

Illustrative Examples of Processes Not Permitted Under Medicaid and CHIP Renewal Requirements

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Objective



The objective of these slides is to remind states of certain renewal requirements and provide illustrative examples of state policy and operational processes that are **not permitted** under federal Medicaid and CHIP redetermination requirements.

These slides are a companion to the CMCS Informational Bulletin: *Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders*, released on March 15, 2024

States that are currently relying on any of the following prohibited processes must change their processes as quickly as possible and should reach out to CMS for technical assistance.

Medicaid and CHIP Renewal Requirement Reminders

- #1** Do not terminate Medicaid or CHIP coverage for an individual who has returned their renewal form or documentation requested by the state within the eligibility period, even if processing the renewal form and documents will need to occur after the eligibility period has ended.
- #2** Do not terminate Medicaid coverage without first determining eligibility on all other bases.
- #3** Do not require a new application from individuals who are eligible on the basis of Modified Adjusted Gross Income (MAGI) and who respond to a renewal request within 90 days after a procedural termination.
- #4** Do not exclude an individual from *ex parte* renewal because wage data show that a household earner is working for an employer that is different from that reflected in the case record, if income remains below the applicable standard.
- #5** Do not exclude individuals from an *ex parte* renewal in Medicaid solely because the state has aligned renewal dates with those for the Supplemental Nutrition Assistance Program (SNAP) or other human services benefit programs.
- #6** Do not transition an individual to the Marketplace, or to an eligibility category with lesser benefits or increased premiums or cost sharing, based on an *ex parte* review, without first sending a renewal form and request for information.
- #7** Do not terminate coverage, or take other adverse action, until after advance notice, including an explanation of fair hearing rights, is provided.
- #8** Do not conduct *ex parte* renewals at the household level.
- #9** Do not provide fewer than 30 days for the response to a renewal form for individuals whose eligibility is based on MAGI.
- #10** Do not send renewal forms and other notices only in English, without providing language services, to households that have requested information in other languages or fail to ensure effective communication with individuals with disabilities.

#1: Do not terminate Medicaid or CHIP coverage for an individual who has returned their renewal form or documentation requested by the state within the eligibility period, even if processing the renewal form and documents will need to occur after the eligibility period has ended.

States must continue to furnish Medicaid to individuals who have returned their renewal form or requested documentation unless and until they are determined to be ineligible on all bases.

Illustrative Scenario

- Elizabeth is enrolled in Medicaid with an eligibility period end date of June 30th. The state is unable to complete her renewal on an *ex parte* basis and sends her a renewal form and request for documentation on May 15th.
- Elizabeth returns her renewal form on June 29th, but the state is unable to review her information before the scheduled end of her eligibility period the following day.
- ✗ As a result, the state disenrolls Elizabeth from coverage on June 30th.
- ✓ The state must keep Elizabeth enrolled in Medicaid, past June 30th, until it has reviewed her renewal form and any additional documentation she submitted. If she is found to be ineligible on all bases, the state can then disenroll her from Medicaid after providing advance notice that includes fair hearing rights.

#2: Do not terminate Medicaid coverage without first determining eligibility on all other bases.

If a state has sufficient information to determine that an individual is no longer eligible for the eligibility group in which they are enrolled, it must consider whether the individual may be eligible under one or more other eligibility groups covered by the state prior to terminating eligibility.

Illustrative Scenario

- Mary is enrolled in Medicaid on the basis of a disability. At renewal, the state is unable to complete an *ex parte* renewal and sends her a renewal form to complete.
- Mary returns the renewal form and provides information that indicates she is financially ineligible for coverage on the same basis. However, Mary is 55 years old and may potentially be eligible for a MAGI eligibility group (e.g., the adult group or family planning eligibility group).
- ✗ Instead of determining her eligibility on a MAGI basis, the state terminates coverage and transfers her account to the Marketplace.
- ✓ The state must assess Mary's eligibility for other eligibility groups (and may request additional information, as needed) prior to termination and cannot disenroll her from Medicaid when she may potentially be eligible for another group. If she is found to be ineligible on all bases, the state can then disenroll her from Medicaid after providing advance notice that includes fair hearing rights and can transfer her account to the Marketplace.

#3: Do not require a new application from individuals who are eligible on the basis of MAGI and who respond to a renewal request within 90 days after a procedural termination.

A state must reconsider eligibility for individuals who are eligible on the basis of MAGI and were disenrolled for failure to submit the renewal form or documentation requested by the state if the individual subsequently submits the necessary information within 90 days after the termination date.

Illustrative Scenario

- Paul is disenrolled from Medicaid on April 30th for non-response to a renewal form.
- On June 5th, Paul visits a pharmacy and realizes he no longer has coverage. He immediately calls the Medicaid agency to complete his renewal by phone.
- ✗ The state call center representative insists that Paul complete a new application and walks him through questions about his age, household size, and citizenship—information that the state already has.
- ✓ If Paul provides information needed to complete his overdue renewal by phone, the Medicaid agency must redetermine his eligibility based on such information and submission of needed documentation. Paul was disenrolled from Medicaid for a procedural reason and attempted to complete his renewal 35 days after termination, which is within the 90-day reconsideration period. As such, when Paul contacted the call center, his renewal should have been completed based on the information he provided.

#4: Do not exclude an individual from *ex parte* renewal because wage data show that a household earner is working for an employer that is different from that reflected in the case record, if income remains below the applicable standard.

An individual continues to meet income eligibility requirements if the data sources at renewal indicate income is below the Medicaid or CHIP income eligibility levels. When verifying income using the reliable data source (e.g., quarterly wage data), the existence in the case record of income from a prior employer that is no longer present at renewal is not a valid reason to request additional information from the individual.

Illustrative Scenario

- Eliana reported income from her job at Martha's Floral Kingdom when she applied for Medicaid 12 months ago. Her income was verified through electronic data sources, and she was enrolled in the adult group.
- At renewal, quarterly wage data pinged during an *ex parte* review indicates that Eliana still has income below 133% of the FPL but now works at Joe's Party Palace. There is no information about income from Martha's Floral Kingdom or other sources.
- ✗ The state sends Eliana a renewal form to complete and return with additional information on income and employment.
- ✓ The state must renew Eliana on an *ex parte* basis if all other eligibility requirements are met because income information from available reliable data sources indicates she continues to be income eligible for Medicaid.

#5: Do not exclude individuals from an *ex parte* renewal in Medicaid solely because the state has aligned renewal dates with those for SNAP or other human services benefit programs.

The *ex parte* renewal requirement applies to all beneficiaries, regardless of whether an individual is also enrolled in SNAP and/or other human services benefit programs. If the *ex parte* review for the Medicaid beneficiary is successful, the state must redetermine Medicaid eligibility and follow up with the SNAP redetermination separately.





Illustrative Scenario

- Marcus is enrolled in both Medicaid and SNAP. His renewal/recertification periods are aligned across programs, with a renewal date of July 31st.
- ✗ In early June, to begin the renewal process for both programs, the state sends Marcus a combined renewal form to complete and return. The form includes questions needed to determine Marcus' continued eligibility for Medicaid and SNAP.
- ✓ The state must initiate Marcus' Medicaid renewal with an *ex parte* review. If the state agency is able to redetermine Medicaid eligibility based on available data, it must do so. If the state agency is unable to redetermine eligibility based on available information, the state must then send him a prepopulated renewal form. The state cannot delay Marcus' renewal because of SNAP requirements, such as submitting income documentation.

#6: Do not transition an individual to the Marketplace, or to an eligibility category with lesser benefits or increased premiums or cost sharing, based on an *ex parte* review, without first sending a renewal form and request for information.

A state may not rely solely on data sources to disenroll individuals or to move individuals to the Marketplace, CHIP, or a group with a reduced Medicaid benefit package or increased premiums or cost sharing. In circumstances where an *ex parte* review suggests eligibility for another program or another Medicaid eligibility group with reduced benefits or higher cost sharing, states are required to: (1) maintain the individual in their existing Medicaid eligibility group or CHIP premium band; and (2) send the individual a renewal form and request for information.

Illustrative Scenario

-  The state initiates Ramona's renewal with an *ex parte* review.
-  Quarterly wage data pinged during Ramona's *ex parte* review indicates that she has income above 133% of the FPL. Ramona, who is enrolled in the adult group, appears to be potentially eligible for the family planning eligibility group with a reduced benefit package.
-  The state moves Ramona into the family planning eligibility group without first sending her a renewal form and request for information.
-  The state must maintain Ramona in the adult group and send her a renewal form and request for information. If Ramona responds to the renewal form, the state must redetermine eligibility based on information provided. If Ramona does not respond to the renewal form, the state must rely on the data sources and transition her to the family planning eligibility group.

#7: Do not terminate coverage, or take other adverse action, until after advance notice, including an explanation of fair hearing rights, is provided.

States must provide all beneficiaries with timely and adequate written notice of any decision affecting eligibility, such as a denial, termination, or suspension of eligibility. States must provide a notice of adverse action at least 10 days prior to implementing the action.

Illustrative Scenario

- Anna returns her renewal form to the state and provides information that indicates she is financially ineligible for coverage under her current eligibility group. The state determines that Anna is not eligible for her current eligibility group or on any other basis.
- ✗ As a result, the state disenrolls Anna from Medicaid before sending a notice informing her of the basis of the state's determination.
- ✓ The state must provide Anna a written notice of adverse action, including an explanation of her fair hearing rights, at least 10 days before terminating her eligibility.

#8: Do not conduct *ex parte* renewals at the household level.

States must complete a redetermination of eligibility based on available information for each individual in the household, and in relation to the eligibility standard appropriate to the individual, regardless of the eligibility of others in the household unit.

Illustrative Scenario

- While available data indicate that Carlos, a child in a household with two adult parents enrolled in Medicaid, continues to be eligible for Medicaid, the state is unable to determine continued eligibility for Carlos' parents based on the data.
- ✗ The state sends a renewal form requesting information from all household members. When the renewal form is not returned, the state disenrolls all individuals in the household, including Carlos.
- ✓ The state must determine Carlos eligible through the *ex parte* process at the individual level. The state must send the renewal form to Carlos' parents and ask for the minimum information required to determine their eligibility. When the renewal form is not returned, the state must provide advance notice and fair hearing rights to Carlos' parents before terminating their coverage.

#9: Do not provide fewer than 30 days for the response to a renewal form for individuals whose eligibility is based on MAGI.

States must provide MAGI beneficiaries a minimum of 30 days from the date of the prepopulated renewal form to return the form and any requested information. Non-MAGI beneficiaries must be provided with a reasonable period of time (e.g., at least 30 days) to return their renewal form and any required information.

Illustrative Scenario

- Priyanka is enrolled in Medicaid on a MAGI basis, with an eligibility period ending on January 31st.
- The state begins Priyanka's annual Medicaid renewal in late December and is unable to redetermine her eligibility on an *ex parte* basis.
- ✗ The state mails Priyanka a renewal form dated January 1st and requests a response by January 21st. Priyanka does not return the form by January 21st, and the state disenrolls her from Medicaid at the end of the month. The state has only given Priyanka 20 days (from January 1st to January 21st) to respond to the renewal form.
- ✓ The state must give Priyanka at least 30 days from the date of the renewal form to respond, which is January 31st. States are encouraged to provide longer periods of time to take into account mailing time and enable individuals more time to complete and return the renewal form.

#10: Do not send renewal forms and other notices only in English, without providing language services, to households that have requested information in other languages or fail to ensure effective communication with individuals with disabilities.

States must take reasonable steps to ensure meaningful access to Medicaid and CHIP for individuals with limited English proficiency (LEP) and must provide effective communication to individuals with disabilities.

Illustrative Scenario

- Jenny is enrolled in Medicaid, and her primary written and spoken language is Mandarin Chinese.
- Jenny requests that forms and notices related to her Medicaid coverage be provided to her in Mandarin.
- ✗ The state is not able to provide the renewal form translated into Mandarin, since it has only pre-written translations in English and Spanish. The state does not offer other language services either.
- ✓ The state must provide language services for Jenny, which could include oral interpretation or written translation of the renewal form in Mandarin, to ensure meaningful access to coverage.

Source: 42 C.F.R. §§ 431.206(e), 431.205(e); 435.905(b); 435.907(g); 435.916(g); 435.917(a); 435.956(b), 457.110(a); HHS Office for Civil Rights, State Health Official Letter, “Ensuring Language Access for Limited English Proficient (LEP) Individuals and Effective Communication for Individuals with Disabilities During the States’ Unwinding of the Medicaid Continuous Enrollment Condition,” April 4, 2023.

CMS Resources to Support States with Renewals

- [Compilation of CMS Resources to Support State Implementation of Renewal Mitigation Strategies from 2023](#)
- [CMCS Informational Bulletin: Ensuring Eligible Children Maintain Medicaid and Children's Health Insurance Program Coverage from December 18, 2023](#)
- [State Letter: Ensuring Compliance with Requirements to Conduct Medicaid and CHIP Renewal Requirements at the Individual Level from August 30, 2023](#)
- [Transitioning Individuals Within Medicaid Eligibility Groups and Between Medicaid and CHIP at Renewal Slide Deck from December 18, 2023](#)
- [Medicaid and CHIP Renewals and Redeterminations Slide Deck from Learning Collaborative Meeting on January 13, 2021](#)
- [Medicaid and CHIP Renewals and Redeterminations Slide Deck from All State Call on December 8, 2020](#)
- [CMCS Informational Bulletin: Medicaid and CHIP Renewal Requirements from December 4, 2020](#)

See the CMS [Unwinding and Returning to Regular Operations after COVID-19](#) webpage for more information and additional resources.