

# CMS Final Rule on Medicaid and CHIP Eligibility, Enrollment, and Renewal

April 11, 2024

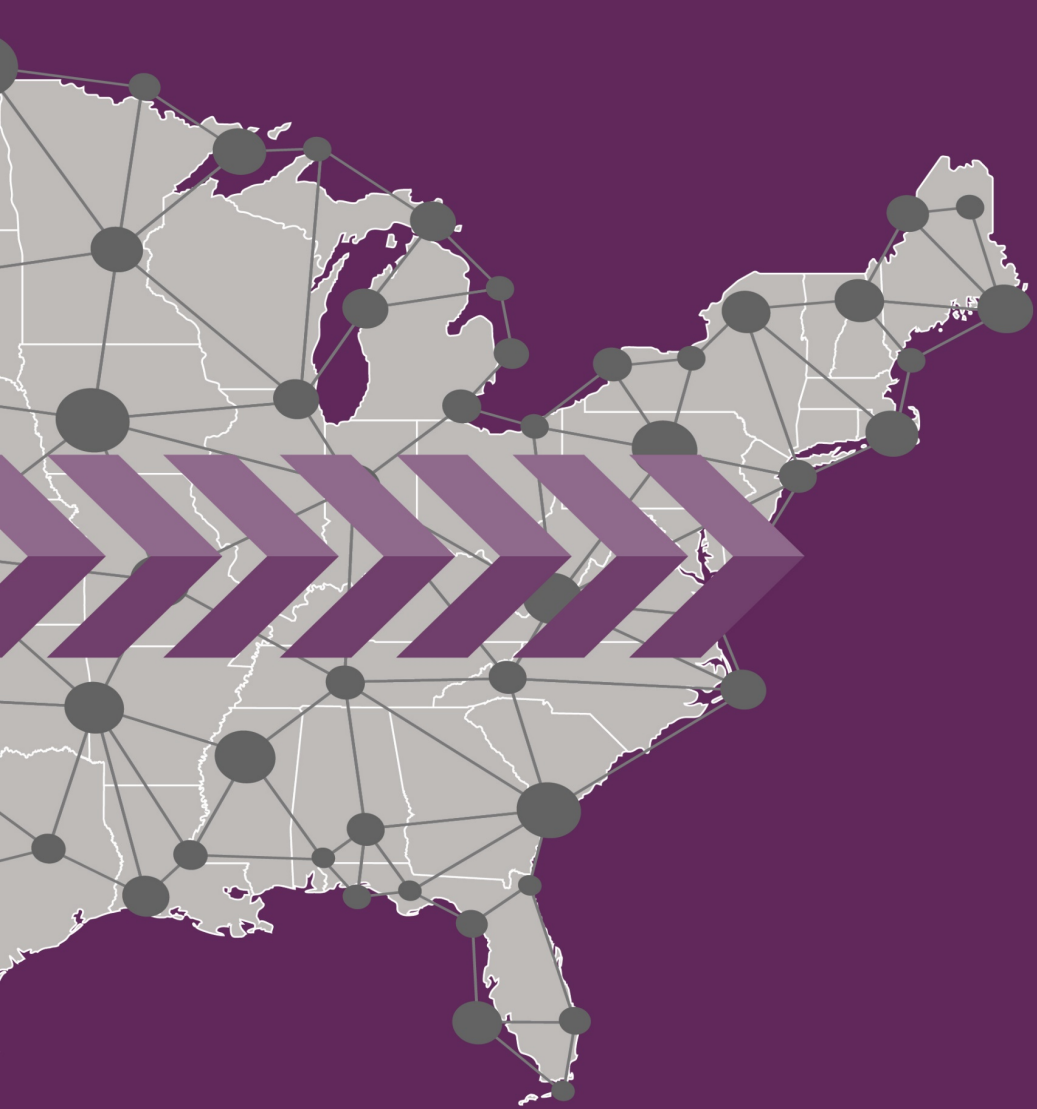
12:30 – 1:30 p.m. ET

*Please stand by, this webinar will begin shortly*

**STATE**  
Health & Value  
**STRATEGIES**

*Driving Innovation  
Across States*

*A grantee of the Robert Wood Johnson Foundation*



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# About State Health and Value Strategies

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

*Support for this webinar was provided by the Robert Wood Johnson Foundation.  
The views expressed here do not necessarily reflect the views of the Foundation.*

# About Manatt Health

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Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit [www.manatt.com/ManattHealth.aspx](http://www.manatt.com/ManattHealth.aspx)

# Housekeeping Details

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- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.** The meeting facilitators will address questions and comments verbally in a manner that maintains the anonymity of the state.
- All participant lines are muted. Use the 'raise hand' feature in Zoom if you would like to speak during the discussion portion. The meeting facilitators will then unmute you.
- After the webinar, the slide deck and a recording will be available at [www.shvs.org](http://www.shvs.org).

# Agenda


- **Level-Setting: CMS Final Rule on Medicaid and CHIP Eligibility, Enrollment, and Renewal**

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- **Key Provisions in the Final Rule and Considerations for States**

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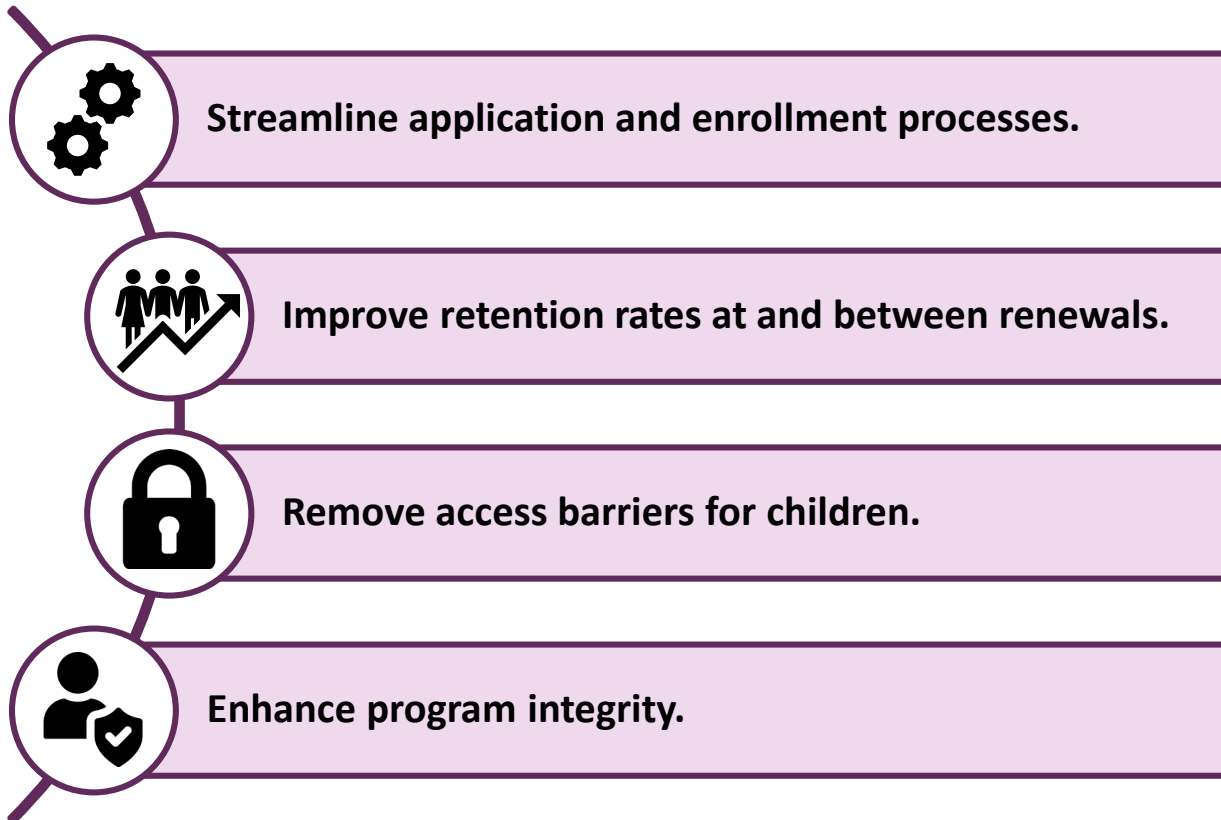
- **Discussion**



# **Level-Setting: CMS Final Rule on Medicaid and CHIP Eligibility, Enrollment, and Renewal**

# Overview of CMS' Final Rule

On March 27, CMS unveiled an expansive final rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes" that seeks to:



The final rule, which largely aligns with the proposed rule, is the most significant eligibility and enrollment rulemaking since two Affordable Care Act implementing regulations were finalized in 2012 and 2013.

Source: CMS, [All State Call #134 on Tuesday, April 2, 2024](#); SHVS/Manatt, [CMS Releases Expansive Final Rule on Medicaid and CHIP Eligibility, Enrollment, and Renewal](#); and SHVS/Manatt, [CMS Finalizes Medicaid Rule to Streamline Enrollment Into Medicare Savings Programs](#).

# Compliance Timeline for New Requirements

CMS provides a three-year phased in timeline for states to comply with new requirements.

Provisions in the Final Rule	Compliance Date
<ul style="list-style-type: none"> <li>Remove Option to Limit the Number of Reasonable Opportunity Periods</li> <li>Apply Electronic Verification and Reasonable Compatibility Standards for Resources</li> <li>Improve Transitions Between Medicaid, CHIP, and Marketplace</li> <li><i>Option</i> to Allow Medically Needy Individuals to Deduct Prospective Medical Expenses</li> <li><i>Option</i> to Establish Optional Eligibility Group for Reasonable Classification of Individuals Under 21</li> </ul>	Final Rule Effective Date <b>(June 3, 2024)</b>
<ul style="list-style-type: none"> <li>Remove Access Barriers for Children (Premium Lock-Outs, Waiting Periods, and Annual or Lifetime Limits)*</li> <li>Remove the Requirement to Apply for Other Benefits</li> </ul>	1 Year After Effective Date <b>(June 2025)</b>
<ul style="list-style-type: none"> <li>Act on Updated Address Information</li> </ul>	1.5 Years After Effective Date <b>(December 2025)</b>
<ul style="list-style-type: none"> <li>Maintain Records Electronically</li> <li>Accept Additional Forms of Electronic Verification of Citizenship</li> </ul>	2 Years After Effective Date <b>(June 2026)</b>
<ul style="list-style-type: none"> <li>Align Modified Adjusted Gross Income (MAGI) and Non-MAGI Enrollment/Renewal Requirements</li> <li>Act on Changes in Circumstances</li> <li>Meet New Timeliness Requirements at Application, at Renewal, and Upon Changes in Circumstances</li> </ul>	3 Years After Effective Date <b>(June 2027)</b>

*\*Note: No new policies starting 6/3/2024; states with existing policies have 1 year to sunset them. States with biennial legislatures can request an extension from CMS.*

Source: CMS, Medicaid Program; [Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes](#) (See Table 2).



# Key Provisions in the Final Rule and Considerations for States

**Source:** CMS, Medicaid Program; [Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes.](#)

# Streamline Medicaid and CHIP Verification Processes (1/2)

The final rule further simplifies Medicaid citizenship and identity verification processes to ensure access to coverage for eligible individuals.



## Remove Option to Limit the Number of Reasonable Opportunity Periods to Establish Citizenship or Immigration Status

- Eliminates state option to limit the number of reasonable opportunity periods during a coverage year
  - The reasonable opportunity period is the 90-day timeframe during which Medicaid/CHIP applicants who have attested to their citizenship or immigration status and for whom a state is unable to verify eligibility are given the chance to provide necessary documentation or information.

**Compliance Date:** June 2024



## Accept Additional Forms of Electronic Verification of Citizenship

- Removes the requirement for applicants to provide separate proof of identity when U.S. citizenship is verified with a state's vital statistics records or the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program.

**Compliance Date:** June 2026

Source: 42 C.F.R. §§ 435.956 and 457.380, 435.407.

# Streamline Medicaid and CHIP Verification Processes (2/2)

The final rule also includes other provisions to simplify enrollment and help individuals stay enrolled.



## Apply Electronic Verification and Reasonable Compatibility Standards for Resources

- Clarifies that reasonable compatibility standards also apply to resource verification and that states are not allowed to request additional information when applicant or enrollee resource information is reasonably compatible with the information received from an electronic data source (e.g., when both data sources and information are below (or above) the resource standard).
- Explains in the preamble that states may also establish a reasonable compatibility threshold when verifying resources.

**Compliance Date:** June 2024



## Remove the Requirement to Apply for Other Benefits

- Eliminates the requirement that individuals apply for other benefits for which they may be entitled as a condition of Medicaid eligibility (e.g., Social Security Disability Insurance and retirement benefits, unemployment compensation).
  - This negates the need for the section 1902(e)(14) “Applying for Other Benefits Strategy” flexibility to suspend the requirement that individuals apply for other public benefits.

**Compliance Date:** June 2025

Source: 42 C.F.R. §§ 435.952 and 435.940, 435.608 and 436.608.

# Align MAGI and Non-MAGI Enrollment and Renewal Requirements

The final rule extends certain MAGI enrollment and renewal simplifications to non-MAGI populations. While alignment will significantly reduce administrative barriers due to age or disability, it will require a heavier operational and IT systems lift from states.



## Application Requirements Applicable to Non-MAGI Enrollees

- Clarifies that states must allow applications and additional information to be submitted through all modalities (mail, telephone, online, in-person).
- Do not require an in-person interview as part of the application process.



## Renewal Requirements Applicable to Non-MAGI Enrollees

- Do not require an in-person interview as part of the renewal process.
- Renew coverage only once every 12 months (with the exception of Qualified Medicare Beneficiaries).
- Pre-populate the renewal form.
- Allow at least 30 days to return the renewal form with required information.
- Provide a 90-day reconsideration period.

*37 states will need to establish a reconsideration period for non-MAGI enrollees or extend their existing reconsideration period to 90 days.*

# Remove Access Barriers for Children

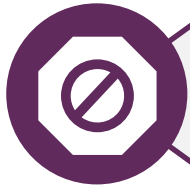
The final rule makes sweeping enrollment changes that will have considerable impact on ensuring continuity of coverage for CHIP and BHP-enrolled individuals.



**Eliminates Premium Lock-Out Periods in CHIP and BHP** and encourages other mechanisms for addressing timely payment of premiums (e.g., frequent reminders, multiple payment options, pursue past due premiums). CMS estimates that 14 states currently have premium lock-out periods.



**Prohibits Waiting Periods Prior to Enrollment in CHIP** but maintains that states must have procedures in place to prevent substitution of group health plan coverage. According to CMS, 22 states currently have waiting periods.



**Prohibits Annual and Lifetime Limits on Any CHIP Benefits** to mitigate barriers to receiving necessary healthcare services. Per CMS, 13 states place an annual or lifetime limit on at least one CHIP benefit (e.g., dental and orthodontia coverage).

**Intersection with 12 months Continuous Enrollment for Children:** Currently, CHIP-enrolled children must stay continuously enrolled in coverage for 12 months, regardless of non-payment of premiums; however, they could be disenrolled at the end of 12 months and prevented from re-enrolling due to unpaid premiums. CMS clarifies that a state can not require payment of past due premiums as a condition of re-enrollment. In June 2025 for states with existing policies, past-due premiums must not be a condition of re-enrollment.

Source: 42 C.F.R. §§ 457.570 and 600.525, 457.65, 457.340, 457.350, 457.805, and 457.810, and 457.480.

\*Note: No new policies starting 6/3/2024; states with existing policies have 1 year to sunset. States with biennial legislatures can request an extension from CMS.

# Improve Coverage Transitions

The final rule requires states to transition individuals to the insurance affordability program for which they are determined eligible (or potentially eligible) based on available data.

## Transitions Between Medicaid and CHIP.

When the Medicaid agency determines an individual ineligible for Medicaid and eligible for CHIP, or the separate CHIP agency determines the individual eligible for Medicaid and ineligible for CHIP:

1. Accept the determination of eligibility and seamlessly transition the individual between programs.
2. Send a combined Medicaid/CHIP eligibility notice.

In the 40 states with a separate CHIP, state Medicaid agencies will need to enter into agreements with the separate CHIP agencies to seamlessly transition individuals. These requirements will prevent eligible children from being disenrolled.

## Medicaid/CHIP Transitions to Other Insurance Affordability Programs.

If an individual is found ineligible for Medicaid or CHIP and potentially eligible for Marketplace coverage, but has not responded to a renewal form or request for information:

1. Transfer the individual to the appropriate other insurance affordability program (e.g., BHP, Marketplace).

Prior to the rule, states were not required to transfer the account when an enrollee failed to respond to a renewal form or request for information, resulting in procedural disenrollments.

# Meet Timeliness Requirements at Application, at Renewal, and Upon Changes in Circumstances

The rule adds requirements related to submission of additional information in the application process and timeframes for determinations at application, at renewal, and upon changes in circumstances.

Time Period	Minimum Period for Individual to Provide Additional Information	Maximum Period for State to Complete Timely Determination	Minimum Period for Individual to Submit Information for Reconsideration
<b>Application</b>	A reasonable period of at least 15 days.	<ul style="list-style-type: none"> <li>90 days for applications based on disability.</li> <li>45 days for all other applications.</li> </ul>	90 days.
<b>Renewal</b>	30 days.	<ul style="list-style-type: none"> <li>End of eligibility period; or</li> <li>End of the month following the end of the eligibility period, if all needed information was submitted less than 30 days prior to the end of the eligibility period.</li> </ul>	
<b>Reported Change in Circumstances</b>		The end of the month that occurs: <ul style="list-style-type: none"> <li>30 days following the state’s receipt of information related to the changes in circumstances; or</li> <li>60 days following the state’s receipt of information related to the changes in circumstances, if additional information is needed.</li> </ul>	
<b>Anticipated Change in Circumstances</b>		<ul style="list-style-type: none"> <li>The end of the month in which the anticipated change occurs; or</li> <li>The end of the month following the month in which the anticipated change occurs, if all needed information is submitted less than 30 days before the end of the month of the anticipated change.</li> </ul>	

Source: 42 C.F.R. §§ 435.907, 435.912, 457.340, and 457.1170. “Days” referenced in this table refers to calendar days.

# Act on Changes in Circumstances

The final rule clarifies expectations for state Medicaid and CHIP agencies when they receive information from an enrollee or a third-party data source about a potential change in circumstances.

If information about a change is reported by the enrollee

State must act on the information in accordance with federal requirements and the state's verification plan

If information about a change is reported by a third party data source



Change would result in additional medical assistance

State may act on the information or first verify the information with the enrollee

State may not terminate coverage if enrollee does not respond to request for verification; individual must remain in their current eligibility group



Change would adversely impact eligibility

State must request information from the enrollee to verify or dispute the information

State may terminate coverage if enrollee does not respond to the request for verification, but the state must redetermine potential eligibility for other affordability programs and provide notice of adverse action/fair hearing rights before adverse action

Source: 42 C.F.R. §§ 435.916, 435.919, 457.344, and 457.960.

\*An adverse action includes termination, suspension, or reduction in covered benefits, or eligibility or an increase in premiums or cost sharing.

# Act on Updated Address Information (1/2)

The final rule simplifies the proposed rule's requirements that states must take in response to returned enrollee mail, balancing the need to prevent procedural disenrollments and state burden.

- States must establish a process to regularly obtain and act on updated enrollee address information from **reliable third-party data sources**, including:



Returned mail with a United States Postal Service (USPS) forwarding address



The USPS National Change of Address (NCOA) database



Contracted managed care plans (if information is received from or verified by the enrollee)






Other Secretary-approved data sources identified by the state

When a state receives an in-state change of address from a reliable data source, the state must accept the information as reliable, update the case record, and notify the enrollee of the update.

This negates the need for the **section 1902(e)(14) "Contact Update Strategy" flexibility** that states have used during their unwinding periods to waive the requirement to verify with enrollees updated contact information from USPS/the NCOA database or managed care plans.

# Act on Updated Address Information (2/2)

 In-State Address	 Out-of-State Address	 No Forwarding Address
<ul style="list-style-type: none"> <li>▪ If from a reliable data source: accept information as reliable, update case record, and notify the enrollee.</li> <li>▪ If from another data source: check Medicaid Enterprise System (MES)/ reliable data sources to confirm the accuracy.               <ul style="list-style-type: none"> <li>– If updated address information is confirmed: accept information as reliable, update case record, and notify the enrollee.</li> <li>– If updated address information is not confirmed: make a “good-faith effort” to contact the enrollee to confirm the information.                   <ul style="list-style-type: none"> <li>• If unable to confirm the information: do not update case record or terminate coverage for failure to respond.</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Make a good-faith effort to contact the enrollee to confirm the address information or obtain information on whether the enrollee continues to meet state residency requirements.               <ul style="list-style-type: none"> <li>– If unable to confirm that the enrollee continues to meet state residency requirements: provide advance notice of termination and fair hearing rights.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Check MES/reliable data sources for additional contact information.               <ul style="list-style-type: none"> <li>– If the updated in-state address information is available from a reliable data source: accept the information as reliable, update case record, and notify the enrollee.</li> <li>– If the updated address information cannot be obtained and confirmed as reliable: make a good-faith effort to contact the enrollee to obtain updated address information.                   <ul style="list-style-type: none"> <li>• If unable to identify and confirm the enrollee’s address and whereabouts remain unknown: take steps to terminate or suspend coverage (and provide notice to the last known address or electronically) or move the individual to fee-for-service.</li> </ul> </li> </ul> </li> </ul>


***Good faith effort*** means: at least two attempts to contact the enrollee; use of two or more modalities; a reasonable period of time between contact attempts; and at least 30 days for the enrollee to respond.

# Maintain Records Electronically

For the first time since 1986, CMS updates in the final rule regulatory requirements for recordkeeping. The level of effort required by states will vary depending on steps taken to date to modernize recordkeeping processes.

The following must be maintained in an electronic format for each applicant/enrollee:

- All information provided on the initial application submitted through any modality (including signature).
- The electronic account and any information from another insurance affordability program.
- The date of, basis for, and all documents or other evidence to support a determination, denial, or adverse action.
- The provision of and payment for services, items, and other medical assistance.
- Any changes of circumstances reported by the individual and actions taken.
- All renewal forms and documentation provided on behalf of the enrollee regardless of modality submitted.
- All notices provided to the applicant or enrollee.
- All records pertaining to any fair hearings requested, including the date of the request, complete record of the hearing decision, and final administrative action.
- The disposition of income and eligibility verification information received through data matching, including evidence that no information was returned.
- Statistical, fiscal, and other records necessary for reporting and accountability.

 States must retain records for the period when an applicant or enrollee's case is active plus a minimum of three years thereafter (or until the state has satisfied estate recovery requirements for certain enrollees).

# Consider Taking Up New State Options

The final rule establishes two new options that states may consider taking up to promote continuity of coverage among eligible individuals.



## Medically Needy Spenddown: Option to Use Prospective Medical Expenses for Non-Institutional Individuals

- Allows individuals to deduct predictable, anticipated non-institutional medical or remedial expenses from their income in order to become eligible for this eligibility group (e.g., prescription drugs, home- and community-based services, personal care services, behavioral health services.)
- Under existing regulations, states may already allow individuals to deduct from income their prospective institutional expenses to establish “medically needy” eligibility.

*Option requires a State Plan Amendment (SPA).*



## Optional Eligibility Group for Reasonable Classification of Individuals Under 21 Who Meet Criteria for Another Optional Group

- Confirms state flexibility to establish income and household composition rules for individuals who are ages 18, 19, 20, or 21 using non-MAGI budgeting methodologies.
- For example, states may use MAGI-equivalent and/or non-MAGI budgeting methodologies for these youth (e.g., a youth initially found ineligible under MAGI methodology could be screened for the medically needy eligibility group using non-MAGI methodology).

Source: 42 C.F.R. §§ 435.831 and 436.831, 435.223.

# Reminder of Compliance Timeline

CMS provides a three-year phased in timeline for states to comply with new requirements.

Provisions in the Final Rule	Compliance Date
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# Discussion

The slides and a recording of the webinar will be available at [www.shvs.org](http://www.shvs.org) after the webinar



# Thank You

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