Medicaid and CHIP
MAC
Learning Collaboratives

Coverage Learning Collaborative

Medicaid and CHIP Renewals and Redeterminations

January 13, 2021
12:30-2:00 p.m. ET

Agenda

- Background
- Renewals
  - Renewals based on available information (*ex-parte* renewals)
  - Renewal forms
  - Consideration of eligibility on other bases
  - Reconsideration period
- Redeterminations based on changes in circumstances
- Discussion

Background

Objective of Presentation Materials

- Support states in meeting the current federal requirements as set forth in 42 C.F.R. §435.916 and 42 CFR §457.343 so that they can make accurate and timely redeterminations:
  - During renewals; and
  - When the state is made aware of a change in circumstances that may impact eligibility.
- Serve as a supplementary resource to the recently released CMCS Informational Bulletin on Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements

CMCS Center Informational Bulletin, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirement, December 2020, available on Medicaid.gov at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf

Renewals

Medicaid/CHIP Renewal Overview

States must periodically renew eligibility for all beneficiaries enrolled in Medicaid and CHIP. The state agency must begin the renewal process early enough in order complete a redetermination prior to the end of the eligibility period. States must first attempt 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, agency renews eligibility on an ***ex-parte* basis**
- ✗ If available information is insufficient to determine continued eligibility, agency sends a **renewal form** and requests additional information from the beneficiary.

42 CFR §435.916
42 CFR §457.343

Medicaid/CHIP Eligibility & Renewal Timeframes

Modified Adjusted Gross Income (MAGI) Beneficiaries & CHIP

- **Renewal Timeframe:** Once every 12 months (and no more frequently than once every 12 months)
- **Eligibility Period**: 12-month period that extends from the effective date of the last determination of eligibility, or to the end of the twelfth month following the effective date of the last eligibility determination, if the state has elected to provide full-month coverage

Non-MAGI Beneficiaries

- **Renewal Timeframe:** At least once every 12 months
- **Eligibility Period:** Up to a 12-month period (or shorter period elected by the state) that extends from the effective date of the last determination of eligibility, or up to the end of the twelfth month (or shorter period elected by the state) following the effective date of the last eligibility determination, if the state has elected to provide full-month coverage

42 C.F.R. §435.916
42 C.F.R. §457.343

Timeliness of Renewals

- States must establish renewal procedures and milestones that allow for adequate time to complete the renewal prior to the end of the beneficiary's eligibility period
- These timelines must account for the time needed for:
  - **Beneficiaries** to submit required documentation, if appropriate
  - The **agency** to verify information returned by the beneficiary and notify the beneficiary of its determination
- The agency may need additional time:
  - To evaluate eligibility on another basis (see slide 13) or if the beneficiary returns information late in the renewal process
  - If an administrative or other emergency beyond agency's control justifies a longer period
- If the agency cannot make the determination by the end of the eligibility period, it is expected to do so as **expeditiously as possible**
- The Medicaid agency must also continue to furnish Medicaid coverage to beneficiaries who have returned their documentation/renewal form prior to the end of their eligibility period unless and until they are determined to be ineligible

42 C.F.R. §435.916, §435.917, §435.930(b) and 42 C.F.R. 431, subpart E
42 C.F.R. §457.340(e) and §457.343

Determining Medicaid Renewal Date Example

John submits an application on **January 11, 2021**, in a state that provides full month coverage.

John is determined eligible for a MAGI-based Medicaid eligibility group with an effective date of coverage of **January 1, 2021**, and his eligibility period extends **until the end of the 12th month after his effective date of coverage to December 31, 2021.**

Agency begins renewal of John's eligibility early enough in order to complete the renewal process, including the required time for John to respond if necessary, by **December 31, 2021.**

Agency completes John's renewal by **December 5, 2021**, and renews John's eligibility **beginning on January 1, 2022, through December 31, 2022.**

If John had medical expenses in the three months prior to his effective date and had been provided retroactive coverage, any months of eligibility provided prior to application under the retroactive coverage period would not be counted as part of his eligibility period

Renewals Based on Available Information (*Ex-Parte*)

- Prior to contacting the beneficiary, state agencies are required to attempt to renew Medicaid eligibility for ***all beneficiaries*** 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 (*ex parte* renewal)
  - States have also referred to this type of renewal as an auto renewal or administrative renewal
  - Process does not require any beneficiary involvement
- If the agency is able to renew eligibility based on the available reliable information, the agency must provide notice to the beneficiary, which includes:
  - Eligibility determination
  - Information state used to determine eligibility and the basis of continued eligibility
  - Beneficiary obligation to inform state if any of the information in the notice is inaccurate or require changes
- Beneficiary does not need to sign or return notice if all information it contains is accurate

42 C.F.R. §435.916(a)(2) and (b)
42 C.F.R. §457.343

Reliable Information

- Reliable information includes, but is not limited to, available data sources
- Reliable information may also include recent information from other benefit programs or reliable sources for the ex-parte determination (e.g., Supplemental Nutrition Assistance Program (SNAP) recertification)
- The agency can renew based on available information in the beneficiary's account that is recent and reliable
- Information from the initial determination at application or the beneficiary's last renewal is not considered recent or reliable unless it relates to circumstances generally not subject to change (e.g., citizenship or satisfactory immigration status)

Renewal Form Requirements

The agency must provide beneficiaries for whom sufficient information is not available or information indicates may be ineligible with a renewal form and request information from the beneficiary

- The renewal form must be **prepopulated** with the most recent, reliable and relevant information about the beneficiary for **MAGI Medicaid and CHIP beneficiaries** whose eligibility cannot be renewed on an ex-parte basis
  - Agencies may but are not required to pre-populate renewal forms for **non-MAGI** beneficiaries
- Form may only require beneficiaries to provide information needed for renewal
- Agencies must include clear instructions on completing the renewal form, the need to sign the renewal form and required timeframes for submission:
  - **MAGI and CHIP:** At least 30 days
  - **Non-MAGI:** Reasonable time frame
- Beneficiaries must be able to return the signed renewal form through all modes of submission available for submitting an application (e.g., mail, in-person, online or phone)
- Similar to the application process, agencies cannot require an in-person interview as part of the renewal process for MAGI Medicaid beneficiaries

42 C.F.R. §435.905(b), §435.916(a)-(b), §435.916(e), and §435.952
42 C.F.R. §457.110(a) and §457.343

Consideration of Other Bases of Eligibility

- If a Medicaid beneficiary is no longer eligible for the category in which s/he has been enrolled, the Medicaid agency must consider whether the beneficiary may be eligible under one or more other eligibility groups covered by the state
- Similarly, if a state determines that a separate CHIP beneficiary is no longer eligible, it must screen the individual for eligibility in other insurance affordability programs, including Medicaid on all bases and Exchange coverage
- If the agency identifies any other eligibility group, but requires additional information to make the determination, it must request additional information and give the beneficiary a *reasonable amount of time* to provide the information
- If the agency is not able to complete a determination of eligibility on another basis before the end of the eligibility period, it must make the determination as *expeditiously as possible*
- The Medicaid agency may not terminate coverage and benefits must continue to be furnished under Medicaid until a beneficiary is found ineligible under all groups covered by the state or until the beneficiary does not timely provide requested information that is needed to make a determination

42 C.F.R. §435.916(e), §435.916(f)(1), and §435.930(b)
42 C.F.R. §457.110(a) and §457.343

Determining Eligibility on Other Basis Example 1

John is enrolled in a MAGI based group, and his renewal date is **June 30, 2021.** Medicaid agency starts the renewal process on **April 1, 2021**.

Agency has information that indicates John may no longer be eligible on a MAGI basis but has information indicating he may be eligible on a non-MAGI basis. State sends pre-populated renewal form and request for additional information on **May 7, 2021,** prior to making a determination of ineligibility.

John submits requested information to the agency on **May 21, 2021.** Agency processes the information provided by John to determine eligibility on all bases.

John is determined ineligible on **June 3, 2021.** Agency sends advance notice on **June 10, 2021**, and terminates John's coverage beginning on **July 1, 2021.**

Determining Eligibility on Other Basis Example 2

Prior to John's renewal date of **June 30, 2021,** Medicaid agency determines that he is no longer eligible for the group in which he is enrolled, and assesses whether he is eligible under a different eligibility group covered by the state.

On **May 7, 2021,** agency requests additional information from John needed to determine his eligibility under a different group.

John submits requested information to the agency on **June 28, 2021.** Agency continues to provide John coverage after his renewal date while processing the information to determine eligibility on all bases.

John is determined eligible for Medicaid under another eligibility group on **July 12, 2020.** John's new eligibility period begins **July 1, 2021, through June 30, 2022.**

Eligibility for Other Insurance Affordability Programs

Insurance Affordability Program Eligibility

- ✓ If a beneficiary is determined ineligible for Medicaid or CHIP, the agency must determine potential eligibility for other insurance affordability programs and transfer the account appropriately
- ✗ The agency does not need to determine eligibility for other insurance affordability programs for beneficiaries who fail to return the renewal form or other documentation in a timely manner
- ✗ The agency should not transfer accounts to the Marketplace for individuals who are terminated for procedural reasons (e.g., beneficiary does not return requested information)

42 C.F.R. §435.916(f)(2)
42 C.F.R. §457.343 and §457.350

Reconsideration Period

For MAGI Medicaid and CHIP beneficiaries whose eligibility has been terminated at renewal for failure to return the renewal form or other needed documentation requested, the agency 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** after the date of termination

- States may adopt a longer reconsideration period

The renewal form returned within the reconsideration period serves as an application, which means the agency must make a determination consistent with application timeliness standards

Effective dates of coverage for those determined eligible are:

- **Medicaid**: Date renewal was submitted or first day of the month the renewal form was returned consistent with the state's 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

For non-MAGI beneficiaries: States may, but are not required to provide a reconsideration period

42 C.F.R. §915 and §435.916(a)(3)(iii) and (b)
42 C.F.R. §457.340(g) and §457.343

Reconsideration Period Example

John fails to submit his renewal form by his renewal date of **June 30, 2021.**

Medicaid agency terminates John's Medicaid coverage as of **July 1, 2021.**

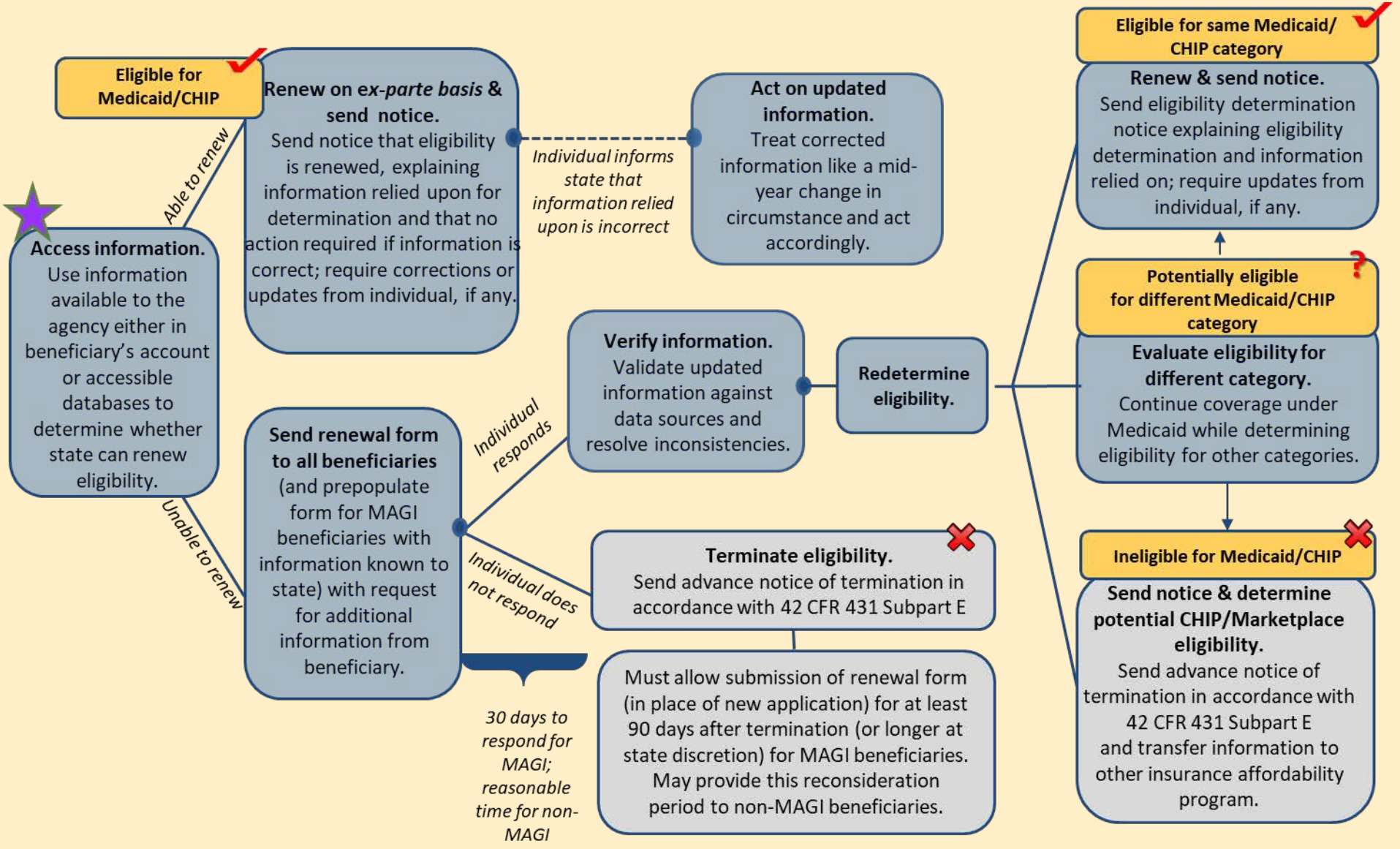
90-day reconsideration period begins

John returns his renewal form on **August 20, 2021.**

John is determined eligible for a MAGI-based Medicaid eligibility group on **September 10, 2021**, with an effective date of coverage of **August 1, 2021.***

*States must follow their practice for determining the effective date of eligibility at application. In this scenario, John lives in a state where the effective date is the first of the month of application.

Medicaid/CHIP Annual Renewal Process Flow



Redeterminations Based on Changes in Circumstances

Changes in Circumstances

States must have procedures in place to ensure beneficiaries make timely and accurate reports of any changes in circumstances that may impact eligibility. Beneficiaries must be able to report changes online, by phone, by mail, or in-person.

State agencies may also run periodic data checks throughout the eligibility period

If the agency receives information about a change during the year (from beneficiary, periodic data match or other reliable source):

- The agency must act promptly to redetermine eligibility
- To conduct the redetermination, the agency must only request information related to the change (all factors of eligibility not affected by the change are presumed unchanged)

If the agency has information about an anticipated change in circumstances that may impact eligibility, it must redetermine eligibility at the appropriate time based on such changes

For individuals the agency determines continue to be eligible following a change in circumstances, a new 12-month renewal period may begin if the agency has enough information available to renew eligibility with respect to all eligibility criteria, or the agency may retain the beneficiary's current eligibility period

42 C.F.R. §435.916(c) and (d) and 42 C.F.R. §435.940
42 C.F.R. §457.343 and §457.380(h)

Redeterminations Following Changes in Circumstances

- Once it receives information indicating a change, the agency must promptly evaluate whether the information received, if correct, would result in a loss of eligibility, higher cost sharing, or a reduction in benefits
- If the agency determines the information would impact eligibility, the agency must contact the beneficiary and give the beneficiary a reasonable period of time to provide information or other documentation to establish that the information received by the agency is not correct and that they continue to meet eligibility criteria
  - If beneficiary does not respond in a timely manner, the agency must provide advance notice of termination and appeal rights
  - If the beneficiary does timely respond to the agency's request, the agency must promptly evaluate all information and documentation before it redetermines the beneficiary's eligibility. If the beneficiary remains eligible, a notice indicating that the eligibility is not affected should be provided
- If the agency determines that the beneficiary no longer meets the eligibility requirements for the eligibility group under which they are receiving coverage, it must consider whether the beneficiary may be eligible under another eligibility group

42 C.F.R. §435.916(d) and §435.952
42 C.F.R. §457.343 and §457.380

Special Considerations for Pregnant Women

- Pregnant women covered under Medicaid through any eligibility group remain ***continuously eligible*** for Medicaid through the end of their ***post-partum period***, regardless of changes in income that would otherwise result in a loss of eligibility

- The steps the state must take to redetermine the women's Medicaid eligibility following their post-partum period differs depending on whether it ends ***prior to*** or ***after*** their renewal date:

Post Partum Ends Prior to Renewal Date

- The end of the post-partum period represents a change in circumstance between regularly scheduled renewals
- State follows same policies and procedures as any other change in circumstances to determine whether woman will remain eligible
- The renewal date stays the same at 12 months following her initial determination

Post-Partum Period: last day of the month in which a 60-day period, beginning on the last day of pregnancy, ends

Post Partum Ends After Renewal Date

- This typically will be the case for women who are enrolled in Medicaid when they become pregnant.
- State must conduct full renewal at the end of the post-partum period (see slide 18)

42 C.F.R. §435.170 and §435.916

Medicaid and CHIP Renewal CIB

For additional information, please see **CMCS Informational Bulletin "Medicaid and Children's Health Insurance Program Renewal Requirements"** on Medicaid.gov.

https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf

Discussion