

Unwinding of the Public Health Emergency: What's Next for States

Manatt Health

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

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Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **www.shvs.org**.

Agenda

- **Context Setting**
- **The Return to Normal Medicaid and CHIP Operations:**
 - **Maximizing Coverage Retention at the End of the PHE**
 - **Learning From and Building Upon the Temporary Changes Made During the PHE**
- **Discussion**

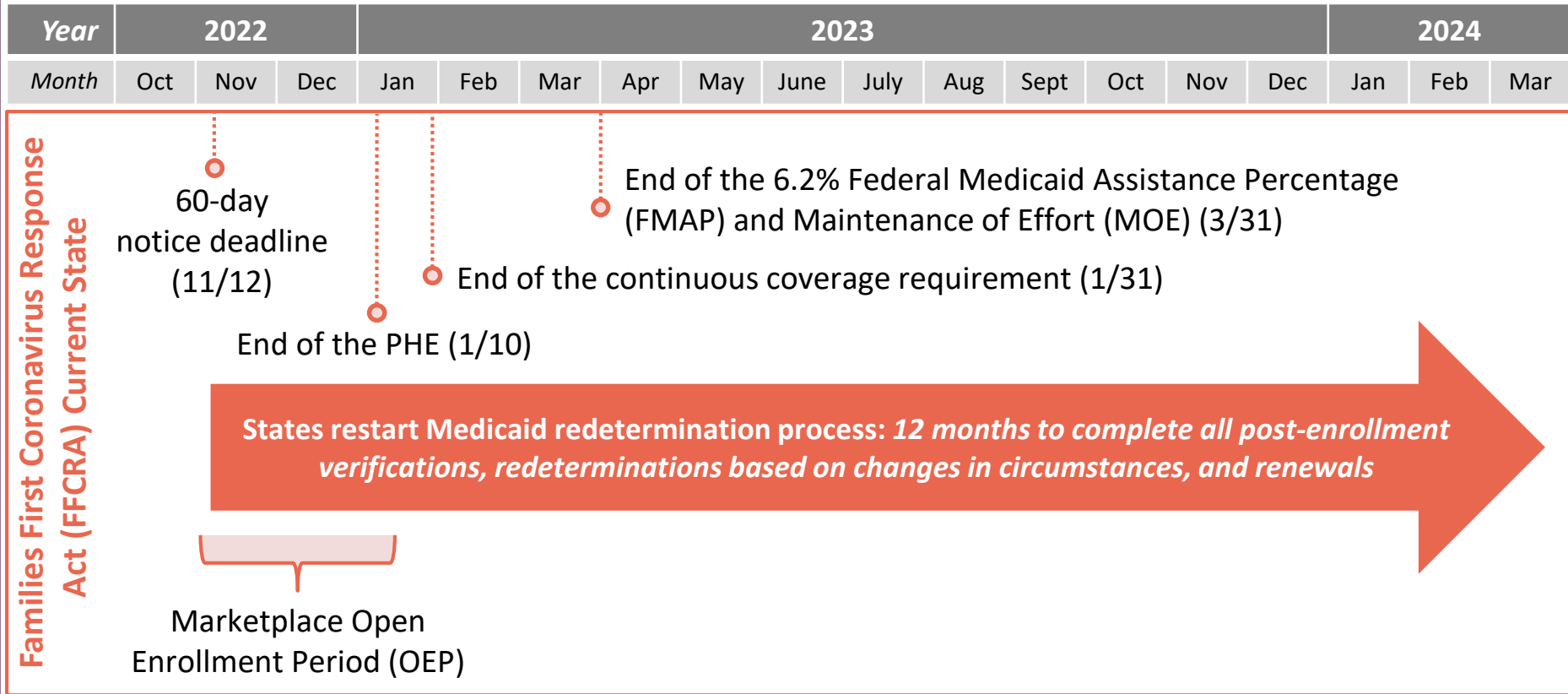


Webinar Objective: Discuss key considerations, challenges, and opportunities for states as they head into the final stretch of planning for the transition back to regular operations at the end of the federal PHE.



Context Setting

Federal PHE Timeline: Medicaid Continuous Coverage Guarantee



Timeline Notes: The federal PHE is currently in effect through January 10, 2023. Because the United States Department of Health and Human Services (HHS) has promised to provide 60 days' notice prior to termination, states will know on November 12, 2022, whether the PHE will get pushed out further. Federal legislation could also change the timeline for when the federal continuous coverage requirement ends and parameters for continued receipt of enhanced FMAP.

Source: HHS, [Renewal of Determination that a Public Health Emergency Exists](#); and Centers for Medicare & Medicaid Services (CMS), State Health Official (SHO) Letter # 22-001.

Federal PHE Timeline: Temporary Medicaid/CHIP Flexibilities



To help states respond to the COVID-19 pandemic, the federal government invoked emergency powers to authorize temporary flexibilities in Medicaid and CHIP.

Temporary Flexibility	Expiration Timeline	Current End Date
Section 1135 Waiver	End of the PHE, per CMS guidance. Note that CMS: (1) may terminate an individual waiver at any time; and (2) has authorized grace periods post-PHE for certain waivers.	January 10, 2023 (except for flexibilities for which CMS has authorized a grace period).
Medicaid and CHIP Disaster Relief State Plan Amendment (SPA)	<u>Medicaid</u> : End of the PHE (or an earlier date chosen by the state). <u>CHIP</u> : End of the PHE or state-declared emergency (or an earlier date chosen by the state).	<u>Medicaid</u> : January 10, 2023 (or earlier) <u>CHIP</u> : January 10, 2023 (or earlier, or later if the state-declared emergency continues).
Section 1915(c) Appendix K	Six months following the end of the PHE, if the state requested CMS approval for this timeline. For states that did not request this extended timeline, Appendix K flexibilities generally expired in the first quarter of 2021.	July 10, 2023, if a state received CMS approval for the extended timeline. If not, flexibilities generally expired in the first quarter of 2021.
Emergency Section 1115 Waiver	60 days after the PHE (or an earlier date approved in the waiver's Special Terms and Conditions).	March 11, 2023 (or earlier).

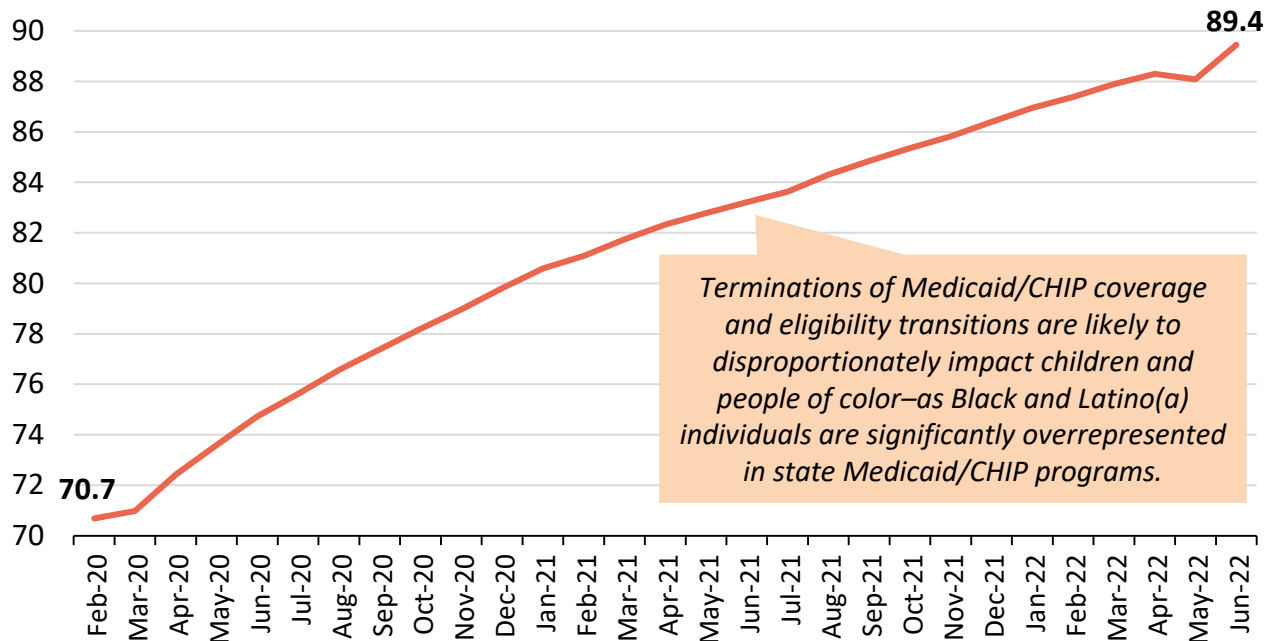
Source: SHVS, Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates.

Preparing for the Largest Health Coverage Event Since the Affordable Care Act

At the end of the PHE, states will need to redetermine eligibility for nearly all 89 million Medicaid enrollees—threatening the historic gains in coverage achieved as a result of continuous coverage.

Medicaid and CHIP Enrollment, February 2020 to June 2022

Millions of People



Terminations of Medicaid/CHIP coverage and eligibility transitions are likely to disproportionately impact children and people of color—as Black and Latino(a) individuals are significantly overrepresented in state Medicaid/CHIP programs.

- Since February 2020, Medicaid/CHIP enrollment has increased by nearly 19 million individuals (26.5%).
- A projected 15 million people, or 17% of current Medicaid/CHIP enrollees, will be disenrolled.
- 6.8 million people (7.9%) are projected to lose coverage despite still being eligible.
- Almost 1/3 of those losing coverage could be eligible for subsidized Marketplace coverage.

Source: CMS, June 2022 Enrollment Trend Snapshot; Assistant Secretary for Planning and Evaluation (ASPE), Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches; and SHVS/Manatt Health, The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage.

Dynamic Policy Environment

The federal and state policy environment is constantly evolving, making unwinding planning complex and difficult for states and their partners to navigate.



PHE Timing

The end of the PHE remains uncertain. The duration of the PHE may be further extended—either by the HHS Secretary or Congress acting to delink the continuous coverage guarantee from the PHE.



E&E NPRM

While this large-scale eligibility and enrollment (E&E) notice of proposed rulemaking (NPRM) is likely to have a positive impact on coverage access and retention, states will face challenges related to planning and implementing the requirements while simultaneously moving through unwinding.



November 2020 IFR

States are grappling with uncertainty around the potential repeal of the November 2020 interim final rule (IFR) interpreting the continuous coverage requirement, which resulted in states transferring Medicaid enrollees from one eligibility group to another within the same “tier” of coverage.



Mid-Term Elections

As the November mid-term elections approach, many states are planning for transitions of elected officials, which may impact state Medicaid agency leadership. States may need to brief new governors, legislators, and staff on continuous coverage and the enhanced FMAP.



States also have competing priorities/regular program operations that require dedicated resources and focus (e.g., Medicaid managed care re-procurements, delivery system transformations, section 1115 waivers, budget initiatives).

Source: SHVS/Manatt Health, [CMS Proposed Rule on Medicaid and CHIP Eligibility, Enrollment, and Renewal: Implications for States](#); and CMS, [November 2020 IFR](#).



The Return to Normal Medicaid and CHIP Operations: *Maximizing Coverage Retention at the End of the PHE*

Critical Levers for Unwinding and Ensuring Continuity of Coverage and Care

States have been planning to implement myriad strategies to maximize coverage retention for eligible individuals and smooth transitions to other coverage programs for people who are determined ineligible when the Medicaid continuous coverage guarantee ends.



Update Member Contact Information



Engage the Community and Other Key Partners



Conduct Integrated Outreach and Education Campaign



Leverage Health Plans and Providers



Develop Unwinding Plan and Monitoring Processes



Address Workforce Constraints



Improve the Redetermination Process



Promote Seamless Coverage Transitions



Subsequent slides in this presentation review key considerations, challenges, and opportunities related to the strategies (or components of the strategies) flagged above.

Source: CMS, [Unwinding and Returning to Regular Operations after COVID-19](#); and SHVS, [SHVS Resources and Tools Related to PHE Unwinding](#).

Unwinding Plan and State Reporting

Recognizing the potential benefits of a comprehensive planning and monitoring strategy, CMS requires states to develop an unwinding operational plan to restore routine operations, a renewal distribution report, and an unwinding E&E data report.

Unwinding Operational Plan

- ✓ Must be made available to CMS upon request.
- ✓ Should describe how the state will complete outstanding actions, ensure continuity of coverage for eligible individuals, and facilitate seamless transitions for individuals who become eligible for other forms of coverage.

Renewal Distribution Report

- ✓ Must be submitted to CMS 45 days before the end of the month in which the PHE ends.
- ✓ Must describe in narrative form how the state intends to distribute renewals.
- ✓ Should indicate which processes and strategies states are considering or have adopted to mitigate against inappropriate coverage loss.

Unwinding E&E Data Report

- ✓ Must submit to CMS a one-time baseline report and a monthly report by the eighth calendar day of each month.
- ✓ Must report on certain metrics to demonstrate state progress towards restoring timely application processing, initiating and completing renewals, and processing fair hearings on an ongoing basis.

Data collection and reporting will also be key to assessing Medicaid/CHIP retention trends and enabling states to adjust their processes if they (or their stakeholders) identify significant decreases in enrollment.

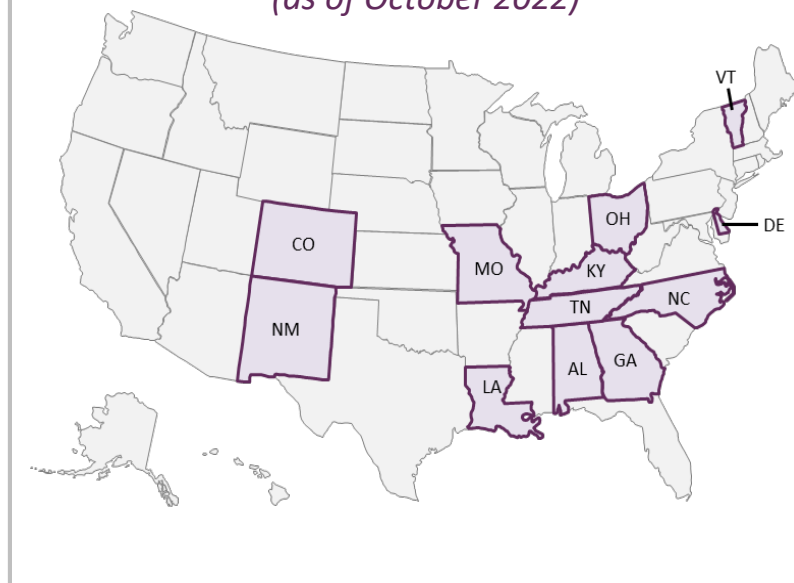
Source: CMS, [SHO# 22-001](#); SHVS/SHADAC, [Public Health Emergency \(PHE\) Unwinding Reporting Requirements: Considerations for States](#); SHVS/Manatt Health, [New CMS Guidance on Expectations for Unwinding Federal Medicaid Continuous Coverage](#); and CMS, [Unwinding and Returning to Regular Operations after COVID-19](#).

1902(e)(14) Targeted SNAP Strategy

To improve redetermination processes and maximize “ex-parte” renewals, CMS has made available the option to more expeditiously rely on Supplemental Nutrition Assistance Program (SNAP) data for conducting renewals for children and adults on a temporary basis during the PHE unwinding period.

- States may redetermine Medicaid income eligibility for adults and children who have SNAP income that is at or below Medicaid eligibility levels, without doing a separate Modified Adjusted Gross Income (MAGI)-based income or household determination.
- In other words, states may temporarily rely on findings from SNAP to enroll or renew eligibility for individuals on a MAGI basis despite the differences in household composition and income-counting rules.
- Because Medicaid determinations based on findings from SNAP must be conducted at the individual level, they do not have any implications on other members of the household.
- States may only apply this strategy to individuals who are currently receiving SNAP benefits.

CMS Targeted SNAP Strategy Approvals
(as of October 2022)



Source: CMS, [COVID-19 PHE Unwinding Section 1902\(e\)\(14\)\(A\) Waiver Approvals](#); CMS, [COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies](#); and SHVS/Manatt Health, [Leveraging Section 1902\(e\)\(14\) Waiver Authority Amid Unwinding](#).

1902(e)(14) Targeted SNAP Strategy (Cont'd)

- States may also use this authority to renew Medicaid eligibility based on findings from Temporary Assistance for Needy Families (TANF) and the Low-Income Home Energy Assistance Program (LIHEAP).
- CMS may consider the use of 1902(e)(14)(A) authority for non-MAGI populations—but will need to work with states interested in this strategy to conduct an individual analysis of the state's non-MAGI eligibility criteria/rules as compared to SNAP rules (i.e., income, resources, household composition).
- Importantly, the targeted SNAP strategy is distinct from the Facilitated Enrollment SPA authority, which requires states to take steps to ensure the individual is certainly eligible under a MAGI-based income determination.

CMS has also made available other time-limited 1902(e)(14) waiver authorities (e.g., conducting ex-parte renewals for individuals with no income and no data returned and accepting updated enrollee contact information from managed care plans or from National Change of Address/United States Postal Service without sending a follow-up notice) and confirmed it will consider approving flexibilities beyond those identified in guidance.

Source: CMS, [COVID-19 PHE Unwinding Section 1902\(e\)\(14\)\(A\) Waiver Approvals](#); CMS, [COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies](#); and SHVS/Manatt Health, [Leveraging Section 1902\(e\)\(14\) Waiver Authority Amid Unwinding](#).

Workforce Solutions

Amid continued workforce constraints as states prepare to address pending E&E actions and the unprecedented volume of transitions, some states are deploying innovative strategies.

- **Leverage partnerships:**
 - ✓ Use private contractors to support administrative E&E tasks (so long as those contractors are not using discretion to evaluate or determine eligibility).
 - ✓ Train community partners to support people in applying for coverage.
 - ✓ Leverage contract requirements and procurement opportunities to solicit commitments from health plans and vendors on unwinding efforts.
 - ✓ Work with sister agencies to find and recruit more staff.
- **Offer incentives for work** (e.g., overtime or increased pay).
- **Dedicate full-time units** to applications and/or renewals; and hire retired or previous eligibility workers who have experience with redeterminations.
- **Enable counties with eligibility determination work to redirect cases** (e.g., through a centralized state-funded site or to a dedicated “overflow” county).
- **Stage redeterminations** such that cases that require the most assistance are evenly distributed or sequenced last (to avoid pile-ups and provide more time to hire).
- **Reassess staffing plans and business processes to identify efficiencies:**
 - ✓ Reassign experienced eligibility workers to focus on more complex assignments, such as processing non-MAGI applications.
 - ✓ Contract with a vendor for data entry to free up eligibility worker time.
- **Develop eligibility training programs**, including refresher courses on redeterminations, computer assisted instruction, rotating team members, role playing/simulation, etc.



Alabama has a distribution unit that sorts applications/renewals, enters them into the system, and then batches to eligibility workers for processing.



South Carolina scans and sends paper applications to the state’s data entry vendor. The vendor is contractually obligated to input paper applications into the eligibility system within three days of receipt. Upon data entry, the eligibility system then conducts the verification.

Source: CMS, [Coverage Learning Collaborative](#).

Account Transfer

To preserve coverage for eligible people, both State-Based Marketplace (SBM) and Federally-Facilitated Marketplace (FFM) states are working to improve account transfer data and ensure system readiness.



Improve Data Completeness

- ✓ Ensure a minimum dataset is present so that accounts can be successfully transferred.
- ✓ Obtain up-to-date consumer contact information including email addresses.
- ✓ Assess outbound accounts that historically failed account transfer, identify the data elements that most commonly drove the failure, and prioritize fixing inconsistencies.



Enhance Systems and Technology

- ✓ Update systems to include additional contact information fields (e.g., cell phone numbers, email addresses) to enable additional outreach.
- ✓ Leverage technology for streamlining data sharing (e.g., in coordinated states, prepopulate SBM application with data from Medicaid system).
- ✓ Conduct regular systems (“logic”) testing/quality assurance (e.g., technical validity testing) to identify system vulnerabilities and eliminate glitches in sending or receiving accounts.

States are also assisting consumers found ineligible for Medicaid/CHIP to help them understand their options and transition to Marketplace coverage (e.g., boosting Navigator/assister and call center capacity, partnering with trusted entities in the community) and leveraging Medicaid managed care plans, especially those with qualified health plans.

Source: SHVS/Manatt/McKinsey & Company, [IT Systems and Data Strategies to Prepare for Medicaid Continuous Coverage Unwinding.](#); and CMS, [Resources to Support System and Logic Testing for Unwinding when the PHE Ends.](#)

Federal Actions to Smooth Transitions

To support states' unwinding needs and make sure HealthCare.gov is prepared for unwinding, CMS is:

- **Developing a comprehensive stakeholder engagement strategy and outreach campaign** for individuals determined ineligible for Medicaid and transferred to the Marketplace, including deploying Navigator direct outreach.
- **Implementing a variety of improvements to federal Marketplace policies and systems**, including revamping notices, streamlining processes to limit the number of people required to submit additional paperwork during the application process, and considering additional flexibilities to allow more time for consumers transitioning off Medicaid to enroll in Marketplace coverage (i.e., a Special Enrollment Period).
- **Enhancing assister resources** by increasing funding and training available to Navigator Grantees for unwinding, extending the certified application counselor designated organization application window, and reviving the Enrollment Assistance Program to supplement support provided by Navigators and certified application counselors in key locations.
- **Partnering closely with SBMs as they develop unwinding plans** (see the published SBM “punchlist” of best practices).
- **Identifying and beginning implementation of longer-term Medicaid/Marketplace improvements** (e.g., streamlining the consumer experience, making systems changes, ramping up data capabilities).

Source: CMS, [Strategies for SBMs to Improve Medicaid to Marketplace Coordination and Maximize Enrollee Transitions at the End of the Continuous Enrollment Requirement](#).

Discussion (Part I)



**The Return to Normal Medicaid and CHIP Operations:
*Learning From and Building Upon the Temporary
Changes Made During the PHE***

Building for the Future: Sustaining Beneficial COVID-Related Changes

States are also working to improve the healthcare system and advance health equity beyond the PHE by building on temporary COVID-related changes that have proven beneficial.

Examples of COVID-Related Changes



Significant expansion of state telehealth policies (e.g., payment parity and elimination of restrictions that impeded access).
(Disaster Relief SPA/ 1915 Appendix K).



Suspension or elimination of copayments and premiums in Medicaid and CHIP.
(Disaster Relief SPA).



Increased access to new benefits, waiving service limits, and removal of prior authorization requirements.
(Disaster Relief SPA).



Easing eligibility requirements and removing barriers that could jeopardize eligibility for services (e.g., increasing reasonable compatibility thresholds).
(Disaster Relief SPA).



Increased payment rates to maintain provider capacity and ensure enrollees can receive needed services.
(Disaster-Relief SPA).



Subsequent slides in this presentation review how states can sustain temporary changes put into place during the PHE so that healthcare advancements are not lost.

Extend Temporary COVID-19 Flexibilities

States are evaluating temporary flexibilities that have been effective in promoting access to coverage and care, and now must determine which to scale back or sustain and how, taking into account fiscal implications.

Emergency Authority	Steps to Continuing Certain Flexibilities
Medicaid and CHIP Disaster Relief SPAs <i>See CMS' February 2022 All-State Call Deck for more information, including template SPA language.</i>	<ul style="list-style-type: none">States may temporarily extend some provisions:<ul style="list-style-type: none"><u>For provisions without modifications</u>: Establish a new Medicaid state plan sub-section: Section 7.4.B., "Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency". CMS will apply a streamlined SPA submission and review process.<u>For provisions with modifications</u>: Establish a new Medicaid state plan sub-section: Section 7.4.C., "Temporary Policies in effect following the COVID-19 National Emergency." Submissions will follow the same CMS review process as non-Disaster Relief/traditional SPA submissions.<u>For additional provisions (not previously approved)</u>: Use this option for provisions that (1) are directly related to the state's COVID-19 PHE unwinding efforts; and (2) differ from what is currently approved in a Disaster Relief SPA.States may continue some provisions indefinitely:<ul style="list-style-type: none">Submit the SPA with a requested effective date of "the day after the PHE ends."Submissions will follow normal CMS processes and timelines.CMS will issue the approval with the effective date as "the day after the PHE ends."Once the end date of the PHE is known, CMS will reissue SPAs with a technical correction adding the specific effective date of the day after the PHE ends (no action required of the state).

Source: CMS, [SHO# 20-004](#); CMS, [All-State Medicaid and CHIP Call \(February 15, 2022\)](#); and SHVS, [New State Guidance on Resuming Normal Operations After the Public Health Emergency](#).

Extend Temporary COVID-19 Flexibilities (Cont'd)

Emergency Authority	Steps to Continuing Certain Flexibilities
1915(c) Waiver Appendix K	<ul style="list-style-type: none">▪ States may temporarily extend some provisions for six months after the end of the PHE by submitting an updated Appendix K application.▪ States may continue some provisions beyond the six-month post-PHE timeline by submitting an amendment to the state's 1915(c) waiver application via the Waiver Management System (WMS).
Verification Processes	<ul style="list-style-type: none">▪ States may update Medicaid and CHIP MAGI Verification Plans to make temporary verification flexibilities permanent. States may submit a revised verification plan addendum for temporary changes.

States will need to comply with appropriate tribal consultation and public notice/comment requirements and consider whether Medicaid managed care contract changes are needed (see detailed CMS technical assistance linked in the footnotes). States that seek to make temporary telehealth flexibilities permanent do not need CMS authority unless they memorialized such temporary changes in a state plan.

Source: CMS, [SHO# 20-004](#); CMS, [All-State Medicaid and CHIP Call \(February 15, 2022\)](#); and SHVS, [New State Guidance on Resuming Normal Operations After the Public Health Emergency](#).

Terminate Temporary Flexibilities

When terminating temporary flexibilities, states will need to adhere to CMS guidance and ensure they do not create added confusion for consumers.



Provide Advance Notice to Enrollees

Prior to terminating many of the temporary flexibilities (including changes to eligibility, benefits, premiums and cost sharing), states must provide Medicaid enrollees with at least 10 days advance notice. CMS encourages states to issue a combined program notice describing all changes occurring at the close of the PHE and providing information about the right to a Medicaid fair hearing, CHIP review, or BHP appeal.



Inform Providers

States should inform providers timely when they terminate certain flexibilities (e.g., some 1135 waivers and SPA authorities) to minimize disruption.



Make Operational Changes

States should evaluate necessary changes to systems/processes; ensure accurate financial reporting; assess managed care implications; and ensure staff are aware of policy changes.

Additional CMS expectations of states are described in the December 2020 [SHO# 20-004](#) and this [SHVS deck](#) (e.g., related to 1135 grace periods post-PHE for finalizing provider enrollments and completing level of care assessments, COVID-19 PHE Section 1115 Demonstrations reporting and monitoring requirements, and Optional Medicaid COVID-19 Testing Group communications with consumers).

Discussion (Part II)

The slides and a recording of the webinar will be available at www.shvs.org after the webinar. For more information, see SHVS' PHE unwinding page, [Resources for States on Unwinding the Medicaid Continuous Coverage Requirement](#).

Thank You

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Appendix

1) Aligned SNAP/Medicaid Renewal Dates:

Recertify SNAP First and Automatically Extend Medicaid Based on SNAP



Jane

- Jane is enrolled in both Medicaid and SNAP.
 - Jane's SNAP recertification is scheduled for March 31, 2023.
 - Jane's Medicaid renewal is also scheduled for March 31, 2023.
- In March 2023, the state processes Jane's SNAP recertification, redetermines her eligible for SNAP, and pushes her SNAP eligibility out for 12 months to March 2024.
- Based on the March 2023 SNAP recertification findings, the state has sufficient information (and 1902(e)(14) authority) to automatically extend Medicaid coverage for 12 months without having to conduct a separate ex-parte renewal and send a prepopulated renewal form.
- The state pushes Medicaid eligibility to March 2024 (so the SNAP recertification and Medicaid renewal periods remain aligned).

Year	2022			2023												2024		
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
						▼ <i>Recertify SNAP; leverage 1902(e)(14) to extend Medicaid automatically</i>												▼ <i>Recertify SNAP; renew Medicaid</i>
	SNAP and Medicaid coverage in place																	

Notes: This scenario (1) is illustrative, building on examples included in CMS' [Integrated Systems Deck](#); (2) assumes the Medicaid continuous coverage requirement ends on January 31, 2023; and (3) assumes the state obtains CMS approval for the temporary section 1902(e)(14) targeted SNAP strategy.

2) Misaligned SNAP/Medicaid Renewal Dates with SNAP Renewal Earlier than Medicaid: Recertify SNAP First and Automatically Extend Medicaid Based on SNAP



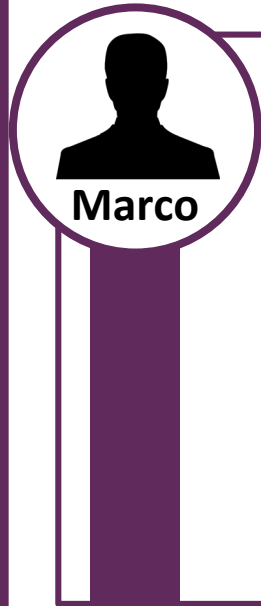
Carla

- Carla is enrolled in both Medicaid and SNAP.
 - Carla's SNAP recertification is scheduled for March 31, 2023.
 - Carla's Medicaid renewal is scheduled for June 30, 2023.
- In March 2023, the state processes Carla's SNAP recertification, redetermines her eligible for SNAP, and pushes her SNAP eligibility out for 12 months to March 2024.
- Based on the March 2023 SNAP recertification findings, the state has sufficient information (and 1902(e)(14) authority) to automatically extend Medicaid coverage for 12 months without having to conduct a separate ex-parte renewal and send a prepopulated renewal form.
- The state pushes Medicaid eligibility to June 2024 (so the SNAP recertification and Medicaid renewal periods remain separate).

Year	2022			2023												2024		
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
						▼ Recertify SNAP			▼ Leverage 1902(e)(14) to extend Medicaid automatically									▼ Recertify SNAP
																		→ Renew Medicaid
	SNAP and Medicaid coverage in place																	

Notes: This scenario (1) is illustrative, building on examples included in CMS' [Integrated Systems Deck](#); (2) assumes the Medicaid continuous coverage requirement ends on January 31, 2023; and (3) assumes the state obtains CMS approval for the temporary section 1902(e)(14) targeted SNAP strategy.

3) Misaligned SNAP/Medicaid Renewal Dates with Medicaid Renewal Earlier Than SNAP: Delay Medicaid Renewals to Follow SNAP Redetermination



- Marco is enrolled in both Medicaid and SNAP.
 - Marco's Medicaid renewal is scheduled for March 31, 2023.
 - Marco's SNAP recertification is scheduled for June 30, 2023.
- Since the SNAP recertification is not scheduled until after the Medicaid renewal, the state delays processing the Medicaid renewal until June 2023. States have flexibility to conduct Medicaid renewals at any time during the unwinding period—including for the purposes of aligning work on pending Medicaid and SNAP actions).
- In June 2023, the state processes Marco's SNAP recertification, redetermines him eligible for SNAP, and pushes his SNAP eligibility out for 12 months to June 2024.
- Based on the June 2023 SNAP recertification findings, the state has sufficient information (and 1902(e)(14) authority) to automatically extend Medicaid coverage for 12 months without having to conduct a separate ex-parte renewal send a prepopulated renewal form. The state pushes Medicaid eligibility to June 2024 (so the SNAP recertification and Medicaid renewal periods become aligned).

Year	2022			2023												2024		
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
						▼ <i>Delay renewing Medicaid</i>			▼ <i>Recertify SNAP; leverage 1902(e)(14) to extend Medicaid automatically</i>									
	<i>SNAP and Medicaid coverage in place</i>																	



Notes: This scenario (1) is illustrative, building on examples included in CMS' [Integrated Systems Deck](#); (2) assumes the Medicaid continuous coverage requirement ends on January 31, 2023; and (3) assumes the state obtains CMS approval for the temporary section 1902(e)(14) targeted SNAP strategy.