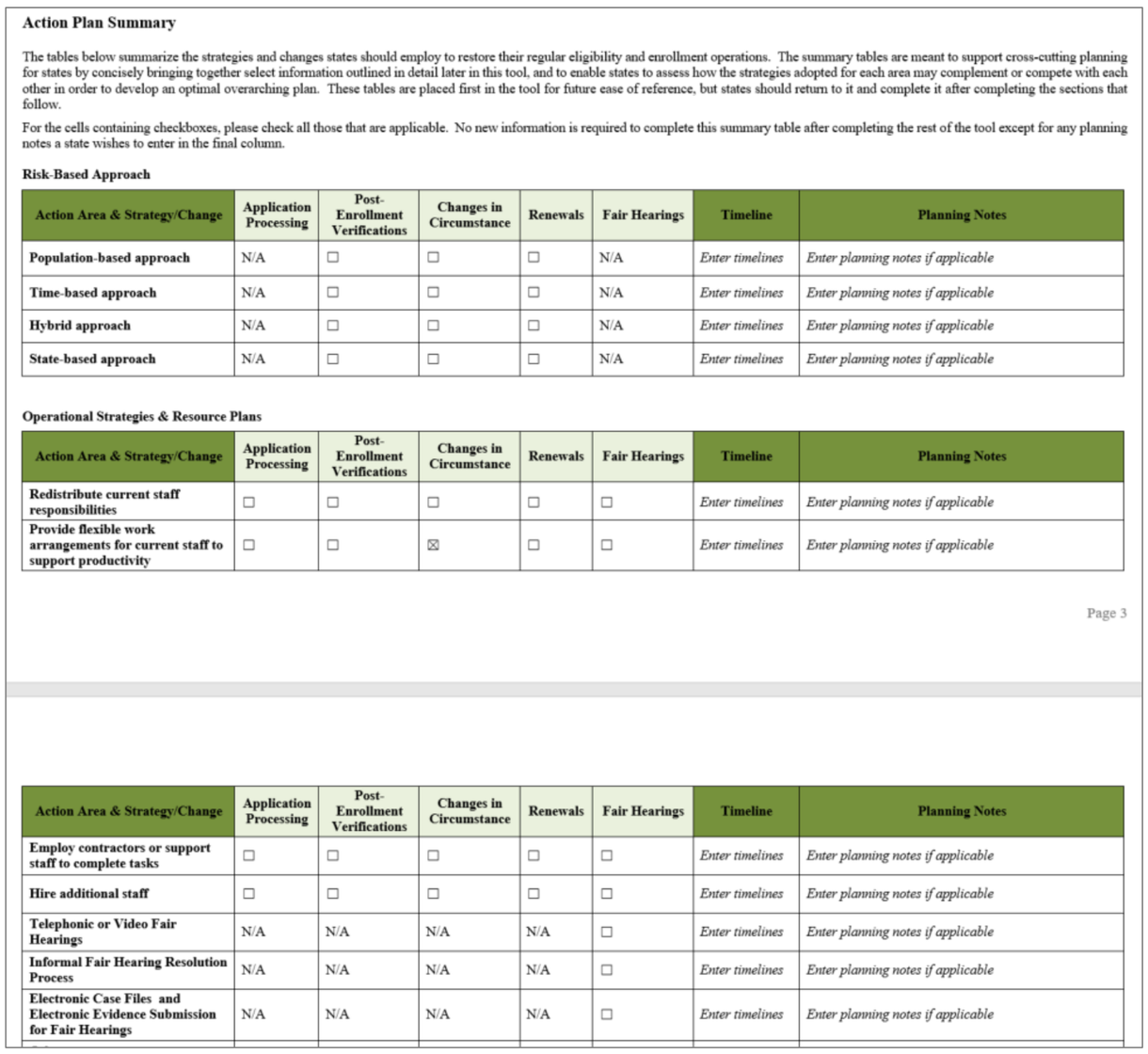
May 2021

- State picks up Amelia's case and sees that she still has not returned her renewal form.
- State intends to terminate Amelia's coverage by the end of May, which is within 6 months from the date of when her renewal form was sent in January
- State sends the required minimum 10-day advance notice with fair hearing rights and terminates coverage for failure to respond

Note: If the state is unable to terminate Amelia's coverage until August, which is more than 6 months after the state sent her renewal form, the state would be required to repeat the renewal based on available data sources at that point, and request information from Amelia, if needed, to complete a determination.

Development of a Post-COVID Operational Plan

Medicaid & CHIP COVID-19 Eligibility & Enrollment Pending Actions Resolution Planning Tool



Action Plan Summary

The tables below summarize the strategies and changes states should employ to restore their regular eligibility and enrollment operations. The summary tables are meant to support cross-cutting planning for states by concisely bringing together select information outlined in detail later in this tool, and to enable states to assess how the strategies adopted for each area may complement or compete with each other in order to develop an optimal overarching plan. These tables are placed first in the tool for future ease of reference, but states should return to it and complete it after completing the sections that follow.

For the cells containing checkboxes, please check all those that are applicable. No new information is required to complete this summary table after completing the rest of the tool except for any planning notes a state wishes to enter in the final column.

Risk-Based Approach

Action Area & Strategy/Change	Application Processing	Post-Enrollment Verifications	Changes in Circumstance	Renewals	Fair Hearings	Timeline	Planning Notes
Population-based approach	N/A	☐	☐	☐	N/A	*Enter timelines*	*Enter planning notes if applicable*
Time-based approach	N/A	☐	☐	☐	N/A	*Enter timelines*	*Enter planning notes if applicable*
Hybrid approach	N/A	☐	☐	☐	N/A	*Enter timelines*	*Enter planning notes if applicable*
State-based approach	N/A	☐	☐	☐	N/A	*Enter timelines*	*Enter planning notes if applicable*

Operational Strategies & Resource Plans

Action Area & Strategy/Change	Application Processing	Post-Enrollment Verifications	Changes in Circumstance	Renewals	Fair Hearings	Timeline	Planning Notes
Redistribute current staff responsibilities	☐	☐	☐	☐	☐	*Enter timelines*	*Enter planning notes if applicable*
Provide flexible work arrangements for current staff to support productivity	☐	☐	☒	☐	☐	*Enter timelines*	*Enter planning notes if applicable*

Page 3

Action Area & Strategy/Change	Application Processing	Post-Enrollment Verifications	Changes in Circumstance	Renewals	Fair Hearings	Timeline	Planning Notes
Employ contractors or support staff to complete tasks	☐	☐	☐	☐	☐	*Enter timelines*	*Enter planning notes if applicable*
Hire additional staff	☐	☐	☐	☐	☐	*Enter timelines*	*Enter planning notes if applicable*
Telephonic or Video Fair Hearings	N/A	N/A	N/A	N/A	☐	*Enter timelines*	*Enter planning notes if applicable*
Informal Fair Hearing Resolution Process	N/A	N/A	N/A	N/A	☐	*Enter timelines*	*Enter planning notes if applicable*
Electronic Case Files and Electronic Evidence Submission for Fair Hearings	N/A	N/A	N/A	N/A	☐	*Enter timelines*	*Enter planning notes if applicable*

Available for download on Medicaid.gov at https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html

- States should develop a post-COVID eligibility and enrollment operational plan to document how the state will achieve the timelines outlined in the SHO.
- To assist states, CMS released a planning tool states may reference for the types of issues that may need to be addressed in the operational plan or to document their plans.
- States do not submit their post-COVID eligibility and enrollment operational plan CMS for approval, and states are not required to use the planning tool.
- States will be required to submit data to CMS to demonstrate their progress. A data submission tool is forthcoming.

Resuming Normal Eligibility and Enrollment Operations: Summary

Prior to the End of the PHE	**Begin Planning: I**dentify needed systems and other operational changes. Develop risk-based plan to address pending actions. **Complete Processing of Cases, Where Feasible:** Prioritize application processing and renewals, redeterminations, and verifications that can be completed based on available information.
End of the PHE	**Begin addressing backlog of pending actions.** After the end of the month the PHE ends, states may begin terminating Medicaid coverage, as appropriate, and completing all pending eligibility and enrollment actions.
2 Months Post PHE	**Non-disability related applications:** States complete pending MAGI and other non-disability applications received during the PHE
3 Months Post PHE	**Disability related applications:** States complete pending disability applications received during the PHE
4 Months Post PHE	**All applications:** States resume timely determinations of eligibility for all applications
6 Months Post PHE	**Verifications:** States complete pending verifications for individuals enrolled based on self-attested information **Changes in Circumstances:** States complete action on pending changes anticipated, received or identified during the PHE **Renewals:** States complete pending renewals due during the PHE
After 6 Month Timeline	**Restoration of enrollment actions:** States resume timely processing of all eligibility and enrollment actions

Questions

January 26th All-State Call

CDC expected to present on vaccines. Topics to include:

- COVID-19 vaccine safety and vaccine hesitancy
- Reduction in routine pediatric vaccines and CDC's "Call to Action"

If states have questions on these topics now, please send by Thursday, January 21st to: MedicaidCOVID19@cms.hhs.gov