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CMCS Informational Bulletin

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SUBJECT: Medicaid and Children's Health Insurance Program Requirements for Providing, Prepopulating and Accepting Eligibility Renewal Forms

The Centers for Medicare & Medicaid Services (CMS) is committed to supporting states in their efforts to conduct renewals of eligibility in a manner that promotes coverage retention for eligible individuals in Medicaid and the Children's Health Insurance Program (CHIP) and is compliant with federal requirements. The purpose of this Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) is to remind states about requirements and expectations for providing renewal forms to Medicaid and CHIP beneficiaries when their eligibility cannot be renewed on an *ex parte* basis using available, reliable information. Specifically, this CIB addresses renewal requirements related to 1) elements of a renewal form, including requesting information on a form, prepopulating renewal forms, and instructions accompanying the form; 2) modality and timeline requirements for accepting renewal forms, including electronic notices and renewals, and accepting telephonic renewals and signatures; 3) completing the renewal process; 4) enabling individuals to designate authorized representatives; and 5) enhanced federal matching for eligibility system changes. The federal renewal requirements are codified in regulations at 42 C.F.R. §§ 435.916 and 457.343. This CIB is part of a series of guidance supporting states' efforts to verify eligibility and conduct renewals in compliance with federal requirements.

The guidance in this CIB focuses on requirements for providing and prepopulating renewal forms for people whose eligibility for Medicaid and CHIP is based on modified adjusted gross income (MAGI). Guidance that is specific to Medicaid beneficiaries who are excepted from the use of MAGI (i.e., non-MAGI beneficiaries) when determining eligibility will be provided separately in the future to support states in implementing the requirements of the final rule entitled, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes," 89 Federal Register 22780 (April 2, 2024) (hereinafter "April 2024 Final Rule"). States that either prepopulate renewal forms for non-MAGI beneficiaries currently or plan to implement the requirement to do so codified in the April 2024 Final Rule before the June 3, 2027, compliance date may use the guidance in this CIB as a framework for how to approach

prepopulating renewal forms for their non-MAGI populations.[1] We note that there may be unique issues that need to be considered in the pre-population of renewal forms for beneficiaries eligible on a non-MAGI basis that are not included in this CIB—for example, prepopulating asset information—which will be addressed in future guidance**.** CMS is available to work with states that are implementing prepopulated renewal forms for non-MAGI populations prior to the June 2027 compliance date on issues specific to non-MAGI populations that are not covered in this guidance.

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[1] 42 C.F.R. § 435.916(b)(2)(i)(A) and CMS, Final Rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," (89 FR 22836) April 2, 2024, available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamliningthe-medicaid-childrens-health-insurance-program-and-basic-health.

I. Overview of Renewal Requirements

Federal regulations at 42 C.F.R. § 435.916 outline the requirements and processes for states to periodically renew eligibility for all Medicaid beneficiaries. Through a cross reference at 42 C.F.R. § 457.343, these requirements apply equally to states administering separate CHIPs; however, for brevity, hereafter only 42 C.F.R. § 435.916 will be cited. These regulations are designed to achieve high levels of program integrity and to ensure that individuals who continue to meet all eligibility requirements can remain enrolled in Medicaid and CHIP with minimal burden on both states and beneficiaries.

States must conduct renewals of eligibility for Medicaid and CHIP beneficiaries' whose financial eligibility is based on MAGI once every 12 months and no more frequently than once every 12 months, as required at 42 C.F.R. § 435.916(a)(1). States must renew eligibility at least once every 12 months for those who are excepted from the use of MAGI (non-MAGI) until June 3, 2027, when states must align non-MAGI with MAGI renewal requirements per the April 2024 Final Rule. Regulations at 42 C.F.R. § 435.916(b)(1) require that states begin the renewal process by first attempting to renew eligibility for all Medicaid and CHIP beneficiaries based on reliable information available to the agency without requiring information from the beneficiary. Such renewals are referred to as *ex parte* renewals.[2]

If the agency can renew eligibility based on available reliable information, the agency must provide notice to the beneficiary consistent with 42 C.F.R. § 435.917, Part 431 Subpart E, and § 457.340(e), as applicable.[3] This includes notifying the individual of the approved eligibility determination, the information upon which the agency relied in making the determination and basis for continued eligibility, and the beneficiary's obligation to inform the agency if any of the information contained in the notice is inaccurate or subsequently changes, consistent with 42 C.F.R. § 435.916(b)(1). As outlined in 42 C.F.R. § 435.916(b)(1)(ii), the beneficiary must not be

[2] An *ex parte* renewal is sometimes referred to as an auto renewal or administrative renewal. For additional information about ex parte renewals, states should refer to the November 26, 2024, CIB, "Basic Requirements for Conducting *Ex Parte* Renewals of Medicaid and CHIP Eligibility," available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11262024.pdf.
[3] 42 C.F.R. § 435.916(b)(1).

required to sign and return such notice or otherwise notify the agency if all information in the notice is accurate.

When unable to renew eligibility on an *ex parte* basis, states must provide Medicaid and CHIP beneficiaries with a renewal form requesting the information needed to renew eligibility per 42 C.F.R. § 435.916(b)(2). This includes sending a renewal form in circumstances when the state does not have enough information to complete the renewal, when the available information indicates the beneficiary may no longer be eligible for Medicaid or CHIP, and when the information indicates the beneficiary may be eligible for an eligibility group with a reduced benefit package[4] or subject to increased premiums or cost sharing. For MAGI beneficiaries, 42 C.F.R. § 435.916(b)(2)(i)(A) requires that the renewal form be prepopulated, containing the information available to the agency that is needed to renew eligibility. This includes requesting that beneficiaries update outdated, incomplete, or incorrect information. In addition, as required by 42 C.F.R. § 435.916(b)(2)(i)(B), MAGI beneficiaries must be provided a minimum of 30 days to return the form, and all beneficiaries must be able to submit their renewal form and necessary information through any of the modes required for submitting an application specified in 42 C.F.R. § 435.907(a), including internet website, telephone, mail, in person, and through other commonly available electronic means.[5] By June 3, 2027, states must also prepopulate the renewal form and provide a minimum of 30 days for non-MAGI beneficiaries to return the form as required by 42 C.F.R. § 435.916(b)(2)(i);[6] however, states may implement these requirements in the April 2024 Final Rule for non-MAGI beneficiaries sooner.

Along with the renewal form, the agency must provide beneficiaries with clear instructions on how to complete and return the form, how to correct any inaccurate prepopulated information, what other additional information or documentation is needed for the state to complete their renewal, the timeframe in which the form must be returned, and how to access support available to the beneficiary to help with this process in accordance with 42 C.F.R. §§ 435.905(a) and 457.340(a). Renewal forms and notices must be accessible to persons who are limited English proficient (LEP) and persons with disabilities, consistent with 42 C.F.R. § 435.905(b), and as required by 42 C.F.R. §§ 435.916(e) and 457.110(a). Under 42 C.F.R. § 435.916(b)(2)(v), the renewal form may only request the information needed to renew eligibility. States may not, consistent with 42 C.F.R. § 435.916, require any Medicaid or CHIP beneficiary to submit a full application to complete a renewal or reapply to retain Medicaid or CHIP coverage. When the state redetermines a beneficiary's eligibility, it must provide a notice of approved eligibility or advanced notice of adverse action, including the right to appeal, as applicable, in accordance with 42 C.F.R. §§ 435.917(b), 457.110(b), 457.340(e), and Part 431 Subpart E.

For an overview of the entire renewal process, see the September 2024 slide deck "Overview: Medicaid and CHIP Renewals"[7] and the December 4, 2020, CIB entitled "Medicaid

[4] This includes, but is not limited to, individuals who are no longer eligible for full Medicaid coverage and may be eligible for Transitional Medical Assistance or a Medicare Savings Program eligibility group.
[5] 42 C.F.R. §§ 435.916(b)(2)(i)(B) and 457.343.
[6] Prior to the June 3, 2027, compliance date for the April 2024 Final Rule, non-MAGI beneficiaries must be provided with a reasonable period to return the renewal form.
[7] CMS Slide Deck, "Overview: Medicaid and CHIP Eligibility Renewals," September 2024, available at: https://www.medicaid.gov/resources-for-states/downloads/eligibility-renewals-overview.pdf.

and Children's Health Insurance Program (CHIP) Renewal Requirements,"[8] available on Medicaid.gov. We note that the 2020 CIB pre-dated the April 2024 Final Rule, which revised certain renewal requirements, and states should refer to the regulations at 42 C.F.R. § 435.916 and the April 2024 Final Rule for a complete explanation of current requirements. The April 2024 Final Rule was effective June 3, 2024, and compliance with most provisions will be phased-in over 36 months.

II. Elements of the Renewal Form

To comply with 42 C.F.R. § 435.916(b), any beneficiary whose eligibility cannot be renewed through the *ex parte* process must be given the opportunity to complete a renewal form. States are reminded that they may not terminate coverage, move a Medicaid beneficiary to an eligibility group with a reduced benefit package,[9] increase cost sharing or premiums, or move a beneficiary between Medicaid and a separate CHIP based solely on available data obtained during the *ex parte* renewal process. States must provide a renewal form before taking any such actions, as the renewal form provides beneficiaries the opportunity to correct information obtained by the state. States may not take any adverse action before providing beneficiaries this opportunity, as required per 42 C.F.R §§ 435.952(d) and 457.1130.

The renewal form enables states to collect the information needed to determine whether a beneficiary continues to be eligible. As required under 42 C.F.R. § 435.916(b)(2)(v), the form may only request information needed to renew eligibility. For those beneficiaries who are determined to no longer be eligible for their current eligibility group, the renewal form also enables the state to obtain information needed to identify whether the individual may be eligible on another basis consistent with 42 C.F.R. § 435.916(d).

Renewal regulations implemented in January 2014, require that when a MAGI-based beneficiary in Medicaid or CHIP cannot be renewed on an *ex parte* basis, states must provide a prepopulated renewal form with the information available to the agency that is needed to renew eligibility as required under 42 C.F.R. § 435.916(b)(2). As noted in the April 2024 Final Rule, using a prepopulated renewal form is intended to reduce the risk of errors both when a beneficiary completes the renewal form and when the state enters information into its system, as well as to reduce administrative burden.[10] As stated above, states have until June 3, 2027, to comply with the changes made by the April 2024 Final Rule to prepopulate renewal forms for all beneficiaries. While this CIB does not focus on providing guidance specific to implementing the April 2024 Final Rule, states may use the guidance in this CIB as a framework for how to approach prepopulating renewal forms for their non-MAGI populations. Guidance that is specific to renewal forms for non-MAGI beneficiaries will be provided separately in the future.

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[8] CMS CIB, "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements," December 4, 2020, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

[9] This includes individuals who are no longer eligible for full Medicaid coverage and may be eligible for Transitional Medical Assistance or a Medicare Savings Program eligibility group.

[10] CMS, Final Rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," (89 FR 22794) April 2, 2024, available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamliningthe-medicaid-childrens-health-insurance-program-and-basic-health.

a. Information Requested on the Renewal Form

States must ensure that their renewal forms collect information needed to redetermine eligibility and complete the renewal process. The form must allow the beneficiary to provide missing information and validate or correct prepopulated information needed to renew their eligibility. The form may only request the beneficiary to respond to questions that are needed to complete their renewal per 42 C.F.R. § 435.916(b)(2)(v).

States are reminded that requests for non-applicant information must comply with 42 C.F.R. §§ 435.907(e) and 457.340(b). Therefore, non-applying household members may only be required to provide information needed to complete the redetermination of eligibility of applicable enrolled household members. For example, non-applying household members must not be required to provide either their immigration status or their Social Security Number (SSN). However, states may include a clear explanation about the importance of providing non-applying household members' SSNs on the renewal form to support verification of the household information needed to complete renewals for beneficiaries.

The following are key types of information that states must include on their renewal form. In addition, states may refer to Appendix A of this CIB for a checklist of the elements described below that should be included on a MAGI renewal form. States also may refer to CMS' revised model renewal form that was released in 2015 for detailed examples of the types of information and sample questions that are included on a renewal form.[11]

- Information to contact the individual: Renewal forms must include the most up-to-date contact information that the state has for the individual. This is needed to provide an opportunity for states to confirm household contact information, such as residential and/or mailing addresses, in addition to other modes of outreach used by the state (such as text and email) to obtain updated contact information.

- Information on the household and to verify financial eligibility: For individuals who are eligible for MAGI-based Medicaid or for CHIP, the renewal form must include questions about:
    - Household composition, such as confirming existing or adding new members of a non-filer household or tax household;
    - Expected tax filing status and tax dependents; and
    - Income from jobs and other sources needed to calculate MAGI-based household income.

- Information on other insurance coverage: For certain populations, such as CHIP or children enrolled in the Medicaid eligibility group for optional targeted low-income children described in 42 C.F.R. § 435.229, the renewal form must include any information the state has about other sources of health coverage the beneficiary may have, as to be eligible for CHIP or the group for optional targeted low-income children, a

[11] CMS, Model Renewal Form, November 2015, available at: https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/revised-model-renewal-form.pdf.

child may not have other coverage per 42 C.F.R. §§ 435.4, 435.229(b), 457.310(b)(2) and 457.350(a)(1).

- Information needed to identify potential eligibility on other bases: The regulations at 42 C.F.R. § 435.916(d)(1) require that states consider eligibility on other bases when a Medicaid beneficiary is no longer eligible for the group in which they are enrolled but may be eligible under one or more other eligibility groups covered by the state. The renewal form must facilitate the state's ability to meet this requirement. At a minimum, states' renewal forms must include screening questions for this purpose. Examples of such screening questions include, but are not limited to, information that helps the agency identify pregnancy, incarceration status or foster care history, and questions used to screen for potential eligibility on non-MAGI bases (see Appendix A of this CIB for examples of non-MAGI screening questions). States may not require beneficiaries to answer all screening questions on a renewal form but must complete a redetermination if the beneficiary returns enough information on the form to renew their eligibility.

  To facilitate a determination of eligibility on a non-MAGI basis, states may choose whether they 1) screen for eligibility on their MAGI renewal form and send a separate request for information to collect additional information needed to redetermine non-MAGI eligibility, or 2) collect all needed information to determine non-MAGI eligibility on the renewal form. States will need to consider certain regulatory requirements and operational considerations in choosing which approach to adopt. Note that states may adopt a different approach for different modalities (e.g., paper versus online renewal forms).

  - *Sending a separate request for information:* States may opt to include only screening questions on their MAGI renewal form and send a request for information to any beneficiary who returns their renewal form and is determined no longer eligible on a MAGI basis, but screens as potentially eligible on a non-MAGI basis. When states take this approach, they must request and give the beneficiary a reasonable period of time to provide the additional information needed.[12]

    This approach provides beneficiaries with a streamlined renewal form that minimizes the risk of collecting information that is not necessary to complete a determination of their eligibility based on MAGI. However, because this approach requires that beneficiaries who are screened as potentially eligible on a non-MAGI basis return a second form or respond to a second request for information, states are encouraged to incorporate additional beneficiary communications in their renewal process that remind individuals to respond to any additional requests for information needed to determine non-MAGI eligibility.

  - *Requesting information on the form:* States may request that a beneficiary complete additional sections of the renewal form or any attachments to the renewal form (e.g., sections that collect detailed information about financial

[12] 42 C.F.R. §§ 435.916(b)(2)(v), 435.916(d)(1), and 435.952.

resources) to help facilitate non-MAGI eligibility determinations if the beneficiary is determined ineligible on a MAGI basis. However, states may not request information that is not needed to complete a redetermination of eligibility, and this prohibition may be challenging for states to comply with in all modalities. In an online, telephonic, or in-person environment that makes use of dynamic functionality, states may be able to determine a beneficiary is no longer eligible on a MAGI basis in real time and request additional information needed to determine non-MAGI eligibility only for individuals whom the state has determined are no longer eligible based on MAGI. However, we do not believe that states could effectively implement this option for beneficiaries completing a paper renewal form, as there is no way for a state to determine ineligibility for MAGI-based coverage before the renewal form is returned (which is a prerequisite for requesting information needed to determine non-MAGI eligibility) and beneficiaries themselves cannot be expected to know whether they continue to be eligible based on MAGI.

- Other information to support completion of the renewal: As discussed later in this CIB, renewal forms must collect a signature, required at 42 C.F.R. § 435.916(b)(2)(i)(B), to complete the renewal. In addition, the renewal form should provide an opportunity for beneficiaries to designate an authorized representative, in accordance with 42 C.F.R. §§ 435.923 and 457.380(a). Finally, states need to assess their mandatory and optional eligibility groups to decide if any additional information should be collected on the form to complete eligibility determinations for all relevant groups in the state.

b. Prepopulating Renewal Forms

States must provide Medicaid and CHIP beneficiaries whose eligibility cannot be renewed on an *ex parte* basis with a "pre-populated renewal form containing information, as specified by the Secretary, available to the agency that is needed to renew eligibility."[13] The information states will use to prepopulate the renewal form will come from electronic data sources accessed by the state during the *ex parte* renewal process and other information in the beneficiary case record.

To the extent possible, states must prepopulate the renewal form with the specific, reliable information from the data sources accessed during the *ex parte* process and beneficiary case record information that they will rely on to complete the redetermination. By including the information accessed through electronic data sources during the *ex parte* process, beneficiaries will have the opportunity to verify or correct information obtained by electronic data sources before the state makes a determination of ineligibility, consistent with 42 C.F.R. §§ 435.952(d) and 457.1130. In addition, beneficiaries will have the opportunity to update or validate prepopulated information from the beneficiary case record that is no longer accurate. Prepopulating renewal forms also helps states meet their ongoing obligation to make accurate and timely determinations of eligibility at renewal under 42 C.F.R. § 435.916(c).

To the extent feasible, states must avoid leaving fields on the renewal form blank if the state has reliable information available to it. Examples of information that would not be prepopulated

[13] 42 C.F.R. § 435.916(b)(2)(i)(A).

include open space on the form for beneficiaries to report information about new household members or space for beneficiaries to answer questions to screen for potential eligibility on other bases. We discuss options for states to prepopulate renewal forms and facilitate timely completion of forms by beneficiaries below.

States are reminded that when prepopulating information on a renewal form, they must safeguard information concerning applicants and beneficiaries in accordance with 42 C.F.R. Part 431 Subpart F and § 457.1110(b) and in accordance with data use or data matching agreements in place with the entities providing data. To limit improper disclosure of information, states also must limit prepopulated information to the information that is needed to redetermine eligibility. For example, if a person's SSN has already been verified there is no need to include the full SSN on the prepopulated renewal form.

In addition to the information needed to redetermine eligibility, states must include on the form or the accompanying instructions basic information from beneficiary case records that, while it does not need to be reverified, helps to facilitate the renewal process. For example, a state would include prepopulated information on the form to identify which members of the household need to complete the renewal form (e.g., prepopulating available names and the last four digits of SSNs of members in the household due for renewal).

i. Information States Must Use to Prepopulate Renewal Forms

To the extent possible, states must prepopulate renewal forms with the information they will use to redetermine a beneficiary's eligibility per 42 C.F.R. § 435.916(b)(2)(i)(A). When reliable data for a specific field on a renewal form is available and there are no applicable laws or data use or data matching agreements that preclude disclosure of that information on the renewal form, the state must include the data on the form and in a manner that is consistent with data use or data matching agreements, if applicable.

States also need to include certain information from the case record on a prepopulated renewal form to provide the beneficiary the opportunity to update information or report changes to contact and other information the state will otherwise rely on in the case record to renew eligibility. This includes information the state has determined is not likely to change and does not reverify at renewal (e.g., income or resource information the state has determined is not subject to change and does not reverify at renewal, such as pension income).

We recognize it is not possible to prepopulate all fields on every beneficiary's renewal form with the information gathered during the *ex parte* process, as states need to take steps to safeguard certain information. States must comply with data use agreements and applicable federal and state laws and regulations governing the confidentiality, privacy, and security of personal information when prepopulating renewal forms. There are instances in which states are not authorized to include available information obtained from data verification sources on a prepopulated form. For example, states are restricted in their ability to disclose federal tax information (FTI), and the steps states must take to safeguard FTI may preclude the state from including FTI on a renewal form through some or all modalities.

If states are unable to prepopulate the form with information obtained from data sources for these reasons, the state must prepopulate the form with remaining reliable information accessed from other allowable data sources when possible. If there is no other reliable data source information available, the state may use information from the last determination or redetermination to prepopulate the renewal form, as described further in the next section.

There may be rare instances for certain eligibility groups when a state has no available information or is unable to pull information from the case record to prepopulate a renewal form for a beneficiary. At a minimum, states must prepopulate renewal forms for these beneficiaries with contact information, such as name and mailing address, if the state does not have any available information for other factors of eligibility needed to complete the renewal or the only information available to the state may not be disclosed on a renewal form due to privacy, data use, or other restrictions under federal or state law.

ii. Prepopulating Forms with Information from the Last Determination or Renewal to Avoid Leaving Fields Blank on a Form

In addition to information from the beneficiary case record noted above, if the data source(s) checked by the state return no information and there is no recently verified information[14] in the case record the state may rely on to renew eligibility, the state may prepopulate a renewal form using information from the most recent eligibility determination or redetermination for that beneficiary instead of leaving the field blank. Prepopulating the renewal form with information from the last determination or redetermination, as opposed to leaving portions of the form blank, will facilitate completion and return of the form and help ensure that beneficiaries provide accurate, updated information needed to complete their renewal.

While information from the last determination or redetermination may be used to prepopulate a renewal form, states are reminded that they must follow federal verification requirements and ensure they are using reliable information in determining whether an individual continues to be eligible at renewal.[15] As noted in section II.d of this CIB, states must provide beneficiaries with clear instructions and directions on how to complete the renewal form, that they must correct any inaccurate prepopulated information, and that beneficiaries must sign the renewal form under penalty of perjury. When a beneficiary returns their renewal form, they are providing a new attestation of all of the information contained in the form, and the state must use that information to determine their eligibility consistent with federal regulations and the state's verification plan. If a beneficiary does not return their renewal form, the state may not use information from the

[14] For additional information on reliable information in a beneficiary's case record that may be used at renewal, including recently verified information, states should refer to pages 4-8 of the November 26, 2024, CIB, "Basic Requirements for Conducting *Ex Parte* Renewals of Medicaid and CHIP Eligibility," available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11262024.pdf.
[14] 42 C.F.R. § 435.916(b)(1).
[15] For additional information on verification requirements, states may refer to the 1) November 20, 2024, CIB, "Financial Eligibility Verification Requirements and Flexibilities," available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11202024.pdf, and 2) November 26, 2024, CIB, "Basic Requirements for Conducting *Ex Parte* Renewals of Medicaid and CHIP Eligibility," available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11262024.pdf.

last determination that is no longer reliable to complete the renewal simply because this information was used to prepopulate the renewal form.

iii. Issues When States Obtain Data from Multiple Data Sources

Many states rely on multiple data sources to verify financial factors of eligibility at renewal. States may need to determine how best to present information gathered from various data sources to prevent beneficiary confusion. When a state has information from multiple data sources relating to the same eligibility factor, the state has flexibility to determine which information is most useful to include on the renewal form rather than necessarily including the values returned from each individual data source. Providing states with the option to select the best data points to include on the prepopulated renewal form when the state receives data for the same criteria from multiple sources is intended to ensure that, whenever possible, there are data included on the renewal form to reduce the risk of errors when the beneficiary reviews the form. This flexibility allows states to include information from data sources based on state-specific operational and policy decisions, as well as help ensure forms are prepopulated in a user-friendly manner.

iv. Variation of Prepopulated Information on Renewal Forms

The information that is prepopulated on a renewal form will depend on how much and what information is available to the state about the individual or household members whose eligibility is being renewed and the information needed to renew eligibility for all mandatory and optional eligibility groups covered in the state. States may be able to prepopulate entire sections of forms for some beneficiaries and may have very little information to include on the renewal form for others.

While there are some beneficiaries for whom the state will have limited information available for purposes of prepopulating the renewal form, states may not prepopulate renewal forms with only contact information for all beneficiaries to satisfy the requirement at 42 C.F.R. § 435.916(b)(2) to provide beneficiaries with a prepopulated renewal form. As noted above, when limited information from data sources is available to prepopulate the renewal form, states may use information from the last determination or redetermination for the purposes of prepopulating the renewal form to facilitate the renewal and ease beneficiary burden rather than leaving fields blank.

c. Requests for Documentation Accompanying a Renewal Form

Prepopulated renewal forms must include or be accompanied by a request for any documentation that is required to verify the relevant information provided or updated by the beneficiary on the form consistent with the state's verification plan, per 42 C.F.R. § 435.916(b)(2)(i)(B). This applies to any beneficiary who receives a renewal form, including those individuals for whom data indicate they may be eligible for a group with fewer benefits or increased premiums or cost sharing. Doing so allows beneficiaries to provide all necessary information and documentation to maintain Medicaid or CHIP and helps to ensure beneficiaries have sufficient time to return the renewal form and required documentation and that states can complete the renewal in a timely manner.

Regulations at 42 C.F.R. § 435.916(b)(2)(ii) and (v) require that the state must limit requests only to documentation and information that must be collected from the beneficiary to complete the renewal or in circumstances when a beneficiary updates information and documentation is required to verify the updated information. For example, if a state provides a beneficiary with a renewal form because data sources indicate household income is above the income eligibility standard, the renewal form, or the communication provided with the renewal form, must inform the individual if they need to provide documentation and, if so, the types of acceptable documents (such as pay stubs). For example, if a state provides a beneficiary with a renewal form because data sources indicate household income is above the income eligibility standard, the renewal form or the communication provided with the renewal form must inform the individual that if they disagree with the income amount on the prepopulated form, that they need to provide documentation and the types of acceptable documents (such as pay stubs).

d. Program Information and Instructions Accompanying a Renewal Form

States must provide clear instructions and information on or with the renewal form for beneficiaries to understand who in the household needs to complete the renewal form to maintain eligibility, what is needed to complete the renewal process, how the renewal form and additional information may be returned, when the renewal form and information must be returned, and the resources available to support beneficiaries in the process, consistent with 42 C.F.R. §§ 435.905(a) and 457.340(a). In order to provide beneficiaries sufficient time to return the form through all required modalities consistent with 42 C.F.R. §§ 435.916(b)(2)(i) (i.e., online, by phone, by mail, in person, or other electronic means), beneficiaries must be informed 1) how they can obtain and submit their renewal form through all required modalities, and 2) when they must return their renewal form and submit any required documentation or information to the state to avoid gaps in coverage. See Section III of this CIB for additional information about required modalities. Beneficiaries must be notified of their rights and responsibilities and informed that they must sign their renewal form under penalty of perjury in a manner consistent with 42 C.F.R. § 435.907(f).[16] States must also provide information on how beneficiaries can obtain assistance in completing and submitting their renewal form and any requested documentation, as well as the steps they may take to designate an authorized representative to assist them in completing the renewal. See section V of this CIB for additional information on the requirement to enable individuals to designate an authorized representative through all modalities.

States must also ensure they request only the information needed to renew eligibility per 42 C.F.R. § 435.916(b)(2)(v). As such, states must include clear instructions on the form to direct beneficiaries to provide only information required to redetermine eligibility and limit unnecessary requests for information. For example, on paper renewal forms, states need to include instructions on which sections of the form must be completed to determine eligibility and directions to skip unneeded portions to ensure beneficiaries are only asked for the information needed to renew coverage.

For all forms, there are certain types of information that are unlikely to change but which the state may want to include on the form to enable the beneficiary to update the information in the

[16] 42 C.F.R. § 435.916(b)(2)(i)(B).

event that the information has changed, and it must be clear that beneficiaries do not need to provide documentation of such information unless it has changed. Examples of such information include, but are not limited to, state residency and certain immigration statuses.[17]

e. Renewal Forms for Households with Multiple Members or Multiple Benefit Programs

i. Renewal Forms That Request Information for Multiple Members in a Household

States must complete a redetermination of eligibility based on available information for each beneficiary in the household due for renewal, regardless of the eligibility of others in the household. This includes ensuring that eligibility for each individual within a household whose eligibility is being renewed is assessed based on the eligibility standard and other criteria applicable to that individual. Further, states must ensure they only request information on a renewal form that is needed to determine eligibility for those members in a household whose eligibility cannot be renewed on an *ex parte* basis, consistent with 42 C.F.R. §§ 435.916(a) and (b). Under 42 C.F.R. §§ 435.916(a) and (b)(2)(v), states may not request information on a renewal form needed only to renew eligibility for those beneficiaries who the state was able to determine remain eligible based on available, reliable information during the *ex parte* renewal process because a renewal form must be provided to other members of the household.

CMS recognizes that, in order to renew eligibility for a beneficiary, states may need to include information on a renewal form, or take into account available information, about other members of the household, including household members who have been renewed on an *ex parte* basis. In these instances, states must include information available about other members of the household that is relevant to renew eligibility for the beneficiary receiving a renewal form, but they may only request information that is needed to complete the renewal of household members whose eligibility could not be renewed during the *ex parte* process. Below are examples that illustrate this requirement. For additional scenarios that help clarify this requirement, states may refer to the October 2023 CMS slide deck, "Scenarios: The Intersection of Continuous Eligibility and Individual Level Renewal Processes."[18]

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[17] States may not reverify U.S. citizenship unless the individual reports a change in citizenship or the state agency has received information indicating a potential change in the individual's U.S. citizenship. *See* 42 C.F.R. §§ 435.956(a)(4)(ii) and 457.380(b)(1)(i). States are not prohibited from reverifying immigration status at renewal for those statuses that are subject to change, such as noncitizens with Temporary Protected Status (TPS). States are not required to verify immigration status at renewal if a noncitizen has a permanent status unless a change is reported. See CMS Final Rule, "Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP" (81 FR 86428) November 30, 2016, available at: https://www.federalregister.gov/documents/2016/11/30/2016-27844/medicaid-and-childrens-health-insurance-programs-eligibility-notices-fair-hearing-and-appeal.

[18] CMS Slide Deck, "Scenarios: The Intersection of Continuous Eligibility and Individual Level Renewal Processes," October 2023, available at: https://www.medicaid.gov/resources-for-states/downloads/int-contin-elig-indiv-lvl-renew-process.pdf.

Example #1: In a household with two married adults on the same renewal schedule, Jane is enrolled in the former foster care child (FFCC) group and the spouse, Joe, is enrolled in the adult group. When the state begins the renewal process for both beneficiaries, Jane is renewed on an *ex parte* basis because there is no income test for the FFCC group and Jane continues to meet all other eligibility requirements to renew coverage in this eligibility group. For Joe, the state must reverify his household income, which includes income earned by Joe and Jane. The data source information indicates Joe's household income is above the income standard for the adult group. The state must provide Joe a prepopulated renewal form that includes available information about the household needed to renew his eligibility. While the state may need to include or request information about Jane's income to complete Joe's renewal, the renewal form must not request additional information related only to renewing Jane's coverage in the FFCC group.

If Joe does not return the renewal form, the state must still complete the *ex parte* renewal for Jane and provide her notice that her eligibility is renewed.

Example #2: In a household with one adult and one child, the eligibility period for the adult in the household, Molly, is July 1, 2024, through June 30, 2025, and the eligibility period for the child in the household, Jack, is January 1, 2024, through December 31, 2024. When the state begins the renewal process for Jack, it is unable to renew Jack on an *ex parte* basis because there are no available data sources to verify Jack's household income. The state must provide a prepopulated renewal form that includes available information about the household needed to renew the child's eligibility. While the state needs to request Molly's income to complete Jack's renewal, the form must not request additional information to renew coverage for Molly since she is in the middle of her 12 month-eligibility period. If the renewal form is not returned, the state must maintain Molly's coverage.

If the renewal form for Jack is returned and it includes information indicating a change in circumstances that may impact Molly's eligibility, the state may use the option at 42 C.F.R. § 435.919(e)(2) to start a new 12-month eligibility period for Molly when it renews Jack's coverage if the state has sufficient information with respect to all factors of eligibility for Molly without requiring additional information for her. This regulatory option can result in the alignment of renewal dates across members in a household.

ii. Multi-Benefit Renewal Forms

Some states provide forms that allow a beneficiary to renew Medicaid or CHIP coverage and recertify or renew benefits for other human services programs, such as the Supplemental Nutrition Assistance Program (SNAP). Although states may use a combined form to renew Medicaid and CHIP eligibility along with other human services programs, states that do so are reminded that they must comply with all Medicaid and CHIP renewal requirements at 42 C.F.R. § 435.916. As such, states may not, consistent with 42 C.F.R. § 435.916(b)(2)(v), request

Medicaid and CHIP beneficiaries to provide information on a multi-benefit renewal form that is only needed to renew eligibility for another program. States also may not delay completing a redetermination of eligibility for Medicaid or CHIP because a beneficiary has not completed what is needed to recertify or renew benefits for another program. For example, states may not delay the completion of a renewal, nor deny Medicaid eligibility, if the beneficiary did not complete a question on the form only needed to recertify SNAP eligibility. In addition, states may not shorten the time period that states must provide a beneficiary to return their Medicaid or CHIP renewal form. States can include information and questions only needed for other programs on a multi-benefit renewal form, but they must ensure multi-benefit renewal forms include clear instructions on which questions must be answered and what information must be provided for purposes of renewing Medicaid and CHIP eligibility to prevent impermissible requests for information.

III. Modality and Timeline Requirements for Accepting Renewals

Federal regulations at 42 C.F.R. § 435.916(b)(2)(i)(B) require that Medicaid and CHIP beneficiaries be able to sign their renewal form under penalty of perjury and to submit their renewal form and any supporting documentation requested by the state through any of the modes required for submitting an application.[19] Telephonic and electronic signatures, as well as handwritten signatures submitted electronically, must be accepted, as required at 42 C.F.R. §§ 435.907(f) and 435.916(b)(2)(i)(B). Renewal forms and signatures must be accepted from the beneficiary, an adult in the beneficiary's household[20] or family,[21] an authorized representative, or, if the beneficiary is a minor or incapacitated, someone acting responsibly for the beneficiary.

The modes of submission at application include online through an internet website, by telephone,[22] by mail, in person, and through other commonly available electronic means. To comply with 42 C.F.R. § 435.916(b)(2)(i)(B), states must:

- Establish a webform that allows a beneficiary to complete, sign, and submit their renewal online;
- Create infrastructure, such as use of a call center, that allows a beneficiary to complete, sign, and submit their renewal with a customer service representative over the phone;
- Provide a mailing address where beneficiaries may mail their completed and signed paper renewal form; and
- Provide physical locations where beneficiaries may receive assistance with the renewal process and/or drop off or physically complete, sign, and submit their renewal form.

[19] The required modes of submission are described at 42 C.F.R. § 435.907(a), which is incorporated by reference at 42 C.F.R § 457.330 for CHIP.

[20] For purposes of signing an application or renewal form on behalf of another individual, "household" has the definition provided in 42 C.F.R. § 435.603(f).

[21] For purposes of signing an application or renewal form on behalf of another individual, "family" includes all individuals in the individual's "family size," as defined in section 36B(d)(1) of the Internal Revenue Code of 1986.

[22] We note that where an individual is required to provide documentation (e.g., pay stubs), states are not required by 42 C.F.R. §§ 435.907(a) and 457.330, to accept the required documentation by telephone insofar as such submission is impossible from a practical perspective. Individuals submitting their renewal form telephonically must be able to submit needed documentation through any of the other required modalities.

States must also accept renewals through other commonly available electronic means as new technologies become available. While CMS has not identified any specific commonly available electronic means through which individuals must be able to apply for or renew coverage at this time, states may consider electronic means such as scanning, imaging, secure email processes, and fax. We note that the requirements to safeguard applicant and beneficiary information at 42 C.F.R. Part 431 Subpart F and § 457.1110 apply to all applicant and beneficiary information, regardless of the mode of submission.

In certain circumstances, a beneficiary may need to utilize different modalities to complete the renewal process – for example, a beneficiary who forgets to sign their paper renewal and calls to sign the renewal form telephonically. States must accept the renewal form, signature, and required documents through any of the modes of submission, as described above and required by 42 C.F.R. § 435.916(b)(2)(i)(B), even if the beneficiary may need to utilize different modalities to complete the process.

While operationally challenging and not required, states are encouraged to implement renewal processes that enable seamless transitions across the modalities to enable beneficiaries to complete the process using more than one modality. For example, states may consider using the same system or connect systems for online and telephonic modes of submission to allow information gathered in one mode to be picked up in another. States may also consider entering information from the paper renewal form into an online system so that it can be accessed online by beneficiaries or by call center employees.

When a state provides a prepopulated renewal form to a beneficiary, it must do so regardless of the modality in which the beneficiary accesses their form, consistent with 42 C.F.R. § 435.916(b)(2)(i)(B). This means that, for beneficiaries who prefer to complete a paper renewal form, the paper renewal form must be prepopulated. For those who prefer to complete their renewal online, their online renewal must be prepopulated. For those renewing by phone, the eligibility worker or call center must verbally share the information that is prepopulated and ask the person to confirm or update the information.

Regardless of the modality in which the renewal form is sent or submitted, states must provide beneficiaries a minimum of 30 days to return the form and requested information per 42 C.F.R. § 435.916(b)(2)(i)(B). As noted in the preamble to the April 2024 Final Rule, this 30-day period begins on the date the renewal form is postmarked or the date the renewal form and notice alerting the beneficiary that they need to renew their coverage are posted to the beneficiary's electronic account.[23] States must ensure that the beneficiary is informed they have a minimum of 30 days to return their renewal form and any required information. As described below, states that send a renewal notification but do not mail a paper renewal form to all beneficiaries may need to restart the 30-day period if the beneficiary requests that the state mail a paper renewal form.

[23] CMS, Final Rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," (89 FR 22808) April 2, 2024, available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamliningthe-medicaid-childrens-health-insurance-program-and-basic-health.

States are reminded that if a beneficiary does not return requested documentation within the required timeframe,[24] but does return a signed renewal form and any requested documentation prior to the end of their eligibility period, the state must act on the information and complete the redetermination in accordance with 42 C.F.R. §§ 435.916, 435.952(a), and 457.380. If it is not possible for the agency to make a determination by the end of the eligibility period, the state is expected to redetermine eligibility as expeditiously as possible and consistent with the timeliness standards at 42 C.F.R. §§ 435.912(c)(4) and 457.340(d).[25, 26] Consistent with regulations at 42 C.F.R. § 435.930(b), the agency must continue to furnish Medicaid to beneficiaries who have returned their renewal form and all requested documentation through the last day of their eligibility period unless and until they are determined to be ineligible. If a renewal form or additional information is returned prior to the end of the eligibility period, the state must have a mechanism in place, pursuant to 42 C.F.R. § 435.930(b), to ensure that eligibility and coverage continue until the information received is evaluated and a final redetermination is made.

a. Providing and Submitting Paper Renewal Forms or a Renewal Notification

States must ensure beneficiaries who do not elect to receive electronic notices either receive their prepopulated renewal form in the mail with a renewal notification that they are due for renewal and instructions for completing the renewal or receive a renewal notification in the mail that explains they are due for renewal with instructions on how they can obtain their renewal form and complete the renewal process through all required modalities. See the text box for a description of a renewal notification versus a renewal form.

Renewal notification: A document mailed to the beneficiary to make them aware of their need to renew their eligibility and how they may access, obtain, or request their prepopulated renewal form. It does not include the renewal form itself.

Renewal form: The form used by the state to collect information from the beneficiary needed for the state to make a Medicaid or CHIP eligibility determination, as prescribed under 42 C.F.R. § 435.916(b)(2)(i).

i. States That Mail Paper Renewal Forms with Renewal Notification to Beneficiaries Due for Renewal

States can mail a prepopulated renewal form to all beneficiaries who elect to receive paper notices and other information per 42 C.F.R. § 435.918(a) along with instructions explaining how to complete the form, the timeframe for submitting the form, what documentation or other additional information is required, and how to return the renewal form and required documentation and other information.

[24] 42 C.F.R. §§ 435.916(b)(2)(i)(B) and 457.343.
[25] 42 C.F.R. §§ 435.916(c) and 457.343.
[26] The April 2024 Final Rule modified requirements to the timeliness standards for completing renewals, and states have until 36 months after the final rule's effective date, or until June 3, 2027, to comply with the timeliness requirements.

ii. States That Send a Renewal Notification and Beneficiaries Must Request a Paper Renewal Form

In states that first provide a renewal notification to beneficiaries to let them know that they need to complete the renewal process, the notification must provide clear information about how the beneficiary may obtain and complete their renewal form (i.e., online, by phone, by mail, or in person) and how to request a paper renewal form if they prefer to complete their renewal via mail or come into an office or other location to complete a paper form in person. States that do not automatically send the prepopulated paper renewal form must (1) inform beneficiaries that they may request and submit their form through all modalities, and (2) provide a reasonable time for beneficiaries to request a paper renewal form to fulfill the requirements at 42 C.F.R. § 435.916(b)(2)(i)(B).

Some beneficiaries who have elected to receive notices and communications electronically may prefer to complete their renewal using a paper renewal form. Beneficiaries must be able to return their renewal form through all modalities available at application per 42 C.F.R. §§ 435.916(b)(2)(i)(B), at the individual's request, and states must provide the form through regular mail at the beneficiary's request, consistent with 42 C.F.R. § 435.918. States must provide beneficiaries a reasonable time to request a paper renewal form and inform them that they may request a paper form through all modalities.

If the beneficiary requests a paper renewal form within the reasonable period established by the state, the state must restart the 30-day clock for returning the renewal form based on the date the paper form is sent. This ensures the beneficiary has the 30 days to complete the renewal form required under 42 C.F.R. § 435.916(b)(2)(i)(B). If the beneficiary requests the paper form after the reasonable period established by the state but before the end of their eligibility period, the state must send the beneficiary a paper renewal form but is not required to provide a new 30-day period for them to return the form. States are reminded that they must accept renewal forms through the last day of a beneficiary's eligibility period and complete the redetermination of eligibility for any beneficiary who returns their renewal form and any requested documentation or other additional information prior to the end of their eligibility period.

Below are two examples to illustrate how states might operationalize the requirement to provide beneficiaries with a reasonable time period depending on when a beneficiary requests a paper renewal form.

Example #3: *Renewal Form Requested Within the Reasonable Timeframe Set by the State*: The state starts its renewal process 90 days in advance of an eligibility period's end date and the reasonable time period set by the state for beneficiaries to request a paper renewal form is 14 calendar days.

Tom's eligibility period is January 1, 2025, through December 31, 2025, and he has elected to receive electronic notifications. The state begins the renewal process for Tom on October 1, 2025. The state is unable to complete an *ex parte* renewal, and emails Tom on October 15, 2025, to let him know an electronic notice was posted to his account. The electronic renewal notification informs him that he must review his prepopulated renewal form, make any

needed corrections, provide any updated information, and upload any required documentation that the state needs to determine if he remains eligible for Medicaid. The electronic notice includes clear instructions that Tom may request a paper prepopulated renewal form, even though he has opted to receive electronic notifications. The notification informs Tom that he must submit his renewal form by November 14, 2025, but if he prefers to complete a paper renewal form, he has until October 29, 2025, to request a paper renewal form, which will ensure he has at least 30 days from when the paper renewal form is sent to him to complete and return the paper renewal.

Tom notifies the agency on October 20, 2025, that he would like to receive his prepopulated paper renewal form via regular mail. When the state sends the paper renewal form on October 22, 2025, the renewal form and accompanying instructions must notify Tom he has until November 21, 2025, to return the form. The state receives Tom's renewal form and supporting documentation on November 17, 2025, and completes processing his renewal.

We note that the state must accept the renewal form if it is returned any time until the end of Tom's eligibility period (through December 31, 2025) and determine eligibility.

Example #4: *Renewal Form Requested Outside the Reasonable Timeframe Set by the State*: The state starts its renewal process 90 days in advance of an eligibility period's end date and the reasonable time period set by the state for beneficiaries to request a paper renewal form is 14 calendar days.

Jane's eligibility period is January 1, 2025, through December 31, 2025, and she has elected to receive electronic notifications. The state begins the renewal process for Jane on October 1, 2025. The state is unable to complete an *ex parte* renewal, and emails Jane on October 15, 2025, to let her know that an electronic notice has been posted to her account. The electronic renewal notification informs her that she must review her prepopulated renewal form, make any needed corrections, provide any updated information, and upload any documentation that the state needs to determine if she remains eligible for Medicaid. The electronic notice includes clear instructions that Jane may request that her prepopulated renewal form be sent via mail, even though she has opted to receive electronic notifications. The notification informs Jane that she must return her renewal form by November 14, 2025, but if she prefers to complete a paper renewal form, she has until October 29, 2025, to request a paper renewal form, which will ensure she can have at least 30 days to complete and return the form and enable the state to process her renewal in a timely manner.

Jane asks to receive her prepopulated paper renewal form via regular mail on November 20, 2024. Because Jane has requested the paper renewal form after the reasonable time period of 14 days, the state does not provide her a new 30 days to complete the form. Even though the 30-day clock to return the form does not restart because Jane did not make a timely request, the state must accept the renewal form if it is returned any time until the end of Jane's eligibility period, December 31, 2025.

b. Electronic Notices and Renewal Forms

States must provide beneficiaries the option to receive notices and information, including renewal notifications and forms,[27] in an electronic format or by regular mail to comply with 42 C.F.R. §§ 435.918(a) and 457.110(a)(1). If a beneficiary has elected to receive eligibility notices and renewal forms electronically instead of through regular mail, the agency must make the online renewal module available to the beneficiary on their secure electronic account and send an email or other electronic communication alerting the beneficiary that the renewal form has been posted to their account, consistent with 42 C.F.R. §§ 435.918(b)(4) and 457.110(a)(1). The email or other electronic communication may not include confidential information. States should ensure any electronic communication complies with applicable federal and state laws and regulations governing the confidentiality, privacy, and security of personal information as well as laws and regulations governing autodialed and prerecorded or artificial voice calls or autodialed text messages. The use of electronic notices for beneficiaries who elect this option reduces administrative burden for the Medicaid/CHIP agency and beneficiaries, reduces administrative costs associated with regular mail, and creates a more timely and effective notification process.

i. Changing Preferred Modality

As noted above, states must provide beneficiaries with a choice to receive notices and other communications, including renewal notices and communications, in an electronic format or by regular mail. In addition, 42 C.F.R. § 435.918(a) requires that beneficiaries be permitted to change their election. Consistent with 42 C.F.R. § 435.918(b)(4), if a beneficiary has elected to receive notices and communications electronically instead of through regular mail, the agency must send communication when it is time for the beneficiary to go into their portal account and complete their renewal. When a beneficiary elects to receive communications from the agency electronically, the agency must comply with all the requirements listed in 42 C.F.R. § 435.918(b).

When beneficiaries elect to receive notifications electronically, including renewal forms, states must follow the same principles for prepopulating the renewal form that apply to prepopulating paper forms. Online renewal functionality must utilize dynamic functionality, meaning that requests for information must be targeted based on the responses provided by the beneficiary. By employing this functionality, states ensure the online renewal process does not request information not needed to renew the individual's eligibility, in accordance with 42 C.F.R. § 435.916(b)(2)(v).

c. Telephonic Renewals and Signatures

States must be able to accept telephonic applications and renewals, including signatures, as required at 42 C.F.R. §§ 435.907(a)(2), 435.916(b)(2)(i)(B), and 457.330. To comply with the

[27]CMS Final Rule, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment," (78 FR 42171) July 15, 2013, available at: https://www.federalregister.gov/documents/2013/07/15/2013-16271/medicaid-and-childrens-health-insurance-programs-essential-health-benefits-in-alternative-benefit.

requirement to accept telephonic renewals, states must have a process that enables a beneficiary to verbally review all the information on the renewal form with an eligibility worker or other customer service representative; to update any incorrect information; provide missing information; and telephonically sign the renewal form under penalty of perjury, as required by 42 C.F.R. §§ 435.907(f), 435.916(b)(2)(i)(B), and 457.330. States may not require a beneficiary seeking to complete the renewal telephonically to instead mail or upload a signed signature page into an online portal. Additionally, as it is not practical to submit required documentation by phone, states must enable beneficiaries who need to submit documentation to do so through any of the other required modalities.

We recognize some states have faced challenges complying with these requirements. To enable telephonic renewals during unwinding through June 30, 2025, CMS exercised authority under section 1902(e)(14)(A) of the Social Security Act to waive the requirement to record and store telephonic signatures for beneficiaries seeking to complete their renewal over the phone. As explained in the November 14, 2024, CIB entitled "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes,"[28] the blanket availability of this waiver authority expires June 30, 2025, and states will need to develop capacity to ensure beneficiaries are able to complete their renewals by phone, including collecting the signature over the phone.

Below we outline additional requirements and considerations for states to be able to maintain and establish compliant processes to accept telephonic renewals and signatures.

i. Conveying Rights and Responsibilities

When accepting renewals and signatures by phone, states must have a process to communicate the beneficiary's rights and responsibilities associated with the renewal, consistent with 42 C.F.R. § 435.905(a)(3). For example, a state may play a recording or conduct a live script reading over the phone for the beneficiary. An additional telephonic signature must not be required for the beneficiary to attest to their understanding of the rights and responsibilities.

ii. Incomplete Telephonic Renewals

If a beneficiary hangs up prior to completing a telephonic renewal (including before providing a telephonic signature), states must permit the beneficiary to call back to complete and submit the renewal form. States may not terminate coverage for procedural reasons unless the beneficiary does not return their renewal form and any requested documents prior to the end of their eligibility period. States are encouraged to establish a process to call back beneficiaries when a telephonic renewal is stopped prior to completion and assist them in completing the renewal. States are also encouraged to reach out to beneficiaries in this situation to remind them to complete and sign the renewal and to submit any needed documentation. States may do this by sending automated calls, texts, emails, or written reminders to remind the beneficiary to complete and sign their renewal through any of the modes of submission available at 42 C.F.R.

[28] CMS CIB, "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid and Enrollment Processes," November 14, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cibe1411142024.pdf.

§§ 435.907(a) and 457.330 (i.e., internet website, telephone, mail, in person, or other commonly available electronic means).

iii. Storage of Telephonic Renewals

Consistent with 42 C.F.R. § 431.17, states must maintain, or supervise the maintenance of, the information provided by beneficiaries to complete their telephonic renewal form, including the telephonic signature, just as they must maintain information and signatures provided on paper or electronically for beneficiaries using those modalities. We remind states that failure to provide a telephonic signature will result in an eligibility error under the Payment Error Rate Measurement (PERM) Program.

States can maintain telephonic signatures in several ways. For example, states can record the entire renewal process, including the individual's attestation that the information they have provided is accurate and that they understand their rights and responsibilities, and store the recording as an audio file or written transcript of the interaction. States may also record only the telephonic signature as an audio file.

The length of storage of these records must comply with existing regulations on maintenance of records at 42 C.F.R. § 431.17. We acknowledge that as part of the April 2024 Final Rule, the requirements related to records retention were updated with an effective date of June 3, 2024. States have until June 3, 2026, to come into compliance with these updated requirements.

iv. Confirmation Receipt

States are strongly encouraged to provide beneficiaries with a confirmation receipt documenting their telephonic renewal on the date the renewal is signed and submitted and any time the beneficiary ends the call without completing their renewal. CMS recommends that confirmation receipts include a summary of the completed renewal form, a copy of the attestations and beneficiary rights and responsibilities, the date the renewal form was signed and submitted, and any other key information identified by the state. For beneficiaries who end the call without completing the telephonic renewal, CMS recommends that a confirmation receipt include the date of the call and the reason the renewal was not completed. States may deliver confirmation receipts electronically or by mail based on the beneficiary's preference.

v. Partnering with Managed Care Plans for Collecting Telephonic Signatures

As discussed in the Appendix of the November 14, 2024, CIB entitled "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes,"[29] states have the option to continue or newly implement the Managed Care Organization Renewal Support Strategy, which permits managed care plans[30] to provide assistance to beneficiaries to complete and submit the Medicaid renewal form. Under this

[29] CMS CIB, "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid and Enrollment Processes," November 14, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cibe1411142024.pdf.

[30] In this document, "managed care plan" means managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, primary care case managers, and primary care case management entities, as defined in 42 C.F.R. § 438.2.

strategy, managed care plans are not permitted to provide choice counseling as defined at 42 C.F.R. § 438.2, complete any renewal form fields related to plan choice, or sign the renewal form on behalf of the beneficiary. States that would like to continue using or newly implement this strategy do not need CMS approval but would need to document their choice to do so in their state policy manual and make the manual available to CMS upon request.

States also can partner with managed care plans to assist in the administrative activity of collecting enrollee signatures on renewal forms and then forward the signature to the state, provided that the telephonic signature is provided by the beneficiary, an adult in the beneficiary's household[31] or family,[32] an authorized representative, or, if the beneficiary is a minor or incapacitated, someone acting responsibly for the beneficiary consistent with 42 C.F.R. § 435.907(a).

CMS has identified three ways that managed care plans may assist in completing telephonic renewals:

- The managed care plan can assist the beneficiary to complete the renewal form, accept and record the telephonic signature, and forward all the information to the state to make the eligibility determination.
- The managed care plan can assist the beneficiary to complete the renewal form, accept and record the telephonic signature, and submit an attestation that the signature was collected to the state. In such cases, the managed care plan must be able to provide the recording of the signature upon request.
- The managed care plan can coordinate a three-way call with the beneficiary (or appropriate representative described at 42 C.F.R. § 435.907(a)) and an eligibility worker at the Medicaid agency or the agency's call center. The beneficiary can provide a telephonic signature directly to the state.

IV. Completing the Renewal Process

As discussed above in section II of this CIB, states must provide a renewal form to individuals who cannot be renewed on an *ex parte* basis, including when the reliable information obtained during the *ex parte* process indicates a Medicaid beneficiary may be eligible for a group with a reduced benefit package,[33] increased cost sharing or premiums or that a beneficiary should move between Medicaid and a separate CHIP. The renewal form provides these beneficiaries the opportunity to correct the data obtained by the state such that no adverse action is taken without first requesting information from the individual, as required per 42 C.F.R. §§ 435.952(d) and 457.1130.

- <u>When a renewal form is returned:</u> States must consider information returned on a renewal form, verify any information provided by the beneficiary in accordance with 42 C.F.R.

[31] For purposes of signing an application or renewal form on behalf of another individual, "household" has the definition provided in 42 C.F.R. § 435.603(f).
[32] For purposes of signing an application or renewal form on behalf of another individual, "family" has the definition provided in section 36B(d)(1) of the Internal Revenue Code of 1986.
[33] This includes individuals who are no longer eligible for full Medicaid coverage and may be eligible for Transitional Medical Assistance or in a Medicare Savings Program eligibility group.

§§ 435.945 through 435.956 and the state's verification plan,[34] and provide notice of the agency's decision consistent with 42 C.F.R. §§ 435.917, 457.340(e) and Part 431 Subpart E, as applicable.[35] Prior to making a determination of ineligibility, states must consider all bases of eligibility, consistent with 42 C.F.R. §§ 435.911(c), 435.916(d)(1) and 435.930(b). As such, if the individual returns the renewal form timely, but the information indicates that they are no longer eligible for their current group, the state must consider whether they may be eligible on another basis prior to determining the beneficiary is ineligible. If the information provided shows the individual is now eligible for a new eligibility group, the state must move the individual to the appropriate group, renew coverage, and send the appropriate notice to notify the individual of the eligibility decision. If the information provided on the form indicates that the individual is no longer eligible for their current eligibility group and may be eligible on another basis, but additional information is needed for the state to make a final determination, the state must request any additional information and documentation needed and provide the individual with a reasonable period of time to respond.

Thus, if a Medicaid beneficiary appears to be eligible for another eligibility group with a reduced benefit package or increased cost-sharing and returns their renewal form, the state must take into account the information returned on and with the renewal form in making a final eligibility determination consistent with 42 C.F.R. § 435.916(b)(2)(ii). If based on the information obtained through the renewal process, the state determines that the beneficiary remains eligible in their current Medicaid eligibility group, coverage should be renewed in that group. If based on the information obtained through the renewal process, the state determines that that the individual is now eligible for a new eligibility group with a reduced benefit package, before moving the individual to the new eligibility group the state must send advance notice informing the beneficiary of the change in eligibility, including the covered benefits, premiums and cost sharing associated with the new group, the reasons for the change, and the opportunity to request a fair hearing to appeal the change in eligibility status or level of benefits or cost-sharing consistent with 42 C.F.R. § 435.917 and Part 431 Subpart E.

- When a renewal form is not returned: States must use available information from data sources and information provided by the beneficiary to complete a renewal of eligibility consistent with 42 C.F.R. § 435.916. As such, if a Medicaid beneficiary does not return their renewal form but data from the *ex parte* review indicates the individual is eligible for another eligibility group with a reduced benefit package or increased cost-sharing, the state must send advance notice informing the beneficiary of the change in eligibility including the covered benefits and/or cost sharing, the reasons for the change, and the opportunity to request a fair hearing to appeal the change in eligibility status or level of benefits or cost-sharing consistent with 42 C.F.R. § 435.917 and Part 431 Subpart E, before moving the individual to the new eligibility group. States may not terminate Medicaid coverage in these circumstances because the state has reliable information to determine that the individual continues to be eligible on another basis. States may only terminate coverage when an individual is determined ineligible for Medicaid on all bases

[34] 42 C.F.R. § 435.916(b)(2)(ii).
[35] 42 C.F.R. § 435.916(b)(2)(i)(C).

per 42 C.F.R. §§ 435.916(d) and 435.930(b). If the beneficiary does not return their renewal form and the state does not have data or sufficient information to determine the individual is eligible for any Medicaid eligibility group, the state must provide notice and fair hearing rights consistent with 42 C.F.R. § 435.917(b) and Part 431 Subpart E and terminate coverage for procedural reasons.

For additional information on transitions between Medicaid eligibility groups, states may refer to the December 2023 slide deck "Transitioning Individuals Within Medicaid Eligibility Groups and Between Medicaid and CHIP at Renewal."[36] CMS is issuing separate guidance that provides additional information about changes made by the April 2024 Final Rule to the requirements for states to effectuate seamless transitions of coverage between Medicaid and separate CHIP programs.

V. Authorized Representatives

In accordance with 42 C.F.R. §§ 435.923 and 457.380(a), the agency must permit applicants and beneficiaries to designate an individual or organization to act on their behalf in assisting with the renewal of eligibility and other ongoing communications with the agency. This individual or organization is called an "authorized representative." Designations of authorized representatives must be signed by the applicant or beneficiary and be accepted through all the modalities required for submitting an application, including internet website, telephone, mail, in person, and through other commonly available electronic means, as required by 42 C.F.R. §§ 435.923(a)(1), 435.923(f), 435.907(a), and 457.330.

Consistent with these federal requirements, states must accept authorized representative designations, including the applicant's or beneficiary's signature, by phone. As such, states must have a process in place for an individual to be guided through the authorized representative designation form with an eligibility worker or other customer service representative and to sign the designation over the phone. States may do this by verbally reading the authorized representative designation form or a script to the individual. States may not require the individual to provide an electronic signature through an online portal or to submit a signed signature page through the mail.

VI. Eligibility Systems Changes

State Medicaid agency IT System costs may be eligible for enhanced Federal Financial Participation (FFP). Approval for enhanced match requires the submission of an Advanced Planning Document (APD). A state may submit an APD requesting approval for a 90/10 enhanced match for the design, development, and implementation of their Medicaid Enterprise Systems (MES) initiatives that contribute to the economic and efficient operation of the program and ensure compliance with the requirements reiterated in this CIB, including the maintenance and operations of these services.

[36] CMS Slide Deck, "Transitioning Individuals Within Medicaid Eligibility Groups and Between Medicaid and CHIP at Renewal," December 2023, available at https://www.medicaid.gov/resources-for-states/downloads/transitions-in-medicaid-and-chip.pdf.

Interested states should refer to 45 C.F.R. Part 95 Subpart F – Automatic Data Processing Equipment and Services–Conditions for FFP for the specifics related to APD submission. States may also request a 75/25 enhanced match for ongoing operations of CMS approved systems. Interested states should refer to 42 C.F.R. Part 433 Subpart C – Mechanized Claims Processing and Information Retrieval Systems for the specifics related to systems approval.

VII. Closing

CMS is committed to supporting state efforts to help eligible beneficiaries renew and maintain coverage, as states continue to make necessary changes to ensure compliance with federal renewal requirements. CMS is available to provide ongoing technical assistance and support to our state partners to improve state systems and address any issues that are identified. For additional information about this CIB, please contact Suzette Seng, Director, Division of Enrollment Policy & Operations, at Suzette.Seng@cms.hhs.gov. States may also submit questions and request technical assistance by contacting their Medicaid state lead or CHIP project officer.

Appendix. Renewal Form Checklist

Checklist* of Elements on Renewal Form to Redetermine MAGI Eligibility
☐ Household contact information
☐ Expected tax filing status and tax dependents
☐ Household composition (confirming existing or adding new members of the household)
☐ Income from jobs
☐ Income from other sources
☐ Other health insurance coverage
☐ Screening questions to consider eligibility on other bases (examples include): • pregnancy status • foster care history • incarceration status • non-MAGI screen questions, such as: o Does [beneficiary] live in a long-term care facility, group home or nursing home, or regularly get medical care, person care, or health services at home or in another community setting (like adult day care)? o Does [beneficiary] have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), a special health care need, or live in a medical facility or nursing home?
☐ Signature under penalty of perjury and rights and responsibilities
☐ Authorized representative designation
☐ Information needed for household members added to the form who are newly applying for coverage
☐ State option depending on modality of form: Sections to collect information to consider eligibility on a non-MAGI basis for individuals no longer eligible on a MAGI basis.

**This checklist should not be considered an exhaustive list of all element's states may need to include on a prepopulated renewal form. States should consider whether other information is needed to redetermine eligibility based on state eligibility decisions.*