



Unwinding Medicaid Continuous Coverage: Checklist for Redeterminations

During the COVID-19 pandemic, Congress enacted continuous Medicaid coverage for almost all Medicaid beneficiaries enrolled as of March 18, 2020. Originally, that coverage was to end with the end of the public health emergency (PHE), but Section 5131 of the [Consolidated Appropriations Act of 2023](#) ends the continuous Medicaid coverage requirement as of March 31, 2023. The increased federal matching percentage (FMAP) that accompanied the requirement will steadily decrease until it ends on December 31, 2023. [CMS guidance allows](#) states an “unwinding period” of 12 months to begin and 14 months to finish all redeterminations for Medicaid beneficiaries enrolled at the end of the continuous coverage period. States must complete these redeterminations in compliance with Medicaid and Constitutional due process requirements.



The 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, decreasing procedural denials, or preventing other harms. Remember, these processes must also not discriminate or violate other beneficiary protections. Please see our [Continuous Coverage Unwinding landing page](#) and [Public Health Emergency and Continuous Coverage Unwinding Resources](#) document for links to relevant CMS guidance, CMS recommendations, and resources from NHeLP and other advocacy organizations.

<p>Did the State Perform a Proper Redetermination? The State must complete a new redetermination after the continuous coverage requirement ends prior to terminating any individual’s 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 individual?</p> <ul style="list-style-type: none"> • Did the State attempt to ensure they have up-to-date contact information for the individual? (FFCRA enhanced FMAP requirement, section 6008(f)(2)(B)) • States have discretion to define recent or reliable information and are supposed to rely on such information during ex parte renewals. However, CMS has said that information from the initial application or the individual’s last renewal is <i>not</i> considered recent or reliable, unless it relates to information that is not subject to change, such as citizenship or satisfactory immigration status. • States must allow for reasonable time for electronic information to be returned, including on assets. <p>Note: States may also use a change in circumstances process, rather than a full renewal if:</p> <ul style="list-style-type: none"> (a) the individual was found eligible following a full renewal or application within the last 12 months (or shorter period for non-MAGI groups, if selected by the State); (b) the State subsequently got a reported change in circumstances during continuous coverage; and (c) the State’s change of circumstances process complies with 431.916(d). <p>If the individual is not within their eligibility period, or was previously found ineligible at their last renewal within the continuous coverage period, the State must complete a full renewal. Individuals with unpaid premiums incurred prior to the PHE are treated similarly.</p> <p>Note: There are exceptions to the requirement that an enrollee must receive a full renewal prior to termination. If a person has been enrolled because they were in the optional COVID group or in their reasonable opportunity period (ROP) to provide verification of immigration or citizenship status, the State does not have to do a full redetermination of that individual, but must provide notice and hearing rights. States have options to extend the ROP.</p>	<p>435.916(a)(2), (b) Jan. 2023 at 9-12 Dec. 2022 PPT Oct. 2022 at 2-4 Oct. 2022 PPT May 2022 at 9-12 Aug. 2021 at 4 Dec. 2020 at 3, 8</p> <p>Oct. 2022 at p. 2-3 Dec. 2020 at p. 9</p>

<p>Step 2: If the eligibility redetermination could not be completed based on information available to the State, did the State request information from the individual? The State:</p> <ul style="list-style-type: none"> • may only request information needed to determine eligibility and must send a pre-populated form to MAGI groups • must provide a reasonable time to respond, at least 30 days for MAGI groups • must allow individuals to provide information online, by phone, by mail, or in-person <p>Step 3: The State must consider all bases of eligibility prior to determining an individual ineligible for Medicaid.</p> <ul style="list-style-type: none"> • The State must make a good faith effort to contact an individual using more than one modality prior to terminating coverage due to returned mail. (FFCRA enhanced FMAP requirement, section 6008(f)(2)(C)). • The State must also screen for eligibility in other affordability programs (e.g., the Marketplace, CHIP) and facilitate enrollment if eligible. <p>Note: If the State is unable to comply with all of the redeterminations requirements, such as pre-populated form for MAGI renewals, it may have received a § 1902(e)(14)(A) waiver to meet the compliance requirements under FFCRA to claim the temporary FMAP.</p> <p>Red Flags:</p> <ul style="list-style-type: none"> • State does not consider disability-based eligibility when an individual 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. • The State uses the change of circumstances process for those who not in a current eligibility period. • The forms used to request information request more than is allowed for a given individual's circumstances (MAGI, change of circumstances, etc.). 	<p>435.916(a), (b), (e) 435.952(c) Jan. 2023 at 8 Mar. 2022 at 9 Dec. 2020 at 10</p> <p>435.916(f)(1)-(2) Jan. 2023 at 12-15 Dec. 2022 PPT Oct. 2022 PPT Dec. 2020 at p. 9 May 2022 at p. Oct. 2022 at p. 9</p> <p>Jan. 2023 at 8</p>

<p>Notice: Did the individual receive advance notice? Once the State determines an individual 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 individual’s hearing rights.</p>	<p>435.917(a) 431.211</p>
<p>Notice Timing: 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/or Limited English Proficiency (LEP), 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 support/require 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 and no individualized information, <i>e.g.</i>, 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 Goldberg v. Kelly Mar. 2022 at p. 22 Oct. 2022 at p. 4, 11</p>

<p>90-Day Cure Period: If a MAGI-eligible 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)(iii)</p>
<p>Hearing</p>	
<p>Access to Fair Hearing: The State must provide an opportunity for a fair hearing 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 because it does not, for example: <ul style="list-style-type: none"> ○ provide language services for limited English proficient (LEP) individuals and/or communication assistance/auxiliary aides for people with disabilities; and ○ provide materials in the beneficiary’s preferred language or accessible format. 	<p>42 U.S.C. § 1396a(a)(3) U.S. Const. amend. XIV 431.200 Dec. 2020 at p. 12 Mar. 2022 at 22</p>
<p>Timely Hearing & Decision: 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. Note: The State may have received a § 1902(e)(14) waiver to allow additional time, but must provide continuing benefits. 	<p>431.244 Mar. 2022 at 22-23</p>

<p>If Your State Implemented the Optional COVID Group Note: coverage for this group is still tied to the PHE, not the continuous coverage end date.</p>	
<p>States that incorporated this optional group into their eligibility and enrollment systems will redetermine eligibility using the change in circumstances process with coverage ending on the last day of the PHE.</p> <p>States that used a streamlined enrollment process outside of their eligibility system may satisfy the requirement to determine eligibility on all other basis by sending the following information and adopting one of the three options below:</p> <ul style="list-style-type: none"> (1) Coverage will end on the last day of the PHE, (2) The individual may be eligible for full Medicaid benefits, (3) How to submit a full Medicaid application, AND (4) Appeal rights in limited circumstances. <p>The State has 3 options for providing the required information to this group:</p> <ul style="list-style-type: none"> (1) If the initial determination provided 1-3 above, the advanced termination notice must be sent at least 10 days in advance and inform the individual of 2-4; (2) If the initial determination did not include 1-3, the State may send a notice before the PHE ends with that information and then send an advance termination notice at least 10 days in advance with 2-4; OR (3) Send one combined notice a least 60 days prior to termination that includes all required information. <p>Red Flags:</p> <ul style="list-style-type: none"> • The State does not evaluate the individual for Medicaid, CHIP, and Marketplace coverage prior to terminating Optional COVID Group coverage, and did not meet the notice criteria. • The beneficiary submits an application for full Medicaid coverage and eligibility is denied, but the State does not provide fair hearing rights. • The State denies a fair hearing based on the end of the optional COVID group even where the person says the issue to be heard is a factual error, such as the wrong person or incorrect data used, rather than the policy change. 	<p>435.916(f)(1) 431.210; 431.211 431.220(b) Jan. 2023 at 22-23 Jan. 2021 at p. 60-61 Oct. 2022 PPT</p>