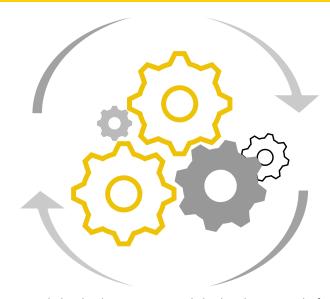


# Notice Considerations for Conducting Medicaid and Children's Health Insurance Program (CHIP) Renewals at the Individual Level

November 2023



This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

# **Objectives of Materials**

- Remind states of requirements for Medicaid and CHIP eligibility determination and adverse action notices.
- Share state options for sending individual eligibility notices to each individual or single eligibility determination notice for the household.
- Provide sample eligibility determination notice language depending on which notice option a state elects.
- Review specific notice considerations when implementing mitigation strategies to conduct renewals at the individual level.



# Eligibility Determination Notice Requirements and Considerations at Renewal

## Federal Requirements: All Eligibility Determination Notices

States must provide to applicants and beneficiaries timely, accessible written notice that meets federal requirements of any decision affecting eligibility, including an approval, denial, termination, or suspension of eligibility.

#### All eligibility decisions notices must be:

- Written in plain language;
- Offered to individuals electronically, at the individual's option in accordance with 42 CFR 435.918.
   The default method for the provision of notices is by mail;
- Accessible to persons who are limited English proficient through the provision of language services at no costs to the individual, including oral interpretation and written translations; and
- Accessible to persons with disabilities through the provision of auxiliary aids and services at no cost to the individual.

NOTE: Individuals must be told about the availability of accessible information and language services and how to access this information and services (including by using taglines in non-English languages)

42 CFR 435.917(a) 435.905(b) 435.918

# **Federal Requirements: Electronic Notices**

#### If the individual elects to receive electronic communications, the state must:

- Confirm that decision by mail;
- Tell the individual that they can change their mind and decide to receive notices through regular mail;
- Post notices to the electronic account within 1 business day of notice generation;
- Send an email or other electronic alert to the individual when a notice is posted to their account (the email or other electronic alert may not include confidential information);
- If there is a failed (undeliverable) electronic communication, send the individual a notice by regular mail within 3 business days; and
- If requested by the individual, send any notice posted to the electronic account to the individual by regular mail.

42 CFR 435.918

## Federal Requirements: Approval Eligibility Determination Notices

#### **Eligibility Determination Notices Must Include:**

- Basis and effective date of eligibility.
- Requirement to report if any of the information contained in such notice is inaccurate.
- Circumstances under which the individual must report a change in circumstances and eligibility and procedures for reporting such a change.
- Any applicable spend-down requirements.
- Basic coverage information, including:
  - Any difference in benefits or services available to individuals enrolled in benchmark or benchmarkequivalent coverage or in an alternative benefit plan;
  - Premium and/or cost sharing obligations;
  - How to receive additional information on benefits and financial responsibilities; and
  - ✓ Right to request a fair hearing regarding the eligibility status or level of benefits.
- For MAGI-based eligibility determinations:
  - ✓ Information on non-MAGI bases of eligibility sufficient for an individual to make a decision about whether to request an eligibility determination on a non-MAGI basis;
  - Services and benefits for the non-MAGI bases of eligibility; and
  - How to request a determination on a non-MAGI basis, if the individual would like to do so.

42 CFR 435.917(b)(1) 435.917(c) 435.916(a)(2)(ii)

# Federal Requirements: Adverse Action Eligibility Determination Notices (1/2)

#### **Denial and Adverse Action Notices Must Include:**

- Description of the action the agency intends to take (e.g., denial, termination, suspension, or reduction in eligibility or services/benefits, or increase in premiums or cost-sharing);
- Effective date of such action;
- Specific reasons supporting the intended action;
- Specific regulations, or changes in federal or state law, that support the action;
- Explanation of fair hearing rights including: how to request a fair hearing (including an expedited fair hearing), who can assist the individual at the hearing, when benefits will be provided pending the outcome of the fair hearing, and timing to take final administrative action; and
- Coordinated content on potential eligibility for another insurance affordability program and transfer of the individual's account to such program.

See Next Slide for Additional Required Denial and Adverse Notice Language

42 CFR 435.4, 435.917(b)(2); 435.917(c); 435.1200(h); 431.206(b); 431.210; 431.211-214

# Federal Requirements: Adverse Action Eligibility Determination Notices (2/2)

#### MAGI-based Eligibility Determinations: Denial and Adverse Action Notices Must Include: For determinations that Information on non-MAGI bases of eligibility sufficient for an are not pending a nonindividual to make a decision about whether to request an MAGI eligibility eligibility determination on a non-MAGI basis; determination Services and benefits for the non-MAGI bases of eligibility; and How to request a determination on a non-MAGI basis, if the individual decides to do so. For determinations that Explanation that the agency is continuing to evaluate Medicaid eligibility on other bases and that eligibility enrollment in other are pending a non-MAGI eligibility determination insurance affordability programs will not affect the non-MAGI eligibility determination.

**Timing Requirement:** With few exceptions, adverse action notices must be sent at least 10 days before the date of the adverse action.

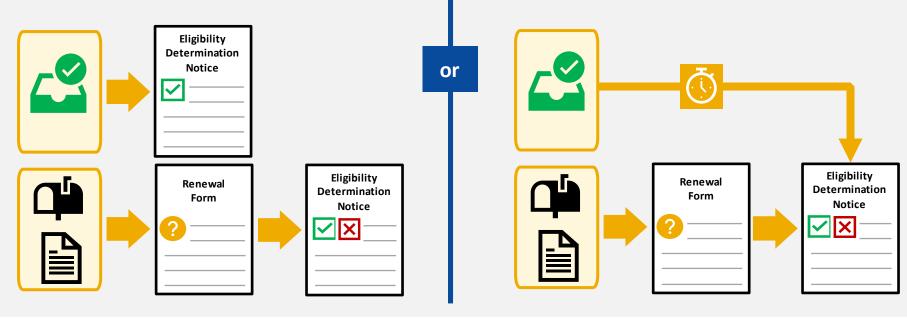
42 CFR 435.4, 435.917(b)(2); 435.917(c); 435.1200(h); 431.206(b); 431.210; 431.211-214

# **State Option: Eligibility Determination Notice Timing**

In some instances, states will need to communicate different messages to individuals in the same household. States can either send eligibility determination notices individually to each beneficiary, or a single notice for the household.

Option A. Send an <u>individual eligibility</u>
<u>determination notice for each individual</u> (with
coordinated content) once the state has made
an eligibility determination (either on an *ex parte*basis or based on the renewal form).

Option B. Send a <u>single eligibility</u>
determination notice for the household only
once the state has enough information to
determine eligibility for all members of the
household (either on an *ex parte* basis or based
on the renewal form).



# **State Option: Eligibility Determination Language Example**

**Option A.** Individual Eligibility Determination Notice for Each Individual (with Coordinated Content)

**Option B.** Single Eligibility

Determination Notice for the Household



You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos al **1-800-XXX-XXXX** (Las personas con problemas para oir – TTY: 1-800-XXX-XXXX).



#### Good news for you

Good news for you, Tina! You qualify for Medicaid health coverage. Your coverage renewed on [insert date].

#### **Update About Your Family**

We are still waiting on information from Martin. Once we receive it, we will let Martin know if he still qualifies for Medicaid health coverage. Martin will be receiving more information in a separate letter. Susie continues to qualify for Medicaid health coverage.



You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos al **1-800-XXX-XXXX** (Las personas con problemas para oir – TTY: 1-800-XXX-XXXX).

#### Why you are getting this letter

#### **Update** for you

Martin, we reviewed your information. We decided that you do not qualify for Medicaid health coverage based on what you told us when we asked for more information because [insert specific reason(s) for ineligibility and supporting regulatory citations]. Your coverage will end on [insert date].

#### **Update About Your Family**

Tina and Susie still qualify for Medicaid health coverage.



You can get this letter in another language, in large print, or in another way that's best for you, Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos al 1-800-XXX-XXXX (Las personas con problemas para oir – TTY: 1-800-XXX-XXXX).

#### News for you and your family

#### Good news for Tina and Susie

Good news for Tina and Susie! They qualify for Medicaid health coverage. Their coverage renewed on [insert date].

#### **Update for Martin**

We reviewed Martin's information. We decided that Martin does not qualify for Medicaid health coverage based on what he told us when we asked for more information because [insert specific reason(s) for ineligibility and supporting regulatory citations]. Martin's coverage will end on [insert date].

Coordinated content provides an overview for the entire family, including determinations for children and the status for the parent(s).

This type of notice provides determinations for the entire household.



# Notice Considerations When Implementing Mitigation Strategies to Conduct Renewals at the Individual Level

### **State Medicaid Director Letter:**

# State Assessments Regarding Compliance with Medicaid and CHIP Automatic Renewal at the Individual Level

On August 30, 2023, CMS sent a letter to all State Medicaid Directors alerting them to a potential eligibility system issue related to automatic renewals for Medicaid and CHIP.

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard,



August 30, 2023

Maryland 21244-1850

Dear State Medicaid Director

I am writing to remind the state of its obligations to conduct Medicaid resewals in accordance with all federal requirements. Adhering to these requirements is necessary to ensure Medicaid and Children's Health Insurance Program (CHIP) eligible individuals retain their coverage, especially during the state's unwinding period, and in order for the state to comply with longstanding federal Medicaid and CHIP enewal regulations and the conditions for the temporary Federal Medicaid Assistance Percentage (FMAP) increase under section 6008 of the Emailies First Coronavirus Response Act (FFCRA) for each quarter in which the state claims the FMAP increase. As the Centers for Medicare & Medicaid Services (CMS) has worked with states on the return regular eligibility operations following the end of the Medicaid continuous enrollment condition, we have identified issues where states are out of compliance with renewal requirements. CMS has worked with those states individually to remediate the issues identified, including by requesting that states pause procedural terminations, reinstate coverage for individuals whose coverage was inappropriately terminated and implement mitigation strategies to prevent future inappropriate discontinellments. We appreciate states: "responsiveness to remedy

Moor recently, however, CMS has learned of additional systems and operational issues affecting multiple states, which may be resulting in eligible individuals being improperly disenrolled. Specifically, we understand that some states are conducting or partie enersuals at the household level, without regard to differing eligibility statues and income thresholds for individuals within the household. As a result, while a state may have sufficient information during the cryparte process to renew Medicard or CHIP coverage for some individuals in a multi-member household, states are sending renewal forms requesting information for all household members, and, if the renewal form is not returned, states are disenrolling all individuals in the household, including those who should have been determined to be eligible through the crypare process. As discussed in more detail below, these actions violate federal renewal requirements and must be addressed immediately.

To date, CMS has identified that this issue most commonly affects:

Children in households with at least one adult enrolled in Medicaid Medicaid and CHIP
eligibility levels for children are generally higher than those for adults, and many children
are frequently able to be determined eligible through the exparier process, even if
additional information may be needed to determine ongoing eligibility for parents or
other adults in the household. While the Medicaid income eligibility limit for adults
enrolled based on medified adjusted gross income (MAGO) in most states is at or below

and CHIP Renewal

aid/CHIP eligibility ibility levels range from ng children at or above for these eligible he ex parte process in we understand that eligibility and pun is not returned. This

tion is needed to verifical renewal regulations and renewal form and nentation needed to gration status, etc.). In ore members of a on an exparte basis for ent information to iniced that due to requesting information d an exparte renewal the household do not irrements at 42 C.F.R. intaining the individuals.

-compliance, states ma holds are ae to incorrect systems luals' differing household member

wal regulations at 42 complete a ividual in the t]he agency must make dividual if able to do so

based on reliable information contained in the individual's account or other more current information available to the agency" (emphasis added). Regulations related to the determination of eligibility at 42 C.F.R. § § 43.5 911(c) and 457.350(b)(1) also specify that the agency must furnish Medicaid "[f]or each individual...whose eligibility is being renewed," if found eligible.

- States were urged to assess their eligibility systems and to determine and report whether they have a systems issue.
- States that identified that they are not autorenewing at the individual level were required to:
  - (1) Pause procedural terminations for those affected individuals;
  - (2) Reinstate coverage for affected populations;
  - (3) Fix the state's systems and processes; and,
  - (4) Implement one or more *ex parte* mitigation strategies to prevent inappropriate terminations of eligibility until such time that the state has fixed all systems and processes to be compliant with the renewal requirements.

# Ex Parte Mitigation Strategy: Identify and Renew Eligibility for Affected Individuals Prior to Disenrollment for a Procedural Reason

#### **Notices Processes and Considerations**

- For any multi-member household with individuals who are scheduled to be procedurally disenrolled, the state must review eligibility for all household members, including children, to identify and renew coverage for and notify those who remain eligible.
  - Individuals who continue to be eligible (e.g., a child who can be determined eligible based on ex parte data) should be renewed and receive a continuation of coverage eligibility determination notice.
  - Members of the household who are not eligible for coverage (e.g., an adult who could not be renewed ex parte and does not return the form) should receive an adverse action eligibility determination notice at least 10 days before the date of action to procedurally terminate coverage.
  - o Communication can be sent *either* through individual eligibility determination notices for each individual or through a single eligibility determination notice for the household.
  - See slides 4 10 on eligibility determination notices for more information.
- If any affected individuals in the household had their coverage terminated prior to the state conducting manual redeterminations, they should receive information regarding reinstatement; notice about next steps in the renewal process can be sent separately or combined with reinstatement notice information. (See slide 14 on reinstatement notices for more information.)

## Reinstatement Notices for Affected Individuals

All states that have identified they are out of compliance with the requirements to determine eligibility for each individual in the household must reinstate coverage for any individuals who have been terminated inappropriately and provide notices to individuals.

#### **Notice Elements**

#### Reinstatement eligibility notices must include:

- Statement that coverage is being reinstated retroactive to the date of their termination (with the retroactive effective date) and how they can access coverage;
- ✓ Statement explaining basis of eligibility;
- ✓ Information on how the individual may seek to obtain payment for medical bills or ensure eligible services are covered for the period while the individual was disenrolled;
- An explanation of how to receive additional detailed information on benefits and financial responsibilities;
- Contact information for help in understanding the letter, including the availability of interpreters and
  accessible format for people with limited English proficiency and disabilities; (See slide 4 for additional details.)
  and
- ✓ Other content required for a notice of approved eligibility consistent with 42 CFR 435.917(b)(1)&(c). (See slide 6 for additional details.)

#### **Additional Important Information:**

- ✓ The date when their Medicaid or CHIP coverage will need to be redetermined, if known; or, if the next redetermination date is still unknown or changes, that coverage will be continued until a notice of action is sent to the individual;
- ✓ Whether the individual will be enrolled in Medicaid or CHIP managed care and, if yes: (1) confirmation that the individual will be reenrolled in their prior plan; or (2) how to select a managed care plan; and
- Call center information and information on community-based resources where they can get additional assistance (e.g., Navigators).

### **Additional Notice Considerations**

#### States that paused procedural terminations may need to send specific notices to individuals who previously received a notice indicating that their coverage will be terminated if a renewal form is not returned. Such states should send notices that include the following information: States that That the individual will continue to be enrolled in coverage past their **Paused** renewal due date or the date that was identified in any notice already **Procedural** sent to the individual indicating coverage was scheduled to end; **Terminations** Information on next steps (i.e., how long the extension is for, and/or that the individual should wait to hear next steps from the state); and Information meeting all other notice requirements, as applicable. (See slides 4-6 for additional details.) States that elected the mitigation strategy to extend coverage for a full 12 months should send a regular renewal notice, at the time of the scheduled renewal, that includes all of the information required in an eligibility States that determination notice. (See slides 4-6 for additional details.) **Extended** Any notices that are provided should meet all other notice requirements. **Coverage for Affected Individuals**

### Resources

- CMS, State Medicaid Director Letter, <u>State Assessments Regarding Compliance with Medicaid and CHIP Automatic Renewal at the Individual Level</u>, 2023.
- CMS Medicaid and CHIP Learning Collaborative, <u>Eligibility-Related Determination Notices State Toolkit</u>, 2017.
- CMS Medicaid and CHIP Learning Collaborative, <u>Effective Communication in Eligibility-Related</u>
   <u>Determination Notices</u>, 2017.
- CMS Medicaid and CHIP Learning Collaborative, <u>Eligibility-Related Determination Notices: 2017</u>
   Refresh Key Messages Menu Set, 2017.
- Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements, 2020.
- CMS Medicaid Unwinding Communications Toolkit
- Medicaid and CHIP Disability and Language Accessibility Requirements, 2023
- CMS State Health Official Letter #22-001, 2022.
- CMS State Health Official Letter #23-002, 2023.