



Medicaid and CHIP Renewals and Redeterminations



CMCS All-State Call

***December 8, 2020
3:00-4:00 p.m. ET***

*Slide deck content developed through
the Medicaid and CHIP Coverage
Learning Collaborative*

CMCS Informational Bulletin (CIB)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



CMCS Informational Bulletin

DATE: December 4, 2020

FROM: Anne Marie Costello, Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements

The purpose of this CMCS Informational Bulletin (CIB) is to remind states about current federal requirements and expectations codified in existing regulations at 42 C.F.R. §435.916 and §457.343 for completing redeterminations of eligibility for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. The Medicaid and CHIP fiscal year (FY) 2019 and 2020 Payment Error Rate Measurement (PERM) program improper payment rates, along with recent federal and state audits, have raised questions concerning state compliance with existing renewal requirements, including the inappropriate continued provision of eligibility for beneficiaries who have become ineligible due to a change in circumstances.¹ The PERM program measures improper payments in Medicaid and CHIP and produces statistically valid improper payment estimates that represent payments that did not meet statutory, regulatory, administrative, or other legally applicable requirements.

States must comply with renewal regulations, which set forth the responsibilities of states to conduct periodic renewals of eligibility for all Medicaid and CHIP beneficiaries and to redetermine eligibility between renewals when the state receives information about a change in a beneficiary's circumstances that may affect eligibility. These regulations are designed to ensure that states achieve high levels of program integrity and make efficient and appropriate use of federal and state dollars, by ensuring that only individuals who meet the Medicaid and CHIP eligibility standards remain enrolled.² The requirements also ease administrative burden on

- CMCS released the Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements CIB on December 4, 2020.

- The CIB reminds states about current federal renewal requirements for Medicaid and CHIP codified at:

- 42 C.F.R. §435.916
- 42 C.F.R. §457.343

Medicaid and CHIP Renewal CIB Contents

– Periodic Renewals of Eligibility

- Renewals based on reliable information (*ex parte* renewals)
- Renewals when sufficient information is not available
- Timeliness of renewals
- Considerations of other bases of eligibility
- Terminations for ineligible beneficiaries and reconsideration periods


– Redetermining Eligibility Based on Changes in Circumstances

- Interaction between redeterminations and eligibility periods for pregnant women

– Appendix

- Appendix A - Acting on Changes in Circumstances
- Appendix B - Frequently Asked Questions (FAQs) document

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 to 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 ***ex-parte*** basis
- ✗ If available information is insufficient to determine continued eligibility, agency sends a **renewal form** and requests additional information from the beneficiary.

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

Renewals Based on Available Information

- 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

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

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 enrollee 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

Eligibility for Other Insurance Affordability Programs

- ✓ 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)

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 the renewal form 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 renewal 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

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

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>