Centers for Medicare & Medicaid Services
Medicaid and CHIP Renewals:
What to Know and How to Prepare, A Partner Education Monthly Series
Wednesday, October 25, 2023
12:00–1:00 PM ET

Webinar recording:
https://cms.zoomgov.com/rec/share/Awgeg5w9Coj1D74rOl7n_YqQ70R5xKSUN_dS-4POf0Ntit4_TWf0skzCXLzRvqvv.6zqBNM8ZGSwu66RR?startTime=1698249902000
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Stefanie Costello: [*Hello and welcome. My name is Stefanie Costello, and I am the Director of the Partner Relations Group in the*] Office of Communications at CMS. Thank you so much for joining us today for our monthly stakeholder webinar on Medicaid and the Children's Health Insurance Program (CHIP) renewals. This is a continuation of HHS and CMS's monthly series of webinars that began in 2022 to keep partners informed and help them prepare for the return of regular operations in Medicaid and CHIP now that states are restarting routine Medicaid and CHIP renewals.

As you may know, states have restarted their regular Medicaid renewals now that pandemic-era protections for Medicaid coverage have ended. From now until the middle of 2024, everyone with health coverage through Medicaid or CHIP will renew their coverage. If an individual is no longer eligible for Medicaid or CHIP, they can transition to another form of health coverage, such as Health Insurance Marketplace, Medicare, or Employer Sponsored Coverage.

Everyone should be able to see today's agenda on their screen. Today's webinar will have some high-level information about the Marketplace and Medicare Open Enrollments that partners like you may find helpful as people transition from Medicaid to the Marketplace or Medicare. First, you will hear from Megan Reilly with the Office of Communications for an overview on the Marketplace Open Enrollment. Next, you will hear from Angela Nickolas with the Office of Communications for an overview on Medicare Open Enrollment. Then, we will use the remainder of the webinar for an extended Q&A, where we will address unanswered questions related to Medicaid renewals, Medicaid appeals and fair hearings, enrollment assistance, communications, and more.

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 Calls web page. The link for the web page will be posted in the chat, and 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. We may have time to answer a few additional questions from attendees during today's webinar. You can submit your questions using the Q&A function from the menu below. Questions that we do not have time to answer today will be used to help inform topics covered

for future calls. And with that, I'd like to turn it over to Megan Reilly with the Office of Communications. Megan?

Megan Reilly: Great. Thank you so much, Stefanie. We can move to the next slide. I'm going to talk a little bit about the Health Insurance Marketplace and our Open Enrollment Period (OEP). We are one week away from Marketplace Open Enrollment starting on November 1. The Marketplace is for anyone that doesn't have health insurance through other sources, such as employer, Medicaid, or Children's Health Insurance Program, Medicare, other government benefit programs such as VA (Veterans Affairs) or TRICARE, or any other health insurance that is comprehensive. So, it creates a Marketplace where people can come and purchase their own health insurance, and then use the health insurance for the following year to get care and services. The Marketplace can help people find out if they're eligible for extra savings that can reduce the cost of their premiums, which are known as premium tax credits. We also have available additional cost savings for some consumers, depending on their income, that can help reduce their out-of-pocket expenses and deductibles, so it can be a little bit less expensive for them when they use their insurance to go get care. And the Marketplace can also help people find out if they are eligible for Medicaid or the Children's Health Insurance Program if they are not already enrolled in those coverage types. Some states operate their own Marketplace, so most of what I will be showing you today is HealthCare.gov, that's the federal Marketplace, and for the upcoming 2024 coverage year, we're going to be supporting 32 states. The other 19 states, including the District of Columbia, run their own Marketplace, so they have their own website and their own call center. If you are not sure if your state may operate its own Marketplace, HealthCare.gov can link you out to your state's resources, and you can check the list and then head on over to your state's information where they have resources for consumers as well as resources for partners in their state.

Some key dates and deadlines for Marketplace Open Enrollment. Starting November 1, consumers can get coverage that will start as early as January 1 if they enroll by December 15. And through the end of Open Enrollment on January 15, anything coming in between December 16 and January 15 will be the effective starting February 1. So, it's really key for anybody that newly needs insurance, if they don't have any coverage right now, or for consumers that currently have Marketplace coverage and want to renew their Marketplace plan for next year, they need to come in December 15 in order to have a full year of coverage that starts on January 1. In a few slides, I'll also talk a little bit about Special Enrollment Period (SEP) opportunities for anyone who may still need coverage for the rest of 2023, as well as information around Special Enrollment Periods that would be effective after open enrollment ends in 2024. You can go to the next slide, please?

What's the experience like on HealthCare.gov? So, hot off the presses today, we actually just released a preview of 2024 plans and prices this morning. So, starting today, consumers can get ready for 2024 Open Enrollment and check out an estimate of their eligibility now, and what plan costs might look like for next year. And then, starting November 1, they can come in, create an account if they are new, or log in if they are an existing consumer, fill out their 2024 application, review their eligibility results, which will tell them if they're eligible for Marketplace plans, if they have eligibility for tax credits to help reduce the cost of their premiums, or extra savings if they enroll in a silver plan, which additionally reduce their out-of-

pocket costs when they go to use care. If they are eligible, then they'll be able to compare Marketplace plans and enroll. In addition, consumers that may be found eligible for Medicaid or CHIP in their state will refer the consumer over to their state program, and their state Medicaid or CHIP agency will follow up with their enrollment next steps at that point in time. Next slide, please?

The Marketplace application at the very beginning sets some context for consumers across the sections of information that they'll be asked, such as, do they want help with cost savings? We need information about who needs coverage in the household, and that can include information like Social Security numbers, or eligible immigration status as well as household income, so we can find out what the household may be eligible for and help them save the most on their access to care. We also have some questions about recent life changes and access to other health insurance. And then we have a sign and submit process for consumers to be able to review their whole application, check to make sure everything is right before submitting it and seeing what their results are. Consumers that start the application and need to pause to gather information and come back later are able to do that and they will be able to jump right back in to where they last left off, or if they need to get a step back and review some information, they have the opportunity, and this page helps provide them with the context of where you are in the process, and we can help you get right back to where you last left off. Next slide, please?

A couple of key highlights in the Marketplace application process are: one, checking for savings. So, that's how consumers can find out if they might be eligible to save on their premiums, their out-of-pocket expenses, or may be eligible for Medicaid and CHIP, if they aren't already enrolled in those programs. So, this is a key step at the beginning of the application that we ask consumers and give them an estimate based on income, whether it's likely that they might actually qualify for extra savings and should consider taking a look at those opportunities. Next slide, please?

Also, for consumers that are transitioning from Medicaid or CHIP—so, during the Unwinding period, but also any time we have—since we've been running the Marketplace, we always have consumers who may just be transitioning from Medicaid or CHIP, but this is of course a slightly larger population that we expect this Open Enrollment Period, to be transitioning out from having Medicaid or children's health insurance coverage over to the Marketplace. And during the Marketplace application experience, we ask consumers "have you recently lost or are you about to lose Medicaid or CHIP?" And "what was the date?" That helps us both provide the consumer an opportunity to enroll, and potentially for a Special Enrollment Period that, depending on when they come in, may give them a longer opportunity to choose a plan beyond just Open Enrollment, depending on when they lost coverage. Consumers that may need coverage for the rest of 2023—so, let's say they just lost Medicaid or CHIP, or they're just about to lose it at the end of this month, for example, they would have the opportunity to also go ahead and apply for 2023, if they need coverage for November, or if they need coverage for December. So, anybody that needs coverage right now, this year, that is transitioning out from Medicaid and CHIP can go ahead and apply now in 2023, and then also once Open Enrollment starts on November 1, take a look at their coverage options for 2024. It's important that consumers take a look at both because costs and prices can change from one year to the next, and they may have different plan options available next year that they find might be a best fit for them. Next slide, please?

These are a couple of just quick highlights of the rest of the application experience. We have a couple of section parts that will tell consumers what information we might be asking for such as household income and helps them think about what information they might need to gather before we ask those questions. For example, we also have that for job-based health coverage. At the end of the application, we have a quick summary of their eligibility results that will let them know, are they eligible to buy a Marketplace plan? Are they eligible for tax credits to reduce the cost of the premiums, and how much? Are they eligible for extra savings on silver plans? And if anybody is eligible for Medicaid or the Children's Health Insurance Program, that will be also here too. Now, we have a full eligibility notice that displays that they can get more information and key dates and deadlines for additional actions they may need to take. When they continue on to enrollment—if you go to the next slide?

We have just a couple highlights to talk about what that experience is. So, we'll break down the types of health plan categories available to consumers. Bronze, silver, gold, are some of the most common in the area. Consumers that are eligible for those extra savings to lower their out-of-pocket costs on silver plans, will see an extra highlight and a way to filter to just take a look at these plans and consider their opportunities to save a little bit more when they go to get care if they enroll in one of those plans. Plans are sorted by default, starting this year, based on the lowest total estimated yearly costs rather than the lowest premium, which we found helps consumers consider what they need to budget for for the whole year, rather than just their monthly premium out-of-pocket costs. But it also takes into account things like deductibles and co-pays and coinsurance that they might need to pay when they go to use care. By default, we set that to a medium level of use, but consumers can customize this based on what they think is best for them and get a sense of how much different plans might cost them during the year. They can compare and choose a few plans, look at the information side by side, consider the cost and benefits, and then, when they're ready to choose a plan and enroll, once they've gotten through that final enrollment confirmation step, the last thing consumers need to do is head on over to their new insurance company and set up arrangements to pay their first month's premium, so that their plan can be effective. Go to the next slide, please?

For Special Enrollment Periods—so, this is relevant right now, for anybody that needs coverage for the rest of 2023—so a plan that starts in November or a plan that starts in December. And this is also relevant for anybody that may have life changes that happen after Open Enrollment. And so, during the Open Enrollment Period, that's when anybody can come in and choose any plan. So, it's really a great opportunity for people who need insurance or who need to renew their Marketplace plans to come in, see what they're eligible for, get updated pricing, and pick the plan that's right for them. Outside of Open Enrollment Period, current consumers may have limited plan choices or ability to change plans, and people who don't have current insurance would need a Special Enrollment Period in order to newly sign up for coverage. Examples of Special Enrollment Periods typically are recent life events, like a move, having a baby, getting married, losing other health coverage including losing Medicaid or CHIP, and also, consumers that are members of a federally recognized tribe, have access to a year-round Special Enrollment Period. So, they can actually come in at any point in the year and gain access to care and enroll in health insurance or change plans if they want to. In addition, there were some recent law changes in the last few years that established a temporary window for a Special Enrollment

Period that lasts through 2025. So, that's through this year, next year, and the following year, for consumers that have an income at or below 150% of the Federal Poverty Level (FPL), they will also have an opportunity to come in and enroll in the middle of the year. Anybody that needs to get that coverage for the rest of this year, for 2023, doesn't need to wait for Open Enrollment. They can go ahead and apply today and take a look at their 2023 options, and then, remember to come back in 2024 for coverage, once November 1 rolls around to make sure that they take a look at what their best options are for next year. And if you need a little bit more information about Special Enrollment Periods, we have a link in the bottom of the slide, and we could also put this in the chat, where HealthCare.gov provides a bit more information around some other circumstances that may qualify consumers for a Special Enrollment Period, to newly enroll in coverage, or to change plans in the middle of the year. Next slide, please?

So, for HealthCare.gov and CuidadoDeSalud.gov, which is our Spanish-facing site, consumers can do everything they need to online—create an account, apply for coverage, take a look at their health and dental options—but they can also get assistance over the phone. They can submit an application by mail, or they can get help from local assistance resources, which might be an assister or an agent/broker in their area. Our call center is available 24/7 with a customer service team that has English and Spanish and also offers oral translation services in over 240 languages. Again, state-based Marketplaces will have their own call center. If you're not sure, you can call our call center. We'll be able to refer consumers to their appropriate state line for assistance. Our local assistance resources on the ground are trained and certified by the Marketplace every year, and they can help consumers submit their application, they can help answer questions for tricky situations if the consumer isn't sure what they need to do or where they need to go, and they can also help consumers compare their plan options to figure out what might be right for their situation for next year. That includes both navigators, who are Marketplace grantees, Certified Application Counselors (CAC), as well as agents and brokers. If the consumers are looking for a local assistance in their area, they can use Find Local Help on HealthCare.gov and look for somebody in their area that fits what they need for their assistance. And with that, I'm going to pass it over to Angela to talk about Medicare Open Enrollment.

Angela Nickolas: Great. Thank you, Megan, and thank you all for being here today to let us talk through some of the things that we have going on during this really busy time of the year, and how they relate to the folks that you are helping. And so, Medicare's Open Enrollment Period runs from October 15 to December 7 every year. If you can go to the next slide? Thank you.

And Medicare Open Enrollment is for everybody with Medicare. So, Medicare is health insurance for people that are age 65 and older, and people that are younger with certain disability situations, and people with ALS. Medicare Open Enrollment is important to understand because, this is the period of time where absolutely anybody with Medicare can look at their current coverage and maybe find something that's a better fit for their budget or health needs. If they don't do it now after December 7, then what happens is people with Medicare may have to wait until the next year's Open Enrollment Period to review or make any changes. And so, that's why we strongly encourage people with Medicare to review their coverage right now. If they are happy, they don't need to make any changes, but it's always worth looking because people change, and plans change too. Next slide, please.

So, Open Enrollment actions—things that people can do during Open Enrollment are like this. First, we can—remembering that for everybody who has Medicare, and this is the time to make changes, they may choose to join a new Medicare Advantage (MA) plan, like an HMO (Health Maintenance Organization) or a PPO (Preferred Provider Organization). They may join a new Medicare prescription drug plan, which is also called Part D—like "dog". They can switch from original Medicare to a Medicare Advantage Plan or the other way—going from a Medicare Advantage Plan to original Medicare, without or with a Medicare Part D prescription drug plan. Any changes that they make between now until December 7 will be effective January 1, for the next year—so, January 1, 2024. And so, if you've been working with seniors who were on Medicaid, and they switched to Medicare with the Unwinding Special Enrollment Period that happened this year—this information applies to them, too. This is that opportunity for them to take a look and see that the plans that they have right now still are the best plans for them. And depending on their location, in addition to the actions that you see on this slide, people with Medicare also may have the opportunity to buy a Medigap policy. And a Medigap policy is also referred to as a supplement or supplemental coverage, and it is what helps to fill the gaps in and pay the cost that original Medicare does not cover. There is limitations to the people that can purchase a Medigap policy and when they can purchase a Medigap policy. And so, the State Health Insurance Assistance Program, also known as SHIP, are the best people to contact to ask about state specific Medigap rights and protections. At the end of this slide, I will have some contact information for the SHIP for you. Beneficiaries can make as many changes as they want to during this Open Enrollment Period, but the last change that they make will be the change that will be effective on January 1 of 2024. Next slide, please?

What we encourage people to do during this period of time is to review the Annual Notice of Change (ANOC). And so, anybody who currently has a Medicare Advantage plan or a Part D plan will get an ANOC—Annual Notice of Change—or an evidence of coverage. And these notices went out and were to be received by Medicare beneficiaries by October 1. And so, they are in hand right now, and this is the summary that tells somebody what the changes are to their plan—what different costs might be, any changes to the benefits or coverage rules, and changes to the formulary or the list of covered drugs for Medicare Part D plan. What we do during this period of time is encourage people to take a look at that list of changes and make sure that your plan still works for you. So, making sure that your drugs that are—were covered currently, will still be covered in your new plan, that you can still go to the doctors that you want to go to, and the pharmacists, and that they will still be in the plan's network. And again, we encourage folks—if they need help reviewing their options, they can contact their SHIP. Information on that one will be on the next slide. Next slide, please? Or on the final slide. Will have the SHIP information.

But comparing plans and reviewing health options is also something that's relatively easy for folks to do themselves at Medicare.gov if they use our Plan Finder tool. So, the experience that we can provide on Medicare.gov/plan-compare is the ability for folks to review and compare the plans in their area. They can enter a list of drugs that they take, they can enter the pharmacies that they like to go to, and then, get a side-by-side comparison of what plans coverage will be, how much it will cost, and also quality rating from current members. People with Medicare, including people who were on Medicaid and then switched with that SEP, can use Plan Finder to go in and make changes to their plan, effective January 1, 2024. There's options in Plan Finder,

and so, you can do either a personalized search, where you're putting in those preferred pharmacies and prescriptions and saving that information, or basic searches—just to see plans that are available by ZIP Code. And the SHIPs are incredibly experienced at helping people use Plan Finder. And again, we do encourage folks to do that. There are changes, thanks to the Inflation Reduction Act (IRA), that have really improved things for beneficiaries in terms of cost and access to care. Plan Finder is all programmed so that when people put their information in, the information that we return shows those improvements from the Inflation Reduction Act, including: the beneficiary pay no more than $35 for a month's supply of covered insulin, and this includes people that have it through Part D or through Part B—getting it through a pump. It also includes the fact that we now cover all of the CDC's Advisory Committee Immunization Practices (ACIP), or ACIP-recommended vaccines at no cost, like the shingles cost or the RSV (respiratory syncytial virus) vaccine. And then, starting January 1, 2024, there is also help for people with higher costs, and so, once somebody's out-of-pocket spending reaches $8,000, that's out-of-pocket spending, meaning what they spend or what other entities make them for them—like if they have Extra Help, also known as LIS, or the Low Income Subsidy. The catastrophic coverage is automatic, so when they hit that $8,000 limit in 2024, then beneficiaries don't have to pay a copayment or a coinsurance for any drugs that are covered under Medicare Part D for the rest of the calendar year.

Another thing that happens, that is thanks to the IRA, which is the January 1 day of 2024, is that Extra Help is a program that is expanded. And so, Extra Help is the program that helps people to pay their Part D premium, their deductible, coinsurance, and other costs and there are right now, in 2023, are levels to Extra Help—there's a partial subsidy and there's a full subsidy. That partial subsidy goes away and becomes a full subsidy for everybody in January of 2024. So, it will be expanded to cover more drug costs for people that have limited income and resources. Generally, what happens is, people who qualify for Extra Help pay no more than $4.50 for each generic drug and no more than $11.20 for each brand-name drug in 2024. And the way that we encourage people to think about this is, apply. It's worth it to apply to see if Extra Help might be right for you. If you make less than $22,000 a year or $30,000 a year for married couples, it's worth it to apply. There's more information on Medicare.gov/Extra Help, and the application process is handled through SSA (Social Security Administration) and can be done online at ssa.gov/extrahelp. Next slide, please?

The other thing that we're trying to really get folks to be vigilant about during this period of time is fraud. Mostly because—just like how I said that ANOC, Annual Notice of Change, or evidence of coverage, arrives in people's mailbox on October 1, a lot of other stuff ends up—arrives in their mailbox too. We're all being bombarded. If you turn on the *Today Show*, you can't not see a Medicare ad. And so, while it's really exciting, it's really confusing, and it can be overwhelming. Generally, we want folks to realize that Medicare.gov and 1-800-MEDICARE are the official sources of Medicare information. And so, we provide these resources as the place that people can go to validate information. If they've got questions about mailing that they get, something that they see on the news, the best thing to do is to come to Medicare.gov or they could call 1-800-MEDICARE to get clarification, and make sure the information that they're getting is legitimate.

We also want people to sort of know what to look for when it comes to fraud. And so, anybody who is pressuring someone to join their plan or says that they represent Medicare and to give them a service for free, anybody who calls them without permission or threatens that they will lose Medicare benefits if they don't sign up for their plan or requires you to provide contact information at a plan event, are all things to watch out for. Those are red flags, and so while plans are allowed to send people emails or direct mailing, they can't call, they can't visit in-person without permission. Medicare will never call somebody directly. And so, if somebody calls, they need to hang up. People who send emails have to have an opt-out option for people. And so, we want people to just kind of have their eyes open a little bit and be aware if something doesn't feel quite right, contact the plan, contact 1-800-MEDICARE or Medicare.gov. Never feel pressure about joining a plan.

So Medicare.gov and 1-800-MEDICARE are those official sources for information. If we could go to the next slide, I've got some other resources listed here for you. And so, there is Medicare.gov, there is 1-800-MEDICARE, which is available 24 hours a day, including weekends, and we have a TTY number up as well. If you need help for someone in a language other than English or Spanish, just let the customer service representative know. The other thing is the "Medicare & You" handbook, and the "Medicare & You" handbook is the one direct mail that goes to every household of people with Medicare, every single year. So, in the same way that people got all those notices and all those marketing materials on October 1, starting September 15, mailboxes started to fill up with "Medicare & You." Some people choose to get it electronically instead, and that's why that second bullet is there. It's available in a variety of formats on Medicare.gov and also a variety of languages.

And so, for shopping or comparing plans, Medicare.gov Plan Finder, that I talked through on the third slide, is the place to go. 1-800-MEDICARE is also able to help people with reviewing and comparing plans and answering their general Medicare questions. And the "Medicare & You" handbook is an excellent resource when you want to figure out what the benefits are rights protections. It does have a list of available health and drug plans but the most current is always on Medicare.gov. "Medicare & You" is really the place to go for frequently asked questions and a summary and understanding of Medicare benefits. Last slide, please?

And of course, we have the SHIP. So, State Health Insurance Assistance Programs are incredibly valuable resources for people to get free and personalized health insurance counseling. And so, for that, the best thing to do is to go visit SHIPhelp.org, and then you can put in the location and figure out who the local SHIP is that can provide that personalized counseling to people with Medicare, their families, their caregivers, so they can make the informed decisions that they need to about their care and benefits. That's all I have for you today, and I know that it's a lot, but if I could just leave you with the *Reader's Digest* takeaway, is that Medicare Open Enrollment is for everybody with Medicare to take a moment and to stop and review and see if what they're doing still meets their needs. So, I always think about it at Thanksgiving when we're all sitting around the table, but you should think about it from December—up until December 7, starting now—starting last week, actually. And it's critically important for people to understand that just because they have Medicare doesn't mean that the coverage they have right now is what's best for them. There are many ways to look at options and compare them to figure out the best thing for them. And Medicare.gov, 1-800-MEDICARE, are the official sources. State Health Insurance

Assistance Programs are for personalized counseling. And with that, I'm going to hand it back to Stefanie. Thank you for your time.

Stefanie Costello: Great. Thank you, Angela, and thank you, Megan, for that update. I know that's a lot of information. But as some of you have been deep into Medicaid space this last year or so, we thought it would be great to just get a little bit of a primer of the other two programs, especially because some of the people you are working with might be transitioning to those, or it might be their first time going through one of these Open Enrollments, either in Marketplace or Medicare. So, you can put a couple more questions in, and we'll try to answer some if we have—um, if we're able to. And right now, we're going to go to some of the questions that we've received, and the first set of questions, is going to be for Jessica Stephens, with the Center for Medicaid and CHIP Services, and they're related to Medicaid renewals and the redetermination process. So, Jessica, the first question I have is, a lot of Medicaid enrollees have not received their renewal letters yet. What should be done to make sure that they don't have a gap in coverage?

Jessica Stephens: Sure. I think the first thing I would highlight is that the renewal process is ongoing. So, no one should panic yet. In many states, individuals have not yet—some individuals—have not yet received information about Medicaid redeterminations for Medicaid and CHIP, especially since many states began the process in April. If an individual hasn't received information yet, it's still coming. But it highlights the importance of continuing to do many other things that we've highlighted on these calls, such as: ensure that information is up to date, check the mail, if you do—and if you do receive information from your state, whether it be through the mail, online, via text message, or any other outreach, read it and respond to it to ensure that there is no gap in coverage.

Stefanie Costello: Thank you. Your next question: will people who are renewed through an ex parte or passive renewal process still receive a letter saying they need to renew? Will every person who had Medicaid or CHIP during the pandemic receive a letter in the mail from their state or Medicaid CHIP office?

Jessica Stephens: No. So, under the ex parte process or passive renewal process—in some cases and some states, it's called the administrative renewal process—states use available information that the state already has in order to complete the renewal for an individual. In those cases, the individual does not need to take action to complete the renewal. Now, all people receive information letting them know that their coverage has been renewed and if additional information is needed. But where a redetermination or renewal has been completed through this ex parte process, the process will already be complete. In thinking, though, about—just—will everybody receive a letter in the mail? I think it's important also to remember generally that not just individuals who go through the ex parte process, but many individuals in a lot of states have elected to receive information not only through the mail, but online, or have opted into other modalities. So, I think, as we talk about making sure that people look out for the mail, also important to note that it's not just a physical letter, if an individual, for example, has elected to receive online notifications.

Stefanie Costello: Great. Thank you. All right, your next question: many people are expected to lose, or already lost, Medicaid coverage. Is this because they did not renew their coverage? Or have the requirements for Medicaid changed significantly?

Jessica Stephens: Medicaid requirements have not changed significantly during the course of the Public Health Emergency. Renewals and redeterminations are an ongoing process. People may lose Medicaid or CHIP coverage for several reasons. In some cases, right, people may no longer be eligible for Medicaid or CHIP. For example, if their income has increased, or they no longer meet certain eligibility criteria. In those cases, I think as we've noted, we are very focused and believe in our all-hands-on-deck approach to ensure that those individuals are able to transition to other coverage, when, for example, through the Marketplace, which—Megan just started talking about. Other people do lose Medicaid or CHIP if they don't complete the renewal process, sometimes referred to as a procedural disenrollment. And that again is very important. It highlights, again, the importance of providing assistance, and ensuring that individuals are aware of the renewal process, that they look for their mail, that they respond, and they renew their eligibility to ensure that they don't lose Medicaid or CHIP for administrative reasons.

Stefanie Costello: Great. Thank you. And your last question on renewals and the redetermination process is, what happens if someone moved to a different state within the last three years? How should they renew their Medicaid coverage?

Jessica Stephens: So, Medicaid eligibility is generally based on the state in which an individual lives. There are state residency rules. So, it is important for everybody to let them—to let the state know, if you're moving out of state, along with other information that may change. So, an individual who moves out of state may no longer be eligible for Medicaid or CHIP in the state in which they moved from, however, they may still be—they may be eligible in the new state in which they live. And in fact, important to note that an individual who has moved to a new state—if they weren't eligible in their old state, may be—may now newly be eligible. So, when moving, it's important to report that change to your old state and then, apply for coverage in the new state to which you moved.

Stefanie Costello: Great, thank you. Our next question set of questions is also for Jessica, but they're going to relate to the Medicaid eligibility for children and young adults. Jessica, if a person is 19 or older and living with their parents as part of a household, are they eligible to be covered based on the parents' income, or must they apply on their own, apart from their parents?

Jessica Stephens: So, as with most things in Medicaid, it depends a little bit. But, at a high level, in most circumstances, for non-elderly individuals without—who aren't enrolled on the basis of a disability, a Medicaid household is determined by, essentially, who files taxes together. Who is—who is counted as a dependent for purposes of tax claiming? So, if a 19-year-old in a household is a dependent of their parents, and their state covers adults—so they've expanded Medicaid to adults—that 19-year-old may be eligible as part of the same household as their parents, but it doesn't mean it's only their parents' income that counts. If that 19-year-old is working and is also earning income, their income will also count. If not, then that young adult will need to apply for themselves on their in—as part of their own household. Now, important again to note that there are exceptions, and differences across states, and individual

circumstances may vary. So, if this is a scenario that applies to you, or someone who you're working with, it's important to reach out to your state specifically, to talk about who may be eligible.

Stefanie Costello: Great, thank you. So, I understand there's new rules about a 12-month continuous eligibility for children next year. So, if a child enrolls in Medicaid in February 2024, will they remain eligible for 12 months? And then, would they need to renew eligibility again in February 2025? Is that correct?

Jessica Stephens: Yes. Generally speaking, yes. There is a new requirement that goes into effect at the beginning of next year that requires all states to implement what we refer to as "12 months continuous eligibility for children." And that is essentially regardless of most changes in circumstances that may occur, a child who is enrolled or renewed, is—continues to be eligible for the next 12 months. And there is a new resource that I think Hailey just put in the chat.

Stefanie Costello: Great. Thank you so much. Alright. Our next set of questions—Jessica is going to help out, but we're also going to have Melissa McChesney from—also from the Center for Medicaid and CHIP Services. And these questions are going to relate to the Medicaid appeals and fair hearings. So, our first question is for Melissa. The consumer got a letter one day saying they had lost Medicaid coverage because their salary was too high but the salary the state—the state had was wrong. What can be done about this?

Melissa McChesney: So, the short answer is that every state—when they disenroll an individual, or plan to disenroll an individual from Medicaid coverage—have to provide them with the opportunity to request a fair hearing. This is often—often also called an appeal. So, like in this scenario you discussed, Stefanie, the states have to provide an individual notice at least 10 days before their disenrollment will become effective. But often, they provide more notice than that. And so, if a person gets a notice that says that they are going to be disenrolled, and they disagree with what the determination was, so, again, using the example, they had an income, the state used income that was higher than the person's actual income, that they should request an appeal and they should do that as quickly as possible.

Stefanie Costello: Great. Thank you. This one is for Jessica. So, after coverage is closed, is it true that the family still has 90 days to return any requested information?

Jessica Stephens: In most cases, yes. And this is what we've often referred to as a "90-day reconsideration period" so that if someone's coverage is closed because they did not complete the renewal process, they can provide the information that was requested that they didn't submit, like the renewal form, within 90 days after the coverage was closed, and the state treats that, essentially, as a new application. If the person is determined eligible, the state provides coverage back to the date of termination for unpaid medical bills.

Stefanie Costello: Thank you. This one is for Melissa. How does a consumer initiate an appeals process with their state Medicaid office?

Melissa McChesney: That's a good question. Each state has its own fair hearing process and timeline. At a minimum, states must offer individuals an opportunity to request a fair hearing in writing and in person. Many states allow people to file a request over the phone, and some states allow a person to submit the request online. Information on how you request a fair hearing must be included in that notice that we were talking about, that comes to let you know that you will be—you will be disenrolled soon. So, look to that notice for your state's process on how to file a request for a fair hearing.

Stefanie Costello: Thank you. So, kind of a follow-up is, how long do appeals typically take?

Melissa McChesney: That's another really good question, and a little bit complicated, but in general, the rule is that if a person requests an appeal within the time frame provided by the state, so states, again, have their own time frames under which a person needs to request an appeal. So, this could be any way—anywhere from 20 days after you get the notice, all the way to 90. We have a few states right now during Unwinding, California specifically, Hawaii—related to their wildfires—that will allow you up to 120 days to request an appeal. So, first thing, you have to request it on time. And again, that's why we encourage everyone to request an appeal if they think their determination was wrong, just as quickly as they can after getting the notice. Now, once you've requested the appeal, the state from that time period, has 90 days to take what we call "final administrative action." And that means they have to decide the case but also, whatever the decision was, they have to make that effective. Now, we do have right now, 25 states that have a flexibility where they can take more than 90 days. And this is because of the great workload that comes with the Unwinding process that we're all talking about. So, they may—those individuals in those states may end up waiting longer on their fair hearing request to be resolved. However, as a part of that authority, these states had to agree to provide an individual that requested an appeal on time—they have to provide them continued benefits until the states takes the final administration—final administrative action on that appeal. So, the very short answer is usually 90 days, but in the Unwinding process, there are states that are taking longer but beneficiaries who request an appeal online—on time, excuse me, will receive benefits while they wait for that appeal in those states, and I think we can add a link in the chat to a list that would—that shows you which states have that authority in place right now.

Stefanie Costello: Great. Thank you. So, Jessica, you—this next question is for you. You touched on it a little bit, but will there be retroactive coverage for anyone who is reinstated after losing Medicaid eligibility?

Jessica Stephens: Yes. So, I think this is similar to the last question. The answer is, generally speaking, yes. If an individual is—there's a retroactive coverage period when an individual applies for coverage for 90 days prior to the date of application. And so, if an individual is reinstated—now, if a state made a mistake and terminated coverage or disenrolled an individual inappropriately, there is retroactive coverage to that date of disenrollment.

Stefanie Costello: Great. Thank you. And our last question on the topic is back to Melissa. If a person requests an appeal because they believe they were erroneously terminated, will they receive retroactive coverage?

Melissa McChesney: So, if a person requests an appeal and ultimately that appeal is determined in their favor—meaning that through the appeal process, it is determined that they were correct, and that their termination should not have occurred, then, um—so they won their appeal, so to speak—then yes, the state is required to reinstate services back to the date of action or for those individuals who are already receiving the benefits pending the outcome of the appeal, then they will just continue to receive benefits.

Stefanie Costello: Great. Thank you, Jessica, and thank you, Melissa. Those were great questions. I know we've received a lot about the appeals process, so thank you for answering those. Our next set of questions today is for Jack Mirabella with the Center for Consumer Information and Insurance Oversight (CCIIO) and relate to Medicaid to Marketplace transitions. So, our first question is, what's the role of state exchanges, if one exits versus going to federal HealthCare.gov for insurance?

Jack Mirabella: Sure, so HealthCare.gov is the federal Marketplace which operates in 32 states. The Unwinding Special Enrollment Period, or SEP, allows consumers to apply for Marketplace coverage if they lose Medicaid or CHIP. Currently, 19 states operate their own Marketplaces and have also implemented SEP flexibilities. If consumers are not sure where to apply for coverage, they can always start with HealthCare.gov and will be automatically redirected to their state-based Marketplace, if applicable.

Stefanie Costello: Great, thank you. Your next question: if someone loses Medicaid and uses the Special Enrollment Period, the Unwinding SEP, would the applicant need to show proof that they lost Medicaid?

Jack Mirabella: If the consumer loses Medicaid or CHIP coverage, they are not required to submit documentation to receive the Unwinding SEP. They will only need to attest to loss of Medicaid or CHIP coverage on their application. We are providing a link in the chat to the FAQ CMS released in January of this year, which covers the Unwinding SEP. If you need to refer back to this question, Q7 addresses this issue.

Stefanie Costello: Alright, thank you, and Hailey has put that in the chat for everybody. So, thank you, Jack. All right, our next question is going to go to Melissa MacLean from the Center for Consumer Information and Insurance Oversight and relates to the Navigators and assisters. So, Melissa, is there any way that assisters can receive training and information about how we can help clients, either that's income limits, requirements to qualify, for different plans or programs?

Melissa MacLean: Yes, there is. Every year, we put out annual assister certification training for our assisters. You can take that as a Navigator, as a Certified Application Counselor, as an Enrollment Assistance Personnel or EAP, or other. And the training is updated annually. It is put out usually sometime in late summer, early fall. It is currently online and available for folks to take—it is actually required training. If you are a federally facilitated navigator or a federally facilitated CAC or Certified Application Counselor, you would sign up for this training on portal.cms.gov and take the training. We also have resources and guides to kind of help you

create accounts on the portal and access the training, if you need help with that, and I can pop that into the chat.

Stefanie Costello: Great, thank you, Melissa. All right, our next set of questions are for Alyssa Walen with the Office of Communications, and this is related to communications and outreach. So, Alyssa, how can we help consumers identify and avoid possible scams related to renewing their Medicaid coverage?

Alyssa Walen: A great question, and I know Angela talked a little bit earlier about how this is an issue with Medicare Open Enrollment, and certainly with Marketplace Open Enrollment happening right now as well as lots of things. People are going through transitions. We have heard some cases of people being contacted either with unsolicited emails or text messages or phone calls that may be scams. So, we encourage folks to just be wary of any unsolicited text messages that aren't coming from a trusted source. Places that seem to ask for your personal information upfront like providing your Social Security number—that should never be requested for, through that—those means. They also shouldn't be requesting money upfront, so things like credit card payments to be able to help you find coverage, and certainly, they shouldn't be threatening you or anyone in your household with any legal action if you don't respond. So, there are a number of resources that we have actually made available, particularly for partners, to help get this information out. They are available at Medicaid.gov/Unwinding in the Outreach and Education Resources section. Feel free to take and use those and help spread the word in your community and just be wary of unsolicited requests for information that you normally would not provide even as you're going these processes.

Stefanie Costello: Thank you. Your next question is, how long do we have to tell our community about these changes and needs with Medicaid renewals?

Alyssa Walen: Well, as Stefanie said at the get go, we know that people are going to be going through the Unwinding process, and through the redetermination renewal process into next year. So, really into—probably later into 2024, folks will be going through this, and returning to regular operations renewal. But ultimately, we want to make sure people are able to get help no matter when they come into our program. So, for anyone who is on the ground helping people with Medicaid and CHIP find new coverage, the resources that we're making available now, will certainly apply into the future. We want to encourage you to continue to help folks as they are working their way through the process. And then, in your individual states, the timelines will look a little bit different. But we encourage folks to continue to use all resources available over the next many months as people are still working through what they need to do and have their coverage renewed.

Stefanie Costello: Thank you. You next question is, are the materials available to be printed and shipped to me? I don't have resources to print a lot of flyers.

Alyssa Walen: Yes, this is actually a really common question. So, we started to make a number of resources available to print and ship. If she hasn't done so already, Hailey will get the link into the chat. We have a resource here at CMS that allows you to create a free account. You can sign up—you do have to sign in and sign up but it's free, and you can request a number of different

resources from that list, including take-home postcards and flyers and other types of things that you can either leave at your desk or hand out to people as you are out in the community. So, we encourage everybody to take advantage of that. We have a lot a lot of stuff available at our warehouse that we are happy to send to you.

Stefanie Costello: And I will add, we do have some printed materials in additional languages as well. So, go in there and check it out. It is not just limited to Unwinding. A lot of Marketplace and Medicare information on there as well. We could spend a whole day going through our—our materials.

Alyssa Walen: Yes.

Stefanie Costello: And your last question, Alyssa is, apart from letters from the State Department alerting people to check their mail, we know the majority are being disenrolled via procedural errors. What steps can the state or stakeholders take to help raise awareness via local newspapers or online communities and organizations?

Alyssa Walen: Yeah, so this is a great question because, you know, a lot of the resources that we have available out there already, are not necessarily, as yet, to get out to, necessarily newspapers or newsletters. However, good news is, within the week, we expect that we will have some additional things available that partners can take and share, either through your own newsletters, through partner newsletters, or things to provide your local newspapers or outlets that will help explain what the process is, what is happening with Unwinding. So, it's really taking those resources that are available on Medicaid.gov/Unwinding, putting it into another format that you can just plug into wherever you need to use it, so hopefully, that will be helpful for folks. We will make sure that that is sent out to everybody who has participated in these calls, so that you have easy access to that going forward.

Stefanie Costello: Awesome. Thank you so much, Alyssa. All right, so our next and last set of questions are for Kim Spalding Bush and Melissa Heitt, with the Medicare-Medicaid Coordination Office, and it's related to people who are dually eligible for Medicaid and Medicare. So, the first question: can you please clarify dual eligibility as it relates to patients who are Medicare eligible but are enrolled in a Medicaid managed care program?

Melissa Heitt: Hi, this is Melissa Heitt. So, dual eligibility is more a status. So, an individual who both has Medicare coverage and Medicaid status is considered dual eligible, whereas a person who is enrolled in managed care is—that's a delivery system. So that's a way an individual gets their benefits is through managed care. So, it doesn't change your status as being eligible for Medicare and Medicaid. It's really just about how you're getting your benefits. Now, there are some dual-eligibles who actually are in these Medicare Advantage Plans, and some of those do provide some extra Medicare benefits, but that's a choice of the individuals. So—but for Medicaid, if you're—if you're Medicaid—whether you're—um, it's—you're in the same eligibility group. It doesn't change your status of which eligibility group you qualify, whether you're in Medicaid managed care or just fee-for-service Medicaid.

Stefanie Costello: Thank you. All right, the next question. Are there any resources available to share with dual eligible individuals around renewing their Medicaid coverage?

Melissa Heitt: So again, because dual-eligibles actually are considered eligible for Medicaid, and it's really the same toolkit that CMS has produced—CMCS (Center for Medicaid & CHIP Services) has produced—for renewing eligibility for Medicaid, also applies to dual-eligibles for their Medicaid coverage. So, the same process. First, states are supposed to do ex parte, to the extent they can, and then they would ask for renewal forms. So, it's really the same process. It's just, sort of what happens after is a bit different. But it's the same process of renewing.

Stefanie Costello: All right. And then, the last question for your office is, are members with Dual Plans with Medicare Advantage plans automatically renewed?

Kim Glaun: Hi, I'll take this one. I'm Kim Glaun and, as Angela—so the answer to that is, yes. So, as Angela described, earlier, Medicare Advantage Plan members stay enrolled in their plans from year to year unless they make an affirmative change to their Medicare coverage during the annual Open Enrollment Period, and the same goes for dually eligible individuals who are enrolled in the specialized plans for dually eligible individuals. And we—we—uh, you may have heard them referred to as D-SNPs (Dual Eligible Special Needs Plans). But it's important to remember that in order to qualify for one of these D-SNPs, people need to be dually eligible for Medicare and Medicaid. So, if a D-SNP member does end up losing Medicaid coverage, plans actually can continue their enrollment for a limited period of up to six months, while the individual tries to regain Medicaid. Just know that the availability and length of any continued D-SNP enrollment will depend upon the plan. Plans need to tell you about that period, but you also can contact them. But during that continued enrollment, the D-SNP plan would continue to provide all the Medicare Advantage Plan covered benefits and supplemental benefits, but members would actually need to pay their plan cost sharing—the Medicare Advantage Plan cost sharing because they have lost Medicaid coverage. And if the individual doesn't end up regaining Medicaid during that continued enrollment period, the D-SNP must terminate the individual with—at the end of the period after 30 days advance notice—a minimum of 30 days advance notice.

Stefanie Costello: Great. Thank you so much, Kim, and thank you, Melissa, for answering those questions about the dually eligible. I want to just thank everyone for staying on just a few minutes longer. I know we went over, but we had so many important topics and questions to cover today. And so, this concludes our webinar. We do hope that the information shared today was helpful for your organizations as you continue your outreach, and sharing information with the communities you serve. We will be sending an email in the next week or so with the link to the recording, and transcripts from today's webinar, as well as the link to the resources Alyssa spoke about. And we, up on the slide right now, you'll see that we have one more remaining webinar for 2023, and that next webinar is going to combine our usual November December webinars, they happen at the end of the month. We're going to combine them, so the last webinar will take place on December 6 at 12:00 p.m. Eastern to accommodate our winter holidays. And you can register for the upcoming webinars using the same link you used to register for today's webinar. Again, we appreciate your partnership and commitment to help ensure that people are connected to the best health care coverage they are eligible for. We look forward to continuing to

work alongside all of you and continuing to engage with you. Thank you, and that concludes today's call.