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CMCS Informational Bulletin

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SUBJECT: ***Ensuring Seamless Coverage Transitions Between Medicaid, Separate CHIPs, and Other Insurance Affordability Programs and Exercise of Enforcement Discretion to Delay Implementation of Certain Coverage Transition Requirements***

The Centers for Medicare & Medicaid Services (CMS) is committed to protecting access to health care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) in a manner that protects the integrity of these programs and helps to ensure that eligible individuals retain coverage. The Center for Medicaid and CHIP Services (CMCS) is releasing this CMCS Informational Bulletin (CIB) to provide guidance about new federal requirements related to coverage transitions of children between Medicaid and separate CHIPs. This CIB also advises states that CMS is exercising temporary enforcement discretion in connection with implementation of certain other new requirements related to the issuance of combined Medicaid and separate CHIP eligibility notices and the transfer of individuals procedurally disenrolled from Medicaid and separate CHIPs to other insurance affordability programs.

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I. Introduction

The Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule that appeared in the Federal Register (FR) on April 2, 2024 ("April 2024 Final Rule"),[1] made changes to ensure seamless transitions of beneficiaries between Medicaid, separate CHIPs, and other insurance affordability programs to promote timely enrollment in the appropriate coverage program and minimize unnecessary losses of coverage for eligible individuals. Specifically, revisions to regulations at 42 C.F.R. §§ 431.10, 435.1200, 457.340, 457.348, 457.350, and 600.330 require Medicaid and CHIP agencies to make determinations of Medicaid and separate CHIP eligibility on behalf of the other program (i.e., Medicaid or separate CHIP), seamlessly transition children between Medicaid and separate CHIP for timely enrollment, accept determinations of Medicaid and separate CHIP eligibility made by the other program, assess eligibility for coverage through the Marketplaces or, if applicable, under a Basic Health Program (BHP), and send combined eligibility notices for each relevant program. The requirements for Medicaid and CHIP agencies are outlined in more detail below:

1. ***Seamless Transitions.*** Make determinations of eligibility for Medicaid and separate CHIP on behalf of, and accept determinations of Medicaid and separate CHIP eligibility made by the other program and, when appropriate, transition the child's account for timely enrollment (42 C.F.R. §§ 435.1200(b)(3)(vi), 435.1200(b)(4), 435.1200(c)(2)(ii), 435.1200(e)(1)(i), 457.348(a)(6), 457.348(e), and 457.350(b)(1)(i)). This is subsequently referred to as the *seamless transitions* requirement.

2. ***Procedural Disenrollment Account Transfer.*** Assess eligibility for coverage through the Marketplaces or, if applicable, under a BHP. Additionally, transfer the individual's account to the Marketplace or to a BHP, as appropriate, if the state has sufficient information to assess such eligibility. These requirements existed prior to the April 2024 Final Rule, but previously states with Marketplaces on the Federal platform were

[1] CMS, Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 89 FR 22780, available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health.

instructed never to transfer accounts for individuals who were procedurally disenrolled from Medicaid or a separate CHIP (i.e., because they have not returned information requested by the state needed to complete a redetermination of eligibility). Under the April 2024 Final Rule, the regulations now require that Medicaid and CHIP agencies transfer accounts of individuals disenrolled from Medicaid or separate CHIP for procedural reasons if available information indicates the individual is potentially eligible for Marketplace or BHP coverage (42 C.F.R. §§ 435.1200(b)(3)(i)-(v), 435.1200(e)(1)(ii), 457.350(b)(1)(ii), 457.350(g), 457.350(h), and 600.330). This is subsequently referred to as the *procedural disenrollment account transfer* requirement.

3. ***Combined Notices.*** Send a combined notice of Medicaid and separate CHIP eligibility determinations when a determination of eligibility for Medicaid or separate CHIP is made for a child by the other program. Regulations relating to combined eligibility notices across insurance affordability programs in place prior to the April 2024 Final Rule generally required that Medicaid and CHIP agencies provide combined eligibility notices across insurance affordability programs to the maximum extent feasible.[2] The April 2024 Final Rule revised the regulations to specify that combined notices must be sent by Medicaid and CHIP agencies when a child is transitioned between these two programs (42 C.F.R. §§ 435.1200(h)(1) and 457.340(f)(1)). The requirement to provide a combined Medicaid and separate CHIP notice is subsequently referred to as the *combined notices* requirement.

These regulatory changes, which are discussed in more detail below, are intended to ensure timely enrollment of eligible children and reduce unnecessary gaps in coverage for children transitioning between programs, as well as make the transition process more seamless for families. The *seamless transitions, procedural disenrollment account transfer*, and *combined notices* requirements apply to all states that operate a separate CHIP, including states that only provide coverage under the from-conception-to-birth option under their separate CHIP and regardless of whether the separate CHIP and Medicaid programs are administered by the same state agency.

II. Exercise of Enforcement Discretion

The preamble to the April 2024 Final Rule explained that states were not expected to come into compliance immediately with many of the provisions included in the rule. In establishing applicability dates for certain requirements, we recognized that different provisions of the April 2024 Final Rule had the potential to impact the enrollment and retention of eligible individuals to differing degrees, and that some provisions would be more complex to implement than others. We also recognized that states have needed to devote considerable resources toward "unwinding" from the COVID-19 Public Health Emergency (PHE) and Medicaid continuous

[2] See 42 C.F.R. §§ 435.1200(h) and 457.340(f), which were in effect prior to June 3, 2024, when the April 2024 Final Rule became effective.

enrollment condition.[3] States are currently addressing deficiencies in some of their renewal and verification policies and operations identified during the unwinding process. Taking these various considerations into account, we determined it appropriate to phase in compliance with certain new provisions in the April 2024 Final Rule. Compliance with a few provisions was required upon the effective date of the Final Rule, which was June 3, 2024. Compliance with other provisions is required within 12 and 18 months from the rule's effective date. For the provisions that are expected to require the greatest change to state systems and workflow processes, we provided 24 to 36 months from the effective date of the April 2024 Final Rule for states to come into compliance.

Given the potentially significant impact of the *seamless transitions* requirement on ensuring coverage retention of children, which states can operationalize in multiple ways, and the fact that we believed many states already were compliant, we determined that compliance with this provision would be required on the effective date of the April 2024 Final Rule, June 3, 2024.

In requiring immediate compliance with the *seamless transitions* requirement, we also required immediate compliance with the *combined notices* and *procedural disenrollment account transfer* requirements. We have come to understand that the *combined notices* and *procedural disenrollment account transfer* provisions may be much more complex to implement than we understood through the rulemaking process, including after reviewing comments submitted in response to the proposed rule. Since June 3, 2024, states have indicated that additional time is needed to make necessary systems changes in order to comply with these provisions. Therefore, CMS has decided to exercise enforcement discretion with respect to these two requirements. Specifically, CMS will not require states to demonstrate compliance with the *combined notices and procedural disenrollment account transfer* requirements for 24 months from the effective date of the April 2024 Final Rule, or until June 3, 2026.[4]

We understand that issuing combined notices for Medicaid and separate CHIP when one program determines eligibility on behalf of the other program requires potentially significant state system changes at a time when many states are also undertaking other complex system modifications. Similarly, implementation of the *procedural disenrollment account transfer* requirement will likely necessitate states to undertake significant system changes while other complex system modifications are in process and require close coordination across multiple systems operated separately by the state Medicaid and CHIP agencies and Marketplaces on the Federal platform[5] or State-Based Marketplaces. We appreciate that states need additional time to be able to make changes for both of these provisions and therefore are exercising enforcement

[3] Throughout the COVID-19 PHE, states adopted many flexibilities to respond to issues caused by the pandemic and to comply with conditions for receipt of a temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase set forth at section 6008 of the Families First Coronavirus Response Act (FFCRA). One of these conditions, referred to as the "continuous enrollment condition," required states claiming the temporary FMAP increase to maintain the enrollment of nearly all Medicaid beneficiaries through March 31, 2023. With the expiration of the continuous enrollment condition, states were required to resume completing renewals, consistent with federal requirements, for all individuals enrolled in their Medicaid programs. This process is often referred to as "unwinding."

[4] States that are able to provide combined Medicaid and separate CHIP eligibility notices and/or to send account transfers of individuals procedurally disenrolled from Medicaid and separate CHIP to the Marketplace prior to this date may implement these requirements sooner than June 3, 2026.

[5] Marketplaces include State-Based and non-State-Based Marketplaces that utilize the Federal platform.

discretion to allow states 24 months from the effective date of the April 2024 Final Rule to demonstrate compliance with them. We will continue to evaluate the facts on the ground, and if states' experience indicates that some additional time may be necessary, we will take that into account in developing further policy.

III. State Options for Complying with the Seamless Transitions Requirement

As outlined above, the *seamless transitions* requirement provides that, effective June 3, 2024, Medicaid and CHIP agencies must make determinations of Medicaid and separate CHIP eligibility on behalf of the other program, accept determinations of Medicaid and separate CHIP eligibility made by the other program, and, as appropriate, transition a child's account between programs for timely enrollment. These requirements are only applicable to individuals under the age of 19 and do not apply to individuals ages 19 to 20 or to adults. This is because eligibility for separate CHIP is limited to individuals under age 19.[6]

States have four options, as outlined below, for how they can comply with the *seamless transitions* requirement. The state Medicaid and CHIP agencies must elect the same option.[7]

1. ***Use a shared eligibility service.*** States may use a shared eligibility service that makes eligibility determinations for both programs.[8] States that utilize this option must ensure compliance with Medicaid's single state agency requirements such that determinations of Medicaid eligibility are governed exclusively by the Medicaid agency, and any functions related to determinations of Medicaid eligibility that are performed by the CHIP agency are solely administrative in nature. This means that the Medicaid agency must have exclusive responsibility for Medicaid requirements programmed in the shared eligibility service.[9]

2. ***Accept findings made by the other agency***. Medicaid and CHIP agencies may apply the same modified adjusted gross income (MAGI)-based methodologies and verification procedures in both programs such that each agency accepts any findings relating to eligibility criteria made by the other agency without further verification.[10] To effectuate this option, states must ensure that the policies elected in the MAGI-based methodologies pages in their approved Medicaid and CHIP state plans and

[6] See 42 C.F.R. § 457.320(a)(2). The use of the terms "child" and "children" in this CIB have the meaning assigned at 42 C.F.R. § 457.10 and refer to children under age 19, including the period from conception to end-of-pregnancy. For individuals ages 19 or older, states must continue to follow existing program coordination requirements as described in section V of this CIB.
[7] See 42 C.F.R. § 457.350(b)(3).
[8] See 42 C.F.R. § 435.1200(b)(4)(ii).
[9] See 42 C.F.R. § 431.10(b)(3). Absent a delegation of authority to determine eligibility for Medicaid in accordance with 42 C.F.R. § 431.10(c), the single state agency is responsible for determining eligibility for all individuals applying for or receiving benefits in accordance with 42 C.F.R. part 435 and for fair hearings filed in accordance with 42 C.F.R. part 431 subpart E. As such, the Medicaid state agency must oversee development of the requirements, rules, and policies operationalized by the shared eligibility system. Staff of the CHIP agency can perform data entry functions and utilize the shared system to run the rules and determine MAGI-based Medicaid eligibility when an individual is determined ineligible for separate CHIP. However, the eligibility system should be automated and should not require CHIP agency staff to use discretion to evaluate any aspect of an individuals' Medicaid eligibility. If the eligibility system is not fully automated and certain steps require staff to use discretion, such as the evaluation of evidence submitted by the family to resolve inconsistencies between attested information and third-party data sources, then the state should consider one of the other permissible options to effectuate seamless transitions between the two programs.
[10] See 42 C.F.R. §§ 435.1200(b)(4)(i) and 457.348(e)(1).

verification plans are in alignment with each other. States may need to submit Medicaid and/or CHIP state plan amendments (SPAs) to fully align MAGI-based methodologies across both programs. To align verification procedures for Medicaid and separate CHIPs, states may also need to update their MAGI-based verifications plans, which is required when making changes to the MAGI-based verification policies and procedures detailed in their plan.[11]

3. ***Delegate authority to the other agency***. Medicaid and CHIP agencies may enter into an agreement under which each agency delegates authority to the other agency to make final determinations of eligibility for its program.[12] To effectuate this option, states must submit a Medicaid single state agency SPA to delegate authority to the CHIP agency to make final eligibility determinations for Medicaid. Similar single state agency requirements do not exist for CHIP agencies that elect to delegate authority to other insurance affordability programs to determine eligibility for separate CHIP, therefore no SPA is needed for the CHIP agency to delegate authority to the Medicaid agency to make final determinations of eligibility for separate CHIP. The CHIP agency must establish procedures to receive electronic accounts from the Medicaid agency, notify the Medicaid agency of account receipt, and maintain proper oversight of eligibility determinations made by the Medicaid agency.[13]

4. ***Other procedures.*** Adopt other procedures approved by the Secretary. Subject to approval by CMS, states have flexibility to elect other options to effectuate these requirements. States interested in exploring alternative options to effectuate these requirements may contact their Medicaid state lead or CHIP project officer for more information and technical assistance.

SPAs: As indicated above in option 2, states that elect to accept findings made by the other agency to comply with the *seamless transitions* requirement may need to submit Medicaid and/or CHIP SPAs as appropriate to fully align their MAGI-based methodologies for both programs. Additionally, states that elect option 3 to effectuate the *seamless transitions* requirement must submit a Medicaid single state agency SPA to delegate authority to the CHIP agency to make MAGI-based determinations of eligibility on behalf of the Medicaid agency. We understand that it may not be possible for SPAs submitted after publication of this guidance to have an effective date that is consistent with the effective date for the *seamless transitions* requirement of June 3, 2024. CMS will exercise enforcement discretion in review

[11] Such changes may include those related to data sources used in the state, application of reasonable compatibility thresholds, implementation of post-enrollment verification, and acceptance of self-attestation. CMS approval of state verification plans is not required, but states must submit their plans to CMS upon request, consistent with 42 C.F.R. §§ 435.945(j) and 457.380(j). States should continue to submit updated MAGI verification plans whenever they make changes to their existing plans. For more information about verification plans, see Section VI of the CMS CIB, *Financial Eligibility Verification Requirements and Flexibilities,* November 20, 2024, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11202024.pdf.

[12] See 42 C.F.R. §§ 435.1200(b)(4)(iii) and 457.348(e)(2).

[13] See 42 C.F.R. § 457.348.

of these SPAs and will not take compliance action against states that submit a SPA on or before June 30, 2025 to effectuate these options.

IV. Implementing the Seamless Transitions Requirement

a. Determining Medicaid and Separate CHIP Eligibility on Behalf of the Other Program

As stated above, the *seamless transitions* requirement provides that, effective June 3, 2024, Medicaid and CHIP agencies must make determinations of Medicaid and separate CHIP eligibility on behalf of the other program. This means that Medicaid agencies are now responsible for making determinations of separate CHIP eligibility, and CHIP agencies are responsible for making determinations of MAGI-based eligibility for Medicaid. The *seamless transitions* requirement applies at initial application, when a child experiences a change in circumstances that might impact their eligibility, and during regularly-scheduled renewals.

The processes used to seamlessly transition children between Medicaid and separate CHIPs will differ depending on the option a state elects in section III of this CIB to comply with the *seamless transitions* requirement. The process to seamlessly transition children between Medicaid and separate CHIP in states that elect option 1 to use a shared eligibility service will likely be the most straightforward, since determinations of eligibility and ineligibility for both programs are contained within a single system. In contrast, the processes to seamlessly transition children between Medicaid and separate CHIP in states that elect option 2 to accept findings made by the other agency or option 3 to delegate authority to the other agency may be more complex and involve more steps than option 1, since options 2 and 3 may require coordination between multiple systems. In this section, we discuss operationalization of the *seamless transitions* requirement at each point in the eligibility cycle in states that elect option 2 to accept findings made by the other agency or option 3 to delegate authority to the other agency to comply with the *seamless transitions* requirement.

b. Seamless Transitions Requirement at Application

Medicaid to Separate CHIP: When an application is submitted to the Medicaid agency and the Medicaid agency has sufficient information to determine that the child is eligible for Medicaid, the Medicaid agency must send a notice of approved Medicaid eligibility to the individual and promptly enroll them in Medicaid.[14] If the Medicaid agency has sufficient information to determine that a child is ineligible for Medicaid, the Medicaid agency must deny eligibility for Medicaid[15] and send notice of denial for Medicaid[16] with fair hearing rights.[17] If the Medicaid agency has sufficient information to determine that the child is eligible for separate CHIP (e.g., the applicant is under age 19, has income at or below the CHIP income eligibility standard, and

[14] See 42 C.F.R. §§ 435.911 and 435.917.
[15] See 42 C.F.R. § 435.912(b)(1).
[16] As discussed in section II of this CIB, states will be required to provide a combined denial notice and eligibility notice when transitioning beneficiaries between Medicaid and separate CHIP no later than June 3, 2027.
[17] See 42 C.F.R. §§ 435.917 and part 431 Subpart E.

does not have other health insurance),[18] the Medicaid agency must make a determination of separate CHIP eligibility, and, if eligible for separate CHIP, transfer the child's account to the CHIP agency.[19] The CHIP agency must then accept the determination of separate CHIP eligibility made by the Medicaid agency,[20] send notice of approved separate CHIP eligibility,[21] conduct any necessary pre-enrollment activities (e.g., managed care plan selection, payment of premiums or enrollment fees), and enroll the child in separate CHIP.[22]

If more information is needed to determine Medicaid or separate CHIP eligibility, the Medicaid agency must send a request for additional information.[23] Several outcomes could ensue:

- If the family responds to the request and provides information from which the Medicaid agency is able to make a determination of eligibility for Medicaid, the Medicaid agency must send notice of approved Medicaid eligibility[24] and enroll the child in Medicaid.
- If the family responds to the request and provides information from which the Medicaid agency is able to make a determination of ineligibility for Medicaid, the Medicaid agency must deny eligibility for Medicaid and send notice of a denial for Medicaid with fair hearing rights.
- If the family responds to the request and provides information from which the Medicaid agency is able to make a determination of eligibility for separate CHIP, the Medicaid agency must make a determination of eligibility for separate CHIP, and if eligible for separate CHIP, transfer the child's account to the CHIP agency. The CHIP agency must then accept the determination of eligibility made by the Medicaid agency, send a notice of approved separate CHIP eligibility, conduct any necessary pre-enrollment activities and enroll the child in separate CHIP.
- If the family responds to the request and provides information from which the Medicaid agency is able to determine that the child is ineligible for both Medicaid and separate CHIP, the Medicaid agency must deny eligibility for Medicaid, send notice of denial for Medicaid with fair hearing rights, assess the child's potential eligibility for coverage through the Marketplace or a BHP (if applicable), and, if potentially eligible, transition the child's account to the appropriate program.[25]
- If the family does not timely respond to the request for information, the Medicaid agency must deny Medicaid eligibility and provide notice of denial with fair hearing rights. The

[18] As a condition of eligibility for separate CHIP, children must be otherwise uninsured. Section 2107(e)(1)(B) of the Social Security Act applies third-party liability (TPL) requirements to CHIP. To meet these requirements, states conduct data matching with available public and private insurance databases to identify other sources of health insurance coverage. States must use available TPL information in determining separate CHIP eligibility to ensure that children do not have other health insurance. States may only request additional information about other health coverage from beneficiaries when TPL information is not accessible electronically or available in the beneficiary's account.
[19] See 42 C.F.R. §§ 435.917(b)(1) and 435.1200(e)(1)(i).
[20] See 42 C.F.R. § 457.348(e).
[21] See 42 C.F.R. § 457.340(e)(1)(i).
[22] See 42 C.F.R. § 457.348(b).
[23] See 42 C.F.R. § 435.952(d).
[24] See 42 C.F.R. § 435.917.
[25] See 42 C.F.R. § 435.1200(e)(1)(ii).

Medicaid agency would issue a procedural denial since it does not have needed information to make a determination of Medicaid eligibility or ineligibility. In this scenario, the Medicaid agency does not need to take action related to determining eligibility for separate CHIP, BHP, or Marketplace coverage.

Separate CHIP to MAGI-Based Medicaid: Similar requirements apply when an application is submitted to the CHIP agency. If the CHIP agency has sufficient information to determine that the child is eligible for Medicaid based on MAGI (e.g., the family income is at or below the applicable Medicaid income standard), the CHIP agency must deny separate CHIP eligibility[26] and send notice of denial[27] for separate CHIP with review rights,[28] make a determination of eligibility for Medicaid based on MAGI,[29] and, if eligible for Medicaid, transfer the child's account to the Medicaid agency.[30] The Medicaid agency must then accept the determination of eligibility for Medicaid made by the CHIP agency,[31] send notice of approved Medicaid eligibility[32]and enroll the child in Medicaid.[33] If the CHIP agency has sufficient information to determine that a child is eligible for separate CHIP, the agency must send notice of approved separate CHIP eligibility, conduct any necessary pre-enrollment activities and enroll the child in separate CHIP.[34] If the CHIP agency has sufficient information to determine that a child is ineligible for both Medicaid and separate CHIP, the CHIP agency must deny separate CHIP eligibility,[35] send notice of denial[36] for separate CHIP with review rights,[37] assess the child's potential eligibility for coverage through the Marketplace or a BHP (if applicable), and, if potentially eligible, transition the child's account to the appropriate program.

If more information is needed to determine separate CHIP or Medicaid eligibility, the CHIP agency must send a request for additional information.[38] Several outcomes could ensue:

- If the family responds to the request and provides information from which the CHIP agency is able to make a determination of eligibility for separate CHIP, the CHIP agency must send notice of approved separate CHIP eligibility[39] and enroll the child in separate CHIP.[40]

[26] See 42 C.F.R. § 457.340(d).
[27] As discussed in section II of this CIB, states will be required to provide a combined denial notice and eligibility notice when transitioning beneficiaries between Medicaid and separate CHIP no later than June 3, 2027.
[28] See 42 C.F.R. §§ 457.110(b)(6), 457.340(e), 457.350(b)(1) and (d), 457.1130(a), and 457.1180.
[29] See 42 C.F.R. § 457.350(b)(1)(i).
[30] See 42 C.F.R. § 457.350(d)(1).
[31] See 42 C.F.R. § 435.1200(b)(4).
[32] See 42 C.F.R. § 435.917(b)(1).
[33] See 42 C.F.R. § 435.1200(c).
[34] See 42 C.F.R. §§ 457.340(d) and 457.340(e)(1)(i).
[35] See 42 C.F.R. § 457.340(d).
[36] As discussed in section II of this CIB, states will be required to provide a combined denial notice and eligibility notice when transitioning beneficiaries between Medicaid and separate CHIP no later than June 3, 2027.
[37] See 42 C.F.R. §§ 457.110(b)(6), 457.340(e), 457.350(b)(1) and (d), 457.1130(a), and 457.1180.
[38] See 42 C.F.R. § 457.380(f).
[39] See 42 C.F.R. § 457.340(e)(1)(i).
[40] If, based on the information provided by the family, the CHIP agency assesses the child as potentially eligible for Medicaid on a non-MAGI basis, the CHIP agency must also transfer the child's electronic account to the Medicaid agency for a final determination of Medicaid eligibility on all bases. The child's enrollment in CHIP would continue unless and until the Medicaid agency determines that the child is eligible for Medicaid. See 42 C.F.R. §§ 457.350(e), 435.1200(d), and 435.1200(e)(2) and discussion in section V of this CIB, below.

- If the family responds to the request and provides information from which the CHIP agency is able to make a determination of ineligibility for separate CHIP, the CHIP agency must deny eligibility for separate CHIP and send notice of denial for separate CHIP with review rights.
- If the family responds to the request and provides information from which the CHIP agency is able to make a determination of eligibility for Medicaid based on MAGI, the CHIP agency must make a determination of eligibility for Medicaid based on MAGI, and, if eligible, transfer the child's electronic account to the Medicaid agency. The Medicaid agency must then accept the determination of Medicaid eligibility made by the CHIP agency, send a notice of approved Medicaid eligibility, and enroll the child in Medicaid.
- If the family responds to the request and provides information from which the CHIP agency is able to determine that the child is ineligible for separate CHIP and Medicaid based on MAGI, the CHIP agency must deny eligibility for separate CHIP, send notice of denial for separate CHIP with review rights, and assess the child's potential eligibility for Medicaid on a basis other than MAGI, coverage available through the Marketplace, or a BHP (if applicable).[41] If the child is assessed as potentially eligible for any of these programs, the CHIP agency must transfer the child's account to the appropriate program.[42]
- If the family does not timely respond to the request for information, the CHIP agency must deny separate CHIP eligibility and provide notice of denial with review rights. The CHIP agency must issue a procedural denial since it does not have needed information to make a determination of eligibility. In this scenario, the CHIP agency does not need to take action related to determining eligibility for Medicaid, the Marketplace, or BHP.

c. Seamless Transitions Requirement at Renewal

This section discusses state Medicaid and CHIP agencies' responsibilities to implement the *seamless transitions* requirement during regularly-scheduled renewals. For a reminder of federal requirements for states in conducting regularly-scheduled renewals, refer to the CMS CIBs, *State Compliance with Medicaid and CHIP Renewal Requirements by December 31, 2026*,[43] published September 20, 2024, and *Guidelines for Achieving Compliance with Medicaid and CHIP Eligibility Renewal Timeliness Requirements Following the Medicaid and CHIP Unwinding Period*, published August 29, 2024.[44]

Medicaid to Separate CHIP: At a regularly-scheduled renewal for a Medicaid-enrolled child, the Medicaid agency must first attempt to renew the child's eligibility without requiring information from the family by using information from the case record and available data sources, a process

[41] See 42 C.F.R. § 457.350(b)(1)(ii).
[42] See 42 C.F.R. §§ 457.350(e) and 457.350(g).
[43] Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib09202024.pdf.
[44] Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib08292024.pdf.

known as an *ex parte* renewal.[45] If the Medicaid agency is unable to determine the child's continued Medicaid eligibility on an *ex parte* basis, the Medicaid agency must send a renewal form and provide the family with at least 30 days to respond.[46] Several scenarios could ensue:

1. The family completes and returns the renewal form and all requested documentation and other additional information.
2. The family does not return the renewal form and the Medicaid agency has information from the *ex parte* process that is sufficient to determine eligibility for separate CHIP eligibility or assess eligibility for Marketplace and BHP coverage (if applicable).
3. The family does not return the renewal form and the Medicaid agency does not have information from the *ex parte* process that is sufficient to determine eligibility for separate CHIP or assess eligibility for Marketplace and BHP coverage.

In the first scenario (the family completes and returns the renewal form and all requested documentation or other additional information), the Medicaid agency must take into account the information in the renewal form and other information and documentation provided by the child's family; make a determination of eligibility for Medicaid and, as appropriate, separate CHIP; and, if needed, assess eligibility for Marketplace and BHP coverage.[47] There are four possible outcomes in this scenario:

1. If the child remains eligible for Medicaid, the Medicaid agency must send a notice of approved Medicaid eligibility[48] and renew the child's Medicaid coverage.[49]
2. If the child is no longer eligible for Medicaid, the Medicaid agency must terminate Medicaid eligibility[50] and send advance notice of termination from Medicaid with fair hearing rights at least 10 days prior to disenrolling the child from Medicaid.[51]
3. If the Medicaid agency determines the child is eligible for separate CHIP coverage, the Medicaid agency must transfer the child's electronic account to the CHIP agency.[52] The CHIP agency must then accept the determination of separate CHIP eligibility made by the Medicaid agency,[53] send a notice of approved separate CHIP eligibility,[54] conduct any necessary pre-enrollment activities and enroll the child in separate CHIP.[55]
4. If the Medicaid agency determines that the child is ineligible for both Medicaid and separate CHIP, the Medicaid agency must terminate Medicaid eligibility, send advance

[45] See 42 C.F.R. § 435.916(b)(1).
[46] See 42 C.F.R. § 435.916(b)(2).
[47] See 42 C.F.R. § 435.916(b)(2) and (d).
[48] See 42 C.F.R. § 435.917(b)(1).
[49] See 42 C.F.R. §§ 435.912(b)(3).
[50] See 42 C.F.R. §§ 435.912(b)(3).
[51] See 42 C.F.R. §§ 435.917 and part 431 Subpart E.
[52] See 42 C.F.R. §§ 435.916(d) and 435.1200(e)(1)(i).
[53] See 42 C.F.R. § 457.348(e).
[54] See 42 C.F.R. § 457.340(e)(1)(i). As discussed in section II of this CIB, states will be required to provide a combined denial notice and eligibility notice when transitioning beneficiaries between Medicaid and separate CHIP no later than June 3, 2027.
[55] See 42 C.F.R. § 457.348(b).

notice of termination from Medicaid with fair hearing rights at least 10 days prior to disenrolling the child from Medicaid, assess the child's potential eligibility for coverage available through the Marketplace or a BHP (if applicable), and, if potentially eligible, transfer the child to the appropriate program, consistent with the requirements described in section V below.[56]

In the second scenario (the family does not return the renewal form and the Medicaid agency has sufficient information from the *ex parte* process to determine separate CHIP eligibility or assess Marketplace and BHP eligibility), the Medicaid agency must (1) provide advance notice of termination and fair hearing rights prior to disenrolling the child from Medicaid[57] and (2) follow the steps outlined in the third or fourth outcomes for the first scenario described immediately above, depending on which outcome is supported by the information from the *ex parte* process.

In the third scenario (the family does not return the renewal form and the Medicaid agency does not have information from the *ex parte* process that is sufficient to determine separate CHIP eligibility or assess potential eligibility for other programs), the Medicaid agency must send advance notice of termination from Medicaid with fair hearing rights at least 10 days prior to disenrolling the child from Medicaid. The Medicaid agency would not take any action with respect to CHIP, Marketplace, or BHP eligibility.

Separate CHIP to MAGI Medicaid: Similar requirements apply when a CHIP agency conducts a regularly-scheduled renewal for a child enrolled in separate CHIP and the CHIP agency is unable to complete an *ex parte* renewal for continued eligibility in separate CHIP. The CHIP agency must send a renewal form and provide the family with at least 30 days to respond.[58] Several scenarios could ensue:

1. The family completes and returns the renewal form and all requested documentation and other additional information.
2. The family does not return the renewal form and the CHIP agency has information from the *ex parte* process that is sufficient to determine Medicaid eligibility based on MAGI or assess eligibility for Medicaid on a basis other than MAGI, coverage through the Marketplace or, if applicable, for a BHP.
3. The family does not return the renewal form and the CHIP agency does not have information from the *ex parte* process that is sufficient to determine Medicaid eligibility based on MAGI or assess eligibility for Medicaid on a basis other than MAGI, Marketplace coverage, and BHP.

In the first scenario (the family completes and returns the renewal form and all requested documentation and other additional information), the CHIP agency must take into account the information in the renewal form and other information and documentation provided by the

[56] See 42 C.F.R. § 435.1200(e)(1)(ii).
[57] See 42 C.F.R. §§ 435.917 and part 431 Subpart E.
[58] See 42 C.F.R. § 457.343.

child's family; make a determination of eligibility for separate CHIP and, as appropriate, Medicaid based on MAGI; and, if needed, assess eligibility for Medicaid on a basis other than MAGI and coverage available through the Marketplace and BHP.[59] There are four possible outcomes in this scenario:

1. If the child remains eligible for separate CHIP, the CHIP agency sends a notice of approved separate CHIP eligibility[60] and renews the child's separate CHIP coverage.[61]
2. If the child is no longer eligible for separate CHIP, the CHIP agency must terminate separate CHIP eligibility[62] and send advance notice of termination from CHIP with review rights prior to disenrolling the child from separate CHIP.[63]
3. If the CHIP agency determines the child is eligible for Medicaid based on MAGI, the CHIP agency must transfer the child's electronic account to the Medicaid agency.[64] The Medicaid agency must then accept the determination of Medicaid eligibility made by the CHIP agency,[65] send a notice of approved Medicaid eligibility,[66] and enroll the child in Medicaid.[67]
4. If the CHIP agency determines that the child is ineligible for both separate CHIP and Medicaid based on MAGI, the CHIP agency must terminate separate CHIP eligibility, send advance notice of termination from CHIP with review rights prior to disenrolling the child from separate CHIP, assess the child's potential eligibility for Medicaid on a basis other than MAGI, coverage available through the Marketplace or a BHP (if applicable), and, if potentially eligible, transfer the child to the appropriate program.[68]

In the second scenario (the family does not return the renewal form and the CHIP agency has information from the *ex parte* process that is sufficient to determine Medicaid eligibility based on MAGI or assess potential eligibility for Medicaid on a basis other than MAGI, BHP and the Marketplace), the CHIP agency must (1) provide advance notice of termination and review rights prior to disenrolling the child from CHIP[69] and (2) follow the steps outlined in the third or fourth outcomes for the first scenario described immediately above, depending on which outcome is supported by the information from the *ex parte* process.

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[59] See 42 C.F.R. §§ 457.343 and 457.350(b)(1).
[60] See 42 C.F.R. § 457.340(e)(1)(i).
[61] See 42 C.F.R. § 457.343.
[62] See 42 C.F.R. § 457.343.
[63] See 42 C.F.R. §§ 457.110(b)(6), 457.340(e), 457.350(b)(1) and (d), 457.1130(a), and 457.1180. 42 C.F.R. § 457.340(e)(1)(ii) requires states to provide "sufficient" notice of suspension or termination of CHIP eligibility, and 42 C.F.R. § 457.1180 requires states to provide "timely" notice of determinations subject to review. In order to be sufficient and timely, states must provide advance notice to afford families an opportunity to request a review and prevent a gap in coverage in the event a beneficiary remains eligible for CHIP.
[64] See 42 C.F.R. § 457.350(d).
[65] See 42 C.F.R. § 435.1200(b)(4).
[66] See 42 C.F.R. § 435.917(b)(1). As discussed in section II of this CIB, states will be required to provide a combined denial notice and eligibility notice when transitioning beneficiaries between Medicaid and separate CHIP no later than June 3, 2027.
[67] See 42 C.F.R. § 435.1200(c).
[68] See 42 C.F.R. § 457.350(b)(1)(ii).
[69] See 42 C.F.R. §§ 457.110(b)(6), 457.340(e), 457.350(b)(1) and (d), 457.1130(a), and 457.1180. 42 C.F.R. § 457.340(e)(1)(ii) requires states to provide "sufficient" notice of suspension or termination of CHIP eligibility, and 42 C.F.R. § 457.1180 requires states to provide "timely" notice of determinations subject to review. In order to be sufficient and timely, states must provide advance notice to afford families an opportunity to request a review and prevent a gap in coverage in the event a beneficiary remains eligible for CHIP.

In the third scenario (the family does not return the renewal form and the CHIP agency does not have information from the *ex parte* process that is sufficient to determine eligibility for Medicaid based on MAGI or assess potential eligibility for non-MAGI Medicaid or other insurance affordability programs), the CHIP agency must send advance notice of termination from separate CHIP with review rights prior to disenrolling the child from separate CHIP. The CHIP agency would not take any action with respect to Medicaid, Marketplace, or BHP eligibility.

d. Seamless Transitions Requirement During a Continuous Eligibility (CE) Period Based on Changes in Circumstances

Children under the age of 19 in Medicaid and CHIP are entitled to 12 months of CE regardless of changes in circumstances, with limited exceptions.[70] The circumstances under which a child's Medicaid or CHIP eligibility may be terminated during a CE period are as follows:

- The child attains age 19;
- The child or child's representative requests a voluntary termination of eligibility;
- The child ceases to be a resident of the state;
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative;
- The child is deceased; or
- A separate-CHIP enrolled child becomes eligible for Medicaid.

States can adopt a CE period for some or all children (and/or other populations) that is longer than 12 months through a demonstration project under section 1115 of the Social Security Act.

Medicaid to Separate CHIP: Becoming eligible for separate CHIP is not an exception to the CE requirement for children enrolled in Medicaid. Therefore, if a state obtains information during a child's Medicaid CE period indicating that the child no longer meets all eligibility requirements for Medicaid and meets all eligibility requirements for separate CHIP, the state must maintain the child's enrollment in Medicaid for the remainder of the CE period. States may not move a child from Medicaid to a separate CHIP during the child's CE period.[71] The Medicaid agency must follow the renewal procedures outlined above at the end of the child's CE period to determine if the child remains eligible for Medicaid or is eligible for separate CHIP and make a determination of eligibility accordingly.

[70] Section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023) amended titles 1902(e)(12) and 2107(e)(1) of the Social Security Act to add this requirement. See CMS's State Health Official letter (SHO) #23-004, available at: www.medicaid.gov/federal-policy-guidance/downloads/sho23004.pdf, and the November 27, 2024 Final Rule that codifies these requirements, available at https://www.federalregister.gov/documents/2024/11/27/2024-25521/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical.

[71] See section II.D. of CMS SHO #23-004, available at: www.medicaid.gov/federal-policy-guidance/downloads/sho23004.pdf.

Separate CHIP to Medicaid: There are special considerations for transitions of children enrolled in separate CHIP who become eligible for Medicaid due to a change in circumstances during a separate CHIP CE period.

If a state obtains information during a child's separate CHIP CE period indicating that the child is eligible for Medicaid based on MAGI, the CHIP agency must:

- Determine the child ineligible for separate CHIP and provide advance notice of termination[72] with review rights prior to disenrolling the child from separate CHIP;[73]
- Make a determination of eligibility for Medicaid;[74] and
- Transfer the child's account to the state Medicaid agency.[75]

The state Medicaid agency must then accept the determination of eligibility made by the CHIP agency,[76] provide a notice of approved Medicaid eligibility,[77] and enroll the child in Medicaid.[78]

If a state obtains information during a child's separate CHIP CE period indicating that the child is potentially eligible for Medicaid on a basis other than MAGI, the CHIP agency must transition the child's account to the Medicaid agency to make a determination of eligibility on a non-MAGI basis.[79] The CHIP agency must continue the child's enrollment in separate CHIP unless and until the Medicaid agency determines that the child is eligible for Medicaid.[80] For additional information on children assessed as Medicaid-eligible on a non-MAGI basis, see section V of this CIB, below.

V. General Requirements for Coordination Between Insurance Affordability Programs

States must continue to comply with regulations related to coordination of eligibility and enrollment between all insurance affordability programs (including Medicaid, separate CHIPs, Marketplaces, and BHPs) that were previously in effect and not changed by the April 2024 Final Rule.[81] These regulations require each program to assess potential eligibility for other insurance affordability programs and transfer an individual's account to another program, as appropriate. Importantly, this includes a requirement that separate CHIPs and other programs assess potential eligibility for Medicaid on a non-MAGI basis when they determine or assess

[72] As discussed in section II of this CIB, states will be required to provide a combined denial notice and eligibility notice when transitioning beneficiaries between Medicaid and separate CHIP no later than June 3, 2027.
[73] See 42 C.F.R. §§ 457.110(b)(6), 457.340(e), 457.350(b)(1) and (d), 457.1130(a), and 457.1180. 42 C.F.R. § 457.340(e)(1)(ii) requires states to provide "sufficient" notice of suspension or termination of CHIP eligibility, and 42 C.F.R. § 457.1180 requires states to provide "timely" notice of determinations subject to review. In order to be sufficient and timely, states must provide advance notice to afford families an opportunity to request a review and prevent a gap in coverage in the event a beneficiary remains eligible for CHIP.
[74] See 42 C.F.R. § 457.350(b)(1).
[75] See 42 C.F.R. § 457.350(d).
[76] See 42 C.F.R. § 435.1200(b)(4).
[77] See 42 C.F.R. § 435.917(b)(1).
[78] See 42 C.F.R. § 435.1200(c).
[79] See 42 C.F.R. § 457.350(e).
[80] See 42 C.F.R. §§ 457.350(e) and 435.1200(d).
[81] See 42 C.F.R. §§ 435.1200(a), 435.1200(d), 435.1200(e)(2)-(e)(3), 435.1200(h)(2)-(h)(3), 457.340(f)(2), 457.348(a)(1)-(5), 457.348(c), 457.348(d), 457.350(c)-(i), and 660.330(b)-(f). Also see corresponding Marketplace regulations at 45 C.F.R. § 155.345.

that someone is not eligible for Medicaid based on MAGI. Separate CHIPs and other programs do not utilize eligibility methodologies other than MAGI, and therefore may not have the information needed to make a final determination of eligibility for Medicaid on a basis other than MAGI, such as information about an individual's disability status, resources, or specific types of income and resources that are disregarded in determining countable income and resources for non-MAGI determinations. Therefore, separate CHIPs and other programs that make an assessment of potential eligibility for Medicaid on a basis other than MAGI must transfer the individual's account to the Medicaid agency to complete the final determination of eligibility for Medicaid.

A final determination of non-MAGI eligibility by the Medicaid agency will require additional time for the Medicaid agency to request, and for the individual to provide, the additional information and/or documentation needed. Separate CHIPs, Marketplaces, and BHPs that have assessed an individual as potentially eligible for Medicaid on a non-MAGI basis must allow the individual to enroll or remain enrolled in coverage in their program if the individual otherwise meets its eligibility requirements (e.g., in the case of separate CHIP, the individual's age and income are at or below the applicable separate CHIP standards and the individual does not have other health insurance)[82] while the non-MAGI determination is underway. Simultaneously, the Medicaid agency must complete the non-MAGI determination and notify the individual's current coverage program of the final determination of eligibility or ineligibility for Medicaid so that the current coverage program can take action, as needed (e.g., provide advance notice and review rights for children enrolled in separate CHIP if the CHIP agency is notified that the child has been determined eligible for Medicaid).[83] If the individual is determined eligible for Medicaid, the Medicaid agency must send the individual a notice of approved eligibility for Medicaid and enroll them in Medicaid.

CMS is available to provide states with technical assistance on these requirements.

VI. Considerations for Transitions in States with Managed Care Delivery Systems

While the *seamless transitions* requirement aims to reduce gaps in health insurance coverage for children transitioning between Medicaid and separate CHIP, children transitioning between programs may experience a disruption in coverage if they need to change managed care plans. In states that operate managed care delivery systems for Medicaid and/or separate CHIP, there are several strategies states may utilize to reduce disruptions to coverage when transitioning children between these two programs. First, states can contract with managed care plans that serve both Medicaid and separate CHIP and allow children to maintain enrollment in the same managed care plan when they move between programs. When a state

[82] As a condition of eligibility for separate CHIP, children must be otherwise uninsured. Section 2107(e)(1)(B) of the Social Security Act applies third-party liability (TPL) requirements to CHIP. To meet these requirements, states conduct data matching with available public and private insurance databases to identify other sources of health insurance coverage. States must use available TPL information in determining separate CHIP eligibility to ensure that children do not have other health insurance. States may only request additional information about other health coverage from beneficiaries when TPL information is not accessible electronically or available in the beneficiary's account.
[83] See 42 C.F.R. §§ 435.1200(d) and 457.350(e).

does not offer the same managed care plans in both Medicaid and separate CHIP, the state may passively assign or default the child to a managed care plan.[84] States may establish passive and default enrollment processes that seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served both Medicaid and separate CHIP beneficiaries.[85]

States that do not effectuate either of these options must distribute children equitably among the managed care plans available to enroll them and can consider additional criteria, including (1) the enrollment preferences of family members, (2) previous plan assignment of the child, (3) quality assurance and improvement performance, (4) procurement evaluation elements, (5) accessibility of provider offices for people with disabilities (when appropriate), and (6) other reasonable criteria related to a child's experience with Medicaid or separate CHIP.[86] States must send clear instructions to the family about (1) how to change managed care plans as needed, (2) how much time the family has to change their managed care plan, and (3) where to go and who to contact with questions about plan selection.[87] CMS is available to provide technical assistance on these strategies.

VII. Considerations for Transitions in States with Premiums or Enrollment Fees

Some state separate CHIPs require the collection of a first month's premium or an enrollment fee to effectuate coverage. To prevent potential gaps in coverage for children transitioning from Medicaid to a separate CHIP, states may elect to waive premiums or enrollment fees for the first month of separate CHIP coverage for children transitioning from Medicaid, or delay collection of initial premiums and enrollment fees until after the child is enrolled in separate CHIP. The adoption of either of these strategies could help states reduce barriers for children to access care as they transition to separate CHIP from Medicaid. States are reminded that once enrolled in separate CHIP coverage, children may not be disenrolled for failing to pay premiums during a CE period.[88]

VIII. Conclusion

The new *seamless transitions*, *procedural disenrollment account transfer,* and *combined notices* requirements described in this CIB support coordination between Medicaid, separate CHIPs, and other insurance affordability programs in transferring beneficiaries between health coverage programs when it is determined that they are not eligible for one program or no longer eligible for the program in which they are currently enrolled. The goal of these requirements is to provide a seamless process for beneficiaries transitioning between programs, which is essential to ensuring that eligible individuals obtain or retain coverage and can access health care services without unnecessary delay or interruption. CMS is available to

[84] See 42 C.F.R. §§ 438.54(c)(2), (d)(2), and 457.1210(a).
[85] See 42 C.F.R. §§ 438.54(c)(6), (d)(7), and 457.1210(a).
[86] See 42 C.F.R. §§ 438.54(c)(7) and (d)(8), and 457.1210(a).
[87] See 42 C.F.R. §§ 438.54(c)(3) and (d)(3).
[88] See section 2103(e)(3)(C) of the Social Security Act and 89 FR 94462.

provide technical assistance to states in complying with these requirements and will release additional instructions related to compliance with the *combined notices* and *procedural disenrollment account transfer* requirements at a later date. For additional information and technical assistance, please contact Tess Hines at Mary.Hines@cms.hhs.gov.