Are you covered by Medicaid?

See how the renewal process may impact benefits.*

Find your state Medicaid agency

Medicaid Renewal FAQs

What is Medicaid redetermination?

Medicaid redetermination, also called renewal, recertification or re-enrollment, is the process through which Medicaid beneficiaries reconfirm their eligibility for Medicaid. The Medicaid redetermination process ensures one is still eligible to receive Medicaid benefits. Medicaid has income and asset (resource) limits, and the Medicaid agency wants to ensure that the individual continues to fall under those financial limits. If household income is not reported or if income is above the Federal Poverty Level for their specific state, Medicaid benefits will be terminated.

Is this new? Why now?

Medicaid agencies are required to confirm people enrolled in the program are eligible. This is typically done each year. However, during the COVID-19 Public Health Emergency (PHE), states were required to maintain enrollments for all individuals already enrolled. Due to the length of the PHE, some individuals have not had their eligibility checked since before 2020. Beginning April 1, 2023, the agency will start processing Medicaid eligibility checks & terminating enrollment for those no longer eligible.

Does the process vary by state?

Yes, the redetermination process varies based on the state & the Medicaid program in which you are enrolled.

Does everyone have their eligibility checked at the same time?

No, the states will work through all their Medicaid enrollees over the course of many months. States have the flexibility to determine how they would like to work through their list of enrollees. Many are working through the list based on categories of individuals & other states are using dates of previous eligibility checks. Talk to your state enrollment office or check the online portal, if one is available in their state, to see when you will be checked for eligibility.

What do beneficiaries need to do today?

Update your contact information – Make sure your state Medicaid/CHIP program has your current mailing address, phone number, email, or other contact information. This way, they'll be able to contact you about your Medicaid/CHIP insurance.
Check your mail – Your state Medicaid/CHIP program will mail you a letter about your insurance. This letter will also let you know if you need to complete a renewal form to see if you still qualify for Medicaid/CHIP.
Complete your renewal form (if you get one) – Fill out the form & return it to your state Medicaid/CHIP program right away to help avoid a gap in your Medicaid/CHIP insurance. In some states & situations, a Medicaid beneficiary may not have to do anything during the renewal process because the state is using available data to confirm eligibility: tax returns, bank accounts, unemployment, SNAP eligibility. The Medicaid agency may be able to process the entire Medicaid renewal electronically without requesting any documentation from the Medicaid recipient. In those situations, the person should receive a notice they have been approved or denied insurance & on what basis. In other states & cases, the Medicaid beneficiaries may have to complete a redetermination form, either via paper, online, or in person. Proof of income or resources may be requested.

How will Medicaid beneficiaries know when they need to act?

State Medicaid agencies will contact beneficiaries in advance of redetermination activities. Contact may be via postal mail &/or email if an email address is on file with the Medicaid agency. Beneficiaries will be given a time window to update their eligibility information, including income documentation & any changes in circumstance. Depending on the state, beneficiaries may also be able to see their redetermination dates & requirements in the electronic portal available to beneficiaries.

What happens if a beneficiary does not renew in time?

If a Medicaid beneficiary does not complete the redetermination process in time, benefits will be terminated. Under federal law, notice must be given to the beneficiary & they have a certain time frame to provide the Medicaid agency with all required information. In this case, Medicaid benefits can be reinstated without the individual going through the application process again if they continue to meet the eligibility criteria.

Medicaid insurance in some states is retroactive. This means any accrued medical bills during the lapse in insurance that are generally covered by Medicaid will be covered. If one does not submit the necessary documentation & complete the redetermination process within the 90-day period, they must reapply for Medicaid benefits & a gap in benefits is very likely to occur. For this reason, it is best to act quickly to ensure no gaps occur.

If a beneficiary is found ineligible, what options do they have?

Beneficiaries that are found ineligible for Medicaid may be able to get insurance through the Health Insurance Marketplace (Marketplace or Exchange) or through their employer. State Medicaid agencies are required to help transition Medicaid ineligible beneficiaries into other insurance. Individuals can explore their insurance options on healthcare.gov or through their state-based health exchange.

If a beneficiary is found ineligible, how long do they have to find other health insurance?

Loss of Medicaid coverage will be treated like a special enrollment period & individuals have 60 days to enroll in new insurance. If they do not take action during this timeframe, they will need to wait until the next open enrollment period. Beneficiaries should act quickly to enroll in a qualified health plan from the exchange or an available employer sponsored health plan as soon as they know they are no longer meeting the Medicaid eligibility criteria.

What resources are available to help individuals find coverage?

Beneficiaries can visit healthcare.gov or call the Marketplace Call Center at 1-800-318-2596 to get details about Marketplace coverage & find out if they might save on premiums.

Individuals can contact their state Medicaid office or visit Medicaid.gov for more information about Medicaid or CHIP renewal.

Additionally, most federally qualified health centers (FQHCs) have navigators on staff & in their facilities to support consumers with plan selection & eligibility questions.

Learn about the process for your state

Contact your state Medicaid office

* All content is provided for informational purposes only & is subject to change without notice. Although we believe that the source of this information is reliable, we do not warrant or guarantee its accuracy, completeness or timeliness. Sam's Club Insurance Services, LLC is a licensed insurance agency that sells Medicare products. Sam's Club Insurance Services, LLC. is an affiliate of Sam's West, Inc. Sam's Club Insurance Services, LLC is not connected with or endorsed by the U.S. government or the federal Medicare program. We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1–800–MEDICARE (TTY users should call 1-877-486-2048) 24 hours a day/7 days a week to get information on all of your options. This ad solicits insurance prospects for Sam's Club Insurance Services, LLC.