State Compliance with Medicaid and CHIP Renewal Requirements by December 31, 2026

Evidence Demonstrating Compliance with Regulatory Requirements
Compliance Template: Assessment and Plan for Compliance with All Federal Medicaid and CHIP Renewal Requirements

On September 20, 2024, the Centers for Medicare & Medicaid Services (CMS) released an informational bulletin to provide updated information on the timing and expectations for all states to achieve compliance with federal renewal requirements. All states are required to complete a compliance assessment, provide evidence demonstrating compliance with federal Medicaid and CHIP renewal requirements described at 42 C.F.R. §§ 435.916 and 457.343, and submit a plan outlining steps and milestones for addressing identified areas of non-compliance to CMS by December 31, 2024. Compliance plans must detail how states will achieve compliance with all applicable requirements no later than December 31, 2026.

To accompany the informational bulletin, CMS also released a compliance template, which the state must use to submit their compliance assessment and plan. For each renewal requirement in the template, states must attest to compliance or non-compliance and provide information that supports the attestation. For attestations of compliance, states must provide evidence that confirms compliance with the associated requirements. Where a state indicates it is out of compliance, it must include a plan for coming into compliance and appropriate mitigation subject to CMS approval. This document provides additional information on the evidence that should be provided to confirm compliance with each renewal requirement.

Evidence of Compliance

To support CMS review and understanding of state renewal policies, procedures, and systems, states must submit documentary evidence demonstrating compliance with each federal renewal requirement listed in the template where the state has attested to compliance. The evidence/documentation to be submitted with the template for each requirement is specified in the tables below and includes policy and systems documentation.

CMS expects that the documentary evidence and other relevant information submitted by states will provide a representative view into state systems, operations, and processes, and will allow CMS and states to work together to ensure compliance with all renewal requirements. CMS may require additional documentation on a case-by-case, including systems demonstrations, as applicable. [1]

All states should provide end-to-end renewal process and systems flows and a sample renewal package, as detailed in Table 1 below. This documentation should be submitted along with the initial compliance template submission, regardless of compliance status, and will support CMS understanding of state renewal processes and compliance attestations. CMS expects that these will be an accurate representation of manual and system processes as they occur in the state at the time of submission. In addition, it is expected that states will submit evidence of compliance with each requirement in the

[1] The requirements outlined in this document are specific to state compliance with federal Medicaid and CHIP renewal requirements as described at 42 C.F.R. §§ 435.916 and 457.343. It does not supersede or negate the need for states to provide additional systems documentation and/or provide demonstrations as required by the Streamlined Modular Certification process: https://www.medicaid.gov/federal-policy-guidance/downloads/smd22001.pdf

template, as detailed in Table 2 below, when the state is attesting to compliance with that provision. Except for renewal package evidence, the evidence in Table 2 is new evidence that should provide additional detail on what was shown in the evidence from Table 1. As a reminder, for any requirement where a state indicates it is noncompliant, the state will need to complete the *Key Activities and Milestones for Resolving each Deficiency* section of the template for that requirement. All documentation that is part of the initial compliance submission, including relevant evidence, should be submitted to CMS together with the completed Compliance Template no later than December 31, 2024 to CMSUnwindingSupport@cms.hhs.gov.

As noted in the information bulletin, CMS will monitor implementation of approved renewal compliance plans to ensure states are achieving their milestones as specified in the plan and are compliant with all federal renewal requirements by December 31, 2026. CMS will require a written update from states with identified areas of non-compliance every six months on the milestones in the renewal compliance template, along with any other necessary information or evidence/documentation from the state, to demonstrate compliance.

Table 1: Documentation of End-to-End Renewal Processes

Evidence	Description
Process flow(s): A full renewal process flow that tracks Medicaid and CHIP renewals from initiation through disposition.	Process flows that show all components of the renewal process, including: • End-to-end processes from initiation of the renewal through renewal or termination, with ex parte processes, renewal form generation and submission, determination on all bases, any account transfer, and final beneficiary outcomes; • All major manual and system processes used to complete renewals, clearly labeled; • Key inputs, outputs, and decision points throughout the renewal process; • The different beneficiary paths and outcomes (ex: different ex parte outcomes, renewal form submission status, and timelines of beneficiary response); • Timelines associated with the various renewal processes; and • If the state uses different processes for different populations (e.g., MAGI vs. non-MAGI populations, separate CHIP) the state should submit all applicable flows. These flows should describe the entire renewal process at the time of submission, regardless of compliance status. In Table 2 below, more detailed process flows are requested as evidence of compliance with specific requirements.
System flow(s): Up-to-date system flow that reflects system renewal processes from initiation through disposition, with an accurate representation of business logic in a human readable format.	System flows and/or diagrams that show an overview of how the eligibility and enrollment and other relevant systems process renewals, from initiation to disposition, using the two scenarios below. Specifically, flows should document: • How renewal data flows through the renewal process, including key data inputs, outputs, and decision points; • Calling and use of available data sources;

Evidence	Description
	• The end-to-end process from initiation of the renewal in the system through renewal or termination, with ex parte processes, renewal form generation and submission, determination on all bases, any account transfer, and final beneficiary outcomes; • Data exchange and interactions between different systems, as needed for determining eligibility on all bases; • The eligibility and enrollment logic used to conduct renewal processes; • Beneficiary communications generated in the system, including timing; • Account transfers. **Scenario 1**: Household of 2 MAGI beneficiaries, including 1 child, with the same renewal date. At ex parte, continuing eligibility could be determined for the child but not the adult. Assumptions: • Age of child: 7 years • The household only has earned income • The household income available is within the threshold for child eligibility and above the threshold for parent/adult eligibility (highest level in the state). A renewal form is required to renew the adult • These are the only household members and there are no non-applicants in the household • Both household members are U.S. citizens • Address verified as part of the ex parte process • Adult does not return the renewal form before the state-provided deadline but does return the form while their coverage is still in effect and before the state effectuated the termination for failure to respond **Scenario 2**: Household of 1 adult non-MAGI beneficiary. Assumptions: • Enrolled in a non-MAGI group with an asset test • At ex parte, continuing eligibility could not be determined • Household income and asset information is required to determine eligibility. Individual cannot be renewed ex parte because data indicates their income is above the threshold. A renewal form must be sent • This is the only household member, and there are no non-applicants in the household • Individual is a U.S. citizen • Address verified as part of the ex parte process • System flow for financial eligibility only and not flows related to how the state processes level of care determinations if relevant

Evidence	Description
	• Individual returns necessary information and is determined eligible These flows should describe the system renewal process and logic at the time of submission. In Table 2 below, more detailed system flows are requested as evidence of compliance with specific requirements.
Sample renewal package: For the described scenario, provide a sample pre-populated renewal form and any accompanying beneficiary instructions/ communications or materials.	Provide a renewal package including form and all accompanying materials for Scenario 1 described above with two MAGI beneficiaries. The renewal package should include the form and accompanying instructions, information and any other communications/materials provided with the form.

Table 2. Specific Evidence Instructions by Requirement in the Compliance Template

Compliance Template Requirement	Evidence Description
A. Ex Parte Renewals	
1. *Ex parte* renewals conducted for MAGI populations are conducted at the individual level	In addition to the system flows in Table 1, more detailed system flow(s) that include business logic in a human readable format, showing: • When and how ex parte renewals are initiated; • Interaction and data exchange between systems; • Appropriate verification of income when using a data source by comparing the data source information to the applicable income standard household member handling; and • Notification of beneficiaries. AND In addition to the process flows in Table 1, more detailed process flow(s) that include all steps taken to conduct and complete an ex parte renewal for beneficiaries, including: • All manual/worker completed processes and system processes for completing the ex parte process, and how they interact, clearly labeled; • Timelines associated with ex parte processes; and • When and the type of communications associated with ex parte are provided to the beneficiary. Separate MAGI and non-MAGI process and system flows should be provided if different.
2. *Ex parte* renewals conducted for non-MAGI populations are conducted at the individual level	

Compliance Template Requirement	Evidence Description
B. Renewal Form	
1. Renewal form is provided to all MAGI and non-MAGI individuals for whom the state cannot renew on an ex parte basis	In addition to the system flows in Table 1, more detailed system flows that include: • Business logic, provided in a human readable format, related to renewal forms, including when and how renewal forms are provided to beneficiaries. AND In addition to the process flows in Table 1, more detailed process flow(s) that include all the steps involved in providing a renewal form to beneficiaries, including: • All manual/worker completed processes and system processes for providing the renewal form; • Processes associated with return of the renewal form and non-return of the renewal form (e.g., steps to process forms and beneficiary communications); • The modalities in which the form is initially provided; • Timelines for providing the renewal form, allowing beneficiary response, state processing of the form, and notification of the determination. Separate MAGI and non-MAGI process and system flows should be provided if different.
2. Renewal form is prepopulated with available information needed to renew eligibility for MAGI-based individuals	Sample renewal package described in Table 1 above.
3. Renewal form only requests information needed to redetermine eligibility	
C. Timeline to Return Renewal Forms	
1. MAGI-based beneficiaries are provided a minimum of 30 days to return a form or needed documentation	Sample renewal package described in Table 1 or the additional process flow provided in Section B1 of Table 2 showing that beneficiaries are provided a minimum of 30 days to return a form and any needed documentation.
2. Non-MAGI beneficiaries are provided a reasonable period of time to return a form/needed documentation	Language excerpted from the beneficiary communication describing the time allotted for returning the form for non-MAGI beneficiaries.

Compliance Template Requirement	Evidence Description
3. Renewal form/notice clearly explains for MAGI-based beneficiaries that the beneficiary has a minimum of 30 days to return a form/document	Sample renewal package described in Table 1 above, showing that beneficiaries are informed about the timeline for returning the form and that it is at least 30 days. The sample renewal package can serve as evidence for both this requirement and C1 above to demonstrate both that a minimum of 30 days is provided and that beneficiaries are aware of that timeline.
D. Submit Renewal Form Through All Modalities	
1. Option for submission of renewal form via the internet website (a web form) (MAGI/Non-MAGI)	In addition to the system flows in Table 1, more detailed system flow(s) that include: • Notification to beneficiaries on how to access their online renewal form and upload supporting documents • Business logic, provided in a human readable format, for the submission of the online renewal form and supporting documentation, as well as acceptance of electronic signature; and • Interactions between systems. AND Link to website for renewal form completion. AND Policy documentation or worker manuals that demonstrate the acceptance of online renewal forms, supporting documents, and signatures via internet website. Separate MAGI and non-MAGI documentation should be provided if different.
a. Accepts electronic signature (MAGI/Non-MAGI)	
2. Option for **phone** submission of renewal form (MAGI and Non-MAGI)	Policy documentation that demonstrates the acceptance of renewal forms and signatures on the phone for MAGI and non-MAGI beneficiaries. AND Call center scripts that demonstrate the acceptance of renewal forms and signatures on the phone for MAGI and non-MAGI beneficiaries. AND Phone number(s) provided to beneficiaries for phone submission of renewal forms for MAGI and non-MAGI beneficiaries.
a. Accepts telephonic signature (MAGI and Non-MAGI)	

Compliance Template Requirement	Evidence Description
3. Paper renewal form readily available for submission (MAGI/non-MAGI)	Policy documentation, such as standard operating procedures, policy manuals, worker manuals, or training materials demonstrating the acceptance of a paper renewal form for MAGI and non-MAGI beneficiaries. AND Policy documentation demonstrating how an individual can request a paper renewal form if one is not mailed with a renewal notice for MAGI and non-MAGI beneficiaries.
4. Option for **in-person** submission of renewal form (MAGI/Non-MAGI)	Policy documentation, such as standard operating procedures, policy manuals, or worker manuals, demonstrating the acceptance of renewal forms in person.
E. Reconsideration Period	
1. Reconsideration period available for individuals enrolled on a MAGI basis.	Documentation demonstrating the acceptance of the renewal form as an application during a reconsideration period and that the period is at least 90 days. Such documentation may include: • Policy documentation, such as standard operating procedures, policy manuals, worker manuals, or training materials; • Agreements with or information provided to managed care entities if they are used to conduct outreach about the reconsideration period; and/or • Beneficiary communications or outreach materials describing the reconsideration period.
2. Reconsideration period for MAGI-based beneficiaries is no less than 90 days	
F. Determine Eligibility on All Bases	
1. Individuals enrolled on a **MAGI basis** are screened for other MAGI eligibility groups and potential eligibility on a non-MAGI basis prior to determining an individual is ineligible, terminating coverage and transferring the individual to another insurance affordability program	In addition to the process flows in Table 1, more detailed process flow(s) that show all steps taken when MAGI and non-MAGI individuals are screened for eligibility on other bases, including: • All manual/worker completed processes and system processes for determining eligibility on all bases; • Steps when the state has the information needed to move someone to a new eligibility group and steps when additional information needs to be requested from the individual;

Compliance Template Requirement	Evidence Description
2. Individuals enrolled on a **basis other than MAGI** are screened for other non-MAGI groups and potential MAGI eligibility prior to determining an individual is ineligible, terminating coverage and transferring the individual to another insurance affordability program	• Types of communications sent to beneficiaries at each point in the process when eligibility needs to be considered on another basis; • Steps to ensure coverage is maintained while eligibility is considered on other bases.; and • If states have multiple systems, such as a MAGI and a non-MAGI system, information on the processes to transition beneficiaries between systems and how coverage is maintained while eligibility is considered on another basis in the other system.
3. State requests additional information from individuals to consider eligibility on another basis without requiring the individual to submit a new application.	Policy documentation, such as standard operating procedures, policy manuals, worker manuals, or worker training materials demonstrating the state's policies for gathering additional information, when needed, from MAGI and non-MAGI beneficiaries without beneficiaries needing to submit a new application, including how states gather additional information (e.g., through initial renewal form or separate RFI). AND Sample beneficiary communication or renewal form instructions that describes the actions a MAGI beneficiary would need to be considered for eligibility on a non-MAGI basis without needing to submit a new application, if such content is not part of the sample renewal package in table 1.
G. Determine Potential Eligibility for Other Programs & Transfer Account	
1. Individuals' accounts are transferred to Marketplace timely (MAGI)	In addition to the system flows in Table 1, more detailed system flow(s) that show the flow of consumer account data is transferred to the Marketplace, including: • At what point in the renewal process individuals are identified for transfer to the Marketplace; • How states indicate in the account transfer which consumers are seeking coverage and being referred for Marketplace coverage and which are not.
2. Individuals' accounts are transferred to Marketplace timely (non-MAGI)	

Compliance Template Requirement	Evidence Description
H. Renewal Every 12 Months	
1. Eligibility redetermination conducted once every 12 months and not more than once every 12 months for MAGI populations	A timeline that demonstrates when the state initiates and completes periodic renewals of eligibility by the end of the individual's eligibility period (i.e., state completes all steps in the renewal process, by the last day of the 12 month eligibility period including: • How far in advance of the end of the individual's eligibility period the state begins the renewal process for MAGI and non-MAGI cohorts; • Timing to complete the ex parte process, send a renewal form, process returned forms, and when appropriate, send advance notice and effectuate terminations; and • The timing of beneficiary communications in the process.
2. Eligibility redetermination conducted at least once every 12 months for non-MAGI populations	