DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

August 29, 2022

Adaline Strumolo
Deputy Commissioner
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

Dear Ms. Strumolo:

This letter is in response to Vermont's request, dated July 7, 2022, for a waiver under section 1902(e)(14)(A) of the Social Security Act (the Act), that will protect beneficiaries in addressing the challenges the state faces as part of a transition to routine operations when the COVID-19 Public Health Emergency (PHE) ends. Section 1902(e)(14)(A) allows for waivers "as are necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries." Such waivers are time-limited and are meant to promote enrollment and retention of eligible individuals by easing the administrative burden states may experience in light of systems limitations and challenges.

The ongoing COVID-19 pandemic and implementation of federal policies to address the PHE have disrupted routine Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment operations. Medicaid and CHIP enrollment has grown to historic levels due in large part to the continuous enrollment requirements that states implemented as a condition of receiving a temporary 6.2 percentage point federal medical assistance percentage increase under section 6008 of the Families First Coronavirus Response Act (P.L. 116-127).

Consistent with the March 3, 2022 Centers for Medicare & Medicaid Services (CMS) State Health Official (SHO) 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*," Vermont has requested that CMS provide authority under section 1902(e)(14)(A) of the Act to temporarily complete *ex parte* renewals when no income data is returned from data sources for individuals who were previously enrolled or whose coverage was renewed based on a verified attestation of zero-dollar income. The state has expressed the need for this authority to support its efforts to increase the state's *ex parte* renewal rate in order to address systems and operational issues related to managing staff workload during the unwinding period. Specifically, the state cited concerns that the additional requests for information from beneficiaries would delay renewal processing, create unmanageable workloads given limited staff capacity, and lead to an increase in procedural closures.

Under Section 1902(e)(14)(A) of the Act, your request to complete *ex parte* renewals when no income data is returned from data sources for individuals who were previously enrolled or whose coverage was renewed based on a verified attestation of zero-dollar income is approved, as described and subject to the conditions below.

Ex Parte Renewal for Individuals with No Income and No Data Returned

The authority provided in accordance with this letter will enable the state, during the period of time specified below, to complete the income determination for *ex parte* renewals without requesting additional income information or documentation if: (1) the most recent income determination (either at initial application or most recent renewal) was no earlier than 12 months prior to the beginning of the PHE (i.e., March 2019) and was based on a verified attestation of zero-dollar income; (2) the state has checked financial data sources in accordance with its verification plan and no information is received. In order to complete the *ex parte* renewal, the state must take appropriate steps to review the non-financial components of eligibility consistent with the state's existing policies and procedures outlined in the state's verification plan implementing 42 C.F.R. §§ 435.916 and 435.956. The state will notify individuals whose eligibility is renewed using this authority that they must inform the agency if any of the information relied upon by the state in completing the renewal is inaccurate, consistent with 42 C.F.R. § 435.916(a)(2)(ii), and that it will redetermine the beneficiary's eligibility in accordance with 42 C.F.R. § 435.916(d) if the individual informs the agency of any such inaccuracies that may impact eligibility. The authority provided in accordance with this letter applies to the Medicaid population within the state.

The authority provided in this letter is effective the start of the state's 12-month unwinding period and will remain effective for renewals initiated through the end of the state's 12-month unwinding period, as defined in SHO #22-001.

The authority provided in this letter is subject to CMS receiving your written acknowledgement of this approval and acceptance of this new authority and the terms described herein within 30 days of the date of this letter.

We look forward to our continuing work together as part of a transition to routine operations. If you have questions regarding this award, please contact Joe Weissfeld in the Division of Enrollment Policy and Operations, at josef.weissfeld@CMS.hhs.gov.

Sincerely,

Sarah deLone, Director,
Children and Adults Health Programs Group