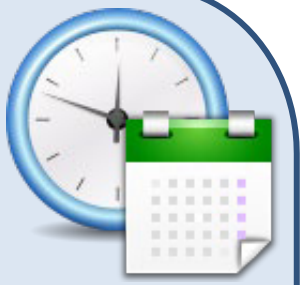
Overview: Medicaid and CHIP Eligibility Renewals

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
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- **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.

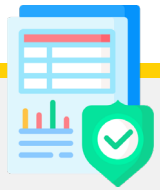
If the agency is able to renew eligibility based on the available reliable information, the agency must **provide timely and adequate notice to the beneficiary**, which includes:

- 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.

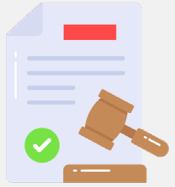
42 C.F.R. §§ 431.10, 435.1200(b),(e) and (h), 457.340(e)(1)(ii) and (f), 457.348, 457.350(b) and (e), 457.1180, and 600.330. CMS, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.

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
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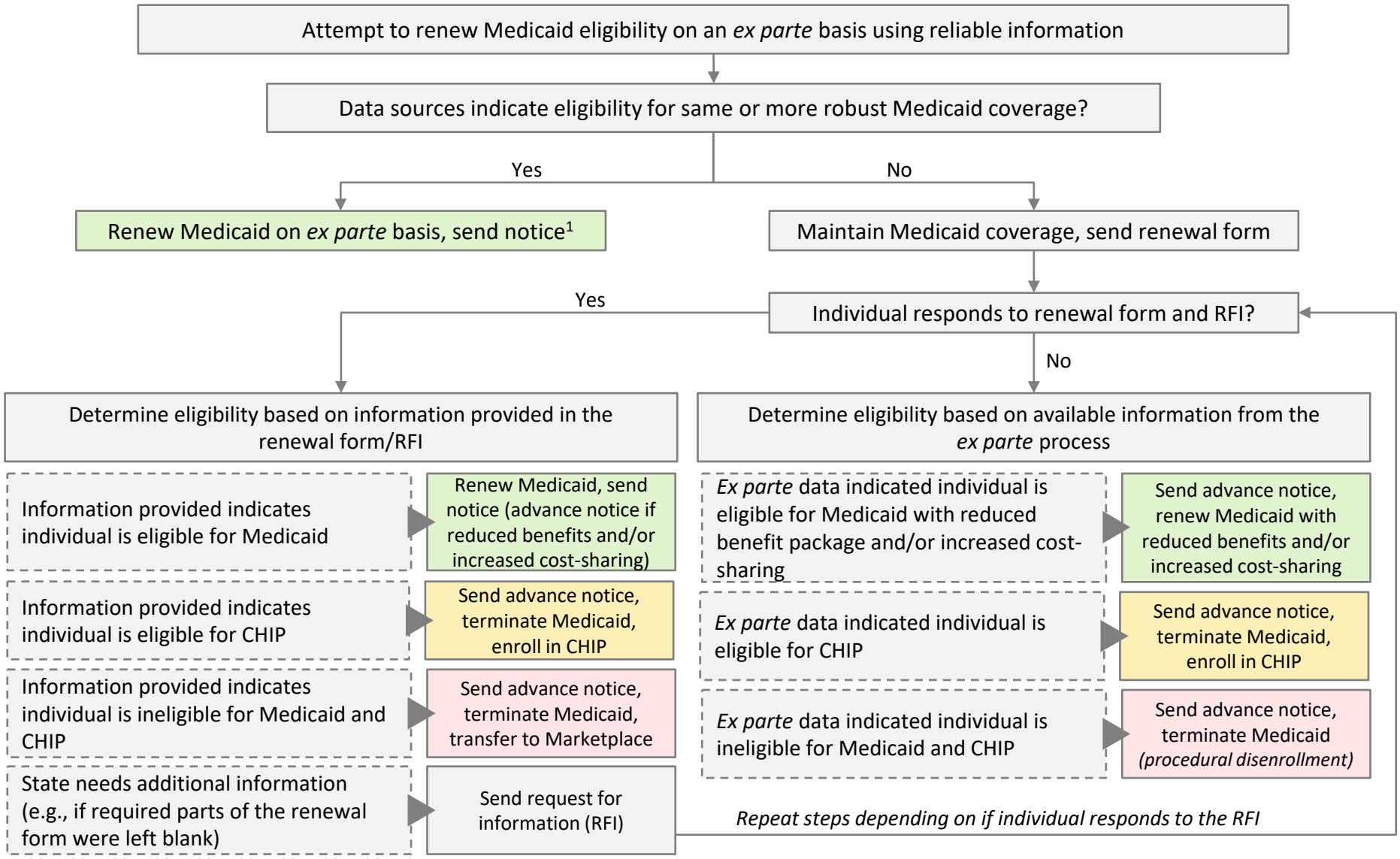
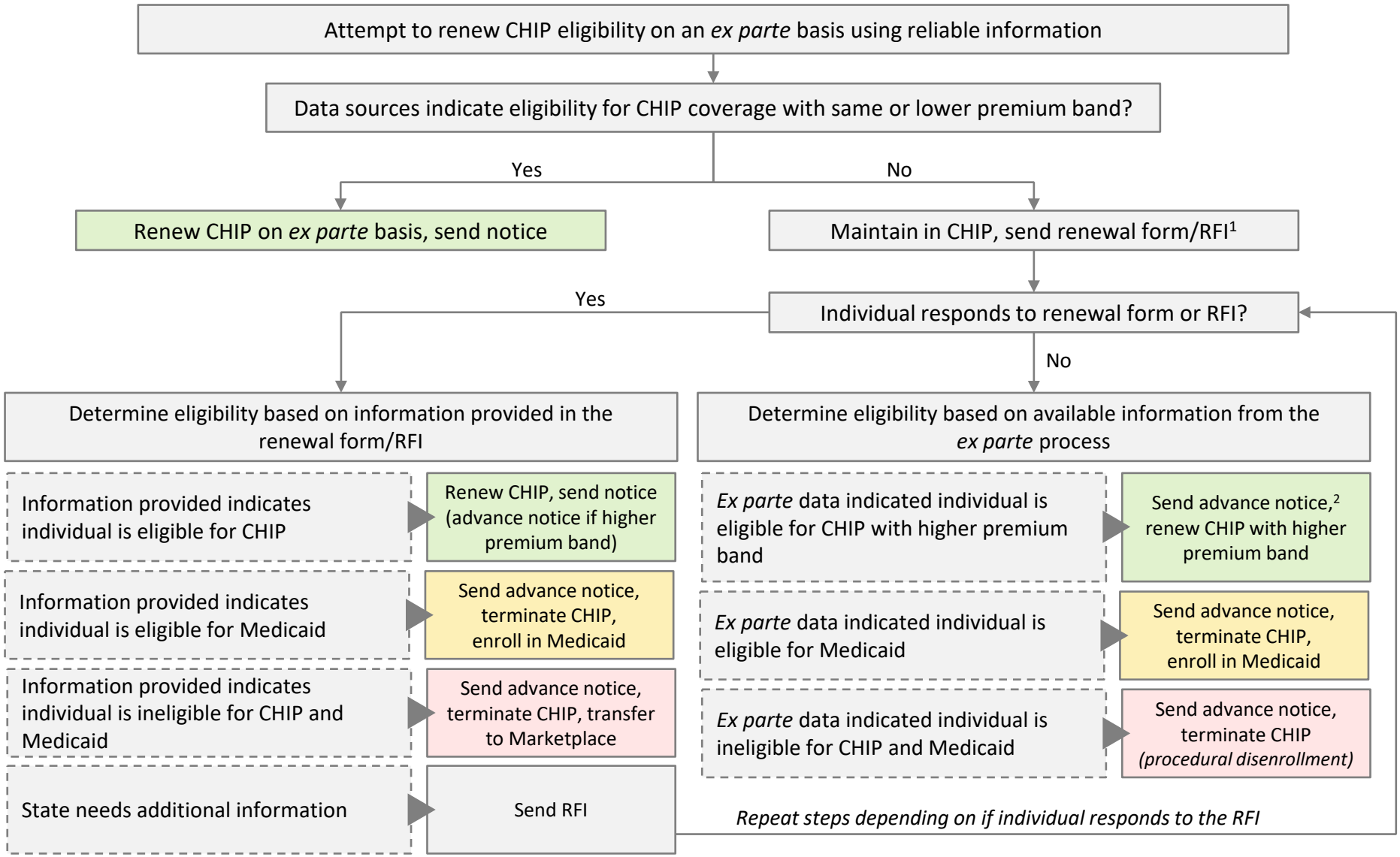
Additional Resources for States

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.