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RETURN TO NORMAL TOWN HALL - SESSION 1
FEBRUARY 28, 2023

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>> Good morning. It is officially that time. We're about to get started.

I see a few more people joining in. We'll give them 30 seconds of pure grace at 7:30 this morning so they can get in this session. Let me reshare my screen. We're going to get started. I will see if all of our speakers are here. Let's see.

We're ready to role.

We're excited to have you here, we're in the middle of something that's exciting, at the same time a little anxious building. We're here with our providers and Medicaid advocate to talk about our federal Medicaid continuous coverage. What that means for so many of you in this field, so many of you that are serving our Medicaid recipients, we're so excited to have you here, to have this discussion, to share where we are in the plans and to give you any advice, guidance, answer any questions we can hear or through a follow-up document in order to make sure you feel reassured and self-assured in the process you're about to embark on.

I'm going to turn this over to -- before I get started, some logistical things. If you have a question, you are more than encouraged to drop them in the Q&A.

We'll be gathering those throughout. I know some of you submitted questions ahead of time. We want to make sure we're pulling as many of those as possible and addressing those and providing as much clarity as we can.

Also if you want to provide any additional information we ask that you limit what's going on in the chat so that we can make sure we focus on answering those questions. The chat, you will be able to have a conversation with the host, myself, any of the presenters. We ask that you use the Q&A primarily in order to submit your questions.

We'll go ahead, get started.

We'll start this morning, each of us will do our introduction first and then hand it over to Mariam. I'm Natalie, the outreach, member engagement manager here. Excited to be here. I'll ask Mariam to pop on and Katherine to both on to introduce themselves and we'll get started.

>> Awesome, good morning, everybody. My name is Mariam, senior director advisor in the Office of DMAS.

>> Good morning, everybody. I am Katherine O'connell-Raymond, a Medicaid program consultant with the Virginia Department of Home services at the home office. Thank you.

>> Okay. Good morning, everybody. Thank you for joining again. It is super, super early. We wanted to make sure this time works for you all.

We are very excited that you can join our first Town Hall on unwinding as I like to call, it unwinding, a household term in my house now, my kids know it.

I want to do a quick level setting, what's that mean for us.

Next slide.

Unwinding process basically means -- involves restarting our refewal process for Medicaid members. The response for COVID-19 pandemic, federal government provided an additional funding for Medicaid agencies to ensure that we can allow members to stay on Medicaid during the pandemic.

Starting March of 2023, next month, we're beginning our 12-month renewal process basically this is when we'll restart renewing our members for the next 12 months. What we really -- why are we really here? We want to make sure we share the information about the upcoming renewal process and how to support us.

Next slide, please. This process is not a DMAS Medicaid process, but a combined effort because the renewals, they're done at the local Department of Social

services where BDSS has oversight. So all of these unwinding efforts is a combined effort between DMAS, Medicaid and the Department of Social Services. For the last two years we have been really -- we knew this was going to come, we were anticipating renewals to restart at some point and so in that effort we have been preparing our systems, our collaborations to really make a big impact and to make it easier for us whenever the renewal were began.

A couple of things you want to highlight here. We have made many system updates, additional automation, making the process more efficient for the local Department of Social services standpoint. That way there is less manual work to be done and more of the renewal could be done automatically.

The other one I want to highlight, collaborating with our SCFOs, they have been a great partner with us, sharing the information and educating our members on what it would look like for them when the renewal begins, in addition, they have been supporting our efforts in getting the up to date contact information for our members. Obviously we have not reached out to them in a couple of years, we want to make sure we have the best contact information to reach them.

Next slide, please.

I just want to talk through -- I wanted to talk through a couple of things and understanding what the process would look like. CMS/HHS has provided lots of guidance to us, lots of guidance to us in terms of what the unwinding or renewals would look like when this begins.

I see lots of -- I'm sorry Natalie. I see chats that there is some noise and it is hard to hear. Can you all -- can everybody hear me? Maybe it is some folks having some problems, okay. Thank you. I'm not a technical person, maybe the best solution is relogin? Log off, come back, maybe that's helpful.

Okay. Thank you, everybody.

I just wanted to highlight a quick process in terms of what it would look like, what do we have to do when we start this renewal process in March. The states must try to redetermination, renewal automatically, meaning going through the system, if somebody is -- if we have all of the information for someone whose going through a renewal process, they don't -- we don't need additional information, they will just get renewed automatically for another year and they'll get a notice of action in the mail that they have been renewed for another 12 months.

If we do need additional information from the member

to verify their eligibility, the state will send a prepopulated renewal form and this is about 10 pages or so of -- it is a prepopulated but a ten-page document that will go to the member's house, whatever the address they have. The member will have 30 days to refond that packet, when we receive that renewal packet, the eligibility marker will review the documentation and make -- and do the eligibility determination. States must send out an adverse notice action prior to, this is a notice of action that members receive if they have not -- if they're no longer eligible for Medicaid. It highlights the 12-month batch process every month, a certain number of groups, a certain number of members will go through the renewal process and they'll have -- if he net paper packet, they'll have 30 days to respond, is and so this will go on for the next 12 months starting in March.

Next slide, please.

Perfect.

I'm trying to make the whole 12-month point come across. I feel it could be a little confusing.

Just what I mentioned, starting in March, we begin the full renewal process, we give folks 30 days to respond, if they bet a paper packet in the first closures, they'll not occur until April 30th. This will go on all the way for the full year and then at the end, we will do some Cleanup, make sure everything is good and basically normal, normal, things will go back to normal starting May, 2024 and it won't be part of the unwinding renewal. It just will be part of the regular Medicaid business.

I won't go into all of the details, this is a that's visual to understand all of the things that Medicaid and DSS was been working in the last two years for preparation of unwinding, resuming normal business. We have done system changes, stakeholder engagement, sent letters to members to make sure that we have the up to date addresses. We have done social media campaign, radio campaigns, just a nice reminder that all of the things we have done to make this process as successful as possible.

At this point I'll punt it to Katie.

>> I'm going over steps we've been taking to prepare for this immense task. As has been said, we are doing things in conjunction with the Department of Medical assistance services and stakeholders by having definite messaging that's going out and going out to the local agencies that gives them information about how this unwinding, quote, unquote, will effect all of the programs, not just medical assistance, it will have an impact on

other programs. We're having on our part joint monthly unwinding meetings, virtual. We're jointly participating in monthly calls to communicate things that are occurring for the local agencies in their other state partners. And, you know, just to reiterate, we're making resources available to local staff whether they're FAQs, scripts that they can take advantage of at the local level, when customers have an interruption in their benefits and they call the local agency, what they can anticipate the calls to be, how to handle them, how to handle subsequent appeals. We're getting out different advice and guidance to them on how to prepare for this. As mentioned, it is going to be a 12-month process to try to take into account all of the overdue reviews and trying not to overwhelm the local agencies with the massive amount of work coming their ways.

There is an unwinding portal that is a one stop shop that's on our internal system, our Internet that we call fusion, and on that Internet there's important information and guidance, different deck, presentations, recordings from all of the different things that we're trying to put out there to help prepare everyone for what's getting ready to occur.

Next slide, please.

On the public facing side, you know, a lot of this is reiterating what's been gone over before, but we're working on having social media messaging. I have seen it. It is pretty handy. They're putting messages out on social platforms that our customers may be involved on such as Facebook and Twitter, and those have been posted consistently since November of this past year letting them know about Virginia's plan for returning to normal operations.

We have a sight where individuals can apply for all benefit programs pretty much, there is a public facing message on that side that has messaging about the public health emergency and the unwinding information. That's been posted since November 22 as well.

That gives you the link to that website, which is pretty helpful for people to go into.

You know, just to short message about common health, it is an online portal where people can apply, that they also can go on and check the status of an application, they can check status of a renewal, report changes, submit renewal, by linking their account. It is very handy, I think in today's world, the majority of people like to do things online.

So that is a helpful tool for the customers to get in touch with local agencies.

VVS has been doing public site messaging and that is on the external page at the DSS.virginia.gov website. There is message interesting that will address this unwinding information and the resources that are available.

We're working on deploying some radio public service announcements, so those are going to go out regionally and are currently in development and will go out and people will start hearing those and I think I saw a schedule for something recently and there's been a joint press release between DMAS and VDSS in development and it will be ready for public reviewing after DMASS review and approval.

Next slide, please.

This, and it is a little bit hard for everybody to see. What we have put together, it is a one pager that will be deployed and it addresses to people all the benefit programs impacted by what we call the unwind. Not just Medicaid, but it is other programs as well that are being impacted and that your customers might remark to you that have had impact on their lives.

Of course. To me, and to probably everybody here, medical assistance is the most important but snap has had a lot of changes as well that are a big impact to the community and so they're trying to handle those as well.

This is going to be available, they're waiting on getting it translated and so that will be disseminated after that, but that's a fairly handy tool that's going to be available.

Next slide, please.

General guidance, we're trying on our end, the state, between us and DMASS to get staff ready for this unwinding after three years. We are making different trainings available to everyone, we have started with refreshers on how do renewal and what to expect when going into the system, everybody else, there is lots of meetings, round be tables to address with local staff the best practices, what to address, you know, how to get ready for this change so we can make sure that people have the coverage that they need. We're also using to disseminate information something called a listserv and a statewide memo that goes out on the Internet and just putting out there to everyone what can they do, how can we prepare and so we have done a different thing internally available to staff guidance and procedures, we have had subject matter expert, I have one later today, that staff can can, you know what, they can do to prepare, what to expect, special scenarios, and just

trying to get the guidance out there so that people are feeling ready for this I mentioned before, different E. learnings are led and making sure everybody is prepared. That's the big thing. I was a Girl Scout lead, let's be prepared. We know this is going to be a massive understanding, and it is going to have an impact from the provider side, which I thought of yesterday. What can you do if someone shows up and I discover that the Medicaid was canceled and you go to bill and the Medicaid was canceled. They're going to have to reach out to the local agency and try to resolve that. If someone is closed for not returning the renewal, they have 90 days to turn information in for the renewal, whether it is verifications that are required, it is the actual redetermination, and they have that opportunity there, the state is also trying to prepare them to do as many renewals, I think it was mentioned earlier, touchless, where it goes through the system, but only certain covered groups on Medicaid meet that criteria.

Unfortunately, the age, blind, disabled population did not meet that criteria and do require a renewal that we have sent to them completed with all of the information returned but we're trying to get everybody ready and have a joint issue.

I saw a question there. When does the 90-day grace period start, a 90-day start period starts after an individual's coverage has been closed.

>> It is important that they maintain coverage, it is important to have health coverage, with us, with someone else, it is important to reach them so that we can do that, we have to make sure that they update that you are their con be tact information. If the first phase of information, if we continue through, if we don't have updated information, we can't do Phase 2 or Phase 3, we have to make sure that's a pervasive message. We encourage the members to update the information. Phase 2 starts -- started this month, we encourage the members to complete their paperwork, when they start to receive it, when the process actually begins, turned on, turned up that lever, now they're starting to receive communication, they have to actually complete that. We have messaging going along with that. Review, respond, renew. We want to make sure that he understand that it is really important that they maintain their coverage. But in order to do so, we need them to actually fill out the paperwork that comes their way. Maybe they'll be lucky, go through ex party, they don't have so many things to do, they'll have a

wonderful notice, that's not the vast majority. That's not everybody. If it is not everybody, you want to make sure that you have what you need. Phase 3 , the main purpose, it is to make sure if members lost coverage due to administration reason, need to complete the paperwork for whatever reason, we have to make sure that they do that, that if they're in that grace period, that Katie had talked about, they return what they need, if they need to be redirected to another resource within the Commonwealth to maintain coverage, we have to make sure they do that. That's the third phase. So we have these three phases, we're making sure that we provide resources and tools. When we talk about the communication plan, we have had a digital ad campaign, strategic communication team and the team over it, they have worked through different ways to coordinate and to respond and to share the information that's going on. Social media campaign, we have had our cover Virginia website with updates and we have others to include this in the main website to redirect to some of the information taking place or that's held on the cover Virginia website, toolkits are developed, they're on the website, I'll show you a preview of what those look like next. We have mailed member flyers, posters, information to our local Department of Social services, and our community services board for Phase 1, we'll do that again in Phase 2 to get the materials available.

We'll share that information where necessary.

We have also had translated documents into 7 different languages to include English, Spanish, a couple of other one, and those are to make sure that, you know, people receive information in different kinds of ways, for us, it is really important that when they're trying to receive that information that they do so in a way that's easy for them to understand to best communicate with stakeholders and partners that they have, whatever they need to do in order to move forward in the process. We have provided memos, informed health plan, others have been great partners and we have held virtual meetings with you, individually, with organizationes, in order to best make sure that you are navigating the process with resources and tools that you need to be successful.

Again, we have toolkits we mentioned before inand we started the Town Halls, listening sessions to share more information with you and gather as many questions as we can about the process so that you feel confident on what's going on.

Our toolkits look like this. They're Phase 1, 2, 3,

they're together, they're on the cover Virginia website under the return to normal tab at the top right corner. Then if you click on that, you will see four bars at the top and it is a toolkit and materials. Our website has gone through shifting in the next couple of weeks, and with that, you see the same prompts and follow the same kind of pathway.

Then you will be able to see a lot of different components. If you're interested in what it looks like, interested in what the traffic information is, reach out, we'll be happy to share those things.

Is this me.

Okay. The main takeaway, making sure that you know renewal begin in March. Some members get renewal papers in the mail, some don't, it is making sure that they have the resources they need to successfully complete whatever comes their way n is the 12 month process, this is not going to happen all at once. Our members, they want -- we want to make sure that they understand when that come, when they actually hear from Medicaid, we want them to respond to it. Not everybody will get renewed at the same time, we have the 1-month process that was mentioned at the begin, this is a staggered approach and we want to make sure that they understand, you may not get it in March, it may come in September, it may come in June. Whenever it comes, we want it to be ready and to be respond, what do you need, how do you support the process? Ensure that our members have the most up to date contact information for all of us to pull from. We want to be able to contact them and it doesn't matter how many times you ask them, you know, life circumstances and changes on a dime for our members, we want to make sure that we're always able to get in contact with them. If they actually receive a packet, please encourage them to actually complete it, there are a different -- a number of different ways and we'll review that, how to review the coverage and the support mechanisms that assist for that. For you, we want you to continue to provide additional feedback and resource about how you're using the resources, how we can better support you as you're supporting our members, it is really important that you know what you're doing, you're comfortable with what you're doing and to the best of your ability so that we can make sure that the members get the best possible experience and outcome from the process. So I'll turn it back over to you and then we'll keep going.

>> Thank you. I want to add one more thing on the previous slide. Another major, major thing that we need

your help with, and, you know, a reminder for all of you who are providers, it is to check the eligibility. For the last few year, all of the members were in Medicaid, nothing changed, so now starting in March, that will be impacted and we're trying to make the renewal date visible on the provider port soul that you can help and support your patients, if you see, you know, somebody is coming in in May, and the renewal date is May, it is great messaging and support and if they had gotten a paper packet, please complete t that's something that we're working on actively right now and should have it done before renewals begin and we'll have resources for you to know and understand how to read the provider portal information and the renewal dates.

Going into how members complete and submit the renewal. The renewal packets, all the same ways that were available throughout the previous years, throughout the whole time, calling, going to common health portal, then visiting your local Department of Social services and submitting it in person.

This last slide, other sessions on specialty groups, you can go to the next slide. Thank you. Here is all of the information, very similar, content will be discussed as what we discussed this morning. Questions will be on specific provider groups or specific populations.

I believe that's all we have. We have gotten lots of good feedback in the chat, I apologize for having that big noise, we'll make sure the future Town Hall, we'll disable that feature to make sure it is available for you and you won't hear that, I have received several great question, in the Q&A, and also the RSVP process, and our hope is to address some of the questions today and if we can't cover it all today, we will -- we're just gathering the questions together, responding and providing the response and then we'll post it all on the same webpage where all of the town hall information is available. In addition, the slides will be publicly available soon and the recording of the session.

You can share with the colleague, friends, anyone who you think it would be helpful for.

I got one really good question, Natalie, if you don't mind, I can take that one first because I think it is really important for folks to not realizing this, the question in the chat, it is can the members self start the renewal process themselves, do they have to wait to get a letter? This one is funny, because we would want people to have Medicaid coverage as long as it is possible. So if you started -- if your renewal is not until December of

2023, but you started in July, you call the call center for example, you want to do the renewal in July, we will take that information, obviously, if you're not -- if you're not eligible, you will lose those had, 5 months of time period of Medicaid coverage that you would have continued on if you waited until December. We encourage folks to stay on Medicaid as long as they have to, when you get a paper packet, renewed automatically, you get a notice, you're done. If you're very, very proactive, we won't discourage that either.

A couple of other ones. We'll start with this one. We have a couple of members from DMAS that joined us. They're in the background. So what is the biggest obstacle for providers during the unwinding,.

>> Whoever wants to take that.

>> I'm the director of operation, the biggest issue, with provider, it is an ongoing issue that we currently have with providers and it goes back to what we talked about with vary verifying eligibility, a quick addition to the statement, Medicaid eligibility is month-to-month, as a provider, always check the members eligibility each and every time that you see them. It will be even more important with them with the unwinding, if you verify the member's eligibility, it should help you be fully aware of any of the individuals that were affected by the unwinding and maybe their coverage was reduced, interrupted for whatever reason, it is very important that you check the members eligibility. I don't want to put a provider in a situation where they're seeing a Medicaid member in the coverage, it has been changed. Obviously we know that's a hardship for you and it is a hardship for us as well.

I see several questions in the chat with regard to updating your provider information, you should be able to log into the portal, if you yourself are not already enrolled, more than likely either a clerk, some, a biller, someone, from who does your billing, who works with DMAS in regard to the viewing, is already administrator of sorts to that portal so they should have access. That's the avenue that you would use if you need to update any of your provider information. Mails, contact information, whatever, we put hipful tips in the portal for providers. From my perspective, the main thing for providers, it is what was said, please be sure that you check eligibility for your members each and every time because that's going to determine what level of service you're able to provide to the members.

>> Thank you. Ann will pop-up too if she needs --

>> I'm here.

>> Hey there! Another question that we have, how can patients and clients cancel their coverage.

I know Kelly is on. I don't know if you want to answer that one. That's easy, you can call -- here we go. You can do that.

>> If someone wants to cancel their coverage, as was mentioned, they can go to cover Virginia and put that request in online. They can contact the local agency and ask to close their case because during the past three years, I think it is mentioned, we did not take any adverse action so there are a lot of people open that maybe they have had a change, just want to close. But they have had that opportunity to close it if they want to. They just need to contact the local agency via the -- they can contact cover Virginia, they can go on common health, or actually contact the local.

>> Sounds good. All right. We have another one that came up. If a client is determined no longer eligible for Medicaid, how much of a notice will they receive before termination of benefits. Who wants to take that one.

We are required by law to provide advance notice, which is at least 10 days prior to closing, for example, if we're going to close you on May 31st, we have to at least ex send you a notice of action by May 20th.

I believe.

However, due to system limitation, we have what's called Medicaid cut-off, the 16th of every month. If someone's renewal is due in May and they have not returned all of the information, we have to close that case in the system by May 16 so that generates a letter to them, advising them that the case is closed effective May 31st. I want to take a quick minute. I saw the question pop-up, on the 90 days, there is that 90-day grace period and if the verification or renewal is returned during that 90-day grace period, coverage is reinstated back to the date of close f a case closed May 31st, all information comes in, renewal or verifications, it is reinstated back. So they have coverage June 1st, so they won't experience a true breaking in coverage, there may be some upset in the NCO getting canceled, because that happened and they go fee for service or straight Medicaid and then it picks right up. That process is in there as a safeguard and that will assist the client. Again, you know, they have that 90-day period and they can get the information in and get it reinstated back the date it closed.

I just wanted to reiterate that.

>> Thank you so much. A couple of questions, I saw some questions in the chat alluding to this. And this one, I can answer, will DMASS send from my provider signage and pro sures to make available in waiting rooms and I saw one on if flyers are available for members, so, yes, we have all of tholes materials on our coverage Virginia website. We have sent information to our CSBs and the LDSSs, any provider stakeholder has the ability to go on to the we believe site under our member section so that you can -- undercover Virginia in order to order materials under the material section in order to order a few things. Right now the only ones that are available regarding update information in the chat, the member flyers, the echo flyer, the member poster. You can order those now. It is really easy to get to. I'll drop a link, I saw somebody drop a link in there about the toolkits. That's great. I'll drop a link in the chat as well for the material page that you can go on, directly order those items and it comes directly to you and takes no more than three minutes to fill out the order form and you have them to place in your waiting rooms or if you're going to community event, if you want to drop them off in a certain organization that you serve, you are more than welcome to do any and all of those things f you find there is something in there that you wish that you had, let us know, we created templates early in the process for Phase 1 so that you can personalize these, it has the standard messaging on it and you can add different things on there from a provider standpoint, to let them know they receive it had from you, if you want to do that, you can do that, contact me directly, it is coverage Virginia and you can contact us there, to make sure you have the information.

So the next question that came up, it is you need more Town Halls for providers and more notice to schedule people to attend, do you want to take this one.

We're happy to do as many as you need to. If you have a specialty group, you think it would be helpful for them or, you know, if the hospital association, you have hospitals that have navigator, assisters in the hospital, and it would be helpful for them. Whatever the need, we're happy to have it. We would like to get this information out there and make it helpful so that we're happy to do that. Feel free to email us and -- or drop it in the chat if you're interested we'll be happy to coordinate that.

Natalie, one question I want to address. It is a few we have gotten in the Q&A box. The question is how many people are we expecting to either lose Medicaid

or -- either lose or to temporarily lose Medicaid. So our data analytic group, they have been looking at national data as well as our data, prepandemic, in terms of the coverage loss potentially, what it would be, we're anticipating 14% of coverage loss during this unwinding period and 4% of that, an additional 4% of coverage loss but they'll come back within 6 months if that's helpful. 14% is what we're anticipating based on the national averages and some of the data. We have reviewed ourselves, for our Medicaid program. So there is a lot of numbers flying everywhere, I want to highlight those two number, 14% is what we're anticipating, 4% of the individuals who will temporary lose but then come back, come back to the Medicaid prom within 6 months period. Sounds good. This may be connected to a question that was answered earlier, but whoever wants to grab this, as a provide, after April, 2023, we must check eligibility of all of our Medicaid patients, correct? Does Medicaid, will Medicaid pay for Claims up to April 2023? I'm trying to find the best way, I may need clarification. As a provider, you should check eligibility today. Medicaid is month-to-month, many members move between service and managed care, there may be an interruption or a change in their coverage, their resources may change, making them eligible for other groups. You should check eligibility today and the reason I say that, I think if you view the amount of claims we receive for numerous reasons that I know relate back to not checking eligibility.

So my suggestion, it would be to get in a good habit, understanding that I know the staffing issues, things of that nature, providers are taking on that task.

Really you will be helping yourself by checking eligibility today.

The second part of the question, it is in regards to Claims, how you bill it, as long as we have eligibility at the time that the service was received.

You had gone ahead, started to answer that question. As long as the patient had fully, they were in a fully Medicaid group at the time that the service was received providers are able to bill 12 months from the date of service that the services were received.

I think what you were alluding to, if I have full coverage Medicaid today and I received benefits -- received some type of service and then I lose my coverage in April after the unwinding, you're still able to bill for the services received as long as there was a fully covered group available to the member at the time services were

rendered.

>> I have a follow-up one --

>> Yeah. Yeah. I want to go back on that. Just for the those providers that are providing services to special populations that need service authorizations, if they're in our waiver, CC be plus, if those medications stop, the authorizations stop. Which it should. Right.
If -- that's even more of a reason for a provider to check that eligibility. Medicaid ends, the authorization ends, particularly in the waiver, if you don't know it has ended, you can't are and as you know, you have to have an advanced request on your authorizations, not retro. You have to stay on top of that and check the eligibility.

This may be a Tia question, so should they check eligibility on partner sites,.

>> We have numerous ways to check, if the partners at the plan allow the option for you to check, we don't have a way, we're all receiving the same information, our partners allow that eligibility, it is okay to use that system if you primarily build fee for service patients, you probably have someone in your office as registered on the MES system and you can check member eligibility on that system. Individuals receive 10-day notice prior to closure, it is not necessarily the provider. The individual has to let them know. Just pushing, checking that eligibility.

>> Thank you. As well as we have very good resources with the provider help line in regards to eligibility, there is a wonderful 800 number and you don't have to speak to a person.

If you have a national provider identifier, you can enter that, it will allow you to check member eligibility and to provide you with the results for that member down to even if the member is enrolled in one of our partners with the managed care plans. It will give you that information.

>> 18008849730, it is medical.

>> 9330? I'll type that in the chat?

>> I did. It is 9730.

This may circle back to what was explained before. But they were asking about reporting and if providers will be able to access reports regarding end dates or the redetermination dates, when they happen. I know our MCOs get reporting, but will the providers be provided reports as well for their group group.

>> We're working on them, the provider portal that was had to make -- when you check the members eligibility, they have a renewal date field as well there so they can see the eligibility. This is a batch process, every month, every

group, certain member, they have renullals coming up, they will go through that and we will make -- look at the final data to make sure we're set for the unwinding, when they make that public, we'll, you know, as provider, members, as advocates, you can see eligibility is in July, Shelley get a packet in the month of May to complete, that's how the system works. So if when she come, sees you, you're a PCP office, the reminder, hey, whatever notice you get, just keep everybody informed and make sure that you flag that for the member, for the patients.

We'll make that, it is a complicated process. And we'll make all of that public -- all of the information public to make sure that you have plenty of resources available to support the patients.

It is a complicated process. It is a process.

The other one to mention, I'm sorry, one more question that I think is a good one. It says how will we help others find other sources of health insurance, marketplace, employer coverage, Medicare.

Great question. That is exactly what we have been thinking through, we obviously want to make sure that we go through all of the eligibility process and maintain our members who are eligible, individuals who are no longer eligible for Medicaid, we transition them into marketplace automatically. If they're considered ineligible for Medicaid, we send a file to marketplace. And so FF -- you know, FFM, market -- the marketplace, they get that information for those folks who are ineligible, and in adirks our partner, they have been supporting that as well so, if they need -- if the individuals are no longer eligible for Medicaid, they'll be helping us with the transition into marketplace plans. So we are -- we're thinking through that transition, we have support from our additional stakeholders and navigators, the navigators to support members that are transitioning off of Medicaid.

>> A really quick one, will the renewal application change, has it changed.

>> It has not. We actually made some additional -- there is a front page of it to make it easier for members to understand how different ways that they can complete it and submit t.

I think we have made our renewal packets simpler in terms of -- you know, understanding how to submit it. The packet itself hasn't been changed. I did note make some of the documentations available as a sample documentation on the website, and it is a great suggestion and we'll make that happen. Just so people see that's the document I

received. Having that visual sample is helpful I think. Thank you for that suggestion.

>> A follow-up. I think that I can start the answer to this question and one of the team members may be able to follow-up.

They said what will the unwinding process look like and funny enough, we were able to create a resource that kind of demonstrates what that looks like and actually I think I have a copy of it here today.

Here.

So we try to make sure that we were able to visualize what that process will look like somewhat. There is always nuances to things, it definitely delineates our responsibility, what's the member's responsibility, these are available, these are actually currently available on our website so that you can download, print them out for the members, stuff like that, we'll have some available for ordering as well when we have that in the warehouse. That's what we're -- that's a visual representation that you handout. If you want to respond to what the process is, a little more detail. You're welcome to could so here.

I guess I will take that. It is a handy flow chart. It gives you an idea of what that process is. I saw in the chat that Kelly had answered the question on where the redetermination packets would be mailed, and those are mailed out the month before they're due or 60 days prior to the date they're due. In March they'll mail out renewal that are due for May. In that process, we talked about the automatic renewal process and I saw a lot of questions on how do people qualify for an ex parte or automatic renewal. Those are cases that don't have a resource test. So cases that have a resource test, individuals that enroll in age, blind, disabled process and also the LTSS recipients, losing my voice.

So because there is a resource test, we can't ex parte the redetermination. They will get sent a packet so some qualify, to qualify for an ex parte, you can't have a resource test. That's primarily your familiars children, individuals, individuals that are SSI recipients for the most part, if you're an SSI recipient, you have real property, you can't be ex parte, we have to evaluate the resource.

That's kind of how the automatic renewal gets generated, if there is a resource test, it will dropout so, the system program to recognize coverage codes that would fall out of that process, and so if they get mail to paper renewal, they're sent out, they have the renewal date on

there that the Pacific is due back to the local agency to complete the redetermination and if that redetermination is not received, then they will be closed by the end of their renewal month.

Example, 531. I saw another question, applications are 45 days, but renewal, they're to be processed by the month they're due if they return their information late, they have 30 days from the date the information is received to process that and again to reiterate, that's a no break in coverage if information is received in the 90-daytime frame.

If the renewal is returned and the information, it is required, such for the age of individuals, we may need verification of some of the resources, we do have an electronic system that can help verify liquid resources such as bank accounts, money markets, et cetera, at times it is very responsive, sometimes it is not, so the customers would be sent a checklist with a due date telling them what they need to return.

Other times, if there are discrepancies or what income is sent back, some may be checked -- sent out a checklist and they have to complete a paper renewal.

>> Good morning, Kim.

>> All right.

We have three minutes left. It may be time for to us do a closeout.

>> One thing I will say, we thoroughly appreciate the engagement, for awful the different work, the components of the work, it is always a thing where you get in a setting with like mindeled people to answer and to ask questions and they can be answered, you may be thinking of those things. We do not have -- it doesn't go unnoticed that you got in early to hop on this morning, as a team, we're encouraged, we're excited about the opportunity to work with you and make sure that you stay engaged. We want to make sure that you have what you need. A shoutout to the team in the background, everybody here that's been trying to get the answers. We have the presentation on the website at a later date and we'll follow-up, make sure that we have an FFAQ document and we want to remind you that we have other sessions coming up, so if you find yourself in an opportunity to join us again, please do so. You can scan this QR code, it takes you right to the website and we also want to remind you that this work is thankful work, good work.

We are often remind that had our members are number one, they're the things that we think of first, last, we

want to make sure that in that process that you are taken care of as a stakeholder while trying to get that done.

If you have any questions for us, don't hesitate to reach out. If you want to join us again, we welcome you to do so. We hope that you have a wonderful, wonderful Tuesday, and I hope that we added joy to your day, if not anxiety and that you join us again at a later date. If you have any questions for us you can continue to drop them in the chat. I'll stay on for another 5 minutes and we're free -- you're free to go. Thank you for the time. Thank you for the all that you do and we hope that you have a wonderful day.