**Sample 1902(e)(14)(A) Waiver Submission Instructions**

As states prepare to restore routine operations, CMS has worked closely with state agencies and other stakeholders to identify ways to efficiently renew eligible individuals, and reduce churn. To support states facing significant operational issues and streamline the renewal or fair hearing processes to protect otherwise eligible beneficiaries at risk of inappropriately losing coverage during the unwinding period, CMS will provide states with limited use of section 1902(e)(14)(A) authority in appropriate circumstances and subject to CMS approval.

States interested in one or more of the temporary waiver authorities described in 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*,” must submit a letter to CMS requesting such authority. CMS is providing the attached sample language to guide states in crafting a letter to request the waiver and to indicate the authority they seek. States will need to include state-specific information and should revise the sample language as appropriate to their circumstances. States requesting authority to adopt a different streamlined strategy should contact their state lead to work with CMS staff to ensure CMS can provide the authority sought and craft appropriate alternative language to ensure that the state’s request includes any necessary information and assurances.

States using the template should:

* Include in the letter the language associated with the flexibilities being requested;
* Delete the language associated with flexibilities not being requested;
* Fill in yellow highlighted sections with state or program specific information and justification for the authority requested;
* Make any other revisions or add additional language appropriate to the state’s circumstances; and
* If the state is seeking authority for a strategy not enumerated in the SHO, add any additional flexibilities not included in our March 3, 2022 SHO letter that the state would like CMS to consider.

Note that states do not have to include all 1902(e)(14)(A) waiver requests in a single letter, but may seek authority to adopt additional at a later date. Once CMS receives the state’s request, we will reach out with any questions regarding the state’s request. States may also request technical assistance when submitting their letter.

**Submitting to CMS:** States should email their final letter requesting 1902(e)(14)(A) waiver authority to Sarah deLone, Director, Children and Adults Health Programs Group ([Sarah.Delone2@CMS.hhs.gov](mailto:Sarah.Delone2@CMS.hhs.gov)), and copy your Medicaid State Lead, Joe Weissfeld ([josef.weissfeld@cms.hhs.gov](mailto:josef.weissfeld@cms.hhs.gov)), Jessika Douglas ([jessika.douglas@cms.hhs.gov](mailto:jessika.douglas@cms.hhs.gov)), and [CMSUnwindingSupport@cms.hhs.gov](mailto:CMSUnwindingSupport@cms.hhs.gov).

**Additional Questions:** For any additional questions or technical assistance requests, please contact your Medicaid State Lead and copy the CMS Unwinding TA mailbox at [CMSUnwindingSupport@cms.hhs.gov](mailto:CMSUnwindingSupport@cms.hhs.gov).

**Sample 1902(e)(14)(A) Waiver Letter**

Date

Sarah deLone, Director

Children and Adults Health Programs Group

Center for Medicaid and CHIP Services

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Baltimore, Maryland 21244-1850

Dear Ms. deLone:

Upon the end of the Public Health Emergency, [STATE] will have a large volume of eligibility and enrollment actions to complete. [STATE] anticipates severe operational and systems challenges in the timely completion of these eligibility and enrollment actions in large part due to an unprecedented caseload of renewals that the state will need to process, coupled with significant staffing shortages that the state currently faces [IF APPLICABLE].

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*,” describes strategies states may request to assist in addressing the challenges states may face as part of a transition to routine operations. CMS can authorize these strategies under Section 1902(e)(14)(A) of the Social Security Act (“1902(e)(14)(A) strategies”).

During this transition period, [STATE] is requesting that CMS approve the 1902(e)(14)(A) strategies outlined below to protect beneficiaries from inappropriate terminations and reduce state administrative burden:

1. ***Renewal for Individuals Based on SNAP Eligibility***

[STATE] requests to temporarily renew Medicaid eligibility for individuals under 65 years of age who are receiving benefits under the Supplemental Nutritional Assistance Program (SNAP), despite the differences in household composition and income-counting rules. Under this authority, [STATE] seeks to renew Medicaid eligibility for SNAP participants whose gross income as determined by SNAP is under the applicable MAGI threshold for Medicaid eligibility without conducting a separate MAGI-based income redetermination. This authority is needed to address the extraordinarily high volume of renewals and other eligibility and enrollment actions that we will need to conduct during the unwinding period [identify any specific issues appropriate to the state – e.g., workforce shortages or other factors].

STATE requests that this authority be effective [Date] and remain effective for renewals initiated through the end of our 12-month unwinding period, as defined in SHO #22-001.

1. ***Ex Parte Renewal for Individuals with No Income and No Data Returned***

[STATE] requests to temporarily complete the income determination for *ex parte* renewals without requesting additional income information or documentation if: (1) an attestation of zero-dollar income was verified within the last twelve months, at the initial application or the previous renewal; and (2) the state has checked financial data sources in accordance with its verification plan and no information is received. This authority is needed to address the extraordinarily high volume of renewals and other eligibility and enrollment actions that we will need to conduct during the unwinding period [identify any specific issues appropriate to the state – e.g., workforce shortages or other factors].

[STATE] will continue to take appropriate steps to complete an *ex parte* determination of 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. [STATE] requests that this authority apply to [select: Medicaid, CHIP, or both Medicaid and CHIP] populations.

STATE requests that this authority be effective [Date] and remain effective for renewals initiated through the end of our 12-month unwinding period, as defined in SHO #22-001].

1. ***Facilitating Renewal for Individuals with no Asset Verification System (AVS) Data Returned within a Reasonable Timeframe***

STATE requests that CMS grant time-limited authority to assume there has been no change in resources that are verified through the AVS when no information is returned through the AVS or when the AVS call is not returned within a reasonable timeframe, and to complete an *ex parte* renewal process without any further verification of assets. This authority is needed to address the extraordinarily high volume of renewals and other eligibility and enrollment actions that we will need to conduct during the unwinding period [identify any specific issues appropriate to the state – e.g., workforce shortages or other factors].

If the state receives information from the AVS indicating potential ineligibility after a beneficiary has received notice that their coverage has been renewed, the state will treat such information as a change in circumstances that may affect eligibility and redetermine the beneficiary’s eligibility in accordance with 42 C.F.R. § 435.916(d). The state also assures that it 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 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.

STATE requests that this authority be effective [Date] and remain effective for renewals initiated through the end of our 12-month unwinding period, as defined in SHO #22-001.

1. ***Partnering with Managed Care Plans to Update Beneficiary Contact Information***

[STATE] requests to temporarily permit the acceptance of updated enrollee contact information from managed care plans without additional confirmation from the individual. Under this authority, the state would treat updated contact information confirmed by and received from the plan as reliable and update the beneficiary record with the new contact information without first sending a notice to the beneficiary address on file with the state. This request is based on identified system or operational issues that prevent [STATE] from implementing the policy to first contact the beneficiary to confirm the accuracy of updated contact information received from managed care plans prior to entering the updated contact information received into its system as the address of record. Our systems or operational issues are related to [identify: eligibility system, workforce, other factors] that [describe the issue]. Given that [STATE] would not be able to partner with managed care plans to update beneficiary contact information without this authority, [STATE] is seeking this authority to protect beneficiaries in the aggregate by reducing the risk of procedural terminations for many beneficiaries. [STATE] requests that this authority apply to [select: Medicaid, CHIP, or both Medicaid and CHIP] populations.

In implementing this option, [STATE] assures that:

* The managed care plans only provide updated contact information received directly from or verified with the beneficiary, an adult who is in the beneficiary’s household or family, or the beneficiary’s authorized representative recognized by the health plan. The state will not accept contact information provided to the plan by a third party or other source if not independently verified by the plan with the beneficiary, an adult who is in the beneficiary’s household or family, or the beneficiary’s authorized representative recognized by the health plan; and
* The beneficiary contact information provided by the managed care plan is more recent than the information on file with the state

[STATE] requests that this authority be effective [Date] and remain effective until 14 months after the end of the month in which the public health emergency for COVID-19, as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. § 247d), ends.

1. ***Extending Automatic Reenrollment into Medicaid Managed Care Plans up to 120 Days***

[STATE] requests to temporarily auto reenroll beneficiaries into their managed care plan for individuals who are reenrolled into Medicaid after a loss of Medicaid coverage for [insert between 60 and 120 days]. Under current policy, consistent with 42 C.F.R. § 438.56(g), Medicaid managed care contracts must provide for automatic enrollment for individuals who are reenrolled into Medicaid after a loss of overage for two months or less. [STATE] requests to extend this automatic reenrollment period to [insert between 60 and 120 days]. [STATE] requests that this authority apply to [select: Medicaid, CHIP, or both Medicaid and CHIP] populations.

In implementing this option, [STATE] will comply with 42 C.F.R. § 438.56(c)(2)(iii), which requires that enrollees subject to automatic reenrollment under 42 C.F.R § 438.56(g), be permitted to request disenrollment without cause if the temporary loss of Medicaid eligibility has caused the beneficiary to miss their annual disenrollment opportunity.

[STATE] requests that this authority be effective [Date] and remain effective until 17 months after the end of the month in which the public health emergency for COVID-19, as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. § 247d), ends.

1. ***Extended Timeframe to Take Final Administrative Action on Fair Hearing Requests***

[STATE] requests to temporarily extend the timeframe permitted for the state to take final administrative action on fair hearing requests, excluding requests for an expedited fair hearing in accordance with 42 C.F.R. § 431.224. As part of this request, [STATE] assures that it will:

* Provide benefits pending the outcome of a fair hearing decision (including reinstating benefits), regardless of whether or not a beneficiary has requested a fair hearing prior to the date of the adverse action or whether the beneficiary has requested benefits pending;
* Not extend the timeframe to take final administrative action for a fair hearing request where benefits cannot be provided pending the outcome of the fair hearing, such as an appeal of denial of eligibility for a new applicant;
* Not recoup the cost of benefits pending from the beneficiary, regardless of whether the fair hearing ultimately upheld the agency’s determination; and
* Not use this authority as a justification to delay taking final action, and only use this authority to the extent to which the state is unable to take final agency action on a given fair hearing.

Given the [identify constraint state faces – e.g., insufficient number of hearing officers, existing fair hearing backlog, estimates of fair hearing volume or other factors], without this authority [STATE] is at risk of being unable to take final administrative action on the extraordinarily high volume of fair hearings that we anticipate during the unwinding period within the maximum 90-day time limit allowed under 42 C.F.R. 431.244.

[STATE] requests that this authority be effective [Date] and remain effective until the end of the 23rd month after the end of the month in which the public health emergency for COVID-19, as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. §247d), ends.

[STATE] looks forward to your review and approval of this request. If you have any questions or concerns, please contact [State point of contact, Title, Phone, Email address].

Sincerely,