



SHO# 21-002

RE: 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

Dear State Health Official:

Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP) have played critical roles in responding to the ongoing Novel Coronavirus Disease 2019 (COVID-19) outbreak. Over the course of the COVID-19 public health emergency (PHE), state Medicaid, CHIP, and BHP agencies adopted many flexibilities offered by the Centers for Medicare & Medicaid Services (CMS) to respond effectively to their local outbreaks. States also made program changes to qualify for the Federal Medical Assistance Percentage (FMAP) funding increase available under section 6008 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127) as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136), including by satisfying a continuous enrollment requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.¹

This State Health Official (SHO) letter outlines policy changes CMS is making to better support states as they address the large volume of pending eligibility and enrollment actions they will need to take after the PHE ends and minimize beneficiary burden. While this letter will assist states in their planning efforts for the eventual end of the PHE, it does not signal nor confirm when the federal PHE declaration will end. In the coming months, CMS will provide additional detailed guidance on the updated policies described in this letter.

¹ This includes Medicaid beneficiaries and beneficiaries enrolled in the state's CHIP Medicaid expansion program.

Background

In December 2020, CMS released 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”² (December 2020 SHO), to support states in planning for the eventual end of the PHE, and to ensure they are able to transition back to normal operations efficiently when the PHE ends in a manner that minimizes burden for both states and beneficiaries as well as limits coverage disruptions. Due to disruptions to state operations during the COVID-19 PHE and the continuous enrollment requirement under section 6008 of the FFCRA, states will be faced with a large number of eligibility and enrollment actions (including renewals, redeterminations, and post-enrollment verifications), which they will need to complete after the PHE ends. States have indicated that the volume of post-enrollment verifications,³ redeterminations based on changes in circumstances, and renewals that will need to be processed when the PHE ends has increased as the PHE has extended further into 2021. Medicaid and CHIP enrollment has grown to a record high of more than 81 million individuals,⁴ and the increase in enrollment is largely attributed to the FFCRA Medicaid continuous enrollment requirement as churn in enrollment operations has ceased.⁵

States have raised concerns that they will need additional time to complete the growing backlog of pending work, especially in states that are relying on manual workarounds to extend coverage during the PHE. In addition, many states have expressed concern that having to complete all pending actions within six months of the end of the PHE will result in a “renewal bulge” in future years, which would result in ongoing administrative burden, as a more even distribution of renewals over the course of the year is more manageable. This could result in additional burden to beneficiaries in the future if states are unable to timely and accurately complete renewals when they experience a “renewal bulge”

Stakeholders have also raised concerns that eligible beneficiaries are at risk of losing coverage if states must complete pending work in a compressed timeframe because states would have less time to conduct outreach and implement strategies to facilitate accurate redeterminations that reduce burden for beneficiaries. In addition, less time to complete the growing backlog of pending work may result in states providing beneficiaries less time to respond to requests for needed information, resulting in increased inappropriate terminations of eligibility for procedural reasons.

² 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>.

³ States have the option to enroll individuals based on self-attested information and verify eligibility post-enrollment, consistent with the state verification plan.

⁴ February 2021 Medicaid and CHIP Enrollment Trends Snapshot, available at <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/february-2021-medicaid-chip-enrollment-trend-snapshot.pdf>.

⁵ Medicaid and CHIP Enrollment Snapshot Shows Almost 10 Million Americans Enrolled in Coverage During the COVID-19 Public Health Emergency, available at <https://www.cms.gov/newsroom/press-releases/new-medicaid-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during>.

Given growing state and stakeholder feedback and the continued extension of the PHE, CMS is updating certain policies set forth in the December 2020 SHO, which we believe are critical to ensuring that states are able to manage the significantly increased workload and ultimately resume normal operations efficiently, while also ensuring that eligible beneficiaries are not inappropriately terminated when the PHE ends.

Revisions to December 2020 State Health Official Letter

This letter outlines policy areas for which CMS is revising the guidance provided in the December 2020 SHO. Many aspects of the December 2020 SHO remain unchanged with this updated guidance. While states should continue to process eligibility and enrollment actions to the extent possible during the PHE, this updated guidance primarily relates to the pending eligibility and enrollment actions that states have not addressed prior to the end of PHE. In the coming months, CMS will provide additional detailed guidance on the updated policies described in this letter.

Specifically, CMS is revising the guidance in the December 2020 SHO in two key areas, as follows.

Extending the timeframe for states to complete pending eligibility and enrollment actions to up to 12 months after the month in which the PHE ends

The December 2020 SHO encouraged states to work through their backlog as expeditiously as possible and would have provided states with up to 6 months after the month in which the PHE ends to complete pending post-enrollment verifications, redeterminations based on changes in circumstances, and renewals (see pages 28-29 of the December 2020 SHO). Under our revised guidance, states may take up to 12 months after the month in which the PHE ends to complete pending verifications, redeterminations based on changes in circumstances, and renewals. CMS believes the additional time is appropriate given the increased program enrollment and to ensure states can reestablish a renewal schedule that is sustainable in future years.

This policy change does not affect the timeframe in which states must resume the timely processing of all applications. The December 2020 SHO provides states with up to 4 months after the month in which the PHE ends to resume timely processing of all applications (see page 28 of the December 2020 SHO). Because the FFCRA did not limit states' ability to process applications during the PHE and to ensure timely access to coverage for eligible individuals, CMS is maintaining this timeframe. Thus, under our revised guidance, states continue to have up to 4 months after the month in which the PHE ends to resume timely processing of all applications.⁶ CMS is available to provide technical assistance to states that are working to complete pending eligibility and enrollment work within the 12-month timeframe, and we remain interested in hearing state feedback and concerns as states plan for and resume routine operations consistent with the expectations outlined in this letter.

⁶ See 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. Section VI. Resuming Normal Eligibility and Enrollment Operations: Addressing Pending Eligibility and Enrollment Actions, pp 28-29; Appendix C: Table C-1, pp 45-46). Available at: <https://www.medicaid.gov/sites/default/files/2020-12/sho20004.pdf>.

Completing an additional redetermination for individuals determined ineligible for Medicaid during the PHE

States have continued to process eligibility and enrollment actions during the PHE, but as a condition for claiming the temporary 6.2 percentage point FMAP increase, they have suppressed taking any adverse actions for Medicaid beneficiaries that would violate the continuous enrollment requirement.⁷ The December 2020 SHO provided states the option to avoid completing another redetermination prior to terminating coverage after the PHE ends if certain conditions were met, including that the eligibility action processed during the PHE was completed within six months of the beneficiary's termination after the PHE (see pages 14-15 of the December 2020 SHO). The option in the December 2020 SHO for states to avoid "repeat redeterminations" carries inherent risk that coverage will be terminated for some eligible beneficiaries. Given that states will now have 12 months to complete all pending post-enrollment verifications, redeterminations based on changes in circumstances, and renewals following the end of the PHE, we are rescinding the option provided in the December 2020 SHO.

Under the revised policy, states may not terminate coverage for any individual determined ineligible for Medicaid, but not terminated, during the PHE, including individuals who failed to respond to a request for information, until the state has completed a redetermination after the PHE ends. States must complete an additional redetermination in accordance with 42 C.F.R. §435.916 prior to taking an adverse action with respect to any beneficiary.⁸ This includes checking available information and data sources to attempt a redetermination without contacting the beneficiary and requesting documentation to obtain reliable information when eligibility cannot be renewed based on available information, as appropriate.

As required at 42 C.F.R. §435.916(a)(3)(i)(B), states must provide beneficiaries eligible based on modified adjusted gross income (MAGI) methodologies 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. For redeterminations based on changes in circumstances, beneficiaries must be given a reasonable period of time to provide information or other documentation to establish that the information received by the agency is not correct and the individual continues to meet any eligibility criterion at issue.

As discussed in the CMCS Informational Bulletin (CIB), "Medicaid and CHIP Renewal Requirements," we believe it would be reasonable for states to allow beneficiaries 30 days to respond and provide any necessary information needed to verify eligibility following a change in circumstances. Renewal forms and notices must be accessible to persons who are limited English proficient and persons with disabilities consistent with 42 C.F.R. 435.905(b). A

⁷ Individuals enrolled in a separate CHIP and BHP are not subject to the FFCRA continuous enrollment requirement, and states should terminate coverage for ineligible individuals enrolled in a separate CHIP or BHP during the PHE.

⁸ For individuals determined ineligible for Medicaid who are still within their 12-month eligibility period (or shorter period elected by the state for individuals enrolled on a basis other than modified adjusted gross income), states must follow the requirements to complete another post-enrollment verification or redetermination of eligibility consistent with 42 C.F.R. § 435.916(d). States must complete a full renewal for individuals determined ineligible at renewal during the PHE or who are no longer within their eligibility period when the state processes the redetermination again after the PHE ends.

minimum of 10 days advance notice and fair hearing rights must also be provided prior to termination or other adverse action, in accordance with 42 C.F.R. Part 431 Subpart E.⁹

States may refer to the “Medicaid and CHIP Renewal Requirements” CIB which is available to assist states in meeting their obligations to make accurate redeterminations of eligibility.¹⁰ A description of the CIB and more information on how states may access the guidance is included in the Appendix of this SHO. States may access the Renewal CIB on Medicaid.gov (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>).

States are also required to take steps to smoothly transition beneficiaries who are determined ineligible after the PHE to other insurance affordability programs, as appropriate, in accordance with 42 C.F.R. § 435.1200 and § 457.350 and 42 C.F.R. §600.330(a). As states redetermine eligibility after the PHE ends, states must assess potential eligibility for other insurance affordability programs for individuals determined ineligible for Medicaid, consistent with 42 C.F.R. § 435.916(f)(2), and transfer individuals’ electronic account to the appropriate program (e.g., the Marketplace) in a timely manner.¹¹

Additional Considerations

The December 2020 SHO requires states to adopt one of four risk-based approaches (based on age of the case, population, a combination, or other approach) in order to prioritize completion of pending work (see pages 23-24 of the December 2020 SHO), and we understand that many states have begun to plan for this work. Given that states will now have 12 months, instead of 6, to complete all pending post-enrollment verifications, redeterminations based on changes in circumstances, and renewals after the PHE ends, states are encouraged to reassess their risk-based approach to prioritizing pending work and make adjustments to their plans to restore routine operations after the PHE ends, as appropriate.

In addition, states must consider ways to ensure that their risk-based approach promotes continuity of coverage for eligible individuals and limits delays in processing actions for individuals who become eligible for new or more comprehensive coverage. States also are encouraged to consider adopting new flexibilities to streamline eligibility and enrollment processes, especially for individuals dually eligible for Medicaid and Medicare, children, and other population whose eligibility tends to be stable (see pages 33-34 of the December 2020 SHO for discussion of such strategies as well as the Appendix of this SHO for a brief description of these strategies). CMS plans to provide additional guidance to assist states in prioritizing actions as well as outline ways states may reestablish a renewal workload that is sustainable in future years given the extended timeframe.

⁹ See 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. Section III. P. 9; Section IV., pp 14 -15; Appendix B: Table B-1, p. 40. Available at: <https://www.medicaid.gov/sites/default/files/2020-12/sho20004.pdf>

¹⁰ CMCS Informational Bulletin, Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements, available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>.

¹¹ Individuals enrolled in a separate CHIP and BHP are not subject to the FFCRA continuous enrollment requirement, and states should terminate coverage for ineligible individuals enrolled in a separate CHIP or BHP and ensure smooth transitions of coverage during the PHE.

CMS also recognizes that some Medicaid Section 1135 waivers approved for states or territories may no longer be in use. States and territories should end any flexibilities that are no longer needed. Prior to ending a Section 1135 waiver before the end of the PHE, states and territories should contact their CMS State Lead and identify the waivers that the state or territory is terminating, so that CMS may provide technical assistance.

Closing

CMS remains committed to providing states and territories with the resources and ongoing technical assistance necessary to respond effectively to the COVID-19 outbreak and restore state operations upon the eventual conclusion of the current PHE. Please submit any additional requests for technical assistance to your CMS State Lead.

Sincerely,



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 State Resources

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): This 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. Unless otherwise noted in this letter the guidance in the December 2020 SHO, including guidance on strategies states may take to support routine eligibility and enrollment operations, remains in effect.

- *Section VII. Strategies to Support Returning to Routine Operations (pages 30-35):* This section outlines strategies states may adopt to facilitate efficient restoration of Medicaid and CHIP operations upon conclusion of the PHE. The strategies include options that require the submission of a state plan amendment, such as providing 12 month continuous eligibility for children, adopting 12 month renewals for non-MAGI beneficiaries, or adopting the facilitated enrollment state plan option to rely on income determinations made by another program if the state is certain the individuals would be income-eligible using MAGI based methods. The listed strategies also include options that states may take without submitting a SPA, such as maximizing the use of *ex parte* renewals by accessing additional data at renewal or modifying verification policies to accept self-attestation to verify certain eligibility criteria.

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

CMCS Informational Bulletin (CIB), “Medicaid and CHIP Renewal Requirements”

(Renewal CIB): This 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 Children’s Health Insurance Program (CHIP) beneficiaries. These requirements are intended to ease 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>.