Ohio Plan submitted to CMS on December 20, 2022

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.

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	157,426	168,604	211,697	166,762	183,322	183,492	193,564	187,254	182,214	176,072	169,806	171,454	2,151,667
Percent of renewals scheduled to be initiated	7%	8%	10%	8%	9%	9%	9%	9%	8%	8%	8%	8%	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?

- [x] Households
- [ ] 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.*

(The monthly distribution above are estimates based on current caseload and includes past due renewals. The numbers above are "program blocks" which are analogous but not identical to "households". Program blocks are the method in which the Ohio Benefits system organizes cases for budgetary purposes to determine eligibility. There are separate budgetary units within one program block for different household members. Budgeting units refer to all individuals who must be counted (either in household size or income). Each program block is approximately equivalent to 1.7 individuals.)

ODM has developed an unwinding plan that:

• Leverages a risk-based approach,
• Systems improvements,
• Resources for counties,
• Policy opportunities and,
• Ensures compliance with our three Corrective Action Plans (CAPs), CMS guidance and provisions within House Bill 110 (the state budget bill)

To comply with the requirements in House Bill 110, Ohio will prioritize cases in the following manner:

1. Individuals who ODM's vendor identifies as "likely ineligible"
2. Individuals who have been enrolled in the program more than 12 months without a redetermination/renewal
3. Individuals with self-reported material changes in circumstances
4. Renewals that failed ex parte review
5. Applications received during the PHE
6. Applications received after the PHE ends

The monthly work outlined in Ohio's plan addresses three primary areas of work: new applications, renewals, and changes in circumstances. While all three areas are elements of the unwinding work; renewals are by far the largest component.

During the PHE, ODM has been running ex parte each month to aid in minimizing renewal backlog. Ohio's unwinding work plan will begin once that notice is issued. Based on CMS guidance, the earliest disenrollment's will occur is the month following the month in which the PHE (e.g., if the last day of the PHE is April 15, any disenrollment cannot occur until May 1 or later).

To set the stage, all individuals with past due renewals will have their anniversary renewal date re-set 12 months forward (e.g., if a renewal was due in March 2023, it will be re-set to March 2024). This is necessary for both systems and CMS compliance reasons.

First, Ohio Benefits – Ohio's Medicaid eligibility system – is not able to look back in time to capture and process past due renewals. It is programmed to look forward in time to process renewals that are coming due. The Ohio Benefits eligibility system is designed to begin processing renewals two months in advance of a renewal date, e.g., the system will initiate the renewal process in June for a case that has a renewal due date in August. The renewal process always starts by running cases through ex parte review.

Second, CMS has stated that states cannot process more than one ninth of its membership in a single month as it would create backlogs and caseload surges in future years that states will not be allowed to undo.

Third, compressing the past due backlog into a three-month span (146,000 past due renewals/month) would both exceed county processing capacity (117,000/month inclusive of new applications, renewals, and changes in circumstances) and would cause Ohio to be immediately out of compliance with federal regulation and out of compliance with Ohio's two CAPs - all because no new applications would be processed at all, and presently due renewals would also not be processed at all.

At the announcement of the end of the PHE, ODM will run ex parte two months before the actual end of the PHE. This will include current renewals that are due, and past due renewals that had their anniversary date moved forward. Individuals will either be renewed, or they will "fall out" of the ex parte renewal process. For those who are renewed, a passive renewal notice will be sent to the individual or household. Ex parte renewals are regularly audited and consistently are between 99% and 100% accurate.

Fallout cases may be eligible or ineligible, although that determination is not made at the point of fallout. ODM will send enrollee information for all fallout cases to PCG, ODM's third party data vendor. PCG will conduct data matching against multiple data sources to evaluate these enrollees' eligibility. PCG will identify individuals who are "likely ineligible" and will supply to ODM that case designation as well as information indicating why the designation of likely ineligible was assigned. That information will serve as a lead that a case worker can use to seek further verification of. County caseworkers will access the PCG system to identify and prioritize processing those likely ineligible cases first. PCG will also identify individuals who are "likely eligible" and will supply to ODM that case designation as well as source data verifications that can be used by caseworkers to conduct an administrative ex parte renewal. ODM will be submitting an update to the MAGI-Based Verification Plan to include the data sources used by PCG in this process.

Concurrent with PCG's data review and report, the Ohio Benefits eligibility system will generate a preprinted

renewal form (“renewal packet”) requesting verification and/or documentation needed to verify the individual’s eligibility. The renewal packet asks specific questions about the household, such as income and expenses.

County eligibility determinations will use information supplied by the enrollee and information supplied by PCG. PCG's review will be conducted in monthly cycles to ensure data is no more than three months old when a county reviews the case, as required by CMS. The eligibility reviews of past due renewals, current renewals, pending new applications, and likely ineligible cases, will be done on monthly cycles over a twelve-month period as described above to comply with requirements of 42 CFR § 435.916, and to prevent backlogs and concurrent violations of both the application backlog CAP and the PERM CAP.

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

1. **Briefly describe any circumstances that may result in the state initiating more than 1/9 of its total caseload of renewals in a particular month (e.g., routine schedule of renewals results in month(s) with more than 1/9 of renewals due; annual workforce and staffing trends affects work volume in particular months; pending work due during the PHE is scheduled to be completed in less than 12 months).**

As the numbers show above, the Medicaid enrolled population is for the most part distributed across the calendar year; however, there are some months with more and others with less. The routine schedule of renewals results in certain months being less or more than 1/9th but only by a point or so.

There may be additional legislative action by Ohio's general assembly to compel compressing unwinding.

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.**

One significant challenge all states have is ensuring they have accurate mailing and contact information for Medicaid members. Ohio is implementing several strategies to ensure ODM has up to date contact information for use in processing renewals.

1. Coordinating with Medicaid managed care plans for outreach to enrollees

Starting in September 2022, ODM began providing Medicaid managed care plans and HCBS waiver care management entities with a list of all their members who will be receiving a renewal packet in the mail. The Medicaid plans and care managers conduct outreach to their members to notify them that they should be looking for a renewal notice in the mail and encourage them to promptly reply to the request for verifications. This is now a monthly occurrence that coincides with the normal process of issuance of renewal packets for individuals not renewed ex parte.

2. Accepting updated address information from Medicaid managed care plans

ODM received approved waivers under authority of 1902(e)(14)(A) to allow the state to accept updated addresses from Medicaid managed care plans and the NCOA with the USPS.

3. Issuing a COVID-19 Public Health Emergency Unwinding Communications Partner Packet

ODM developed a partner packet toolkit that provides a variety of materials and templates for entities that interact with Medicaid enrollees to help them prepare their constituencies for the end of the public health emergency. The prevailing messages conveyed throughout the toolkit are for healthcare providers, teachers, advocates, elected officials, professional associations, community organizations, and other entities to encourage Medicaid enrollees to update their contact information with ODM and to respond to requests for information from the agency. The partner packets have been distributed to stakeholder partners and posted on the agency's website.

4. Ohio Medicaid has commenced design and development of an automated telephonic IVR and text messaging system that will enable the system to gather and update address information directly from enrollees and issue reminder notifications.

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.

☐ 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

☑ 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:

Renew Medicaid eligibility for SNAP participants whose gross income as determined by SNAP is under the applicable MAGI threshold for Medicaid eligibility without conducting a separate MAGI-based income redetermination. Section 1902(e)(14)(A) authority

☐ Other strategies under consideration or planned

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

☑ 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

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ 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

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Send periodic mailed notices, texts, and email/online account alerts reminding individuals to update their contact information (e.g., on a quarterly basis)

- ☐ Already adopted
- ☑ Planning or considering to adopt

☑ Other adopted strategies

Please specify:

Identify households to conduct outreach to based upon returned mail.

☐ Other strategies under consideration or planned

c. <u>Improve Consumer Outreach, Communication, and Assistance</u>

☑ 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)

- ☐ Already adopted
- ☑ Planning or considering to adopt

☐ 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)

☑ Implement a text messaging program to quickly communicate eligibility reminders and requests for additional information, as permitted

- ☐ Already adopted
- ☑ Planning or considering to adopt

☑ 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

- ☐ 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

- ☐ Already adopted
- ☑ Planning or considering to adopt

☐ Other adopted strategies

☐ Other strategies under consideration or planned

d. <u>Improve Coverage Retention</u>

☑ Adopt 12 months continuous eligibility for children (via SPA)

- ☑ Already adopted
- ☐ Planning or considering to adopt

☐ Adopt 12 months continuous eligibility for adults (via 1115 Authority)

☑ Provide 12 months of postpartum coverage (via SPA, beginning April 2022)

- ☑ 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)

☐ 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

☑ Other adopted strategies

Please specify:

Encourage managed care plans and HCBS care management entities to conduct outreach and provide support to individuals enrolled in Medicaid and CHIP to complete the renewal process.

☐ Other strategies under consideration or planned

e. <u>Promote Seamless Coverage Transitions</u>

☑ Ensure accounts are seamlessly transferred to the Marketplace when individuals are found ineligible for Medicaid, CHIP, or BHP

- ☑ Already adopted
- ☐ Planning or considering to adopt

☐ 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

☑ 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

- ☐ Already adopted
- ☑ Planning or considering to adopt

☐ Other adopted strategies

☐ Other strategies under consideration or planned

f. <u>Enhance Oversight of Eligibility and Enrollment Operations</u>

☑ Identify a centralized team responsible for tracking emerging issues and needed solutions

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ Create tracking and management tools, data reports, and/or dashboards to monitor case volume, renewal rates, and workforce needs

- ☑ Already adopted
- ☐ Planning or considering to adopt

☑ 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

- ☐ 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.

For beneficiaries whose Medicaid eligibility cannot be renewed via the ex parte process, ODM will send their information to PCG, ODM's third party data vendor. PCG will conduct data matching against multiple data sources to evaluate the eligibility of these enrollees. In addition to the identification of beneficiaries who are "likely ineligible", PCG's data will also identify beneficiaries who continue to be eligible for Medicaid.

42 CFR § 435.916 requires that ODM must make a redetermination [renewal] of eligibility without requiring information from the beneficiary if able to do so based on reliable information contained in the beneficiary's case record or other more current information available to the agency, including information accessed through databases. Because PCG's data for beneficiaries who are identified as "eligible" is considered reliable information, ODM will use the data without requiring additional information from the beneficiary to process the renewal. PCG's data will not be integrated into Ohio Benefits, Ohio's eligibility and enrollment system, so county caseworkers will use the data to conduct "administrative ex parte renewals" to ensure that beneficiaries who continue to be eligible for Medicaid and/or CHIP maintain their coverage.

ODM's regular processes will be used to ensure that account transfers are sent to the FFM for individuals who are ineligible for Medicaid and/or CHIP.

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.

- [x] Expand informal resolution processes (e.g., informal troubleshooting, administrative review, or alternative resolution processes prior to a fair hearing)
  - [ ] Already adopted
  - [x] Planning or considering to adopt
- [ ] Redeploy state resources (e.g., adjusting state or local agency staffing and use of contractors to support the fair hearing process, as permissible)
- [x] Streamline current fair hearing processes and operations (e.g., intake of fair hearing requests, scheduling)
  - [ ] Already adopted
  - [x] Planning or considering to adopt
- [ ] 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
- [x] Other strategies under consideration or planned

Please specify:

Ohio's Bureau of State Hearings (BSH) within the Ohio Department of Job and Family Services (ODJFS) is the entity responsible for conducting hearings for those individuals who are determined ineligible for coverage and wish to appeal.

Hearing officers currently conduct hearings by phone but are moving to leverage technology in its shift to virtual hearings. This shift is expected to result in hearings being conducted more effectively and efficiently.

BSH is also working to group “like” appeals so similar hearings can be scheduled on the same day with the same hearing officers.

Lastly, BSH is in the process of creating appeal summary templates for specific issues, as well as template questions for hearing officers to use so they know what questions to ask based on the termination reason(s). BSH will also be developing template decisions for these issues to help speed the process.

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.