Frequently Asked Questions to Support the Return to Normal Eligibility Operations:

Transitional Medical Assistance and Medical Support

November 22, 2023

The Centers for Medicare & Medicaid Services (CMS) has released numerous guidance documents and tools to help states prepare for the end of the Medicaid continuous enrollment condition, effective on March 31, 2023, under the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127), as amended by the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328). These resources include two State Health Official (SHO) letters:

(1) *Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID19 Public Health Emergency* (SHO #22-001, dated March 3, 2022); and
(2) *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act*, 2023 (SHO #23-002, dated January 27, 2023), along with a number of other guidance materials.[1]

As described in prior CMS guidance, the expiration of the continuous enrollment condition began the process for states to return to normal eligibility and enrollment operations, including the process of resuming renewals for all enrolled beneficiaries. This process has commonly been referred to as "unwinding."

CMS is releasing these answers to frequently asked questions (FAQs) regarding SHO # 22-002 and SHO #23-002, and related CMS guidance. For more information, including resources and tools to support state unwinding efforts, as well as information shared during all-state calls, please visit www.Medicaid.gov/unwinding.

Transitional Medical Assistance

Q1. What are the general requirements of Transitional Medical Assistance (TMA)?

A1. Section 1925 of the Social Security Act (the Act) generally requires that individuals who are enrolled in the mandatory eligibility group for parents and other caretaker relatives (P/CR group), described in 42 C.F.R. § 435.110, and who become ineligible for that group due to their earnings or hours of employment are entitled to up to 12 months of continued Medicaid eligibility, known as "transitional medical assistance" (TMA).[2] Because the general requirement

[1] These materials are available at https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html#Guidance.

[2] Prior to the Temporary Assistance of Needy Families (TANF) program, individuals qualifying for the Aid to Families and Dependent Children (AFDC) program were automatically eligible for and, in most states, automatically enrolled in Medicaid. Section 1925(a)(2) of the Act refers to recipients of AFDC. Upon termination of the AFDC program in 1996, section 1931 of the Act became the basis for mandatory P/CR group coverage, as section 1931(b)(1) of the Act requires that individuals eligible under its provision be treated as receiving AFDC, and section 1902(a)(10)(A)(i) of the Act, which describes the mandatory eligibility groups, still includes, at (I), AFDC beneficiaries. Because parents and caretaker relatives eligible under section 1931 of the Act are to be treated as

for TMA under section 1925(a)(1)(A) of the Act refers to "each family" that qualifies, this TMA coverage must also be extended to the dependent children and spouse of a parent/caretaker relative who becomes eligible for TMA. The earnings or hours of employment resulting in TMA eligibility is referred to herein as a "TMA-qualifying event." States have a choice of providing either two six-month TMA periods or a single 12-month TMA period. In states that choose to provide two six-month TMA periods, to be eligible for the second six-month period, beneficiaries must comply with certain reporting requirements and their gross earnings, less certain childcare expenses, must be at or below 185 percent of the federal poverty level (FPL). In states that choose to offer a single 12-month TMA period, these additional requirements do not apply.[3]

Federal statute provides specific requirements relating to Medicaid eligibility, coverage, and disenrollment for TMA beneficiaries. Some of TMA's key statutory requirements include:

- Financial Methodology: The initial TMA period (this includes the first six-month period in states that provide two six-month periods and the single 12-month period in all other states), does not have an income test. In states that elect to have two six-month TMA periods, the second six-month TMA period includes an income test based on information provided in quarterly reports submitted by the family.[4]

- Benefits and Coverage during a TMA Period: States that elect the single 12-month TMA period must provide to TMA-eligible individuals Medicaid coverage that is not less than the coverage that would be available to such individuals but for the TMA-qualifying event.[5] States that elect to have two six-month TMA periods must also provide during the first six-month period Medicaid coverage that is not less than the coverage that would be available to TMA-eligible individuals but for the TMA-qualifying event.[6] However, these states may reduce the scope of coverage offered during the second six-month period by eliminating coverage for certain acute care services that are otherwise available under the state plan and/or offering as an alternative source of coverage certain family health plans.[7] States also may provide for the payment of premium and cost sharing for employer-sponsored coverage to which a beneficiary may have access.[8] States that provide two six-month TMA periods also have the option to impose a premium on families during the second six-month TMA period.[9]

- Disenrollment: Section 1925 of the Act only permits states to disenroll individuals from TMA during the initial TMA period (including the single 12-month period) if the family

AFDC beneficiaries, the loss of their eligibility in the P/CR group effectively constitutes the loss of AFDC benefits. When this loss of eligibility (and effectively AFDC benefits) is the result of a TMA-qualifying event, it triggers section 1925 of the Act, including its notice provisions.

[3] Section 1925(a)(5) of the Act. The State option to elect two six-month periods or a single 12-month period is elected and described in the Medicaid state plan.

[4] Section 1925(b)(3)(A)(iii) of the Act.

[5] Section 1925(a)(4)(A) and (5) of the Act.

[6] Section 1925(a)(4)(A) of the Act.

[7] Sections 1925(b)(4) of the Act.

[8] Section 1925(a)(4)(B) of the Act.

[9] Section 1925(b)(5) of the Act.

no longer includes a dependent child.[10] States that elect to have two six-month TMA periods may disenroll TMA-eligible individuals during the second six-month TMA period only if one of the following conditions is met: (1) the family no longer includes a dependent child; (2) the beneficiary fails to submit a required report; (3) the family fails to pay a required premium; or (4) the family either has no earned income during one or more of the previous three months (although some exceptions apply) or the average gross monthly earnings for the immediately preceding three months, less childcare expenses necessary for employment, exceed 185 percent of the FPL.[11]

Q2. What are the beneficiary reporting requirements for TMA and what impact does noncompliance have on eligibility?

A2. Beneficiaries enrolled in TMA in states that have elected to provide two six-month TMA periods must provide quarterly reports on their gross monthly earnings and childcare costs necessary for employment of the caretaker relative.[12] Reports are due no later than the 21st day of the month following the quarterly reporting period.[13] Table 1 summarizes TMA quarterly reporting requirements:

Table 1.

Quarterly Report	Reporting Period	Due Date
1st Quarterly Report	Months 1-3 of the initial TMA period	21st day of month 4
2nd Quarterly Report	Months 4-6 of the initial TMA period	21st day of month 7
3rd Quarterly Report	Months 7-9 of TMA in the second TMA period	21st day of month 10

For example, if the initial TMA period begins on January 1st, the family's first report is due on April 21st for the period of January, February, and March. The second report would be due July 21st for the period of April, May, and June. And the third report would be due October 21st for the reporting period of July, August, and September.

If a TMA-eligible individual fails to meet these reporting requirements during their TMA period (without having good cause as determined by the state), or the information in the report leads the state to determine the individual no longer meets the eligibility requirements for TMA, the state may disenroll the family from TMA during the second six-month TMA period,[14] provided that

[10] Section 1925(a)(3)(A) of the Act. States may also disenroll individuals during a TMA period who are no longer a state resident, who request voluntary disenrollment or who are deceased.
[11] Sections 1925(a)(3) and 1925(b)(3) of the Act.
[12] Section 1925(b)(2)(B)(i) and 1925(b)(2)(B)(ii) of the Act.
[13] Section 1925(b)(2)(B) of the Act.
[14] Section 1925(b)(3) of the Act.

the state evaluates each family member on all other bases of eligibility[15] and provides advance notice, as discussed in more detail below at **Q11**.[16]

These reporting requirements do not apply to individuals in states that have elected a single 12-month TMA period.[17]

For a more detailed discussion of the TMA program requirements, please refer to the MACPro Implementation Guide for the TMA group.[18]

Q3. Many families experienced changes in earnings or hours of work during the COVID-19 public health emergency (PHE). Are states required to provide TMA to individuals who experienced such changes while the continuous enrollment condition was in effect?

A3. It depends. States had flexibility in how they operationalized renewals and redeterminations while the continuous enrollment condition under section 6008(b)(3) of the FFCRA, as amended, was in effect. In SHO #22-001[19] and SHO #23-002,[20] CMS provided guidance to states on resuming regular enrollment operations at the end of the continuous enrollment condition on March 31, 2023. Whether a state is required to extend TMA to an individual whose eligibility is being renewed during the unwinding period depends on whether the state continued conducting regular eligibility renewals and redeterminations while the continuous enrollment condition was in effect.[21] The following response addresses both scenarios.

States that were conducting regular eligibility renewals and redeterminations based on changes in circumstances while the continuous enrollment condition was in effect:

In a state that was conducting regular eligibility renewals and redeterminations while the continuous enrollment condition was in effect, the following requirements apply. If the state had determined that a parent/caretaker relative in the P/CR group experienced a TMA-qualifying event while the continuous enrollment condition was in effect and placed the individual in TMA status (after providing advance notice and fair hearing rights), the state generally may not provide the beneficiary with a new TMA period upon conducting their renewal during unwinding. The one exception would be if the individual's TMA period expired while the continuous enrollment condition was still in effect; then the individual was subsequently enrolled again in the P/CR group upon being determined eligible for that group; and the individual is determined at the renewal during unwinding to be ineligible for the P/CR group due to another TMA-qualifying event.

As part of the eligibility renewal conducted during the unwinding period for an individual whose TMA period expired while the continuous enrollment condition was in effect, the state must

[15] 42 C.F.R. § 435.916(f)(1).
[16] Section 1925(b)(3)(B) of the Act and 42 C.F.R. § 431.210-214.
[17] Section 1925(a)(5) of the Act.
[18] https://www.medicaid.gov/sites/default/files/2021-01/macpro-ig-transitional-medical-assistance.pdf
[19] https://www.medicaid.gov/sites/default/files/2022-03/sho22001.pdf
[20] https://www.medicaid.gov/sites/default/files/2023-08/sho23002.pdf
[21] The "Medicaid continuous enrollment condition" refers to the requirement in section 6008(b)(3) of the FFCRA, as amended by the CAA, 2023, under which, generally, states were required to continue the Medicaid enrollment of all Medicaid beneficiaries during the COVID-19 public health emergency as a condition of receiving additional federal funding. Section 5131 of subtitle D of title V of division FF of the CAA, 2023, directed that the continuous enrollment condition end on March 31, 2023.

determine whether the individual is eligible on another basis before disenrolling the individual, in accordance with the Medicaid redetermination requirements.[22]

For an individual whose TMA period is still in effect during the unwinding period because it was initiated while the continuous enrollment condition was in effect, the state must maintain eligibility until at least the end of their TMA period, at which time the state must conduct a full renewal, including determining whether the individual is eligible on another basis, before disenrolling them.[23]

States that did not conduct regular eligibility renewals and redeterminations while the continuous enrollment condition was in effect:

For states that did not conduct regular renewals and redeterminations of eligibility during the period in which the continuous enrollment condition was in effect and did not place individuals into TMA status as a result, the following requirements apply. If in conducting a renewal during the state's unwinding period the state determines that the individual experienced a TMA-qualifying event, the state must place the individual into TMA status and begin the individual's TMA period prospective from that point. This outcome is required because such individuals have not yet received the TMA coverage to which they are statutorily entitled, consistent with section 1925(a)(1) of the Act. The state may not retroactively begin the TMA period on the date of the TMA-qualifying event and count the time the individual remained enrolled in the P/CR group due to the continuous enrollment condition as part of the individual's TMA period; this is because a state must provide advance notice to a beneficiary prior to initiating a TMA period, as described in more detail in **Q10** and **Q11** below.

Q4. If a parent or caretaker relative has experienced a TMA-qualifying event, but the state determines that the parent or caretaker relative is eligible for another eligibility group, should the parent or caretaker relative be enrolled in TMA or the other group? Similarly, if the dependent child of a parent or caretaker relative who has experienced a TMA-qualifying event remains eligible for coverage under the eligibility group for low-income children described in 42 C.F.R. § 435.118, should the child remain enrolled in the low-income children's group or be transitioned to TMA?

A4. Some parents and caretaker relatives who become eligible for TMA may be eligible under another full-benefit group, for example, the adult group, described under 42 C.F.R. § 435.119, in states that cover the group. The parent or caretaker's dependent children, although entitled to TMA, will commonly remain eligible under the mandatory eligibility group serving infants and children under age 19, described in 42 C.F.R. § 435.118 ("low-income children's group").[24] States may enroll, or maintain enrollment of, TMA-eligible individuals in a different group for which they are eligible, provided that (1) the scope of Medicaid coverage provided to the individual under the different group is not less than that provided under TMA, and (2) if eligibility under the separate group is lost before the end of the individual's TMA period, the state will transition the beneficiary to TMA coverage for the balance of their TMA period.

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[22] 42 C.F.R. § 435.916(f)(1).

[23] *Id*.

[24] Because the income standard for the low-income children's group (under 42 C.F.R 435.118) in a given state is generally higher than the income standard for parents and caretaker relatives in the P/CR group (under 42 C.F.R. 435.110) in the state, children typically remain eligible and enrolled in the low-income children's group when the parent/caretaker relative becomes eligible for TMA.

We would expect, for example, that many children of a parent or caretaker transitioned to TMA would remain eligible for and enrolled in the low-income children's group. However, if the state determines that such a child is no longer eligible under the low-income children's group prior to the end of the TMA period, the state must transition the child to TMA for the remainder of the TMA period unless the child is determined eligible on another basis for Medicaid coverage that is the same or greater than the coverage provided under TMA. Similarly, we would expect that many parents and caretaker relatives who become eligible for TMA also will be eligible for the adult group in states that have adopted that group. For such parents and caretaker relatives, the state may enroll the individual in the adult group if the coverage under the state's Alternative Benefit Plan provides the same or greater coverage than the coverage available to other beneficiaries under the state plan. Regardless of whether an individual remains in TMA or is transitioned to another group, the state must provide a TMA-eligible individual with notice of their TMA period, including the date that coverage begins and when it will end.

Q5. Our state processed but did not act on changes in circumstances while the continuous enrollment condition was in effect. Are individuals who experienced a TMA-qualifying event while the continuous enrollment condition was in effect entitled to TMA following a renewal of eligibility during the state's unwinding period?

A5. Yes. Some states conducted renewals or redeterminations while the continuous enrollment condition was in effect, but did not transition individuals from the P/CR group to TMA coverage when they experienced a TMA-qualifying event. These states are required to provide prospective TMA coverage to individuals who experienced a TMA-qualifying event prior to the beginning of the state's unwinding period. Similar to the scenario in **Q3** above, in which the state did not conduct regular eligibility renewals and redeterminations while the continuous enrollment condition was in effect, this outcome is required because such individuals have not yet received TMA coverage consistent with section 1925(a)(1) of the Act. The individual's TMA period would begin after the state has conducted the individual's renewal and provided advance notice that the state has determined that the individual experienced a TMA-qualifying event and will be transitioned to TMA coverage.

Q6. Our state has individuals who were in TMA status before the PHE began and continued to receive TMA coverage (beyond 12 months) while the continuous enrollment condition was in effect. Are these individuals eligible for another prospective TMA period after the state conducts the individual's renewal?

A6. No. For individuals who were already in TMA status at the beginning of the continuous enrollment condition and retained TMA for the entirety of the time the continuous enrollment condition was in effect, the TMA period will have expired prior to the beginning of the state's unwinding period. This is true regardless of whether the state conducted eligibility renewals during the period that the continuous enrollment condition was in effect. When the state conducts the individual's renewal during the unwinding period, it must determine whether the individual continues to be eligible for Medicaid on another basis in accordance with 435.916(f), but the state will not consider this individual for another TMA period at this renewal. (See **Q3** for more detail related to an individual who was enrolled again in the P/CR group while the continuous enrollment condition was in effect would potentially be provided another TMA period, if the individual experienced another TMA-qualifying event.)

Q7. When may states conduct a renewal during the unwinding period for individuals who were in TMA status while the continuous enrollment condition was in effect?

A7. In general, states must maintain enrollment of individuals until they conduct a renewal during the unwinding period. Consistent with the March 3, 2022 SHO #22-001,[25] states have broad flexibility in how they prioritize and distribute renewals during the unwinding period, including when to conduct renewals for individuals who have been in TMA status and who the state believes are no longer eligible for TMA. For an individual who was in TMA status for at least 12 months during the continuous enrollment condition period, the state may conduct the individual's renewal at any time during the state's unwinding period, consistent with its prioritization plan, as the individual's TMA period will have necessarily exceeded the statutory limits.[26]

In a state that conducted renewals and transitioned individuals to TMA while the continuous enrollment condition was in effect, some individuals would be within a TMA period (i.e., have not yet received 12 months of TMA coverage) when unwinding began. The state may not conduct a renewal for these individuals during the unwinding period until their TMA period has concluded. Because the state may not disenroll the individual during the TMA period (as explained in **Q3** above) in this scenario, the individual's renewal must take place no earlier than when the TMA period ends. For example: Sean was initially transitioned to TMA on January 1, 2023, and the state either has elected a 12-month TMA period or Sean has satisfied the requirements for a second six-month TMA period. The state would need to conduct Sean's renewal at the end of Sean's TMA period in December, 2023, and ensure any disenrollment from eligibility is not effective before January 1, 2024.

Q8. What does "conduct a full renewal" mean during the unwinding period for individuals enrolled in TMA while the continuous enrollment condition was in effect. Are states required to conduct an *ex parte* renewal (i.e., using information available to the state, including available external data sources) if able to do so and send a full renewal packet if unable to confirm continued eligibility through the *ex parte* process?

A8. For individuals who were placed in TMA status while the continuous enrollment condition was in effect, and whose TMA period expired prior to renewal during the unwinding period, a full renewal on all bases of eligibility will operate in the same manner as for other individuals. States must use the *ex parte* process first and, if unable to renew eligibility using the available reliable information on a basis other than TMA (e.g., for the adult group, P/CR group, or a disability-related group), the state must send the individual a renewal form to obtain information needed to determine eligibility on other possible bases, consistent with existing renewal regulations.[27]

Q9. If our state is conducting an *ex parte* renewal of a family consisting of a parent and a child, and the household income based on information obtained by the state for the parent is over the income eligibility standard for the P/CR group due to earnings but under the applicable income standard for the child, can the state transition the parent to TMA and renew the child's eligibility on an *ex parte* basis? Or must the state send the parent a full

[25] https://www.medicaid.gov/sites/default/files/2022-03/sho22001.pdf
[26] Section 1925(a) and (b) of the Act
[27] 42 C.F.R. § 435.916.

renewal packet and wait for additional information regarding the parent's eligibility before renewing the child's eligibility?

A9. If the state cannot renew the parent's eligibility under the P/CR group or on another basis using the information obtained through the *ex parte* process, the state must send the parent a pre-populated renewal form (1) to confirm whether the information indicating that the parent's income is over the income standard for the P/CR group is accurate; and (2) to determine whether the parent may be eligible on another basis independent of TMA.

As described in the Continuous Eligibility and Individual Level Renewal Processes Deck[28] released by CMS in October 18, 2023, at state option, the child may be renewed on an *ex parte* basis for continued coverage in the mandatory low-income children's group even if the eligibility of the child's parent cannot be renewed on an *ex parte* basis. States may also choose to hold the final determination of eligibility for the child until the parent's eligibility determination is completed and use the information provided by the parent to redetermine the child's eligibility.[29]

Depending on the information returned by the parent, the state may determine that the parent remains eligible for the P/CR group, another eligibility group, or should be placed into TMA status.[30] The state must send the parent an appropriate notice based on the determination.

If the parent does not respond to the renewal packet, since the state has enough information from the *ex parte* review to determine the parent eligible for TMA, the state must send advance notice to the parent that their coverage under the P/CR group is ending and they are being transitioned to TMA. The parent would then be moved to TMA status. *See* **Q11**, below, for additional details on advance notice requirements. Note that whenever a parent is determined eligible for TMA, the child also will be eligible for TMA, but the child may remain enrolled in their original eligibility group (e.g., in the low-income children's group) provided that they continue to meet the eligibility criteria for that group.

Q10. What is the start date of the TMA period for renewals conducted during the unwinding period? Specifically, does an individual's TMA period start when the individual experiences a TMA-qualifying event or when the state conducts the eligibility determination?

A10. The first month of the TMA period is the month after a state determines through the renewal process under 42 CFR 435.916 that an individual has experienced a TMA-qualifying event and has provided the individual with an advance notice in accordance with 42 C.F.R part 431, subpart E: (1) that they have been determined ineligible for the P/CR group and eligible for TMA; (2) the basis for that determination and that the individual is being transitioned to TMA status; and (3) the individual's fair hearing rights.[31] Even if the state has information indicating that the TMA-qualifying event occurred in the past, the TMA period begins the month after the

[28] https://www.medicaid.gov/sites/default/files/2023-10/int-contin-elig-indiv-lvl-renew-process.pdf

[29] *See* the Continuous Eligibility and Individual Level Renewal Processes Deck released by CMS on October 18, 2023.

[30] If the information returned by the parent indicates that the individual is eligible for another group but not one whose benefit package is at least equivalent to the P/CR group benefit package, the state should keep the individual in TMA status (assuming that the information returned by the parent also confirms that the individual is no longer eligible for the P/CR group due to a TMA-qualifying event).

[31] If the outcome of the fair hearing is a decision that the individual did not lose eligibility for the P/CR group, the individual's TMA period would not continue.

state has both made its determination under 42 CFR 435.916 that a TMA-qualifying event occurred and provided the required advance notice.

For example, suppose a TMA-qualifying event occurred in February 2023 and the state did not act upon the individual's change in circumstances at that time. If the state initiates the individual's renewal in August 2023 and determines the individual is no longer eligible for the P/CR group due to the TMA-qualifying event that occurred in February, the state cannot begin the TMA period until September 2023, after it has completed the renewal process 42 CFR 435.916 and provided the required advance notice.[32] The state may not retroactively begin the TMA period dating back to February 2023, as this would constitute a retroactive adverse action that would deny the individual the advance notice and fair hearing rights to which they are entitled.

See **Q11** for more information about advance notice requirements and the content of such notices.

Advance Notice Requirements for TMA-Eligible Individuals

Q11. What are the advance notice requirements that apply to individuals who the state determines are eligible for TMA?

A11. When a state determines that an individual is no longer eligible for the P/CR group due to a TMA-qualifying event, the state must provide notice in accordance with two authorities: section 1925 of the Act (TMA-specific requirements) and 42 C.F.R. part 431, subpart E (advance notice and fair hearing requirements). As explained below, CMS recommends that states issue a single TMA notice satisfying all requirements.

TMA-specific Requirements

Section 1925(a)(2) of the Act requires that a state, upon determining that a P/CR group enrollee has experienced a TMA-qualifying event, notify the individual of: their loss of P/CR group eligibility and entitlement to TMA; the basis for the state's determination; and the circumstances under which the individual may lose TMA. States that offer two separate six-month TMA periods must also include notice of the beneficiary reporting requirement and a description in the notice that:

- The parent/caretaker relative must report the family's gross monthly earnings and the costs for the childcare necessary for the employment of the parent/caretaker for each of the first three months of TMA, due no later than the 21st day of the 4th month of TMA;[33] and
- Explains that the state may continue TMA without a beneficiary report if the family has established good cause for not reporting, what constitutes good cause, and how the family can notify the state that it has good cause for not reporting.[34]

States that elect the option under section 1925(a)(5) of the Act to provide a single 12-month TMA period are not required to include reporting requirements in their notices.

[32] 42 C.F.R. § 431.211.
[33] Section 1925(b)(2)(B)(i).
[34] *Id*.

Advance Notice and Fair Hearing Requirements

Separately, federal regulations require states to provide beneficiaries with at least 10-day advance written notice (either by mail or electronically, depending on the individual's election) of an adverse action.[35] An adverse "action," defined at 42 C.F.R. 431.201, includes any "termination, suspension of, or reduction in covered benefits or services, or a termination, suspension of, or reduction in Medicaid eligibility." Placement of an individual in TMA status means that the state has determined that the individual is ineligible for the P/CR group and will begin a maximum 12-month period of TMA eligibility (the basis for which cannot be renewed) after which the individual's coverage will end, unless they become eligible on another basis. In all states, the shift to time-limited eligibility under TMA is a reduction in Medicaid eligibility, therefore it constitutes an adverse "action" for which advance notice with fair hearing rights is required. In addition, in some states, new conditions also must be met for an individual to receive the full 12 months of TMA (as described in **Q1** and **Q2** above). A shift to eligibility under TMA with new eligibility conditions would also be a reduction in eligibility and constitute an adverse "action" for which advance notice with fair hearing rights is required.

States must provide individuals with certain information in the advance notice, including the basis for the state's determination and the circumstances under which an individual has a right to a fair hearing.[36] The advance notice must be an individualized notice to each beneficiary affected by the change – general public notice is insufficient to meet these requirements. In addition, the notices must meet accessibility requirements for individuals who are limited English proficient and individuals with disabilities consistent with 42 C.F.R. 435.905(b).

Use of a Single Combined Notice

CMS recommends that states issue a single notice that combines the required content of both legal authorities. For an individual who has experienced a TMA-qualifying event, such a single combined notice must:

- Be issued at least 10 days prior to the date on which the state intends to disenroll the individual from the P/CR group based on a TMA-qualifying event and place the individual in TMA status;
- Inform the individual of the state's intention to transition the individual to TMA status;
- Provide a clear statement of the specific reason for the loss of eligibility for the P/CR group and placement in TMA status, including the relevant regulations supporting the placement;
- Notify the individual that they will be in TMA status for either six or 12 months (depending on the state's elected TMA period);
- In states that apply a six-month initial TMA period, notify the individual of the reporting requirements to which they will be subject;
- Notify the individual of the circumstances under which their TMA status may be terminated; and
- Inform the individual of their right to a fair hearing to contest the state's determination that they are no longer eligible for the P/CR group (and include all other required information relating to the hearing, as described in 42 C.F.R. §§ 431.206 and 431.210).

[35] 42 C.F.R. part 431, subpart E and § 435.918.
[36] 42 C.F.R. §§ 431.206 and 431.210.

While a state would be permitted to issue two separate notices to the individual to comply with both notice-related legal authorities, instead of the combined notice described above, CMS believes that a single notice is advantageous to states because it is more administratively efficient and less likely to create confusion for beneficiaries.

Q12. Our state has two six-month TMA periods. If we provided advance notice to beneficiaries who experienced a TMA-qualifying event that they were being transitioned to TMA while the continuous enrollment condition was in effect, but did not require these beneficiaries to satisfy the TMA reporting requirements in order to receive a second six-month period, do we have to require that the beneficiary satisfy the reporting requirements and provide them with a second six-month TMA period after conducting their renewal during unwinding?

A12. No. States that provide two six-month TMA periods were not required to impose the reporting requirements described in section 1925(b) of the Act against individuals who were placed in TMA status. States claiming the temporary FMAP increase available under section 6008(b) of the FFCRA would not have been able to disenroll individuals from TMA during the second six-month TMA period due to failure to meet the TMA reporting requirements described in section 1925(b) of the Act. As a result, CMS permitted these states to suspend the TMA reporting requirements while the continuous enrollment condition was in effect. As long as the beneficiary was determined eligible for and notified of their transition to TMA in accordance with federal requirements and has received 12 months of TMA, the individual is not entitled to additional coverage under TMA.

States were permitted to begin applying the TMA reporting requirements for beneficiaries who had not yet received 12 months of TMA when the continuous enrollment condition ended on March 31, 2023 (provided that the state first provided the beneficiary with proper notice, as described in **Q11**, above). Alternatively, states had the option to suspend the TMA reporting requirements for all beneficiaries and maintain their enrollment until the individual receives a full renewal during the unwinding period.

Continuous Eligibility and TMA

Q13. Our state has elected Continuous Eligibility (CE) for children or will be doing so under the new CE requirement effective January 1, 2024. How does CE interact with the requirement to provide TMA to qualifying families? Will a child's CE period run concurrently with TMA?

A13. TMA and CE are separate requirements with separate federal statutory authorities that are not affected by each other.[37] As we have explained above in **Q3**, when an individual is enrolled in the P/CR group, the individual's child (or children) will most commonly be enrolled in the mandatory low-income children's group (although some children may be enrolled in a different group, e.g., based on receipt of supplemental security income or disability status). When the parent/caretaker relative experiences a TMA-qualifying event and is transitioned to TMA, the children likely will remain eligible in their current group (e.g., the mandatory low-income

[37] Note that beginning January 1, 2024, all states must provide 12 months of CE to children under 19 in Medicaid and the Children's Health Insurance Program, under section 5112 of the Consolidated Appropriations Act, 2023 (Pub. L. 117-328), *See* SHO Letter #23-004, available at: https://www.medicaid.gov/sites/default/files/2023-09/sho23004.pdf.

children's group), even as they also become eligible for TMA. If the child is in a CE period when a TMA-qualifying event occurs and the parent/caretaker relative is transitioned to TMA, the child will be simultaneously eligible for coverage on the bases of CE *and* TMA. The child's CE period will begin on the date of their last determination of eligibility and run for 12 months, with the following exceptions: the child reaches the maximum age for CE, moves out of the state, voluntarily disenrolls from Medicaid, is determined to have been erroneously granted eligibility, or dies, in accordance with section 1902(e)(12) of the Act, 42 C.F.R. § 435.926, and SHO Letter #23-004. The child's TMA entitlement will extend for up to 12 months, beginning with the transition of their parent to TMA status.

For example: Amirah is enrolled in the mandatory low-income children's group in a state that has elected the option under section 1902(e)(12) of the Act to provide a 12-month CE period. Amirah's eligibility was last determined for a new eligibility period, effective March 1, 2023 through February 29, 2024. Unless Amirah experiences an exception to CE, her eligibility is protected under section 1902(e)(12) of the Act through the end of February 2024.[38] In October 2023, the eighth month of Amirah's CE period, her parent (enrolled in the P/CR group) experiences a TMA-qualifying event, which the parent reports to the Medicaid agency. The state redetermines the parent's eligibility and determines that the parent is no longer eligible for the P/CR group based on the TMA-qualifying event and is not eligible on any basis other than TMA. Under section 1925(a)(1) of the Act, Amirah and her parent become entitled to TMA in November 2023, the month following the month of the state's determination that Amirah's parent is no longer eligible for the P/CR group. That Amirah is separately in a CE period is not a factor in determining her entitlement to, or the duration of, TMA under section 1925 of the Act, nor do section 1902(e)(12) of the Act or 42 C.F.R. § 435.926 permit any reduction in her CE period due to her TMA entitlement. Thus, the first four months of her initial TMA period, beginning November 2023, will run concurrently with her CE period, which extends through February. Whether Amirah must be transitioned to TMA status depends on whether or not she remains eligible for the mandatory low-income children's group effective March 1, 2024 (see **Q14** below for more information on this question).

Q14. In the example in Q13, where a child whose CE period ends while the child is in TMA status, when should the state conduct Amirah's next renewal?

A14. The timing of Amirah's next renewal depends on whether the premiums and/or cost sharing charged under TMA are greater than the premiums and/or cost sharing charged under her original eligibility group. Given that states must provide comprehensive Medicaid services to children under age 21 under the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit at section 1905(r) of the Act, benefits should not be less for Amirah under TMA than her original eligibility group. If the premiums and/or cost sharing charged under TMA are less than or equal to (i.e., not greater than) the premiums and/or cost sharing charged in the original group, the state has the option either to (1) conduct a renewal of Amirah's eligibility on an *ex parte* basis by the end of Amirah's 12-month eligibility period (February 2024, which is also the end of her CE period); or (2) conduct a full renewal of her eligibility in accordance with 42 C.F.R. § 435.916 at the end of the TMA period (October 2024, assuming the state either has elected a single 12-month TMA period or Amirah's parent meets the requirements for the second six-

[38] 42 CFR § 435.926(d).

month TMA period). If any applicable cost sharing and premiums imposed under TMA are greater than the cost sharing and premiums under Amirah's original eligibility group, the state must attempt to conduct a full renewal of Amirah's eligibility by the end of her eligibility period (February 2024) before transitioning Amirah to TMA for the balance of the TMA period.

Q15. In the example in Q13, where a child whose CE period overlaps with a period of TMA status, if the state has sufficient information when the TMA period begins to determine Amirah continues to be eligible in the group in which she is enrolled, may the state renew her eligibility at that time? How would this affect Amirah's TMA period?

A.15. Yes. States may use the regulatory option at 42 C.F.R. § 435.916(d)(1)(ii) to begin a new 12-month eligibility period after processing a redetermination based on a change in circumstances. However, the state must have sufficient information, with respect to all factors of eligibility, to renew her eligibility without requiring the individual to provide additional information unrelated to the change in circumstances. If the state has sufficient information with respect to all factors of eligibility based on the redetermination in October 2023 to determine that Amirah continues to be eligible for the low-income children's group, the state may begin a new 12-month eligibility period beginning November 1, 2023. In this case, a new 12-month CE period for Amirah also will begin November 1, 2023, and her next renewal would be due by October 31, 2024. Amirah's TMA period (also beginning November 1, 2023) will run concurrently with her new 12-month CE period (November 1, 2023, through October 31, 2024).

<u>Cooperation with Medical Support Requirements and Unwinding</u>

Q16. If an individual did not cooperate with medical support requirements during the COVID-19 Public Health Emergency and the state did not disenroll them while the continuous enrollment condition was in effect, during the unwinding period, does the state have to conduct a full renewal and provide another opportunity to cooperate prior to disenrolling the individual from Medicaid?

A16. Sections 1912 and 1902(a)(45) of the Act and implementing regulations at 42 C.F.R. §§ 435.610, 433.145, 433.147, and 433.148 require beneficiaries to either cooperate with the state in obtaining medical support and payments from liable third parties for themselves or for a person for whom the individual can legally assign rights, or establish good cause for not doing so.[39] Beneficiaries who assign the rights of a child must also cooperate with the state in establishing the identity of the child's non-custodial parent(s) or establish good cause for not doing so.[40] We refer to these requirements collectively as "medical support cooperation requirements." Pregnant individuals are exempt from medical support cooperation requirements.[41]

During the unwinding period, states generally must complete a full renewal of eligibility before disenrolling any individual who was determined ineligible for Medicaid but not disenrolled while the continuous enrollment condition was in effect, including individuals who did not meet medical support cooperation requirements. During this renewal, the state must provide the beneficiary with an opportunity to either meet medical support cooperation requirements or

[39] 42 C.F.R. §§ 433.147(c) and 435.610(a)(3).
[40] 42 C.F.R. §§ 433.147 and 435.610.
[41] 42 C.F.R. §§ 435.610(a)(2) and 433.145(a)(2). More information on Medicaid medical support requirements is available at: https://www.medicaid.gov/sites/default/files/2023-06/mm-supp-req-impl-strategies.pdf.

establish good cause for not doing, even if the individual was previously provided such opportunity and did not do so.

States may disenroll beneficiaries who did not meet medical support cooperation requirements and did not establish good cause for not doing so without conducting a full renewal during the unwinding period only if:

- The beneficiary's last full determination (at initial application or regular renewal) was within the previous 12 months (or shorter period elected by the state per 42 C.F.R. § 435.916(b) for individuals enrolled on a basis other than modified adjusted gross income), such that the beneficiary is within a 12-month eligibility period (or shorter timeframe, if applicable); and

- The state provided the beneficiary an opportunity to meet medical support cooperation requirements or establish good cause for not doing so during or after the beneficiary's last full determination (at initial application or regular renewal).

The state must send advance notice, including fair hearing rights, that the individual's coverage will be terminated for failure to cooperate with the medical support requirements or establish good cause for not doing so, at least 10 days before the date of disenrollment.[42]

If a beneficiary is not within a 12-month eligibility period (or such shorter period as the state elected for non-MAGI beneficiaries) either because the state has not completed a full renewal within the previous 12 months (or shorter timeframe, if applicable) or the individual was determined ineligible during their last renewal, the state must complete a full renewal during its unwinding period consistent with periodic redeterminations of Medicaid eligibility under 42 C.F.R. § 435.916 and CMS guidance issued in SHO #22-001 (dated March 3, 2022).[43] The state may not disenroll individuals for failure to meet medical support cooperation requirements until the full renewal has been completed. As noted, the individual must be given an opportunity at the time of such renewal to either meet medical support cooperation requirements or establish good cause for not doing so.

[42] 42 C.F.R. §§ 435.917 and 435.918, and 42 C.F.R. part 431, subpart E.
[43] https://www.medicaid.gov/sites/default/files/2022-03/sho22001.pdf.