



## State of New Jersey

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**MEDICAID COMMUNICATION NO. 23-03**

**DATE: March 27, 2023**

**TO:** NJ FamilyCare Eligibility Determining Agencies

**SUBJECT:** COVID-19 Public Health Emergency (PHE) Unwinding Guidance  
Effective April 1, 2023

On December 29, 2022, the Federal Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted. Under the provisions of this bill, the continuous enrollment condition of the Families First Coronavirus Response Act ends on March 31, 2023, enabling states to terminate Medicaid enrollment of individuals who no longer meet Medicaid eligibility requirements on or after April 1, 2023. Under the CAA and related CMS guidance, states must complete the eligibility renewal process for all Medicaid members by June 1, 2024.

This Medicaid Communication describes the process New Jersey intends to follow during this unwinding period, and provides guidance for eligibility determining agencies (EDAs) on how to complete the eligibility renewal process during this period. EDAs must follow this guidance in order to remain in compliance with state and federal requirements around unwinding.

### 1. General Unwinding Requirements

The federal continuous enrollment requirement ends March 31, 2023 and the first official renewal cycle begins in April 2023 (for members that have a June 2023 due date). Based on the monthly timeline described in greater detail below, the earliest possible termination for members whose renewals are initiated in April 2023 is May 31, 2023, with the earliest possible termination date for non-response being June 30, 2023.

No member may lose eligibility before the EDA has completed an eligibility renewal process.

EDAs are reminded that they are required to offer in-person and telephonic support to all members completing renewals. This includes members not under their supervision (e.g., if members supervised by the Health Benefits Coordinator (HBC) come to a County Welfare Agency (CWA) office, or if CWA-supervised members come to an HBC office).

During the unwinding period, CWAs may not transfer supervision of active NJ FamilyCare cases to another CWA, even if the member has changed their county of residence. However, CWAs should continue to transfer cases to the HBC in instances where children previously enrolled in Medicaid are found, after completing the redetermination process, to be eligible for CHIP.

## 2. Timeline for Renewal Process

- **Member spread across Unwinding year** – As required by CMS, all NJ FamilyCare members must have their eligibility renewed before June 1, 2024. DMAHS will spread renewal dates so that each agency will initiate approximately 1/12<sup>th</sup> of their total renewals each month between April 2023 and March 2024.

As of April 1, every person in the Medicaid Eligibility System (MES) will have a future renewal due date between June 1, 2023 and May 30, 2024. All households who have been determined to be eligible either through a new application or a successfully completed renewal during the twelve months before the initiation of unwinding will maintain their existing renewal schedule. All other households will be scheduled in a manner to support an even spread over the 12-month unwinding period. In general, households whose last previous eligibility action date is less recent will have their renewal initiated earlier in the twelve-month period.

For individuals receiving continuous coverage, the Supervisor/Worker codes (i.e., PW/PW or NB/NB) will identify the protected person, so that if other members of the household are terminated during the continuous eligibility period, coverage for the protected person(s) will continue.

Renewals of members enrolled in NJ WorkAbility will be delayed to the last quarter of the unwinding schedule (i.e., will not be initiated until January 2024 at the earliest). This is to allow DMAHS to complete implementation of P.L. 2021, c.344, which expands eligibility for NJ Workability. New NJ WorkAbility program rules are expected to be fully implemented by the fourth quarter of 2023 and separate Medicaid Communications will be issued detailing updated program policies.

DDD members not enrolled in NJ WorkAbility will be evenly distributed across the unwinding year.

- **Renewal Cycles** -- Each month between April 2023 and March 2024, EDAs will initiate a 90-day renewal cycle for a new cohort of members (representing approximately 1/12<sup>th</sup> of the total). The key stages of the renewal cycle are as follows:
  1. *Days 1 — 14: Ex parte (administrative renewal) process.* EDAs (or DMAHS in some circumstances as described below) must attempt ex parte renewal for all members prior to mailing a renewal packet. Members successfully renewed ex parte will receive notice that this process has occurred. The process for ex parte renewals is described in greater detail below:
    - **MAGI Members:**
      - MAGI renewals under the supervision of a CWA will be evaluated for ex parte approval by DMAHS using SNAP data (without CWA

involvement). If the SNAP income is less than the Medicaid standard, the member will be administratively renewed.

- MAGI renewals under the supervision of the HBC will be automatically evaluated against all available data sources.

- Non-MAGI Members:

- EDAs must attempt ex parte renewals for *all* non-MAGI (ABD) members.
- For members in ABD eligibility categories with asset/resource requirements, EDAs must use the Asset Verification System (AVS) as part of the ex parte process prior to sending renewal packets to members.

2. *On or Around Day 15: Renewal packets are sent to members.* Renewal invitations and packets may be distributed only after ex parte has been attempted and the available information has been found insufficient to determine continued eligibility. Non-MAGI (ABD) renewal packets will be mailed by the supervising EDA, with the exception that those members receiving benefits as a result of their SSI cash payments will be reviewed by the Social Security Administration. MAGI renewals will be sent by a print vendor.

All renewal packets will have a 30-day response/return deadline. However, members may request additional time to complete their renewal packet and EDAs must grant all such reasonable requests. MAGI requests for additional time will be documented in the worker portal by selecting a “Good Cause” extension. This will suppress automatic termination and allow the member additional time to comply with the renewal request. For Non-MAGI (ABD) requests processed outside the worker portal, additional time must be clearly noted in the case file.

All EDAs *must* have capacity to receive renewals via fax. EDAs *may* offer members the option to submit renewals via secure e-mail.

3. *Days 15 – 75: EDAs process returned applications.* EDAs must complete application processing by day 75 (i.e., system cutoff date) in order to provide proper notice to members.

When processing member renewals, EDAs must assess eligibility for all Medicaid eligibility groups, not just the group in which the member is currently enrolled.<sup>1</sup> As part of this policy, EDAs are reminded that if a member is working and has a disability, they may qualify for NJ WorkAbility.

Members who are no longer eligible for coverage may be referred to the State Based Exchange (SBE/GetCoveredNJ) or the Medicare Savings Program (MSP), as appropriate. MAGI terminations due to income or immigration status will be

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<sup>1</sup> Continues existing requirement described in Medicaid Communication No 14-12  
[https://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2014/14-12\\_Affordable\\_Care\\_Act.pdf](https://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2014/14-12_Affordable_Care_Act.pdf)

transferred to the SBE automatically.<sup>2</sup> Non-MAGI (ABD) terminations that are appropriate for enrollment in a Medicare Savings Program will be identified in the worker portal and processed in partnership with the Division of Aging Services.

Note that individuals with Medicare coverage will not be referred to the SBE. Where appropriate, termination notices must include language informing the recipient that the member has either been transferred automatically or referred to the SBE or Medicare Savings Program.

If EDAs have sufficient information to determine a member is eligible, they must renew that member. EDAs may not deny/terminate eligibility based on beneficiaries not providing requested information, if that information is not necessary for renewal. For example, if the member responds to a request for information but does not include a social security number in the response, then the EDA may not terminate the member on that basis (since the EDA already has access to the member's social security number).

4. *Days 90 – 180: Members terminated for failure to respond may request reconsideration.* Members who have been terminated from coverage due to a failure to respond to the renewal request, or a failure to provide information necessary to determine eligibility, will have ninety days after the date of termination in which to submit information and have eligibility reconsidered. EDAs must process the renewal based on the information provided. If the member is determined to be eligible, coverage will be reinstated. For Medicaid members, reinstatement must occur retroactively to the date of termination in order to avoid a gap in coverage.

### 3. Updates to Member Contact Information

DMAHS is taking steps to ensure that member mailing addresses are accurate and up-to-date. This includes accepting address updates from Managed Care Organizations, SNAP, and the United States Postal Service under authority from the federal government, and continuing to take member updates through EDAs and the Social Security Administration.

### 4. Enhanced Member Outreach

NJ FamilyCare managed care organizations (MCOs) will be conducting multiple rounds of outreach to members during the renewal process. These include:

- MCOs will send a postcard to all members at the beginning of the month in which they are scheduled to renew, to alert them that their renewal mail is on the way and remind them to respond to NJ FamilyCare mailings.
- Later in the mailing month, MCOs will send reminders in multiple modalities, including phone calls, text messages and/or email when available.
- MCOs will conduct targeted outreach to members deemed high risk, and broad outreach to members who have been terminated but are in their 90-day reconsideration period.

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<sup>2</sup> Continues existing requirement from Medicaid Communication No 15-06  
[https://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2015/15-06\\_Evaluating\\_NJFC\\_Recipients\\_For\\_All\\_Medicaid\\_Programs.pdf](https://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2015/15-06_Evaluating_NJFC_Recipients_For_All_Medicaid_Programs.pdf)

**In order to comply with federal requirements**, EDAs must follow appropriate processes for renewal packets that are returned undeliverable by the USPS.

- EDAs should compare the address on the returned mail to the address in the member's record, checking for errors and completeness. If the address is missing an apartment number, for example, the packet should be resent to the correct address.
- Packets that are returned with a forwarding address must be sent to the new address.
- Prior to procedural terminations for members whose mailings are returned without a forwarding address, EDAs must attempt to outreach to members via phone (if a phone number is available) and e-mail (if an e-mail is address available). If only one modality is available (phone or e-mail, but not both), the EDA must attempt to contact the member via this modality.
- If an individual's eligibility is terminated due to returned mail, and the member makes contact with the EDA within thirty days of the date of termination, coverage should be reopened back to the first of the month in which contact was made. EDA should then process the renewal to a substantive determination. If a member makes contact after thirty days but before ninety days, the case should be handled as described above for reconsideration after failure to respond. However, if a member makes contact and reports living out of state, coverage should not be reinstated.

## 5. End of the Federal Public Health Emergency

In addition to the end of the continuous enrollment requirement on April 1, 2023, the COVID-19 federal public health emergency is scheduled to end on May 11, 2023. This will impact eligibility operations in the following ways:

- Presumptive Eligibility flexibilities will end on May 11, 2023. Hospitals will no longer be able to offer presumptive eligibility for members in ABD eligibility categories. Additionally, individuals will no longer be able to receive a second presumptive eligibility period within a given 12-month period.
- Flexibilities around the assessment of members' clinical eligibility for MLTSS will continue for six months after the end of the federal public health emergency (i.e., through November 2023). During this period, EDAs should assume that existing MLTSS members retain clinical eligibility unless they have been specifically informed otherwise by the Office of Community Choice Options (OCCO). DMAHS expects to issue additional guidance on this topic in the near future.

## 6. Fair Hearings

Members retain all fair hearing rights during the unwinding period. Due to anticipated high volumes, CMS has granted DMAHS authority to extend the timeframe to take final administrative action on fair hearing requests. Under the terms of this waiver, during the period of unwinding, those individuals who requested a fair hearing based on a termination

notice will have their benefits continued pending the outcome of the fair hearing. Note that the cost of benefits provided during the fair hearing period may not be recouped, even if a termination of coverage is ultimately sustained.

The DMAHS Office of Legal and Regulatory Affairs (OLRA) will continue to receive fair hearing requests. Certain requests, including those regarding a termination of benefits due to failure to return or failure to complete the annual renewal, will be shared with the CWA in order to determine if a substantive determination can be made during the 90-day reconsideration period. OLRA will follow up with the designated CWA liaison on each such case. Cases that are unable to be resolved will be transmitted to the Office of Administrative Law for a hearing.

## 7. Reporting Requirements

On a monthly basis, EDAs must report to DMAHS supplemental data required to enable DMAHS to comply with CMS unwinding reporting requirements. These supplemental reports will include, but may not be limited to, counts of non-MAGI members for whom the EDAs initiated renewals within each month's renewal cohort, including members receiving ex parte renewals and members receiving renewal packets after ex parte renewals were attempted. DMAHS will provide EDAs with a standardized template for reporting this information each month.

As directed by DMAHS, EDAs will also comply with additional coding requirements within MES or the Worker Portal that may be required to track specific renewal outcomes or to provide other data needed to fulfill CMS monitoring requirements.

## 8. Other Requirements

- **Reporting issues/challenges to DMAHS** - EDAs are always expected to quickly report issues and challenges to DMAHS. However, during unwinding it is especially important to immediately alert DMAHS of issues and challenges because of the increased volume of cases being processed and the unique circumstances of restarting eligibility after the maintenance of effort period.
- **Anticipated future systems changes** - During the unwinding period, DMAHS is continuing to make technical and operational improvements to the renewal process. Examples of system upgrades in process include:
  - Availability of online and telephonic renewals for all members,
  - Inclusion of renewals of non-MAGI members in the worker portal, and
  - Full pre-population of renewal forms for all MAGI members.

As appropriate, DMAHS will issue additional guidance to EDAs related to technical and operational improvements.

If you have any questions regarding this Medicaid Communication, please refer them to the Division's Office of Eligibility field service staff member for your agency at 609-588-2556.

JLJ:bp

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