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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: September 20, 2024

FROM: Daniel Tsai, Deputy Administrator and Director
Center for Medicaid & CHIP Services

SUBJECT: State Compliance with Medicaid and CHIP Renewal Requirements by December 31, 2026

Section 5131 of title V of division FF of the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) amended the Families First Coronavirus Response Act by creating new conditions for states to receive a temporary Medicaid federal matching percentage increase. These new conditions were in effect from April 1, 2023 through December 31, 2023 as states resumed regular eligibility renewals following the end of the Medicaid continuous enrollment condition. Among these funding conditions was a requirement that states conduct Medicaid eligibility redeterminations consistent with all applicable federal requirements, including renewal strategies authorized under section 1902(e)(14)(A) of the Social Security Act (the Act) or other alternative processes and procedures approved by CMS.[1]

As CMS engaged with states prior to and during their unwinding periods, CMS identified many states that were not in compliance with some aspect of federal renewal requirements. Specifically, in March 2023, CMS required that 36 states implement mitigation strategies to avoid further agency action. Through data analysis, discussions with states, and ongoing review of available information on state policies and processes during unwinding, CMS has continued to assess states' renewal compliance and require mitigations, as appropriate. Nearly all states were required to implement at least one mitigation strategy during unwinding, including states that needed to reinstate beneficiaries or temporarily pause renewal processing to protect coverage for eligible individuals.

Ensuring states' compliance with federal renewal requirements is core to CMS' stewardship of the Medicaid program and essential to protecting eligible individuals' ability to maintain coverage. Because CMS identified areas of non-compliance with renewal requirements in nearly every state during unwinding, with many common areas of non-compliance across states, CMS believes a standardized process will support states to achieve compliance with all renewal requirements in the most timely and efficient manner.

[1] The CAA, 2023, also added section 1902(tt) to the Social Security Act, which (among other things) created enforcement authorities for the Centers for Medicare & Medicaid Services (CMS) to address state noncompliance with certain federal requirements if that noncompliance occurred during a period that ended on June 30, 2024.

This Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) provides updated information on the timing and expectations for all states to achieve compliance with all federal renewal requirements, including states that implemented CMS-approved mitigation strategies and those who have since identified areas of non-compliance with renewal requirements. As described in more detail in this CIB, all states are required to complete a compliance assessment, demonstrate compliance with federal Medicaid and CHIP renewal requirements described at 42 C.F.R. §§ 435.916 and 457.343, and submit a plan outlining steps and milestones for addressing identified areas of non-compliance to CMS by **December 31, 2024.** Compliance plans will detail how states will achieve compliance with all applicable requirements no later than **December 31, 2026.**

While all states must complete the compliance assessment and plan, states with existing mitigation plans and those already identified as having at least one area of non-compliance with renewal requirements must complete the compliance assessment and plan as a condition of CMS's continued non-enforcement of the underlying compliance issues in those states. Failure to do so may result in additional agency action based on CMS' assessment of the state's individual circumstances and the nature of the non-compliance. CMS notes that all states are required by 42 C.F.R. 431.16 and 431.17(b)(2) to submit all reports as instructed by the Secretary and to maintain "records necessary for reporting and accountability as required by the Secretary," and, therefore, any state that fails to obtain approval for a compliance assessment and plan may be required to provide additional documentation of its compliance with federal regulations in accordance with 42 C.F.R. 431.17(d)(2).[2]

Background

Following the passage of the Affordable Care Act (ACA) in 2010, CMS issued new regulations for Medicaid and CHIP intended to help realize the vision of a streamlined, data-driven eligibility process that minimizes burden on individuals and states and supports timely and accurate eligibility determinations. The new regulations on Medicaid and CHIP renewal processes prioritized the use of data and other available information to verify eligibility and built on state best practices, lessons learned, and research on how best to minimize churn in and out of coverage for eligible individuals.

State efforts to implement ACA-era rules for streamlining eligibility and enrollment over the last decade have been notable. Most states have implemented required policies to allow for online, phone, and paper submissions of information and implemented other technology-based approaches like mobile-friendly applications, which help improve accessibility and reduce administrative barriers to coverage and care. In many states, historically paper-based processes for reverifying eligibility with pay stubs and other documentation have been replaced by more automated systems that provide real-time access to electronic wage and other information, allowing for faster and more accurate decisions at renewal.

Yet, many states are not yet compliant with all renewal requirements, especially for beneficiaries enrolled in Medicaid on a basis other than Modified Adjusted Gross Income (MAGI). Based on CMS' assessment of state compliance with renewal requirements in March 2023, 35 states were non-compliant with at least one requirement.[3] Nearly half of states (23)

[2] *See also* 42 C.F.R. 457.720 and 457.965(d)(2).
[3] https://www.medicaid.gov/resources-for-states/downloads/sum-st-mit-strat-comply-medi-renew-req.pdf

were unable to renew eligibility based on available information (*ex parte* renewal) for non-MAGI beneficiaries, as required under 42 C.F.R. § 435.916(a). In 19 states, at least some beneficiary populations were unable to submit information to complete the renewal process via all required modalities (online, phone, and in person, and other commonly available electronic means). The unwinding process itself also uncovered areas where renewals were not being processed correctly. For example, in the summer of 2023, CMS identified an issue in 29 states that resulted in inappropriate disenrollments at renewal of over 400,000 children and families in multi-member households (referred to as the household *ex parte* issue).[4]

To continue to qualify for the temporary federal matching percentage increase under the CAA, 2023's amendments to the Families First Coronavirus Response Act (P.L. 116-127), and to avoid CMS taking an enforcement action under section 1904 of the Social Security Act, each state that CMS identified as non-compliant with renewal requirements implemented approved mitigation strategies and/or temporary waivers of certain requirements under section 1902(e)(14)(A) of the Act. These strategies, which included policy, operational, outreach, and systems changes, were tailored to the state's area(s) of non-compliance and designed to support continuity of coverage for eligible beneficiaries. For example, a state that lacked functionality for online submission of renewal forms consistent with 42 C.F.R. § 435.916(b)(2) may have extended call center hours and deployed additional outstationed eligibility workers to provide alternate options for submitting forms.

As unwinding progressed and CMS identified other compliance issues such as the household *ex parte* issue described above, states were required to reinstate coverage for affected individuals, pause procedural disenrollments, and implement other mitigations to prevent improper disenrollments. These strategies, however, were not meant to be permanent. As a condition of approval of mitigation strategies put in place before or during the unwinding period, states agreed to work towards compliance with all federal statutory and regulatory renewal requirements.

Renewal Compliance Approach and Timeline

Renewal Guidance

Working with states to prepare for unwinding underscored the need for CMS to remind states of statutory and regulatory renewal requirements, and how CMS interprets and applies those requirements, as states assess and confirm compliance. To address that need, CMS will be issuing updated guidance to states in late 2024 providing clarity on renewal requirements across several key topics, including income verification, *ex parte* renewals, and requirements related to renewal forms. This new guidance is intended to further assist states to build compliant systems and processes.

Compliance Assessment and Plan

To avoid further agency action, including compliance action under section 1904 of the Act and/or more detailed and particularized requests for records under 42 C.F.R. 431.17(d)(2), all states must complete an assessment of their compliance with renewal requirements; submit the results of their assessment to CMS, along with evidence demonstrating their compliance;

[4] https://www.medicaid.gov/resources-for-states/downloads/state-ltr-ensuring-renewal-compliance.pdf

and develop and submit a plan to correct any areas of non-compliance. States must use the template[5] released alongside this CIB for this assessment, attestation and demonstration of compliance, and, as applicable, submission of a compliance plan. This standardized format will facilitate CMS' ability to provide technical assistance, as needed, and conduct monitoring and oversight of states' progress across all states. The State Medicaid Agency is responsible for compliance with all federal renewal requirements and each state must submit a single completed template with compliance information provided for each requirement, even if information must be collected from multiple state agencies. Submitted compliance assessments and plans will be reviewed and approved by CMS.

In keeping with CMS' ongoing commitment to transparency, and in light of the large number and wide variety of individuals affected, we intend to post the final and approved compliance assessments and plans (the completed and approved compliance template) on Medicaid.gov[6].

CMS will monitor progress on implementation of the compliance plans and achievement of compliance with all requirements through regular updates from states, as detailed below. In addition, CMS will continue to monitor renewals and potential compliance issues through review of data collected from states and other available information.

Compliance Timeline

CMS is providing the following timeline for renewal compliance.

- **By December 31, 2024,** all states must assess compliance with renewal requirements and submit the completed template to CMS. This provides sufficient time for states to complete most unwinding-related renewals and review relevant guidance and tools to evaluate their compliance.

- States that identify deficiencies must submit updates to their approved compliance assessments and plans using the renewal compliance template ***every six months,*** until compliance with all requirements is confirmed by CMS.

- States with identified deficiencies must demonstrate compliance with all renewal requirements **by December 31, 2026,** as detailed below.

CMS acknowledges that the 2024 eligibility and enrollment final rule (89 FR 22780) made additional changes to the renewal process, including establishing new requirements to align renewal simplifications for non-MAGI populations with those for MAGI applicants. State compliance with the renewal requirements in the 2024 final rule will be assessed on a different timeline, as many provisions have delayed compliance dates through June 2027.[7] Because the new regulations build on existing rules, states' compliance with these existing requirements will set a necessary foundation for the successful implementation of the new rules.

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[5] *Compliance Template: Assessment and Plan for Compliance with All Federal Medicaid and CHIP Renewal Requirements*, available at https://www.medicaid.gov/resources-for-states/downloads/renewal-assessment-plan-comp-temp.pdf

[6] *See* 42 CFR §§ 401.105(a) and (b)(2)

[7] "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes," final rule (89 FR 22836), available at: https://www.govinfo.gov/content/pkg/FR-2024-04-02/pdf/2024-06566.pdf

Renewal Requirements

States have an obligation to conduct redeterminations of eligibility for individuals enrolled in Medicaid and CHIP in compliance with all existing federal requirements at 42 C.F.R. §§ 435.916 and 457.343, as interpreted and described in the CIB, "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements."[8] As a condition of CMS's continued non-enforcement of previously identified compliance issues, and to avoid more detailed and particularized requests for further action in other states, all states will be required to assess and demonstrate their compliance with certain key federal renewal requirements, including the following:

- *Ex Parte Renewals:* States must first attempt to conduct a renewal for all beneficiaries based on available information, without requiring information from the individual (an ex parte renewal) (42 C.F.R. § 435.916(b)(1); 42 C.F.R. § 457.343).

- *Provision and Availability of Renewal Forms:* States must provide a renewal form and request only information needed to determine eligibility when eligibility cannot be renewed on an *ex parte* basis. For MAGI beneficiaries, the renewal form must be prepopulated with information available to the agency (42 C.F.R. § 435.916(b)(2)(i)(A); 42 C.F.R. § 435.916(b)(2)(v); 42 C.F.R. § 457.343).

- *Timeline to Return Renewal Forms:* States must provide MAGI beneficiaries with at least 30 days from the date of the pre-populated renewal form to return the form and provide any additional information requested by the agency (42 C.F.R. § 435.916(b)(2)(i)(B); 42 C.F.R. §457.343). Non-MAGI beneficiaries must be given a reasonable amount of time to return forms and documentation (42 C.F.R. § 435.916(b)(2)(i)(B);[9] 42 C.F.R. §435.952).

- *Ability to Submit Renewal Forms Through All Required Modalities:* All beneficiaries must be able to submit their renewal form through any of the modes of submission available for submitting an application (i.e., via the internet Web site described in 42 C.F.R. § 435.1200(f), by phone, by mail, in person; and through other commonly available electronic means) (42 C.F.R. § 435.916(b)(2)(i)(B); 42 C.F.R. § 435.907(a); 42 C.F.R. § 457.343).

- *Reconsideration Period:* For MAGI beneficiaries whose eligibility has been terminated for failure to return their renewal form or requested information, if the renewal form and/or necessary information is returned within 90 days after the date of termination, or a longer period elected by the state, the agency must reconsider the individual's eligibility without requiring the individual to fill out a new application (42 C.F.R. § 435.916(b)(2)(iii)[10]; 42 C.F.R. § 457.343).

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[8] *Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements*, CMCS Informational Bulletin, December 4, 2020: https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf

[9] Compliance with the new requirements to provide prepopulated renewal forms for beneficiaries enrolled on a basis other than MAGI and a minimum of 30 days for all beneficiaries to return renewal forms and information is required by June 2027. Until then, the requirements in effect prior to June 4, 2024 and as reflected here will be the basis for CMS' assessment of states' compliance.

[10] Compliance with the new requirement to providing a minimum 90-day reconsideration period at renewal for individuals disenrolled from a non-MAGI group will be effective in June 2027 and will be evaluated separately.

- *Determination of Eligibility on All Bases:* States are required to consider eligibility on all bases prior to determining an individual is ineligible for Medicaid (42 C.F.R. § 435.916(d)(1); 42 C.F.R. § 435.916(b)).

- *Determination of Potential Eligibility for Other Programs & Transfer Account:* For beneficiaries who are determined ineligible for Medicaid and CHIP, the agency must determine potential eligibility for other insurance affordability programs and timely transfer the beneficiary's electronic account to such program (42 C.F.R. §§ 435.916(d)(2) and 435.1200(e); 42 C.F.R. §§ 457.343 and 457.350(b)).[11]

To ensure successful renewals and support retention of eligible individuals, CMS notes that states must also comply with other critical requirements outside of Medicaid and CHIP renewal regulations at 42 C.F.R. §§ 435.916 and 457.343. These include, but are not limited to requirements at 42 C.F.R. §§ 435.905(b) and 457.340(e) regarding information provided in plain language and in an accessible and timely manner and 42 C.F.R. §§ 435.908 and 457.340 regarding assistance with application and renewal. CMS intends to develop additional resources to support states' compliance in these areas as well.

Requirements for Compliance Assessments and Plans

Attestation, Description, and Supporting Evidence of Compliance

For each renewal requirement, states must attest to compliance or non-compliance and provide additional supporting information using the renewal compliance template. States must provide a description of the policies and processes in the state associated with each requirement. This information should include sufficient detail to assist CMS with confirming the current compliance status for that requirement. Supporting evidence of compliance should be described in the template and submitted along with the completed template. CMS will provide states with additional information on what evidence will be sufficient to confirm compliance for each requirement, for example detailed policy and systems documentation.

Compliance Deficiencies

For each compliance deficiency identified in the compliance assessment, states should describe the issue and the impact on beneficiaries in the template under the relevant requirement. Any policy, operational, or technical deficiency related to the renewal requirement should be identified and included in the information provided to CMS.

Key Activities to Achieve Compliance

To provide a roadmap to compliance, states should list major milestones towards resolving each deficiency in the renewal compliance template in each non-compliant area. Milestones could include Advance Planning Document (APD) submissions, system releases, process changes, or other activities required for reaching compliance. As described below, states will be providing regular updates to CMS on progress towards these milestones and ultimate compliance.

[11] Compliance with the new requirements for t**r**ansitioning accounts for certain individuals no longer eligible for Medicaid to a separate CHIP and to the Marketplace (§§ 431.10, 435.1200(b),(e) and (h), 457.340(f), 457.348, 457.350(b) and (e)) will be evaluated separately.

Federal Financial Participation (FFP) at a 90 percent matching rate is available to states for their expenditures on design, development, or installation of mechanized claims processing and information retrieval systems, including on designing, developing, and installing approved processes, systems, and activities necessary to ensure compliance with the requirements reiterated in this CIB. FFP at a 75 percent matching rate is available for state expenditures to operate such systems.

Ongoing Mitigation Strategies

As states work toward full compliance with renewal requirements by December 2026, CMS expects states to continue or initiate mitigation strategies to minimize any harmful impact of a state's non-compliance with requirements on Medicaid and CHIP beneficiaries. For each area of non-compliance described in the template, states should outline proposed mitigations or seek approval for waivers, as appropriate, under section 1902(e)(14)(A). Waivers requested beyond June 30, 2025 will be considered individually and approved on a time-limited basis, if needed to remediate issues and protect beneficiaries.

Review and Approval

After compliance assessments, evidence and plans are submitted CMS will review submitted information and work with states to finalize and approve compliance plans. As noted above, approved assessments and plans will be posted on Medicaid.gov.

Monitoring

To avoid further agency action, states are expected to demonstrate compliance with all renewal requirements by December 31, 2026. That timing provides these states two years to remediate areas of non-compliance after submission of compliance assessments and plans. To provide support to states and oversight of the activities described in the approved compliance plans, CMS will require a written update from states with identified areas of non-compliance every six months on the milestones in the renewal compliance template along with any other necessary information or documentation from the state to demonstrate compliance. States that are not meeting milestones from their compliance plans and are at risk for not achieving compliance by December 31, 2026 may be subject to additional information requests and/or more frequent reporting of their progress.

As part of its regular monitoring efforts, CMS will also continue to review state-submitted data and other available information and will follow up with all states on potential renewal compliance issues identified.

States that fail to demonstrate compliance with all renewal requirements by December 31, 2026, may face additional agency action based on CMS' assessment of the state's circumstances and the nature of the non-compliance.

Conclusion

CMS is available to provide ongoing assistance to support state efforts to achieve compliance with renewal requirements to help ensure that eligible individuals successfully renew their Medicaid and CHIP coverage. CMS will also use standing meetings with states to provide technical assistance on compliance assessments and the development and implementation of

compliance plans. CMS is releasing this information now so states can prepare to conduct compliance assessments and provide information to CMS. For additional questions, please email CMSUnwindingSupport@cms.hhs.gov.

Compliance Template:

Assessment and Plan for Compliance with All Federal Medicaid and CHIP Renewal Requirements

This template is intended to support state compliance with federal Medicaid and Children's Health Insurance Program (CHIP) renewal requirements described at 42 C.F.R. §435.916 and §457.343. Every state must submit a completed template to the Centers for Medicare & Medicaid Services (CMS), which includes:

- Assessment and evidence of compliance status
- Descriptions of all redetermination requirement deficiencies
- Plan, including key activities and milestones/timelines, for resolving each deficiency
- Date by which the state will achieve compliance with each renewal requirement, if not already compliant
- Mitigations, including 1902(e)(14) waivers and other strategies that the state proposes maintaining or implementing until the state is in compliance with each renewal requirement

DEADLINE: Completed template must be submitted by December 31, 2024.

Instructions: This template is organized by Medicaid and CHIP renewal requirement. In each section, states should assess compliance and indicate any compliance deficiencies, as well as the state's plan for coming into compliance with the requirement, as detailed below. States should review all relevant regulations and available guidance before completing their compliance assessment to ensure understanding and alignment with requirements. CMS will provide additional renewal guidance and clarifications related to renewal compliance throughout Fall of 2024. Compliance will be assessed based on regulations in effect when the template is submitted, unless otherwise noted. For current renewal guidance, as well as more information on resources and strategies, please visit Medicaid.gov. In addition, states can contact their state lead for technical assistance. CMS will review submissions and will work with states to provide approval of compliance plans, including mitigation strategies.

Please complete each section of the template according to the instructions listed below:

1. **Assessment:** After reviewing all CMS renewal guidance and assessing state systems, policies, and operations, please select whether your state is compliant or noncompliant for each requirement listed.
2. **Evidence of compliance:** For areas in compliance, including areas with deficiencies that have been addressed, please list documentation or other evidence submitted to demonstrate compliance with requirements. CMS will provide additional guidance on appropriate documentation and other evidence of renewal compliance, which could include systems, policy, and operational documentation.
3. **Description of policies and processes:** Please describe the policies and processes, including system functionality, that support your

assessment with each requirement in each section. Please explain how these policies and procedures are consistent with the compliance assessment.

4. **Description of compliance deficiencies:** Please include a description of any deficiencies in compliance with the regulatory requirement.
5. **Key activities and milestones for resolving each deficiency:** Please list major milestones towards resolving each deficiency and achieving compliance with the associated timelines. Milestones could include advance planning document (APD) submissions, system releases, process changes, or other activities required for reaching compliance. If states require more than the formatted number of rows available in each table, continue the table in a separate document and attach the document as an appendix to the compliance plan.
    - **Deficiency:** Please describe the relevant deficiency noted in the assessment. If the deficiency will have multiple activities listed in the table, this column of the subsequent table rows associated with the same deficiency can be left blank.
    - **Key Activity:** Please list the high-level activities or steps the state will undertake to resolve each deficiency. Each activity should be listed on its own row in the table. For example, updating system functionality, revising notice language, and updating worker processes would each be separate activities. As applicable, states are encouraged to consider required system changes, vendor procurement, submission of APDs, systems testing, submission of state plans and requests for additional authorities, updates to state policy and operations, adoption of new data sources, staff training, etc.
    - **Targeted Timeline:** Please list the timeline for completing the listed activity. Please include any key milestone dates.
    - **APD (Date):** If an APD will be submitted or has been submitted to support completion of an activity, please indicate that here, along with the anticipated/completed submission date.
    - **Status:** Please describe the status of the activity (not started, in progress, completed), including any delays in implementation or additional support needed from CMS and provide regular updates to CMS as activities are completed and compliance is achieved for each requirement.
6. **Date by which state will achieve compliance with the renewal requirement:** Enter the date by which the state will achieve compliance with the redetermination requirements in that section of the template. If the state has multiple deficiencies within a section, enter the date by which *all* deficiencies will be resolved.
7. **Mitigations state will maintain or implement until compliant with the renewal requirement:** List any mitigations for the relevant redetermination requirement that the state proposes maintaining or implementing until it achieves compliance. Please include any section 1902(e)(14) flexibilities and the rationale.
8. **Additional notes (optional):** Add any details not captured elsewhere in the table as needed. This section is not required.

State:
Medicaid Director:
State point of contact for compliance plan:
Date of compliance plan submission:

ASSESSMENT OF AND PLAN FOR COMPLIANCE WITH FEDERAL MEDICAID AND CHIP RENEWAL REQUIREMENTS

A. *Ex Parte* Renewals**:** States must first attempt to conduct a renewal for all beneficiaries based on available information, without requiring information from the individual (an *ex parte* renewal) (42 C.F.R. §435.916(b)(1); 42 C.F.R. §457.343).

1. Assessment: *Select current status of compliance with the requirements below.*

Compliant	Noncompliant	Requirement
☐	☐	1. *Ex parte* renewals conducted for Modified Adjusted Gross Income (MAGI) populations at the individual level
☐	☐	2. *Ex parte* renewals conducted for non-MAGI populations at the individual level
☐	☐	3. Other (please specify) _____

2. Evidence of compliance: *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

3. **Description of policies and processes:** *Please describe how your state has implemented ex parte for MAGI and non-MAGI populations in your systems and program operations, including policies and processes for use of data sources, automated processes, and ensuring accurate determinations.*

4. **Description of compliance deficiencies:** *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. **Key activities and milestones for resolving each deficiency described above:**

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. If not in compliance, date by which state will achieve compliance with *ex parte* renewal requirements:

7. List mitigations state will maintain or implement until compliant with requirement:

8. Additional notes (optional):

B. Renewal Form: States must provide a renewal form and request only information needed to determine eligibility when eligibility cannot be renewed on an *ex parte* basis. For MAGI beneficiaries, the renewal form must be prepopulated (42 C.F.R. §435.916(b)(2)(i)(A); 42 C.F.R. §435.916(b)(2)(v); 42 C.F.R. §457.343).[1]

1. Assessment: *Select current status of compliance with the requirements below.*

Compliant	Noncompliant	Requirement
☐	☐	1. Renewal form is provided to all MAGI and non-MAGI individuals for whom the state cannot renew on an ex parte basis
☐	☐	2. Renewal form is prepopulated with available information needed to renew eligibility for MAGI-based individuals in all modalities
☐	☐	3. Renewal form only requests information needed to redetermine eligibility
☐	☐	4. Other (please specify) _____

2. Evidence of compliance: *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

[1] CMS released the Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule on April 2, 2024, which modified renewal requirements. While the final rule went into effect June 4, 2024, states have until June 2027 to comply with new requirements to provide to all MAGI and non-MAGI beneficiaries who cannot be renewed on an ex parte basis a prepopulated renewal form and a minimum of 30 days to return the form. Until June 2027, CMS will rely on the requirements in effect prior to June 4, 2024, to assess states' compliance with federal renewal requirements.

3. **Description of policies and processes:** *Please describe your policies and processes for generating and providing pre-populated renewal forms, including system functionality, any automated or manual processes, what information is pre-populated, and how the form is available through all modalities.*

4. **Description of compliance deficiencies:** *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. **Key activities and milestones for resolving each deficiency described above:**

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. If not in compliance, date by which state will achieve compliance with renewal form requirements:

7. List mitigations state will maintain or implement until compliant with requirement:

8. Additional notes (optional):

C. Timeline to Return Renewal Forms: States must provide MAGI beneficiaries with at least 30 days from the date of the pre-populated renewal form to return the form and provide any additional information requested by the agency (42 C.F.R. §435.916(b)(2)(i)(B); 42 C.F.R. §457.343). Non-MAGI beneficiaries must be given a reasonable amount of time to return forms and documentation (42 C.F.R. §435.916(b)(2)(i)(B)[2]; 42 C.F.R. §435.952).

1. Assessment: *Select current status of compliance with the requirements below.*

Compliant	Noncompliant	Requirement
☐	☐	1. MAGI-based beneficiaries are provided a minimum of 30 days to return a form and requested information/documentation
☐	☐	2. Non-MAGI beneficiaries are provided a reasonable period of time to return a form/needed documentation
☐	☐	3. Renewal form or related notice for MAGI-based beneficiaries clearly explains that the beneficiary has a minimum of 30 days
☐	☐	4. Other (please specify) _____

2. Evidence of compliance: *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

[2] CMS released the Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule on April 2, 2024, which modified renewal requirements. While the final rule went into effect June 4, 2024, states have until June 2027 to comply with new requirements to provide to all MAGI and non-MAGI beneficiaries who cannot be renewed on an *ex parte* basis a prepopulated renewal form and a minimum of 30 days to return the form. Until June 2027, CMS will rely on the requirements in effect prior to June 4, 2024, to assess states' compliance with federal renewal requirements.

3. **Description of policies and processes:** *Please provide a description of policies and processes for providing and communicating that MAGI-based beneficiaries have at least 30 days to return the renewal form and non-MAGI beneficiaries have a reasonable period of time (including number of days provided).*

4. **Description of compliance deficiencies:** *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. **Key activities and milestones for resolving each deficiency described above:**

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. If not in compliance, date by which state will achieve compliance with renewal form timeline requirements:

7. List mitigations state will maintain or implement until compliant with requirement:

8. Additional notes (optional):

D. Submit Renewal Form Through All Modalities: All beneficiaries must be able to submit their renewal form through any of the modes of submission available for submitting an application (i.e., via the internet Web site described in 42 CFR 435.1200(f), by phone, by mail, in person; and through other commonly available electronic means) (42 C.F.R. §435.916(b)(2)(i)(B); 42 C.F.R. §457.343).

1. Assessment: *Select current status of compliance with the requirements below.*

MAGI		Non-MAGI		
Compliant	**Noncompliant**	**Compliant**	**Noncompliant**	**Requirement**
☐	☐	☐	☐	1. Option for submission of renewal form via the internet website (a web form)
☐	☐	☐	☐	1a. Accepts electronic signature
☐	☐	☐	☐	2. Option for phone submission of renewal form
☐	☐	☐	☐	2a. Accepts telephonic signatures
☐	☐	☐	☐	3. Paper renewal form readily available for submission
☐	☐	☐	☐	4. In-person submission of renewal form
☐	☐	☐	☐	5. Other (please specify) _____

2. Evidence of compliance: *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

3. **Description of policies and processes:** *Please provide a description of how the state accommodates submission of renewal forms through each modality, including how beneficiaries are notified of options, worker actions required, and supporting technology. Please also describe how electronic and telephonic signatures are collected and stored.*

4. **Description of compliance deficiencies:** *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. **Key activities and milestones for resolving each deficiency described above:**

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. If not in compliance, date by which state will achieve compliance with renewal form submission requirements:

7. List mitigations state will maintain or implement until compliant with requirement:

8. Additional notes (optional):

E. Reconsideration Period at Renewal: For MAGI beneficiaries whose eligibility has been terminated for failure to return their renewal form or requested information, if the renewal form and/or necessary information is returned within 90 days after the date of termination, or a longer period elected by the state, the agency must reconsider the individual's eligibility without requiring the individual to fill out a new application (42 C.F.R. §435.916(b)(2)(iii)[3]; 42 C.F.R. §457.343).

1. **Assessment:** *Select current status of compliance with the requirements below.*

Compliant	Noncompliant	Requirement
☐	☐	1. Reconsideration period available for individuals enrolled on a MAGI basis
☐	☐	2. Reconsideration period for MAGI-based beneficiaries is no less than 90 days
☐	☐	3. Other (please specify) _____

2. **Evidence of compliance:** *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

3. **Description of policies and processes:** *Please provide a description of policies and processes for providing a reconsideration period of at least 90 days for MAGI beneficiaries, including how this is handled in the eligibility system and communicated to beneficiaries.*

[3] The requirement for compliance with the regulation to provide a minimum 90-day reconsideration period at renewal for individuals disenrolled from a non-MAGI group will be effective in June 2027 and will be evaluated separately.

4. **Description of compliance deficiencies:** *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. **Key activities and milestones for resolving each deficiency described above:**

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. **If not in compliance, date by which state will achieve compliance with the reconsideration period renewal requirements:**

7. **List mitigations state will maintain or implement until compliant with requirement:**

8. Additional notes (optional):

F. Determine Eligibility on All Bases: States are required to consider eligibility on all bases prior to determining an individual is ineligible for Medicaid (42 C.F.R. § 435.916(d)(1); 42 C.F.R. § 435.916(b)).

1. Assessment: *Select current status of compliance with the requirements below.*

Compliant	Noncompliant	Requirement
☐	☐	1. Individuals enrolled on a **MAGI basis** are screened for other MAGI eligibility groups and potential eligibility on a non-MAGI basis prior to determining an individual is ineligible, terminating coverage, and transferring the individual to another insurance affordability program
☐	☐	2. Individuals enrolled on a **basis other than MAGI** are screened for other non-MAGI groups and potential MAGI eligibility prior to determining an individual is ineligible, terminating coverage, and transferring the individual to another insurance affordability program
☐	☐	3. State requests additional information from individuals to consider eligibility on another basis without requiring the individual to submit a new application
☐	☐	4. Other (please specify) _____

2. Evidence of compliance: *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

3. **Description of policies and processes:** *Please provide a description of policies and processes for determining eligibility on all bases at renewal, including how this is processed in the eligibility system and communicated to beneficiaries.*

4. **Description of compliance deficiencies:** *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. **Key activities and milestones for resolving each deficiency described above:**

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. If not in compliance, date by which state will achieve compliance with the requirement to determine eligibility on all bases:

7. List mitigations state will maintain or implement until compliant with requirement:

8. Additional notes (optional):

G. Determine Potential Eligibility for Other Programs & Transfer Account: For beneficiaries who are determined ineligible for Medicaid and CHIP, the agency must determine potential eligibility for other insurance affordability programs and timely transfer the beneficiary's electronic account to such program (42 C.F.R. §§ 435.916(d)(2) and 435.1200(e); 42 C.F.R. §457.343 and 457.350(b)).[4]

1. Assessment: *Select current status of compliance with the requirements below.*

Compliant	Noncompliant	Requirement
☐	☐	1. Individuals' accounts are transferred to the Marketplace timely (MAGI)
☐	☐	2. Individuals' accounts are transferred to the Marketplace timely (non-MAGI)
☐	☐	3. Other (please specify) _____

2. Evidence of compliance: *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

3. Description of policies and processes: *Please provide a description of policies and processes for determining potential eligibility for other programs and transferring the account, including how this is handled in the eligibility system and communicated to beneficiaries.*

[4] CMS will evaluate compliance with new requirements from the *Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* rule separately. This includes compliance with new requirements for transitioning accounts for certain individuals no longer eligible for Medicaid to a separate CHIP and to the Marketplace (§§ 431.10, 435.1200(b),(e) and (h), 457.340(f), 457.348, 457.350(b) and (e)).

4. **Description of compliance deficiencies:** *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. **Key activities and milestones for resolving each deficiency described above:**

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. **If not in compliance, date by which state will achieve compliance with the requirement to determine potential eligibility for other programs and transfer the account:**

7. **List mitigations state will maintain or implement until compliant with requirement:**

8. Additional notes (optional):

H. Renew Eligibility Once Every 12 Months: States are required to renew eligibility once every 12 months for beneficiaries determined on a MAGI basis in Medicaid and CHIP and at least once every 12 months for beneficiaries determined eligible for Medicaid on a non-MAGI basis (42 C.F.R. § 435.916(a)(1)[5]; 42 C.F.R. §457.343).

1. Assessment: *Select current status of compliance with the requirements below.*

Compliant	Noncompliant	Requirement
☐	☐	1. Eligibility redetermination conducted once every 12 months and not more than once every 12 months for MAGI populations
☐	☐	2. Eligibility redetermination conducted at least once every 12 months for non-MAGI populations
☐	☐	3. Other (please specify) _____

2. Evidence of compliance: *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

[5] CMS released the Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule on April 2, 2024, which modified renewal requirements. While the final rule went into effect June 4, 2024, states have until June 2027 to comply with new requirements to conduct renewals once and only once every 12 months for almost all beneficiaries, including those enrolled on a non-MAGI basis. Until June 2027, CMS will rely on the requirements in effect prior to June 4, 2024, to assess states' compliance with federal renewal requirements.

3. **Description of policies and processes:** *Please provide a description of policies and processes for renewing eligibility once every 12 months for MAGI beneficiaries and at least once every 12 months for non-MAGI beneficiaries, including how this is handled in the eligibility system and communicated to beneficiaries.*

4. **Description of compliance deficiencies:** *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. **Key activities and milestones for resolving each deficiency described above:**

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. If not in compliance, date by which state will achieve compliance with the requirement to renew eligibility once every 12 months:

7. List mitigations state will maintain or implement until compliant with requirement:

8. Additional notes (optional):

I. Other: If CMS requests information on additional renewal requirements, that information can be included in this section. Please list specific additional requirements below with the regulatory citation.

1. Assessment: *Select current status of compliance with the requirements below.*

Compliant	Noncompliant	Requirement
☐	☐	1. Requirement: _____
☐	☐	2. Requirement: _____
☐	☐	3. Requirement: _____

2. Evidence of compliance: *Please list documentation or other evidence submitted to demonstrate compliance with requirements specified above.*

3. Description of policies and processes: *Please provide a description of policies and processes related to this requirement.*

4. Description of compliance deficiencies: *Please include a description of any deficiencies in compliance with the regulatory requirement.*

5. Key activities and milestones for resolving each deficiency described above:

Deficiency	Key Activity	Targeted Timeline	APD (Date)	Status (Not Started/In Progress/Complete)

6. If not in compliance, date by which state will achieve compliance with renewal requirements:

7. List mitigations state will maintain or implement until compliant with requirement:

8. Additional notes (optional):

PRA Disclosure Statement States have an obligation to conduct redeterminations of eligibility for all individuals enrolled in Medicaid and CHIP in compliance with all existing federal requirements at 42 CFR 435.916 and 457.343. It is critical that states ensure their compliance with federal renewal requirements to help individuals eligible for Medicaid or CHIP successfully renew their coverage. To confirm compliance with these regulations, CMS is providing a template for states to indicate their current compliance status with renewal regulations, describe policies and processes, and identify planned mitigations for any identified deficiencies. Completion of the template is required for all states, with updates provided as states with compliance deficiencies inform CMS of progress and come into compliance with requirements.

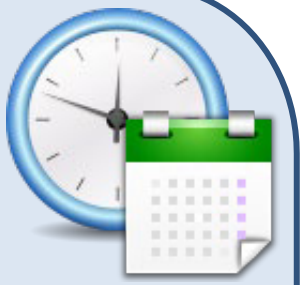
Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #66). The time required to complete this information collection is estimated to average 40 HOURS per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Overview: Medicaid and CHIP Eligibility Renewals

September 2024

Objectives

This slide deck is intended to:



1. Provide an overview of and support state compliance with federal Medicaid and Children's Health Insurance Program (CHIP) eligibility renewal requirements in place as of September 2024 and described at 42 C.F.R. §§ 435.916 and 457.343.[1]

2. Serve as a supplementary resource to the *State Compliance with Medicaid and CHIP Renewal Requirements by December 31, 2026* CMCS Informational Bulletin (CIB) and additional, forthcoming guidance related to renewal compliance.

3. Acknowledge new federal regulatory requirements for completing renewals and associated compliance dates to assist states in their planning for policy, operational, and IT systems changes as they streamline non-Modified Adjusted Gross Income (MAGI) Medicaid renewal processes to align with those for MAGI Medicaid and CHIP beneficiaries.[2]

1. This slide deck is focused exclusively on renewal processes; as such, it does not include discussion of redeterminations based on changes in circumstances.
2. CMS's Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule, which took effect June 3, 2024, phases in new requirements through June 3, 2027, with compliance timeframes varying by provision.

Contents Overview

- **Context Setting: Overview of Federal Medicaid and CHIP Renewal Requirements**
- **Federal Requirements Related to Medicaid and CHIP Renewals Focusing on:**
  - *Ex Parte* Renewals
  - Renewal Form
  - Timeframes to Return and Process the Renewal Form
  - Modalities to Return the Renewal Form
  - Determining Eligibility on All Potential Bases
  - Advance Notice and Fair Hearing Rights
  - Transferring Accounts to Other Insurance Affordability Programs (IAPs)
  - Reconsideration Period at Renewals
- **Additional Resources for States**

Note: Changes in federal Medicaid and CHIP renewal requirements with compliance timeframes after September 2024—as defined in CMS's Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule—are noted as future state requirements in relevant sections of this slide deck.

Context Setting: Overview of Federal Medicaid and CHIP Renewal Requirements

Overview of Medicaid and CHIP Renewal Period

Renewal Frequency

- **MAGI Medicaid and CHIP Beneficiaries:** States must renew eligibility once every 12 months and no more frequently than once every 12 months.
- **Non-MAGI Medicaid Beneficiaries:** States must renew eligibility at least once every 12 months.
  - ***Future State Requirement:*** By June 3, 2027, states must renew eligibility once every 12 months and no more frequently than once every 12 months for almost all non-MAGI beneficiaries.* States may implement this requirement for non-MAGI beneficiaries sooner.

Eligibility Period Definition

- The 12-month period (or shorter period elected by the state for non-MAGI beneficiaries, until June 3, 2027) that begins on the effective date of the last determination or redetermination of eligibility.

Renewal Period Definition

- The period of time from the date when the agency initiates the steps to renew eligibility based on information available to the agency (the start of the *ex parte* process) until the date the agency sends the eligibility determination notice or terminates eligibility and transfers the electronic account to another insurance affordability program.

42 C.F.R. §§ 435.916, 457.343. CMS, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes. *Section 1902(e)(8) of the Social Security Act allows states to renew eligibility for Qualified Medicare Beneficiaries (QMBs) no more frequently than once every 6 months.

Overview of Medicaid and CHIP Renewal Requirements

States must begin the renewal process for all Medicaid and CHIP beneficiaries by **first attempting to redetermine eligibility based on reliable information** available to the agency without requiring information from the individual (*ex parte* renewal).

- If available information is sufficient to determine continued eligibility without requiring information from the individual, states must renew eligibility on an *ex parte* basis and notify the individual that their coverage has been renewed and the basis for the renewal. The beneficiary does not need to sign or return the notice if all information contained in the notice is accurate.
- If available information is insufficient to determine continued eligibility, states must send a renewal form that requests from the beneficiary only the information or documentation needed to renew eligibility.

States must provide a **renewal form that is prepopulated** for individuals enrolled on a MAGI basis.

— ***Future State Requirement:*** By June 3, 2027, states must prepopulate the renewal form for non-MAGI beneficiaries. States may implement this requirement for non-MAGI beneficiaries sooner.

States must allow beneficiaries to return the signed renewal form through **all modes of submission** available for submitting an application (i.e., online, phone, mail, in-person, other commonly available electronic means).

States must provide individuals enrolled in **MAGI Medicaid and CHIP with a minimum of 30 days to respond to the renewal form**, and provide a reasonable timeframe (a minimum of 30 days is recommended) for individuals enrolled on a non-MAGI basis.

— ***Future State Requirement:*** By June 3, 2027, states must provide a minimum of 30 days for non-MAGI beneficiaries to respond to the renewal form and any requested information. States may implement this requirement for non-MAGI beneficiaries sooner.

42 C.F.R. §§ 435.916, 435.952, and 457.343.

Federal Requirements Related to Medicaid and CHIP Renewals

Ex Parte Renewals

At renewal, states must first attempt to renew eligibility for all MAGI and non-MAGI Medicaid and CHIP beneficiaries on an *ex parte* basis.

States are required **to renew Medicaid and CHIP eligibility for all beneficiaries on an *ex parte* basis**, based on reliable information contained in the beneficiary's account or other more current information available to the agency without requiring information from the beneficiary, if able to do so. This process does not require action by the beneficiary.

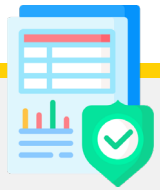
If the agency is able to renew eligibility based on the available reliable information, the agency must **provide timely and adequate notice to the beneficiary**, which includes:

- Eligibility determination and basis for the determination (i.e., the information the agency relied upon in approving eligibility).
- Effective date of eligibility.
- Beneficiary obligation to inform the state if any of the information in the notice is inaccurate, and an explanation that the beneficiary does not need to sign or return the notice if all information is accurate.
- The requirement and process to report changes in circumstance that may impact eligibility.
- Information on benefits and services, and any premiums, enrollment fees, and cost sharing.
- An explanation of the right to a fair hearing.

42 C.F.R. §§ 435.905(b), 435.916(b)(1), 435.917(a)(1)-(2) & (b)(1), 457.340(e)(1), and 457.343.

Reliable Information

To conduct an *ex parte* renewal, states must utilize reliable information to verify eligibility.



Reliable information includes:

- ✓ Information accessed through electronic data sources;
- ✓ Information in the beneficiary's account; and
- ✓ Recent information from other agencies in the state and other state and federal programs (e.g., Supplemental Nutrition Assistance Program (SNAP) recertification).

Unless otherwise authorized, information from the initial determination at application or the beneficiary's last renewal is generally *not* considered reliable unless it relates to circumstances generally not subject to change (e.g., U.S. citizenship, qualified noncitizen immigration status).

42 C.F.R. §§ 435.916, 435.948, 435.949, 435.956, 457.343, and 457.380.

Reminders About the *Ex Parte* Renewal Process

- ☑ States must complete a redetermination of eligibility based on available information **for each individual in the household** and in relation to the eligibility standard appropriate to the individual, regardless of the eligibility of others in the household unit.
- ☑ States must **attempt to verify financial assets using the state's Asset Verification System (AVS)** for non-MAGI-based *ex parte* renewals.
- ☒ States **must not request additional income information from individuals prior to making a redetermination of eligibility** if data sources indicate income is below the Medicaid or CHIP income eligibility levels, regardless of the circumstances (e.g., if the employer in the data sources differs from the previous case record or to collect information needed for SNAP/other human services programs, if the state aligns the renewal dates).
- ☒ States **must not transition** an individual to the Marketplace or to an eligibility category with lesser benefits or increased premiums or cost sharing, based on an *ex parte* review, **without first sending a renewal form**.
- ☒ States **must not require all household members to return a renewal** form simply because one member cannot be determined on an *ex parte* basis.

Renewal Form

When eligibility cannot be renewed on an *ex parte* basis, states must provide Medicaid and CHIP beneficiaries a renewal form that requests only the information or documentation needed to determine eligibility.

- The renewal form must be **prepopulated** with information about the beneficiary for **MAGI Medicaid and CHIP beneficiaries** whose eligibility cannot be renewed on an *ex parte* basis.
  - ***Future State Requirement:*** By June 3, 2027, states must prepopulate the renewal form for non-MAGI beneficiaries and remove any in-person interview requirements as part of the renewal process. States may implement this requirement for non-MAGI beneficiaries sooner.
- The renewal form must **only require beneficiaries to provide the information needed** to redetermine Medicaid or CHIP eligibility. If states need income or other information to renew eligibility for certain household members who are unable to be renewed on an *ex parte* basis, states may not request additional information from other household members who have already been determined eligible based on available, reliable information.
- States must **include clear instructions** on completing the renewal form and correcting inaccurate information, the need to sign the form, how to return the form, and required timeframes for submission.
- The renewal form must be **provided in a format that is accessible** to individuals with limited English proficiency (through the provision of language services at no cost to the beneficiary) and with disabilities (through the provision of auxiliary aids and services at no cost to the beneficiary).

42 C.F.R. §§ 435.905(b), 435.916(b)(2)(i)(A) and (iv) and (e), 435.917(a), 457.340(a) and (e), and 457.343. CMS, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.

Timeframes to Return the Renewal Form

States must give beneficiaries enough time to complete and return the renewal form and the requested information.

- States must provide **MAGI Medicaid and CHIP beneficiaries a minimum of 30 days** from the date the prepopulated renewal form is sent to return the form and must provide a reasonable period of time **for non-MAGI beneficiaries**. (States are encouraged to provide a longer period of time - a minimum of 30 days.)
  - ***Future State Requirement:*** By June 3, 2027, states must provide at least 30 days for non-MAGI beneficiaries to return the renewal form. States are encouraged to align timeframes for non-MAGI beneficiaries with those for MAGI populations sooner.

42 C.F.R. §§ 435.916(b)(2)(i)(B); 435.952, and 457.343. CMS, Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.

Timeframes to Process the Renewal Form

States must ensure they process renewals timely.

States must initiate the renewal process with sufficient time to ensure the renewal process is completed prior to the end of the beneficiary's eligibility period.

State timelines must account for the time needed for:

- **Beneficiaries to return their signed renewal form and submit required documentation**, if appropriate.
- **The agency to verify information** returned by the beneficiary, determine eligibility, and notify the beneficiary of its determination (including advance notice of adverse action, if appropriate).
- **Considering eligibility on all potential bases** in Medicaid, if the beneficiary is ineligible in their current group.

States must **continue to furnish Medicaid and CHIP to beneficiaries who have returned their renewal form or documentation** requested by the state within the eligibility period unless and until they are determined to be ineligible and provided appropriate advance notice and fair hearing rights. For Medicaid, this requirement also applies in cases when processing the renewal form/requested information will need to occur after the eligibility period has ended.

42 C.F.R. §§ 435.912(c), 435.916, 435.917, 435.930(b), 431 subpart E, 457.340(d), and 457.343. CMS, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.

Modalities to Return the Renewal Form

States must ensure beneficiaries are able to return the renewal form through all modalities required at application.

Required modalities include:

Online

By Phone

By Mail

In-Person

Other Commonly Available Electronic Means

CMS encourages states to conduct more intensive outreach through multiple modalities, including through text messaging, email, online accounts, and telephone calls, to remind individuals to respond to the renewal form and requests for additional information.

States are also encouraged to work with their stakeholder partners—managed care plans, community-based organizations, application assisters (including Navigators and certified application counselors), providers, schools, and other partners—to remind individuals to respond to the renewal form in a timely manner.

42 C.F.R. §§ 435.907(a), 435.916(b)(2)(i)(B), and 457.343.

Determining Eligibility on All Potential Bases

States must consider all bases of Medicaid eligibility prior to determining an individual is ineligible for Medicaid and terminating coverage.

- If a state has sufficient information after sending a renewal form to determine that an individual is no longer eligible for the eligibility group in which they are enrolled, it must **consider whether the individual may be eligible under all other eligibility groups covered by the state prior to terminating eligibility**.
- If the Medicaid agency identifies another eligibility group for which an individual may be eligible, but requires additional information to make the determination, the state must:
  - **Maintain coverage** in the group in which the individual is currently enrolled; and
  - **Request additional information** from the individual needed to consider eligibility on other bases.
- If an individual is determined eligible for an eligibility category with lesser benefits or increased premiums or cost sharing, the Medicaid agency must provide advance notice and fair hearing rights regarding the change in eligibility category and in benefits and/or costs.
- The Medicaid agency **may not terminate an individual's coverage** until:
  - The individual is found ineligible under all groups covered by the state or until the individual does not provide requested information that is needed to make a determination in a timely manner; and
  - The individual is provided advance notice and fair hearing rights regarding the termination (see slide 17).

42 C.F.R. §§ 435.916(d)(1), 435.930(b), 435.952(c).

Medicaid and CHIP Transitions

As of June 3, 2024, when the Medicaid agency determines a beneficiary is ineligible for Medicaid and eligible for CHIP, or the Separate CHIP agency determines a beneficiary is ineligible for CHIP and eligible for Medicaid, states must seamlessly transition eligibility to the other program.

Operationally, if during an *ex parte* renewal, a Medicaid-enrolled child appears eligible for Separate CHIP coverage based on available data, or a CHIP-enrolled child appears eligible for Medicaid, the state must:

- **Maintain the child's coverage** in the program in which they are currently enrolled;
- **Send a renewal form** to the family, requesting only the information or documentation needed to determine eligibility for the program in which the beneficiary is currently enrolled, providing adequate time to return the form; and
- Provide **advance notice of adverse action and notice of approved eligibility** any time a child is determined eligible for the other coverage program.[1]
  - ***Future State Requirement:*** All states will be required to send a **combined eligibility notice.** (Compliance date is still to be determined.)

Note: If the household does not return the renewal form and the information obtained during the ex parte review indicates that the child is eligible for the other program, ***the state must terminate coverage in the program in which the child is currently enrolled, provide advance notice, and move them to the other coverage program****.*

In states with a Separate CHIP, the Medicaid and CHIP state agencies must enter into an agreement to seamlessly transition individuals between programs.

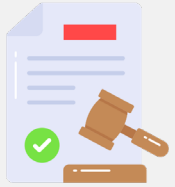
42 C.F.R. §§ 431.10, 435.1200(b),(e) and (h), 457.340(e)(1)(ii) and (f), 457.348, 457.350(b) and (e), 457.1180, and 600.330. CMS, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.

1. 42 C.F.R. § 457.340(e)(1)(ii) requires states to provide "sufficient" notice of suspension or termination of CHIP eligibility, and § 457.1180 requires states to provide "timely" notice of determinations subject to review. In order to be sufficient and timely, states must provide advance notice to afford families an opportunity to request a review and prevent a gap in coverage in the event a beneficiary remains eligible for CHIP.

Advance Notice and Fair Hearing Rights

States must provide advance notice of adverse action prior to terminatingr Medicaid or CHIP eligibility or reducing benefits

- **Medicaid:** States must send a notice of adverse action to the beneficiary **at least 10 days** before the date of action (except in limited circumstances).
- **CHIP:** States must provide timely and adequate written notice ("sufficient notice to enable the child's parent or other caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption").
- The **advance notice of adverse action** must include:
  - ❑ **An explanation of the beneficiary's right to a Medicaid fair hearing or CHIP review** (including the right to request an expedited hearing), how to request a fair hearing, who can assist the beneficiary at the hearing, when benefits will be provided pending the outcome of the fair hearing, and the timeframe for when the state must take final administrative action.
  - ❑ A statement of the action the agency intends to take (e.g., termination of eligibility, reduction in services/benefits).
  - ❑ The effective date of the action.
  - ❑ Reasons and regulations that support, or changes in federal or state law that require the action.



42 C.F.R. §§ 431.206(b), 431.210, 431.211, 435.917, Part 431 Subpart E, 457.340(e)(1)(iii), 457.1130(a), and 457.1180
Adverse action includes any action by the state Medicaid agency that affects their eligibility, services, or benefits, such as Medicaid benefits being denied, suspended, terminated, or reduced.

Transferring Accounts to Other IAPs

If an individual is determined ineligible for Medicaid or CHIP, states must determine potential eligibility for other IAPs and transfer the electronic account, if appropriate.

- CMS is temporarily exercising enforcement discretion and will not require states to determine eligibility for other IAPs (e.g., Basic Health Program (BHP), qualified health plan (QHP) coverage) for **beneficiaries who fail to return the renewal form or other documentation** in a timely manner. CMS will provide additional guidance on when states will be expected to determine eligibility for other IAPs for these beneficiaries.

- States with Marketplaces that use the **federal eligibility and enrollment platform** should:
  - Only transfer accounts to the Marketplace for individuals about whom the state has sufficient information to determine that they do not meet Medicaid and CHIP eligibility requirements.
  - Not transfer accounts to the Marketplace for individuals who are terminated for procedural reasons (e.g., beneficiary does not return renewal form or other requested information.)

- States that operate **State-Based Marketplaces (SBMs)** using their own platform:
  - Must transfer accounts to the Marketplace for individuals about whom the state has sufficient information to determine that they do not meet Medicaid and CHIP eligibility requirements.
  - May transfer accounts to the Marketplace for individuals who have been terminated for procedural reasons.

- ***Future State Requirement:*** Under recent changes in regulations, states will be required to transfer individuals terminated from Medicaid and CHIP for procedural reasons to the Marketplaces when *ex parte* information indicates that the individual is likely eligible for Marketplace coverage.

42 C.F.R. §§ 435.916(d)(2); 435.1200; 457.350(b). CMS, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.

Reconsideration Period at Renewal

States must provide a reconsideration period at renewal.

- **For MAGI Medicaid and CHIP beneficiaries** whose eligibility has been terminated at renewal for failure to return the renewal form or other requested information, **states must reconsider the individual's eligibility** without requiring the individual to fill out a new application if the renewal form and/or requested information is returned within **90 days (or a longer period if elected by the state)** after the date of termination.
  - ***Future State Requirement:*** By June 3, 2027, states must provide non-MAGI beneficiaries with a 90-day (or longer) reconsideration period. States may implement this requirement for non-MAGI beneficiaries sooner.

- The renewal form returned within the reconsideration period serves as an application, so states must make a determination consistent with application timeliness standards (90 days for individuals applying for Medicaid on the basis of a disability, and 45 days for all other Medicaid and CHIP applicants).

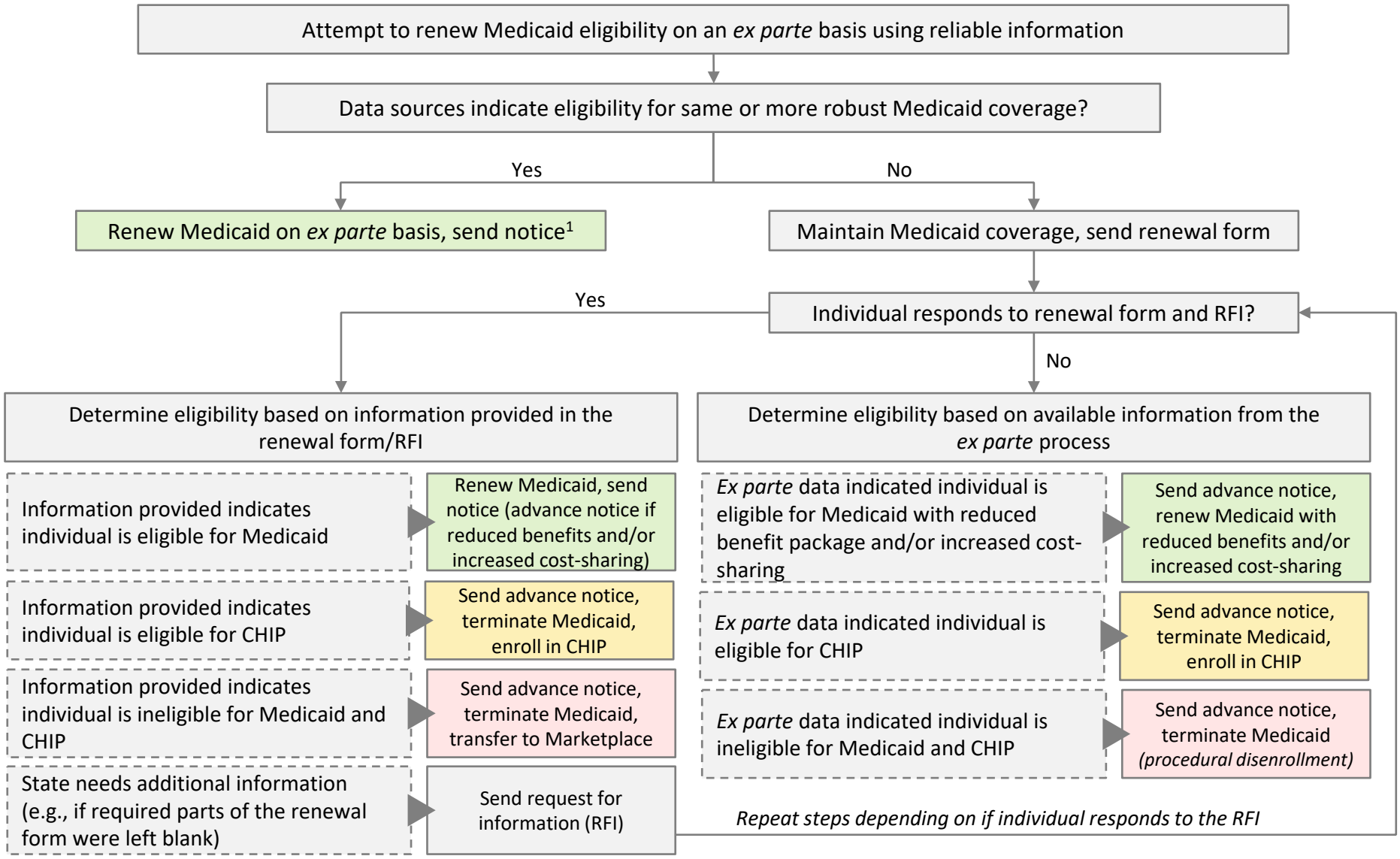
- Effective dates of coverage for those determined eligible are:
  - **Medicaid:** Date the renewal form was submitted or first day of the month the renewal form was returned consistent with the Medicaid state plan. (Up to three months of retroactive coverage is available if the individual received Medicaid services following their termination and met Medicaid eligibility requirements when services were received.)
  - **CHIP:** Date the form is returned, or a reasonable method indicated in the state plan.

42 C.F.R. §§ 435.912(c)(3), 435.915, 435.916(b)(2)(iii), 457.340(g), and 457.343. CMS, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

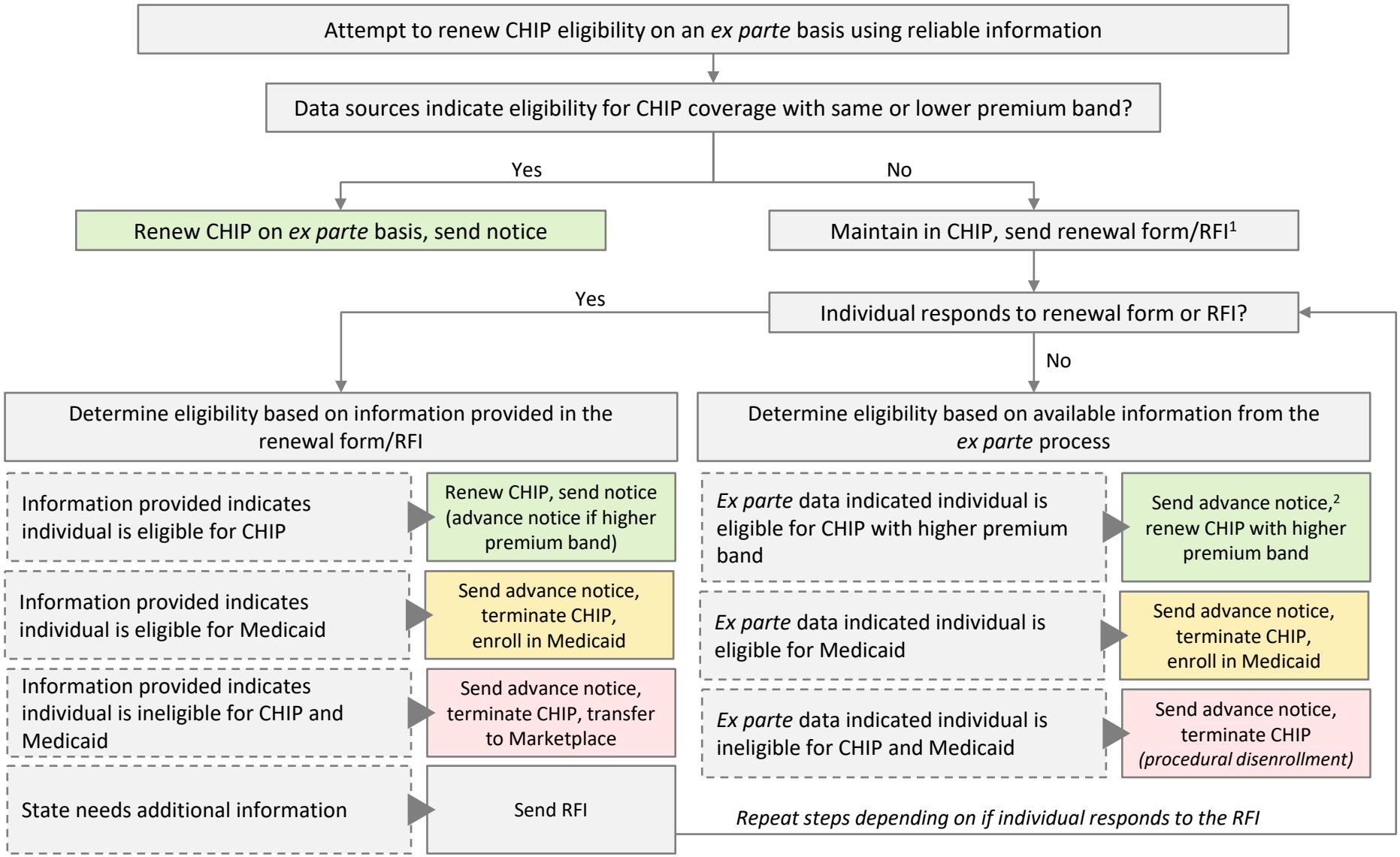
Additional Resources for States

Medicaid Renewal Process Flow



1. If the individual informs the state that the information relied upon is inaccurate, then the state must act on the updated information. (This also applies to the CHIP flow on the next slide.)

CHIP Renewal Process Flow



1. States must only send an RFI if the available data shows the child may be subject to a higher premium band. Otherwise, states must send a renewal form.
2. 42 C.F.R. § 457.340(e)(1)(ii) requires states to provide "sufficient" notice of suspension or termination of CHIP eligibility; § 457.1180 requires states to provide "timely" notice of determinations subject to review. To be sufficient and timely, states must provide advance notice to afford families an opportunity to request a review and prevent a gap in coverage in the event a beneficiary remains eligible.

State Resources

- CMS, Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders, March 2024.
- CMS, State Letter: Ensuring Compliance with Requirements to Conduct Medicaid and CHIP Renewal Requirements at the Individual Level, August 2023.
- CMS, Notice Considerations for Conducting Medicaid and Children's Health Insurance Program (CHIP) Renewals at the Individual Level, November 2023.
- CMS, State Health Official (SHO) Letter # 23-002, January 2023.
- CMS, Ex Part Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts, October 2022.
- CMS, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements, December 2020.

In addition to the resources above and citations included in this slide deck, states should refer to the following relevant regulations: 42 C.F.R §§:

- 435.905(b) and 457.340(e) regarding information provided in plain language and in an accessible and timely manner.
- 435.908 and 457.340 regarding assistance with application and renewal.
- 435.917 and 457.340 regarding notice of the agency's decision concerning eligibility, benefits, or services.
- 435.918 and 457.110 regarding use of electronic notices.