Medicaid and Children's Health Insurance Program Requirements for Providing, Prepopulating and Accepting Eligibility Renewal Forms
January 2025

Objectives

This deck is a companion to the CMCS Information Bulletin (CIB), *Medicaid and Children's Health Insurance Program Requirements for Providing, Prepopulating and Accepting Eligibility Renewal Forms*, and is part of a series of resources for states as they work to comply with federal renewal requirements.

This slide deck is intended to remind states about requirements and expectations for providing and accepting renewal forms for beneficiaries when their eligibility cannot be renewed on an *ex parte* basis using available, reliable information.

Source: CMS CIB, Medicaid and Children's Health Insurance Program Requirements for Providing, Prepopulating and Accepting Eligibility Renewal Forms.

Background

Federal regulations at 42 C.F.R. § 435.916 outline the requirements and processes for states to periodically renew eligibility for all Medicaid beneficiaries. Through a cross reference at 42 C.F.R. § 457.343, these requirements apply equally to states administering separate CHIPs; however, for brevity, only 42 C.F.R. § 435.916 will be cited here.

The guidance described here focuses on requirements for providing, prepopulating, and accepting renewal forms for people whose eligibility for Medicaid and CHIP is based on modified adjusted gross income (MAGI).

By June 3, 2027, states must also prepopulate the renewal form and provide a minimum of 30 days to return the form for Medicaid beneficiaries who are excepted from the use of MAGI (i.e., non-MAGI beneficiaries).[1] States that either currently prepopulate renewal forms for non-MAGI beneficiaries or plan to do so before the June 3, 2027, compliance date may use this guidance as a framework for how to approach prepopulating renewal forms for their non-MAGI populations.

This requirement was finalized in the April 2024 final rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes." We use footnotes throughout the deck to note when states must implement changes to requirements made by the April 2024 rule.

Guidance that is specific to renewal forms for non-MAGI beneficiaries will be provided separately in the future.

Notes:

1. CMS Final Rule, Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes, 89 Federal Register 22780 (April 2, 2024).

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Overview of Renewal Requirements

Overview of Renewal Requirements: Renewal Forms

States must conduct periodic renewals of Medicaid and CHIP beneficiaries' eligibility by first attempting to renew coverage based on existing information.

- For MAGI Medicaid and CHIP beneficiaries, states must renew eligibility once every 12 months and no more frequently. For non-MAGI beneficiaries, states must renew eligibility at least once every 12 months (42 C.F.R. § 435.916(a)(1)).[1]
- States must begin the renewal process for all Medicaid and CHIP beneficiaries by first attempting to renew eligibility based on reliable information available to the agency without requiring information from the beneficiary (*ex parte* renewal) (42 C.F.R. § 435.916(b)(1)).

Notes: For an overview of the entire renewal process, see September 2024 slide deck Overview: Medicaid and CHIP Eligibility Renewals.

1. To align with the requirements for MAGI beneficiaries, as of June 3, 2027, states must renew eligibility once every 12 months and no more frequently than once every 12 months for almost all non-MAGI beneficiaries. States may implement these requirements sooner. These requirements were finalized in the April 2, 2024, rule, Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes (89 FR 22794).

Overview of Renewal Requirements: Renewal Forms, continued 1

When eligibility cannot be renewed through *ex parte* processes, states must provide beneficiaries with a renewal form requesting the information needed to renew eligibility.

States must provide a renewal form in the following circumstances:

- when the state does not have enough information to complete the renewal on an *ex parte* basis,
- when available information indicates the beneficiary may no longer be eligible, and
- when available information indicates the beneficiary may be eligible for a reduced benefit package or subject to increased cost sharing or premiums (42 C.F.R. § 435.916(b)(2)).

States must provide beneficiaries the option to receive eligibility notices and renewal forms in an electronic format or by regular mail (42 C.F.R. §§ 435.918(a) and 457.110(a)(1)). Beneficiaries must also be permitted to change their election (42 C.F.R. §§ 435.918(a)).

Overview of Renewal Requirements: Renewal Forms, continued 2

- States must provide MAGI beneficiaries with a prepopulated renewal form. States have the option to provide a pre-populated form to non-MAGI beneficiaries (42 C.F.R. § 435.916(b)(2)(i)(A)).[1]
- The prepopulated renewal form must contain the available information needed to renew eligibility and request that beneficiaries update outdated, incomplete, or inaccurate information (42 C.F.R. § 435.916(b)(2)(i)(A)).
- MAGI beneficiaries must be provided a minimum of 30 days to return the form. Non-MAGI beneficiaries must be given a reasonable period of time to respond (42 C.F.R. § 435.916(b)(2)(i)(B)).[1]
- All beneficiaries must be able to submit the renewal form through any of the modes available for applications, including online, telephone, mail, in person, and through other commonly available electronic means (§§ 42 C.F.R. 435.916(b)(2)(i)(B) and 435.907(a)).

Notes:

1. To align with the requirements for MAGI beneficiaries, as of June 3, 2027, states must provide non-MAGI beneficiaries a prepopulated renewal form and 30 days to respond. These requirements were finalized in the April 2, 2024, rule, Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes (89 FR 22794).

Overview of Renewal Requirements: Renewal Forms, continued 3

- Along with the renewal form, the agency must provide clear instructions to beneficiaries (42 C.F.R. §§ 435.905(a) and 457.340(a)). The instructions must include information on:
  - how to complete and return the form,
  - how to correct any inaccurate prepopulated information,
  - what other additional information or documentation is needed for the state to complete the renewal,
  - the timeframe in which the form must be returned, and
  - how to obtain assistance with this process.
- Renewal forms must be accessible to individuals who are limited English proficient and persons with disabilities (42 C.F.R. §§ 435.905(b), 435.916(e), and 457.110(a)).
- States may not require a beneficiary to submit a full application to complete a renewal or reapply to retain coverage (42 C.F.R. § 435.916).

Elements of the Renewal Forms

Information Requested on the Renewal Form

Any beneficiary whose eligibility cannot be renewed through the *ex parte* process must be given the opportunity to complete a renewal form. The renewal form enables states to collect, and the beneficiary to update, the information needed to determine whether a beneficiary continues to be eligible.

- States must ensure that their renewal forms collect information needed to redetermine eligibility, including information needed to identify whether an individual may be eligible on another basis if the individual is no longer eligible for their current eligibility group.
  - This applies to all modalities in which the renewal forms and signatures must be accepted (i.e., online through an internet website, by telephone, by mail, in person, or other electronic means).
- The form must allow the beneficiary to provide missing information and validate or correct prepopulated information.

42 C.F.R. § 435.916(b)(2)(v)

Information Requested on the Renewal Form, continued

- Although renewals must be conducted on an individual level, states typically send one renewal form to all household members. The form sent to a household may only request the beneficiary to respond to questions that are needed to complete the renewal for household members whose renewal could not be completed during the *ex parte* renewal process.[1]

- Information regarding non-applying household members may only be required if needed to complete the redetermination of eligibility of applicable enrolled household members.[2]
  - States may request information from non-applicants if helpful to support completion of a beneficiary's renewal (e.g., a Social Security Number of a non-applicant parent) provided that the state includes a clear explanation of the importance of the information and how it will be used, consistent with federal regulations.

Notes:
1. 42 C.F.R. § 435.916(b)(2)(v)
2. 42 C.F.R. §§ 435.907(e) and 457.340(b)

Key Types of Information States Must Include on the Prepopulated MAGI Renewal Form

Information to Contact the Individual

Renewal forms must include the most up-to-date contact information that the state has for the household. This provides an opportunity to confirm household contact information, such as residential and/or mailing addresses, in addition to other outreach modes used by the state, such as phone (e.g., text or voice call) and email.

Information Needed to Verify Financial Eligibility

For MAGI beneficiaries, the renewal form must include questions about:

- Household composition (e.g., confirming existing or adding new members of the household);
- Expected tax filing status and tax dependents; and
- Income from jobs and other sources or earned and unearned income needed to calculate MAGI-based income.

Information on Other Insurance Coverage

For certain populations, such as individuals enrolled in CHIP or children enrolled in the Medicaid eligibility group for optional targeted low-income children, the renewal form must include any information the state has about other sources of coverage the beneficiary may have, as to be eligible for CHIP or for this optional Medicaid eligibility group, the beneficiary may not have other coverage.[1]

Notes:

1. 42 C.F.R. §§ 435.4, 435.229(b), 457.310(b)(2), and 457.350(a)(1)

Key Types of Information States Must Include on the Prepopulated MAGI Renewal Form, continued 1

Information to Identify Potential Eligibility on Other Bases

At a minimum, renewal forms must include screening questions to consider eligibility on other bases.[1] This could include, for example, information that helps the state identify pregnancy status, foster care history, and questions used to screen for potential eligibility based on disability status or another non-MAGI basis.

To facilitate a non-MAGI eligibility determination for beneficiaries no longer eligible based on MAGI, states may choose whether they:

- Include only questions to screen for eligibility on their MAGI renewal form and send a separate request for information to collect any additional information when needed to determine non-MAGI eligibility, or
- Collect any information needed to determine non-MAGI eligibility on the MAGI renewal form.

Notes:

42 C.F.R. § 435.916(d)(1)

1. States may not require beneficiaries to answer all screening questions on a renewal form to complete a redetermination if the beneficiary returns enough information on the form to renew their eligibility.

Key Types of Information States Must Include on the Prepopulated MAGI Renewal Form, continued 2

Information to Identify Potential Eligibility on Other Bases, continued

In choosing whether to screen for eligibility on their MAGI renewal form or collect any information needed to determine non-MAGI eligibility on the MAGI renewal form, states will need to consider regulatory requirements and operational challenges. States may adopt different approaches for different modalities.

- Sending a separate request minimizes the risk of collecting unnecessary information for beneficiaries who can be renewed based on MAGI (which is not permitted), but requires other beneficiaries screened for potential eligibility on a non-MAGI basis to return a second form or respond to a second request for information. States adopting this approach are encouraged to incorporate additional beneficiary communications to remind individuals to respond.
- Requesting that a beneficiary complete additional sections of the renewal form can facilitate non-MAGI eligibility determinations. In a dynamic environment (e.g., online, telephonic, or in-person), while complicated and requiring an experienced eligibility worker in a telephonic or in-person environment, a state may be able to determine MAGI eligibility in real time and only request additional information, if needed, to determine non-MAGI eligibility. CMS does not believe states could effectively implement this option for beneficiaries completing a paper renewal form.

Key Types of Information States Must Include on the Renewal Form, continued 3

Other Information Needed to Support Renewal Completion

- Renewal forms must collect a signature as beneficiaries must be able to sign their renewal form under penalty of perjury (slide 27).
- Beneficiaries must be notified of their rights and responsibilities and when they must return their renewal form and any requested documentation to avoid gaps in coverage (slides 20-21).
- At renewal, beneficiaries must be able to designate an authorized representative. States may enable such designation either through or with the renewal form (slide 44).
- Renewal forms may also need to include additional information to ensure states can complete eligibility determinations for all relevant mandatory and optional eligibility groups covered by the state.

STATE RESOURCES:

States may refer to Appendix A of the December 2024 CIB, Medicaid and Children's Health Insurance Program Requirements for Providing, Prepopulating and Accepting Eligibility Renewal Forms, for a checklist of elements that should be included on a MAGI renewal form. The CIB is available here: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-12202024.pdf.

States can also refer to CMS' revised model renewal form released in 2015 for detailed examples about the types of information and sample questions that could be included on a renewal form. The model renewal form is available here: https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/revised-model-renewal-form.pdf.

Prepopulating Renewal Forms

States must prepopulate the renewal form with information from the electronic data sources accessed during the *ex parte* renewal and other information in the beneficiary case record.

To the extent possible, states must prepopulate the renewal form with the specific, reliable information from the data sources accessed during the *ex parte* process and the beneficiary case record that they will rely on to complete the redetermination. Doing so:

- Provides beneficiaries with the opportunity to:
  - verify or correct information obtained by electronic data sources before the state makes a determination of ineligibility; and
  - update or validate prepopulated information from the beneficiary case record that is no longer accurate.
- Helps states meet their ongoing obligation to make accurate and timely determinations of eligibility at renewal.

REMINDER: States are reminded that when prepopulating a renewal form, they must safeguard individuals' information in accordance with 42 C.F.R. Part 431 subpart F and § 457.1110(b) and in accordance with data use agreements.

To limit the disclosure of information, states must limit what is included on the form to information that is needed to redetermine eligibility.

To the extent feasible, states must avoid leaving fields on the renewal form blank if the state has reliable information available to it. If the state does not have reliable information from data sources or the case record, it must include a field for the beneficiary to provide updated information and has the option to prepopulate that field with information from the last determination or leave it blank.

Information States Must Use to Prepopulate Renewal Forms

- When reliable data for a specific field on a renewal form is available and there are no applicable laws or data use agreements that preclude disclosure, the state must include the data on the form.
- States also must include contact information and information from the case record that will be used in determining eligibility to provide the beneficiary the opportunity to update the information or report changes. This includes information the state has determined is unlikely to change and does not reverify at renewal (such as stable pension income).[1]
- If states are unable to prepopulate the renewal form due to data use restrictions, the state must prepopulate the form with information accessed from remaining allowable data sources when possible and may consider including information from the last determination (see slide 19).
- In rare instances when a state has no available information that can be disclosed or is unable to pull information from the case record, states must, at a minimum, prepopulate renewal forms with beneficiaries' contact information.

Notes:

1. For additional information related to state determinations of stable income, see November 2024 CIB, Financial Eligibility Verification Requirements and Flexibilities.

Considerations in Prepopulating Renewal Forms

Prepopulating Forms with Information from the Last Determination or Renewal to Avoid Leaving Fields Blank on the Form. If data sources return no information and there is no recently verified information in the case file, states may prepopulate renewal forms using information from the most recent eligibility determination or redetermination instead of leaving the field blank.

- If a beneficiary does not return the renewal form, the state may not use information from the last determination that is no longer reliable to complete the renewal simply because this information was used to prepopulate the renewal form.[1]

When States Obtain Data from Multiple Data Sources. When a state has information from multiple sources relating to the same eligibility factor, the state has the flexibility to determine which information is most useful to include on the renewal form. The state is not required to include the values from each individual data source.

Variation of Prepopulated Information. The information that is prepopulated will depend on both what information for each beneficiary is available from data sources and the case record and what information is needed to renew their eligibility.

Notes:

42 C.F.R. §§ 435.916(b)(2)(ii) and (v)

1. For additional information on verification of financial eligibility, see November 2024 CIB, Financial Eligibility Verification Requirements and Flexibilities.

Requests for Documentation Accompanying a Renewal Form

Prepopulated renewal forms must include or be accompanied by a request for any documentation needed to verify eligibility.

- States must limit documentation requests only to information that must be collected from the beneficiary to verify eligibility.
- The renewal form, or an accompanying notice, must inform the individual if they need to provide documentation, and if so the types of acceptable documents.
- There are certain types of information prepopulated on the form that are unlikely to change or that the state has determined is information unlikely change, and the form should be clear that beneficiaries do not need to provide documentation to reverify this information unless it has changed and the state does not accept self-attested information.

42 C.F.R. §§ 435.916(b)(2)(ii) and (v)

Program Information and Instructions Accompanying a Renewal Form

States must provide beneficiaries clear instructions on or with the renewal form.

States must provide clear instructions and information on or with the renewal form for beneficiaries to understand:

- Who in the household needs to complete the renewal form to maintain eligibility;
- What is needed to complete the renewal process, including the information on which sections must be completed;[1]
- How the renewal form and additional information may be returned, including through all required modalities (discussed on slide 27);
- When they must return their renewal form and any requested documentation to avoid gaps in coverage;
- Their rights and responsibilities and that they must sign the renewal form under penalty of perjury; and
- How beneficiaries can obtain assistance completing and submitting their renewal and the steps to designate an authorized representative.

Notes:

42 C.F.R. §§ 435.905(a)) and 457.340(a)

1. For paper renewal forms, states need to include instructions on which sections must be completed to determine eligibility and include skip language to ensure beneficiaries are only asked the information needed to renew coverage.

Renewal Forms for Households with Multiple Members

States must complete a redetermination of eligibility based on available information for each beneficiary in the household due for renewal, regardless of the eligibility of others in the household.

- To renew eligibility for a beneficiary, states may need to include information on a renewal form or take into account available information about other members of the household, including members who have been renewed on an *ex parte* basis.
- States must include information available about other members of the household that is relevant to renew eligibility for the beneficiary(ies) receiving a renewal form and only request information that is needed to complete the renewal of household members whose eligibility could not be renewed during the *ex parte* process.
- States may not request information needed only to renew eligibility for those beneficiaries who the state was able to determine remain eligible during an *ex parte* renewal simply because a renewal form must be provided to other members of the household.

42 C.F.R. §§ 435.916(a) and (b)(2)(v)

Example Scenario 1: Renewal Form for Household with Multiple Members on Same Renewal Schedule

Household with Two Married Adults on Same Renewal Schedule, Additional Information Needed to Renew Eligibility for One Adult

Jane (adult enrolled in the former foster care child (FFCC) group) and Joe (adult enrolled in the Medicaid adult group) are married and on the same renewal schedule.

The state begins the renewal process for Jane and Joe.

- There is no income test for the FFCC group, and Jane continues to meet all other FFCC eligibility requirements. The state renews Jane's coverage in the FFCC group on an *ex parte* basis.
- *Ex parte* data sources indicate Joe's household income is above the threshold for the adult group. The state must reverify his household income, which includes income earned by Joe and Jane.

The state sends Joe a prepopulated renewal form that:

- Includes available information about the household (e.g., composition, contact information, income) needed to renew Joe's eligibility,
- Includes or requests information about Jane's income, which is needed to complete Joe's renewal as she is part of Joe's Medicaid household, and
- Does not include or request information related only to the renewal of Jane's coverage in the FFCC group.

If Joe does not return the renewal form, the state must still complete the *ex parte* renewal for Jane.

Example Scenario 2: Renewal Form for Household with Multiple Members on Different Renewal Schedules

Household with One Adult and One Child on Different Renewal Schedules, Additional Information Needed to Renew Eligibility for Child

Molly and Jack are in the same household and have different renewal schedules. Molly (adult) has an eligibility period of July 1, 2024 – June 30, 2025, and Jack (child) has an eligibility period of January 1, 2024 – December 31, 2024.

The state is unable to complete the *ex parte* renewal process for Jack because there are no available data sources to verify his household's income.

The state sends Jack a prepopulated renewal form that:

- Includes available information about the household (e.g., composition, contact information, income) needed to renew Jack's eligibility,
- Requests Molly's income to complete Jack's renewal, and
- Does not request additional information to renew coverage for Molly since she is in the middle of her 12 month-eligibility period.

If the renewal form is not returned, the state must maintain Molly's coverage.

If the renewal form is returned and the state has sufficient information with respect to all factors of eligibility for Molly without requiring additional information from her, the state may start a new 12-month eligibility period for Molly when it renews Jack's coverage.[1]

Notes:

1. Under the option at 42 C.F.R. § 435.919(e)(2), the state may redetermine Molly's eligibility for a new 12-month eligibility. This regulatory option can result in the alignment of renewal dates across members in a household.

Multi-Benefit Renewal Forms

States may use a combined form to renew Medicaid and CHIP eligibility along with other human services programs, such as the Supplemental Nutrition Assistance Program (SNAP), but must comply with all Medicaid and CHIP renewal requirements.

- States providing multi-benefit renewal forms **may not** request Medicaid or CHIP beneficiaries to provide information that is only needed to renew eligibility for another program.
  - States can include questions only needed for other programs but must ensure multi-benefit renewal forms include clear instructions on which questions must be answered and which information must be provided for purposes of renewing Medicaid and CHIP eligibility to prevent impermissible requests for information.
- States **may not** delay completing a redetermination of eligibility or deny eligibility for Medicaid or CHIP because a beneficiary did not complete a question on the form that is only needed to recertify or renew benefits for another program.
- States **may not** shorten the time period that states must provide a beneficiary to return their Medicaid or CHIP renewal form.

42 C.F.R. §§ 435.916(b)(2)(v)

Modality and Timeline Requirements for Accepting Renewals

Modes of Submission

Medicaid and CHIP beneficiaries must be able to sign their renewal form under penalty of perjury[1] and submit their renewal form and any supporting documentation through any of the modes required for submitting an application.

				
States must establish a webform that allows a beneficiary to complete, sign, and submit their renewal and any requested documentation online.	States must create infrastructure, such as use of a call center, that allows a beneficiary to complete, sign, and submit their renewal with a customer service representative or eligibility worker over the phone.	States must provide a mailing address where beneficiaries may mail their completed and signed paper renewal form and send requested documentation.	States must provide physical locations where beneficiaries may receive assistance with the renewal process and/or drop off or physically complete, sign, and submit their renewal form and provide requested documentation.	States must accept renewals through other commonly available electronic means as new technologies become available.[2]

☑ Telephonic signatures, electronic signatures, and handwritten signatures must be accepted.

Notes:

42 C.F.R. §§ 435.907, 435.916(b)(2)(i)(B) and 457.330

1. Renewal forms and signatures must be accepted from the beneficiary, an adult in the beneficiary's household or family, an authorized representative, or, if the applicant is a minor or incapacitated, someone acting responsibly for the beneficiary applicant.
2. While CMS has not identified any specific commonly available electronic means through which individuals must be able to apply for or renew coverage at this time, states may consider electronic means such as scanning, imaging, secure email processes, and fax. The requirements to safeguard applicant and beneficiary information at 42 C.F.R. Part 431 Subpart F and § 457.1110 apply to all applicant and beneficiary information, regardless of the mode of submission.

Considerations for Submission Modalities

Beneficiary Preferences for Modality. When a state provides a prepopulated renewal form to a beneficiary, it must do so regardless of the modality in which the beneficiary accesses their form. For example, for beneficiaries who prefer to complete a paper renewal form, the paper renewal form must be prepopulated.

Use of Different Modalities. In certain circumstances, a beneficiary may need to utilize different modalities to complete the renewal process. States must accept the renewal form, signature, and required documents through any modes of submission, as previously mentioned, even if the beneficiary may need to utilize different modalities to complete the process.

Transitions Across Modalities. States are encouraged to consider renewal processes that enable seamless transitions across the modalities to enable beneficiaries to complete the process using more than one modality. For example, states may consider:

- Using the same system or connect online and telephonic systems to allow information gathered in one mode to be picked up in another.
- Entering information from the paper renewal form into an online system so that it can be accessed online by beneficiaries or by call center employees.

42 C.F.R. §§ 435.916(b)(2)(i)

Timelines for Beneficiary Submission

Regardless of the modality in which the renewal form is sent, states must provide MAGI beneficiaries a minimum of 30 days to return the form and requested information.

- The 30-day period begins on the date the renewal form is postmarked or the date the renewal form and notification alerting the beneficiary that they need to renew their coverage are posted to the beneficiary's electronic account.
- States must ensure that the beneficiary is informed they have a minimum of 30 days to return their renewal form and any required information.
- If a beneficiary does not respond within the required 30-day timeframe but does return a signed renewal form and any requested documentation prior to the end of their eligibility period, the state must act on the information to complete the redetermination as expeditiously as possible and consistent with timeliness standards.
- The agency must continue to furnish Medicaid to beneficiaries who have returned their renewal form and all requested documentation before the end of the last day of their eligibility period unless and until they are determined to be ineligible.

States that send an **electronic renewal notification** may need to restart the 30-day period if the beneficiary requests the state mail a paper renewal form. See slide 31.

Notes:

42 C.F.R. §§ 435.907, 435.912(c)(4), 435.916(b)(2)(i)(B), 435.930(b), and 457.340(d)

1. As of June 3, 2027, states must provide non-MAGI beneficiaries 30 days to respond. These requirements were finalized in the April 2, 2024, rule, Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes (89 FR 22794).

Providing and Submitting Paper Renewal Forms

States must send in the mail either a prepopulated renewal form or a renewal notification to beneficiaries who do not elect to receive electronic notices.

- In states that mail a prepopulated renewal form to all beneficiaries who elect to receive paper notices, the states will mail the prepopulated renewal form along with instructions.[1]
- In states that first mail a renewal notification to beneficiaries who elect to receive paper notices, the notification must provide clear information about how the beneficiary may renew their eligibility (i.e., online, by phone, by mail, or in person) and how to request a paper renewal form if they would prefer to complete their renewal via mail or to complete a paper form in person.

DEFINITIONS:

A ***renewal notification*** is a document mailed to the beneficiary to make them aware of their need to renew their eligibility and how they may access, obtain, or request their prepopulated renewal form. It does not include the renewal form itself.

A ***renewal form*** is the form used by the state to collect information from the beneficiary needed for the state to make a Medicaid or CHIP eligibility determination, as prescribed under 42 C.F.R. § 435.916(b)(2)(i).

Notes:

1. The instructions provided on or with the renewal form should explain how to complete the form, the timeframe for submitting the form, what documentation or other additional information is required, and how to return the renewal form and required documentation and other information.

Requesting and Sending a Paper Renewal Form

States that do not automatically send the prepopulated paper renewal form must inform beneficiaries that they may request and submit a paper form and provide them a reasonable time to request a paper renewal form through all modalities.

- At a beneficiary's request and regardless of whether the beneficiary has elected to receive notices electronically or via mail, states **must** provide the prepopulated renewal form through regular mail.
- States **must** provide beneficiaries a reasonable time to request a paper renewal form and inform them that they may request a paper form through all modalities.
  - If the beneficiary requests a paper renewal form within the reasonable period established by the state, the state must restart the 30-day clock for returning the renewal form based on the date the paper form is sent.
  - If the beneficiary requests the paper form after the reasonable period established by the state but before the end of their eligibility period, the state must send the beneficiary a paper renewal form but is not required to provide a new 30-day period for them to return the form.
- States **must** accept renewal forms and complete a redetermination of eligibility prior to taking any adverse action for any beneficiary who returns their renewal form and any requested documentation prior to the end of their eligibility period.

Electronic Notices and Renewal Forms

States must provide beneficiaries a choice to receive notices and information in an electronic format or by regular mail and beneficiaries must be permitted to change their election.

- If a beneficiary elects to receive information electronically, the agency must:
  - Make the online renewal module available to the beneficiary on their secure electronic account, and
  - Send an email or other electronic communication alerting the beneficiary that the renewal form has been posted to their account.
- The email or other electronic communication may not include confidential information.
- States must follow the same principles for prepopulating online renewals as those that exist for paper forms.
- Online renewal functionality must use dynamic functionality to target requests for information based on beneficiary responses.

42 C.F.R. §§ 435.918(a) and (b)(4), and 457.110(a)(1)

Example Scenario 3: Renewal Form Requested Within the Reasonable Timeframe Set by the State

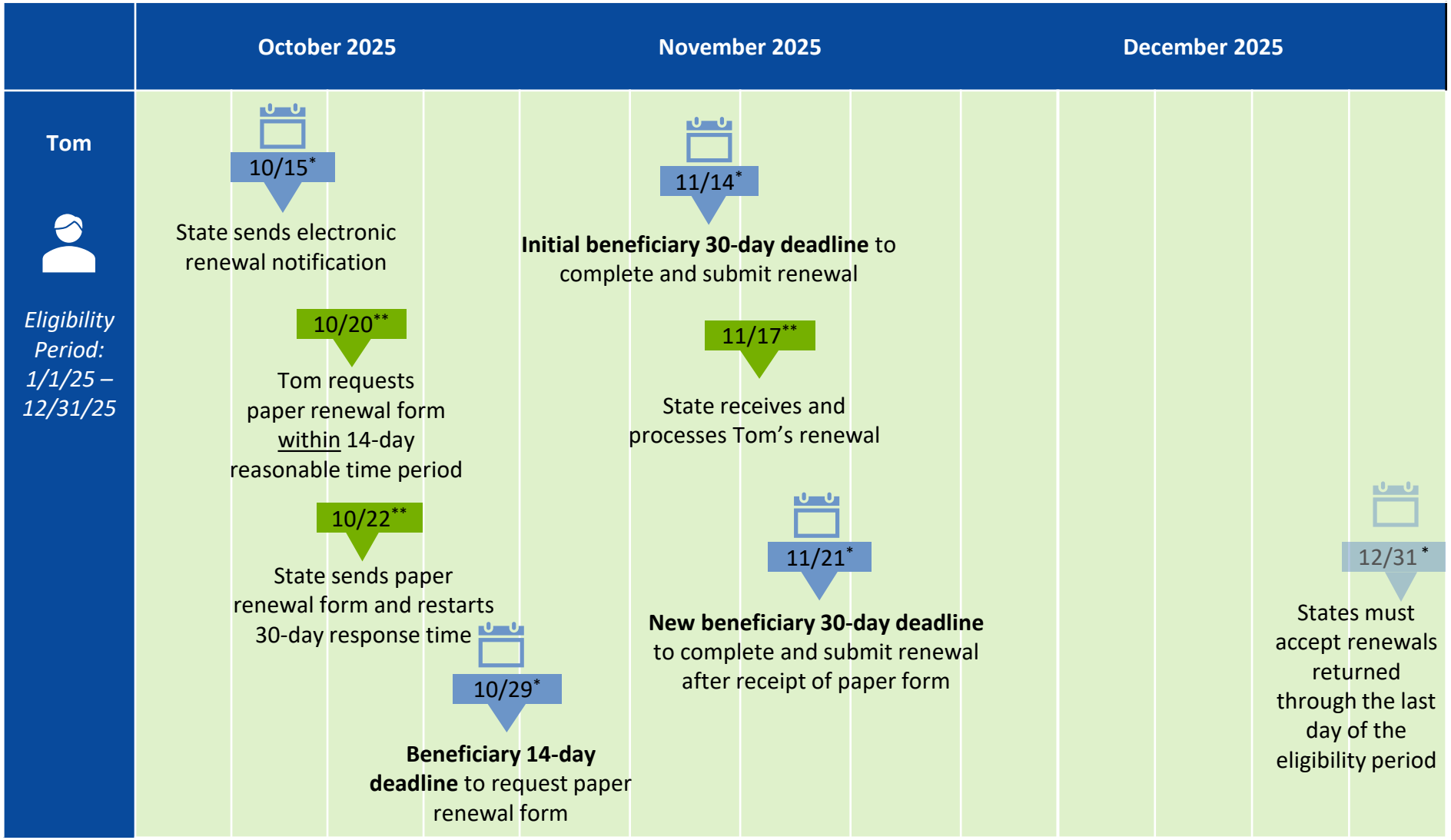
Scenario

- Tom is enrolled in Medicaid, and his eligibility period is January 1, 2025, through December 31, 2025.
- Tom has elected to receive electronic notifications.
- At renewal, Tom's eligibility cannot be renewed on an *ex parte* basis, and he must complete a renewal form.
- Tom requests a paper renewal form within the state's reasonable time period.
- Tom's renewal should be completed by the end of his eligibility period – December 31, 2025.

State Renewal Policies

- The state starts the renewal process approximately 90 days in advance of a beneficiary's eligibility period end date.
- The state sends beneficiaries a renewal notification when they elect to receive electronic notices and must return a renewal form to complete their renewal. The notification includes information on how to request a paper prepopulated renewal form.
- The state provides beneficiaries a reasonable time period of 14 calendar days to request a paper renewal form.

Example Scenario 3: Renewal Form Requested Within the Reasonable Timeframe Set by the State, continued



Example Scenario 4: Renewal Form Requested Outside the Reasonable Timeframe Set by the State

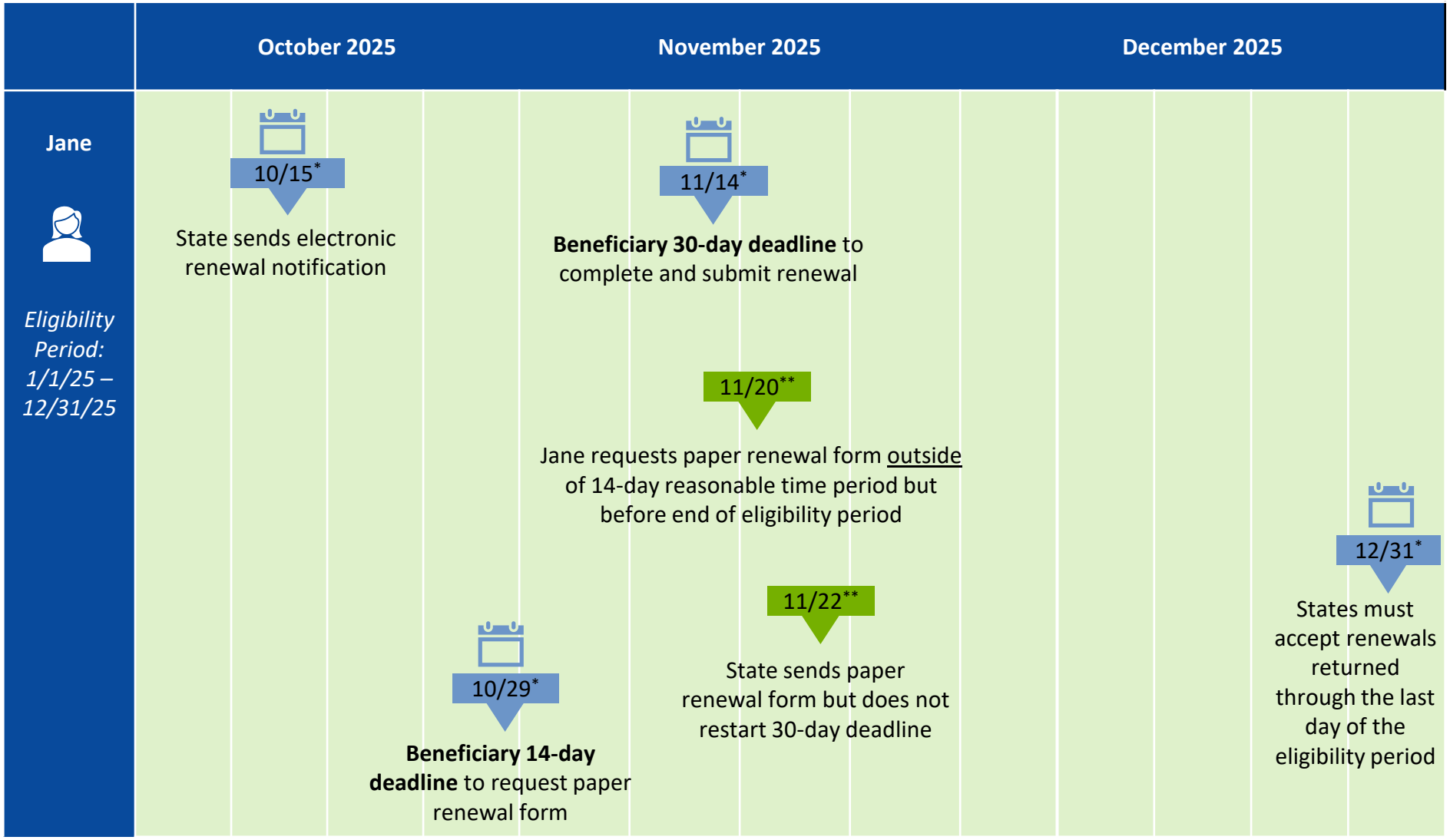
Scenario

- Jane is enrolled in Medicaid, and her eligibility period is January 1, 2025, through December 31, 2025.
- Jane has elected to receive electronic notifications.
- At renewal, Jane's eligibility cannot be renewed on an *ex parte* basis, and she must complete a renewal form.
- Jane requests a paper renewal form after the reasonable time period set by the state.
- Jane's renewal should be completed by the end of her eligibility period – December 31, 2025.

State Renewal Policies

- The state starts the renewal process approximately 90 days in advance of a beneficiary's eligibility period end date
- The state sends beneficiaries a renewal notification when they elect to receive electronic notices and must return a renewal form to complete their renewal. The notification includes information on how to request a paper prepopulated renewal form.
- The state provides beneficiaries a reasonable time period of 14 calendar days to request a paper renewal form.

Example Scenario 4: Renewal Form Requested Outside the Reasonable Timeframe Set by the State, continued



Considerations for Accepting Telephonic Renewals and Signatures

States must be able to accept telephonic applications and renewals, including telephonic signatures.

Accepting Telephonic Renewals and Signatures. States must have a process that enables a beneficiary to:

- verbally review all the information on the renewal form with an eligibility worker or other customer service representative;
- update any incorrect information;
- provide missing information; and
- telephonically sign the renewal form under penalty of perjury.

As it is not practical to submit required documentation by phone, states must enable beneficiaries who need to submit documentation to do so through any of the other modalities.

Conveying Rights and Responsibilities. States must have a process to communicate the beneficiary's rights and responsibilities associated with the renewal. An additional telephonic signature must not be required for the beneficiary to attest to their understanding.

42 C.F.R. §§ 435.905(a)(3), 435.907(a), 435.916(b)(2)(i)(B), and 457.330

Considerations for Accepting Telephonic Renewals and Signatures, continued 1

- **Incomplete Telephonic Renewals.** States may not terminate coverage for procedural reasons if a telephonic application is stopped prior to completion unless the beneficiary does not complete their renewal form and submit requested documentation before the end of their eligibility period.
  - States are encouraged to establish a callback process when a telephone renewal is not completed and to reach out to beneficiaries through automated calls, texts, emails, and in writing to remind them to complete and sign their renewal.

- **Storage of Telephonic Renewals.** States must maintain, or supervise the maintenance of, the information provided by beneficiaries to complete their telephonic renewal form and their signature, just as they must maintain information and signatures provided on paper or electronically. States can record the entire telephonic renewal process or record only the telephonic signature.[1]

Notes:

1. The length of storage of these records must comply with existing regulations on maintenance of records at 42 C.F.R. §§ 431.17. As part of the April 2, 2024, final rule, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (89 FR 22794), the requirement related to records retention were updated with an effective date of June 3, 2024, although states have 24 months to come into compliance. Failure to provide required records, including a telephonic signature, will result in an eligibility error under the Payment Error Rate Measurement (PERM) Program.

Considerations for Accepting Telephonic Renewals and Signatures, continued 2

Confirming Receipt. States are strongly encouraged to provide beneficiaries with a confirmation receipt, documenting the telephonic renewal and the date the renewal is signed and submitted, as well as any time the beneficiary ends the call without completing their renewal. States may deliver confirmation receipts electronically or by mail based on the beneficiary's notice preference.

Partnering with Managed Care Plans for Collecting Telephonic Signatures. States can partner with managed care plans in three ways to assist in collecting enrollee signatures on renewal forms and forwarding completed forms to the state for processing:

1. Assist the beneficiary in completing the renewal form, accept and record the telephonic signature, and forward the information to the state to make a determination.
2. Assist the beneficiary in completing the renewal form, accept and record the telephonic signature, submit an attestation that the signature was collected, and provide the recording upon request.
3. Coordinate a three-way call with the beneficiary or an appropriate representative and an eligibility worker at the Medicaid agency or the agency's call center so that the beneficiary or their representative can provide a telephonic signature directly to the state.

Completing the Renewal Process

Completing the Renewal Process

The renewal form provides beneficiaries who cannot be renewed on an *ex parte* basis the opportunity to correct the data obtained by the state such that no adverse action should be taken without requesting information from the individual, including when the reliable information indicates a Medicaid beneficiary may be eligible for a group with a reduced benefit package or increased cost sharing or premiums.

When a renewal form is returned…

- The state must consider information returned on the renewal form, verify information provided by the beneficiary per the state's verification plan, and provide notice of the agency's decision.
- If additional information is needed to make a final determination when the individual may be eligible under another eligibility group, the state must request any additional information and documentation needed and provide the individual with a reasonable period of time to respond.

If the information shows the individual remains eligible in their current eligibility group, coverage must be renewed in that group

- If the information shows the individual is now eligible for a new eligibility group, the state must move the individual to the appropriate group, renew coverage, and send the appropriate notice to notify the individual of the eligibility decision.
- Before moving the individual to a new Medicaid eligibility group with a reduced benefit package, the state must send advance notice informing the beneficiary of the change in eligibility, including the covered benefits, premiums and cost sharing associated with the new group, the reasons for the change, and the opportunity to request a fair hearing to appeal the change in eligibility status or level of benefits or cost-sharing.

42 C.F.R. §§ 435.911(c), 435.916, 435.917, 435.930(b), and Part 431 Subpart E

Completing the Renewal Process, continued

When a renewal form is NOT returned…

States must use available information from data sources and reliable information from the case record to complete a renewal of eligibility.

If data from the *ex parte* review indicates the individual is eligible for another Medicaid eligibility group with a reduced benefit package, the state must send advance notice informing the beneficiary of the change in eligibility including the covered benefits and/or cost sharing, the reasons for the change, and the opportunity to request a fair hearing to appeal the change in eligibility status or level of benefits or cost-sharing before moving the individual to the new eligibility group. **States may not terminate coverage.**

If the state does not have data or sufficient information to determine the individual is eligible for any Medicaid eligibility group, the state must:

- Provide advance notice and fair hearing rights and
- Terminate coverage for procedural reasons.

STATE RESOURCE:

For guidance related to requirements for states to effectuate seamless transitions between Medicaid and separate CHIP programs and assessing eligibility for other insurance affordability programs, 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. The CIB is available here: https://www.medicaid.gov/federal-policy-guidance/downloads/cib12202024.pdf.

42 C.F.R. §§ 435.911(c), 435.916, 435.917, 435.930(b), and Part 431 Subpart E

Authorized Representatives

Authorized Representatives

States must permit applicants and beneficiaries to designate an individual or organization, as an authorized representative, to act on their behalf in completing renewals and other ongoing agency communication.

- Designations of authorized representatives must be signed by the applicant or beneficiary and must be accepted through all the modalities required for submitting an application, including through the internet website, by telephone and mail, in person, and through other commonly available electronic means.
- States must have a process in place for an individual to be guided through the authorized representative designation form with an eligibility worker or customer service representative and to sign the designation over the phone.
  - States may do this by verbally reading the authorized representative designation form or a script to the individual.
- States may not require the beneficiary to provide an electronic signature through an online portal or to submit a signed signature page through the mail.

42 C.F.R. §§ 435.923 and 457.380(a)