THORN RUN PARTNERS
GOVERNMENT RELATIONS

Memorandum *March 9, 2022*

CMS Releases Updated PHE Guidance to States on Unwinding the Medicaid Continuous Coverage Requirement

Executive Summary

Recently, the Centers for Medicare and Medicaid Services (CMS) released new guidance to state health officials to assist states in planning efforts to resume Medicaid and Children's Health Insurance Plan (CHIP) eligibility determinations and renewals after the public health emergency (PHE) comes to an end. Specifically, this guidance provides tools and resources for states to **restore routine Medicaid and CHIP eligibility and enrollment** during the unwinding period, **promote coverage continuity**, and **facilitate beneficiary transitions into qualified health plans** (QHPs) in federal or state marketplaces, among other things.

- **Background.** Under the Families First Coronavirus Response Act (H.R. 6201), states are required to satisfy a "continuous enrollment" maintenance of effort (MOE) requirement for nearly all their Medicaid enrollees who have been eligible and enrolled in Medicaid during the PHE to receive a temporary 6.2 percentage point increase in their federal medical assistance percentage (FMAP) made available under the Act. During this time, states have not been able to remove beneficiaries from Medicaid who are no longer eligible for the program or conduct eligibility redeterminations to verify eligibility. This policy and the immediate loss of the enhanced FMAP at the end of the PHE has created uncertainty about how states are to resume these activities. In previously released guidance, the Biden administration had given states 12 months to complete the redetermination process, and states raised concern that this was not enough time to complete all the enrollment actions necessary that have accumulated during the PHE, particularly if the enhanced FMAP ends. Other temporary authorities for states are set to expire at the end of the PHE, such as the section 1135 waivers, which will require states to plan for a return to regular operations across their programs.

Specifically, the updated guidance notes that states can begin the redetermination process up to two months before the PHE ends, which is roughly the same amount of time that the Biden administration expects to provide before bringing an end to the PHE. Notably, the guidance provides information to states to support the transition of individuals into a QHP if an individual is found to be ineligible for Medicaid. To support these efforts, the guidance indicates that states have the authority to treat enrollees who are deemed ineligible for Medicaid or CHIP as eligible for marketplace coverage unless the ineligibility determination is due to a procedural reason. Additionally, CMS issued data reporting requirements that instruct states to submit baseline Medicaid data and include additional data for the preceding 14 months. States will also have to submit supplementary data if CMS raises concerns about data compliance or if the state in question is not meeting reporting timelines.

CMS's key goals for states within the new guidance are discussed below:

Restoring routine eligibility and enrollment operations after the PHE ends

- *Unwinding Operational Plan* — CMS's guidance requires states to develop and document a comprehensive plan to restore routine operations in Medicaid, CHIP, and the Basic Health Program (BHP), referred to as the "unwinding operational plan." This plan should include a description of how the state intends to address any outstanding actions in a way that: (1) reduces coverage loss for beneficiaries; (2) cultivates a manageable renewal distribution in the future; and (3) includes consideration of reviewing new applications and eligibility within the timelines outlined below.
- *Timelines to Complete Eligibility and Enrollment Actions after PHE Ends* — CMS notes that agencies can use a phased approach to process applications and resume eligibility redetermination. Notably, this guidance provides states with 14 months for states to process Medicaid and CHIP renewals after the PHE ends. This updated timeline gives states a two-month buffer zone for renewals starting two months before the end of the PHE and ending two months after the expiration of the original 12-month window. While the guidance does *not* change the steps states must take to complete renewals, the Center for Medicaid and CHIP Services (CMCS) previously offered detailed information for the renewal requirements.
    - States must commence the unwinding period on the first day of the month following the end of the PHE. For example, if the PHE ends mid-August, states must begin the unwinding process on September 1. However, states may begin their 12-month unwinding period up to two months prior to end of the month in which the PHE ends. This is predicated on a commitment from the Administration to provide states with a 60-day notice that it intends to end the PHE. Details of these suggested timelines can be seen in Appendix A, included in the guidance from CMS.
- *Completing Renewals During the Post-PHE Unwinding Period* — The table in Appendix B, included in the guidance from CMS, provides guidelines for states when setting beneficiary renewal dates during the unwinding period, based on the outcome and timing of the beneficiary's last attempted renewal during prior to the PHE.
- *Acting on Changes in Circumstances during the Unwinding Period* — This section requires states, during the unwinding period, to complete a full renewal for any beneficiary unless a renewal was completed in the 12 months prior to an identified or reported beneficiary change in circumstances.

Promoting Continuity of Coverage

- *State Plan and Operational Strategies* — This guidance suggests that states consider strategies that will: (1) help eligible individuals maintain coverage; (2) prevent churn; and (3) mitigate procedural denials based on paperwork and administrative delays. To accomplish these goals, the guidance suggests that states consider state plan options to promote coverage of children and provide continuous enrollment, options to streamline renewals, and improving communications and outreach. Please see this CMS Communications Toolkit for Continuous Enrollment Unwinding for more information.

- *Temporary Waiver* — In an effort to reduce churn, CMS will enable states to implement section 1902(e)(14)(A) waivers. These waivers will be granted to states that are at risk of stripping beneficiaries of their coverage due to operational issues related to the renewal process. The temporary waivers allow states to implement flexibilities, such as reducing the need for additional information from beneficiaries, to streamline the redetermination process, and to reduce the risk of improper enrollment. These flexibilities will *not* permit states to extend or shorten the 14-month timeline.

Facilitating Transitions between Medicaid, CHIP, the Basic Health Program, and the Health Insurance Marketplaces

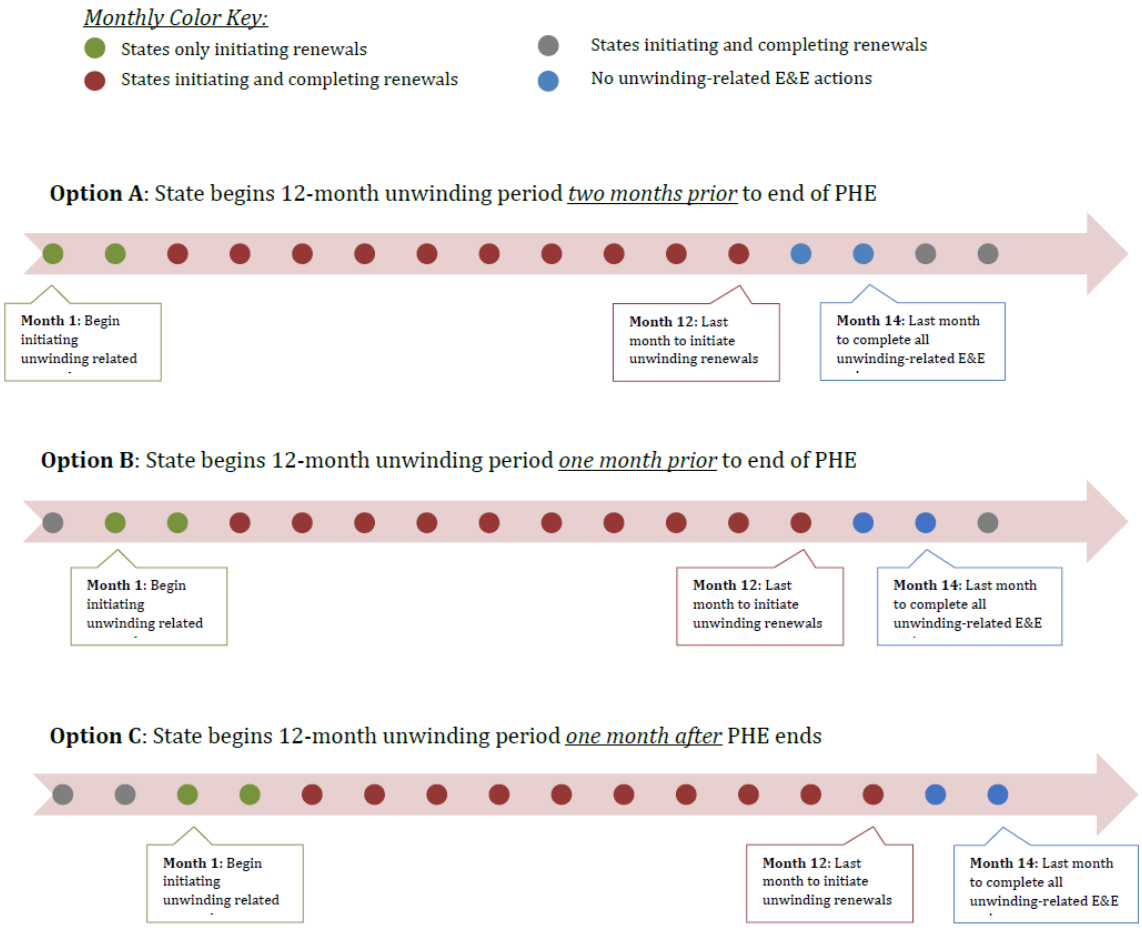
- *Transitioning to a QHP through the Marketplace* — In order to facilitate continuity of coverage, the recent CMS guidance notes that states can treat individuals no longer eligible for Medicaid, CHIP, and BHP coverage as eligible for a QHP through federal or state marketplaces. Additionally, states are required to have a coordinated process to transfer the beneficiary's electronic account, including any eligibility information, to the appropriate marketplace in a timely fashion. CMS noted that this requirement does *not* apply to beneficiaries deemed ineligible for Medicaid or CHIP due to a procedural reason, like a failure to complete renewal paperwork.
- *Additional Approaches* — To further help with transitions and increase enrollments in QHPs, CMS is encouraging states to implement additional approaches such as:
    - Including all available beneficiary contact and eligibility information in the data transferred to the Marketplace;
    - Improving notices sent to beneficiaries informing them that they are no longer eligible for Medicaid and CHIP, so individuals are aware that states have transmitted their information to the Marketplace; and
    - Working with community-based organizations and beneficiary advocates so that beneficiaries get the information and assistance they need to navigate the transition.
- *Managed Care Organizations* — Additionally, this guidance has created flexibilities so that managed care organizations (MCOs) can play a larger role in supporting states regarding outreach to consumers during the unwinding period. CMS released an updated slide deck that highlights MCOs' role and provides additional information to collect beneficiary contact information, strategies for enrolling those who lose Medicaid coverage, and clarifications of the updated federal framework to engage plans in the unwinding efforts.

Prioritization and Distribution of Pending Eligibility and Enrollment Work

- *Adopting a Risk-Based Approach to Prioritize Work* — In order to prioritize pending eligibility and enrollment actions, CMS is encouraging states to create a risk-based approach to prioritizing redetermination backlogs. The guidance instructs states to choose from approaches that would prioritize beneficiaries based on population characteristics, time that the case has been pending, a hybrid of these options, or a unique approach determined by the state.
- *Prioritization Schedule* — Upon prioritization of work, states are expected to distribute a schedule detailing its redetermination timeline. CMS notes that this plan would include: (1)

assurances that the state can maintain coverage and facilitate coverage transitions; and (2) a mitigation strategy to address potential roadblock to the plan.

APPENDIX A — 12-MONTH UNWINDING TIMELINE*



*Modified from CMS Appendix A: 12-Month Unwinding Timeline

APPENDIX B — POST-PHE RENEWAL TIMELINE*

Outcome of Last Renewal Attempted During the Last 12 Months of the PHE	Permissible Timing of Renewal During 12-Month Unwinding Period
Renewal attempted but not completed. No further state action taken.	Any time (states are encouraged to consider strategies to align renewals with SNAP recertifications or renewals for members of a household)
Renewal attempted but not completed. State sent renewal form. Beneficiary determined ineligible or did not respond.	Any time (states are encouraged to consider strategies to align renewals with SNAP recertifications or renewals for members of a household)
Renewal completed based on beneficiary's return of renewal form and/or additional information. Individual continues to meet eligibility requirements. New eligibility period established.	12 months after beneficiary's last renewal for MAGI-beneficiaries; 12 months or shorter eligibility period established by the state for non-MAGI beneficiaries.
Renewal attempted and successfully completed. New eligibility period established.	12 months after beneficiary's last renewal or original renewal month, at state option, for MAGI-beneficiaries; 12 months or shorter eligibility period established by the state for non-MAGI beneficiaries.
No renewal attempted in last 12 months of PHE.	Any time

*Modified from CMS Table 1. Guidelines for Establishing Renewal Dates during the 12-Month Unwinding Period