

**End of the Medicaid Continuous Enrollment Condition Frequently Asked Questions
for State Medicaid and CHIP Agencies
May 12, 2023**

The Centers for Medicare & Medicaid Services (CMS) has released numerous guidance documents and tools to help states prepare for the end of the Medicaid continuous enrollment condition under the Families First Coronavirus Response Act (FFCRA) on March 31, 2023, including these two State Health Official (SHO) Letters: (1) *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* (SHO #22-001, dated March 3, 2022); and (2) *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023* (SHO #23-002, dated January 27, 2023).

CMS is releasing these answers to frequently asked questions (FAQs) regarding the changes made to the FFCRA by section 5131 of subtitle D of title V of division FF of the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023), SHO #23-002, and related CMS guidance. These answers also address questions regarding changes made by section 1002(a)(1) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (“SUPPORT”) Act, Pub. L. 115-271, enacted on October 24, 2018, regarding eligibility changes for the Former Foster Care Children (FFCC) group under section 1902(a)(10)(A)(i)(IX) of the Social Security Act. For additional information regarding the SUPPORT Act changes for youth formerly in foster care, see State Health Official letter #22-003 and accompanying slide deck (issued December 16, 2023), available on Medicaid.gov. CMS plans to update this document as needed to support state unwinding efforts and provide additional guidance to states. For more information, including resources and tools to support state unwinding efforts, as well as information shared during all-state calls, please visit www.Medicaid.gov/unwinding.

Returned Mail Condition Under Section 6008(f)(2)(C) of the Families First Coronavirus Response Act (FFCRA)

Section 6008(f)(2)(C) of the FFCRA, which was added by the CAA, 2023, establishes a new condition of receiving the FFCRA temporary FMAP increase, applicable for quarters in the period beginning April 1, 2023 and ending December 31, 2023. Under this condition, known as the “returned mail condition,” states claiming the temporary FMAP increase during this period must undertake a good-faith effort to contact an individual using more than one modality prior to terminating their enrollment on the basis of returned mail. The following questions and answers relate to this condition.

Q1: For the purpose of the returned mail condition, how does CMS define a good faith effort to contact an individual using more than one modality?

A1: When states receive returned mail in response to a redetermination of eligibility, they must undertake a good faith effort to contact an individual using more than one modality prior to disenrollment on the basis of returned mail. For the purposes of meeting this returned mail condition, a good-faith effort to contact an individual using more than one modality means: (1) consistent with section 6008(f)(2)(B) of the FFCRA, the state has a process in place to obtain up-to-date mailing addresses and additional contact information (including phone numbers and email addresses) for all beneficiaries for whom the state conducts a renewal of eligibility; and (2) the state attempts to reach an individual whose mail is returned through at least two modalities using the most up-to-date contact information the state has for the individual, which could include a forwarding address if one is provided on the returned mail.

Q2: Can a state satisfy the returned mail condition by conducting outreach to a beneficiary through one or more modalities before the state receives the applicable returned mail?

A2: Generally, yes. Beneficiary outreach conducted either at the same time as or after the state sends notice to a beneficiary instructing them to return a renewal form or a request for additional information needed to make an eligibility determination at renewal, but before the state receives returned mail, counts as a good faith effort to contact the individual through one or more modalities only if the following conditions are met:

1. The outreach provides information specific to the beneficiary's renewal;
2. An attempt to contact the beneficiary after receiving the returned mail would be duplicative of the state's attempts to contact the beneficiary before receiving the returned mail; and
3. The outreach includes language that:
 - a) explains that a renewal notice has been sent by mail,
 - b) directs a beneficiary on how to complete the renewal, and
 - c) provides instructions on how to reach the state agency for assistance through all other available modes with information on available language access and auxiliary aids and services (e.g., instructs the beneficiary to complete the renewal in the online portal or to call the state at a number provided, including the TTY number, in the outreach to complete the renewal by phone or obtain a paper renewal form).

Q3: Must a state take further action to comply with the returned mail condition if the state has attempted to use two modalities at the same time as or after the mail with a renewal notice or request for additional information is sent to the beneficiary, but before returned mail is received?

A3: No. No further action is required to meet the returned mail condition under section 6008(f)(2)(C) of the FFCRA if the state follows the requirements specified in the answer to question 2 above by attempting two modalities at the same time as or after sending the beneficiary notice with instructions about completing the renewal form or requesting additional information necessary to make a renewal determination, provided this beneficiary outreach is conducted before the returned mail is received.

If the state is only able to conduct outreach using one modality prior to receiving the returned mail because it only has one mode of contact available (e.g., only an email address), the state must send any mail that is returned with a forwarding address to the forwarding address provided the state is able to do so.

Q4: Does a state need to conduct outreach through more than one modality under the returned mail condition if mail with a beneficiary's renewal notice or request for additional information is returned after an individual's coverage has been terminated?

A4: Yes. For beneficiaries whose renewal is initiated during the state's unwinding period, if a beneficiary's renewal notice or request for additional information is returned to the state within 30 days after a beneficiary's coverage is terminated for failure to respond, a state seeking to satisfy the returned mail condition must attempt to contact the individual using more than one modality, including phone, email, text, or a forwarding address provided on the returned mail. States have the option to act on mail returned to the agency within 90 days, or a longer period elected by the state, after a beneficiary's coverage is terminated.

Q5: In order to comply with the returned mail condition, must states reinstate coverage for a beneficiary if mail with a renewal notice or request for additional information is returned after a beneficiary's coverage has been terminated for failure to respond to a renewal form or request for additional information?

A5: Generally, yes. If a beneficiary responds to the state's outreach as described in the answer to question 5 above, the state must promptly reinstate the beneficiary's coverage with an effective date of either: (1) the date that the state reestablishes contact with the beneficiary; or (2) the first day of the month when the contact is made.

After the state obtains up-to-date contact information from the beneficiary as required by section 6008(f)(2)(B) of the FFCRA, the state must provide the beneficiary with an opportunity to furnish any information needed to complete the eligibility determination. If the state needs to send a new renewal form, the state must provide modified adjusted gross income (MAGI)-based beneficiaries with 30 days and non-MAGI beneficiaries a reasonable period of time to respond. If the returned mail was a request for additional information needed to complete the beneficiary's renewal, the state must provide the reasonable amount of time it generally provides beneficiaries to respond to requests for information, such as 10 days or more.

If the beneficiary timely returns the information and is determined eligible, the state must provide coverage for any Medicaid-covered services furnished back to the date of termination. If the beneficiary fails to respond within the time allowed, the state must send a 10-day advance notice of termination and fair hearing rights.

Q6: Would the returned mail condition be satisfied if a managed care plan acted on behalf of a state agency to conduct the beneficiary outreach that is required through more than one modality?

A6: Yes, managed care plans may act on behalf of a state agency to conduct beneficiary outreach if the state has approved such activity. Medicaid managed care plans cannot engage in marketing or marketing activities prohibited under the managed care marketing regulations at 42 CFR § 438.104, which provides that a managed care plan must not distribute marketing materials without the state’s approval. The same requirements (except subsection § 438.104(c), related to state agency review) also apply to separate CHIPs through a cross reference at 42 CFR § 457.1224. The regulation at 42 CFR § 438.104 provides that managed care plans, as permitted by their contracts with the state, may send materials to their enrollees about the importance of completing the state’s Medicaid eligibility renewal process in a timely fashion and about Qualified Health Plan (QHP) enrollment options. We remind states and managed care plans that Medicaid managed care contracts must include provisions for prompt notification to the state by the plan of information about changes in an enrollee’s circumstances that may affect the enrollee’s eligibility, including changes in residence (42 CFR 438.608(a)(3)). The same requirements also apply to separate CHIPs through a cross reference at 42 CFR § 457.1285, incorporating most of Part 438, subpart H of our regulations.

In addition, states may engage managed care plans to conduct outreach on the state’s behalf to beneficiaries about the eligibility renewal process. State agencies seeking to work with managed care plans to conduct such additional outreach to support the eligibility renewals of their enrollees should ensure they have the appropriate contracts in place for the managed care plan to conduct outreach activities on behalf of the state. Such arrangements would be separate and independent from the managed care plan’s contract governed by section 1903(m)(2)(A) and 42 CFR Part 438, and payment to managed care plans for performing such administrative activities for the state may not be included in the actuarially sound capitation rates paid for covering Medicaid benefits.

For additional information on how managed care plans can conduct outreach with their enrollees, please refer to the Overview of Strategic Approach to Engaging managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations available at <https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy-12062021.pdf>.

Q7: When will states need to implement the returned mail condition? Does it need to be implemented for an entire quarter for a state to claim the temporary FFCRA FMAP increase?

A7: The returned mail condition for the FFCRA FMAP increase applies, as described in section 6008(a) and (f)(1) of the FFCRA, for each calendar quarter occurring during the period that begins on April 1, 2023, and ends on December 31, 2023. States cannot claim the temporary FFCRA FMAP increase in a quarter during this period unless they comply with the returned mail condition under section 6008(f)(2)(C) of the FFCRA during that entire quarter.

Medicaid Resumption of Premiums

Prior to the enactment of the CAA, 2023, under section 6008(b)(2) of the FFCRA states could not claim the FFCRA temporary FMAP increase if they imposed any premium “with respect to an individual” that exceeded the amount of such premium as of January 1, 2020. CMS

interpreted this condition to mean that a state claiming the FFCRA temporary FMAP increase could not increase the amount of any premium charged to an individual enrollee (even if that person's income increased). The CAA, 2023 modified this condition, as described in SHO #23-002 and in the questions and answers that follow.¹

Q8: Did the CAA, 2023, give states claiming the FFCRA temporary FMAP increase greater flexibility regarding the amount of Medicaid premiums imposed on a specific individual?

A8: Generally, yes. The CAA, 2023 amended section 6008(b)(2) of the FFCRA effective April 1, 2023 to remove the language “with respect to an individual.” As discussed in SHO #23-002, this change gives states claiming the FFCRA temporary FMAP increase greater flexibility to increase the amount of Medicaid premiums imposed on a given individual, as long as the amounts in the state's Medicaid premium schedule don't exceed the amounts that were in place as of January 1, 2020.² Between April 1, 2023, and December 31, 2023, states claiming the FFCRA temporary FMAP increase must meet the condition in section 6008(b)(2) of the FFCRA, as amended.

Under the amended FFCRA section 6008(b)(2) condition, subject to the conditions and requirements discussed in this FAQ and the beneficiary protections described in Q12, states claiming the FFCRA temporary FMAP increase may charge individual beneficiaries higher premium amounts than they were charged as of January 1, 2020, as long as the amounts in the state's Medicaid premium schedule don't exceed the amounts that were in place as of January 1, 2020. For example, a change in a beneficiary's household income or household composition may place the beneficiary in a higher premium tier or band, or a beneficiary may have been moved to a different eligibility group that is subject to a higher premium amount.³

In addition to meeting the FFCRA section 6008(b)(2) condition (and other applicable FFCRA conditions) if the state is claiming the FFCRA temporary FMAP increase, any state charging Medicaid premiums must always comply with certain general requirements, including:

- Ensuring that premiums charged are consistent with the state's approved Medicaid premium schedule;
- Complying with all applicable premium requirements and limitations specified at sections 1916 and 1916A of the Social Security Act (the Act) and 42 CFR §§ 447.50 through 447.57; and

¹ CMS. (2023). *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023*. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf>.

² CMS. (2023). *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023*. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf>

³ Previous guidance indicated that states must maintain premiums for an individual at the same or lower level that was assessed as of January 1, 2020. See discussion in FAQ#II.B.9-10, and 12 of: CMS. (2021). COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, Available at: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>. This document updates that guidance due to the CAA, 2023 amendments to FFCRA section 6008.

- Complying with all applicable advance notice and fair hearing requirements at 42 CFR § 435.917 and 42 CFR Part 431, Subpart E.

Q9: Does the end of the Secretary-declared COVID-19 public health emergency (COVID-19 PHE) on May 11, 2023, have implications for states that had suspended Medicaid premiums via a disaster relief state plan amendment (SPA)?

A9: Yes. The end of the Secretary-declared COVID-19 PHE on May 11, 2023 means that all state disaster relief SPAs that sunset at the end of that COVID-19 PHE sunsetted on May 11, 2023.

After these disaster relief SPAs sunset, states must resume imposing Medicaid premiums consistent with their state plan unless they take action to delay or cancel the resumption of premiums. This is because states are generally required to implement the policies documented in their Medicaid state plan, unless the state takes permissible action to adopt a different policy.⁴ States' options for delaying or canceling resumption of premiums after a disaster relief SPA sunsets are discussed in Q11 below.

Q10: After April 1, 2023, but before the Secretary-declared COVID-19 PHE ended, could states claiming the FFCRA temporary FMAP increase resume charging Medicaid premiums that had been suspended via a disaster relief SPA that sunsets at the end of this PHE?

A10: Yes, subject to certain requirements and conditions, states claiming the FFCRA temporary FMAP increase that suspended premiums via a disaster relief SPA that sunset at the end of the Secretary-declared COVID-19 PHE could resume charging premiums on or after April 1, 2023, but before the Secretary-declared COVID-19 PHE ended. States that resumed charging Medicaid premiums before the sunset date of a disaster relief SPA must have complied with the general requirements described in Q8, and the beneficiary protections described in Q12. To resume Medicaid premiums that were suspended, the state should have rescinded the premium suspension provision of the relevant disaster relief SPA by submitting a section 7.4.A rescission SPA. Please see additional information from the February 14, 2023 All State Call here: <https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall02142023.pdf>. If the state is claiming the FFCRA temporary FMAP increase on or after April 1, 2023, it must also comply with the amended condition at section 6008(b)(2) of the FFCRA (as described in Q8 and in the last paragraph of this FAQ response).

When submitting a rescission SPA, a state must comply with the following general SPA submission requirements:⁵

⁴ See previous guidance on the resumption of Medicaid premiums after the sunset of disaster relief SPAs in the first paragraph of the response to Q24 of: CMS. (2022). *COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies*. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>.

⁵ As CMS has previously informed states, the Medicaid disaster relief SPA template and related section 1135 waivers and modifications of the above-listed SPA submission requirements are not available for state plan changes

- Public notice requirements at 42 CFR § 447.57(c);
- SPA effective date requirements at 42 CFR § 430.20; and
- Tribal consultation requirements at section 1902(a)(73) of the Act.

A state wishing to rescind the relevant section of a disaster relief SPA prior to the disaster relief SPA's sunset date may contact its CMS state lead for assistance.

As indicated in Q8, States claiming the FFCRA temporary FMAP increase on or after April 1, 2023 must comply with the amended condition in section 6008(b)(2) of the FFCRA; thus, if such states resume premiums, they must ensure that the resumed premium schedule amounts do not exceed the amounts in effect as of January 1, 2020.

Q11: How may states claiming the FFCRA temporary FMAP increase further delay resumption of Medicaid premium charges when a disaster relief SPA sunsets, or eliminate premium charges entirely?

A11: States that wish to delay the resumption of Medicaid premiums after the sunset of disaster relief SPAs at the end of the Secretary-declared COVID-19 PHE on May 11, 2023, have several options. If a state wants to delay resumption of premiums temporarily (such as for a year or less after the end of the Secretary-declared COVID-19 PHE), it can either:

- (1) submit a Section 7.4.B or 7.4.C SPA to temporarily extend a disaster relief SPA provision for a limited period of time following the end of the Secretary-declared COVID-19 PHE;⁶ or
- (2) request authority under section 1902(e)(14)(A) of the Act to delay the resumption of Medicaid premiums during the unwinding period until a full redetermination is completed for beneficiaries who are subject to premiums. States that want to remove premium requirements for more than a year after the end of the Secretary-declared COVID-19 PHE should consult their state lead.

States submitting premium-related SPAs must comply with the general requirements described in Q8 and general submission requirements described in Q10.

that would restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers. See <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-instructions.pdf> and <https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall02142023.pdf>. Therefore, states should follow the regular SPA submission process and requirements when rescinding a suspension of premiums. Additionally, section 1135 waivers and modifications of the above-listed SPA submission requirements are not available with regard to disaster relief SPAs for COVID-19 submitted on or after April 10, 2023. House Joint Resolution 7 (H.J. Res. 7), signed into law on April 10, 2023, ended the COVID-19 Presidential National Emergency declaration effective immediately. Enactment of H.J. Res. 7 also ended CMS's authority to issue new, prospective section 1135 waivers related to the COVID-19 pandemic. Because section 1135 waivers and modifications of the above-listed SPA submission requirements apply to the date that the state submits the SPA, they are not available for disaster relief SPAs related to COVID-19 submitted on or after April 10, 2023. See <https://www.medicaid.gov/state-resource-center/downloads/cib050823.pdf>.

⁶ See discussion on extending disaster relief SPAs at Q26 of: CMS. (2022). *COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies*. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>.

States may refer to SHO #22-001⁷ for details on how to request approval of section 1902(e)(14)(A) waivers. States may also contact their CMS state lead for more information.⁸ States requesting a section 1902(e)(14)(A) waiver aren't required to complete public notice requirements, but CMS encourages states to maintain public transparency. CMS is providing public information on approved section 1902(e)(14)(A) waivers in a chart available to the public here: <https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html>.

Q12: Which beneficiary protections are states required to provide, such as conducting a redetermination of eligibility, prior to resuming Medicaid premium charges that had been suspended during the Secretary-declared COVID-19 PHE or increasing a Medicaid beneficiary's premiums after April 1, 2023?

A12: All states must provide certain beneficiary protections prior to resuming premiums that were suspended during the Secretary-declared COVID-19 PHE or increasing an individual Medicaid beneficiary's premium after April 1, 2023. States must:

- Ensure that a determination of the beneficiary's income has been made within the previous 12 months.⁹ This means that:
 - If the state has completed a renewal for the beneficiary in the last 12 months, the state may resume or increase Medicaid premiums for that beneficiary without completing a redetermination.
 - If the state hasn't completed a renewal for the beneficiary in the last 12 months, the state must complete a redetermination before resuming or increasing Medicaid premiums for that beneficiary.
- Comply with the general requirements described in Q8.

If submitting a SPA, the state must comply with the SPA submission requirements described in Q10. States claiming the FFCRA temporary FMAP increase must also ensure that their premium schedule amounts do not exceed the amounts in effect as of January 1, 2020, as discussed in Q8.

⁷ CMS. (March 3, 2022). *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* [State Health Official Letter #22-001]. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.

⁸ See discussion on requesting a 1902(e)(14)(A) waiver at Q27: CMS. (2022). *COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies*. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>.

⁹ See previous guidance regarding redetermination requirements prior to resumption of Medicaid premiums, including individualized notice requirements and when a state must obtain updated income information before reinstatement, at the first paragraph of Q24 and at Q25 of: CMS. (2022). *COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies*. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>.

Q13: Can a state claiming the FFCRA temporary FMAP increase for a quarter beginning on or after April 1, 2023, make changes to its Medicaid premium schedule before January 1, 2024?

A13: It depends. States claiming the FFCRA temporary FMAP increase may submit a SPA to change the Medicaid premium schedule to reduce premium amounts or exempt additional populations from premium requirements. States submitting such a SPA must generally comply with SPA submission requirements, as described in Q10. Additionally, consistent with previous guidance, states claiming the temporary FFCRA FMAP increase may adopt new premiums before January 1, 2024, for new optional eligibility groups.¹⁰

However, until January 1, 2024, states claiming the temporary FFCRA FMAP increase may not increase the amounts in their Medicaid premium schedules over the amounts in place for each eligibility group subject to premiums as of January 1, 2020. For example, if all beneficiaries in a certain eligibility group with household income at or over 200 percent of the federal poverty level (FPL) were charged premiums of \$10 per month as of January 1, 2020, a state claiming the temporary FFCRA FMAP increase cannot increase the premium amount charged to beneficiaries in that eligibility group with household income at 200 percent of the FPL to any amount greater than \$10 prior to January 1, 2024. If a state wishes to increase premium amounts above the amounts in place for any eligibility group as of January 1, 2020, it must forgo claiming the temporary FFCRA FMAP increase.¹¹

States making changes to premiums must also comply with general requirements described in Q8.

Q14: Beginning April 1, 2023, can a state claiming the FFCRA temporary FMAP increase disenroll Medicaid beneficiaries for failure to pay premiums?

A14: Yes, with some limitations. Now that the FFCRA section 6008(b)(3) continuous enrollment condition has ended, states claiming the FFCRA temporary FMAP increase may resume implementation of a policy to disenroll some beneficiaries who haven't paid Medicaid premiums for at least 60 days, provided that conditions specified at 42 CFR § 447.55(b)(2) are met and the state's disenrollment policy was in place as of January 1, 2020.¹²

¹⁰ See discussion of the permissibility of charging Medicaid premiums for new optional eligibility groups at FAQ#II.B.13 of: CMS. (2021). COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies. Available at: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>. Please note that the last two sentences of FAQ#II.B.13 are no longer applicable on and after April 1, 2023, the effective date of the CAA, 2023 amendments to section 6008(b)(2) and 6008(b)(3) of the FFCRA.

¹¹ Please note that the FPL level and premium amount included in this example are hypothetical only.

¹² Previous guidance indicated that states may terminate enrollment for failure to pay after the last day of the month in which the COVID-19 PHE ends. This document updates that guidance to reflect the amendments to FFCRA section 6008 delinking the end of the continuous enrollment condition from the end of the COVID-19 PHE. See discussion at FAQ#II.B.7 of: CMS. (2021). COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies. Available at: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

However, adoption of a new policy (i.e., after January 1, 2020) to disenroll a beneficiary for failure to pay Medicaid premiums would constitute a more restrictive eligibility standard, methodology, or procedure under section 6008(b)(1) of the FFCRA for any eligibility group that the state covered as of January 1, 2020. Thus, new adoption of such a policy prior to January 1, 2024 for such eligibility groups would be a violation of the FFCRA section 6008(b)(1) condition. Therefore, states claiming the FFCRA temporary FMAP increase cannot implement a policy to disenroll a beneficiary for failure to pay Medicaid premiums if that beneficiary is enrolled in an eligibility group that the state covered as of January 1, 2020, unless that disenrollment policy for that eligibility group was documented in the state plan pursuant to 42 CFR § 447.55(c)(4) as of January 1, 2020. States that are claiming the temporary FFCRA FMAP increase can adopt a new policy to disenroll such beneficiaries for failure to pay Medicaid premiums after December 31, 2023, when the condition under section 6008(b)(1) of the FFCRA will end.

Prior to disenrolling a beneficiary for failure to pay Medicaid premiums, states must:

- Consider whether the beneficiary is eligible on all bases prior to making a determination of ineligibility and disenrolling the beneficiary;
- Ensure all beneficiary protections described in Q12; and
- Comply with all general requirements listed in Q8.

Although the continuous enrollment condition has ended, states cannot disenroll beneficiaries for unpaid premium charges accumulated during the period when the continuous enrollment condition was in effect. Similarly, states may not count any days that occurred during the period the continuous enrollment condition was in effect toward the minimum 60-day period of non-payment required under 42 CFR § 447.55(b)(2) before taking action to disenroll a beneficiary based on non-payment of premiums.¹³ States may disenroll beneficiaries for unpaid premiums incurred prior to the beginning of the continuous enrollment condition on March 18, 2020, as long as no dates between March 18, 2020, and March 31, 2023 are counted toward the minimum 60 days. Additionally, states may not count any days that occurred during any period that Medicaid premiums were suspended via a disaster relief SPA. CMS encourages states not to count days of nonpayment accumulated prior to March 18, 2020, given the lengthy time period that has passed since that date and the difficulty individuals may have documenting payments made that long ago.

¹³ Previous guidance indicated that states may terminate enrollment for failure to pay after the last day of the month in which the COVID-19 PHE ends. Although the underlying policy described in that guidance was primarily based on the continuous enrollment condition at FFCRA section 6008(b)(3), the FAQs referred broadly to the COVID-19 PHE when discussing the period during which that condition applied. This document updates that guidance to reflect the amendments to FFCRA section 6008 delinking the end of the continuous enrollment condition from the end of the COVID-19 PHE. Additionally, although not referenced in that previous guidance, the condition at section 6008(b)(1) is also applicable if states claiming the FFCRA temporary FMAP increase newly adopt a policy to terminate beneficiary enrollment for failure to pay Medicaid premiums, for beneficiaries in an eligibility group that the state covered as of January 1, 2020, as discussed above. See discussion at FAQ#II.B.7-8 and 11 of: *CMS COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*. (2021). Available at: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>. See also further discussion at Q30 of: CMS. (2022). *COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies*. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>.

CHIP Resumption of Premiums

Q15: If a state suspended the collection of premiums for separate CHIP enrollees during the Secretary-declared COVID-19 PHE through a CHIP disaster SPA, may it resume collection of premiums during the unwinding period?

A15: It depends. States that suspended CHIP premiums during the Secretary-declared COVID-19 PHE may resume the collection of premiums only for beneficiaries who have had a full renewal within the last 12 months.¹⁴ The amount of the premium imposed should be based on the state's most recent determination of the beneficiary's household income. Additionally, the state may resume collecting premiums only after providing timely and adequate written notice and information about the beneficiary's rights to the CHIP review process.

If a beneficiary hasn't had a redetermination of household income in the last 12 months, the state must complete a redetermination before reimposing premiums.

If a state wishes to resume premiums, but has not completed a renewal for all beneficiaries in the past 12 months, it will need to have flexibilities authorized through a CHIP disaster relief SPA or disaster relief SPA activation letter in place because the state will be following its state plan policies (i.e., charging premiums) for only a subset of beneficiaries (those that have had a redetermination in the last 12 months). See Q17 for a discussion of the disaster relief flexibilities needed in this situation.

Disaster flexibilities authorized through a CHIP disaster relief SPA or disaster relief SPA activation letter are not needed to resume the collection of premiums in states that have completed renewals for all individuals in the last 12 months.

Q16: If a state continued to collect premiums for separate CHIP enrollees during the Secretary-declared COVID-19 PHE but did not terminate coverage for anyone for failure to pay premiums during this time, may the state begin terminating coverage for failure to pay premiums during the unwinding period?

A16: It depends. A state may only terminate an individual's coverage for failure to pay premiums during the unwinding period if the individual has had a full renewal within the last 12 months. The state must also provide beneficiaries with timely and adequate written notice and information about their rights to the CHIP review process prior to resuming the premium grace period policy and terminating the individual for failure to pay premiums. As a reminder, states are required by section 2103(e)(3) of the Act to provide enrollees with a minimum 30-day grace period to pay any required premiums or enrollment fees before termination of coverage.

If a beneficiary hasn't had a redetermination of household income in the last 12 months, the state must complete a redetermination before terminating for failure to pay premiums.

¹⁴ See discussion of resuming the collection of premiums at Q25 of: *COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies*. CMS. (2022). Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>.

If a state wishes to resume terminations of coverage for failure to pay premiums, but has not completed a renewal for all beneficiaries in the past 12 months, it will need to have flexibilities authorized through a CHIP disaster relief SPA or disaster relief SPA activation letter in place because the state will be following its state plan policies (i.e., terminating for failure to pay premiums) for only a subset of beneficiaries (those that have had a redetermination in the last 12 months). See Q17 for a discussion of the disaster relief flexibilities needed in this situation.

Disaster flexibilities authorized through a CHIP disaster relief SPA or disaster relief SPA activation letter are not needed to resume terminations of coverage for failure to pay premiums in states that have completed renewals for all individuals in the last 12 months.

Q17: What authority do states need to resume their CHIP premium policies (e.g., charging premiums or terminating for failure to pay premiums) if only a subset of CHIP beneficiaries has had a renewal in the past 12 months?

A17: For states with an Evergreen Disaster Relief SPA, the state must submit to CMS a disaster SPA activation letter specifying the date when the state will resume their CHIP state plan premium policy (e.g., charging premiums or terminating for failure to pay premiums) for those beneficiaries who have completed a renewal within the last 12 months. The letter should also specify that the state will resume the CHIP state plan premium policy on a rolling basis as renewals are conducted through the state’s COVID-19 PHE unwinding period and specify the state’s COVID-19 PHE unwinding period end date.

For states with a disaster relief SPA that was specific to the Secretary-declared COVID-19 PHE, the state must submit to CMS either:

1. A SPA specific to the unwinding period, stating the state will resume its CHIP state plan premium policies for those beneficiaries who have completed a renewal within the last 12 months; or
2. An Evergreen Disaster Relief SPA. In the SPA cover letter, the state should describe how it will resume its CHIP state plan premium policies during the unwinding period.

Renewals for Individuals Receiving Supplemental Security Income (SSI) in Section 1634 States

Q18: Are states with an agreement with the Social Security Administration (SSA) under section 1634 of the Act (also known as a “1634 state”) required to conduct regular renewals for individuals eligible for Medicaid based on receipt of SSI?

A18: It depends. While there is no exception for conducting regular renewals for any populations under regulations at 42 CFR § 435.916, states that have an agreement with the SSA under section 1634 of the Act (“1634 agreement”) do not need to take affirmative steps to renew Medicaid for individuals who continue to receive SSI. Such individuals remain eligible for Medicaid based on their continued receipt of SSI as described at 42 CFR § 435.120. States with section 1634 agreements can rely on information provided through the State Data Exchange (or “SDX”) to renew on an *ex-parte* basis individuals who continue to receive SSI. Once SSA has notified a state through the SDX that a given individual is receiving SSI and eligible for Medicaid on that

basis, SSA does not transmit additional information about that individual unless their circumstances have changed. Thus, states with 1634 agreements may rely on the original information provided through the SDX that the individual is receiving SSI and eligible for Medicaid on that basis until they receive new information through the SDX reflecting a change in circumstances.

If new information for an SSI recipient indicating a change in circumstances is received through the SDX, states are required to process the change in accordance with 42 CFR § 435.916(d). States must redetermine eligibility for these individuals on all bases, in accordance with 42 CFR §§ 435.916(f) and 435.930, before terminating coverage. When acting on the change, if the state doesn't have sufficient information to determine eligibility on another basis, the state must collect the information needed to consider eligibility on other bases.

Data Sharing

Q19: Under what circumstances may states share beneficiary information, including renewal dates, with enrolled Medicaid and CHIP providers (such as nursing facilities and Indian health care providers) without violating Medicaid and CHIP confidentiality standards under section 1902(a)(7)(A) of the Act, 42 CFR part 431, subpart F, and 42 CFR § 457.1110(b)?

A19: Under section 1902(a)(7) of the Act and implementing regulations at 42 CFR part 431, subpart F, states must restrict the use or disclosure of information concerning Medicaid applicants and beneficiaries to purposes directly connected with the administration of the state plan. The same requirements also apply to separate CHIPs through a cross reference at 42 CFR § 457.1110(b). The state Medicaid or CHIP agency's disclosure of beneficiary data (e.g., beneficiary renewal dates) to an enrolled Medicaid or CHIP provider to enable the provider to give information about renewals to beneficiary patients and/or to encourage a patient to complete a renewal is a purpose directly related to the administration of the Medicaid or CHIP state plan. Such activities support establishing eligibility—one of the purposes directly related to state plan administration listed at 42 CFR § 431.302(a). Thus, the state Medicaid or CHIP agency may disclose beneficiary data to an enrolled provider so that the provider can assist the beneficiary in completing their renewal, without violating Medicaid and CHIP confidentiality standards under section 1902(a)(7)(A) of the Act, 42 CFR part 431, subpart F, and 42 CFR § 457.1110(b). Thus, any type of enrolled provider might be able to encourage and assist its patients to complete renewals, including nursing facilities, Federally Qualified Health Centers, hospitals, Indian health care providers, and others. Any enrolled provider receiving information concerning beneficiaries must be subject to standards of confidentiality that are comparable to those of the state agency, per 42 CFR § 431.306(b). For states seeking to make such disclosures, each data element disclosed must be consistent with a purpose that is directly connected to the administration of the Medicaid or CHIP state plan.

States are typically required to seek consent from beneficiaries or a beneficiary's personal representative before making a disclosure of beneficiary data to an outside source under 42 CFR § 431.306(d). However, the state Medicaid or CHIP agency would not be required to seek consent prior to sharing a beneficiary's information with an enrolled Medicaid or CHIP provider to enable the provider to encourage a patient to complete a renewal or assist a beneficiary in

completing their renewal if these activities are authorized under a written agreement between the provider and the state. In such circumstances, the enrolled provider is assisting the agency in a purpose directly related to the administration of the Medicaid or CHIP state plan, as expressly authorized by the Medicaid or CHIP agency, and thus would not be considered to be an “outside source.” We note that while advance consent is not required under Medicaid or CHIP regulations at § 431.306(d) or § 457.1110 in these circumstances, state or other laws may require such consent.

States should review current agreements with enrolled providers to evaluate if they authorize the provider to use beneficiary data from the state to support beneficiaries in maintaining Medicaid or CHIP coverage. States should also review current agreements with enrolled providers to evaluate if they include applicable Medicaid and CHIP confidentiality requirements and restrictions on the use of information regarding beneficiaries. States should make modifications to current agreements with enrolled providers, if needed.

In summary, it would be consistent with section 1902(a)(7) of the Act and implementing regulations at 42 CFR part 431, subpart F and 42 CFR § 457.1110(b) for a state Medicaid or CHIP agency to share Medicaid or CHIP beneficiaries’ information with an enrolled Medicaid or CHIP provider so that the provider can help patients maintain coverage, subject to a written agreement (e.g., the provider agreement) with the state agency authorizing such data sharing and activities. States should confer with their counsel to ensure compliance with otherwise applicable law when sharing this information.

States can also partner with managed care plans to conduct outreach to their enrollees. For information on requirements and limitations relating to states’ partnership with managed care plans during unwinding, see: “Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations,” available at <https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf>.

Former Foster Care Child Group 1115 Authority

Q20: Is section 1115 authority needed to enroll individuals in the Medicaid state plan group for former foster care children (“FFCC group”) who meet all eligibility criteria for the group, but who turned 18 prior to January 1, 2023, and may be eligible for another mandatory eligibility group?

A20: Prior to enactment of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (“SUPPORT”) Act, Pub. L. 115-271, enacted on October 24, 2018, eligibility for the FFCC group under section 1902(a)(10)(A)(i)(IX) of the Social Security Act excluded individuals who had been placed in foster care in another state when they reached age 18 and aged out of such foster care as well as individuals who are eligible for another mandatory group described in section 1902(a)(10)(A)(i) of the Act (other than the adult group, described in section 1902(a)(10)(A)(i)(VIII) of the Act). Section 1002(a)(1) of the SUPPORT Act revised section 1902(a)(10)(A)(i)(IX) of the Act to remove these limitations on eligibility for individuals who reach age 18 on or after January 1, 2023. This frequently asked question addresses the eligibility exclusion related to eligibility for other

mandatory eligibility groups, which continues to be in effect for individuals who turned age 18 prior to January 1, 2023.

Although the statutory change that enables states to enroll individuals in the FFCC group even if they are eligible for another mandatory group (other than the adult group) applies only to individuals who reached age 18 on or after January 1, 2023, as a practical matter, states would rarely be required to apply the eligibility exclusion to individuals who reached age 18 prior to January 1, 2023. These individuals formerly in foster care might meet the requirements for another mandatory eligibility group if: (1) they are receiving supplemental security income (SSI), have a disability and are in a 209(b) state (whether or not they are receiving SSI), or are pregnant or a parent or caretaker relative; and (2) they meet the financial eligibility requirements applicable to such individuals. If an individual who turned 18 prior to January 1, 2023 and has aged out of foster care applies for Medicaid and the state has all information it needs to determine eligibility for one of these other mandatory eligibility groups, it would need to do so and enroll the individual in the appropriate group. (If the individual is receiving SSI and is in a 1634 state, the enrollment will have already occurred.)

However, except for SSI beneficiaries in non-209(b) states, states generally are not able to determine that an applicant to the FFCC group is eligible for another mandatory group described in section 1902(a)(10)(A)(i) of the Act based on the information in the application the state received. This inability is because determining eligibility for such mandatory groups would generally require that states collect additional information about the individual's income and household beyond the information needed to determine eligibility in the FFCC group. Gathering this additional information would create an unnecessary administrative burden for both the individual and the state with no value for the individual since the FFCC group provides full benefits. Moreover, with no income or asset test, the annual renewal of eligibility for individuals enrolled in the FFCC group can usually be achieved on an *ex parte* basis until the individual reaches age 26, vastly simplifying retention of coverage as compared to enrollment in another mandatory eligibility group.

As such, CMS has determined that states do not need to seek section 1115 authority to enroll individuals who turned 18 prior to January 1, 2023, in the state plan FFCC group even if the individual has a disability, is pregnant or is a parent or caretaker relative and might be eligible on one of those bases. (SSI beneficiaries in non-209(b) states will already be enrolled in Medicaid by the Social Security Administration through a state's 1634 Agreement, or, in SSI "criteria" states, will clearly have a separate basis for mandatory eligibility.) States do not need to collect more information than necessary to enroll people in the FFCC eligibility group. However, if a state has all information needed to determine that an applicant who is a former foster care child and who turned 18 before January 1, 2023, is eligible for another mandatory eligibility group (other than the adult group), the state should enroll the individual in that other group. If a state has information indicating that a beneficiary enrolled in the FFCC group is potentially eligible for another mandatory eligibility group (other than the adult group), the state must provide the individual with an informed choice and attempt to collect the information needed to determine eligibility for that group.