



Unwinding the Public Health Emergency: Checklist for Redeterminations

Once the COVID-19 public health emergency (PHE) ends, all Medicaid beneficiaries who have not had their coverage renewed during the PHE will need to go through the redetermination process to maintain Medicaid coverage. States must complete these redeterminations in compliance with Medicaid and Constitutional due process requirements.

This following checklist provides an overview of the minimum redetermination requirements and identifies some common red flags that may indicate failures by the Medicaid agency to meet those requirements. If you identify any red flags in your state, please reach out to the National Health Law Program (NHeLP) for further technical assistance.

Because the checklist is focused on minimum requirements, it does not include best practices or other recommendations for retaining eligibility and decreasing procedural denials. The CMS guidance cited includes some recommendations, as do other CMS [PHE unwinding](#) tools such as ones on [retention strategies](#), [retention strategies for kids](#), and [using managed care to maximize continuity of coverage](#). Other organizations have also compiled information on best practices, such as the [webinar series](#) from CBPP and Georgetown CCF.



<p>Did the State Perform a Proper Redetermination? The state must complete a new redetermination after the PHE ends prior to terminating Medicaid coverage. This includes all individuals who were determined ineligible for Medicaid during the PHE because they failed to respond to a request for information.</p>	<p>Citations 42 C.F.R. § 435.916 Aug. 2021 at p. 4</p>
<p>Step 1: Did the state first attempt to redetermine eligibility based on recent and reliable available information without seeking information from the beneficiary?</p> <ul style="list-style-type: none"> States have discretion to define recent or reliable information. However, CMS has said that information from the initial application or the beneficiary’s last renewal is <i>not</i> considered recent or reliable, unless it relates to information that is not subject to change, like citizenship or satisfactory immigration status. 	<p>435.916(a)(2), (b) Dec. 2020 at p. 3, 8 Aug. 2021 at p. 4</p>
<p>Step 2: If the eligibility redetermination could not be complete based on information available to the state, did the state request information from the beneficiary?</p>	<p>435.916(a)(3), (b)</p>
<p>The state must consider all bases of eligibility prior to determining a beneficiary ineligible for Medicaid. The state must also screen for eligibility in other affordability programs (e.g. the marketplace) and facilitate enrollment if eligible.</p> <p>Red Flags:</p> <ul style="list-style-type: none"> State not considering disability-based eligibility when a beneficiary is losing non-disability (e.g. MAGI) based eligibility. The forms used to request information do not ask about current and former receipt of Social Security benefits. 	<p>435.916(f)(1)-(2) Dec. 2020 at p. 9</p>
<p>Notice: Did the beneficiary receive advance notice? Once the state determines a beneficiary is not eligible in any category or on any basis, coverage must be maintained until the individual receives advance written notice that states the legal and factual reason for the termination and includes information on the beneficiary’s hearing rights.</p>	<p>435.917(a); 431.211</p>

<p>The written notice must be timely, generally mailed 10-days in advance of the effective date of the termination.</p> <p>Red Flags:</p> <ul style="list-style-type: none"> • The date on the notice letter is significantly different from the envelope postmark date. • The effective date of termination is prior to receipt of the notice. 	<p>435.917(b)(2); 431.211</p>
<p>Required Notice Elements:</p> <p>(a) Uses plain language and is accessible to individuals with disabilities and LEP individuals, including taglines at a minimum.</p> <p>(b) A statement of what action the state is taking and the effective date.</p> <p>(c) A clear statement of the specific reasons supporting the intended action.</p> <p>(d) The specific regulations that supports/requires the action.</p> <p>(e) The right to a hearing to appeal the decision.</p> <p>(f) An explanation of the right to continuing Medicaid coverage if a hearing is requested.</p> <p>Red Flags:</p> <ul style="list-style-type: none"> • The notice only contains general information and no individualized beneficiary information, e.g. the person’s income. • The notice requires the beneficiary to contact a call center or log in to their account for information that must be included in the notice. • The notice does not include taglines or other instructions for language or disability access. • The notice language is overly complex such that it is not easily understood or accessible. • The notice does not explain how to appeal or access a fair hearing, or uses language to improperly limit access to an appeal. 	<p>435.905(b), 435.916(a)(3)(i)(C) 431.210(a) 431.210(b) 431.210(c) 431.210(d) 431.210(e) <i>Goldberg v. Kelly</i></p>
<p>90-Day Cure Period: If the individual submits the requested information within 90 days of the termination date, the state must timely reconsider eligibility without requiring a new application.</p>	<p>435.916(a)(3)(C)(iii)</p>

<p>Potential PHE Specific Issues:</p> <p>(a) State must provide advance notice to those whose coverage is ending or changing due to:</p> <ul style="list-style-type: none"> (1) A Disaster State Plan Amendment ending; (2) An 1135 waiver ending; (3) The end of maintenance of effort (MOE) requirements. <p>(b) The state must send a second written notice in advance of any adverse action at the end of the PHE even if the state sent a prior written notice of adverse action during the PHE.</p>	<p>Dec. 2020 at p. 11-12</p>
<p>Hearing</p>	
<p>Access to Fair Hearing:</p> <p>The state must provide an opportunity for a fair hearing before the State agency to any applicant or beneficiary whose claim for medical assistance is denied or not acted upon with reasonable promptness. The state must provide the individual with an opportunity for a Medicaid fair hearing when an individual believes the state has taken an action erroneously.</p> <p>Red Flags:</p> <ul style="list-style-type: none"> • The state does not grant a fair hearing. • The hearing is not accessible. The hearing does not provide language services for limited English proficient (LEP) individuals and/or communication assistance/auxiliary aides for people with disabilities, including hearing materials in the beneficiary’s preferred language or accessible format. 	<p>42 U.S.C. § 1396a(a)(3); U.S. Const. XIV Amendment; 42 C.F.R. 431.200</p> <p>Dec. 2020 at p. 12</p>
<p>Timely Hearing & Decision:</p> <p>The fair hearing must be held and a decision rendered within 90 days of the individual timely requesting an appeal.</p> <p>Red Flags:</p> <ul style="list-style-type: none"> • The hearing is not held timely, or the decision is not rendered timely. 	<p>431.244</p>

If Your State Implemented the Optional COVID Group	
<p>(a) Did the state determine Medicaid eligibility on all bases prior to determining an individual ineligible for the Optional COVID Group? Also, did the state determine eligibility for other insurance affordability programs and transfer the case, if appropriate? AND</p> <p>(b) Did the state provide at least 10-day advance written notice of termination from the Optional COVID Group?, OR</p> <p>(c) Did the state meet the following requirements instead of (a) above? The state can bypass the requirement in (a) above if, at the time of enrollment, the state provided a notice stating:</p> <ul style="list-style-type: none"> • Coverage will end on the last day of the PHE, • The individual may be eligible for full Medicaid benefits, and • How to submit a full Medicaid application, AND <p>In the advance written notice of termination, the state again informed the individual how to apply for full Medicaid benefits and the circumstances when fair hearing rights would apply.</p> <p>Red Flags:</p> <ul style="list-style-type: none"> • The state does not evaluate the individual for Medicaid and Marketplace coverage prior to terminating Optional COVID Group coverage, and did not meet the notice criteria in (c). • The beneficiary submits an application for full Medicaid coverage and eligibility is denied, but the state does not provide fair hearing rights. 	<p>435.916(f)(1); 431.210; 431.211 Jan. 2021 at p. 60-61</p>