Centers for Medicare & Medicaid Services

Medicaid and CHIP Continuous Enrollment Unwinding:

What to Know and How to Prepare

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Webinar recording:
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Eden Tesfaye: Thank you for joining. We will give this a couple more minutes while we let folks join and we will get started shortly. Hello and welcome. My name is Eden Tesfaye, and I am an advisor for external affairs in the Office of the Administrator for CMS. Thank you so much for joining us for our monthly stakeholder webinar on the Medicaid and Children's Health Insurance Program, continuous enrollment unwinding. This is a continuation of HHS and CMS monthly series of webinars that began 2022 to keep partner informed and help them prepare for the eventual return to normal operations in Medicaid and CHIP after the end of the continuous enrollment condition. Last month's webinar reviewed what the process looks like for people who may need to transition to the Marketplace if they are no longer eligible for Medicaid. We also reviewed some information about the unwinding Special Enrollment Period available through HealthCare.gov. I wanted to take this time to remind everyone that the Medicaid continuous enrollment condition is no longer linked to the end of the COVID-19 Public Health Emergency. The continuous enrollment condition will now end on March 31st, 2023. Beginning April 1, 2023, states will be able to terminate Medicaid enrollment for individuals no longer eligible.

On February 9th the Department of Health and Human Services announced the Public Health Emergency for COVID-19 will end on May 11, 2023. Again, the ending of the Public Health Emergency, which is May 11, 2023, is separate from the ending of the Medicaid continuous enrollment condition we will be talking about today. Today's webinar will mostly focus on addressing commonly asked questions from partners. First, we will walk through some recently released CMS resources that partners can use in their continuous outreach efforts. Next, we will hear from a variety of CMS experts on questions related to Medicaid renewals, terminations, Medicaid to Marketplace transitions, Medicaid to Medicare transitions, communication and outreach strategies, and more. Lastly, we will wrap up with closing remarks.

Before we get started, I wanted to share couple of housekeeping items. This webinar is recorded. The recording will be available on our CMS national stakeholder calls webpage at www.cms.gov/cms-national-stakeholder-calls, and we will put that link into the chat. Also, while members of the press are welcome to attend the call, all press or media questions should be submitted using our media inquiry form which can be found at www.cms.gov/newsroom/media-inquiries. All participants will be muted. Additionally, close captioning is available via the link shared in the chat by our Zoom moderator. We have selected some previously submitted

questions to address during our extended Q&A but, we encourage you all to use the Q&A function from the menu below to submit any additional questions you have. Questions we do not get to because we ran out of time today will be used to help inform topics covered on future calls. With that, I'd like to turn it to the phenomenal Stefanie Costello, who is the Director of the Partner Relations Group in CMS who we all know here in our Office of Communications to walk through some of our recently released resources and outreach materials. With that, turning it over to you, Stefanie.

Stefanie Costello: Great, thank you Eden. Thank you all for being here today. I am going to take a moment and share my screen and I will walk through all of the new information we have posted. As you all are well aware, we are using Medicaid.gov resources for states as our house for all things related to Medicaid unwinding, and we do have a few updates. For anyone new joining this is a great resource. We ask that you bookmark it. This is where all of our new information is going to be housed. If you are looking for state specific information, you can click on the renew your Medicaid or CHIP coverage link. It will open another page, and on this page, it has a map to all the states. If you click on your state, it will bring up the website for your state and the phone number. That is the state specific information we have. For enrollment links, every state is here, so we encourage you to use this, share with your partners. This is a one-stop shop for their state enrollment information.

Back on our page we have a few updates that we have put up since our last call in February. The first one which was much anticipated is the anticipated timelines for initiating unwinding-related renewals. That has been added and the link looks like this. It has all the states and two columns where it tells you the first month unwinding related renewals are initiated and the effective date of the first anticipated terminations for procedural reasons. This has been very helpful.
If you have not seen it, we encourage you to take a look at it. This is by state, not that every state is different, so if you want to know what your state is doing you can go to this link. You can find that, it is the first link under tools and templates, anticipated 2023 state timelines. Next, we will go to our communications tools and speaking requests. We have updated our toolkit as promised, so I said last month we will be adding new materials, so they are all located in our toolkit here. This is a great place again to bookmark and look at. We have updated our social media as we have new social media in here. At the bottom we have some new resources. I am going to pull up the PDFs in a moment but know that they are also in this document. The new items we have are a Three Things to Know About Your Healthcare Options sheet, so this you can use as a cheat sheet for anybody who might be a front-line worker, who might be communicating with somebody who comes to them and says I have lost my Medicaid or CHIP, what do I do?

This is the three things that they can do. The first, they can reapply for Medicaid or CHIP to find out if they still qualify. The second option is if they may be able to get a low cost, quality health coverage through the Health Insurance Marketplace. We have information about HealthCare.gov and our call center. The third is that they might be eligible for Medicare depending on their age, and we have information there. These are three things that we can tell the person if they come in. Print this out and keep it on your computer, and it is a great cheat sheet for you to give the exact information someone needs to know.

If someone comes to you about losing Medicaid or CHIP or they say they have not received anything in the mail yet or they might have additional questions, this is for somebody who you can say make sure your contact information is up-to-date, and you can ask them if they have received a letter about their state. There is information here you can provide them. If they have received a letter, then they have other healthcare options and so this talks through what other health care options somebody has. We want to make sure those who have lost Medicaid have the information to find other low-cost and affordable health insurance.

We also have this losing Medicaid coverage. This is about the Medicare SEP specifically, so if you have lost Medicaid and Medicare could be an option, we have this tip sheet right here. This is really easy thing for anyone if you are working with individuals who might have aged into Medicare during the past three years and they are coming off of Medicaid, then this talks about the Medicare SEP so this is a great tip sheet there.

We also have this new postcard, and this is part of our phase 2 messaging. This is the front. This is available, as all the materials I have just gone through, in English and Spanish. In the back it has a QR code that someone can go to HealthCare.gov. The main messages here, we have talked about every month we want folks to know that if they have lost Medicaid to go to HealthCare.gov to see if they qualify for a plan in the Marketplace, and the four out of five people are able to find plans for $10 or less per month. So, it is really affordable, and we want to make sure that message is being shared. All of this is located in our toolkit, so the toolkit is here. If you want to download these and have them in a PDF version like the ones I just pulled up, those are going to be right here in this Medicaid unwinding toolkit supporting materials.

When you click on that link it will pop up a zip file full of all the materials right here. You can scroll through and find the materials and this is also where we have the additional languages. We also have heard from stakeholders that it was hard to get some of the graphics from the toolkit itself for social media, so the social media graphics are now located in this zip folder. We are going to rename them. We have a shorthand name here, but we will be renaming these and you can use these. What it will do is if you click on one of those, it will pop up in a ping version of the social media graphic so you can pop these into your social media. Here for example, renewals are coming back, and another example is don't delay, check out your options on HealthCare.gov. So, we have all the phase two social media in English right now, and we are working at putting the Spanish versions in as well. Come back to that folder. Again, you can find that folder by going under Medicaid and CHIP continuous enrollment unwinding toolkit materials, and it is the first link listed here. You can download that. That is also where we're going to be putting any new materials over the coming month so be sure to check that toolkit out frequently. Of course, every month we will be going over the new materials that we are adding.

So, with that, I am going to go ahead and transition to our question and answer period. We're going to go through a number of different topics that we have heard from you all over the last two months or so, and if you have additional questions as Eden mentioned, you can put those in the chat and we will do our best to get to those. The first topic of questions that we are going to go over today is Medicaid renewals and the redetermination process, and Jessica Stephens our expert is going to be answering a number of these questions. To start, our first question we have

is, is there a federal schedule for redetermination for those enrolled or is this determined by the state?

Jessica Stephens: Thanks, Stefanie. There is no federal schedule for renewals except for the broad guidance that we provided noting that states have 12 months to initiate renewals and an additional two months, so 14 months total, to complete the renewals that were initiated in the context of the unwinding period. It varies by state and each state has a different process for identifying what schedule will be used for the renewals.

Stefanie Costello: Great, thank you. Your next question is, once an individual receives a renewal packet, how long do they have to respond?

Jessica Stephens: That too also varies within broad federal guidance. For MAGI populations, and again MAGI populations are generally children, pregnant individuals, nondisabled adults, etc., states must provide a minimum of 30 days for individuals who need to provide a renewal form and documentation to provide that information. For other individuals, those enrolled on the basis of disability, states need to provide reasonable timeframe. States really vary in how much time they provide individuals, but generally it is between 30 and 60-ish days, sometimes a little bit longer.

Stefanie Costello: Great, thank you. Your next question is, will the termination letters tell the beneficiary whether the state agency was using ex parte data and if so where they got it from?

Jessica Stephens: Generally, yes. The state first needs to attempt eligibility on an ex parte basis for everyone, so that is based on available information. If they are able to renew, the agency sends a notice with the basis of the determination, and the basis of the determination includes not necessarily the specific data sources although that could be included in some circumstances but something like "we identified that X person makes $300 a week" as an example. Then, all the notices have information in them indicating that if the information that was used to make that eligibility determination is incorrect, that beneficiary should contact the agency and provide an update with that information.

Stefanie Costello: Great, thank you. Your next question is, even though states cannot terminate coverage until April 1st, will consumers start receiving letters in February or March stating they will lose coverage in April?

Jessica Stephens: Yes, that is possible. We are now in March and it is much more likely in March, especially because as I said earlier, individuals need to be provided a minimum of 30 days to respond to the renewal form, but states must provide what we refer to as advance notice of termination before closing coverage for an individual, and that is a minimum of 10 days. If somebody is scheduled to have their coverage ended on March 31st effective April 1st, they probably should receive a notice right about now indicating that would be the case.

So yes, it is possible that they will receive notices and individuals may have already received notices and some will be receiving those notices in the next day or two indicating their coverage will end. Often, let me highlight there, if it is because an individual has not provided needed

information it is not too late at that point. The fact that someone gets an advance notice of termination does not mean they can no longer provide the information that is needed to complete redetermination, and I think often, as we all know, getting that final notice may be the thing that spurs someone to return the documentation that is needed.

Stefanie Costello: Great, thank you for that reminder. Your next question, are states required to provide people with advance notice before termination of coverage occurs? If so, how far in advance will the notice be provided?

Jessica Stephens: Yes, and I sort of touched on that in the last question. The answer is yes, an advanced notice of termination must be provided with a minimum of 10 days. That too varies by states, though. Ten to 15 days is generally an average amount of time.

Stefanie Costello: Thank you. Should consumers expect their review during their anniversary month of when they first enrolled in Medicaid? I know we get this question a lot. For example, a person signed up for Medicaid in November of 2021, should they expect their renewal in November of 2023?

Jessica Stephens: Not necessarily, and I know I have already said number of times that there is lots of state variation, and this is another area where that is the case. States have implemented or planning to implement a number of different approaches to determining when somebody will come up for their renewal during the unwinding period. For some individuals it will keep the regular renewal date that they may have had before and the time will be applied, so using your example, somebody who applied in November, then they come up again in November. But some states are prioritizing certain populations or starting with individuals who need to likely be ineligible for coverage, so you should not assume generally speaking that an individual's renewal date will match the original date or their date of application.

Stefanie Costello: Thank you. What happens if they send their renewal form and they do not return it within the allotted timeframe? Will the coverage continue until the updated information is received or will they lose their coverage?

Jessica Stephens: Generally speaking, an individual will lose their coverage at that moment. I will note, individuals, as a said earlier, can return their information all the way to the end of the month in which the coverage will end. If somebody has returned that information and may be returned late in the process, the state is required to keep that coverage open until they actually process the information. They review it and figure out if someone is still eligible. However, if someone does not return the information on time, coverage will end at the end of that period. However, there is something referred to as 90-day reconsideration period in which an individual should still return the documentation even if it is after the time, and the state will use that information kind of as a new application in order to process ongoing eligibility.

Stefanie Costello: Thank you. Next question, I think is similar to some of the others but phrased differently. How can we identify when an individual renewals date is? I think that is the question of the hour.

Jessica Stephens: Yes, and this I have to say again, varies by state. Not all states will you necessarily know up front, like now, when an individual's scheduled renewal date will be. In some states a notice is being sent to all individuals indicating when they are scheduled for renewal, otherwise, I think the guidance we have shared and Stefanie highlighted again, is watch for the mail, watch for the notice, keep your contact information up to date. An individual will know at that point when the state reaches out to complete that redetermination.

Stefanie Costello: Great, thank you. The last question in this section is, how will the states notified individuals if they will be continuing coverage if they retrieve information from other sources via ex parte renewal and not the insured individual?

Jessica Stephens: So, I think that actually is similar to one of the earlier questions that you asked, too. If the state completes an ex parte determination based on other data sources they will send notice to the individual indicating that is what was done, that they were renewed, no action is needed unless information that was used to make that eligibility determination is incorrect.

Stefanie Costello: Thank you. Our next set of questions is also for Jessica, is about what happens with next steps after losing Medicaid. The first question we have for you here is, can you offer any guidance about how to advise those who may lose Medicaid for procedural reasons?

Jessica Stephens: I think this is similar to, may a goof follow-up from one of the earlier questions you asked, Stefanie. If somebody does not return a form, for example, by the appropriate deadline, they will lose coverage for procedural or administrative reasons. The best course of action for that individual if they find out and it is within 90 days after they lost coverage is to return the documentation if they have it to the state and the state will then use that information in order to complete a new eligibility determination if appropriate. In certain circumstances, coverage will then be provided back to the original termination date. Technically it is payment of unpaid medical bills if they were incurred between the time that somebody lost coverage and when they applied. Generally speaking, if somebody loses coverage for procedural reasons, the best approach is to return documentation to try and complete that process and get back into coverage or at least get a determination and figure out if they are still eligible.

Stefanie Costello: Great, thank you. One more question. If a person believes they were dropped for Medicaid because they did not report a change of address, for example, could they reapply for Medicaid on a state's website?

Jessica Stephens: Theoretically, yes. But losing coverage for incorrect address, for example because they did not receive information, is also considered a procedural reason. So, the guidance that I provided earlier still applies. I think the first course of business if somebody realizes that the Medicaid agency did not have their original address, their correct address or contact information and they have lost coverage is to contact the state agency and provide that updated information to be able to receive the documentation or whatever other information that is needed in order to complete a redetermination. In some cases, you may have to reapply.

Stefanie Costello: Great, thank you. Alright, you get our next set of questions as well. This is your last set, though. We are going to talk a little bit about how CMS is coordinating with states. Do we have a list of dates for when each state will start unwinding?

Jessica Stephens: We do, and I think you shared that a little while ago. A couple of weeks ago we posted on Medicaid.gov a list of anticipated start dates and that was the PDF document. Thank you, Hailey who just put it in the chat. That document indicates, as of February 24th, we know that situations can be fluid, but as of February 24th anticipated start dates for every state.

Stefanie Costello: Alright, next question is, when or how will we find out the date when our state will start the renewal process?

Jessica Stephens: I think this question may be similar to what was just asked. The initiation of the renewal process aligns with the timelines that are in the document that we just referred to.

Stefanie Costello: Great. Your last question, how will states decide who will be redetermined first? Example, is it going to be by category, the date of initial enrollment in Medicaid, or something else?

Jessica Stephens: This is going to be maybe my last, it varies by state, but I'll give you a little bit of a flavor on the different ways in which states are deciding. As we said earlier, there are some states that are scheduling individuals' renewal dates based on the date in which they applied for coverage or their last scheduled renewal. So, keeping everyone on a 12-month schedule, first in, first out. In other cases, states are redistributing renewals based on characteristics such as potential likelihood of ineligibility, so many states have been conducting renewals throughout the Public Health Emergency and may have identified individuals who are over income or did not respond to requests for information. Some state will be prioritizing or de-prioritizing those populations. Then there are number of states considering other factors, such as a need for outreach or starting with particular populations or utilization rates of care. It varies by state.

Stefanie Costello: Great, thank you so much. If we have time at the end, we might take some of the questions that were entered in the chat for you. For now, we are going to transition to our next topic, which is Medicaid to Marketplace transitions, and our expert today is Jessica Brill Ortiz, so Jessica, our first question for you is will the transfer of information to the Marketplace result in an application automatically being created in HealthCare.gov?

Jessica Brill Ortiz: Hey everyone. So, to speak to that question, for consumers who are denied eligibility for Medicaid and CHIP at the state agency, their state agency will send their account information to Marketplace via the regular, what is referred to as an inbound account transfer process, and when they receive that account information from the state, the Marketplace will send a notice via postal mail to these consumers. That notice instructs consumers to create and submit a new Marketplace application for coverage and for help paying for that coverage. The Marketplace will not automatically evaluate Marketplace coverage eligibility for these consumers who are denied Medicaid or CHIP or who are losing Medicaid or CHIP coverage.

Consumers in this scenario who are denied Medicaid or CHIP or who are losing Medicaid or CHIP, they need to take action by starting and submitting a new application at the Marketplace.

Stefanie Costello: Great, thank you. Your next question is, can a current Medicaid recipient submit a Marketplace application now to see if they are still eligible for Medicaid? What if a Medicaid enrollee is sure they no longer qualify for Medicaid but they have not yet been disenrolled. Should they initiate the process to disenrolled for Medicaid and apply through the Marketplace now?

Jessica Brill Ortiz: Well, for consumers who are currently enrolled in Medicaid or CHIP, even if they think they are no longer eligible for that coverage, what we recommend is they ensure that their contact information is up to date with their state Medicaid or CHIP agency and they wait for the state agency to conduct a redetermination of eligibility during the unwinding period. At that time when the state does conduct a redetermination, if the state finds that the consumer is indeed no longer eligible for Medicaid or CHIP, then the consumer should take action. They should immediately create and submit their application at the Marketplace to see if they are eligible for QHP coverage and help paying for it.

Stefanie Costello: Great, thank you. Your next question is, does the inbound account transfer provide the Marketplace with the Medicaid denial information or will consumers need to provide proof that Medicaid was denied?

Jessica Brill Ortiz: Consumers who were not enrolled in Medicaid or CHIP and they applied at the state and were denied, they will not be asked for proof of their Medicaid or CHIP denial in order to qualify for Medicaid or CHIP denial Special Enrollment Period at the Marketplace and that is due to a recent regulatory change that CMS finalized for 2023. Generally speaking, consumers, who had Medicaid or CHIP coverage who recently lost it or will soon lose it, do need to provide proof of their loss of minimum essential coverage (MEC) and that is part of the process so they can qualify for loss of MEC Special Enrollment Period. However, during the unwinding period consumers will have access to the unwinding Special Enrollment Period, and they will not need to show proof of their loss of Medicaid or CHIP in order to access that unwinding Special Enrollment Period.

Stefanie Costello: Great, thank you. And your last question, will states send account information to the FFE for consumers below 100% of FPL in a non- expansion state?

Jessica Brill Ortiz: Generally speaking, states should be sending account information for consumers to the Marketplace via inbound account transfer for any consumers who fall into one of two buckets. Either they applied for Medicaid or CHIP at the state and were denied eligibility or they were enrolled in Medicaid or CHIP but have been found ineligible when the state conducted a redetermination and are, therefore, losing coverage. Anyone who falls into those buckets should be sent from the state Medicaid Agency to the Marketplace. A note there though that states should not be sending over consumers to the Marketplace if the consumers were denied Medicaid or CHIP or terminated on a procedural basis. For instance, if a consumer did not send in the paperwork that the Medicaid agency requested, that is the reason for the denial or

loss of coverage. States should not be referring those consumers to the Marketplace because they have not been fully determined ineligible for Medicaid or CHIP.

Stefanie Costello: Great, thank you for that important distinction. Thank you for answering those questions. Up next we have a couple of questions related to the unwinding Special Enrollment Period for Marissa Beatley. She is from the Center for Consumer Information and Insurance Oversight. Alright Marisa your first question is, what is the timeframe from when someone loses their Medicaid to when they need to begin their Marketplace application?

Marisa Beatley: Hello. Sorry, my phone dropped the call. I think you read the first question, right Stefanie?

Stefanie Costello: Yes, I did.

Marisa Beatley: Sorry about that. So, consumers don't need to wait for their Medicaid or CHIP coverage to end before coming to HealthCare.gov to submit an application for coverage. We recommend the consumer submit a new application or update an existing one as soon as they receive their letter from their state Medicaid agency with their Medicaid or CHIP coverage termination date. So, to be crystal clear, also this will help them enroll to avoid a gap in coverage so it is really important they come as soon as they get that letter. Also, we really want to stress that the FFE will not automatically evaluate Marketplace coverage eligibility for consumers who are losing Medicaid or CHIP. Those consumers still need to take action by applying for coverage at the Marketplace to see if they are eligible for Marketplace coverage and any financial assistance to help pay for it.

Stefanie Costello: Great, thank you. Your next question. For the temporary SEP, does this mean that individuals can apply for Marketplace more than 60 days after they lost coverage and that their 60-day window starts only based on their Marketplace application date?

Marisa Beatley: Yes. Consumers who are losing Medicaid or CHIP coverage, anytime between March 31, 2023 and July 3, 2024, and also attest they lost their coverage during that timeframe will receive the unwinding SEP. Consumers will then have 60 days from the date they either submit a new application or update an existing one on HealthCare.gov to select a plan. For example, if someone submits their Marketplace application today they would then have 60 days from today to select the plan via the Special Enrollment Period for unwinding, otherwise known as the Unwinding SEP.

Stefanie Costello: Great, thank you. I know we get that one a lot, so I appreciate the clarification there. Your next question. Does a Medicaid denial alone allow access to the unwinding SEP (Special Enrollment Period)? For example, if they were denied for being over income with no prior Medicaid or CHIP coverage?

Marisa Beatley: The answer here is no. The Unwinding SEP is for consumers who are losing their Medicaid or CHIP coverage. They have been enrolled in Medicare or CHIP and they are losing it. However, there is separate authority -- Special Enrollment Period authority -- for consumers denied Medicaid or CHIP coverage, and they may be eligible for a Special

Enrollment Period or SEP if they meet some criteria. So, one, the consumer applied at HealthCare.gov for Marketplace or Medicaid CHIP coverage during open enrollment. Or with a different Special Enrollment Period like a move, and then it's sent by the Marketplace to the State because they are found to be potentially eligible for Medicaid or CHIP. Or the consumer applied for Medicaid or CHIP coverage directly with their state during open enrollment. In either of those cases, if the applicant finds out from their state Medicaid or CHIP agency that they are ineligible for Medicaid or CHIP, after enrollment period, after open enrollment, or after their SEP has ended, then they qualify for a Special Enrollment Period due to this Medicaid or CHIP denial. That SEP, the Medicaid CHIP denial SEP, is available up to 60 days after their Medicaid or CHIP denial date.

Stefanie Costello: Alright, thank you. Your next question. Can you clarify possible retroactive coverage effective dates in the context of the Unwinding SEP?

Marisa Beatley: Yes, there may be certain situations where a consumer is attesting to multiple life events that qualify them for more than one Special Enrollment Period. When consumers are eligible for multiple Special Enrollment Periods, the HealthCare.gov application logic chooses the best SEP based on hierarchy that prioritizes SEPs that provide earlier or retroactive coverage date over those that do not. For example, if someone attests to both the Unwinding SEP and also a birth or adoption, in those situations those consumers would receive a coverage effective date retroactive back to the date of birth or date of adoption rather than first of the month after plan selection, which is what the coverage effective date for the Unwinding SEP is. If it the consumer preferred that their coverage does not start retroactively in those cases, they can contact the Marketplace call center to request the coverage start the first of the month after plan selection rather than retroactive back to that date of birth or date of adoption.

Stefanie Costello: Great, thank you. Your next question is, if a consumer loses Medicaid on the 17th of the month, completes the Marketplace application and picks a plan that day, will they still have that normal lapse in coverage, i.e. the Marketplace policy won't become effective until the first of the month?

Marisa Beatley: Yes, that is correct. If someone loses Medicaid or CHIP coverage on July 15th for example, selects a plan on July 15th, their Marketplace coverage will be effective August 1st. A couple of things to keep in mind. Most consumers Medicaid or CHIP coverage will end on the last day of the month. If the consumer knows they lost their Medicaid or CHIP coverage, but isn't sure the exact end date you can enter the last day of the most recent month when the consumer knows that they had their Medicaid or CHIP coverage.

Also, it is important to answer the application question about the date that Medicaid or CHIP coverage is ending by entering the last day of coverage. Not the first day after coverage has ended. That is really important. You have to enter the last day of coverage, not the first day after coverage has ended. So, consumers Medicaid will end on March 31st, it is important to enter March 31st as the end date on application, not April 1st. We want to make sure people were aware of that. Thank you.

Stefanie Costello: Thank you so much, Marissa. We have our next set of questions is also our friends in CCIIO related to Navigators and assisters, so Evonne, if you can help us answer these two questions. Can you please clarify how navigator agencies will be included in the communication sent to the client from the Marketplace?

Evonne Muoneke: Sure, one second. Can you hear me?

Stefanie Costello: Yes, we can hear you.

Evonne Muoneke: Okay, excellent. To answer the question, during unwinding consumers will receive a reminder letter that includes information for an assister organization serving their community. This new letter will inform consumers that this organization may reach out to them directly, and the Marketplace will provide direct assister to consumer assignments or assister organizations to contact and offer the enrollment assistance. The Marketplace will assign consumers to an assister organization for outreach and enrollment assistance based off the consumers proximity to the assister and the availability of assisters at the organization to provide assistance. The assisters engaging in the direct outreach include Navigator grantees and enrollment assistance personnel. CMS has invested approximately 10 million in reviving the Enrollment Assistant Personnel (EAP) program to serve as mobile assisters and help consumers navigate unwinding transitions. EAPs operate under a contracted assistance model by Cognosante LLC have been routine to conduct direct outreach to consumers alongside Navigators in preparation for unwinding.

EAPs will serve the population centers over a 12-month period of performance that includes Arizona, Florida, Illinois, Louisiana, Michigan, Montana, North Carolina, Oklahoma, South Dakota, Tennessee, and Utah. Cognosante is coordinating on the ground efforts and engaging CDO organizations so the certified application and counselor-designated organization as well as other eligible consumer assistors to conduct direct outreach to the impacted consumers in the days leading up to the unwinding. If you are an active CDO serving any of the above-mentioned states, you may have already received outreach from Cognosante to discuss potential partnerships, so on and so forth, go ahead and respond to them if they have reached out to you so far. The Marketplace of course intends to share updates on the entire assistors strategy for Medicaid unwinding and the training onboarding approach for assisters in preparation for unwinding in the coming days. We are encouraging folks to stay tuned to our assister Listerv and I will post the link in the chat to stay in the loop. Hopefully that answers the question, Stefanie.

Stefanie Costello: That was great information. I know you have gone over this, that assistors and Navigators are going to play a big role in the next 14 months in helping make sure people keep their health insurance. Can you let us know if it is too late for organizations to apply to be assistors or Navigators or if there is anyone on the call who might be interested in applying to be an assister or Navigator?

Evonne Muoneke: Thankfully it is not too late for our Navigator program. That is a multiyear funding cycle, so our Navigator program is closed to new applications at the moment. However, our Certified Application Counselor Designation program that I just alluded to in coordination with the EAP program is open for applications beginning June 1st, so we are encouraging any

organization that has the potential to support consumers through the Medicaid transition or any sort of coverage transition with regard to Marketplace or Medicaid are welcome to and encouraged to apply to the CAC program. I will also put an inbox in the chat for folks to learn more about the CAC program if they wish to join.

Just to solidify and bring it back home, folks wanting to support consumers for unwinding and wanting to connect with the Marketplace are able to do that through CDO program and the applications for that open June 1st.

Stefanie Costello: Thank you so much. Evonne will put that in the chat for us, and it is nice to know they will have some time to get ready to apply starting June 1st if you are interested in becoming a CDO. Thank you so much, Evonne. The next couple of questions we will focus on Medicaid to Medicare transitions. We have Kim Glaun from the Medicare-Medicaid Coordination Office, so a few questions for you, Kim, today. If someone loses Medicaid can they enroll in Medicare if otherwise eligible based on age or a disability without a late enrollment penalty?

Kim Glaun: Thanks, Stefanie, for that question. The answer is yes. If an individual qualifies for Medicare based on age or disability and they did not sign up when they first became eligible, they can use a new SEP to sign up for Medicare without paying the usual penalty or waiting for a Medicare enrollment period. This SEP starts the day that their state notifies them that their Medicaid coverage is ending and it continues for six months after the Medicaid coverage ends.

Stefanie Costello: Great, thank you. Your next question is, when Medicaid continuous enrollment ends, will losing Medicaid coverage qualify as a Special Enrollment Period for Medicare?

Kim Glaun: Thanks again. This is very similar to the first question that I answered. I wanted to note that yes, that SEP I just described would apply. I also wanted to note something important that this SEP is not just available during the unwinding period, it also will be available for Medicare eligible individuals who lose Medicaid coverage on an ongoing basis. So, after unwinding, the 14-month period that will occur, the individual who loses Medicaid could also use an SEP to apply for Medicare.

Stefanie Costello: Thank you. As a reminder, I showed you all our new fact sheet on the Medicaid to Medicare transition, so if you are working with this population, please download that, share it and e-mail it out. It is a great resource the talks about the Medicare SEP. Kim, can you answer if this will, how unwinding will affect the Medicare Savings Program?

Kim Glaun: It will affect individuals enrolled in the Medicare Savings Program. That is because everyone in Medicaid, including those in the Medicare Savings Program, will need to undergo an eligibility renewal during unwinding. So just know that if you are guiding clients who are currently enrolled in the Medicare Savings Programs, you should be giving them the same advice that we recommend for other populations, for example, updating their addresses and being ready to respond to letters from their states.

Stefanie Costello: Great, thank you. I understand losing Medicaid is a qualifying life event and may then be able to enroll in Marketplace coverage. Does this also apply for a Medicare supplement? A person can apply for supplement since losing Medicaid?

Kim Glaun: The answer to this is actually no. Federal rules do not require insurers to sell individuals who lose Medicaid a Medicare supplemental plan, and you may know them as Medigap policies as well. It is important to note that some states have laws they give individuals additional protections, so it is important to check in each person's state for what rules would apply.

Stefanie Costello: Thank you. Your last question is, how are determinations being handled for dual eligibles?

Kim Glaun: Again, as I just mentioned, everyone in Medicaid will need to undergo an eligibility renewal during the unwinding period and, again, that includes dually eligible individuals. But I can quickly review some of the rules, the basic guidelines, the federal minimum guidelines that states must follow. So, earlier as Jessica noted, states have to first try to renew on an ex parte basis, which essentially means that to the extent that a state has reliable information or more recent third-party data and they renew using that information and don't ask the beneficiary to produce it. To the extent that the state needs more information, it can reach out to the individual. Just note that the rules are little bit different for the dually eligible population than they are for the actual MAGI, the individuals who are in the MAGI populations, but essentially, we have encouraged states to use pre-populated renewal forms for individuals, and we also encouraged states to employ a minimum of a 30-day response time. It is not required for this population, but we have recommended it.

Stefanie Costello: Great. Thank you so much, Kim, for answering our questions about Medicare. We are going to transition to our last and next topic. These are questions around outreach and communications, and we have with us today Alyssa Walen with the Office of Communications. So, Alyssa, is the term “unwinding” being used in communication materials?

Alyssa Walen: Thanks, Stefanie. We are not using the term unwinding in any of our communications to consumers, and this is a very specific distinction. We want to make sure the messaging to consumers is focusing on explaining to them what they need to do to get renewed through Medicaid or CHIP, what information they may need and that they can come to the Marketplace to find coverage but not using the term “unwinding” in that description.

Stefanie Costello: Great, thank you. We have received quite a few questions about our outreach campaign, so will the Marketplace outreach campaign focus on only people who are determined ineligible for Medicaid or will it also focus on people who did not respond to Medicaid re-enrollment as well?

Alyssa Walen: Yeah, we have a multipronged outreach strategy that we are trying to use to reach as many people as possible who might lose coverage. That might include people who are no longer eligible and it will hopefully also include people might lose coverage for procedural reasons, like if they didn't respond or receive one the notices from their state. We are trying to

cover as many people in as broad a swath as we can with our outreach. We are currently focused on encouraging anyone with Medicaid to ensure their contact information is up-to-date to hopefully reduce the number of people that might be procedurally terminated.

Through those variety of means we will try to reach folks who might not have gotten direct to communication from their state. That includes paid advertising, national stakeholder engagement, on the ground local support, and aiming to reach people where they are. For example, we have worked with pharmacy chains like CVS and Walgreens who have committed to training their staff about unwinding, posting signage, sharing handouts about Medicaid coverage. So, really just reaching people where they might find out that they have lost their Medicaid coverage.

Stefanie Costello: What role can the media play in getting the word out about Medicaid unwinding?

Alyssa Walen: As many have seen the media has been paying close attention to this issue. We are regularly at CMS engaging with the media to educate reporters about the redetermination process and we do encourage any members of the press with questions to reach out to our media relations team. That can be done by submitting an inquiry through the form that we have on the CMS newsroom at CMS.gov/newsroom or you can e-mail press@cms.hhs.gov, but ultimately, we are just trying to make sure that the information is out there in whatever way we can.

Stefanie Costello: Thank you. Your next question is, what kind of marketing or outreach will CMS or the Marketplace be doing to consumers who lose Medicaid eligibility for procedural reasons since states won't be transferring applications to the Marketplace for these consumers?

Alyssa Walen: Good question. So, I mentioned earlier that we have a multipronged approach. One of the prongs of our approach for outreach at CMS is a nationwide paid marketing campaign. It captures two phases of messaging, particularly focused on getting folks into coverage, but right now phase one is actually happening. Many of you may have seen these ads, it's the "Don't Wait, Update!" campaign encouraging anyone with Medicaid coverage to ensure that their contact information is updated with the state office so that they receive notifications about coverage in the next several months. Phase two will begin later this spring and will focus on reaching people who might have lost Medicaid or CHIP for whatever reason that may be, encouraging them specifically to come into HealthCare.gov to enroll. So, these ads will run in states that have Federally Facilitated Marketplaces and will be honing in on the fact that 4 out of 5 enrollees can find a plan for ten dollar or less a month. I will note that for states that have State -based Marketplaces, those states will potentially be running their own communications, so that will not be coming from CMS.

Stefanie Costello: Great, thank you. Your last question for today is, what can providers be doing to help people enrolled in Medicaid and CHIP prepare for their renewal?

Alyssa Walen: Great question. Providers are certainly a first point of contact for many people who might not be aware of the redetermination process or who have recently lost coverage. We know that folks sometimes find out they lost coverage by going to a pharmacy or showing up at

the doctor's office and learning their coverage is no longer active, so we have been encouraging all providers that we work with to use the resources we made available in the communications toolkit that Stefanie went over at the beginning, and really to help drive some of the conversations with patients and clients. We outline some of those additional tools and handouts.

Ideally, we want to make sure these resources help familiarize providers with the steps that someone might need to take to retain coverage or to find a new health plan, whatever stage they are in, and we really encourage any provider offices to keep some of these resources available as handouts. Postcards, other information that may need to be displayed, so you can send that home with anyone who might have questions or need a little bit more help.

Stefanie Costello: Great, thank you. I see that Hailey put the toolkit back in the link to re-up it. Those have the tip sheets you all can print for your front-line workers. They are in the postcards to take as well. Thank you so much, Alyssa. I think that is all the time we have for the Q&A's today. We thank everybody again for submitting the questions. The questions that were submitted and were not able to get to, those are going to help us inform topics for our future webinars. I would now like to turn it to Jonathan Blanar from the Partner Relations Group to close out today's call. Jonathan?

Jonathan Blanar: Great, thanks Stef, and thank you to all of our speakers today. We hope the information presented here today is helpful as your organization continues planning and preparing the end of the Medicaid continuous enrollment condition. We encourage you all to review the resources available on Medicaid.gov/unwinding as well as the resources Hailey dropped into the chat. Again, we appreciate your partnership and dedication to making sure that people stay connected to health insurance coverage, whether that is remaining on Medicaid or CHIP or transitioning to another coverage option such as the Marketplace.

As mentioned earlier the recording, transcript, and slides from today's webinar will be posted to our national webpage in the next week or so. We hope you're able to join us again for our upcoming webinars in this series. They are held the fourth Wednesday of every month at 12:00 p.m. Eastern time, and all of those dates going through June are on the screen now.
Again, we appreciate your partnership and commitment to helping ensure that people are connected to the best healthcare coverage they are eligible for, and we look forward to continuing to work alongside all of you and continuing to engage with you all. Thank you, and this concludes today's webinar.