Centers for Medicare & Medicaid Services
Medicaid and CHIP Renewals:
What to Know and How to Prepare, A Partner Education Monthly Series
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Stefanie Costello: [*Good afternoon. We're going to give just a minute or two for folks to enter the room before we get started. We'll get started. Welcome. My name is Stefanie Costello, and I'm the Director of the Partner Relations Group in the Office of Communications at CMS. Thank you so much for joining us today for our monthly stakeholder webinar on Medicaid and Children's Health Insurance (CHIP) renewals. This is a continuation of HHS and CMS's monthly*] series of webinars that began in 2022 to keep partners informed and keep them prepared for the return to regular operations in Medicaid and CHIP now that states have started their routine Medicaid and CHIP renewals. As you likely know, states have restarted their regular Medicaid renewals now that the pandemic protections for Medicaid coverage have ended. So, over the next several months, everyone with health care coverage through Medicaid or CHIP will renew their coverage, but individuals no longer eligible for Medicaid or CHIP, they can transition to another form of health coverage, such as the Health Insurance Marketplace, Medicare, or employer-sponsored coverage.

Now, everyone should be able to see today's agenda on the screen. Today's webinar will focus on Medicaid fair hearings, also known as Medicaid appeals. First, you will hear some opening remarks from Perrie Briskin with the Centers for Medicaid and CHIP Services. Next, you will hear from Melissa McChesney, who is also with the Center for Medicaid and CHIP Services, about the Federal Medicaid Fair Hearings rights. And then you'll hear from Elizabeth Edwards with the National Health Law Program about how partners can help people navigate the Medicaid Fair Hearing process. And finally, I'll review where to go for specific questions about Medicaid and CHIP renewals or other coverage options, and I will walk through some of our recently released resources before opening it up for a Q&A.

Before I pass things over to our speakers, I want to share just a few housekeeping items. The webinar today is being recorded. The recording, transcript, and slides will be available on our CMS National Stakeholder Call webpage. The link for that webpage will be posted in the chat, and you will receive an email once the recording is posted. Also, while members of the press are welcome to attend the call, please note that all press and media inquiries should be submitted using our media inquiries form, which may be found at cms.gov/newsroom/media-inquiries. All participants today are muted. Closed captioning is available via the link shared in the chat by our

Zoom moderator. And as I mentioned, we will have time to answer a few questions today. You can submit your questions using the Q&A function from the menu below. Questions that we do not have time to answer today will be used to help us inform topics for future calls. And with that, I'd like to turn it over to Perrie Briskin with the Center for Medicaid and CHIP Services. Perrie?

Perrie Briskin: Thank you so much, Stefanie. Hi everyone, my name is Perrie Briskin. I am a Senior Advisor at the Center for Medicaid and CHIP Services. First, knowing that this is the last one of these for the calendar year of 2023, I just wanted to be one of hopefully many people to thank everyone that is in attendance on this call for all of your tremendous work on the return to Medicaid renewals. It has been an incredibly challenging time for CMS, for states, and especially for enrollees going through all of these Medicaid renewals, and we know how hard everyone on this call has worked to try and minimize coverage loss for people still eligible for Medicaid and CHIP, for helping people transition to other forms of coverage. So, we know how hard everyone has worked, and we just can't thank this group enough for your continued support and advocacy. So, I wanted to start there.

I think as a quick overview of some things that have been released in the last month since this group last met. We, of course, had our monthly data release at the end of November that included verified August data and preliminary September data, so go to Medicaid.gov/unwinding under data to look at those. We also, this past Monday, released an interim final rule with a comment period, otherwise known as IFC, on CMS enforcement of state compliance with reporting and federal Medicaid renewal requirements as stemming from the Consolidated Appropriations Act, the CAA 2023. So, what this IFC does is it codifies enforcement authority, and the rule includes new enforcement authority for CMS to use if it determines that a state is not in compliance with the reporting requirements under Section 1902 TT of the Social Security Act, which is where the CAA amended the Social Security Act. So, I know, I think that link will be sent. We also did an all Medicaid, all state call regarding the IFC that can provide everyone more details of what's included there. So, I think those are our updates. We have a few more releases coming up before the year is out in December, so keep a lookout for those. We're looking forward to sharing more information shortly. And with that, I am going to turn it over to our next speaker, Melissa McChesney, to talk about fair hearings. So, with that, I'll turn it over to you, Melissa. Thank you so much.

Melissa McChesney: Thank you, Perrie. So today, I will be providing a high-level overview of the federal requirements for state fair hearings. These are also sometimes called appeals, but in Medicaid we typically call them fair hearings. There are federal requirements and also some options states may choose in setting up their fair hearing process. So, there are differences in the fair hearing process from state to state. At a high level, federal statute and regulations require states to provide applicants and beneficiaries an opportunity for a fair hearing when the individual has a concern that there was an error in a decision made by the Medicaid agency. Examples of when a person can request a fair hearing include: when there was a denial, termination, suspension of a reduction in eligibility, benefits, or services; or if there's an increase in cost sharing and premiums. The fair hearing process generally begins with the state Medicaid agency sending the applicant or beneficiary notice of the agency's decision and intended action. States must provide individuals at least 10 days' advance notice before the date the state intends

to take an adverse action. For example, if someone is determined ineligible for Medicaid at renewal, the state must send a notice to the individual at least 10 days before the date the person's termination for Medicaid is effective.

The notice must include a number of key pieces of information, such as: a statement of what action the agency intends to take; the effective date of that action; a clear statement about the reason for the action; specific regulations that support the action; an explanation of an individual's right to request a fair hearing, including the right to an expedited fair hearing; and the process for continuation of benefits if a fair hearing is requested. So that's the first step. Once the notice of an adverse action is sent, states must provide individuals a reasonable amount of time, not to exceed 90 days, to request a fair hearing. Many states provide individuals 90 days, but some provide a shorter time frame, such as 60 days or maybe 45 days. And we do know there are a few states that provide only 20 days to request a fair hearing.

So, in terms of how a person requests a fair hearing, at a minimum, states must allow individuals to request a fair hearing in writing and in person. But we also know that many states allow people to file a fair hearing request by phone, or some states even have an online portal where individuals can input their fair hearing request and send it to the state. Many state Medicaid agencies delegate authority to conduct fair hearings to another agency. This means that fair hearings are processed and conducted by a state agency other than the Medicaid agency. In those states, individuals may need to file their fair hearing request with the other state agency that handles Medicaid fair hearings. Information about how to file a fair hearing request and with which agency should be included in the Medicaid eligibility determination notice sent by the state. It also is usually available somewhere on the state's website and other communications to beneficiaries, such as an enrollment handbook.

If an individual requests a fair hearing before the date the action becomes effective. So again, we call this the date of action, and that may be, for example, the date the notice says that the individual's Medicaid eligibility will end. So, if an individual requests a fair hearing before that date, the Medicaid agency must continue to provide benefits to that person until the final fair hearing decision is issued. There may be as few as 10 dates between the date the adverse eligibility determination notice is sent and the date of action. If people file their fair hearing requests before the date of action, they will be able to have their benefits continue. States have the option to reinstate a person's benefits if they requested a fair hearing no more than 10 days after the date of action, and some states may require the beneficiary to pay back the cost of these services if the agency's decision is sustained by the hearing decision. Information about how long you have to file a fair hearing request and the process for continuation of benefits, again, must be included in your fair hearing notice, excuse me, in your eligibility determination notice.

In general, state Medicaid agencies must make and implement a fair hearing decision within 90 days of receiving a fair hearing request. However, during Unwinding, we know that many states have a much higher than normal workload, and they may take longer than 90 days to process a fair hearing request. CMS has provided authority to states to take longer than 90 days to complete a fair hearing request if they meet certain beneficiary protections. States granted this authority must provide benefits pending the outcome of the hearing to anyone who requests a fair hearing within the time frame provided by the state. Also, these states are not allowed to ask

beneficiaries to repay back these benefits to the state regardless of the outcome of the hearing. We will share a list of the states who have requested and been granted this authority in the chat momentarily.

The state hearing system must also meet beneficiary protections set by case law and federal regulation, called due process standards. I'll give you a few examples of some of those standards. Individuals must be given written notice of the hearing date, which must be held at a reasonable time, date, and place. Individuals have the right to represent themselves at the hearing, or they also have the right to use a lawyer, a family member, a friend, or someone else to help them during the hearing. Prior to the hearing, individuals must be provided their case file and any documents or records the state will use at the hearing. The hearing officer, that's the person who holds the hearing and writes the decisions, must be impartial and cannot have played a role in the state's original determination. The state must send the appellant the decision in writing. Finally, state fair hearing systems must be accessible to people who do not speak English and people with disabilities. For example, the state must provide things such as oral interpretation, written translation, auxiliary aids, and services at no cost to the appellant. And I will turn it over to Elizabeth Edwards with the National Health Law Program to keep speaking to you about fair hearing. Elizabeth?

Elizabeth Edwards: Thanks, Melissa. So, for accessibility purposes, I'm Elizabeth Edwards. I'm a white woman with short, curly brown hair and wearing a black jacket and orange shirt. If you can advance the slide for me that would be helpful. So, just quickly about the National Health Law Program, the information is on this slide, but we're a national nonprofit. We work a lot with local legal services organizations as well as disability rights advocates, the states, as well as DC. We also have other national partners, and we are closely following Unwinding and as we also do a mix of federal policy as well as litigation, and there's various ways you can contact us. The visual image on this slide just has the map of the U.S. with our three offices in DC, LA, and North Carolina. Next slide, please.

So, as Melissa talked about, there are basic core federal requirements for fair hearings, but as she also mentioned, every state is slightly different. So, although there are sort of minimums about timelines, there will be different timelines for when you have to ask for a fair hearing and critically important when a person would have to ask for continued benefits pending appeal. So, just know that how a person appeals in each state is quite different, but there are some core features. So, one other important area is that the notice is really the key piece of what will tell you or the individual what they need to do and what the basis of the decision was. But the level of detail in a notice does also vary by state. Also, it is not always the same across states whether or not the notice includes all the policies that may be relevant. So, for example, many states have what they call good cause exceptions or other exceptions that would allow a person to potentially file for a fair hearing even if they may have missed deadlines, or they may have good cause exceptions for allowing a person to send in other information past deadlines. So, there may be policies that are relevant that aren't explained in the notices and may be helpful that if you as a community service organization or others can sort of make sure that information is available to people. Also, notices for fair hearings don't always include referrals to legal services organizations. So, in many states, they do, but in states that don't have that, it's harder for people always to be connected to and know that they can call local legal aid potentially for assistance in

a fair hearing. But I'll note that, as Melissa said earlier, a person does not need an attorney to go to a fair hearing. They can do it themselves, but they can also have help from friends and family. But sometimes, it's really helpful to have help from an attorney or advocate. The other thing that is important is that self-advocacy materials are also usually state specific. So, you know, we could create a general "how to fair hearing", but because everything is very different by state, you really want to look for state specific self-advocacy materials often developed by legal services, advocacy organizations, or even the state Medicaid agency that tells people exactly what the timelines are in the state and who to contact and where to get other information. And as we've talked before, really, the notice that a person receives, that adverse action before the termination that Melissa talked about, is the best source of information, usually for the key pieces of information. Next slide.

So, as I said, the notice really contains the information that the person needs to understand the decision and how to appeal. Most importantly, it has the deadlines. It does have the deadlines about when to file an appeal and how to maintain benefits pending appeal. As Melissa talked about, there are some different things happening with states right now. If, for example, they have a 1902(e)(14) waiver about deadlines and other such things, but the pending – sorry, maintaining benefits pending appeal can be very important for people, and you have to usually request that pretty early on in the appeal process. Often, the choice is if you apply for a fair hearing early, you'll be able to keep your benefits. If you ask for one later, you may not always get them. This is important because if a person does not ask for benefits pending appeal, they may have to wait the entirety of the appeal timeline to get their benefits back if they are eligible. And for many people, retroactive coverage doesn't always help them as much as having the benefits from the beginning because they may not be able to afford to pay for care and get reimbursed. I will flag that oftentimes, the appeals information is at the end of a notice, and sometimes these notices can be very long, so definitely pay attention to where the information is and keep looking for it. I also flagged, I think I saw a question earlier on about timelines and mailing. One thing is to always pay attention if you have it available from the individual you're trying to help but to pay attention to the date on the envelope, so the mailing date versus the date on the letter. So, if there is a big difference there, you may be able to say that the person has additional time to request a hearing due to the date being on the mailing date rather than the date on the letter. Usually, the date on the letter is the key date, but if there's a big difference, you may be able to make that argument. As I mentioned earlier, not all policies are always on the notice, including the exceptions policies. But also states often use informal resolution processes so when a person appeals, they may be – the problem may be resolved informally rather than through the actual hearing process. Next slide, please.

So, as I mentioned, the notice really is the key source of information, and it's supposed to – it's legally required to include the basis of the decision. So, it's really required to tell the person why the decision was made and provide them sufficient information to understand what they would need to tell a state to indicate that they are still eligible, or the decision was wrong. So, as I mentioned earlier, there are varying levels of information used by states. So, for example, in one state, they may tell you every single piece of information about the income that they used and the standard of income they used to make the decision. So, a person can tell where the error may have been. In other states that information may not be as specific, but regardless, at the very base level, it has to tell the person why. There should be enough information in the notice, but

sometimes as a sort of reality, people need to know more information than what's in the notice. So, for example, it may involve looking at the eligibility policies that the notice sites to fully understand why the decision was made and whether or not the person is eligible. Sometimes, this is hard for individuals to do either because they don't have easy access to the internet, or they don't necessarily – the policies may be hard to understand. So, as organizations and advocates helping people through the appeals processes, it's often helpful to help the person go through those policies or, in general, understand how they may be eligible because if they understand how they're eligible, they can understand better whether or not the decision was wrong that the state made and to understand what information they would have to show at a hearing. So, I think we're seeing a lot of instances where people are saying, "well, nothing about my income or situation changed. I don't understand why I'm not eligible anymore." And so, making sure a person understands what the income standards are, what other categories – what other criteria for categories of eligibility matter can really help them be successful in a hearing. Otherwise, they may not have the tools they need. The other part I wanted to flag is that a big part of the notice may also direct a person to other options for coverage just in case they perhaps are not eligible for Medicaid; it should tell them whether or not they've been referred to example the Marketplace for coverage or if a child has been referred to CHIP. So, next slide, please.

So, I know that we've all been working very hard on Unwinding. I wanted to flag a few issues that you may encounter in terms of access to hearing. So, I talked a little bit about earlier about some states are using informal options for fair hearing. So that's one issue where states may be improperly deferring people, say, well go resolve it through this process. I want to encourage people to make sure that you understand what the appeal does in terms of continuing benefits and the like. But I got a little bit ahead of myself. That's the third bullet point. The first thing to talk about is there is some diversion from fair hearings to reapplication. So, in some states it may actually be practically quicker to reapply for coverage if the person is supposed to be eligible, but that may mean the person doesn't have continued benefits if just they reapply versus file for fair hearing. Like I said earlier, continued benefits are keeping – if they're already eligible for Medicaid, they are able to keep their benefits. Retroactive coverage, if the state has retroactive coverage, would just mean that the state would pay for it after the person already gets the coverage and may have paid for it themselves. For many people, they're not able to pay for cover – to pay for services and so retroactive coverage isn't as helpful as continued benefits. The other thing I wanted to flag is there is reconsideration for the MAGI (Modified Adjusted Gross Income) populations, which means if, for example, a person was denied for a procedural reason, for example, they didn't send in information that the state requested, they can submit that information up to 90 days after their denial, and it should be – the state should pick it up and work the information again and may determine them eligible. But like I said, with continued benefits or a reapplication, that doesn't actually have the same benefits as filing for an appeal and selecting continued benefits.

Another issue that we're seeing is wrongful denials. So, a state may actually improperly limit access to hearings or not appropriately apply any type of exceptions where the policies allow it. So, if that's happening, if it seems like a person's being denied a hearing in your state when they really should be having it, I would say please refer them to legal services who may be able to help that person because it could actually be a misapplication of policies. And then, as I said before, there is a little bit of fear that states are improperly using informal resolution to deter

appeals. Sometimes there's informal resolution before, but it should be always that the person files the appeal first and then the state can resolve the appeal. For example, they may say, “Oh, we looked at your case again and found you eligible” as an informal resolution. So just making sure that you're paying attention to appeal rights first and foremost before following other processes.

Then, I think the next slide is resources. Yes. So, just wanted to flag a few NHeLP (National Health Law Program) resources that are available. We have an Unwinding landing page that has all of these resources. One of the big things that may be most helpful is the checklist we made at the beginning of the Unwinding to understand the different processes that are supposed to be happening, which includes fair hearing, and we also have some red flags on that checklist of things to watch out for. And then the rest of these, I won't go over them one by one, but we have a wide array of options available, resources available on our website, and then we also have, you can find our cases that we've filed about redeterminations and Medicaid renewals as well as our blog where we post sort of more up-to-date, smaller quick things that might be helpful to people. And I think that covers everything I was planning to talk about, and I will turn it back to Stefanie now.

Stefanie Costello: Great, thank you so much for that information, Elizabeth and Melissa. So, keep putting the questions in. We'll do our best to filter them and get to as many as we can. I do want to take just a moment to just talk through where to go for questions. So, there is a slide up that just says where to direct people if you have questions. Our next slide is the first bullet is for questions about Medicaid or CHIP; contact your state Medicaid or CHIP office directly. This includes a link to Medicaid.gov/renewals, which is where to contact them. So, I know a lot of folks who attend these webinars have some specific questions about individual situations. I wanted to review where to go to get help for those right now. So, this is what this contact information is for. Questions about Medicaid or CHIP renewals do need to go to your state Medicaid or CHIP office directly. Again, you can find that contact information at Medicaid.gov/renewals if you don't have it.

Now, we understand that some of your questions might be about the Health Insurance Marketplace. So, the second bullet on the slide has a link to go to HealthCare.gov or to contact a local enrollment assister in your area and you can do that one in a couple ways. You can find a list of enrollment assisters in your area at LocalHelp.HealthCare.gov, or you can call our call center at 1-800-318-2596. There's also a TTY number at 1-855-889-4325, and I do want to mention that help is available 24 hours a day, seven days a week, in over 200 languages. And as a reminder, the federal government runs the Marketplace, sometimes known as an exchange for individuals and families in some states, while other states run their own Marketplace at a different website. We do work in close partnership with those states. If you're unaware of if your state has its own Marketplace or if you use HealthCare.gov, you can go to HealthCare.gov and enter your ZIP Code. It will either keep you on HealthCare.gov or take you to your state's website. For example, if you live in California, it will take you to the California website. Again, these are for questions about individual private health insurance that you would purchase through HealthCare.gov, not for your Medicaid specific questions.

We also understand that there's some individuals who are going to have questions about Medicare, and for that we want – we have our second slide up that is, directs you to the hyperlink Medicare.gov. It also includes call information for 1-800-MEDICARE. If you need help with the enrollment form, you can also contact your local Social Security Administration field office at ssa.gov/locator. And then for additional help navigating Medicare, you can contact your local State Health Insurance Assisters Program—those are known as SHIPs. You can find those by visiting www.shiphelp.org to find your local SHIP. And lastly, for questions about Medicaid for hearings, please encourage people to refer back to the letter they received from their state. So, we heard that today—that letter should have additional information about who to contact for a Medicaid fair hearing.

All right, I want to take just a moment to share some recently released resources, and I'm going to take just a moment to share my screen and take a look at the new information that we posted. What I'm showing on my screen is our newest resource that we've posted. It is a PDF for our patient-centered messaging for clinical offices and health care settings. So, as you might be aware, we produced a toolkit for faith groups, and we produced a toolkit for children – for schools, for children and families, and we now have a toolkit for patient-centered messaging for clinical offices and health care. So, there's a PDF with that title as well as a picture of a male physician speaking to a woman patient. On our second page, we have a dear clinician letter. This is a letter from our acting Chief Medical Officer, Dora Hughes, and so she's written a message about the importance of this toolkit and messaging from trusted clinicians to patients around Medicaid. The third page is our contents. So, going through the toolkit, you'll find things that you can do, frequently asked questions from patients, a recorded phone or hold message so the provider's office can put that hold message up. We also have no reply text messages and banner messaging, and push notifications. This can be used for apps, patient portals, text messages, all of that. We also included an e-newsletter and additional patient portal messages. And then, we have a list of our outreach materials and resources. Similar to the previous toolkits on page five, for the things you can do, we group them into different individuals who might be assisting folks for – with Medicaid questions. So, we have things that front office administrative staff can do, we have items that billing and administrative staff can do, messaging that clinicians can provide, that's on page six, and then messaging for clinical support staff as well. So, this can be very helpful for them. All right, so our next piece of information, and we'll drop this link in the toolkit, so you'll be able to access that. We also have, if you are on our Medicaid.gov/renewals – our outreach and education page, at the top here we have a section that says what languages our materials and resources are available in. We want it to draw your attention that we have postcards now available in Ukrainian, Dari, and Pashto. If you click here, it will download a ZIP file. If you open that ZIP file, it will include all translated postcards and some fact sheets, and it will pop open a postcard that has been translated if you click on the different language. So, here's an example. The postcards themselves are two-sided. They have language about if you've lost Medicaid and CHIP, there's an Asian woman on the front of it with a young Asian child kissing the Asian woman's cheek. And then there's a QR code that someone can scan and take them to Medicaid.gov/renewals. On the second page it is the same actions we've been sharing for all three – the same three actions that we've been sharing for this entire year, which are check your mail, open your letter, and then respond to it. So those factsheets – excuse me, those postcards are up.

And then the last thing, when you're on the same Medicaid.gov Outreach and Education Resources, if you scroll down to the section of additional materials and resources and you click into "Helping People Who've Lost Medicaid and CHIP Coverage," in there at the bottom, we have a drop-in article for people who lost Medicaid and CHIP coverage. That is in English and Spanish. So, this drop-in article can be in listservs; it can be in newsletters, any place that you want to use it. So local newsletters – excuse me, local newspapers, listservs, anything that would find it helpful. So, this is a new article that we just posted this past month. So those are our three new resources we wanted to highlight today.

And I know we've got five minutes left, but we did want to get to a few questions. Our first question is for Melissa, and this rounds up a couple of questions that we had from several participants who asked about the impact of mailing delays on advanced notice and expressed concern that the 10 days is not enough time for someone to receive a notice and request a fair hearing. Can states provide only 10-day advanced notice in light of ongoing mail delays?

Melissa McChesney: So, the federal – thank you, Stefanie, for the question, and we know that it was asked in many different forms, so we are trying to provide an overarching response. So, the federal requirement is that the state has to provide at least 10 days' advance notice before the date that the action that the state is taking takes effect. However, if a state – if a person receives the notice, they should have 10 days from the date that they receive it. The date on the note – that the notice is received is considered to be five days after the date on the notice unless the individual can show that he or she did not receive the notice within that five-day period. So, there are – there should be first, states should be providing the opportunity for the person to request a fair hearing and reinstating services if that person is showing them that I did receive this notice within the last 10 days from the date that I'm requesting this fair hearing. And again, that 10-day period is – is considered to be five days after the date on the notice. But again, they should also be able to say, I didn't get it, that period didn't apply to me if there's some way that they can prove that. We know it can be really hard to prove exactly when a notice got in the mail. But there are opportunities for individuals to show that I got this within the last 10 days, and I'm requesting my fair hearing even though it's after the date of action. Now, that's for reinstating and continuing benefits. I do want to differentiate a little bit between, I know that that's very important. That's not to say that that's not very important, but most states provide more time for just requesting a fair hearing. So, as I said before, they can provide up to 90 days for an individual to request a fair hearing. Many states provide that full 90-day time frame. Some states provide 60, 45, and we know there are a few states that only provide 20, but that's for requesting a fair hearing. We also know that many states send their notice out far before the 10-day period. They may send that notice out at the 30-day period. So many states are providing it longer than a 10-day, but it is true that 10 days is the minimum. But if you can show that you received the notice within 10 days, maybe using the postmark date, you should be able to get your services reinstated and continue those benefits until the outcome of the appeal.

Stefanie Costello: Great. Thank you, Melissa. Our next question is for Elizabeth. We had a question about informal resolution that just needed some clarification, so I will turn it to Elizabeth to answer that.

Elizabeth Edwards: Yeah, I think I may have confused it at the very end there. I was trying to make sure that people paid attention to the appeal deadlines and when to ask for a fair hearing. Informal resolution by states can be very helpful because it both saves time and it saves effort from individuals from having to go through the whole hearing process. But I just wanted to flag that we had heard in a few states that people were being directed to informal resolutions rather than appeals, which can ultimately make people miss deadlines that shouldn't be happening. But to make sure that a person first files the appeal, if they want to appeal, first files the appeal, and then goes through informal resolution just to make sure they don't miss any of those important deadlines that Melissa was talking about earlier. So informal resolution is helpful, but just making sure that you don't miss out on any appeal deadlines by sort of going through the informal resolution process.

Stefanie Costello: Great. I know we're almost at time. I'm trying to squeeze two questions in real quick. The next one's for Melissa—are states allowed to recoup the cost of continued benefits if the Medicaid enrollee loses the appeal? This could have a big impact on making people afraid to file appeals.

Melissa McChesney: So yes, states are allowed to recoup the cost of benefits provided during the appeal process. There are a few caveats to that. One is that that's the state option. Many states do not recoup, so you should refer to your state Medicaid agency as to their policy on recoupment, or some states may only recoup in certain cases. I know that's not as helpful from the deterrence factor, but it will vary state to state. Also, one variation that exists right now during Unwinding, as I mentioned before, CMS has granted authority—I think we're up to 26 states that have authority to go beyond the 90-day time frame to process fair hearings. However, as I mentioned earlier, that authority does come with some required beneficiary protections. One of those is that individuals, as long as they request their fair hearing within the reasonable time frame provided by the state, have to be given continued benefits until the resolution of the appeal, and states are not allowed to recoup benefits as long as that (e)(14) – excuse me, as long as that authority, which is called a 1902(a)(e)(14), that as long as that authority is in place, they can't recoup benefits. We did put a link in the chat to all the attendees so you can take a look at which states currently have that authority in place.

Stefanie Costello: Thanks, Melissa. And the next – our final question, it might be a little bit of Melissa, a little bit of Elizabeth, but how would customer advocates go about requesting an expedited hearing when the Office of Appeals in a state might be very behind in conducting the pre-trial conferences on the day of the hearing? Any suggestions there?

Melissa McChesney: So, I'll start, and then I'll pass it to Elizabeth to give some real world suggestions. But I can sort of give the federal framework here, which is that number one, states are required to include on their notices the process for requesting an expedited fair hearing. But I do want to clarify under what circumstances a person would be granted an expedited fair hearing. This interpretation may vary state to state, but the federal requirement is that a person has to be granted a fair hearing if the agency determines that the time otherwise permitted for a fair hearing could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. So, that is – there are standards that you would need to meet in order to be granted that expedited fair hearing. And if you need to request one, that information should be on

your notice. So, I'll pass it to Elizabeth to try to answer maybe some of the best practices in real life on how this process works.

Elizabeth Edwards: I think that the basics are what most states will apply in our experience, although there are certainly state differences. I think, as a practical matter, you really have to outline what the person may lose or what the actual injuries would be to the person. Commonly, things like if a person's receiving home and community-based services, that type of ongoing care, if they're going to miss a surgery or missing important medications, those types of issues. I would say that for an expedited hearing, it's almost more common to see it for applications because if it's a renewal issue, like an ongoing renewal issue, the person can usually get continued benefits pending appeal. And so that should address some of those issues. And there may be, like we mentioned earlier, some exceptions, policies that states have. For example, if the person missed the appeal deadline to keep benefits continue to appeal, they may be able to file for some sort of exception to also solve the problem in that other way other than trying to get the expedited hearing.

Stefanie Costello: Great. Thank you very much. And I know we had a few more questions. Unfortunately, we weren't able to get to them all today, but we might be able to address some of them in our future webinars. We appreciate y'all joining today. We hope that the information shared today was helpful as your organizations continue outreach of work to get this information out to the communities you serve. We'll be sending an email next week with the link to the recording, transcript, and slides from today's webinar. We really need your help in getting the information out, as you've been doing all year. We just need that continued, and we appreciate your partnership in this effort and we're here to support you through the process.

We do have one slide up on the screen. It does say upcoming monthly webinar dates. Right now, we just have one, which is the first bullet, Wednesday, January 24, 2024, at 12:00 p.m. We hope to see you on our first webinar next year. You can register for this webinar using the same link you've used to register for today's webinar, and other dates for 2024 will be announced in the future. Again, we appreciate your partnership and commitment. We want to thank the speakers for being on today's call and talking about this really important topic, and providing great information to y'all, and we look forward to continuing to work alongside you in the new year. We hope you have a great holiday season and a very happy new year, and we look forward to our continued partnership in 2024. Thank you.