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

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CMCS Informational Bulletin

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

SUBJECT: **Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes**

The Centers for Medicare & Medicaid Services (CMS) is committed to protecting access to health care for individuals enrolled in Medicaid and the Children's Health Insurance Program (CHIP) in a manner that ensures eligible individuals maintain enrollment and protects the integrity of these programs. This Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) is part of a series of guidance supporting states' efforts to verify eligibility and conduct renewals in compliance with federal requirements. This CIB specifically provides states with guidance regarding the continued use of certain streamlined eligibility and enrollment strategies that CMS made available to states to address challenges brought on by the COVID-19 Public Health Emergency (PHE) and the return to regular Medicaid and CHIP renewal operations following the end of the Medicaid continuous enrollment condition under section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127).[1] With the expiration of the continuous enrollment condition, states were required to resume renewals, including disenrolling individuals who were no longer eligible, for all individuals enrolled in their Medicaid programs. This undertaking has also commonly been referred to as the Medicaid "unwinding" process.

During unwinding, CMS provided strategies to states, including waivers authorized under section 1902(e)(14)(A) of the Social Security Act (the Act) (hereinafter "unwinding-related section 1902(e)(14)(A) waivers strategies") and other regulatory flexibilities, that have been critical to states' ability to ensure eligible individuals retain coverage, to transition those no longer eligible to other Insurance Affordability Programs (IAPs), and to reduce administrative burden on states and beneficiaries. On May 9, 2024, CMS released the "Extension of Temporary Unwinding-Related Flexibilities" CIB ("May 9, 2024, CIB"), which announced that all unwinding-related section 1902(e)(14)(A) waivers and CMS's concurrence with states' use of other unwinding-related flexibilities authorized under federal regulations would be extended through June 30, 2025, if the terms and conditions of the original waiver continue to be met.[2]

Since publishing the May 9, 2024, CIB, and as states continue conducting eligibility renewals, CMS evaluated the potential for making permanent each of the unwinding-related section 1902(e)(14)(A) waiver strategies in order to support state efforts to sustain and build upon improvements to their eligibility and enrollment systems. In this CIB, CMS outlines which of these strategies states may continue long-term at state option under Medicaid or CHIP state plan authority, which strategies will be required under recent changes to Medicaid and CHIP regulations, and which strategies will sunset after June 30, 2025. More information regarding

[1] Throughout the COVID-19 PHE, states adopted many flexibilities to respond effectively to issues caused by the pandemic and to comply with conditions for receipt of a temporary 6.2 percentage point federal medical assistance percentage (FMAP) increase set forth at section 6008 of the FFCRA. One of these conditions, the continuous enrollment condition, required states to maintain the enrollment of nearly all Medicaid beneficiaries through March 31, 2023. FFCRA (P.L. 116-127) as amended by CAA, 2023 (P.L. 117-328, Section 5131 of division FF, title V).

[2] CMS, CIB, "Extension of Temporary Unwinding-Related Flexibilities," May 9, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf.

how states may request authority to continue use of a strategy whose blanket approval is sunsetting after June 30, 2025, is included later in this CIB.

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I. Use of Eligibility and Enrollment Strategies During Unwinding

The Medicaid unwinding process presented major challenges for states and individuals renewing their coverage. States were required to process an unprecedented volume of renewals as they resumed eligibility and enrollment activities, while millions of beneficiaries were required to navigate renewals and potential disenrollment for the first time in as long as three years. These conditions created significant operational challenges for states' income and eligibility determination systems as well as for beneficiaries.

To address these issues, CMS and states worked expeditiously to identify strategies that could mitigate emerging issues in a manner that helped eligible individuals successfully renew their coverage. These strategies included measures allowed by (1) waivers granted under section 1902(e)(14)(A) of the Act, which permits CMS to approve time-limited waivers of any provisions of titles XIX and XXI of the Act "as are necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries," and (2) the use of regulatory flexibility under 42 C.F.R. § 435.912(e), which provides an exception to the timeliness standards for processing applications and renewals in unusual circumstances.

Since April 2022, CMS granted over 400 unwinding-related section 1902(e)(14)(A) waivers to 52 states and territories that enabled them to streamline different parts of their renewal processes in support of their unwinding efforts.[3] A combined 50 states and territories received over 200 waiver approvals to adopt strategies to increase *ex parte* renewal[4] rates, thereby minimizing

[3] CMS, "COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals," October 30, 2024, available at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html.

[4] An *ex parte* renewal is a renewal that results from a state having available, reliable information that is sufficient to determine continued eligibility without requiring information from the individual. *Ex parte* renewal is also known as auto-renewal, passive renewal, or administrative renewal. Per 42 C.F.R. § 435.916(b)(1), states must begin a beneficiary's renewal process by first attempting an *ex parte* renewal.

administrative burdens for states and beneficiaries while supporting eligible individuals' ability to renew their coverage. Thirty states received waiver approvals to better support beneficiaries with renewal form submission or completion. CMS approved waivers in 45 states that facilitated their ability to streamline updating beneficiary contact information with information from trusted sources, minimizing coverage losses due to states' inability to reach people. Twenty states used waivers to ensure the reinstatement of eligible individuals who had been disenrolled for procedural reasons.

States invested considerable time and resources to adopt these strategies, which together streamlined eligibility and enrollment processes, protecting eligible individuals from being disenrolled while alleviating administrative and operational burdens on beneficiaries as well as state systems and staff. As signaled in prior guidance, CMS reviewed all section 1902(e)(14)(A) waiver strategies to determine which could be implemented on a longstanding basis under other authorities.[5] CMS outlines below which of these strategies may be continued at state option under existing state pan authority, will be required under recent rulemaking, and will sunset after June 30, 2025.

II. The Future of Unwinding-Related Section 1902(e)(14)(A) Waiver Strategies

Receiving input from states, beneficiaries, and other stakeholders that these strategies meaningfully improved efforts to renew eligible people's coverage, CMS reviewed strategies made available during unwinding to determine whether states could continue using these strategies under existing federal statutory or regulatory authorities to strengthen and streamline renewal systems on a long-term basis. Federal renewal and verification requirements in 42 C.F.R. §§ 435.916, 435.940 – 435.965, and 457.380 seek to ensure that eligible individuals retain coverage and ineligible individuals are properly disenrolled from Medicaid and CHIP and transitioned to other sources of coverage, as appropriate. Thus, in evaluating statutory and regulatory authorities, CMS considered the importance of enabling states to support both of these goals. CMS contemplated the extent to which these strategies support the retention of eligible beneficiaries by minimizing administrative burden and disenrollment of likely eligible individuals for procedural reasons (e.g., failure to complete a renewal form or provide other paperwork). CMS also considered how the strategies may affect the state's responsibility to identify ineligible individuals who should be disenrolled from Medicaid and CHIP and referred to other IAPs, as appropriate. To augment our statutory and regulatory analysis, CMS reviewed available studies to assess these potential program integrity risks.

CMS determined that states either have the option to continue or will be required by recent rulemaking to implement over half of the unwinding-related section 1902(e)(14)(A) waiver strategies under their state plan in accordance with statutory and regulatory authorities. Several strategies were codified in regulation by the "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes" final rule, which appeared in the Federal Register on April 2, 2024 (hereinafter "April 2024 Eligibility and Enrollment Final Rule).[6,7]

With the codification of these policies, states no longer need waiver authority to implement these strategies. Additionally, adoption of some strategies will be required as of the compliance date identified in the April 2024 Eligibility and Enrollment Final Rule. For example, by December 2025, states are required to establish a process to obtain updated address information from reliable sources, including the National Change of Address service and mail returned by U.S. Postal Service with a forwarding address. CMS has also determined that some other strategies

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[5] CMS, "Extension of Temporary Unwinding-Related Flexibilities," May 9, 2024, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf

[6] CMS, Final Rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," April 2, 2024, available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health.

[7] Changes to 42 C.F.R. §§ 435.608, 435.919, 436.608, and 457.344 implemented certain strategies regarding updating contact information that were previously approved under section 1902(e)(14)(A) waiver authority.

may be continued beyond June 30, 2025, under other state plan authorities in a materially similar way to the unwinding-related section 1902(e)(14)(A) waiver strategies currently in place in many states.

During the unprecedented challenges brought on by the PHE and the subsequent unwinding, CMS and states worked together expeditiously to put in place measures that would prevent inappropriate coverage loss. Under such exigent circumstances and in the interest of protecting eligible beneficiaries, CMS approved waivers of program requirements in order for states to implement a variety of strategies under section 1902(e)(14)(A) of the Act. With the benefit of understanding states' experiences with these strategies during unwinding, CMS reviewed each of the unwinding-related section 1902(e)(14)(A) waiver strategies and existing statutory and regulatory authorities more closely and determined that some of these strategies are permissible at state option (some with and some without modification) without waiving any particular program requirements under section 1902(e)(14)(A). As such, those strategies may continue under existing statutory, regulatory, and state plan authorities. CMS also recognizes that states invested substantial time and resources in adopting these strategies and engaged in planning that took into account the potential continued availability of those strategies as CMS determined which could be implemented on a longstanding basis.[8]

The appendix contains a description of each unwinding-related section 1902(e)(14)(A) wavier strategy, indicating whether the strategy may or must be continued and the necessary steps to do so, or if the blanket authority for the strategy sunsets on June 30, 2025.

A. Strategies Related to Verifying Financial Eligibility

This section of the CIB outlines how states may continue to implement the most commonly approved unwinding-related section 1902(e)(14)(A) waiver strategies related to verifying financial eligibility. Specifically, this section provides information on how states can implement existing verification policies to achieve long-term use of certain strategies related to income and resource verification.

The unwinding-related section 1902(e)(14)(A) waiver strategies aimed at streamlining income and resource verification during the *ex parte* renewal process have been particularly effective in supporting states' efforts to minimize the administrative burden associated with conducting renewals and preventing the improper disenrollment of eligible beneficiaries. CMS has determined that, subject to certain modifications and conditions, the following strategies may be adopted in accordance with the Medicaid statute and implementing regulations without a section 1902(e)(14)(A) waiver:

- Using gross income determinations from the Supplemental Nutrition Assistance Program (SNAP);
- Completing an *ex parte* renewal when no data sources return income information (including both the "Zero-Dollar" and "100 Percent Federal Poverty Level (FPL)" strategies); and
- Streamlining use of the asset verification system (AVS).

CMS notes that throughout the following sections, "data sources" refers to those data sources a state uses to verify eligibility factors for Medicaid and identifies in its verification plan, as required by 42 C.F.R. § 435.945(j).[9]

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[8] CMS, "Extension of Temporary Unwinding-Related Flexibilities," May 9, 2024, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf

[9] In general, section 1902(e)(14)(A) waiver authority is applicable to both Medicaid and CHIP under section 2107(e)(1)(I) of the Act. However, CMS notes that certain financial strategies outlined in this section of the CIB may not apply to CHIP, either because the eligibility requirements related to the strategy do not apply to CHIP (e.g., the AVS strategy or Fair Hearing Timeframes Extension strategy), or relevant conditions do not apply to CHIP beneficiaries. States may contact their state CHIP officer if they are interested in applying these strategies to the CHIP population.

1. *Using Gross Income Determinations from SNAP and Other Human Services Programs*

Under section 1137 of the Act and regulations at 42 C.F.R. §§ 435.948 and 435.952, states may use information from human services programs, such as SNAP and Temporary Assistance for Needy Families (TANF), in a number of ways to facilitate Medicaid eligibility determinations and enrollment. To simplify the use of SNAP and/or TANF information when making eligibility determinations during unwinding, CMS used section 1902(e)(14)(A) authority to waive the requirement to make a Medicaid income determination at application or at renewal for individuals whose gross income determined by the state's SNAP and/or TANF agency was at or below the applicable Medicaid income standard. During unwinding, this strategy protected beneficiaries by enabling states to enroll or renew coverage without unnecessary paperwork, reducing burden on both state eligibility staff and beneficiaries, and helping states increase the number of renewals that could be completed on an *ex parte* basis.

When the blanket authority for unwinding-related section 1902(e)(14)(A) waiver strategies expires on June 30, 2025, states must resume making Medicaid income determinations and may generally no longer rely on the SNAP or TANF findings to make a Medicaid eligibility determination. However, states may use SNAP gross income to verify Modified Adjusted Gross Income (MAGI)-based income determinations.

Section 1137 of the Act and implementing regulations at 42 C.F.R. § 435.948 identify the data sources states are required to access to the extent the state determines the source to be useful for verifying income in accordance with subpart G of 42 C.F.R. part 435. In determining usefulness, states are expected to consider such factors as the accuracy of the financial information, the timeliness of the information returned, the complexity of accessing the data or data source, the age of the financial records, the comprehensiveness of the data, any limitations imposed by the owner of the data on its use, as well as other relevant factors. No data source provides an individual's current monthly MAGI-based income precisely. For example, federal tax information, although providing MAGI-based income, is typically one to two years old; quarterly wage data provides earnings over three months, which states use to approximate average monthly wage income, and only reflects wage income. Thus, states have to consider various factors in identifying the data sources they find useful to ensure both that individuals with income over the income standard are not approved or renewed for coverage, and that individuals with income at or below the income standard are not inappropriately denied or disenrolled from coverage.

Section 1137 of the Act names SNAP as one of the data sources states must use, if useful, to verify income at application and/or renewal. However, statute and regulations do not identify the specific SNAP income data that must be used. Further, CMS regulations do not require that, to be useful, a verification data source provide data that matches the methodology used to determine income eligibility for Medicaid or CHIP. CMS believes it would be reasonable for states to use gross income calculated by the SNAP agency and/or the underlying data for specific types of income in an applicant's or beneficiary's SNAP record if, after considering the aforementioned factors, the state determines either or both to be useful for verifying income for Medicaid purposes.

Generally, SNAP gross income is comprehensive and includes more income sources than would be counted in MAGI. This means that if someone's SNAP gross income is below the applicable Medicaid standard, then their Medicaid MAGI is likely to be below the applicable standard as well. Studies have found that, despite differences in household composition and income-counting rules, the vast majority of non-elderly, non-disabled individuals who receive SNAP benefits are highly likely to be financially eligible for MAGI-based Medicaid.[10] These studies provide further

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[10] Center on Budget and Policy Priorities, "A Technical Assessment of SNAP and Medicaid Financial Eligibility Under the Affordable Care Act (ACA)," June 6, 2013, available at: https://www.cbpp.org/research/a-technical-assessment-of-snap-and-medicaid-financial-eligibility-under-the-affordable-care;

The Urban Institute, "Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act," December 23, 2013, available at: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//44311/rpt_integrationproject.pdf.

support for state flexibility to determine that the gross income determination made by SNAP provides a reliable and useful source of information for purposes of verifying Medicaid income eligibility. Additionally, nearly three-quarters of SNAP households live at or below the poverty level,[11] underscoring that there is a high likelihood that those who qualify for SNAP are also eligible for Medicaid.

State Plan Strategy & Implementation Considerations

States may use a gross income determination from SNAP, if determined useful, as a data source to verify MAGI-based income at application, at renewal, or both. As a counterexample, CMS does not believe that states could reasonably conclude that net income for purposes of SNAP eligibility is useful in verifying MAGI-based income, as the determination of net SNAP income involves deduction of several significant income disregards from the gross income amount (e.g., 20 percent of earned income and shelter, utility and childcare expenses).

Below are two examples describing how a state might implement use of SNAP gross income in verifying MAGI-based income for an individual applying for Medicaid and an individual whose Medicaid eligibility is being renewed.

Example #1: In verifying the attested income of an individual applying for coverage on the basis of MAGI, a state electing this strategy could compare the individual's MAGI-based attested household income to the gross income determined by SNAP for the individual's SNAP household. If the MAGI-based attested household income is reasonably compatible with the individual's SNAP gross income, the state would consider the attested household income information to be verified. If the SNAP gross income information is not reasonably compatible with the attested MAGI-based household income, the state would follow its verification plan to complete the verification process.[12]

Example #2: When attempting an *ex parte* renewal, a state adopting this strategy for renewals would compare a beneficiary's gross income, as determined by SNAP, to the applicable Medicaid income standard. If the beneficiary's SNAP gross income is at or below the applicable income standard, the state would conclude that the beneficiary is income eligible for Medicaid. If SNAP gross income is above the applicable standard, the state would follow its verification plan to complete the verification process. The state cannot deny coverage solely based on the SNAP gross income.[13]

Based on a state's assessment of the reliability and usefulness of SNAP gross income in verifying income and supporting the interests of ensuring ineligible individuals are not enrolled and eligible individuals are not denied coverage, states may also target this strategy to specific populations. For example, a state could opt to use the strategy only for individuals whose SNAP program gross income is at or below a specified level (e.g., 100 percent of the FPL), or set other reasonable limits on the populations for whom the strategy is used.

CMS recognizes that states may find other human services programs to be effective data sources for verifying income, and that gross income from SNAP or other human services programs may be effective for verifying income of non-MAGI applicants and beneficiaries. Indeed, some states were granted section 1902(e)(14)(A) authority to waive the requirement to make an income determination for non-MAGI individuals with SNAP gross income at or below the applicable non-MAGI income standard, and some were granted similar authority with respect to MAGI and/or non-MAGI individuals whose TANF gross income was at or below the applicable MAGI or non-MAGI income standard.

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[11] U.S. Department of Agriculture Food and Nutrition Service (FNS), "Characteristics of USDA's Supplemental Nutrition Assistance Program (SNAP) Households: Fiscal Year 2022 (Summary)," June 2024, available at: https://fns-prod.azureedge.us/sites/default/files/resource-files/ops-snap-fy22characteristics-summary.pdf.

[12] Additional CMS guidance on verifying income using information from other data sources is forthcoming.

[13] Additional CMS guidance on verifying financial eligibility during an *ex parte* renewal is forthcoming.

CMS is not aware of any analyses that indicate how accurate verification using TANF's or another program's income determination will be in verifying an individual's income for purposes of Medicaid eligibility (based on either MAGI or non-MAGI methodologies) or of any analyses that indicate how accurate verification using SNAP gross income would be in verifying income for purposes of Medicaid eligibility based on non-MAGI methodologies. Additionally, there may be significant state variation in other programs' eligibility and income counting rules, which would require a state-specific analysis to determine the usefulness of the data source for Medicaid purposes. If a state is interested in using the gross income determination from a human services program other than SNAP or is interested in using SNAP gross income for non-MAGI populations, the state must conduct and share with CMS an analysis to demonstrate that the program's gross income determination would be a useful data source for verifying income and identify such program's gross income determination as a useful data source in its verification plan in accordance with 42 C.F.R. § 435.945(j).[14]

2. ***Options to Complete Ex Parte Renewal When No Data Sources Return Income Information, Including the Zero-Dollar and 100 Percent FPL Income Strategies***

Regulations at 42 C.F.R. §§ 435.916(b)(1) and (b)(3) provide that states must renew eligibility without requiring information from beneficiaries if able to do so based on reliable information available to the state, and send a renewal form to the beneficiary to obtain needed information if unable to do so. CMS generally has interpreted these provisions to mean that, when information from a reliable data source regarding eligibility criteria that are subject to change is not available, states must send a renewal form and may not conclude that a household has income below the applicable income standard based on information verified 12 months prior.[15]

To address challenges during unwinding, CMS authorized two related section 1902(e)(14)(A) waiver strategies, known as the "Zero-Dollar" and "100 Percent FPL" income strategies, that enabled states to complete an *ex parte* renewal when the state reviews all available income data sources, but no income data is returned. Under the Zero-Dollar and 100 Percent FPL income strategies, CMS waived the requirements in 42 C.F.R. §§ 435.916(b)(1) and (b)(3) to enable states to assume no change in income in conducting an *ex parte* renewal when the following conditions are met: (1) the individual's income at the last full determination of eligibility was $0 or at or under 100 percent of the FPL, respectively; (2) the state pings all income data sources used by the state in accordance with its verification plan; and (3) no information is returned from the data sources. The Zero-Dollar and 100 Percent FPL income strategies approved by CMS under section 1902(e)(14)(A) waiver authority initially required that a beneficiary's most recent income determination, verified in a manner other than use of these strategies, had been completed no earlier than 12 months prior to the beginning of the PHE. In the May 9, 2024, CIB, CMS subsequently permitted states to continue use of these strategies through June 30, 2025, without regard to whether the strategy had been previously used (so long as certain additional conditions were met to ensure the strategy was not used to renew coverage of individuals who were no longer a state resident).

States adopting the Zero-Dollar and 100 Percent FPL income strategies reported that these waivers were highly effective in streamlining the income verification process during *ex parte* renewals. Further, data analyzed by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health & Human Services (HHS) reinforces that

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[14] Note this is different than the option that is available for children under section 1902(e)(13) of the Act, which allows states to use income or other findings from one or more Express Lane Agencies designated by the state in determining Medicaid or CHIP eligibility for children at application and/or renewal. States are not required to provide CMS any analyses in order to adopt Express Lane Eligibility, which can be used for children seeking coverage on either a MAGI or non-MAGI basis.

[15] In discussing the *ex parte* renewal process in the preamble to a final rule published in 2012, CMS wrote: "[I]f information subject to change is missing…then a State must seek information from the individual before renewing eligibility." CMS, final rule, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," March 3, 2012, available at: https://www.federalregister.gov/d/2012-6560/p-484.

these strategies effectively achieve states' program integrity responsibilities.[16] ASPE estimates that, nationally, about 16 percent of Medicaid beneficiaries would likely meet the criteria for the Zero-Dollar or 100 Percent FPL income strategy—that is, had income at or below 100 percent of FPL at their last determination and have no data sources return financial information when the state is conducting their renewal. For this population, according to ASPE's analysis, employing the 100 Percent FPL income strategy and renewing financial eligibility without requiring additional information would result in an accurate determination of financial eligibility in 92 percent of cases. When considering the use of this strategy within the broader context of all Medicaid renewals, ASPE estimates that employing the 100 Percent FPL income strategy would result in a potentially erroneous eligibility determination for 1.2 percent of all Medicaid beneficiaries at renewal. The analysis of the 100 Percent FPL income strategy is inclusive of the population that would meet the criteria for the Zero-Dollar income strategy. This evidence underscores that the income eligibility of the population of beneficiaries with household income below 100 percent of FPL, including those with no household income (i.e., zero-dollar income), may be considered highly unlikely to change from year-to-year if certain conditions are met.

Regulations at 42 C.F.R. § 435.916(b)(1) provide that the reliable information states must use in attempting an *ex parte* renewal includes reliable information available in a beneficiary's account. Thus, in conducting a renewal, states must use information from a beneficiary's account (such as citizenship status and date of birth for determining age) that is not subject to change. As will be discussed in more detail in forthcoming CMS guidance, states also have flexibility to consider information in a beneficiary's account reliable if the state has determined the information is highly unlikely to change or, in the case of income or assets, highly unlikely to increase (e.g., the value of a vehicle or certain types of life insurance policies).[17]

State Plan Strategy & Implementation Considerations

Based on ASPE's analysis, CMS has determined that it would be reasonable for a state to determine that the previously-verified household income (for MAGI-based beneficiaries) or total countable income (for non-MAGI beneficiaries) in a beneficiary's account is reliable in conducting an *ex parte* renewal if: (1) the individual had a previously-verified attestation of income at or below an income level (including zero-dollar income) elected by the state, not to exceed 100 percent of the FPL; (2) the state has checked all available income data sources in accordance with its verification plan and no information is received; and (3) the state follows its verification plan to confirm the beneficiary's continued state residency.[18]

States adopting this strategy may elect to apply it only to individuals whose previously-verified income was zero dollars or to individuals whose previously-verified income was at or below an income standard elected by the state up to 100 percent of the FPL (e.g., 75 percent of the FPL). States also may elect a different income standard for different eligibility groups (e.g., 100 percent of the FPL for individuals enrolled in the adult group described at 42 C.F.R. § 435.119, and 50 percent of the FPL for individuals enrolled in the group for parents and caretaker relatives described at 42 C.F.R. § 435.110), provided that the state documents a reasonable basis for its belief that the different standards are necessary to ensure program integrity.

States that adopt this strategy on a permanent basis also must establish and document the maximum amount of time that is permitted to elapse since the state last verified a beneficiary's attested income without using this strategy (either at initial application or a renewal). CMS

[16] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Evaluating Medicaid Strategies to Streamline *Ex Parte* Renewals," November 14, 2024, available at: https://aspe.hhs.gov/reports/medicaid-ex-parte-renewals.

[17] For additional information about assets unlikely to change, see question 9 from CMS, "COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies," October 17, 2022, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf.

[18] Effective December 3, 2025, consistent with 42 CFR § 435.919(f) and 457.344, states are required to regularly obtain updated address information from reliable data sources and update the beneficiary's record with that information if the data source provides an updated in-state address. If a reliable data source provides an out-of-state address, the state must terminate the beneficiary's coverage if the beneficiary does not confirm they continue to meet the residency requirements.

considers a verified attestation of income that was made no earlier than three years prior to be reasonable, although states may establish a different reasonable maximum period of time.

States electing this strategy must have the beneficiary information necessary to match with the income data sources used by the state (for example, Social Security Number). States are reminded that they must comply with the following regulatory requirements, which apply regardless of whether the state has adopted this strategy:

- The state must review other eligibility requirements (such as assets for beneficiaries enrolled on a non-MAGI basis) before making a final determination of eligibility during the *ex parte* renewal process.
- As part of the eligibility determination notice, states must notify individuals whose coverage is renewed using this strategy that they must inform the agency if any of the information relied upon by the state in completing the renewal is inaccurate (including an increase in income), consistent with 42 C.F.R. § 435.916(b)(1)(ii).

3. *Strategy to Streamline Use of Asset Verification System (AVS)*

For individuals subject to an asset test whose eligibility is being determined on the basis of being age 65 or older or having blindness or a disability, section 1940 of the Act requires that states implement and use an AVS for assets held by a financial institution. During the unwinding period, CMS approved an unwinding-related section 1902(e)(14)(A) waiver that has allowed states to assume no change in assets verified through the AVS when no information is returned through the AVS or when the AVS call is not returned within a reasonable timeframe, and to complete the *ex parte* renewal process without any further verification of assets. This strategy helped to minimize procedural terminations by facilitating more *ex parte* renewals and limiting the instances in which states had to request documentation from beneficiaries.

Compliance with 42 C.F.R. § 435.952(c), under which states may not request additional information or documentation from an individual if data to verify attested information is available to the state, and 42 C.F.R. § 435.916(b)(1), under which states must attempt to conduct an *ex parte* renewal based on available data and information in a beneficiary's account, requires that states establish a reasonable timeframe to wait for information to be returned from its AVS before requesting documentation or other information to verify assets. Not all financial institutions participate in all states' AVS, and the response times may vary between states, AVS vendors, and/or participating financial institution. In establishing a reasonable timeframe to wait for data to be returned through their AVS, states should consider the response times experienced in their AVS. States also set a general timeline in order to complete beneficiaries' renewals timely, consistent with 42 C.F.R. § 435.916(c). In setting this overall renewal timeline, states may consider initiating the AVS check ahead of other data sources that are checked during the *ex parte* process to account for the potential lengthy AVS response time.

State Plan Strategy & Implementation Considerations

Provided a state builds into its *ex parte* renewal process a reasonable period of time for financial institutions to respond to an AVS query,[19] CMS has determined that the state may assume no change in the value of a previously-verified asset if the state submits a request through its AVS and no information is returned or there is no response from the AVS within the reasonable timeframe the state has established. Regulations at 42 C.F.R. § 435.916 afford states the flexibility to determine that certain assets are unlikely to appreciate in value and allow states to rely on the value of the asset in a beneficiary's account at renewal. This strategy would enable the state to complete an *ex parte* renewal for some beneficiaries without requesting additional documentation for asset types that can be verified with AVS. Specifically, if an individual only has assets held in financial institutions, or their only other assets are not likely to appreciate in value, the state would be able to complete an *ex parte* renewal, without any further verification of assets.

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[19] The amount of a time a state allots for financial institutions to respond to an AVS query in its *ex parte* renewal process can be different than the timeframe allotted at application.

As part of the eligibility determination notice, a state electing this strategy must notify individuals whose coverage is renewed using this strategy that they must inform the agency if any of the information relied upon by the state in completing the renewal is inaccurate, consistent with 42 C.F.R. § 435.916(b)(1)(ii). If the state receives asset information from AVS that indicates the individual's total assets may have increased after a beneficiary has been renewed on an *ex parte* basis, the information from AVS must be processed as a change in circumstance, in accordance with 42 C.F.R. § 435.919(b).[20]

B. Discontinued Blanket Authority for Unwinding-Related 1902(e)(14)(A) Waiver Strategies

As the unprecedented conditions created by the COVID-19 PHE and unwinding that necessitated the unwinding-related section 1902(e)(14)(A) waiver strategies are abating, the broad availability of a number of these strategies will end on June 30, 2025, consistent with the May 9, 2024, CIB. These strategies are described in the appendix. While existing statutory or regulatory requirements do not allow states to continue these strategies as approved under section 1902(e)(14)(A) waiver authority, where applicable, CMS has described potential alternative approaches to some of these strategies in the appendix. CMS advises states to prepare to end use of these sunsetting strategies, or to implement the alternative described in the appendix, by that date. States that would like to sunset any unwinding-related section 1902(e)(14)(A) waivers prior to June 30, 2025, should notify CMS.

CMS recognizes that states are in various stages of resuming routine eligibility and enrollment operations. As many states work toward full compliance with federal requirements related to eligibility renewals, CMS expects states to continue or initiate mitigation strategies to minimize the impact of any non-compliance with requirements on Medicaid and CHIP beneficiaries. States are instructed to seek approval for waivers, as appropriate, under section 1902(e)(14)(A) of the Act as part of the renewal compliance template.[21] To use any of the strategies for which the blanket approval is sunsetting and that are not permissible under current regulations, a state must request and receive CMS approval of, new authority under section 1902(e)(14)(A) of the Act. Generally, states may also seek CMS approval for waivers under section 1902(e)(14)(A) of the Act for strategies beyond those captured in the appendix. Such requests, whether needed in the context of renewal compliance or for another purpose, will be considered individually and approved on a time-limited basis, if needed to address compliance and/or systems issues that prevent the state from establishing income and eligibility determination systems that protect beneficiaries. CMS is committed to working with states to ensure that state systems and operations meet the goals of the Medicaid and CHIP programs and support program integrity.

III. <u>Regulatory Exception to Timely Determinations: State Options to Delay Procedural Disenrollments</u>

The exception to timely determinations of eligibility at 42 C.F.R. § 435.912(e) permits states to exceed the timeliness standard established in accordance with paragraphs (b) and (c) of that section when there is an administrative or other emergency beyond the agency's control. In the May 9, 2024, CIB,[22] CMS announced that the unprecedented volume of renewals during unwinding warranted the continued use of this exception for renewals initiated through June 30, 2025, and that states may continue to rely on the timeliness exception to delay a procedural disenrollment for up to three months while the state conducts targeted outreach to encourage the

[20] Note that, in the case of a child who is excepted from MAGI-based methodologies and subject to an asset test, AVS information returned after the child's coverage is renewed cannot result in disenrollment due to the requirement to provide continuous eligibility under section 1902(e)(16) of the Act. See slide 2, CMS, "Scenarios: The Intersection of Continuous Eligibility and Individual Level of Renewal Processes," October 2023, available at: https://www.medicaid.gov/resources-for-states/downloads/int-contin-elig-indiv-lvl-renew-process.pdf.

[21] CMS, CIB, "State Compliance with Medicaid and CHIP Renewal Requirements by December 31, 2026" September 20, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib09202024.pdf.

[22] CMS, CIB, "Extension of Temporary Unwinding-Related Flexibilities," May 9, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf.

beneficiary to return their renewal form, if the state continues to meet the conditions set forth in the regulations.

As states return to regular operations, CMS's broad concurrence with application of this option will not continue after June 30, 2025, as states are expected to have made significant progress in their efforts to resume routine operations (e.g., reduction in backlog of pending renewals, completion of work towards system compliance with federal renewal regulations). However, to achieve a similar result, states can build additional time into their renewal processes by adjusting the timing of renewal notifications to provide beneficiaries additional time to return their renewal form and by conducting targeted outreach to beneficiaries at risk of losing coverage for procedural reasons. If a state experiences an administrative or other emergency (e.g., natural disaster affecting all or parts of the state, such as a hurricane, flood, or wildfire) beyond the agency's control and the state believes the circumstances meet the conditions to apply the exception at 42 C.F.R. § 435.912(e) such that the state would be justified in delaying procedural terminations in order to conduct targeted outreach, CMS strongly recommends that the state seek CMS concurrence to use the exception.

IV. Eligibility System Changes

A state may need to make changes to its eligibility and enrollment system to ensure compliance with the requirements described in this CIB. State Medicaid agency IT system costs may be eligible for enhanced federal financial participation (FFP). Approval for enhanced match requires the submission of an Advanced Planning Document (APD). A state may submit an APD requesting approval for a 90/10 enhanced match for the design, development, and implementation of their Medicaid Enterprise Systems (MES) initiatives that contribute to the economic and efficient operation of the program and ensure compliance with the requirements reiterated in this CIB, including the maintenance and operations of these services. Interested states should refer to 45 C.F.R. Part 95 Subpart F—Automatic Data Processing Equipment and Services—Conditions for FFP for the specifics related to APD submission. States may also request a 75/25 enhanced match for ongoing operations of CMS approved systems. Interested states should refer to 42 C.F.R. Part 433 Subpart C—Mechanized Claims Processing and Information Retrieval Systems for the specifics related to systems approval.

V. Closing

CMS advises that states carefully review the appendix for additional details regarding the unwinding-related section 1902(e)(14)(A) waiver strategies that may be continued at state option and the necessary steps to do so, and those that are newly required by the April 2024 Eligibility and Enrollment final rule, and that must discontinue on June 30, 2025, absent new authority granted by CMS. To implement any of the strategies discussed in this CIB, states must document their use of such strategies in their verification policies and procedures. At this time, CMS is not requiring states to submit updated verification plans with any new policies based on the flexibilities described in this guidance. However, CMS may require specific policies detailed in this guidance be included in verification plans submitted to CMS in the future. CMS approval of state verification plans is not required, but states must submit their plans to CMS upon request, consistent with 42 C.F.R. § 435.945(j).

For additional information about this CIB, please contact Suzette Seng, Director, Division of Enrollment Policy and Operations, at Suzette.Seng@cms.hhs.gov. States may also submit questions and request technical assistance by contacting their Medicaid state lead.

Appendix: Continued Availability of Certain Strategies Based on Unwinding-Related Section 1902(e)(14)(A) Waivers Beyond June 30, 2025

To support states' efforts to protect continuity of coverage during their unwinding periods, the Centers for Medicare & Medicaid Services (CMS) approved the use of certain temporary authorities, including waivers under section 1902(e)(14)(A) of the Social Security Act (the Act).[23] Section 1902(e)(14)(A) of the Act permits CMS to approve time-limited waivers "as are necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries." CMS approved section 1902(e)(14)(A) waivers in relation to unwinding-related challenges that states faced; this included waivers to: increase *ex parte* renewal rates, support beneficiaries with renewal form submission or completion, obtain updated beneficiary contact information, promote continuity of coverage and care, and facilitate reinstatement of eligible individuals disenrolled for procedural reasons. In the May 9, 2024, Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS) Informational Bulletin (CIB), CMS announced that all unwinding-related section 1902(e)(14)(A) waivers would be extended through June 30, 2025.[24] Since publishing the May 9, 2024 CIB, CMS has reviewed the potential for making available permanently each of the strategies facilitated by unwinding-related section 1902(e)(14)(A) waivers.

The table below outlines which unwinding-related section 1902(e)(14)(A) waiver strategies (1) may continue long-term in a materially similar way to the unwinding-related strategies currently in place at states' option under their Medicaid or CHIP state plan, (2) are required[25] under recent changes to Medicaid and CHIP regulations, or (3) will sunset after June 30, 2025. Through our work with states and feedback from other stakeholders, CMS has recognized the effectiveness of these strategies in streamlining eligibility and enrollment processes to reduce inappropriate terminations and mitigate the burden on state systems, eligibility staff, and beneficiaries. For each unwinding-related section 1902(e)(14)(A) waiver strategy listed, CMS provides a rationale for continued availability or discontinuation of the strategy. CMS advises that states carefully review the chart for the steps that states may need to take to continue use of a strategy, if applicable. For strategies that will be discontinued, as well as for some unique unwinding-related section 1902(e)(14)(A) waiver strategies that were approved in individual states and are therefore not captured in the chart below, states may request approval from CMS to continue use after June 30, 2025, on an individual basis. At this time, CMS does not require states to submit updated verification plans including any of the continuing strategies discussed in this chart. However, CMS may require states to submit updated verification plans—including to identify any strategies discussed in this CIB that the state has adopted —in the future. CMS approval of state verification plans is not required, but states must submit their plans to CMS upon request, consistent with 42 C.F.R. §435.945(j).

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[23] CMS, "COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals," July 12, 2024, available at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html. See the full section 1902(e)(14)(A) waiver dataset at: https://www.medicaid.gov/resources-for-states/downloads/covid19-phe-unwinding-full-table-waiver-chart.xlsx.

[24] CMS, CIB, "Extension of Temporary Unwinding-Related Flexibilities," May 9, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf.

[25] CMS, Final Rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," April 2, 2024, available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health. The April 2024 Eligibility and Enrollment final rule codified several strategies in the regulations (89 FR 22780).

States may submit questions and request technical assistance by contacting Suzette Seng, Director, Division of Enrollment Policy and Operations, at Suzette.Seng@cms.hhs.gov or by contacting their Medicaid state lead.

Table 1: Availability of Unwinding-Related Section 1902(e)(14)(A) Waivers Beyond June 30, 2025

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
Strategies to Increase Ex Parte Renewal Rates				
1	Applying for Other Benefits Strategy	Suspend the requirement to apply for other benefits under 42 C.F.R. § 435.608.	Strategy required by the April 2024 Eligibility and Enrollment Final Rule.	Under the April 2024 Eligibility and Enrollment Final Rule, the requirement to apply for other benefits as a condition of Medicaid eligibility (42 C.F.R. § 435.608) has been eliminated for all applicants and beneficiaries, effective June 3, 2024. All states must eliminate any requirement to apply for other benefits as a condition of Medicaid eligibility by no later than June 3, 2025, and may do so sooner.
2	Supplemental Nutrition Assistance Program (SNAP)/Temporary Assistance for Needy Families (TANF) Strategy	Enroll and/or renew Medicaid eligibility for Modified Adjusted Gross Income (MAGI) or non-MAGI-based individuals based on gross income findings from SNAP or TANF.	Optional strategy under state plan to use SNAP gross income* (see note in last column) for MAGI populations.	Section 1137 of the Act and implementing regulations at 42 C.F.R. § 435.948 identify SNAP as one of the data sources states are required to access to the extent the state determines SNAP to be useful for verifying income. In determining usefulness, CMS expects states to consider such factors as the accuracy of the financial information, the timeliness of the information returned, the complexity of accessing the data or data source, the age of the financial records, the comprehensiveness of the data, any limitations imposed by the owner of the data on its use, as well as other relevant factors. Consistent with the aforementioned factors for consideration, CMS expects states to exercise reasonable judgement in determining what data from the data source is useful for verifying income. To implement this strategy at application, renewal, or both, states must document their use of SNAP gross income in their verification policies and procedures. At this time, CMS is not requiring states to submit updated verification plans with any new policies based on the flexibilities described in this guidance.** CMS may require specific policies detailed in this guidance be included in verification plans in the future. CMS approval of state verification plans is not required, but states must submit their plans to CMS upon request, consistent with 42 C.F.R. § 435.945(j). *Note: If a state is interested in using the gross income determination from a human service program other than SNAP, such as TANF, or is interested in using SNAP gross income for non-MAGI populations, the state must conduct and share with CMS an analysis to determine whether that program's gross income determination would be a useful data source for verifying income. **CMS is requiring states to submit their updated MAGI-based verification plans to CMS if a state implementing this policy does not already include SNAP as a useful data source for verifying financial information.

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
3	$0 Income Strategy	Renew Medicaid eligibility for individuals with no income and no data returned on an *ex parte* basis.	Optional strategy under state plan.	For individuals with a previously-verified attestation of zero-dollar income, if the state has checked all available income data sources in accordance with its verification plan and no information is received, the state may consider the previously-verified income determination in the beneficiary's account as reliable under 42 C.F.R. § 435.916(b)(1) in conducting an *ex parte* renewal without requesting additional information or documentation of income. To implement this strategy, a state would need to comply with regulatory requirements and guardrails detailed in this CIB. States that adopt this strategy on a permanent basis must establish the maximum amount of time that has elapsed since the state last verified zero-dollar income without using this strategy (either at initial application or a renewal). To implement this strategy, states must document its use in their verification policies and procedures. At this time, CMS is not requiring states to submit updated verification plans with any new policies based on the flexibilities described in this guidance. CMS may require specific policies detailed in this guidance be included in verification plans in the future. CMS approval of state verification plans is not required, but states must submit their plans to CMS upon request, consistent with 42 C.F.R. § 435.945(j).
4	100 Percent Income Strategy	Renew Medicaid eligibility for individuals with income at or below 100 percent of the federal poverty level (FPL) and no data returned on an *ex parte* basis.	Optional strategy under state plan.	For individuals with previously-verified income at or below 100 percent of the FPL, if the state has checked all available income data sources in accordance with its verification plan and no information is received, the state may consider the previously-verified income determination in the beneficiary's account as reliable under 42 C.F.R. § 435.916(a) in conducting an *ex parte* renewal without requesting additional information or documentation of income. To implement this strategy, a state would need to comply with regulatory requirements and guardrails detailed in this CIB. States that adopt this strategy on a permanent basis must establish the maximum amount of time that has elapsed since the state last verified income at or below 100 percent of FPL without using this strategy (either at initial application or a renewal). States may choose a lower FPL at which to implement the 100 percent FPL strategy. To implement this strategy, states must document its use in their verification policies and procedures. At this time, CMS is not requiring states to submit updated verification plans with any new policies based on the flexibilities described in this guidance. CMS may require specific policies detailed in this guidance be included in verification plans in the future. CMS approval of state verification plans is not required, but states must submit their plans to CMS upon request, consistent with 42 C.F.R. § 435.945(j).

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
5	Streamlining Asset Determinations Strategy	Renew Medicaid eligibility without regard to the resource test for non-MAGI beneficiaries who are subject to a resource test.	Optional strategy under state plan.	Pursuant to the longstanding authority in section 1902(r)(2) of the Act, states may disregard (i.e., not count) otherwise countable income and/or resources in making non-MAGI eligibility determinations. For example, a number of states disregard all assets for the Medicare Savings Program groups described in Section 1902(a)(10)(E)(i), (iii), and (iv) of the Act. Similarly, states may disregard increases in assets beneficiaries experience after their date of application. To implement this strategy, a state would need to submit an eligibility state plan amendment to apply a 1902(r)(2) disregard and specify the non-MAGI eligibility groups to which the disregard would apply.
6	Asset Verification System (AVS) Strategy	Renew Medicaid for individuals for whom information from the AVS is not returned or is not returned within a reasonable timeframe.	Optional strategy under state plan.	Provided a state builds into its *ex parte* renewal process a reasonable period of time for financial institutions to respond to an AVS query, CMS has determined that the state may assume no change in the value of a previously-verified asset if the state submits a request through its AVS and no information is returned or there is no response from the AVS within the reasonable timeframe the state has established. Regulations at 42 C.F.R. § 435.916 afford states the flexibility to determine that certain assets are unlikely to appreciate in value and allow states to rely on the value of the asset in a beneficiary's account at renewal. This strategy would enable the state to complete an *ex parte* renewal for some beneficiaries without requesting additional documentation for asset types that can be verified with AVS. Specifically, if an individual only has assets held in financial institutions, or their only other assets are not likely to appreciate in value, the state would be able to complete an *ex parte* renewal, without any further verification of assets. To implement this strategy, states should document its use in their verification policies and procedures. At this time, CMS is not requiring states to submit updated verification plans with any new policies based on the flexibilities described in this guidance CMS may require specific policies detailed in this guidance be included in verification plans in the future. CMS approval of state verification plans is not required, but states must submit their plans to CMS upon request, consistent with 42 C.F.R. § 435.945(j).

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
7	Stable Income and Asset Strategy	Renew Medicaid eligibility for individuals with only Title II or other stable sources of income (e.g., pension income) or stable assets (e.g., burial funds) without checking required data sources.	Optional strategy under state plan.	States have flexibility to make a reasonable determination of what types of income and assets are highly likely to remain stable (or decrease in value) in conducting an *ex parte* renewal under 42 C.F.R. § 435.916(b)(1). Stable sources of income may include income from a fixed pension, as this generally does not change year to year. Fixed distributions of dividends or interest and non-retirement fixed annuities are also likely to remain stable. Assets that are highly unlikely to increase in value, and may even decrease, include the value of a second vehicle (if considered in determining countable assets), burial funds, special needs trusts (provided that the state clearly advises beneficiaries on their responsibility to report any changes to the terms of the trust), and some life insurance policies. Therefore, states may, when attempting an *ex parte* renewal per 42 C.F.R. § 435.916(b)(1), assume no change in those income sources or assets determined by the state to be stable without checking data sources. In these instances, states use the stable income or asset in the beneficiary case file as verified information when determining financial eligibility. To implement this strategy states should document its use in their verification policies and procedures. At this time, CMS is not requiring states to submit updated verification plans with any new policies based on the flexibilities described in this guidance. CMS may require specific policies detailed in this guidance be included in verification plans in the future. CMS approval of state verification plans is not required, but states must submit their plans to CMS upon request, consistent with 42 C.F.R. § 435.945(j).

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
8	Medical Support Cooperation Strategy	Suspend the requirement to cooperate with the agency in establishing the identity of a child's parents and in obtaining medical support.	Blanket authority discontinued after June 30, 2025.	Under sections 1912 and 1902(a)(45) of the Act and 42 C.F.R. §§ 435.610, 433.145, 433.147, and 433.148, beneficiaries are required either to cooperate with the state in obtaining, from liable third parties, medical support and payments for themselves or for a person for whom the individual can legally assign rights, or to establish good cause for not doing so. Individuals who assign the rights to medical support and payments on behalf of a child must also cooperate with the state in establishing the identity of the child's non-custodial parent(s) or establish good cause for not doing so. Individuals (unless exempt per regulations at 42 C.F.R. §§ 435.610, such as pregnant individuals) must agree to cooperate in establishing paternity and obtaining medical support at application. At application, individuals must indicate that they are willing to fulfill these cooperation requirements unless they are exempt, but states cannot require such individuals to take concrete steps to meet medical support cooperation requirements until after enrollment. CMS encourages states to evaluate their policies and practices to identify opportunities to streamline medical support cooperation enforcement and ensure eligible individuals enroll in and retain Medicaid coverage. For more information see CMS, "Medicaid Medical Support Requirements and Implementation Strategies," June 2023.[26]
Strategies to Support Beneficiaries with Renewal Form Submission or Completion				
9	Managed Care Organization (MCO) Renewal Support Strategy	Permit MCOs to provide assistance to beneficiaries to complete and submit Medicaid renewal forms.	Optional strategy under state plan.	Existing managed care regulations do not prohibit MCOs from conducting outreach and assisting beneficiaries with completing and submitting renewal forms, provided that the plan does not provide choice counseling (defined at 42 C.F.R. § 438.2). MCOs may not complete any renewal form fields related to plan choice and may not sign the renewal form on behalf of the beneficiary. To implement this strategy, a state would need to document their choice to do so in their state policy manual and make the manual available to CMS upon request.
10	Telephonic Signature Recording Strategy	Waive the recording of the telephone signature at application and/or renewal from the applicant or beneficiary.	Blanket authority discontinued after June 30, 2025.	Per 42 C.F.R. §§ 435.907(f) and 435.916(b)(2)(ii)(B), all initial applications and renewal forms must be signed under penalty of perjury. Signatures transmitted telephonically must be recorded. When recording a telephonic signature, states have flexibility to record the entire application or renewal conversation, including the signature under penalty of perjury, or to record only the signature under penalty of perjury.

[26] CMS, "Medicaid Medical Support Requirements and Implementation Strategies," June 2023, available at: https://www.medicaid.gov/medicaid/eligibility/downloads/mm-supp-req-impl-strategies.pdf.

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
11	Authorized Representative Designation Strategy	Permit the designation of an authorized representative for the purposes of signing an application or renewal form via the telephone without a signed designation from the applicant or beneficiary.	Blanket authority discontinued after June 30, 2025.	42 C.F.R. § 435.923 requires that applicants and beneficiaries be able to designate an authorized representative to act on their behalf and that the signature of the applicant or beneficiary be included with the designation. Signatures must be accepted in all modalities available at 42 C.F.R. § 435.907(f), including by telephone.
Strategies to Obtain Updated Beneficiary Contact Information				
12	National Change of Address (NCOA) and/or U.S. Postal Service (USPS) Contact Update Strategy	Update the beneficiary's case record with the updated in-state contact information received from the NCOA database or USPS returned mail without first sending a notice to the beneficiary address on file with the state.	Strategy required by the April 2024 Eligibility and Enrollment Final Rule.	Under 42 C.F.R. §§ 435.919(f)(1) and 457.344, states must establish a process to obtain updated address information from reliable sources, including the NCOA, mail returned by USPS with a forwarding address, and MCOs. If the state receives an updated in-state address from a reliable source, it must accept the information, update the beneficiary's case record with the updated address, and notify the beneficiary of the change in accordance with 42 C.F.R. §§ 435.919(f)(2) and 457.344. States may not require verification of an address change from the beneficiary prior to updating their record. This requirement was finalized by the April 2024 Eligibility and Enrollment final rule. All states must comply with this requirement by December 3, 2025, and may implement it sooner.
13	Managed Care Organization (MCO) Beneficiary Contact Update Strategy	Update the beneficiary's case record with the updated in-state contact information received from an MCO without first sending a notice to the beneficiary address on file with the state.	Strategy required by the April 2024 Eligibility and Enrollment final rule.	See description above for NCOA and/or USPS Contact Update Strategy.

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
14	Enrollment Broker and/or Program of All-Inclusive Care for the Elderly (PACE) Contact Update Strategy	Update the beneficiary's case record with the updated in-state contact information received from enrollment brokers and/or PACE organizations without first sending a notice to the beneficiary address on file with the state.	Optional strategy under April 2024 Eligibility and Enrollment final rule.	42 C.F.R. §§ 435.919(f)(1)(iii)(D) and 457.344 provide states with flexibility to deem other sources identified by the agency and approved by the Secretary as reliable for purposes of obtaining updated contact information. States may opt to deem enrollment brokers and/or PACE organizations to be reliable sources. If this option is elected, the state must, upon receipt of an updated in-state address from an enrollment broker and/or PACE organization, accept the information, update the beneficiary's case record with the updated address, and notify the beneficiary of the change in accordance with 42 C.F.R. §§ 435.919(f)(2) and 457.344. To implement this option, states should clearly document use of this strategy in internal files, for audit and other purposes. States may be asked to provide these documents to CMS upon request.
Strategies to Promote Continuity of Coverage and Care				
15	12-Month Extension for Children and/or Non-MAGI Beneficiaries Strategy	Renew Medicaid eligibility for children and/or non-MAGI beneficiaries for 12 months based on the individual's most recent Medicaid determination (either at initial application or most recent renewal) without conducting a renewal or making a new eligibility determination.	Blanket authority discontinued after June 30, 2025.	Regulations at 42 C.F.R. §§ 435.916 and 457.343 require states to conduct renewals and make a new eligibility determination for most individuals enrolled in Medicaid and CHIP once every 12 months. States currently must conduct MAGI-based renewals once every 12 months. The requirement for states to conduct non-MAGI based renewals once every 12 months (instead of at least once every 12 months) was finalized by the April 2024 Eligibility and Enrollment final rule. All states must comply with this requirement for non-MAGI based renewals by June 3, 2027, and may implement it sooner.
16	Medicaid Premium Resumption Delay Strategy	Delay the resumption of Medicaid premiums otherwise approved under the state plan for a beneficiary until the individual's redetermination is completed.	Blanket authority discontinued after June 30, 2025.	States may not generally suspend premiums for some individuals in a population subject to a premium and not others. States may request to eliminate premiums for all individuals in a given population(s) currently subject to a premium by submitting a state plan amendment.

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
17	Former Foster Care Children (FFCC) Strategy	Extend eligibility in the FFCC group to youth formerly in foster care from any state, without regard to when the individual turned age 18.	Blanket authority discontinued after June 30, 2025.	Under section 1002(a) of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Pub. L. 115-271), states must apply different eligibility rules in determining eligibility for the FFCC group under section 1902(a)(10)(A)(i)(IX) of the Act based on when an individual reaches age 18. As discussed in State Health Official Letter #22-003[27], states may request to establish a section 1115 demonstration to cover youth formerly in foster care from other states regardless of when an individual reaches age 18.
18	Fair Hearings Timeframe Extension Strategy	Extend the timeframe permitted for the state to take final administrative action on fair hearing requests, greater than the 90-day time limit, provided that state provides benefits pending the outcome of the fair hearing to all appellants.	Blanket authority discontinued after June 30, 2025.	States must take final administrative action on all fair hearing requests within 90 days from the date the individual filed the fair hearing request in accordance with 42 C.F.R. § 431.244(f)(1), unless the agency cannot reach a decision because the appellant requests a delay or fails to take a required action, or an administrative or other emergency beyond the agency's control prevents it from doing so (42 C.F.R. § 431.244(f)(4)(i)(A) and (B)).

[27] CMS. (December 16,2022). State Health Official Letter #22-003 RE: Coverage of Youth Formerly in Foster Care in Medicaid (Section 1022(a)of the SUPPORT Act). Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho22003.pdf

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
Strategies to Facilitate Reinstatement of Eligible Individuals Disenrolled for Procedural Reasons				
19	State Agency and/or Other Qualified Entities Using Presumptive Eligibility (PE) Strategy	Designate state agency, pharmacies, community-based organizations (CBOs), and/or other providers as qualified entities to make determinations of PE on a MAGI basis for individuals not enrolled in Medicaid or CHIP. Designate the state agency as a qualified entity to make PE determinations on a MAGI basis and allow the option to make PE determinations based on information provided on a renewal form or a full Medicaid application, and extend the PE period until the state determines eligibility based on the renewal form or a full Medicaid application.	Optional strategy under state plan.	Under federal regulations at 42 C.F.R. §§ 435.1103 and 457.355, states may permit qualified entities, including the state agency itself, pharmacies, CBOs, and/or other providers, to make PE determinations on a MAGI-basis for individuals not enrolled in Medicaid or CHIP. Once determined eligible for PE, the PE period begins on the day that the qualified entity approves PE. If a full Medicaid/CHIP application is submitted by the last day of the month after the month that PE is determined, the PE period ends on the date full Medicaid eligibility is approved or denied. If a full Medicaid and/or CHIP application is not submitted by the last day of the month after the month that PE is determined, the PE period ends on that day. States may require qualified entities to assist individuals with a PE determination in completing a Medicaid/CHIP application. Consistent with requirements at 42 C.F.R. §§ 435.916(b)(2)(iii) and 457.343, this strategy allows state agencies to treat a renewal form returned during the reconsideration period for individuals with a PE determination as a Medicaid/CHIP application for the purposes of extending the PE period until the state determines eligibility. States electing this option would provide adequate training to qualified entities making PE determinations to assist individuals with completing a Medicaid application or renewal form for individuals whose coverage had been terminated for failure to timely submit the renewal form. If a state designates itself as a qualified entity to make PE determinations, the state agency would treat a Medicaid application or renewal as a PE application and use the information on the application or renewal form to make a PE determination. To implement this strategy, states would submit a PE state plan amendment to adopt PE (if not already adopted in the state plan), and elect the option to treat renewal forms returned during the reconsideration period as a Medicaid/CHIP application for purposes of extending the PE period. States electing this option must also allow full Medicaid applications to extend the PE period for individuals with a PE determination. The state would list the qualified entities it is designating to make PE determinations and the MAGI populations it is electing to cover through PE in accordance with 42 C.F.R. § 435.1103.

#	1902(e)(14)(A) Strategy	Original Strategy Description	Continued Availability of Strategy	Rationale and Authority for Continued Availability or Discontinuation of Strategy
20	Reinstate Eligibility Back to Termination Date During Reconsideration Period Strategy	Reinstate eligibility effective on the individual's prior termination date for individuals who were disenrolled based on a procedural reason and are subsequently redetermined eligible for Medicaid during a 90-day reconsideration period.	Blanket authority discontinued after June 30, 2025.	Medicaid and CHIP regulations do not otherwise support reinstatement of an individual's eligibility back to the date of termination prior to a determination of eligibility based solely on the returned renewal form. However, consistent with 42 C.F.R. § 435.915, states must provide up to three months of retroactive eligibility for individuals disenrolled for procedural reasons who are subsequently determined eligible for Medicaid during the reconsideration period, if the individual received Medicaid services in the three months prior to returning the renewal form and met Medicaid eligibility requirements when services were received. This enables a state to close or minimize potential coverage gaps.
21	Managed Care Plan Auto-Reenrollment Strategy	Extend automatic reenrollment into an MCO to up to 120 days after a loss of Medicaid coverage.	Blanket authority discontinued after June 30, 2025.	There is no regulatory authority to extend the automatic reenrollment period. Under section 1903(m)(2)(H)(ii) of the Act and 42 C.F.R. § 438.56(g), states may require that Medicaid managed care contracts provide for automatic reenrollment into a beneficiary's original plan for individuals who are reenrolled into Medicaid after a loss of Medicaid coverage for two months or less.