All-State Medicaid and CHIP Call
January 15, 2025

Agenda

- Medicare Beneficiary Identifier (MBI) Lookup Tools Request for Information
- Ensuring Seamless Coverage Transitions Between Medicaid, Separate CHIPs, and Other Insurance Affordability Programs and Exercise of Enforcement Discretion to Delay Implementation of Certain Coverage Transition Requirements
- Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions
- Open Mic Q and A

Medicare Beneficiary Identifier (MBI) Lookup Tools Request for Information

Dennis Sendros

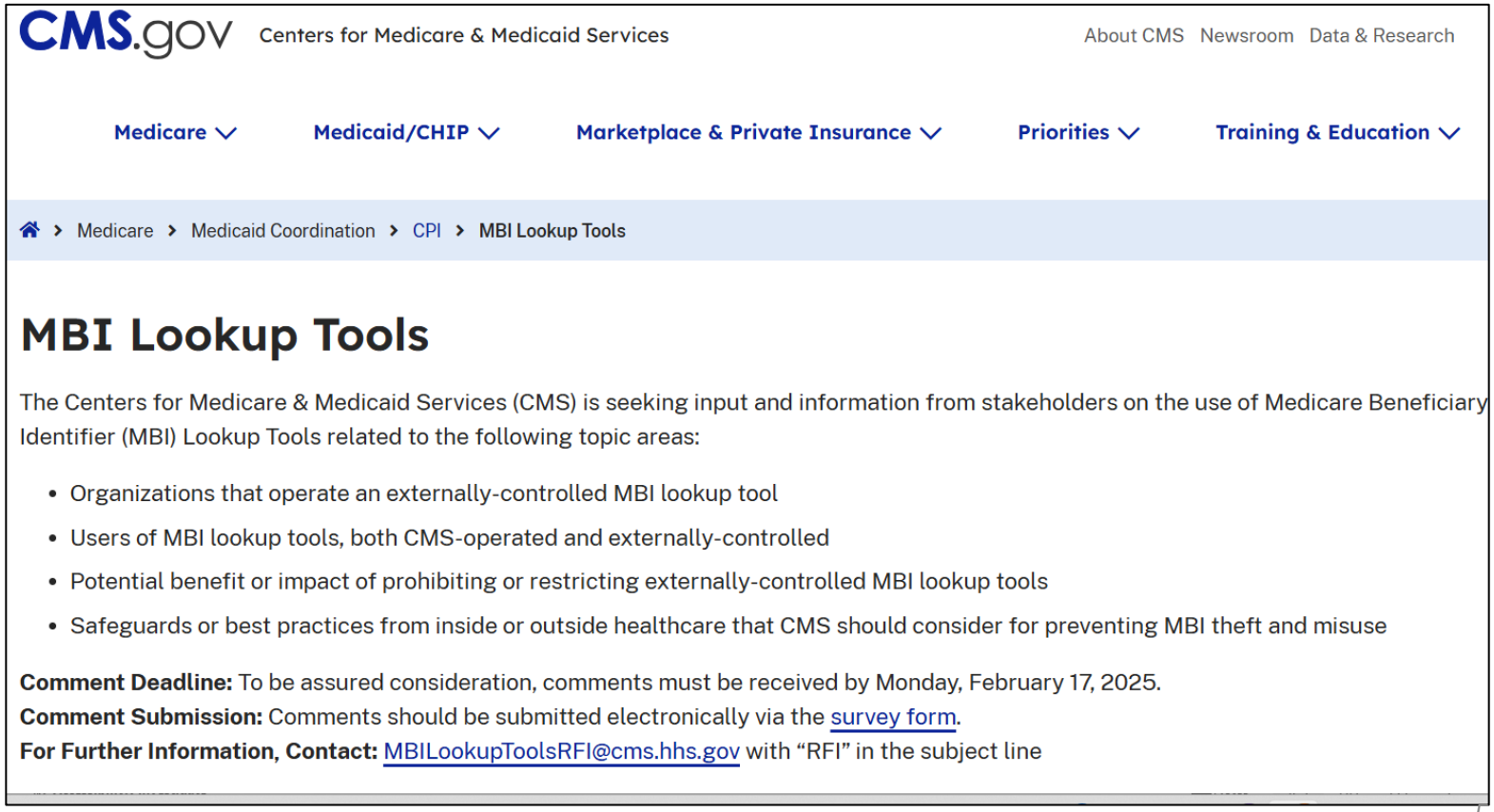
Center for Program Integrity

Medicare Beneficiary Identifier (MBI) Lookup Tools RFI (1/2)

- Stolen MBIs are a major driver of almost all Medicare fraud schemes
- MBIs are sometimes stolen through MBI lookup tools
- Many states have established their own MBI lookup tools to assist in care coordination
- CMS is considering prohibiting or restricting external MBI lookup tools

Medicare Beneficiary Identifier (MBI) Lookup Tools RFI (2/2)

- CMS is soliciting comments to inform future decision-making regarding how we can best protect MBIs and Medicare beneficiaries



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Medicare Medicaid/CHIP Marketplace & Private Insurance Priorities Training & Education

Medicare > Medicaid Coordination > CPI > MBI Lookup Tools

MBI Lookup Tools

The Centers for Medicare & Medicaid Services (CMS) is seeking input and information from stakeholders on the use of Medicare Beneficiary Identifier (MBI) Lookup Tools related to the following topic areas:

- Organizations that operate an externally-controlled MBI lookup tool
- Users of MBI lookup tools, both CMS-operated and externally-controlled
- Potential benefit or impact of prohibiting or restricting externally-controlled MBI lookup tools
- Safeguards or best practices from inside or outside healthcare that CMS should consider for preventing MBI theft and misuse

Comment Deadline: To be assured consideration, comments must be received by Monday, February 17, 2025.
Comment Submission: Comments should be submitted electronically via the survey form.
For Further Information, Contact: MBILookupToolsRFI@cms.hhs.gov with "RFI" in the subject line

CENTERS FOR MEDICARE & MEDICAID SERVICES

Ensuring Seamless Coverage Transitions Between Medicaid, Separate Children's Health Insurance Programs (CHIPs), and Other Insurance Affordability Programs

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Background

The April 2, 2024, *Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* Final Rule, 89 FR 22780, ("April 2024 Final Rule") made changes to ensure seamless transitions of beneficiaries between Medicaid, separate CHIPs, and other insurance affordability programs to promote timely enrollment in the appropriate coverage program and minimize unnecessary losses of coverage for eligible individuals.

These slides summarize the December 20, 2024, CIB, *Ensuring Seamless Coverage Transitions between Medicaid, Separate CHIPs, and Other Insurance Affordability Programs and Exercise of Enforcement Discretion to Delay Implementation of Certain Coverage Transition Requirements*, that provides guidance to states on new requirements at 42 C.F.R. §§ 431.10, 435.1200, 457.340, 457.348, 457.350, and 600.330. These regulatory provisions contain three key requirements for Medicaid and CHIP agencies:

- The seamless transitions requirement (defined on slide 5);
- The procedural disenrollment account transfer requirement (defined on slide 6); and
- The combined notices requirement (defined on slide 6).

These requirements became effective on June 3, 2024; however, CMS is exercising enforcement discretion and will not require states to demonstrate compliance with the combined notices and procedural disenrollment account transfer requirements until June 3, 2026.

Requirements apply to all states that operate a separate CHIP, regardless of whether the CHIP and Medicaid programs are administered by the same state agency.

Content

Context Setting: New Requirements to Ensure Seamless Coverage Transitions

New Seamless Transitions Requirement for Children*

Beginning **June 3, 2024**, Medicaid and CHIP agencies must:

- Make determinations of Medicaid based on Modified Adjusted Gross Income (MAGI) and separate CHIP eligibility for children on behalf of the other program;
  - The agency must have sufficient information to determine that the child is eligible for the other program (i.e., for separate CHIP, the child is under age 19, has income at or below the CHIP income eligibility standard, and does not have other health insurance; for Medicaid, the family income is at or below the applicable Medicaid income standard).
- Accept determinations of MAGI-based Medicaid and separate CHIP eligibility for children made by the other program; and
- When appropriate, transition a child's account between programs for timely enrollment.

States have flexibility in how to implement the seamless transitions requirement.

- The processes used to seamlessly transition children between Medicaid and separate CHIP will differ depending on the option elected by the state (see slide 8).

**Children refers to individuals under the age of 19, including those covered under the from-conception-to-end-of-pregnancy (FCEP) option; this requirement does not apply to individuals ages 19 to 20 or to adults.*

42 C.F.R. §§ 435.1200(b)(3)(vi), 435.1200(b)(4), 435.1200(c)(2)(ii), 435.1200(e)(1)(i), 457.348(a)(6), 457.348(e), and 457.350(b)(1)(i)). Also see the December 2024 CIB, *Ensuring Seamless Coverage Transitions between Medicaid, Separate CHIPs, and Other Insurance Affordability Programs and Exercise of Enforcement Discretion to Delay Implementation of Certain Coverage Transition Requirements*.

New Combined Notices Requirement and Procedural Disenrollment Account Transfer Requirement

By June 3, 2026, states must (1) provide a combined Medicaid and separate CHIP notice, and (2) transfer accounts of individuals disenrolled from Medicaid or separate CHIP for procedural reasons if available information indicates the individual is potentially eligible for Marketplace or BHP coverage.

For the combined notices and procedural disenrollment account transfer requirements, CMS is exercising enforcement discretion and will not require states to demonstrate compliance until June 3, 2026, to account for complex system changes that may be needed for states to implement these requirements**.** CMS will continue to evaluate the facts on the ground, and if states' experience indicates that additional time may be necessary to comply, CMS will take that into account in developing further policy.

Combined Notices Requirement: The April 2024 Final Rule requires states to send a combined notice of Medicaid and separate CHIP eligibility determinations when a child's account is transitioned between these two programs.

Procedural Disenrollment Account Transfer Requirement: States must:

1. Assess eligibility for coverage through the Marketplace, and, if applicable, under a BHP; and
2. If the state has sufficient information to assess such eligibility, transfer the individual's account to the Marketplace or to a BHP, as appropriate, including when a beneficiary has not returned information requested by the state needed to complete a redetermination of eligibility for Medicaid or separate CHIP (procedural disenrollment).

The procedural disenrollment account transfer requirement existed prior to the April 2024 Final Rule, but previously states were instructed never to transfer accounts for individuals who were procedurally disenrolled from Medicaid or a separate CHIP—i.e., because they have not returned information requested by the state needed to complete a redetermination of eligibility.

42 C.F.R. §§ 435.1200(b)(3)(i)-(v), 435.1200(e)(1)(ii), 435.1200(h)(1), 457.340(f)(1), 457.350(b)(1)(ii), 457.350(g), 457.350(h), and 600.330. Also see the December 2024 CIB, *Ensuring Seamless Coverage Transitions between Medicaid, Separate CHIPs, and Other Insurance Affordability Programs and Exercise of Enforcement Discretion to Delay Implementation of Certain Coverage Transition Requirements*.

Operationalizing the Seamless Transitions Requirement

State Options for Complying with the Seamless Transitions Requirement

States have four options for how to comply with the seamless transitions requirement. The state Medicaid and CHIP agencies must elect the same option.

Option 1

Use a shared eligibility service. Use a shared eligibility service that makes eligibility determinations for both programs. Under this option, the Medicaid agency must have exclusive responsibility for Medicaid requirements programmed in the shared eligibility service.

Option 2

Accept findings made by the other agency. Apply the same MAGI-based methodologies and verification procedures in both programs so that each agency accepts any findings relating to eligibility criteria made by the other agency without further verification.

Option 3

Delegate authority to the other agency. Enter into an agreement to delegate final determinations of eligibility to the other program. Under this option, states must submit a Medicaid single state agency SPA to delegate authority to the CHIP agency. CHIP agencies do not need a SPA. Both agencies must establish procedures to receive electronic accounts from the other agency, notify it of account receipt, and maintain proper oversight of eligibility determinations made by the other agency.

Option 4

Other procedures. Elect another option to effectuate these requirements subject to CMS approval. States interested in exploring alternative options to effectuate these requirements may contact their Medicaid state lead or CHIP project officer.

CMS is exercising enforcement discretion and will not take compliance action against states that submit a SPA on or before June 30, 2025 to effectuate these options.

42 C.F.R. §§ 431.10(b)(3), 435.1200(b)(4), 457.348, and 457.350(b)(3).

Seamless Transitions Requirement at Application for States[1] that Accept Findings Made by the Other Agency or Delegate Authority to the Other Agency: *Medicaid to Separate CHIP* (1a)

1. Determine the child's eligibility based on information provided in the Medicaid application.

2. If the Medicaid agency has sufficient information to determine eligibility based on information provided in the application and:

3. If more information is needed to determine eligibility based on information provided in the application, send a request for additional information.

(See next slide)

a 

The Medicaid agency determines the child eligible for Medicaid:

- Send notice of approved Medicaid eligibility.
- Timely enroll the child in Medicaid.

b 

The Medicaid agency determines the child ineligible for Medicaid, but eligible for separate CHIP (e.g., under age 19, has income at or below the CHIP income eligibility standard, and does not have other health insurance):

- Send notice of denial for Medicaid with fair hearing rights.
- Transfer the child's account to the CHIP agency.
- The CHIP agency would then accept the determination of eligibility made by the Medicaid agency, send notice of approved separate CHIP eligibility,[2] complete any pre-enrollment activities, and timely enroll the child in separate CHIP.

c 

The Medicaid agency determines the child ineligible for both Medicaid and separate CHIP:

- Coordinate with CHIP agency to ensure child receives notice of denial and appropriate appeal rights for both programs.[3]
- Assess eligibility for Marketplace/BHP coverage.
- Transfer the child's account to the appropriate program.

1. States that use a shared eligibility service can determine eligibility and ineligibility for both programs within the same system, so some or all of the steps described in this slide and the following may be combined.
2. States that are able to provide combined Medicaid and separate CHIP eligibility notices may do so before June 3, 2026.
3. Notices may be separate until June 3, 2026, at which time, states must comply with the combined notices requirement.

Seamless Transitions Requirement at Application for States that Accept Findings Made by the Other Agency or Delegate Authority to the Other Agency: *Medicaid to Separate CHIP* (1b)

1. Determine the child's eligibility based on information provided in the Medicaid application.

2. If the Medicaid agency has sufficient information to determine eligibility based on information provided in the application and:

(See previous slide)

3. If more information is needed to determine eligibility based on information provided in the application, send a request for additional information.

a. <u>If the family responds timely</u>:

- Return to box 2 on previous slide.

b.  <u>If the family does not respond timely</u>:

- Send notice of denial for Medicaid with fair hearing rights (procedural denial).

Note: If family later returns requested information, the agency may, but is not required to, reopen the application and make a new determination.

Seamless Transitions Requirement at Application for States[1] that Accept Findings Made by the Other Agency or Delegate Authority to the Other Agency: *Separate CHIP to Medicaid* (2a)

1 Determine the child's eligibility based on information provided in the separate CHIP application.

2 If the CHIP agency has sufficient information to determine eligibility based on information provided in the application and:

3 If more information is needed to determine eligibility based on information provided in the application, send a request for additional information.

(See next slide)

a 

The CHIP agency determines the child eligible for separate CHIP:

- Send notice of approved separate CHIP eligibility.
- Complete any pre-enrollment activities.
- Timely enroll the child in separate CHIP.

b 

The CHIP agency determines the child ineligible for separate CHIP, but eligible for MAGI Medicaid:

- Send notice of denial for separate CHIP with review rights.
- Transfer the child's account to the Medicaid agency.
- The Medicaid agency would then accept the determination of eligibility made by the CHIP agency, send notice of approved Medicaid eligibility,[2] and timely enroll the child in Medicaid.

c 

The CHIP agency determines the child ineligible for both separate CHIP and MAGI Medicaid:

- Coordinate with Medicaid agency to ensure child receives notice of denial and appropriate appeal rights for both programs.[3]
- Assess eligibility for non-MAGI Medicaid and Marketplace/BHP coverage.
- Transfer the child's account to the appropriate program(s).

1. States that use a shared eligibility service can determine eligibility and ineligibility for both programs within the same system, so some or all of the steps described in this slide and the following may be combined.
2. States that are able to provide combined Medicaid and separate CHIP eligibility notices may do so before June 3, 2026.
3. Notices may be separate until June 3, 2026, at which time, states must comply with the combined notices requirement.

Seamless Transitions Requirement at Application for States that Accept Findings Made by the Other Agency or Delegate Authority to the Other Agency: *Separate CHIP to Medicaid* (2b)

1. Determine the child's eligibility based on information provided in the separate CHIP application.

2. If the CHIP agency has sufficient information to determine eligibility based on information provided in the application and:

(See previous slide)

3. If more information is needed to determine eligibility based on information provided in the application, send a request for additional information.

a. <u>If the family responds timely</u>:

- Return to box 2 on previous slide.

b.  <u>If the family does not respond timely</u>:

- Send notice of denial for separate CHIP with review rights (procedural denial).

Note: If family later returns requested information, the agency may, but is not required to, reopen the application and make a new determination.

Seamless Transitions Requirement at Renewal for States[1] that Accept Findings Made by the Other Agency or Delegate Authority to the Other Agency: *Medicaid to Separate CHIP* (1a)

1 Attempt to renew the child on an *ex parte* basis.

2 If unable to determine Medicaid eligibility on an *ex parte* basis, send a renewal form.

3 If the family returns the renewal form[2] and:

4 If the family does not return the renewal form[2] and *ex parte* data is sufficient:

5 If the family does not return the renewal form[2] and *ex parte* data is insufficient:

(See next slide)

a The Medicaid agency determines the child eligible for Medicaid based on the renewal form:

- Send notice of approved Medicaid eligibility.
- Renew Medicaid coverage.

b The Medicaid agency determines the child ineligible for Medicaid, but eligible for separate CHIP based on the renewal form:

- Send advance notice of termination for Medicaid with fair hearing rights.
- Terminate Medicaid eligibility.
- Transfer the child's account to the CHIP agency.
- The CHIP agency would then accept the determination of eligibility made by the Medicaid agency, send notice of approved separate CHIP eligibility,[3] complete any pre-enrollment activities, and timely enroll the child in separate CHIP.

c The Medicaid agency determines the child ineligible for both Medicaid and separate CHIP based on the renewal form:

- Coordinate with CHIP agency to ensure child receives advance notice of termination for Medicaid, denial of separate CHIP eligibility, and appropriate appeal rights for both programs.[4]
- Terminate Medicaid eligibility.
- Assess eligibility for Marketplace/BHP coverage.
- Transfer the child's account to the appropriate program.

1. States that use a shared eligibility service can determine eligibility and ineligibility for both programs within the same system, so some or all of the steps described in this slide and the following may be combined.
2. Renewal form also includes any other requested information/documentation.
3. States that are able to provide combined Medicaid and separate CHIP eligibility notices may do so before June 3, 2026.
4. Notices may be separate until June 3, 2026, at which time, states must comply with the combined notices requirement.

Seamless Transitions Requirement at Renewal for States that Accept Findings Made by the Other Agency or Delegate Authority to the Other Agency: *Medicaid to Separate CHIP* (1b)

1. Attempt to renew the child on an *ex parte* basis.
2. If unable to determine Medicaid eligibility on an *ex parte* basis, send a renewal form.

3. If the family returns the renewal form[1] and:

(See previous slide)

4. If the family does not return the renewal form[1] and *ex parte* data is sufficient:

a. For the Medicaid agency to determine the child ineligible for Medicaid, but eligible for separate CHIP based on *ex parte* data:

- Send advance notice of termination for Medicaid with fair hearing rights.
- Terminate Medicaid eligibility.
- Transfer the child's account to the CHIP agency.
- The CHIP agency would then accept the determination of eligibility made by the Medicaid agency, send notice of approved separate CHIP eligibility,[2] complete any pre- enrollment activities, and timely enroll the child in separate CHIP.

b. For the Medicaid agency to determine the child ineligible for both Medicaid and separate CHIP based on *ex parte data:*

- Coordinate with CHIP agency to ensure child receives advance notice of termination for Medicaid, denial of separate CHIP eligibility, and appropriate appeal rights for both programs.[3]
- Terminate Medicaid eligibility (procedural disenrollment).[4]

5. If the family does not return the renewal form[1] and *ex parte* data is insufficient:

a. For the Medicaid agency to determine the child ineligible for Medicaid:

- Send advance notice of termination for Medicaid with fair hearing rights.
- Terminate Medicaid eligibility (procedural disenrollment).

1. Renewal form also includes any other requested information/documentation.
2. States that are able to provide combined Medicaid and separate CHIP eligibility notices may do so before June 3, 2026.
3. Notices may be separate until June 3, 2026, at which time, states must comply with the combined notices requirement.
4. CMS is exercising enforcement discretion such that assessments of eligibility for Marketplace/BHP coverage in these cases is not required at this time. See slide 6 for more information.

Seamless Transitions Requirement at Renewal for States[1] that Accept Findings Made by the Other Agency or Delegate Authority to the Other Agency: *Separate CHIP to Medicaid* (2a)

1. Attempt to renew the child on an *ex parte* basis.
2. If unable to determine separate CHIP eligibility on an *ex parte* basis, send a renewal form.

3. If the family returns the renewal form[2] and:

4. If the family does not return the renewal form[2] and *ex parte* data is sufficient:

5. If the family does not return the renewal form[2] and *ex parte* data is insufficient:

(See next slide)

a 

The CHIP agency determines the child eligible for separate CHIP based on the renewal form:

- Send notice of approved separate CHIP eligibility.
- Renew separate CHIP coverage.

b 

The CHIP agency determines the child ineligible for separate CHIP, but eligible for MAGI Medicaid based on the renewal form:

- Send advance notice of termination for separate CHIP with review rights.
- Terminate separate CHIP eligibility.
- Transfer the child's account to the Medicaid agency.
- The Medicaid agency would then accept the determination of eligibility made by the CHIP agency, send notice of approved Medicaid eligibility,[3] and timely enroll the child in Medicaid.

c 

The CHIP agency determines the child ineligible for both separate CHIP and MAGI Medicaid based on the renewal form:

- Coordinate with Medicaid agency to ensure child receives advance notice of termination for separate CHIP, denial of MAGI Medicaid eligibility, and appropriate appeal rights for both programs.[4]
- Terminate separate CHIP eligibility.
- Assess eligibility for non-MAGI Medicaid and Marketplace/BHP coverage.
- Transfer the child's account to the appropriate program(s).

1. States that use a shared eligibility service can determine eligibility and ineligibility for both programs within the same system, so some or all of the steps described in this slide and the following may be combined.
2. Renewal form also includes any other requested information/documentation.
3. States that are able to provide combined Medicaid and separate CHIP eligibility notices may do so before June 3, 2026.
4. Notices may be separate until June 3, 2026, at which time, states must comply with the combined notices requirement.

Seamless Transitions Requirement at Renewal for States that Accept Findings Made by the Other Agency or Delegate Authority to the Other Agency: *Separate CHIP to Medicaid* (2b)

1. Attempt to renew the child on an *ex parte* basis.
2. If unable to determine separate CHIP eligibility on an *ex parte* basis, send a renewal form.

3. If the family returns the renewal form[1] and:

(See previous slide)

4. If the family does not return the renewal form[1] and *ex parte* data is sufficient:

5. If the family does not return the renewal form[1] and *ex parte* data is insufficient:

a For the CHIP agency to determine the child ineligible for separate CHIP, but eligible for MAGI Medicaid based on *ex parte* data:

- Send advance notice of termination for separate CHIP with review rights.
- Terminate separate CHIP eligibility.
- Transfer the child's account to the Medicaid agency.
- The Medicaid agency would then accept the determination of eligibility made by the CHIP agency, send notice of approved Medicaid eligibility,[2] and timely enroll the child in Medicaid.

b For the CHIP agency to determine the child ineligible for both separate CHIP and MAGI Medicaid based on *ex parte* data:

- Coordinate with Medicaid agency to ensure child receives advance notice of termination for separate CHIP, denial of MAGI Medicaid eligibility, and appropriate appeal rights for both programs.[3]
- Terminate separate CHIP eligibility (procedural disenrollment).[4]

a For the CHIP agency to determine the child ineligible for separate CHIP:

- Send advance notice of termination for separate CHIP with review rights.
- Terminate separate CHIP eligibility (procedural disenrollment).

1. Renewal form also includes any other requested information/documentation.
2. States that are able to provide combined Medicaid and separate CHIP eligibility notices may do so before June 3, 2026.
3. Notices may be separate until June 3, 2026, at which time, states must comply with the combined notices requirement.
4. CMS is exercising enforcement discretion such that assessments of eligibility for Marketplace/BHP coverage in these cases is not required at this time. See slide 6 for more information.

Implementation of Seamless Transitions Requirement During a Continuous Eligibility (CE) Period

- Children under the age of 19 in Medicaid and CHIP are entitled to 12 months of CE regardless of changes in circumstances, with limited exceptions, including an exception for a separate CHIP-enrolled child who become eligible for Medicaid. There is no exception for children enrolled in Medicaid who become eligible for separate CHIP.[1]

- States can adopt a CE period for some or all children (and/or other populations) that is longer than 12 months through a demonstration project under section 1115 of the Social Security Act.

- If a state obtains information *during a child's Medicaid CE period* indicating that the child is ineligible for Medicaid and eligible for separate CHIP, **the state must maintain the child's enrollment in Medicaid for the remainder of the CE period**.[2] At the end of the child's CE period, the state must conduct a full renewal in accordance with 42 C.F.R. § 435.916.

- If a state obtains information *during a child's separate CHIP CE period* indicating that the child is eligible for Medicaid, **special considerations apply** (see next slide).

1. Section 5112 of the Consolidated Appropriations Act, 2023 amended titles 1902(e)(12) and 2107(e)(1) of the Social Security Act to add this requirement. See CMS's SHO #25-001 and the November 27, 2024 Final Rule that codified these requirements.
2. Section II.D. of CMS SHO #25-001.

Implementation of Seamless Transitions Requirement During a CE Period, continued

There are special considerations for transitions of children from separate CHIP to Medicaid in response to a change in circumstances during a CE period.

1. If a state obtains information during **a child's separate CHIP CE period** indicating that the child is ineligible for separate CHIP and:

a. Eligible for Medicaid based on MAGI:

- Determine the child ineligible for separate CHIP and provide advance notice of termination with review rights.
- Terminate separate CHIP eligibility.
- Determine eligibility for Medicaid.
- Transfer the child's account to the Medicaid agency.
- The Medicaid agency would then accept the determination of eligibility made by the CHIP agency, provide notice of approved Medicaid eligibility,[1] and timely enroll the child in Medicaid.
- The Medicaid agency must provide the child with either a new 12-month CE period or with CE for the remainder of the child's separate CHIP CE period (state option).

b. Potentially eligible on a basis other than MAGI:

- Transition the child's account to the state Medicaid agency to make a determination of eligibility on a non-MAGI basis.
- Continue the child's enrollment in separate CHIP unless and until the Medicaid agency determines that the child is eligible for Medicaid.

1. States that are able to provide combined Medicaid and separate CHIP eligibility notices may do so before June 3, 2026.

Reminder of Program Coordination Requirements

States must continue to comply with the following requirements related to coordination of eligibility and enrollment that have been in effect and were not changed by the April 2024 Final Rule.

- All insurance affordability programs (Medicaid, separate CHIPs, Marketplaces, and BHPs) must **assess potential eligibility for other insurance affordability programs and transfer individuals' accounts** to another program, as appropriate.

- All insurance affordability programs must **assess potential eligibility for Medicaid on a non-MAGI basis** when they determine or assess that someone is not eligible for Medicaid based on MAGI.

Separate CHIPs and other programs do not utilize eligibility methodologies other than MAGI. Therefore, when another program assesses an individual as potentially eligible for Medicaid on a non-MAGI basis, it must transfer the individual's account to the Medicaid agency to complete the final determination of Medicaid eligibility.

- **Individuals assessed as potentially eligible for Medicaid on a non-MAGI basis must be permitted to enroll or remain enrolled in coverage** through a separate CHIP, the Marketplace, or a BHP if they otherwise meet eligibility requirements for the program while the non-MAGI determination is underway.

- **The Medicaid agency must complete the non-MAGI determination** and notify the individual's coverage program of the final determination of eligibility or ineligibility for Medicaid. If determined eligible for Medicaid, the Medicaid agency must send the individual a notice of approved eligibility and enroll them in Medicaid

42 C.F.R. §§ 435.1200(a), (d), (e)(2)-(e)(3), (h)(2)-(h)(3), 457.340(f)(2), 457.348(a)(1)-(5), (c), (d), 457.350(c)-(i), (e), 660.330(b)-(f), and 45 C.F.R. § 155.345.

Considerations for Managed Care States

Children transitioning between Medicaid and separate CHIP in managed care states may experience a disruption in coverage if they need to change managed care plans. States should consider strategies to minimize such disruption.

State Strategies to Reduce Disruptions to Coverage for Children

- States may contract with managed care plans that serve both Medicaid and separate CHIP and allow children to maintain enrollment in the same managed care plan when they move between programs.
- States may passively assign or default children to a plan (when a state does not offer the same managed care plans in both Medicaid and separate CHIP) using a process that seeks to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served both Medicaid and separate CHIP beneficiaries.
- States that do not effectuate either of the above options must distribute children equitably among managed care plans available to enroll them and can consider additional criteria:
  - ✓ Enrollment preferences of family members.
  - ✓ Previous plan assignment of the child.
  - ✓ Quality assurance and improvement performance.
  - ✓ Procurement evaluation elements.
  - ✓ Accessibility of provider offices for people with disabilities (when appropriate).
  - ✓ Other reasonable criteria related to a child's experience with Medicaid or separate CHIP.
- States must send clear instructions to the family about: how to change managed care plans, how much time the family has to change managed care plans, and where to go and who to contact with questions about plan selection.

42 C.F.R. §§ 438.54(c)(2), (c)(3), (c)(6), (c)(7), (d)(2), (d)(3), (d)(7), (d)(8), and 457.1210(a).

Considerations for States with Premiums or Enrollment Fees

States that require the collection of a first month's premium or an enrollment fee to effectuate separate CHIP coverage may take steps to prevent potential gaps in coverage for children transitioning from Medicaid to a separate CHIP.

State Strategies to Prevent Gaps in Coverage for Children

- Waive premiums or enrollment fees for the first month of separate CHIP coverage for children transitioning from Medicaid.
- Delay collection of initial premiums and enrollment fees until after the child is enrolled in separate CHIP.

The adoption of either of these strategies could help states reduce barriers for children to access care as they transition to separate CHIP from Medicaid.

Reminder: *Once enrolled in separate CHIP coverage, children may not be disenrolled for failing to pay premiums during a CE period.*

See section 2103(e)(3)(C) of the Social Security Act and 89 FR 94462.

Reminders

- CMS is available to provide technical assistance to states in complying with the requirements described in this slide deck and the December 20, 2024, CIB, *Ensuring Seamless Coverage Transitions between Medicaid, Separate CHIPs, and Other Insurance Affordability Programs and Exercise of Enforcement Discretion to Delay Implementation of Certain Coverage Transition Requirements*.

- CMS will release additional instructions related to compliance with the combined notices requirement and the procedural disenrollment account transfer requirement at a later date.

- For additional information and technical assistance, please contact Tess Hines at Mary.Hines@cms.hhs.gov.

SMDL #24-005: Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions

Jennifer Sheer
Children & Adults Health Programs Group

Agenda for Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions

- Background
- Penalties for Beneficiary Fraud
- Permissible Sanctions for Beneficiary Abuse
- Impermissible Administrative Sanctions
- Due Process for Beneficiary Fraud and Abuse
- Documentation
- Resources
- Questions

Objectives

This slide deck provides an overview of State Medicaid Director Letter (SMDL) #24-005, *Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions*, (issued on December 5, 2024). The SMDL builds upon guidance released in the October 17, 2022 Unwinding FAQs.

This slide deck reminds states about current requirements for operating a Medicaid beneficiary fraud and abuse program, certain eligibility determination and redetermination processes, and that:

- With narrow exceptions, federal law does not permit state Medicaid agencies to recoup funds from, or lock-out from Medicaid coverage, a beneficiary who the state determined abused or defrauded the Medicaid program.
- CMS expects state Medicaid agencies to promptly cease the use of any sanctions or penalties for beneficiary fraud and abuse that are inconsistent with this guidance.

CMS, Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions; CMS, COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies

Background (1/2)

Background (2/2)

- Each state Medicaid agency is **required** to operate a fraud and abuse detection and investigation program.[1]

- Although states' Medicaid program integrity efforts are generally focused on provider fraud and abuse, these programs are also responsible for addressing instances of alleged beneficiary fraud and abuse.

Providers **Beneficiaries**

[1] 42 CFR § 455.12.

Background

Definitions

What is Fraud?

- "…an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."
- Offending conduct must be "*knowing and willful.*"

What is Abuse?

Includes "…beneficiary practices that result in unnecessary cost to the Medicaid program."

What is a Lock-Out?

A situation where a state Medicaid agency bars an individual from applying for and/or receiving Medicaid coverage for a specified length of time and/or makes receipt of Medicaid services contingent upon repayment of funds.

State Medicaid agency error does not fall within the scope of fraud or abuse.

42 CFR § 455.2.

Background

Determinations of Medicaid Eligibility

State Medicaid agencies must:

- ☑ Make timely and accurate eligibility determinations and redeterminations in accordance with federal regulations and state verification plans.
- ☑ Have procedures in place to ensure that beneficiaries timely and accurately report any change in circumstances that may affect their eligibility.
- ☑ Educate applicants and beneficiaries about their responsibility to provide accurate information at initial application, when completing a renewal form, and whenever they experience a change in circumstances that may impact their eligibility.
  - Must be done in a manner that is accessible to individuals with limited English proficiency and individuals living with disabilities.

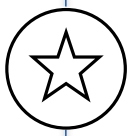
42 CFR §§ 435.905, 435.911-912, 435.916, 435.917(b), 435.919, 435.940, and 435.945-956.

Background

Determinations of Medicaid Ineligibility

Whenever a state receives reliable information (for example: beneficiary report, data match, or at renewal) indicating that a beneficiary may no longer be eligible, regardless of whether or not the state suspects fraud or abuse, it must:

- ☑ Treat the information that led to this conclusion as a **possible change in circumstances**.
- ☑ Conduct a **redetermination of the beneficiary's eligibility**, in accordance with federal regulations.
- ☑ Consider the beneficiary's eligibility **on all bases, prior to termination of eligibility**.
- ☑ Comply with these requirements even if the state determines that the previous determination of eligibility was incorrect or that a change in circumstances resulting in ineligibility occurred in the past.



A **Medicaid beneficiary** is entitled to Medicaid benefits until a state Medicaid agency:

1. Has made a determination of ineligibility; and
2. Provided at least 10 days advance notice and fair hearing rights.

Retroactively terminating a beneficiary's coverage back to the date of the inaccurate determination or a previous change in circumstance violates the beneficiary's due process rights.

Section 1902(a)(3) of the Social Security Act (the Act); 42 CFR §§ 435.916(d), 435.919(b) and 42 CFR part 431 subpart E.

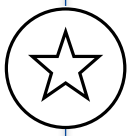
Background

Existing Processes Regarding Fraud and Abuse

Federal regulations describe the steps a state Medicaid agency must take to address instances of potential beneficiary fraud or abuse.

This guidance does not alter the existing and longstanding requirements for state Medicaid agencies to:

- Refer suspected incidents of beneficiary fraud to an appropriate law enforcement agency.
- Conduct a full investigation of alleged abuse.



It will be important for State Medicaid agencies to **develop reasonable criteria** to determine when a beneficiary's actions **rise to the level of abuse** in establishing or maintaining eligibility.

42 CFR §§ 455.12-455.15.

Background

Fraud, Abuse, or Both?

There is potential overlap between actions that could constitute beneficiary fraud and actions that could constitute beneficiary abuse.

What could a state do?

- ☑ Pursue a concurrent investigation of beneficiary abuse in some cases where suspected fraud is referred to law enforcement, if appropriate.
- ☑ Coordinate with the applicable law enforcement agency to ensure that continued state Medicaid agency investigative activity does not jeopardize or interfere with law enforcement activity.

Penalties for Beneficiary Fraud

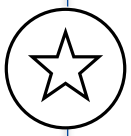
Penalties for Beneficiary Fraud

Beneficiary Penalties

Beneficiaries

Individuals convicted of fraud in either state or federal court would be subject to the penalties imposed by the court.

State Medicaid agencies should consult with their legal counsel on court orders or criminal or civil penalties that they are concerned may be inconsistent with federal Medicaid statute and regulations.



Individuals may be subject to criminal and civil penalties for fraud, or liable for civil damages due to fraud, and such penalties or damages are beyond the scope of this guidance.

Section 1128B(a) of the Act; 42 CFR §§ 455.15(b) and 1001.2.

Permissible Sanctions for Beneficiary Abuse(1/2)

Permissible Sanctions for Beneficiary Abuse(2/2)

- Sanctions for beneficiary abuse may only be applied by a state Medicaid agency to a beneficiary after the completion of a full investigation by the state Medicaid agency that results in a determination that the beneficiary committed abuse.
- State Medicaid agencies must conduct a full investigation of alleged abuse that:
  - ☑ Does not infringe on the legal rights of the individuals involved.
  - ☑ Affords the impacted individual due process of law.

Because not all failures to timely report a change in circumstances will meet the definition of abuse, state Medicaid agencies may not automatically treat every beneficiary failure to report as abuse.

42 CFR §§ 455.15(c) and 455.16(c)(4).

Permissible Sanctions for Beneficiary Abuse

Permissible Sanctions

Sanctions may include:

Warning Letters

Fines approved in the state plan

Other Sanctions approved in the state plan

Sanctions cannot conflict with other federal statutory or regulatory requirements.

42 CFR §§ 455.15(c) and 455.16(c)(4).

Permissible Sanctions for Beneficiary Abuse

Permissible Sanctions – Warning Letters

State Medicaid agencies may send a warning letter to a beneficiary if, after a full investigation, the agency determines that a beneficiary has engaged in abusive behavior.

Warning Letters

- Warning letters may provide notice that continuation of the conduct in question may result in further action.
- Use of warning letters as a sanction does not need to be identified in the Medicaid state plan.

42 CFR §§ 455.15(c) and 455.16(c)(1).

Permissible Sanctions for Beneficiary Abuse

Permissible Sanctions – Fines and Other Sanctions

Fines

- The circumstances under which fines may be imposed and the amount of such fines must be documented in an approved Medicaid state plan amendment.
- Fines:
  - Cannot equal or exceed the value of items and/or services provided to, or capitation payments made on behalf of, the beneficiary after the instance of abuse.
  - Must be reasonable in amount and not be correlated with the value of items and services provided to the beneficiary after the instance of abuse.

A fine effectively increases beneficiary liability. State Medicaid agencies must provide at least 10 days advance written notice and fair hearing rights to the beneficiary prior to imposing a fine for abuse.

Other Sanctions

Any sanctions for beneficiary abuse other than a warning letter must be approved by CMS and documented in the state plan.

42 CFR §§ 455.15(c) and 455.16(c)(4).

Impermissible Administrative Sanctions

Impermissible Administrative Sanctions

1. Recoupment of Funds ("Overpayments")

Recoupment of funds from beneficiaries for the cost of medical assistance provided prior to the effective date of a beneficiary's termination denies the beneficiary their rights to advance notice of termination and a fair hearing.

- State Medicaid agencies **are not permitted** to recoup from beneficiaries funds, or "overpayments," except in circumstances explicitly provided in federal statute and implementing regulations, which include:
  - ☑ Liens placed on a beneficiary's property prior to the beneficiary's death pursuant to the judgment of a court that Medicaid benefits were incorrectly paid (section 1917(a)(1)(A) of the Act and 42 CFR § 433.36(g)(1)).
  - ☑ Estate recovery proceedings for correctly paid Medicaid benefits (section 1917(b)(1) of the Act).
  - ☑ Benefits provided pending the outcome of a fair hearing (42 CFR § 431.230).
- Recoupment of the cost of medical assistance is not a permissible administrative sanction for beneficiary abuse.

Voluntary repayment would be a violation of the Medicaid beneficiary's due process rights.

Sections 1902(a)(3), 1917(a)(1)(A), and 1917(b)(1) of the Act; 42 CFR § 433.36(g)(1) and part 431 subpart E.

Impermissible Administrative Sanctions

2. Lock-outs

Lock-outs impermissibly prevent individuals from applying for Medicaid and violate the requirement that states furnish benefits to eligible individuals with reasonable promptness and in accordance with their state plans.

State Medicaid agencies **do not have authority** under either the federal Medicaid statute or governing regulations **to impose a lock-out** as an administrative sanction.

- *Exception*: Section 1128B(a) of the Act provides the state Medicaid agency the discretion to limit, restrict, or suspend, for **up to one year**, Medicaid coverage of an otherwise-eligible individual who is **convicted of fraud in federal court**.

The lock-out penalty under section 1128B(a) of the Act cannot affect the Medicaid eligibility of any other person regardless of the relationship between the individual and the penalized beneficiary.

Sections 1128B(a), 1902(a)(8), and 1902(a)(10) of the Act.

Impermissible Administrative Sanctions

3. Terminations of Eligibility

Prior to making a determination of ineligibility, the state must consider the beneficiary's eligibility on all bases.

State Medicaid agencies **cannot** terminate the eligibility of any beneficiary, including a beneficiary suspected of committing or determined to have committed fraud or abuse, prior to:

- ☑ Conducting a redetermination of eligibility based on a change in circumstances in accordance with 42 CFR 435.919(b) or a full renewal in accordance with 42 CFR 435.916 that results in a determination that the beneficiary is ineligible for Medicaid on all bases.
- ☑ Providing advance notice of termination and fair hearing rights in accordance with 42 CFR part 431 subpart E.

- In cases of suspected beneficiary fraud, the period of advance notice may be shortened from 10 days to 5 days if the state Medicaid agency has verified facts indicating possible fraud through independent sources.
- No reductions in the advance notice period are authorized for cases of suspected beneficiary abuse.

Section 1902(a)(3) of the Act; 42 CFR §§ 435.916, 435.919, 435.930(b); 42 CFR part 431, subpart E.

Due Process for Beneficiary Fraud and Abuse(1/2)

Due Process for Beneficiary Fraud and Abuse(2/2)

Individuals must be provided with the opportunity to challenge allegations of fraud or abuse.

Fraud	In cases of suspected fraud, the ability to challenge the allegation is provided through the law enforcement process.
Abuse	In cases of suspected abuse, the state Medicaid agency must provide a process for the beneficiary to challenge the state's allegation of abuse and any sanctions imposed.

42 CFR § 455.13(b); 42 CFR part 431, subpart E.

Documentation

Documentation

State Medicaid Plan

If a State Medicaid agency wishes to impose administrative sanctions (other than a warning letter), it must document the proposed sanctions in its **State Plan** and receive **CMS approval**.

- States can submit an **attachment to Section 4.5** as a paper-based SPA to document proposed sanctions.
- State Medicaid agencies should **contact their CMS state lead for additional technical assistance** on whether potential administrative sanctions being considered are permissible under federal law and regulations.

Resources

State Medicaid Director Letter (SMDL)

- CMS, SMDL #24-005: Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions, December 5, 2024.

CMCS Informational Bulletins (CIB)

- CMS, Ensuring Seamless Coverage Transitions Between Medicaid, Separate CHIPs, and Other Insurance Affordability Programs and Exercise of Enforcement Discretion to Delay Implementation of Certain Coverage Transition Requirements, December 20, 2024.
- CMS, State Compliance with Medicaid and CHIP Renewal Requirements by December 31, 2026, September 20, 2024.

Other Guidance

- CMS, Overview: Medicaid and CHIP Eligibility Renewals, September 2024.
- CMS, COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies, October 17, 2022.

Please send questions to MedicaidPIBeneficiaryProtections@cms.hhs.gov

Questions