

Redetermination CoP Session 3: Intervene, Recover and Stabilize

September 15, 2026

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Community of Practice at a Glance

- Build the policy and population foundation so teams can anticipate who will be affected and where the greatest disenrollment risk sits.

Prevent

1



- Be prepared to intervene the moment a client receives a renewal notice with redesigned staffing, billing, workflows, EHR alerts, and proactive outreach that keep eligible clients on coverage.

Prevent & Identify

2



- Keep renewed clients connected to care and bring back those who fell off, while ensuring adequate policies to support the work.

Intervene,
Recover, &
Restabilize

3

- Close the loop by quantifying and qualifying impact at every intercept point so teams can refine workflows and tell the story to policymakers.

Measure &
Sustain

4



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Coverage Continuity Intercept Model (CCIM)

0. PREVENT

Capacity Building & Pre-Redetermination

Key Partners: CBOs, MCOs, housing providers, schools, faith-based orgs

Key Activities: develop communication plans, outreach campaigns, update contact info, educate individuals affected and staff on requirements, identify and build relationships with work/volunteer opportunities and related relationship building, develop workflows, establish tracking tools, plan for financial impact, develop policies

Client receives renewal notice

01. IDENTIFY

Renewal Notification & App Support

Key Partners: State vendors, case managers, care coordinators, community health workers

Key Activities: assist with application/renewal assistance, support with document gathering/ interpretation/ literacy, prompt individuals to check mail/texts, track application completeness and renewal status

02. INTERVENE

Coverage Loss/Gap

Key Partners: Pharmacies, hospitals/EDs, crisis services, legal aid

Key Activities: engage rapid re-enrollment workflows, engage bridge programs (charity care, sliding scale), support access to emergency medication

03. RECOVER

Re-enrollment & Coverage Recovery

Key Partners: Medicaid staff, MCOs, navigators

Key Activities: support community engagement, leverage presumptive eligibility, support transition to marketplace (if income change)

04. STABILIZE

Restabilization

Key Partners: Peer support, social services, care coordinators

Key Activities: track renewals and community engagement, maintain updated contact info, address social drivers of health

workforce, text reminders, technology (e.g., EHR alerts, shared referral platforms)



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Today's Presenters

- **Nina Marshall**
Oak Street Outcomes
- **Cathy Garrett-Davis**
Mental Health Partnerships
- **Katy DeBriere**
National Health Law Program
- **Kathryn Cohen**
Association for Behavioral Health and Wellness
- **Aileen Brady**
Community Alliance



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Session 3

Learning Objectives

- Identify strategies for receiving timely notice of client termination (or pending termination) of benefits
- Develop rapid response protocols that support timely appeals and client continuation of benefits
- Identify community partnerships that aid rapid response/re-enrollment
- Outline organizational policies to modify or develop that support communication, retention, reengagement, and transitions of care

Supporting Clients

Cathy Garrett-Davis,
Mental Health Partnerships

Adults on Medicaid come from all backgrounds, live in all types of communities, are of differing abilities

Qualifying for Medicaid is not easy and challenges a person's beliefs about self, others, and the process

Concerns for one's health can worsen a person's hopefulness and vice versa

Thomas Carlyle: "He who has health has hope, and he who has hope has everything."



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Keeping Hope Alive

- Current hope:
 - Communities working to expand access for all types of people
 - Peer specialist perspectives and roles
- Walking alongside
 - Emotionally: empathy; acknowledge the stress; neutralize the embarrassment
 - Psychologically: attentive listening, body language, atmosphere, encourage & elevate
 - Fundamental practical tips:
 - Update most current address with US Postal Service and Human Services offices; working phones; check email; have Social Security Numbers and birth certificates
 - Submit copies, get dated receipts, in office or online; keep the envelopes for date stamps, follow up
 - Appeal: Fair Hearing/good cause, sign papers, confirm hearing dates, show up ready
 - Get in-person help: in county assistance offices, legislators' offices, community groups, lawyers
- Share your story with groups concerned about health care issues to affect systemic changes

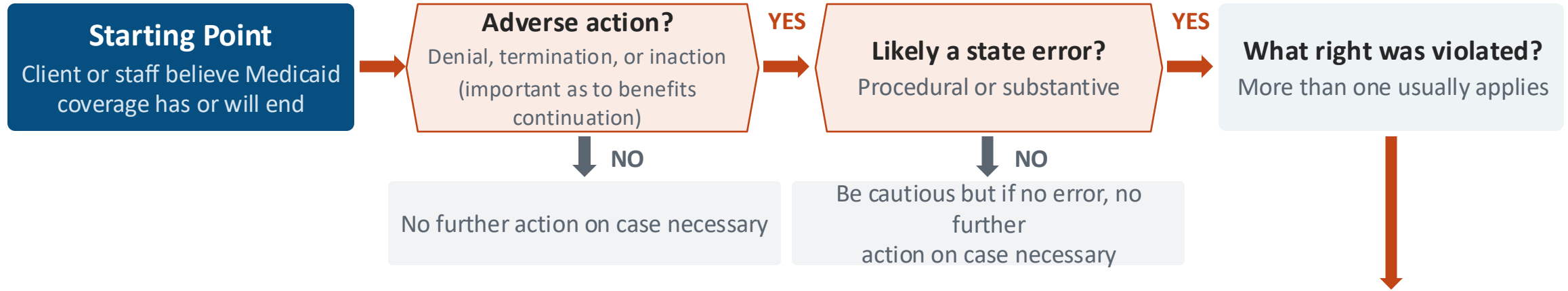


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**Medicaid
Redeterminations:
Supporting clients
when Medicaid is
denied or lost**

Katy DeBriere, Senior Attorney
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Monitoring a Medicaid Eligibility Case



Enforcement – not limited to a single approach

Appeal • preferred

Preserves coverage and builds a record. For new applications, ask for an expedited hearing if the ordinary timeline could jeopardize the client's life or health, or their ability to attain, maintain, or regain maximum function.

Direct Contact with the State

Particularly useful where your staff has an established relationship.
Medicaid staff turnover is common; do NOT rely on this method.

Reapply

Sometimes the fastest path to coverage, but it forfeits continued benefits and leaves the original error unreviewed.



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Has there been an adverse action?

- Types of adverse actions and how to identify
- Why it matters

Three Types of Adverse Action

1

Denial

The state turns down a new application. The person was never enrolled.

2

Termination

The state ends coverage for someone already enrolled.

3

State inaction

The state does not timely act on an application or renewal. Inaction is the adverse action — a “constructive” denial or termination.

State Inaction Wrinkle –

On all but disability-related applications, the state must reach a determination within 45 days, but new 42 CFR 435.912(e)(3) lets a state extend that deadline indefinitely once it issues a notice of noncompliance — although only for applications. This shouldn’t deter you from making a “constructive” denial argument but will need to allow more than 45 days to pass. Client circumstances will dictate for how long.



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Which Action Is It?

Look at context clues

Notices can be vague about prior coverage status.

- 1 Check the MMIS / Eligibility System**
Was this person recently enrolled?
- 2 Ask the client**
When was the last time you used your coverage?
Do you have a Medicaid or member card?
- 3 Pull the portal record, if an option**
Review – even sketch out a timeline – tracking the dates of applications, renewals, and notices received.

Why the action type matters

The type of action drives procedural protections as well as deadlines.

- 1 Termination**
Appeal within 10 days —or before action takes affect — benefits continue automatically.
- 2 Denial**
No continuation is available. No coverage while the appeal runs.
- 3 No notice at all**
Where the client learns of the loss elsewhere rather than being provided required notice, Medicaid must reinstate coverage.

Notice of Non-Compliance vs. Notice of Adverse Action – Clients May Be Confused!!

A notice of noncompliance comes first and tells the client the state believes a requirement has not been met. The notice of adverse action follows and informs changes in eligibility and triggers appeal rights. Importance of notice content is discussed later.



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Has there been an error?

- Defining issue spotting
- Where patients will fall off
- Exclusions worth knowing

Issue Spotting 101

ISSUE SPOTTING, DEFINED

A fast, structured read of the client's facts to find where the state may have broken a rule — and how strong a claim may be.



Spot

What looks off here? This could be a notice that never came, a document the state already had, a missed alternative eligibility category.

Match

What law did the state potentially violate? The more you can name the regulation or protection, the greater likelihood for success.

Weigh

How strong is the claim? How critical is the continued coverage?

When you are trying to make a match, know that “law” is broadly defined and can be found in state policy documents or guidance. Having legal aid as a partner is invaluable in this process.



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Work Requirements | Compliance/Exclusions Worth Knowing

\$580 / month

Federal minimum wage (\$7.25) x 80 hours. Taxable income, regardless of whether “earned,” satisfies the requirement.

SNAP household

Is a member of a household receiving SNAP benefits and is not exempt from SNAP work requirements. (Compliance with SNAP not required.)

Treatment program

Drug or alcohol treatment participation. Separate from medically frail. Emphasis on “program.”

Those who meet an exclusion are not "applicable individuals" — the look-back does not apply.



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Medically Frail | Current Criteria

1

A qualifying condition

Blind or disabled per SSA; SUD but not stable recovery; disabling mental disorder; physical or I/DD significantly impairing 1 + ADLs; serious or complex medical condition.

2

That significantly impairs compliance

Diagnosis alone is likely not enough; “significantly impairs” is undefined.

Two-part test under litigation.

Note: Implementation will vary substantially by state



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Legal Protections

- Regulatory
- Constitutional
- System Accessibility

Legal Protections | Regulatory

1 *Ex parte* verification

State must use data it already possesses before requiring documentation from the individual. Reduces procedural terminations and critical when documentation is hard to obtain.

2 Self-attestation

Available through 2027 when data is missing. Some states will never accept (AR, HI, IN, MT, NC, UT); however, option for pregnancy self-attestation is always required.

3 Not reasonably available

When documentation is not reasonably available, state must accept self-attestation (except for Medical Frailty). State **MUST** provide assistance with obtaining documentation.

4 Processing deadlines

Processing must be completed in 45 days, or 90 when based on disability *but see* 42 C.F.R. 435.912(e)(3) (applications only!). Note the state must document reason for delay.

5 Designated representatives

A person has the right to choose their advocate and rep does not have to be a lawyer; when designated, the "right to notice" extends to the representative.

6 Retroactive eligibility

H.R. 1 reduces retro coverage from 3 months to 1. The reduction of this safety net means that if only reapply and don't appeal, could be losing critical period of eligibility. Also changes months to be reviewed for "lookback."



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Legal Protections | Example #1



Marcus, 41

Warehouse worker. In SUD treatment.

Marcus applied for Medicaid in March. The state already had his quarterly wage data but asked him for pay stubs from an employer that had since closed. Marcus knows he's in compliance so he offered to attest to his hours but Medicaid refused and did not offer help to track records down. After 70 days, there was still no determination and no reason for the delay. His sister, named as his representative, was never sent anything. When Marcus finally called, a worker told him to just start a new application — which would leave February's emergency room bill uncovered.

1

Ex parte verification

The state had his wage data in hand and demanded pay stubs anyway.

2

Self-attestation

With documentation not reasonably available, his attestation was refused.

3

Not reasonably available

The employer closed. No records existed, no help offered.

4

Processing deadlines

Day 70: no decision, no noncompliance notice, no reason on file.

5

Designated representative

His named representative received no notice of anything, ever.

6

Retroactive eligibility

Reapplying rather than appealing forfeits the month with the ER bill.



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Legal Protections | Constitutional

1 Written notice

NOAA must contain: the action, reason for the action, legal basis, and how to appeal. The purpose of notice is to provide enough information to determine whether to appeal.

2 Benefits continued

An appeal must be heard “pre-termination” so benefits must continue through the date of the hearing.

3 Reinstatement

Where the state fails to provide timely notice of a termination and an individual later requests an appeal, no deadline attaches to the request and benefits must be reinstated.

4 Other eligibility paths (“*ex parte*”)

Technically not constitutional – regulatory – but oftentimes tied to inadequate or no notice and inability to assert eligibility at req’d hearing.

5 Fair hearing

The standard to be given a hearing is very low. Just need to say “I want a hearing.” State cannot require a special form to be completed or certain facts to be stated.

6 Expedited hearing

Use when delay would jeopardize health. For new applications it can expedite access to needed health coverage. Less critical during a re-determination appeal and benefits continue.



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Legal Protections | Example #2



Dana, 52

Enrolled 3 years. Bipolar disorder. Mother to a 16 yr. old; receives help from family.

Dana's coverage stopped at the end of April which she learned about when she went to have an important Rx filled. She received written notice of the adverse action on May 5. The notice stated "you are not complying with the community engagement requirement." She called Medicaid and said she wanted a hearing; the worker told her to submit a form and put her reasons in writing. No one asked whether she still qualified on some other basis, though she has been in treatment for years and her condition renders her "medically frail." She told the state that she badly needed her medication. Once Dana completed the form, the state scheduled her hearing date sixty days out.



Written notice

Late notice and, when received, did not provide enough information to determine whether an error.



Benefits continued

Coverage ended with no pre-termination hearing offered.



Reinstatement

Untimely notice: no deadline runs, and coverage must be restored.



Other eligibility paths

No one checked eligibility for another category. As a low-income parent and PWD, may have qualified under another pathway.



Fair hearing

The heightened pleading burden is illegal; an appeal should have immediately been granted.



Expedited hearing

Clearly meets the expedited hearing standard but not informed of the right.



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Legal Protections | System Accessibility

Persons with a disability (as defined under 28 C.F.R. § 35.108) & **limited English proficiency**

1 Applications/Renewals

States must accept applications and renewals via phone, in-person, and through online customer portals (if available). Must allow an individual to select own representative.

2 Verification

As with applications/renewals, when verification is required to prove eligibility criteria – including community engagement – states must have accessible systems in place to accept.

3 Notices

Individuals must expressly request accommodations, but all written communications must be made accessible. Medicaid must have an “ADA Coordinator” to process the request and answer any questions. Accessibility could include large print, Braille, audio or electronic formats. Notices must always be written in plain English and made available in the language of the applicant/beneficiary.

4 Other Medicaid Communications

Call centers, websites, communications at storefronts, or directly with case managers must all be accessible. Where an individual cannot use one modality, others need to be offered/made available.

5 Fair Hearings

Individuals are entitled to interpreters at hearings and must be informed about the option. Evidence must be provided in accessible format; hearing locations should be changed based on mobility needs.



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Legal Protections | Example #3

R

Rosa, 58

Low vision. Speaks Spanish. Lives with major depressive disorder.

Rosa's renewal packet arrived in Spanish and in large print but the accompanying "exclusions" form came in English and at standard print size. The form required to be submitted through online portal her screen reader could not navigate. While the call center menu was only in English, was able to reach a live agent in Spanish but was told renewals not taken by phone. When she asked to send her documents some other way, she was told to upload them. She asked twice for large print and Spanish and never heard back from anyone. Her coverage ended in June. At her hearing, no one offered an interpreter. She attempted to explain her condition but the hearing officer denied her regardless.

1

Applications / renewals

Both the renewal packet and the portal inaccessible.

2

Verification

The state only provided one modality for uploading documents necessary to determine eligibility.

3

Accommodation requests

Express requests for accessible materials in own language ignored.

4

Other communications

The call center menu was only offered in English; other written materials also inaccessible.

5

Fair hearings

No interpreter offered; the evidence necessary to prepare for the hearing wasn't readable.

4

No ADA Coordinator/Protocol

The call center staff were not trained on forwarding any accommodation requests to a designated coordinator.



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Enforcement

- Filing an appeal
- Engaging legal partners

Filing An Appeal

Medicaid is complex and state action is often unclear. Appeals preserve the client's rights.

DEADLINE

90

**days at most but shorter (30-60)
in many states. Read the notice of
adverse action carefully!**

CORRECTIVE ACTION

**Protection runs from the
action**

Coverage is restored to the date of
the erroneous action (+ retro
period if otherwise eligible), *not*
the date you filed.

BEST PRACTICE

**Preserve and file request
for hearing & arguments
with Medicaid in writing**

Check the hearing request
modalities for your state. If allow
requests by email, far and above
the best method.



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Expedited Hearings

Standard

Delay would jeopardize the client's life or health, or their ability to attain, maintain, or regain maximum function.

Decided in roughly 7 days.

Ask for expedited hearing in the hearing request itself and keep proof of the ask.

Best Practices

Track the standard word for word

Draft a letter that quotes the language and ideally incorporates the federal (42 C.F.R. § 431.224) and state regulations.

Apply the standard to the individual facts

Detail the client's diagnosis and what services the client will have to forego, and how it will impact their health if eligibility is not quickly decided.

**If benefits are already continuing during the appeal,
an expedited hearing is usually no longer required.**



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Engaging Legal Partners



Get to know your service area

Geographic region; issues addressed; intake process; leadership; don't forget Protection & Advocacy orgs



Medical-legal partnership

Direct referral system ideal for capitalizing on expertise of both professions



Explore other partner opportunities

Apply for joint grants; sponsor trainings or legal clinics



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How MCOs are Supporting Redeterminations

Kathryn Cohen
Association for Behavioral Health
and Wellness

MCOs Supportive Action

- **Building on unwinding experience:** Leveraging outreach tools and lessons learned during the Medicaid unwinding.
- **State coordination:** Participating in state workgroups to align outreach and messaging.
- **Targeted member outreach:** Using texts, emails, call-center scripts, and care management prompts to reach members.
- **Provider & community engagement:** Equipping providers and community partners to reinforce messages and connect members to support.
- **Renewal navigation:** Directing members to state renewal tools and resources, including documentation support.
- **Coordinated reminders:** Reinforcing state notices and six-month renewal deadlines while minimizing duplication.

Note: MCOs support and educate members; states retain responsibility for eligibility determinations.



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MCO & Provider Partnerships

- Sharing consistent **member-facing messages**
- **Educating providers** on new requirements and implementation changes
- **Identifying members at risk** of coverage loss
- Reinforcing reminders and requirements **during routine care**
- Connecting members to **documentation and navigation support**
- Coordinating **care transitions** to minimize disruptions
- Creating **feedback loops** to identify and escalate implementation barriers



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Agency Preparation for Coverage Loss

Aileen Brady
President & CEO
Community Alliance (Nebraska)

How Do we Prepare for the Changes?

- Educate yourself on who is impacted; who is exempt/excluded; learn how your state is planning its implementation.
- Start training staff now so they know what to be aware of and what to ask the clients they are working with who may be impacted.
- Engage and educate the people who are impacted (expansion population) on what may change for them. Build the trust so they seek you out for assistance.
- Don't ignore it and hope it all goes away!



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How Do We Track Client Coverage?

- Assist clients in responding to any requests from Medicaid for redetermination prior to start date for work requirements. If they move, update their address with Medicaid. Stress the importance of responding to Medicaid.
- Assist clients in calling Medicaid to find out their own redetermination date. Prepare them now for potential changes.
 - Most states have an online system to check for Medicaid eligibility.
- Ask clients if they are receiving mail from Medicaid. Don't wait for them to tell you.
- If manageable, track redetermination dates for the expansion population (or a subset) to anticipate when clients may need support.



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What Policies & Protocols Do We Reinforce?

- With billing staff:
 - Client eligibility verification processes. If you have an electronic verification process, make sure it's working and you are using it; cross check for accuracy
 - Reconciling billing for retroactive coverage: new rules impact new applications and enrollment churn will create more flux in coverage periods
 - Transitions to general fund and block grant funding; billing and covered services
 - Re-screening currently uninsured for Medicaid eligibility; circumstances may change
- With intake staff:
 - Ask about interest in employment, know client job history, connect people to programs that can help. Assess, refer, close the loop on job connections (as appropriate)
- With care coordinators:
 - Talk with clients about Medicaid coverage; ensure clients have accurate information
 - Ask clients about what they have received in the mail and of any insurance changes.



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What Should Leadership Know About?

- Ask and listen to what your staff need to help clients through redeterminations.
- Solicit staff ideas for improvements to state systems or processes.
- Track your data on how many clients have lost Medicaid coverage related to work requirements.
- Know if you are experiencing revenue shortfalls related to loss of Medicaid coverage.
- Are your uncompensated care costs increasing?



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What Do We do When Medicaid Benefits Are Terminated?

- Identify why it was lost – State error? Missing paperwork?
 - If believe client eligible: help client appeal, fix the issue, or reapply
 - Connect with legal aid for complex cases
- If you don't have one already, implement a sliding fee schedule. Make sure intake staff and care coordinators understand it. Important for both:
 - Temporary coverage if re-applying for Medicaid
 - Ongoing care if Medicaid won't be reinstated
- Connect clients who can work to supportive work programs
- Assist people with marketplace enrollment for insurance
- Seek out private foundation assistance to support uncompensated care



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Questions



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Register for Session 4: Measure and Sustain

Tuesday, October 13 at 12 pm ET



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WN_5X0tEESuQzG-y4VxRfddEA](https://us06web.zoom.us/webinar/register/WN_5X0tEESuQzG-y4VxRfddEA)

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Definitions for Specified Excluded Individuals

Category	Definition in Interim Final Rule with Comment Period (IFC)
Former foster care youth	Enrolled in Medicaid while in foster care and then exited foster care or "aged out" without an adoption or other permanency and are <u>under age 26</u> .
American Indians or Alaska Natives	Individuals from federally recognized tribes and any individuals eligible for services at an IHS facility, Tribally-operated facility, or Urban Indian Organization. <u>States will not be required to re-verify this exception once established.</u>
Caregivers of a dependent child 13 and under, or a disabled individual	Parent, guardian, caretaker relatives, or family caregivers. CMS adopts the Americans with Disabilities Act definition of disability to determine who qualifies as a disabled individual. An individual need not be eligible for Medicaid or other federal programs on the basis of a disability to be a disabled individual under this definition. This definition applies to any age, including older adults who require assistance of varying scope in performing activities of daily living.

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Definitions for Specified Excluded Individuals

Category	Definition in IFC
Veterans with a total disability rating	Total disability based on individual unemployability, as well as veterans with a combined rating of 100%.
Meet the TANF work requirements	States should confirm if an individual meets TANF work requirements according to state criteria as requirements will vary.
SNAP household member subject to work requirements	Individuals in households receiving SNAP and subject to SNAP work requirements (not exempt from). CMS interprets statutory language in H.R.1 saying “not exempt from” SNAP work requirements to mean “subject to” SNAP work requirements. States are not required to confirm compliance with SNAP work requirements.
Participant in a Drug or Alcohol Rehabilitation Program 	Any individual participating in a drug addiction or alcoholic treatment and rehabilitation program. Programs include any such program conducted by a private <u>non-profit</u> organization or institution or a <u>publicly operated</u> community mental health center to provide treatment that can lead to rehabilitation. States may establish a minimum time commitment requirement.

1



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Definitions for Specified Excluded Individuals

Category	Definition in IFC
Inmates of a Public Institution	An individual that is in custody and held involuntarily by law enforcement. Individuals in correctional institutions such as state and federal prisons, local jails, detention facilities, or other penal settings.
Pregnant or Postpartum	A pregnant woman or a woman who is receiving Medicaid under either the mandatory postpartum period or the 12-month postpartum extension.
Medically Frail	 CMS notes that this exception should not be determined by a diagnosis alone, but rather by the impact of the condition on an individual's ability to comply with community engagement requirements. See following slides for detail.

1



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Definitions of Medical Frailty Categories

Category	Definition in IFC
Blind or Disabled	Blind: Central visual acuity of 20/200 or less in the better eye with use of a correcting lens. Disabled: Unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.
Substance Use Disorder	SUD <u>significantly impairs an individual's ability to comply with the community engagement requirements</u> . Excludes individuals in recovery for 5 or more years. CMS believes the exception applies whether someone is in active treatment or not. CMS declines to further define SUD in regulation but directs states to DSM-5 and ICD-10 as useful resources.
Disabling Mental Disorder	CMS declines to fully define a disabling mental disorder and directs states to consider <u>whether the disorder significantly impairs an individual's ability to comply with the community engagement requirements</u> . CMS further notes states may find ISMICC, DSM-5, and ICD-10 to be useful resources. CMS notes states may also consider including specific conditions as disabling mental conditions.

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Definitions of Medical Frailty Categories

Category	Definition in IFC
Physical, intellectual, or developmental disability	Disability must impair the individual from performing at least one or more activity of daily life (ADL). CMS again notes it may be reasonable for states to consider including specific conditions.
Serious or complex medical condition	A medical condition that is life threatening, seriously disabling without necessarily being life threatening, causing significant pain or discomfort that can cause serious interruptions to life activities, requiring a major time or effort commitment from caregivers for a substantial period of time, requiring frequent monitoring, associated with severe consequences or negative consequences for someone else, affecting multiple organ systems, requiring management to tight physiological parameters, requiring coordination of multiple specialties, requiring treatment that carries a risk of serious complications, or requiring adjustment in non-medical environments. CMS notes there may be variance in acuity even within the same condition and throughout the course of illness. As such, CMS directs states to evaluate and verify an individual's condition according to the impact on their ability to comply with community engagement requirements.

1



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Mandatory Exceptions

Under the age of 19

Entitled to or enrolled
for benefits under
Medicare Part A

Enrolled in
Medicare Part B

In a mandatory
categorically needy
eligibility group

Was an inmate in a public
institution at any point
during a 3-month period
preceding community
engagement applicability



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(Optional) Short-Term Hardship Exceptions

Short-term hardship exceptions that states may choose to allow

Receives inpatient hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of similar acuity

Resides in a county in which an emergency or disaster has been declared

Resides in a county in which unemployment is at or above 8% or 1.5 times the national unemployment rate (the lesser of)

Must travel outside of their area for medical services not available in their community to treat a serious or complex medical condition

This is “all or nothing.” If states choose to allow short-term hardship exceptions, they must allow all. The state selected review (lookback) period also applies. If an applicable individual was not working or meeting another exception in the review period prior to the qualifying hardship, they could still lose coverage temporarily. Individuals also must request a short-term hardship exception; it is **not automatic**.



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Community Engagement Requirements

OR

- Can demonstrate a monthly income of at least \$580
- Can demonstrate 80 hours per month enrolled in an educational program at least half-time

OR

- Can demonstrate 80 hours per month of any combination of the following activities:
 - Work: paid, in-kind, or unpaid
 - Community service: unpaid work completed as part of a structured program under a public or non-profit organization
 - Participation in a work program: State or federally recognized employment and training programs



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Expedited Hearings

Standard

Delay would jeopardize the client's life or health, or their ability to attain, maintain, or regain maximum function.

Decided in roughly 7 days.

Ask in the hearing request itself and keep proof of the ask.

Best Practice

- 1 Track the standard word for word**
Draft a letter that quotes the language and ideally incorporates the federal (42 C.F.R. § 431.224) and state regulations.
- 2 Apply the standard to the individual facts**
Detail the client's diagnosis and what services the client will have to forego, and how it will impact their health if eligibility is not quickly decided.

**If benefits are already continuing during the appeal,
an expedited hearing is usually no longer required.**



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Requesting the Case File

Ask for the entire file

Don't let the state control what information is provided.

- 1 All applications and supporting documentation
- 2 All notices, requests for information, and case communications
- 3 Data matches and wage pulls (The Work Number, SWICA, SSA)
- 4 Caseworker notes and internal memoranda
- 5 System screenshots and portal records

Lean on local knowledge

Lots of terms of art and computer jargon. Other Medicaid advocates know what to ask for by name.

Independent medical exam

This is where your particularly handy because if the issue is one of a medical determination, you can lean on your expertise. Asking for an independent exam is an option. See 42 C.F.R. § 431.250(b)



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At the Hearing

Rights of client in a fair hearing:

1

Be represented

By counsel, a lay advocate, or a relative.

2

Bring witnesses

Including the treating clinician.

3

Present argument

Law and facts, in the client's own words.

4

Cross-examine

Question the worker who made the call.

Usually telephonic

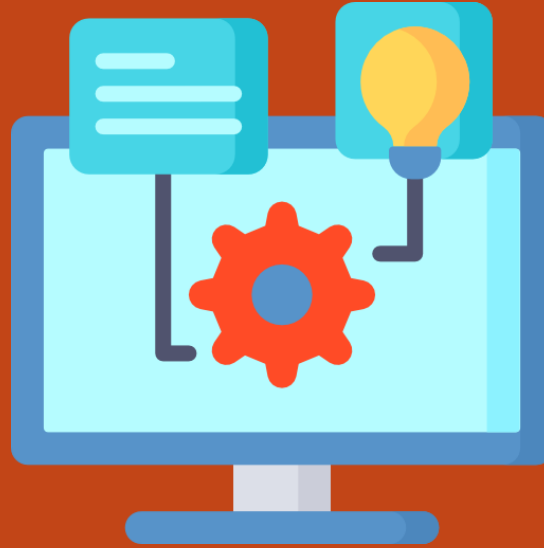
Ask whether the state offers video — seeing the hearing officer is worth requesting.

Decision timeline

Written decisions are generally due within 90 days of the agency receiving the request.



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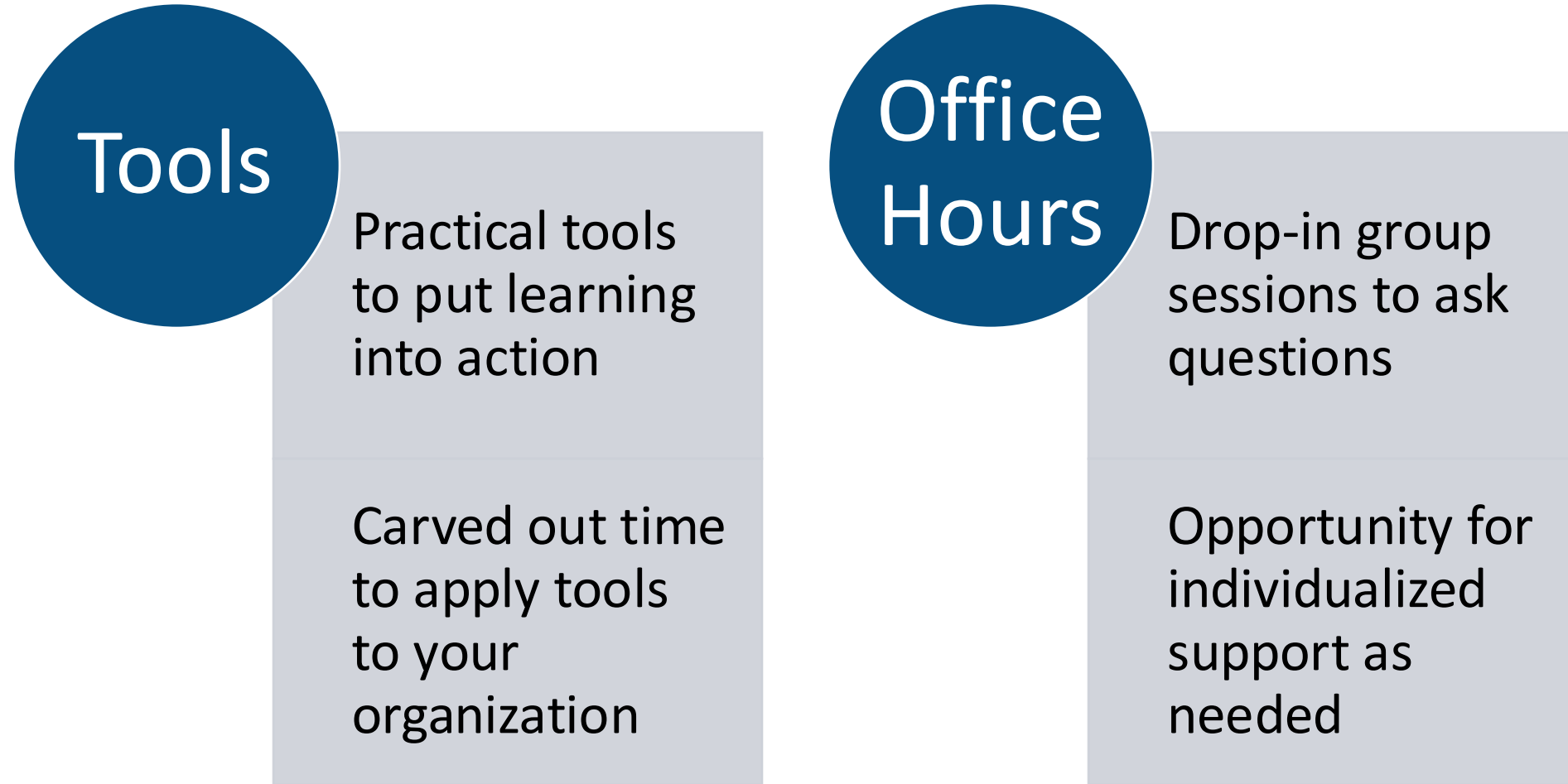
Practice Transformation Cohort

Operationalizing our Learning with Practical Tools



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Structure of the PTC



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Last month: Tools for Intercepts 0 and 1

Client FAQs *(template)*

Client Identification Decision Tree *(resource)*

Mapping Activities to Staff & Services *(template)*

Developing Continuity Pathways *(resource)*

Outreach Protocol *(template)*



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Practical Tools at Intercepts 2, 3 and 4

Policies and Protocols to Review or Update (*resource*)

Community Partnerships Exploration (*resource*)



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Select a Breakout Group

Community
partnerships

Identifying
coverage loss/gap

Preserving high-
priority services
during an initial
loss of coverage

Supporting appeals
or securing new
coverage

Early
implementation
experiences



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Office Hours

Drop in any time during either of the office hours sessions:

- **Option 1:**
Thursday, Sept 24 from 2 - 4pm ET
- **Option 2:**
Wednesday, Oct 7 from 12 - 2pm ET

Join us for free Office Hours



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