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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 23-002

RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023

January 27, 2023

Dear State Health Official:

On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted.[1] This state health official (SHO) letter discusses section 5131 of subtitle D of title V of division FF of the CAA, 2023 (hereinafter referred to as "section 5131"). This section makes significant changes to the continuous enrollment condition and availability of the temporary increase in the Federal Medical Assistance Percentage (FMAP) under section 6008 of the Families First Coronavirus Response Act (FFCRA) (hereinafter referred to as "temporary FMAP increase") and establishes new state reporting requirements and enforcement authorities for the Centers for Medicare & Medicaid Services (CMS). Specifically, as discussed in further detail in this letter, section 5131:

(1) Separates the end of the FFCRA continuous enrollment condition from the end of the COVID-19 public health emergency (COVID-19 PHE), and ends that condition on March 31, 2023, thus enabling states to terminate Medicaid enrollment of individuals who no longer meet Medicaid eligibility requirements on or after April 1, 2023;
(2) Amends the conditions states must meet to claim, and extends the availability of, the temporary FMAP increase beginning April 1, 2023, gradually phasing down the increase until December 31, 2023;
(3) Adds new reporting requirements for all states under section 1902(tt) of the Social Security Act (the Act); and
(4) Creates new enforcement authorities for CMS related to the new reporting requirements and to state renewal activities during the period that begins on April 1, 2023 and ends on June 30, 2024 (a time frame that will overlap with states' unwinding periods).[2]

The newly enacted CAA, 2023 does not address the end date of the COVID-19 PHE. On

[1] https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.
[2] As described in prior CMS guidance, states will have up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid, CHIP, and the Basic Health Program (BHP) following the end of the continuous enrollment condition—this process has commonly been referred to as "unwinding."

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

January 11, 2023, the Secretary renewed the COVID-19 PHE, which is still in effect as of the date of this letter.[3]

On January 5, 2023, CMS released a Center for Medicaid and CHIP Services Informational Bulletin (CIB), *Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023*,[4] which is the first in a series of guidance on the changes made by section 5131 to the continuous enrollment condition and the impact of these changes on prior CMS guidance.[5] The January 5, 2023, CIB relays key dates and deliverables for states as they resume renewals and other eligibility and enrollment actions following the end of the continuous enrollment condition (referred to in prior guidance as the "unwinding period"). This SHO letter is the next in this series of guidance and builds on the guidance provided in the January 5, 2023, CIB. CMS also expects to provide additional guidance on the CAA, 2023 in the future.

CMS will be reviewing data, state activity, and other information to ensure all states comply with federal eligibility renewal requirements and the new section 1902(tt) reporting requirements in preparation for and during the state's unwinding period. States may need to make programmatic and operational changes to eligibility and enrollment policies, procedures, systems, and operations and consider adopting alternative strategies and mitigation plans to ensure compliance. CMS is available to consult with states as they prepare for and resume renewals and other eligibility determinations. States may contact their CMS state lead for assistance.

Changes to the FFCRA Continuous Enrollment Condition and Temporary FMAP Increase

Section 5131(a)(2)(C) separates the end of the continuous enrollment condition from the end of the COVID-19 PHE by amending section 6008(b)(3) of the FFCRA to end continuous Medicaid enrollment as a condition for claiming the temporary FMAP increase on March 31, 2023. This means that, on or after April 1, 2023, states claiming the temporary FMAP increase will no longer be required to maintain the enrollment of a Medicaid beneficiary for whom the state completes a renewal and who no longer meets Medicaid eligibility requirements. With the changes made in section 5131, states must end the enrollment of ineligible beneficiaries on or after April 1, 2023, after a full renewal is conducted during the state's unwinding period, no matter when the COVID-19 PHE ends.

Consistent with the March 3, 2022, SHO #22-001, *RE: 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* (hereinafter SHO #22-001), and as explained in the January 5, 2023, CIB:

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[3] The Secretary renewed the COVID-19 PHE, effective January 11, 2023. See: https://aspr.hhs.gov/legal/PHE/Pages/covid19-11Jan23.aspx.

[4] CMS. (January 5, 2023). *Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023* [CMCS Informational Bulletin]. Available at https://www.medicaid.gov/sites/default/files/2023-01/cib010523_1.pdf.

[5] CMS. (March 3, 2022). *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* [State Health Official Letter #22-001]. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

- States can begin their unwinding period as early as February 1, 2023, by *initiating* renewals that may result in eligibility terminations on or after April 1, 2023. States must begin their unwinding period by initiating renewals no later than April 2023.
- For states that initiate renewals prior to April 1, 2023, terminations of Medicaid eligibility *may not be effective* earlier than April 1, 2023.
- States must *initiate* renewals for all individuals enrolled in Medicaid, CHIP, and BHP within 12 months of the beginning of the state's unwinding period and must *complete* renewals for all individuals within 14 months of the beginning of the state's unwinding period.[6]

A renewal is considered initiated when the state begins the renewal process by attempting to renew eligibility on an *ex parte* basis – i.e., based on available reliable information without contacting the individual. CMS encourages states to distribute renewals in a reasonable manner and recommends that states initiate *no more than* 1/9 of their total caseload of Medicaid and CHIP renewals in a given month during the unwinding period for several reasons discussed in SHO #22-001, including to ensure states have a renewal schedule that is sustainable in future years. States may refer to SHO #22-001 (pages 14-21) for information on strategies states may use to prioritize and distribute workload during the unwinding period.[7]

Section 5131 also separates the end of the temporary FMAP increase from the end of the COVID-19 PHE. Specifically, section 5131(a) amends section 6008(a) of the FFCRA to continue the temporary FMAP increase through December 31, 2023 (instead of through the end of the quarter in which the COVID-19 PHE ends), and phases down the amount of the FMAP increase beginning April 1, 2023. Table 1 displays the amount of the FMAP increase that will be available in each quarter of calendar year (CY) 2023, provided that the state claiming the FMAP increase meets the applicable conditions in subsections (b) and (f) of section 6008 of the FFCRA, as amended by section 5131 (discussed below). If the state meets the applicable conditions, the FMAP increase applies to the same match rates to which it applied prior to the enactment of the CAA, 2023.[8]

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[6] CMS. (March 3, 2022). *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* [State Health Official Letter #22-001] (pages 7-9). Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[7] CMS. (March 3, 2022). *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* [State Health Official Letter #22-001] (pages 14-21). Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[8] In general, the FFCRA FMAP increase is available for allowable Medicaid medical assistance expenditures for which federal matching is paid ordinarily at the state-specific FMAP defined in the first sentence of section 1905(b) of the Act. For additional guidance on the match rates that can be temporarily increased under section 6008 of the FFCRA (as amended), see Section IV.F in: CMS. (2021). *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*. Available at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

Table 1. CAA, 2023 FMAP Increase Phase Out

2023 Calendar Overview	Temporary FMAP Increase Available
Q1: January 1-March 31, 2023	6.2 percentage points
Q2: April 1-June 30, 2023	5.0 percentage points
Q3: July 1-September 30, 2023	2.5 percentage points
Q4: October 1-December 31, 2023	1.5 percentage points

Conditions for Receipt of Temporary FMAP Increase

The conditions for claiming the temporary 6.2 percentage point FMAP increase remain unchanged for the first quarter of CY 2023. States claiming the temporary FMAP increase for quarter 2, 3, or 4 of CY 2023 (that is, for any quarter in the period beginning April 1, 2023, and ending December 31, 2023) must continue to meet three of the conditions originally set forth in section 6008(b) of the FFCRA during each quarter in which the state claims the FMAP increase: (1) section 6008(b)(1) (related to maintenance of effort); (2) section 6008(b)(2) (related to premiums), with one modification made by section 5131 (discussed below); and (3) section 6008(b)(4) (related to coverage of COVID vaccination, testing, and treatment services, without cost-sharing). The applicability of these conditions during quarters 2, 3, and 4 of CY 2023 is discussed in this section of the SHO.[9]

Section 5131 also amended section 6008 of the FFCRA to establish new conditions for states to claim the temporary FMAP increase during quarters 2, 3, and 4 of CY 2023 under a new section 6008(f) of the FFCRA. States that claim the temporary FMAP increase during quarter 2, 3, or 4 of CY 2023 must comply with the new FFCRA section 6008(f) conditions for Medicaid renewals that are conducted during each quarter for which the state claims the FMAP increase. Guidance on the new conditions established in section 6008(f) of the FFCRA is provided later in this SHO letter. As noted above, states will continue to have 12 months to *initiate* their work on renewals, redeterminations based on changes in circumstances, and post-enrollment verifications, and 14 months to *complete* this work once the state's unwinding period begins, consistent with the guidance in the January 5, 2023, CIB and SHO #22-001.

In preparation for and during the unwinding period, CMS will review data, state activities, and other information to ensure states are complying with federal eligibility renewal requirements and, for states claiming the FFCRA temporary FMAP increase, the applicable conditions for claiming that increase. States may need to make programmatic and operational changes to eligibility and enrollment policies, procedures, systems, and operations and consider adopting alternative strategies to ensure compliance. States that are not compliant with federal redetermination requirements, regardless of whether they continue to claim the FFCRA section 6008 FMAP increase, may be subject to corrective action and penalties under section 1904 or section 1902(tt)(2)(B) of the Act (see discussion below). States not in compliance with all

[9] For additional information on the condition under section 6008(b)(3) of the FFCRA to maintain enrollment of individuals effective through March 31, 2023, see: 42 CFR § 433.400, and CMS. (2021). *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*. Available at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

redetermination requirements may work with CMS to develop and implement an approved mitigation plan.

Maintenance of Effort Condition through December 31, 2023

Under section 6008(b)(1) of the FFCRA, states may not claim the temporary FMAP increase for a quarter if, during that quarter, they impose eligibility standards, methodologies, or procedures that are more restrictive than those in effect on January 1, 2020. Section 5131 did not change this condition, and states must continue to meet it for any quarter in which they claim the temporary FMAP increase, through December 31, 2023. See previous guidance in Section IV.F. in the *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*[10] for additional guidance on this condition.

Maintenance of Medicaid Premium Levels through December 31, 2023 (Modified by Section 5131)

Prior to the enactment of the CAA, 2023, section 6008(b)(2) of the FFCRA provided that states could not claim the temporary FMAP increase if they imposed any premium "with respect to an individual" enrolled under the state plan (or a waiver of the plan) that exceeded the amount of such premium as of January 1, 2020. CMS interpreted this condition to mean that a state claiming the temporary FMAP increase could not increase the amount of any premium charged to an individual enrollee (even if that person's income increased).[11]

Beginning April 1, 2023 (that is, beginning in quarter 2 of CY 2023), section 5131(a)(2)(B) amends section 6008(b)(2) of the FFCRA to remove the language "with respect to an individual enrolled under such plan (or waiver)." Under the amended section 6008(b)(2) condition, states claiming the temporary FMAP increase for quarters beginning on or after April 1, 2023, must continue to ensure that the amounts in their Medicaid premium schedule do not exceed the amounts that were in place under the state plan or any waiver of the plan (including a section 1115 demonstration) as of January 1, 2020. However, beginning April 1, 2023, states may, under the amended section 6008(b)(2) of the FFCRA, increase the premium amount that is imposed on a given individual (e.g., put an individual in a higher premium band if their income has increased, or newly charge an individual a premium if they are moved into an eligibility group that is subject to premiums) without jeopardizing the state's ability to claim the temporary FMAP increase, subject to the following three conditions:

1) The increase must be consistent with the state's Medicaid premium schedule.
2) The premium schedule amounts must not have increased over the amounts in effect as of January 1, 2020.

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[10] See: CMS. (2021). *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*. Available at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

[11] For guidance on the condition described in section 6008(b)(2) in effect through March 31, 2023, see FAQ #II.B.9-10, 12-13 of: CMS. (2021). *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP)*. Available at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

3) The state must comply with redetermination requirements prior to resumption of Medicaid premiums, as discussed in response to Q24-25 of the COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies.[12]

The state also must comply with all premium requirements and limitations specified at sections 1916 and 1916A of the Act and 42 CFR §§ 447.50 through 447.57; all applicable advance notice and fair hearing requirements at 42 CFR § 435.917 and 42 CFR Part 431, Subpart E; public notice requirements at 42 CFR § 447.57; state plan amendment (SPA) effective date requirements at 42 CFR § 430.20; and tribal consultation requirements at section 1902(a)(73) of the Act. CMS plans to provide additional guidance on the CAA, 2023 amendment to section 6008(b)(2) of the FFCRA, including information about the implications of this change for state decisions about rescinding disaster relief SPAs.

States may request authority under section 1902(e)(14)(A) of the Act to delay the resumption of Medicaid premiums during the unwinding period until a full redetermination is completed for beneficiaries who are subject to premiums under the State plan or a waiver, including through a section 1115 demonstration project. States can refer to SHO #22-001[13] for details on how to request approval of section 1902(e)(14)(A) waivers. States may also contact their CMS state lead for more information.

Coverage without Cost Sharing for COVID-19 Testing, Vaccines, and Treatment through December 31, 2023

States claiming the temporary FMAP increase for any quarter in the period beginning April 1, 2023, and ending December 31, 2023, must continue to meet the condition in section 6008(b)(4) of the FFCRA, under which the state must provide coverage, without cost sharing, for any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies.[14] This condition was not changed by section 5131. However, it is important to note

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[12] See previous guidance regarding redetermination requirements prior to resumption of Medicaid premiums, including individualized notice requirements and when a state must obtain updated income information before reinstatement, at Q24-25 of: CMS. (2022). *COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies*. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf.

[13] CMS. (March 3, 2022). *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* [State Health Official Letter #22-001]. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[14] For information regarding implementation of this condition, see previous guidance at FAQ #II.B.2, 4,14-15 of: CMS. (2021). *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*. Available at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf. See also the discussions of section 6008(b)(4) of the FFCRA in the interim final rule with request for comments entitled "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," 85 FR 71142, 71148-50 (Nov. 6, 2020) (available at: https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency), and in CMS. (2022). *Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program.* Available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf.

that section 9811 of the American Rescue Plan Act of 2021 (ARP) (P.L. 117-2) amended various provisions of the Act to require states to provide coverage, without cost sharing, of: COVID-19 vaccinations; COVID-19 testing; treatments for COVID-19, including specialized equipment and therapies (including preventive therapies); and, when certain conditions are met, treatment of conditions that may seriously complicate the treatment of COVID-19. These requirements under section 9811 of the ARP remain in place until the last day of the first calendar quarter that begins one year after the last day of the COVID-19 PHE. The requirements under section 9811 of the ARP generally overlap with, are in many circumstances broader than, and will extend longer than the coverage and cost-sharing condition under section 6008(b)(4) of the FFCRA, and they apply even if the state is not claiming the FFCRA temporary FMAP increase. CMS therefore expects the CAA, 2023's amended sunset date for section 6008(b)(4) of the FFCRA will not have much practical impact on states' coverage of these services without cost sharing. For additional information, see the June 3, 2021, CIB,[15] SHO #21-003,[16] SHO #21-006,[17] SHO #22-002,[18] and the CMCS COVID-19 Vaccine Toolkit.[19]

Overview of New Conditions for Receipt of the Temporary FMAP Increase in Effect April 1, 2023, through December 31, 2023

Section 5131 added a new subsection (f) to section 6008 of the FFCRA. States claiming the temporary FMAP increase for quarter 2, 3, and/or 4 of CY 2023 must satisfy the conditions under sections 6008(b)(1), 6008(b)(2), and 6008(b)(4), as described above, in addition to the following new conditions under section 6008(f) of the FFCRA:

- Conduct Medicaid eligibility redeterminations in accordance with all applicable federal requirements, including renewal strategies authorized under section 1902(e)(14)(A) of the Act or other alternative processes and procedures approved by CMS (section 6008(f)(2)(A));
- Attempt to ensure that they have up-to-date contact information for a beneficiary before redetermining eligibility for such beneficiary (section 6008(f)(2)(B)); and
- Undertake a good-faith effort to contact an individual using more than one modality prior to terminating their enrollment on the basis of returned mail (section 6008(f)(2)(C)).

These new conditions apply to Medicaid renewals that are conducted during any quarter during the period beginning April 1, 2023, and ending December 31, 2023, in states claiming the temporary FMAP increase for that quarter. In addition to being a condition of receiving the

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[15] CMS. (June 3, 2021). *Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Related Provisions in the American Rescue Plan Act of 2021* [CMCS Informational Bulletin]. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib060321.pdf

[16] CMS. (August 30, 2021). *Medicaid and CHIP Coverage and Reimbursement of COVID-19 Testing under the American Rescue Plan Act of 2021 and Medicaid Coverage of Habilitation Services* [State Health Official Letter #21-003]. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-003.pdf

[17] CMS. (October 22, 2021). *Mandatory Medicaid and CHIP Coverage of COVID-19-Related Treatment under the American Rescue Plan Act of 2021* [State Health Official Letter #21-006]. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho102221.pdf.

[18] CMS. (May 12, 2022). *Medicaid and CHIP Coverage of Stand-alone Vaccine Counseling* [State Health Official Letter #22-002]. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho22002.pdf.

[19] CMS. (2022). *Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program*. Available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf.

temporary FMAP increase beginning April 1, 2023, implementation of these conditions will help states minimize procedural denials and reduce the administrative burden associated with churn. These new conditions and how states may comply with them are described in detail below.

We understand that states may be concerned about whether their plan to comply with one or more conditions for receiving the temporary FMAP increase beginning April 1, 2023, is sufficient. CMS is available to work with states to evaluate the sufficiency of their plans and identify additional measures that states can consider to ensure satisfaction of all conditions.

Compliance with Federal Renewal Requirements

As indicated above, in order to claim the temporary FMAP increase after March 31, 2023, under section 6008(f)(2)(A) of the FFCRA, states must conduct Medicaid redeterminations consistent with federal requirements, including any renewal strategy approved under section 1902(e)(14)(A) of the Act or other CMS-authorized processes and procedures.

Federal requirements related to redeterminations of eligibility are described at 42 CFR § 435.916. Under federal regulations at § 435.916, states must comply with the following requirements:

- *Ex Parte* Renewals: Begin the renewal process for all beneficiaries, including both those whose financial eligibility is based on modified adjusted gross income (MAGI) ("MAGI-based beneficiaries") and those whose financial eligibility is not based on MAGI ("non-MAGI beneficiaries"), by redetermining eligibility without requiring information from the individual, if the state is able to do so based on reliable information contained in the individual's account or more current reliable information available to the state. This information may include, but is not limited to, information accessed through data sources, consistent with the state's verification plan;
- Renewal Form: Provide a renewal form that requests only information needed to determine eligibility[20] when eligibility cannot be renewed on an *ex parte* basis. This form must be pre-populated for MAGI-based beneficiaries;
- Reasonable Timeframe and Modalities to Return Form: Provide MAGI-based beneficiaries with a minimum of 30 days to return their pre-populated renewal form and any requested information. Provide non-MAGI beneficiaries with a reasonable period of time to do so. Beneficiaries must be able to return their renewal form through any of the modes of submission described at § 435.907(a) (online, by phone, by mail, or in-person);
- Determine Eligibility on All Bases: Consider all bases of Medicaid eligibility prior to determining an individual is ineligible for Medicaid and terminating coverage;[21]
- Advance Notice and Fair Hearing Rights: Provide a minimum of 10 days' advance notice[22] and fair-hearing rights prior to terminating or reducing Medicaid eligibility, in

[20] For example, a form that requests that a beneficiary provides their Social Security Number, citizenship or immigration status would not satisfy the requirement. Such information is only needed once and, thus, would not be needed to renew eligibility.

[21] 42 CFR §§ 435.916(f)(1) and 435.930(b).

[22] 42 CFR § 431.211 requires the state to send a notice at least 10 days before the date of action, which is defined at § 431.201 as "the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective."

accordance with § 435.917 and 42 CFR Part 431, Subpart E;

- Assess Eligibility for Other Insurance Affordability Programs (IAPs) and Transfer Accounts as Appropriate: For individuals determined ineligible for Medicaid, assess eligibility for other IAPs (including CHIP, BHP, and qualified health plans (QHPs) offered through a Health Insurance Marketplace®[23] with advance payments of premium tax credits or cost-sharing reductions), and transfer the individual's account to the appropriate program. States with Marketplaces that use the federal eligibility and enrollment platform are reminded that they should only transfer accounts to the Marketplace for individuals about whom the state has sufficient information to determine Medicaid and CHIP ineligibility. States with Marketplaces that use the federal eligibility and enrollment platform should not transfer accounts to the Marketplace for individuals whose Medicaid or CHIP coverage is terminated for procedural reasons, such as failure to return a renewal form or other requested information needed to determine eligibility.[24] States that operate State-based Marketplaces using their own platform may, at state option, transfer accounts to the Marketplace for a determination of advance payments of premium tax credits or cost-sharing reductions for individuals whose coverage has been terminated from Medicaid or CHIP for procedural reasons; and
- Reconsideration Period: Reconsider eligibility without requiring a new application for MAGI-based beneficiaries whose coverage is terminated for failure to return their renewal forms or necessary information if the individual's renewal form or information is returned within 90 days (or longer if elected by the state) after coverage is terminated. States may, at their option, apply this policy to non-MAGI beneficiaries.

In evaluating compliance with § 435.916, states are directed to the CIB, *Medicaid and Children's Health Insurance Program Renewal Requirements*,[25] released on December 4, 2020, for more information on federal redetermination requirements.

States that are unable to comply with one or more of the requirements in § 435.916 may satisfy the condition in section 6008(f)(2)(A) of the FFCRA, as added by section 5131(a), by implementing renewal strategies authorized under section 1902(e)(14)(A) of the Act or other alternative policies and procedures that CMS authorizes and approves as sufficient for purposes of satisfying section 6008(f)(2)(A) and claiming the temporary FMAP increase. Depending on the state's systems and processes, states that are unable to comply with all requirements set forth in § 435.916 may need to adopt multiple alternative strategies in order to claim the temporary FMAP increase after March 31, 2023. States can refer to SHO #22-001[26] or the section

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[23] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.
[24] CMS. (July 25, 2016). *Coordination of Eligibility and Enrollment Between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace")* [CMCS Informational Bulletin]. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf.
[25] CMS. (December 4, 2020). *Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements* [CMCS Informational Bulletin]. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.
[26] CMS. (March 3, 2022). *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* [State Health Official Letter #22-001]. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

1902(e)(14)(A) waivers portion of the CMS unwinding website[27] for details on section 1902(e)(14)(A) alternative renewal strategies that CMS can authorize and how to submit a request for such authorization to CMS. States may also reach out to their CMS state lead for more information and to obtain technical assistance. CMS is available to work with states that are unsure of whether they meet a given regulatory renewal requirement and to provide technical assistance on section 1902(e)(14)(A) waivers or other CMS authorized alternative processes that may be implemented to satisfy section 6008(f)(2)(A) of the FFCRA for purposes of claiming the temporary FMAP increase after March 31, 2023.

We remind states that, regardless of whether a state is claiming the temporary FMAP increase, all states must comply with federal renewal requirements. States that do not meet federal renewal requirements may be subject to corrective action under section 1904 and, if the noncompliance occurs during the period that begins on April 1, 2023, and ends on June 30, 2024, may be subject to corrective action under section 1902(tt)(2)(B) of the Act (added by section 5131). See discussion in the **Monitoring State Progress and Corrective Action** section of this letter for additional information on corrective action under section 1902(tt)(2)(B) of the Act.

Up-to-Date Contact Information

As a condition of claiming the temporary FMAP increase after March 31, 2023, under section 6008(f)(2)(B) of the FFCRA, as added by section 5131(a), a state must attempt to ensure that it has up-to-date contact information for each individual for whom it conducts a renewal.[28] This condition requires that states use the United States Postal Service (USPS) National Change of Address (NCOA) database, information maintained by state health and human services agencies, or other reliable sources of contact information. For purposes of compliance with this condition, the types of contact information a state must attempt to update include a beneficiary's mailing address, phone number, and email address. States may need to use multiple data sources and/or adopt multiple strategies in order to update all types of beneficiary contact information.

The NCOA database information is limited to mailing address information and does not provide email addresses or phone numbers. Additionally, for some beneficiaries, the NCOA database will not provide up-to-date mailing address information, and other state agency databases may not have such contact information either. Therefore, to satisfy this condition, states will need to take other reasonable actions in an effort to obtain up-to-date information. Managed care organizations (MCOs) are a particularly effective source of reliable contact information for beneficiaries, and CMS strongly encourages states that contract with MCOs to work with them to obtain up-to-date contact information. States could also look to beneficiaries themselves as a reliable source of contact information and use beneficiary outreach initiatives encouraging beneficiaries to update their contact information.

Implementing a robust plan to obtain up-to-date contact information for multiple modes of communication will also assist states in meeting the returned-mail condition under section

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[27] CMS. (2022). *COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals*. Available at https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html.

[28] As noted above, the conditions in section 6008(f) of the FFCRA apply to Medicaid renewals that are conducted during any quarter during the period beginning April 1, 2023, and ending December 31, 2023, in states claiming the temporary FMAP increase for that quarter.

6008(f)(2)(C) of the FFCRA, described below, under which states must make a good-faith effort to contact an individual through more than one modality prior to terminating coverage on the basis of returned mail.

In order to comply with the up-to-date contact information condition, states should consider the following:

- Sources of Up-to-Date Contact Information: States must use the NCOA database, information maintained by a state health and human services agency, or other reliable sources of contact information. States have broad discretion to determine which other sources of contact information are reliable for the purposes of this provision but must document the sources and other processes used in their unwinding operational plan. For example, many states have implemented beneficiary outreach strategies using direct phone calls, mass mailings, social media, or other mass communication strategies to prompt beneficiaries to provide up-to-date information themselves. Contact information received directly from beneficiaries in response to an outreach campaign could reasonably be considered reliable. States have also worked with other entities to obtain up-to-date beneficiary contact information, in addition to accessing the NCOA. Updated contact information received from an MCO under contract with the state, for example, is generally considered to be a reliable source of information. Further, states can request section 1902(e)(14)(A) waiver authority to update an individual's case record with up-to-date contact information from one of its MCOs without first having to confirm the change with the individual.
- Attempt to Ensure Up-To-Date Contact Information: States must attempt to ensure they have up-to-date contact information for each individual for whom they will conduct an eligibility redetermination. We interpret this condition to mean that a state must implement a comprehensive plan for confirming that they have up-to-date information on beneficiaries before their eligibility is redetermined, including a plan that uses reliable data sources and adopts other reasonable strategies that apply broadly to the state's Medicaid population (e.g., routinely obtaining updated contact information from managed care organizations or broad outreach campaigns).
- Timing of Attempt to Ensure Up-to-Date Contact Information: States must have recent and reliable information, or have recently attempted to obtain up-to-date contact information as described immediately above, prior to initiating a renewal for an individual to minimize the possibility that the information in the case record has become outdated. For example, CMS would consider quarterly data matches with NCOA or adoption of the section 1902(e)(14)(A) strategy involving MCOs providing updated contact information about a beneficiary whenever they obtain it, to be a recent attempt.
- Document Strategies to Update Contact Information in Unwinding Operational Plan: States must document in their unwinding operational plan the strategies and processes for obtaining up-to-date contact information for beneficiaries in order to demonstrate compliance with the condition for claiming the temporary FMAP increase described in section 6008(f)(2)(B) of the FFCRA.

In implementing policies and procedures to satisfy this condition, states may want to review pages 36-40 of SHO #22-001,[29] in which CMS discusses several strategies for states to reestablish communication with beneficiaries, such as working with MCOs, social services organizations, and other entities. States are strongly encouraged to implement several strategies to ensure an attempt is made to obtain up-to-date contact information for all beneficiaries, including strategies that target hard-to-reach, homeless, rural, or Tribal populations for whom many strategies may be less effective. For instance, due to limited postal delivery and broadband services in Tribal communities, we encourage states to engage with the Indian Health Service (IHS), Tribes and Tribal organizations, and urban Indian organizations (collectively, ITU) to help with updated contact information for Tribal Medicaid beneficiaries, including sharing enrollment and renewal data with ITUs. We remind states that such data sharing must be consistent with Medicaid confidentiality standards under section 1902(a)(7)(A) of the Act and 42 CFR part 431, subpart F, and applicable privacy laws.[30]

Further, we remind states that if they have received approval under a section 1902(e)(14)(A) waiver related to updating beneficiary contact information,[31] there may be several sources of up-to-date contact information they can rely on without first confirming a change with beneficiaries. The waiver(s) could make it easier for the state to ensure that it has up-to-date beneficiary contact information and complies with this condition. We encourage states that do not currently have such an approved waiver to consider submitting a request to CMS for approval.[32]

Contact Beneficiaries Using More Than One Modality Prior to Terminating Enrollment on the Basis of Returned Mail

In order to claim the FFCRA temporary FMAP increase after March 31, 2023, states must comply with section 6008(f)(2)(C) of the FFCRA, as added by section 5131(a), which provides that when states receive returned mail in response to a redetermination of eligibility, they must undertake a good-faith effort to contact an individual using more than one modality prior to disenrollment on the basis of returned mail ("returned-mail condition").

Nothing in the CAA, 2023 changes federal Medicaid rules regarding the steps that states are required to take upon receipt of returned mail. These rules apply regardless of whether a state is conducting redeterminations during its unwinding period. We remind states that there are

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[29] CMS. (March 3, 2022). *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* [State Health Official Letter #22-001]. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[30] See "Presentation: Strengthening Tribal and State Partnerships to Prepare for Unwinding" (Posted 8/30/2022) Available at https://www.medicaid.gov/sites/default/files/2022-08/strengthening-tribal-partner-to-prepare-unwinding-081822.pdf.

[31] See the COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals page for more information on these strategies at https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html.

[32] To request authority to implement one or more of these strategies, states can request such waiver authority under section 1902(e)(14)(A) of the Act on a time-limited basis during the unwinding period. CMS is available to provide technical assistance and can provide sample language the state can use to craft a letter requesting the waiver authority. States interested in one or more of the temporary waiver authorities described above should contact their CMS State Lead.

generally three types of beneficiary mail that could be returned to the Medicaid agency: (1) mail with an in-state forwarding address; (2) mail with an out-of-state forwarding address; and (3) mail that does not include a forwarding address. States must continue to follow existing requirements for processing each of these types of returned mail including confirming whether the address information on the piece of returned mail is complete and consistent with the address information the state has on file.[33]

The new returned-mail condition under section 6008(f)(2)(C) of the FFCRA applies specifically to situations in which the state sends a notice to a beneficiary, instructing them to return a renewal form. For the purposes of meeting this returned mail condition, we define a good faith effort to contact an individual using more than one modality to mean: (1) the state has a process in place to obtain up-to-date mailing addresses and additional contact information (i.e., telephone numbers, email addresses) for all beneficiaries; and (2) the state attempts to reach an individual whose mail is returned through at least two modalities using the most up-to-date contact information the state has for the individual, which could include a forwarding address if one is provided on the returned mail.

States also should consider the following:

- Up-to-Date Contact Information: The requirement to obtain up-to-date contact information for purposes of complying with the returned mail condition will be satisfied if the state has met the condition described in section 6008(f)(2)(B) of the FFCRA to attempt to obtain an up-to-date mailing address, phone number, and email address for all beneficiaries due for a renewal. In addition to the data sources described in section 6008(f)(2)(B) of the FFCRA, MCOs are a particularly effective source of reliable contact information for beneficiaries, and CMS strongly encourages states that contract with MCOs to work with them to obtain up-to-date contact information.
- Permissible Modalities: States have discretion in the types of modalities they rely upon to satisfy the returned mail condition. Such modalities may include mail, telephone, email, text messaging, communication through an online portal, or other commonly available electronic means.[34]

The returned-mail condition under section 6008(f)(2)(C) of the FFCRA applies whenever beneficiary mail is returned to the state agency in response to a redetermination of eligibility, thus prompting states to process the returned mail and requiring states to make a good faith effort to attempt to contact the beneficiary using more than one modality. States should follow these steps to meet the returned mail condition of attempting to make a good faith effort to contact the beneficiary through two modalities.

- Returned Mail has Complete Information: Generally, when beneficiary mail is returned, states must ensure that the mail was sent to the intended address by comparing the

[33] For a detailed discussion on the requirements for processing returned mail, see Appendix C of: CMS. (March 2022). *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* [State Health Official Letter #22-001]. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[34] Phone calls and text messages, initiated either directly by the state agency or through a state contractor or partner, must be compliant with Federal communications laws such as the Telephone Consumer Protection Act. For more information, see: https://www.fcc.gov/document/fcc-provides-guidance-enable-critical-health-care-coverage-calls.

completeness and accuracy of the address on the returned mail against the information in the beneficiary's record. If the address listed on the original mailing contains an error or is missing information, such as an apartment number, the state must resend the returned notice to a completed address. If the subsequent mailing to the beneficiary's correct address is not returned, the state is no longer required to take additional steps to meet the returned mail condition by attempting to contact the beneficiary using an additional modality. If the subsequent mailing to a corrected address is returned, the state would proceed as indicated below based on whether the returned mail has a forwarding address or not.

- Returned Mail with No Forwarding Address: When a state receives returned mail with no forwarding address, it must attempt to contact the beneficiary through two modalities, including by phone, email, text, or other available modalities. If the state only has one other mode of contact available, such as only an email address, the state must attempt to contact the beneficiary using that one modality; in this instance, the state will be compliant with the returned mail condition provided that it has complied with the up-to-date contact information condition. Similarly, if the state has no other modalities available to contact the beneficiary, the state similarly will be compliant with the returned mail condition if it has satisfied the up-to-date contact information condition.
- Returned Mail with a Forwarding Address:
    - States are not required to send the returned mail to the forwarding address, but doing so would represent one attempt to contact the beneficiary for purposes of the returned mail condition.
    - If the beneficiary's returned mail contains a forwarding address, and the state sends the original mailing to the forwarding address,[35] except as noted below, the state would need to attempt to contact the beneficiary through at least one other modality, if available, to comply with the returned mail condition. If the state has no other modalities available to contact the beneficiary, the state will be compliant with the returned mail condition if it has satisfied the condition to obtain up-to-date contact information from all beneficiaries. Importantly, if the notice is mailed to the forwarding address and is not returned to the state, the returned mail condition no longer applies because the original mailing has been completed and is no longer considered to be returned. Under these circumstances, no additional outreach is required.
    - If a state is unable to or does not send the correspondence to the forwarding address, the state must attempt to contact the beneficiary through two modalities, if available, prior to termination. If the state only has one other mode of contact available, such as only an email address, the state must make a good faith effort to contact the beneficiary using that one modality. If the state does not send the notice to the forwarding address and does not have two other modes of contact, the state will need to document in their unwinding operational plan why it is unable to send notices to a forwarding address.
- Lack of Alternative Contact Information: A state that has satisfied the condition described in section 6008(f)(2)(B) of the FFCRA to attempt to obtain up-to-date contact information for other modalities but was not able to obtain such alternative contact

[35] States may request section 1902(e)(14)(A) waiver authority to update a beneficiary's address information from the USPS without first reaching out to confirm the change with the individual.

information for a given beneficiary will not violate the returned mail condition due to not reaching out to the beneficiary through another modality as long as the state has taken the steps outlined above to reach the individual by mail (i.e., resending the notice to a corrected address, if applicable, and sending the notice to a forwarding address, if provided and the state is able to do so). For example, if after complying with the condition described in section 6008(f)(2)(B), the only contact information available to the state is the address in the individual's case record, and the state does not have a phone number, email address or other means to contact the individual, the state would be in compliance with section 6008(f)(2)(C). If a state has documented in its unwinding operational plan why it is unable to mail a notice to a forwarding address and has no other modalities available, the state has complied with the returned mail condition.

- Document Returned Mail Policies in Unwinding Operational Plan: States must document in their unwinding operational plans their process for undertaking a good-faith effort to contact individuals using more than one modality prior to disenrollment on the basis of returned mail. States must also document their inability to send mail to a forwarding address, if applicable.

Attempting to reach beneficiaries through other modalities after beneficiary mail is returned in response to a redetermination of eligibility is necessary to satisfy the returned mail condition, and it may also help reduce procedural denials and churn. In addition, MCOs are an important tool for conducting outreach to individuals when a state is not able to reach a beneficiary. CMS strongly encourages states that contract with MCOs to work with them on other avenues to reach and support eligible beneficiaries in maintaining coverage through Medicaid or the Marketplace.[36] To ensure beneficiaries are able to complete the renewal process, states should ensure that, if they successfully contact an individual after receiving beneficiary returned mail, the beneficiary receives any necessary renewal forms at their correct address and has sufficient time to return the renewal form and complete the renewal process.

Additional Considerations and Process for Claiming the Temporary FMAP Increase

State Attestation of Compliance

As discussed above, states may claim federal financial participation (FFP) associated with the temporary FMAP increase under section 6008 of the FFCRA, as amended by section 5131(a), after March 31, 2023, only if they meet the conditions described in subsections 6008(b)(1), (2), (4), and 6008(f). While states are ineligible for the temporary FMAP increase unless they meet these conditions, CMS will not require that states submit a demonstration of compliance prior to drawing FFP associated with the temporary FMAP increase. Each state should be aware that when it draws FFP associated with the temporary FMAP increase in the Payment Management System (PMS), it is attesting that:

(1) It is eligible for the temporary FMAP increase;
(2) The expenditures for which it is drawing FFP are those for which the temporary FMAP increase is applicable; and

[36] For a detailed discussion on engaging managed care plans, see: CMS. (January 2023). *Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations*. Available at: https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf.

(3) It meets the applicable conditions in section 6008(b) and (f) of the FFCRA for claiming the temporary FMAP increase.

To minimize the need for separate review, avoid state burden, and expedite providing federal matching funds to states, CMS will indicate in each grant award letter it sends to states that, by drawing down the funds, the state is attesting that it is in compliance with all federal requirements, including that the state meets all applicable conditions for receiving the temporary FMAP increase, subject to expenditure review. This is the same process states have been using to draw FFP associated with the temporary FMAP increase under FFCRA section 6008 since the temporary FMAP increase became available.

Further, CMS intends to engage states to provide technical assistance regarding compliance and, as necessary, will request additional information to assess compliance. States may propose additional strategies and mitigation plans to achieve compliance with section 6008(f)(2) of the FFCRA for purposes of claiming the temporary FMAP increase. For example, we understand that many states face challenges in conducting *ex parte* renewals for some or all of their populations. These states can adopt alternative strategies, such as section 1902(e)(14)(A) waiver strategies, including using the Supplemental Nutrition Assistance Program (SNAP)-based income enrollment strategy, in order to satisfy the conditions described in section 6008(f)(2) of the FFCRA. As noted above, states can refer to SHO #22-001 or the section 1902(e)(14)(A) waivers portion of the CMS unwinding website for details on section 1902(e)(14)(A) alternative renewal strategies that CMS can authorize and how to submit a request for such authorization to CMS.

CMS is also considering additional strategies to support states seeking to adopt alternative CMS-approved strategies to satisfy the conditions in section 6008(f)(2) of the FFCRA needed to claim the temporary FMAP increase between April 1, 2023, and December 31, 2023. States interested in using any alternative strategies should contact their CMS state lead.

If CMS determines that a state that drew down FFP associated with the temporary FMAP increase did not satisfy the conditions under section 6008(b) and (f) of the FFCRA, as modified by section 5131, during a quarter in which those conditions applied, the state will be required to return the FFP associated with the temporary FMAP increase for any quarter when it did not qualify.

Process for Claiming FFP Associated with the Temporary FMAP Increase

Qualifying states can claim the FFP associated with the temporary FMAP increase for qualifying expenditures on a quarterly basis using the Form CMS-64 submission in the automated Medicaid Budget and Expenditure System (MBES).[37] States should ensure that their quarterly and, if applicable, supplemental budget request on the Form CMS-37 for the relevant period clearly indicates whether the state is requesting FFP associated with the temporary FMAP increase and the amount of FFP. CMS will ensure that the MBES and Medicaid and CHIP Financial System

[37] In addition to the attestation outlined above within the grant award, states certify on the Form CMS-64 that they are claiming expenditures under the Medicaid program (and as applicable, under CHIP) only if the expenditures are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan.

(MACFin) are updated to enable state reporting, as applicable.

Beginning April 1, 2023, the temporary FMAP increase is available for each quarter's qualifying medical assistance expenditures until (and including) December 31, 2023, for states that have met conditions in section 6008(b) and the new section 6008(f) of the FFCRA (discussed above). States should follow existing federal policy regarding the particular match rates that are available for a given quarter. Per 45 CFR § 95.13(b), the applicable FMAP is based on date of payment, not date of service, for current quarter original expenditures. The FMAP applicable to expenditures for all prior period adjustments should be the FMAP at which the original expenditure was claimed, consistent with 45 CFR § 95.13(b). States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including when the original rate incorporated the FFCRA FMAP increase. Therefore, if a Medicaid expenditure was claimed using the FFCRA FMAP increase, the returned federal share of any recoveries associated with that expenditure would reflect that same FMAP increase. Consistent with existing requirements at 42 CFR § 433.32(a), states must document expenditures to ensure a clear audit trail, including by isolating expenditures that are matched at increased FMAPs. CMS will conduct oversight to ensure that state expenditures are allowable and accurate, including with respect to the matching rate claimed.

Please note that under the timely claims filing requirement at section 1132 of the Act and 45 CFR part 95 subpart A, states must claim federal Medicaid matching funds for qualifying expenditures within the two-year time limit unless they meet one of the four exceptions (see 45 CFR § 95.19).

Reporting Requirements

States regularly provide a variety of data about Medicaid and CHIP applications, enrollment, and call-center activity through the submission of the Medicaid and CHIP Eligibility and Enrollment Performance Indicator data and the Transformed Medicaid Statistical Information System (T-MSIS) data, as well as other reporting mechanisms. SHO #22-001 announced that states would be required to submit additional data through a new reporting tool as they restore routine eligibility and enrollment operations, including resuming renewals, after the Medicaid continuous enrollment condition ends. In March 2022, CMS released a new Unwinding Eligibility and Enrollment Data Reporting Template ("Unwinding Data Report")[38] that states will use to submit a baseline data report and ongoing monthly reports during a state's unwinding period.[39] States that operate a State-based Marketplace (SBM) with its own eligibility and enrollment platform also submit QHP and BHP enrollment metrics ("State-based Marketplace (SBM) Priority Metrics") to CMS, as required under 45 CFR 155.1200(a)(3). CMS anticipates

[38] The Unwinding Data Report and Unwinding Data Report Specifications are available at www.Medicaid.gov/unwinding. States will submit their baseline and monthly Unwinding Data Reports through the same portal used to submit Performance Indicator data, which is available at https://sdis.medicaid.gov/user/login.

[39] For an explanation that states must submit baseline unwinding data by February 8, 2023, March 8, 2023, or April 8, 2023, depending on when a state initiates renewals, see: CMS. (2023). *Key Dates Related to Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023* [CMCS Informational Bulletin]. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf.

that SBMs with their own eligibility and enrollment platforms will use these existing reports to submit monthly data during a state's unwinding period.

New section 1902(tt)(1) of the Act, as added by section 5131(b), requires that, during the period that begins on April 1, 2023, and ends on June 30, 2024, states submit to CMS, and CMS makes public, certain monthly data about activities related to eligibility determinations and redeterminations conducted during that same period. CMS currently believes that all the data states must report under these new reporting requirements are included in existing data sources, including the unwinding data report and SBM priority metrics. As such, CMS does not anticipate that states will need to submit a separate report (or additional reporting) to CMS to comply with section 1902(tt)(1) of the Act. Rather, CMS anticipates that states will be able to submit the data metrics required under section 1902(tt)(1) through the appropriate existing CMS data reporting tool. CMS reserves the right to add reporting metrics, if needed, in the future. As needed, CMS will provide states additional guidance and information on the data specifications for metrics reported to satisfy the reporting requirements under section 1902(tt)(1) of the Act.

While CMS currently believes that states can meet the reporting requirements in section 1902(tt)(1) of the Act through existing reports and reporting tools, the timing of certain state reporting may need to change to satisfy the timeline under section 1902(tt)(1) of the Act. Specifically, states will need to submit monthly unwinding data reports through June 30, 2024. This timeline reflects a change from previous guidance regarding unwinding data, as some states may submit monthly unwinding data for a period that exceeds 14 months, depending on when the state initiates its first batch of renewals.[40]

As noted, with regard to the reporting of data under section 1902(tt)(1)(D), CMS anticipates that states with Marketplaces that operate their own eligibility and enrollment platform will use existing reports to satisfy this requirement. Additionally, for states with Marketplaces that use the Federal eligibility and enrollment platform, CMS expects to report the required data on behalf of states, to the extent possible. CMS therefore does not anticipate that states with Marketplaces that use the Federal eligibility and enrollment platform will need to report any additional data to satisfy this requirement.

CMS will publish all data that is reported to comply with section 1902(tt)(1) of the Act. However, for a number of reasons, Medicaid and CHIP data sent to Marketplaces that use the Federal eligibility and enrollment platform[41] do not, on their own, specify when an individual's account has been transferred to the Marketplace because that person is not eligible for, or is losing, Medicaid or CHIP coverage. CMS intends to explore using additional data sources to determine and report which account transfers to Marketplaces that use the Federal eligibility and enrollment platform result from Medicaid or CHIP redeterminations. To publish data that identifies which of these account transfers result from Medicaid or CHIP redeterminations, CMS might have to make estimates based on several administrative data sets, which limits both the

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[40] CMS. (March 3, 2022). *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* [State Health Official Letter #22-001]. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[41] All Marketplaces that use the Federal eligibility and enrollment platform have eligibility systems that are not integrated with Medicaid or CHIP.

accuracy and timeliness of public reporting. Working within these constraints, CMS expects to make these account transfer data public as expeditiously as possible.

In Table 2, CMS identifies each reporting element under section 1902(tt)(1) of the Act and the data source that CMS anticipates that states (or the Marketplaces that use the Federal platform) will use to satisfy each element.

Table 2. Reporting Elements Under Section 1902(tt)(1) for the Period from April 1, 2023, through June 30, 2024, and Corresponding Data Sources

	Reporting Element	Data Source
Apply to All States		
1	Total number of Medicaid and CHIP beneficiaries for whom a renewal was initiated	Unwinding Data Report, Monthly Metric 4[42]
2	Total number of Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed	Unwinding Data Report, Monthly Metric 5a
3	Of the Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed, those whose coverage is renewed on an *ex-parte* basis	Unwinding Data Report, Monthly Metric 5a(1)
4	Total number of individuals whose coverage for Medicaid or CHIP was terminated	Unwinding Data Report, Monthly Metric 5b and Unwinding Data Report, Monthly Metric 5c
5	Total number of individuals whose coverage for Medicaid or CHIP was terminated for procedural reasons	Unwinding Data Report, Monthly Metric 5c
6	Total number of beneficiaries who were enrolled in a separate CHIP	T-MSIS, CHIP-CODE[43]
7	For each state call center, total call center volume	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 1[44]
8	For each state call center, average wait times	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 2
9	For each state call center, average abandonment rate	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 3

[42] Unwinding Data Report Specifications are available at: https://www.medicaid.gov/sites/default/files/2022-12/unwinding-data-specifications-dec-2022.pdf.
[43] The T-MSIS Data Dictionary is available at: https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/t-msis-data-dictionary/index.html.
[44] The Performance Indicator Data Dictionary is available on the Performance Indicator Technical Assistance page at: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/performance-indicator-technical-assistance/index.html.

	Reporting Element	Data Source
Apply to Marketplaces that use the Federal eligibility and enrollment platform (Non-Integrated Eligibility System)		
10	Total number of individuals whose accounts are received at the Marketplace from the state Medicaid/CHIP agency due to a Medicaid/CHIP redetermination	Marketplaces that use the Federal eligibility and enrollment platform (Federally-facilitated Marketplaces and State-based Marketplaces on the Federal platform); states do not need to report
11	In the accounts received at the Marketplace due to a Medicaid/CHIP redetermination, the number of individuals who apply for and are determined eligible for a QHP	Marketplaces that use the Federal eligibility and enrollment platform (Federally-facilitated Marketplaces and State-based Marketplaces on the Federal platform); states do not need to report
12	In the accounts received at the Marketplace due to a Medicaid/CHIP redetermination and who apply for and are determined eligible for a QHP, the number of individuals who select a plan	Marketplaces that use the Federal eligibility and enrollment platform (Federally-facilitated Marketplaces and State-based Marketplaces on the Federal platform); states do not need to report
Apply to SBMs with their own platforms that use a Non-Integrated Eligibility System		
13	Number of individuals whose accounts are received by the SBM or BHP	SBM Priority Metrics, Monthly Metrics 7a and 7b
14	Number of individuals whose accounts are received by the SBM or BHP and are determined eligible for a QHP or BHP	SBM Priority Metrics, Monthly Metric 9a and 172a
15	Number of individuals whose accounts are received by the SBM or BHP and are determined eligible for a QHP or a BHP who make a QHP plan selection or are enrolled in a BHP	SBM Priority Metrics, Monthly Metric 1a and 169a
Apply to SBMs with Integrated Eligibility System		
16	Number of individuals who are determined eligible for a QHP or a BHP	SBM Priority Metrics, Monthly Metric 9a and 172a
17	SBMs with Integrated Eligibility System: Number of individuals who are determined eligible for a QHP or BHP and make a QHP plan selection or are enrolled in a BHP	SBM Priority Metrics, Monthly Metric 1a and 169a

As noted in SHO #22-001, states may be expected to report additional data and/or report information more frequently in cases where additional CMS oversight or enforcement is needed, such as when reported data indicate states are not meeting the timelines to initiate and complete

renewals for total caseload during the unwinding period. CMS is available to provide technical assistance to ensure states understand metric data specifications and are able to fulfill statutory reporting requirements.

Monitoring State Progress and Corrective Action

In SHO #22-001, CMS announced that it will monitor states' compliance with reporting required data and meeting timelines relating to initiating and completing required eligibility and enrollment actions during the state's unwinding period. Where reported data or other information indicates that states are not meeting unwinding timelines in SHO #22-001 and subsequent guidance, or in circumstances where data or other information demonstrate other potential compliance issues – including potential erroneous disenrollment of eligible beneficiaries – states may be expected to report additional data, including the state's unwinding operational plan, and/or report information more frequently.[45] As explained in SHO #22-001, states that do not resolve their pending eligibility and enrollment actions within the timelines specified may be required to submit a corrective action plan (CAP) to CMS outlining strategies and a timeline to come into compliance with federal requirements.

In addition to enforcement and oversight authorities CMS already has under existing laws and regulations, section 1902(tt)(2) of the Act (added by section 5131(b)) includes new enforcement mechanisms for CMS to apply if CMS determines that a state is not in compliance with the reporting requirements in section 1902(tt)(1) of the Act, or if CMS determines that a state is non-compliant with federal eligibility redetermination requirements during the period that begins on April 1, 2023 and ends on June 30, 2024. Specifically:

- FMAP Reduction for Failure to Comply with Section 1902(tt)(1) Reporting Requirements: If a state does not satisfy the reporting requirements in section 1902(tt)(1) of the Act during any fiscal quarter that occurs during the period that begins on July 1, 2023, and ends on June 30, 2024, the FMAP determined for the state for the quarter under section 1905(b) shall be reduced by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the state has failed to satisfy such requirements. CMS will apply FMAP reductions using MBES and intends to provide more information in future guidance regarding the FMAP reduction process.
- Corrective Action for Failure to Comply with Section 1902(tt)(1) Reporting Requirements or Federal Eligibility Redetermination Requirements: If a state has been determined by CMS to be out of compliance with the reporting requirements in section 1902(tt)(1) and/or federal eligibility redetermination requirements during the period that begins on April 1, 2023, and ends on June 30, 2024, CMS may require the state to submit and implement a CAP. Under section 1902(tt)(2)(B) of the Act, not later than 14 days

[45] For explanation that unwinding operational plans must be made available to CMS upon request, see both: CMS. (December 22, 2020). *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* [State Health Official Letter #20-004], and CMS. (March 3, 2022). *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* [State Health Official Letter #22-001]. These guidance documents are available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf and https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

after receiving a written notice that the state is out of compliance, the state must submit a CAP to CMS. The state must receive CMS approval for its proposed CAP not later than 21 days after submitting it to CMS. The state must initiate implementation of the plan not later than 14 days after CMS approves it.

- Suspension of Terminations for Procedural Reasons and Civil Monetary Penalties: If a state fails to submit or implement an approved CAP in accordance with the timelines and requirements described above, CMS may require a state under section 1902(tt)(2) to suspend some or all terminations of Medicaid eligibility that are for procedural reasons until the state takes appropriate corrective action (as determined by CMS), and/or may impose on that state a civil money penalty of not more than $100,000 for each day that the state is not in compliance.

Implications for Optional COVID-19 Group, Waivers Approved Under Section 1902(e)(14)(A) of the Act, and Other Authorities

Even though section 5131 does not address when the COVID-19 PHE will end, the changes in the CAA, 2023 could have implications for certain COVID-19 PHE-related flexibilities and authorities. We outline below certain implications that the changes made by section 5131 may have for state redeterminations for the optional COVID-19 group and for waivers already approved under section 1902(e)(14)(A) of the Act that states intended to have in place when the continuous enrollment condition ends. Certain other COVID-19 PHE related flexibilities can remain in effect for the duration of the COVID-19 PHE, including, but not limited to, Medicaid and CHIP section 1135 waivers and disaster SPAs. As a reminder, the requirements under sections 9811 and 9821 of the ARP apply until the last day of the first calendar quarter that begins one year after the COVID-19 PHE ends. These ARP requirements include providing coverage, without cost sharing, of: COVID-19 vaccinations; COVID-19 testing; treatments for COVID-19, including specialized equipment and therapies (including preventive therapies); and, when certain conditions are met, treatment of conditions that may seriously complicate the treatment of COVID-19. The CAA, 2023 generally does not impact authorities tied to the end of the COVID-19 PHE (e.g., 1135 waivers, disaster relief SPAs).

Optional COVID-19 Group

Section 6004(a)(3) of the FFCRA created a new optional COVID-19 Medicaid eligibility group at section 1902(a)(10)(A)(ii)(XXIII) of the Act. Section 9811(a)(2) of the ARP amended the language following section 1902(a)(10)(G) of the Act describing the coverage that must be provided to the optional COVID-19 eligibility group. Federal authority for this eligibility group expires on the last day of the COVID-19 PHE. States that adopted the optional COVID-19 group may continue to provide coverage to this eligibility group while the COVID-19 PHE is in effect. While federal authority for the optional COVID-19 group was not amended in the CAA, 2023, the changes made by the CAA, 2023 make it possible for the continuous enrollment condition to expire before the end of the COVID-19 PHE, which will have implications for redeterminations of eligibility for beneficiaries enrolled in the optional COVID-19 group.

If the COVID-19 PHE ends after the continuous enrollment condition ends, states that opt to continue covering the optional COVID-19 eligibility group after the continuous enrollment condition ends on March 31, 2023, will need to establish a process to initiate renewals for

individuals enrolled in the group following the end of the continuous enrollment condition. CMS recognizes that states that adopted a streamlined enrollment process outside of their eligibility system to implement the optional COVID-19 group (e.g., using a separate application to facilitate enrollment) may face operational challenges initiating renewals during unwinding and may not have sufficient information to complete a full renewal of eligibility, including assessing all other bases of eligibility. These states may choose to deprioritize redeterminations for this group during the unwinding period while they work to establish such a process. CMS is available to provide technical assistance if needed.

When the COVID-19 PHE ends (or earlier if the state initiates a regular renewal for beneficiaries in the optional COVID-19 group after the state begins its unwinding period and before the end of the COVID-19 PHE), states must redetermine eligibility on all bases for beneficiaries who are enrolled in the optional COVID-19 group and sunset the eligibility group. Guidance to assist states with meeting the requirements to redetermine eligibility on all bases when authority for the group expires can be found in the "Ending Coverage in the Optional COVID-19 Group Preparing States for the End of the Public Health Emergency" slide deck.[46] States are reminded that they must stop claiming FFP for services provided to individuals enrolled in this group once the COVID-19 PHE ends.

CMS will provide states that adopted the optional COVID-19 group with additional guidance on redetermining eligibility for these beneficiaries during the unwinding period if the COVID-19 PHE remains in effect. States that opt to end coverage for this optional eligibility group before the COVID-19 PHE ends may submit a SPA to CMS. See the May 11, 2021, all-state call slides for additional information.[47]

Section 1902(e)(14)(A) Waiver Effective Dates

To support states facing significant operational issues with income and eligibility determination systems and to protect eligible beneficiaries from inappropriate coverage losses during the unwinding period, CMS has granted more than 40 states section 1902(e)(14)(A) waivers to support unwinding efforts. The effective and/or expiration date of many of these approved waivers is linked to the end of the COVID-19 PHE. Given that the CAA, 2023 has de-linked the end of the continuous enrollment condition and the start of the unwinding period from the end of the COVID-19 PHE, the effective dates of section 1902(e)(14)(A) waivers granted for the purpose of assisting states in their unwinding efforts may no longer align with states' unwinding timelines. To minimize administrative burden on states as they begin their unwinding process, CMS is providing the following guidance to allow states to implement modified effective dates, without needing to submit a revised request to CMS. States should, however, document any change in the effective date of a section 1902(e)(14)(A) waiver in their records and maintain a copy of this guidance.

- Approved section 1902(e)(14)(A) waivers with a start date tied to the COVID-19 PHE: Some states elected to make a section 1902(e)(14)(A) waiver effective in the month the

[46] CMS. (October 2022). *Ending Coverage in the Optional COVID-19 Group Preparing States for the End of the Public Health Emergency*. Available at https://www.medicaid.gov/resources-for-states/downloads/ending-covrg-optnl-covid-grp-guidance.pdf.
[47] CMS. (May 11, 2021). *All State Medicaid and CHIP Call*. Available at https://www.medicaid.gov/sites/default/files/2021-05/allstatecall-20210511.pdf.

COVID-19 PHE ends or the month following the end of the COVID-19 PHE. These states can now use the date of the end of the continuous enrollment condition (March 31, 2023) in lieu of the end date of the COVID-19 PHE. For example, if a state received CMS approval to begin a section 1902(e)(14)(A) waiver in the month after the end of the COVID-19 PHE, the state's new start date would be the month after the end of the continuous enrollment provision (i.e., April 1, 2023).

- Approved section 1902(e)(14)(A) waivers with an expiration date tied to the COVID-19 PHE: Some states have section 1902(e)(14)(A) waivers that expire a certain number of months after the COVID-19 PHE ends. These states can now replace the date that the COVID-19 PHE ends with the date that the continuous enrollment conditions ends (March 31, 2023) for purposes of these waivers. For example, if a state's approved section 1902(e)(14)(A) waiver ends 14 months after the month that the COVID-19 PHE ends, the state can elect to change the end date to 14 months after the end of the continuous enrollment condition (i.e., May 31, 2024).
- Approved section 1902(e)(14)(A) waivers with an effective and/or expiration date tied to the state's unwinding period: Some states have waivers that are effective when their state-specific unwinding period begins. Additionally, some states have waivers that end 12 months or longer after the state-specific unwinding period, as defined in SHO #22-001. These dates do not need to be adjusted as a result of the CAA, 2023.

ARP Section 9817 Maintenance of Effort Requirements

Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point FMAP increase for certain Medicaid home and community-based services (HCBS) expenditures provided between April 1, 2021 and March 31, 2022. Under ARP section 9817, states must use the federal funds attributable to the increased FMAP to supplement, not supplant, state funds expended for Medicaid HCBS in effect as of April 1, 2021. As discussed in SMD #21-003[48] and SMD #22-002,[49] states are expected to demonstrate compliance with this requirement by maintaining HCBS eligibility, covered services, and payment rates until the state funds equivalent to the amount of federal funds attributable to the increased FMAP are fully expended.

The CAA, 2023 did not change ARP section 9817, including the conditions related to receiving that FMAP increase. However, as discussed in SMD #21-003, the conditions for the FMAP increase under ARP section 9817 do not supersede other statutory or regulatory requirements that apply to section 1915(c) waivers, or other requirements under other provisions authorizing HCBS. As a result, if states have implemented temporary changes to HCBS eligibility, covered services, and/or payment rates, states are expected to retain those changes for as long as allowable under those authorities (e.g., according to the end date approved under an Appendix K but no later than 6 months after the COVID-19 PHE ends), but CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP once the authority for those

[48] CMS. (May 13, 2021). *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency* [State Medicaid Director Letter #21-003]. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf.
[49] CMS. (June 3, 2022). *Updated Reporting Requirements and Extension of Deadline to Fully Expend State Funds Under American Rescue Plan Act of 2021 Section 9817* [State Medicaid Director Letter #22-002]. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd22002.pdf.

temporary changes has expired or if the state needs to implement changes to comply with other federal statutory or regulatory requirements.

Closing

As states restore routine eligibility and enrollment operations, CMS shares states' goals of ensuring that eligible individuals remain enrolled in Medicaid, CHIP, and/or BHP coverage, and that individuals who are no longer eligible are able to transition seamlessly to other coverage options (if they are eligible for those other coverage options), including Marketplace coverage. We are committed to providing states with updated guidance and resources, as appropriate, as well as ongoing technical assistance, to better enable states to proceed with eligibility and enrollment work in a manner that is consistent with the changes made under the CAA, 2023, as described in this letter. For additional information and resources, states are encouraged to review guidance and other information posted to the Medicaid.gov/Unwinding page. States may also submit technical assistance questions directly to CMSUnwindingSupport@cms.hhs.gov.

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