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## ***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.<sup>1</sup> 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.<sup>2</sup> The requirements also ease administrative burden on

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<sup>1</sup> CMS Fact Sheet: 2019 Estimated Improper Payment Rates for Centers for Medicare & Medicaid Services (CMS) Programs. November 18, 2019. Available at <https://www.cms.gov/newsroom/fact-sheets/2019-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs>; FY 2020 HHS Agency Financial Report. November 13, 2020. Available at <https://www.hhs.gov/sites/default/files/fy-2020-hhs-agency-financial-report.pdf>. Examples of recent federal and state audits are available at [https://www.la.la.gov/PublicReports.nsf/1CDD30D9C8286082862583400065E5F6/\\$FILE/0001ABC3.pdf](https://www.la.la.gov/PublicReports.nsf/1CDD30D9C8286082862583400065E5F6/$FILE/0001ABC3.pdf), <https://oig.hhs.gov/oas/reports/region7/71604228.pdf>, <https://oig.hhs.gov/oas/reports/region5/51800026.pdf>, <https://oig.hhs.gov/oas/reports/region4/41806220.pdf>, and <https://oig.hhs.gov/oas/reports/region5/51700008.pdf>.

<sup>2</sup> During the 2019 Novel Coronavirus (COVID-19) Public Health Emergency (PHE), the requirement to ensure only eligible individuals remain enrolled is temporarily modified under the Families First Coronavirus Act for states receiving a temporary 6.2 percentage point FMAP increase. Section 6008(b)(3) of the FFCRA generally prevents states from terminating coverage for individuals enrolled as of or after March 18, 2020, through the end of the month in which the COVID-19 PHE ends as a condition of the temporary FMAP increase. See Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-9912-IFC) for additional

states by minimizing the churn of beneficiaries on and off Medicaid and CHIP coverage when their eligibility is terminated at renewal for procedural reasons, and they then reapply or return required information during the reconsideration period to establish that they continue to meet eligibility requirements.

Accurate and timely eligibility redeterminations are critical to ensuring that states provide medical and child health assistance only to individuals who remain eligible and avoid making payments for ineligible individuals. Since 2014, states have made significant progress on the development and implementation of modernized enrollment and renewal systems and processes. These efforts have improved states' ability to leverage electronic data to verify eligibility information in a timely manner and make accurate Medicaid and CHIP eligibility determinations and redeterminations to ensure that only eligible individuals remain enrolled. Despite these efforts, a contributing factor driving the FY 2019 and 2020 PERM improper payment rates in Medicaid and CHIP is states' failure to conduct timely and accurate redeterminations.<sup>3</sup>

In addition, the disruption to program operations in a number of states due to the 2019 Novel Coronavirus (COVID-19) Public Health Emergency (PHE) further heightens the importance of states accurately and efficiently processing the backlog of overdue renewals that is accumulating over the course of the PHE. States and territories have faced stay-at-home orders, social-distancing recommendations, and transitions to telework, which affected routine state operations. This volume of pending actions is also likely to be larger in light of the requirement that states continue enrollment for Medicaid beneficiaries enrolled as of or after March 18, 2020, through the end of the month in which the PHE ends, to qualify for a temporary 6.2 percentage point increase in the federal medical assistance percentage (FMAP).<sup>4</sup> CMS released initial guidance on the continuous enrollment requirement for states seeking the temporary FMAP increase in the form of Frequently Asked Questions in the spring of 2020, and revised guidance in an interim final rule, the Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency interim final rule with request for comments, published on November 06, 2020.<sup>5</sup> In addition, CMCS intends to release additional guidance to assist states to restore eligibility and enrollment operations after the PHE when the continuous enrollment requirement for states seeking the temporary FMAP increase sunsets.

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information. Available at <https://www.federalregister.gov/public-inspection/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

<sup>3</sup> Fiscal Year (FY) 2019 Medicare Fee-For-Service Improper Payment Rate is Lowest Since 2010 While Data Points to Concerns with Medicaid Eligibility. November 18, 2019. Available at <https://www.cms.gov/newsroom/press-releases/fiscal-year-fy-2019-medicare-fee-service-improper-payment-rate-lowest-2010-while-data-points>; FY 2020 HHS Agency Financial Report. November 13, 2020. Available at <https://www.hhs.gov/sites/default/files/fy-2020-hhs-agency-financial-report.pdf>

<sup>4</sup> Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127, Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136: Frequently Asked Questions (FAQs). April 12, 2020. Available at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>.

<sup>5</sup> Families First Coronavirus Response Act – Increased FMAP FAQs. Updated April 13, 2020. Available at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-9912-IFC). Available at <https://www.federalregister.gov/public-inspection/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

This CIB will assist states in meeting their ongoing obligations to make accurate and timely redeterminations of eligibility both during regular periodic renewals and when the state agency receives information indicating a change in a beneficiary's circumstances that may impact eligibility. In addition, this CIB will serve as a resource for states that are restoring eligibility and enrollment operations to their routine functioning after the COVID-19 PHE. CMCS will continue to work with states to ensure timely redeterminations of eligibility, especially as states resolve backlogs of redeterminations that may have developed during the PHE.

### **Periodic Renewal Requirements**

As required at 42 C.F.R. §435.916 and §457.343, which generally requires states administering a separate CHIP to follow the renewal procedures described in 42 C.F.R. §435.916, states must renew eligibility for Medicaid and CHIP beneficiaries whose eligibility is determined using methodologies based on modified adjusted gross income (MAGI), whom we refer to in this CIB as MAGI beneficiaries, once every 12 months and no more frequently than once every 12 months. For beneficiaries excepted from MAGI-based financial methodologies under 42 C.F.R. §435.603(j) (non-MAGI beneficiaries), states must renew eligibility at least once every 12 months.<sup>6</sup> States have flexibility to implement periodic data checks of electronic data sources between regular renewals in order to identify beneficiaries who may have experienced a change in circumstances affecting their eligibility.<sup>7</sup> Such periodic checks, which are discussed later in this CIB, can further enhance states' effectiveness in minimizing the provision of coverage to beneficiaries whose circumstances have changed such that they no longer meet all eligibility requirements.

We refer to the time between initial application and regularly scheduled renewals as a beneficiary's "eligibility period." States must begin their renewal process early enough in order to complete a redetermination of eligibility prior to the end of the eligibility period consistent with 42 C.F.R. §435.916 and §457.343. This includes the time beneficiaries have to return the renewal form and any required documentation as well as the time needed by the agency to verify the accuracy of the returned information, redetermine eligibility, and send appropriate notice to the beneficiary of the agency's decision.

#### *Renewals based on reliable information available to the state (ex parte renewals)*

States must first attempt to conduct an *ex parte* renewal for all beneficiaries.<sup>8</sup> An *ex parte* renewal is a redetermination of eligibility that states can make based on reliable information available to the agency without requiring information from the individual.<sup>9</sup> Reliable information may include information available in the beneficiary's account and other more current information available to the state. This includes, but is not limited to, information accessed through electronic data sources described in 42 C.F.R. §435.948, §435.949, and §457.380 as well as recent information available from other benefit programs or reliable sources (e.g., information from a recent Supplemental Nutrition Assistance Program (SNAP) recertification). Information

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<sup>6</sup> 42 C.F.R. §435.916(b)

<sup>7</sup> 42 C.F.R. §435.940 and §457.380(h)

<sup>8</sup> 42 C.F.R. §435.916(a)(2) and (b) and §457.343

<sup>9</sup> An *ex parte* renewal is sometimes referred to as auto renewal, passive renewal, or administrative renewal.

from the initial determination at application or the beneficiary's last renewal is not considered recent or reliable, unless it relates to a circumstance generally not subject to change, such as citizenship<sup>10</sup> or satisfactory immigration status.<sup>11</sup> Eligibility criteria for which a beneficiary's information is not generally subject to change does not need to be re-verified in conducting an eligibility renewal.

If the agency is able to renew eligibility based on the available reliable information, the agency must provide notice consistent with 42 C.F.R. §435.917, 42 C.F.R. 431, subpart E, and 42 C.F.R. §457.340(e), as applicable. This includes notifying the individual of the eligibility determination, the information upon which the agency relied in making the determination and basis for continued eligibility, and the beneficiary's obligation to inform the agency if any of the information contained in the notice is inaccurate or subsequently changes.<sup>12</sup> The beneficiary is not required to sign and return such notice or otherwise notify the agency if all information in the notice is accurate.<sup>13</sup>

Renewals when sufficient information is not available to the state

If sufficient information is not available to complete a redetermination through an *ex parte* process, or if the state has information that indicates the beneficiary may be ineligible, the agency must provide the beneficiary with a renewal form and inform the individual of any additional information or documentation needed to determine eligibility.<sup>14</sup> For CHIP and MAGI Medicaid beneficiaries, the renewal form must be prepopulated with the most recent and reliable information about the beneficiary which is known by the agency and relevant to the redetermination.<sup>15</sup> The agency may, but is not required to, provide a prepopulated renewal form to non-MAGI beneficiaries.<sup>16</sup> The renewal form may only require beneficiaries to provide the information needed to renew eligibility.<sup>17</sup>

Along with the renewal form, the agency must provide the beneficiary with clear instructions on how to complete the form and correct any inaccurate pre-populated information; the need to sign the form; how the form and additional documentation needed can be returned, and the date by which the beneficiary must do so.<sup>18</sup> States must provide MAGI beneficiaries with at least 30 days from the date of the prepopulated renewal form to return the form and provide any additional information requested by the agency;<sup>19</sup> non-MAGI beneficiaries must be provided

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<sup>10</sup> Verification of citizenship is a one-time occurrence and states should not re-verify citizenship at renewal or subsequent application unless the individual reports a change in citizenship or the state agency has received information indicating a potential change in the individual's citizenship status. See 42 C.F.R. §435.956(a)(4)(ii).

<sup>11</sup> An individual's immigration status does not need to be re-verified if it is not likely to change (e.g. Lawful Permanent Resident status) unless the individual reports such a change has occurred. However, while the immigration status of many non-citizens is not likely to change, there are some exceptions such as individuals with Temporary Protected Status. The immigration status of such beneficiaries must be re-verified at renewal.

<sup>12</sup> 42 C.F.R. §435.916(a)(2)(i) and (ii), §435.917, and §457.343

<sup>13</sup> 42 C.F.R. §435.916(a)(2)(ii) and §457.343

<sup>14</sup> 42 C.F.R. §435.916(a)(3) and (b) and §457.343

<sup>15</sup> 42 C.F.R. §435.916(a)(3)(i)(A) and §457.343

<sup>16</sup> 42 C.F.R. §435.916(b)

<sup>17</sup> 42 C.F.R. §435.916(e) and §457.343

<sup>18</sup> 42 C.F.R. §435.905(b) and §457.340

<sup>19</sup> 42 C.F.R. §435.916(a)(3)(i)(B) and §457.343

with a reasonable period of time to return their renewal form and any required documentation.<sup>20</sup> As at application, states may not require MAGI beneficiaries to complete an in-person interview as part of the renewal process.<sup>21</sup> States may adopt the procedures required for MAGI beneficiaries for non-MAGI beneficiaries whose redetermination cannot be completed on an *ex parte* basis.<sup>22</sup>

All beneficiaries must be able to submit their renewal form through any of the modes of submission available for submitting an application (i.e., online, by phone, by mail, or in person). The beneficiary (or as appropriate, a parent, guardian, or authorized representative) must sign the renewal form under penalty of perjury; telephonic and electronic signatures, as well as handwritten signatures submitted electronically, must be accepted.<sup>23</sup> Renewal forms and notices must be accessible to persons who are limited English proficient and persons with disabilities, consistent with 42 C.F.R. §435.905(b).<sup>24</sup> Once the renewal form is received, the agency must verify any information provided by the beneficiary in accordance with 42 C.F.R. §435.945 through §435.956 or 42 C.F.R. §457.380, as applicable, and the state's verification plan.<sup>25</sup>

Once a final determination is made, the agency must provide all beneficiaries with timely and adequate written notice of any decision affecting their eligibility consistent with 42 C.F.R. §431.206 through §431.214, 42 C.F.R. §435.917, and 42 C.F.R. §457.340(e), as applicable. A minimum of 10 days advance notice must be provided for adverse determinations under Medicaid.<sup>26</sup> Separate CHIPs must provide 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.<sup>27</sup>

### Timeliness of renewals

States must establish renewal procedures and internal milestones that allow for adequate time to complete the renewal process before the end of a beneficiary's eligibility period in order to meet the requirements at 42 C.F.R. §435.916 and §457.343. Such processes need to account for the time given to beneficiaries to provide documentation as well as sufficient time for the agency to process and verify any information received from the beneficiary and provide proper notice of the agency's determination. Exceptions may occur when (1) the agency needs additional time to evaluate eligibility on another basis (see discussion below); or (2) an administrative or other emergency beyond the agency's control justifies a longer period, consistent with 42 C.F.R. §435.912(e) and §457.340(d), as applicable. In such cases, the state must document the reasons for delay in the beneficiary's case record.<sup>28</sup>

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<sup>20</sup> 42 C.F.R. §435.952

<sup>21</sup> 42 C.F.R. 435.916(a)(3)(iv) and §457.343

<sup>22</sup> 42 C.F.R. 435.916(b)

<sup>23</sup> 42 C.F.R. §435.916(a)(3)(i)(B) and §457.343. The required modes of submission are described at 42 C.F.R. §435.907(a), which is referenced at 42 C.F.R. §457.330 for CHIP.

<sup>24</sup> 42 C.F.R. §435.916(g), §457.110(a), and §457.343

<sup>25</sup> 42 C.F.R. §435.916(a)(3)(ii) and §457.343

<sup>26</sup> 42 C.F.R. §431.211

<sup>27</sup> 42 C.F.R. §457.340(e)(1)(D)(iii)

<sup>28</sup> 42 C.F.R. §435.912(f) and §457.340(d)

In addition, if a beneficiary does not return requested documentation within the timeframe established by the state, but does return a signed renewal form and any requested documentation prior to the end of the eligibility period, the state must act on the information.<sup>29</sup> If it is not possible for the agency to make a determination by the end of the eligibility period, the state is expected to redetermine eligibility as expeditiously as possible. We believe that 30 days from the date all information provided by, or on behalf of, the beneficiary is received by the agency generally provides ample time for state agencies to determine eligibility based on the renewal form and information received.<sup>30</sup>

Consistent with regulations at 42 C.F.R. §435.930(b), the agency must continue to furnish Medicaid to beneficiaries who have returned their renewal form and all requested documentation unless and until they are determined to be ineligible. If a renewal form or additional information is returned prior to the end of the eligibility period, the state must have a mechanism in place, pursuant to 42 C.F.R. §435.930(b), to ensure that eligibility and coverage continue until the information received is evaluated and a final redetermination is made.

#### Consideration of other bases of eligibility

If a Medicaid beneficiary is found to no longer be eligible for the eligibility group under which he/she is receiving coverage, the agency must consider whether the beneficiary may be eligible under one or more other eligibility groups covered by the state.<sup>31</sup> Other possible eligibility group(s) or bases of eligibility should be identified using information provided on the initial application or in the current or previous renewal forms and other information known to the agency. If the Medicaid agency identifies any such other group(s) but additional information is necessary to make a determination of eligibility, the Medicaid agency must request, and give the beneficiary a reasonable period of time to provide, the additional information needed.<sup>32</sup> For Medicaid enrollees, eligibility cannot be terminated, and benefits must continue to be furnished, until a beneficiary is found ineligible for eligibility under all groups covered by the state, or until the beneficiary does not timely provide requested information that is needed to make a determination.<sup>33, 34, 35</sup>

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<sup>29</sup> 42 C.F.R. §435.916(a) and (b), §435.952(a), §457.343, and §457.380

<sup>30</sup> The reasonable timeframe described reflects the time for the state to process the renewal after necessary information is received and not an extension to a beneficiary's eligibility period. However, given that some states provide coverage through the end of the month, this period may extend until the end of the month following the beneficiary's scheduled renewal date.

<sup>31</sup> 42 C.F.R. §435.916(f)(1)

<sup>32</sup> 42 C.F.R. §435.916(e), §435.916(f)(1), and §435.952

<sup>33</sup> 42 C.F.R. §435.916(f)(1) and §435.930

<sup>34</sup> Section 6008(b)(3) of FFCRA generally prevents states from terminating coverage for individuals enrolled as of or after March 18, 2020, through the end of the month in which the COVID-19 PHE ends as a condition of the temporary 6.2 percentage point FMAP increase authorized under FFCRA. See Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-9912-IFC) for additional information. Available at <https://www.federalregister.gov/public-inspection/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

<sup>35</sup> States are required to determine eligibility on other bases prior to terminating coverage. In the case of beneficiaries enrolled in the COVID-19 testing group described under section 1902(a)(10)(A)(ii)(XXIII) of the Act, states may satisfy the requirement to determine eligibility on all bases by providing individuals enrolled in the COVID-19 testing group with notice at their initial determination of eligibility and enrollment into the group, and

If a state determines that a separate CHIP enrollee is no longer eligible for CHIP, it must screen the individual for eligibility in other insurance affordability programs, including Medicaid on all bases and Exchange coverage.<sup>36</sup> Other possible bases of eligibility should be identified using information provided on the initial application or in the current or previous renewal forms and other information known to the agency. If the CHIP agency identifies any such other bases of eligibility but additional information is necessary to make a determination of eligibility, the agency must request, and give the beneficiary a reasonable period of time to provide, the additional information needed.<sup>37</sup>

We recognize that states may not be able to complete a determination of eligibility on another basis prior to the end of a beneficiary's eligibility period. States are expected to make determinations in this situation as expeditiously as possible, and terminate eligibility for individuals who either are determined ineligible on all bases or do not provide needed information or documentation in a timely manner.

*Termination of eligibility for ineligible beneficiaries and reconsideration period*

For beneficiaries who are determined ineligible for Medicaid or CHIP, the agency must (1) determine potential eligibility for other insurance affordability programs and transfer the beneficiary's electronic account to such program;<sup>38</sup> and (2) provide advance notice of termination and appeals rights consistent with 42 C.F.R. 431, Subpart E and 42 C.F.R. §457.340(e), as applicable.<sup>39</sup>

For beneficiaries who fail to return the renewal form or other needed documentation requested by the agency in a timely manner, the agency still must provide advance notice of termination, but need not determine potential eligibility for other insurance affordability programs. Consistent with guidance provided in a July 25, 2016, CIB, states should not transfer accounts for individuals whose eligibility has been terminated for procedural reasons.<sup>40</sup> For MAGI beneficiaries whose eligibility has been terminated, if the renewal form and/or necessary information is returned within 90 days after the date of termination, or a longer period

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again in the advance notice required prior to termination, on how to submit an application for comprehensive Medicaid coverage. For additional detail, see the COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agency's, available at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf> and the Operationalizing Implementation of the Optional COVID-19 Testing (XXIII) Group Potential State Flexibilities available at <https://www.medicaid.gov/state-resource-center/downloads/potential-state-flexibilities-guidance.pdf>.

<sup>36</sup> 42 C.F.R. §457.350(b)

<sup>37</sup> 42 C.F.R. §457.343, and §457.380

<sup>38</sup> 42 C.F.R. §435.916(f)(2) and §457.350

<sup>39</sup> Section 6008(b)(3) of FFCRA generally prevents states from terminating Medicaid coverage for individuals enrolled as of or after March 18, 2020, through the end of the month in which the COVID-19 PHE ends as a condition of the temporary 6.2 percentage point FMAP increase authorized under FFCRA. See Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-9912-IFC) for additional information. Available at <https://www.federalregister.gov/public-inspection/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

<sup>40</sup> CMCS Informational Bulletin: Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace"). July 25, 2016. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf>.

elected by the state, the agency must reconsider the individual's eligibility without requiring the individual to fill out a full new application to be determined eligible for benefits.<sup>41</sup> States may, but are not required, to provide a similar reconsideration period for non-MAGI beneficiaries who return their renewal form or needed documentation after their termination date.

The renewal form returned within the reconsideration period serves as an application. This means that a determination or denial of eligibility must be made consistent with timeliness standards in 42 C.F.R. §435.912 and §457.340(d), as applicable. For individuals who are determined to be eligible for Medicaid, the effective date of coverage will be the date that, or first day of the month in which, the renewal form was returned, in accordance with the state's election in the state plan. In addition, for those individuals for whom retroactive eligibility may apply, up to three months of retroactive coverage, (based on the date the renewal form was returned) is available if the individual received Medicaid services following his or her termination and met the Medicaid eligibility requirements at the time services within the retroactive period were received.<sup>42</sup> For individuals who are determined to be eligible for CHIP, the effective date of coverage will be based on the date the form is returned or another reasonable method that is specified in the state plan, as specified in 42 C.F.R. §457.340(g).

### **Redetermining Eligibility Based on Changes in Circumstances**

States must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility, and beneficiaries must be able to report such changes online, by phone, by mail, or in-person.<sup>43</sup> States also have the option to seek information about any changes in circumstances through periodic data checks or other information available to the agency.<sup>44</sup>

Whenever the state receives information on a change in circumstances that may affect a beneficiary's eligibility, the agency must act promptly to determine whether the beneficiary continues to meet the eligibility criterion to which the change relates.<sup>45</sup> This includes, but is not limited to, taking action on information reported to states or obtained electronically that indicates a beneficiary has an increase in income, has moved out of state, or is deceased. Similarly, if the agency has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, it must redetermine eligibility at the appropriate time based on such changes.<sup>46</sup> This includes, but is not limited to, anticipating action when beneficiaries reach an age milestone that impacts eligibility such as a child enrolled in a group for individuals under age 19 in Medicaid or a separate CHIP who is turning 19 or an individual enrolled in the adult group described at 42 C.F.R. §435.119 who is turning 65. See Appendix A for the steps states need to take in acting on a change in circumstances.

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<sup>41</sup> 42 C.F.R. §435.916(a)(3)(iii) and §457.343; 77 FR 17182 (March 23, 2012)

<sup>42</sup> 42 C.F.R. §435.915; 77 FR 17182 (March 23, 2012)

<sup>43</sup> 42 C.F.R. §435.916(c) and §457.343

<sup>44</sup> 42 C.F.R. §435.940 and §457.380(h)

<sup>45</sup> 42 C.F.R. §435.916(d). Examples of a change in circumstances on which states need to act promptly include a change in income, state residency, household composition, immigration status, or the death of the beneficiary.

<sup>46</sup> 42 C.F.R. §435.916(d)(2) and §457.343. Anticipated changes may include, for example, a child turning 19 who would no longer be eligible for the eligibility group described at 42 C.F.R. §435.118, an anticipated future increase in earnings reported at application, or the end of a postpartum period.



For certain individuals whom the agency determines continue to be eligible following a change in circumstances, a new 12-month renewal period may begin if the agency has information available to it to verify eligibility with respect to all eligibility criteria without requiring any additional information from the beneficiary (other than the information related to the change in circumstances).<sup>47</sup> Alternatively, the agency may retain the beneficiary's current eligibility period. States may request, but not require, additional information from the beneficiary about other factors needed to start a new renewal period when the state is unable to verify all eligibility criteria based on information available to the agency.

*Interaction between Redeterminations Based on Change in Circumstances and Eligibility Periods for Pregnant Women*

Under Medicaid, pregnant women are entitled to continuous eligibility through the last day of the month in which a 60-day period, beginning on the last day of pregnancy, ends, regardless of changes in income that would otherwise result in a loss of eligibility.<sup>48</sup> This protection applies both to women eligible based on pregnancy under 42 C.F.R. §435.116 as well as women who are pregnant, but eligible under an eligibility group unrelated to pregnancy status. Hereinafter in this CIB, we refer to the period following the end of the woman's pregnancy to the last day of the month in which the 60-day period falls as her postpartum period.

For many pregnant women, the end of the postpartum period represents a change in circumstances that may impact their eligibility.<sup>49</sup> Because the end of a given woman's postpartum period may not coincide with the end of her eligibility period and regularly-scheduled renewal, the steps states must take to comply with the regulations differ depending on whether the end of the woman's postpartum period occurs before or after her renewal date.

For women who apply while pregnant and are determined eligible under the group for pregnant women described in 42 C.F.R. §435.116, their postpartum period typically will end before the end of their 12-month eligibility period and first regularly scheduled renewal. For these women, the end of the postpartum period represents a change in circumstances between regularly scheduled renewals, which is subject to the same policies and procedures as any other change in circumstances. Once the birth or other end of her pregnancy is confirmed, the state will need to determine whether or not the woman will remain eligible following the end of the postpartum period under another eligibility group – most typically, as a parent or caretaker relative under 42 C.F.R. §435.110 or under the adult group described in 42 C.F.R. §435.119. Since the woman would still be within her eligibility period in this case, the state generally would not contact the woman to verify her income consistent with 42 C.F.R. §435.916(d)(1)(i) when determining if she is eligible under another group at the end of her post-partum period. The state, however, would

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<sup>47</sup> 42 C.F.R. §435.916(d)(1)(ii) and §457.343

<sup>48</sup> Section 1902(e)(5) and 1902(e)(6) of the Social Security Act; 42 C.F.R. §435.170

<sup>49</sup> For example, women eligible during their pregnancy under the group for pregnant women described in 42 C.F.R. §435.116 will no longer be eligible under that group following the end of the postpartum period; however, such women may be eligible as a parent or caretaker relative under 42 C.F.R. §435.110 or under the adult group described in 42 C.F.R. §435.119. For a woman covered under the group for parents and caretaker relatives, who becomes pregnant while receiving coverage under that group, the end of the postpartum period does not itself represent a change in circumstances likely to impact her eligibility.

need to verify income when her post-partum period ends in the middle of her eligibility period if it has received other information indicating her income has changed since her initial determination such that her income may exceed the income standard for coverage under the other eligibility groups under which she might be eligible. Such verification often will require additional documentation or other information from the woman. If the state is able to determine the woman eligible under another group (with or without requiring additional information from her), she would be moved to the new eligibility group, and her next regular renewal date would remain the same – i.e., 12 months after her initial determination.

For women whose postpartum period ends after their regularly-scheduled renewal date, the agency must conduct the full renewal at the end of the individual woman's postpartum period (when her continuous eligibility ends) in accordance with the regulations at 42 C.F.R. §435.916(a) or (b), depending on whether the woman is enrolled in a MAGI or non-MAGI eligibility group. This typically will be the case for women who are enrolled in Medicaid when they become pregnant.

### **Medicaid Agency Oversight Responsibilities**

The single state Medicaid agency is responsible for administering or supervising the administration of the Medicaid state plan, including determinations of eligibility at initial application, regular renewals, and following changes in beneficiary circumstances.<sup>50</sup> States are permitted to delegate all or part of this responsibility to another state or local agency, such as a state human services agency. 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.<sup>51</sup>

### **Additional Resources**

CMS previously provided states a model renewal form for populations whose eligibility is based on MAGI and information on state practices and lessons learned through the Medicaid and CHIP Coverage Learning Collaborative. These resources are available on [Medicaid.gov](https://www.medicare.gov).<sup>52</sup>

For additional information about this CIB, please contact Jessica Stephens, Director, Division of Enrollment Policy & Operations, at [Jessica.Stephens@cms.hhs.gov](mailto:Jessica.Stephens@cms.hhs.gov).

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<sup>50</sup> Section 1902(a)(5) of the Social Security Act, 42 C.F.R. §431.10(b)

<sup>51</sup> 42 C.F.R. §431.10(c) and (d)

<sup>52</sup> Expanding Coverage under Medicaid and CHIP, Medicaid & CHIP Renewals & Coverage Transitions. Available at <https://www.medicare.gov/state-resource-center/mac-learning-collaboratives/coverage/index.html>.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

## Appendix A

### Acting on Changes in Circumstances

Whenever a state has information indicating a change in a beneficiary's circumstances, the agency must act promptly to determine whether or not the beneficiary's eligibility is impacted as required at 42 C.F.R. §435.916(d) and §457.343. The following steps will help states to ensure that they are acting appropriately on such information, and that only eligible individuals continue to receive coverage.

1. For a change in circumstances that is reported by the beneficiary, promptly evaluate whether the information received, if correct, would result in a loss of eligibility or change in the amount of medical assistance to which the beneficiary is entitled (e.g., a change in premiums, cost sharing, or covered benefits). If the agency determines eligibility would not be impacted, no further action is required. However, CMS encourages states to acknowledge the reported change by providing the beneficiary with notice acknowledging receipt of information and explaining that there is no impact on eligibility or coverage.
2. For information received from an electronic data source or other third-party source, if the agency determines that the information received, if correct, would impact a beneficiary's eligibility, the agency must contact the beneficiary. The beneficiary must be given an opportunity to provide information or other documentation to establish that the information received by the agency is not correct and the individual continues to meet the eligibility criterion at issue.<sup>53, 54</sup> The agency must provide the beneficiary with a reasonable period of time to provide such information or documentation and must enable the beneficiary to respond to the agency's request online, by phone, by mail, or in person.<sup>55</sup>
  - a. If the beneficiary does not respond to the request in a timely manner, the agency must provide advance notice of termination and appeal rights in accordance with 42 C.F.R. §435.917, 42 C.F.R. 431, subpart E, and 42 C.F.R §457.340(e), as applicable.
  - b. 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; we recommend that the

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<sup>53</sup> 42 C.F.R. §435.952(d) and §457.380

<sup>54</sup> Per 42 C.F.R. §435.916(d)(1)(i) and 42 C.F.R §457.343, for renewals of Medicaid and CHIP beneficiaries whose financial eligibility is determined using modified adjusted gross income (MAGI)-based financial methodologies, the agency must limit any requests for additional information from the individual to information relating to the eligibility criterion impacted by the change in circumstances.

<sup>55</sup> 42 C.F.R. §435.952(c) and §457.380. The required modes of submission are described at 42 C.F.R. §435.907(a), which is referenced at 42 C.F.R §457.330 for CHIP.

agency inform beneficiaries who continue to be eligible when their next regular periodic renewal will occur.

3. Similar to the requirements at a periodic renewal, if while processing a change in circumstances the agency determines that the beneficiary no longer meets the eligibility requirements for the eligibility group under which he or she is receiving coverage, it must consider whether the beneficiary may be eligible under one or more other eligibility groups covered by the state.<sup>56</sup> The agency must follow up with the beneficiary to make an appropriate determination, prior to sending advance notice of termination; in this case, the agency must follow the same process described for periodic renewals (see discussion in the CIB on “Consideration of other bases of eligibility”).
  - a. If the agency determines the beneficiary is eligible on another basis, the agency must provide notice of such determination.<sup>57</sup>
  - b. If the agency determines that the beneficiary is not eligible on another basis, the agency must provide advance notice of termination in accordance with 42 C.F.R. §435.917, 42 C.F.R. 431, subpart E, and 42 C.F.R. §457.340(e), as applicable. The state must also assess eligibility for other insurance affordability programs, as applicable.<sup>58</sup>
  - c. If the beneficiary does not provide the information or documentation requested by the agency in a timely manner, the agency must also provide advance notice of termination in accordance with 42 C.F.R. §435.917, 42 C.F.R. 431, subpart E, and 42 C.F.R. §457.340(e), as applicable.
4. Current regulation indicates that states must promptly act on changes in circumstances that may affect eligibility. While promptly is not currently defined in regulations, CMS believes the following parameters for processing changes generally would be reasonable.
  - a. When the state receives information about a change in circumstances and has sufficient information to evaluate any potential impact on eligibility, we believe that thirty days from the date the state received the information generally would be a reasonable timeframe to complete the processing of the change in circumstances.
  - b. If additional information is needed, it may be reasonable for states to allow beneficiaries 30 days to respond and provide any necessary information. This is consistent with the minimum timeframe allowed to beneficiaries whose financial eligibility is determined using MAGI-based financial methodologies, during their annual renewal, to return a pre-populated renewal form and provide needed documentation.<sup>59</sup> In these instances, we believe that it generally would be reasonable

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<sup>56</sup> 42 C.F.R. §435.916(f)(1) and §457.350

<sup>57</sup> 42 C.F.R. §435.917 and §457.340(e)

<sup>58</sup> 42 C.F.R. §435.916(f)(2) and §457.343

<sup>59</sup> 42 C.F.R. §435.916(a)(3)(i)(B) and §457.343

for the state to complete the processing of changes in circumstances within 60 days from the date the state received the information.

## Appendix B

### Frequently Asked Questions (FAQs) Medicaid and Children's Health Insurance Program Renewals December 2020

**Q1. When does a new eligibility period begin and end for an individual whose eligibility is being redetermined at renewal? How is a beneficiary's renewal date determined?**

**A1.** Individuals enrolled in CHIP or in a Medicaid eligibility group for which the determination of financial eligibility is based on modified adjusted gross income (MAGI), have a 12-month eligibility period. The 12-month period 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. In the case of individuals enrolled in a non-MAGI-based eligibility group, the eligibility period extends for the length specified by the state, up to 12 months or until the end of the last month of the beneficiary's eligibility period of up to 12 months.

For example, John submitted an application on January 10, 2020, in a state that has elected to provide full month coverage. John was determined eligible for a MAGI-based Medicaid eligibility group. His effective date of coverage is January 1, 2020, and his eligibility period would extend to the end of the twelfth month after his effective date of coverage, to December 31, 2020, which would be his next renewal date. The state would be required to complete John's renewal by December 31, 2020. If his eligibility is renewed at that time, a new eligibility period would begin on January 1, 2021, and extend 12 months through December 31, 2021. 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, consistent with 42 C.F.R §435.915, would not be included as part of his eligibility period for purposes of determining his renewal date.

**Q2. If an individual whose coverage was terminated at renewal for non-response to requested information returns the renewal form during the reconsideration period and is determined to be eligible, what is the effective date of coverage for the new eligibility period?**

**A2.** As described at 42 C.F.R. §435.916(a)(3)(i)(C)(iii) and §457.343, the state must redetermine eligibility in a timely manner for an individual whose coverage is terminated at renewal for failure to complete the renewal process if the individual returns their renewal form or requested information during the 90-day reconsideration period (or longer period elected by the state). The state must accept the renewal form or information and determine the individual's eligibility without requiring the person to submit a full application. The returned renewal form in this case is treated as an application. The state must follow its practice for determining the effective date of eligibility at application consistent with 42 C.F.R. §435.915 for Medicaid (either the first of the month of application or the date of application at state option) or §457.340(g) for CHIP (either the date of application or another reasonable method that is specified in the state plan).

Additionally, consistent with rules related to the provision of retroactive coverage at 42 C.F.R. §435.915(a), the state must provide coverage for unpaid medical bills incurred in any of the three months prior to returning the renewal form if the individual would have been found eligible for Medicaid had the renewal form been returned in (or before) that month. In most cases, retroactive coverage will close the gap in coverage for an eligible individual between the date of termination and the date of reinstatement.

**Q3. Which data sources are states required to access in conducting *ex parte* reviews?**

**A3.** Each state's verification plan identifies the electronic data sources which the state has determined useful in verifying different eligibility criteria. States must access the data sources, identified in their verification plan, which return data on beneficiary circumstances subject to change (such as wages).

**Q4. Must states use the Asset Verification System (AVS) to verify assets at renewal for beneficiaries subject to a resource test?**

**A4.** Yes, for beneficiaries subject to a resource test and for whom verification of resources using the AVS described in Section 1940(b) of the Social Security Act is required, states must seek information from the AVS to verify financial resources at renewal. Because states are required to attempt an *ex parte* renewal for all beneficiaries using all reliable information contained in the individual's account or other more current information available to the agency, including those subject to an asset test, use of the AVS is a required part of the *ex parte* renewal process. States must begin their renewal process early enough to complete a redetermination of eligibility prior to the end of the renewal period. Because not all asset information available from financial institutions participating in the AVS is returned in real time, states must allow for a reasonable timeframe for electronic information from the AVS to be returned to complete an *ex-parte* renewal when possible. This reasonable timeframe must also leave sufficient time for beneficiaries to receive and return a renewal form and any other needed documentation to complete a timely renewal when renewal through an *ex parte* process is not possible.

**Q5. When must a state request additional information from a beneficiary at renewal?**

**A5.** If, during an *ex parte* review, available information suggests that a beneficiary is no longer eligible, if the state does not have access to reliable information regarding beneficiary circumstances subject to change, or if the state has information that suggests that available information is inaccurate, the state may not complete an *ex parte* renewal. In this situation, the state must send the beneficiary a renewal form and request any other information needed before either renewing or terminating eligibility.

**Q6. What information may the state require beneficiaries to provide at renewal?**

**A6.** When a state is unable to renew eligibility through an *ex parte* process, the state may only require information from beneficiaries at renewal about circumstances that (1) are subject to change, (2) are necessary to determine eligibility, and (3) cannot be verified based on available data sources. This will generally include income information for individuals eligible in an income-based eligibility category and assets for non-MAGI based eligibility groups with a

resource test. It may also include information related to residency, household composition, or other eligibility factors. States may not request information to re-verify citizenship or other circumstances not subject to change. As at application, consistent with 42 C.F.R. §435.907(e) and 457.340(b), Social Security Numbers (SSNs) may be requested of non-applicants or other unenrolled household members of beneficiaries. However, SSNs may only be requested if provision of the SSN is voluntary, the SSN will be used only to redetermine a beneficiary's eligibility, and clear notice is provided to the individual whose SSN is requested about how the SSN will be used.

**Q7. When must states complete renewals for beneficiaries who return required documentation needed to complete a renewal too late in the renewal month for a state to complete renewal processing?**

**A7.** As explained in the Information Bulletin, consistent with regulations at 42 C.F.R. §435.930(b), states must continue to furnish Medicaid to beneficiaries who have returned their renewal form prior to the end of their eligibility period unless and until they are determined to be ineligible or fail to return requested documentation. When it is not possible for the state to make a determination before the renewal date because the beneficiary returned the renewal form or additional information too close to the end of the eligibility period, the state is expected to act as expeditiously as possible to redetermine eligibility and provide appropriate notice. CMS believes this generally should take at most 30 days from the date the renewal form and all requested documentation is received.

**Q8. Are states required to conduct periodic renewals for children receiving federal foster care maintenance payments or subject to a federal adoption assistance agreement under title IV-E of the Social Security Act (the Act)? What about children in state-funded foster care or subject to a state adoption assistance agreement?**

**A8.** Yes, periodic renewals for all beneficiaries are required. However, states generally will be able to renew eligibility for beneficiaries, such as children receiving federal foster care maintenance payments, through an *ex parte* process as long as the individual continues to be a resident of the state. This will be the case for:

- Beneficiaries whose eligibility is based on receipt of another income-tested benefit – such as Supplemental Security Income (SSI) recipients eligible under section 1902(a)(10)(A)(i)(II)(aa) of the Act or 42 C.F.R. §435.120 or children for whom foster care or kinship guardianship assistance maintenance payments are being made under title IV-E of the Act, who are eligible under §1902(a)(10)(A)(i)(I) and 42 C.F.R. §435.145 – until the beneficiary no longer receives such benefit; and
- Beneficiaries eligible based on a particular status for which there is no income test. This includes, but is not limited to, children for whom an adoption assistance agreement under title IV-E of the Act is in effect, or for whom a state adoption assistance agreement is in effect, if the state covers such children with no effective income test under section 1902(a)(10)(A)(ii)(VIII) of the Act and 42 C.F.R. §435.145; former foster youth under age 26 eligible under 1902(a)(10)(A)(i)(IX) and 42 C.F.R. §435.150; or individuals with breast or cervical cancer eligible under 1902(a)(10)(A)(ii)(XVIII) of the Act and 42 C.F.R. §435.213). For these individuals, the agency will likely need to request additional



information to redetermine eligibility when the beneficiary ages out of, or otherwise no longer qualifies for the status.

**Q9. When must states conduct renewals for women who apply and are determined eligible for Medicaid under the pregnant women group described at 42 C.F.R. §435.116?**

**A9.** Women determined eligible at application for the pregnant women group described at 42 C.F.R. §435.116 must be provided a 12 month eligibility period in accordance with requirements for renewals for MAGI-based individuals at 42 C.F.R. §435.916(a)(1). The state must anticipate the end of her postpartum period (i.e., the last day of the month in which a 60-day period, beginning on the last day of her pregnancy, ends) and determine whether she remains eligible at that point on another basis. Many women losing coverage under the eligibility group for pregnant women, for example, will be eligible under the adult group described in 42 C.F.R. §435.119 if covered by the state and if her income is at or below 133 percent FPL. If the woman remains Medicaid eligible under another MAGI-based group, the date of her next regularly-scheduled renewal would not change, unless the state is able and elects to begin a new eligibility period in accordance with 42 C.F.R. §435.916(d)(1)(ii).

For example, Jane submitted an application on January 10, 2020, and was determined eligible for and enrolled in the pregnant women group with verified income equal to 50 percent FPL. Her effective date of coverage is January 1, 2020, and her eligibility period extends to the end of the twelfth month after her effective date of coverage, or December 31, 2020. Jane's baby is born on August 16, 2020, and her postpartum period ends October 31, 2020. The state's income standard for parents and caretaker relatives is 65 percent FPL. The state does not have any information indicating Jane's income has changed. Therefore, at the end of her postpartum period, the state will shift Jane's coverage to the eligibility group for parents and caretaker relatives effective November 1, 2020. The state will need to complete Jane's next regular renewal by December 31, 2020. Alternatively, if the state is able to verify Jane's income and state residency at the end of her postpartum period without contacting Jane in accordance with the state's verification plan, it may elect to begin a new 12-month eligibility period on November 1, 2020, which would mean her next regularly scheduled renewal would be due October 31, 2021.

**Q10. When must states conduct renewals for women enrolled in Medicaid who become pregnant during their eligibility period?**

**A10.** When a woman enrolled in Medicaid subsequently becomes pregnant, she is entitled to continued coverage through the end of her postpartum period regardless of any changes in income. If her next regularly scheduled renewal falls after the end of her postpartum period, the date of her next regularly scheduled renewal will not change. If the end of her postpartum period is after the date her regularly scheduled renewal had been scheduled, the state will need to complete a full regular renewal, consistent with 42 C.F.R. §435.916, by the end of her postpartum period.

For example, Jane is enrolled as a parent under 42 C.F.R. §435.110. Her eligibility period extends from January 1, 2020, to December 31, 2020. Jane becomes pregnant in August 2020, and is eligible for continuous eligibility under 42 C.F.R. §435.170(c). Because Jane is pregnant and in a period of continuous eligibility, the state does not need to conduct a full regular renewal

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by the end of December 2020. Jane's baby is born in May 2021, and her postpartum period ends July 31, 2021. The state must conduct a full renewal, consistent with 42 C.F.R. §435.916, by July 31, 2021.

**Q11. Are there any exceptions to the timeliness requirements for completing renewals or acting on changes in circumstances?**

**A11.** Yes. Generally, states must establish renewal procedures and internal milestones that allow adequate time to complete the renewal process before the end of a beneficiary's eligibility period. However, when there is an administrative or other emergency beyond the agency's control, the state may be excused from meeting expected timeliness standards under 42 C.F.R. §435.912(e) and §457.340(d). This may include a natural disaster or public health emergency during which damage to infrastructure or impact on a state's workforce may affect the agency's ability to complete timely renewals and/or impacted individuals may be unable to receive or respond to notices or provide information needed to complete the redetermination process. In such cases, the state must continue to furnish Medicaid to enrolled beneficiaries until the state determines they are ineligible for Medicaid in accordance with 42 C.F.R. §435.930(b). The state must document the reason for delay in the Medicaid and CHIP beneficiary's case record per 42 C.F.R. §435.912(f) and §457.340(d).

Medicaid agencies seeking to use the exception are advised, though not required, to seek CMS concurrence that the use of the exception is warranted under the circumstances. States do not need to make a formal request for CMS concurrence, but may send a request via email to the CMS state lead.

CHIP agencies seeking to rely on the exception for a broader cohort of cases should submit a disaster relief state plan amendment (SPA) to reflect the delay in processing renewals and changes in circumstances due to the disaster or emergency. States that already have a disaster relief SPA related to processing renewals and changes in circumstances need only notify CMS that they are activating this exception.

We remind states that use of the exception is limited to unusual circumstances beyond the agency's control, and any concurrence received from CMS that the circumstances justify a delay does not authorize an extension beyond that required due to the circumstances. States are obligated to process the redetermination as soon as possible.

**Q12. Can Medicaid managed care entities assist with consumer outreach during renewal?**

**A12.** Yes, nothing in federal regulations prohibits managed care entities from conducting outreach to their Medicaid and CHIP managed care plan enrollees about upcoming renewal periods and assisting their enrolled beneficiaries in the renewal process. Many states partner with managed care entities as a best practice at renewal. However, managed care entities may not conduct outreach to individuals who are not enrolled with the managed care entity.