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

CMCS Informational Bulletin

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SUBJECT: State Compliance with Medicaid and CHIP Renewal Requirements by December 31, 2026

Section 5131 of title V of division FF of the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) amended the Families First Coronavirus Response Act by creating new conditions for states to receive a temporary Medicaid federal matching percentage increase. These new conditions were in effect from April 1, 2023 through December 31, 2023 as states resumed regular eligibility renewals following the end of the Medicaid continuous enrollment condition. Among these funding conditions was a requirement that states conduct Medicaid eligibility redeterminations consistent with all applicable federal requirements, including renewal strategies authorized under section 1902(e)(14)(A) of the Social Security Act (the Act) or other alternative processes and procedures approved by CMS.[1]

As CMS engaged with states prior to and during their unwinding periods, CMS identified many states that were not in compliance with some aspect of federal renewal requirements. Specifically, in March 2023, CMS required that 36 states implement mitigation strategies to avoid further agency action. Through data analysis, discussions with states, and ongoing review of available information on state policies and processes during unwinding, CMS has continued to assess states' renewal compliance and require mitigations, as appropriate. Nearly all states were required to implement at least one mitigation strategy during unwinding, including states that needed to reinstate beneficiaries or temporarily pause renewal processing to protect coverage for eligible individuals.

Ensuring states' compliance with federal renewal requirements is core to CMS' stewardship of the Medicaid program and essential to protecting eligible individuals' ability to maintain coverage. Because CMS identified areas of non-compliance with renewal requirements in nearly every state during unwinding, with many common areas of non-compliance across states, CMS believes a standardized process will support states to achieve compliance with all renewal requirements in the most timely and efficient manner.

[1] The CAA, 2023, also added section 1902(tt) to the Social Security Act, which (among other things) created enforcement authorities for the Centers for Medicare & Medicaid Services (CMS) to address state noncompliance with certain federal requirements if that noncompliance occurred during a period that ended on June 30, 2024.

This Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) provides updated information on the timing and expectations for all states to achieve compliance with all federal renewal requirements, including states that implemented CMS-approved mitigation strategies and those who have since identified areas of non-compliance with renewal requirements. As described in more detail in this CIB, all states are required to complete a compliance assessment, demonstrate compliance with federal Medicaid and CHIP renewal requirements described at 42 C.F.R. §§ 435.916 and 457.343, and submit a plan outlining steps and milestones for addressing identified areas of non-compliance to CMS by **December 31, 2024.** Compliance plans will detail how states will achieve compliance with all applicable requirements no later than **December 31, 2026.**

While all states must complete the compliance assessment and plan, states with existing mitigation plans and those already identified as having at least one area of non-compliance with renewal requirements must complete the compliance assessment and plan as a condition of CMS's continued non-enforcement of the underlying compliance issues in those states. Failure to do so may result in additional agency action based on CMS' assessment of the state's individual circumstances and the nature of the non-compliance. CMS notes that all states are required by 42 C.F.R. 431.16 and 431.17(b)(2) to submit all reports as instructed by the Secretary and to maintain "records necessary for reporting and accountability as required by the Secretary," and, therefore, any state that fails to obtain approval for a compliance assessment and plan may be required to provide additional documentation of its compliance with federal regulations in accordance with 42 C.F.R. 431.17(d)(2).[2]

Background

Following the passage of the Affordable Care Act (ACA) in 2010, CMS issued new regulations for Medicaid and CHIP intended to help realize the vision of a streamlined, data-driven eligibility process that minimizes burden on individuals and states and supports timely and accurate eligibility determinations. The new regulations on Medicaid and CHIP renewal processes prioritized the use of data and other available information to verify eligibility and built on state best practices, lessons learned, and research on how best to minimize churn in and out of coverage for eligible individuals.

State efforts to implement ACA-era rules for streamlining eligibility and enrollment over the last decade have been notable. Most states have implemented required policies to allow for online, phone, and paper submissions of information and implemented other technology-based approaches like mobile-friendly applications, which help improve accessibility and reduce administrative barriers to coverage and care. In many states, historically paper-based processes for reverifying eligibility with pay stubs and other documentation have been replaced by more automated systems that provide real-time access to electronic wage and other information, allowing for faster and more accurate decisions at renewal.

Yet, many states are not yet compliant with all renewal requirements, especially for beneficiaries enrolled in Medicaid on a basis other than Modified Adjusted Gross Income (MAGI). Based on CMS' assessment of state compliance with renewal requirements in March 2023, 35 states were non-compliant with at least one requirement.[3] Nearly half of states (23)

[2] *See also* 42 C.F.R. 457.720 and 457.965(d)(2).
[3] https://www.medicaid.gov/resources-for-states/downloads/sum-st-mit-strat-comply-medi-renew-req.pdf

were unable to renew eligibility based on available information (*ex parte* renewal) for non-MAGI beneficiaries, as required under 42 C.F.R. § 435.916(a). In 19 states, at least some beneficiary populations were unable to submit information to complete the renewal process via all required modalities (online, phone, and in person, and other commonly available electronic means). The unwinding process itself also uncovered areas where renewals were not being processed correctly. For example, in the summer of 2023, CMS identified an issue in 29 states that resulted in inappropriate disenrollments at renewal of over 400,000 children and families in multi-member households (referred to as the household *ex parte* issue).[4]

To continue to qualify for the temporary federal matching percentage increase under the CAA, 2023's amendments to the Families First Coronavirus Response Act (P.L. 116-127), and to avoid CMS taking an enforcement action under section 1904 of the Social Security Act, each state that CMS identified as non-compliant with renewal requirements implemented approved mitigation strategies and/or temporary waivers of certain requirements under section 1902(e)(14)(A) of the Act. These strategies, which included policy, operational, outreach, and systems changes, were tailored to the state's area(s) of non-compliance and designed to support continuity of coverage for eligible beneficiaries. For example, a state that lacked functionality for online submission of renewal forms consistent with 42 C.F.R. § 435.916(b)(2) may have extended call center hours and deployed additional outstationed eligibility workers to provide alternate options for submitting forms.

As unwinding progressed and CMS identified other compliance issues such as the household *ex parte* issue described above, states were required to reinstate coverage for affected individuals, pause procedural disenrollments, and implement other mitigations to prevent improper disenrollments. These strategies, however, were not meant to be permanent. As a condition of approval of mitigation strategies put in place before or during the unwinding period, states agreed to work towards compliance with all federal statutory and regulatory renewal requirements.

Renewal Compliance Approach and Timeline

Renewal Guidance

Working with states to prepare for unwinding underscored the need for CMS to remind states of statutory and regulatory renewal requirements, and how CMS interprets and applies those requirements, as states assess and confirm compliance. To address that need, CMS will be issuing updated guidance to states in late 2024 providing clarity on renewal requirements across several key topics, including income verification, *ex parte* renewals, and requirements related to renewal forms. This new guidance is intended to further assist states to build compliant systems and processes.

Compliance Assessment and Plan

To avoid further agency action, including compliance action under section 1904 of the Act and/or more detailed and particularized requests for records under 42 C.F.R. 431.17(d)(2), all states must complete an assessment of their compliance with renewal requirements; submit the results of their assessment to CMS, along with evidence demonstrating their compliance;

[4] https://www.medicaid.gov/resources-for-states/downloads/state-ltr-ensuring-renewal-compliance.pdf

and develop and submit a plan to correct any areas of non-compliance. States must use the template[5] released alongside this CIB for this assessment, attestation and demonstration of compliance, and, as applicable, submission of a compliance plan. This standardized format will facilitate CMS' ability to provide technical assistance, as needed, and conduct monitoring and oversight of states' progress across all states. The State Medicaid Agency is responsible for compliance with all federal renewal requirements and each state must submit a single completed template with compliance information provided for each requirement, even if information must be collected from multiple state agencies. Submitted compliance assessments and plans will be reviewed and approved by CMS.

In keeping with CMS' ongoing commitment to transparency, and in light of the large number and wide variety of individuals affected, we intend to post the final and approved compliance assessments and plans (the completed and approved compliance template) on Medicaid.gov[6].

CMS will monitor progress on implementation of the compliance plans and achievement of compliance with all requirements through regular updates from states, as detailed below. In addition, CMS will continue to monitor renewals and potential compliance issues through review of data collected from states and other available information.

Compliance Timeline

CMS is providing the following timeline for renewal compliance.

- **By December 31, 2024,** all states must assess compliance with renewal requirements and submit the completed template to CMS. This provides sufficient time for states to complete most unwinding-related renewals and review relevant guidance and tools to evaluate their compliance.

- States that identify deficiencies must submit updates to their approved compliance assessments and plans using the renewal compliance template ***every six months,*** until compliance with all requirements is confirmed by CMS.

- States with identified deficiencies must demonstrate compliance with all renewal requirements **by December 31, 2026,** as detailed below.

CMS acknowledges that the 2024 eligibility and enrollment final rule (89 FR 22780) made additional changes to the renewal process, including establishing new requirements to align renewal simplifications for non-MAGI populations with those for MAGI applicants. State compliance with the renewal requirements in the 2024 final rule will be assessed on a different timeline, as many provisions have delayed compliance dates through June 2027.[7] Because the new regulations build on existing rules, states' compliance with these existing requirements will set a necessary foundation for the successful implementation of the new rules.

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[5] *Compliance Template: Assessment and Plan for Compliance with All Federal Medicaid and CHIP Renewal Requirements*, available at https://www.medicaid.gov/resources-for-states/downloads/renewal-assessment-plan-comp-temp.pdf

[6] *See* 42 CFR §§ 401.105(a) and (b)(2)

[7] "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes," final rule (89 FR 22836), available at: https://www.govinfo.gov/content/pkg/FR-2024-04-02/pdf/2024-06566.pdf

Renewal Requirements

States have an obligation to conduct redeterminations of eligibility for individuals enrolled in Medicaid and CHIP in compliance with all existing federal requirements at 42 C.F.R. §§ 435.916 and 457.343, as interpreted and described in the CIB, "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements."[8] As a condition of CMS's continued non-enforcement of previously identified compliance issues, and to avoid more detailed and particularized requests for further action in other states, all states will be required to assess and demonstrate their compliance with certain key federal renewal requirements, including the following:

- *Ex Parte Renewals:* States must first attempt to conduct a renewal for all beneficiaries based on available information, without requiring information from the individual (an ex parte renewal) (42 C.F.R. § 435.916(b)(1); 42 C.F.R. § 457.343).

- *Provision and Availability of Renewal Forms:* States must provide a renewal form and request only information needed to determine eligibility when eligibility cannot be renewed on an *ex parte* basis. For MAGI beneficiaries, the renewal form must be prepopulated with information available to the agency (42 C.F.R. § 435.916(b)(2)(i)(A); 42 C.F.R. § 435.916(b)(2)(v); 42 C.F.R. § 457.343).

- *Timeline to Return Renewal Forms:* States must provide MAGI beneficiaries with at least 30 days from the date of the pre-populated renewal form to return the form and provide any additional information requested by the agency (42 C.F.R. § 435.916(b)(2)(i)(B); 42 C.F.R. §457.343). Non-MAGI beneficiaries must be given a reasonable amount of time to return forms and documentation (42 C.F.R. § 435.916(b)(2)(i)(B);[9] 42 C.F.R. §435.952).

- *Ability to Submit Renewal Forms Through All Required Modalities:* All beneficiaries must be able to submit their renewal form through any of the modes of submission available for submitting an application (i.e., via the internet Web site described in 42 C.F.R. § 435.1200(f), by phone, by mail, in person; and through other commonly available electronic means) (42 C.F.R. § 435.916(b)(2)(i)(B); 42 C.F.R. § 435.907(a); 42 C.F.R. § 457.343).

- *Reconsideration Period:* For MAGI beneficiaries whose eligibility has been terminated for failure to return their renewal form or requested information, if the renewal form and/or necessary information is returned within 90 days after the date of termination, or a longer period elected by the state, the agency must reconsider the individual's eligibility without requiring the individual to fill out a new application (42 C.F.R. § 435.916(b)(2)(iii)[10]; 42 C.F.R. § 457.343).

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[8] *Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements*, CMCS Informational Bulletin, December 4, 2020: https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf

[9] Compliance with the new requirements to provide prepopulated renewal forms for beneficiaries enrolled on a basis other than MAGI and a minimum of 30 days for all beneficiaries to return renewal forms and information is required by June 2027. Until then, the requirements in effect prior to June 4, 2024 and as reflected here will be the basis for CMS' assessment of states' compliance.

[10] Compliance with the new requirement to providing a minimum 90-day reconsideration period at renewal for individuals disenrolled from a non-MAGI group will be effective in June 2027 and will be evaluated separately.

- *Determination of Eligibility on All Bases:* States are required to consider eligibility on all bases prior to determining an individual is ineligible for Medicaid (42 C.F.R. § 435.916(d)(1); 42 C.F.R. § 435.916(b)).

- *Determination of Potential Eligibility for Other Programs & Transfer Account:* For beneficiaries who are determined ineligible for Medicaid and CHIP, the agency must determine potential eligibility for other insurance affordability programs and timely transfer the beneficiary's electronic account to such program (42 C.F.R. §§ 435.916(d)(2) and 435.1200(e); 42 C.F.R. §§ 457.343 and 457.350(b)).[11]

To ensure successful renewals and support retention of eligible individuals, CMS notes that states must also comply with other critical requirements outside of Medicaid and CHIP renewal regulations at 42 C.F.R. §§ 435.916 and 457.343. These include, but are not limited to requirements at 42 C.F.R. §§ 435.905(b) and 457.340(e) regarding information provided in plain language and in an accessible and timely manner and 42 C.F.R. §§ 435.908 and 457.340 regarding assistance with application and renewal. CMS intends to develop additional resources to support states' compliance in these areas as well.

Requirements for Compliance Assessments and Plans

Attestation, Description, and Supporting Evidence of Compliance

For each renewal requirement, states must attest to compliance or non-compliance and provide additional supporting information using the renewal compliance template. States must provide a description of the policies and processes in the state associated with each requirement. This information should include sufficient detail to assist CMS with confirming the current compliance status for that requirement. Supporting evidence of compliance should be described in the template and submitted along with the completed template. CMS will provide states with additional information on what evidence will be sufficient to confirm compliance for each requirement, for example detailed policy and systems documentation.

Compliance Deficiencies

For each compliance deficiency identified in the compliance assessment, states should describe the issue and the impact on beneficiaries in the template under the relevant requirement. Any policy, operational, or technical deficiency related to the renewal requirement should be identified and included in the information provided to CMS.

Key Activities to Achieve Compliance

To provide a roadmap to compliance, states should list major milestones towards resolving each deficiency in the renewal compliance template in each non-compliant area. Milestones could include Advance Planning Document (APD) submissions, system releases, process changes, or other activities required for reaching compliance. As described below, states will be providing regular updates to CMS on progress towards these milestones and ultimate compliance.

[11] Compliance with the new requirements for t**r**ansitioning accounts for certain individuals no longer eligible for Medicaid to a separate CHIP and to the Marketplace (§§ 431.10, 435.1200(b),(e) and (h), 457.340(f), 457.348, 457.350(b) and (e)) will be evaluated separately.

Federal Financial Participation (FFP) at a 90 percent matching rate is available to states for their expenditures on design, development, or installation of mechanized claims processing and information retrieval systems, including on designing, developing, and installing approved processes, systems, and activities necessary to ensure compliance with the requirements reiterated in this CIB. FFP at a 75 percent matching rate is available for state expenditures to operate such systems.

Ongoing Mitigation Strategies

As states work toward full compliance with renewal requirements by December 2026, CMS expects states to continue or initiate mitigation strategies to minimize any harmful impact of a state's non-compliance with requirements on Medicaid and CHIP beneficiaries. For each area of non-compliance described in the template, states should outline proposed mitigations or seek approval for waivers, as appropriate, under section 1902(e)(14)(A). Waivers requested beyond June 30, 2025 will be considered individually and approved on a time-limited basis, if needed to remediate issues and protect beneficiaries.

Review and Approval

After compliance assessments, evidence and plans are submitted CMS will review submitted information and work with states to finalize and approve compliance plans. As noted above, approved assessments and plans will be posted on Medicaid.gov.

Monitoring

To avoid further agency action, states are expected to demonstrate compliance with all renewal requirements by December 31, 2026. That timing provides these states two years to remediate areas of non-compliance after submission of compliance assessments and plans. To provide support to states and oversight of the activities described in the approved compliance plans, CMS will require a written update from states with identified areas of non-compliance every six months on the milestones in the renewal compliance template along with any other necessary information or documentation from the state to demonstrate compliance. States that are not meeting milestones from their compliance plans and are at risk for not achieving compliance by December 31, 2026 may be subject to additional information requests and/or more frequent reporting of their progress.

As part of its regular monitoring efforts, CMS will also continue to review state-submitted data and other available information and will follow up with all states on potential renewal compliance issues identified.

States that fail to demonstrate compliance with all renewal requirements by December 31, 2026, may face additional agency action based on CMS' assessment of the state's circumstances and the nature of the non-compliance.

Conclusion

CMS is available to provide ongoing assistance to support state efforts to achieve compliance with renewal requirements to help ensure that eligible individuals successfully renew their Medicaid and CHIP coverage. CMS will also use standing meetings with states to provide technical assistance on compliance assessments and the development and implementation of

compliance plans. CMS is releasing this information now so states can prepare to conduct compliance assessments and provide information to CMS. For additional questions, please email CMSUnwindingSupport@cms.hhs.gov.