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August 30, 2023

Dear State Medicaid Director:

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

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

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

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

133 percent of the federal poverty level (FPL), the median Medicaid/CHIP eligibility level for children across states is 255 percent FPL. Children’s eligibility levels range from 170 percent FPL to 400 percent FPL with all but two states covering children at or above 200 percent FPL. States must renew Medicaid or CHIP coverage for these eligible children based on available income information obtained during the *ex parte* process in accordance with 42 C.F.R. 435.916(a)(2) and 457.343. However, we understand that some states are requesting additional information to redetermine eligibility and disenrolling these children from Medicaid or CHIP if a renewal form is not returned. This practice violates federal renewal requirements.

- Eligible individuals in a household in which additional documentation is needed to verify eligibility for the other household members. Consistent with federal renewal regulations at 42 C.F.R. §435.916(a)(3) and (b) and §457.343, states must provide individuals whose eligibility cannot be renewed based on available information with a renewal form and must inform the individual of any additional information or documentation needed to determine eligibility (e.g., for income, resources, residency, immigration status, etc.). In instances where states are unable to renew eligibility for one or more members of a household on an *ex parte* basis, states must still renew eligibility on an *ex parte* basis for all other members of the household for whom the state has sufficient information to determine the individual continues to be eligible. CMS has determined that due to incorrect systems programming or other operations, some states are requesting information or documentation for individuals for whom the state has completed an *ex parte* renewal and are terminating coverage for individuals if other members of the household do not provide requested verification. This practice violates renewal requirements at 42 C.F.R. 435.916(a)(2) and 457.343 and may be resulting in improper terminations of individuals in multiple circumstances.

While the scenarios above may be among the most common areas of non-compliance, states may identify other circumstances in which individuals in multi-member households are inappropriately disenrolled from their Medicaid and/or CHIP coverage due to incorrect systems programming or state processes that do not accurately account for individuals’ differing eligibility statuses or in which the state denies ongoing eligibility for one household member based on missing documentation needed only to renew eligibility for another.

Each of these examples is a violation of federal Medicaid and CHIP renewal regulations at 42 C.F.R. §§ 435.916(a)(2) and 457.343. The regulations require that states complete a redetermination of eligibility based on available information for each individual in the household, regardless of the eligibility of others in the household unit: “[t]he agency must make a redetermination of eligibility without requiring information from *the individual* if able to do so based on reliable information contained in *the individual’s* account or other more current information available to the agency” (emphasis added). Regulations related to the determination of eligibility at 42 C.F.R. §§ 435.911(c) and 457.350(b)(1) also specify that the agency must furnish Medicaid “[f]or each individual...whose eligibility is being renewed,” if found eligible.

Further, while states may need to obtain information, such as income, from all household members, to renew eligibility for those whose eligibility cannot be established via the *ex parte* process, states may not require additional information to renew coverage for those, such as children, who should have already been determined eligible based on other available reliable information. Requesting additional information under these circumstances is inconsistent with 42 CFR 435.916(e), which specifies that “the agency may request from beneficiaries only the information needed to renew eligibility.” As a result, any state that conditions renewal of Medicaid eligibility for individuals in the household on the return of a renewal form, when such individuals’ eligibility has already been established based on available information via the *ex parte* process, is out of compliance with longstanding federal Medicaid and CHIP renewal requirements and, as a result, may be ineligible to claim the temporary FMAP increase under section 6008(f)(2)(A) of the FFCRA.

**Required State Action:**

To ensure compliance, CMS is instructing all Medicaid and CHIP agencies to review their renewal processes, including all related standard operating procedures, renewal forms, and notices and to test the renewal logic in your eligibility system to assess that your system is compliant with requirements to determine eligibility for each individual in the household, consistent with the requirements described above. To avoid jeopardizing the FMAP increase under section 6008 of the FFCRA and compliance action under section 1902(tt)(2) of the Social Security Act or other available authority, states that are not operating in compliance with federal renewal requirements must immediately:

1. **Pause** procedural terminations for those individuals for whom the *ex parte* renewal process is not currently compliant and whose Medicaid or CHIP coverage may be terminated inappropriately due to improper implementation of renewal requirements, until the state implements mitigations or other updates to ensure that eligible individuals are not disenrolled;
2. **Reinstate** coverage for all affected individuals who have been procedurally disenrolled due to a failure to account for the individual’s eligibility status, independent of that of others in the household. States unable to quickly identify individuals within a household affected by this issue must reinstate coverage for the full household. When reinstating eligibility for affected individuals, the state must:
  - a. Provide retroactive eligibility back to the date of termination, without a gap in coverage; and
  - b. Notify affected individuals that their coverage has been reinstated and provide information about next steps, including what actions, if any, the beneficiary must take to obtain payment for unpaid medical bills and/or ensure that eligible services are covered for the period while the individual was disenrolled. The state may *not* require the individual to provide documentation of eligibility during this period;

3. **Fix** the state’s systems and processes to ensure that redeterminations are conducted appropriately for all individuals in the household; and
4. **Implement** one or more mitigation strategies to prevent continued inappropriate terminations of eligibility until such time that the state has fixed all systems and processes to be compliant with the renewal requirements. Such strategies include:
  - a. **Identify and renew eligibility for affected individuals prior to disenrollment for a procedural reason.** In implementing this mitigation, a state must continue to conduct an *ex parte* review to determine eligibility for all household members based on available information. States may continue to send a renewal form to the household requesting additional information. However, for any multi-member household that does not return a form, the state must review eligibility for all children and household members to identify and manually renew coverage for those who remain eligible. This mitigation must continue until a system fix is fully implemented.
  - b. **Suspend renewals for while the state implements needed systems and operational fixes.** Under this approach, a state would pause renewals for all multi-member households, including those with children and those with members with at least one individual for whom additional information or documentation is required at renewal, as well as any other affected population. States unable to accurately identify affected individuals or households must suspend all Medicaid renewals. During this pause, the state would be expected to implement systems and operational updates needed to ensure that eligible individuals retain eligibility regardless of the eligibility of others in the household, which may include implementation of the mitigation described in 4a, above.

To ensure sufficient time to complete renewals and prevent other inappropriate coverage losses due to increased renewal volume, depending on the volume of impacted households, a state adopting this mitigation approach may need to extend its COVID-19 unwinding period consistent with the length of the renewal pause, in order to ensure that the state can spread out the paused renewals once the systems and operational fixes are complete. For example, if a state pauses renewals for two months in September and October 2023 to ensure compliance with renewal requirements and was scheduled to complete its 14-month unwinding period in June 2024, the state may extend the unwinding period through August 2024. CMS will work with any state adopting this approach to determine whether it should extend its unwinding period and how to distribute delayed renewals once the state resumes its regular renewal cycle.

- c. **Waive the requirement to redetermine eligibility and extend Medicaid or CHIP eligibility for impacted household members for up to 12 months from the member’s scheduled renewal during the unwinding period.** Under this approach, a state would need to identify all potentially affected individuals and

extend Medicaid or CHIP eligibility for these household members for up to an additional 12 months from the member’s scheduled renewal during the unwinding period (e.g., automatically extend eligibility for a child in a multi-member household due for renewal in December 2023 until December 2024, if the child is at risk of losing coverage inappropriately due to state systems and operational issues). This option provides a state until the end of the state’s unwinding period to implement the necessary fixes for full compliance. It may be particularly beneficial in states unable to implement the mitigation strategies described in option 4a and those able to continue regular, accurate renewals for household members unaffected by issues described in this letter, without inappropriate terminations of other individuals. Because individuals automatically renewed through this strategy may remain on the same renewal cycle, it may also be beneficial in states with a large volume of affected individuals, for whom the manual approach may not be feasible or where a redistribution of renewals would result in an unmanageable caseload of renewals in a given month.

- d. **State-identified alternative strategy approved by CMS.** CMS will review and approve state-developed mitigation strategies that ensure that eligible individuals are not disenrolled and demonstrate a path to full compliance with relevant federal requirements by the end of a state’s unwinding period.

Please review your state’s renewal processes and policies. If you identify any areas of non-compliance related to the appropriate determination of eligibility for individuals in multi-member households, please contact CMS no later than September 13, 2023, with additional information on the population of individuals affected and the state’s plan and timeline for reinstatement and implementation of mitigation strategies described above. CMS has provided a template, “Mitigation Plan Template for *Ex Parte* Renewal Compliance Issues, August 2023,” available on Medicaid.gov at <https://www.medicaid.gov/resources-for-states/downloads/ex-parte-renewal-miti-plan-template.pdf> to facilitate states’ reporting, though use of the template is not required. If your state’s assessment is not complete by September 13, 2023, please submit your preliminary findings along with a timeline for completing the analysis by the deadline. States may submit the completed template or information in other formats via email to the CMS Unwinding Mailbox at [CMSUnwindingSupport@cms.hhs.gov](mailto:CMSUnwindingSupport@cms.hhs.gov).

If your state has completed a thorough analysis of systems functionality and confirmed that eligibility is appropriately conducted on an individual level and no individuals have been inappropriately disenrolled, please complete “Section 1: State Attestation for Completing Compliant *Ex Parte* Renewals” (page 3) in the template and email the template or requested information to the CMS Unwinding Mailbox by September 13, 2023, to affirm your state’s continued compliance.

Failure to identify and address issues of non-compliance, including these issues with multi-member households, reinstate eligibility for affected individuals, and prevent further inappropriate terminations will lead to CMS taking compliance action under section 1902(tt)(2)

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of the Social Security Act. Such an action may include a request to submit a corrective action plan, and if the state fails to submit or implement such a plan, civil money penalties. Failure to act may also result in additional penalties, including but not limited to disqualification of the state from eligibility for the temporary FMAP increase under section 6008 of the FFCRA.

CMS is committed to ensuring that eligible individuals remain enrolled and appreciates states' efforts to simplify and streamline renewal practices. We look forward to our ongoing partnership in this endeavor. We also recognize that states not currently operating *ex parte* processes consistent with requirements may have significant work ahead to mitigate the impact of the issue and ensure compliance. The 90 percent matching rate for FFP is available to States for approved processes, systems, and activities necessary to ensure compliance with the requirements noted in this letter. CMS is also available to help and will be providing ongoing assistance and resources for states in the coming weeks to support state efforts to achieve compliance. For additional questions, please email the CMS Unwinding Mailbox at [CMSUnwindingSupport@cms.hhs.gov](mailto:CMSUnwindingSupport@cms.hhs.gov).

Sincerely,

Daniel Tsai  
Director

**Attachments:**

- A: An Overview of Medicaid and CHIP Renewal Requirements
- B: Scenarios: Conducting *Ex Parte* Renewals at the Individual Level

## Attachment A: An Overview of the Medicaid and CHIP Renewal Requirements

States are required to conduct redeterminations of eligibility for all individuals enrolled in Medicaid and CHIP in compliance with federal regulatory requirements at 42 C.F.R. §§ 435.916 and 457.343 and as outlined in the Centers for Medicaid and CHIP Services Informational Bulletin, “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements”.<sup>1</sup> At renewal, states are required to first attempt to renew eligibility for all Medicaid Modified Adjusted Gross Income (MAGI) and non-MAGI and CHIP beneficiaries based on reliable information available to the state agency without requiring information from the individual.<sup>2</sup> This is referred to as an *ex parte* renewal.<sup>3</sup> If the agency is able to renew eligibility based on the available reliable information, the agency must provide notice of the determination and basis for eligibility,<sup>4</sup> and the individual is not required to sign and return the form if all information is accurate.<sup>5</sup> If information is insufficient to renew or redetermine eligibility on an *ex parte* basis, the agency must send a renewal form and request only the information necessary to redetermine eligibility.<sup>6</sup>

Renewal forms must be prepopulated for MAGI Medicaid and CHIP beneficiaries.<sup>7</sup> The agency may, but is not required to, provide a pre-populated renewal form for non-MAGI beneficiaries.<sup>8</sup> States must provide MAGI beneficiaries a minimum of 30 days to return the form and any requested information;<sup>9</sup> non-MAGI beneficiaries must be provided with a reasonable period of time to return their renewal form and any required information.<sup>10</sup> Renewal forms and notices must be accessible to individuals with limited English proficiency and persons with disabilities.<sup>11</sup> The agency must continue to furnish Medicaid to beneficiaries who have returned their renewal form and all requested documentation unless and until they are determined to be ineligible.<sup>12</sup> The agency should provide clear instructions for all beneficiaries on how to complete the form and correct any inaccurate prepopulated information, how the form and other documentation can be returned, and the timeframe in which the individual must respond.<sup>13</sup>

States determine and redetermine Medicaid and CHIP eligibility on an individual basis. When multiple members of a household are enrolled in Medicaid or CHIP, the state may process renewals for an entire household or multiple members of a household at the same time if their eligibility periods are aligned. However, the state must conduct the renewal for each individual

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<sup>1</sup> 42 C.F.R. § 435.916; CMCS Informational Bulletin, “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements,” December 4, 2020, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>.

<sup>2</sup> 42 C.F.R. §§ 435.916 (a)(2) and (b) and § 457.343

<sup>3</sup> An *ex parte* renewal is sometimes referred to as auto renewal, passive renewal, or administrative renewal.

<sup>4</sup> Notice must be provided consistent with 42 C.F.R. §435.917, 42 C.F.R. 431, subpart E, and 42 C.F.R. §457.340(e), as applicable

<sup>5</sup> 42 C.F.R. §§ 435.916(a)(2)(i) and (ii) and 435.916(b), §435.917, and §457.343

<sup>6</sup> 42 C.F.R. §§ 435.916 (a)(3), 435.916(b), 435.916(e) and § 457.343

<sup>7</sup> 42 C.F.R. §§ 435.916(a)(3)(i)(A), 457.343.

<sup>8</sup> 42 C.F.R. § 435.916(b).

<sup>9</sup> 42 C.F.R. §§ 435.916(a)(3)(i)(B), 457.343.

<sup>10</sup> 42 C.F.R. § 435.952.

<sup>11</sup> 42 C.F.R. § 435.916(g)

<sup>12</sup> 42 C.F.R. § 435.940(b)

<sup>13</sup> 42 C.F.R. § 435.905(b) and §457.340 and CMCS Informational Bulletin (page 4), “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements,” December 4, 2020, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>.

consistent with 42 C.F.R. §§ 435.916 and 457.343, including renewing eligibility on an *ex parte* basis if able to do so and only requesting information necessary to redetermine eligibility.

In instances where states are unable to renew eligibility for one or more members of a household on an *ex parte* basis, such as a parent or guardian, states must still renew eligibility on an *ex parte* basis for all other members of the household, including any children, for whom the state has sufficient information to determine the individual continues to be eligible. States may only request information needed to determine eligibility for those family members for whom the state does not have sufficient information to renew eligibility on an *ex parte* basis. States may not require household members whose eligibility may be renewed on an *ex parte* basis to return a renewal form simply because another member of the household must complete and return a renewal form. See Attachment B for specific examples and scenarios. For more information on Medicaid and CHIP renewal requirements, see CMCS Informational Bulletin, “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements,” December 4, 2020, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>.



**Attachment B:  
Scenarios: Conducting *Ex Parte* Renewals at the  
Individual Level**

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# Scenario 1: Family of 2 with Parent and Child



## Household and State Profile



**Maria**

*Parent, Age 35*



**John**

*Child, Age 4*

- Maria (age 35) is the head of the household and a parent who lives with her child, John (age 4).
- Maria and John each have a Medicaid MAGI household of 2 and belong to each other's Medicaid household.
- Their state's MAGI Medicaid eligibility threshold for adults is 133% of the FPL.
- Their state's MAGI Medicaid eligibility threshold for children is 210% of the FPL; the separate CHIP eligibility threshold is 250% of the FPL.

# Scenario 1: Ex Parte Review

## John Can Be Renewed, Information Needed for Maria

State initiates renewal for the household by beginning the *ex parte* process.

The available data and reliable information show household income is 200% of the FPL.

State uses household information to determine eligibility for each individual in the household.



John

200% FPL is **below** the state's child Medicaid eligibility level of 210% FPL.  
John continues to be eligible for Medicaid.

John's coverage must be renewed based on the *ex parte* determination.  
No action is needed to continue John's coverage.

The state can either: (1) send an individual eligibility determination notice for John; or (2) wait until the state has enough information to determine Maria's eligibility and send a single eligibility determination notice for the household, including both John and Maria's coverage determinations.

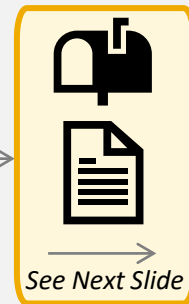


Maria

200% FPL is **above** the state's MAGI adult Medicaid eligibility level of 133% FPL.  
Maria's coverage cannot be redetermined *ex parte*.

Additional information is needed to renew Maria's eligibility.  
Action is needed to continue Maria's coverage.

The state must send a prepopulated renewal form requesting the additional information needed to determine Maria's eligibility.  
The renewal form should only ask for the minimum information required to determine Maria's eligibility.



See Next Slide

# Scenario 1a: Renewal Form Sent for Parent Maria Returns the Form, John Remains Eligible



John



John's coverage is renewed based on the *ex parte* determination.



John's *ex parte* eligibility determination is not impacted by the information returned on Maria's renewal form because the updated information does not indicate that John may be ineligible.  
John's Medicaid coverage is maintained.



Maria



State sends renewal form.\*



Maria completes and returns the renewal form with income documentation that verifies that the household income is 200% FPL, which is **above** the state's adult Medicaid eligibility level of 133% FPL.  
Maria is not eligible on another basis and is determined ineligible.



Maria has at least 30 days to respond.



State must provide Maria a minimum 10 days advance notice and fair hearing rights before her coverage is terminated.

The notice can be: (1) an individual eligibility determination notice for Maria if the state has already sent John a notice; or (2) a single eligibility determination notice for the household including both Maria and John's coverage determinations.

The state transfers Maria's account to the Marketplace.

\*The renewal form should only ask for the minimum information required to determine Maria's eligibility.

# Scenario 1b: Renewal Form Sent for Parent

## *Maria Returns the Form, Information May Impact John's Eligibility*



John



John's coverage is renewed based on the *ex parte* determination.



The information returned on Maria's renewal form may impact John's eligibility (i.e., household income above the state's child Medicaid eligibility level).

The state must act on the updated information as a change circumstance and redetermine John's eligibility, in the same manner as if Maria had responded to John's individual eligibility determination notice to indicate the information in the notice was inaccurate.



The verified household income provided by Maria is 230% FPL, which is **above** the state's child Medicaid eligibility level of 210% FPL. The state considers other bases of eligibility, but determines John is ineligible for Medicaid.

The state must assess eligibility for coverage in CHIP and finds John eligible in the state's separate CHIP.



State must provide to both John and Maria the minimum 10 days advance notice and fair hearing rights before Medicaid coverage is terminated.

The state's notice must also inform the household that John has been enrolled in the state's separate CHIP.

The state transfers Maria's account to the Marketplace.



Maria

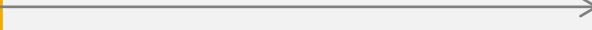


States sends renewal form.\* Maria completes and returns the renewal form.



Maria completes and returns the renewal form with income documentation that verifies the household income is 230% FPL, which is **above** the state's adult Medicaid eligibility level of 133% FPL.

Maria is not eligible on another basis and is determined ineligible.



\*The renewal form should only ask for the minimum information required to determine Maria's eligibility.

# Scenario 1c: Renewal Form Sent for Parent

## Maria Does Not Return the Renewal Form, John Remains Eligible

Redetermination Actions



John



John's coverage is renewed based on the *ex parte* determination.



John's *ex parte* eligibility determination is not impacted because the state does not have information indicating the information used to renew his eligibility is inaccurate.

John's Medicaid coverage is maintained even though Maria did not respond to the form to renew her coverage.



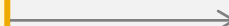
Maria



State sends renewal form.\*



No form is returned.



Maria has at least 30 days to respond.



State must provide Maria a minimum 10 days advance notice and fair hearing rights before her coverage is terminated.

The notice can be: (1) an individual eligibility determination notice for Maria if the state has already sent John a notice; or (2) a single eligibility determination notice for the household including both Maria and John's coverage determinations.

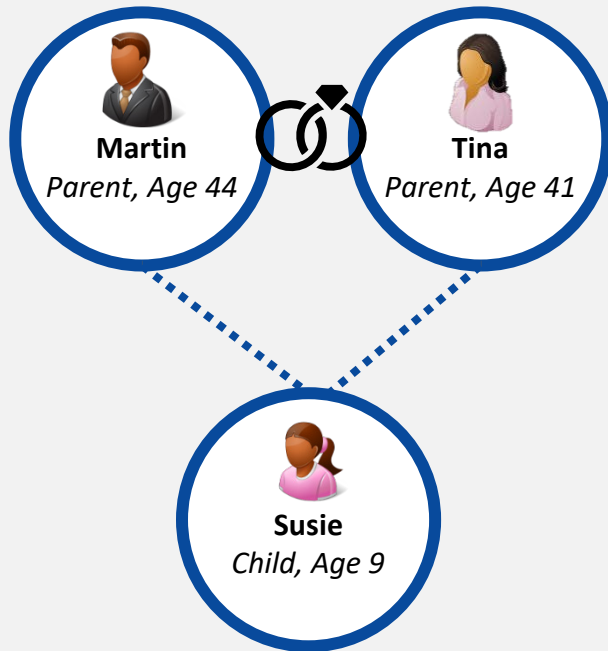
Maria may return her renewal form within 90 days of termination and have her eligibility reconsidered without needing to complete a new application.

\*The renewal form should only ask for the minimum information required to determine Maria's eligibility.

# Scenario 2: Family of 3 with Parents and Child



## Household and State Profile



- Martin (parent, age 44) is the head of household and is married to Tina (parent, age 41). Martin and Tina live with their child, Susie (age 9).
- Martin, Tina, and Susie each have a MAGI Medicaid household of 3 and belong to each other's Medicaid household.
- Their state's MAGI Medicaid eligibility threshold for adults is 133% of the FPL
- Their state's MAGI Medicaid eligibility threshold for children is 250% of the FPL; there is no separate CHIP.

# Scenario 2: *Ex Parte* Review

## *Tina and Susie Eligible, Information Needed for Martin*

State initiates renewal for the household by beginning the *ex parte* process.

The available data and reliable information shows household income is 90% of the FPL.

State uses household information to determine eligibility for each individual in the household.


State identifies an inconsistency with another factor of eligibility for Martin.



Tina

Available data indicate that Tina continues to be eligible for Medicaid because 90% FPL is **below** the state's Medicaid eligibility level of 133% FPL for adults. Tina continues to meet all other factors of eligibility.

Tina's coverage must be renewed based on the *ex parte* determination. No action is needed to continue Tina's coverage.

  
The state can: (1) send individual eligibility determination notices to Tina and to Susie; (2) send a combined eligibility determination notice to Tina and Susie; or (3) wait until the state has enough information to determine Martin's eligibility and send a single eligibility determination notice for the household, including Martin, Tina, and Susie's coverage determinations.



Susie

Available data indicate that Susie continues to be eligible for Medicaid because 90% FPL is **below** the state's Medicaid eligibility level of 250% FPL for children. Susie also meets all other factors of eligibility.

Susie's coverage must be renewed based on the *ex parte* determination. No action is needed to continue Susie's coverage.



Martin

While available data indicate that Martin continues to be income eligible, available data is unable to verify other factors of eligibility to determine Martin's continued eligibility.

Martin's coverage cannot be redetermined *ex parte*.  
Action is needed to continue Martin's coverage.

The state must send a prepopulated renewal form that requests additional information needed to redetermine Martin's eligibility.  
The renewal form should only ask for the minimum information required to determine Martin's eligibility.



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# Scenario 2a: Renewal Form Sent for Parent

## Martin Returns the Form, Household Eligibility Not Impacted



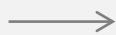
Tina



Susie



Tina and Susie's coverage is renewed based on the *ex parte* determination.



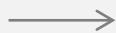
Tina and Susie's eligibility determinations are not impacted by the information returned on Martin's renewal form because the information does not include updates to household information that indicates they may be ineligible. Tina and Susie's Medicaid coverage is maintained.



Martin



State sends renewal form.\*



Martin has at least 30 days to respond.

Martin completes and returns the renewal form with updated information regarding the factors of eligibility for which: (1) an inconsistency was identified; or (2) additional documentation or information is needed.

He does not provide updated information that impacts eligibility for the household (e.g., no change in income).

Martin is determined ineligible for Medicaid because, although he is income eligible, he does not meet all factors of eligibility.



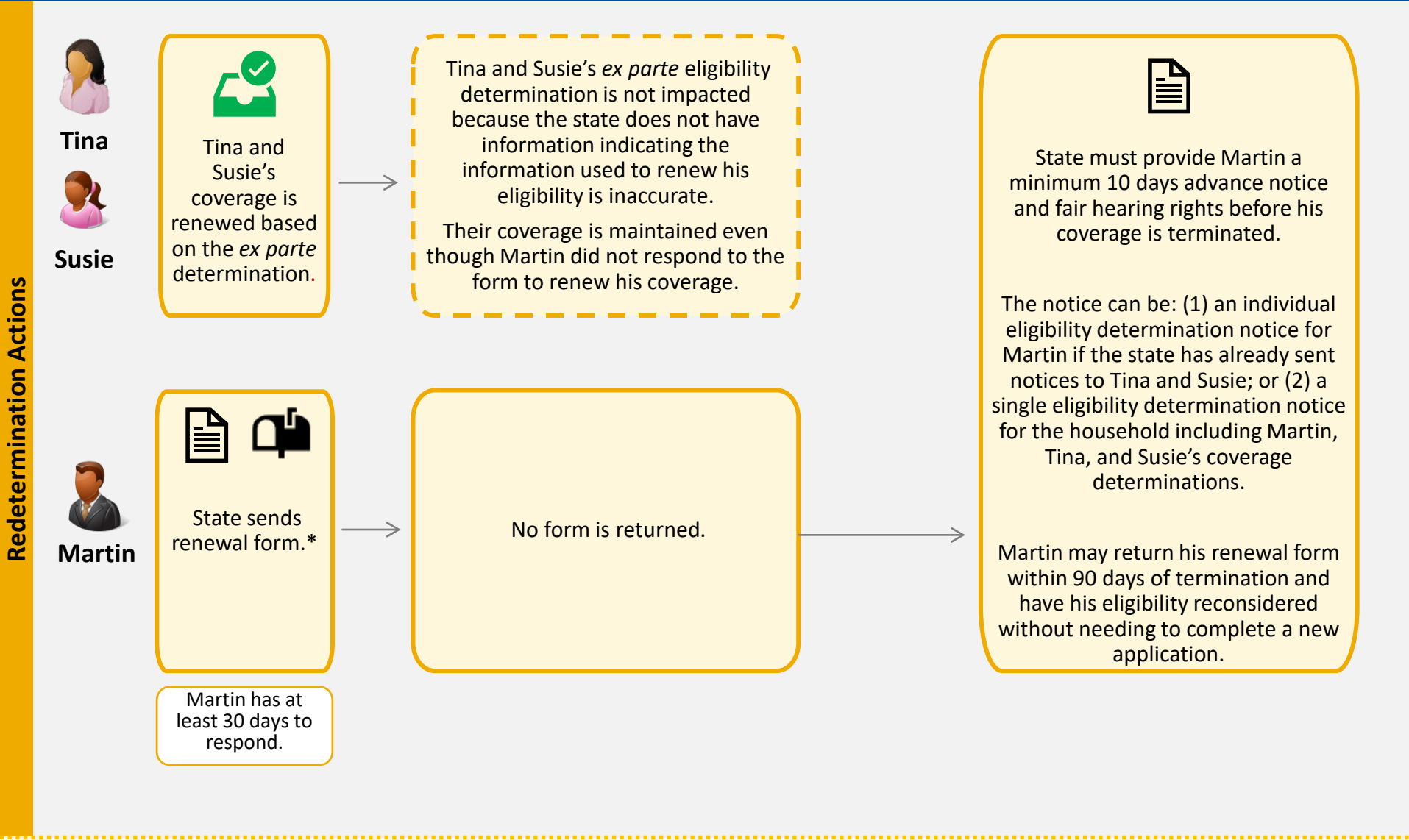
State must provide Martin a minimum 10 days advance notice and fair hearing rights before his coverage is terminated. The notice can be: (1) an individual eligibility determination notice for Martin if the state has already sent Tina and Susie a notice; or (2) a single eligibility determination notice for the household including Martin, Tina, and Susie's coverage determinations.

\*The renewal form should only ask for the minimum information required to determine Martin's eligibility.



# Scenario 2c: Renewal Form Sent for Parent

## Martin Does Not Return the Renewal Form



\*The renewal form should only ask for the minimum information required to determine Martin's eligibility.