COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies
October 17, 2022

The Centers for Medicare & Medicaid Services (CMS) has released numerous guidance documents and tools designed to help states[1] prepare for the eventual end of the COVID-19 public health emergency (PHE), including a State Health Official Letter, 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 (SHO #22-001, dated March 3, 2022). CMS is releasing these answers to frequently asked questions (FAQs) regarding SHO #22-001 and related guidance. For more information, including resources, tools to support state unwinding efforts, and information shared during All State Calls, please visit www.Medicaid.gov/unwinding.

Unwinding Period

Q1: When can states begin the 12-month unwinding period described in SHO Letter #22-001?

A: States may choose to begin their unwinding period in one of three months: (1) one month prior to the month in which the PHE ends, (2) the month in which the PHE ends, or (3) the month after the month in which the PHE ends. For example, if the PHE ends in January 2023, states may begin their unwinding period anytime in December 2022, January 2023, or February 2023. A state's unwinding period begins during the month it first initiates renewals for beneficiaries who may be terminated because they no longer meet eligibility requirements or do not provide information needed for the state to renew eligibility.

Q2: When is a renewal considered initiated for the purposes of beginning the state's unwinding period?

A: A renewal is considered "initiated" when the state begins the *ex parte* renewal process for a cohort of beneficiaries by accessing electronic data sources and other information available to the state in order to determine if a beneficiary's eligibility can be successfully renewed without contacting the beneficiary.

Q3: If a state has been conducting renewals throughout the PHE, when does the state's 12-month unwinding period begin?

A: States that have been conducting renewals during the PHE are subject to the options outlined in the answer to Q1 regarding the month in which the state may begin its unwinding period. The unwinding period will begin for these states during the month when the state initiates renewals for a cohort of beneficiaries *who may be terminated* because they no longer meet eligibility requirements or do not provide information needed for the state to renew eligibility. Conversely, prior to the initiation of the unwinding period, states claiming the 6.2

[1] Throughout this document, "states" refers to states, the District of Columbia, and the U.S. Territories.

percentage point federal medical assistance percentage (FMAP) increase made available under the Families First Coronavirus Response Act (FFCRA) *have not been permitted to terminate coverage* for most Medicaid beneficiaries, even where they have been completing renewals.

Q4: If a state begins its unwinding period before the PHE ends, consistent with the guidance in SHO Letter #22-001, in what month can a termination first occur?

A: Regardless of the month when the state begins its unwinding period, states that continue to claim the temporary FMAP increase authorized under section 6008 of the FFCRA may not terminate enrollment (with limited exceptions permitted under the FFCRA and described in regulations at 42 CFR § 433.400) until the first day of the month after the month when the PHE ends.

Renewals and Changes in Circumstances

Q5: If the state has been redetermining eligibility based on changes in circumstances during the PHE and an individual is determined ineligible during the PHE before the state has commenced its unwinding period, may the state send advance notice and terminate coverage once the state's unwinding period begins without conducting a redetermination based on a change in circumstances or renewal during the unwinding period?

A: No. As explained on pages 4 and 5 in SHO 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," published on August 13, 2021, states must complete a full renewal or, in certain circumstances explained in response to Q6 below, a redetermination of eligibility based on a change in circumstances during the state's unwinding period before taking action to terminate coverage for any individual who, during the PHE but before the state's unwinding period has commenced, was determined by the state to be ineligible for Medicaid but whose enrollment was not terminated. This includes individuals who failed to respond to a request for information sent during the PHE. For individuals who were determined ineligible during the PHE based on a change in circumstances and who are still within the 12-month eligibility period since their last full eligibility determination (i.e., at initial application or last full renewal, or a shorter period elected by the state for individuals enrolled on a basis other than modified adjusted gross income (MAGI)), a state may either complete another redetermination of eligibility based on the identified change in circumstances or conduct a full renewal during the unwinding period. During the states' unwinding period, states must complete a full renewal for individuals who were determined ineligible at renewal during the PHE or who are no longer within their eligibility period when the state processes the redetermination.

Q6: If a beneficiary enrolled in Medicaid or CHIP reports a change in circumstances during the PHE or unwinding period, may the state redetermine eligibility based on the change in circumstances or must the state complete a full renewal?

A: The state may be able to redetermine eligibility based on a change in circumstances, but only in limited circumstances. During the unwinding period, states can only redetermine

eligibility based on a change in circumstances if, in the previous 12 months (or shorter period elected by the state for individuals enrolled on a basis other than MAGI), the state has already either: (1) completed an initial eligibility determination or (2) renewed the individual's eligibility. In these cases, the beneficiary is still within their 12-month eligibility period (or shorter eligibility period elected by the state for individuals enrolled on a basis other than MAGI) when the state revisits the case during the unwinding period, and the state may act on the change in circumstances.[2]

If the beneficiary is not within an eligibility period, the state must complete a full renewal and may not redetermine eligibility based only on a change in circumstances during the unwinding period. A beneficiary is not considered to be within an eligibility period if the state was unable to complete a full renewal for the individual during the PHE because the individual was determined ineligible during their last renewal.

Q7: If a beneficiary enrolled in Medicaid or CHIP and within a 12-month eligibility period reports a change in circumstances during the unwinding period, may the state delay acting on the change in circumstances until it completes a full renewal?

A: Yes. States may wait to process the information from a reported or identified change in circumstances until the full renewal that is initiated for the beneficiary during the unwinding period. This alignment strategy, which is discussed in more detail on page 19 of SHO Letter # 21-002, creates efficiencies for states by allowing them to use information obtained at renewal to resolve other pending eligibility and enrollment actions simultaneously and avoid needing to send individuals multiple requests for information to complete pending actions.

Non-MAGI *Ex Parte* Renewals

Q8: In conducting a periodic renewal of eligibility for non-MAGI Medicaid beneficiaries subject to an asset test, do states have to attempt to renew eligibility on an *ex parte* basis using reliable information available to the state without contacting the beneficiary?

A: Yes. As explained on pages 3-4 and 15 in the December 4, 2020, Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB), entitled "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements," per federal requirements at 42 CFR §§ 435.916(a)(2) and (b) and 457.343, states are required to attempt an *ex parte* renewal for all Medicaid and CHIP beneficiaries using all reliable information contained in the individual's account or other more current information available to the agency, including those Medicaid beneficiaries who are subject to an asset test. We also explained in the December 2020 CIB that use of the state's Asset Verification System (AVS) is a required part of the *ex parte* renewal process. However, not all asset information available from financial institutions participating in the AVS is returned in real time. In conducting an *ex parte* renewal, states must allow for a reasonable period of time for electronic information from the AVS to be returned. As described on page 25 in SHO Letter #22-001, to support states' efforts to streamline renewal processes and

[2] States that act on a change in circumstances must redetermine eligibility consistent with federal requirements at 42 CFR § 435.916(d).

increase *ex parte* renewal rates during the unwinding period following the end of the PHE, states can request authority under section 1902(e)(14)(A) of the Act to complete renewals of beneficiaries for whom no information is returned by the AVS within a reasonable timeframe using an assumption that there has been no change in resources when no information is returned through the AVS, or when the AVS call is not returned within a reasonable timeframe, and to complete an *ex parte* renewal process without any further verification of assets.

Q9: In conducting a periodic renewal of beneficiaries subject to an asset test, are states required to obtain a new attestation from the beneficiary of the value of assets which cannot be verified through the state's AVS before completing the renewal?

A: Not necessarily. States have some discretion regarding whether to require a new attestation regarding the value of assets that cannot be verified through their AVS prior to completion of an *ex parte* renewal for a beneficiary subject to an asset test, as described below. In attempting to complete an *ex parte* renewal of eligibility, states are required to check data sources and other information available to the state. States are also required to use reliable information in the beneficiary's account.[3] Some assets are likely to fluctuate in value. If the value of an asset held by a beneficiary at their last determination (i.e., at initial application or periodic renewal) could appreciate over time, the state cannot rely on the value recorded. However, some assets are unlikely to appreciate in value over time – indeed, some assets are likely to depreciate in value. For example, a second vehicle, most personal property, burial funds,[4] and some life insurance policies are unlikely to appreciate in value, and may actually depreciate in value over time. States have the discretion under the renewal regulations at 42 CFR § 435.916, to determine that certain types of assets are unlikely to appreciate in value. If a state opts to use this discretion, the state could find that the value of the asset previously verified by the state and recorded in a beneficiary's case record is reliable for purposes of conducting at *ex parte* renewal, and use the previously recorded value in an *ex parte* renewal to determine eligibility.

The above examples of assets that CMS believes are unlikely to increase in value are shared for illustrative purposes only. As noted, states have discretion to determine what types of assets are unlikely to increase appreciably in value for purposes of conducting an *ex parte* renewal.

A determination that certain types of assets are unlikely to change must be applied consistently across all beneficiaries subject to an asset test. In addition, while states are not required to obtain prior approval from CMS for the list of assets that the state has determined are unlikely to appreciate, these asset types must be documented clearly in state verification policies and procedures for audit and other purposes. In addition, consistent with federal verification regulations at 42 CFR § 435.945(j), states may be asked to provide to CMS the list of assets they have determined are unlikely to appreciate in value. CMS maintains oversight responsibility in

---

[3] See 42 CFR § 435.916(a)(2), incorporated by cross reference in 42 CFR § 435.916(b) (relating to periodic renewals of beneficiaries excepted from application of financial methodologies based on modified adjusted gross income) and 42 CFR § 457.343 (relating to renewal of eligibility for CHIP beneficiaries).
[4] Burial funds up to $1,500 generally are excluded from countable assets.

the event that the state's determination that any given asset is unlikely to appreciate in value is not reasonable.

Q10: What are the notice requirements states must follow if they are able to renew eligibility on an *ex parte* basis, including for non-MAGI beneficiaries?

A: Whenever the state is able to renew any beneficiary's eligibility on an *ex parte* basis using information available to the state, the state must notify the beneficiary of: (1) the determination, (2) the information upon which the agency relied in making the determination, (3) the basis of the beneficiary's continued eligibility, and (4) the beneficiary's obligation to inform the agency if any of the information contained in the notice upon which the state relied is inaccurate or subsequently changes. Beneficiaries are not required to sign and return such notice or otherwise notify the agency if all information in the notice is accurate.

Section 1902(e)(14)(A) Waivers

Q11: How does a state apply for a waiver under the authority of section 1902(e)(14)(A) of the Act?

A: States interested in a 1902(e)(14)(A) waiver must submit a letter to CMS requesting approval for such authority. In April, CMS shared 1902(e)(14)(A) waiver submission instructions and sample language with states through both the Eligibility Technical Assistance Group (ETAG) and an email to state Medicaid directors. That sample language is intended to help guide states in crafting a letter to request the waiver and indicate the authority they seek. Any state that did not receive this information or has additional questions should reach out to their state lead.

States should email their letter requesting 1902(e)(14)(A) waiver authority to Sarah deLone, Director, Children and Adults Health Programs Group (Sarah.Delone2@CMS.hhs.gov); copy their Medicaid state lead; and include Joe Weissfeld (josef.weissfeld@cms.hhs.gov), Jessika Douglas (jessika.douglas@cms.hhs.gov), and CMSUnwindingSupport@cms.hhs.gov. Upon receipt of the request, CMS will reach out with any questions for the state as part of the CMS review process. For any additional questions or technical assistance (TA) requests, states may contact their Medicaid state lead and copy the CMS Unwinding TA mailbox at CMSUnwindingSupport@cms.hhs.gov.

Q12: Will CMS consider approving section 1902(e)(14)(A) waivers to allow flexibilities beyond those identified in the SHO Letter #22-001?

A: Yes. As outlined on pages 23-26 in SHO Letter #22-001, CMS will consider other strategies states may want to propose. Since releasing SHO Letter #22-001, CMS has approved a number of new strategies not identified in the SHO Letter. Interested states can learn more about waivers CMS has approved by reviewing *COVID-19 PHE Section 1902(e)(14)(a) Waiver Approvals* at https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html. Consistent with the limitations outlined in the SHO Letter interpreting the statutory language and established in the Medicaid statute, CMS will only approve

1902(e)(14)(A) waiver requests that protect beneficiaries. States should reach out to their state lead if they would like technical assistance prior to submitting a request not identified in the SHO.

Q13: Can CMS approve section 1902(e)(14)(A) waiver authority to allow states to use Supplemental Nutrition Assistance Program (SNAP) gross income to support non-MAGI redeterminations?

A: Yes. CMS will consider approving section 1902(e)(14)(A) waiver authority to allow states to use SNAP gross income to support non-MAGI redeterminations if certain conditions are met. As described on page 24 in SHO Letter #22-001, based on the strong correlation between SNAP income eligibility and MAGI-based financial eligibility for Medicaid, CMS believes it is appropriate for states to use section 1902(e)(14)(A) authority to enroll certain individuals in MAGI-based Medicaid given a beneficiary's gross income, as determined for purposes of SNAP eligibility. CMS may offer a state section 1902(e)(14)(A) authority to apply a similar strategy for non-MAGI populations, provided that the correlation between SNAP methodologies for determining gross income and the income methodologies for determining Medicaid eligibility for individuals excepted from MAGI-based methodologies (i.e., income counting and household composition rules) in the state remains strong. CMS will need to work with states interested in applying this strategy in renewing some or all of its non-MAGI populations during unwinding in order to determine the strength of this correlation. States should reach out to their state lead for TA and copy the CMS Unwinding TA mailbox at CMSUnwindingSupport@cms.hhs.gov.

Q14: What effective dates for 1902(e)(14)(A) waiver approvals will CMS allow? Can CMS make retroactive approvals?

A: As part of the 1902(e)(14)(A) submission, states are advised to propose an effective date on their request for CMS' review. A state may request a 1902(e)(14)(A) waiver that would take effect prior to or during the unwinding period. States may also request a retroactive effective date, which would allow the state to implement before the date of the 1902(e)(14)(A) waiver request. The state will need to provide CMS with a justification for the request and explain whether the state has already implemented the flexibility.

Q15: Do the section 1902(e)(14)(A) waiver opportunities also apply to CHIP?

A: In general, section 1902(e)(14)(A) waiver authority is applicable to both Medicaid and CHIP. However, many of the strategies specifically identified in SHO Letter #22-001 will not apply to CHIP, either because the eligibility requirements related to the strategy do not apply to CHIP (e.g., the Asset Verification System or Fair Hearing strategy) or relevant conditions do not apply to CHIP enrollees (e.g., CHIP enrollees will not have $0 income, so $0 income is not applicable; SNAP's gross income test is below the minimum income standard permitted for separate CHIPs, so the SNAP flexibility strategy is not applicable). There are two strategies identified in SHO Letter #22-001 that could apply to CHIP: (1) permitting the state to accept updated in-state enrollee contact information from managed care plans without additional confirmation from the individual and (2) permitting automatic re-enrollment of beneficiaries into

their managed care plan for individuals who lost Medicaid coverage for up to 120 days and are later reenrolled.

Verification of $0 Income: Under General Rules at Application and Renewal and Under 1902(e)(14) Strategy

Q16: What verification processes must states follow to verify $0 income at application ?

A: Upon receiving a $0 income attestation from an individual, a state must check all earned and unearned income electronic data sources identified as useful in the state's verification plan. If the aggregate income amount returned by the data sources is at or below Medicaid/CHIP eligibility thresholds, then the individual's attestation is considered reasonably compatible with the data sources and the attested income is verified. If the aggregate income amount returned by the data sources is above the Medicaid/CHIP eligibility threshold levels, then additional information and/or documentation must be requested.

If no electronic data sources are returned, then the state may accept the individual's attestation without requiring further documentation or the state may request additional documentation and/or a reasonable explanation (e.g., of how the individual meets their basic needs) to verify the individual's $0 attestation.

Q17: What verification processes must states follow to verify $0 income at renewal?

A: Per 42 CFR § 435.916, states must first attempt to conduct an *ex parte* renewal for all individuals. An *ex parte* renewal is a redetermination of eligibility that can be made based on reliable information available to the agency without requiring additional information from the individual. Income information from the initial determination at application or the individual's last renewal is not considered recent or reliable.

When conducting an *ex parte* renewal, states will not have a new attestation of income from the beneficiary. Thus, if no electronic data sources are returned, there is no attestation upon which to rely, and a state may not conclude that the household has $0 income. If the income data sources accessed by the state return information indicating that the individual's income is at or below the applicable income standard, the beneficiary's income would be verified as eligible. If no information is returned from data sources, or if information available to the state does not verify the individual's income eligibility, then the state must provide the individual with a renewal form and inform the individual of any additional information or documentation needed to determine eligibility. If the individual attests to $0 income on the renewal form, the state would follow the same process that it follows for individuals attesting to $0 income at application.

Q18: What is the section 1902(e)(14)(A) waiver authority strategy for verifying income during an *ex parte* renewal for individuals who previously attested to $0 income?

A: Under this strategy, a state with an approved 1902(e)(14)(A) waiver can temporarily complete the income determination for *ex parte* renewals without requesting additional income information or documentation if (1) the most recent income determination (either at initial

application or most recent renewal) was no earlier than 12 months prior to the beginning of the PHE (i.e., March 2019), (2) the state verified an attestation of $0 income at such determination, and (3) the state checks financial data sources in accordance with its verification plan and no information is received.

Countable Resources

Q19: Is pandemic-related financial assistance retained by an individual considered a countable resource in determining an individual's financial eligibility?

A: For most beneficiaries, the answer is "No." Retained income (i.e., the portion of income from a particular source not spent in the month when it is received) generally becomes countable as a resource in the month following its receipt for Medicaid applicants and beneficiaries whose eligibility includes a resource test. However, for individuals whose Medicaid eligibility is determined using supplemental security income (SSI) methodologies, most pandemic-related disaster assistance is permanently disregarded from income and resources. A state plan amendment (SPA) is not necessary to effectuate this policy. This permanent disregard includes the Economic Impact Payments (otherwise known as the "Recovery Rebates") authorized in section 2201 of the CARES Act, Pandemic Related Unemployment Assistance authorized in section 2101 of the CARES Act, and other types of disaster assistance. A complete list of the types of assistance that are permanently disregarded from income and resources under SSI's disaster assistance policy can be found in Social Security Administration's (SSA's) emergency memo SSA EM-20014 REV 5.

Please note that previous CMS guidance indicated that the Recovery Rebates were only excluded from resources for the 12 months following receipt.[5] As noted above, for SSI-based eligibility determinations, SSA has stated in more recent guidance that the Recovery Rebates are permanently disregarded as resources. Going forward, states must disregard these resources, per SSA guidance, in SSI-based eligibility determinations.

For non-MAGI individuals whose eligibility is not based on SSI methodologies (e.g., medically needy parents/caretaker relatives whose eligibility would be determined using aid to families with dependent children (AFDC) or MAGI-like methodologies), retained pandemic-related income may be countable if a resource test is applied. However, such assistance could be disregarded under the authority of section 1902(r)(2) of the Act (for which a SPA would be necessary).

Reasonable Opportunity Period (ROP)

Q20: As a condition of receiving the 6.2 percentage point FMAP increase under section 6008 of the FFCRA, states have been required to continue enrollment for applicants with

[5] COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, Question C. 11, p. 24, C. 18, p. 27, and L. 4, p. 65, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

verified citizenship or satisfactory immigration status pending during a ROP. In the case of such applicants whose citizenship or satisfactory immigration status has not been verified as of the end of the PHE, can states take steps to continue to verify their immigration or citizenship status during the unwinding period? If so, what steps should states take to continue to verify the individual's immigration status or citizenship?

A: Under sections 1902(ee)(1)(B)(ii) and 1137(d)(4) of the Act and implementing regulations at 42 CFR § 435.956(b), if a state cannot promptly verify an individual's declared U.S. citizenship or immigration status, the state must provide benefits during a 90-day ROP.[6] During the ROP, the state must continue efforts to complete verification of the individual's citizenship or immigration status, including assisting the individual with obtaining any necessary documentation. If, by the end of the ROP, the individual's citizenship or satisfactory immigration status has not been verified, the agency must take action within 30 days to terminate eligibility, in accordance with advance notice and fair hearing rights under part 431 subpart E.

In pages 19-20 of SHO Letter #22-001, we encouraged states to attempt to continue efforts to verify citizenship or immigration status before the end of the PHE for individuals whose status has not been verified but who have remained enrolled in coverage during an ROP in order to comply with the continuous enrollment condition under section 6008 of the FFCRA during the PHE. We also explained that individuals who have been provided an ROP and whose status remains unverified at the end of their ROP are not entitled to a full renewal of eligibility during the unwinding period. This is because individuals whose status has not been verified have not had an eligibility determination completed. Thus, unless the state exercises the options described below, it must take appropriate actions to terminate benefits for individuals whose status has not been verified during their 90-day ROP.

The options for states with respect to continued verifications for these individuals during the unwinding period depend on whether the individual attested to satisfactory immigration status or U.S. citizenship.

- *Individuals attesting to satisfactory immigration status*: When the unwinding period begins, states may continue to attempt to verify the status of individuals who attested to satisfactory immigration status under existing regulations at 42 CFR § 435.956(b)(2)(ii)(B). This provision allows states to provide a reasonable extension of the ROP for individuals attesting to satisfactory immigration status in two situations: (1) the individual is making a good-faith effort to obtain any necessary documentation and (2) the state needs more time to verify the individual's status or assist the individual in obtaining documents needed to verify their status. States adopt the option to extend the ROP for individuals attesting to satisfactory immigration status in these situations by submitting a SPA. CMS is available to provide technical assistance to interested states.

[6] 42 CFR § 435.956(b)(2)(ii)(A)(B) permits states to extend the ROP beyond 90 days for individuals declaring to be in a satisfactory *immigration* status if the agency determines the individual is making a good faith effort to obtain any necessary documentation, or if the agency needs more time to verify the individual's status or to assist the individual in obtaining documents needed to verify their status.

- *Individuals attesting to U.S. citizenship:* For individuals who have attested to U.S. citizenship, states may request a COVID-19 1115 demonstration in order to extend the ROP to provide additional time during the unwinding period for verifying an individual's citizenship. The primary goal of this demonstration opportunity is to enable states to adopt the same ROP policies and processes for individuals who have either attested to U.S. citizenship or to satisfactory immigration status. States may request this 1115 demonstration authority for the entire unwinding period to align with and manage their renewal workload and other outstanding eligibility actions.

CMS believes that, due to the extraordinary circumstances presented by the PHE and the challenges states face in returning to normal operations during the unwinding period, it is reasonable under both the state plan and section 1115 demonstration options discussed above for states to extend the ROP for any given individual up to 90 days after the state initiates work on the individual's case during the unwinding period. This means that, by adopting the state plan option for individuals who have attested to satisfactory immigration status and section 1115 demonstration authority for individuals who have attested to U.S. citizenship, states can align the work required to process individuals receiving benefits during an ROP at the end of the PHE with the work of conducting renewals and completing other eligibility actions, including conducting outstanding verifications, during the state's unwinding period.

Q21: Is there a time limitation for states seeking a COVID-19 1115 demonstration to extend an ROP period for individuals who have attested to U.S. citizenship?

A: Yes. For this COVID-19 section 1115 demonstration, states must submit a demonstration request before the end of the PHE. Interested states should contact their 1115 project officer for more information.

Q22: If a state were to request COVID-19 1115 demonstration authority to extend its ROP to continue to verify an individual's attested U.S. citizenship, how long could the 1115 demonstration authority last?

A: CMS will consider requests for section 1115 demonstration authority to extend the ROP, as described above, with a maximum duration of 15 months beginning with the first month of a state's unwinding period. These 15 months include a state's 12-month unwinding period, plus 90 additional days for the state to extend the ROP to complete the verification of U.S. citizenship for a given individual whose case comes up for processing in month 12 of the state's unwinding period. For any given beneficiary, the authority to extend the ROP will terminate 90 days after the state initiates work on the beneficiary's case.

Q23: Why do states need to request section 1115 demonstration authority to extend the ROP for U.S. citizens? Can the state use the existing regulatory authority under 42 CFR 435.956(b)(2)(ii)(B) for citizens like it can for non-citizens?

A: The statutory provision governing the ROP for individuals declaring U.S. citizenship and the statutory provision for individuals declaring satisfactory immigration status are different. Section 1137 of the Act governs verification requirements for noncitizens and does not specify a

timeframe for the ROP. As such, CMS established the option under 42 CFR 435.956(b)(2)(ii)(B) for states to extend the ROP beyond 90 days for individuals whom the state has determined to be making a good faith effort to obtain any necessary documentation, or to allow the state additional time to verify the individual's status.

Section 1902(ee)(1)(B)(ii) of the Act governs the provision of an ROP for individuals declaring to be citizens or nationals of the United States. This statutory provision requires that the ROP must be 90 days. Absent the 1115 demonstration authority described in this section, CMS does not have authority to permit states to extend the ROP for individuals declaring U.S. citizenship.

Premiums

Q24: Are states that suspended Medicaid and/or CHIP premiums through a disaster SPA during the PHE required to resume charging premiums after the end of the PHE?

A: Yes. Once the PHE ends, the suspension of premiums under a disaster SPA expires and states are required to resume Medicaid and CHIP premiums in accordance with their state plan unless the state takes permissible action to adopt a different policy, as described in Q26,Q27, and Q28 below. For Medicaid, states must provide each beneficiary with a minimum of 10 days advance notice, including the right to a fair hearing prior to resuming charges, in accordance with federal regulations at 42 C.F.R. 431 Subpart E. The advance notice must provide the premium amount, a clear statement of the specific reasons supporting the assessment of a premium, and the basis for the premium calculation, in accordance with 42 C.F.R. §§ 431.210-11 and 431.201.

For CHIP, states must provide timely and adequate written notice and rights to the CHIP review process prior to resuming CHIP premiums, in accordance with 42 C.F.R. § 457.1180.

We note that for Medicaid, under section 6008(b)(2) of the FFCRA, states claiming the temporary FMAP increase are required to maintain Medicaid premiums at the same or lower level as those assessed on January 1, 2020, with respect to an individual until the end of the calendar quarter when the PHE ends.[7]

Q25: Are states that suspended Medicaid and/or CHIP premiums through a disaster SPA during the PHE required to make a new determination of income prior to imposing premiums after the PHE ends?

A: It depends. If the state has completed a renewal in the last 12 months, the amount of the premium imposed after the PHE ends may be based on the state's most recent determination of the beneficiary's household income. If the beneficiary has not had a redetermination of household income in the last 12 months, the state must complete a redetermination before reimposing premiums.

---

[7] See COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, Question B.12, p. 17, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

Q26: Where states suspended Medicaid and/or CHIP premiums through a disaster SPA during the PHE, can states extend their suspension of premiums beyond the end of the PHE?

A: Yes. States can delay resuming Medicaid and CHIP premiums for all applicable beneficiaries beyond the end of the PHE by either extending their disaster SPA (including evergreen disaster SPAs for CHIP) or submitting a regular SPA. Delaying the resumption of CHIP premiums will smooth the transition from Medicaid to CHIP, mitigating coverage losses for children during unwinding. States that wish to extend a suspension of premiums should reach out to their Medicaid state lead or CHIP project officer to discuss these options.

Q27: Where states suspended Medicaid and/or CHIP premiums through a disaster SPA during the PHE, may states delay resumption of Medicaid premiums only for beneficiaries enrolled in coverage at the end of the PHE until a full renewal has been completed?

A: Yes, states can delay resumption of Medicaid premiums by requesting CMS approval of a section 1902(e)(14(A) waiver for Medicaid. States generally may not charge premiums only to some Medicaid beneficiaries who are otherwise subject to premiums under the state plan. However, if the state is facing a systems or operational barrier to resuming premiums for all individuals at the same time, states may request authority under section 1902(e)(14)(A) of the Act to delay resumption of Medicaid premiums otherwise required under the state plan until the state has conducted a full renewal of eligibility for a beneficiary during the unwinding period. For more information on this authority and how to submit such a request, see Q11 above.

Q28: Where states suspended Medicaid and/or CHIP premiums through a disaster SPA during the PHE, may states delay resumption of CHIP premiums only for beneficiaries enrolled in coverage at the end of the PHE until a full renewal has been completed?

A: Yes. States have authority under the CHIP state plan to delay resumption of CHIP premiums for current beneficiaries until a full renewal of eligibility has been completed by activating an existing evergreen disaster SPA, or, if the state does not have an approved evergreen disaster SPA, by submitting a new disaster SPA that is specific to the unwinding period. These two types of CHIP disaster SPAs do not contain any section 1135 waivers and can be in effect until the end of the unwinding period. States interested in this option should reach out to their CHIP Project Officer for technical assistance.

Q29: Where states suspended Medicaid and/or CHIP premiums through a disaster SPA during the PHE, is public notice required prior to resumption of Medicaid and CHIP premiums after the end of the PHE?

A: No. States that suspended Medicaid premiums through a disaster SPA are not required to complete public notice under 42 C.F.R. § 447.57(c) prior to resuming charging Medicaid premiums. States that suspended CHIP premiums through a disaster SPA are not required to complete public notice under 42 C.F.R. § 457.65(b)(1) if state law does not require such notice.

However, if a state's schedule of premium amounts has changed (due, for example, to a regular cost of living adjustment in the premium price schedule), the state must update the Medicaid and CHIP premium public schedules to provide public notice consistent with federal requirements described at 42 C.F.R. § 447.57(a) for Medicaid and 42 C.F.R. § 457.525 for CHIP.

Q30: Can states terminate beneficiaries based on non-payment of premiums during unwinding period?

A: Under the Medicaid regulations at 42 C.F.R. § 447.55(b)(2), states may terminate coverage for some beneficiaries based on non-payment of premiums for at least 60 days, provided that conditions specified in the regulation are met. Due to the continuous enrollment condition required for states claiming the temporary FMAP increase available under section 6008 of the FFCRA, states have had to suspend implementation of that policy in order to claim the temporary FMAP increase.

Effective the beginning of the month following the month when the PHE ends, a state may resume implementation of a policy to terminate beneficiaries based on non-payment of premiums. CMS explained in previous guidance that states cannot terminate beneficiaries' eligibility or coverage following the end of the PHE for unpaid premiums accumulated during the PHE. [8] States may terminate beneficiaries for unpaid premiums incurred prior to the PHE. To implement this termination, states may not count any days that fell during the PHE as part of the 60 days of nonpayment.

Prior to terminating a beneficiary for non-payment of premiums after the PHE ends, states must consider all bases of eligibility for which an individual may qualify, consistent with 42 CFR § 435.916(f)(1), including eligibility for a group that does not have premium requirements. If the state completed an initial determination of eligibility at application or a successful renewal in the past 12 months, the state may rely on the information in the individual's case record to determine other bases of eligibility for which a beneficiary might qualify. If the state has **not** completed a successful renewal in the past 12 months, the state must conduct a full renewal and consider all bases of eligibility before termination.

Before an individual is terminated for nonpayment of premiums, the state must provide each beneficiary with a minimum of 10 days' advance written notice of the termination per 42 CFR §§ 435.917 and 431.206–214, and provide fair hearing rights, per 42 CFR § 431.220(a). Consistent with 42 CFR § 431.210, this advance notice must contain a statement that the agency intends to terminate the beneficiary, the effective date of such action, the specific reasons supporting the termination, the specific regulations that support the action, and information about the beneficiary's fair hearing rights.

For CHIP, states were not required to maintain coverage for individuals enrolled during the PHE. Therefore, some states may currently be terminating enrollment due to non-payment of premiums, which is permitted under section 2103(e)(3) of the Act after 30 days of non-payment.

---

[8] *See* COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, Question B.11, p. 17, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

For states that suspended premiums or ceased terminating individuals for non-payment of premiums during the PHE through a disaster relief SPA, they must provide beneficiaries with timely and adequate written notice and information about the beneficiaries' rights to the CHIP review process prior to resuming CHIP premiums and the premium grace period policy.

Fraud & Abuse/Recoupment

Q31: Can a state recover or recoup the cost of services from a beneficiary who committed Medicaid fraud or abuse?

A: No. States cannot recover or recoup the cost of services from a beneficiary, even if they have been found after an administrative or criminal proceeding to have committed Medicaid beneficiary fraud or abuse. States must continue furnishing Medicaid to all beneficiaries until they are determined ineligible per 42 CFR § 435.930(b), and such recovery or recoupment would effectively represent a retroactive termination of Medicaid eligibility, which would violate a beneficiary's due process rights under section 1902(a)(3) of the Act, 42 CFR part 431 subpart E, and relevant Supreme Court due process jurisprudence (*see* Goldberg v. Kelly, 397 U.S. 254 (1970) and its progeny).

The only circumstances under which a state may recover funds from a beneficiary are those explicitly provided for in federal statute and regulation. These include: (1) liens placed on a beneficiary's property when a court judgment finds that Medicaid benefits were improperly paid under section 1917(a) of the Act and 42 CFR § 433.36(g)(1); (2) estate recovery proceedings required under section 1917(b)(1) of the Act; and (3) benefits provided pending the outcome of a fair hearing under 42 CFR § 431.230 (except that benefits provided pending the outcome of a fair hearing during the PHE may not be recouped, and states that do so risk losing enhanced match claimed pursuant to section 6008 of the FFCRA; *see* footnote 9 in the March 2022 SHO Letter # 22-001).

Single State Agency Requirements & Use of Private Contractors

Q32: Can states use private contractors to assist the Medicaid agency or delegated agency with eligibility actions during the unwinding period, when workloads will be significantly increased?

A: Yes, subject to certain restrictions. For eligibility determination functions that require discretion, states must use employees of a government agency that maintains personnel standards on a merit basis. However, states can use contractors to support the administrative functions of the eligibility determination process that do not require discretion.

If an eligibility system is automated and requires no discretion to evaluate/determine an individual's eligibility, then a contractor can perform data entry functions and provide IT support

to operate the system, as long as the state agency has overseen development of the requirements, rules, and policies operationalized by the system.

Examples of administrative functions that do not require discretion include intake of applications, renewal forms, and income or resource verifications; follow up on requests sent by the state agency (e.g., calling to collect missing information); call center support to help provide status updates on application or renewal submissions; and other administrative tasks. Examples of functions that must be performed by government agency staff (which could include county staff) who have merit personnel protections include evaluating evidence submitted to resolve inconsistencies between attested information and third-party data sources, determining whether an individual meets the standard of disability for a Medicaid eligibility determination based on disability, or determining if an individual's specific financial resource should be excluded under the terms of the state plan.

Eligibility and Enrollment Data Reporting During Unwinding

Q33: Are there special data reporting requirements for states during unwinding?

A: As described in SHO Letter #22-001, states will have a large volume of eligibility and enrollment actions to complete when the COVID-19 PHE ends. As outlined in the SHO Letter, states will be required to submit eligibility and enrollment data to CMS. In later guidance,[9] CMS explained that states will submit a baseline data report intended to serve as a starting point to track pending eligibility and enrollment actions that the state will need to address when its unwinding period begins. States will submit monthly reports to illustrate progress in addressing pending eligibility and enrollment actions during the unwinding period. Note that this unwinding reporting requirement is separate from states' monthly performance indicator data reporting.

Q34: When are the baseline and monthly data reports due to CMS?

A: The baseline data report is due by the 8th calendar day of the month in which a state begins its unwinding period. Should the 8th calendar day fall on a weekend or holiday, states may submit by the next business day. For illustrative purposes only, if a state begins its unwinding period in January 2023, then the baseline data report would be due to CMS by January 8, 2023. However, since the 8th of January is a Sunday, states may submit by January 9, the next business day. Please note that this FAQ reflects a revised due date for the baseline data report to align and simplify reporting procedures for states.

The monthly data reports are due to CMS by the 8th calendar day of the month following the report month. For example, if a state were compiling data for the month of February 2023, this report would be due by March 8, 2023. Should the 8th calendar day fall on a weekend or holiday, states may submit by the next business day.

[9] Medicaid and Children's Health Insurance Program Eligibility and Enrollment Data Specifications for Reporting During Unwinding (Medicaid 2022). Available at: https://www.medicaid.gov/resources-for-states/downloads/unwinding-data-specifications.pdf.

Please submit any questions about these due date to UnwindingMetricsTA@mathematica-mpr.com.

Q35: CMS is requiring states to submit baseline and monthly data reports that separate pending MAGI and non-disability applications from pending disability-related applications. What is considered a disability-related application for the purposes of these reports?

A: A disability-related application is an application for which the state must make a determination of disability to determine the applicant's eligibility. Disability-related applications are subject to the 90-day timeliness standard at 42 CFR § 435.912(c)(3)(i).

Q36: For reporting on the application processing metrics, should states report at the household/case or individual level?

A: States have the option to report the application processing metrics, including pending applications, at the household/case or individual level. States that report applications at the individual level are asked to note this approach in the comments field when submitting the data through the portal, and report consistently across the baseline and monthly reports.

Electronic Outreach Under the Telephonic Consumer Protection Act (TCPA)

Q37: What guidance is available for states regarding application of the TCPA to outreach conducted by state Medicaid and CHIP agencies, counties, and state contractors?

A: Implementation of the TCPA falls under the purview of the Federal Communications Commission (FCC). On April 29, 2022, HHS Secretary Xavier Becerra and CMS Administrator Chiquita Brooks-LaSure submitted a letter to the FCC, requesting clarification on the permissibility of certain automated text messages and prerecorded voice calls relating to enrollment in health coverage. As of October 17, 2022, the FCC had not yet issued guidance in response to this request. However, the CMS/HHS letter, along with all comments submitted in response to the letter, are available through the FCC's Electronic Comment Filing System (ECFS), which can be accessed at FCC.gov/ecfs. This request is filed under proceeding number 02-278. This is the FCC docket number for rules and regulations implementing the TCPA.

Unwinding Administrative Match for Outreach/Advertising

Q38: Can states claim Medicaid and CHIP administrative costs and receive federal financial participation for advertising efforts related to communicating with beneficiaries about applying for Medicaid or renewing coverage during the unwinding of the COVID-19 PHE?

A: Yes. In Medicaid, states can receive 50 percent administrative federal financial participation (FFP) for advertising/outreach efforts related to unwinding. In CHIP, states receive

regular enhanced FMAP (eFMAP) for outreach expenses, subject to the 10 percent cap on administrative costs.

In an effort to reach the most Medicaid and CHIP beneficiaries as efficiently as possible, some states are conducting paid digital marketing campaigns across social media to deliver information to target Medicaid and CHIP audiences as part of the PHE unwinding. In addition to online advertising, states are also using a mix of television, radio, and print advertising about these programs to motivate beneficiaries to take important steps related to renewals. States can claim administrative match in Medicaid and CHIP for the costs of these advertising activities, subject to the limitations outlined below.

In Medicaid, informing beneficiaries about upcoming changes to enrollment requirements and the need to respond to renewal notices in connection with the unwinding of the PHE is necessary for the proper and efficient administration of the Medicaid state plan (1903(a)(7) of the Act), and states may claim related expenditures (See, e.g., https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf). CMS has allowed administrative cost claiming for media placements or media buys related to outreach efforts pursuant to 45 CFR 75.421(b)(4), which permits advertising expenditures for program outreach and other specific purposes necessary to meet the requirements of the federal award (See Q8 in https://www.medicaid.gov/federal-policy-guidance/downloads/sho10007.pdf).

In CHIP, states are required to include a description of their outreach plan in the state plan (section 2102(c) of the Act). Federal funding for outreach is drawn from a state's CHIP title XXI fiscal year allotment, and outreach expenditures are subject to a 10 percent cap that applies to CHIP administrative expenses. Under section 2105(c)(2)(A) of the Act, claims for administrative expenses cannot exceed 10 percent of the total amount of title XXI funds claimed by the state each quarter.

States that combine advertising activities for Medicaid and CHIP into joint messages must develop a statistically valid methodology to allocate the costs between the two programs (See 45 CFR 75.405, 75.416). This is accomplished by developing a method to assign costs based on the relative benefit to, in this case, the Medicaid program and the CHIP program. This methodology must be incorporated into the state's existing Cost Allocation Plan (CAP) required under 45 CFR Part 95 Subpart E. When developing its cost allocation methodology, a state should consider the impact of the 10 percent administrative limit applicable to all costs for non-health activities conducted under a separate CHIP. States should also ensure that the CHIP eFMAP rate is claimed appropriately for the costs of CHIP activities. CMS is available to work with states in developing a cost allocation methodology and on a cost allocation plan.