



Eligibility & Enrollment Processing for Medicaid, CHIP, and BHP During COVID-19 Public Health Emergency Unwinding Key Requirements for Compliance



May 17, 2022

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.

Background & Context

- Medicaid and CHIP enrollment has increased by more than 20 percent since the beginning of the COVID-19 public health emergency (PHE).¹ Growth in Medicaid enrollment is largely due to the continuous enrollment condition of the Families First Coronavirus Response Act (FFCRA).
- Under the FFCRA, states must maintain continuous enrollment of Medicaid beneficiaries through the last day of the month in which the PHE ends, among other conditions, in order to receive a temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase. All states implemented this option.
- Many states also received authority to adopt other flexibilities to facilitate enrollment and retention of coverage in their Children's Health Insurance Program (CHIP) and/or Basic Health Program (BHP).
- When the PHE ends, states will be tasked with addressing a significant volume of pending renewals, redeterminations, and other eligibility actions across Medicaid, CHIP and BHP. The volume of pending actions is expected to place a heavy burden on state workforce and operations, and states will need to take to minimize the risk of inappropriate terminations of eligible individuals.

¹ <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-november-2021-medicaid-chip-enrollment-trend-snapshot.pdf>

Background & Context (Cont'd)

- CMS has issued an array of guidance and tools to support state processing of eligibility and enrollment actions during and after the PHE, including new flexibilities and requirements for states. (see www.Medicaid.gov/unwinding).
- States are also still obligated to meet existing federal requirements for renewals, verifications, applications, and oversight of their programs. Compliance with these existing requirements will be critical to ensuring that timely and accurate eligibility determinations are completed and that eligible individuals remain enrolled or are transferred seamlessly to other coverage.
- To refresh states' awareness of these requirements to support compliance, this deck provides an overview of key eligibility and enrollment requirements for states in the context of unwinding.
- States that do not to comply with federal requirements may be required to develop a corrective action plan (CAP). If at any point CMS determines that the state is not meeting the requirements outlined in an established CAP, CMS may initiate formal compliance proceedings and Federal Financial Participation may be at risk.

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Renewals

Medicaid: 42 CFR 435.916

CHIP: 42 CFR 457.343

BHP: 42 CFR 600.340

Overview - Conducting Renewals for Medicaid, CHIP, and BHP

- States must renew eligibility only once every 12 months for MAGI beneficiaries and at least once every 12 months for non-MAGI beneficiaries.
- The state agency must **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).
 - 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. (see slide 8 for more information on *ex parte* renewals)
 - If available information is insufficient to determine continued eligibility, agency sends a **renewal form** and requests additional information from the beneficiary. (See slide 9 for more information on renewal forms)

Overview - Conducting Renewals for Medicaid, CHIP, and BHP (Cont'd)

- In establishing renewal procedures and milestones, states must take into account the time needed for:
 - Completing the renewal prior to the end of a beneficiary's eligibility period.
 - Beneficiaries to return their renewal form and submit required documentation, if appropriate.
 - The agency to verify information returned by the beneficiary and notify the beneficiary of its determination.
 - Additional time to evaluate eligibility on another basis or if the beneficiary returns information late in the renewal process.

The *Ex-Parte* Renewal Process

- **State agencies must attempt to renew eligibility for *all individuals* enrolled in Medicaid, CHIP, or a BHP 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 entail any beneficiary involvement, and states typically begin the process 60-90 days prior to the beneficiary's renewal date
- If the agency is able to renew eligibility based on the available reliable information, the agency must provide notice to the beneficiary, which includes:
 - That the individual's coverage has been renewed for another eligibility period (and length of that period – i.e., 12 months for MAGI-based beneficiaries and the period up to 12 months elected by the state for non-MAGI beneficiaries, as specified in the state plan)
 - 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 requires changes
- Beneficiary does not need to sign or return the notice if all information contained in the notice is accurate
- Generally, states may not complete an *ex parte* renewal if information needed to make a determination of eligibility is missing, or available information suggests that a beneficiary may be ineligible.

Renewal Form Requirements

- If an *ex parte* renewal cannot be completed, the agency must provide beneficiaries with a **renewal form** and request information from the beneficiary.
- The renewal form must be **prepopulated** with the most recent, reliable and relevant information for beneficiaries whose eligibility is determined using methodologies based on modified adjusted gross income (**MAGI**)
- Agencies may but are not required to pre-populate renewal forms for **non-MAGI** beneficiaries
- The renewal form may only require beneficiaries to provide information needed to determine eligibility
- Agencies must include clear instructions on completing the renewal form, the need to sign, and required timeframes for submission:
 - **MAGI Medicaid, CHIP, and BHP:** At least 30 days
 - **Non-MAGI:** Reasonable time frame (minimum 30 days recommended)

Renewal Form Requirements (Cont'd)

- Beneficiaries must be able to return the signed renewal form through **all modes** of submission available for submitting an application (i.e., mail, in-person, online or phone)
 - States may encourage individuals to use a particular modality, provided that all options remain available. E.g. States may include prominent language on paper renewal forms reminding individuals that they can submit online instead. These approaches may be faster for states and enrollees and reduce state administrative burden.
- Agencies cannot require an in-person interview as part of the renewal process when making a determination using MAGI-based methodologies.

Considering Eligibility on Other Bases and Eligibility for Other Insurance Affordability Programs

- If a Medicaid beneficiary is no longer eligible for the category in which the beneficiary is enrolled, the Medicaid agency must consider whether the beneficiary may be eligible under one or more other eligibility groups covered by the state.
- If the Medicaid agency identifies another eligibility group for which a beneficiary may be eligible, but requires additional information to make the determination, it must request additional information and give the beneficiary a *reasonable amount of time* to provide the information.
 - If the agency is not able to complete a determination of eligibility on another basis before the end of the eligibility period, it must make the determination as *expeditiously as possible*.
- The Medicaid agency may not terminate coverage and must continue to furnish benefits under Medicaid until a beneficiary is found ineligible under all groups covered by the state for which the beneficiary may be eligible or until the beneficiary does not timely provide requested information that is needed to make a determination.
- If the Medicaid agency determines that an individual is ineligible for Medicaid under any other basis, the state must determine potential eligibility under another insurance affordability program and transfer that individual's electronic account.
- If a state determines that a separate CHIP beneficiary is no longer eligible, it must screen the individual for eligibility in other insurance affordability programs, including Medicaid and Marketplace coverage, on all bases.

Reconsideration Period

- For **MAGI Medicaid and CHIP** beneficiaries whose eligibility has been terminated at renewal, the agency must **reconsider** the individual's eligibility without requiring the individual to fill out a new application if the renewal form and/or requested information is returned within **90 days** after the date of termination. States may adopt a longer reconsideration period.
 - **For non-MAGI beneficiaries:** States are encouraged, but are not required, to provide a reconsideration period.
- A renewal form returned within the reconsideration period serves as an application, which means the agency must make a determination consistent with application timeliness standards (see slide 21).
- Effective dates of coverage for those determined eligible during the reconsideration period are:
 - **Medicaid:** Date renewal was submitted or first day of the month the renewal form was returned consistent with the state's Medicaid state plan
 - Up to three months of retroactive coverage is available if the individual received Medicaid services following their termination and met Medicaid eligibility requirements when services were received
 - **CHIP:** Date the form is returned or a reasonable method indicated in the state plan

Renewals During Unwinding

- When the PHE ends, a state must **initiate** renewals for the state's entire Medicaid, CHIP, and BHP population (total caseload) within 12 months of the beginning of the state's unwinding period and **complete** renewals within 14 months of the beginning of the state's unwinding period.
 - States may choose the month in which they begin initiating renewals that result in terminations, and begin their unwinding period, in the month before, during, or after the PHE's end date.
- States must initiate and complete renewals consistent with federal Medicaid, CHIP and BHP renewal requirements for the total caseload during the unwinding period, including for:
 - Enrollees for which the state already conducted a renewal during the PHE and found ineligible but did not terminate, and
 - Enrollees who were receiving benefits pending the outcome of a fair hearing on or after March 18, 2020 and were continuously enrolled during the PHE
- In **distributing renewals** during the unwinding period, states should **consider the impact of their choices** on their monthly renewal and fair hearing volume, both during the unwinding period and in future years, taking into account their systems and workforce capacity
 - States will **not have authority to allow states to redistribute renewals in future years** (either by extending or shortening renewal periods) after the 12-month unwinding period.

Distribution of Renewals Over the Unwinding Period

- CMS strongly encourages states to distribute renewals across the 12-month unwinding period and to initiate renewals for no more than 1/9 of a state's total caseload in a given month.
- States that initiate renewals at a faster pace risk:
 - Inappropriate terminations in violation of federal regulations
 - Increased churn, resulting in additional burden on states and beneficiaries
 - Unmanageable volume of fair hearing requests
 - Unsustainable peaks in renewal volume in future years, causing ongoing staffing and workforce challenges
 - Imposition of a compliance action for violations of federal requirements

Acting on Changes in Circumstances

Medicaid: 42 CFR 435.916

CHIP: 42 CFR 435.343

BHP: 42 CFR 600.340

Changes in Circumstances

- States must have procedures in place designed to ensure that beneficiaries in Medicaid, CHIP, and a BHP can timely and accurately report changes in circumstances that may affect their eligibility.
- Beneficiaries must be able to report information on changes in circumstances online, by phone, by mail, and in person.
- Whenever the state receives information on a change in circumstances that may affect a beneficiary's eligibility, it must act promptly to determine whether the beneficiary continues to meet the eligibility criterion to which the change relates.
- States also have the option to seek information about any changes in circumstances through periodic data checks or other information available to the agency.

Processing Changes in Circumstances

- When processing a change in circumstances:
 - The agency must *request additional information* from the beneficiary if third-party data indicates the individual is no longer eligible
 - The agency must *limit requests* for additional information to information relating to the change in circumstance
 - *Prior to making a determination of ineligibility*, the agency must determine whether an individual may be eligible for Medicaid on another basis, and request information needed to make such determination if applicable
 - *Upon determination of ineligibility*, the agency must assess potential eligibility for other insurance affordability programs and transfer an individual's account, as appropriate
- States must provide a reasonable period of time (minimum 10 days) for Medicaid beneficiaries to provide information requested by the agency.
 - CMS believes it would be reasonable for states to allow beneficiaries 30 days to respond and provide any necessary information needed to verify eligibility following a change in circumstances. (see CMS Informational Bulletin at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>)

Changes in Circumstances During Unwinding

During the unwinding period:

- States may not redetermine eligibility based solely on a change in circumstances unless the beneficiary was determined or renewed for eligibility in the previous 12 months .
 - States must conduct a full renewal for beneficiaries who have an identified change in circumstances but whose eligibility has not been renewed (either because the state did not complete the renewal timely or the individual was determined ineligible at renewal and enrollment was maintained during the PHE).
 - States have the option to conduct a full renewal either when a change in circumstances is reported/detected or later in the unwinding period as part of a beneficiary's scheduled renewal.
- For beneficiaries who were determined eligible or whose eligibility was renewed in the previous 12 months (and is therefore within their 12-month eligibility period), the agency has the option to
 - Redetermine the beneficiary's eligibility either when a change in circumstances is reported/detected as it ordinarily would, or
 - Align acting on the change as part of a beneficiary's scheduled renewal during the state's unwinding period.

Application Processing

Medicaid: 42 CFR 435.907; 435.912; 435.915

CHIP: 42 CFR 457.330, 457.340

BHP: 42 CFR 600.310, 600.320

Processing New Applications

- For Medicaid, CHIP, and BHP, states must accept applications from the applicant, an adult in the applicant's household, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant.
- States must accept applications online, by telephone, in person, by mail or through other available electronic means.
- For individuals who have submitted an application and whose responses indicate they may be eligible on a basis other than MAGI, the agency must collect the additional information needed to determine non-MAGI eligibility. The agency may use either supplemental forms or an application designed specifically to determine non-MAGI eligibility to collect such information.
- For individuals not eligible for Medicaid, the agency must assess their potential eligibility for other insurance affordability programs and transfer the individual's electronic account to the appropriate program (CHIP, BHP or Marketplace)

Processing New Applications (Cont'd)

Timeliness standards:

- The agency must make a determination of eligibility for Medicaid/CHIP/BHP expeditiously and without undue delay. Determinations of eligibility must be made within:
 - 90 days for applicants who apply for Medicaid on the basis of disability
 - 45 days for all other Medicaid applicants, and for applicants for CHIP and BHP
- The timeliness standards are measured from the date the application is submitted to the state or the date it is transferred from another insurance affordability program (e.g., the Marketplace).
- Additional Resource: [Medicaid & CHIP MAGI Application Processing: Ensuring Timely and Accurate Eligibility Determinations](#)

Effective Dates of Coverage

Effective Dates of Coverage for Eligible Individuals at Application:

- **Medicaid:** Date application was submitted or first day of the month the application was submitted consistent with the state's Medicaid state plan (42 CFR 435.915)
 - Up to three months of retroactive coverage is available if the individual received Medicaid services during the three months prior to application and met Medicaid eligibility requirements when services were received
 - To verify eligibility during the retroactive period, states may accept the individual's attestation that their circumstances did not change prior to the month of application or seek to verify eligibility electronically and request documentation, as needed
 - An individual may be eligible for coverage in a retroactive period, even if they are not eligible prospectively
- **CHIP:** Date of application or a reasonable method indicated in the state plan
- **BHP:** State must establish a uniform method of determining the effective date of eligibility for enrollment in a standard health plan following either the Exchange standards at 45 CFR 155.420(b)(1) or the Medicaid process at 42 CFR 435.915, exclusive of 435.915(a). This election is made in the state's BHP Blueprint.

Application Processing During Unwinding

- States have until **4 months after the month in which the PHE ends** to resume timely processing of all applications, including those received during the unwinding period. Any outstanding backlogs of pending applications states received during the PHE should be addressed by the following milestones:
 - **2 months after the month in which the PHE ends:** Complete eligibility determinations for all pending MAGI and other non-disability-related applications received during the PHE.
 - **3 months after the month in which the PHE ends:** Complete eligibility determinations for all pending disability-related applications received during the PHE.

Verifying Eligibility at Application

Medicaid: 42 CFR 435.910; 435.940-960

CHIP: 42 CFR 457.380

BHP: 42 CFR 600.345

Verifying Eligibility at Application

- States must verify financial and non-financial information needed to determine the eligibility of an individual for Medicaid, CHIP, or BHP.
- To the maximum extent possible, states must rely on available electronic data to complete verifications.
- States may choose to use electronic data before determining eligibility or may accept self-attestation and perform required data matches within a reasonable timeframe following determination (post-enrollment verification), except where prohibited by law (e.g., for verification of citizenship and immigration status).
- **Documentation can only be requested when:**
 - Electronic data is unavailable,
 - Information needed to verify eligibility cannot be obtained through an electronic data source, or
 - When electronic data is not reasonably compatible.
 - States may accept reasonable explanations of discrepancies in lieu of requesting documentation.
- Regulations at 42 CFR 435.945(j) and 457.380(j), require states to develop and update a plan describing the Medicaid and CHIP eligibility verification policies and procedures adopted by the state.
- States must submit a MAGI Verification Plan to CMS for review and must document a non-MAGI Verification plan in their internal state policies. For BHP, states elect to follow the Medicaid or Exchange eligibility verification standards and procedures in their Blueprint.

Use of Self-Attestation

Self-Attestation of Information and Reasonable Explanations:

- States may accept self-attestation of non-financial eligibility criteria for Medicaid, CHIP, and BHP, except as required by law or regulation (citizenship and immigration status, Asset Verification System).
 - States must accept self-attestation of pregnancy, unless the state has information that is not reasonably compatible with attestation.
- States may accept self-attestation for certain types of income/asset data for which there is no required data match (e.g., self-employment income).
- States may accept reasonable explanations of discrepancies between attested information and data sources instead of documentation.
 - A state must resolve discrepancies when electronic data is not reasonably compatible with attested information, based either on a reasonable explanation or documentation.
- States must accept self attestation of information needed to determine eligibility, including reasonable explanations, from all of the following:
 - the applicant,
 - an adult in the applicant's household or family,
 - authorized representative, or
 - someone acting responsibly for the individual (if minor or incapacitated).

Reasonable Compatibility

- When applicable, states must determine an individual eligible if information provided is reasonably compatible with data sources
- States must consider **income** reasonably compatible *if attestation and data are both above, at, or below the applicable income standard*
- States must consider **assets** reasonably compatible *if attestation and data are both above, at, or below the applicable resource standard*
- States have flexibility to establish additional standards:
 - Establish a reasonable compatibility standard that applies a percent difference or other threshold such as a fixed dollar amount
 - Apply reasonable compatibility standard to individual income or asset types (e.g., accept attested wage earning if quarterly wage data is within 10 percent of attested level)

Verification of Key Non-Financial Eligibility Criteria

Social Security Number (SSN) (verified through SSA)

- Individuals must provide an SSN as a condition of eligibility, unless they meet an exception (not eligible to receive an SSN, can only receive an SSN for a valid non-work reason, religious objection, children covered under CHIP from conception to birth).
- States must assist individuals with applying for an SSN if they don't have one or verifying an SSN if they can't recall the number.
- An agency cannot deny or delay services to an otherwise eligible individual pending issuance or verification of the SSN, as long as the individual is attempting to obtain an SSN.

Verification of Key Non-Financial Eligibility Criteria (Cont'd)

Verification of Citizenship or Immigration Status and Provision of a Reasonable Opportunity Period (ROP)

- For Medicaid, CHIP, and BHP, states must first attempt to verify citizenship, status as a US national, or immigration status through use of the SSA and SAVE Hub services or an approved alternative (“Hub waiver”).
- States generally must provide a 90-day ROP to applicants who have attested to citizenship, nationality, or satisfactory immigration status, if the agency is unable to promptly verify their status through the Hub approved alternative.
- States must notify the applicant of the ROP and that during the ROP the applicant must provide other documentation of citizenship or satisfactory immigration status. During the ROP, the state also must continue attempts to verify an individual’s attested status and resolve any inconsistencies.
- States must provide full Medicaid/CHIP benefits during the ROP if the applicant meets all other eligibility criteria.
- States may elect to extend the ROP for non-citizens who are making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or when the state agency needs more time to complete the verification process.

Verifying Citizenship & Immigration Status During Unwinding

During the Unwinding Period:

- If a state **did not** provide an ROP that is fully compliant with the requirements described on the previous slide, including the required notice, or otherwise did not take all available steps to verify the individual's status, the agency must send the required notice and provide a 90-day ROP after the PHE ends.
- If a state **already provided** a fully compliant notice and ROP, states are encouraged to attempt to reverify the citizenship or immigration status of affected individuals **before their unwinding period begins**, and for these individuals:
 - States are not required, but may extend the ROP for individuals who have attested to satisfactory immigration status and who are making a good faith effort to obtain any necessary documentation, or if the state needs more time to verify the individual's status or assist the individual in obtaining the necessary documents.
 - For individuals who have attested to U.S. citizenship, states may re-verify their citizenship during the unwinding period through a Disaster Relief 1115 demonstration, which would provide for an extension of the ROP beyond the 90-day timeframe.
- The ROP begins on the date the enrollee receives notice of such opportunity from the agency.

Completing Post-Enrollment Verification During Unwinding

- Many states conduct “**post-enrollment verification**” for Medicaid, CHIP, and/or BHP.
 - Post-enrollment verification requires states to determine eligibility based on an applicant’s attested information and conduct required verifications after the individual has enrolled in coverage.
 - Some states elected this option temporarily during the PHE through a disaster verification addendum
 - States that opt to discontinue post-enrollment verification during the unwinding period must return to pre-enrollment verification processes, accessing data sources and verifying eligibility prior to enrolling new applicants.
- For applicants enrolled based on attested information during the PHE, states have up to **12 months** after the end of the PHE to initiate post-enrollment verifications for such enrollees.
- States may align work on pending post-enrollment verifications with a scheduled renewal date during the unwinding period.
- States must complete a full renewal for individuals enrolled based on self-attested information if:
 - more than 12 months has elapsed since such enrollment and
 - the state has not otherwise conducted a full determination of eligibility, including required verifications, or renewal within the previous 12 months.

States may initiate such full renewal at any point during the state’s unwinding period.

Coordination with the Marketplace

Medicaid: 42 CFR 435.1200

CHIP: 42 CFR 457.350

BHP: 42 CFR 600.330

Facilitating Transfers to the Marketplace for Individuals Ineligible for Medicaid, CHIP, and BHP

- For each individual determined ineligible for Medicaid, CHIP, or BHP at application or renewal, the agency must assess the individual's potential eligibility for coverage through the Marketplace and, as appropriate, transfer the individuals' electronic account (including all of the individual's Medicaid, CHIP, and/or BHP eligibility information collected and generated by the state) to the Marketplace.
 - States served by the Federally-facilitated Marketplace (FFM) must transfer accounts to the FFM
- States may treat anyone who is determined ineligible for Medicaid, CHIP, or BHP as potentially eligible for qualified health plan (QHP) enrollment, other than those denied or terminated for a procedural reason and those who do not attest to U.S. citizenship or lawful presence.

Examples of Accounts to Transfer to the Marketplace

Medicaid and CHIP agencies must transfer accounts for:

1. Parents with income verified as above the Medicaid limit, even though children may be eligible and remain enrolled in Medicaid or CHIP.
2. Applicants determined ineligible for MAGI-based Medicaid, even if they are being evaluated for coverage on a non-MAGI basis.
3. Children determined ineligible for CHIP during a “waiting period.” (States must have safeguards in place to prevent loss of coverage at the end of the waiting period, when these children become eligible for CHIP.)
4. Applicants who are lawfully present but ineligible for Medicaid/CHIP based on immigration status (e.g., applicants within 5-year waiting period).
5. Individuals only eligible for coverage that is not Minimum Essential Coverage (MEC), such as coverage limited to family planning services or other limited-benefit programs.

Examples of Accounts to Transfer to the Marketplace (Cont'd)

Medicaid and CHIP agencies in states that rely on the Federally-facilitated Marketplace (FFM) for Marketplace determinations should not transfer accounts for:

1. Individuals denied or terminated for failure to respond to a request for additional information to verify eligibility
2. Applicants who do not attest to citizenship or lawful presence in the US.

Medicaid and CHIP agencies in State-based Marketplace (SBM) states without an integrated eligibility system*:

**An integrated eligibility system in an SBM state is one that handles determinations of eligibility for all health insurance affordability programs (Medicaid/CHIP, QHP with APTC, and BHP, if applicable) in a single system.*

1. May, but are not required to, transfer accounts for individuals denied or terminated for failure to respond to a request for additional information to verify eligibility
Please contact CMS if your state is looking to implement this approach
2. Should not transfer account for applicants who do not attest to citizenship or lawful presence in the US.

Processing Accounts Received from the Marketplace

States that rely on the FFM to complete determinations of eligibility for Marketplace coverage and to enroll individuals into a Qualified Health Plan (QHP) receive accounts for applicants assessed or determined eligible for Medicaid or CHIP in real time. Upon receipt of an account transfer, the state must take the following actions:

In Determination States:

1. Notify the Marketplace that the state has received the electronic account
2. Promptly enroll individual whose eligibility information has been fully verified by the Marketplace in MAGI-Based Medicaid or CHIP
3. For individuals with outstanding verification:
 - a) Collect additional information to resolve inconsistencies
 - b) Provide a reasonable opportunity for the applicant to document citizenship/immigration status, if needed. Individuals whose only outstanding issue is to document citizenship/immigration status must be enrolled in coverage, with the ROP.
 - c) Complete a final determination
 - d) Determine eligibility on a non-MAGI basis, if applicable

Processing Accounts Received from the Marketplace (Cont'd)

Upon receipt of an account transfer, the state must take the following actions:

In Assessment States:

1. Notify the FFM that the state has received the electronic account
2. Do not request information already included in the electronic account
3. Accept findings related to specific eligibility criteria made by the FFM, without further verification, if such finding was made in accordance with policies and procedures applied by the agency or approved by it in the agreement between the agency and the FFM
4. Promptly determine eligibility for MAGI-based coverage, and non-MAGI coverage, if appropriate, without requiring a new application, and begin providing coverage if eligible
5. Notify the FFM of final determination of the individual's eligibility or ineligibility

Marketplace Coordination – Unwinding Considerations

- States served by the FFM are encouraged to review their outbound account transfer processes (state sends account to FFM) and update systems, as needed, to include all available contact information (mailing address, phone number, and email address) collected for individuals who will be transferred to the Marketplace
 - CMS will conduct additional outreach and provide assistance to individuals transferred to the Marketplace from states
- States are also encouraged to help with enrollees' transition to a QHP.
 - States can revise eligibility determination notice language for ineligible Medicaid/CHIP/BHP individuals to notify the beneficiary that the agency will transfer their account to the Marketplace and that the Marketplace will send them a notice with information on applying for coverage and financial assistance through the Marketplace
- FFM states may also consider temporarily accepting FFM assessments as determinations or switching to become a determination states. CMS is available to provide additional technical assistance
- Resources:
 - [Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace \(2016 CMCS Informational Bulletin\)](#)
 - [Understanding the Consumer Experience in Transfers from the State Medicaid/CHIP Agency to the Federal Facilitated Marketplace](#)

Notices

Medicaid: 42 CFR 435.917, 435.918, 42 CFR 431.206-214

CHIP: 42 CFR 457.340(e)

BHP: 42 C.F.R. 600.330(e), 600.335(a)

Notices

- States must provide all applicants and beneficiaries with **timely and adequate written notice of any decision** affecting their eligibility (e.g., approvals, denials, and terminations of eligibility; and changes in benefits).
- When a Medicaid or CHIP agency takes an action which adversely impacts a beneficiary:
 - The state generally must send a Medicaid beneficiary a notice at least 10 days prior to the date of action, which is the intended date the change takes effect.
 - States may send notice not later than the date of the action in certain circumstances outlined at 42 CFR 435.213 and 435.214.
 - CHIP notices must be timely, but the advance 10 day notice is not required.
 - Actions that adversely impact beneficiaries include: a termination, suspension or reductions in eligibility; an increase in beneficiary liability; and a termination, suspension, or reduction in covered benefits or services.
- BHP agencies must provide written notice of eligibility determinations.

Notices (Cont'd)

- Notices must be written in plain language and be accessible to persons who are limited English proficient and individuals with disabilities.
- Notices must include information on an applicant's/beneficiary's right to a Medicaid fair hearing, CHIP review, or BHP appeal
- Notices that must be sent prior to an adverse action (e.g., termination of eligibility) must include the following:
 - The date the action will take effect and a clear statement of the reason for the intended action.
 - An explanation of the circumstances under which the individual's Medicaid benefits will continue, if a fair hearing is requested; or the circumstances under which the individual's CHIP enrollment may continue pending review
- Notices must be provided electronically, if the applicant/beneficiary has elected to receive electronic notices.
- Please see the 2017 Model Notices materials available at <https://www.medicaid.gov/resources-for-states/mac-learning-collaboratives/expanding-coverage-under-medicaid-and-chip/index.html> for examples of notice content.

Fair Hearings/Reviews/Appeals

Medicaid: Section 1902(a)(3) of the Social Security Act, 42 CFR part 431 subpart E

CHIP: 42 CFR 457.1120

BHP: 42 CFR 600.335

Fair Hearings/Reviews/Appeals (Cont'd)

- States must provide an individual the opportunity to have a Medicaid fair hearing, CHIP review, or BHP appeal when an individual believes the state has taken an action erroneously or when the state has denied or delayed the individual's claim for eligibility or for covered benefits or services.
 - Actions subject to fair hearings include termination, suspension or reduction in Medicaid eligibility; an increase in beneficiary liability; and a termination, suspension, or reduction in covered benefits or services
 - **Exception:** States are not required to provide a Medicaid fair hearing or a CHIP review when the action is due to a change in law or policy (e.g., the extension of eligibility to non-residents temporarily residing in the state due to the PHE).
- States must allow the individual a reasonable timeframe, not to exceed 90 days from the date that the notice of action is mailed, to request a Medicaid fair hearing.
- States must give individuals the opportunity to appeal BHP eligibility determinations applying the appeals rules of the state's Medicaid program or the Exchange. States elect which set of rules they apply through their BHP Blueprint.
- States must provide a fair hearing system that is accessible to persons who are limited English proficient and persons who have disabilities.

Fair Hearings/Reviews/Appeals (Cont'd)

- States must provide Medicaid beneficiaries benefits pending the fair hearing decision when the beneficiary requests the fair hearing before the date of the action. States may reinstate Medicaid benefits pending the fair hearing decision, when the individual requests the fair hearing not more than 10 days after the date of action (e.g., date the individual's eligibility terminated).
- States must ensure the opportunity for continuation of enrollment pending the completion of the review for separate CHIP utilizing a program specific review.
- States must generally take final administrative action within 90 days from the date the agency receives a request for a Medicaid fair hearing.
- States must take final administrative action as expeditiously as possible for requests granted an expedited Medicaid fair hearing, CHIP review, or BHP appeal.

Medicaid Fair Hearings During the PHE and Unwinding Period

- During the COVID-19 PHE, a number of states were granted section 1135 waiver authority to allow applicants or beneficiaries more than 90 days to request a Medicaid fair hearing. This authority expires at the end of PHE.
- During the COVID-19 PHE, a number of states were granted a regulatory concurrence that allowed a state to take more than 90 days to take final administrative action on Medicaid fair hearing requests due to an emergency beyond the state's control. CMS expects states to resume timely processing during the unwinding period.
- As states develop their operational plans for the unwinding period, they should assess the anticipated volume of fair hearing requests and their operational capacity as they determine how to distribute pending actions across the unwinding period.

Medicaid Fair Hearings During the PHE and Unwinding Period (Cont'd)

- States may need to adopt new fair hearing strategies and mitigations to accommodate increased fair hearing volume, and can do so without the need for additional state plan authority. For example:
 - Establish or expand an informal resolution process to resolve fair hearing requests prior to a fair hearing.
 - Hold fair hearings and reviews by telephone or video, as long as the state is providing access to the fair hearing process (including providing access to individuals with disabilities and those who have limited English proficiency).
- **Resource:** “Strategic Approaches to Support State Fair Hearings as States Resume Normal Eligibility and Enrollment Operations,” -<https://www.medicaid.gov/resources-for-states/downloads/strat-apps-state-fair-hearings.pdf>

State Administration & Oversight

*Medicaid: Sections 1902(a)(4), and (a)(5) of the Social Security Act
42 CFR 431.10-11, 431.15, 431.50, 432.10 and 42 CFR 432 Subpart B*

Single State Medicaid Agency Requirements and Oversight

- The Single State Agency (meaning the “Medicaid agency”) is responsible for determining eligibility in accordance with 42 CFR Part 435.
- The state Medicaid agency can delegate the authority to conduct eligibility determinations to state Title IV-A agencies (i.e., TANF or tribal agencies), Exchanges, the Social Security Administration, or local agencies (e.g., counties). If the Medicaid agency does so it must ensure the delegated agency complies with all relevant laws, regulations and policies and may only delegate authority to make eligibility determinations to government agencies which maintain personnel standards on a merit basis.
- Medicaid agencies that delegate eligibility determinations to other entities must establish written agreements with those entities. The agreements must:
 - Clearly delineate roles and responsibilities of the Medicaid agency and the delegated entity.
 - Address quality control and oversight by the Medicaid agency, including reporting requirements.
 - Include assurances that the delegated entity will comply with all relevant federal and state laws, regulations and policies.

Single State Medicaid Agency Requirements and Oversight (Cont'd)

- Medicaid agencies must take corrective action in the case of a delegated entity that is not complying with all requirements under the written agreement.
- The Medicaid agency cannot delegate the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters. Only officials of the Medicaid agency can perform these functions.
- States must provide initial and ongoing training that is needed for staff of all levels (including volunteers) in order to provide effective and efficient administration of the Medicaid program.
- The Medicaid single state agency rules and regulations do not apply to BHP and CHIP.

CMS Monitoring & Enforcement

CMS Monitoring

- CMS uses a number of tools to monitor state Medicaid eligibility operations on an ongoing basis, including:
 - Monitoring of enrollments, terminations using monthly Performance Indicator and T-MSIS data
 - Monitoring of state expenditures through the automated Medicaid Budget and Expenditure System/State Children's Health Insurance Budget and Expenditure System (MBES/CBES) through state submission of quarterly CMS-64
 - Periodic and ongoing calls with states

CMS Monitoring During Unwinding

- CMS has created two new reporting tools to support state efforts to retain and transition beneficiaries during unwinding period after the public health emergency ends:
 - State Renewal Distribution Report: States will submit this one-time report to summarize plans to distribute renewals and mitigate against inappropriate coverage loss during the state's 12-month unwinding period.
 - Due 45 days before the end of the month when the PHE ends
 - Unwinding Eligibility and Enrollment Data Report: States will submit a monthly report on metrics to demonstrate progress towards restoring timely application processing, initiating and completing all renewals for Medicaid and CHIP, and processing fair hearings.
 - Baseline report due before PHE ends; monthly reports due beginning the month following the end of the PHE
- States must comply with these new reporting requirements.
- CMS plans to use these tools, along with those described on the previous slide to actively monitor state experience, identify challenges and barriers, and provide technical assistance as needed to support state success.

CMS Enforcement

- CMS will closely monitor state enrollment and disenrollment data to identify potential violations of federal requirements resulting in inappropriate terminations.
- Where violations are identified, CMS will:
 - Work with the state to address the violation, provide technical assistance, and discuss options to correct.
 - States experiencing issues with inappropriate or high volumes of terminations or other possible violations will be asked to share their Operational Plans for review.
 - Require states to develop mitigation plans to reduce adverse consequences flowing from any violation of requirements where appropriate.
 - If violations are not corrected or addressed through technical assistance and mitigation plans, CMS will initiate compliance action, beginning with a request for a corrective action plan (CAP) and more intensive monitoring until the violation is corrected.
- CMS has the authority to withhold federal matching funds in cases where an action is deemed in violation with certain statutory requirements.
- States at risk of violating federal requirements should contact their state lead for guidance and technical assistance as early as possible to avoid adverse consequences for beneficiaries or the state.

Appendix: Temporary Flexibilities Available During Unwinding

Renewal Flexibilities

- States can adopt various **flexibilities to streamline renewals** during the PHE unwinding period, reducing administrative burden on state agencies and the potential for inappropriate terminations, such as aligning renewals for an entire household or acting on a renewal when a SNAP recertification is due for beneficiaries also enrolled in SNAP.
- States have considerable flexibility under regulations in designing their **verification policies and renewal procedures**. States can, for example:
 - Improve *ex parte* renewal rates by increasing data sources relied on by the agency and creating a data source hierarchy to guide verification, prioritizing the most recent and reliable data sources.
 - For non-MAGI populations: provide a prepopulated renewal form, eliminate any in-person interview, provide a 90-day reconsideration period at renewal
 - Extend the deadline for individuals to respond to requests for information
 - Extend temporary verification policies adopted during the PHE, or implement new policies via a temporary verification plan addendum, to apply during the unwinding period

Renewal Flexibilities (Cont'd)

- States can also request temporary authority to adopt **streamlined renewal processes under section 1902(e)(14)(A)** of the Social Security Act, including to:
 - Use income determination from SNAP or other human services program to renew eligibility
 - Assume \$0 income when information is not available through data sources at renewal, and there is a \$0 income attestation in the case file verified within the last 12 months.
 - Assume no change in assets that can be verified through the state's Asset Verification System (AVS)-when no information is returned through the AVS or is not returned within a reasonable timeframe.
 - Information received from the AVS after a renewal is completed that indicates a beneficiary may be ineligible would be treated like a change in circumstances.
- States interested in these flexibilities can contact their CMS state lead and cc: the CMS Unwinding Mailbox (CMSUnwindingSupport@cms.hhs.gov) for additional information.

Application & Enrollment Flexibilities

- States may want to consider approaches to facilitate streamlined processing of applications, including:
 - Maximizing automation of electronic verification, including expanding the number and types of data sources used
 - Dedicated specialized staff to complex households or applications
 - For additional options, see: [Medicaid & CHIP MAGI Application Processing: Ensuring Timely and Accurate Eligibility Determinations](#)
- States may also consider adopting a **targeted enrollment strategy using SNAP data** to facilitate enrollment. This includes:
 - Use of 1902(e)(14) authority enroll non-elderly, non-disabled SNAP participants into Medicaid using SNAP income, state residency, and citizenship/immigration status determinations as well as other findings from SNAP
 - States seeking to implement these strategies should contact their CMS state lead for additional information and copy CMSUnwindingSupport@cms.hhs.gov.
 - States may adopt a similar strategy on a permanent basis through the Facilitated Enrollment SPA Option. This ensures that individuals enrolled or renewed are certain to be eligible but requires that the state take additional steps before conferring Medicaid enrollment.
 - This strategy requires submission of a State Plan Amendment

Verification Flexibilities

- To facilitate verification at application during the PHE unwinding period, states may consider adopting additional flexibilities, including:
 - Adoption of post-enrollment verification
 - Requesting authority under section 1902(e)(14)(A) of the Social Security Act to use of income determinations from SNAP or other human services programs.
 - For assessment states, temporarily accepting an assessment of eligibility by the Federally-facilitated Marketplace (FFM) as a determination of eligibility, or becoming a determination state
 - Requesting an extension or modification of an existing MAGI verification disaster addendum or the creation of a MAGI verification disaster addendum for unwinding.
- States seeking to implement these strategies should contact their CMS state lead for additional information and copy CMSUnwindingSupport@cms.hhs.gov .
- Additional waiver or state plan authority may be required. States may also need to update and submit updated MAGI verification plans or addendums.

Temporary Fair Hearing Flexibilities

- As states resume processing renewals and other eligibility actions during the unwinding period, they may experience a number of factors (e.g., increase in fair hearing volume, shortage of fair hearing officers) that may challenge their ability to process fair hearings timely.
- States should assess the anticipated volume of fair hearing requests and their operational capacity as they determine how to distribute pending actions across the unwinding period. CMS will consider providing authority under section 1902(e)(14) of the Social Security Act to provide the state with additional time to take final administrative action provided that certain beneficiary protections are provided.
- States seeking to implement this strategy should contact their CMS state lead for additional information and copy CMSUnwindingSupport@cms.hhs.gov.