State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions

Instructions

All states must complete and submit to Centers for Medicare & Medicaid Services (CMS) this reporting form summarizing state's plans for initiating renewals for its total caseload within the state's 12-month unwinding period. States must submit this form to CMS by the 45th day before the end of the month in which the COVID-19 public health emergency (PHE) ends. States submit completed forms to CMS via the COVID unwinding email box at CMSUnwindingSupport@cms.hhs.gov.

Background

The end of the continuous enrollment requirement for states[1] receiving the temporary increase in their Federal Medical Assistance Percentage (FMAP) ("temporary FMAP increase") under section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127) presents the single largest health coverage transition event since the first Marketplace Open Enrollment following enactment of the Affordable Care Act ("continuous enrollment condition"). To ensure states maintain coverage for eligible individuals, all states must provide the CMS with a summary of their plans to prioritize, distribute and process renewals during the 12-month unwinding period described in State Health Official Letter #21-002, "Updated Guidance Related to 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,"[2] and #22-001 "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."[3]

Over the course of their 12-month unwinding period, states will need to conduct a renewal of every beneficiary enrolled in their Medicaid and CHIP programs as of the end of the month prior to their unwinding period ("referred to herein as the state's "total caseload"). 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 the risk of inappropriate terminations. The volume of renewals and other eligibility actions that states will need to initiate during the 12-month unwinding period creates risk that eligible beneficiaries will be inappropriately terminated. This risk is heightened in states that intend to initiate a large volume of their total caseload in a given month during the unwinding period, particularly if a state initiates more than 1/9 of its total caseload in a given month.

Therefore, in order to better understand states' plans to process renewals during the unwinding period, CMS is requiring states to describe how they intend to distribute renewals as well as the processes and 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 and will follow up with states as needed to ensure that proper mitigations are in place to reduce risk of inappropriate terminations and that states' plans will establish a sustainable workload in future years.

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[1] Throughout this document, the term "states" means states, the District of Columbia, and the U.S. territories.

[2] CMS State Health Official Letter #21-002, "Updated Guidance Related to 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" (August 13, 2021). Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.

[3] CMS State Health Official Letter #22-001, "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). Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

Section A. Renewal distribution plan

1. Please complete questions 1a. and 1b. to describe how the state intends to initiate Medicaid and CHIP renewals during the state's 12-month unwinding period.

a. Please indicate the approximate number of Medicaid and CHIP renewals that the state intends to initiate each month during the state's 12 months unwinding period using the following chart:

Note that the percentage of renewals scheduled to be initiated in a given month is based on the state's total caseload as of the end of the month before the state begins to initiate renewals that may result in termination of beneficiaries who do not meet eligibility requirements or who fail to timely return information needed to complete a renewal. States may not initiate renewals that may result in terminations more than two months before the continuous enrollment condition ends in the state. A state's total caseload may be the state's total enrollment of individuals or the total number of households with one or more household members enrolled in Medicaid.

Unwinding Period Month	1	2	3	4	5	6	7	8	9	10	11	12	Total
Number of renewals scheduled to be initiated	1,022,02	1,022,16	1,093,65	1,111,6	1,079,09	1,123,5	1,105,78	1,094,23	1,269,12	1,081,55	1,081,55	1,081,55	13,166,214
Percent of renewals scheduled to be initiated	8%	8%	8%	8%	8%	9%	8%	8%	10%	8%	8%	8%	100%

b. Is the state measuring the volume of renewals that it intends to initiate each month by households (which may include more than 1 beneficiary) or individuals?

- ☐ Households
- ☑ Individuals

2. Please briefly summarize the state's plan to prioritize and distribute work during the 12-month unwinding period. *This summary should identify any populations the state is prioritizing for completion sooner or the order in which the state intends to initiate renewals; any unwinding-specific strategies the state intends to adopt in order to align work for all beneficiaries in a household, to align renewals with SNAP recertifications, or to align work on changes in circumstances with a full renewal; and any other information related to how the state plans to prioritize and distribute work associated with processing renewals and redeterminations during the unwinding period.*

To simplify the complexity of the continuous coverage unwinding process, California will maintain the Medicaid beneficiaries' current renewal month in their case records and conduct a full redetermination at the next scheduled renewal month following the end of the continuous coverage requirement. California is already processing changes in circumstances that result in positive changes through the course of the continuous coverage requirement, and resetting the redetermination date as appropriate. In addition, California has continued with the auto ex parte processes throughout the continuous coverage requirement.

Additional strategies adopted by California via the 1902(e)(14)(A) waiver includes: 1) Ex Parte Renewal for Individuals with No Income and No Data Returned; 2) Facilitating Renewal for Individuals with no Asset Verification System (AVS) Data Returned within a Reasonable Time frame; and 3) Partnering with Managed Care and Program of All-Inclusive Care for the Elderly (PACE) Plans to Update Beneficiary Contact Information.

Aligned with the goal of keeping the continuous coverage unwinding process as simple as possible, California is not requiring the prioritization of most populations. Individuals will be redetermined using their current renewal month. However, California has identified a small subset of the renewal population who may have their Medi-Cal eligibility redetermined outside of their normal renewal period.

As enacted by Senate Bill 184 (Chapter 47, Statutes of 2022), California will implement state-funded full scope Medi-Cal to individuals age 26 through 49, regardless of immigration status if otherwise eligible beginning on January 1, 2024. This Medi-Cal expansion is another important step to help close health equity gaps in California, and will improve access to care to the some of the state's most vulnerable populations. As part of the federal continuous coverage requirements, California maintained ongoing Medi-Cal coverage for young adults who were conferred state-only full scope Medi-Cal under the Young Adult Expansion, and who would have otherwise lost their Medi-Cal eligibility due to aging out at 26 years of age. Under federal requirements outlined by the CMS, California must redetermine all individuals in Medi-Cal once the continuous coverage requirement ends. As such, this population will most likely be determined ineligible for state-funded full scope Medi-Cal due to their age once the post-continuous coverage requirement renewals begin. In an effort to maintain continuity of coverage for these individuals who would have aged out during the continuous coverage requirement until the 26 through 49 expansion takes effect on January 1, 2024, California will continue existing state-funded full scope Medi-Cal coverage for this population and deprioritize these post-continuous coverage requirement renewals until the end of the Continuous Coverage Unwinding period.

Footnote:
Months 10, 11, and 12 (2024 renewals) are an estimate of months 1-9. The renewals for these months are currently in the 2023 renewal process and is not yet available until the 2023 renewal process is completed. DHCS anticipates the renewal caseload of Months 10, 11, and 12 to be at similar levels as Months 1-9 per historical renewal caseload information.

Section B. Strategies to promote coverage retention and prevent inappropriate terminations of coverage

1. **Please briefly summarize the state's plan to prioritize and distribute work during the 12-month unwinding period.** *This summary should identify any populations the state is prioritizing for completion sooner or the order in which the state intends to initiate renewals; any unwinding-specific strategies the state intends to adopt in order to align work for all beneficiaries in a household, to align renewals with SNAP recertifications, or to align work on changes in circumstances with a full renewal; and any other information related to how the state plans to prioritize and distribute work associated with processing renewals and redeterminations during the unwinding period.*

Strategies adopted by California via the 1902(e)(14)(A) waiver includes: 1) Ex Parte Renewal for Individuals with No Income and No Data Returned; 2) Facilitating Renewal for Individuals with no Asset Verification System (AVS) Data Returned within a Reasonable Timeframe; and 3) Partnering with Managed Care Plans to Update Beneficiary Contact Information.

In alignment with the goal to keep the continuous coverage unwinding process as simple as possible, California is not requiring prioritization of any populations. Individuals will be redetermined using their current renewal month. However, California has identified a small subset of the renewal population that may benefit from having eligibility redetermined prior to their scheduled annual renewal date. During the continuous coverage requirement, California continued to protect individuals who were inadvertently moved from a Medi-Cal program without a share of cost into a program with a share of cost by correcting the record in the Medi-Cal Eligibility Data System (MEDS). Due to the complexity of maintaining correct eligibility for these beneficiaries in MEDS, counties may conduct a full redetermination on these beneficiaries prior to the scheduled annual renewal date. Additionally, California will provide one-to-one technical assistance for any counties requesting guidance related to prioritization.

2. **Describe how the state will ensure that eligible individuals retain coverage and limit coverage losses for procedural reasons (i.e., for a reason other than a determination that the individual no longer meets eligibility requirements for coverage) as the state initiates and processes renewals and other eligibility actions during the 12-month unwinding period.**

California coordinated a phased communication campaign called DHCS Coverage Ambassadors to reach beneficiaries with messages across multiple channels to educate and inform individuals of what to expect and what they need to do to retain coverage and limit coverage losses. California is also in the process of procuring a marketing vendor to implement a broad and targeted education and outreach communications campaign targeted to enrolled Medi-Cal beneficiaries during and after the end of the continuous coverage requirement. The vendor will be responsible for designing, implementing, and executing a robust media campaign, including paid media advertisements, social and digital marketing, and targeted social media.

3. **Select which strategies the state currently utilizes or is planning to adopt to ensure eligible individuals remain enrolled or are transferred to the appropriate program during the unwinding period.**

For a comprehensive list of strategies that promote continuity of coverage, states may refer to the "Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations" available on Medicaid.gov at https://www.medicaid.gov/sites/default/files/2021-11/strategies-for-covrg-of-indiv.pdf.

a. <u>Strengthen Renewal Processes</u>

☑ Expand the number and types of data sources used for renewal (e.g., use both Internal Revenue Service (IRS) and quarterly wage data; leverage unemployment income data sources)

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Create a data source hierarchy to guide verification, prioritizing the most recent and reliable data sources (e.g., leverage SNAP data that is updated every six months; first ping IRS data and if not reasonably compatible, then ping quarterly wage data) and verify income when data source in the hierarchy confirms reasonably compatibility.

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Use a reasonable compatibility threshold (e.g., 10%) for income for MAGI and non-MAGI populations and a reasonable compatibility threshold for assets for non-MAGI populations, if not already used

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Ensure that individuals can submit requested information to the agency over the phone, via mail, online, and in-person, consistent with federal regulations

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Ensure renewal forms are pre-populated for individuals enrolled in Medicaid, CHIP, and BHP on a MAGI basis, consistent with federal requirements

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Other adopted strategies

Please specify:

Strategies adopted by California via the 1902(e)(14)(A) waiver includes: 1) Ex Parte Renewal for Individuals with No Income and No Data Returned; 2) Facilitating Renewal for Individuals with no Asset Verification System (AVS) Data Returned within a Reasonable Timeframe

Updates to MAGI Verification Plan:
1) Using Reasonable Explanation as a verification source/attestation
2) Increasing the reasonable compatibility standard by 20 percent.
2) Using the National Change of Address and United States Postal Service in-state forwarding address as a verification source.

☐ Other strategies under consideration or planned

b. <u>Update Mailing Addresses to Minimize Returned Mail and Maintain Coninuous Coverage</u>

☑ Engage community-based organizations, application assisters (including Navigators and certified application counselors), and providers to conduct outreach to remind individuals enrolled in Medicaid, CHIP, and BHP to provide updated contact information

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Require managed care plans to seek updated mailing addresses and either share updated information with the state Medicaid or CHIP agency and/or remind individuals to update their contact information with the state

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Send periodic mailed notices, texts, and email/online account alerts reminding individuals to update their contact information (e.g., on a quarterly basis)

- ☑ Already adopted
- ☐ Planning or considering to adopt

☐ Other adopted strategies

☐ Other strategies under consideration or planned

c. <u>Improve Consumer Outreach, Communication, and Assistance</u>

☐ Revise consumer notice language to ensure that information is communicated in plain language, including that it clearly explains the appeals process (also known as the Medicaid fair hearing and CHIP review process, as applicable)

☑ Conduct more intensive outreach via multiple modalities to remind individuals enrolled in Medicaid, CHIP, or BHP of anticipated changes to their coverage and obtain needed information (e.g., require eligibility workers to make follow-up telephone calls and to send an email if an individual has not responded to a request for information)

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Implement a text messaging program to quickly communicate eligibility reminders and requests for additional information, as permitted

- ☐ Already adopted
- ☑ Planning or considering to adopt

☑ Review language access plan to provide written translation of key documents (e.g., notices, applications, and renewal forms) into multiple languages, oral interpretation, and information about how individuals with limited English proficiency (LEP) can access language services free of charge, provided in a culturally competent manner

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Ensure that information is communicated to individuals living with disabilities accessibly by providing auxiliary services at no cost to the individual, including but not limited to written materials in large print or Braille, and access to sign language interpretation and/or a teletypewriter (TTY) system, consistent with the Americans with Disabilities Act (ADA) and section 1557 of the Affordable Care Act

- ☑ Already adopted
- ☐ Planning or considering to adopt

☐ Other adopted strategies

☐ Other strategies under consideration or planned

d. Improve Coverage Retention

☑ Adopt 12 months continuous eligibility for children (via SPA)

- ☑ Already adopted
- ☐ Planning or considering to adopt

☐ Adopt 12 months continuous eligibility for adults (via 1115 Authority)

☑ Provide 12 months of postpartum coverage (via SPA, beginning April 2022)

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Consider reducing or eliminating periodic data matching to support efficient operations (e.g., reduce or eliminate periodic data checks for income changes mid-coverage year to mitigate additional requests for information and manual work by state agencies)

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Direct managed care plans via contract requirements to conduct outreach and provide support to individuals enrolled in Medicaid and CHIP to complete the renewal process

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Other adopted strategies

Please specify:

Strategies adopted by California via the 1902(e)(14)(A) waiver: Partnering with Managed Care Plans and PACE Plans to Update Beneficiary Contact Information.

☑ Other strategies under consideration or planned

Please specify:

Implementing a DHCS Coverage Ambassador Campaign with DHCS-approved language/messaging for community advocates, legislative offices, community-based organizations, provider/hospital associations, state agencies to disseminate to Medicaid (Medi-Cal) beneficiaries. Our Ambassadors are our trusted messengers to help spread the word and raise awareness the impacts of the continuous coverage requirement ending: https://www.dhcs.ca.gov/toolkits/Pages/PHE-Outreach-Toolkit.aspx

e. Promote Seamless Coverage Transitions

☑ Ensure accounts are seamlessly transferred to the Marketplace when individuals are found ineligible for Medicaid, CHIP, or BHP

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Obtain and include robust contact information (e.g., mailing address, email address, and telephone numbers) in the Account Transfer to the Marketplace so that individuals may be easily reached post-transition

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Revise notices to ensure they clearly explain the Account Transfer process and next steps and applicable deadline(s) for applying for and enrolling in a QHP with financial assistance, and where to seek answers to questions at the Marketplace

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Other adopted strategies

Please specify:

DHCS (State Medicaid Agency) and Covered California (State-based marketplace) collaborated to implement California's Senate Bill (SB) 260 (Chapter 845, Statutes of 2019) which authorizes Covered California to enroll individuals in a qualified health plan when they lose coverage in Medi-Cal, Medi-Cal Access Program (SCHIP), and CCHIP(SCHIP) and gain eligibility for financial assistance through Covered California. The auto-plan selection program was launched in July 2022 and will seamlessly transition individuals into Covered California once Medi-Cal discontinuances resume at the conclusion of the continuous coverage requirement. The provisions of SB 260 will ensure that individuals losing Medi-Cal will not experience a gap in coverage if they confirm their selection of the qualified health plan and pay a premium (only if required) for Covered California coverage within a month of their disenrollment from Medi-Cal.

☐ Other strategies under consideration or planned

f. <u>Enhance Oversight of Eligibility and Enrollment Operations</u>

☑ Identify a centralized team responsible for tracking emerging issues and needed solutions

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Create tracking and management tools, data reports, and/or dashboards to monitor case volume, renewal rates, and workforce needs

- ☐ Already adopted
- ☑ Planning or considering to adopt

☑ Implement "early warning/trigger" mechanisms that flag when a large number of individuals lose, or are slated to lose, coverage due to no response or missing paperwork

- ☐ Already adopted
- ☑ Planning or considering to adopt

☑ Automate a "circuit breaker" flag based on a data review for the agency to pause and consider a change in its practices to mitigate inappropriate coverage loss

- ☐ Already adopted
- ☑ Planning or considering to adopt

☐ Other adopted strategies

☑ Other strategies under consideration or planned

Please specify:

County Oversight:
California will be planning weekly technical assistance calls with the county social services agencies (similar to the ACA roll out and post implementation).

Data:
In an effort to maintain transparency and accountability, California will be releasing a public facing Medi-Cal Eligibility Unwinding Dashboard on a monthly basis on the DHCS webpage. The dashboard measures will be updated monthly to include Medi-Cal total enrollment, newly enrolled, total applications received, applications in process, determination outcomes, and the following redetermination measures: total renewals due for the redetermination month being reported, renewed via ex parte, and redeterminations resulting in discontinuance. This dashboard will include both statewide and county-level data. DHCS anticipates the first reporting month to be the last month of the continuous coverage requirement for baseline purposes, with a public dashboard posted publicly approximately 45 days after the end of the reporting month. On a go-forward basis, the dashboard will be refreshed on a monthly basis.

4. Please describe any other type of strategy the state intends to implement to ensure that the state will not inappropriately terminate coverage for beneficiaries who continue to be eligible for Medicaid and/or CHIP and will appropriately transition the appropriate ineligible individuals to other health insurance affordability programs.

County Readiness: Under the administrative guidance and supervision of DHCS, the 58 local county offices are responsible for completing Medi-Cal determinations of eligibility, distributing notices, managing ongoing activities for active Medi-Cal cases, and renewing eligibility at least annually. To assist counties with readiness for the Continuous Coverage Unwind, and to provide the appropriate technical assistance, DHCS created a County Readiness Toolkit, similar to what CMS provided for states, as outlined in Medi-Cal Eligibility Division Letter (MEDIL) 22-33, later superseded by MEDIL 23-03, for counties to develop and document a county-level plan for the unwinding of the continuous coverage requirement that considers local business processes and needs. Counties are required to use the County Continuous Coverage Unwinding Readiness Plan Template to document their Continuous Coverage Unwinding operations plan which includes staffing levels, assignment of outstanding work, and staff training. Creation of the county level readiness plan will ensure the counties' success in performing federal and state mandated Continuous Coverage Unwinding activities, and a seamless transition to normal business operations. The County Continuous Coverage Unwinding Readiness Plan is due no later than February 21, 2023 to DHCS.

System Prevention of Loss in Coverage: DHCS plans to continue the State's automatic reinstatements if there is a huge loss of coverage each month. Prior to the end of each calendar month, the State will review total statewide discontinuances and review/monitor the volume on a monthly basis.

5. Select which strategies the state currently utilizes or is planning to adopt to ensure the fair hearing process is timely and accessible for any beneficiaries who lose coverage due to redeterminations triggered by the end of the continuous enrollment period.

☐ Expand informal resolution processes (e.g., informal troubleshooting, administrative review, or alternative resolution processes prior to a fair hearing)

☐ Redeploy state resources (e.g., adjusting state or local agency staffing and use of contractors to support the fair hearing process, as permissible)

☐ Streamline current fair hearing processes and operations (e.g., intake of fair hearing requests, scheduling)

☐ Engage internal and external stakeholders to increase beneficiary understanding, resolve cases before they need an appeal, and reduce inappropriate denials that generate appeals

☐ Other adopted strategies

☑ Other strategies under consideration or planned

Please specify:

California has requested 1902(e)(14)(A) waiver authority for the following:

• An extension of the timeframe to take final administrative action on fair hearing requests, on the condition that states provide benefits pending the outcome of the fair hearing and without recoupment if the final decision is adverse to the individual. DHCS anticipates the volume of fair hearing request to increase significantly. Allowing additional administrative time to complete the fair hearing process ensures beneficiaries remain in coverage pending a decision and the state remains in compliance with the fair hearing processing time frames.
• An extension of the timeframe for beneficiaries to request a fair hearing. This would allow beneficiaries to go beyond the current 90 day timeframe and provide them the ability to request a fair hearing that does not exceed 21120 days from the date when the adverse notice of action was mailed to them.

This is pending CMS review and approval.

Data Export