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	24,211	24,294	24,505	24,692	24,918	24,990	25,041	24,953	25,030	24,748	24,507	17,934	289,823
Percent of renewals scheduled to be initiated	8%	8%	8%	9%	9%	9%	9%	9%	9%	9%	8%	6%	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.*

Utah continued to complete reviews during the Public Health Emergency (PHE) period. For cases that remained eligible, the review dates remain constant in the eligibility system.

If the case were found to be ineligible or if the review was incomplete, the case was "flagged". Utah used priority logic to place the flagged cases in the following order:

1. Individuals with known eligibility issues (approx. 10% of flagged cases)
2. Cases where no review was completed (approx. 90% of flagged cases) was ranked by:
   - Length of time the case was kept open – more months held open was given higher priority
   - Utilization of medical services – more months of not utilizing services was given higher priority
   - Assuring a broad mix of medical programs to involve all of the DWS teams.
3. Emergency only services programs were pushed to the end of the priority as other MMIS system edits ensure that Medicaid only pays for emergency claims.

After determining the priority list, cases were added to the existing reviews already set to make sure that each month has a similar number of cases. This load balancing ensures that eligibility case workers have an even workload over 12 months.

Note: A lower number of cases were assigned to month 12 as approximately 8000 reviews are yet to be created for that final month. Utah will provide updated figures when they are available.

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

1. **Briefly describe any circumstances that may result in the state initiating more than 1/9 of its total caseload of renewals in a particular month (e.g., routine schedule of renewals results in month(s) with more than 1/9 of renewals due; annual workforce and staffing trends affects work volume in particular months; pending work due during the PHE is scheduled to be completed in less than 12 months).**

Although the State has engaged in significant planning, workforce and staffing constraints could cause reviews to be initiated late or out-of-order. The State balanced workload across the 12 months as much as possible to try and prevent these circumstances.

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.**

Continued efforts to maintain updated contact information:

- Mailed a flyer in December 2021 to all members reminding them to update their contact information
- Added messages to update contact information to the Medicaid website and DWS myCase portal
- Created a Provider and Partner toolkit with standard messages for them to post on their social media or communications that go to members
- Used Equifax as an additional address verification service.
- Sent email communication in September 2022 encouraging members to use their benefits while they are active and again asking for updated contact information.
- On the general notice we requested “return service” to try and update as many new addresses as possible from the returned mail.

Presented unwinding plan to several community stakeholders, advocates, and policy-makers. Received and implemented constructive feedback on outreach methods.

Engaged in efforts to maximize the use of ex parte renewals. Received technical assistance from CMS and met with other states to better adhere to best practices.

Created a dashboard to monitor and work with Utah's Department of Workforce Services (DWS) to correct improper closures that might occur.

Requested 1902 (e)(14)A Waivers to increase review flexibilities.

Utah will send the Medicaid health plans a detailed advance closure list broken down by those cases sent to the Federally Facilitated Marketplace (ineligible for Medicaid) and those cases closed for paperwork issues (not sent to the exchange).

- The Medicaid health plans will contact all who are closing to encourage them to return and complete their review with DWS. (Except for cases closed at the individual's request, or have moved out of state, or if the member is deceased.)

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>

- [x] 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)
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] 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.
  - [x] 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
- [x] Ensure that individuals can submit requested information to the agency over the phone, via mail, online, and in-person, consistent with federal regulations
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] Ensure renewal forms are pre-populated for individuals enrolled in Medicaid, CHIP, and BHP on a MAGI basis, consistent with federal requirements
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [ ] Other adopted strategies
- [ ] Other strategies under consideration or planned

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

- [x] 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
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] 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
  - [x] Already adopted
  - [ ] Planning or considering to adopt

- [x] Send periodic mailed notices, texts, and email/online account alerts reminding individuals to update their contact information (e.g., on a quarterly basis)
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [x] Other adopted strategies

    Please specify:

e(14) option for the MCO to update contact information from return mail. e(14) NCOA option to update contact information from return mail.

- [ ] Other strategies under consideration or planned

c. Improve Consumer Outreach, Communication, and Assistance

- [x] 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)
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [ ] 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)
- [ ] Implement a text messaging program to quickly communicate eligibility reminders and requests for additional information, as permitted
- [x] 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
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [x] 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
    - [x] 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)

- [ ] Adopt 12 months continuous eligibility for adults (via 1115 Authority)
- [ ] Provide 12 months of postpartum coverage (via SPA, beginning April 2022)
- [ ] 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)
- [x] 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
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [x] Other adopted strategies

  Please specify:

  e(14) option to complete an Ex Parte Renewal for Individuals with No Income and No Data Returned

  Facilitating renewals for individuals with no asset verification system (AVS) data returned within a reasonable timeframe.
- [ ] Other strategies under consideration or planned

e. <u>Promote Seamless Coverage Transitions</u>

- [x] Ensure accounts are seamlessly transferred to the Marketplace when individuals are found ineligible for Medicaid, CHIP, or BHP
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [x] 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
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [x] 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
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [ ] Other adopted strategies
- [ ] Other strategies under consideration or planned

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

- [x] Identify a centralized team responsible for tracking emerging issues and needed solutions
    - [x] Already adopted
    - [ ] Planning or considering to adopt

- [x] Create tracking and management tools, data reports, and/or dashboards to monitor case volume, renewal rates, and workforce needs
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [x] 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
    - [x] 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
- [ ] Other adopted strategies
- [ ] Other strategies under consideration or planned

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.

The State will publish a press release to use media partners to get the word out for Medicaid members. Members will be reminded to update their contact information, know their review date, and respond to requests for information. In addition, the press release will remind members about their ability to enroll in other health insurance, through healthcare.gov, if their Medicaid coverage ends.

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.

- [x] Expand informal resolution processes (e.g., informal troubleshooting, administrative review, or alternative resolution processes prior to a fair hearing)
    - [x] Already adopted
    - [ ] Planning or considering to adopt
- [x] Redeploy state resources (e.g., adjusting state or local agency staffing and use of contractors to support the fair hearing process, as permissible)
    - [ ] Already adopted
    - [x] Planning or considering to adopt
- [x] Streamline current fair hearing processes and operations (e.g., intake of fair hearing requests, scheduling)
    - [x] Already adopted
    - [ ] Planning or considering to adopt

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

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Other adopted strategies

Please specify:

e(14) option to allow extended timeframe to take final administrative action on Fair Hearing Requests

☐ Other strategies under consideration or planned

PRA Disclosure Statement The Centers for Medicare & Medicaid Services (CMS) is collecting this mandatory report under the authority in sections 1902(a)(4)(A), 1902(a)(6) and 1902(a)(75) of the Social Security 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 the Children's Health Insurance Program (CHIP) in an effective and efficient manner. This reported information will be used to assess the state's plans for processing renewals and mitigating against inappropriate beneficiary coverage losses when states begin restoring routine Medicaid and CHIP operations after the COVID-19 public health emergency ends. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #66). The time required to complete this information collection is estimated to average 8 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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