STATE Health & Value STRATEGIES

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Ensuring Compliance With Federal Renewal Requirements: State Diagnostic Assessment Tool

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Background

State Medicaid agencies are preparing for the largest health coverage event since the implementation of the Affordable Care Act: the "unwinding" of the Medicaid continuous coverage guarantee that has been in place for the duration of the COVID-19 public health emergency and will end on March 31, 2023. As states begin the herculean task of redetermining eligibility for 91 million enrollees in Medicaid and the Children's Health Insurance Program (CHIP), they are readying their systems, staff, and vendors that support Medicaid eligibility operations. Their readiness is essential to mitigate coverage loss for eligible individuals and sustain historic gains in coverage achieved over the past several years, particularly among Latino(a) and Black populations as well as children and adolescents who are at increased risk for loss of coverage during unwinding.

The Consolidated Appropriations Act, 2023 (CAA) provides enhanced federal funding to states to support unwinding, provided that they conduct eligibility redeterminations and renewals in compliance with federal regulatory requirements at 42 CFR § 435.916 and meet certain additional conditions.[1] The statute also directs the Centers for Medicare & Medicaid Services (CMS) to oversee state compliance with these conditions and exercise targeted enforcement powers in the event that states do not comply with federal renewal and CAA reporting requirements.[2] Conducting renewals and redeterminations of eligibility as well as transitions to other coverage programs in accordance with federal requirements will not only ensure that states have the resources and capacity they need to support unwinding, it will also reduce rates of procedural denials and churn—minimizing state workforce constraints and mitigating loss of coverage among eligible individuals.

Between now and the end of March, CMS is providing guidance and technical assistance to states with regard to the CAA provisions. States must comply with all CAA conditions to receive the enhanced Federal Medical Assistance Percentage (FMAP). However, states that are not able to fully comply with federal regulatory renewal requirements may still access the enhanced FMAP and/or avoid corrective action by adopting CMS-approved mitigation strategies. As part of this process, CMS expects states to assess compliance with the federal renewal requirements, identify and communicate to CMS any deficiencies, and devise and implement mitigations commensurate with such deficiencies. States will also need to attest to CMS that they will come into full compliance with all federal renewal requirements within two years following the end of a state's unwinding period.[3] CMS intends to monitor data and state activity throughout the unwinding period; states that are subsequently determined to be out of compliance will need to return federal financial participation associated with the enhanced FMAP and/or face corrective action/related penalties. As such, all states should evaluate their compliance with 42 CFR § 435.916.

Using the diagnostic assessment tool below, states can take the critical step of evaluating their compliance with 42 CFR § 435.916, helping them to qualify for the sustained enhanced FMAP, avoid corrective action imposed by CMS, promote continuity of coverage and care during unwinding, and make long-term improvements to eligibility and enrollment infrastructure.

Federal Renewal Requirements: Diagnostic Assessment Tool

Federal Medicaid Regulatory Requirements at 42 CFR § 435.916[4]	Applicable to[5]		
	MAGI	Non-MAGI	CHIP
General Renewal Processes			
When regular eligibility and enrollment operations resume, states must:			
☐ Renew eligibility only once every 12 months and no more frequently than once every 12 months	✓		✓
☐ Renew eligibility at least once every 12 months		✓	
☐ Establish an eligibility period that extends from the effective date of the last determination of eligibility	✓	✓	✓
Ex Parte Renewals			
To begin the renewal/redetermination process, states are required to:			
☐ Attempt to renew and redetermine eligibility on an *ex parte* basis by using reliable information[6] available in a person's account or through electronic data sources and only request information/documentation when sufficient information is not available through electronic data sources[7]	✓	✓	✓
☐ Use a variety of income and other data to verify eligibility, including data that was already verified[8] (e.g., information from other human service programs)	✓	✓	✓
☐ Do not: ☐ Require consent as a condition of conducting an *ex parte* determination ☐ Exclude specific populations from *ex parte* (e.g., individuals who previously reported self-employment income) ☐ Limit the number of consecutive *ex parte* renewals ☐ Require all household members to return a renewal form because one member was not determined on an *ex parte* basis	✓	✓	✓
☐ Use the state's Asset Verification System to check financial assets prior to sending the renewal form [for non-Modified Adjusted Gross Income (MAGI) populations that have an asset test]		✓	
☐ Do not delay completion of an *ex parte* renewal for Medicaid pending provision of documentation or other requirements for the Supplemental Nutrition Assistance Program (SNAP) or other human services programs that are not needed for Medicaid	✓	✓	
☐ Provide notice to enrollees when the agency is able to renew eligibility on an *ex parte* basis, including: ☐ Of the eligibility determination and basis ☐ That the enrollee is not required to sign or return the notice if the information is accurate, but has an obligation to inform the state of any inaccuracies or subsequent changes	✓	✓	✓
Renewal Form			
If information is insufficient to determine eligibility on an *ex parte* basis, states must:			
☐ Send a renewal form[9] and request from the enrollee only the information necessary to determine eligibility	✓	✓	✓
☐ Prepopulate the renewal form with the most recent, reliable, and relevant information **State option to prepopulate for non-MAGI enrollees*	✓		✓

Federal Medicaid Regulatory Requirements at 42 CFR § 435.916[4]	Applicable to[5]		
	MAGI	Non-MAGI	CHIP
☐ Include clear instructions on: ☐ How to complete the form and correct any inaccurate information ☐ How the form and additional documentation needed can be returned ☐ The date by which the enrollee should do so	✓		✓
Timeline to Return the Renewal Form			
Regarding the timeframe for submission, states must:			
☐ Provide a minimum of 30 days from the date of the prepopulated renewal form to respond and provide additional documentation **State option to temporarily extend the period of time to respond to the renewal form—e.g., from 30 to 60 days*	✓		✓
☐ Provide a reasonable timeframe to respond and provide additional documentation (at least 30 days is recommended)		✓	
Submitting and Processing the Renewal Form			
States are required to:			
☐ Ensure enrollees can return the signed renewal form through all available modalities: ☐ Online ☐ Telephone ☐ Mail ☐ In-person	✓	✓	✓
☐ Accept signatures that are: ☐ Handwritten ☐ Electronic ☐ Telephonic	✓	✓	✓
☐ Ensure renewal forms and notices are accessible to individuals with limited English proficiency and disabilities	✓	✓	✓
☐ Not require an in-person interview as part of the renewal process when making a determination	✓		✓
☐ Establish renewal procedures and milestones that allow for sufficient time, consistent with timeliness standards,[10] for: ☐ Enrollees to return the renewal form/required documentation ☐ The state to verify information returned by the enrollee and notify the enrollee of its determination	✓	✓	✓
☐ Verify information provided by the enrollee in accordance with federal requirements and the verification plan	✓	✓	✓
☐ Continue to furnish Medicaid to enrollees who have returned their renewal form/documentation unless and until they are determined to be ineligible	✓	✓	✓
☐ Redetermine eligibility as expeditiously as possible if the state is unable to make a determination by the end of the eligibility period	✓	✓	✓

Federal Medicaid Regulatory Requirements at 42 CFR § 435.916[4]	Applicable to[5]		
	MAGI	Non-MAGI	CHIP
☐ Provide timely and adequate notice, once final determination is made, of any decision of their eligibility, including: ☐ A 10-day advance notice for adverse determinations for Medicaid ☐ Sufficient notice to take any appropriate actions that may be required to allow coverage to continue for CHIP	✓	✓	✓
Determining Eligibility on All Bases			
Prior to determining an individual is ineligible, states must:			
☐ Screen the enrollee for eligibility for all other eligibility groups covered by the state	✓	✓	✓
☐ Require enrollees to provide only information necessary to determine eligibility, and give a reasonable period of time to provide the information	✓	✓	✓
☐ Continue coverage and benefits until the enrollee is found ineligible under all other Medicaid eligibility groups covered by the state or until the individual does not timely provide requested information that is needed to make a determination	✓	✓	✓
Determining Potential Eligibility for Other Programs and Transferring Accounts			
For individuals determined ineligible for Medicaid, states must:			
☐ Determine potential eligibility for other insurance affordability programs	✓	✓	✓
☐ Transfer electronic accounts to appropriate insurance affordability programs timely[11]	✓	✓	✓
Reconsideration Period			
For enrollees whose eligibility has been terminated for failure to return the renewal form/documentation, states must:			
☐ Reconsider eligibility without requiring the individual to fill out a full new application if the renewal form/documentation is returned within 90 days after the date of termination, or a longer period elected by the state **State option to (1) adopt a reconsideration period of longer than 90 days for MAGI enrollees, and (2) provide a 90-day (or longer) reconsideration period for individuals enrolled on a non-MAGI basis who do not respond to the renewal form*	✓		✓
☐ Make a determination based on the submission of the renewal form consistent with timeliness standards (e.g., 90 days for disability-related determinations and 45 days for all other determinations)	✓		✓
☐ Make coverage effective for those determined eligible ☐ For Medicaid, the effective date is the date the renewal was submitted or the first day of the month the renewal form was returned, consistent with the state's Medicaid state plan ☐ For CHIP, the effective date is the date the form is returned or a reasonable method indicated in the state plan	✓		✓
☐ Provide up to three months retroactive coverage if the individual received Medicaid services following their termination and met Medicaid eligibility requirements when services were received	✓		

Appendix: Key Resources for States

CMS Unwinding Resources

- "State Health Official (SHO) # 23-002: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023," January 27, 2023.
- "CMCS Informational Bulletin: Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023," January 5, 2023.
- "Improving Efficiency and Beneficiary/Staff Experience Through Improved Renewal Automation For Unwinding," December 2022.
- "Preparing for the End of the COVID-19 Public Health Emergency: Opportunities to Support Medicaid and SNAP Unwinding Efforts," November 3, 2022.
- "Eligibility & Enrollment Processing for Medicaid, CHIP, and BHP During COVID-19 Public Health Emergency Unwinding Key Requirements for Compliance," May 17, 2022.
- "SHO # 22-001: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency," March 3, 2022.

See CMS' Unwinding and Returning to Regular Operations after COVID-19 webpage for additional unwinding resources.

CMS Renewal Resources

- "CMCS Informational Bulletin: Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements," December 4, 2020.
- "Coverage Learning Collaborative: Medicaid and CHIP Renewals and Redeterminations," January 13, 2021.
- "Ex Parte Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts," October 20, 2022.
- "Opportunities to Support Unwinding Efforts for States with Integrated Eligibility Systems and/or Workforces."

State Health & Value Strategies (SHVS) Unwinding Resources

- "New CMS Guidance on Medicaid Continuous Coverage Unwinding Provisions in the Consolidated Appropriations Act, 2023," February 8, 2023.
- "Omnibus Unwinding Provisions and Implications for States," January 11, 2023.
- "Improving Ex Parte Renewal Rates to Support Unwinding: Questions and Answers," January 3, 2023.
- "Improving Ex Parte Renewal Rates to Support Unwinding," November 29, 2022.
- "Leveraging Section 1902(e)(14) Waiver Authority Amid Unwinding," August 5, 2022.
- "Improving Ex Parte Renewal Rates: State Diagnostic Assessment Tool," June 2022.

See SHVS' Resources for States on Unwinding the Medicaid Continuous Coverage Requirement webpage for additional unwinding resources.

ENDNOTES

1. The enhanced federal match is phased down over a nine-month period from April 1, 2023 through December 31, 2023.
2. Penalties include a reduction in a state's regular Federal Medical Assistance Percentage (FMAP) for failure to report required information, corrective action for failure to comply with the CAA reporting requirements or any federal requirements applicable to eligibility redeterminations, and suspension of procedural terminations and/or civil monetary penalties for failure to submit or implement the corrective action plan.
3. CMS will not allow states to submit a mitigation strategies plan for the CAA enhanced FMAP conditions related to obtaining up-to-date contact information prior to redetermination and conducting multiple modality outreach based on returned mail prior to termination.
4. See 42 CFR § 457.343 for the corresponding federal CHIP regulatory requirements.
5. MAGI refers to Modified Adjusted Gross Income-Based enrollees; non-MAGI refers to non-Modified Adjusted Gross Income-Based enrollees; and CHIP refers to Children's Health Insurance Program enrollees.
6. Reliable information may include information in the enrollee's account and other current information available to the state (e.g., information accessed through electronic data sources, recent information from other benefit programs).
7. While automated *ex parte* processes are considered the gold standard, states with manual *ex parte* renewal processes will still meet this requirement.
8. Per CMS guidance, recently verified data can include: (1) data verified within the last six months; and (2) information not subject to change that has been verified more than six months ago.
9. Renewal forms need to include clear instructions on how to complete the form—including the need to sign and timeframes/available modes for submission—as well as how to correct inaccurate information.
10. Exceptions are permissible if a state needs additional time to evaluate eligibility on another basis, or if an emergency beyond the agency's control justifies a longer period.
11. The agency should not transfer account information to the Federally-Facilitated Marketplace for individuals who are terminated for procedural reasons (e.g., the enrollee does not return requested information).

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ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have.

Health is more than an absence of disease. It is a state of physical, mental, and emotional wellbeing. It reflects what takes place in our communities, where we live and work, where our children learn and play, and where we gather to worship. That is why RWJF focuses on identifying, illuminating, and addressing the barriers to health caused by structural racism and other forms of discrimination, including sexism, ableism, and prejudice based on sexual orientation.

We lean on evidence to advance health equity. We cultivate leaders who work individually and collectively across sectors to address health equity. We promote policies, practices, and systems-change to dismantle the structural barriers to wellbeing created by racism. And we work to amplify voices to shift national conversations and attitudes about health and health equity.

Through our efforts, and the efforts of others, we will continue to strive toward a Culture of Health that benefits all. It is our legacy, it is our calling, and it is our honor.

For more information, visit ***www.rwjf.org.***

ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

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.***

ABOUT MANATT HEALTH

This toolkit was prepared by Patricia Boozang, Kinda Serafi, Kaylee O'Connor, and Michelle Savuto. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future. For more information, visit ***https://www.manatt.com/Health.***