CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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Objectives

This deck summarizes the CMCS Informational Bulletin (CIB), *Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes,* and is part of a series of resources for states as they work to comply with federal requirements.

This slide deck is intended to provide states with guidance regarding the continued use of certain streamlined eligibility and enrollment strategies that were available to address challenges during the COVID-19 Public Health Emergency (PHE) and the return to regular operations following the end of the Medicaid continuous enrollment condition described in section 6008(b)(3) of the Families First Coronavirus Response Act, the process commonly referred to as "unwinding."

Source: CMS CIB, Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes.

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Context Setting

Use of Strategies Authorized by Section 1902(e)(14)(A) of the Act During Unwinding

- To support states facing operational and systems issues and to protect eligible beneficiaries from inappropriate coverage losses during the unwinding period, the Centers for Medicare & Medicaid Services (CMS) provided states with the option to request authority under section 1902(e)(14)(A) of the Social Security Act (the Act).
- As outlined in the March 3, 2022, State Health Official (SHO) letter, CMS granted approval for states to use time-limited authority to streamline eligibility and enrollment processes, protect eligible individuals from becoming disenrolled, facilitate the renewal process, reduce the number of procedural terminations, and ease the state administrative burden during the unwinding.
- On May 9, 2024, CMS extended the use of these waivers through June 30, 2025, provided that the terms and conditions of the original waiver continue to be met.

Sources: CMS CIB, Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes; CMS SHO, Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency; CMS CIB, Extension of Temporary Unwinding-Related Flexibilities.

Approved Section 1902(e)(14)(A) Waivers

Since April 2022, CMS has granted over 400 unwinding-related waivers to 52 states and territories that enabled them to streamline different parts of their renewal processes in support of their unwinding efforts.

- A combined fifty states and territories received waiver approval to adopt strategies to **increase *ex parte* rates**, thereby minimizing administrative burdens for states and beneficiaries while supporting eligible individuals' ability to renew their coverage.
- Thirty states received approval for waivers designed to better **support enrollees with renewal completion and submission.**
- Forty-five states received approval for strategies that facilitated their ability to **update 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.**

Note: For additional information on the section 1902(e)(14)(A) waivers CMS has approved for states and territories to support the unwinding period, see 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.

Continued Availability of Unwinding-Related Waiver Strategies Beyond June 30, 2025

Future Use of Unwinding-Related 1902(e)(14)(A) Waiver Strategies

To continue supporting states' ability to strengthen and streamline renewal, CMS reviewed all section 1902(e)(14)(A) waiver strategies to determine which can be implemented on a long-term basis.

- CMS received 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.
- CMS determined that states have the option or will be required by recent rulemaking to implement over half of the strategies under their state plan in accordance with statutory and regulatory authorities.
- The remaining unwinding-related strategies cannot continue absent extenuating circumstances necessitating their use. As such unwinding-related circumstances are abating, existing statutory and regulatory requirements do not allow states to continue these strategies without justification and approval under section 1902(e)(14)(A) of the Act.

Strategies Codified in Final Eligibility and Enrollment Rule

Several strategies were codified in regulations by the final eligibility and enrollment rule published on April 2, 2024.[1]

- **Applying for Other Benefits Strategy** – The requirement to apply for other benefits as a condition of Medicaid eligibility has been eliminated for all applicants and beneficiaries. 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.
- **Strategies to Obtain Updated Beneficiary Contact Information** – States must establish a process to obtain updated address information from reliable sources.
  - States must use the National Change of Address (NCOA) database, mail returned by the U.S. Postal Service (USPS) with a forwarding address, and managed care organizations (MCOs) to update beneficiary contact information. 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. All states must comply with this requirement by December 3, 2025, and may do so sooner.
  - Additionally, the final rule provides 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 Program of All-Inclusive Care for the Elderly (PACE) organizations to be reliable sources.

Notes:

1. These strategies were codified in the final rule, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, which took effect June 3, 2024. Compliance with new requirements is phased in through June 3, 2027, with compliance timeframes varying by provision.

Strategies Available Under State Plan Authority

Certain waiver strategies are permissible in a materially similar way at states' option under state plan authority.

- **Streamlining Asset Determinations Strategy** – Under section 1902(r)(2) of the Act, states may disregard (i.e., not count) otherwise countable income and/or resources in making non-MAGI[1] eligibility determinations. States can disregard increases in beneficiary's assets after their date of application.

Further details on the most-commonly-used strategies related to **verifying income and resources** can be found on slides 11–17.

- **Stable Income and Asset Strategy** – States have flexibility to make a reasonable determination of what types of income and assets are highly likely to remain stable (or even decrease in value) in conducting an *ex parte* renewal.[2]
- **MCO Renewal Support Strategy** – Under existing managed care regulations, states may permit MCOs to conduct outreach and assist beneficiaries with completing and submitting renewal forms, provided that the plan does not provide choice counseling and does not sign the renewal form on behalf of the beneficiary.
- **State Agency and/or Other Qualified Entities Using Presumptive Eligibility (PE) Strategy** – Under existing regulations, states may permit qualified entities, including the state agency itself, to make PE determinations on a MAGI-basis for individuals not enrolled in Medicaid or CHIP. State agencies must treat a renewal form returned during the reconsideration period as an application. Thus, in adopting this strategy, states would extend the individual's PE status until the state has completed a determination of eligibility based on the renewal form.

Notes:

1. MAGI is Modified Adjusted Gross Income. Non-MAGI refers to individuals excepted from MAGI-based financial methodologies under 42 C.F.R. § 435.603(j).
2. Additional information on *ex parte* renewals will be included in forthcoming guidance.

Strategies Related to Verifying Income and Resources

Unwinding-related waiver strategies to streamline income and resource verification during the *ex parte* process were particularly effective in supporting states' efforts to minimize the administrative burden associated with conducting renewals and prevent the improper disenrollment of eligible beneficiaries.

Existing verification policies can be used to achieve long-term use of these strategies.[1]

Using Gross Income Determinations from SNAP[2] and Other Human Services Programs

Completing an *ex parte* renewal when no data sources[3] return income information

Streamlining the use of the state's asset verification system (AVS)

Notes:

1. Additional information regarding the data and analyses supporting the rationale for long-term use of these strategies is included in the CIB.
2. SNAP is the Supplemental Nutrition Assistance Program.
3. Throughout the following sections, references to "data sources" means those data sources a state uses to verify eligibility factors for Medicaid. These data sources must be identified in the state's verification plan, as required by 42 C.F.R. 435.945(j).

Using Gross Income Determinations from SNAP and Other Human Services Programs

States may use SNAP gross income as a data source for verifying MAGI-based income eligibility.

Section 1902(e)(14)(A) Waiver Authority:

- To simplify the use of SNAP and TANF information when making eligibility determinations during unwinding, CMS waived the requirement to make a Medicaid income determination for individuals whose gross income, as determined by the state's SNAP and/or TANF agency, was at or below the applicable Medicaid income standard.

State Plan Option:

- States have flexibility, within certain parameters, to determine which data sources are useful in verifying income.[1] States have flexibility to determine that the gross income determination made by SNAP is a useful source of data to verify income for MAGI-based eligibility.
- States may find SNAP gross income or other program data useful in verifying income for non-MAGI beneficiaries. States may also find data from other human services programs, such as TANF, useful for verifying MAGI-based eligibility. If interested, a state must conduct and share with CMS an analysis to demonstrate the data's usefulness and identify it in the state's verification plan.

Notes:

1. States can continue to use the underlying data for specific types of income in an applicant or beneficiary's SNAP record.

Implementing the Use of SNAP Gross Income as a Data Source

- When considering implementation of this strategy, states should assess the usefulness of SNAP data in the same manner as they are expected to do for other data sources, considering such factors as the accuracy, timeliness, comprehensiveness, and complexity of accessing the data.
- States can use a gross income determination from SNAP as a data source for verifying income eligibility for MAGI Medicaid.[1]
- If determined useful, states can use SNAP gross income determinations as a data source at application, at renewal, or both.
- States may also target this strategy to specific populations, for example, using the strategy only for individuals whose SNAP gross income is at or below a specified level, e.g., 100 percent of the federal poverty level (FPL).

Notes:

1. 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.

Options to Complete *Ex Parte* Renewal When No Data Sources Return Income Information

States may consider individuals with a previously-verified attestation of zero-dollar income or income at or below 100% of the FPL as having income that is highly unlikely to change.

Section 1902(e)(14)(A) Waiver Authority:

- During unwinding, CMS authorized two related waiver strategies for individuals with prior determinations of zero-dollar income and individuals with a prior determination of income at or below 100% of the FPL that enabled states to renew coverage on an *ex parte* basis when the state checked all available income data sources, but no income data was returned.

State Plan Option:

- Under current verification policies,[1] states 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.
- CMS has determined it would be reasonable for a state to determine that the previously-verified income 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% FPL;
  2. The state has checked all available income data sources according to its verification plan and no information is received; and
  3. The state follows its verification plan to confirm the beneficiary's continued state residency.[2]

Notes:

1. Additional guidance on state verification requirements and flexibilities is forthcoming.
2. Effective December 3, 2025, consistent with 42 C.F.R. § 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 a 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.

Implementing the Strategy to Complete *Ex Parte* Renewal When No Data Sources Return Income Information

- States may elect to apply this strategy only to individuals whose previously-verified income was zero dollars or to individuals whose previously-verified income was at or below a standard elected by the state, up to 100% FPL, and may elect a different income standard for different eligibility groups.
- States adopting this strategy must also establish and document a maximum amount of time that is permitted to elapse since the state last verified a beneficiary's income (either at application or renewal).[1]
- States must have the information necessary to match with the income data sources used by the state (e.g., Social Security Number).
- States must take steps to review other non-financial eligibility criteria.
- States must notify individuals of the requirement to inform the agency if the information relied on in the renewal is inaccurate.

Notes:

1. CMS considers a verified attestation of income that was made no earlier than three years prior to be reasonable. However, states may establish a different reasonable amount of time.

Strategy to Streamline Use of Asset Verification System (AVS)

States can assume no change in resources when no information is returned through the AVS or when information is not returned within a reasonable timeframe.

Section 1902(e)(14)(A) Waiver Authority:

- 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 states to use an Asset Verification System (AVS) to verify assets held in a financial institution.
- During unwinding, CMS approved a waiver strategy that allowed states to assume no change in assets verified through the AVS when no information is returned or when information is not returned within a reasonable timeframe and complete the *ex parte* renewal process without any further verification of assets.

State Plan Option:

- Current verification policies require that a state establish a reasonable timeframe to wait for information to be returned from its AVS before requesting documentation or other information to verify assets.
- 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.[1] This would enable the state to complete an *ex parte* renewal without requesting additional documentation of asset types that can be verified with AVS.
- If the 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 the *ex parte* renewal.
- Any information returned by AVS that might impact eligibility after an individual's eligibility has been renewed must be treated as a change in circumstances in accordance with 42 CFR 435.919.

Notes:

1. 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.

Implementing the Streamlined Use of AVS

- In establishing a reasonable timeframe to wait for data to be returned from its AVS, states should consider the response times experienced in their AVS.
- The reasonable timeframe does not need to be the same at application as at renewal.
- States may consider initiating the AVS check ahead of other data sources that are checked during the *ex parte* process to account for a potentially lengthier AVS response time.
- The state must notify individuals of the requirement to inform the agency if the asset information used in the renewal is inaccurate (required for all *ex parte* renewals).
- If the state receives asset information from the AVS after a beneficiary has been renewed on an *ex parte* basis, the information from the AVS must be processed as a change in circumstance.

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

Discontinued Blanket Waiver Authority

Existing statutory and regulatory requirements do not allow states to continue the following strategies under section 1902(e)(14)(A) of the Act after June 30, 2025.

- Suspend the requirement to cooperate in obtaining medical support
- Waive the requirement to record telephonic signatures
- Permit designation of an authorized representative over the telephone without a signed designation
- Renew Medicaid eligibility for children and/or non-MAGI beneficiaries for 12 months based on the individual's most recent Medicaid determination
- Delay resumption of Medicaid premiums until after redetermining eligibility
- Extend eligibility in the Former Foster Care Children group to youth formerly in foster care from any state, without regard to when the individual turned age 18
- Extend the timeframe to take final action on fair hearing requests and provide benefits pending a final decision to all individuals who request a hearing
- Reinstate eligibility back to termination date for those procedurally terminated who are determined eligible during the reconsideration period without determining retroactive eligibility
- Extend automatic reenrollment into a managed care plan up to 120 days after loss of Medicaid

Notes: Additional details regarding the strategies whose blanket authority will be discontinued after June 30, 2025, and potential alternative approaches states may adopt are included in the appendix table that accompanies the CIB.

Use of 1902(e)(14)(A) Waiver Authority Beyond June 30, 2025

- CMS recognizes that states are in various stages of resuming routine eligibility and enrollment operations. States may continue to use unwinding-related flexibilities through June 30, 2025.
- As states work toward full compliance with renewal requirements, 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 outline proposed mitigations or seek approval for waivers, as appropriate, under section 1902(e)(14)(A) as part of the renewal compliance template.
  - 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 waiver authority.
- States may also seek CMS approval for section 1902(e)(14)(A) waivers for strategies beyond those noted in the CIB, whether needed in the context of renewal compliance or for another purpose.
- Any requests to use 1902(e)(14)(A) waiver authority will be considered individually and approved on a time-limited basis.

Notes: For additional information, see September 20, 2024, CIB, State Compliance with Medicaid and CHIP Renewal Requirements by December 31, 2026.

Regulatory Exception to Timely Determinations to Delay Procedural Terminations

Regulatory Exception to Timely Determinations to Delay Procedural Terminations

During the unwinding, CMS concurred with states' use of the regulatory timeliness exception[1] to delay procedural disenrollments for up to three months. This enabled states to conduct targeted outreach to encourage beneficiaries to return their renewal form.

- As states return to regular operations, CMS's broad concurrence with the application of this option will sunset after June 30, 2025, as states are expected to have made significant progress in resuming operations.
- However, to achieve a similar result, states can build additional time into their renewal process by adjusting the timing of renewal notifications to:
  - provide beneficiaries more time to return their renewal form; and
  - conduct targeted outreach before the end of the eligibility period to beneficiaries at risk of losing coverage for procedural reasons.
- If a state experiences an administrative or other emergency (e.g., natural disaster) and the state would like to use the timeliness exception to delay procedural terminations to conduct targeted outreach, CMS strongly recommends that the state seek CMS concurrence to do so.

Notes:

1. The exception to timely determinations of eligibility at 42 C.F.R. § 435.912(e) permits a state to exceed the timeliness standard when there is an administrative or other emergency beyond the agency's control.

State Resources

CMS Resources to Support States

- CMCS Informational Bulletin, Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes, November 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cibe1411142024.pdf

- CMCS Informational Bulletin, Extension of Temporary Unwinding-Related Flexibilities, May 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf

- Medicaid Program; "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes" final rule (89 FR 22836) available at: https://www.federalregister.gov/d/2024-06566

- SHO# 22-001, Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency, March 2022, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf

- COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals, 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