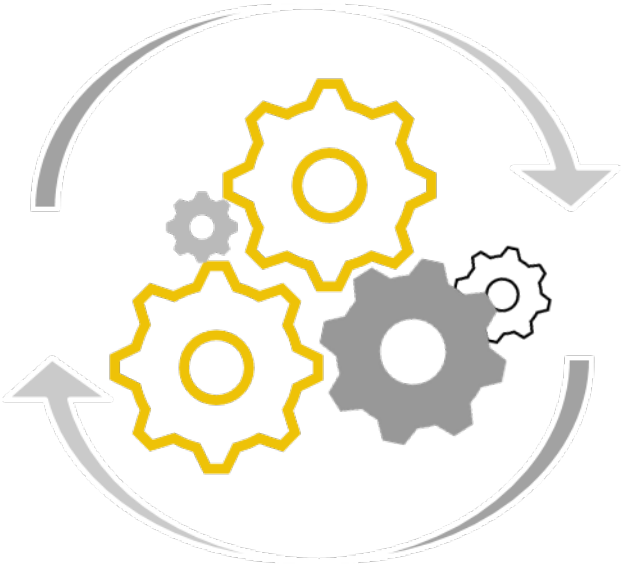
CENTERS FOR MEDICARE & MEDICAID SERVICES

Ex Parte Renewal:
Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts

October 20, 2022



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Agenda

- Setting the Context
- Understanding Federal Renewal and *Ex Parte* Requirements
- *Ex Parte* Considerations
- *Ex Parte* “Do’s and Don’ts”
- Deeper Dive on Select Strategies to Increase *Ex Parte* Rates
- Other Strategies to Automate Renewals
- Moving Forward on Improving *Ex Parte* Renewal Rates
- Questions

Setting the Context

Increasing *Ex Parte* Rates Can Help States During Unwinding

- State *ex parte* determination rates vary greatly, with some states at or below 25% of cases and other states over 75% of cases.[1]
- During the Public Health Emergency (PHE), many states saw their *ex parte* rates fall; other states haven't maximized application of *ex parte* or fully leveraged its tools to automate the renewal process.
- States will have a large volume of eligibility and enrollment actions to complete during the unwinding period.
- Increasing *ex parte* rates could ease state challenges by:
  - Making it easier for states to manage increased volume with fewer manual touches
  - Improving retention of beneficiaries at renewal and reducing the volume of new application processing due to churn
- Unwinding presents an opportunity for states to re-examine their *ex parte* policies and processes to improve capacity.

[1] Brooks, Tricia, et. al., *Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022,* Kaiser Family Foundation (Washington, DC March 2022), p. 50

Ex Parte Learning Collaborative Project Approach

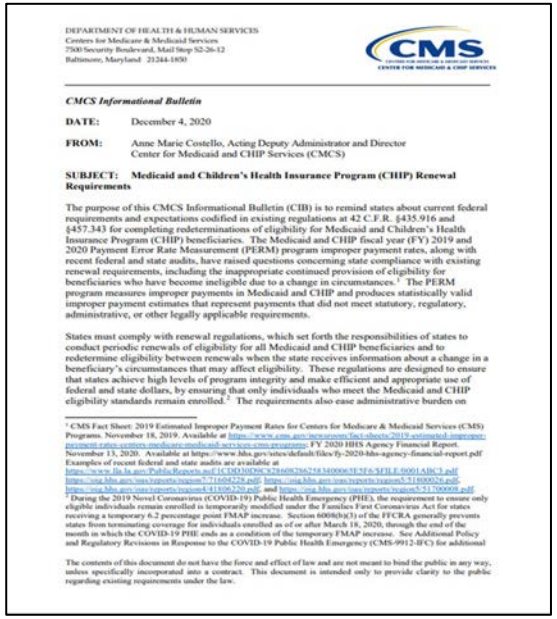
This Learning Collaborative builds upon the December 2020 Information Bulletin, "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements" and lays out best practice state policy and operational processes.

Methodology

To identify *ex parte* renewal best practices, the CMS Coverage Learning Collaborative team:

- Conducted state interviews with policy and IT systems teams/vendors;
- Reviewed *ex parte* renewal data and Medicaid and CHIP MAGI verification plans; and,
- Examined states' verification and renewal policy guidance, renewal process flows, and renewal business rules.

CMS also reviewed *ex parte* guidance to further clarify state requirements and flexibilities.



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CMS
CENTER FOR MEDICAID & CHIP SERVICES

CMS Informational Bulletin

DATE: December 4, 2020

FROM: Anne Marie Costello, Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: **Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements**

The purpose of this CMCS Informational Bulletin (CIB) is to remind states about current federal requirements and expectations codified in existing regulations at 42 C.F.R. §435.916 and §457.343 for completing redeterminations of eligibility for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. The Medicaid and CHIP fiscal year (FY) 2019 and 2020 Payment Error Rate Measurement (PERM) program improper payment rates, along with recent federal and state audits, have raised questions concerning state compliance with existing renewal requirements, including the inappropriate continued provision of eligibility for beneficiaries who have become ineligible due to a change in circumstances.[1] The PERM program measures improper payments in Medicaid and CHIP and produces statistically valid improper payment estimates that represent payments that did not meet statutory, regulatory, administrative, or other legally applicable requirements.

States must comply with renewal regulations, which set forth the responsibilities of states to conduct periodic renewals of eligibility for all Medicaid and CHIP beneficiaries and to redetermine eligibility between renewals when the state receives information about a change in a beneficiary's circumstances that may affect eligibility. These regulations are designed to ensure that states achieve high levels of program integrity and make efficient and appropriate use of federal and state dollars, by ensuring that only individuals who meet the Medicaid and CHIP eligibility standards remain enrolled.[2] The requirements also ease administrative burden on

[1] CMS Fact Sheet: 2019 Estimated Improper Payment Rates for Centers for Medicare & Medicaid Services (CMS) Programs. November 18, 2019. Available at https://www.cms.gov/newsroom/fact-sheets/2019-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs; FY 2020 HHS Agency Financial Report. November 13, 2020. Available at https://www.hhs.gov/sites/default/files/fy-2020-hhs-agency-financial-report.pdf Examples of recent federal and state audits are available at https://www.lla.la.gov/PublicReports.nsf/1CDD30D9C87846082862583400065E5F6/$FILE/0001ABC3.pdf https://oig.hhs.gov/oas/reports/region5/51604228.pdf; https://oig.hhs.gov/oas/reports/region5/51800026.pdf; https://oig.hhs.gov/oas/reports/region4/41806220.pdf; and https://oig.hhs.gov/oas/reports/region5/51700008.pdf

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

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

Source: CMCS Informational Bulletin (CIB), "Medicaid and CHIP Renewal Requirements" (December 2020)

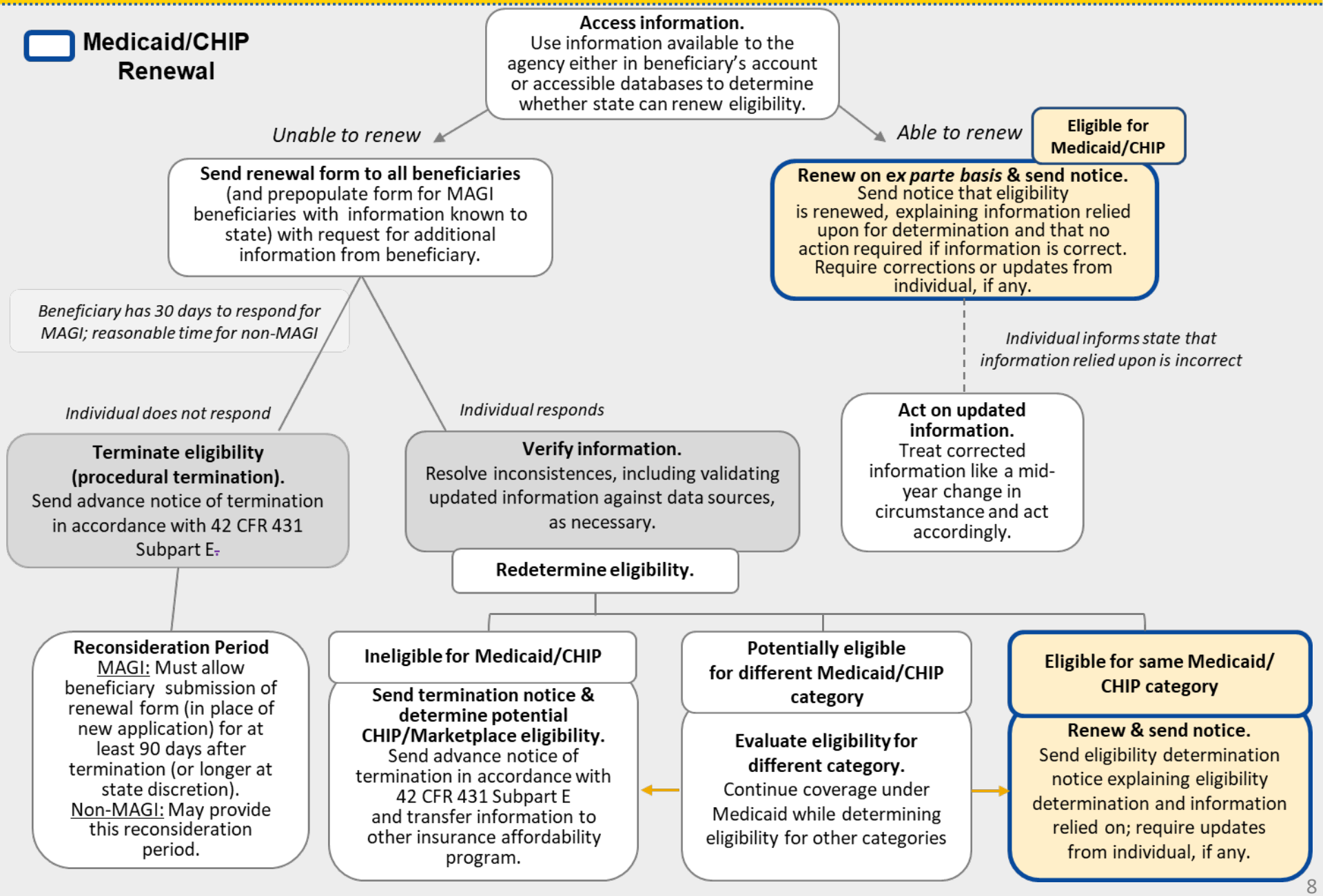
Federal Renewal and *Ex Parte* Requirements

Overview of Regulatory Renewal Requirements for Medicaid and CHIP

- **Renew eligibility only once every 12 months for MAGI** beneficiaries and **at least once every 12 months for non-MAGI** beneficiaries.
- Begin the renewal process by **first attempting to redetermine eligibility based on reliable information** available to the agency without requiring information from the individual (*ex parte* renewal, also known as auto-renewal, passive renewal, or administrative renewal).
  - If available information is sufficient to determine continued eligibility without requiring information from the individual, agency renews eligibility on an *ex parte* basis and notifies the beneficiary that their coverage has been renewed and the basis for the renewal
    - Beneficiary does not need to sign or return the notice if all information contained in the notice is accurate
  - If available information is insufficient to determine continued eligibility, send a renewal form and request additional information from the beneficiary
- Provide a **renewal form that is prepopulated** for beneficiaries enrolled on a MAGI basis**.** Agencies may but are not required to pre-populate renewal forms for non-MAGI beneficiaries.
- Allow beneficiaries to return the signed renewal form through **all modes of submission** available for submitting an application (i.e., mail, in-person, online or phone).
- Provide individuals enrolled in **MAGI Medicaid and CHIP with a minimum of 30 days to respond to the form** and provide a reasonable time frame (minimum 30 days recommended) for individuals enrolled on a non-MAGI basis.

42 C.F.R. §435.905(b), §435.916(a)-(b), §435.916(e), and §435.952; 42 C.F.R. §457.110(a) and §457.343; 42 C.F.R. §600.340

Medicaid/CHIP Annual Renewal Process Flow



Focus on *Ex Parte* Renewal Process

- State agencies are required to attempt to renew Medicaid eligibility for ***all beneficiaries*** on an ***ex parte basis,*** based on reliable information contained in the beneficiary's account or other more current information available to the agency without requiring information from the beneficiary.
  - *Ex parte* renewal is also known as auto-renewal, passive renewal, or administrative renewal.
  - Process does not require any beneficiary involvement.
- If the agency is able to renew eligibility based on the available reliable information, the agency must provide notice to the beneficiary, which includes:
  - Eligibility determination
  - Information state used to determine eligibility and the basis of continued eligibility
  - Beneficiary obligation to inform state if any of the information in the notice is inaccurate or require changes
- Beneficiary does not need to sign or return notice if all information it contains is accurate.

42 C.F.R. §435.916(a)(2) and (b)
42 C.F.R. §457.343

Ex Parte Renewals: Key Steps

Step 1: Identify Renewal Cohort

- Include all individuals enrolled in Medicaid and/or CHIP and due for renewal in a monthly cohort.

Step 2: Access Available Information

- Identify recent and reliable information in the enrollee's account.
- Access data sources, consistent with the state's verification plan.

Step 3: Run Logic to Determine Eligibility

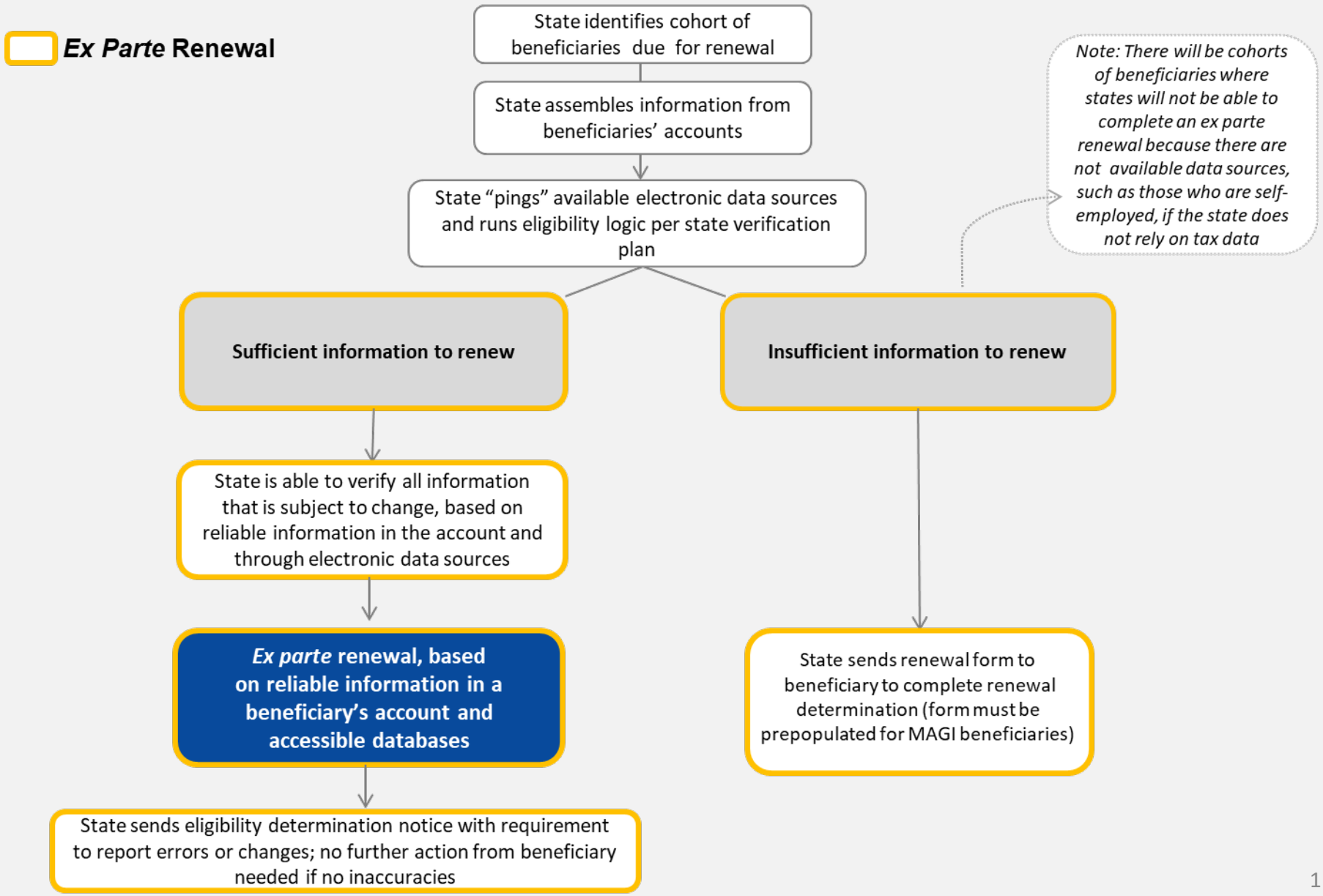
- Compare financial information from data sources (e.g., State Wage Information Collection Agency (SWICA), Internal Revenue Service (IRS), Social Security Administration (SSA), Supplemental Nutrition Assistance Program (SNAP), etc.) to the applicable eligibility threshold for the enrollee's eligibility group.
- Check non-financial data sources (e.g., DMV, SNAP, etc.) to verify additional factors of eligibility (e.g., residency), if applicable and consistent with the state's verification plan/processes.
  - States are only required to re-verify state residency at renewal if the state has reason to believe the individual's state of residency has changed (e.g., returned mail with out-of-state address).

Step 4: If Eligible, Provide Notice

- No further action is required from the beneficiary to effectuate coverage.
- Notice should include the eligibility determination, the information the agency relied upon to make the determination and basis for continued eligibility, and the beneficiary's obligation to inform the agency if any of the information in the notice is inaccurate or subsequently changes.

Step 5: If Unable to Determine Eligibility, Send Renewal Form

Renewal Processes: *Ex Parte*



Ex Parte Considerations

Reliable Information

- To conduct an *ex parte* renewal, states must make a redetermination of eligibility without requiring information from the individual if feasible based on **reliable information** available to the agency.
- "Reliable information" includes:
  - Information in the beneficiary's account and available data sources
  - Information from other benefit programs or reliable sources (e.g., SNAP recertification, Quarterly Wage Data)
- States have flexibility to determine whether recently verified information should be considered reliable. CMS believes that states can consider information reliable if it was:
  - Verified within the last 6 months, or
  - Verified more than 6 months ago and not subject to change.
- Information from the initial determination at application or the beneficiary's last renewal is *not* considered reliable unless it relates to circumstances generally not subject to change (e.g., citizenship or satisfactory immigration status).

42 CFR §435.916, §435.948, and §435.949
42 CFR §457.343 and §457.380

Ex Parte Renewal Notice Requirements

If an agency is able to renew based on information in the account or electronic databases, the beneficiary must be notified of the following:

- The eligibility determination;
- The basis for the determination (i.e., the information the agency relied upon in approving eligibility) and the effective date of eligibility;
- That the individual must inform the agency if any information contained in the notice is inaccurate;
- If all information is accurate, the individual does not need to take any action;
- The requirement and process to report changes in circumstance that may impact eligibility;
- Information on benefits and services, and if applicable, premiums, enrollment fees and cost sharing; and,
- Their appeal rights and the process to appeal.

42 CFR 435.916(a)(2); 45 CFR 457.353; 45 CFR 457.340(e); Notice of Proposed Rulemaking, "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule" 78 Fed. Reg. 4593 (January 22, 2013).

Additional Considerations for Non-MAGI Based *Ex Parte* Renewals

Income

- While income methodologies are different, the same *ex parte* processes for verification of income apply to both MAGI and non-MAGI beneficiaries.

Assets

- States must attempt to verify financial assets using the state's Asset Verification System (AVS).
- If the data returned indicate financial assets at or below the applicable resource standard, and no other sources of asset information are available, states may consider assets verified if:
  - ✓ The beneficiary did not have any countable non-financial assets at their last full determination, **or**
  - ✓ The beneficiary only has non-financial assets that are stable (i.e., not likely to change in value)* and the value of assets returned by the AVS + the value of the beneficiary's other assets is at or below the applicable resource standard
- If other asset information in addition to AVS is available, states may consider assets verified if:
  - ✓ The value of financial assets returned by the AVS + the value of assets verified through other available sources + the value of the beneficiary's other stable assets* is at or below the applicable resource standard, **and**
  - ✓ The beneficiary does not have other countable assets whose value is subject to change.

* CMS explained in forthcoming guidance that in completing an *ex parte* renewal, states have discretion to determine that the value of certain asset types is unlikely to increase in value such that the state can rely on the previously-verified value of such assets recorded in the case record.

Non-MAGI Based *Ex Parte* Renewals (cont'd.)

Disability & Blindness Status

- Disability status is not typically re-examined as part of a regular renewal.
- The state's disability review team must determine whether and when re-examinations of disability status are needed in accordance with 42 CFR 435.541(f)(3).
- States may consider blindness and disability as continuing until the agency's review team determines that the beneficiary no longer meets the definition of blindness or disability described in the state plan (see 42 CFR 435.916(b)(2)).
- Unless required by the protocol established by the state's disability review team, in accordance with Medicaid regulations, states must assume an individual being renewed on the basis of disability continues to have a disability for purposes of their Medicaid eligibility.

Ex Parte Renewal Do's & Don'ts

Ex Parte Do's

States Must:

- Attempt *ex parte* renewals for all populations using available reliable information.
- Use a variety of income and other data and automate verifications to the greatest extent feasible to increase states' capacity to do no-touch *ex parte* renewals.
- Leverage information recently verified by the state (with the option to use information from other human services programs if available and reliable).

States Are Encouraged To:

- Implement a strategic data hierarchy to support consistent and efficient application of data.
- Review business rules, logic and operational procedures (e.g., using process mapping) to identify opportunities to expand verification data strategies and increase *ex parte* rates.

Ex Parte Don'ts

States Must Not:

- **Require consent** before applying *ex parte* processes to beneficiary renewals – this isn't permitted
  - Beneficiary consent *is required* ~~for~~ to obtain IRS data, and can be requested for up to five years.
  - Beneficiary consent *is not required* for *ex parte* renewals – even if a beneficiary withholds consent for use of IRS data, the state can still conduct *ex parte* reviews with other reliable data sources.
- **Exclude specific populations** from *ex parte* (e.g., because one factor of eligibility cannot be verified electronically).
- **Limit the number of consecutive *ex parte* renewals.** There are no limits on the number of *ex parte* reviews an individual can receive. States can use this strategy at every renewal.
- **Require all household members to return a renewal form** simply because one member cannot be determined on an *ex parte* basis.
  - States should ~~process~~ complete renewals for those who can be determined *ex parte* and require a response to a renewal form for other household members, only if needed.

Additional Considerations Related to Including All Populations in Ex Parte Processes

- If no data source is available to verify a beneficiary's income, an *ex parte* renewal will not be successful.
- However, the state still must access all available information for use in pre-populating the renewal form for MAGI-based beneficiaries (and non-MAGI beneficiaries if the state uses a pre-populated renewal form for all beneficiaries).
- For example, states that do not access either federal or state tax information cannot verify income eligibility for a self-employed individual on an *ex parte* basis, but may identify wage income during the *ex parte* process.

Deeper Dive on Select Strategies to Increase *Ex Parte* Rates

Attempt *Ex Parte* Renewals for All Populations

- States must ensure all beneficiaries in all eligibility groups are subject to *ex parte* process and attempt to renew their eligibility using available reliable information, including:
  - Non-MAGI beneficiaries
  - Individuals with self-employment income
  - Medicaid beneficiaries concurrently enrolled in SNAP
- For each population, states should identify data sources needed and can tailor system logic and business rules for each population.

State Spotlight

Kentucky applies *ex parte* to MAGI and non-MAGI populations. For non-MAGI groups, Kentucky uses AVS and other data sources including SSA Retirement, Survivors, Disability Insurance Accounting (RSDI-ACCT) System.

Review the Quality and Number of Data Sources Used to Verify Eligibility at Renewal

States should evaluate the data sources they are currently using as part of their *ex parte* renewal processes and may consider additional earned and unearned income data, and other sources to supplement the current process.
(Recommended for use in tandem with strategic hierarchy reviewed in later slides.)

MAGI and Earned Income Data Source Examples

- IRS (MAGI)
- State Income Tax (MAGI)
- SW ICA (earned income)
- The Work Number/TALX (earned income)
- SNAP (earned income)
- Temporary Assistance for Needy Families (TANF) (earned income)

Unearned Income Data Source Examples

- SSA
- SNAP*
- TANF*
- State Unemployment Compensation
- State Public Employees Retiree System
- State Administered Supplementary Payment Program

Residency Data Source* Examples

- SSA
- DMV
- Vital Statistics Agency
- SNAP
- TANF
- Women Infants and Children (WIC) Program

Asset Data Sources

- Asset Verification System (AVS)
- Lexis/Nexis
- Real Estate/Homeowners database

* States cannot reverify citizenship and can only reverify immigration statuses that are likely to change. States may accept self-attestation of residency at renewal and assume no changes if the state does not have information indicating that a beneficiary has moved out of state. States may also reverify residency electronically using these or other data sources.

Leverage Already Verified Data for *Ex Parte* Renewals

- States must leverage recent and reliable data that was previously verified by the agency in conducting an *ex parte* renewal.
- States must use recently verified data, including from other human services programs, that is available to the agency to support making *ex parte* renewal determinations.
- CMS believes data verified within the last 6 months is reasonable for state reliance. Information not subject to change that has been verified more than 6 months ago may also be considered reliable.
  - *Example:* If an individual reported a change in circumstances 6 months prior to their regular renewal date and state verified income eligibility using available data sources when the change in circumstances was processed, the state can rely on the verified income and does not need to re-verify income eligibility at the regular renewal.

State Spotlight

If an individual's income data was verified by Kentucky's eligibility system in the three months prior to the renewal process, the state relies on that previously verified income without re-verifying eligibility.

Use a Strategic Data Hierarchy

States are encouraged to implement a strategic data hierarchy to ensure consistent and efficient application of data to determine eligibility on an *ex parte* basis.

- A strategic data hierarchy is a business logic rule that governs how data sources and other available information are used in making an *ex parte* eligibility determination.
- States can, but are not required to, establish a "reliability hierarchy" of data sources, such that one data source is considered more reliable than another in certain circumstances.
- Strategic data hierarchy models may include:
  - **Consecutive review of data sources**:
    - State's system reviews data sources and other available information for a given eligibility criterion (e.g., income) in a prescribed order and stops once eligibility is verified.
    - If none of the sources verify eligibility, state sends beneficiary a renewal form.
  - **Concurrent review of data sources:** State's system reviews information from all data sources accessed and other available information for a given eligibility criterion (e.g., income):
    - If any data source verifies eligibility but others don't, states may consider the eligibility criterion verified. States also may establish objective rules establishing the circumstances in which one data source is sufficient to verify the criterion even if other sources do not.
    - If no data sources verify eligibility, state sends beneficiary a renewal form.

Strategic Hierarchy: Consecutive Data Sources Review Example*

Primary Source

Federal Tax Information (FTI) Data Check: State checks FTI for a MAGI-based beneficiary.

- If FTI data is at or below applicable MAGI income standard, beneficiary is verified as income eligible and state income verification process stops.
- If no data or data is above income standard, state moves to secondary data source.

Secondary Source

Quarterly Wage Data (QWD): State checks QWD as the secondary data source.

- If QWD data is at or below applicable MAGI income standard, beneficiary is verified as income eligible and state income verification process stops.
- If no data or data is above income standard, state moves to tertiary data source.

Tertiary Source

SNAP Data: State checks for income types and amounts in SNAP case file.

- If at or below applicable MAGI income standard, beneficiary is verified as income eligible and the state income verification process stops.
- If no SNAP data or SNAP data indicates MAGI-based income is above the applicable MAGI income standard, state sends prepopulated renewal form.

* States are not required to use a strategic hierarchy, these data sources, or the order used in this example.

Strategic Hierarchy: Concurrent Review of Data Sources Example 1

State Reviews All Data Sources

- State obtains both Federal Tax Information and Qualified Wage Data for a MAGI-based beneficiary

State Analyzes Findings to Verify Eligibility

- *Any Source At or Below Income Standard:* If any information obtained from the data sources checked is either at or below the applicable MAGI income standard, beneficiary is verified as income eligible and state income verification process stops.
- *No Data or All Sources Above the Income Standard:* If there is no data from these data sources, or if all are above applicable income standard, state cannot verify income eligibility on an *ex parte* basis and must send the beneficiary a prepopulated renewal form.

Strategic Hierarchy: Concurrent Review of Data Sources Example 2

State Reviews FTI Data Sources For Individuals Who are Self- Employed

- State obtains Federal Tax Information for MAGI-based beneficiary who is self-employed

State Reviews FTI and Quarterly Wage Data Sources

- State obtains both Federal Tax Information and Quarterly Wage Data for all non self-employed MAGI-based beneficiaries

State Analyzes Findings to Verify Eligibility

- *Any Source At or Below Income Standard:* If any information obtained from the data sources checked is either at or below the applicable MAGI income standard, beneficiary is verified as income eligible and state income verification process stops.
- *No Data or All Sources Above the Income Standard:* If there is no data from these data sources, or if all are above applicable income standard, state cannot verify income eligibility on an *ex parte* basis and must send the beneficiary a prepopulated renewal form.

Review Business Rules, Logic and Operational Procedures to Improve *Ex Parte* Rates

States are encouraged to take a methodical step-by-step approach to map out *ex parte* processes and implement policy and operational changes.

- Compile policy manuals, IT systems business rules, and diagram process flows related to *ex parte* renewal process;
- Review and compile federal guidance on *ex parte* review, including rules, sub-regulatory guidance, and CMS Coverage Learning Collaborative slide decks (see resources slides);
- Facilitate working sessions with Medicaid policy and IT systems teams to create a process map and walk through each business rule/process flow step-by-step and explore opportunities to maximize capacity for automated determinations;
- Identify and prioritize systems changes that will maximize *ex parte* renewal capacity;
- Develop implementation plans for executing systems changes;
- Update internal and external policy documents; and
- Revise IT systems business rule documents and systems.

Other Strategies to Increase Automation & Reduce Manual Touches at Renewal (Long-Term and Temporary Options)

Express Lane Eligibility SPA Option

The Express Lane Eligibility (ELE) authority at sections 1902(e)(13) and 2107(e)(1) of the Social Security Act permits states to rely on findings from an entity designated by the state to determine whether a child satisfies one or more factors of eligibility for Medicaid or CHIP, including income.

- ELE permits states to rely on findings from other programs designated as express lane agencies (ELA) when determining or renewing Medicaid/CHIP eligibility, without regard to differences in rules between the programs for counting income and household composition.
- Medicaid programs can apply the ELE option to children up to age 19, 20, or 21, and CHIP can do so for children up to age 19.
- ELAs include SNAP, TANF, School Lunch, Head Start, National School Lunch Program (NSLP), and Women, Infants, and Children (WIC), among others.

State Spotlight

Alabama conducts *ex parte* renewal through ELE via data file sharing between the state's SNAP/TANF and Medicaid systems. Through this process, the state successfully redetermines about one-third of the state's caseload up for renewal through *ex parte*.

Sources: Express Lane Eligibility Option (SHO 10-003) (February 2010); Express Lane Eligibility for Medicaid and CHIP Coverage | Medicaid (August 2021)

Facilitated Enrollment SPA Option

The Facilitated Enrollment State Plan Amendment (SPA) option allows states to determine financial eligibility for a MAGI-based Medicaid eligibility group using gross household income determined by SNAP or other means tested benefit programs.

- States may use the Facilitated Enrollment SPA option, which permits states to rely on income determinations made by another program (e.g., SNAP), to renew Medicaid for non-elderly children and adults.
- States must ensure that individuals enrolled through this strategy are certain to be income-eligible using MAGI-based methods.
- The Facilitated Enrollment SPA option generally does not require additional information from the household at renewal.
- To elect this option, states must submit a SPA.
- Additional non-financial information is needed to use this strategy at initial application.

State Spotlight

Louisiana was the first state to receive approval to use a Facilitated Enrollment SPA to enroll and renew individuals in Medicaid. This SPA authority was leveraged to support the State's roll-out of its Medicaid expansion coverage efforts.

Sources: Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies (SHO 15-001) (August 2015)

Special Unwinding *Ex Parte* Strategies Under 1902(e)(14)(A) Authority: SNAP, Zero Dollar, AVS

- In exceptional circumstances, CMS may grant 1902(e)(14)(A) waiver authority to states facing operational issues or navigating serious challenges with eligibility systems in order to protect enrollees' access to coverage and prevent the risk of inappropriate loss of coverage, or to facilitate enrollment of eligible individuals.
- States may seek approval to use this temporary authority in a time-limited manner during the COVID unwinding period to implement targeted enrollment strategies outlined in CMS SHO letter #22-001.*
- For *ex parte renewals, s*tates may use this authority to:
  - Renew Medicaid eligibility for SNAP or other program participants (children and adults) without conducting a separate MAGI-based income redetermination, despite the differences in household composition and income-counting rules.
  - Complete *ex parte* renewals for households whose attestation of zero-dollar income was verified within last twelve months prior to the beginning of the PHE (either at initial application or prior renewal) when no information is received/returned from income data source.
  - Complete *ex parte* renewals allowing assumption of no change in resources when no information is returned through the AVS or when the AVS call is not returned within a reasonable timeframe.
- States seeking this authority must submit a letter requesting the waiver.

- State Health Official Letter (SHO) #21-002, "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program Operations Upon Conclusion of the COVID-19 Public Health Emergency"(issued March 3, 2022). *See also* https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html.

Moving Forward on Improving *Ex Parte* Renewal Rates

Key Takeaways

***Ex parte* renewal processes are required and can help states manage increased volume of cases and reduce burdens for beneficiaries.**

States can increase their *ex parte* rates by:

- Including all populations and making every effort to renew using available data;
- Reviewing available data sources and expanding and automating where possible;
- Leveraging already verified data, including from human service program determinations;
- Using a strategic hierarchy to organize data for consistent and efficient determinations; and
- Creating a process map to identify policy or operational changes needed to better leverage data and improve *ex parte* rates.

States should also review their current requirements, assess whether they impermissibly impede *ex parte* rates, and implement necessary policy, procedural, and IT systems changes. For example, states should eliminate:

- Policies that limit the number of *ex parte* renewals that an individual may undergo;
- Processes that require consent for *ex parte;*
- Systems logic that disallows *ex parte* renewals for certain eligibility groups when reliable data sources could support a determination; and,
- Policies that pull individuals out of the *ex parte* process if no IRS tax data is returned or consent to obtain IRS tax data was not provided.

Improving *ex parte* rates can greatly enhance states' capacity to manage increased volume and maintain coverage during the unwinding of the COVID-19 PHE.

Questions?

Appendix

Additional Resources for States

- "Achieving Real Time Eligibility Determinations" (June 2015)
  Supports states in making timely eligibility determinations for Medicaid and CHIP enrollees and identifies best practices that will enable states to determine eligibility in real time.

- CMCS Informational Bulletin (CIB), "Medicaid and CHIP Renewal Requirements" (December 2020)
  Reminds states about current federal requirements and expectations codified in existing regulations at 42 C.F.R. § 435.916 and 457.343 for completing redeterminations of eligibility for Medicaid and CHIP enrollees.

- Medicaid and CHIP Coverage Learning Collaborative: Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Enrollees: Part 1 (July 2021)
  Provides guidance and strategies for states to address workflow processes, leverage other program data and strengthen consumer outreach and communication to promote continuity of coverage.

- Medicaid and CHIP Coverage Learning Collaborative: Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Enrollees: Part 2 (August 2021)
  Provides guidance and strategies for states to maintain communication with enrollees and address returned mail.

- Medicaid and CHIP Coverage Learning Collaborative: Medicaid and CHIP Renewals and Redeterminations (January 2021)
  Supports states in meeting the federal requirements set forth in 42 C.F.R. § 435.916 and 457.343 for making accurate and timely redeterminations during renewals for Medicaid and CHIP enrollees.

Relevant Federal Medicaid/CHIP *Ex Parte* Renewal Requirements

States are required to attempt to renew Medicaid and CHIP eligibility for all enrollees via *ex parte* prior to requesting any information from the enrollee.

- **States must conduct *ex parte* renewal for all enrollees, including non-MAGI populations, and for every household member.** — 42 CFR § 435.916; 42 CFR § 457.343
- **Use information available to the Agency:** States must attempt to determine and redetermine eligibility using available information whenever possible and only request documentation when sufficient information is not available through electronic data sources. — 42 CFR § 435.916; 42 CFR § 435.911; 42 CFR § 457.343
- **Use of electronic data sources.** States must use electronic data sources to the maximum extent possible when verifying eligibility criteria. Only request documentation/additional information if data sources are unavailable or are unable to be used to verify eligibility. — 42 CFR § 435.940
- **Annual renewals may be no more frequently than every 12 months for MAGI populations and at least every 12 months for non-MAGI populations.** — 42 CFR § 435.916; 42 CFR § 457.343

Source: Medicaid and Children's Health Insurance Program Renewal Requirements (December 2020).