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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

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SUBJECT: Basic Requirements for Conducting *Ex Parte* Renewals of Medicaid and CHIP Eligibility

The Centers for Medicare & Medicaid Services (CMS) is committed to protecting access to health care for the individuals enrolled in Medicaid and the Children's Health Insurance Program (CHIP) in a manner that ensures eligible individuals continue to be enrolled and protects the integrity of these programs. This Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) is part of a series of guidance supporting states' efforts to verify eligibility and conduct renewals in compliance with federal requirements.

The purpose of this CIB is to remind states about current requirements and expectations for renewing eligibility for Medicaid and CHIP beneficiaries based on reliable information available to the state without contacting the beneficiary, also referred to as an *ex parte* renewal.[1] Although this CIB addresses verification of all criteria for eligibility during an *ex parte* renewal, it focuses largely on requirements and state options for verifying financial eligibility.

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[1] An *ex parte* renewal is sometimes referred to as auto renewal or administrative renewal.

I. Overview

The requirements and processes for states to periodically renew eligibility for Medicaid beneficiaries are described at 42 C.F.R. § 435.916. 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. The renewal regulations are designed to ensure that individuals who continue to meet all eligibility requirements remain enrolled in Medicaid and CHIP with minimal burden to both states and beneficiaries while maintaining the integrity of the programs. When conducting renewals, states must first attempt to complete an *ex parte* renewal (42 C.F.R. § 435.916(b)(1)). This is a redetermination of eligibility completed with reliable information available to the agency without contacting the beneficiary. It is important to note that states must attempt an *ex parte* renewal for all beneficiaries. States may not exclude a specific population or group of individuals from the *ex parte* renewal process (42 C.F.R. § 435.916(b)(1)).

In conducting an *ex parte* renewal, states must use reliable information in a beneficiary's account and other, more current information available from electronic data sources determined useful by the state to renew eligibility, if able to do so (42 C.F.R. § 435.916(b)(1)). States may not require beneficiaries to provide new attestations, submit additional information, or fill out a renewal form in attempting to conduct an *ex parte* renewal (42 C.F.R. §§ 435.916(b)(1), 435.952(c), and 457.380(f)).

If the state can determine eligibility through the *ex parte* renewal process, the state must send a notice of approved eligibility, consistent with 42 C.F.R. §§ 435.916(b)(1), 435.917(b)(1), 457.340(e)(1), and 457.343, explaining that coverage has been renewed, identifying the information that the state relied on in renewing the coverage, and instructing the beneficiary to

notify the state if any of the information it relied upon is inaccurate (42 C.F.R. §§ 435.916(b)(1)(i) and (ii)). Through the *ex parte* process, states may only renew eligibility; a state may not terminate eligibility, reduce benefits, or increase premiums or cost sharing on the basis of information obtained through the *ex parte* renewal process without first contacting the beneficiary and offering them an opportunity to provide new information (42 C.F.R. §§ 435.952(d) and 457.380(f)).

If eligibility cannot be renewed on an *ex parte* basis, the state must send the beneficiary a renewal form and provide a reasonable period of time to return needed information. The renewal form must be prepopulated for beneficiaries whose financial eligibility is based on modified adjusted gross income (MAGI), and the state must provide at least 30 days for such individuals to return needed information (42 C.F.R. § 435.916(b)(2)).[2]

By maximizing the use of reliable data, the *ex parte* renewal process permits states to achieve high levels of program integrity while reducing administrative burden, including the need for eligibility workers to process and review redundant paper-based documentation. Equally important, *ex parte* renewals minimize the churn of eligible beneficiaries on and off Medicaid and CHIP coverage by avoiding unnecessary procedural terminations for otherwise eligible individuals. Such churn can lead to delayed care, reduced use of preventive services, disruptions in prescription refills, greater use of the emergency department, and additional administrative costs and burden for states.[3]

For an overview of the entire renewal process, including actions required when a state is unable to renew eligibility on an *ex parte* basis, see the September 2024 slide deck "Overview: Medicaid and CHIP Renewals"[4] and the December 2020 CIB entitled "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements."[5]

II. Steps in the *Ex Parte* Renewal Process

Every Medicaid and CHIP renewal must begin with the *ex parte* process. In summary, the *ex parte* renewal process is comprised of four basic steps:

1. Identify the cohort of beneficiaries who are due for renewal;

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[2] For beneficiaries excepted from use of the MAGI-based methodologies (or non-MAGI beneficiaries), states must begin providing a prepopulated renewal form and a minimum 30-day response period no later than June 3, 2027 (89 FR 22836). Until that date, states must provide non-MAGI beneficiaries with a reasonable period to return their renewal form.

[3] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Sugar S, Peters C, DeLew N, Sommers BD, "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic," (Issue Brief No. HP-2021-10), April 12, 2021, available at: https://aspe.hhs.gov/sites/default/files/documents/5f6e4d78d867b6691df12d1512787470/medicaid-churning-ib.pdf.

[4] CMS, "Overview: Medicaid and CHIP Eligibility Renewals," September 2024, available at: https://www.medicaid.gov/resources-for-states/downloads/eligibility-renewals-overview.pdf.

[5] 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.

2. Gather available information for each individual beneficiary in the cohort without requiring additional information from the beneficiary;

3. Run logic in the eligibility system, including both automated and any manual steps, to determine whether each beneficiary continues to meet eligibility requirements; and,

4. Communicate the outcome for each beneficiary:

    a. When eligibility can be renewed, send notice of approved eligibility, or

    b. When additional information is needed to renew eligibility, send renewal form.

III. Step 1 - Identify Cohort of Beneficiaries Due for Renewal

Each month, states identify the individuals enrolled in Medicaid and CHIP for whom a renewal must be initiated to ensure timely completion of the renewal process by the end of each beneficiary's eligibility period (42 C.F.R. § 435.916(a) and (c)). States must initiate renewals, and, therefore, begin the *ex parte* process, well in advance of the end of an individual beneficiary's eligibility period. Many states initiate renewals 60 to 90 days before the end of a beneficiary's eligibility period to ensure timely completion of the renewal process for beneficiaries whose eligibility cannot be renewed *ex parte*. The process must begin early enough to provide beneficiaries with sufficient time to return a renewal form, when needed, and ensure the state can process renewal forms that are returned in a timely manner by the end of the eligibility period.

States must attempt an *ex parte* renewal for <u>all</u> beneficiaries, including every individual member of a household with multiple beneficiaries. A specific population or group of individuals may not be excluded from the *ex parte* renewal process for any reason. States may not, for example, exclude a specific population from the *ex parte* renewal process because one or more factors of eligibility cannot be verified electronically.

Key Point: States may not exclude specific populations in a renewal cohort from the *ex parte* process.

IV. Step 2 - Gather Reliable Information Available to the State

Once the cohort of beneficiaries has been identified for renewal, the state must collect the information needed to redetermine eligibility for factors that are subject to change. To verify continued eligibility, the state must gather reliable information about each individual from two general sources: (1) the beneficiary's account, and (2) data sources, which may include other public benefit programs, identified by the state as useful at renewal (42 C.F.R. § 435.916(b)(1)).

a. Reliable Information in a Beneficiary's Account

Beneficiary accounts provide an important source of information for *ex parte* renewals. When appropriate, states must rely on previously-verified, reliable information in a beneficiary's account to conduct an *ex parte* renewal (42 C.F.R. § 435.916(b)(1)). Information in a

beneficiary's account may be considered reliable for use in an *ex parte* renewal if: (1) the information is constant and not subject to change, (2) the information is highly unlikely to change, or (3) the information is subject to change but was recently verified.

1. *Information Not Subject to Change.* Certain information in a beneficiary's account may be considered reliable because it is constant or not subject to change. This includes the beneficiary's citizenship status, date of birth, and Social Security Number (SSN). Generally, such information must not be reverified. Indeed, states are prohibited from reverifying U.S. citizenship, even after a break in coverage, unless the state has received information indicating a potential change in the individual's citizenship (42 C.F.R. § 435.956(a)(4)(ii)). While a state could verify an individual's date of birth and SSN electronically with the Social Security Administration (SSA) at renewal, CMS believes doing so when the information was previously verified would not be a proper or efficient method of administering the state plan (as required by 42 C.F.R. § 431.15).

2. *Information Highly Unlikely to Change.* Some information in a beneficiary's account is highly unlikely to change, for example, certain immigration statuses and the amount or value of certain types of income and assets. States have flexibility in determining what previously-verified information in a beneficiary's account is highly unlikely to change, as discussed in further detail below. Such information may be considered reliable for purposes of an *ex parte* renewal.

3. *Recently Verified Information.* Some information in a beneficiary's account, like income from wages, is more likely to change. CMS also finds it reasonable for states to utilize information from the beneficiary's account that is subject to change but has been recently verified. This would include, for example, income information related to a change in circumstances that the state has recently verified. States have flexibility to make reasonable determinations about when to consider a previous verification to be recent for purposes of conducting an *ex parte* renewal. CMS believes that verification conducted within the previous six months may reasonably be considered recent, but states may make their own determination of what constitutes recency.

Some types of income and assets are known to be highly unlikely to change (or even likely to decrease in value), hereafter described as "stable." A defined-benefit pension plan, for example, is stable, because it provides a fixed monthly income for the duration of an individual's retirement. An income type may also be considered stable when it is subject to a predictable increase over time, such as a cost-of-living adjustment (COLA). The previously-verified amount of types of income or assets determined by a state to be stable (adjusted by a COLA or other predictable increase, if applicable) is considered reliable for the purpose of conducting an *ex parte* renewal (42 C.F.R. § 435.916(b)(1)). Identifying stable income and asset types and relying on the previously-verified amount of such income and asset types in beneficiaries' accounts eliminates the need to obtain a new attestation from the beneficiary and/or documentation for the stable types, which may increase states' *ex parte* renewal rates.

States have flexibility to make a reasonable determination of what types of income and assets are stable. Examples of income types that are likely stable include income from a fixed pension, fixed distributions of dividends or interest, and non-retirement fixed annuities. While these stable

income types are more likely to be considered in a non-MAGI financial eligibility determination, MAGI-based beneficiaries may also have stable income. Stable assets, however, are applicable only to non-MAGI groups that have a resource test for eligibility. Examples of assets that may be considered stable, and may even decrease in value, include the value of a second vehicle (if considered in determining countable assets), burial funds, and some life insurance policies.[6]

Key Point: States have flexibility to determine types of income and assets that are stable and can rely on previously-verified amounts of such income and asset types in a beneficiary's account. This can increase the rate of successful *ex parte* renewals.

The examples provided in this CIB are for illustrative purposes only; they are not an exhaustive list of income or asset types that states may designate as stable, nor are states required to determine the types of income and assets described in the examples as stable. States may make their own reasonable determinations about stable income and assets.

When determining which types of income and assets are stable, states should consider several points:

- *The type of verification previously conducted is not relevant.* States may rely on an income or asset amount in a beneficiary's account that is considered stable regardless of how the state previously verified that amount. Thus, states may determine that any of the following income or assets are stable: an amount that was previously verified using an electronic data source, an amount previously verified with documentary evidence or reasonable explanation, and an amount previously verified based on attestation. For example, when determining resource eligibility based on the methodologies used by the Supplemental Security Income (SSI) program, the equity value of one vehicle is excluded from a beneficiary's countable resources, but the equity value of a second vehicle will generally be countable. A state may choose to consider the value of a beneficiary's second vehicle in which the beneficiary has full equity as a stable asset, such that the state would not need to reverify the value of this asset to complete an ex parte renewal.

Example #1: Henry applied for Medicaid as a single individual based on disability status in January of last year. For the Age and Disability-related Poverty Level eligibility group, the income standard is $1,255 per month, and the resource standard is $2,000. At that time, his income was $860, and his only countable assets were a savings account valued at $300, which was verified through the state's AVS, and a second vehicle, which the state verified had a value of $1,600.

When gathering information for the *ex parte* renewal in the current year, the state assumes no change in the value of the second vehicle and therefore uses the previously-verified amount of $1,600. The state checks quarterly wage, Social Security, and unemployment insurance data for income, which return only $925 in wages. The state also checks its AVS to obtain data on the value of Henry's current financial assets, which returns $350 in a savings account. The

[6] Designating specific types of assets as stable does not impact states' obligation to obtain information from their asset verification system (AVS) at renewal.

state adds the value of the assets returned from AVS ($350) with the value of the second vehicle ($1,600) to get total assets and compares that amount ($1,950) to the applicable resource standard for Henry's eligibility group ($2,000). Then the state compares Henry's total income ($925) to the applicable income standard ($1,255). Since the total amount of Henry's income and assets is below the applicable income and resource standards, and Henry meets all other eligibility criteria, the state must determine him eligible and send a notice of approved eligibility.

- *Population-specific policies are permitted.* States may determine that certain types of income or assets are stable (or likely to decrease) only for certain populations provided that the state has a reasonable basis for treating select populations differently. In such cases the state would rely on information in the account when conducting an *ex parte* renewal for beneficiaries included in the specified population but would not rely on account information for other beneficiaries.

Example #2: Emma is a 10-year-old child enrolled in Medicaid through the "Katie Beckett group" which, per section 1902(e)(3) of the Social Security Act (the Act), provides coverage for children under age 19 with a disability who require an institutional level of care and who would be eligible if living in an institution. The income standard for a child seeking coverage in the Katie Beckett group in her state is $2,829 per month. The resource standard is $2,000. Only the child's income and assets are included in determining the total countable income and assets for purposes of eligibility for the Katie Beckett group, and the state determines that the income and assets of a child who meets the disability and level-of-care criteria for this group are highly unlikely to change. At application, the state verified that Emma had no income, the value of her attested financial assets was $1,500, and the value of her non-financial assets was $0.

During Emma's *ex parte* renewal, the state compares the income listed in Emma's account ($0) to the applicable income standard for the Katie Beckett group ($2,829 per month) and determines she meets the income standard. The state pings its AVS, which returns $1,500 in financial assets. The state adds the AVS amount to the value of Emma's non-financial assets in her account ($0). Since the total ($1,500) is under the applicable resource standard ($2,000), as long as Emma continues to meet all other nonfinancial criteria, the state must renew her enrollment and send her a notice of approved eligibility.

- *Decisions about stable income and assets may impact a state's use of data sources*. When a state designates a specific income type, such as title II Social Security benefits, as stable, the state may rely on previously-verified information about this type of income to complete the *ex parte* eligibility determination. The state is not required to check an available electronic data source, such as SSA data, to verify the current income amount, provided that the previously-verified amount has been adjusted for the COLA. While specific types of assets may also be identified as stable, with limited exception, states are still required to check

AVS.[7] For more information on requirements related to AVS, see the November 2024 CIB on "Financial Eligibility Verification Requirements and Flexibilities," hereafter described as the "2024 Financial Verification Requirements CIB."[8]

States are not required to obtain CMS approval of their determinations about which types of income and assets they consider stable. However, for audit purposes and to ensure appropriate staff training, these determinations must be documented clearly in the state's verification policies and procedures, along with the state's rationale for determining that the income and asset types identified by the state are stable. CMS is not requiring states to submit updated MAGI-based verification plans with their designation of stable income/asset types at this time, but updated verification plans including these designations may be requested in the future. CMS has not requested that states submit their non-MAGI verification plans to CMS but may request that states do so in the future. Further information on verification plan requirements can be found in the 2024 Financial Verification Requirements CIB.

Key Point: States do not need CMS approval of the income and asset types they designate as stable but must clearly document each designation and the rationale for the designation in their verification policies and procedures.

b. Information from Useful Data Sources

Income Data Sources. As explained in detail in the 2024 Financial Verification Requirements CIB, section 1137 of the Act and implementing regulations at 42 C.F.R. §§ 435.948(a) and 457.380(d) identify the data sources that states are required to access to the extent they are useful in verifying income.[9] Examples of data sources listed in section 1137 of the Act include quarterly wage data from the State Wage Information Collection Agency (SWICA) or a similar agency; unemployment insurance benefit data from the state agency administering the state's unemployment compensation laws; title II income data from the SSA; and income information from the Supplemental Nutrition Assistance Program (SNAP). States also have the option to use reliable data sources in addition to those identified in section 1137 of the Act and 42 C.F.R. § 435.948. Some examples of data sources for MAGI-based income include information from state income tax returns; commercial or other current income data sources; and Federal Tax Information (FTI). However, 42 C.F.R. §§ 435.945(k) and 457.380(i) require that states must seek CMS approval to rely solely on alternative sources of information in lieu of one or more section 1137 data sources.

States may not determine that a mandatory data source identified in section 1137 of the Act and described at 42 C.F.R. §§ 435.948(a) and 457.380(d) is not useful based solely on the age of the

[7] Section 1940 of the Act requires that states implement and use an AVS in verifying assets held in a financial institution.

[8] CMS CIB, November 20, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11202024.pdf.

[9] Under section 1137 of the Act, the Secretary has the authority to make this usefulness determination. CMS delegated this authority to state Medicaid agencies, and current regulations at §§ 435.948(a) and 457.380(d) provide that states have the responsibility to determine the usefulness of accessing each of the section 1137 data sources in determining initial and ongoing eligibility for Medicaid and CHIP.

data returned by that data source. Thus, if a state does determine that a data source is useful to verify an individual's income, the state may not determine that data returned from that source is not useful based solely on the age of the data returned, and thereby require individuals to provide documentation or other information. For example, states cannot request documentation of wages without first attempting to verify income using quarterly wage or other available data sources used in the state.

Asset Data Sources. As explained in detail in the 2024 Financial Verification Requirements CIB, states are required under section 1940 of the Act to obtain information from their AVS for all individuals who are subject to an asset test and whose eligibility is being determined on the basis of being age 65 or older or having blindness or a disability. States have the option to use other electronic data sources or systems that may be available to verify other assets and must do so per 42 C.F.R. § 435.952(c) to the extent that available electronic data sources are useful in verifying the information before requesting documentation or other information. Many states, for example, verify the value of a home or other real property with a real estate or homeowners database. States should consider what data sources in their state may be available for verifying assets and whether it would be effective to establish a data connection to obtain such data in accordance with 42 C.F.R. § 435.952(c)(2)(ii).

Regulations at 42 C.F.R. §§ 435.952(c) and 457.380(f) require that states must attempt to verify information using all available data sources prior to requiring additional information or documentation from an individual. As such, a state that uses more than one data source to verify financial information may not require information or documentation from an individual unless it has attempted verification using all available data sources. For example, in a state that verifies earned income using quarterly wage data, FTI, and SNAP, if no data are returned from quarterly wage or FTI, the state must also attempt to verify information using SNAP prior to requiring additional information or documentation. States are not required to access data from all data sources relating to the same income or asset type if another of the data sources returns information that is not reasonably compatible with attested information.

For additional information on federal requirements and state flexibilities in verifying financial eligibility, see the 2024 Verification Requirements CIB.

Data Sources at Renewal. Typically, the data sources states identify as useful in verifying financial eligibility at application will also be useful in verifying financial eligibility at renewal. In some cases, a state may use a data source at application that is not used at renewal or vice versa. For example, a state may determine that a commercial source of income (CSI) data source is not useful at application but may determine that the same CSI data source is a useful data source at renewal. However, a state may not bypass the *ex parte* renewal process for some or all Medicaid and CHIP beneficiaries by determining that no data sources are useful for verification of financial eligibility (42 C.F.R. § 435.916(b)(1)). States must identify the data sources they deem useful for verifying income and assets at renewal in their verification plans, which are required under 42 C.F.R. §§ 435.945(j) and 457.380(j).

Although the statute does not require that states use their AVS to verify financial assets of individuals seeking coverage under a Medicare Savings Program (MSP) group described in section 1902(a)(10)(E) of the Act, regulations at 42 C.F.R. § 435.916(b)(1) require that states

access all reliable information available to the state in an effort to redetermine eligibility for all Medicaid beneficiaries if able to do so without requiring information from the individual. Thus, in conducting an *ex parte* renewal, states must access information from their AVS for all beneficiaries subject to an asset test, unless at application the beneficiary had attested to not having any assets.[10]

V. Step 3 - Run Logic to Determine Continued Eligibility

Once the state has identified the reliable information from the beneficiary account and data sources available to it, the information is run through the logic in the eligibility system, which may include a combination of automated and manual steps. If the available information is sufficient to determine continued eligibility, then the state must renew the beneficiary's eligibility without requiring them to complete a renewal form or provide any additional information (42 C.F.R. §§ 435.916(b)(1), 435.952(c), and 457.380(f)). Specific requirements and state flexibilities for determining whether a beneficiary continues to meet applicable financial and nonfinancial eligibility criteria during an *ex parte* renewal are discussed below.

If a state does not have sufficient information to complete the eligibility renewal on an *ex parte* basis or if the information available to the state indicates that the individual may not meet all eligibility requirements, the state must send a renewal form and request only the additional information needed to determine eligibility.[11]

a. Determining Whether Applicable Income and Resource Requirements are Satisfied

Most beneficiaries must meet income eligibility requirements, and most beneficiaries eligible on a non-MAGI basis who are subject to a resource test must also meet resource requirements. In determining whether a beneficiary continues to meet applicable income and resource eligibility requirements during the *ex parte* renewal process, the state must use the reliable information obtained from data sources and the beneficiary's account to calculate total household income in accordance with 42 C.F.R. § 435.603 for MAGI-based eligibility, or total countable income and assets in accordance with 42 C.F.R. §§ 435.601 and 435.602 for MAGI-excepted eligibility[12] if

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[10] As explained in the 2024 Financial Verification Requirements CIB, when determining eligibility for an MSP group at application, states have the option either to accept self-attestation of financial assets or to verify such assets through their AVS. However, in accordance with 42 C.F.R. § 435.952(c), in determining MSP eligibility, if a state does not accept self-attestation of financial assets verifiable through the state's AVS, the state must attempt to verify such assets through the state's AVS before requiring proof of such assets.

[11] States will be required to start sending prepopulated renewal forms for non-MAGI beneficiaries by June 2027, per the April 2024 Final Rule, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health. See §§ 435.916(b)(2)(i)(A).

[12] Under 42 C.F.R. § 435.602, income that is included in a non-MAGI income eligibility determination is limited to the income of: the individual; the individual's spouse, if the spouse is living with the individual; and, in some circumstances, the individual's parents (e.g., if the individual is under age 21 and living with their parents). "Total countable income" is used in this guidance to distinguish the income included in a non-MAGI eligibility determination from the "household income" that is used to determine MAGI-based income eligibility. "Total countable assets" is used to refer to the total amount of assets considered in determining whether an individual seeking coverage on a non-MAGI basis satisfies any applicable asset test.

the state is able to do so (42 C.F.R. § 435.916(b)(1)). Total income and assets are then compared to the applicable income and resource standards for the eligibility group in which the beneficiary is enrolled.

If the state can determine eligibility through the *ex parte* renewal process, the state must send a notice of approved eligibility, including all the required content discussed in section VI.a. of this CIB. As an additional program integrity safeguard, as required by 42 C.F.R. § 435.916(b)(1)(ii), the notice of approved eligibility must remind the beneficiary that they "must inform the agency...if any of the information contained in such notice is inaccurate."

If no data are available from the beneficiary's account or returned from any data source for a given income type, the state generally will be unable to complete the renewal on an *ex parte* basis and must send the beneficiary a renewal form and request any additional information or documentation needed to complete the renewal.

We note that, when processing an *ex parte* renewal for which no information is returned, in some cases the lack of information returned from a specific data source may indicate only that no information is available from that data source. In other cases, no information returned may support a determination that the beneficiary does not have that specific type of income. For example, no response from a state's unemployment compensation program would support a determination that the individual is not receiving unemployment compensation. In contrast, no information returned regarding state or federal tax data would indicate that the individual did not file taxes and would not provide verification that the household has no income.

When the state is unable to obtain reliable information about a given income or resource type from any of the available data sources or the beneficiary's account, the state must send a renewal form to obtain additional information from the individual; if the state does not accept attested information for the income or resource type (e.g., self-employment income), it will also need to request a reasonable explanation and/or documentation depending on state verification policy. An exception may apply in states that adopt a strategy to complete *ex parte* renewal when no data sources return income information, such as the $0 Income Strategy and 100 Percent Income Strategy described in the November 2024 CIB, "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes" (hereafter referred to as the "November 2024 Unwinding-Related Strategies CIB").[13]

Example #3: Jacob is an unmarried adult with no children enrolled in the adult group described in 42 C.F.R. § 435.119. The applicable income standard is $1,669 per month (133 percent of the federal poverty level (FPL) for a household size of one). Jacob had only wage income of $450 at his last renewal. To gather information for Jacob's *ex parte* renewal, State A accesses quarterly wage data and unemployment compensation data. Quarterly wage data returns an amount of $500, and unemployment compensation data returns no information, indicating $0 unemployment income in State A. Since Jacob's total income ($500) does not exceed the applicable income standard ($1,660), provided that he continues to meet all

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

nonfinancial criteria, the state must renew Jacob's eligibility and send him a notice of approved eligibility.

Example #4: Joan is a single individual in State B who is enrolled in a non-MAGI eligibility group for individuals receiving home and community-based services (HCBS) with a nursing home level of care (LOC) that has an income limit of $2,829/month and is subject to a resource standard of $2,000. Joan only had $750 in fixed pension income and financial assets of $950 at her last renewal. When beginning the *ex parte* renewal process for Joan, State B accesses title II income from SSA and its AVS for assets. The state determined that previously-verified income from pensions is stable and are considered reliable for the purpose of conducting an *ex parte* renewal. SSA does not return any income information for Joan. AVS returns an amount of $1,000, and Joan's account includes $750 from a stable pension. State B calculates Joan's countable income as $750 and Joan's countable assets as $1,000. State B compares those amounts to the income and resource standards for Joan's eligibility group. Since her total income ($750) and assets ($1,000) do not exceed the applicable standards for her eligibility group ($2,829 in income and $2,000 in assets), provided that she continues to meet all other nonfinancial criteria, the state must renew Joan's eligibility and send her a notice of approved eligibility.

The process used to determine income and resource eligibility for an *ex parte* renewal differs from the process used at application. At application, states determine whether attested income and asset information provided on the application is reasonably compatible with information from electronic data sources when both are compared to the applicable income or resource standard. In accordance with 42 C.F.R. § 435.952(c)(1), attested information provided by or on behalf of an individual at application is considered reasonably compatible with the information obtained from data sources if both are either above, at, or below the applicable standard or other relevant threshold. At application, states may also establish a reasonable compatibility threshold, under which they establish a percentage or dollar amount by which an income or asset value from the data source(s) may exceed attested income or assets and still be used to verify financial information.[14]

When conducting an *ex parte* renewal, the state does not have a recent attestation from the beneficiary, so reasonable compatibility and the reasonable compatibility threshold do not apply. Instead, if the state is able to calculate household income or total countable income and, if applicable, total countable resources based on available information, that amount is compared directly to the applicable income or resource standard. If the household income or total countable income is at or below the income standard, then the beneficiary continues to satisfy the income requirement. Likewise, if total countable assets are at or below the resource standard, then the beneficiary continues to satisfy the resource requirement. If income or assets exceed the applicable income or resource standard for the beneficiary's current eligibility group and the

[14] For additional discussion of the applicability of reasonable compatibility at application , see the 2024 Financial Verification Requirements CIB, November 20, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11202024.pdf.

state is unable to determine eligibility for another eligibility group with equal or greater medical assistance, then the state must request additional information and provide a renewal form.[15]

Key Point: Reasonable compatibility does not apply during an *ex parte* renewal, and states may not apply a reasonable compatibility threshold during the *ex parte* process. During an *ex parte* renewal, available reliable information from data sources and the beneficiary's account is compared to the applicable income and/or resource standards.

i. Use of Strategic Data Hierarchies

Most states use multiple data sources to verify financial information at renewal. When using multiple data sources, states can elect to use or not to use a strategic data hierarchy, as described in further detail below.

States that do not employ a strategic data hierarchy and use more than one data source for a specific type of income or asset must check all available data sources determined useful by the state during the *ex parte* renewal process. If any of those data sources returns information that exceeds the applicable income or resource standard, the state must request additional information from the individual. For example, if the state uses two data sources to verify wages and either one of those sources returns data indicating potential ineligibility, the state must reach out to the individual to request additional information or documentation.

States also have the option to establish a strategic data hierarchy that lays out the order in which electronic data sources will be accessed or when data returned from a source will be used for verifying income to the exclusion of another data source. A strategic data hierarchy is a set of optional business logic rules in which one data source is considered more useful than other sources. A state's business logic may be designed to consider a given data source more useful than another in all or a defined subset of circumstances. A strategic data hierarchy could, for example, entail checking multiple data sources concurrently or consecutively. See the 2024 Financial Verification Requirements CIB for a detailed discussion of the use of data hierarchies in verifying eligibility at application. Here, we provide a brief overview and examples of two types of strategic data hierarchies that states may find useful in conducting *ex parte* renewals: consecutive and concurrent.

- *Consecutive Review of Data Sources.* Consecutive review is one type of strategic data hierarchy in which a state's eligibility system accesses data sources for a given eligibility criterion in a prescribed order and stops once the eligibility criterion—such as household income, total countable income, or the amount of a type of income—is verified. A

[15] If the state is able to determine eligibility on an *ex parte* basis for an eligibility group with reduced benefits or higher beneficiary liability (i.e., premiums or cost sharing) and the beneficiary does not return the renewal form, the state must (1) provide advance notice of adverse action with fair hearing rights for the termination of the beneficiary's current eligibility group and the reduction in benefits/increase in premiums or cost sharing. and (2) transition the beneficiary to the new eligibility group and send the beneficiary notice of approved eligibility for the new eligibility group consistent with 42 C.F.R. § 435.917. States should combine the adverse action notice and notice of approved eligibility into a single notice whenever possible.

consecutive strategic hierarchy allows states to utilize a dynamic verification process that prioritizes the data sources that they deem most useful, and pings or reviews secondary data sources lower in the hierarchy only when needed. States that implement a consecutive strategic hierarchy begin the process of verifying income at renewal by pinging or reviewing the earned and unearned income data sources that the state has identified as most useful in the hierarchy. If no data are returned, or, at state option, if the data returned from the highest priority source(s) exceeds the applicable income standard, the state checks secondary sources in the state's hierarchy until it has determined the individual eligible, has determined that additional information or documentation is needed from the individual because the data indicates potential ineligibility, or has exhausted the available data sources.

Example #5: State C has established a data hierarchy in which it prioritizes quarterly wage data over FTI income data. Juan is a Medicaid beneficiary in State C. He has a household size of one and is enrolled in the adult group, which has an income standard of $1,669 per month. Juan was enrolled with verified monthly wage income of $1,000. The state first accesses quarterly wage data to check for Juan's wage-based income, but the data source returns no information. The state then accesses FTI, which returns $12,000 in annual income. The state uses FTI to calculate $1,000 in monthly income. Since Juan's total household income ($1,000 from FTI) is below the applicable income standard for his eligibility group ($1,669), the state must renew his enrollment and send a notice of approved eligibility if he continues to meet the non-financial eligibility criteria.

- *Concurrent Review of Data Sources.* States may elect to ping all useful data sources listed in their verification plans and review the information concurrently. Under a concurrent strategic data hierarchy, the state would establish clear rules governing when it will rely on one data source over another, even if data returned from the other data source results in household income or total income or assets that exceeds the applicable income or resource standard. States that implement a concurrent strategic data hierarchy begin the process of verifying income during an *ex parte* renewal by pinging all the earned and unearned income data sources used by the state. The state then evaluates the information returned in accordance with the rules it has established to determine if the individual is eligible or if additional information or documentation is needed. If income is verified by information from a data source in accordance with the state's rules, the state does not need to consider information from other data sources that the state has determined are less reliable.

Example #6: State D has established a data hierarchy in which it accesses both quarterly wage data and state tax information concurrently. The state prioritizes the reliability of the state tax information over quarterly wage data for individuals with reasonably predictable changes in income per the option at 42 C.F.R. §§ 435.603(h)(3) and 457.315(a),[16] because the former accounts for fluctuations in income. Isabella, age 15, lives with her parents, Jason and Alice. Isabella is currently enrolled in a separate CHIP in the targeted low-income child

[16] Under 42 C.F.R. §§ 435.603(h)(3) and 457.315(a), in determining current monthly income, states may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both.

group, which has a monthly income standard of $5,681 for a household of three. Isabella was enrolled with a verified monthly household income of $5,000, comprised of $2,750 in wages from her mother and $2,250 in wages from her father, which fluctuate predictably with the seasons. State D accesses both quarterly wage data and state tax information to obtain information on Isabella's MAGI-based household income at renewal. The state checks quarterly wage data, which returns $6,000 in monthly household income, while the state tax data source returns $58,260 in annual income (divided by 12 for $4,855 in monthly income) for the household. State D prioritizes the state tax information because Isabella's parents have predictably fluctuating income and uses the $4,855 in monthly income to compare against the income standard for targeted low-income children ($5,681) to verify Isabella's continued income eligibility. However, if no data had been returned from state tax information, the state would have used the quarterly wage data to complete Isabella's income verification, in which case Isabella's household income would exceed the income standard based on the available data, and the state would be required to send a renewal form and request additional information or documentation of income.

States that elect to implement a data hierarchy must document in their verification plan the type of data hierarchy used and the justifications for relying on a lower priority data source in certain circumstances. At this time, CMS is not requiring states to submit updated verification plans with any new policies based on the flexibilities described in this guidance; however, states must document all verification policies and procedures for staff training and audit purposes.

ii. Discrepancies Between Employer Names for Wage Income

While income is a factor in determining eligibility for most Medicaid eligibility groups and CHIP, the identity of an individual's employer is not a factor of eligibility. The employer(s) returned from wage data sources during the *ex parte* renewal and the employer(s) of record from a beneficiary's last eligibility determination do not need to match in order for a beneficiary's eligibility to be renewed.

At *ex parte* renewal, information from the data source(s) accessed and reliable income information from the beneficiary's account are used to calculate household or total countable income for the beneficiary. This amount is then compared directly to the applicable income eligibility standard for the beneficiary's eligibility group. If the household or total countable income amount calculated by the state is at or below the applicable income standard, the state must determine the beneficiary income eligible regardless of whether the wage income obtained from the data source is from the same employer that the beneficiary worked for at the point of their last determination. States may not end the *ex parte* process and request additional information from a beneficiary to confirm their current employer(s) or provide information on prior employers (42 C.F.R. § 435.952(c)).

The requirement at renewal differs from the policy at application in which the state has a new attestation of wages from one or more employers, and data sources accessed by the state return

wage information from one or more different employers.[17] At application, in determining whether attested wage information is reasonably compatible with wage information from a data source, states have the option (1) to ignore a discrepancy when the employer in the attestation does not match the data source information or (2) to request additional information to resolve the discrepancy.[18] During an *ex parte* renewal, there is no recent attestation of income or the employer's name, only the employment information from data sources. Therefore, states must only determine if the household or total countable income amount calculated by the state is at or below the applicable income standard. Whether an individual changed employers is not relevant for determining their income eligibility during an *ex parte* renewal.

Example #7: Ethan is single and lives with his 10-year-old child, Asher. Ethan is currently enrolled in a MAGI-based eligibility group for parents and caretaker relatives, which in his state has a monthly income standard of $1,278 (75 percent of the FPL) for his household of two. The state verified Ethan's wage income from ABC Café at application as $1,100 using quarterly wage data. Ethan had no other types of income. When conducting Ethan's *ex parte* renewal, quarterly wage data returns wage income of $1,200 monthly from XYZ Grill. Ethan's wage income from XYZ Grill ($1,200) is below the income standard for his eligibility group ($1,278). Since no information was returned for ABC Café, the state must assume that Ethan is no longer earning income from ABC Café, determine him income-eligible based on the information available. Provided that Ethan continues to meet all non-financial eligibility criteria, the state must send him a notice of approved eligibility. The state may not require Ethan to provide additional information to explain the difference between the employer identified at application or during prior renewal and the employer returned by the data source during the *ex parte* renewal.

iii. Income and Asset Types with No Data Source

While multiple data sources exist for verifying some types of income, other types of income (such as interest income, dividend income, and pension income) and assets (such as the cash surrender value of a life insurance policy) may not have any data sources for electronic verification. While self-employment income can be verified electronically using tax data, many states have found that the stringent requirements for accessing FTI pose challenges to making effective use of FTI for verifying self-employment income. Utilizing recent information available from other benefit programs, like information from a recent SNAP certification as a data source, may permit states to verify these types of income and resources without requiring information from the beneficiary.

In conducting an *ex parte* renewal, states must assume that a beneficiary who did not previously have a particular type of income or asset for which there is no available data source continues to not have that type of income or asset (as discussed in section VI.a. of this CIB, if the beneficiary

[17] See Section IV.a.i. of the 2024 Financial Verification Requirements CIB, November 20, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11202024.pdf.

[18] See the 2024 Financial Verification Requirements CIB, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11202024.pdf, for additional discussion on state flexibilities in applying reasonable compatibility when the employer reflected in attested information and information from a data source do not match.

is successfully renewed on an *ex parte* basis, they must notify the state if any of the information that the state relied upon in renewing their eligibility is inaccurate). However, for beneficiaries whose account history indicates that they had one or more types of income or assets at their last eligibility determination for which electronic data are not available, states may employ one or more of the following three options in order to optimize the effectiveness of their *ex parte* process. A state may use different options in different circumstances.

- First, as discussed in section IV.a. of this CIB, states have the option to make a reasonable determination that specific types of income and resources are stable. Identifying a specific income or asset type as stable permits the state to utilize information in a beneficiary's account for that income or asset type from a prior eligibility determination. This permits states to determine continued income eligibility for beneficiaries with that income or asset type without requiring them to return a renewal form, if the beneficiary has no other income or only has other types of income that also are stable or have an available data source. As a reminder, beneficiaries are required to inform the state if any of the information used to renew their eligibility, including the amount of income or assets considered stable, is inaccurate (42 C.F.R. § 435.916(b)(1)(ii)).
- Second, a state may assume that a beneficiary's income has transitioned from one income type to another or that a resource has been transitioned from one type to another if available information indicates such a change has occurred. For example, just as someone may change jobs, a beneficiary may transition from being a gig worker or self-employed to earning wages from an employer. If available wage data indicates that a person who was self-employed at their last renewal is now earning wages, consistent with federal requirements, a state may, but is not required to, assume that they have replaced their former self-employment status with paid employment and use wage data received from data sources to determine their income eligibility during the *ex parte* renewal. Again, the beneficiary would be obligated to inform the state if any of the information used to determine eligibility is inaccurate (42 C.F.R. § 435.916(b)(1)(ii)).
- Third, a state can utilize strategies set forth in the November 2024 Unwinding-Related Strategies CIB.[19] Utilizing the gross income determination from SNAP, for example, may permit the state to verify continued income eligibility without having to collect additional information from the beneficiary about specific types of income or resources. A state adopting this strategy for renewals would compare a beneficiary's gross income, as determined by SNAP, to the applicable Medicaid income standard. If the beneficiary's SNAP gross income is at or below the applicable income standard, the state would conclude that the beneficiary is income eligible for Medicaid.

Even when using one or more of these options, a state may still need to provide a renewal form to obtain updated information on an income or asset type that is not stable and cannot be verified with available data.

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

b. Determining Whether Applicable Non-Financial Eligibility Requirements are Satisfied

Some factors of non-financial eligibility are not subject to change, such as date of birth (to calculate age) or citizenship status. For non-financial eligibility criteria that are not subject to change states must rely on previously-verified information in a beneficiary's account when determining eligibility (42 C.F.R. §§ 435.916(b)(1) and 435.952(c)). For factors that are stable and highly unlikely to change, states may, but are not required to, rely on information in a beneficiary's account. For example, noncitizen status is generally stable and does not need to be reverified unless the individual reports a change in status. Similarly, states are not required to reverify household composition since this tends to remain stable, unless the state has information indicating a change in household composition, such as information reporting the birth of a new child. However, states are responsible for ensuring that established procedures are designed to detect changes in status that may result in ineligibility.

If a state determines that information in a beneficiary's account is not reliable or otherwise sufficient to renew a factor of non-financial eligibility, the state must check available data sources in accordance with 42 C.F.R. § 435.916(b)(1) before sending a renewal form or asking for documentation. States are reminded that whenever a state does receive information regarding a change in circumstances impacting a non-financial eligibility requirement, or when the state can anticipate such a change (such as an individual aging out of an eligibility group for which being under a certain age is required), the state must act timely on such a change in accordance with 42 C.F.R. §§ 435.919(b) and 457.344(b).[20]

Following is a discussion of considerations specific to verifying non-financial eligibility criteria.

- *Citizenship Status*: States *may not* reverify U.S. citizenship at renewal (or at reapplication following a break in coverage) unless the beneficiary reports a change, or the state receives information indicating a change in citizenship (42 C.F.R. §§ 435.956(a)(4)(ii) and 457.380(b)).

- *Immigration Status*: Many qualified noncitizen immigration statuses, for example Lawful Permanent Resident, asylee, and refugee, generally do not change (or, if they change, it is to another qualifying status or U.S. citizenship). An individual's immigration status does not need to be reverified if it is not likely to change unless the state receives information that such a change has occurred. However, while the immigration status of most noncitizens is not likely to change, there are some exceptions, such as individuals with Temporary

[20] See the preamble to April 2024 Final Rule, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," for a full discussion of requirements related to changes in circumstances, including compliance with new requirements no later than 36 months after the effective date of the rule (June 3, 2027) (89 FR 22836), available at https://www.federalregister.gov/d/2024-06566/page-22836.

Protected Status and noncitizens who are granted parole for a specified period (e.g., two years). The immigration status of such beneficiaries must be re-verified at renewal.[21]

- *State Residency*: States are not required to actively reverify state residency at renewal unless the information available to the state indicates that the beneficiary's state of residency may have changed. In checking data sources for other eligibility criteria, such as checking wage data for income eligibility, a return of information will generally provide confirmation of continued state residency. If a state elects to verify state residency at renewal, it must first access available data sources it has determined useful for verifying state residency (e.g., Department of Motor Vehicles, other human services programs) during the *ex parte* process to confirm continued state residency. States may only request documentation or additional information from the beneficiary at renewal if continued state residency cannot be confirmed based on information available to the state (42 C.F.R. § 435.952(c)). States are reminded that, while state residency is a factor of eligibility, an in-state address change does not affect eligibility, and therefore states may not require beneficiaries to verify an in-state change in address in order to renew their coverage.[22]

- *Blindness and Disability:* When renewing eligibility for beneficiaries who are eligible based on blindness or disability, states may consider their blindness or disability as continuing until determined otherwise in accordance with 42 C.F.R. § 435.531 (for blindness) or 42 C.F.R. § 435.541 (for disability) (42 C.F.R. § 435.916(b)(3)). Generally, the SSA's determination that an individual has blindness or a disability is binding on a state Medicaid agency until the SSA itself changes its determination (42 C.F.R. §§ 435.530(a), 435.541(b)). In certain circumstances, however, the Medicaid agency is responsible for making disability and blindness determinations, such as when the individual is in a 209(b) state that uses a blindness and/or disability standard more restrictive than the SSI program[23] (42 C.F.R. §§ 435.530(a)(2), 435.541(c)), or the individual's disability status has not been evaluated by

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[21] See CMS, "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 86382, page 86428, November 30, 2016, available at: https://www.govinfo.gov/content/pkg/FR-2016-11-30/pdf/2016-27844.pdf; and CMS CIB, "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements," page 4, footnotes #10 and #1, December 4, 2020, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

[22] The April 2024 Final Rule, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health, (89 FRFR 22789) promulgated 42 C.F.R. § 435.919(f), which requires states to establish a process to regularly obtain and act upon updated address information from reliable sources, including the National Change of Address (NCOA), mail returned by the U.S. Postal Service (USPS) with a forwarding address, and managed care organizations. If the state receives an updated in-state address from such a reliable source, it must accept the information, update the beneficiary's case record with the updated address, and notify the beneficiary of the change in accordance with 42 C.F.R. §§ 435.919(f)(2) and 457.344. States may not require verification of an address change from the beneficiary prior to updating their record. All states must comply with this requirement by December 3, 2025, and may implement it sooner.

[23] Certain states have elected the authority provided under section 1902(f) of the Act to apply financial methodologies more restrictive than the SSI program in determining eligibility for individuals 65 years old or older or who have blindness or a disability, subject to certain conditions. See 42 C.F.R. § 435.121. These states are referred to as "209(b)" states, after the provision of the Act Amendments of 1972, Pub. L. No. 92-603, section 209(b), which enacted what became codified at 1902(f) of the Act.

the SSA (42 C.F.R. § 435.541(c)).[24] If an individual is eligible for Medicaid based on a determination of blindness or disability made by the state Medicaid agency, a physician skilled in the diseases of the eye (for blindness) or the state's disability review team (for disability) must determine whether and when reexaminations will be necessary for purposes of ongoing eligibility (§42 C.F.R. §§ 435.531(a)(3)(ii) and 435.541(f)(3)). Thus, when conducting an *ex parte* renewal, if the favorable determination of blindness or disability has not changed, whether it has been made by the SSA or the state, no further action is required.

- *Categorical eligibility requirements*: States may, but are not required to, seek additional information to reverify other categorial eligibility requirements that are subject to change, such as parent/caretaker relative status for beneficiaries enrolled in the eligibility group serving parents and other caretaker relatives described in 42 C.F.R. § 435.110. For these requirements, states may consider information in the beneficiary's account reliable for purposes of conducting a renewal, including during the *ex parte* renewal process, without additional verification, unless information known to the state indicates a change (42 C.F.R. §§ 435.916(b)(1) and 435.952(c)). As noted above, when states anticipate an individual's change in status (e.g., the only dependent child of a parent aging out of dependency or an individual in the group for former foster care youth turning age 26), the state must act on such change in accordance with 42 C.F.R. §§ 435.919(b)(6) and 457.344(b)(6).

- *Access to other health insurance*: As a condition of eligibility for separate CHIPs and for the Medicaid eligibility group for optional targeted low-income children described at 42 C.F.R. § 435.229, individuals must be otherwise uninsured.[25] States also have a responsibility to ensure that CHIP coverage does not substitute for group health plan coverage, consistent with section 2102(b)(3)(C) of the Act and 42 C.F.R. § 457.805(a).

  Longstanding third-party liability (TPL) requirements for Medicaid, described in section 1902(a)(25) of the Act and 42 C.F.R. § 433.138(b), apply to CHIP by cross reference in section 2107(e)(1) of the Act. To meet these requirements, states conduct data matching with available public and private insurance databases to identify other sources of coverage. States must use available TPL information in conducting a renewal of individuals enrolled in CHIP or the Medicaid optional targeted low-income children eligibility group to ensure that they have not obtained other coverage. States may only request additional information about other health coverage from CHIP beneficiaries and optional targeted low-income children in Medicaid at renewal when TPL information is not accessible electronically or available in the beneficiary's account.

VI. Step 4 - Communicate Outcome for Each Beneficiary

After the state has completed the *ex parte* process, the next step is to communicate with the beneficiary. If eligibility can be renewed *ex parte*, the state must send a notice of approved eligibility (42 C.F.R. § 435.916(b)(1)). When eligibility cannot be renewed *ex parte*, the state

[24] The circumstances in which states are responsible for making blindness and disability determinations are described in 42 C.F.R. §§ 435.531(a) and 435.541(c).

[25] This requirement applies to targeted low-income children per section 2110(b)(1)(C) of the Act and to targeted low-income pregnant women consistent with section 2112(d)(2)(C) of the Act.

must provide a renewal form and instructions for submitting additional information and any documentation needed to renew eligibility (42 C.F.R. § 435.916(b)(2)).

a. Notice of Approved Eligibility

If available information is sufficient to calculate household income or total income and assets, as applicable, and such income and assets are at or below the applicable standards for the beneficiary's current eligibility group or another eligibility group that provides at least the same level of coverage, the state must determine that the beneficiary remains financially eligible (42 C.F.R. § 435.916(b)(1)). If the individual also continues to meet all applicable nonfinancial eligibility requirements, the state must renew the beneficiary's eligibility and send a notice of approved eligibility (42 C.F.R. §§ 435.916(b)(1), 435.917(a)-(b)(1), and 457.340(e)). The notice to the beneficiary must be written in plain language, meet general accessibility standards,[26] and include: the eligibility determination and basis for the determination (i.e., the information the agency relied upon in approving eligibility); the effective date of eligibility; the requirement and process to report changes in circumstance that may impact eligibility; information on benefits and services, including any premiums, enrollment fees, and cost sharing; and an explanation of any right to a fair hearing or review. The notice must clearly explain that the beneficiary must notify the state if any of the information that the state relied upon in making the *ex parte* determination is inaccurate but that the beneficiary does not need to sign or return the notice if all information is accurate.[27]

If the state completes the *ex parte* process, and a Medicaid beneficiary appears to be eligible for an eligibility group providing more medical assistance (either a more robust benefit package or lower premiums or cost sharing), then the state must move the individual to the more advantageous eligibility group without requiring additional information. Similarly, if, during an *ex parte* review, a CHIP beneficiary appears to be eligible for a lower premium band, the state must move the individual to the lower premium band without requiring additional information. In each of these scenarios, the state must send a notice of approved eligibility, as described above.[28]

If, in response to a notice of approved eligibility, the beneficiary provides updated information that may impact their eligibility, the state must redetermine the beneficiary's eligibility in accordance with the changes in circumstances requirements specified at 42 C.F.R. §§ 435.919 or 457.344. As a reminder, a new continuous eligibility period for a child begins on the effective date of the child's renewal. Once a child's eligibility has been renewed, states may not terminate the child's eligibility based on changes in circumstances during a continuous eligibility period, except under specific circumstances.[29] As described in section VII.a. of this CIB, states have options regarding when to consider the outcome of an *ex parte* renewal final for a child in a

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[26] 42 C.F.R. §§ 435.905(b), 435.917(a)(1)-(2), 457.110(a), and 457.340(e). For more information, see CMS, "Accessibility Requirements in Medicaid and CHIP," February 2023, available at: https://www.medicaid.gov/resources-for-states/downloads/accessibility-unwinding-slides.pdf.

[27] 42 C.F.R. §§ 435.916(b)(1), 435.917(b)(1), 457.340(e)(1), and 457.343.

[28] Ibid.

[29] Medicaid and CHIP continuous eligibility requirements are described in sections 1902(e)(12) and 2107(e)(1)(K) of the Act and 42 C.F.R. §§ 435.926 and 457.342. Additional information can be found in CMS State Health Official (SHO) # 23-004, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23004.pdf.

household in which other household members whose eligibility also is being renewed must return a renewal form.

b. Renewal Form

States will not be able to complete an *ex parte* renewal if household income or total countable income or assets, as applicable, are not verified based on the reliable information available to the state, or if the state is not able to confirm all non-financial eligibility criteria. When a state is unable to complete an *ex parte* renewal or when the data indicate an individual is eligible for a group providing fewer benefits or increased cost sharing or premiums, the state must provide the individual with a renewal form, which must be prepopulated for MAGI beneficiaries,[30] together with a request for any additional information or documentation that the beneficiary must provide in order to renew their eligibility.

States may not terminate coverage, move an individual to a group with reduced benefits or increased beneficiary liability, or send advanced notice of adverse action based on the information gathered during the *ex parte* process. If the beneficiary cannot be renewed for their current (or more advantageous) coverage on an *ex parte* basis, the state must send a renewal form, complete the remaining steps of the renewal process, as described in the September 2024 slide deck "Overview: Medicaid and CHIP Renewals"[31] and the December 2020 CIB entitled "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements."[32]

VII. Special Considerations

a. Completing the Ex Parte Process for Multiple Beneficiaries in the Same Household

States must determine eligibility for each beneficiary individually. While a state may initiate the renewal process at the same time for all household members whose renewal is due at the same time, the state may not conduct *ex parte* renewals at the household level, without regard to differing eligibility statuses and income thresholds for individuals within the household. If a state has sufficient information during the *ex parte* process to renew eligibility for some individuals in a multi-member household, such as children, the state may not require a renewal form or documentation for those household members, even if the state cannot successfully complete an *ex parte* renewal for other household members, such as a parent. Further, if the renewal form required for some household members is not returned, states may not disenroll household members whose eligibility the state was able to determine through the *ex parte* process.

Medicaid and CHIP regulations require that states complete a redetermination of eligibility based on available information for each individual in the household, regardless of the eligibility of others in the household unit: "The agency must make a redetermination of eligibility for all

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[30] For beneficiaries excepted from use of the MAGI-based methodologies (or non-MAGI beneficiaries), states must comply with the requirement to provide a prepopulated renewal form and 30-day response period no later than 6/3/2027 (89 FR 22836).

[31] CMS, "Overview: Medicaid and CHIP Eligibility Renewals," September 2024, available at: https://www.medicaid.gov/resources-for-states/downloads/eligibility-renewals-overview.pdf.

[32] 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.

Medicaid [and CHIP] beneficiaries without requiring information from *the individual* if able to do so based on reliable information contained in *the individual's* account or other more current information available to the agency" (emphasis added) (42 C.F.R. § 435.916(b)(1)). Regulations related to the determination of eligibility at 42 C.F.R. § 435.911(c) also specify that the agency must furnish Medicaid "[f]or each individual…whose eligibility is being renewed," if found eligible.

Consistent with federal renewal regulations at 42 C.F.R. § 435.916(b), states must make a redetermination of eligibility for all Medicaid beneficiaries without requiring information from the individual if able to do so and may only send a renewal form if the state cannot renew eligibility for a beneficiary based on available information. While states may need to obtain information, such as income, about all household members in order to renew a given member's eligibility, they may not require a renewal form to be returned or additional information to be provided for purposes of renewing coverage for those individuals for whom the state has sufficient information to determine continuing eligibility at *ex parte* renewal.

In circumstances where the eligibility of some, but not all, beneficiaries in a household who are due for renewal at the same time can be successfully renewed on an *ex parte* basis, states have two options for when they consider the *ex parte* determination final and send the notice of approved eligibility to complete the renewal.[33]

- *Option 1 – Hold the final determination:* States may wait to finalize the determination and send the notice of approved eligibility to the individual(s) whose renewal can be completed via the *ex parte* process ("*ex parte* individuals") until after completing the renewal process for everyone in the household whose eligibility is being renewed, provided that the state is able to send timely notice of eligibility (i.e., before the end of the eligibility period) to the *ex parte* individuals. If the renewal form sent to other household members and any documentation requested is returned in a timely manner, the state would assess whether any of that information would impact the eligibility of the *ex parte* individuals and redetermine their eligibility accordingly. We remind states that they must follow all renewal requirements, such as considering eligibility on other bases, and their verification policies prior to determining that an individual initially found eligible via the *ex parte* process is no longer eligible based on the information returned by another household member.

  If the renewal form required by some household members is not returned timely, the state must provide a timely eligibility notice (confirming continued eligibility effective the day after the end of the current eligibility period) for those household members whom the state determined continue to be eligible on an *ex parte* basis. If the renewal form and any requested documentation for other household members is subsequently returned, the state must act on any updated information as a change in circumstance for the household members whose eligibility was renewed. Note that individuals entitled to a 12-month continuous eligibility period cannot be disenrolled once their coverage has been renewed and a new

[33] For detailed examples of how states may process the ex parte renewals of different members of a household on an individual basis, refer to Attachment B: Scenarios: Conducting Ex Parte Renewals at the Individual Level in the August 30, 2023, CMS State Medicaid Director Letter available at: www.medicaid.gov/sites/default/files/2023-08/state-ltr-ensuring-renewal-compliance.pdf.

continuous eligibility period has begun, except in limited circumstances, as described below (42 C.F.R. §§ 435.919(b) and 457.344(b)).

- *Option 2 – Finalize ex parte renewal*: States may finalize the determination and send the notice of approved eligibility to the household member(s) whose eligibility can be renewed *ex parte* at the same time as the state sends a renewal form to the other household members whose eligibility could not be renewed on an *ex parte* basis. The state would treat any information that is received after the notice of approved eligibility is provided, including information returned on another household member's renewal form that may affect eligibility, as a change in circumstances and redetermine eligibility as appropriate (42 C.F.R. §§ 435.919(b) and 457.344(b)), subject to the protections provided to individuals entitled to continuous eligibility.

We note that most children under age 19 enrolled in Medicaid and CHIP must be provided 12 months of continuous eligibility, and a state's election of the above options has implications for whether it can act on information returned by another household member due for renewal at the same time as the child. Under the first option, in which the state holds the final determination of eligibility for the child until the renewal form needed for the parent's or other household member's eligibility determination is returned, the state would consider any information submitted by the parent or other household member before the end of the child's current eligibility period as part of the child's renewal. If information returned before the end of the current eligibility period results in a determination of ineligibility for the child, the state would send the child advance notice of termination and fair hearing rights (42 C.F.R. §§ 435.917(b)(2), 435.917(c), 435.1200(h), 431.206(b), 431.210, 431.211-214).

Under the second option, in which the *ex parte* determination is considered final when completed, the child's eligibility is renewed irrespective of information returned by other household members, and a new eligibility period and continuous eligibility period will begin on the day following the end of the current eligibility period. Thus, under the second option, the state would not act on information provided by other household members as a change in circumstances with respect to the child. For detailed examples of how conducting renewals at the individual level intersects with continuous eligibility, refer to the October 2023 slide deck, "Scenarios: The Intersection of Continuous Eligibility and Individual Level Renewal Processes."[34]

b. Ensuring States Attempt Ex Parte *Renewals for All Beneficiaries*

The *ex parte* renewal requirement applies to *all* beneficiaries. States are required to "make a redetermination of eligibility for all Medicaid [and CHIP] beneficiaries without requiring information from the individual if able to do so[.]" (42 C.F.R. § 435.916(b)(1)). Specific populations may not be excluded from the *ex parte* process because a factor of eligibility cannot be verified electronically or for any other reason. The *ex parte* process steps of (1) identifying

[34] CMS, "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.

beneficiaries due for renewal, (2) gathering reliable information available to the state, and (3) running logic to determine continued eligibility, are necessary even for beneficiaries whose eligibility cannot be renewed *ex parte*. These steps are needed to prepopulate the renewal form[35] and accurately identify the information and documentation that a beneficiary must provide to determine continued eligibility.

In this section, we highlight several situations for which additional clarity on the applicability of this requirement may be helpful.

- *Beneficiaries with Self-Employment Income.* States must initiate the *ex parte* renewal process for individuals whose account history indicates that they had self-employment income at their last eligibility determination even if the state does not utilize an electronic data source to verify self-employment income (i.e., FTI or state income tax data). The state must still check wage and other data sources to obtain updated information and determine which information and documentation is needed from the beneficiary prior to sending a renewal form. See section V.a.iii. of this CIB for additional information on state options for beneficiaries with income or asset types for which there is no available data source.

- *Beneficiaries Excepted from MAGI-Based Methodologies.* States must attempt an *ex parte* renewal for all non-MAGI as well as MAGI-based beneficiaries, even if a non-MAGI beneficiary subject to a resource test has assets that the state cannot verify electronically. As noted, reliable information about income and assets and any other relevant eligibility criteria that may be available must be obtained during the *ex parte* process even if the state knows that additional information will be needed from the beneficiary to verify their income or assets.

- *Beneficiaries Enrolled in Both Health Coverage and other Human Services Programs*. States must attempt an *ex parte* renewal for all Medicaid and CHIP beneficiaries, including those who are also enrolled in other human services benefit programs, such as SNAP. For states with an integrated system that determines eligibility for multiple programs, if the *ex parte* review for the Medicaid or CHIP beneficiary is successful, the state must renew Medicaid or CHIP eligibility and separately complete any additional requirements needed to renew eligibility for the other program(s), such as an interview or additional documentation requirements. States may not prevent a Medicaid or CHIP beneficiary from being renewed on an *ex parte* basis or delay the timely completion of a renewal or redetermination of eligibility for Medicaid or CHIP pending provision of documentation or completion of other requirements for another human services program that are not needed to determine eligibility for Medicaid or CHIP.[36]

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[35] States will be required to start sending prepopulated renewal forms for non-MAGI beneficiaries by June 2027, per the April 2024 Final Rule, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health. See 42 C.F.R. § 435.916(b)(2)(i)(A).

[36] CMS, "Opportunities to Support Unwinding Efforts for States with Integrated Eligibility Systems and/or Workforces," September 16, 2022, available at: https://www.medicaid.gov/resources-for-states/downloads/opp-unwind-eff-st-integ-elig-sys-workforce.pdf.

If a beneficiary returns information or documentation related to renewal of eligibility for another program prior to the completion of their Medicaid or CHIP renewal and that information or documentation may impact the individual's Medicaid or CHIP eligibility, the state may take the additional information or documentation into account in finalizing the Medicaid or CHIP determination. If such additional information or documentation is returned after the completion of the Medicaid or CHIP renewal, the state would treat that information as a change in circumstances in accordance with 42 C.F.R. §§ 435.919(b) and 457.344(b). As a reminder, once a child's eligibility has been renewed, states may not terminate the child's eligibility based on changes in circumstances during a continuous eligibility period, except under specific circumstances.[37]

- *SSI Recipients*. For states that have an agreement with the SSA, as authorized by section 1634 of the Act, to have the SSA determine Medicaid eligibility for SSI beneficiaries (a "1634 state"), there is effectively no action that the state needs to take to complete an *ex parte* renewal for SSI beneficiaries. Unless and until the SSA notifies the state Medicaid agency of any changes to the individual's circumstances through the file SSA shares identifying the SSI beneficiaries in the state, the state must assume that the beneficiary continues to receive SSI and to reside in the state. Thus, unless SSA has notified the state to the contrary, the state must assume that the beneficiary is eligible for Medicaid on the basis of receiving SSI. Section 1634 states are required to treat loss of SSI or other changes in the SSI file as a change in circumstances and redetermine eligibility in accordance with 42 C.F.R. § 435.919.

  In states that do not have a 1634 agreement with the SSA but provide Medicaid to all SSI recipients (i.e., "SSI criteria states") and in 209(b) states, the state Medicaid agency must take steps to conduct an *ex parte* renewal. In SSI criteria states, the Medicaid agency will only need to confirm with SSA that an individual continues to receive SSI to complete an *ex parte* renewal. Section 209(b) states must conduct an *ex parte* renewal for SSI beneficiaries in the same manner as they would for beneficiaries enrolled in any other eligibility group for which being age 65 or older or having blindness or a disability is a condition of eligibility. Depending on a beneficiary's specific circumstances, the state may be able to renew eligibility on an *ex parte* basis.

c. Eligibility System Changes

A state may need to make changes to its eligibility and enrollment system to ensure compliance with the requirements described in this CIB. 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. Interested

[37] Medicaid and CHIP continuous eligibility requirements are described in sections 1902(e)(12) and 2107(e)(1)(K) of the Act and 42 C.F.R. §§ 435.926 and 457.342. Additional information can be found in SHO # 23-004, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23004.pdf.

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. For questions related to FFP or the APD process, please contact your assigned State Officer.

VIII. Strategies to Increase *Ex Parte* Rates and Overall Efficiency

There are many actionable strategies that states can adopt to promote continuous coverage of beneficiaries who remain eligible for Medicaid and CHIP. For example, as discussed in section IV.a. of this CIB, states have flexibility to determine that specific types of previously-verified information are stable for some or all beneficiaries and can be relied upon to complete an *ex parte* renewal, thereby reducing the need to obtain additional information. Likewise, by establishing data hierarchies, states can resolve inconsistencies in information from different data sources without having to request more information from the beneficiary. In the November 2024 Unwinding-Related Strategies CIB, we discuss a number of other options that have been found to increase *ex parte* rates and the overall efficiency of *ex parte* processes, including use of SNAP gross income in renewing eligibility for MAGI-based beneficiaries and renewal of certain beneficiaries when no income data is returned, among other strategies.[38] States are encouraged to review the November 2024 Unwinding-Related Strategies CIB and consider whether any of the available strategies would benefit their state and its beneficiaries. Additional detail and examples of state strategies to increase the effectiveness of *ex parte* renewal processes also can be found in the October 2022 slide deck, "*Ex Parte* Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts."[39]

The following are examples of strategies states can use to increase *ex parte* rates and streamline their renewal processes, which can be found in the referenced resources.

Express Lane Eligibility (ELE).[40] The ELE authority at sections 1902(e)(13) and 2107(e)(1) of the Act permits states to rely on findings from one or more express lane agencies (ELA) designated by the state to determine whether a child satisfies one or more factors of eligibility for Medicaid or CHIP, including income. ELE permits states to rely on findings from an ELA when determining Medicaid or CHIP eligibility at initial application and/or renewal without regard to differences in rules between the programs for counting income and household composition. Medicaid programs can apply the ELE option to children up to age 19, 20, or 21, and CHIP can do so for children up to age 19. States have broad discretion in designating ELAs. Some states, for example, have designated the agencies administering SNAP, TANF, Head Start, National

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

[39] CMS, "*Ex Parte* Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts," October 20, 2022, available at: https://www.medicaid.gov/resources-for-states/downloads/ex-parte-renewal-102022.pdf.

[40] CMS, SHO #10-003, February 4, 2010, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/SHO10003.PDF; and CMS, "Express Lane Eligibility for Medicaid and CHIP Coverage," August 2021, available at: https://www.medicaid.gov/medicaid/enrollment-strategies/express-lane-eligibility-medicaid-and-chip-coverage/index.html.

School Lunch Program (NSLP), and Women, Infants, and Children (WIC), among other programs, as an ELA.

Facilitated Enrollment.[41] The facilitated enrollment state plan option allows states to determine financial eligibility for a subset of beneficiaries using gross household income determined by other means tested benefit programs, where the relevant beneficiaries are certain to meet the income eligibility criteria for Medicaid. States must collect any additional information needed to verify that an individual being determined eligible or renewed for Medicaid would be certainly eligible. States may use the facilitated enrollment option to renew Medicaid for children and nonelderly adults and to renew CHIP. See CMS SHO #15-001, Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies, for more information.

Obtaining SSNs for Household Members. Encouraging parents to provide their SSN when applying for coverage only for their children makes it easier to verify the child's household income both at application and when completing an *ex parte* renewal. States cannot require non-applicants like parents to provide their SSN.[42] However, a clear explanation about the value/importance of providing an SSN can be included in application and renewal materials.

IX. Closing

CMS believes that, when implemented effectively and consistent with federal rules, *ex parte* renewal is a benefit to both states and beneficiaries. By ensuring eligible individuals stay enrolled without the need to provide unnecessary paperwork, *ex parte* renewals reduce the administrative burden on states associated with processing renewal forms. And by maximizing the use of reliable data, the *ex parte* renewal process permits states to achieve high levels of program integrity while reducing the burden on beneficiaries associated with gathering and submitting additional documentation, churning off and on program enrollment, and experiencing gaps in coverage. For technical assistance on *ex parte* renewal requirements and state flexibilities or assistance with implementing strategies to increase the effectiveness of a state's *ex parte* renewal process, states should contact their state lead. For additional information about this CIB, please contact Suzette Seng, Director, Division of Enrollment Policy and Operations, at Suzette.Seng@cms.hhs.gov.

[41] CMS SHO # 15-001, "Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies," August 31, 2015, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/SHO-15-001.pdf.
[42] 42 C.F.R. § 435.907(e)(3)(1)

CENTERS FOR MEDICARE & MEDICAID SERVICES

Basic Requirements for Conducting *Ex Parte* Renewals of Medicaid and CHIP Eligibility
December 2024

Objectives

This deck summarizes the CMCS Information Bulletin (CIB), *Basic Requirements for Conducting Ex Parte Renewals of Medicaid and CHIP Eligibility,* and is part of a series of resources for states as they work to comply with federal renewal requirements.

This slide deck is intended to remind states about current requirements and expectations for renewing eligibility for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries based on reliable information available to the state without contacting the beneficiary, also referred to as an *ex parte* renewal.[1]

Source: CMS CIB, Basic Requirements for Conducting *Ex Parte* Renewals of Medicaid and CHIP Eligibility.
Notes:
1. An *ex parte* renewal is sometimes referred to as auto renewal or administrative renewal.

Background

Federal regulations at 42 C.F.R. §§ 435.916 and 457.343 outline the requirements and processes for states to periodically renew eligibility for all Medicaid and CHIP beneficiaries.

The *ex parte* renewal processes described here apply equally to a state's Medicaid[1] and separate CHIP programs.

For an overview of the entire renewal process, including actions required when a state is unable to renew someone on an *ex parte* basis, see the September 2024 slide deck, Overview: Medicaid and CHIP Eligibility Renewals, and the December 2020 CMCS Informational Bulletin Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements.

Additional information on renewal forms is forthcoming.

Notes:

1. The *ex parte* renewal requirement applies to individuals determined eligible using modified adjusted gross income (MAGI) methods and those exempted from MAGI-based financial methodologies under 42 C.F.R. § 435.603(j).

Content Overview

- **Overview**
- **Steps in the *Ex Parte* Renewal Process**
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    2. Gather Reliable Information Available to the State
    3. Run Logic to Determine Continued Eligibility
    4. Communicate Outcome for Each Beneficiary
- **Special Considerations**
- **Strategies to Increase *Ex Parte* Rates and Overall Efficiency**
- **State Resources**

Overview

Overview of Requirements for Conducting *Ex Parte* Renewals

An *ex parte* renewal is a redetermination of eligibility completed with reliable information available to the agency without contacting the beneficiary.

- States must attempt to renew eligibility for all Medicaid and CHIP beneficiaries on an *ex parte* basis (42 C.F.R. § 435.916(b)(1)).
- In conducting an *ex parte* renewal, states must use reliable information contained in the beneficiary's account and other more current information available from electronic data sources determined useful by the state (42 C.F.R. § 435.916(b)(1)).
- States may not require beneficiaries to provide new attestations, submit additional information, fill out a renewal form, or provide a signature when conducting an *ex parte* renewal (42 C.F.R. §§ 435.916(b)(1), 435.952(c), and 457.380(f)).
- States may only renew eligibility through the *ex parte* process. A state may not terminate eligibility, reduce benefits, or increase premiums or cost sharing on the basis of information obtained through the *ex parte* renewal process without sending the beneficiary a renewal form and providing a reasonable period of time to respond (42 C.F.R. §§ 435.952(d), 435.916(b)(2), and 457.380(f)).
- If the state can determine eligibility through the *ex parte* process, the state must send a notice of approved eligibility. If eligibility cannot be renewed on an *ex parte* basis, the state must send a renewal form and provide a reasonable period of time to respond (42 C.F.R. § 435.916(b)(2)).

Steps in the *Ex Parte* Renewal Process

Every Medicaid and CHIP renewal begins with the *ex parte* process, which is comprised of four basic steps.

1. Identify the cohort of beneficiaries who are due for renewal.
2. Gather available information for each individual beneficiary in the cohort without requiring additional information from the beneficiary.
3. Run logic in the eligibility system, including automated and manual steps, to determine whether each beneficiary continues to meet eligibility requirements.
4. Communicate the outcome to each beneficiary:
    - When eligibility can be renewed, send notice of approved eligibility.
    - When additional information is needed to renew eligibility, send renewal form.

Step 1: Identify the Cohort of Beneficiaries Due for Renewal

Identify the Beneficiaries Due for Renewal

Each month, states identify the cohort of individuals enrolled in Medicaid and CHIP for whom a renewal must be initiated.

States must initiate the *ex parte* process well in advance of the end of an individual's eligibility period to ensure timely completion of the renewal process, including for those individuals the state is unable to successfully renew via *ex parte*.

- Many states initiate renewals 60 to 90 days before the end of an individual's eligibility period to ensure timely completion of the renewal process for beneficiaries whose eligibility cannot be renewed *ex parte*.

States may not exclude specific populations in a cohort from the *ex parte* renewal process for any reason. For example, states may not exclude populations because one or more factors of eligibility cannot be verified electronically.

States must attempt an *ex parte* renewal for all beneficiaries, including every individual member of a household with multiple beneficiaries.

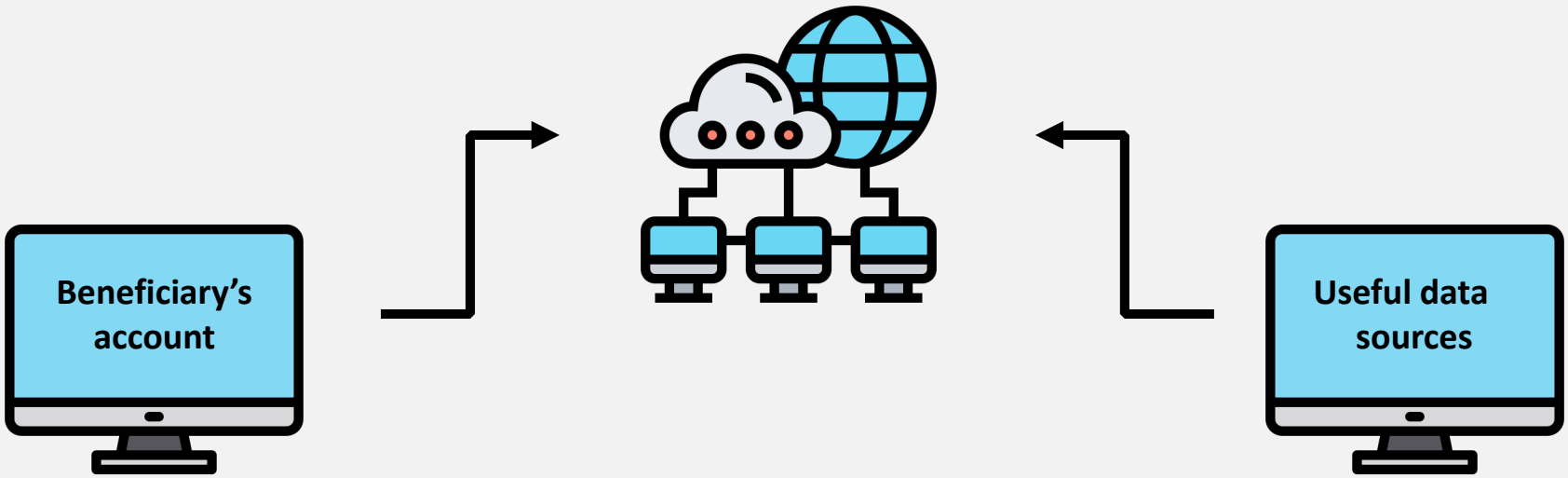
42 C.F.R. §§ 435.916(a), (b)(1), and (c)

Step 2: Gather Reliable Information Available to the State

Reliable Information Available to States

Once the cohort of beneficiaries has been identified for renewal, the state must collect the information needed to redetermine eligibility.

States gather reliable information from two general sources:



42 C.F.R. § 435.916(b)(1)

Reliable Information in a Beneficiary's Account

States must rely on previously-verified, reliable information in a beneficiary's account to conduct an *ex parte* renewal.

- Information in a beneficiary's account may be considered reliable for use in an *ex parte* renewal if the information is:
  1. Constant and not subject to change, e.g., citizenship status,[1] date of birth, and Social Security Number (SSN);
  2. Highly unlikely to change (hereafter described as stable), or
  3. Subject to change but was recently verified.
- States have flexibility in determining what previously-verified information in a beneficiary's account is stable and may be considered reliable for purposes of an *ex parte* renewal. For example, immigration statuses, such as Lawful Permanent Resident, asylee, and refugee, generally do not change.
- States have flexibility in determining when they will consider a previous verification to be recent for purposes of an *ex parte* renewal.
  - Based on state experience with data, verification conducted within the previous six months may reasonably be considered recent.

Notes:

1. States are prohibited from reverifying U.S. citizenship, even after a break in coverage, unless the state has received information indicating a potential change in the individual's citizenship (42 C.F.R. § 435.956(a)(4)(ii)).

Stable Income and Assets in a Beneficiary's Account

States may make a reasonable determination of income and asset types they consider stable and then rely on previously-verified amounts of such income and assets in conducting an *ex parte* renewal.

- When a state designates a specific income or asset type as stable, the state is not required to check an electronic data source provided that the previously-verified amount has been adjusted for any predictable increase (e.g., cost-of-living adjustment).[1]
- States may rely on an income or asset amount in a beneficiary's account that is unlikely to change regardless of how the information was previously verified (i.e., data source, documentation, attestation).
- States may determine that certain types of income or assets are likely to remain stable only for certain populations (e.g., all income and asset types only for Katie Beckett children).[2]
- States are not required to obtain approval from CMS about which types of income or assets they consider stable but must document these policies for staff training and audit purposes, along with the state's rationale for determining that the income and asset types identified by the state are stable.[3]

Notes:

1. While specific types of assets may also be identified as stable, states are still required to check AVS, with limited exception.
2. The Katie Beckett eligibility group (described in section 1902(e)(3) of the Act) provides coverage for children under age 19 with a disability who require an institutional level of care and who would be eligible if living in an institution. Only the child's income is used to determine eligibility. As such, a state may reasonably determine that the income and assets of the children enrolled in this group are unlikely to change.
3. States must document their determinations about which types of income and assets they consider stable and the rationale for the determination in their verification plans. CMS is not requiring states to submit updated verification plans for review at this time.

Information from Useful Data Sources

States must obtain information from the data sources, which may include other public benefit programs, they deem useful for verifying eligibility at renewal.

- Typically, the data sources states identify as useful in verifying financial eligibility at application will also be useful in verifying financial eligibility at renewal, although a state may determine that a data source useful at application is not useful at renewal or vice versa.
- When using multiple data sources, states have the option to establish a strategic data hierarchy that lays out the order in which electronic data sources will be accessed or when data returned from a given source will be used for verifying the relevant eligibility criterion (e.g., income).
- In conducting an *ex parte* renewal, states must access information from their AVS for all beneficiaries subject to an asset test, unless the beneficiary attested at application to not having any assets.

Section 1940 of the Act requires states to implement and use an Asset Verification System (AVS) to verify assets held in a financial institution.

Notes: For additional guidance on the mandatory and optional financial data sources, strategic data hierarchies, and AVS, see the November 2024 CIB, Financial Eligibility Verification Requirements and Flexibilities.

Ex Parte Renewal Example: Non-MAGI Individual with Stable Resource

Household Composition and Income

- Henry is age 62, has a disability and lives alone. The state is renewing his eligibility in the Age and Disability-Related Poverty Level group.
- Henry has a family size of 1.
- Henry was enrolled based on wage income of $860, having $300 in a savings account at ABC Bank, and owning a second vehicle with a previously-verified value of $1,600.

State's Verification Business Rules

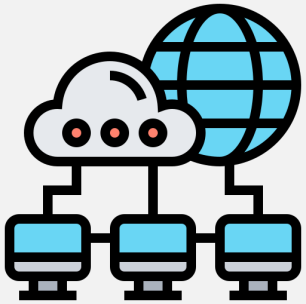
- State accesses:
  - Earned income data using quarterly wage data.
  - Unearned income data through SSA and Unemployment Insurance data.
  - Financial assets using AVS.
- State treats certain assets as stable, including the value of a second vehicle.

Reminder of State Income and Resource Standards

- The income standard for the Age and Disability-Related Poverty Level group for a family size of 1 is $1,255 per month.
- The resource standard is $2,000 for an individual.

Ex Parte Renewal Example: Non-MAGI Individual with Stable Resource, continued

Gather Available Data



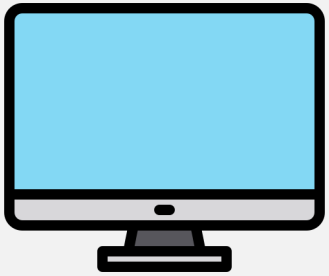
Data sources return the following:

- Quarterly Wage: $925 a month
- SSA: No return
- Unemployment Insurance: No return
- AVS Data: $350

Henry's account includes:

- 2nd vehicle with previously-verified value of $1,600

Run Logic



- AVS data ($350) added to previously-verified value of 2nd vehicle ($1,600).
- Combined assets ($1,950) are below resource standard ($2,000).
- No data returned from Social Security or Unemployment Insurance, indicating $0 unearned income.
- Earned income ($925 from quarterly wage) added to unearned income ($0).
- Total countable income ($925) is below income standard ($1,255).

Outcome

Henry's financial eligibility has been verified *ex parte.* Provided that Henry meets all non-financial eligibility criteria, the state must renew his eligibility.

Ex Parte Renewal Example: Child Enrolled in Katie Beckett Group

Household Composition and Income

- Emma is a 10-year-old child enrolled in Medicaid through the "Katie Beckett" eligibility group (which provides coverage for children under age 19 with a disability who require an institutional level of care and who would be eligible if living in an institution).
- Emma was enrolled with $0 income and financial assets of $1,500. She did not have any non-financial assets.
- Emma has a family size of 1 and the state is renewing her Medicaid eligibility in the Katie Beckett group.

State's Verification Business Rules

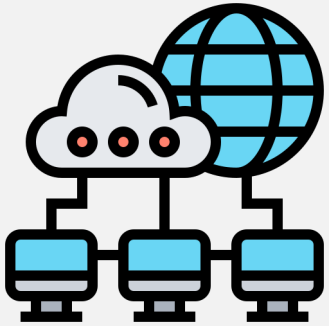
- State accesses:
  - Earned income using quarterly wage data.
  - Unearned income through SSA and Unemployment Insurance data.
  - Financial assets using AVS.
  - Disability status.
- State treats the income of children who need institutional level of care as stable.

Reminder of State Income and Resource Standards

- State covers the Katie Beckett group, which allows qualified children to be found eligible without regard to the income or assets of their parents.
- The income standard for the Katie Beckett group in the state is $2,829 per month (300% of SSI federal benefit rate).
- The resource standard is $2,000.

Ex Parte Renewal Example: Child Enrolled in Katie Beckett Group, continued

Gather Available Data



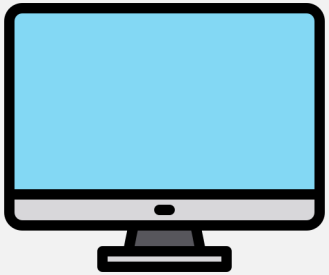
Emma's account includes:

- Income: $0
- Non-financial assets: $0

Data sources return the following:

- AVS Data: $1,500

Run Logic



- Emma's countable income ($0) is below income standard ($2,829).
- AVS data ($1,500) is added to the non-financial assets in the account ($0).
- Combined assets ($1,500) are below resource standard ($2,000).

Outcome

Emma's income and resources have been verified *ex parte.* Provided that Emma meets all non-financial eligibility criteria, the state must renew her eligibility.

Step 3: Run Logic to Determine Continued Eligibility

Determining Whether Applicable Income and Resource Requirements are Satisfied

- The state uses information obtained from data sources and the beneficiary's account to calculate total household income for MAGI eligibility or total countable income and assets for MAGI-excepted eligibility.
- Total income and assets are compared against the applicable income and resource standards for the eligibility group in which the beneficiary is enrolled.[1]
- If total income is at or below the applicable income standard, and, if applicable, the total assets are at or below the applicable resource standard, the beneficiary continues to satisfy the income and resource requirements.
- Reasonable compatibility does not apply during the *ex parte* process because the state does not have a recent attestation.[2]

If available information is not sufficient to complete the eligibility renewal on an *ex parte* basis or if the information available indicates that the individual may not meet all eligibility requirements, the state must send a renewal form.

Notes:

1. The process used to determine income and resource eligibility for an *ex parte* renewal differs slightly from the process used at application. At application states determine whether attested income and asset information provided on the application is reasonably compatible with information from electronic data sources and both are compared to the applicable income or resource standard.
2. Reasonable compatibility, as defined at 42 C.F.R. § 435.952(c)(1), is a policy used by states to evaluate an inconsistency between attested information provided by or on behalf of an individual and information obtained from data sources. Additional information is discussed in the November 2024 CIB, Financial Eligibility Verification Requirements and Flexibilities.

Ex Parte Renewal Example: Determining MAGI Financial Eligibility

Household Composition and Income

- Jacob is under age 65 and lives alone.
- Jacob has a household size of 1 and is enrolled in the Medicaid adult group.
- Jacob was enrolled with monthly wages of $450.

State's Verification Business Rules

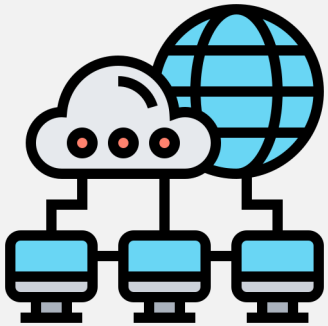
- State accesses:
  - Earned income using quarterly wage data.
  - Unearned income through Unemployment Insurance data.

Reminder of State Income Standard

- The income standard for the Medicaid adult group is $1,669 per month (133% of the FPL for a household of one).

Ex Parte Renewal Example: Determining MAGI Financial Eligibility, continued

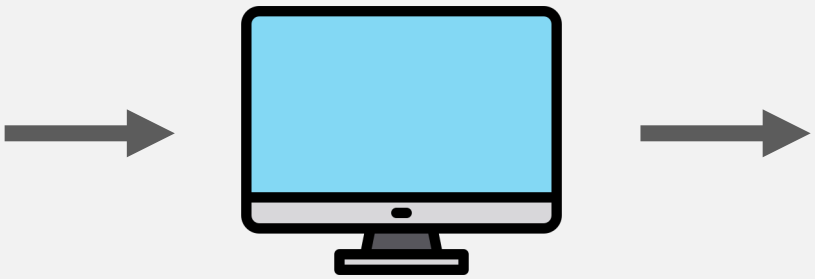
Gather Available Data



Data sources return the following:

- Quarterly Wage: $500 a month
- Unemployment Insurance: No return

Run Logic



- Earned income ($500 from quarterly wage) is added to unearned income ($0).
- Jacob's household income ($500) is below the income standard ($1,669).

Outcome

Jacob's MAGI household income has been verified *ex parte.* Provided that Jacob meets all non-financial eligibility criteria, the state must renew his eligibility.

Ex Parte Renewal Example: Determining Non-MAGI Financial Eligibility

Household Composition and Income

- Joan is 55 and lives alone. She is enrolled in Medicaid on a non-MAGI basis in an eligibility group for individuals receiving home and community-based services (HCBS) with a nursing home level of care.
- Joan was enrolled with income from a fixed pension of $750 a month and financial assets of $950.
- Joan has a family size of 1.

State's Verification Business Rules

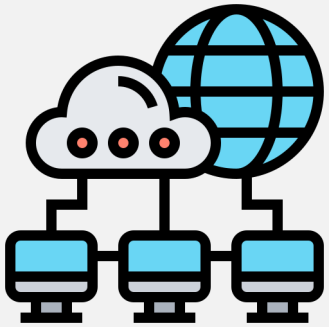
- State accesses:
  - Unearned income using SSA and Unemployment Insurance data.
  - Financial assets using AVS.
- State considers previously verified pension income to be stable.

Reminder of State Income and Resource Standards

- The income standard for an individual receiving HCBS with a nursing home level of care is $2,829 per month (300% of the FPL for an individual).
- The resource standard is $2,000 for an individual.

Ex Parte Renewal Example: Determining Non-MAGI Financial Eligibility, continued

Gather Available Data



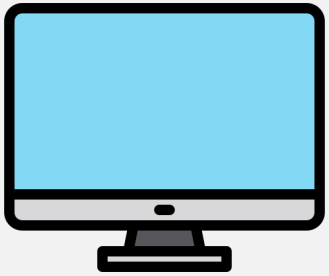
Data sources return the following:

- SSA: No return
- Unemployment Insurance: No return
- AVS Bank Account: $1,000 from XYZ Bank

Joan's account includes:

- Stable pension income: $750
- Stable assets: $0

Run Logic



- No data returned from SSA and no data from Unemployment Insurance indicates $0.
- Joan's pension income ($750) is added to other income ($0).
- Total countable income ($750) is below income standard ($2,829).
- AVS data ($1,000) is added to stable assets ($0).
- Combined assets ($1,000) are below resource standard ($2,000).

Outcome

Joan's non-MAGI income and assets have been verified *ex parte.* Provided that Joan meets all non-financial eligibility criteria, the state must renew her eligibility.

Prioritizing Data Sources to Determine Financial Eligibility

Most states use multiple data sources when verifying financial information and can elect to use a strategic data hierarchy to lay out the order in which data sources will be used.

- A strategic data hierarchy is a set of optional business logic rules in which one data source is considered more useful than other sources.
  - Two common types of strategic hierarchies involve a consecutive or concurrent review of information returned from data sources.
- States that do not employ a strategic data hierarchy and use more than one data source for a specific type of income or asset must check all useful data sources during the *ex parte* renewal process. If any of those data sources returns information that exceeds the applicable income or resource standard, the state must request additional information.
- States must document the use of a strategic data hierarchy in their verification plans.[1]

For additional information on strategic data hierarchies, see the November 2024 CIB, Financial Eligibility Verification Requirements and Flexibilities.

Notes:

1. At this time, CMS is not requesting states to submit updated verification plans with any new policies based on the flexibilities described in this guidance; however, states must document all verification policies and procedures for staff training and audit purposes.

Examples of Strategic Data Hierarchies

Consecutive Review of Data Sources

- States begin the process of verifying income at *ex parte* renewal by pinging or reviewing the earned and unearned income data sources that the state has identified as most useful.
- If no data are returned, or, at state option, if the data returned from the highest priority source results in total income over the applicable income standard, the state checks secondary sources in the state's hierarchy until it has:
  - determined the individual eligible,
  - determined it needs additional information, or
  - exhausted the available data sources.

Concurrent Review of Data Sources

- States begin the process of verifying income during an *ex parte* renewal by pinging all the earned and unearned income data sources used by the state.
- The state evaluates the information returned in accordance with the hierarchy it has established (starting with data source determined generally most reliable) to determine if the individual is eligible or if additional information or documentation is needed from the individual.
- If income is verified by information from a data source, the state does not need to consider information from other data sources that the state has determined are less reliable.

Ex Parte Renewal Example: Consecutive Data Hierarchy

Household Composition and Income

- Juan is 45 and lives alone. He is enrolled in the Medicaid adult group.
- Juan has a household size of 1.
- Juan was enrolled with verified monthly wage income of $1,000.

State's Verification Business Rules

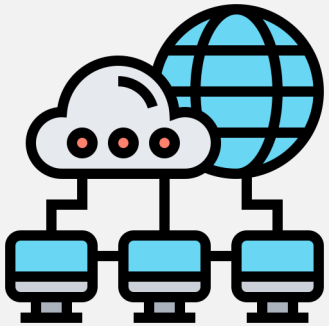
- State accesses:
  - Earned income using quarterly wage data and Federal Tax Information (FTI).
    - Priority is given to quarterly wage data as it is more-timely than FTI.

Reminder of State Income Standard

- The income standard for the Medicaid adult group is $1,669 per month (133% of the FPL for a household of one).

Ex Parte Renewal Example: Consecutive Data Hierarchy, continued

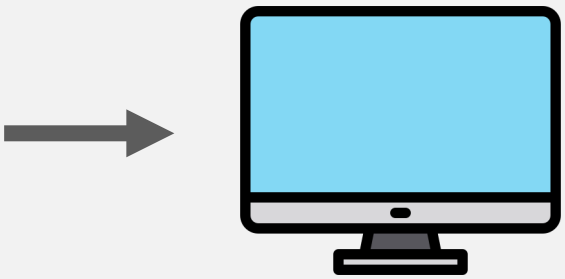
Gather Available Data



Data sources return the following:

- Quarterly Wage: No return
- FTI: $12,000 for the year

Run Logic



State applies a consecutive strategic hierarchy for income, relying first on quarterly wage data then FTI.

- Quarterly wage data returns no data.
- State then checks FTI ($12,000/yr).
- $12,000 is divided by 12 for monthly income of $1,000.
- Total household income is below income standard ($1,669).

Outcome

Juan's MAGI household income has been verified *ex parte.* Provided that Juan meets all non-financial eligibility criteria, the state must renew his eligibility.

Ex Parte Renewal Example: Concurrent Data Hierarchy

Household Composition and Income

- Isabella is 15 and lives with her parents, Jason and Alice. She is enrolled in the state's separate CHIP program.
- Isabella has a household size of 3.
- Isabella was enrolled with verified monthly income of $5,000, comprised of $2,750 in wages from her mother and $2,250 in wages from her father, which fluctuate predictably with the seasons.

State's Verification Business Rules

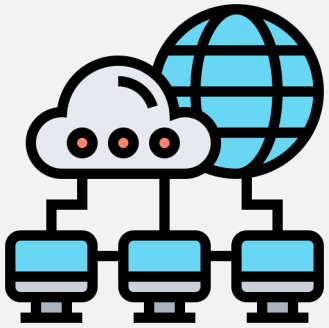
- State accesses:
  - Earned income using quarterly wage data and state tax information.
    - Priority is given to state tax information for individuals with reasonably predictable changes in income per the option at 42 C.F.R. §§ 435.603(h)(3) and 457.315(a).

Reminder of State Income Standard

- The income standard for the separate CHIP program is $5,681 per month for a household of three (264% of the FPL).

Ex Parte Renewal Example: Concurrent Data Hierarchy, continued (Data Sources Return Conflicting Results)

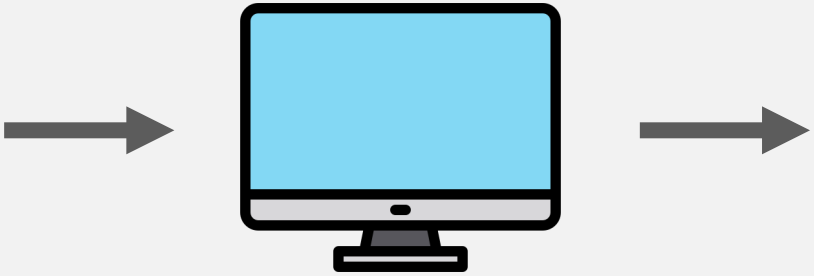
Gather Available Data



Data sources return the following:

- State Tax Information: $58,260 for the year
- Quarterly Wage: $6,000

Run Logic



State applies a concurrent strategic hierarchy for income, relying first on state tax information then quarterly wage data for households with reasonably predictable changes.

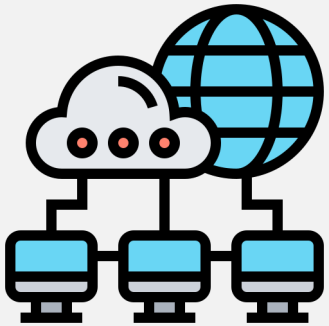
- State tax information ($58,260) is divided by 12 for monthly income of $4,855.
- Quarterly wage data are not used because it does not account for predictably fluctuating income.
- Total household income ($4,855) is below CHIP income standard ($5,681).

Outcome

Isabella's MAGI household income has been verified *ex parte.* Provided that Isabella meets all non-financial eligibility criteria, the state must renew her CHIP eligibility.

Ex Parte Renewal Example: Concurrent Data Hierarchy, continued (No Return from Highest Priority Data Source)

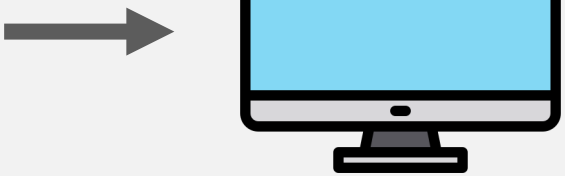
Gather Available Data



Data sources return the following:

- State Tax Information: No return
- Quarterly Wage: $6,000 a month for both parents

Run Logic



State applies a concurrent strategic hierarchy for income, relying first on state tax information then quarterly wage data for households with reasonably predictable changes.

- Since state tax information did not return data, state uses quarterly wage data ($6,000/month).
- Total household income ($6,000) is above CHIP income standard ($5,681).

Outcome

Isabella's MAGI household income has not been verified *ex parte.* State sends a renewal form and a request for additional information or documentation of wage income from both parents.

Discrepancies Between Employer Names at *Ex Parte*

The employer returned from wage data sources and the employer from the individual's last determination do not need to match in order for a beneficiary's eligibility to be renewed through the *ex parte* process.

- The identity of an individual's employer is not a factor of eligibility and states may not end the *ex parte* process and request additional information from a beneficiary to confirm their current employer(s) or provide information on prior employer(s).

- If the household or total countable income amount for the beneficiary calculated by the state based on data sources and reliable information from the beneficiary's account is at or below the applicable income standard, the state must determine the beneficiary income eligible regardless of whether the wage income obtained from the data source is from the same employer that the beneficiary worked for at the point of their last determination.[1]

Notes:

1. At application, in determining whether attested wage information is reasonably compatible with wage information from a data source, states have the option (1) to ignore a discrepancy when the employer in the attestation does not match the data source information or (2) to request additional information to resolve the discrepancy. Additional information is discussed in the November 2024 CIB, Financial Eligibility Verification Requirements and Flexibilities. During an *ex parte* renewal, there is no recent attestation of income or an employer's name, only the wage information from data sources. Whether an individual changed employers is not relevant for determining income eligibility during an *ex parte* renewal.

Ex Parte Renewal Example: Individual with Different Employer

Household Composition and Income

- Ethan is single and lives with his 10-year-old child, Asher. Ethan is enrolled in Medicaid as a parent/caretaker relative.
- Ethan has a household size of 2.
- Ethan was enrolled with monthly wage income of $1,100 from ABC Café.

State's Verification Business Rules

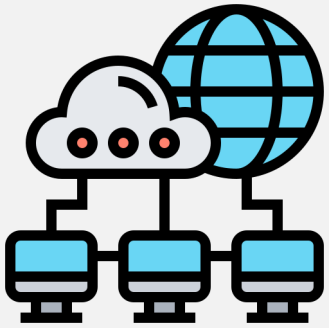
- State accesses:
  - Earned income through quarterly wage data.

Reminder of State Income Standard

- The income standard for the parent/caretaker relative eligibility group is $1,278 per month (75% of the FPL for a household of two).

Ex Parte Renewal Example: Individual with Different Employer, continued

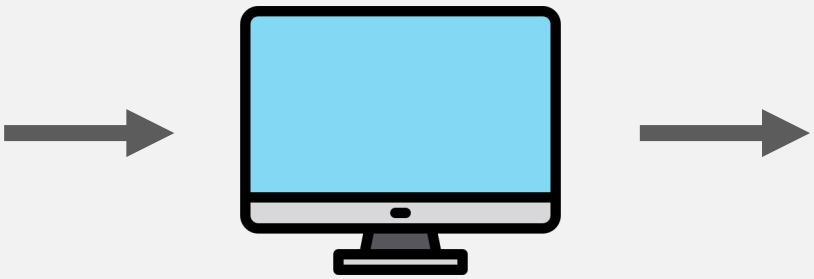
Gather Available Data



Data sources return the following:

- Quarterly Wage: $1,200 a month from XYZ Grill

Run Logic



- Quarterly wage returned data for XYZ Grill ($1,200).
- Since quarterly wage data did not return wages for ABC Café, the state must assume Ethan changed jobs.
- Total household income ($1,200) is below income standard ($1,278).

Outcome

Ethan's MAGI household income has been verified *ex parte*. Provided that Ethan meets all non-financial eligibility criteria, the state must renew his eligibility.

Strategies to Determine Financial Eligibility for Income and Resource Types with No Data Source

While multiple data sources exist for verifying some types of income, other income types may not have specific data sources for electronic verification.

Several options are available to optimize *ex parte* renewal for a beneficiary who has income or resources for which electronic data are not available.

- Identify income and asset types that are stable and use the information contained in a beneficiary's account (see slide 13).
- Assume that a beneficiary's income or resource has transitioned from one type of employment or resource to another if available information indicates such a change has occurred.
  - For example, a beneficiary may transition from being self-employed to earning wages from an employer.
- Utilize strategies set forth in the November 2024 Unwinding-Related Strategies CIB, such as using the gross income determination from the Supplemental Nutrition Assistance Program (SNAP) to verify continued income eligibility.[1]

Notes:

1. Under this strategy, a state compares a beneficiary's gross income, as determined by SNAP, to the applicable MAGI-based Medicaid income standard. If the beneficiary's SNAP gross income is at or below the applicable income standard, the state would conclude that the beneficiary is income eligible for Medicaid. For additional guidance on the SNAP option, see the November 2024 CIB, Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes.

Determining Whether Applicable Non-Financial Eligibility Requirements are Satisfied

- States **must** rely on previously-verified information in a beneficiary's account for non-financial eligibility criteria that are not subject to change, such as date of birth or citizenship status.
- States **may**, but are not required to, rely on information in a beneficiary's account for factors that are stable and highly unlikely to change, such as household composition or noncitizen status, unless the state has information indicating a change.
- If a state determines that information in a beneficiary's account is not reliable or otherwise sufficient to renew a factor of non-financial eligibility, the state **must** check available data sources before sending a renewal form or asking for documentation.

***Reminder*:** Whenever the state receives information regarding a change in circumstance or can anticipate a change that impacts non-financial eligibility (e.g., an individual aging out of an eligibility group), the state **must** act timely on that change.

42 C.F.R. §§ 435.916(b)(1), 435.919(b), 435.952(c), and 457.344(b)

Considerations for Verifying Non-Financial Eligibility Criteria

Citizenship Status

- States may not reverify U.S. citizenship during a renewal (or at reapplication following a break in coverage) unless the beneficiary reports a change or the state receives information indicating a change in citizenship.

Immigration Status

- Many qualified immigration statuses, for example Lawful Permanent Resident, asylee, and refugee, generally do not change or, if they do change, it is to another qualifying status or U.S. citizenship. An individual's immigration status does not need to be reverified if it is not likely to change, unless the state receives information that such a change has occurred.
- However, there are some exceptions, such as individuals with Temporary Protected Status. The immigration status of such beneficiaries must be reverified at renewal.

Considerations for Verifying Non-Financial Eligibility Criteria, continued 1

State Residency

- States are not required to reverify state residency unless available information indicates the individual's state of residency may have changed.
- If a state elects to reverify state residency, it must first access available data sources before requesting additional information from the individual. In checking data sources for other criteria, such as wage data, returned information will generally provide confirmation of continued state residency.
- An in-state address change does not affect eligibility, and states may not require beneficiaries to verify an in-state address change to renew coverage.[1]

Blindness and Disability

- States must consider blindness and disability as continuing until determined otherwise by the Social Security Administration (SSA) or, where the state is responsible for the blindness/disability determination, a physician or the state's disability review team (as the case may be).
- When conducting an *ex parte* renewal, if the favorable determination of blindness or disability has not changed, whether it has been made by SSA or the state, no further action is required.

Notes:

1. The final rule, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, requires states to update in-state address changes without verifying with the individual if updated information comes from certain trusted data sources (e.g., returned mail from the U.S. Postal Service). All states must comply with this requirement by December 3, 2025, and may do so sooner.

Considerations for Verifying Non-Financial Eligibility Criteria, continued 2

Categorical Eligibility Requirements

- States may, but are not required to, reverify other categorical requirements that are subject to change (e.g., parent/caretaker status).
- States may consider information in the account as reliable unless information known to the state indicates a change. When states anticipate a change in status (e.g., the individual's only dependent is aging out of dependency status), the state must act on the change.

Access to Other Health Insurance

- As a condition of eligibility for separate CHIP and for the Medicaid eligibility group for optional targeted low-income children, individuals must be otherwise uninsured.
- States conduct data matching with public and private insurance databases to identify other sources of coverage in accordance with longstanding third party liability (TPL) requirements.
- States must use that available information at renewal and may only request additional information when TPL information is not accessible electronically or available in the beneficiary's account.

Step 4: Communicate Outcome for Each Beneficiary

Notice of Approved Eligibility

If available information is sufficient to determine that the individual continues to meet all applicable financial and non-financial eligibility criteria, the state must renew the beneficiary's eligibility and send a notice of approved eligibility.

When eligibility is renewed *ex parte,* the state sends a notice of approved eligibility to the beneficiary that must be written in plain language, meet accessibility standards, and include:

- the eligibility determination and basis for the determination,
- the effective date of eligibility,
- the requirement and process to report changes in circumstance that may impact eligibility,
- information on benefits and any premiums and/or cost sharing, and
- an explanation of any right to a fair hearing or review.

The notice must clearly explain the beneficiary's obligation to inform the agency if any of the information relied upon is inaccurate but that the beneficiary does not need to sign or return the notice if the information is accurate.

If in response to a notice of approved eligibility, the beneficiary provides updated information that may impact their eligibility, the state must process the new information as a change in circumstances, except for children in a continuous eligibility period.[1]

42 C.F.R. §§ 435.919(b) and 457.344(b))

Notes:

1. A new continuous eligibility (CE) period for children begins on the effective date of the child's renewal. Once a child's eligibility has been renewed, states may not terminate the child's eligibility based on changes in circumstances during a CE period, except under specific circumstances.

Renewal Form

When eligibility cannot be renewed *ex parte*, the state must provide the beneficiary a renewal form.[1]

- States will not be able to complete an *ex parte* renewal if household income or total countable income or assets, as applicable, are not verified based on the reliable information available to the state, or if the state is not able to confirm all non-financial eligibility criteria.
- When a state is unable to complete an *ex parte* renewal or when the data indicate an individual is eligible for a group with fewer benefits or higher cost sharing or premiums, the state must provide a renewal form together with a request for any additional information or documentation needed to renew eligibility.
- States may not terminate coverage, move an individual to a group with reduced benefits or increased beneficiary liability, or send advanced notice of adverse action based on the information gathered during the *ex parte* process.

Notes:

1. MAGI beneficiaries must be provided a prepopulated renewal form and a minimum of 30 days to respond. Non-MAGI beneficiaries must be provided a reasonable period of time to respond. To align with the requirements for MAGI beneficiaries, states must begin providing non-MAGI beneficiaries with a prepopulated renewal form and at least 30 days to return the renewal form and any supporting documentation by June 3, 2027. See the final rule, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes. Guidance on prepopulated renewal forms and requirements of Medicaid and CHIP agencies to determine eligibility for the other program and ensure a smooth transition of coverage between these programs when appropriate are forthcoming.

Special Considerations

Reminders for Completing the *Ex Parte* Process for Multiple Beneficiaries in the Same Household

- States **must** determine eligibility for each beneficiary individually as different household members may be subject to different eligibility criteria.
- If a state has sufficient information to renew Medicaid or CHIP eligibility for some beneficiaries in a household, the state **may not** require a renewal form or documentation for those household members even if other household members must return a renewal form.
- If the renewal form or other requested information from other household members is not returned, the state **may not** disenroll individuals whose eligibility the state was able to determine through the *ex parte* process.

State Options When Completing *Ex Parte* Renewals for Multiple Household Members

In circumstances where eligibility for some, but not all, beneficiaries can be renewed *ex parte*, states have two options for when they consider the *ex parte* determination final and send the notice of approved eligibility.

Option 1: Wait to finalize the *ex parte* renewal(s) until after completing the renewal process for everyone in the household, provided that the state is able to send a timely notice.

- If the renewal form is returned timely, the state would assess any impact of the information on the eligibility of household member(s) initially found eligible via *ex parte* and redetermine their eligibility accordingly.
- If the renewal form is not returned timely, the state must provide timely notice of approved eligibility for member(s) whom the state determined eligible via *ex parte.* If information for other household members is subsequently returned, the state must act on the information as a change in circumstance.[1]

Option 2: Finalize the determination and send the notice of approved eligibility to household members whose eligibility can be renewed *ex parte* at the same time as the state sends a renewal form to the other household members.

The state would treat any information received after the approval notice is provided, including information returned on another household member's renewal form, as a change in circumstance.[1]

Notes:

1. Once the state finalizes a determination of eligibility for a child (under either option) and sends them an eligibility notice, a new eligibility period and CE period will begin on the day after the current eligibility period ends. Any information received by the state after the child's eligibility has been renewed will not impact the child's eligibility during the new CE period unless it relates to one of the few exceptions to CE permitted under the statute. See CMS SHO, Section 5112 Requirement for all States to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023.

Ensuring States Attempt an *Ex Parte* Renewal for All Beneficiaries

States may not exclude specific populations from the *ex parte* process because a factor of eligibility cannot be verified electronically or for any other reason.

- **Self-employed individuals.** Even if the state does not utilize an electronic data source to verify self-employment income, the state must still check wage and other data sources to obtain updated information and determine which information and documentation is needed from the beneficiary prior to sending a renewal form.[1] (For more information, see slide 35.)

- **Non-MAGI beneficiaries.** If a beneficiary subject to a resource test has assets that cannot be verified electronically, the state must attempt an *ex parte* renewal to obtain reliable information about income, assets, and other relevant eligibility criteria to determine which information and documentation is needed from the beneficiary prior to sending a renewal form.[1]

- **Beneficiaries enrolled in both health coverage and other human services programs**. If the *ex parte* review is successful in a state with an integrated system, the state must renew Medicaid or CHIP eligibility and may not prevent or delay the timely completion of the renewal pending provision of documentation or completion of other requirements (e.g., interviews) for another human services program.

Notes:
1. Guidance on prepopulating renewal forms is forthcoming.

Strategies to Increase *Ex Parte* Rates and Overall Efficiency

Increasing Efficiency and Effectiveness of *Ex Parte*

There are many actionable strategies that states can adopt to promote continuous coverage of beneficiaries who remain eligible for Medicaid and CHIP.

- **Continued use of certain unwinding-related strategies**[1] that have been found to increase *ex parte* rates and the overall efficiency of *ex parte* processes, including:
  - use of SNAP gross income in renewing MAGI-based beneficiaries,
  - renewal of certain beneficiaries when no income data are returned, and
  - assuming no change in resources when no information is returned through the AVS or when information is not returned within a reasonable timeframe.
- **Express Lane Eligibility** permits states to rely on findings from express lane agencies, such as SNAP, Temporary Assistance for Needy Families (TANF), School Lunch, Head Start, National School Lunch Program (NSLP), and Women, Infants, and Children (WIC), when determining Medicaid or CHIP eligibility at initial application and/or renewal without regard to differences in rules between the programs for counting income and household composition.
- **Obtaining SSNs for non-applicant household members** applying for coverage for their children only makes it easier to verify household income. Including a clear explanation about the value of providing an SSN on application and renewal materials can increase willingness of non-applicants to provide their SSN.

Notes:

1. For additional guidance on the SNAP option, as well as the ongoing availability of other unwinding-related strategies, see the November 2024 CIB on Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes.

State Resources

CMS Resources to Support States

- CMCS Informational Bulletin, Basic Requirements for Conducting *Ex Parte* Renewals of Medicaid and CHIP Eligibility, November 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11262024.pdf.
- CMCS Informational Bulletin, Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders, March 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib03152024.pdf.
- State Letter: Ensuring Compliance with Requirements to Conduct Medicaid and CHIP Renewal Requirements at the Individual Level, August 2023, available at: https://www.medicaid.gov/resources-for-states/downloads/state-ltr-ensuring-renewal-compliance.pdf.
- Slide Deck, Notice Considerations for Conducting Medicaid and Children's Health Insurance Program (CHIP) Renewals at the Individual Level, November 2023, available at: https://www.medicaid.gov/sites/default/files/2023-11/individual-lvl-renewal-notices.pdf.
- State Health Official (SHO) Letter # 23-002, Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023, January 2023, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf.
- Slide Deck, Ex Part Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts, October 2022, available at: https://www.medicaid.gov/resources-for-states/downloads/ex-parte-renewal-102022.pdf.
- CMCS Informational Bulletin, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements, December 2020, available at: https://www.medicaid.gov/sites/default/files/2020-12/cib120420_0.pdf.