Centers for Medicare & Medicaid Services
Medicaid and CHIP Renewals: What to Know and How to Prepare
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Stefanie Costello: Well, good morning. Hello and welcome. My name is Stefanie Costello, and I'm the Director of the Partner Relations Group in the Office of Communications at CMS. Thank you so much for joining us today for our partner education webinar on Medicaid and Children's Health Insurance Program, CHIP, renewals. This is a continuation of HHS and CMS' series of webinars to keep partners informed about the return to regular operations in Medicaid and CHIP now that states have restarted routine Medicaid and CHIP renewals. Everyone should be able to see today's agenda on their screen. Today's webinar will focus on recently released guidance and new resources for partners. First, you will hear some opening remarks from Perrie Briskin with the Center for Medicaid and CHIP Services (CMCS). Next, Jessica Stephens with the Center for Medicaid and CHIP Services will review some of CMS' guidance that has been released in the past couple of weeks. Next, Melissa McChesney, also from the Center for Medicaid and CHIP Services, will walk through a new resource for partners on Medicaid fair hearings. And then Terence Kane from the Center for Consumer Information and Insurance Oversight (CCIIO) will share some updates related to the Marketplace Special Enrollment Period (SEP) for people who have lost Medicaid or CHIP coverage. And finally, I will review some key messages and resources for partners before opening it up for Q&A.

Before I pass things over to our speakers, I want to share a few housekeeping items. The webinar today is being recorded. The recording, transcript, and slides will be available on our CMS National Stakeholder Call webpage. The link for the webpage will be posted in the chat. You will receive an email once the recording is posted. Also, while members of the press are welcome to attend the call, please note that all press or media questions should be submitted using our media inquiries form, which may be found at cms.gov/newsroom/media-inquiries. All participants today are muted. Closed captioning is available via the link shared in the chat by our Zoom moderator. And as I mentioned, I will have time to answer a few questions today. You can submit your questions using the Q&A function from the menu below. Questions that we do not have time to answer will be used to help us inform topics for future calls. And with that, I'd like to turn it over to Perrie Briskin with the Center for Medicaid and CHIP Services. Perrie?

Perrie Briskin: Thank you, Stefanie, and hi, everyone. My name is Perrie Briskin, and I am a Senior Advisor at the Center for Medicaid and CHIP Services. So, as Stefanie mentioned, today on the call we'll be going over a few of our recent releases. Last week, we had a number of releases at CMS and around unwinding we released what was called a bundle of things, which, much of which will be reviewed on today's call. We released guidance about extending the availability of the Unwinding Special Enrollment Period on HealthCare.gov. The Unwinding SEP, as it is known, is extended to November 30, 2024, leaving more options for people

transitioning off of Medicaid and CHIP coverage. There is a Medicaid fair hearings partner resource that will be reviewed today on today's call. We lifted up a CMS, CMCS, informational bulletin and slide deck around compliance and certain renewal practices to remind states of certain requirements. We reissued an unwinding managed care deck with some information for how managed care organizations can assist in unwinding. We lifted up a USDS, U.S. Digital Service, blog post that showed how USDS has partnered with states to help improve ex parte processes. And we also posted our monthly unwinding data for March that showed sustained improvements in both auto renewal, or ex parte rates, which is incredibly important just to see the progress that states have made.

We also – separately from unwinding – last week, released our CMS Enrollment and Eligibility Final Rule, which had a number of new requirements for states to make it easier for children and adults across the country to get and keep their coverage. For instance, eliminating arbitrary waiting periods before a child determined eligible is able to receive coverage, eliminating annual and lifetime limits on coverage in CHIP for children, and many more. So just did want to flag that not directly as a result of unwinding, but definitely related to all of the things enrollment eligibility that unwinding obviously focuses on. And I would just be remiss if I didn't mention that we are at the one-year mark when full Medicaid and CHIP renewals restarted. So, all of these improvements are especially critical given the backdrop of unwinding over the last year, unwinding as we've been calling it, or the return to full Medicaid and CHIP renewals, has put a huge spotlight on what many of us have known for so long—that renewing Medicaid and CHIP coverage is far from easy and sometimes leads people to fall through the cracks. Our priority a year ago, now ongoing, it does not stop with quote, unquote unwinding. This is an ongoing priority is to help people stay covered, whether Medicaid, CHIP, or other options like the Marketplace. And we are absolutely very, very [inaudible] everyone's work, everyone who's in attendance, your work, your advocacy, your outreach to help people stay covered over the last year. And so, we want to acknowledge that year mark and just say that the work is continuing, the work is not stopping. Making it easier for people to get Medicaid and CHIP and stay covered continues to be a priority for us, and we hope for all of you. And so, with that, I will turn it over, I believe to Jessica Stephens, also in the Center for Medicaid and CHIP Services, to share more. Thank you.

Jessica Stephens: Thank you, Perrie, and good morning, good afternoon to everyone. I will start off by talking through two of the documents that Perrie just referenced that we actually put out a little bit earlier than last week, but we lifted them up as part of the highlight of the bundle of materials that Perrie highlighted. The first, which we released on March 15 and is available on Medicaid.gov/unwinding, is what we referred to as a package of materials on conducting Medicaid and CHIP renewals during the unwinding period and beyond, and it included what we're referring to as some essential reminders for states and others about generally prohibited practices when conducting Medicaid and CHIP renewals along with illustrative examples. So, if we go to the next slide, you can see that we highlighted 10 specific renewal prohibited practices in the materials that we put out. And I will briefly go through them here. All of the materials are in both the slide deck and the informational bulletin that we put out and include some examples for each one of them. But just want to highlight maybe the first few. So, for example, the first one we highlight here is a reminder for states not to terminate Medicaid or CHIP coverage for individuals who return the renewal form or documentation requested by the state. If they do that

within the eligibility period, even if that means the state is unable to process the renewal before the eligibility period has ended. So, this is one that essentially ensures that all individuals who submit documentation as part of their renewal process in time are not disenrolled until the state has a chance to fully process those renewals. Another one as an example that we highlighted is not to terminate Medicaid coverage for individuals without first determining eligibility on all other bases. So, for example, that includes an individual may no longer be eligible in the children's group, but they may be eligible as an adult—they may be eligible as a pregnant individual or an individual who has a disability. So, for each one of these items, we went through and provided both the example of – sorry – both the requirement, the reminder of what not to do, and an example. And so, if we go to the next slide, please.

What I pulled out is an example that we included in the slide deck for the first one that I walked through, which was the reminder that states must not terminate Medicaid or CHIP coverage for individuals without first fully processing their eligibility paperwork, even if that paperwork is returned late in the renewal process. And so, as an example here, we include the reminder that states must continue to furnish Medicaid to individuals who have returned their form or requested documentation unless and until the state has determined them to be ineligible on all bases. We include an example here of a fictional Elizabeth who's enrolled in Medicaid with an end date of June 30. The state is unable to renew her eligibility on an ex parte or auto-renewal basis and sends her a renewal form with a request for documentation, and they send that on May 15. So, as I said, Elizabeth's renewal date is June 30, she returns it on June 29, which is perfectly appropriate, but, of course, doesn't leave sufficient time for a state to fully process the documentation that she has received – I'm sorry – that she sent in before the end of June 30. In that circumstance, the state must keep her enrolled past June 30 while the state reviews the information, and if at that point she's found ineligible, then the state can do the advance notice of disenrollment and close her eligibility. So, this reminds states that the state cannot disenroll Elizabeth from coverage on, excuse me, on June 30 and must keep her enrolled.

This is just one example. In the materials that we put out, we included 10 of these, both the 10 examples and 10 illustrative scenarios that describe each one of them. I would note that many of the items that we included were based on questions that we've received from partners like you, from states and others, but are not reflective of any specific identified issue in any state. So, I encourage everybody to take a quick look at the materials and see if there are questions. Now, moving on to the next slide.

One of the other materials – one of the other documents that we put out again on March 15 and highlighted again last week was I think our third update to a document that we have released largely for managed care organizations working with states to support the unwinding process and renewal process for individuals in states. And in that deck, we have included essentially five sections on ways in which Medicaid managed care organizations can partner with states to support the renewal process, which include things like working to help update beneficiary contact information, sharing renewal files so the state shares renewal files with the managed care organizations to be able to support outreach and enrollment, completing forms, enabling those who have lost coverage for procedural reasons – so, for example, for not returning documentation to come back into the program – and, of course, transitioning to other programs.

What this update did, if we go to the next slide please, is provide some clarification on requirements and options for managed care organizations to support individuals with the renewal process as it relates to submitting enrollee signatures. So, we had included in prior updates clarifications about many ways in which managed care organizations can help individuals with their renewal process, including things like conducting a three-way call with a Medicaid agency with the enrollee on the phone, helping them sort of complete that process with a live handoff over to the Medicaid agency. Excuse me. What we've highlighted here, which was relatively new, was the idea that the managed care plan can accept an electronic signature from the enrollee or an authorized representative and pass that signature onto the state for processing, provided that the state has processes in place to be able to accept that signature, and it is within the managed care contracts and agreements between the managed care organizations and states. So, that was just an update and a clarification for those two documents. But to turn over to Melissa McChesney to talk about another resource we put out last week.

Melissa McChesney: Thank you, Jessica. So, Hailey is going to start sharing her screen. Last week, we posted a fact sheet for partners to better understand the Medicaid fair hearing process, and today, I'm going to go over a lot of the content that's in here, and there will be an opportunity at the end of the call for individuals to ask questions if you have them. We want to start by reminding everyone that each state operates its own Medicaid program, and there are federal rules on how this has to be done, but within those rules, there are state options, and that means that the fair hearing process can vary from state to state. This fact sheet explains the federal rules for Medicaid fair hearings and is often also referred to as an appeal related to eligibility determinations that apply to all states, but we try to also identify areas state practices may vary.

First, let's just start with what is a fair hearing process. It's an administrative process that lets individuals challenge actions taken by their state Medicaid agency. For example, if the person thinks that their Medicaid eligibility determination was incorrect or maybe the Medicaid agency hasn't taken action on an application promptly. Medicaid agencies are required to inform people at specific times of their fair hearing rights. So, this is where people can get information on the fair hearing process itself. State agencies must provide information on exactly how a person can request a fair hearing and how long they have to make that request. This information has to be provided in writing when a person applies for Medicaid, and anytime the state makes a decision that impacts their Medicaid eligibility, benefits, or services. Many states also post fair hearing information on their website. You'll see in the fact sheet that there is a link to a website with information on how someone can learn more about the agency that administers Medicaid in their state so that you can find more about the state practices in your state. I think we can scroll down some, Hailey.

All right, so let's move on to talk about how and when a person can request a fair hearing. A person has the right to request a fair hearing if their Medicaid benefits are denied, suspended, terminated, or reduced. This includes any action by the state Medicaid agency that affects a person's eligibility, services, or their benefits. Individuals may also request a fair hearing if they believe the state has not made a decision about their eligibility within a reasonable amount of time. People have the right to ask for an expedited or a faster fair hearing if they have an urgent health care need that could result in serious harm if it's not treated soon. The agency must include information on how to ask for an expedited fair hearing in the decision notice. As I mentioned

before, each state operates its own fair hearing processes, and therefore, there's some variation from state to state. So, in every state, a person must be allowed to request a fair hearing by mail or in person. Many states also allow individuals to file a request over the phone or, in some, even use an online form where you can submit a request.

It's important to note that in many states, Medicaid fair hearings are managed by state agencies other than the Medicaid agency. In those states, people may need to file their fair hearing request with that state agency instead of the Medicaid agency. Can you scroll some more for me, Hailey? Thank you. The number of days someone has to request a fair hearing. So how long you have in order to request this fair hearing varies by state. In some states, a person must ask for a hearing within 30 days from the date that the notice of action is mailed. Other states give up to 90 days from this date. Now, while there is variation from state to state, the best place to look for the information on when you request a fair hearing and how you request a fair hearing is in your notice related to the action that you're appealing. So that's where individuals should look if they want to understand exactly how long they have and the steps they need to take in order to request a fair hearing.

So now I'm going to move on to discuss the requirements state agencies must file prior to and during a fair hearing. Once someone is granted a fair hearing, the state must give adequate written notice of the hearing date, which must be held at a reasonable time, date, and place. Hearings may be held in person, by phone, or by video conference depending on the state's practices and the person's needs. The person who asked for the hearing must be given an opportunity to review their Medicaid record, this includes the case file of the electronic account, at a reasonable time before their hearing dates so that they are prepared for the hearing. There are, during the hearing, people also have rights, and I'll go through those. They're listed in the bullets on the fact sheet. A person can represent themselves at the hearing. They can use a lawyer, but they don't have to use a lawyer. They could also use a family – they could also have a family member or a friend, or someone else help represent them during the hearing. They can – they must be able to examine both before and during the hearing their case file and any documents or records the state will use at the hearing. They can bring witnesses to the hearing. They must be allowed to present their case without undue interference. They must be given the opportunity to question or refute the state's case and ask questions of the state's witnesses. This is often referred to as a cross-examination, and the hearing itself must be conducted by an impartial hearing officer. The hearing officer is the person who holds the hearing and issues the decision. In order for them to be impartial, that means that they cannot have played a direct role in the state's original eligibility determination.

Great. Just scroll a little bit for me. Thank you. One common question that beneficiaries may ask while you're helping them through the fair hearing process is whether they can keep their benefits while they wait for the fair hearing and for the decision on the fair hearing. There are federal rules that dictate when states must continue a person's benefits while they're going through the fair hearing process. So, if someone who already has Medicaid asks for a fair hearing before the effective date of the agency's decision, this is called a date of action. So, just to give you an example, if a person has been denied eligibility, maybe based on the information that they provided on their renewal, then that is an adverse action that would occur, and the state must give them notice of that action in advance of it actually happening. So, we call this advance notice.

When you get that notice, if that individual requests a fair hearing before the action actually takes effect, so before the date that their benefits would be terminated, then the state must continue those benefits through the fair hearing process and until a decision is rendered. There's also some state flexibility in this rule. We do have a state option in our regulations that would allow states to give as many as 10 days after the date of action to accept fair hearing requests, and then if they occurred in those 10 days, they would reinstate the benefits and then continue those benefits on. Now again, this doesn't mean that a person has to request a fair hearing before the date of action or in that 10-day window. This is just the time period during which a person must request a fair hearing if they want their benefits to continue through the fair hearing process. We also want to note, and it's noted in the fact sheet, that if the result of the fair hearing upholds or agrees with the state's original decision, some states may require a person to pay back the cost for any services they got while the fair hearing was pending.

Beneficiaries may also want to understand how long they should expect the fair hearing process to take. The straightforward answer is that a state Medicaid agency must make a fair hearing decision and implement it within 90 days of receiving a fair hearing request. So that means once you request a fair hearing and they receive your fair hearing request, they need to schedule a fair hearing, to conduct the fair hearing, make a decision, and implement the decision all within that 90 days. But we do want to note that we understand that we are in a unique circumstance right now, and as states transition back to normal operations after the end of the COVID-19 public health emergency, the fair hearing process may take longer than 90 days. CMS has granted 25 states – currently 25 states – temporary authority to take longer than 90 days, but they must provide certain protections for people during the process in order to have received that authority. Specifically, they have to continue benefits for any fair hearing request that is submitted timely and not require anyone to pay back the cost of these services if the fair hearing upholds the state's original decision. You'll notice in the fact sheet that there's a link to the list of states with temporary authority to take longer than 90 days. I want to note that when you follow that link, you're going to get a nice website with a map of the United States and a table, and we just scroll all the way down to the bottom and download the Excel sheet. That's where you'll get that detailed information about this specific authority in which 25 states have been granted this authority.

All right, so what happens after the fair hearing is over. After the hearing, the agency must notify the person who asked for the fair hearing of the decision in writing. If the hearing's decision is in the person's favor, the Medicaid agency must take corrective action right away and implement the decision retroactively to the date of the incorrect action. If the decision isn't in the person's favor, the notice must include information about any additional appeal rights the state, the person has in that state. Many states may offer something called the judicial review, for example, and if you have a right to one of those, it would be included in that notice of the decision of your fair hearing.

Finally, we note that all state fair hearing systems must be accessible to people with limited English proficiency and people with disabilities, and the fact sheet includes some examples of accommodations that should be made for people in these circumstances. All right, thank you for your time as we go over this and we, as I said earlier, we're happy to take questions at the end of the call, but I will be now turning it to Terence Kane with CCIIO, who's going to cover the

Marketplace Special Enrollment Period extension and updates to the regular Medicaid Special Enrollment Period. Terence?

Terence Kane: Thank you, Melissa. Hi everyone. As Melissa said, I'm with CCIIO—specifically, I'm the Director of the DAVSP (Division of Automated Verifications, and SEP Policy) division in the Center for Consumer Information and Insurance Oversight. That's the Marketplace side of CMS. I wanted to share some exciting news regarding opportunities for individuals and families that are leaving Medicaid and CHIP during unwinding to gain Marketplace coverage. As you probably are aware, in January 2023, CMS announced a SEP to allow qualified consumers to enroll in Marketplace Health Insurance coverage outside of the annual Open Enrollment Period. To implement this, CMS and improved enrollment partners updated eligibility logic in the application so people seeking coverage could attest to the loss of Medicaid or CHIP coverage during the unwinding period, and they would be able to select a Marketplace plan within 60 days.

As you may recall, this Unwinding SEP was going to sunset on July 31, 2024. However, we were very pleased to announce that last week, an addendum to our original guidance from January 2023, CMS announced that the Unwinding SEP end date will be extended to November 30, 2024. This flexibility is optional for state-based Marketplaces. There are no other operational changes to receive the Unwinding SEP. Consumers who lost or are losing Medicaid or CHIP coverage between March 31, 2023, and November 30, 2024, and attest to having lost Medicaid or CHIP during that time period will receive a 60-day Unwinding SEP starting from the day they submit or update their Marketplace application. For example, if I attest today, on April 3, as having lost Medicaid or CHIP on February 29, I would have 60 days from today to select a plan.

Finally, we are able to provide additional information for what will happen after the Unwinding SEP ends on November 30th. Specifically, in 2024, CMS and approved enrollment partners will be working on logic changes to implement the new special rule that consumers could have 90 days to select a plan if they're coming from Medicaid or CHIP. That's a change from when consumers used to have 60 days to enroll. Just to note, there are specific state rules that allow even more time to select a plan. I'd now like to turn it back to Stefanie Costello to review some key messaging for partners and moderate the Q&A. Stefanie?

Stefanie Costello: Great, thank you, Terence. Thank you, Melissa and Jessica, for all that information. So, a few questions we've received so far. I will try my best to get to as many as we can. We did have a question about the recording and slides. So, the recording and transcript of this will be available following the webinar. We will send an email out once those get posted, and then in the chat function, we put some of the links to the slides that have already been posted prior. So, if you go in the chat, you can find the resources that we've listed.

One of the questions we received in the chat—and I will say, continue to put your questions in the chats, and we'll do our best to get to as many as we can—one of the first questions we received was about an end date for the Medicare, Medicare SEP for people who lost Medicaid. The Medicare SEP is still ongoing, so if you have anybody who lost, who was on Medicaid during this time and qualifies for Medicare, then they can still qualify for the Medicare SEP. We

will put the Medicare SEP link in the chat for you. We have a fact sheet about that, so you can use that moving forward. So again, Medicare SEP is still ongoing.

So, my next set of questions is for Jessica. These are related to the examples you gave about Elizabeth. So, in this example, how would the state know that Elizabeth mailed the form back one day prior to June 30 termination? And does this mean that when the state receives the postmarked form, they would have to re-enroll Elizabeth upon receiving the form? Or does this mean that a consumer might lose coverage for 5, 10, 15 plus days?

Jessica Stephens: Good question. So, there are a number of different ways in which this can work in states. Many states have sort of barcodes or other processes for immediately identifying when information comes back from an individual, whether that's by mail or online, to be able to stop a disenrollment before it occurs, such that even if it's returned on the last day if they're able to stop the disenrollment that would otherwise have occurred if paperwork were not returned. That isn't the case in every circumstance, though. So yes, there will be circumstances in which the state doesn't recognize that it has received the information until after the end date, where a person may be disenrolled. In those circumstances, we note in the guidance that the state must immediately reinstate coverage for that individual back to the original date of disenrollment even before the state processes the information. So, the requirement is that there be no gap in coverage and that, ideally, that that gap be prevented in the event that an individual's coverage is ended because the state just didn't, for example, see a mail or wasn't able to make a systems change to prevent the disenrollment. They must immediately reinstate the coverage for the individual and keep that individual enrolled until a determination of ineligibility has been made.

Stefanie Costello: Great, thank you. Jessica, one more question for you. How long can a child remain on CHIP?

Jessica Stephens: So, CHIP, like Medicaid, there's no time limit for enrollment provided that an individual still meets the eligibility requirements. Of course, one of the eligibility requirements is age, meaning that, and this may vary by state, but if this individual or child becomes 18 or 19, some of this varies by state, then a child would no longer be eligible and need to sort of, again, as I sort of noted, get a determination of eligibility on all other basis, and be transitioned over. But there's otherwise no, for example, time limits that you can only be enrolled in Medicaid or in CHIP for 2, 3, however many years, it's provided that you still meet the eligibility requirements, which, of course, include things like age, like residency status, and of course income and other requirements.

Stefanie Costello: Great, thank you. We have a few questions for Melissa around the fair hearings. So, the first question I know I can answer, and then I'll kick you the others, is there a website listed for each state? In that fair hearings document fact sheet that was posted in the chat, there is a link to the state's, to how you can contact each of your states there. So that is in that fact sheet.

All right, so for you, Melissa, can you clarify for states that use the, I'm sorry, that's the wrong, too many questions have come in. Sorry. For you, is there free services or a fee associated for the fair hearing, for a fair hearing?

Melissa McChesney: So, the fair hearing itself would not require a fee. Many states provide information on local legal aid services available to them in the notice of action. So that's one place to look for legal aid services if an individual is interested in having a legal aid lawyer represent them during the hearing. So that may be what they're referring to, and often, depending on their eligibility, they would receive those services free of charge. Again, many states include that information in the eligibility determination notice. So that's a good place to start looking for something in your area.

Stefanie Costello: Thank you. One more question. Does CMS give guidance to states on how they're to allow individuals to review their case files if they just have electronic case files?

Melissa McChesney: I am actually going to let that—great, Marc has come on. I was going to say I think they were chatting about this one. Go ahead, Marc or Jennifer, if you want to take that one. Marc is my director, by the way.

Marc Steinberg: Yeah, you're the expert, Melissa. We do not have formal guidance to states. There's nothing written about reviewing electronic records. We do, however, have all the accessibility rules that apply to fair hearings processes apply to access any records, so if someone has a disability, the state needs to accommodate that and make sure that the records are available.

Stefanie Costello: Thank you, Marc. All right, I think we…

Marc Steinberg: And if people have specific questions, it's a great issue. If people want to give us examples of things they're concerned about, happy to look into it.

Stefanie Costello: Awesome, thanks Marc. All right, we're going to switch over to Terence. We had a couple of questions about the Marketplace SEP. So, one of the ones we received is starting in 2025, will it be 90 days? Right now, and until November 30, 2024, consumers who lost Medicaid coverage since the beginning of unwinding can access the SEP once they submit their application, they have 60 days to select a plan. So, can you talk through that timeline one more time?

Terence Kane: Yeah, it's a little confusing. So right now, anyone could come to the Marketplace who lost coverage during Medicaid, CHIP unwinding, back to the beginning and attest to that loss of coverage, and they will have 60 days to select a plan. So, the actual SEP window goes all the way back to the beginning of unwinding, but they have 60 days to select a plan. Starting in 2025, we released a rule last year where there's a specific new SEP rule for folks who have lost Medicaid CHIP, and they will now have 90 days since the loss of that coverage to come to the Marketplace. Where previously, it was 60 days, and I think there was a question as well about someone who lost job-based insurance, and that remained 60 days. So, the rule is specifically for those that lost Medicaid CHIP coverage.

Stefanie Costello: Great, thank you very much, Terence. One more question for Melissa. Can you repeat about the 10-day timeline for appeals in order to have coverage continued until a decision?

Melissa McChesney: Absolutely. And this one is a little complicated because I'm going to start with what the rules require and then the 10-day window is actually an option for states. So, the rules require if an individual requests a fair hearing before the date of action. Now, I know that doesn't mean a lot to folks. So basically, that is the effective date of the action that's going to be taken. So, the best example I can provide, maybe the easiest to understand, is if someone's been denied Medicaid at renewal, the date of action is the day that their denial will actually be effective. So, if we're in April now, so if you were getting services through the end of the month through April 30, then the date of action is March 1. So, if someone got a denial this month and they appeal and it was effective as of May 1, and they appealed that action before that date, that effective date, then the state is required to provide benefits pending the outcome of that appeal.

Some states may provide an additional 10-day window. This is a state option in our rules so that if a person misses that state just by a little bit and maybe they filed their request for an appeal on April 3, then their benefits would still have terminated, I'm sorry, May 3, excuse me, using my example, I apologize. Their benefits would've terminated on May 1, but the state has the option to accept that request for the appeal to reinstate services back to May 1, and then you get continuing benefits through the end of the appeal period. So that is, that 10-day window is a state option. But what has to happen is if you request your appeal before the date of action, then you do get benefits pending the outcome of the appeal.

Stefanie Costello: Great, thank you, Melissa. All right, one question. We might have a little bit of Jessica, a little bit of Terence for this one. I'll let Jessica start, but if a consumer doesn't qualify for Medicaid but is eligible for CHIP full pay, can he get enrolled in the Marketplace instead?

Jessica Stephens: So, I'll let Terence jump in afterwards, but an individual, there's Marketplace and then there's subsidies for Marketplace coverage. An individual can be eligible for Marketplace coverage, full pay meaning without subsidies, but to be eligible for APTC (advance premium tax credit), which are subsidies, an individual cannot be eligible for Medicaid or for CHIP. Terence, anything to add?

Terence Kane: No, that's exactly right.

Jessica Stephens: OK.

Stefanie Costello: Great. Thank you. Still going through some of the questions, we're trying to stick with some general questions. I appreciate some of the specifics in here. We'll try and loop back with those. So, Terence, can you just briefly touch on the SEP and the 60 days and when they would apply, and when their coverage would begin after they applied to the Marketplace?

Terence Kane: Sure. So, let's say I applied for Marketplace coverage today—my coverage on the Marketplace would be effective the first day of the month after I apply. So, if it came in today, I'd have Marketplace coverage on May 1.

Stefanie Costello: Great, thank you. All right, one for Melissa. Can navigators or other assisters participate in a beneficiary's Medicaid hearing if they request assistance?

Melissa McChesney: Great. As we mentioned in the fact sheet, individuals are allowed to represent themselves, but they may also ask for representation from a legal aid lawyer, maybe the assister that helped them work on the case. So, there is nothing in the Medicaid regulations that limits who can represent a person from a fair hearing perspective. And in fact, it is encouraged that you should be able to use whomever you'd like. Of course, we can't speak to any funding limitations that your organization may have on how you use your time, but from a Medicaid fair hearing policy perspective, absolutely, individuals can request anyone that they would like to help them during the fair hearing process and the fair hearing itself.

Stefanie Costello: Great, thank you. All right, I think this is going to be our last question for Jessica, and then we're going to go over some of our resources and messaging after that. But Jessica, someone asked that they've heard the governors can request a one-year extension for unwinding, especially for children. Is that true?

Jessica Stephens: So, I think this question might be referencing one of the many flexibilities and waiver options that we've provided to states. I wouldn't call it a sort of a one-year extension to unwinding, but one of the available flexibilities that we have offered to states to adopt is to essentially extend the renewal period for children such that you give them an additional year to complete that renewal process. So, for example, if a child would have been scheduled to be renewed back in June of 2023, the state could consider that child renewed until June of 2024 when the state would have to complete a full renewal. There are a couple of states that have adopted this option, but it is an available one for all states under waiver authority.

Stefanie Costello: Great. And could you just take just a moment, I've had a couple questions about CHIP and Medicaid, just high level about the difference between Medicaid and CHIP.

Jessica Stephens: Sure. I think about it as CHIP sits on top of Medicaid. So, thinking about it for children, Medicaid provides – CHIP provides eligibility for generally slightly higher income children and some pregnant individuals, and, yes, has some slight differences in benefits as well. So, for CHIP, for example, families may be required to pay premiums for CHIP coverage that may not be allowable in Medicaid, but in many states, Medicaid eligibility for children goes up to, you know, 133% of the poverty level, and then CHIP goes up between 133 and let's say 200 or 250% of the poverty level. So, it is very, very similar to Medicaid in general, but often for individuals with slightly higher incomes.

Stefanie Costello: Great, thank you, Jessica. I will note I chatted with Terence just to confirm, but we did get a question, too, about the SEPs for state-based exchanges. Please check your own state-based exchange, but generally, the states have extended these flexibilities to enroll in the Marketplace during unwinding, too. So, if you are in a state that has their own state-based exchange, check with them.

All right, so right now, we're going to go over just a few of the resources. And again, I wanted to thank everyone for their presentations today, and we want you to know that all of our materials are still on our Outreach and Education Resource page on Medicaid.gov/unwinding, and that's where you find all the resources we've created for partners. And so, we're going to put that in the

chat. Once you're on the Outreach and Education webpage, you'll want to scroll down to the "Helping People Who Have Lost Medicaid or CHIP Coverage" drop-down folders. It's about halfway down, and if you expand that folder, you'll see that the Medicaid Fair Hearings Partner Resource has been added as the first resource under that folder. So again, to find it, go to the Outreach and Education Resource on Medicaid.gov/unwinding, and it's under the "Helping People Who Have Lost Medicaid or CHIP Coverage." As Melissa showed, there's a great resource for partners to help someone understand and navigate the Medicaid fair hearing process if they think that their Medicaid eligibility determination was wrong.

Also under that section, we have our Partner Tip Sheet that covers key steps to help people renew their coverage or transition to another health coverage option if they're no longer eligible for Medicaid or CHIP. And also, we have our Health Care Options Fact Sheet, and this is another great resource to help make sure people understand what health coverage options may be available to them if they're no longer eligible for Medicaid or CHIP and how they can enroll in an option that's best for them.

The Medicare Special Enrollment Period Fact Sheet and an Employer Fact Sheet are also available in this section, and they have more detailed information on those two coverage options. We also have a drop-in article that has more information about how people who are no longer eligible for Medicaid can get enrolled in coverage options through the Health Insurance Marketplace at HealthCare.gov. This is a great resource that y'all can take and put in a blog or a newsletter or send out in a listserv email, any way y'all want to communicate with folks about this. It's a great resource for you to share with your members, colleagues, partners, and people that serve your community. I'll also note that we'll be making some updates to these materials – a couple of these materials in the coming months. And we will keep you all informed as these updates are completed. But the Medicaid.gov/unwinding website is still the best place for you to get the most up-to-date information and resources as a trusted partner and stakeholder for you to educate folks.

And lastly, I want to remind everyone that many of the resources are still available to order through our CMS product order website for free. You can request a free account and place orders for printed materials. So, you can request, for example, 50 postcards and have those out on your counter for free. We have more information on that same webpage, on the Outreach and Education Resource page that will include how to order products, and we'll also send that out after the webinar.

So, with that, I'd like to thank everyone for joining today's webinar. We hope that the information shared today was very helpful to your organization as they continue outreach to get this information to the people you serve. And we definitely echo Perrie's thanks to y'all for the hard work you put in over this last year and really educating folks and helping make sure that as many people as possible have coverage, either if they still are eligible to stay on Medicaid and CHIP or if they have transitioned to another coverage option like Marketplace, Medicare, or their employer coverage.

Again, we'll be sending an email in the next week or so with the link to access this recording, transcript, and slides from today's webinar. And as we've said before, your partnership is very

important, and we appreciate your continued work to get this information out through networks and people in your communities to keep people who are enrolled in Medicaid and CHIP. And this is, again, an all-hands-on-deck effort. We want to make sure that people keep health coverage, whether that's through CHIP or another coverage like the Health Insurance Marketplace. Please keep an eye out for future webinar dates. We'll make sure to share those dates via email as additional webinars are scheduled. And again, we appreciate your partnership and commitment to help ensure that people are connected to the best health care coverage that they're eligible for. And we look forward to continuing to work alongside you in the coming months. Thank you all, and this concludes today's webinar.