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

CMCS Informational Bulletin

DATE: March 15, 2024

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

SUBJECT: ***Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders***

As states continue conducting eligibility renewals following the end of the Medicaid continuous enrollment condition on March 31, 2023,[1] the Centers for Medicare & Medicaid Services (CMS) is sharing important reminders to states for conducting renewals consistent with federal Medicaid and Children's Health Insurance Program (CHIP) requirements. Adhering to these longstanding federal requirements is necessary to ensure Medicaid- and CHIP-eligible individuals retain their coverage during the state's "unwinding" period and beyond. 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 C.F.R. §§ 435.916 and 457.343, and as outlined in the CMCS Informational Bulletin (CIB), "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements."[2]

During the unwinding process, CMS has received questions from states, stakeholders, and external partners regarding the permissibility of certain practices during Medicaid and CHIP renewals. To clarify what is permitted under federal renewal requirements, both during and beyond unwinding, we are reiterating some of the relevant federal renewal requirements for state reference and outlining policy and operational practices below that are **not permitted** under existing federal Medicaid and CHIP redetermination regulations. We also provide, in the Appendix, illustrative examples of processes that are not permitted under federal requirements.

It is critical that states ensure their full compliance with federal renewal requirements in order to help individuals eligible for Medicaid or CHIP successfully renew their coverage. States that are currently relying on prohibited practices described in this CIB must change their practices as quickly as possible and should reach out to CMS for technical assistance. CMS stands ready to assist states with ensuring compliance with federal renewal requirements and adopting modifications and improvements to state systems that support continuity of coverage.

[1] CMS, CIB, "Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023," January 5, 2023, available at https://www.medicaid.gov/sites/default/files/2023-01/cib010523_1.pdf.
[2] CMS, CIB, "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements," December 4, 2020, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

Medicaid and CHIP Renewal Requirement Reminders

1. ***Do not terminate Medicaid or CHIP coverage for an individual who has returned their renewal form or documentation requested by the state within the eligibility period, even if processing the renewal form and documents will need to occur after the eligibility period has ended.***

States must continue to furnish Medicaid to individuals who have returned their renewal form or requested documentation **unless and until they are determined to be ineligible on all bases.**[3] If a renewal form and/or additional information is returned prior to the end of the eligibility period, the state must have a mechanism in place to ensure that coverage continues until the information received is evaluated and a final redetermination is made. If it is not possible for the state to make a determination before the renewal end date because the individual returned the renewal form and/or additional information too close to the end of the eligibility period, the state must maintain coverage until the state is able to either determine that the individual is ineligible on all bases or that the individual has not provided needed information or documentation in a timely manner. In instances where the state is not able to make a determination before the end of the individual's eligibility period, the state is expected to make determinations as expeditiously as possible. If the individual is disenrolled from coverage prior to the state making a final determination of eligibility, the state must **immediately** reinstate eligibility until a final determination has been completed and the individual has been determined to be ineligible.

2. ***Do not terminate Medicaid coverage without first determining eligibility on all other bases.***

If a state has sufficient information 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 one or more other eligibility groups covered by the state prior to terminating eligibility**.[4]

If the Medicaid agency identifies another eligibility group for which a beneficiary may be eligible, but requires additional information to make the determination, the state must maintain coverage in the group in which the individual is enrolled, request additional information from the individual, and give the individual a reasonable amount of time to provide the information.[5]

The Medicaid agency may not terminate an individual's coverage until: (1) 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 (2) the individual is provided advance notice and fair hearing rights regarding the termination. If the Medicaid program determines that the individual is ineligible for Medicaid on all bases, it must determine potential eligibility for other insurance affordability programs (e.g., CHIP or Marketplace coverage) and transfer that individual's electronic account to such program, as appropriate.[6]

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[3] States Medicaid agencies must continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible. 42 C.F.R. §§ 435.916(f); 435.930(b).
[4] 42 C.F.R. §§ 435.916(f); 435.930(b).
[5] 42 C.F.R. §§ 435.916(a)(3)(i)(B); 435.952(c).
[6] 42 C.F.R. §§ 435.916(f)(2); 435.1200; 457.350(b).

3. Do not require a new application from individuals who are eligible on the basis of Modified Adjusted Gross Income (MAGI) and who respond to a renewal request within 90 days after a procedural termination.

A state must reconsider eligibility for individuals who are eligible on the basis of MAGI and were disenrolled for failure to submit the renewal form or documentation requested by the state if the individual subsequently submits the necessary information within 90 days after the termination date.[7] **During this reconsideration period, a state must reconsider the individual's eligibility without requiring the individual to complete a new application.** As a reminder, for MAGI Medicaid and CHIP populations, states may elect to establish a reconsideration period that is longer than 90 days.[8] For non-MAGI Medicaid populations, states may also elect to establish a 90-day or longer reconsideration period.

4. Do not exclude an individual from ex parte renewal because wage data show that a household earner is working for an employer that is different from that reflected in the case record, if income remains below the applicable standard.

At renewal, states are required to first attempt to renew eligibility for all MAGI and non-MAGI Medicaid and CHIP beneficiaries based on reliable information available to the state agency, without requiring information from the individual.[9] **An individual continues to meet income eligibility requirements if the data sources at renewal indicate income is below the Medicaid or CHIP income eligibility levels.**[10] When verifying income using the reliable data source (e.g., quarterly wage data), the existence in the case record of income from a prior employer that is no longer present at renewal is not a valid reason to request additional information from the individual.[11] It is not uncommon for low-income individuals to change jobs, and the identity of an individual's employer is not a factor of eligibility. Further, a state's quarterly wage data system will return data for multiple employers if an individual holds multiple jobs, including data from the employer of record if the enrollee remains employed by that employer. Finally, consistent with regulations at 42 C.F.R. §§ 435.916(a)(2)(ii) and 457.343, the notice provided to the individual following the determination of eligibility on an *ex parte* basis must notify the enrollee of the obligation to inform the agency if any of the information contained in the notice is inaccurate. The agency must have procedures designed to ensure that enrollees make timely and accurate reports of any change in circumstances that may affect their eligibility.[12]

5. Do not exclude individuals from an ex parte renewal in Medicaid solely because the state has aligned renewal dates with those for the Supplemental Nutrition Assistance Program (SNAP) or other human services benefit programs.

At renewal, states are required to first attempt to renew eligibility for all beneficiaries based on reliable information available to the state agency without requiring additional information from

[7] 42 C.F.R. §§ 435.916(a)(3)(iii); 457.343.
[8] 42 C.F.R. §§ 435.916(a)(3)(iii); 457.343.
[9] 42 C.F.R. §§ 435.916; 457.343.
[10] 42 C.F.R. §§ 435.916(a); 457.343.
[11] 42 C.F.R. §§ 435.952(c); 457.380(d).
[12] 42 C.F.R. §§ 435.916(c); 457.343.

the individual.[13] **The *ex parte* renewal requirement applies to all beneficiaries, regardless of whether an individual is also enrolled in SNAP and/or other human services benefit programs**. If the *ex parte* review for the Medicaid enrollee is successful, the state must redetermine Medicaid eligibility and follow up with the SNAP redetermination separately. States may not delay the completion of a renewal or redetermination of eligibility for Medicaid pending provision of documentation or other requirements for SNAP or other human services programs that are not needed for Medicaid.[14]

6. Do 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 and request for information.

A state may not rely solely on data sources to disenroll individuals or to move individuals to the Marketplace, CHIP, or a group with a reduced Medicaid benefit package or increased premiums or cost sharing.[15] States must consider all bases of eligibility prior to making a determination of ineligibility and must determine potential eligibility for other insurance affordability programs for individuals found to be ineligible.[16] **In circumstances where an *ex parte* review suggests eligibility for another program or another Medicaid eligibility group with reduced benefits or higher cost sharing, states are required to: (1) maintain the individual in their existing Medicaid eligibility group or CHIP premium band; and (2) send the individual a renewal form and request for information.**[17] If the individual returns the renewal form, the state must determine eligibility based on the information provided in the renewal form. If the information provided shows that the individual remains eligible in their current Medicaid eligibility group, coverage should be renewed in that group. If the information provided shows that the individual is now eligible for a new eligibility group with a reduced benefit package or higher cost sharing, the state should move the individual to the new eligibility group and renew eligibility in that group. The state must send an advance notice informing the individual of the change in eligibility including the covered benefits and/or cost sharing, the reasons for the change, and the opportunity to request a fair hearing to appeal the change in eligibility status or level of benefits or cost sharing. (See below for more information on advance notice and fair hearing rights.)

If the individual does not return the renewal form, the state must then move the individual to the new eligibility group, which may include eligibility groups with a reduced benefit package or higher cost sharing, based on the data review. The state must send an advance notice informing the individual of the change in eligibility, including the covered benefits and/or cost sharing, the reasons for the change, and the opportunity to request a fair hearing to appeal the change in eligibility status or level of benefits or cost sharing.

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[13] 42 C.F.R. §§ 435.916(a); 457.343.
[14] CMS, "Opportunities to Support Unwinding Efforts for States with Integrated Eligibility Systems and/or Workforces," September 16, 2022, available at https://www.medicaid.gov/sites/default/files/2022-09/opp-unwind-eff-st-integ-elig-sys-workforce.pdf.
[15] 42 C.F.R. §§ 435.952(d); 457.380(d)
[16] 42 C.F.R. §§ 435.916(f).
[17] 42 C.F.R Part 431 Subpart E; CMS, "Transitioning Individuals Within Medicaid Eligibility Groups and Between Medicaid and CHIP at Renewal," December 2023, available at https://www.medicaid.gov/sites/default/files/2023-12/transitions-in-medicaid-and-chip.pdf.

7. Do not terminate coverage, or take other adverse action, until after advance notice, including an explanation of fair hearing rights, is provided.

States must provide all beneficiaries with timely and adequate written notice of any decision affecting eligibility, such as a denial, termination, or suspension of eligibility.[18] **States must provide a notice of adverse action at least 10 days prior to implementing the action.**[19] Adverse actions include termination, suspension, or reduction in eligibility or services/benefits; and increases in premiums or cost sharing.[20] An adverse action notice must include:

- A description of the adverse action that the agency intends to take;
- The effective date of such action;
- A clear statement of the specific reason supporting the intended action;
- The specific regulations or changes in federal or state law supporting such action;
- An explanation of the individual's right to a fair hearing (including the right to request an expedited fair hearing), how to request a fair hearing, who can assist the individual at the hearing, circumstances under which benefits will be provided pending the outcome of the fair hearing, and the timing for taking final administrative action; and
- Coordinated content on potential eligibility for another insurance affordability program and transfer of the individual's account to such program.[21]

For Medicaid eligibility determinations based on MAGI **that are not pending** a non-MAGI eligibility determination, the adverse action notice must include: basic information on non-MAGI bases of eligibility covered by the state; services and benefits afforded to individuals eligible on a non-MAGI basis; and the process for requesting a non-MAGI determination.[22] For MAGI determinations **that are pending** a non-MAGI eligibility determination, the adverse action notice must include an explanation that the agency is continuing to evaluate Medicaid eligibility on all other bases and that eligibility and enrollment in other insurance affordability programs will not affect the non-MAGI eligibility determination.[23]

8. Do not conduct ex parte renewals at the household level.

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**.[24] Regulations related to the determination of eligibility also specify that the agency must furnish Medicaid "[f]or each individual…whose eligibility is being renewed," if found eligible.[25] Further, states may not

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[18] 42 C.F.R. §§ 435.917(a); 457.340(e).
[19] 42 C.F.R. § 431.211.
[20] 42 C.F.R. § 431.201.
[21] 42 C.F.R. §§ 435.4; 435.917(b)(2); 431.206(b); 431.210; 431.211-214; CMS, "Notice Considerations for Conducting Medicaid and Children's Health Insurance Program (CHIP) Renewals at the Individual Level," November 2023, available at https://www.medicaid.gov/sites/default/files/2023-11/individual-lvl-renewal-notices.pdf.
[22] 42 C.F.R. § 435.917(c).
[23] 42 C.F.R. § 435.1200(h).
[24] 42 C.F.R. §§ 435.916(a)(2); 457.343; CMS, "Notice Considerations for Conducting Medicaid and Children's Health Insurance Program (CHIP) Renewals at the Individual Level," November 2023, available at https://www.medicaid.gov/sites/default/files/2023-11/individual-lvl-renewal-notices.pdf; CMS, "Scenarios: The Intersection of Continuous Eligibility and Individual Level Renewal Processes," October 18, 2023, available at https://www.medicaid.gov/media/164691.
[25] 42 C.F.R. §§ 435.911(c); 457.350(b)(1).

require additional information to renew coverage for those who have already been determined eligible based on available reliable information even if additional information is required to renew coverage for other members of the household.[26]

9. Do not provide fewer than 30 days for the response to a renewal form for individuals whose eligibility is based on MAGI.

States must provide MAGI beneficiaries a minimum of 30 days from the date of the prepopulated renewal form to return the form and any requested information.[27] Non-MAGI beneficiaries must be provided with a reasonable period of time (e.g., at least 30 days) to return their renewal form and any required information.[28] States are encouraged to provide a longer period of time for both their MAGI and non-MAGI beneficiaries (e.g., 60 or 90 days) to give enrollees enough time to complete and return the renewal form and the requested information.

CMS also 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 should also 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 encourage individuals to respond to the renewal form timely.

10. Do not send renewal forms, adverse action notices, and other notices only in English, without providing language services, to households that have requested information in other languages, or fail to ensure effective communication with individuals with disabilities.

States must take reasonable steps to ensure meaningful access to Medicaid and CHIP for individuals with limited English proficiency (LEP) and must provide effective communication to individuals with disabilities.[29] This may include taking the following actions:

- Provide program information in plain language, timely, and in a manner that is accessible to enrollees with LEP at no cost to the individual;[30]
- Provide language services, including oral interpretation and written translations;[31]
- Inform individuals that language services are available and how individuals can access these services through, at a minimum, providing taglines in non-English languages;[32]
- Provide information accessibly to individuals with disabilities through the provision of auxiliary aids and services at no cost to the individual;[33] and

[26] 42 C.F.R. § 435.916(e).
[27] 42 C.F.R. §§ 435.916(a)(3)(i)(B); 457.343.
[28] 42 C.F.R. § 435.952.
[29] 42 C.F.R. §§ 435.905(b); 435.907(g); 435.916(g); 435.917(a); 435.956(b), 431.206(e), 431.205(e).
[30] 42 C.F.R. §§ 435.905(b); 457.110(a).
[31] 42 C.F.R. § 435.905(b)(1).
[32] 42 C.F.R. § 435.905(b)(3).
[33] 42 C.F.R. § 435.905(b)(2); 457.110(a)

- Provide renewal forms, notices (e.g., eligibility and adverse action), and the fair hearing process in a format that is accessible to individuals with LEP.[34]

Federal laws and regulations also require Medicaid and CHIP agencies to ensure communication with individuals with disabilities is as effective as communication with other individuals, including by providing information and communication technology accessible to individuals with disabilities (e.g., websites and information kiosks).[35] Effective communication may require states to provide appropriate auxiliary aids and services, including but not limited to Braille, large print, captioning, plain language explanations, qualified sign language interpreters, qualified readers, qualified speech-to-speech transliterators, and accessible websites, at no cost to the individual. When interpreting services are required, they must be provided free of charge and in a timely manner.[36] "Qualified" generally means having the ability to interpret effectively, accurately, and impartially using any necessary specialized vocabulary.

State Action

CMS strongly encourages all states to review their renewal processes, including standard operating procedures, renewal forms, and notices, and to test the renewal logic in eligibility systems to confirm that processes and systems are compliant with these existing federal requirements. If states identify any areas in which such processes are not compliant, or there are any questions about their compliance, please reach out to CMCS immediately. CMCS is available to provide technical assistance to states in remediating problems at the policy, operational, and systems levels.

We remind states that the single state Medicaid agency is responsible for administering or supervising the administration of the Medicaid state plan, including determining eligibility at initial application, regular renewals, and following changes in beneficiary circumstances. States are permitted to delegate all or part of this responsibility to certain state or local agencies. If the Medicaid agency does so, it must: ensure the delegated agency complies with all relevant laws, regulations, and policies; establish a written agreement with those agencies; and take corrective action in the case of a delegated agency that is not complying with all requirements under the written interagency agreement. However, the single state Medicaid agency ultimately is responsible for exercising appropriate oversight to ensure that eligibility determinations and renewals are compliant with the Medicaid statute, federal regulations, and the Medicaid state plan.

Failure to comply with the statutory and regulatory requirements reiterated in this bulletin could lead to CMS taking compliance action, including under Sections 1902(tt)(2) and/or 1904 of the

[34] 42 C.F.R. §§ 435.907(g); 435.916(g); 435.917(a); 435.956(b); 431.206(e); 431.205(e).
[35] Specifically, these laws require that programs must be accessible to and usable by people with disabilities (Title II, Section 504); communication with individuals with disabilities must be as effective as it is with others (Title II); reasonable steps must be taken to provide meaningful access to LEP individuals (Section 1557; 2003 United States Department of Health and Human Services (HHS) LEP Guidance (infra n. 21), and individuals must be provided with an equal opportunity to participate in and benefit from programs (Title VI, Section 1557, Title II, Section 504).
[36] HHS Office for Civil Rights, State Health Official Letter, "Ensuring Language Access for Limited English Proficient (LEP) Individuals and Effective Communication for Individuals with Disabilities During the States' Unwinding of the Medicaid Continuous Enrollment Condition," April 4, 2023, available at https://www.hhs.gov/sites/default/files/medicaid-unwinding-letter.pdf.

Social Security Act. Such an action may include a requirement to submit a corrective action plan, and, if the state fails to submit or implement such a plan, civil money penalties.

Closing

CMS is committed to ensuring that eligible individuals remain enrolled in Medicaid and CHIP and appreciates states' efforts to simplify and streamline renewal practices while maintaining compliance with federal requirements. We stand ready to provide ongoing assistance and support to our state partners to improve state systems and address any issues that are identified. We also remind states that 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 bulletin. FFP at a 75 percent matching rate is available for state expenditures on operating such systems. CMS is also available to provide ongoing assistance to states to support state efforts to achieve compliance. For additional questions, please email the CMS Unwinding Mailbox at CMSUnwindingSupport@cms.hhs.gov.

Illustrative Examples of Processes Not Permitted Under Medicaid and CHIP Renewal Requirements

March 2024

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Objective

The objective of these slides is to remind states of certain renewal requirements and provide illustrative examples of state policy and operational processes that are **not permitted** under federal Medicaid and CHIP redetermination requirements.

These slides are a companion to the CMCS Informational Bulletin: *Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders,* released on March 15, 2024

States that are currently relying on any of the following prohibited processes must change their processes as quickly as possible and should reach out to CMS for technical assistance.

Medicaid and CHIP Renewal Requirement Reminders

#1	Do not terminate Medicaid or CHIP coverage for an individual who has returned their renewal form or documentation requested by the state within the eligibility period, even if processing the renewal form and documents will need to occur after the eligibility period has ended.
#2	Do not terminate Medicaid coverage without first determining eligibility on all other bases.
#3	Do not require a new application from individuals who are eligible on the basis of Modified Adjusted Gross Income (MAGI) and who respond to a renewal request within 90 days after a procedural termination.
#4	Do not exclude an individual from *ex parte* renewal because wage data show that a household earner is working for an employer that is different from that reflected in the case record, if income remains below the applicable standard.
#5	Do not exclude individuals from an *ex parte* renewal in Medicaid solely because the state has aligned renewal dates with those for the Supplemental Nutrition Assistance Program (SNAP) or other human services benefit programs.
#6	Do 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 and request for information.
#7	Do not terminate coverage, or take other adverse action, until after advance notice, including an explanation of fair hearing rights, is provided.
#8	Do not conduct *ex parte* renewals at the household level.
#9	Do not provide fewer than 30 days for the response to a renewal form for individuals whose eligibility is based on MAGI.
#10	Do not send renewal forms and other notices only in English, without providing language services, to households that have requested information in other languages or fail to ensure effective communication with individuals with disabilities.

#1: Do not terminate Medicaid or CHIP coverage for an individual who has returned their renewal form or documentation requested by the state within the eligibility period, even if processing the renewal form and documents will need to occur after the eligibility period has ended.

States must continue to furnish Medicaid to individuals who have returned their renewal form or requested documentation unless and until they are determined to be ineligible on all bases.

Illustrative Scenario

- Elizabeth is enrolled in Medicaid with an eligibility period end date of June 30th. The state is unable to complete her renewal on an *ex parte* basis and sends her a renewal form and request for documentation on May 15th.
- Elizabeth returns her renewal form on June 29th, but the state is unable to review her information before the scheduled end of her eligibility period the following day.
- ✗ As a result, the state disenrolls Elizabeth from coverage on June 30th.
- ✓ The state must keep Elizabeth enrolled in Medicaid, past June 30th, until it has reviewed her renewal form and any additional documentation she submitted. If she is found to be ineligible on all bases, the state can then disenroll her from Medicaid after providing advance notice that includes fair hearing rights.

Source: 42 C.F.R. §§ 435.916(f); 435.930(b).

#2: Do not terminate Medicaid coverage without first determining eligibility on all other bases.

If a state has sufficient information 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 one or more other eligibility groups covered by the state prior to terminating eligibility.

Illustrative Scenario

- Mary is enrolled in Medicaid on the basis of a disability. At renewal, the state is unable to complete an *ex parte* renewal and sends her a renewal form to complete.
- Mary returns the renewal form and provides information that indicates she is financially ineligible for coverage on the same basis. However, Mary is 55 years old and may potentially be eligible for a MAGI eligibility group (e.g., the adult group or family planning eligibility group).
- ✗ Instead of determining her eligibility on a MAGI basis, the state terminates coverage and transfers her account to the Marketplace.
- ✓ The state must assess Mary's eligibility for other eligibility groups (and may request additional information, as needed) prior to termination and cannot disenroll her from Medicaid when she may potentially be eligible for another group. If she is found to be ineligible on all bases, the state can then disenroll her from Medicaid after providing advance notice that includes fair hearing rights and can transfer her account to the Marketplace.

Source: 42 C.F.R. §§ 435.916(a)(3)(i)(B); 435.916(f); 435.930(b); 435.952(c); 435.1200; 457.350(b).

#3: Do not require a new application from individuals who are eligible on the basis of MAGI and who respond to a renewal request within 90 days after a procedural termination.

A state must reconsider eligibility for individuals who are eligible on the basis of MAGI and were disenrolled for failure to submit the renewal form or documentation requested by the state if the individual subsequently submits the necessary information within 90 days after the termination date.

Illustrative Scenario

- Paul is disenrolled from Medicaid on April 30th for non-response to a renewal form.
- On June 5th, Paul visits a pharmacy and realizes he no longer has coverage. He immediately calls the Medicaid agency to complete his renewal by phone.
- ✗ The state call center representative insists that Paul complete a new application and walks him through questions about his age, household size, and citizenship—information that the state already has.
- ✓ If Paul provides information needed to complete his overdue renewal by phone, the Medicaid agency must redetermine his eligibility based on such information and submission of needed documentation. Paul was disenrolled from Medicaid for a procedural reason and attempted to complete his renewal 35 days after termination, which is within the 90-day reconsideration period. As such, when Paul contacted the call center, his renewal should have been completed based on the information he provided.

Source: 42 C.F.R. §§ 435.916(a)(3)(iii); 457.343.

#4: Do not exclude an individual from *ex parte* renewal because wage data show that a household earner is working for an employer that is different from that reflected in the case record, if income remains below the applicable standard.

An individual continues to meet income eligibility requirements if the data sources at renewal indicate income is below the Medicaid or CHIP income eligibility levels. When verifying income using the reliable data source (e.g., quarterly wage data), the existence in the case record of income from a prior employer that is no longer present at renewal is not a valid reason to request additional information from the individual.

Illustrative Scenario

- Eliana reported income from her job at Martha's Floral Kingdom when she applied for Medicaid 12 months ago. Her income was verified through electronic data sources, and she was enrolled in the adult group.
- At renewal, quarterly wage data pinged during an *ex parte* review indicates that Eliana still has income below 133% of the FPL but now works at Joe's Party Palace. There is no information about income from Martha's Floral Kingdom or other sources.
- ✗ The state sends Eliana a renewal form to complete and return with additional information on income and employment.
- ✓ The state must renew Eliana on an *ex parte* basis if all other eligibility requirements are met because income information from available reliable data sources indicates she continues to be income eligible for Medicaid.

Source: 42 C.F.R. §§ 435.916; 435.952(c); 457.343; 457.380(d).

#5: Do not exclude individuals from an *ex parte* renewal in Medicaid solely because the state has aligned renewal dates with those for SNAP or other human services benefit programs.

The *ex parte* renewal requirement applies to all beneficiaries, regardless of whether an individual is also enrolled in SNAP and/or other human services benefit programs. If the *ex parte* review for the Medicaid beneficiary is successful, the state must redetermine Medicaid eligibility and follow up with the SNAP redetermination separately.

Illustrative Scenario

- Marcus is enrolled in both Medicaid and SNAP. His renewal/recertification periods are aligned across programs, with a renewal date of July 31st.
- In early June, to begin the renewal process for both programs, the state sends Marcus a combined renewal form to complete and return. The form includes questions needed to determine Marcus' continued eligibility for Medicaid and SNAP.
- The state must initiate Marcus' Medicaid renewal with an *ex parte* review. If the state agency is able to redetermine Medicaid eligibility based on available data, it must do so. If the state agency is unable to redetermine eligibility based on available information, the state must then send him a prepopulated renewal form. The state cannot delay Marcus' renewal because of SNAP requirements, such as submitting income documentation.

Source: 42 C.F.R. §§ 435.916(a); 457.343; CMS, "Opportunities to Support Unwinding Efforts for States with Integrated Eligibility Systems and/or Workforces," September 16, 2022.

#6: Do 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 and request for information.

A state may not rely solely on data sources to disenroll individuals or to move individuals to the Marketplace, CHIP, or a group with a reduced Medicaid benefit package or increased premiums or cost sharing. In circumstances where an *ex parte* review suggests eligibility for another program or another Medicaid eligibility group with reduced benefits or higher cost sharing, states are required to: (1) maintain the individual in their existing Medicaid eligibility group or CHIP premium band; and (2) send the individual a renewal form and request for information.

Illustrative Scenario

- The state initiates Ramona's renewal with an *ex parte* review.
- Quarterly wage data pinged during Ramona's *ex parte* review indicates that she has income above 133% of the FPL. Ramona, who is enrolled in the adult group, appears to be potentially eligible for the family planning eligibility group with a reduced benefit package.
- ✗ The state moves Ramona into the family planning eligibility group without first sending her a renewal form and request for information.
- ✓ The state must maintain Ramona in the adult group and send her a renewal form and request for information. If Ramona responds to the renewal form, the state must redetermine eligibility based on information provided. If Ramona does not respond to the renewal form, the state must rely on the data sources and transition her to the family planning eligibility group.

Source: 42 C.F.R. §§ 435.952(d); 435.916(f); 457.380(d); Part 431 Subpart E; CMS, "Transitioning Individuals Within Medicaid Eligibility Groups and Between Medicaid and CHIP at Renewal," December 2023.

#7: Do not terminate coverage, or take other adverse action, until after advance notice, including an explanation of fair hearing rights, is provided.

States must provide all beneficiaries with timely and adequate written notice of any decision affecting eligibility, such as a denial, termination, or suspension of eligibility. States must provide a notice of adverse action at least 10 days prior to implementing the action.

Illustrative Scenario

- Anna returns her renewal form to the state and provides information that indicates she is financially ineligible for coverage under her current eligibility group. The state determines that Anna is not eligible for her current eligibility group or on any other basis.
- As a result, the state disenrolls Anna from Medicaid before sending a notice informing her of the basis of the state's determination.
- The state must provide Anna a written notice of adverse action, including an explanation of her fair hearing rights, at least 10 days before terminating her eligibility.

Source: 42 C.F.R. §§ 431.201; 431.206(b); 431.210; 431.211; 431.211-214; 435.4; 435.917(a); 435.917(b)(2); 435.917(c); 435.1200(h); 457.340(e); CMS, "Notice Considerations for Conducting Medicaid and Children's Health Insurance Program (CHIP) Renewals at the Individual Level," November 2023.

#8: Do not conduct *ex parte* renewals at the household level.

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.

Illustrative Scenario

- ○ While available data indicate that Carlos, a child in a household with two adult parents enrolled in Medicaid, continues to be eligible for Medicaid, the state is unable to determine continued eligibility for Carlos' parents based on the data.
- ✗ The state sends a renewal form requesting information from all household members. When the renewal form is not returned, the state disenrolls all individuals in the household, including Carlos.
- ✓ The state must determine Carlos eligible through the *ex parte* process at the individual level. The state must send the renewal form to Carlos' parents and ask for the minimum information required to determine their eligibility. When the renewal form is not returned, the state must provide advance notice and fair hearing rights to Carlos' parents before terminating their coverage.

Source: 42 C.F.R. §§ 435.911(c); 435.916(a)(2); 435.916(e); 457.343; 457.350(b)(1); CMS, "Notice Considerations for Conducting Medicaid and Children's Health Insurance Program (CHIP) Renewals at the Individual Level," November 2023; CMS, "Scenarios: The Intersection of Continuous Eligibility and Individual Level Renewal Processes," October 18, 2023.

#9: Do not provide fewer than 30 days for the response to a renewal form for individuals whose eligibility is based on MAGI.

States must provide MAGI beneficiaries a minimum of 30 days from the date of the prepopulated renewal form to return the form and any requested information. Non-MAGI beneficiaries must be provided with a reasonable period of time (e.g., at least 30 days) to return their renewal form and any required information.

Illustrative Scenario

- Priyanka is enrolled in Medicaid on a MAGI basis, with an eligibility period ending on January 31st.
- The state begins Priyanka's annual Medicaid renewal in late December and is unable to redetermine her eligibility on an *ex parte* basis.
- ✗ The state mails Priyanka a renewal form dated January 1st and requests a response by January 21st. Priyanka does not return the form by January 21st, and the state disenrolls her from Medicaid at the end of the month. The state has only given Priyanka 20 days (from January 1st to January 21st) to respond to the renewal form.
- ✓ The state must give Priyanka at least 30 days from the date of the renewal form to respond, which is January 31st. States are encouraged to provide longer periods of time to take into account mailing time and enable individuals more time to complete and return the renewal form.

Source: 42 C.F.R. §§ 435.916(a)(3)(i)(B); 435.952; 457.343.

#10: Do not send renewal forms and other notices only in English, without providing language services, to households that have requested information in other languages or fail to ensure effective communication with individuals with disabilities.

States must take reasonable steps to ensure meaningful access to Medicaid and CHIP for individuals with limited English proficiency (LEP) and must provide effective communication to individuals with disabilities.

Illustrative Scenario

- Jenny is enrolled in Medicaid, and her primary written and spoken language is Mandarin Chinese.
- Jenny requests that forms and notices related to her Medicaid coverage be provided to her in Mandarin.
- ✗ The state is not able to provide the renewal form translated into Mandarin, since it has only pre-written translations in English and Spanish. The state does not offer other language services either.
- ✓ The state must provide language services for Jenny, which could include oral interpretation or written translation of the renewal form in Mandarin, to ensure meaningful access to coverage.

Source: 42 C.F.R. §§ 431.206(e), 431.205(e); 435.905(b); 435.907(g); 435.916(g); 435.917(a); 435.956(b), 457.110(a); HHS Office for Civil Rights, State Health Official Letter, "Ensuring Language Access for Limited English Proficient (LEP) Individuals and Effective Communication for Individuals with Disabilities During the States' Unwinding of the Medicaid Continuous Enrollment Condition," April 4, 2023.

CMS Resources to Support States with Renewals

- Compilation of CMS Resources to Support State Implementation of Renewal Mitigation Strategies from 2023
- CMCS Informational Bulletin: Ensuring Eligible Children Maintain Medicaid and Children's Health Insurance Program Coverage from December 18, 2023
- State Letter: Ensuring Compliance with Requirements to Conduct Medicaid and CHIP Renewal Requirements at the Individual Level from August 30, 2023
- Transitioning Individuals Within Medicaid Eligibility Groups and Between Medicaid and CHIP at Renewal Slide Deck from December 18, 2023
- Medicaid and CHIP Renewals and Redeterminations Slide Deck from Learning Collaborative Meeting on January 13, 2021
- Medicaid and CHIP Renewals and Redeterminations Slide Deck from All State Call on December 8, 2020
- CMCS Informational Bulletin: Medicaid and CHIP Renewal Requirements from December 4, 2020

See the CMS Unwinding and Returning to Regular Operations after COVID-19 webpage for more information and additional resources.