



SHO# 22-001
RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency

March 3, 2022

Dear State Health Official:

The ongoing Coronavirus Disease 2019 (COVID-19) outbreak and implementation of federal policies to address the public health emergency (PHE) have disrupted routine Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) eligibility and enrollment operations. Over the course of the PHE, states have made policy, programmatic, and systems changes to respond effectively to COVID-19 and qualify for the temporary Federal Medical Assistance Percentage (FMAP) increase under section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127), including by satisfying a “continuous enrollment condition” for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

It has been a top priority for the Centers for Medicare & Medicaid Services (CMS) to ensure, when the PHE eventually ends and states resume routine operations, including terminations of eligibility, that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage. This State Health Official (SHO) letter expands on the guidance released in SHO #21-002, “Updated Guidance related to Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency,” published on August 13, 2021 (“August 2021 SHO”), by describing how states may distribute eligibility and enrollment work when states restore routine operations, mitigate churn for eligible beneficiaries, and smoothly transition individuals between coverage programs, including coverage through the Federally-facilitated Marketplace or a State-Based Marketplace (SBM).

As with previous SHO letters issued by CMS regarding the PHE, this SHO letter is intended to assist states in their planning efforts whenever the federal PHE declaration eventually ends and does not presuppose a specific time frame in which that will occur. The Department of Health and Human Services (HHS) will determine when the federal PHE declaration will end, and CMS will share with states any communication released by HHS.

In addition to resuming normal eligibility and enrollment operations, authority for other types of disaster relief flexibilities will conclude when the PHE eventually ends, and states will need to return to regular operations across their programs. CMS has approved almost 1,000 disaster relief actions for states during the PHE, many for non-eligibility and enrollment-related flexibilities, including section 1135 waivers to delay provider revalidations, disaster relief state plan amendments (SPAs) to extend telehealth flexibilities, and section 1915(c) Appendix Ks to allow the provision of services by family members, among many others.

States need to determine which temporary flexibilities they intend to extend temporarily or permanently, as allowable, and make plans to terminate other flexibilities after the PHE eventually ends. Guidance to support states in these planning efforts is available in SHO #20-004, “Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency” (“December 2020 SHO”).¹ This guidance, which was released on December 23, 2020, provides information on returning to normal operations across these programs, including requirements for making temporary changes permanent and ending temporary authorities, as well as operational and managed care considerations for returning to normal operations. Additional information will continue to be provided to states on streamlined processes to temporarily extend authorities initially adopted through disaster relief SPAs, as well as to add or modify authorities needed on a temporary basis as a state returns to normal operations.²

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¹ SHO #20-004, “Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency,” available at: <https://www.medicaid.gov/sites/default/files/2020-12/sho20004.pdf>.

² Details on extending Medicaid disaster relief SPA provisions, either temporarily or indefinitely, were provided during the February 15, 2022 All-State Medicaid and CHIP call. Information discussed during the call is available at: <https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall02152022.pdf>.

I. **Executive Summary**

This SHO letter is part of a series of guidance and tools that outlines how states may address the large volume of pending eligibility and enrollment actions that will need to be addressed when they restore routine operations, including terminations of coverage. This letter expands on the August 2021 SHO by describing how states may distribute eligibility and enrollment work in the post-PHE period, mitigate churn for eligible beneficiaries who lose coverage and later reenroll, and smoothly transition individuals between coverage programs, including coverage through the Marketplace with financial subsidies. This SHO reiterates options for states to align work on pending eligibility and enrollment actions after the PHE eventually ends and provides that states must *initiate*, rather than complete, all pending actions during the 12-month unwinding period. In addition, this SHO informs states that they are at risk of inappropriately terminating coverage for eligible individuals if they plan to initiate a high volume of renewals in a given month and that CMS intends to collect information on all states' plans to adopt strategies that will promote continuity of coverage and guard against inappropriate terminations.

A. ***Background***

The ongoing COVID-19 outbreak and implementation of federal policies to address the PHE have disrupted routine Medicaid, CHIP, and BHP eligibility and enrollment operations. Medicaid and CHIP enrollment has grown to nearly 85 million individuals due, in large part, to the continuous enrollment condition.³ It is critical to ensure, when the PHE eventually ends, that renewals of eligibility occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage, including for individuals eligible for other insurance affordability programs, and maximizes state effectiveness.

B. ***Operational Plans and Timelines to Complete Eligibility and Enrollment Actions***

As discussed in prior guidance, states will need to develop a comprehensive “unwinding operational plan” to restore routine operations in their Medicaid, CHIP, and BHP programs. This unwinding operational plan is intended to reflect how states will complete outstanding work and maximize uninterrupted coverage for eligible individuals.

CMS acknowledges that states will have some pending applications that will need to be completed and will continue to receive new applications as they work to resume normal processing of renewals. This SHO permits states to use a phased approach to complete processing of any pending applications and resume timely and accurate determinations of eligibility on all new applications within four months after the eventual end of the PHE.

To account for the time needed to complete renewals, CMS will consider states to be in compliance with the 12-month unwinding period announced in the August 2021 SHO provided that the state has *initiated* all renewals and other outstanding eligibility actions by the last month of the 12-month period. States will have two additional months (14 months total) to *complete* all

³ Medicaid and CHIP Enrollment Snapshots (September 2021). Available at <https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html>.

pending actions initiated during the 12-month unwinding period. Prior guidance suggested all renewals and other actions must be completed within the 12-month unwinding period.

C. Adopting a Risk-Based Approach and Speed of State Unwinding

CMS expects states to adopt a risk-based approach to prioritize pending renewals, changes in circumstances, and post-enrollment verifications that the state needs to address during the unwinding period. A risk-based approach must take into consideration the need to prevent inappropriate terminations and promote smooth transitions for individuals no longer eligible for Medicaid, CHIP, or a BHP to other coverage. States may select among four risk-based approaches to address the backlog of pending cases: (1) *Population-Based Approach* prioritizing outstanding actions for cohorts of beneficiaries more likely to have become eligible for more expansive benefits or for different coverage (e.g., a Qualified Health Plan (QHP)); (2) *Time or Age-Based Approach* prioritizing cases based on the length of time the action has been pending; (3) *Hybrid Approach* combining population- and time-based approaches; or (4) *State-Developed Approach* meeting the goals of keeping eligible individuals enrolled, reducing churn, maximizing successful transition to other coverage where appropriate, and achieving a sustainable renewal schedule. This letter also outlines various alignment strategies, which can support states in achieving an even distribution of work both during the 12-month unwinding period and in subsequent years.

Over the course of the 12-month unwinding period, states will need to initiate a renewal of every beneficiary enrolled in their Medicaid and CHIP programs as of the end of the month prior to their unwinding period. We refer in this letter to these beneficiaries enrolled in Medicaid and CHIP as of such month as the state's "total caseload." States have flexibility to determine whether their total caseload is based on the total number of individuals enrolled in the program or the total number of households with one or more family members enrolled in Medicaid in the state as of the end of the month prior to the month in which the state's unwinding period begins.

States will need to distribute these renewals in a reasonable manner over the course of the unwinding period in order to mitigate the risk of inappropriate terminations and churn as well as to ensure that the state also resumes timely processing of new applications during the unwinding period. As this SHO letter explains, CMS is concerned that if states attempt to initiate more than 1/9 of their total caseload in a given month, there will be an increased risk that state processes will not meet federal renewal requirements, and eligible individuals will be erroneously determined ineligible or lose coverage for avoidable procedural reasons. CMS will work with states and provide continued technical assistance to ensure they are able to restore routine operations in a manner that promotes continuity of coverage for eligible individuals and seamless coverage transitions for those who become eligible for other insurance affordability programs.

D. Facilitating Transitions to the Marketplace

Facilitating smooth transitions to the Marketplace for individuals eligible for enrollment in a QHP will be critical to minimizing periods of uninsurance as states identify beneficiaries who are no longer eligible for Medicaid, CHIP or a BHP. States are required to transfer to the Marketplace the electronic accounts of beneficiaries whom the state assesses as potentially eligible for coverage through the Marketplace; such transfer must include all eligibility-related information available to the state. This SHO letter identifies strategies for states to improve successful transitions and enrollment in a QHP, including improving notice language and

transmitting all available contact information and other information that the state has for an individual, regardless of the minimum technical requirements for account transfers.

E. Monitoring State Progress, Corrective Action, Payment Error Rate Measurement (PERM) or Medicaid Eligibility Quality Control (MEQC) Programs, and Technical Assistance

This SHO letter explains that CMS will (1) not consider eligibility and enrollment actions delayed due to the PHE as untimely for purposes of the PERM or MEQC programs if such actions are initiated within the timelines detailed in the SHO letter and completed before the end of the 14th month once the state begins its 12-month unwinding period; (2) release an updated planning template to support state efforts to develop unwinding operational plans; (3) provide states with data reporting tools to monitor and evaluate state progress to complete outstanding work after the PHE ends; (4) monitor states' progress in meeting the timelines and completing required eligibility and enrollment actions described in the letter; and (5) be available to provide technical assistance to states individually and through various forums.

II. Restoring Routine Eligibility and Enrollment Operations after the PHE Ends

CMS recognizes that states will not be able to immediately address the large number of pending eligibility and enrollment actions that continue to accumulate during the PHE, and states will need time to complete the work in a manner that prevents inappropriate terminations of coverage. CMS also understands many Medicaid beneficiaries' circumstances may have changed and that these individuals may now be eligible for other insurance affordability programs, such as CHIP, BHP, or coverage through the Marketplace with financial subsidies. States will need to be able to distribute work in a systematic way that maintains coverage for eligible beneficiaries, manages coverage transitions, and reestablishes a renewal schedule that is sustainable for the state agency in future years.

A. Developing a Plan to Address PHE-Related Eligibility and Enrollment Work

As discussed in the December 2020 SHO, states will need to develop and document a comprehensive plan to restore routine operations in their Medicaid, CHIP, and BHP programs ("unwinding operational plan").⁴ This plan is intended to help states plan for how they will complete outstanding work in accordance with the timelines specified in this letter and the August 2021 SHO and maximize continuous coverage for eligible individuals.

States will have a significant volume of eligibility actions to complete once they begin the unwinding period, including pending applications, renewals, and redeterminations necessitated by changes in beneficiary circumstances. Some states also will have outstanding verifications for individuals determined eligible for enrollment based on self-attested information pending post-enrollment verification.⁵ States' unwinding operational plans should include a description of how the state intends to address these outstanding actions in an efficient manner that reduces

⁴ State Health Official Letter SHO #20-004, Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency, (December 2020). Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>.

⁵ States have the option to enroll individuals based on self-attested information and verify eligibility criteria post-enrollment, consistent with the state verification plan.

erroneous loss of coverage for beneficiaries, ensures a sustainable distribution of renewals in future years, and ensures timely processing of new applications and eligibility actions within the timelines specified in this letter. States will need to decide which flexibilities to retain and whether to adopt new flexibilities. CMS is available to provide technical assistance to states as they develop their unwinding operational plans.

To the extent these decisions require states to submit SPAs, updates to verification plans, or updates to policy and procedure manuals, states should make efforts to start these processes as soon as possible before the state implements its plans to restore routine operations. States should also begin work as soon as possible on any necessary system changes needed to process eligibility and enrollment actions and resume terminations of coverage for ineligible individuals after the continuous enrollment condition expires. To the extent possible, states should make plans to have these system changes ready, and scheduled for an off-cycle release if necessary, to ensure they are not delayed in their ability to begin work during the unwinding period.

States that began to develop a plan to return to routine operations prior to the release of this letter should reassess their plans and adjust how they will prioritize and distribute their workloads in light of this guidance. CMS also released an updated Medicaid and CHIP planning tool to assist states in their planning efforts.⁶ This updated tool will take into account the new timelines to complete pending work and help states develop an unwinding operational plan that takes into account strategies and options to maintain coverage for eligible individuals. While CMS expects states to develop and document their unwinding operational plans to address pending applications, verifications, changes in circumstances, and renewals, states are not required to use the tools developed by CMS to document their plans and, generally, will not be expected to submit their entire unwinding operational plans to CMS for approval. However, states must make their plans available to CMS upon request.

The perspectives and partnership of Medicaid and CHIP managed care organizations (MCOs), providers, beneficiary advocates, and other stakeholders are critical to the resumption of renewals and other eligibility actions in a manner that supports retention of coverage, including the successful transition to other programs. CMS encourages states to solicit input on their unwinding operational plans from these partners and to share their plans publicly, prior to their implementation.

B. Timelines to Complete Eligibility and Enrollment Actions after the PHE Ends

Applications: 4 Months after the End of the PHE (with Milestones)

While states are expected to work as expeditiously as possible to process applications now, CMS anticipates most states will have some pending applications that were received during the PHE that will need to be completed during the unwinding period. Agencies may use a phased approach to complete processing of these applications and resume timely and accurate determinations of eligibility on new applications within the following timelines, measured going forward from the end of the month in which the PHE ends:

- **2 months after the end of the month in which the PHE ends:** States should complete eligibility determinations for all pending modified adjusted gross income (MAGI) and

⁶ CMS previously released the Medicaid and CHIP Health Insurance Program COVID-19 Public Health Emergency Eligibility and Enrollment Pending Actions Resolution Tool. The updated tool reflects the guidance issued in SHO #21-002 and this letter.

other non-disability-related applications (e.g., individuals determined on the basis of being age 65 or older) received during the PHE.

- **3 months after the end of the month in which the PHE ends:** States should complete eligibility determinations for all pending disability-related applications received during the PHE.
- **4 months after the end of the month in which the PHE ends:** States should resume timely processing of all applications.

CMS reminds states that an application is considered to be processed timely when the agency enrolls an eligible applicant or denies coverage for an individual whom the agency could not determine as eligible within the application time standards described at 42 C.F.R. §§ 435.912(c), 457.340(d), and 600.320(b). The maximum time permitted under these regulations is 90 days for individuals applying on the basis of disability and 45 days for all other applicants. Consistent with requirements at 42 C.F.R. §§ 435.912(g), 457.340(d), and 600.320(b), agencies may not use the application timeliness standards – or the timelines described in this letter – as a waiting period to delay determining eligibility or as a reason for denying eligibility because the state has not determined eligibility within the timeliness standards.

Post-Enrollment Verifications, Changes in Circumstances, and Renewals: 12 months after the End of the PHE

In the August 2021 SHO, CMS announced that it would provide states up to 12 months after the end of the PHE to complete renewals as well as post-enrollment verifications and redeterminations of eligibility due to changes in beneficiary circumstances. The renewal process includes the time states need to attempt to renew eligibility based on electronic data and other information available to the agency; the time beneficiaries have to return the renewal form and any required documentation; and the time needed by the agency to verify the accuracy of the returned information, redetermine eligibility, and send appropriate notice to the beneficiary of the agency's decision.

Since the August 2021 SHO was released, states have raised concerns that they will be unable to complete renewals within a 12-month unwinding period because, except for beneficiaries who can be renewed based on information available to the state, states typically cannot complete a renewal in the same month in which the renewal was initiated. We understand that many states budget between 60 and 90 days to complete the full renewal process, and therefore initiate renewals between 60 and 90 days prior to the end of a beneficiary's eligibility period.

To account for the time needed to initiate and complete renewals, CMS will consider states to be in compliance with the 12-month unwinding period announced in the August 2021 SHO provided the state has initiated all renewals, as well as post-enrollment verifications and redeterminations based on changes in circumstances, for the state's total caseload by the last month of the 12-month unwinding period (and completed such actions by the end of month 14).

Defining the Beginning and End of the 12-month Unwinding Period

While states will be required to initiate renewals, post-enrollment verifications, and redeterminations for all individuals enrolled when the continuous enrollment condition expires within 12 months, the unwinding period may vary by state but is based on the month in which the PHE eventually ends. The unwinding period for all states must begin *no later* than the first

day of the month following the month in which the PHE ends. However, states may begin their 12-month unwinding period up to two months prior to the end of the month in which the PHE ends. This means that states that continue to comply with the continuous enrollment condition through the end of the month in which the PHE ends may initiate renewals that may result in termination of coverage the month after the continuous enrollment conditions ends for some beneficiaries up to two months prior to the end of the month in which the PHE ends.

As discussed further in this letter, states must initiate a renewal of eligibility for its total caseload during the state's unwinding period, including for individuals who were determined ineligible during the PHE before the state begins its unwinding period.

For example, if the PHE were to end on May 15, 2022, renewals initiated as early as April 2022 could result in terminations effective as early as June 1, 2022 (with the beneficiary's last day of coverage being May 31, 2022, which would be the last day the continuous enrollment condition is in effect in this example) for beneficiaries whom the state determines no longer meet all eligibility requirements or who do not timely return information needed by the state to complete the renewal.

Note that the same two-month period before the state would need to initiate another renewal would be true regardless of when the PHE eventually ends. For example, if the PHE ended on August 15, 2022, states complying with the continuous enrollment condition could begin their 12-month unwinding period as early as July 2022, using the information gathered during a renewal initiated in July 2022 to terminate coverage as early as September 1, 2022 for beneficiaries whom the state determines no longer meet all eligibility requirements or who do not timely return information needed by the state to complete the renewal. Thus, in this example (i.e., if the PHE is extended to August 15, 2022), renewals for cases initiated prior to July 2022 that did not result in a determination of eligibility must be initiated again during the state's 12-month unwinding period associated with the August 15, 2022 PHE end date, consistent with the guidance in the August 2022 SHO and this letter.

While states must initiate all pending eligibility actions (including renewals, post-enrollment verifications, and redeterminations based on changes in circumstances) for its total caseload at the end of the PHE within their particular 12-month unwinding period, states are expected to complete all work initiated during their unwinding period by the end of the 14th month after the first month of the unwinding period. For example, if the PHE ends in May 2022 and a state begin its 12-month unwinding period) in June 2022, the state would be required to initiate all renewals, post-enrollment verifications, and redeterminations no later than May 2023 and complete initiated work by the end of July 2023.

States are reminded that regardless of when a state begins its unwinding period, it must maintain continuous enrollment of beneficiaries through the last day of the month in which the PHE ends in order to satisfy the continuous enrollment condition necessary to receive the temporary FMAP increase under the FFCRA for the entire quarter in which the month falls. To comply with the continuous enrollment condition, termination of a beneficiary's enrollment can be effective no earlier than the first day of the month following the month in which the PHE ends, with limited

exceptions.⁷ Any state that chooses to end the continuous enrollment condition prior to the end of the month the PHE eventually ends and no longer claim the temporary FMAP increase is still required to follow the timelines and expectations outlined in this letter. This includes the requirement that the state initiate a renewal for the state’s total caseload during the 12-month period beginning in the month in which renewals initiated by the state end in termination of beneficiaries who no longer meet eligibility requirements or did not timely return information needed by the state to complete the renewal.

Appendix A illustrates how a state may process its unwinding related renewals, redeterminations, and post-enrollment verifications and achieve compliance with the 12-month unwinding period.

C. Requirements for Conducting Renewals

This guidance does not change the steps states must take to complete a renewal consistent with requirements at 42 C.F.R. §§ 435.916, 457.343, and 600.340. During the 12-month unwinding period, all states must begin the renewal process by checking available information and data sources to attempt to redetermine eligibility without contacting the beneficiary and requesting documentation to obtain reliable information when eligibility cannot be renewed based on available information, as appropriate. States must provide beneficiaries who are eligible based on MAGI methodologies with a minimum of 30 days to return their pre-populated renewal form and any requested information. Non-MAGI beneficiaries must be provided with a reasonable period of time to return their renewal form and any required documentation. Renewal forms and notices must be accessible to persons who have limited English proficiency (LEP) and persons with disabilities consistent with §§ 435.905(b) and 457.340(e). In Medicaid, states must determine eligibility on all bases prior to making a determination of eligibility as required at § 435.916(f)(1), including the Medicare Savings Programs. In Medicaid, a minimum of 10 days advance notice and fair hearing rights must also be provided prior to termination or other adverse action, in accordance with § 435.917 and 42 C.F.R. Part 431 Subpart E. Separate CHIPs must provide sufficient notice to enable the child’s parent or other caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption consistent with § 457.340(e)(1)(iii). For individuals determined ineligible, states must assess eligibility for other insurance affordability programs and transfer the individual’s account as appropriate in accordance with §§ 435.916(f)(2) and 457.350(i).

States may refer to the December 2020 Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB), “Medicaid and CHIP Renewal Requirements,” which is available to assist states in meeting their obligations to make accurate redeterminations of eligibility.⁸ A description of the CIB and more information on how states may access the guidance is included in Appendix C of this SHO letter.

D. Completing Renewals During the Post-PHE Unwinding Period

⁷ Consistent with 6008(b)(3) of the FFCRA and 42 C.F.R. § 433.400, states claiming the temporary 6.2 percentage point FMAP increased authorized under FFCRA must ensure “validly enrolled” beneficiaries remain enrolled through the end of the month in which the PHE ends unless the individual requests voluntary termination, is no longer considered to be a resident of the state, or dies.

⁸ CMCS Informational Bulletin, “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements,” (December 2020). Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>.

While most states have continued to process eligibility and enrollment actions during the PHE, states claiming the temporary FMAP increase authorized by section 6008 of the FFCRA have needed to suppress terminations and other adverse actions for Medicaid beneficiaries that would violate the continuous enrollment condition. States that have conducted renewals during the PHE, but did not terminate Medicaid eligibility for beneficiaries who were determined not eligible or who did not respond to requests for documentation, generally may not terminate coverage for such beneficiaries after the continuous enrollment condition expires until the state completes a new full renewal, as beneficiaries' circumstances may have changed since the completion of the renewal conducted during the PHE. This includes beneficiaries who were receiving benefits pending the outcome of a fair hearing on or after March 18, 2020, and were continuously enrolled during the PHE in order to comply with the continuous enrollment condition.⁹

Completing a full renewal after the continuous enrollment condition expires will ensure that: 1) the state is collecting information from the beneficiary that allows the state to redetermine eligibility on all bases prior to terminating coverage in accordance with 42 C.F.R. § 435.916(f)(1); 2) any adverse action is based on recently available, reliable information and that the state is not terminating eligibility or reducing benefits unless it has sought information from the individual in accordance with § 435.952(d); and 3) the state fulfills its obligation to complete a renewal of eligibility.

Subject to the expectations relating to prioritization and distribution of pending eligibility and enrollment work discussed in Section II of this letter, states will have considerable flexibility in determining how best to distribute renewals over the 12-month unwinding period. Thus, while states may not conduct a new renewal for MAGI-based beneficiaries whose eligibility was successfully renewed during the PHE less than 12 months after such renewal, states have the flexibility to initiate renewals at any time during the unwinding period for beneficiaries for whom the state did not conduct a renewal during the PHE or for whom the state did not conduct a successful renewal within the previous 12 months. Additionally, because individuals determined ineligible during a renewal conducted during the PHE were not granted a new eligibility period, states may initiate a new renewal for such individuals at any point during the 12-month unwinding period – i.e., the state is not required to wait for 12 months after a renewal conducted during the PHE that resulted in a determination of ineligibility or for which a beneficiary did not respond to a request for additional information.

Table 1 below 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 or prior to the PHE. CMS encourages states to use the flexibilities afforded by the unique circumstances of the PHE and the end of the continuous enrollment condition to set a renewal schedule that spreads renewal volume over a full 12-month period and aligns renewal dates for

⁹ While 42 C.F.R. § 431.230(b) grants states the option to institute recovery for benefits pending if the state's action is sustained by the fair hearing decision, states cannot do so if they claim the temporary FMAP increase authorized by section 6008 of the FFCRA. An individual whose Medicaid eligibility is maintained in order to comply with the continuous enrollment condition, which includes individuals receiving benefits pending, may not have their eligibility retroactively terminated. In order to receive the temporary FMAP increase authorized under section 6008 of the FFCRA, states must maintain the eligibility, and benefits, of all individuals who are enrolled or determined eligible for Medicaid as of March 18, 2020, through the end of the month in which the public health emergency ends. Section 6008(b) of the FFCRA does not authorize recoupment of funds from any individual whose Medicaid eligibility was continued in order to comply with the terms of section 6008(b) of the FFCRA.

individuals within households and with recertification timing for the Supplemental Nutrition Assistance Program (SNAP) and other human services programs. Additional information on how to implement these strategies is available in Appendix B of this letter.

Table 1. Guidelines for Establishing Renewal Dates during the 12-Month Unwinding Period

Outcome of Last Renewal Attempted During the Last 12 Months of PHE	Permissible Timing of Renewal During 12-Month Unwinding Period
<i>Ex parte</i> 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)
<i>Ex parte</i> 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 per 42 C.F.R. § 435.916(b)
<i>Ex parte</i> renewal attempted and successfully completed. New eligibility period established. ¹⁰	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 per 42 C.F.R. § 435.916(b)
No renewal attempted in last 12 months of PHE.	Any time

E. Acting on Changes in Circumstances during the Unwinding Period

Consistent with regulations at 42 C.F.R. §§ 435.916(d) and 457.343, states must promptly redetermine eligibility between regular renewals of eligibility whenever they receive information about a change in a beneficiary's circumstances that may affect eligibility. However, due to the continuous enrollment condition, states have been unable to complete regular renewals during the PHE for many Medicaid beneficiaries. Given how long it has been since some individuals have been renewed, there is an increased risk that individuals who may be eligible for CHIP or Medicaid on another basis may be terminated based on a change in circumstances related to a single factor of eligibility. Consequently, during the unwinding period, prior to taking adverse action based on an identified or reported beneficiary change in circumstances, states must complete a full renewal for any beneficiary unless a renewal was completed in the 12 months prior to the identified change. The one exception to this general rule involves beneficiaries for whom (1) a renewal completed within the prior 12 months resulted in a determination that the beneficiary continues to meet eligibility requirements, and (2) the state has received information that the beneficiary’s circumstances changed after the last renewal was completed. If a state identifies a change in circumstances during the unwinding period for an individual who has not received a renewal in the prior 12 months, the state may choose to complete a full renewal at the

¹⁰ For beneficiaries whose eligibility is renewed during the PHE based on information available to the state without requiring additional information from the individual (“*ex parte* renewal”) consistent with 42 C.F.R. § 435.916(a)(2) and (b), states continue to have the option described in the December 2020 SHO (1) to retain the beneficiary’s initial eligibility period had the renewal been completed timely or (2) to start a new eligibility period based on the date the *ex parte* renewal was completed during the PHE. States electing to retain the eligibility period associated with the *ex parte* renewal completed during the PHE must do so for all such renewals through the end of the PHE; states may not implement the option on a case-by-case basis.

time when the change in circumstances is identified, or the state may wait to process the new information when it completes the beneficiary’s renewal in a subsequent month.

F. Special Considerations for CHIP and BHP

As states are aware, the continuous enrollment condition does not apply to separate CHIP programs and BHPs. However, states have taken different approaches to processing CHIP and BHP renewals during the PHE, and these approaches will impact how states must handle CHIP and BHP renewals following the eventual end of the PHE. We have included several scenarios below, highlighting where renewal processes may differ for CHIP and BHP from Medicaid.

CHIP Beneficiaries Who Became Ineligible During the PHE

As stated in the January 6, 2021, “COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies” (“January 2021 FAQs”),¹¹ states are not permitted under the CHIP state plan to extend eligibility periods for separate CHIP enrollees who have been determined ineligible for coverage. If a state receives information from an enrollee, processes that information, and determines the individual ineligible for its separate CHIP, the state must process the termination and transfer the individual to Medicaid or the Marketplace, in accordance with 42 C.F.R. § 457.350(b) and (i). States that completed CHIP renewals during the PHE are expected to have terminated ineligible individuals and to continue to process terminations throughout the remainder of the PHE and unwinding period.

Similarly, as stated in the January 2021 FAQs, states are not permitted under the CHIP state plan to extend coverage to young adults aging out of CHIP or, for pregnant individuals enrolled in CHIP, ending their postpartum coverage period. Because this guidance was not formally published until January 6, 2021, we recognized that some states may have continued to provide coverage to these individuals until that date. However, we explained that states are expected to continue to process terminations of individuals determined ineligible for a separate CHIP under the state plan throughout the remainder of the PHE.

CMS is aware that some states, using state-only funds, have continued to cover CHIP beneficiaries found not eligible for coverage during the PHE, including young adults aging out of CHIP, and/or pregnant individuals ending their postpartum period, and/or children found ineligible for coverage after a change in circumstances. States may submit a COVID-19 section 1115 demonstration application for CMS consideration requesting expenditure authority to enable the state to claim federal financial participation (FFP) for such CHIP beneficiaries through the end of the unwinding period, or until a redetermination is conducted during the unwinding period. States interested in pursuing a section 1115 demonstration to receive FFP for these individuals should contact their state lead or section 1115 demonstration project officer.

In addition, we note that states may elect to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP beginning April 1, 2022, under sections 9812 and 9822 of the American Rescue Plan Act of 2021 (P.L. 117-2) (ARP). States that elect this “postpartum extension” option may consider deprioritizing renewals and redeterminations of

¹¹ “COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies,” January 6, 2021, available at: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

eligibility for CHIP beneficiaries who are pregnant or in a postpartum period during the unwinding period to ensure smooth implementation of the extended postpartum coverage option.

CHIP Beneficiaries Whose Renewals were Delayed during the PHE

We recognize that some states may not have been able to process CHIP renewals in accordance with the timeliness standards of 42 C.F.R. § 457.340(d)(1) during the PHE. These states requested and received authority through CHIP SPAs to waive the timely processing of renewals during the PHE. As states resume processing renewals, we strongly encourage states to initiate CHIP renewals along the same timeline as Medicaid renewals and follow the guidance in Sections D and E above. States should incorporate CHIP eligibility and enrollment actions in their unwinding operational plans and must restore operations consistent with the timeframes and guidance outlined in the August 2021 SHO and this letter. This includes ensuring that states initiate CHIP renewals no later than when the state begins its 12-month unwinding period and complete all work initiated during the 12-month unwinding period by the end of the 14th month once the state begins its unwinding period.

BHP Beneficiaries Whose Renewals were Delayed During the PHE

We also recognize that states that operate a BHP may not have been able to process BHP renewals in accordance with the timeliness standards of 42 C.F.R. § 600.340 during the PHE. These states requested and received authority through BHP Blueprint amendments to waive the timely processing of renewals during the PHE. States that have been unable to process BHP renewals during the PHE may follow the same processes for resuming the timely processing of renewals for BHP as they are for Medicaid. However, we note that a state may not be able to begin processing BHP renewals within one month of the end of the PHE if that month does not align with when the state typically conducts BHP renewals.

For example, if the PHE ends in April 2022, but a state has elected to align renewals with the Open Enrollment period in the Marketplace such that the state would not normally process any BHP renewals until Fall 2022 for a new coverage year beginning January 1, 2023, the state would not be required to change its typical renewal processing timelines. However, states can elect to change this policy by submitting a BHP Blueprint revision, and we encourage states that operate a BHP and currently only conduct renewals to coincide with the Marketplace Annual Open Enrollment to consider whether to instead spread out the processing of BHP renewals throughout the year. The 12-month unwinding period presents a unique opportunity for BHP states to reestablish a renewal schedule that is sustainable in future years. CMS is available to provide technical assistance to states exploring this option.

III. Prioritization and Distribution of Pending Eligibility and Enrollment Work

For states to maintain coverage for eligible individuals, complete the volume of work that will need to be addressed in the 12-month unwinding period, and reestablish a renewal schedule that is sustainable in future years, states will need to determine how they will prioritize and distribute their work across the unwinding period. States should first assess the scope of their workload and consider strategies discussed in Section V of this letter on “Strategies to Promote Continuity of Coverage and Mitigate Churn.” States will then need to prioritize the order in which they will initiate and complete eligibility and enrollment actions to minimize the extent to which ineligible individuals remain enrolled, prevent inappropriate terminations of coverage for eligible

individuals, and achieve a manageable distribution of renewals in future years. Finally, states will need to identify how they will distribute prioritized work scheduled to be initiated within the timelines specified in this letter.

A. Adopting a Risk-Based Approach to Prioritize Work

CMS expects states to adopt a risk-based approach to prioritize pending eligibility and enrollment actions related to post-enrollment verifications, changes in circumstances, and renewals the state will conduct during the 12-month unwinding period. A risk-based approach ensures states prioritize their workload in a manner that considers the need to prevent inappropriate terminations and enables smooth program transitions for individuals no longer eligible for Medicaid, CHIP, or a BHP. CMS also encourages states to prioritize work in a way that will achieve an evenly-distributed renewal workload that is sustainable in future years.

States may select among four risk-based approaches to address the backlog of pending cases.

1. *Population-Based Approach*: Prioritizes outstanding eligibility and enrollment actions based on characteristics of cohorts or populations who are likely to have become eligible for more expansive benefits or who are likely to be eligible for different coverage (e.g., QHP through the Marketplace). Examples of populations states may wish to prioritize include individuals who have reported a decrease in income, individuals enrolled during the PHE through a temporary eligibility option, or individuals who have aged out of a group or otherwise have become categorically ineligible for the group in which they are enrolled.

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. However, CMS encourages states to consider available options and flexibilities to streamline enrollment and promote continuity of coverage for individuals as they prioritize their work.

For example, states electing the extended postpartum coverage option under sections 9812 and 9822 of the ARP that implement the option during the state's unwinding period may choose to deprioritize renewals and redeterminations of eligibility for beneficiaries who are pregnant or in a postpartum period when the continuous enrollment condition expires, to ensure smooth implementation of the extended postpartum coverage option. States may refer to the December 2021 SHO, "Improving Maternal Health and Extending Postpartum Coverage in Medicaid and CHIP," for more information on the state plan option to provide 12 months of continuous postpartum coverage.¹²

A population-based approach should address both the risk that ineligible individuals remain enrolled and the risk that eligible individuals may be inappropriately terminated.

¹² CMS State Health Official Letter #21-007: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP). December 7, 2021. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>.

However, unless authority for, or expanded eligibility under, a group expires at the end of the PHE (e.g., as is the case for the optional COVID-19 group¹³ or in the case of an income or resource disregard adopted temporarily for the duration of the PHE), states may not prioritize populations based solely on the Medicaid eligibility group in which they are enrolled, de-prioritize cases based on the availability of FFP at a matching rate that exceeds the state’s regular FMAP (e.g., states may not de-prioritize completion of outstanding eligibility actions for individuals enrolled in the adult group) or prioritize populations in a manner that would constitute a violation of federal law, including, but not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Further, compliance with these laws includes providing reasonable accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

2. *Time or Age-Based Approach*: Prioritizes cases based on the length of time the action has been pending. Under a time-based approach, states can process the oldest cases first in the 12-month unwinding period, or they may process cases by maintaining the original month of renewal.
3. *Hybrid Approach*: Combined population- and time-based approaches. For example, a state may adopt a time-based approach to prioritizing outstanding post-enrollment verifications and changes in circumstances and a population-based approach to prioritizing pending renewals. Alternatively, states may adopt a population-based approach for processing the first wave of pending actions and then switch to a time-based approach.
4. *State-Developed Approach*: Any other approach that meets the goals of keeping eligible individuals enrolled, minimizes the extent ineligible individuals may remain enrolled, achieves a sustainable renewal schedule, and meets the 12-month unwinding timeline for addressing outstanding eligibility actions.

Regardless of how a state chooses to categorize its risk-based approach and prioritize its work, states must ensure their risk-based approach is described in the unwinding operational plan.

B. Distributing Pending Actions Across the Unwinding Period

Once a state determines how it will prioritize its eligibility and enrollment work, we expect states to establish a distribution schedule to initiate and process renewals and other actions over the 12-month unwinding period. The redistribution plan should ensure that states are able to maintain coverage for eligible individuals and manage transitions to other coverage for individuals determined potentially eligible for enrollment in another insurance affordability program. An

¹³ Section 6004(a)(3) of the FFCRA added a new optional Medicaid eligibility group for uninsured individuals during the COVID-19 PHE. This group, added at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act, was previously referred to as the “COVID-19 optional testing group”; the ARP expanded the coverage available to such individuals.

evenly-distributed renewal schedule will also mitigate future challenges states might experience if they process a large volume of actions at the beginning of the unwinding period, or if they delay beginning to process renewals until later in the unwinding period. States that do not make plans to distribute their work during the 12-month unwinding period run the risk of errors in processing renewals and inappropriately terminating coverage for eligible individuals, not only during the 12-month unwinding period but also in future years as distributing this work over a shorter period could create peaks in routine renewal volume in particular months.

In addition to the pending renewals and redeterminations that states will need to address when the continuous enrollment condition expires, new eligibility actions also will arise during the 12-month unwinding period (e.g., for eligible beneficiaries who experience a change in circumstances and individuals whose enrollment or whose eligibility was renewed in the last 12 months of the PHE). States can address such new actions in accordance with the timeframes that ordinarily would apply in accordance with 42 C.F.R. § 435.916 (i.e., in the absence of the continuous enrollment condition). Alternatively, states can integrate such new actions into the prioritization plan and distribution schedule developed by the state for backlogged actions pending at the end of the continuous enrollment condition, even if doing so would result in some delay in addressing the newly-arising actions.

C. Preventing Inappropriate Terminations

Based on our experience in working with states over the years, CMS is concerned that the combination of several factors creates an acute risk that eligible beneficiaries will lose coverage when states begin to process renewals and other eligibility and enrollment actions, including, the significant increases in Medicaid and CHIP enrollment during the PHE, the disruption to eligibility and enrollment operations, the length of time that has elapsed since state agencies had any contact with their beneficiaries, and significant staffing shortages. While states will need to expeditiously restore routine operations, states are obligated to ensure accurate determinations of eligibility and are advised to take steps during the PHE to complete as much eligibility and enrollment work as possible in order to limit the volume of actions that will need to be completed in the 12-month unwinding period. Once states have begun to conduct renewals and process other eligibility actions, they will need to balance how quickly they work through their total caseload with the need to prevent errors resulting in the termination of coverage for eligible beneficiaries and churn, as eligible individuals terminated from coverage subsequently re-apply.

In providing technical assistance to states to ensure they are able make timely and accurate redeterminations of eligibility, we have found that states that have a more even distribution of renewals over the course of a year are better able to maintain a workload that is sustainable in future years, thereby enabling the state to avoid renewal backlogs and reduce risk of inaccurate redeterminations and inappropriate terminations in future years. Based on this experience, CMS recommends that states initiate *no more than* 1/9 of their total caseload of Medicaid and CHIP renewals in a given month during the unwinding period.

We believe this target will not only mitigate the risk of inappropriate terminations and churn, but also establish a sustainable renewal schedule by helping states avoid “renewal bulges” in some months that increase the risk of future renewal backlogs. We believe states that distribute the unprecedented volume of renewals that must be initiated during the 12-month unwinding period

will be more likely to avoid erroneous determinations of ineligibility and avoid coverage losses for procedural reasons. In addition, CMS believes that initiating more than 1/9 of renewals in a given month risks a compressed renewal workload that could put states at risk of inappropriately shortening or extending beneficiary eligibility periods described at 42 C.F.R. §§ 435.916(a) and (b) and 457.343 in order to manage workload in future years.

The 1/9 threshold also recognizes that there are natural fluctuations in the volume of renewals typically processed in different months that would prevent a state from evenly distributing renewals throughout the entire unwinding period (i.e., initiating 1/12 of a state's total caseload each month). For example, some states experience higher application volume during certain periods in a given year (e.g., due to Open Enrollment or adoption of a coverage expansion). In others, staffing levels may drop in certain months (e.g., over the winter holidays), which may impact a state's preferred distribution of renewals in future years. For these reasons, CMS believes that initiating renewals for no more than 1/9 of a state's total caseload in a given month strikes a reasonable balance between achieving a relatively even distribution of renewals with the need to accommodate fluctuations in the volume of work and state staff capacity that naturally occur throughout the year.

Note that in calculating 1/9 of total caseload as of the end of the month prior to the month in which the state's unwinding period begins, some states may measure their total caseload based on the total number of individuals enrolled in their programs, while others may measure total caseload based on the total number of households with one or more household members enrolled in the state's programs.

CMS will require states to submit certain information, including how each state plans to distribute renewals as well as what strategies the state is considering or has adopted to mitigate against inappropriate coverage loss during the unwinding period. CMS will use this information to identify states at greatest risk of inappropriate coverage losses.¹⁴ CMS will provide states with a form to submit summary information about their renewal distribution plans and will follow up with states as needed to ensure that proper mitigation strategies are in place to reduce risk of inappropriate terminations and that states' plans will establish a sustainable workload in future years (this form is separate from the state's unwinding operational plan which, as mentioned in Section II.A., states are not required to submit to CMS for approval). For more information on the monitoring and evaluation of a state's distribution schedule and strategies to prevent inappropriate terminations, please see Section VII of this letter on "Monitoring State Progress and Corrective Action."

D. Aligning Work on Pending Actions

All beneficiaries, including limited benefit populations or groups, will require a renewal during the 12-month unwinding period, which means there is a unique opportunity for states to align other eligibility actions with renewals during the unwinding period to manage workload and reestablish a renewal schedule that is sustainable in future years. The following alignment strategies, which can support states in achieving an even distribution of work both during the 12-

¹⁴ These reports will be required under the authority in sections 1902(a)(4)(A), 1902(a)(6) and 1902(a)(75) of the Act and at 42 C.F.R. § 431.16 to ensure proper and efficient administration of the Medicaid program and section 2101(a) of the Act to promote the administration of CHIP in an effective and efficient manner.

month unwinding period and in subsequent years, are only available during the 12-month unwinding period. However, states may not shorten an individual's established eligibility period when using these strategies for the purposes of alignment. After the 12-month unwinding period ends, states must resume timely processing of periodic renewals and redeterminations of eligibility in accordance with 42 C.F.R. §§ 435.912, 435.916, 457.340, and 600.320 as well as post-enrollment verifications in accordance with the verification plan described at § 435.945(j) developed by the state. BHP states must follow the verification requirements of § 600.345 and their certified BHP Blueprints.

Aligning Work on Verifications and Changes in Circumstances at Renewal

States may wait to complete pending post-enrollment verifications and act on changes in circumstances reported or identified during the PHE and unwinding period for beneficiaries with a renewal scheduled to be initiated during the 12-month unwinding period, with one exception related to verification of citizenship or immigration status and the reasonable opportunity period (ROP) required under 42 C.F.R. §§ 435.406 and 435.956, which allows applicants and states additional time to complete those verification processes. This alignment strategy will create efficiencies for states by allowing them to use information obtained at renewal to simultaneously resolve other pending eligibility and enrollment actions and also limit the need to send multiple requests for information to individuals to complete multiple pending actions.

As required under current regulations at 42 C.F.R. § 916(a)(2), states must ensure eligibility notices inform beneficiaries of the basis of the eligibility determination and remind them that they must inform the state if any of the information used to determine their eligibility is not accurate. After the 12-month unwinding period, states must resume timely processing of post-enrollment verifications and promptly act on changes in circumstances that occur between renewals consistent with federal regulations.

Individuals whose Medicaid benefits have been maintained during an ROP have not had an eligibility determination completed pending verification of U.S. citizenship or satisfactory immigration status; rather, they are receiving benefits pending a determination of eligibility that rests on the verification of their status. Therefore, states will need to review the verification and ROP process applied during the PHE in order to determine the appropriate action for individuals whose citizenship or verification status was not completed during the PHE but whose enrollment has been maintained under an ROP to comply with the continuous enrollment condition. If a state did not send an individual notice to initiate an ROP during the PHE, or delayed or otherwise did not complete the regular verification of satisfactory immigration status or U.S. citizenship process as required under §§ 435.406 and 435.956, the agency must send the required notice after the PHE ends and provide the 90-day ROP for the individual to provide any needed documentation and the state to complete its verification process in accordance with §§ 435.406, 435.407, and 435.956. We note that the ROP begins on the date the beneficiary receives notice of such opportunity from the agency, in accordance with § 435.956(b)(2)(i).

Even if a state has provided a fully compliant notice and ROP to all affected beneficiaries but some beneficiaries have not resolved their citizenship or immigration status inconsistency during the PHE, we encourage states to attempt to reverify eligibility for these beneficiaries before the state's unwinding period begins. This may be necessary in order to provide the due process protections, including advance notice of termination and fair hearing rights, for these individuals.

States may extend the ROP period during this additional verification in certain situations. Specifically, for individuals who have attested to satisfactory immigration status, states may attempt to re-verify immigration status again after the continuous enrollment condition expires, as § 435.956(b)(2)(ii)(B) allows states to provide for a reasonable extension of the ROP for individuals attesting to satisfactory immigration status and who are making a good faith effort to obtain any necessary documentation, or if the state needs more time to verify the individual's status or assist the individual in obtaining documents needed to verify their status. For individuals who have attested to U.S. citizenship status, states may re-verify their US citizenship during the unwinding period through a COVID-19 1115 demonstration, which would provide for an extension of the ROP beyond the 90-day timeframe required under section 1902(ee) of the Social Security Act (the Act). CMS is available to provide technical assistance to states interested in pursuing this approach.

After the continuous enrollment condition expires, the state can terminate individuals who still have not provided needed documentation of citizenship or immigration status during a fully compliant ROP and for whom the state is not able to verify their status, as long as the state provides a minimum of 10 days advance notice of termination and fair hearing rights consistent with § 435.917 and 42 C.F.R. Part 431, Subpart E.

Aligning Renewals with SNAP Recertification

For beneficiaries also enrolled in SNAP, states may schedule their Medicaid renewals to coincide with the individual's SNAP recertification, provided such recertification occurs within the 12-month unwinding period. This strategy not only may achieve greater administrative efficiencies for states but also can minimize the burden for individuals.

Aligning Renewals for all Individuals in a Household

States may choose to align work on renewals for all members in a household during the 12-month unwinding period. This strategy will minimize beneficiary burden by allowing families to receive one request for information from the state. It also will help to align renewals for all members of a household in future years.

CMS reminds states that, while states may process renewals for an entire household at the same time, redeterminations of eligibility are made on an individual basis. Thus, a state may not terminate coverage for one member whose eligibility is verified with information available to the state because the state was not able to verify eligibility for another member in the household. For example, a family of four (two parents and two children) is enrolled in Medicaid through different eligibility groups. The parents are enrolled in the adult group and the two children are enrolled in the children's group. The state chooses to align work on renewals for the entire family during the 12-month unwinding period. The state initiates the renewal by checking available data. The state has sufficient income and other information to determine eligibility continues for the two children, but the income data obtained by the state indicates that the parents' income exceeds the standard for the adult group. The state sends the family a pre-populated renewal form and provides a minimum of 30 days for the family to return the renewal form. The family does not return the renewal form. Because the state does not have sufficient information to renew eligibility for the parents, it must send advance notice of termination related to their coverage. However, the state may not terminate coverage for the children and must begin a new 12-month eligibility period for them.

Aligning Renewals for Individuals Who Missed Their Medicare Initial Enrollment Period

Some individuals who have retained Medicaid coverage during the PHE may have become eligible for Medicare since March 2020 but have not signed up for Medicare during their Medicare initial enrollment period because they continue to be covered by Medicaid and may think they do not need Medicare coverage at this time. An individual's Medicare initial enrollment period is the 7-month period that starts three months before an individual is first eligible to enroll in Medicare.

Unless the individual is eligible for a special enrollment period, individuals who miss their Medicare initial enrollment period may only sign up for Medicare during the Medicare general enrollment period, which runs from January 1 to March 31 each year. Those individuals may also have to pay a monthly late enrollment penalty. However, certain Medicaid enrolled individuals may obtain Medicare coverage at other times of the year through their state's Medicare buy-in process.

A Medicare-eligible beneficiary who misses their Medicare initial enrollment period, is not enrolled into Medicare through the state's buy-in process, and loses their Medicaid eligibility outside of the Medicare general enrollment period (i.e., after the state resumes regular terminations), may experience a gap in coverage before their Medicare coverage begins. Such individuals also may incur late enrollment penalties once they do enroll in Medicare.

States may leverage available data matching processes to help identify beneficiaries who may have become eligible for Medicare during the PHE.¹⁵ To minimize disruptions in coverage and to avoid imposition of late enrollment penalties, CMS encourages states to attempt to identify these beneficiaries and to reach out to advise them to enroll in Medicare during their initial enrollment period or during the current Medicare general enrollment period (before March 31, 2022), whichever applies. States should refer these individuals to their local State Health Insurance Assistance Program (SHIP) for counseling. Additionally, states should consider the timing of the next Medicare general enrollment period in scheduling renewals during the unwinding period for individuals who may be Medicare eligible, in order to facilitate seamless coverage transitions and avoid gaps in coverage by scheduling these individuals' renewals to coincide with the Medicare general enrollment period.

IV. Notices and Fair Hearings

A. *Notices*

Whenever a Medicaid or CHIP agency makes a decision affecting a beneficiary's eligibility, the state generally must send the beneficiary a notice at least 10 days prior to the date of action (defined at 42 C.F.R. § 431.201 as "the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective") of the agency's decision. This advance

¹⁵ CMCS Informational Bulletin, "Strategies to Streamline Transitions for Medicare-eligible Beneficiaries Who Newly Qualify for Medicare," (June 2017). Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060717.pdf>. The 2021 MAPD State User Guide is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelphdesk/MAPD-State-User-Guide>.

notice must include certain information, including the beneficiary’s right to a Medicaid fair hearing, as described at 42 C.F.R. § 435.917 and 42 C.F.R. Part 431, Subpart E, or a CHIP review, as described at 42 C.F.R. §§ 457.340(e) and 457.1120-1190.

States must provide beneficiaries with advance notice of any action resulting from an eligibility determination conducted during the unwinding period. This requirement applies even in cases where the unwinding period eligibility determination yields the same action as a determination conducted during the PHE, and for which the state previously provided notice, as it is important for beneficiaries to have accurate and up-to-date information regarding the specific end date for their Medicaid and CHIP eligibility. Regulations at 42 C.F.R. §§ 431.210(a) and 457.340(e)(1)(ii)(A) require the notice to include the effective date of the action.

As a reminder, states may need to revise timeframes for individuals to request a fair hearing. During the PHE, CMS approved section 1135 waiver authority to provide many states with the flexibility to allow applicants or beneficiaries more than 90 days to request a fair hearing. Following the end of the PHE, states using this flexibility may either revert back to the time provided for individuals to request a fair hearing prior to the grant of section 1135 authority or may modify their policy to provide another reasonable time period not to exceed 90 days, in accordance with federal regulations (42 C.F.R. § 431.221(d)), which does not require a submission of a SPA. As discussed in the December 2020 SHO, the state must provide individuals the amount of time the individual was informed they have to request a fair hearing following an adverse action after the PHE ends, even if the state stops providing the additional time allowed during the PHE going forward.

For additional information regarding notice requirements for the end of flexibilities and authorities granted to states during the PHE, see the December 2020 SHO.

B. Medicaid Fair Hearings and CHIP Reviews

Typically, a state Medicaid or CHIP agency must provide an individual the opportunity to have a Medicaid fair hearing or a CHIP review when an individual believes the state has taken an action erroneously, including suspensions, terminations, or reductions of eligibility or when the state has denied the individual’s claim for eligibility (42 C.F.R. §§ 431.220(a) and 457.1120). One exception is that states are not required to provide a Medicaid fair hearing or a CHIP review when the action is due to a change in law or policy, such as the end of eligibility that was authorized only during the PHE (e.g., the extension of eligibility to non-residents temporarily residing in the state due to the PHE) (*see* 42 C.F.R. §§ 431.220(b) and 457.1130(c)). However, a beneficiary always has the right to request a Medicaid fair hearing or a CHIP review to contest that the eligibility determination was wrong on another basis under existing authority. In Medicaid, beneficiaries also have the right to continue to receive benefits pending the fair hearing decision when the individual requests the fair hearing prior to the date of the action in accordance with 42 C.F.R. § 431.230.

During the PHE, a number of states were granted a regulatory concurrence that allowed a state to take more than 90 days to take final administrative action on Medicaid fair hearing requests due to an emergency beyond the state’s control (42 C.F.R. § 431.244(f)(4)(i)(B)). All states, including those granted this regulatory concurrence, are expected to begin processing fair

hearing requests timely when the continuous enrollment condition ends (*see* 42 C.F.R. § 431.244(f)(1)-(3)). However, we understand that some states are concerned that the volume of fair hearings may increase dramatically and exceed the state’s capacity to adjudicate all fair hearing requests within the regulatory time limits.

For states that encounter such challenges in their fair hearing process, CMS will consider providing authority under section 1902(e)(14) of the Act to provide the state with additional time to take final action provided that certain beneficiary protections are provided. For more information on the section 1902(e)(14) waiver opportunity, *see* section V.A. below. The CHIP review regulations require states to complete the reviews of eligibility and enrollment matters in a “reasonable amount of time” (42 C.F.R. § 457.1160(a)). CMS interpreted that regulation to contain sufficient flexibility for states to take additional time to complete CHIP reviews during the PHE, and thus did not find it necessary to grant states explicit authority to do so. Following the end of the PHE, states will need to continue completing reviews within a reasonable timeframe as described at 42 CFR § 457.1160(a).

As states restore routine eligibility and enrollment practices, including eligibility terminations, states may see a return to a normal or higher than normal volume of fair hearing requests. As states develop their unwinding operational plans, they should consider the volume of requests their fair hearing programs can process in a timely fashion and take the anticipated volume of requests and the state’s operational capacity into account as they determine how to distribute pending actions across the unwinding period. Just as some states may have been unable to hold in-person fair hearings and reviews during the PHE or had reduced the number of in-person hearings, states may modify certain fair hearing and review processes without the need for additional state plan authority to avoid and reduce backlogs of fair hearings. States may hold fair hearings and reviews by telephone or video, as long as the state is providing access to the fair hearing process in accordance with 42 C.F.R. Part 431 subpart E (including providing access to individuals with disabilities and those who have LEP) and 42 C.F.R. § 457.1140(d). States may also explore establishing or expanding an informal resolution process to resolve fair hearing requests prior to holding a fair hearing, an option which is available to states without additional state plan authority.

CMS plans to post on Medicaid.gov a resource document with additional strategies that states may want to consider to help manage the anticipated increase in fair hearing requests and is available to provide technical assistance to states related to fair hearing processes generally, and specifically regarding timeframes after the PHE eventually ends.

V. Strategies to Promote Continuity of Coverage and Mitigate Churn

A. Temporary 1902(e)(14)(A) Waiver Unwinding Strategies to Promote Continuity of Coverage and Mitigate Churn in Medicaid

As states prepare to restore routine operations, CMS has worked closely with state agencies and other stakeholders to identify ways to efficiently enroll eligible individuals, and reduce churn. In order to support states facing significant operational issues and streamline the renewal or fair hearing processes to protect otherwise eligible beneficiaries at risk of inappropriately losing

coverage during the unwinding period, CMS will allow for the limited use of section 1902(e)(14)(A) authority.

Section 1902(e)(14)(A) of the Act, added by section 2002 of the Affordable Care Act, allows for waivers “as are necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries.” Since 2013, CMS has granted section 1902(e)(14)(A) waiver authority to protect beneficiaries’ access to coverage by providing administrative relief to many states facing operational issues (e.g., backlogs and application processing delays), navigating serious challenges with eligibility systems, and facilitating the enrollment of newly eligible individuals.

To protect beneficiaries in addressing the challenges states may face as they transition to routine operations during the unwinding period, CMS has determined that states may seek approval to use this authority in a time-limited manner to implement the five specific targeted strategies outlined below. These strategies can efficiently facilitate the renewal process by limiting the need for requests for additional information from beneficiaries, thus leading to fewer procedural terminations and reducing state administrative burdens during this transition period. The strategy to address states’ significant operational challenges in the fair hearing process can protect the due process rights and maintain coverage of individuals pending the outcome of a fair hearing, reducing loss of coverage and state administrative burden during this transition period.

1. Renewal for Individuals Based on SNAP Eligibility: Consistent with guidance for implementing Strategy 3 in SHO letter #13-003¹⁶ and revised parameters in SHO letter #15-001¹⁷, states may use this authority to renew Medicaid eligibility for SNAP participants without conducting a separate MAGI-based income redetermination. An approved section 1902(e)(14)(A) waiver request would allow states to rely on SNAP data for renewals for individuals under 65 years of age, despite the differences in household composition and income-counting rules, when necessary to protect beneficiaries in the face of systems limitations. Please note that a state can permanently leverage SNAP information for renewal, by pursuing the facilitated enrollment strategies described in Appendix B.
2. Ex Parte Renewal for Individuals with No Income and No Data Returned: CMS may grant section 1902(e)(14)(A) authority to temporarily permit renewals, on an *ex parte* basis, for households whose attestation of zero-dollar income was verified within the last twelve months, at the initial application or the previous renewal, when no information is received/returned from a financial data source at renewal. In order to complete the *ex parte* renewal, the state must take appropriate steps to review the non-financial components of eligibility consistent with the requirements at 42 C.F.R. §§ 435.916 and 435.956. CMS reminds states that the renewal notice also must instruct beneficiaries to inform the agency if any of the information used to make the eligibility determination is inaccurate.

¹⁶ State Health Official letter #13-003, “Facilitating Medicaid and CHIP Enrollment and Renewals in 2014,” May 17, 2013. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-13-003.pdf>.

¹⁷ State Health Official letter #15-001, “Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies,” August 31, 2015. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-15-001.pdf>.

3. Facilitating Renewal for Individuals with No Asset Verification System (AVS) Data Returned within a Reasonable Timeframe: Under this approach, CMS may grant states authority under section 1902(e)(14)(A) of the Act to permit renewals of beneficiaries for whom no information is returned by the AVS within a reasonable timeframe.

In accordance with regulations at 42 C.F.R. § 435.916, states must attempt to make an *ex parte* determination at renewal and check income data sources at renewal, consistent with its verification plan. Additionally, section 1940 of the Act requires that states verify assets using the state’s AVS for individuals excepted from MAGI-based methodologies and subject to an asset test. While states are required to comply with these requirements, the state may establish a reasonable time frame for AVS information to be returned. Currently, if the AVS does not return information within the timeframe established by the state, the state must attempt to redetermine eligibility in accordance with its verification process, which may include requesting additional information and documentation or obtaining a new attestation of assets from the individual by sending the beneficiary a renewal form requesting the additional information. Time-limited authority granted under this approach would allow a state to assume there has been no change in resources that are verified through the AVS when no information is returned within a reasonable timeframe, and therefore complete the renewal process without any further verification of the assets that are verified through the AVS.

4. Partnering with Managed Care Plans to Update Beneficiary Contact Information: States generally are required to contact the beneficiary to confirm the accuracy of updated contact information received from a health plan and to provide a reasonable period for the beneficiary to dispute the information provided by the plan, prior to updating the beneficiary record (see “Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations - February 2022 Update”). However, CMS recognizes that some states may have system or operational limitation that prevent the state for doing so. CMS may grant section 1902(e)(14)(A) authority to temporarily permit such states to accept updated enrollee contact information from managed care plans without additional confirmation with the individual where doing so would serve to protect beneficiaries in the aggregate. Under this temporary waiver authority, states may treat updated contact information received from the plan as reliable and update the beneficiary record with the new contact information without first sending a notice to the address on file with the state.
5. Extended Timeframe to Take Final Administrative Action on Fair Hearing Requests: CMS may grant states authority under section 1902(e)(14)(A) to temporarily extend the timeframe to take final administrative action on fair hearing requests. In order to use this option in a manner that protects beneficiaries, states would be required to provide benefits pending the outcome of a fair hearing decision (including reinstating benefits pursuant to 42 C.F.R. § 431.231), regardless of whether or not a beneficiary has requested a fair hearing prior to the date of the adverse action, and to forgo recoupment from beneficiaries if the fair hearing ultimately upheld the agency’s determination.

While we have outlined five targeted strategies requiring approval under section 1902(e)(14)(A) of the Act, CMS may consider other 1902(e)(14)(A) waiver renewal strategy requests that impact the state’s ability to process renewals, including flexibilities that address streamlining application processing in order to maximize state resources or enrollment strategies for other populations to promote continuity of coverage.

However, CMS will not approve 1902(e)(14)(A) waiver requests unrelated to the state’s unwinding period or requests that fail to protect beneficiaries. For example, states may not use the authority to extend beneficiary eligibility periods beyond the unwinding period. In addition, CMS will not approve requests to shorten eligibility periods or bypass renewal or fair hearing requirements that minimize beneficiary burden and ensure eligible individuals remain enrolled (e.g., eliminating the requirement to complete *ex parte* renewals), as such requests would not serve to protect beneficiaries, as required by section 1902(e)(14)(A) of the Act.

To request authority to implement one or more of these strategies, states can request such waiver authority under section 1902(e)(14)(A) of the Act on a time-limited basis during the unwinding period. CMS is available to provide technical assistance and can provide sample language the state can use to craft a letter requesting the waiver authority. States interested in one or more of the temporary waiver authorities described above should contact their CMS State Lead.

B. State Plan and Operational Strategies to Promote Continuity of Coverage and Mitigate Churn

As states develop their plans to complete pending eligibility and enrollment actions, they should also consider strategies that will help eligible individuals maintain coverage, prevent churning on and off of coverage, and mitigate procedural denials based on the absence of a returned renewal form or other information needed by the state to complete a redetermination of eligibility. These strategies may include:

- State plan options, such as:
 - continuous eligibility for children
 - 12 months continuous postpartum coverage (beginning April 2022)
 - express lane eligibility for children
- Options to streamline renewals, such as:
 - expanding the number and type of data sources used to attempt an *ex parte* renewal
 - aligning MAGI and non-MAGI renewal policies
- Improving communications and outreach to beneficiaries, such as by:
 - updating contact information
 - partnering with health plans
 - establishing processes to address returned beneficiary mail
 - using multiple modalities to reach individuals (e.g., mail, email, text)¹⁸

¹⁸ CMS is working with other federal partners to examine potential statutory constraints around the use of text messaging. We will pass along additional information as it becomes available.

As part of their unwinding operational planning, states should assess their readiness to complete eligibility and enrollment actions and adopt policy options and operational strategies that will address situations in which eligible beneficiaries may be at risk of losing coverage and create efficiencies for states to address the volume of work during the unwinding period. States should ensure that their eligibility and enrollment workforce is aware of any new strategies that are adopted through memorandums, updated internal procedures and policy manuals, formal trainings, or other methods of communication. States may refer to Appendix B and the November 2021 tool, “Strategies States and U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as they Return to Normal Operations,” for examples of strategies that promote continuity of coverage and mitigate churn and additional guidance on how states may implement them.¹⁹

VI. Facilitating Transitions between Medicaid, CHIP, BHP, and the Marketplace

In completing renewals once the continuous enrollment condition expires, states are likely to identify many beneficiaries who are no longer eligible for Medicaid, CHIP, or coverage through a BHP. Many of these individuals will likely be eligible for enrollment in a QHP through the Marketplace with significant financial assistance. Facilitating smooth transitions to the Marketplace for these beneficiaries will be critical to ensuring that such eligible individuals do not become uninsured.

Regardless of whether a state has an SBM that operates its own eligibility and enrollment platform or a Marketplace that relies on the federal eligibility and enrollment platform to complete eligibility determinations for coverage in a QHP, state Medicaid, CHIP, and BHP agencies are required to have an agreement with the relevant Marketplace and, consistent with the requirements at 42 C.F.R. §§ 435.1200, 457.350, and 600.330, have a coordinated process to send electronic accounts and other information to the Marketplace, to receive electronic accounts and other information from the Marketplace, and to ensure prompt determinations of eligibility and enrollment in the appropriate program. As noted above, for individuals determined by the agency as not eligible for Medicaid, CHIP, or BHP following a renewal or redetermination of eligibility, the agency must promptly assess the individual’s potential eligibility for Marketplace coverage and timely transfer the individual’s electronic account to the Marketplace. The account must include all of the information collected and generated by the state regarding the individual’s Medicaid, CHIP, and/or BHP eligibility.

Medicaid and CHIP agencies may have insufficient information to assess an individual as potentially eligible for Advanced Premium Tax Credits or Cost-Sharing Reductions through the Marketplace, as such assessment requires application of different financial methodologies, evaluation of access to or enrollment in employer-sponsored or other forms of coverage, and, in some cases, non-citizen eligibility criteria. States are not required to conduct individual assessments but instead may implement a streamlined approach that will reduce the administrative burden for states and ensure timely transfer of individuals potentially eligible for QHP enrollment. States can treat anyone who is determined ineligible for Medicaid or CHIP as potentially eligible for QHP enrollment, other than individuals whose coverage was denied or

¹⁹ “Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations,” (November 2021). Available at: <https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf>.

terminated for a procedural reason (e.g., failing to complete the renewal process) and individuals who do not attest to U.S. citizenship or a lawfully present non-citizen status. BHP agencies should continue to follow the requirements related to coordination with other insurance affordability programs under § 600.330.

States are also encouraged to implement additional approaches that may help with transitions to and enrollment in a QHP. While most appropriate for states served by a Marketplace that relies on the federal eligibility and enrollment platform or those in which the state Medicaid/CHIP/BHP and Marketplace systems are not integrated, the following strategies may be helpful for all states to consider. States can:

- Improve eligibility determination notice language for individuals found ineligible for Medicaid/CHIP/BHP so that they are aware that the Medicaid/CHIP/BHP agency will be transferring their application to the Marketplace and that the Marketplace will be sending them a notice with information on applying for coverage and financial assistance through the Marketplace;
- Transmit all available contact information provided on the application or contained in the beneficiary record for individuals on the application, including email addresses, phone numbers, and beneficiary communication preferences, to the Marketplace. The Medicaid Enterprise State Systems Officer assigned to each state will follow up with states' technical teams to discuss any missing contact information from accounts that are transferred to the Marketplace and will offer technical assistance as necessary to ensure that accounts are transferred with complete contact information as quickly as feasible;
- Transmit all eligibility information the state has on an individual in the account transfer to the Marketplace. Consider including notice language to beneficiaries that includes contact information for Navigator and assister programs which can help them with the transition to the Marketplace; and
- Work with community-based organizations that comprise the Administration for Community Living (ACL)'s aging and disability networks, including Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), and Protection and Advocacy organizations (P&As), as well as beneficiary advocates to ensure consumers get information and assistance they need to navigate this transition.

For more information, states may refer to the July 2016 CIB, "Coordination of Eligibility and Enrollment Between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace")," which is available to assist states in meeting their obligations to coordinate eligibility and enrollment among insurance affordability programs and the account transfer process.²⁰

VII. Monitoring State Progress and Corrective Action

CMS will monitor states' progress in meeting the timelines and completing required eligibility and enrollment actions described in this letter. Under the authority in sections 1902(a)(6) and 1902(a)(75) of the Act and 42 C.F.R. § 431.16, all states will be expected to submit data

²⁰ CMCS Informational Bulletin, "Coordination of Eligibility and Enrollment Between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace")," (July 2016). Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf>.

demonstrating progress in completing pending applications and initiating the state’s total caseload of renewals, along with the disposition of renewals. States will be required to submit baseline data to CMS and report additional data on a monthly basis, for a minimum of 14 months. Where reported data indicate that states are not meeting timelines described in this letter, or in circumstances where data demonstrate other potential compliance issues, including potential erroneous disenrollments of eligible beneficiaries, states may be expected to report additional data and/or report information more frequently. CMS will identify the data elements to be reported and provide a reporting template for states to use.

In addition, states that do not resolve their pending eligibility and enrollment actions within the timelines specified may be required to separately submit a corrective action plan to CMS outlining strategies and a timeline to come into compliance with federal requirements.

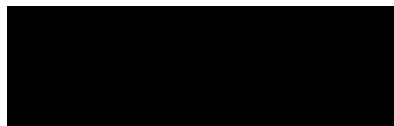
VIII. PERM or MEQC Programs

CMS will not consider eligibility and enrollment actions that are delayed due to the PHE as untimely for purposes of the PERM or MEQC programs if such actions are initiated within the timelines detailed in this letter and completed before the end of the 14th month once the state begins its unwinding period. States with an approved section 1902(e)(14)(A) waiver, that are compliant with the parameters outlined in Section V.A. of this SHO letter, shall be not be considered in violation of Medicaid statute and regulations for purposes of PERM and MEQC reviews.

IX. Closing

CMS shares states’ goal of ensuring that eligible individuals remain enrolled in Medicaid, CHIP, and/or BHP coverage and that individuals who are no longer eligible are able to transition seamlessly to other coverage options for which they are eligible, including Marketplace coverage. CMS also remains interested in hearing state and stakeholder feedback and concerns as states plan for the eventual end of the PHE and the continuous enrollment condition, and the return to routine operations. We are committed to providing states with updated guidance and resources, as appropriate, as well as ongoing technical assistance necessary for states to complete eligibility and enrollment work as described in this letter. Please submit any additional requests for technical assistance to your CMS State Lead.

Sincerely,

A solid black rectangular box redacting the signature of Daniel Tsai.

Daniel Tsai
Deputy Administrator and Director

Cc:

National Association of Medicaid Directors
National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

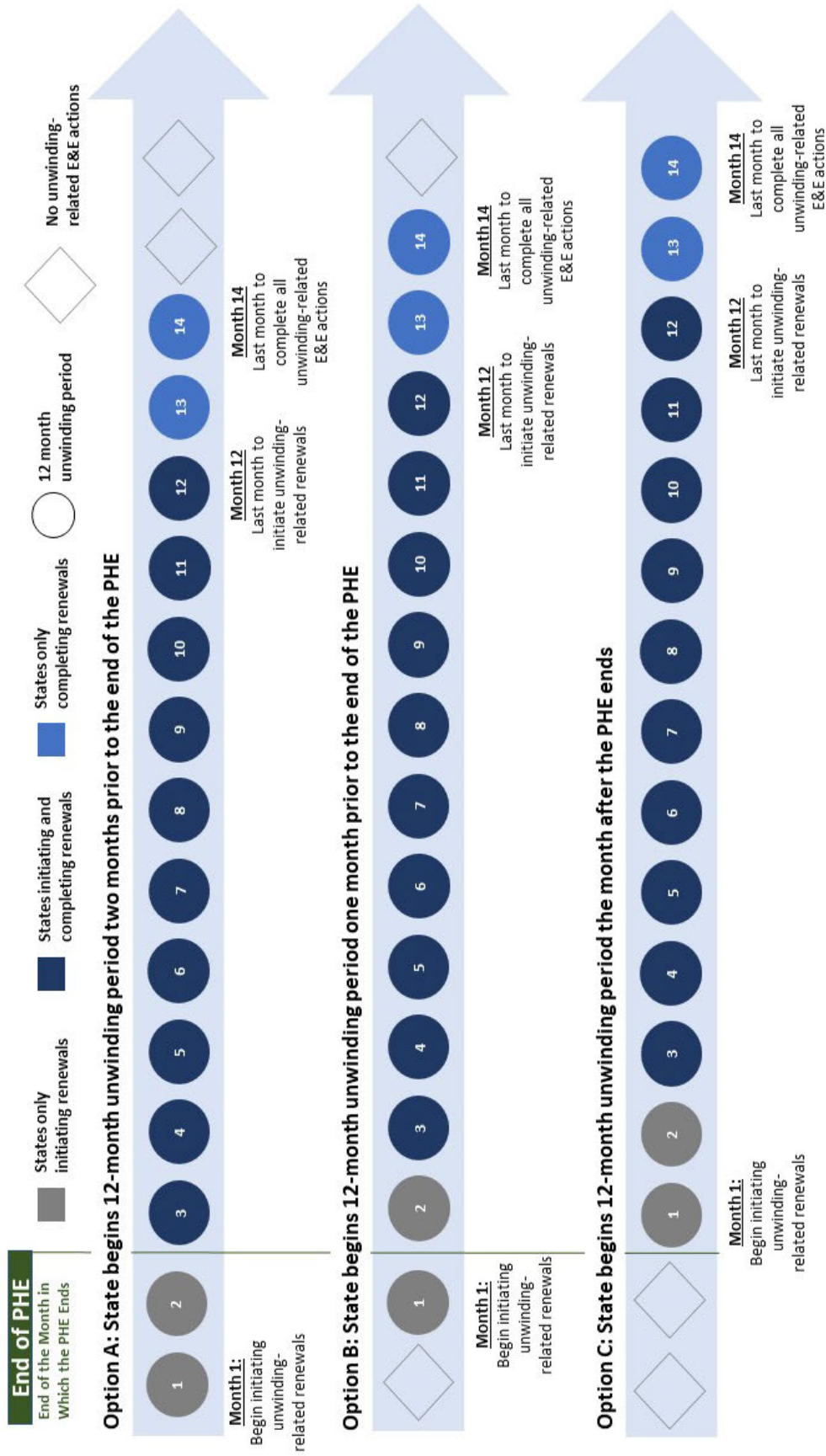
National Conference of State Legislatures

Academy Health

National Association of State Alcohol and Drug Abuse Directors

Appendix A: 12-Month Unwinding Timeline

Note: The options in this graphic are illustrative of when a state may begin its 12-month unwinding period when the PHE eventually ends and are based on a state with a 75-day renewal processing timeline for a cohort of individuals. There will be variation depending on individual state renewal processing timelines.



Appendix B: Strategies to Promote Continuity of Coverage and Mitigate Churn

States will need to consider strategies that ensure eligible individuals remain enrolled and allow states to efficiently complete outstanding work. As states develop their unwinding operational plans, they should identify where there is a risk that eligible individuals may lose coverage in their current and planned processes and adopt strategies that mitigate particular risks in the state. The following are examples of strategies states may adopt to promote continuous coverage and reestablish communications with beneficiaries.

A. Promote Continuous Coverage for Eligible Individuals

Provide Continuous Eligibility to Maintain Coverage for Eligible Individuals

Under continuous eligibility, beneficiaries retain eligibility for a period, up to 12 months, elected by the state. A beneficiary for whom continuous eligibility applies generally retains eligibility, regardless of changes in circumstances, for the duration of the continuous eligibility period elected by the state. Adopting continuous eligibility for some or all populations can ease the burden on states during the unwinding period by relieving the state of any need to conduct a redetermination based on changes in circumstances after a beneficiary has been renewed for coverage during the unwinding period, until the next regularly-scheduled renewal. This would ensure that the state would only need to take action on the beneficiary's case once during the unwinding period.

Under 42 C.F.R. §§ 435.926 and 457.342, a state may provide up to 12 months of continuous eligibility in Medicaid and CHIP for children who are under age 19 or under a younger age specified by the state. This option provides the state with the authority generally to not act on changes in circumstances for children during the continuous eligibility period.²¹ States implementing continuous eligibility in Medicaid must apply the policy to all children under the age specified by the state who are eligible under all mandatory and optional categorically needy groups under Section 1902(a)(10)(A) of the Act.

Action: To elect this option, states must submit a SPA.

States can adopt income and resource disregards under the authority of section 1902(r)(2) of the Act to provide continuous eligibility for most adult beneficiaries enrolled on the basis of being age 65 or older, living with a disability or blindness, or need for long-term care services and supports. States that would like to provide continuous eligibility for MAGI-based adult beneficiaries may consider submitting a section 1115 demonstration waiver application.

Action: States interested in pursuing a section 1902(r)(2) disregard for individuals eligible on a non-MAGI basis must submit a SPA. States interested in pursuing a section 1115 demonstration to provide continuous eligibility should contact their state lead or section 1115 demonstration project officer.

²¹ There are several exceptions specified in the regulations to this general rule, in which states are expected to act on changes in a child's circumstances, including children turning age 19, changes in state residency, death, or voluntary termination, and, for children enrolled in CHIP, becoming eligible for Medicaid.

Extend Postpartum Coverage in Medicaid and CHIP

Sections 9812 and 9822 of the ARP give states a new option to provide 12-months of extended postpartum coverage to individuals who were enrolled in Medicaid or CHIP while pregnant. Individuals eligible for extended postpartum coverage are entitled to continuous eligibility despite changes in circumstances that would otherwise affect eligibility during the extended postpartum period. States may adopt this option beginning April 1, 2022, and, as noted earlier in this letter, states may wish to deprioritize work on actions for pregnant and postpartum individuals during the 12-month unwinding period until the extended postpartum coverage option becomes effective and the state has taken steps to adopt it. States may refer to SHO #21-007 “Improving Maternal Health and Extending Postpartum Coverage in Medicaid and CHIP,” for more information on implementing this option.²²

Action: To elect this option, states must submit a Medicaid and CHIP SPA.

Maximize Success of Ex Parte Renewals Through Use of Expanded Data Sources

States must attempt to renew eligibility based on available information (*ex parte* renewal) for all beneficiaries as required at 42 C.F.R. § 435.916(a)(2) and (b). States may expand the number and type of data sources used during the *ex parte* process as well as create a data source hierarchy to prioritize sources that provide the most recent and reliable data. States can also adopt policies during the unwinding period (or longer) to maximize the use of the *ex parte* renewal processes and increase the rate at which beneficiaries’ eligibility may be renewed using information available to the state and without requiring a renewal form or other documentation from beneficiaries. For example, states may rely on information in the case record which the state determines is highly unlikely to change, especially for particular populations (such as income for children eligible for coverage under section 1902(e)(3) of the Act (“Katie Beckett group”) without regard to their parents’ income, beneficiaries dually eligible for Medicare and Medicaid, or beneficiaries over a specified age), as reliable information even if the state requires documentation of income not verified electronically from other beneficiaries. States pursuing this option may need to update their verification plan.

Action: No SPA is needed, but updated verification plans for MAGI-based determinations must be submitted to CMS.

Adopt MAGI Renewal Policies for Non-MAGI Renewals to Minimize Beneficiary Burden

States that currently renew eligibility more frequently than once every 12 months for some or all of their non-MAGI beneficiaries may elect to renew eligibility for some or all of their non-MAGI populations only once every 12 months. Extending the renewal timeframe may also support other state priorities, such as increasing access to home and community-based services, by reducing the frequency in which beneficiaries must respond to state requests.

Action: To elect this option, states must submit a SPA.

Under 42 C.F.R. § 435.916(b), states may also adopt renewal procedures required for MAGI beneficiaries under § 435.916(a)(3) for non-MAGI beneficiaries. Such procedures include using

²² CMS State Health Official Letter #21-007, “Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children’s Health Insurance Program (CHIP),” December 7, 2021. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>.

a pre-populated renewal form for beneficiaries whose renewal cannot be completed using only information available to the state; providing a minimum of 30 days for beneficiaries to respond; and providing a reconsideration period for beneficiaries whose eligibility is terminated at renewal for failure to return their renewal form or other required information, but who subsequently do so after their eligibility is terminated, without requiring the submission of a new full application.

Action: States may need to submit a SPA for CMS approval to implement these options or update internal procedures.

Use Information from Other Programs like SNAP and Temporary Assistance for Needy Families (TANF) to Renew Eligibility

States have several options to leverage information from programs like SNAP or TANF to verify eligibility and facilitate renewals in a manner that minimizes beneficiary burden. Some of these options will require states to submit a SPA. As noted in Section V.A. of this SHO letter, states may also use a temporary 1902(e)(14)(A) waiver. Under the Express Lane Eligibility authority at sections 1902(e)(13) and 2107(e)(1) of the Act, states are permitted to rely on findings from an entity designated by the state to determine whether a child satisfies one or more factors of eligibility for Medicaid or CHIP, including income. States may also adopt the facilitated enrollment SPA option for adults and children. This option allows states to rely on income determinations made by another program if the state is certain the individual would be income-eligible using MAGI-based methods. Both the Express Lane Eligibility and facilitated enrollment SPA options may be used at application, renewal, or both. States interested in these options may refer to the SHO #10-003, “Express Lane Eligibility”²³ and the SHO #15-001 “Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies” for additional guidance.²⁴

States may also use verified information from other state and federal programs to verify the financial eligibility of an individual. For example, SNAP wage or other income data captured in an integrated eligibility and enrollment system may be used to verify continued eligibility at renewal or a redetermination based on a change in circumstances.

Action: States electing to use other program information as a reliable data source should update their verification plans. Changes made to MAGI verifications plans must be submitted to CMS.

Modify or Suspend Periodic Data Matching

States can improve coverage retention and reduce churn between regular renewals by suspending periodic data matching or modifying the approach by reducing the frequency with which periodic data matches are conducted. This strategy will avoid or reduce the administrative burden associated with redeterminations between regular renewals during the 12-month unwinding period, including the need to process new applications submitted by beneficiaries terminated because they did not respond to a mid-year request for additional information.

²³ CMS State Health Official Letter # 10-003, “Express Lane Eligibility Option,” February 4, 2020. Available at <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SHO10003.PDF>.

²⁴ CMS State Health Official Letter # 15-001, “Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies,” August 31, 2015. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-15-001.pdf>.

Action: States need to update their verification plans in order to suspend or reduce the frequency of periodic data matches. Changes made to MAGI verifications plans must be submitted to CMS.

Extend Beneficiary Response Times

States are strongly encouraged to review their policies regarding the amount of time beneficiaries are given to provide requested information and to provide additional time as appropriate. Extending the timeframe for beneficiaries to respond to requests for information will minimize the risk that beneficiaries lose coverage for procedural reasons. As discussed in the “Medicaid and CHIP Renewal Requirements” CIB, we believe it would be reasonable for states to allow beneficiaries 30 days to respond and provide any necessary information needed to verify eligibility.²⁵

Action: Update internal state procedures; states do not need to submit a SPA for CMS approval to implement this option.

Offer a Reconsideration Period for Coverage Losses following Changes in Circumstances

States may offer a minimum 90-day reconsideration period, similar to the reconsideration period provided for MAGI beneficiaries at renewal under 42 C.F.R. §§ 435.916(a)(3)(iii) and 457.343, for beneficiaries whose eligibility has been terminated for failure to respond to a request for information needed to redetermine eligibility following a change in circumstances, if the individual subsequently returns the needed information. Offering a reconsideration period allows states to reconsider an individual’s eligibility without requiring the individual to fill out a new application. The required information returned within the reconsideration period serves as an application. If adopted, a determination or denial of eligibility based on the returned information must be made consistent with timeliness standards specified in § 435.912 or § 457.340(d), as applicable. In Medicaid, retroactive eligibility would be available, consistent with § 435.915(a), to provide coverage for up to three months prior to the date the information was returned. States would also need to ensure they collect any additional information from the individual that is not available to the state but required at application, such as a signature.

Action: Update internal state procedures; states do not need to submit a SPA for CMS approval to implement this option.

B. Reestablish Communication and Conducting Outreach with Beneficiaries

CMS recognizes that states may have had minimal or no contact with many beneficiaries for an extended period, as many have not experienced a periodic renewal of eligibility in several years due to the continuous enrollment condition. There is an inherent risk that eligible individuals will lose coverage after the continuous enrollment condition expires because they have a new address or other contact information, which has not been updated with the state. Further, beneficiaries may not understand that renewals of eligibility are resuming, or know when their renewal may occur during the 12-month unwinding period. States will need to employ a variety of strategies

²⁵ CMCS Informational Bulletin, “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements,” (December 2020). Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>.

to reestablish communication with beneficiaries and engage in outreach efforts to ensure eligible individuals maintain coverage.

Update Beneficiary Contact Information

All states should take steps during the PHE to update beneficiary contact information to prevent coverage losses for eligible individuals and remind beneficiaries that they may report updated information online, by phone, by mail, or in person. Maintaining complete and accurate contact information is critical to ensuring beneficiaries get renewal forms and program information timely in order to promote retention of coverage or facilitate seamless coverage transitions to BHP or the Marketplace, as appropriate. States can begin sending reminders to beneficiaries to update their contact information and identify individuals for whom the state may have outdated information.

States are also encouraged to work with MCOs to establish a process to engage in outreach to beneficiaries to update their contact information and use information made available to the Medicaid agency by MCOs and/or establish processes to receive updated information on an ongoing basis from MCOs. When updated address information is received by the state from managed care plans, states may update the beneficiary record with the new address, provided that it is an in-state address and provided that the state sends a notice to the address on file with the state and provides the individual with a reasonable period of time to verify the accuracy of the new contact information. States are also encouraged to contact the beneficiary through other modalities, such as via telephone, electronic notice, email, or text message, and to send information to the new address, where feasible. If the beneficiary does not respond to the mailing to verify the accuracy of the contact information provided by the managed care plan or if the beneficiary responds to the outreach through the other modalities and confirms the new address on file with the MCO, the state may update the beneficiary record with the new contact information from the managed care plan. Critically, states should ensure that managed care plans only provide updated contact information received directly from or verified by the beneficiary, and not from a third party or other source. Information provided from such sources is not considered reliable. For strategies centered on working with MCOs, states may refer to the “Overview of Strategic approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations” resource available on Medicaid.gov.²⁶ As noted in Section V.A. of this SHO letter, states may also request temporary authority under section 1902(e)(14)(A) of the Act if systems or operational limitations prevent them from sending the beneficiary a notice to the address on file prior to updating the beneficiary’s record with new contact information provided by an MCO.

States are strongly encouraged to establish linkages with the U.S. Postal Service (USPS) National Change of Address (NCOA) database as they prepare to return to normal operations. The NCOA is a set of data that includes the permanent change-of-address records maintained by the USPS. Every time an individual or family moves and submits a change-of-address form to their local post office, their new address is recorded in the NCOA database. States can establish agreements with USPS to gain access to the NCOA database in order to utilize these address

²⁶ “Overview of Strategic approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations,” (December 2021). Available at <https://www.medicaid.gov/sites/default/files/2021-12/health-plan-strategy-12062021.pdf>.

changes. States are also encouraged to leverage address information received from USPS when mail is returned to the state with an in-state forwarding address.²⁷ Under USPS forwarding mail, an individual can elect to have their mail forwarded to their new address. To mitigate against errors, USPS implements controls, which include charging a fee by credit card to validate online change of address (COA) requests, requiring individuals submitting a hardcopy COA request to verify that they understand an unauthorized COA order is a federal offense, and sending two confirmation letters (to the new and old address) to authenticate the order.

Given the increased likelihood of individuals moving during the PHE, leveraging the NCOA and USPS in-state forwarding address information provides states with a streamlined tool to improve address accuracy and locate beneficiaries who would otherwise be at risk for a procedural termination during the unwinding period. State agencies may treat information obtained from the NCOA and USPS returned mail with an in-state forwarding address as reliable and update the beneficiary record with the new contact information, provided that the state conducts the following outreach.

When updated address information is received by the state from NCOA or from USPS returned mail with an in-state forwarding address, states must send a notice to the address on file with the state and provide the individual with a reasonable period of time to verify the accuracy of the new contact information. States are also encouraged to contact the beneficiary through other modalities, such as via telephone, electronic notice, email, or text message, and to send information to the new address, where feasible. If the beneficiary does not respond to verify the accuracy of the contact information provided by NCOA or from USPS returned mail or if the beneficiary responds to the outreach through the other modalities and confirms the new address, the state may update the beneficiary record with the new contact information. States pursuing this option need to update their verification plan and may use the “Other” electronic data section to indicate how the state will use NCOA. Please refer to Appendix C of this section for a detailed discussion on processing returned mail, including mail returned with an out-of-state or with no forwarding address.

Use Multiple Modalities to Reach Beneficiaries

While beneficiaries must be able to communicate with the state agency and return eligibility and enrollment information online, by phone, by mail, or in person, often states rely entirely on mail to facilitate communication with beneficiaries. States are required to communicate with beneficiaries through electronic notices pursuant to an individual’s election under 42 C.F.R. § 435.918 and are encouraged to explore and adopt consumer communication and outreach strategies through a variety of modalities, including phone and text messaging. States are also encouraged to pursue using additional methods of outreach beyond mail to follow up in specific situations such as when there are outstanding requests for information, incomplete renewal forms, or returned mail.

Update Notices and Other Consumer Facing Messages

States are encouraged to review existing applicant and beneficiary notices and communications and make modifications needed to effectively convey key messages in plain language, consistent with 42 C.F.R. §§ 435.905 and 435.917(a). Notices must provide clear instructions on how to

²⁷ Please refer to Appendix C of this section for additional information on processing returned beneficiary mail.

complete renewal forms or respond to requests for information as well as explain what information is needed for the state to determine eligibility. Notices should advise beneficiaries to keep their contact information up-to-date.

Review Communication Strategies for Individuals who have LEP and People with Disabilities.

States are reminded that program information on Medicaid and CHIP must be provided in plain language and in a manner that is accessible to individuals who have LEP and for people with disabilities, as required at 42 C.F.R. §§ 435.905(b) and 457.110(a). Applicants and beneficiaries with LEP must be able to access information about Medicaid and CHIP, including through use of oral interpretation and written translation. States should ensure that written notices, applications, and renewal forms are translated into multiple languages and that such information is otherwise available to individuals through oral interpretation (see §§ 435.206(e), 435.907(g), 435.916(g), 435.917(a), 435.956(b), and 457.340(e)). States may consider providing qualified oral interpretation by hiring qualified bilingual staff who speak frequently spoken non-English languages within the state's population (e.g., Spanish), partnering with community-based organizations with qualified interpretation services, and providing qualified interpreters by telephone, consistent with 42 C.F.R. § 435.901 and 45 C.F.R. Part 92. Language services needed by individuals who have LEP must be provided free of charge in accordance with 42 C.F.R. §§ 435.905(b)(3) and 457.110(a). States must inform individuals who have LEP how to access the language services that are available, including through use of taglines (i.e., a short statement written in non-English languages that indicate the availability of language assistance services free of charge).²⁸

To provide people with disabilities accessible information, states must take appropriate steps to ensure that communications with applicants, beneficiaries and members of the public are as effective as communications with others. This includes providing appropriate auxiliary aids and services at no cost to qualified individuals with disabilities where necessary to afford an equal opportunity to participate in, and enjoy the benefits of, a service, program, or activity, in accordance with 42 C.F.R. § 435.905(b), federal law and implementing regulations.²⁹

For additional detail on providing accessible information to individuals with LEP and people with disabilities, see 45 C.F.R. Part 92.

Utilize MCOs and Stakeholders to Conduct Outreach

Close collaboration between states and contracted managed care entities, social service organizations, and other stakeholders can help ensure eligible individuals retain coverage in Medicaid and CHIP and ease transitions for individuals eligible for coverage through the Marketplace. States are strongly encouraged to engage with their contracted managed care entities as they develop their unwinding operational plans and identify clear roles and ways in which health plans can assist with outreach and enrollment efforts. States are encouraged to

²⁸ See also Title VI of the Civil Rights Act of 1964 and its implementing regulations at 45 C.F.R. Part 80, and Section 1557 of the Affordable Care Act and its implementing regulations at 45 C.F.R. Part 92.

²⁹ See Section 504 of the Rehabilitation Act of 1973 and HHS's implementing regulations at 45 C.F.R. Part 84, Title II of the Americans with Disabilities Act and DOJ's implementing regulations at 28 C.F.R. Part 35, specifically 28 C.F.R. § 35.160, and Section 1557 of the Affordable Care Act and its implementing regulations at 45 C.F.R. Part 92.

provide contracted managed care entities with a monthly list of individuals who are due for renewal to allow health plans to provide secondary outreach to ensure individuals complete the renewal process. This will be especially useful during the 12-month unwinding period as states are redistributing renewals and beneficiaries and health plans may not otherwise know which cohort of individuals is due for renewal in each month.

Engage Other Stakeholders

States are also strongly encouraged to engage with other key stakeholders (e.g., providers, beneficiary advocacy groups) and with the Indian Health Service, Tribes and Tribal organizations, and urban Indian organizations (ITUs) located in your state on an ongoing basis. Communicating with stakeholders and ITUs regularly will help identify opportunities to leverage their support with assisting beneficiaries in updating eligibility information and ensure that they understand the need to respond to states' notices and complete the renewal process.

C. Consider Additional Strategies

CMS has identified several additional policies and operational strategies to streamline workflow, strengthen renewal processes to ensure eligible beneficiaries remain enrolled in coverage and facilitate coverage transitions between programs, and enhance oversight of eligibility and enrollment operations. These strategies are listed in the November 2021 tool, “Strategies States and the U.S. Territories Can Adopt to Maintain Coverage for Eligible Individuals as They Return to Normal Operations.”³⁰ States are strongly encouraged to review available strategies described in this letter as well as the November 2021 tool and take any steps needed to ensure that those strategies the state wants to implement are in place before the state begins its unwinding period.

³⁰ “Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations,” November 2021. Available at: <https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf>.

Appendix C: Processing Returned Mail

States should take steps during the PHE to establish procedures and update policy manuals to ensure that staff know the specific actions they should take in response to returned beneficiary mail, as depicted in Graphic 1, below. States are encouraged to create a specialized and dedicated unit (either centralized or within each region/county) for processing returned mail from the USPS.

Receipt of returned mail indicates a potential change in circumstances that may impact eligibility (i.e., state residency). However, returned mail does not necessarily mean a move out of state or that a beneficiary is ineligible. At the same time, if a state does not obtain updated contact information when mail is returned, beneficiaries are at high risk for procedural termination. For all returned beneficiary mail, states are strongly encouraged to attempt to contact the beneficiary by mail and send notices to both the current address on file and the forwarding address, if one is provided, requesting that the beneficiary confirm the new address provided by USPS. States also are strongly encouraged to attempt to contact the beneficiary using one or more other modalities, such as by phone, electronic notice, email, or text messaging as permissible. If a state is unable to locate the beneficiary by mail or by using another modality, states should check data sources for updated address information (e.g., MCOs, the state agency that administers SNAP or TANF, the Department of Motor Vehicles records, or the USPS NCOA database). More information on state flexibilities to update addresses based on MCO and NCOA data is included in Appendix B of this SHO letter (See Appendix B, Section B. “Reestablish Communication and Conducting Outreach with Beneficiaries”).

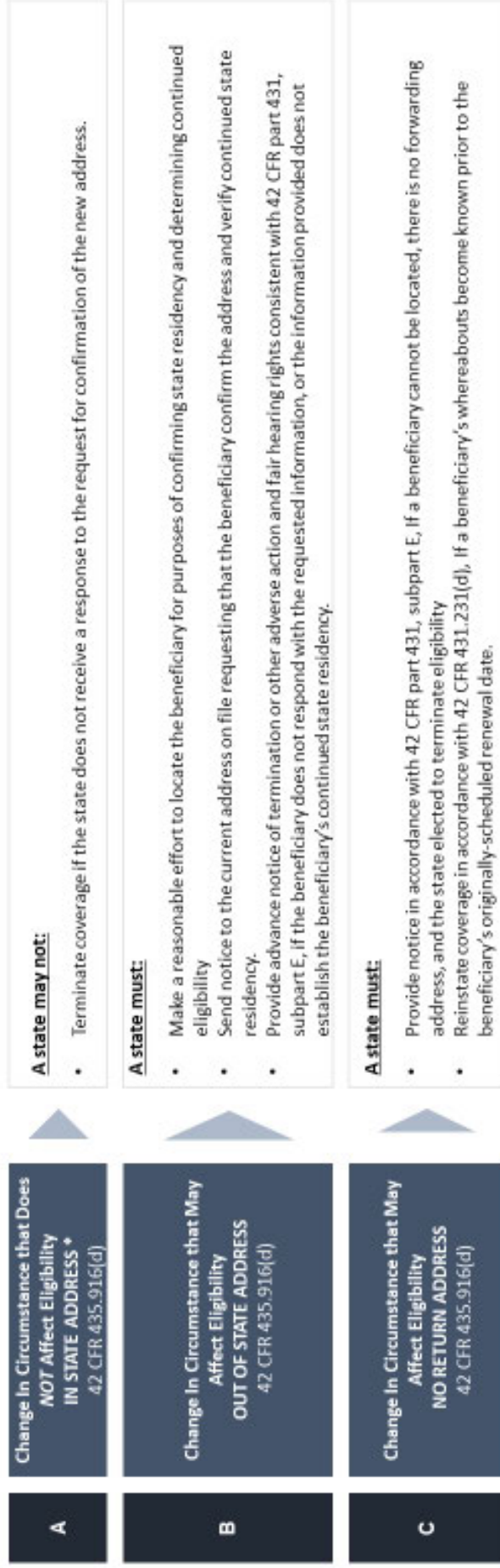
If the state’s attempts to locate the beneficiary to confirm the contact information are unsuccessful, the action states need to take upon receipt of returned mail will depend on whether the USPS has provided a new in-state address, a new out-of-state address, or no new address on the returned mail. States must take steps to locate beneficiaries who may have moved prior to taking any adverse action. Mail returned with an in-state forwarding address is not an indication of a change affecting eligibility. Nonetheless, it is important for the state to confirm the accuracy of the information to ensure future ability to contact the beneficiary. Because this is a change that does not affect eligibility, states are strongly encouraged to verify the information by sending notice by mail to the current address and also to the forwarding address and attempt to contact the beneficiary using one or more other modalities. States may accept the USPS in-state forwarding address and update the beneficiary’s record provided that the state first sends a notice to the current address on file confirming the accuracy of the information. A state may not terminate coverage if the state does not receive a response to the request for confirmation of an in-state address change, even if the state does not update the beneficiary’s record with the new in-state address.

When a beneficiary’s mail is returned to the state agency with an out-of-state address, the state must send notice and attempt to contact the beneficiary to confirm the accuracy of the information and verify continued state residency. Because the out-of-state address may be an indication of a change in residency, the state must send notice consistent with the beneficiary’s elected format, either electronically or by mail, to the current address the state has on file, requesting that the beneficiary confirm the address and state residency. States are strongly encouraged also to send notice to the out-of-state forwarding address and/or other address provided by a third party, attempt to locate the beneficiary using other electronic or telephonic

modalities, and by checking third-party data sources for more recent address information. If the beneficiary does not respond with the requested information, or the information provided does not establish the beneficiary's continued state residency, the state must provide advance notice of termination or other adverse action and fair hearing rights consistent with 42 C.F.R. §§ 431.206-214.

We encourage states attempt to locate beneficiaries whose mail is returned to the state agency without a forwarding address consistent with the steps described above prior to discontinuing coverage based on a determination that a beneficiary's whereabouts are unknown. If a beneficiary cannot be located, and there is no forwarding address, the state may terminate eligibility in accordance with regulations at 42 C.F.R. part 431, subpart E. If a beneficiary's whereabouts become known prior to the beneficiary's originally-scheduled renewal date, the state must reinstate coverage in accordance with regulations at § 431.231(d).

Graphic 1. Agency Action Required by Three Types of Returned Mail



Best Practices on Returned Mail

States are strongly encouraged to locate beneficiaries whose mail is returned to the state by doing the following:

1. Confirm the accuracy of the returned mail, which may include:
 - Checking the information on the returned mail matches the address in the beneficiary record
2. Conduct outreach to the beneficiary, which may include:
 - Sending notice to current and forwarding address, if provided, requesting the beneficiary confirm the new address provided by USPS
 - Accepting in-state forwarding address information from USPS, provided the state conducts outreach to the beneficiary's address on file
 - Attempting to contact beneficiary by phone, email, electronic notice, or text messaging, if such contact information is provided
 - Checking data sources for updated address (e.g., managed care plans, the state agency that administers SNAP or TANF, the Department of Motor Vehicles records, or the USPS National Change of Address (NCOA) database)
 - Sending notice to the updated address if one is obtained from a third-party data source, requesting the beneficiary confirm the new address

* For more information on state flexibilities to update addresses based on MCO and NCOA data, for mail returned with an in-state forwarding address states may refer to Appendix B of this SHO (See Appendix B, Section B, Reestablish Communication and Conducting Outreach with Beneficiaries).

Appendix D: Related CMS Guidance

Guidance Related to Returning to Routine Operations after the PHE Ends

- **State Health Official Letter (SHO) #20-004, “Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency”** (“December 2020 SHO”): Provides guidance to states on planning for the eventual return to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent in certain circumstances, procedures for ending coverage and policies authorized under expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE.

States may access the December 2020 SHO at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>.

- **State Health Official Letter (SHO) #21-002, “Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program Operations Upon Conclusion of the COVID-19 Public Health Emergency”** (“August 2021 SHO”): Updates guidance in the December 2020 SHO to provide states 12-months after the PHE ends to complete pending eligibility and enrollment work and ensures states renew eligibility for all beneficiaries prior to taking any adverse action.

States may access the August 2021 SHO at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>.

Medicaid and CHIP Renewal and Account Transfer Requirements

- **CMCS Informational Bulletin (CIB), “Medicaid and CHIP Renewal Requirements”** (“Renewal CIB”): Reminds states about current federal requirements and expectations codified in existing regulations at 42 C.F.R. §§ 435.916 and 457.343 for completing redeterminations of eligibility for Medicaid and CHIP beneficiaries. These requirements are intended to ease the administrative burden on states and beneficiaries by limiting requests for information to information needed to determine eligibility, ensuring beneficiary eligibility is assessed on all bases before determining an individual is ineligible and promoting seamless transitions of coverage, and minimizing the churn of beneficiaries on and off Medicaid and CHIP coverage for procedural reasons.

States may access the Renewal CIB at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>.

- **CMCS Informational Bulletin Coordination of Eligibility and Enrollment Between Medicaid, CHIP, and the Federally Facilitated Marketplace (FFM or “Marketplace”)** (“Account Transfer CIB”): Reminds states about federal requirements related to coordination of eligibility and enrollment among insurance affordability programs and the account transfer process. These requirements are intended to ensure determinations of eligibility and enrollment in the appropriate program are made promptly and without delay.

States may access the Account Transfer CIB at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf>.

Strategies to Promote Continuity of Coverage and Prevent Inappropriate Terminations

- **Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations:** Provides states strategies to work with health plans to update beneficiary contact information, conduct outreach, support individuals enrolled in Medicaid during renewal and assist individuals transitioning to the Marketplace.

States may access the “Overview of Strategic approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations” resource at <https://www.medicaid.gov/sites/default/files/2021-12/health-plan-strategy-12062021.pdf>.

- **Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations:** Provides states a list of policy and operational strategies that states can implement to support unwinding activities at the end of the COVID-19 PHE in order to ensure continuous coverage for eligible beneficiaries and facilitate coverage transitions for individuals eligible for other forms of coverage.

States may access the “Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations” tool at <https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf>.

- **Medicaid and CHIP Coverage Learning Collaborative: Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Beneficiaries Part 1** (“Preventing Inappropriate Terminations of Coverage Part 1 deck”): Provides guidance and strategies for states to address workflow processes, leverage other program data and strengthen consumer outreach and communication to promote continuity of coverage.

States may access the Preventing Inappropriate Terminations of Coverage Part 1 deck at <https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/ensrng-contnty-cvrg-prvntng-inprprte-trmntns-part-1.pdf>.

- **Medicaid and CHIP Coverage Learning Collaborative: Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Beneficiaries Part 2** (“Preventing Inappropriate Terminations of Coverage Part 2 deck”): Provides guidance and strategies for states to maintain communication with beneficiaries and address returned mail.

States may access the Preventing Inappropriate Terminations of Coverage Part 2 deck at <https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/ensrng-contnty-cvrg-prvntng-inprprte-trmntns-part-2.pdf>.

- **Medicaid and CHIP Coverage Learning Collaborative: Connecting Kids to Coverage: State Outreach, Enrollment and Retention Strategies.** Highlights effective and practical strategies to improve state outreach, enrollment, and renewal activities.

States may access “Connecting Kids to Coverage: State Outreach, Enrollment, and Retention Strategies” at <https://www.medicaid.gov/state-resource-center/downloads/kids-coverg-outreach-enrolmnt-retention-strategies.pdf>.

Tools for Effective Communication of Eligibility Determinations

- **Medicaid and CHIP continuous Coverage Unwinding Phase 1: Plan & Educate** (Unwinding Communications Toolkit): Provides important information to help inform people with Medicaid and CHIP about steps they need to take to renew coverage.

States may access the Unwinding Communications Toolkit at <https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf>.

- **Effective Communication of Eligibility Determinations:** Provides states a set of tools to assist in the development of key messages, including model notices.

States may access the Effective Communication of Eligibility Determinations tools at <https://www.medicaid.gov/resources-for-states/mac-learning-collaboratives/expanding-coverage-under-medicaid-and-chip/index.html>.