

# New CMS Guidance on Unwinding Provisions in the Consolidated Appropriations Act, 2023

February 8, 2023

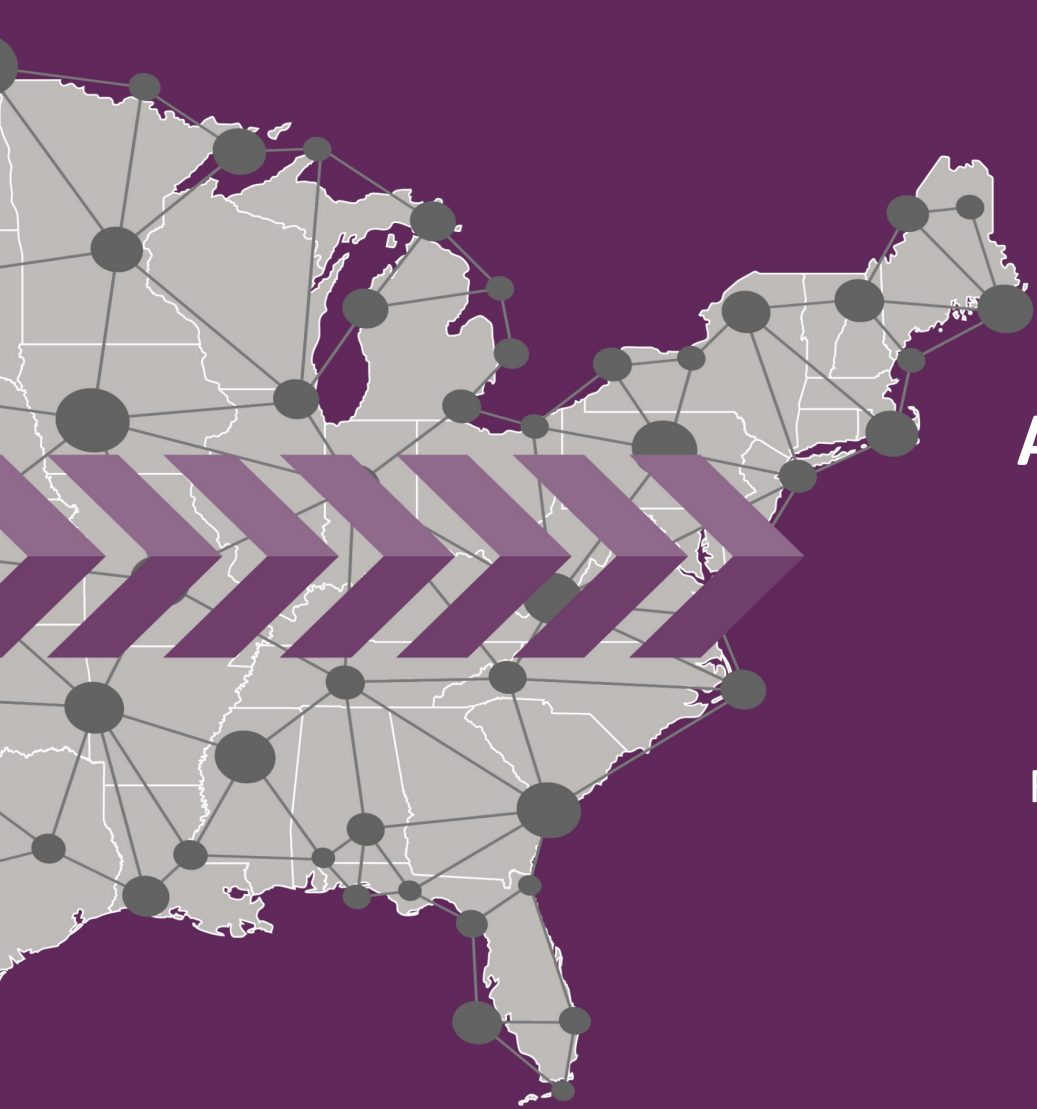
1:00 to 2:00 p.m. ET

*Please stand by, this webinar will begin shortly*

**STATE**  
Health & Value  
**STRATEGIES**

*Driving Innovation  
Across States*

*A grantee of the Robert Wood Johnson Foundation*



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Manatt Health

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# About State Health and Value Strategies

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

*Support for this webinar was provided by the Robert Wood Johnson Foundation.  
The views expressed here do not necessarily reflect the views of the Foundation.*

# About Manatt Health

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Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit [www.manatt.com/ManattHealth.aspx](http://www.manatt.com/ManattHealth.aspx)

# Housekeeping Details

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All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box.

After the webinar, the slides and a recording will be available at **[www.shvs.org](http://www.shvs.org)**.

# Agenda

- **Level-Setting**
- **Review of the New Centers for Medicare & Medicaid (CMS) State Health Official (SHO) Letter**
  - Conditions for Receipt of Enhanced Federal Match
  - State Reporting Requirements and Federal Monitoring/Oversight
  - Public Health Emergency (PHE)-Related Flexibilities and Authorities
- **Discussion**



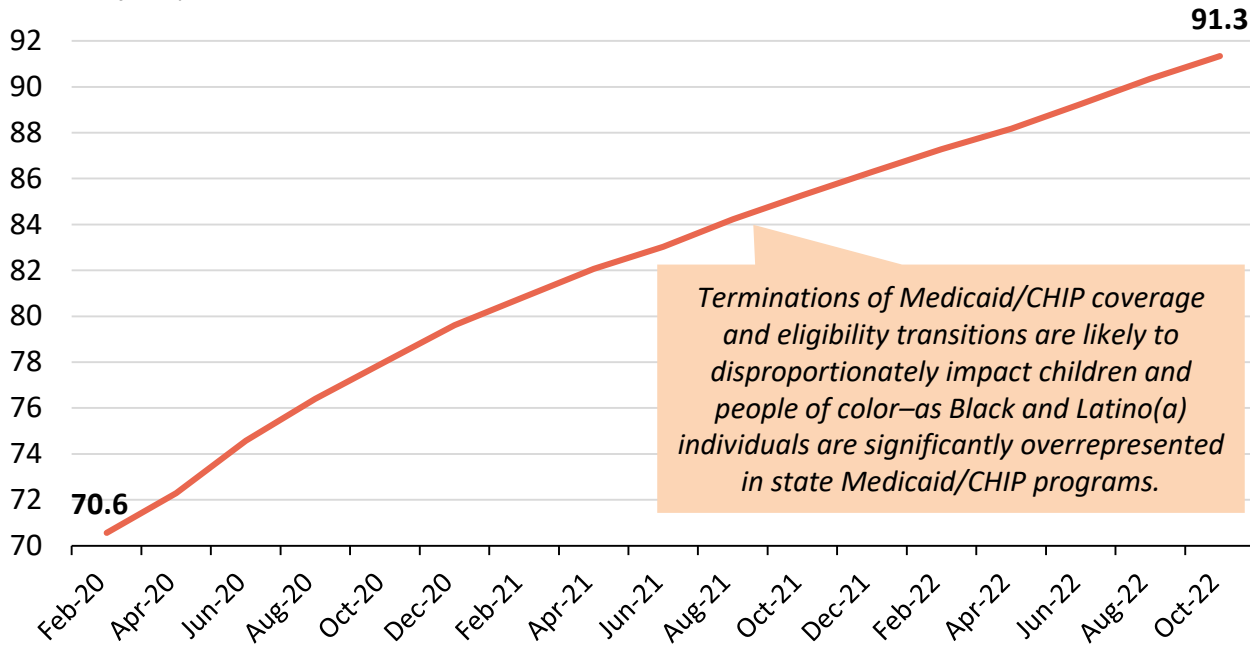
# Level-Setting

# The Largest Health Coverage Event Since Affordable Care Act Implementation

Between now and April, states will begin to redetermine eligibility for nearly all 91 million Medicaid/CHIP enrollees—threatening the historic gains in coverage achieved as a result of continuous coverage.

**Medicaid and CHIP Enrollment, February 2020 to October 2022**

Millions of People



- Since February 2020, Medicaid/CHIP enrollment has increased by 20 million individuals (29%).
- A projected 15 million people, or 17% of current Medicaid/CHIP enrollees, will be disenrolled.
- 6.8 million people (7.9%) are projected to lose coverage despite still being eligible.
- Almost 1/3 of those losing coverage could be eligible for subsidized marketplace coverage.

Source: CMS, June 2022 Enrollment Trend Snapshot; Assistant Secretary for Planning and Evaluation (ASPE), Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches; and SHVS/Manatt Health, The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage.

# Consolidated Appropriations Act, 2023 (CAA) Changes to Unwinding Parameters

Section 5131 of the recently enacted CAA makes key changes to the parameters for unwinding that will ultimately support coverage retention for eligible individuals among states that are able to comply.



Decouples the Medicaid continuous coverage requirement from the end of the COVID-19 PHE, and sets a new statutory end date of March 31, 2023, enabling states to initiate renewals as early as February 1, 2023 (though states may not terminate Medicaid enrollment until April 1, 2023).



Provides for extended enhanced federal medical assistance percentage (eFMAP) to support unwinding during a nine-month phase-down from April 1, 2023, through December 31, 2023, and establishes conditions for claiming eFMAP.



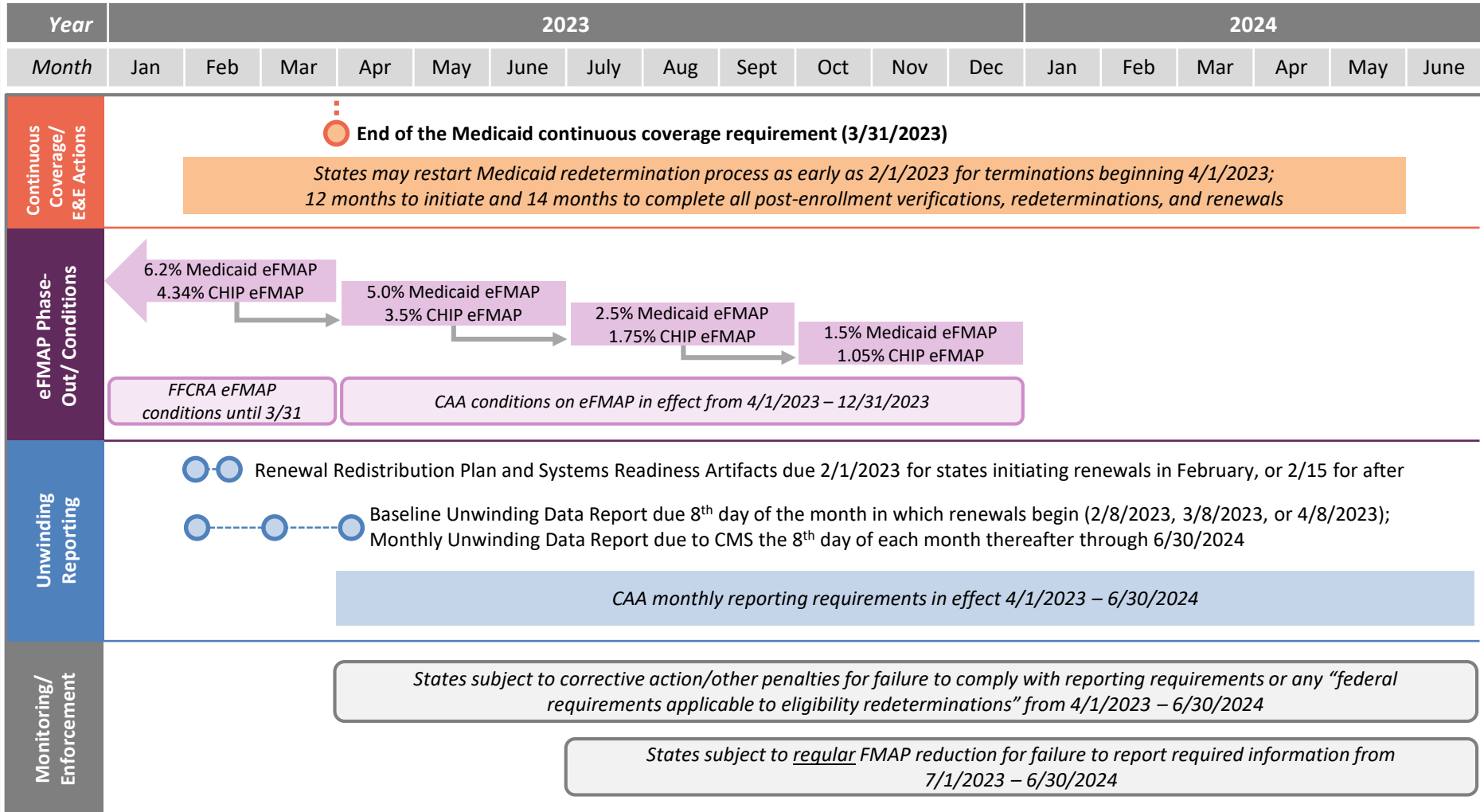
Institutes new Medicaid, CHIP, and marketplace reporting requirements to enable oversight of unwinding and improve transparency.



Gives CMS targeted enforcement powers to reduce states' *regular* FMAP, require corrective action, suspend procedural terminations, and impose civil monetary penalties as a result of non-compliance with federal renewal and CAA reporting requirements.

Source: CAA Section 5131; CMCS Informational Bulletin, [Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA](#); SHVS, [Omnibus Unwinding Provisions and Implications for States](#); and National Association of State Medicaid Directors (NAMD), [NAMD Supports Redetermination Certainty in FY 2023 Omnibus Release](#).

# Medicaid Continuous Coverage Timeline



Source: SHVS, Unwinding Provisions in the 2023 Consolidated Appropriations Act; and CMCS Informational Bulletin, [Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the CAA](#).

# Remaining PHE-Related Flexibilities Timeline

The PHE is currently in effect through April 10, 2023; however, in a Statement of Administration Policy, the White House announced its intent to terminate the PHE on May 11, 2023.

Temporary Flexibility	Expiration Timeline	Expected End Date
Section 1135 Waiver	<b>End of the PHE.</b> Note that CMS: (1) may terminate an individual waiver at any time; and (2) has authorized grace periods post-PHE for certain waivers.	May 11, 2023 (except for flexibilities for which CMS has authorized a grace period).
Medicaid and CHIP Disaster Relief State Plan Amendment (SPA)	<b>Medicaid: End of the PHE (or an earlier date chosen by the state).</b> <b>CHIP: End of the PHE or state-declared emergency</b> (or an earlier date chosen by the state).	<b>Medicaid:</b> May 11, 2023 (or earlier) <b>CHIP:</b> May 11, 2023 (or earlier, or later if the state-declared emergency continues).
Section 1915(c) Appendix K	<b>Six months following the end of the PHE,</b> if the state requested CMS approval for this timeline. For states that did not, Appendix K flexibilities generally expired in the first quarter of 2021.	November 11, 2023, if a state received CMS approval for the extended timeline. If not, flexibilities generally expired in the first quarter of 2021.
Emergency Section 1115 Waiver	<b>60 days after the PHE (or an earlier date approved in the waiver's Special Terms and Conditions).</b>	July 10, 2023 (or earlier).
Families First Coronavirus Response Act (FFCRA) Optional COVID-19 Eligibility Group	<b>End of the PHE.</b>	May 11, 2023.

Source: SHVS, Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates; and Office of Management and Budget, Statement of Administration Policy.

# Overview of New CMS Guidance on Unwinding Medicaid Continuous Coverage

On January 27, 2023, CMS released a SHO letter, *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the CAA*, that builds on the January 5, 2023, Centers for Medicaid and CHIP Services (CMCS) Informational Bulletin.



**Details the requirements with which states must comply in order to continue to receive eFMAP** during the phase-down period including: (1) complying with federal renewal requirements; (2) updating contact information prior to sending renewal forms; and (3) conducting outreach via more than one modality upon returned mail prior to termination.



Clarifies expectations for states to comply with the Medicaid, CHIP, and marketplace **reporting elements** required by the CAA.



Reiterates CMS' existing and new authority to establish a **corrective action plan and impose penalties for non-compliance** with the CAA reporting requirements and federal regulatory redetermination requirements.



Reviews implications of the CAA on **select COVID-19 PHE-related flexibilities and authorities**.



**New CMS SHO Letter: *Conditions for Receipt of  
Enhanced Federal Match***

# Federal Renewal Requirements

As a condition of receipt of the eFMAP and a potential trigger for corrective action/related penalties, states must conduct eligibility redeterminations and renewals in compliance with federal regulatory requirements at 42 CFR 435.916.



Conduct *ex parte* renewals for both Modified Adjusted Gross Income (MAGI) and non-MAGI populations.



Send renewal forms (must be pre-populated for MAGI enrollees).



Provide a reasonable timeframe (30 days for MAGI) and make available all modalities to return the renewal form.



Redetermine eligibility on all other eligibility group bases.



Provide advance notice of termination and fair hearing rights.



Assess eligibility for other insurance affordability programs and transfer account information.\*



Allow a reconsideration period (must be at least 90 days for MAGI enrollees), during which terminated individuals may re-enroll without reapplying.

\*Note: While procedural denials should not be sent to the federally-facilitated marketplace (FFM), states that do not use the federal eligibility and enrollment platform are encouraged to (1) identify individuals who have been terminated for procedural reasons and are highly likely for marketplace coverage, and (2) transfer those accounts to the SBM.

Source: [42 C.F.R. 435.916](#); SHVS, [Improving Ex Parte Renewal Rates: State Diagnostic Assessment Tool](#); and SHVS, [Leveraging Section 1902\(e\)\(14\) Waiver Authority Amid Unwinding](#).

# Updated Contact Information Before Renewal

As a condition of receipt of the eFMAP, states must attempt to obtain up-to-date contact information for each enrollee prior to redetermining eligibility.

- States are required to use multiple data sources, which can include:
  - ✓ The National Change of Address (NCOA) database.
  - ✓ Other state health and human services agency information (e.g., Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families).
  - ✓ Other recent and reliable sources of contact information (e.g., Department of Labor, Department of Motor Vehicles).
  
- States are expected to deploy strategies to update contact information:
  - Conducting broad outreach campaigns.
  - Partnering with managed care plans on broad outreach campaigns.
  - Leveraging section 1902(e)(14) authority to update the case record with contact information from a managed care plan or other reliable data source without first having to confirm the change with the individual.

Contact information must include:



Mailing Address



Telephone Number



Email Address



States need to memorialize the data sources and processes they plan to use for updating contact information in their Unwinding Operational Plans.

Source: CMS, [Unwinding and Returning to Regular Operations after COVID-19](#); CMS, [Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations](#); and SHVS, [Leveraging Section 1902\(e\)\(14\) Waiver Authority Amid Unwinding](#).

# Returned Mail Outreach Prior to Termination

As a condition of receipt of the eFMAP, states must make a good faith effort to contact an individual using two modalities before terminating enrollment based on mail returned to the state in response to a redetermination.


The SHO letter clarifies that allowable modalities include:



▪ **States must:**

- ✔ Have a process to obtain up-to-date mailing addresses, telephone numbers, and email addresses for all enrollees (i.e., condition 2).
- ✔ Attempt to reach an individual whose mail is returned through at least two modalities using the most up-to-date contact information available prior to termination.
- ✔ Be able to process returned mail—comparing accuracy/completeness of the address on the mail against the enrollee’s record—and adhering to the steps outlined by CMS.

- **CMS acknowledges that states may not be able to collect updated contact information for all enrollees.** States may still satisfy this condition as long as they attempt to obtain up-to-date contact information for each enrollee prior to redetermining eligibility and follow the steps outlined in CMS guidance.

 States need to memorialize in their Unwinding Operational Plans the way in which they will contact individuals using two modalities prior to disenrollment on the basis of returned mail.

# Satisfying the eFMAP Conditions

For states seeking to ensure access to the eFMAP, now is the time to assess compliance with the CAA conditions. If gaps are identified, states should pursue CMS-approved mitigation strategies.

- States that are not able to comply with eFMAP conditions may propose mitigation plans.
  - States will want to seek confirmation from CMS that their proposed mitigation strategies fulfill the expectations for receiving the eFMAP.
  - CMS has indicated it will work with states to evaluate the sufficiency of planned approaches and provide technical assistance.
  - Forthcoming CMS guidance will need to address key questions (e.g., the mode of and timing for submission of the plans, which additional mitigation strategies CMS will consider, whether plans will be made public, the method for approving the plans, etc.).
- States may claim eFMAP by attesting that they comply with these conditions. If CMS later determines that a state has failed to comply, the state may have to return federal financial participation (FFP).

## Mitigation Plans

- ☑ Should expressly include strategies identified in existing CMS guidance and resources.
- ☑ May include additional alternative strategies (e.g., tailored or new section 1902(e)(14) waiver flexibilities).

### Reminder:

Regardless of whether the eFMAP is being claimed, states must comply with federal renewal requirements at all times or face corrective action.

Source: CMS, [Unwinding and Returning to Regular Operations after COVID-19](#).



**New CMS SHO Letter: *State Reporting Requirements  
and CMS Monitoring/Oversight***

# CAA Reporting Requirements: *Medicaid and CHIP*

The SHO letter clarifies that “all the data states must report under these new reporting requirements are included in existing data sources,” meaning states will not need to submit additional reports to CMS.

Reporting Element	Mode of Submission
<ul style="list-style-type: none"><li>Number of eligibility renewals initiated</li><li>Number of enrollees renewed, including a breakdown of coverage renewed on an <i>ex parte</i> basis</li><li>Number of enrollees whose coverage for Medicaid or CHIP was terminated, including a breakdown of terminations for procedural reasons</li></ul>	Unwinding Data Report*
<ul style="list-style-type: none"><li>Number of individuals enrolled in a separate CHIP</li></ul>	T-MSIS, CHIP-CODE
<ul style="list-style-type: none"><li>Total call center volume, average wait-times, and average abandonment rates</li></ul>	Medicaid and CHIP Eligibility and Enrollment Performance Indicators



\*To adhere to the legislatively required timeline of April 1, 2023, through June 30, 2024, for state reporting, CMS will require state Medicaid agencies to submit the monthly Unwinding Data Report through June 2024, regardless of when a state initiates renewals.

Source: CMS, [SHO Letter # 23-002](#); and CMS, [Unwinding Data Report](#).

# CAA Reporting Requirements: *Marketplace*

Reporting Element	Mode of Submission
<p><b>States that use the federal eligibility and enrollment platform:</b></p> <ul style="list-style-type: none"> <li>▪ Number of individuals whose accounts are received at the marketplace due to a Medicaid/CHIP redetermination.*</li> <li>▪ Of these, the number of individuals determined eligible for a qualified health plan (QHP).</li> <li>▪ Of these, the number of individuals who select a QHP.</li> </ul>	<p>N/A—CMS plans to report on behalf of states with FFMs and SBMs on the federal platform.</p>
<p><b>SBMs that do not have an integrated eligibility system:</b></p> <ul style="list-style-type: none"> <li>▪ Number of individuals whose accounts are received by the SBM or Basic Health Program (BHP).</li> <li>▪ Of these, the number of individuals determined eligible for a QHP or BHP.</li> <li>▪ Of these, the number of individuals who make a QHP selection or are enrolled in a BHP.</li> </ul>	<p>SBM Priority Metrics</p>
<p><b>SBMs that have an integrated eligibility system:</b></p> <ul style="list-style-type: none"> <li>▪ Number of individuals determined eligible for a QHP or a BHP.</li> <li>▪ Of these, the number of individuals who make a QHP selection or are enrolled in a BHP.</li> </ul>	<p>SBM Priority Metrics</p>



\*CMS is working to address federal reporting constraints related to reporting on account transfer data.

Source: CMS, [SHO Letter # 23-002](#); and [45 CFR 155.1200](#).

# Meeting the CAA Reporting Requirements

Because the CAA reporting requirements are tied to federal enforcement mechanisms, states will want to ensure that they are sufficiently reporting on each metric using the CMS-prescribed reporting tools.

## Reminder of Federal Enforcement Mechanisms

Penalty	Trigger
1) <b><i>Regular</i></b> FMAP reduction for failure to report required information	CMS determines that for the period from July 1, 2023, through June 30, 2024, a <b>state fails to comply with the CAA reporting requirements</b> (see previous slides).
2) <b>Corrective Action Plan</b>	CMS determines that for the period from April 1, 2023, through June 30, 2024, a state has failed to comply with: <ul style="list-style-type: none"><li>▪ <b>The CAA reporting requirements</b>; or</li><li>▪ Any “federal requirements applicable to eligibility redeterminations.”</li></ul>
3) <b>Suspension of procedural terminations* and/or civil monetary penalties of up to \$100,000 a day</b>	CMS determines that a state has failed to submit or implement its corrective action plan.



CMS intends to monitor the data submitted, and, if issues are identified, may require states to report on additional metrics, submit the Unwinding Operational Plan, or report more frequently.

Source: CMS, SHO Letter # 23-002.



**New CMS SHO Letter: *PHE-Related Flexibilities and Authorities***

# Implications for PHE Flexibilities/Authorities

The SHO provides additional guidance on CAA unwinding-related provisions that have implications for PHE-related flexibilities and authorities.



## Section 1902(e)(14) Waiver Dates

- Enables states to modify section 1902(e)(14) waiver end dates without needing to submit revised requests to CMS (see companion SHVS [expert perspective](#)).



## Optional COVID-19 Group

- Requires states that want to continue providing coverage after March 31, 2023, to determine a process to delay renewals for this group.
- Allows states to end coverage for this group by submitting a SPA.



## Medicaid Premiums

- Permits states to apply individual premium increases starting April 1, 2023, permitted they adhere to certain requirements.
- Reminds states of section 1902(e)(14) waiver authority to delay premiums during unwinding.



## American Rescue Plan (ARP) Maintenance of Effort (MOE)

- Directs states to retain temporary changes to HCBS eligibility, services, and payment rates in accordance with the relevant authorities [e.g., 1915(c) Appendix K]—without risk of penalty by CMS.

# Unwinding Special Enrollment Period (SEP)

HealthCare.gov recently announced it will allow people who lose Medicaid eligibility to claim a SEP between March 31, 2023, and July 31, 2024, as the continuous coverage requirement ends.



The “Unwinding SEP” will be available in all states using the federal enrollment platform and is optional for SBMs.



To access the Unwinding SEP, a marketplace-eligible person must submit a new application or update an existing one between March 31, 2023, and July 31, 2024, and attest to loss of Medicaid coverage during that time period. Consumers will have 60 days after they submit their application to select a plan.



Coverage starts the first day of the month following plan selection. Consumers who are aware that their Medicaid is ending may report loss of coverage and select a plan up to 60 days prior to the event for coverage as early as the first day of the month following coverage loss.

Source: [45 CFR 155.420\(d\)\(9\)](#); and CMS, [Temporary Special Enrollment Period \(SEP\) for Consumers Losing Medicaid or the Children’s Health Insurance Program \(CHIP\) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition– Frequently Asked Questions \(FAQ\)](#).

# Discussion

The slides and a recording of the webinar are available at [www.shvs.org](http://www.shvs.org). For more information, see SHVS' unwinding page, [Resources for States on Unwinding the Medicaid Continuous Coverage Requirement](#).



# Thank You

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