Federal Requirements and State Options: Enrollment and Renewal Procedures

Federal statute and regulations define a common approach across states for individuals to apply for, enroll in, and renew eligibility for Medicaid. States retain flexibility in how they design their applications and conduct eligibility verifications, and the processes they use to streamline enrollment and renewal (Table 1).

Applications. States must use the single, streamlined application developed by the Secretary of the U.S. Department of Health and Human Services or an approved alternative to determine eligibility for individuals applying on the basis of modified adjusted gross income (MAGI). For a determination on other bases, states may provide applicants with supplemental forms to collect additional information or create separate applications. Individuals must be able to submit their applications by phone, mail, in person, and online. Applications for MAGI-based coverage must also allow individuals to apply for all health insurance programs (including Medicaid, CHIP, and subsidized coverage on the exchange). States have the option of allowing individuals to apply for other human services programs through the use of a multi-benefit application (42 CFR 435.907). As of January 2017, 25 states offer online applications that enable individuals to apply for Medicaid, the Supplemental Nutrition Assistance Program (SNAP, previously known as food stamps), and cash assistance. Thirty states have made online applications available to all applicants, including individuals age 65 and older and people with disabilities (Brooks et al. 2017).

Income counting. Medicaid eligibility determinations that are based on MAGI standards use federal tax rules for counting income and household size, with narrow exceptions. The MAGI-based methods apply generally to children, pregnant women, parents, and adults without dependent children. MAGI methods do not apply to individuals whose eligibility is determined on the basis of age or disability; those whose eligibility for Medicaid does not require a Medicaid determination of income, such as individuals receiving Supplemental Security Income (SSI) or Title IV-E child welfare assistance; those in need of long-term services and supports (LTSS); and certain individuals applying for Medicare cost-sharing assistance or medically needy pathways. In determining income eligibility for MAGI groups, states disregard five percentage points of the federal poverty level (FPL) (42 CFR 435.603).

Eligibility verification. Some individuals are automatically eligible for Medicaid based on receipt of other federal benefits, including individuals receiving SSI and Title IV-E child welfare assistance. For those who are not automatically eligible for Medicaid, states are required to verify individuals' eligibility for coverage. For some eligibility factors, such as citizenship and immigration status, federal law and regulations generally prescribe the verification procedures which must be followed; for other factors, states have greater flexibility, including accepting self-attestation (§§ 1137 and 1902(a)(46)(B) of the Social Security Act, 42 CFR 435.945, 42 CFR 435.956).

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States must verify citizenship, satisfactory immigration status, and Social Security numbers (42 CFR 435.910, 42 CFR 435.407). States are also required to verify financial eligibility; however, this can be done post-enrollment after the state has made a determination based upon the applicant's attestation (42 CFR 435.948, CMS 2013c). States must accept self-attestation for pregnancy, and may elect to do so for other non-financial eligibility criteria (such as age and state residency) (42 CFR 435.945, 42 CFR 435.956, CMS 2013c).

Additionally, states should rely on electronic data sources to the greatest extent possible when verifying eligibility. If data cannot be obtained electronically or the data are not reasonably compatible with the applicant's attestation, the state must ask for additional information, which could include paper documentation (42 CFR 435.949, 42 CFR 435.952, CMS 2013c).[1]

Redeterminations. For those eligible on the basis of MAGI, states renew eligibility once every 12 months; for those eligible on another basis (e.g., such as those eligible on the basis of disability) states can conduct regular renewals of eligibility more frequently (42 CFR 435.916). States must also establish procedures under which enrollees can report changes that may affect their eligibility. To renew coverage, states must first attempt to confirm ongoing eligibility based on information available from a beneficiary's account or other available data sources (also known as an administrative or ex parte renewal). If the state cannot renew eligibility using available information for beneficiaries eligible on the basis of MAGI, it provides a prepopulated renewal form for the beneficiary to complete.[2] States can use a prepopulated renewal form for non-MAGI populations, but are not required to do so (42 CFR 435.916(b)). States must also consider eligibility through all other potential pathways prior to terminating eligibility (42 CFR 435.916(f), 42 CFR 435.930).

Eligibility processing and coordination. In processing applications, states must meet timeliness and performance standards and make eligibility determinations "promptly and without undue delay." States are expected to establish their own timeliness and performance standards, but must meet federal requirements of completing eligibility determinations within 90 days for those applying on the basis of disability and within 45 days for all others (42 CFR 435.912). State Medicaid agencies and the exchanges must also coordinate eligibility determinations and share applicant data (§ 1943 of the Act, 42 CFR 435.1200).

Additional policy options. States have a number of options available to streamline enrollment and renewal. Specifically, states can allow qualified entities, such as providers, to make a presumptive eligibility determination for MAGI-based eligibility groups and certain other populations (§§ 1920, 1920(A), 1920(B), 1902(C) of the Act, 42 CFR 435.1100-1103). A hospital may elect to be a qualified entity and conduct presumptive eligibility determinations for Medicaid, regardless of whether the state has adopted any of the options for specific populations (§ 1902(a)(47)(B) of the Act, 42 CFR 435.1110). As of January 2017, 20 states use presumptive eligibility for children and 30 use presumptive eligibility for pregnant women, while smaller numbers have adopted the option for parents or other adults. Forty-six states have implemented hospital-based presumptive eligibility (Brooks et al. 2017).

States can also rely on findings from other programs, such as SNAP, to enroll or renew children in Medicaid. Under express lane eligibility (ELE), states can accept the determination of income made by

another program in determining a child's eligibility for Medicaid (§ 1902(e)(13) of the Act). Seven states have adopted this option for children for an initial determination of eligibility and six have adopted the option at renewal (Brooks et al. 2017). Similar to ELE, states may enroll or renew parents and adults using the income determination made by another means-tested benefit program, provided that the income determination is no less than it would have been if determined using MAGI (CMS 2015). As of March 2017, three states have adopted this option, using information from SNAP, Temporary Assistance for Needy Families (TANF), or the Low Income Home Energy Assistance Program (LIHEAP).

States can also extend eligibility for children for 12 continuous months, regardless of changes in income (§ 1902(e)(12) of the Act, 42 CFR 435.926). As of January 2017, almost half (24 states) had 12-month continuous eligibility for children (Brooks et al. 2017).

Waivers

State use of waivers to change enrollment and renewal procedures has been limited. For example, New York and Massachusetts use the findings from other programs to determine eligibility for parents or adults without dependent children under Section 1115 waivers. Although CMS guidance has also clarified that 12-month continuous eligibility for adults is possible through a Section 1115 waiver, only two states (Montana and New York) have adopted it (CMS 2013b, Brooks et al. 2017). In their waivers to expand Medicaid to adults under the ACA, Indiana received a waiver of retroactive coverage and New Hampshire and Arkansas both have provisional waivers of retroactive coverage (MACPAC 2017).

TABLE 1. Federal Requirements and State Options: Summary of State Flexibilities Related to Enrollment and Renewal Procedures

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
Application	• States must use a single application that allows individuals to be screened for all health insurance affordability programs (42 CFR 435.907(b)). • States may only require applicants to provide information necessary to make an eligibility determination (42 CFR 435.907(e))[1]. • States must accept applications through the mail, over the phone, online, in person (42 CFR 435.907(a)). • States must accept applications at outstation locations for pregnant women, infants, and children (§ 1902(a)(55); 42 CFR 435.904).[2] • States cannot require a face-to-face interview for MAGI-based populations (42 CFR 435.907(d)). • States must provide assistance to all individuals seeking help with the application or renewal process (42 CFR 435.908(a)).	• States may use the Secretary-developed model application or an approved alternative (42 CFR 435.907(b)). • Multi-benefit applications are permitted, but states must have a health-only option (CMS 2013a). • States may use a supplement to the single application or another application for non-MAGI populations (42 CFR 435.907(c)). • States can determine the outstation locations and whether to use state employees, volunteers, or community-based organizations to assist individuals (42 CFR 435.904). • States may certify staff and volunteers to act as application assisters (42 CFR 432.908(c)).
Income counting	• Monthly MAGI-based methodologies are used to determine financial eligibility for children, pregnant women, parents, and adults without	• For MAGI populations, states have the option to consider changes in income (42 CFR 435.603(h)).[3]

TABLE 1. (continued)

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
	dependent children (i.e., MAGI populations) (§ 1902(e)(14), 42 CFR 435. 603). • For non-MAGI populations, states must apply the financial methodologies and requirements of the cash assistance program most closely related to the individual's status (e.g., Supplement Security Income (SSI)) (42 CFR 435.601-602, 42 CFR 435.603(j), 42 CFR 435.622). • No asset limit allowed for MAGI populations (§ 1902(e)(14)(C), 42 CFR 435.603(g)). • In determining eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the FPL (42 CFR 435.603(d)(4)).	• States may apply an asset test to non-MAGI populations (§ 1902(e)(14)(D)). • States may use less restrictive income counting methodology for non-MAGI populations (42 CFR 435.601(d)). • States determine budget period and deductions for those eligible as medically needy (42 CFR 435.831).
Verification: Citizenship or immigration status	• The state may not accept self-attestation to verify citizenship or immigration status (§ 1137(d), 1903(x), 1902(ee), 42 CFR 435.945(a)), 42 CFR 435.956(a)). • The state must first attempt to verify citizenship and immigration status through electronic data prior to requesting documentation (42 CFR 435.435.945(a) and (k)), and 42 CFR 435.407).[4]	

TABLE 1. (continued)

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
	• Applicants must be given a 90 day reasonable opportunity period to provide documentation during which the state must provide benefits to an otherwise eligible individual (42 CFR 435.456(a)(5)) and 42 CFR 435.456(b)). • The state may not re-verify citizenship at renewal or during a subsequent application unless a change in status is reported (42 CFR 435.956(a)(4)). • Social Security numbers must be verified (42 CFR 435.910).	
Verification: Financial eligibility	• States must request and use electronic data to the extent available in verifying eligibility before requesting paper documentation (§ 1137; 42 CFR 435.949).[5] • Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by an individual if both are either above or at or below the applicable income standard (42 CFR 435.952(c)(1)).	• States have flexibility to determine which electronic data sources are useful and which to use to verify income (§1137; 42 CFR 435.948). • States determine the timing of verification of financial eligibility (at application or post-enrollment) (CMS 2013c). • States can adopt a less restrictive reasonable compatibility standard (e.g., accept as reasonably compatible attested income which is within 10 percent of electronic income data). • If attested information is not consistent with

TABLE 1. (continued)

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
		information obtained from other sources, the state may require additional documentation or accept a reasonable explanation (42 CFR 435.952(c)(2)).
Verification: Other criteria	• States must accept self-attestation for pregnancy (42 CFR 435.956(e)). • States must first attempt to verify information electronically prior to requiring documentation from applicants (42 CFR 435.952).	• States can accept self-attestation of other eligibility criteria (such as age and residency) (42 CFR 435.945(a), 435.956). • States may consider blindness and/or disability as continuing until the physician or review team determines otherwise (42 CFR 435.916(b)).
Eligibility determinations	• Eligibility determinations must be made within 90 days for those applying on the basis of disability and within 45 days for all others (42 CFR 435.912(c)(3)).[6] • States must establish performance and timeliness standards for processing applications (42 CFR 435.912(a)). • Eligibility is effective no later than the date of application (42 CFR 435.915). • States must provide three months retroactive coverage if an individual received covered services and would have been eligible at the	• States have the option to make coverage effective on the first day of the month of the date of application (42 CFR 435.915).

TABLE 1. (continued)

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
	time the service was provided (42 CFR 435.915).	
Notice	• States must provide beneficiaries with timely and adequate written notices regarding any decisions affecting their eligibility or a change in benefits (42 CFR 435.917(a)). • States must provide information in plain language that is accessible to individuals who are limited English proficient and individuals with disabilities (42 CFR 435.917(a), 42 CFR 435.905(b)). • Notices must include specific information regarding eligibility, benefits, cost sharing, procedures for reporting changes, and appeals rights (42 CFR 435.917(b)). • States must provide individuals the choice to receive notices electronically or by mail (42 CFR 435.918).	
Coordination with other programs	• States must transfer the application and account of individuals determined ineligible for Medicaid to the exchange or appropriate health insurance affordability programs (including Medicaid, CHIP, and subsidized	• States have the option to accept exchange eligibility determination as an assessment or final determination of Medicaid eligibility (431.10(c)).

TABLE 1. (continued)

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
	coverage on the exchange) (§ 1943, 42 CFR 435.1200). • States must accept applications and individuals transferred from the exchange or other health insurance affordability programs (§ 1943, 42 CFR 435.1200).	
Renewal period	• States must conduct regular renewals of eligibility no more than once every 12 months for MAGI populations (42 CFR 435.916(a)). • For non-MAGI populations, states must redetermine eligibility at least every 12 months (42 CFR 435.916(b)). • States must establish procedures to ensure that beneficiaries make timely and accurate reports of changes in circumstances (42 CFR 435.916(c)). • States must redetermine eligibility whenever a change in circumstances (either reported by the enrollee or through a data match) may affect eligibility (42 CFR 435.916(d)).	• States have the option of establishing more frequent regular renewal periods for non-MAGI populations (42 CFR 435.916(b)). • States may provide up to 12 months continuous eligibility for children under age 19 regardless of changes in circumstances (§ 1902(e)(12); 42 CFR 435.926). • State may begin a new 12-month renewal period when conducting a redetermination after a change in circumstance (42 CFR 435.916(d)).
Renewal processes	• States must first attempt to renew eligibility for all enrollees using information available to the state (often referred to as an ex parte,	• States may use a prepopulated form for non-MAGI populations (42 CFR 435.916(b)). • States may provide more than the minimum

TABLE 1. (continued)

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
	passive, or administrative renewal) (42 CFR 435.916(a)(2)). • For MAGI populations, if eligibility cannot be renewed based on available information, states must send beneficiaries a prepopulated renewal form. Beneficiaries must be able to respond and provide necessary documentation through mail, over the phone, online, or in person and have a minimum of 30 days to do so (42 CFR 435.916(a)(3)). • For MAGI populations, states must reconsider eligibility without requiring a new application if the individual returns the form within 90 days of being terminated (42 CFR 435.916(a)(3)(iii)).	of 30 days to respond to the renewal form and request for additional information (42 CFR 435.916(a)(3)(B)). • States may establish a longer reconsideration period for MAGI populations (42 CFR 435.916(a)(3)(iii)). • States may establish a reconsideration period for non-MAGI beneficiaries (42 CFR 435.916(b)).

TABLE 1. (continued)

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
Presumptive eligibility (PE)[7]	• Hospitals participating in Medicaid have option to make presumptive eligibility determinations. States must provide coverage during a presumptive eligibility period for individuals determined presumptively eligible by hospitals (§ 1902(a)(47)(B); 42 CFR 435.1110).	• States have the option to allow hospital PE for non-MAGI populations (42 CFR 435.1110(c)).[8] • States have the option to select other qualified entities to make PE determinations for one or more of the following: children, pregnant women, former foster care youth, individuals with breast or cervical cancer, individuals receiving family planning services, and parents and adults in Medicaid (§§ 1920, 1920A, 1920B, 1920C, 42 CFR 435.1100-1103).
Express lane eligibility	• No requirement	• States have the option of relying on eligibility findings from other assistance programs when determining eligibility at application and renewal for children in Medicaid (§ 1902(e)(13), CMS 2010). • States have the option of choosing which agencies or assistance programs, from a defined list, they will use and whether to implement the program at enrollment and/or renewal (§ 1902(e)(13)(F) and CMS 2010).

TABLE 1. (continued)

Enrollment or renewal procedure	Federal statutory and regulatory requirements	State plan options
Facilitated enrollment state plan option	• No requirement	• States have the option to enroll or renew individuals known to be financially eligible for Medicaid using the income determination made by another public means-tested program. • States can elect which program(s) to use and whether to implement the program at enrollment and/or renewal (CMS 2015).

Notes: CHIP is the State Children's Health Insurance Program. FPL is the federal poverty level. MAGI is modified adjusted gross income. The Secretary is the Secretary of the U.S. Department of Health and Human Services.

[1] States can request the Social Security number of a non-applicant if the application makes clear that providing a non-applicant's Social Security number is voluntary and will be used only to determine an applicant's eligibility for Medicaid or other insurance affordability programs (42 CFR 435.907(e)(3)).

[2] An outstation location is a location in a community other than the Medicaid office where individuals may apply for Medicaid benefits. These may include local hospitals, federally qualified health centers, schools, day care centers, or other locations that are convenient for eligible populations.

[3] States also have the flexibility to determine how to count pregnant women when determining the family size of other members of the household (42 CFR 435.603(b)), whether to consider 19 and 20 year olds who are full time students to be "children" for purposes of household family composition rules (42 CFR 435.603(f)(3)(iv)), and whether to count actual cash support that exceeds nominal amounts as income in the case of tax dependents claimed by a taxpayer other than a parent (42 CFR 435.603(d)(3)).

[4] States have the option of establishing this linkage with the Social Security Administration (SSA) and the Department of Homeland Security (DHS) through the Federal Data Service Hub or through an alternative approved mechanism.

TABLE 1. (continued)

[5] To the extent useful, states must request information related to wages, net earnings for self-employment, unearned income and resources from the State Wage Information Collection Agency (SWICA), the Internal Revenue Service (IRS), the SSA, the Supplemental Nutrition Assistance Program (SNAP) and agencies that administer state unemployment and state supplementary payment programs, among others (§ 1137; 42 CFR 435.948).

[6] States must enroll applicants as expeditiously as possible on the basis that is easiest to determine (typically an eligibility pathway based on MAGI) and provide the individual an option to pursue an eligibility determination on other bases (e.g., based on disability) (42 CFR 435.911).

[7] Presumptive eligibility occurs when a qualified entity (such as a hospital) conducts preliminary eligibility determinations pending submission and processing of a regular application.

[8] The state may require PE hospitals to assist individuals determined presumptively eligible to in submitting full application (42 CFR 435.1110(b)(2)). States also have the option to establish expectations and performance standards for PE hospitals, and to disqualify hospital after attempting corrective action for poor performance (42 CFR 435.1110(d)).

Sources: MACPAC analysis of the Social Security Act, the *Code of Federal Regulations*, CMS 2015, CMS 2013a, and CMS 2013c.

Endnotes

[1] To facilitate efficiency in verification, section 1413(c) of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires the Secretary of HHS to establish an electronic service, known as the federal data services hub (hub) (See also 42 CFR § 435.949). The hub enables states to verify information from multiple federal agencies and other data sources, including the Social Security Administration, the Department of Treasury, and the Department of Homeland Security. States may request CMS approval to access these data sources for verification via an alternate mechanism provided that the alternative mechanism will reduce the administrative costs and burdens on individuals and states while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs (42 CFR 435.945(k)).

[2] States must reconsider an individual's eligibility (without requiring a new application) if he or she is terminated for failure to submit the renewal form or necessary information and the individual subsequently submits the renewal form within 90 days of termination, or a longer period selected by the state.

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