Michigan Department of Health and Human Services
Behavioral & Physical Health & Aging Services Administration

COVID-19 Public Health Emergency Unwinding and Restart of Medicaid Renewals Operational Plan

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Important note!

This document is updated as quickly as possible. However, changes can occur as the federal government further releases guidance on how to address Medicaid eligibility following the public health emergency (PHE).

Updated versions of this plan can be accessed at:
https://www.michigan.gov/2023benefitchanges.

For questions, comments, or concerns on the information presented in this guide, email:
MDHHS-PHE-End@michigan.gov.

Change Log:

Change Date	Page #	What Changed	Reason for Change
March 2023	All	Updates to all sections, reflecting changes needed	The issuance of CAA of 2023
June 2023	All	Additional updates on new flexibilities waivers	New waiver flexibilities from CMS

Table of Contents

Background and Overview 5
- Consolidated Appropriations Act of 2023 5
- Public Health Emergency Ending 6

MDHHS Global Unwinding Approach 6

Unwinding PHE Specific Flexibilities and Policies 7
- COVID-19 Testing, Treatment, and Vaccine Coverage 8

Resumption of Standard Eligibility Operations 8
- Resumption of Standard Medicaid Renewals 9
- Ex Parte Rates and Redeterminations Caseload 9
- Maintaining Continuity in Coverage 10
- Renewals Timeline 11
- Mapping 12

PHE Unwind Special Flexibilities and Waivers 13
- Maintaining Up-To-Date Beneficiary Contact Information 13
- Returned Renewal Packets and Multiple Modality Outreach 14
- Increasing Ex Parte Renewals for Beneficiaries 14
- Phone Renewals 14
- Flexibilities for Beneficiaries Undergoing Life Saving Treatment 15
- Strategies to Prevent Procedural Terminations 15
- Workforce Strategies 17
- Transition to the Marketplace 17

Stakeholder Communications and Public Outreach 18
- Beneficiary Letters 18
- Media Campaign 18
- Beneficiary Communications 19
- Data Sharing with Managed Care Organizations & Other Provider Organizations 20

Monitoring PHE Unwinding Operations 21
- Eligibility System Builds 22

Resources 23
- State Guidance 23
- Federal Guidance 24

Appendices 25

Appendix A: COVID-19 PHE Unwind Crosswalk 25
Appendix B: State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions 26
Appendix C: Beneficiary Awareness Letter 34
Appendix D: Available State Strategies to Minimize Terminations for Procedural Reasons During the COVID-19 Unwinding Period 35
Appendix E: Sample Stakeholder Toolkit Materials 36

Background and Overview

During the federal Coronavirus 2019 Public Health Emergency (PHE) declaration, the Centers for Medicare and Medicaid Services (CMS) provided state Medicaid programs flexibilities allowing for individuals to gain or maintain coverage and access to care. Since the initiation of the PHE, the Michigan Department of Health and Human Services (MDHHS) implemented more than 100 programmatic flexibilities to help minimize the strain to the Medicaid program and its beneficiaries and Michigan's (MI) health care providers and systems. These changes were implemented under a variety of federal and state authorities and impact almost all aspects of the Medicaid delivery systems. The termination date of each flexibility was defined by the federal authority that granted the flexibility. In preparation for the end of the federal PHE declaration, MDHHS developed this Unwinding Operational Plan to help inform beneficiaries, providers, managed care plans, and other valued stakeholders of the steps MDHHS is taking to return to standard operations. States will have up to 12 months to return to normal eligibility and enrollment operations.

Most of the flexibilities implemented in Michigan Medicaid during the PHE were authorized through federal pathways in partnership with the Centers for Medicare and Medicaid Services (CMS). Examples of these pathways include the Disaster Relief State Plan Amendment (DR SPA), Disaster 1135 Waiver Authority (1135), section 1115 demonstration authority, and the Appendix K process for 1915(c) Home and Community-Based Services (HCBS) waivers. Each federal authority differs in terms of the applicable policy, approval process, and unwinding requirements, resulting in important implications for MDHHS' approach to unwinding. These differences influence the department's ability and timeline to make permanent changes to the Medicaid program or return to policies in place before the PHE.

In addition to these federal authority pathways, significant changes to Medicaid programs were authorized through federal legislation. The Families First Coronavirus Response Act (FFCRA) authorized enhanced federal funding for Medicaid programs conditioned upon Maintenance of Eligibility (MOE) requirements that prohibit disenrollment in most circumstances. This requirement is commonly referred to and throughout this document as the continuous coverage requirements under the FFCRA. The American Rescue Plan Act (ARPA) extended coverage of COVID-19 vaccines and treatment services to limited benefit populations at no cost to states, and also provided an enhanced funding opportunity for state Medicaid programs to spend on increasing access to HCBS. As with the flexibilities granted by CMS through the DR SPA and waiver pathways, the FFCRA and ARPA also influenced MDHHS' unwinding plan. The end of the FFCRA continuous coverage requirements have great impact across the Medicaid and health care systems. Therefore, MDHHS' primary goal is to maximize continuity of coverage for beneficiaries throughout the unwinding of the FFCRA continuous coverage requirement.

Consolidated Appropriations Act of 2023

In December 2022, Congress passed the Consolidated Appropriations Act of 2023 (CAA 2023) that decoupled the Medicaid continuous enrollment provisions from the end of the Public Health Emergency. Additionally, the CAA 2023 included new provisions for state Medicaid agencies related to restarting eligibility renewals. The CAA 2023 ended the continuous enrollment provisions under the FFCRA March 31, 2023. Beginning April 1, 2023, states must

end enrollment for beneficiaries no longer eligible for Medicaid after conducting a full eligibility renewal during the 12-month unwinding period. MDHHS will begin renewals with the June 2023 cohort and begin conducting passive[1] enrollment for this cohort in April 2023.

Section 5131 of the CAA 2023 added a new subsection for FFCRA for which states must be in compliance with to claim enhanced Federal Medical Assistance Percentages (FMAP). The new conditions include:

- Conduct Medicaid eligibility redeterminations in accordance with all applicable federal requirements, including renewal strategies authorized under section 1902(e)(14)(A) of the act or other alternative processes and procedures approved by CMS.
- Attempt to ensure that states have up-to-date contact information for a beneficiary before redetermining eligibility.
- Undertake a good-faith effort to contact an individual using more than one modality prior to terminating their enrollment on the basis of returned mail.
- New monthly data reporting requirements including elements such as: counts of redeterminations initiated, total renewals, number of passive renewals, terminations, number of procedural terminations, number of CHIP enrollments, and other metrics. MDHHS has made these CMS reporting requirements publicly available at https://www.michigan.gov/mdhhs/end-phe/michigan-medicaid-renewals-data.

Greater details on how MDHHS will meet each of these requirements are discussed under the section, Resumption of Standard Eligibility Operations.

Public Health Emergency Ending

While the Medicaid continuous enrollment provisions were separated from the PHE, there were several other policies and flexibilities that remain tied to the end of the PHE. The public health emergency allowed for the use of a range of Medicaid emergency authorities, including Disaster-Relief state plan amendments (SPAs), Section 1135 waivers, Section 1915(c) Appendix K waivers, and Section 1115 waivers.

On February 9, 2023, the U.S. Department of Health and Human Services announced that the Public Health Emergency will end on May 11, 2023. Additional details on the unwinding of specific policies and flexibilities are described in the section Unwinding PHE Specific Flexibilities and Policies.

MDHHS Global Unwinding Approach

To support states through this challenging transition, CMS issued a set of guidance to Medicaid programs, providing details and requirements for unwinding each type of federal flexibility. CMS published multiple State Health Official (SHO) letters specifically on the topic of unwinding federal flexibilities authorized during the PHE, —in addition to tool kits, presentation slide decks, and other materials. CMS also published an Informational Bulletin January 5, 2023,

[1] Passive or ex parte renewal means the state attempts to renew the beneficiary with existing data and information without first contacting the beneficiary.

outlining the new requirements authorized in the CAA of 2023. Numerous all-state webinars and individualized technical assistance calls were established by CMS. MDHHS has leveraged the guidance and various materials from CMS in the unwinding efforts. The resources available through CMS provide details regarding timeframes associated with each authority, the requirements that must be followed when they expire and if states choose to make eligible flexibilities permanent. MDHHS is following this guidance closely to ensure compliance with all applicable requirements. The latest federal guidance for unwinding the PHE can be found on CMS' website linked in the Resources Section of this document.

It is important to keep in mind that, while flexibilities were authorized in the form of DR SPAs and federal waiver approvals, MDHHS often implemented these changes through policy letters, provider bulletins, and other forms of sub-regulatory guidance. As the department unwinds the temporary flexibilities of the PHE, we will publish, revise, and/or rescind guidance to ensure that Michigan Medicaid beneficiaries, managed care plans (health, dental, and behavioral health), counties, providers, and stakeholders all understand the applicable policies and procedures that are in effect, as appropriate. All MDHHS policy guidance specific to the PHE can be found on the department's Medicaid Policy and Forms webpage. Further, the department will utilize its existing stakeholder groups and forums to share unwinding information as it becomes available. As necessary, MDHHS will also host new stakeholder events to discuss the unwinding process when existing forums are not sufficient.

Unwinding PHE Specific Flexibilities and Policies

In addition to the significant effort to prepare for resumption of standard eligibility operations, there are many programmatic flexibilities that MDHHS, Michigan's managed care organizations (MCOs), counties, providers, and other partners and stakeholders must now take action to unwind. MDHHS has reviewed the catalogue of policies released in response to the PHE and has assessed the impacts of the impending end of the PHE declaration.

Examples of policy flexibilities that were implemented in response to the PHE include Telemedicine, Face-to-Face, Person-Centered Service Plan, Prior Authorization, Direct Care Worker/Wage Increase, and Level of Care Determinations, among others. Each flexibility has been reviewed and determination made for continuation with or without modification beyond the PHE end, temporary extension for a defined period of time following PHE end, or termination upon PHE end.

COVID-19 response policies that will change or end will be fully promulgated, which includes a 35-day public comment period and final distribution at least 30 days prior to the effective date. Beneficiaries will be provided with timely and adequate notice of the ending or reduction of any COVID-19 response services. For services that will continue either permanently or temporarily under a new authority appropriate tribal notices and public notices will be issued according to required timelines.

To support providers and community partners in tracking the transitions in policy, MDHHS plans to update the information about various policy groups and has produced a detailed crosswalk

illustrating the outcome of policies issued during the PHE, referencing to any adaptations, new, or discontinued policies as they are promulgated.

The policy unwind crosswalk can be found at PHE Unwind Policy Crosswalk (michigan.gov) and is updated weekly as unwind decisions are made and policies and letters are issued.

COVID-19 Testing, Treatment, and Vaccine Coverage

Under the ARPA, MDHHS plans to continue to cover COVID-19 testing, and vaccines and their administration, without cost-sharing, for nearly all Medicaid beneficiaries, including most groups receiving limited-benefit packages under the state plan or a section 1115 demonstration. The ARPA also requires Medicaid coverage without cost sharing for COVID-19-related treatment, and treatment for conditions that may seriously complicate the treatment of COVID-19. This coverage period generally continues through end of the first calendar quarter that starts one year after the end of the PHE. Following the extended coverage period available through the ARPA, MDHHS intends to cover COVID-19 testing and vaccine administration consistent with existing testing, treatment and vaccine services.

Resumption of Standard Eligibility Operations

Under the continuous coverage requirement in the FFCRA, states have been required to maintain enrollment of nearly all beneficiaries through the end of the month in which the PHE ends. When continuous coverage requirements expire, states are required to conduct a full redetermination for all beneficiaries who would otherwise have been subject to redetermination over the course of the PHE. When the CAA 2023 was enacted, it delinked the Medicaid continuous enrollment provisions from the end of PHE and ended the continuous enrollment provisions under the FFCRA on March 31, 2023. Beginning on April 1, 2023, States must end enrollment for beneficiaries no longer eligible for Medicaid after conducting a full eligibility renewal during the 12-month unwinding period. MDHHS will begin renewals with the cohort of Medicaid beneficiaries with June redetermination dates.

CMS has released guidance to support state Medicaid and Children's Health Insurance Program (CHIP) agencies in returning to standard operations through a series of State Health Official (SHO) letters. SHO guidance released between 2020 and 2023 sets out federal expectations and requirements related to case processing timelines and beneficiary communications for redetermining Medicaid coverage for those who had their coverage continuously maintained. The March 2022 guidance builds upon the August 2021 SHO letter, where CMS clarifies that it will consider a state in compliance with resuming normal eligibility operations if it has: (1) initiated all renewals for the state's entire Medicaid and CHIP caseload by the last month of the 12-month unwinding period; and (2) completed all such actions by the end of the 14th month after the end of the PHE. CMS also clarifies that states may use information gathered during a renewal that was initiated up to two months prior to the end of the PHE to take final action in the month after the month in which the PHE ends. The PHE Unwinding Period would be 12-months, with an additional two months, totaling 14 months, to complete all outstanding eligibility and enrollment actions from the PHE. The "PHE Unwinding Period," is defined throughout this document as 12 months. In support of the PHE Unwinding Period and beyond,

MDHHS has developed this PHE Unwinding and Medicaid Renewal Restart Operational Plan that overviews the MDHHS guiding principles and implementation approach in preparing for the resumption of normal eligibility operations, specifically in the areas of redeterminations, eligibility coverage retention strategies, beneficiary communications and outreach, county and system readiness, and data reporting. This PHE Unwinding and Medicaid Renewal Restart Operational Plan, in part, reflects the federal requirement of an operational plan that describes how states will address outstanding eligibility and enrollment actions in a way that reduces erroneous loss of coverage and enables a sustainable distribution of renewals in future years. All published PHE Unwinding guidance from CMS is published on their website at https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.

Resumption of Standard Medicaid Renewals

At the start of the Public Health Emergency, MDHHS quickly made changes to IT systems in order to prevent closure of Medicaid benefits for all recipients except for those that were deceased, living out-of-state, or who requested to end their Medicaid coverage. The system changes included stopping the normal processes, which are run in order to complete a redetermination of eligibility, as well as preventing any changes from reducing or terminating coverage while still allowing approval of coverage and increases in benefits. As part of the unwinding process for the Public Health Emergency, MDHHS is now restoring those system processes that were previously stopped. The system changes include restarting the ex-parte renewal process to automatically renew all beneficiaries whose eligibility can be redetermined without needing to request further information from them, resending renewal packets through the mail for those that cannot be automatically renewed, and allowing the termination or reduction of benefits for those who have been renewed and are no longer eligible. Additional system changes and improvements have been made to streamline processes that existed prior to the Public Health Emergency.

MDHHS, with the support of its IT vendors, and the Department of Technology Management and Budget (DTMB), had been completing a full set of testing around the IT system changes that are being implemented as part of the Public Health Emergency Unwinding and the restart of Medicaid renewals. These tests include Quality Assurance Testing (QAT), system testing, Integration testing, User Acceptance Testing (UAT) and performance testing. Testing continues as new system changes are implemented and MDHHS is following the standard DTMB and state of Michigan requirements for IT system readiness based on those testing results.

Ex Parte Rates and Redeterminations Caseload

Ex parte is one of the most critical components of the Medicaid determination process, as it allows redeterminations to process automatically using existing data and information the state has from both federal and state databases. Beneficiaries going through the ex parte renewal process, and those who are successfully renewed, would have their case renewed for another year without having to complete a renewal packet.

The ex parte process is even more critical now that the continuous coverage requirement has ended, and the Medicaid program has added more than 1 million new beneficiaries since

March 2020. Currently nearly one third of Michiganders are on Medicaid, and the ex parte process will be instrumental as it prevents delays in eligibility determinations, reduces the administrative burden, and alleviates beneficiaries from having to provide unnecessary information.

To maximize opportunities within the current ex parte renewal process, MDHHS collaborated with CMS to design an approved mitigation strategy. The mitigation strategy, coupled with other flexibilities MDHHS is harnessing during the continuous coverage unwinding period, will aim to limit the number of renewal packets that must be sent out and completed, as well as reduce the number of cases local office staff must manually process as a result.

For Medicaid recipients whose eligibility is not based on Modified-Adjusted Gross Income (MAGI) rules, MDHHS will utilize currently known information about income and assets to attempt to automatically renew their eligibility without further request of information from the beneficiary. Those individuals who appear to be ineligible based on known information, or who do not have enough information to automatically renew them, will receive a renewal packet to complete through the mail. As part of the mitigation plan, MDHHS will work towards developing a fully compliant ex parte renewal process for non-MAGI Medicaid recipients.

Maintaining Continuity in Coverage

As indicated throughout this document, maximizing continuity of coverage for Medicaid beneficiaries through the course of the PHE Unwinding Period is a priority for MDHHS. A key goal is to keep the PHE unwinding process as simple as possible. When the continuous coverage requirement expires, CMS guidance provides that states will generally have up to 12 months to return to normal eligibility and enrollment operations. This means Michigan has a total of 12 months to initiate and complete redeterminations for nearly all of Michigan Medicaid beneficiaries. This will include local county offices conducting a full renewal for all individuals enrolled, through ex parte renewals and requests for information where necessary. This is in addition to regular, ongoing operational requirements such as, processing any outstanding applications that were received during the PHE, conducting routine verifications, and processing changes in circumstances.

To simplify the complexity of the PHE unwinding process, MDHHS will maintain beneficiaries' current renewal month in their case records and conduct a full redetermination at the next scheduled renewal month following the end of the PHE. This approach achieves the following:

1) Least disruptive to county workloads on both an initial and ongoing basis.
2) Aligns, to the greatest extent possible, on when beneficiaries usually expect to receive their auto-renewal letters or packets requesting additional information if auto-renewal is not successful, prior to the PHE. This familiarity is critical as MDHHS rolls out the communication and outreach campaign discussed below.
3) Retains a similar redetermination caseload distribution in future years.

Per federal and state guidelines that have existed since before the PHE, the annual redetermination process occurs in several steps, spanning across multiple months. See the

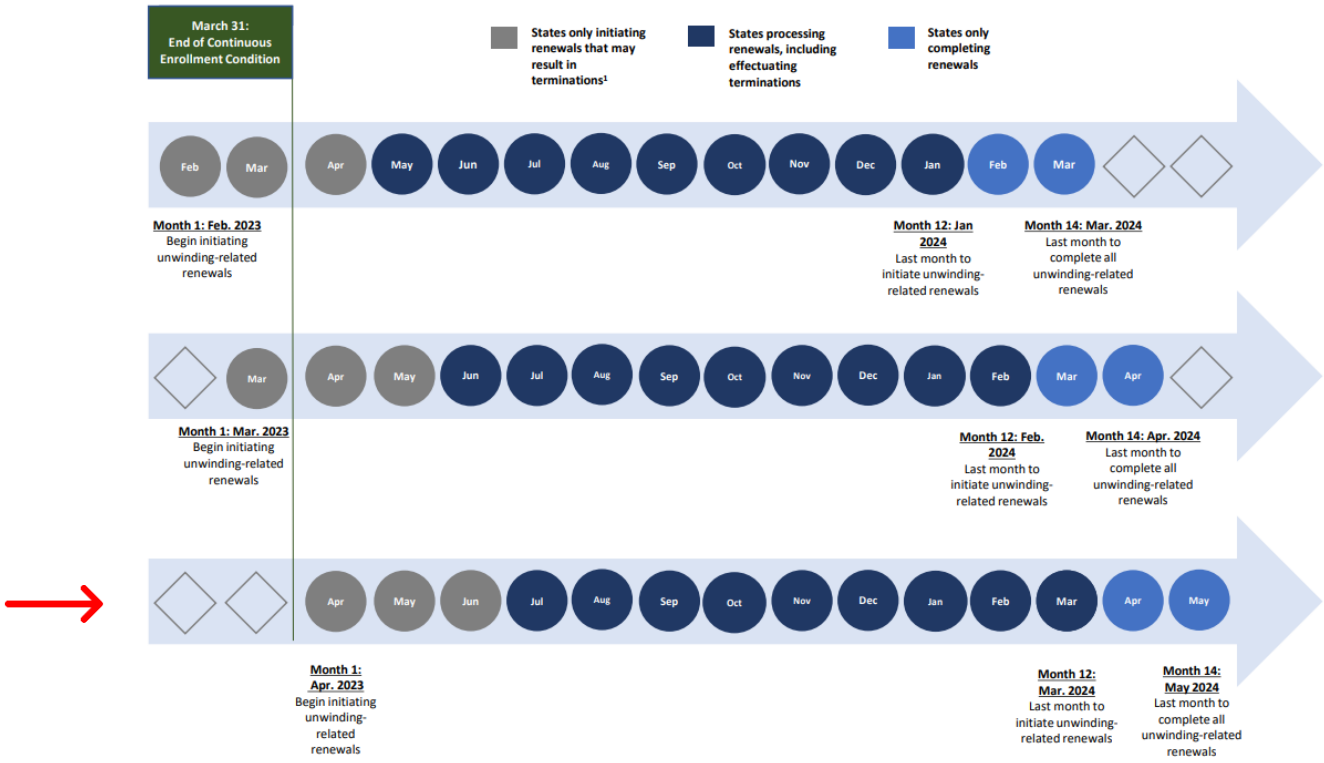
Renewals Mapping section below for a full mapping of the 12-months of expected begin and end dates of renewal activities.

Renewals Timeline

Shortly after the passage of CAA 2023, CMS issued an Informational Bulletin that outlined the renewal options available to states with the end of the continuous coverage requirement occurring March 31, 2023. MDHHS utilizes a 90-day renewal timeline and reviewed CMS's guidance to select a timeline start that would allow beneficiaries ample time to update their contact information, receive MDHHS's one page awareness letter, and ensure broad messaging across the state.

In the below timeline from CMS, MDHHS has selected the third timeline, indicated with a red arrow. In this timeline, April 2023 is the first month that MDHHS began initiating its unwinding with the first coverage terminations effective in July 2023. Starting in April 2023, MDHHS began running the ex parte process for all the June 2023 cohort, with packets mailed out as needed in the beginning of May 2023. MDHHS will wrap up all unwinding activities by the end of May 2024, which is the last month that MDHHS is permitted to complete all unwinding related activities.

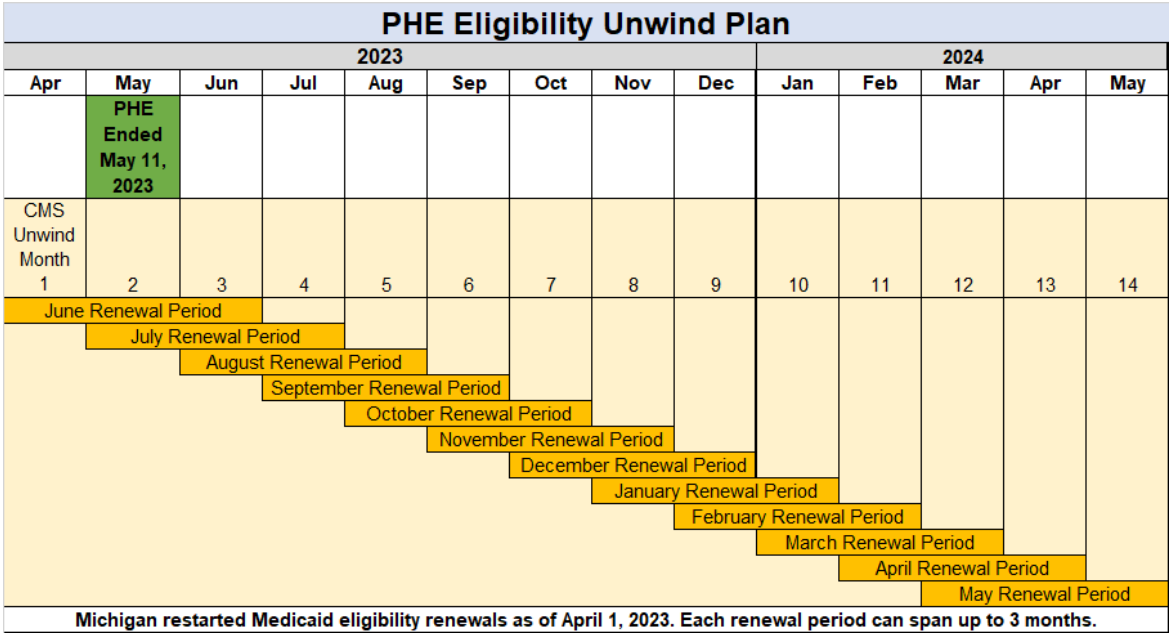
Appendix B2 – Example – Unwinding Timeline for State with a 90-Day Renewal Process



In order to help beneficiaries understand the renewal timeline and when they should expect outreach from MDHHS, the state developed an Eligibility Notification Timeline which is publicly available on the MDHHS website. A video walkthrough of the timeline is also available.

Mapping

MDHHS will establish an updated system logic aimed at selecting and including all beneficiaries in an eligible data group of the same month, regardless of enrollment year for redetermination processing. This will ensure that no matter when a beneficiary enrolled and/or was initially scheduled for redetermination, they would be included in the process during the resumption of standard activities. For example, October 2023 would include not only October 2023 but also renewals for October 2022, October 2021, October 2020, October 2019, etc. Following the timeline below:



As part of the MDHHS's State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions, MDHHS provided to CMS February 15, 2023, a breakdown of the approximate number of Medicaid and CHIP renewals that MDHHS intends to initiate each month during the state's 12 months unwinding period. The full report is available in Appendix B.

a. Please indicate the approximate number of Medicaid and CHIP renewals that the state intends to initiate each month during the state's 12 months unwinding period using the following chart:

Note that the percentage of renewals scheduled to be initiated in a given month is based on the state's total caseload as of the end of the month before the state begins to initiate renewals that may result in termination of beneficiaries who do not meet eligibility requirements or who fail to timely return information needed to complete a renewal. States may not initiate renewals that may result in terminations more than two months before the continuous enrollment condition ends in the state. A state's total caseload may be the state's total enrollment of individuals or the total number of households with one or more household members enrolled in Medicaid.

Unwinding Period Month	1	2	3	4	5	6	7	8	9	10	11	12	Total
Number of renewals scheduled to be initiated	228,081	264,067	276,765	274,021	295,948	280,967	281,056	248,051	248,536	267,036	222,637	221,312	3,108,477
Percent of renewals scheduled to be initiated	7%	8%	9%	9%	10%	9%	9%	8%	8%	9%	7%	7%	100%

b. Is the state measuring the volume of renewals that it intends to initiate each month by households (which may include more than 1 beneficiary) or individuals?

- [ ] Households
- [x] Individuals

PHE Unwind Special Flexibilities and Waivers

Maintaining Up-To-Date Beneficiary Contact Information

To ensure all Medicaid beneficiaries receive updates from MDHHS on the restart of renewals and receive renewals packets, MDHHS has taken a multipronged effort to update contact information. These actions also ensure MDHHS is fully in compliance with provisions of the CAA 2023.

MDHHS has undertaken a robust media campaign to raise awareness across the state of the importance of maintaining updated contact information with MDHHS. This campaign began in 2022 and will continue through the end of the PHE unwind in 2024. The media campaign as included radio and streaming advertisements, social media posts, paid and earned media opportunities, and development of toolkit materials to amplify the message to beneficiaries to update their contact information with MDHHS.

MDHHS is also working on several strategies with its MCOs to update addresses. MDHHS worked with CMS to receive a 1902(e)(14)(A) waiver to allow MCOs to engage in outreach to beneficiaries to update their contact information and then transmit that information directly to the state. This has allowed MCOs, who may be in more frequent contact with beneficiaries, to share updates to contact information without the state duplicating outreach efforts.

MDHHS is also mailing to all beneficiaries three months before their renewal a one-page awareness letter explaining the restart of renewals and what actions beneficiaries can take now. A copy of this letter is available in Appendix C. Additionally, MDHHS is standing up a process to identify all returned awareness letters and send text messages to those beneficiaries alerting them to the need to update their address with MDHHS. Since the awareness letters are sent three months before renewals, this will allow beneficiaries time to update their addresses before renewal packets are mailed.

Returned Renewal Packets and Multiple Modality Outreach

For beneficiaries whose renewal packets are returned to MDHHS by the U.S. Postal Service, MDHHS will be logging a record of the returned mail in the beneficiary case file. MDHHS will then robocall, text, and/or email those beneficiaries to alert them of additional ways they can submit their renewal paperwork (through the MI Bridges portal, via phone). For those beneficiaries with returned mail who contact MDHHS within 30 days of closure, their coverage will automatically be reinstated, and the beneficiary will then have 90 days to complete and return their renewal packet.

In addition to outreach to beneficiaries with returned mail, MDHHS will also conduct targeted outreach to any beneficiary who has not returned a renewal packet. MDHHS will conduct the first outreach at the beginning of the renewal month (for example July for the July 2023 cohort) reminding beneficiaries of the need to complete and submit their paperwork. Shortly before closure, MDHHS will conduct additional outreach again to those beneficiaries who have not submitted a packet stressing the urgency of responding so they do not lose coverage.

Increasing Ex Parte Renewals for Beneficiaries

MDHHS is working to make the Medicaid renewal process as smooth and efficient as possible, coordinating across administrations and with other state departments to ensure Michiganders remain covered. To ensure MDHHS is in compliance with all existing federal regulations, MDHHS is using temporary strategies to increase number of Medicaid members renewed using existing data the state has, such as income information from other social service programs. This process is known as ex parte or passive renewal. These temporary strategies will reduce the number of Medicaid members that must complete forms and submit supplemental documentation to maintain coverage.

While implementing these temporary strategies, MDHHS is also planning for long-term solutions to deliver efficiency in the Medicaid ex parte renewal process and increase the number of individuals that can maintain Medicaid coverage on an ongoing basis. In addition to efforts to streamline the ex parte renewal process, MDHHS is employing a number of flexibilities provided by the federal government to support individuals who receive renewal packets and submit documentation to maintain coverage.

Phone Renewals

To ensure federal compliance with renewal requirements, MDHHS has set a renewal phone line to allow beneficiaries to opportunity to complete their renewal over the phone. The renewal phone line is available Monday through Friday from 8 a.m. to 7 p.m. The number for the renewal line is 1-833-599-6444. This expands the ways beneficiaries can complete their

renewals which includes online through the MI Bridges portal, by filling out pre-populated paperwork and mailing it back, in-person at local offices, or over the phone.

Flexibilities for Beneficiaries Undergoing Life Saving Treatment

MDHHS recognizes that some beneficiaries may be undergoing lifesaving treatment and the loss of Medicaid coverage could result in catastrophic effects, including death for those beneficiaries. To try and mitigate these situations, MDHHS partnered with a workgroup from the Medical Care Advisory Council to understand what populations this would affect and ideas for how to provide additional support.

Based on criteria outlined in the proposal, MDHHS looked for Medicaid beneficiaries who were receiving one of the following treatments: chemotherapy, radiation, immunotherapy infusions, or dialysis. Each month, after the ex parte renewal process was run, MDHHS pulled the list of beneficiaries with these conditions who were unable to be ex parte renewed. Then, MDHHS looked to see whether the beneficiary had another form of comprehensive insurance coverage, such as Medicare.

If a beneficiary had other comprehensive insurance coverage, they were mailed a renewal packet to check their Medicaid eligibility. If they were no longer eligible for Medicaid, they should still be able to receive their life-saving treatments under their other insurance.

For those who could not be passively renewed and MDHHS could not find other credible insurance coverage, MDHHS chose to move these beneficiaries to the last month of the unwinding: May 2024. This would allow beneficiaries the opportunity to finish their treatment and/or have time to make necessary plans for obtaining new insurance coverage if they were found to be ineligible. Beneficiaries will still have to undergo a full renewal in May 2024, but MDHHS believes this is the best way to balance life-savings treatment needs within the rules of the unwind.

Strategies to Prevent Procedural Terminations

In mid-June 2023, CMS released a guidance document to states entitled, “Available State Strategies to Minimize Terminations for Procedural Reasons During the COVID-19 Unwinding Period.” A copy of this document with details about each strategy is available on CMS’s website.

To fully vet these new strategies, MDHHS opted to immediately elect one of the strategies and delay procedural terminations for one month for the June 2023 cohort. MDHHS requested concurrence from CMS for this decision. MDHHS engaged in proactive delaying of procedural terminations – i.e., MDHHS did not terminate benefits in June for procedural reasons and did not send closure notifications. MDHHS continued robust outreach and engagement to these populations over the following month. For any individual in June 2023 cohort that does not respond to the additional outreach and fails to complete renewal paperwork, they will be terminated as of July 31, 2023. MDHHS will provide proper advance notice and follow all applicable federal requirements for advance notice of termination.

Around 15,000 beneficiaries leveraged this extra month to submit their renewal paperwork in July who were part of the June cohort. Because of this positive response, MDHHS has adopted this one-month delay on procedural terminations for all cohorts.

MDHHS is also electing several other strategies put forth by CMS that will help to increase ex parte renewal numbers, decrease procedural terminations, and facilitating efficient re-enrollment of eligible beneficiaries who are terminated for procedural reasons. MDHHS is submitting 1902(e)(14)(A) waivers for the following strategies:

- Renew Medicaid eligibility for individuals with no income and no data returned on an ex parte basis ($0 income strategy).
- Renew Medicaid eligibility for individuals with only Title II or other stable sources of income (e.g., pension income) without checking required data sources.
- Permit managed care plans to provide assistance to enrollees to complete and submit Medicaid renewal forms.
- Designate pharmacies, community-based organizations, and/or other providers as qualified entities to make determinations of PE on a MAGI basis for individuals disenrolled from Medicaid or CHIP for a procedural reason in the prior 90 days (or longer period elected by the state).
- Reinstate eligibility effective on the individual's prior termination date for individuals who were disenrolled based on a procedural reason and are subsequently redetermined eligible for Medicaid During a 90-day Reconsideration Period.
- Extend automatic reenrollment into a Medicaid managed care plan to up to 120 days after a loss of Medicaid coverage ("Managed Care Plan Auto-Reenrollment Strategy").

In addition to these strategies requiring an 1902(e)(14)(A) waiver, MDHHS is also electing the following flexibilities that do not require waiver approval from CMS:

- Renew Medicaid eligibility for individuals with stable sources of income or assets (e.g., many life insurance policies) when no useful data source is available.
- Delay procedural terminations for beneficiaries for one month while the state conducts targeted renewal outreach.
- Send lists to managed care plans and providers for individuals who are due for renewal and those who have not responded.
- Inform all beneficiaries of their scheduled renewal date during unwinding.
- Use managed care plans and all available outreach modalities (phone call, email, text) to contact enrollees when renewal forms are mailed and when they should have received them by mail.
- Extend the 90-day reconsideration period for MAGI and/or add or extend a reconsideration period for non-MAGI populations during the unwinding period.
- Extend the amount of time managed care plans have to conduct outreach to individuals recently terminated for procedural reasons.

MDHHS will continue to review all strategies, flexibilities, and guidance documents from CMS to determine if any additional strategies or flexibilities can be adopted during the unwinding period.

Workforce Strategies

The local county MDHHS offices play a significant role in the PHE unwinding as they administer the Medicaid eligibility and manage Medicaid cases on behalf of MDHHS. Counties are expected to redetermine the full Michigan Medicaid population during the unwinding period after the PHE ends. Recognizing that the significant volume of redeterminations, in addition to the existing workload of application adjudication and ongoing case management, the Public Act 87 of 2021 (Article 6, Part 1, Section 122) has appropriated a one-time augmentation of $20.9 million that will in part be leveraged to support existing staff re-assignments, new local county office eligibility staff onboarding, staff training, and resources for the PHE-related redeterminations.

Transition to the Marketplace

MDHHS is working in close coordination and partnership with the Michigan Department of Insurance and Financial Services (DIFS) to ensure beneficiaries no longer eligible for Medicaid have a smooth transition to the marketplace. Medicaid beneficiaries, who have lost their Medicaid eligibility, qualify for a Special Enrollment Period in the health care marketplace. To ensure individuals are fully aware of all their health care options, MDHHS and DIFs have implemented a joint Marketplace Coordination Workgroup to support robust interagency communication and coordination.

This workgroup has also led to the release of joint guidance to MDHHS's contracted Medicaid Health Plans (MHPs) regarding permissible beneficiary outreach, including establishing an outreach strategy for MHPs that offer a marketplace plan. The workgroup has developed an outreach strategy to assure that individuals who are transitioning from Medicaid coverage due to excess income are aware of their options for staying covered. This outreach strategy includes providing education about the federal marketplace and how to find additional resources, including navigators and assisters in their community. To provide a comprehensive resources, education, and other resources to help impacted Michiganders understand their coverage options, DIFS has created a website at https://michigan.gov/staycovered.

MDHHS has also contracted with Maximus to develop a cost-effective outreach proposal for those who are transitioning from a Medicaid health plan that does not have a marketplace plan in their area. Maximus has implemented an outbound dialer campaign for those losing Medicaid coverage due to excess income or assets who do not have other comprehensive insurance.

Outreach calls provide federal marketplace education and contact information (i.e., what is the federal marketplace, website URL navigation and telephone number) and provides an option to speak to a customer service representative if the individual would like additional information or assistance. The outreach campaign began in June 2023 and will continue for the duration of the redetermination period.

Stakeholder Communications and Public Outreach

Working alongside communications partners, Michigan has developed a human-centered communication approach to ensure that beneficiaries are provided accurate information about the end of the PHE and the potential impact to their coverage. One of the goals of the approach is to reach as many Medicaid beneficiaries as possible; therefore, MDHHS has designed direct messaging campaigns across multiple communication platforms (social media, digital ads, text message, mail, website, radio, email/newsletter copy, poster, wallet card and flyer), and has developed resources to support consistent messaging for community partners to leverage and amplify the outreach efforts. Toolkits and resources are available to MDHHS community partners, regularly updated to align with various phases of the PHE unwind process. Toolkit materials have also been translated into several languages, including Spanish and Arabic. Key components of the messaging will focus on ensuring beneficiaries know it is critically important to:

- Keep contact information up to date so MDHHS can reach them.
- Look for and respond to letters from MDHHS in a timely manner.
- Understand their coverage options and where to go for help.

As resources are finalized, beneficiaries, providers, and community partners can access them at www.michigan.gov/2023benefitchanges. Sample toolkit materials can also be found in Appendix E.

Beneficiary Letters

MDHHS designed standard streamlined communications, using human-centered language to alert beneficiaries of the changes coming and how to take action (if necessary). The department understands that excessive mailings can lose their effectiveness and will work with stakeholders to find the right balance. Currently, beneficiary alert letters are mailed three months before a beneficiary's renewal month and any additional communications come from the department in the form of robo calls, text messages, and/or email. The department will ensure that mailings, individual notices and any information included will be made accessible in the format or language that the beneficiary has selected.

Media Campaign

MDHHS's media efforts began in May 2022. The objective was to encourage beneficiaries to update mailing addresses so they would receive notices and respond. MDHHS also encouraged beneficiaries to renew their coverage as soon as they received renewal packets. The target audience was (primary) Medicaid beneficiaries and (secondary) providers and other professional who may interact with Medicaid beneficiaries. Efforts were focused statewide.

Media efforts include:

- Radio/streaming information.
- Mobile and social placement.
- Work with minority media outlets.

- Outdoor posters.
- Dollar Store/Dollar General (receipts).
- Stakeholder toolkit.

Paid outreach began May 2022. The media plan included statewide radio, audio streaming, mobile ads, and social media placement to encourage people to ensure their contact information is up-to-date so they would receive written renewal notices and also to provide education on the PHE ending.

In February 2023, communication efforts increased with the addition of targeted minority digital display, minority print, minority targeted radio, outdoor, Dollar Store/Dollar General receipts, additional social ads, and leveraged earned media with faith-based relationships to educate the African American community. These efforts are scheduled to continue through September 2023 at which time a new media proposal will be received to continue messaging.

Timeframe	Message	Content
May 2022 – October 2022	Address Updates	Encourage Medicaid beneficiaries to update their mailing addresses so they get notices and can respond once they receive them.
October 2022 – December 2022	What is PHE?	Encourage Medicaid beneficiaries to renew their insurance within 90 days of receiving a notice.
January 2023 – March 2023	Encourage Preparedness	Paid and earned media messaging specific to Medicaid beneficiaries to help increase awareness and education and encourage preparedness.
April 2023 – September 2023	Take Action	Paid and earned media continue to run. Presentations, interviews and sharing information with community partners and advocates, including minority media partners on the restart of Medicaid renewals.

Beneficiary Communications

MDHHS has planned specific outreach campaigns in alignment with various phases of PHE unwinding efforts. The table below provides a description of materials beneficiaries can expect to receive:

TARGET TIMEFRAME	MATERIAL	ASSOCIATED ACTION	MEDIUM
May 2022 – Sept 2023	Awareness campaign	Inform about Public Health Emergency impact to Medicaid & call to	• MDHHS website/stakeholder toolkit

		action: update contact information and renew coverage if needed.	• Social Media (Facebook, Twitter) • Radio/Audio streaming • Mobile ads • Outdoor posters • Dollar Store/Dollar General (receipts)
Two months prior to PHE end	Beneficiary alert PHE unwind notification[2]	Prepare for redetermination, prepare materials needed to ensure maintenance of coverage.	• Beneficiary mailing or electronic communication
Month prior to PHE end – 12 months following PHE end	Eligibility renewal notification[3]	Complete renewal package, including submission of required supplemental materials.	• Beneficiary mailing or electronic communication

Data Sharing with Managed Care Organizations & Other Provider Organizations

To facilitate outreach, improve communications, and create additional resources for beneficiaries, MDHHS will be providing MCOs with data files on beneficiaries undergoing monthly renewals. This includes:

- Initial Beneficiary Renewal Report – A one-time file with individual tabs listing MHP members by month of redetermination. This was a preliminary file run prior to the start of the unwinding to give the MCOs a sense of what members would be renewed each month. Members listed in this report may still be passively renewed and may not need action during the renewal month.

- Monthly DHS-1010 Report – MCO members who are being sent a 1010 renewal packet either via U.S. Mail or electronically. This file is generated after all passive renewals have completed and the 1010 renewal packet has been mailed out to those beneficiaries who could not be passively renewed.

- Monthly Closure Report – MCO members who are scheduled to have their Medicaid terminated, with separate tabs for the four primary closure reasons (income, assets, procedural, and other). These reports are utilized by health plans to target their outreach and education efforts to improve beneficiaries access to coverage. The goal of any outreach and communication is to ensure Medicaid beneficiaries have sufficient

[2,3] Communications for most will be in the form of physical letters sent via United States Postal Service, some may receive SMS text message communications if they have opted into receiving electronic communications about benefits from MDHHS. Eligibility renewal notifications will be sent based on the month of renewal.

information to select health care coverage that best fits their needs without any gaps in service.

- National change of address database files – MCOs are provided lists of their beneficiaries who are identified on the NCOA as having a forwarding address which differs from the address within the state's Bridges and Community Health Automated Medicaid Processing System (CHAMPS) systems. The MCOs will contact the beneficiary to confirm the address change and then provide any updated addresses to the state via an electronic data exchange process which updates the address within Bridges.

Additionally, provides can directly access redetermination information through the CHAMPS. Through CHAMPS, providers can search for individual information directly within CHAMPS to find eligibility details and renewal date information. Providers can also send batch 270/271 requests to confirm eligibility and renewal date information for multiple beneficiaries in a single transaction.

MDHHS has required Medicaid health plans to conduct outreach to Medicaid members regarding the restart of Medicaid redeterminations through the Comprehensive Health Care Program contract. Outreach may include text messaging, messaging on contractor's website, beneficiary communications, such as member newsletters or individual mailings or other activities. MHPs must follow Marketing Requirements and Guidelines and submit all newly developed call scripts, text scripts, letters, or other communication to their assigned MDHHS contract manager prior to use for approval. This work must align with CMS guidance. MHPs may use verbal or written communications to conduct outreach.

Monitoring PHE Unwinding Operations

The Consolidated Appropriations Act of 2023 and the State Health Official (SHO) letter 22-001 lay out required data reporting for all states through a CMS-developed reporting template during their unwind period. CMS requires all states to report on specific metrics described in this "Unwinding Eligibility and Enrollment Data Reporting Template" (Unwinding Data Report). These metrics are designed to demonstrate states' progress towards restoring timely application processing and initiating and completing renewals of eligibility for all Medicaid and CHIP enrollees consistent with the guidance outlined in SHO 22-001. Subsequent CMS guidance requires states to complete a baseline and subsequent monthly Unwinding Data Report, due on the eighth of every month, which captures activities from the previous month.

In addition, MDHHS completed and submitted to CMS a summary of the state's plans for initiating renewals for its total caseload within the state's 12-month unwinding period (Statewide Renewal Distribution Plan) on February 15, 2023. A copy of this plan is available in Appendix B. For states that are out of compliance, CMS may require the submission of a corrective action plan that details strategies and timelines for coming into compliance. MDHHS is publishing these reports to the public-facing Michigan Medicaid Renewals Data along with other additional data MDHHS on the unwinding efforts.

MDHHS has also developed a Quality Assurance (QA) workgroup with diverse representation from across the department. The goal of this workgroup is to ensure that standard quality assurance practices are followed, design and document any new QA processes, and conduct spot checks to ensure the restart to Medicaid renewals is operating properly.

Eligibility System Builds

As MDHHS transitioned to respond to the COVID-19 PHE, there were several system adaptations and operational changes that were implemented to align with the continuous enrollment period and the various COVID-19 response policies. As such, there has significant effort to assess and plan for the necessary actions to return to standard operations.

To resume redeterminations and new application processing in a timely fashion, MDHHS deployed several system changes as described in the table below:

DEPLOYMENT DATE[4]	PROJECT	DESCRIPTION
The month before the PHE ends.	Resume Negative Actions	Resume DHS-1010 redetermination packet generation (applies to beneficiaries which passive renewal fails or are non-MAGI populations).
The month after the PHE ends.	Initiate Eligibility Review	Resume DHS-1606 Healthcare Coverage Determination Notice generation for closures and reductions in benefits.
The month after the PHE ends.	Initiate Spenddown & Deductibles	Generate special notice (DHS-1606-E) for individuals that are now subject to spenddown/deductible requirements due to PHE end after a full redetermination has been completed.
The month after the PHE ends.	Implement Case Closure/Reductions	Allow for case closures/reductions based on full renewal/redetermination process (either passive/automatic or manual via DHS-1010).
The month before the PHE ends.	Monitor PHE Unwind	Generate federally required and state specific reports to support monitoring and oversight of activities associated with the return to normal operations .

[4] The deployment dates represented in this table are reflective of the initial deployment for the action. Actions are taken based on the month of the renewal, and associated notices would follow. Refer to Renewals Mapping for further illustration.

Resources

State Guidance

Throughout the course of the PHE, MDHHS and the Medicaid agency have issued a number of guidance and policy documents to support providers in ensuring coverage and access to services to member beneficiaries.

GUIDANCE	DATE	TOPIC
MDHHS Epidemic Orders	Issued date	Orders issued to protect Michigan citizens under authority of Michigan law, which imposes on MDHHS a duty to continually and diligently endeavor to "prevent disease, prolong life, and promote the public health," and gives the department "general supervision of the interests of the health and life of the people of this state." MCL 333.2221. A range of orders were issued over the course of the pandemic covering primary health concerns including actions to keep vulnerable populations in long-term care facilities safe from the spread of infection from COVID-19, required testing protocol, etc. At the conclusion of the federal declaration of the COVID-19 PHE, all MDHHS orders expired.
Medicaid Provider L Letters	Calendar Year	Provider letters are provided to communicate new developments, information, policy clarifications, etc. COVID-19 related provider guidance issued contain "COVID-19" in Subject line: • 2020 Medicaid Provider L Letters • 2021 Medicaid Provider L Letters • 2022 Medicaid Provider L Letters • 2023 Medicaid Provider L Letters
Michigan Medicaid Approved Policy	Calendar Year	MDHHS periodically issues notices of policy. These documents inform providers of changes in Michigan Medicaid policy. COVID-related policies are notated with "COVD-19 Response" in Subject: • 2020 Medicaid Policy Bulletins • 2021 Medicaid Policy Bulletins • 2022 Medicaid Policy Bulletins • 2023 Medicaid Policy Bulletins

Michigan Medicaid Proposed Policy	Calendar Year	These documents inform interested parties of proposed changes in Michigan Medicaid policy. Proposed new policy and changes to existing policy must undergo a public comment period before becoming final. *Proposed Medicaid Changes*

Federal Guidance

MDHHS developed the COVID-19 PHE Unwinding Operational Plan utilizing the guidance and tools released by CMS. The guidance can be found on CMS's website: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Appendices

Appendix A: COVID-19 PHE Unwind Crosswalk

The COVID-19 Policy Crosswalk table identifies Medicaid COVID-19 response bulletins and L letters issued and crosswalks to the unwind bulletins or L letters that change or impact the bulletin or letter. The table will be updated frequently as new policies and letters are issued.

The COVID-19 Policy Crosswalk can be accessed on the MDHHS PHE 2023 Benefit Changes website.

Appendix B: State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions

CMS distributed a standard template to support all states in summarizing plan for initiation renewals across the total Medicaid case load within the allowable unwinding period. Below is Michigan's submission.

State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions

Instructions

All states must complete and submit to Centers for Medicare & Medicaid Services (CMS) this reporting form summarizing state's plans for initiating renewals for its total caseload within the state's 12-month unwinding period. States must submit this form to CMS by the 45th day before the end of the month in which the COVID-19 public health emergency (PHE) ends. States submit completed forms to CMS via the COVID unwinding email box at CMSUnwindingSupport@cms.hhs.gov.

Background

The end of the continuous enrollment requirement for states[1] receiving the temporary increase in their Federal Medical Assistance Percentage (FMAP) ("temporary FMAP increase") under section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127) presents the single largest health coverage transition event since the first Marketplace Open Enrollment following enactment of the Affordable Care Act ("continuous enrollment condition"). To ensure states maintain coverage for eligible individuals, all states must provide the CMS with a summary of their plans to prioritize, distribute and process renewals during the 12-month unwinding period described in State Health Official Letter #21-002, "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency,"[2] and #22-001 "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency."[3]

Over the course of their 12-month unwinding period, states will need to conduct a renewal of every beneficiary enrolled in their Medicaid and CHIP programs as of the end of the month prior to their unwinding period ("referred to herein as the state's "total caseload"). States that have a more even distribution of renewals over the course of a year are better able to maintain a workload that is sustainable in future years, thereby enabling the state to avoid renewal backlogs and reduce the risk of inappropriate terminations. The volume of renewals and other eligibility actions that states will need to initiate during the 12-month unwinding period creates risk that eligible beneficiaries will be inappropriately terminated. This risk is heightened in states that intend to initiate a large volume of their total caseload in a given month during the unwinding period, particularly if a state initiates more than 1/9 of its total caseload in a given month.

Therefore, in order to better understand states' plans to process renewals during the unwinding period, CMS is requiring states to describe how they intend to distribute renewals as well as the processes and strategies the state is considering or has adopted to mitigate against inappropriate coverage loss during the unwinding period. CMS will use this information to identify states at greatest risk of inappropriate coverage losses and will follow up with states as needed to ensure that proper mitigations are in place to reduce risk of inappropriate terminations and that states' plans will establish a sustainable workload in future years.

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[1] Throughout this document, the term "states" means states, the District of Columbia, and the U.S. territories.

[2] CMS State Health Official Letter #21-002, "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency" (August 13, 2021). Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.

[3] CMS State Health Official Letter #22-001, "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency" (March 3, 2022). Available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

1 of 8

Section A. Renewal distribution plan

1. **Please complete questions 1a. and 1b. to describe how the state intends to initiate Medicaid and CHIP renewals during the state's 12-month unwinding period.**

   a. **Please indicate the approximate number of Medicaid and CHIP renewals that the state intends to initiate each month during the state's 12 months unwinding period using the following chart:**

   Note that the percentage of renewals scheduled to be initiated in a given month is based on the state's total caseload as of the end of the month before the state begins to initiate renewals that may result in termination of beneficiaries who do not meet eligibility requirements or who fail to timely return information needed to complete a renewal. States may not initiate renewals that may result in terminations more than two months before the continuous enrollment condition ends in the state. A state's total caseload may be the state's total enrollment of individuals or the total number of households with one or more household members enrolled in Medicaid.

Unwinding Period Month	1	2	3	4	5	6	7	8	9	10	11	12	Total
Number of renewals scheduled to be initiated	228,081	264,067	276,765	274,021	295,948	280,967	281,056	248,051	248,536	267,036	222,637	221,312	3,108,477
Percent of renewals scheduled to be initiated	7%	8%	9%	9%	10%	9%	9%	8%	8%	9%	7%	7%	100%

   b. **Is the state measuring the volume of renewals that it intends to initiate each month by households (which may include more than 1 beneficiary) or individuals?**

   - [ ] Households
   - [x] Individuals

2. **Please briefly summarize the state's plan to prioritize and distribute work during the 12-month unwinding period.** *This summary should identify any populations the state is prioritizing for completion sooner or the order in which the state intends to initiate renewals; any unwinding-specific strategies the state intends to adopt in order to align work for all beneficiaries in a household, to align renewals with SNAP recertifications, or to align work on changes in circumstances with a full renewal; and any other information related to how the state plans to prioritize and distribute work associated with processing renewals and redeterminations during the unwinding period.*

Implement a renewal strategy that initiates regular renewals for all individuals by month as they come due after the PHE ends. This process identifies overdue renewals by month, without regard to year or how long the renewal is overdue. For example, all overdue renewals for January would be processed for January. Overdue cases are processed for all years and would not follow the time-based approach that would identify oldest cases first. Normal renewal processes will be initiated beginning in April 2023 for June 2023 renewals, including ex parte renewal processes and sending timely pre-populated paper renewals for those that cannot be renewed through the ex parte process.

Section B. Strategies to promote coverage retention and prevent inappropriate terminations of coverage

1. **Please briefly summarize the state's plan to prioritize and distribute work during the 12-month unwinding period.** *This summary should identify any populations the state is prioritizing for completion sooner or the order in which the state intends to initiate renewals; any unwinding-specific strategies the state intends to adopt in order to align work for all beneficiaries in a household, to align renewals with SNAP recertifications, or to align work on changes in circumstances with a full renewal; and any other information related to how the state plans to prioritize and distribute work associated with processing renewals and redeterminations during the unwinding period.*

Implement a renewal strategy that initiates regular renewals for all individuals by month as they come due after the PHE ends. This process identifies overdue renewals by month, without regard to year or how long the renewal is overdue. For example, all overdue renewals for January would be processed for January. Overdue cases are processed for all years and would not follow the time-based approach that would identify oldest cases first. Normal renewal processes will be initiated beginning in April 2023 for June 2023 renewals, including ex parte renewal processes and sending timely pre-populated paper renewals for those that cannot be renewed through the ex parte process.

2. **Describe how the state will ensure that eligible individuals retain coverage and limit coverage losses for procedural reasons (i.e., for a reason other than a determination that the individual no longer meets eligibility requirements for coverage) as the state initiates and processes renewals and other eligibility actions during the 12-month unwinding period.**

Utilize 1902(e)(14)(A) waivers to 1) partner with managed care plans to update beneficiary contact information, 2) partner with Enrollment Broker to update beneficiary contact information, and 3) extending automatic reenrollment into Medicaid managed care plans up to 120 days The state is launching a multi-media advertising campaign prior to the end of the continuous coverage requirement, notifying beneficiaries that renewals will be restarting and they should update their contact information and watch their mail for renewal information. This multimedia campaign will include radio, audio streaming, outdoor, mobile and social media ads, including minority media outlets and stakeholder communications. The state will also send a monthly beneficiary outreach alert letter notifying beneficiaries that renewals will be restarting and they should update their contact information and watch their mail for renewal information. The beneficiary outreach letter will be sent on a rolling monthly basis prior to renewal activities beginning for each cohort. For example, letters for the June enrollment cohort will be sent in March. The state has initiated a series of stakeholder engagement webinars with provider groups to update them on the states unwind plans and the potential impact to their members. The state has also worked with provider groups to help reach out to beneficiaries on the importance of updating contact information and completing and returning any renewal information they receive in a timely manner. The state has also worked with health plans to help reach out to beneficiaries on the importance of updating contact information and completing and returning any renewal information they receive in a timely manner. The state has created new computer based training for local office staff focusing on conducting proper renewals; providing a refresher for tenured staff and a focus on new staff that were hired during the PHE and have not processed Medicaid renewals before. In addition, the state has authorized overtime for local office staff to conduct Medicaid renewals. System changes have been made to ensure that eligibility cannot be terminated or reduced prior to completion of a full renewal

3. **Select which strategies the state currently utilizes or is planning to adopt to ensure eligible individuals remain enrolled or are transferred to the appropriate program during the unwinding period.**

For a comprehensive list of strategies that promote continuity of coverage, states may refer to the "Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations" available on Medicaid.gov at https://www.medicaid.gov/sites/default/files/2021-11/strategies-for-covrg-of-indiv.pdf.

a. **Strengthen Renewal Processes**

☑ Expand the number and types of data sources used for renewal (e.g., use both Internal Revenue Service (IRS) and quarterly wage data; leverage unemployment income data sources)

- ☐ Already adopted
- ☑ Planning or considering to adopt

☑ Create a data source hierarchy to guide verification, prioritizing the most recent and reliable data sources (e.g., leverage SNAP data that is updated every six months; first ping IRS data and if not reasonably compatible, then ping quarterly wage data) and verify income when data source in the hierarchy confirms reasonably compatibility.

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Use a reasonable compatibility threshold (e.g., 10%) for income for MAGI and non-MAGI populations and a reasonable compatibility threshold for assets for non-MAGI populations, if not already used

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Ensure that individuals can submit requested information to the agency over the phone, via mail, online, and in-person, consistent with federal regulations

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Ensure renewal forms are pre-populated for individuals enrolled in Medicaid, CHIP, and BHP on a MAGI basis, consistent with federal requirements

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Other adopted strategies

Please specify:

The state has utilized a human-centered design approach to update the renewal form.

☑ Other strategies under consideration or planned

Please specify:

The state has utilized a human-centered design approach to update the health care determination notice (approval/denial notice) – scheduled for implementation later in the year.

b. **Update Mailing Addresses to Minimize Returned Mail and Maintain Coninuous Coverage**

- [x] Engage community-based organizations, application assisters (including Navigators and certified application counselors), and providers to conduct outreach to remind individuals enrolled in Medicaid, CHIP, and BHP to provide updated contact information
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] Require managed care plans to seek updated mailing addresses and either share updated information with the state Medicaid or CHIP agency and/or remind individuals to update their contact information with the state
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] Send periodic mailed notices, texts, and email/online account alerts reminding individuals to update their contact information (e.g., on a quarterly basis)
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [ ] Other adopted strategies
- [ ] Other strategies under consideration or planned

c. **Improve Consumer Outreach, Communication, and Assistance**

- [x] Revise consumer notice language to ensure that information is communicated in plain language, including that it clearly explains the appeals process (also known as the Medicaid fair hearing and CHIP review process, as applicable)
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] Conduct more intensive outreach via multiple modalities to remind individuals enrolled in Medicaid, CHIP, or BHP of anticipated changes to their coverage and obtain needed information (e.g., require eligibility workers to make follow-up telephone calls and to send an email if an individual has not responded to a request for information)
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] Implement a text messaging program to quickly communicate eligibility reminders and requests for additional information, as permitted
  - [ ] Already adopted
  - [x] Planning or considering to adopt
- [x] Review language access plan to provide written translation of key documents (e.g., notices, applications, and renewal forms) into multiple languages, oral interpretation, and information about how individuals with limited English proficiency (LEP) can access language services free of charge, provided in a culturally competent manner
  - [x] Already adopted
  - [ ] Planning or considering to adopt

- [ ] Ensure that information is communicated to individuals living with disabilities accessibly by providing auxiliary services at no cost to the individual, including but not limited to written materials in large print or Braille, and access to sign language interpretation and/or a teletypewriter (TTY) system, consistent with the Americans with Disabilities Act (ADA) and section 1557 of the Affordable Care Act
- [ ] Other adopted strategies
- [ ] Other strategies under consideration or planned

d. Improve Coverage Retention

- [x] Adopt 12 months continuous eligibility for children (via SPA)
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [ ] Adopt 12 months continuous eligibility for adults (via 1115 Authority)
- [x] Provide 12 months of postpartum coverage (via SPA, beginning April 2022)
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [ ] Consider reducing or eliminating periodic data matching to support efficient operations (e.g., reduce or eliminate periodic data checks for income changes mid-coverage year to mitigate additional requests for information and manual work by state agencies)
- [x] Direct managed care plans via contract requirements to conduct outreach and provide support to individuals enrolled in Medicaid and CHIP to complete the renewal process
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [ ] Other adopted strategies
- [ ] Other strategies under consideration or planned

e. Promote Seamless Coverage Transitions

- [x] Ensure accounts are seamlessly transferred to the Marketplace when individuals are found ineligible for Medicaid, CHIP, or BHP
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] Obtain and include robust contact information (e.g., mailing address, email address, and telephone numbers) in the Account Transfer to the Marketplace so that individuals may be easily reached post-transition
  - [x] Already adopted
  - [ ] Planning or considering to adopt

- [x] Revise notices to ensure they clearly explain the Account Transfer process and next steps and applicable deadline(s) for applying for and enrolling in a QHP with financial assistance, and where to seek answers to questions at the Marketplace
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [ ] Other adopted strategies
- [ ] Other strategies under consideration or planned

f. **Enhance Oversight of Eligibility and Enrollment Operations**

- [x] Identify a centralized team responsible for tracking emerging issues and needed solutions
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] Create tracking and management tools, data reports, and/or dashboards to monitor case volume, renewal rates, and workforce needs
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [x] Implement "early warning/trigger" mechanisms that flag when a large number of individuals lose, or are slated to lose, coverage due to no response or missing paperwork
  - [x] Already adopted
  - [ ] Planning or considering to adopt
- [ ] Automate a "circuit breaker" flag based on a data review for the agency to pause and consider a change in its practices to mitigate inappropriate coverage loss
- [ ] Other adopted strategies
- [ ] Other strategies under consideration or planned

4. **Please describe any other type of strategy the state intends to implement to ensure that the state will not inappropriately terminate coverage for beneficiaries who continue to be eligible for Medicaid and/or CHIP and will appropriately transition the appropriate ineligible individuals to other health insurance affordability programs.**

The State is also implementing an outreach strategy that leverages Medicaid Health Plans that offer a marketplace plan and potential for additional outreach via the state or vendor. The State will provide Federal Marketplace education and contact information and options to speak to a customer service representative for more information.

5. **Select which strategies the state currently utilizes or is planning to adopt to ensure the fair hearing process is timely and accessible for any beneficiaries who lose coverage due to redeterminations triggered by the end of the continuous enrollment period.**

- [ ] Expand informal resolution processes (e.g., informal troubleshooting, administrative review, or alternative resolution processes prior to a fair hearing)

- ☐ Redeploy state resources (e.g., adjusting state or local agency staffing and use of contractors to support the fair hearing process, as permissible)
- ☐ Streamline current fair hearing processes and operations (e.g., intake of fair hearing requests, scheduling)
- ☐ Engage internal and external stakeholders to increase beneficiary understanding, resolve cases before they need an appeal, and reduce inappropriate denials that generate appeals
- ☐ Other adopted strategies
- ☐ Other strategies under consideration or planned

PRA Disclosure Statement The Centers for Medicare & Medicaid Services (CMS) is collecting this mandatory report under the authority in sections 1902(a)(4)(A), 1902(a)(6) and 1902(a)(75) of the Social Security Act and at 42 C.F.R. § 431.16 to ensure proper and efficient administration of the Medicaid program and section 2101(a) of the Act to promote the administration of the Children's Health Insurance Program (CHIP) in an effective and efficient manner. This reported information will be used to assess the state's plans for processing renewals and mitigating against inappropriate beneficiary coverage losses when states begin restoring routine Medicaid and CHIP operations after the COVID-19 public health emergency ends. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #66). The time required to complete this information collection is estimated to average 8 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Appendix C: Beneficiary Awareness Letter

MDHHS worked collaboratively with community partners to develop the contents of a letter all Medicaid beneficiaries will receive to provide advanced awareness of the upcoming renewal process. This letter is available for electronic viewing and will be distributed to a beneficiary's current address on file up to three months prior to their scheduled renewal date. The letter is available in English, Spanish, and Arabic.

Awareness Letter - **English**
Awareness Letter - **Spanish**
Awareness Letter - **Arabic**

Michigan Department of Health and Human Services
PO Box 30809
Lansing, MI 48909

John Smith
1234 Main Street
Anytown, MI 48044

<Date>

About your Medicaid renewal

Dear Beneficiary,

At the start of the COVID-19 pandemic, the federal government declared a public health emergency (PHE). We stopped the Medicaid renewal process during the PHE. We are restarting renewals. A renewal is when we check if you are still eligible for free or low-cost Medicaid coverage. To keep your coverage, you may need to fill out a renewal form. If you need a form, we will send you one in the next 3 months.

What to do now

1. **Update your address, phone number, and email address now.**
   Update your information at michigan.gov/mibridges or contact your local MDHHS office.
2. **Report any changes to your household or income now.**
   Report changes at michigan.gov/mibridges or contact your local MDHHS office.
3. **Check your mail or text messages for a renewal packet.**
   Learn more about renewals and filling out the forms at michigan.gov/mibridges.

What to do if you get a renewal packet

Be sure to fill it out, sign the forms, and return them by the due date with any proof we need. If you do not complete your renewal, you may lose your Medicaid coverage.

If you are no longer eligible, you can choose to buy health insurance through HealthCare.gov.

Questions?

Call the Beneficiary Help Line at **1-800-642-3195** (TTY: 1-866-501-5656), Monday – Friday, 8 a.m. to 7 p.m. To learn more, go to michigan.gov/2023benefitchanges.

Thank you,
Michigan Department of Health & Human Services

Capitol Commons Center • P.O. Box 30752 • Lansing, Michigan 48909-7979
michigan.gov/mdhhs • 800-642-3195

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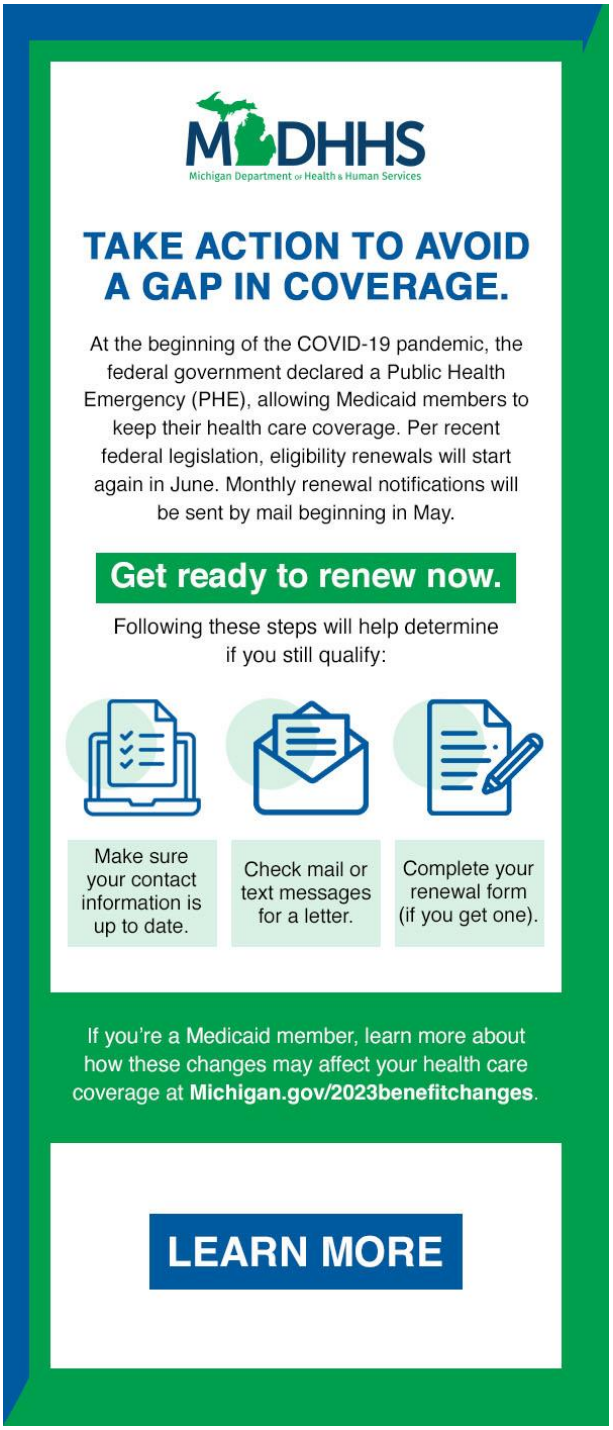
Appendix D: Available State Strategies to Minimize Terminations for Procedural Reasons During the COVID-19 Unwinding Period

The document is available on the CMS website: https://www.medicaid.gov/resources-for-states/downloads/state-strategies-to-prevent-procedural-terminations.pdf

Appendix E: Sample Stakeholder Toolkit Materials



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