CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid and CHIP Overview

September 2024

This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator personnel in a Federally-facilitated Marketplace. The terms "Federally-facilitated Marketplace" and "FFM," as used in this document, include FFMs where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

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A Note about this Presentation

This presentation applies if you:

- Are a Navigator, enrollment assistance personnel, or certified application counselor (collectively, an assister) in a Federally-facilitated Marketplace.
- Are assisting low-income individuals, families, or children who may be uninsured or exploring different health coverage options.

Overview: Medicaid and CHIP

Medicaid and the Children's Health Insurance Program (CHIP) are federal health coverage programs administered individually by each state and territory according to federal requirements. These programs provide comprehensive coverage for tens of millions of individuals and families. Adults and children with Medicaid or CHIP are often eligible based on one of the following categories[1]:

- In Medicaid:
  - Parents and children
  - Pregnant individuals
  - Individuals receiving Supplemental Security Income (SSI)
  - People with disabilities
  - Other low-income adults, depending on the state
- In CHIP:
  - Uninsured children up to age 19 whose household income is too high for them to qualify for Medicaid
  - In some states, low-income pregnant individuals

Medicaid and CHIP eligibility requirements and program benefits vary by state.

Eligibility Basics

- Medicaid and CHIP eligibility varies by state and depends on several factors, including:

1. An individual's household income level
2. The number of people in the household
3. The individual's U.S. citizenship, U.S. national, or immigration status
4. The state in which the individual lives
5. For some Medicaid eligibility groups, the individual's age, pregnancy status, and disability status
6. For some Medicaid eligibility groups, the individual's assets and resources

Eligibility Basics (Cont.)

- Modified Adjusted Gross Income (MAGI)-based methodology is used to determine most individuals' financial eligibility for Medicaid and CHIP, including most children, pregnant individuals, parents, and non-elderly adults.
- Non-MAGI methods are used to determine Medicaid eligibility for older adults and people with blindness or a disability, and other resources and assets may be considered, varying by state.

Expansion for the Medicaid Adult Group

Under the Affordable Care Act (ACA), states have the opportunity to expand Medicaid coverage to low-income adults under the age of 65 with incomes up to 138 percent of the federal poverty level (FPL).

As of June 2024, 41 states including the District of Columbia have implemented Medicaid expansion. Assisters can find the status of Medicaid expansion implementation in each state using the map provided here: Adult Coverage Expansion Map.

2024 Medicaid Eligibility By Household Size and Income, based on a Medicaid Adult Group Expansion Threshold of 138 Percent FPL*

Number of People in the Household	Income Below 138% of the FPL**
1	$20,783
2	$28,207
3	$35,632
4	$43,056
5	$50,480
6	$57,905
7	$65,329
8	$72,754
More than 8	For each additional person, add $7,424

*Some states that have not implemented Medicaid expansion have approved demonstration authority to cover some individuals who would otherwise be in the adult group if their state had expanded. Therefore, not all states that cover individuals who would otherwise be in the Adult Group have a 138% FPL threshold; some have a lower threshold in place.

**An applicant with household income at or below 138 percent of the FPL in a state that has expanded Medicaid coverage to the adult group may qualify for Medicaid in the adult group.

Note: These numbers represent 2024 FPLs for the 48 contiguous states and DC. FPL amounts are higher in Alaska and Hawaii. The figures in this table are annual income amounts; however, MAGI-based Medicaid and CHIP eligibility is determined using current monthly income.

2024 Medicaid Eligibility Based on Medicaid Adult Group, Income, and Household Size (Cont.)

- In states that have not expanded Medicaid coverage to the adult group, adults with household income below 100 percent FPL ($15,060 for a household of one for the 48 contiguous states and D.C., with an increase of $5,380 for each additional person) may not qualify for either adult group Medicaid or financial assistance for a Marketplace plan unless they are lawfully present* and ineligible for Medicaid due to their immigration status (in which case they can enroll in a Marketplace plan with financial assistance if they meet all other eligibility requirements for Marketplace eligibility). Assisters should help individuals in this situation understand that they may still qualify for Medicaid on another basis, such as a parent or caretaker relative, a former foster care youth, pregnant woman, or a disability.

*Lawfully present is defined and described at Healthcare.gov: Coverage for lawfully present immigrants

150 Percent FPL Special Enrollment Period

- If an individual is not eligible for Medicaid, but their household income is at or below 150 percent FPL, they may be eligible for a Special Enrollment Period (SEP), if they are also eligible for advance payments of the premium tax credit (APTC). These individuals are eligible for a monthly SEP in the Marketplaces on the federal platform to enroll in a qualified health plan (QHP) or change from one QHP to another.
  - State-based Marketplaces operating their own platforms (SBMs) have the option to offer this SEP.[2]
  - This SEP is available at any time for which the individual is eligible and is no longer limited to an individual whose applicable premium credit percentage is zero.
  - Individuals can access this SEP by submitting a new application or updating an existing one online at HealthCare.gov, or with the help of an enhanced direct enrollment (EDE) partner, a traditional direct enrollment (DE) partner that supports SEPs, or by calling the Marketplace Call Center.

Knowledge Check #1

States have the opportunity to expand Medicaid coverage to low-income adults under the age of 65 up to what percent of the federal poverty level?

Knowledge Check #1 Answer

Answer: 138 percent

Benefits

- States establish and administer their own Medicaid and CHIP programs in accordance with federal requirements and determine the type, amount, duration, and scope of most services within federal guidelines.
- Medicaid benefits for eligible children under the age of 21 must generally include the full range of medically necessary services under the Early and Periodic, Screening, and Diagnostic (EPSDT) benefit*,[3] even if the services are not covered under the state plan for individuals over the age of 21. Medicaid benefits for adults may vary but generally must be comprehensive in scope and must include all mandatory benefits.

- CHIP provides comprehensive benefits to children and some adults. States have flexibility to design their own program within federal guidelines, so benefits vary by state and by the type of CHIP program. However, with respect to children enrolled in CHIP, all states must provide coverage for well-baby and well-child care visits, dental services, behavioral health care, the COVID vaccine, and all other Advisory Committee on Immunization Practices (ACIP)-recommended, age-appropriate vaccines.

* Under section 1905(a) of the Social Security Act.

Additional Requirements on Providing and Maintaining Medicaid and CHIP Coverage

- Under the Consolidated Appropriations Act of 2023 (CAA, 2023), effective January 1, 2024, states must maintain 12 months of continuous eligibility for most children enrolled in Medicaid and CHIP.
- As of January 1, 2023, section 1002 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act mandates that former foster care youth who are covered under Medicaid and turn 18 on or after January 1, 2023, are eligible to keep their Medicaid coverage across the country. Under previous federal law, states were not mandated to cover youth when they relocate from the state in which they were in foster care. Currently, the Marketplace considers eligibility for Medicaid for the former foster care category by asking specific questions about past participation in foster care for applicants aged 18-26 for this reason.

Medicaid and CHIP Changes in Eligibility Based on Pregnancy

- Medicaid and CHIP provide eligible pregnant individuals with free or low-cost comprehensive health care during pregnancy, as well as postpartum care.
- Pregnant individuals who are receiving Medicaid or are eligible for CHIP as "targeted low-income pregnant women" when their pregnancy ends must continue to be eligible for Medicaid or CHIP coverage through their postpartum period. The postpartum period includes the 60 days after the end of the pregnancy and must last through the end of the month in which the 60 days postpartum period ends. After the 60-day postpartum period ends, they may lose eligibility, depending on the state in which they reside, particularly if they were eligible for Medicaid or CHIP on the basis of their pregnancy. We also note that targeted low-income children in CHIP who become pregnant generally would also be eligible for a 60-day postpartum period.

Medicaid and CHIP Changes for Eligibility Based on Pregnancy (Cont.)

- Beginning on April 1, 2022, the American Rescue Plan Act of 2021, gave states the option to extend coverage for pregnant Medicaid and CHIP beneficiaries beyond the required 60-day postpartum period, through the end of the month in which the beneficiary's 12-month postpartum period ends.
- If adopted by the state for Medicaid, the extended postpartum coverage election applies to the state's separate CHIP if the state provides coverage of targeted low-income children or targeted low-income pregnant women.
- The Consolidated Appropriations Act 2023 (CAA, 2023), enacted on December 29, 2022, makes this state option permanent beginning January 1, 2024.
- As of June 2024, 46 states*, the District of Columbia and the U.S. Virgin Islands have extended postpartum eligibility to 12 months via state plan amendments or approved Medicaid Section 1115 demonstrations. Assisters should check with their state Medicaid and CHIP agency to learn whether their state has elected to extend postpartum coverage to 12 months or plans to exercise this option.

*The remaining states are Arkansas, Idaho, Iowa, and Wisconsin.

Medicaid Out-of-Pocket Costs

- Within limits, states can impose nominal copayments, coinsurance, deductibles, and other similar charges on most Medicaid-covered benefits. Out-of-pocket amounts vary depending on a Medicaid beneficiary's income. All out-of-pocket charges are based on the specific state's defined payment amount for that service.
- Out-of-pocket costs cannot be imposed for emergency services, family planning services, pregnancy-related services, or preventive services for children. Additionally, cost-sharing cannot be imposed on exempted groups including children, terminally ill individuals, and individuals residing in an institution. Services cannot be withheld for failure to pay, but enrollees may be held liable for unpaid copayments.

Medicaid Out-of-Pocket Costs (Cont.)

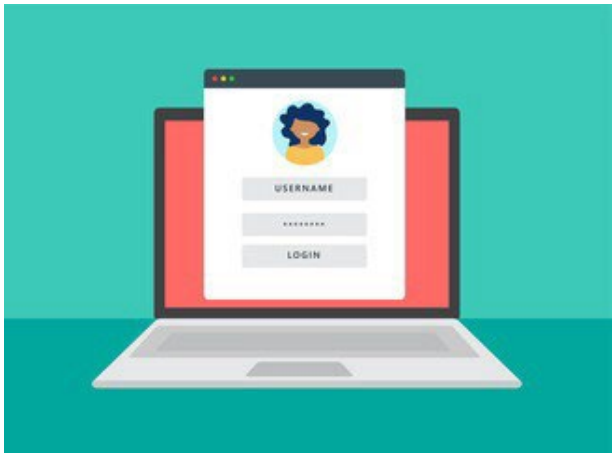
FY 2024 Maximum Allowable Medicaid Copayments Determined by Eligible Population's Household Income

Services and Supplies	≤100% of the FPL	101-150% of the FPL	>150% of the FPL
Inpatient Hospital	$97.50	10% of the cost the agency pays	20% of the cost the agency pays
Outpatient Services	$5.20	10% of the cost the agency pays	20% of the cost the agency pays
Non-emergency Use of the Emergency Department	$10.40	$10.40	No limit; must remain within the 5% aggregate family cap
Preferred Drugs	$5.20	$5.20	$5.20
Non-preferred Drugs	$10.40	$10.40	20% of the cost the agency pays

Applying for Medicaid or CHIP

You can help people find out whether they are eligible for Medicaid or CHIP at any time during the year in two main ways:

1. **Through their state's website**: People can find their state's website at: Medicaid & CHIP coverage.
2. **Fill out a Marketplace application**: Help individuals complete a Marketplace application and indicate that they want to see if they're eligible for help paying for coverage to learn about the programs for which they may be eligible.



Coverage for Certain Adults Below 100 Percent of FPL

- In states that have not expanded Medicaid to the adult group, many adults with incomes below 100 percent of the FPL do not qualify for Medicaid or savings on Marketplace coverage.
- These adults should still fill out a Marketplace application and indicate that they want to see if they're eligible for help paying for coverage, in order to explore all available coverage options. In addition, you could discuss the following options:
  - Obtain health care services at federally qualified community health centers. Use the following tool to find a community health center near the consumer: How to find low-cost health care in your community.
  - Purchase catastrophic coverage, which is available for people under 30 years old and people granted a hardship or affordability exemption. For more information, visit: Catastrophic health plans.
  - Find out what pharmaceutical assistance programs may be available. You can help consumers find out if assistance is available for the medications they take by visiting: Find a Pharmaceutical Assistance Program.
  - Other coverage options, including short-term, limited-duration insurance. Assisters should recommend consumers read STLDI plan documents to fully understand what is covered.
- For more resources, please see the Resources for the Uninsured webinar and the Health Coverage Options for the Uninsured job aid.

Medicaid/CHIP and Minimum Essential Coverage

- Most Medicaid and CHIP coverage qualifies as minimum essential coverage (MEC).
- However, certain types of limited Medicaid coverage are not recognized as MEC, including limited coverage offered by some states that only pays for family planning services, treatment for an emergency medical condition for noncitizens who do not have satisfactory immigration status, or limited services to treat a specific condition.
- Individuals who are determined eligible for or are enrolled in coverage through Medicaid or CHIP that counts as MEC are ineligible for APTC for themselves, and for income-based cost-sharing reductions (CSRs) to help pay for the cost of their Marketplace coverage. Individuals who are enrolled in coverage through Medicaid or CHIP that does not count as MEC may be eligible for such Marketplace financial assistance.
- If individuals are enrolled in both Medicaid or CHIP that qualifies as MEC and Marketplace coverage with APTC/CSRs, they should visit Canceling a Marketplace plan when you get Medicaid or CHIP or contact the Marketplace Call Center at 1-800-318-2596 for instructions on how to end their Marketplace coverage with APTC/CSRs. Individuals should seek to end any overlapping coverage in order to avoid having to pay back all or some of the APTC they may have incorrectly received while eligible for or enrolled in Medicaid.

Medicaid Family Planning Services and Eligibility

- Since 1972, states have been required to provide family planning services in their Medicaid programs. Under the Affordable Care Act, states have the option to offer coverage that includes only such services, under state plan authority, to individuals who would not otherwise be eligible for Medicaid.[4] These services are not considered MEC coverage.
- Examples of family-planning services include:
  - Drugs for the treatment of sexually-transmitted diseases (STD) or sexually-transmitted infections (STI), except for HIV/AIDS and hepatitis, when the STD/STI is identified/ diagnosed during a routine/periodic family planning visit.
  - Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit.
  - Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to a family planning service in a family planning setting.
- Family planning state plan eligibility varies greatly by state including income thresholds and benefit packages

Medicaid and CHIP Eligibility and Citizenship/Immigration Status

- In general, to be eligible for full Medicaid benefits or CHIP coverage, an individual must be a U.S. Citizen, U.S. national, or be a "qualified noncitizen" (QNC).[5]
- Federal law requires that many qualified noncitizens must satisfy a five-year waiting period (also called the "five-year bar") before becoming eligible for Medicaid or CHIP.
- This five-year waiting period begins when individuals receive their qualifying immigration status, not when they first enter the United States
- Other QNCs are exempt from the five-year waiting period (e.g., refugees and asylees). Examples of QNC immigration statuses exempt from the five-year waiting period can be found at Coverage for lawfully present immigrants.[6]

Medicaid and CHIP Eligibility and Citizenship/Immigration Status (Cont.)

- Under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (commonly referred to as the "CHIPRA 214 option"[7]), states have the option to cover all lawfully residing children (up to age 19 for CHIP and up to age 21 for Medicaid) and/or pregnant individuals in Medicaid and CHIP, even if they're not a QNC or are within their first five years of the waiting period. A child or pregnant individual is "lawfully residing" if they're "lawfully present" and otherwise meet the residency requirements for Medicaid or CHIP in the state.[8]
- Medicaid must also provide limited Medicaid coverage for the treatment of an emergency medical condition (including emergency labor and delivery) for people who meet all Medicaid eligibility criteria in the state (such as income and state residency) but who do not have a satisfactory immigration status or who are still within the first five years of the waiting period.
- If an individual is a lawfully present immigrant and is determined ineligible for Medicaid due to immigration status, they may be eligible for Marketplace coverage with financial assistance, even though their household income may be below 100 percent of the FPL.

Refugee Medical Assistance (RMA)

- RMA provides short-term medical coverage to refugees ineligible for Medicaid. The benefits are generally similar to Medicaid.
- In addition to providing access to health care, RMA funds enable refugees to receive a Medical Screening[9] upon arrival in the United States and replacement designees (RDs) contract with local public and private health clinics to carry out the medical screenings and are then reimbursed for allowable costs. The goal is to protect the public health of resettling communities and to promote the self-sufficiency and successful resettlement of refugees.
- RMA and Medical Screening programs differ by location. Services vary depending on state Medicaid programs and medical screening processes. State governments and RDs are required to outline the delivery of both programs in their annual plans and budget estimates that are submitted to ORR.

Medicaid “Unwinding” SEP

- CMS recently announced an extension to the “Unwinding SEP” which is available to individuals in states with Exchanges on the federal platform who lose Medicaid or CHIP coverage between March 31, 2023, and November 30, 2024, and who attest to a last date of Medicaid or CHIP coverage within that time period. The SEP is now available on HealthCare.gov until November 30, 2024.
- As a condition of receiving enhanced federal Medicaid funding, states were required to maintain enrollment of nearly all Medicaid enrollees during the COVID-19 Public Health Emergency, referred to as the “continuous enrollment condition.” When the continuous enrollment condition ended on March 31, 2023, states resumed routine eligibility and enrollment operations, including renewals and coverage terminations for people who are no longer eligible for the program. States were permitted to disenroll people found ineligible for Medicaid beginning April 1, 2023.
- Individuals who lose Medicaid or CHIP coverage between April 1, 2023, and November 30, 2024, can submit or update a Marketplace application anytime on HealthCare.gov and will have 60 days after that to pick a plan. Consumers will receive the Unwinding SEP automatically based on their answers to application questions.
- Consumers who receive notice of a termination may start applying and enrolling immediately in other coverage, such as on the Marketplace, to ensure continuity of coverage.

Knowledge Check #2

All Medicaid is minimum essential coverage.

A. True

B. False

Knowledge Check #2 Answer

Answer: **B. False**

Most Medicaid programs are considered "minimum essential coverage" or qualifying health coverage. However, certain types of limited Medicaid coverage are not recognized as MEC, including coverage that only pays for family planning, the treatment of an emergency medical condition for non-citizens who do not have satisfactory immigration status, and tuberculosis services (among others).

Complex Case #1

- On April 16, 2024, Joanne came in to meet with an assister and reported that she enrolled herself in a qualified health plan (QHP) through the Marketplace and thought she enrolled her 2-year-old son in CHIP during the Marketplace's Open Enrollment (OE) with an effective date of January 1, 2024.
- Joanne stated that her son was hospitalized on January 27, 2024, and that her insurance claims for his hospitalization were rejected. She did not realize her son had been denied CHIP coverage. Joanne did receive a CHIP denial on March 9, 2024. Therefore, her son is eligible for an SEP for QHP coverage because the CHIP denial occurred after OE ended but the CHIP application was submitted during OE.
- However, when Joanne called the Marketplace on April 15, 2024, she was told that the effective date of her son's QHP coverage via the SEP would be May 1, 2024, if Joanne selects a plan on April 15. Joanne wants to know if it would be possible to get her son's coverage date set back to January 1, 2024, so that his hospitalization would be covered.

Applicable Rule(s)

- Consumers may be eligible for an SEP to enroll in a QHP through the Marketplace if they:
  - Applied for coverage through the Marketplace or their state Medicaid or CHIP agency during OEP, or through the Marketplace during an SEP for which they were eligible;
  - Were assessed potentially Medicaid or CHIP-eligible and referred to their state's Medicaid agency for a final eligibility determination; and
  - Received a Medicaid or CHIP denial from the state after OE or their other SEP window ended.
- The SEP is available for 60 days from the date of the denial by the state.
- If an individual is found ineligible for Medicaid or CHIP by the state, their account may be sent to the FFM via Inbound Account Transfer. The FFM will generate and mail the individual a notice encouraging them to apply for Marketplace coverage and see if they can get help paying for it. Individuals don't need to wait to receive the Inbound AT notice from the FFM to apply for Marketplace coverage; to help prevent a gap in coverage, they should apply for Marketplace coverage as soon as they are notified by their state that they are not eligible for Medicaid or CHIP.

Applicable Rule(s) (Cont.)

- Consumers who first applied at the Marketplace during OE or during an SEP for which they were eligible, have the option to request a retroactive coverage effective date back to the effective date they would have received based on the date of their original Marketplace application, so long as they pay any outstanding premiums.
- Every time a consumer applies to the Marketplace and indicates they want to see if they can get help paying for coverage, their eligibility for Medicaid or CHIP will be reassessed based on factors including their household size and income, unless they attest to a Medicaid/CHIP denial by the state in the last 90 days, and also attest to no changes since the denial.
- Depending on the state in which a consumer submitting a Marketplace application resides, the Marketplace either makes the final determination of eligibility for MAGI-based Medicaid or CHIP (when the Marketplace is able to fully verify application information) or refers the applicant to the state's Medicaid or CHIP agency for a final eligibility determination.

Helpful Tips

- Remember, for Joanne to receive the SEP with a retroactive coverage effective date in this specific scenario, she and her son had to have applied through the Marketplace during OE or due to a qualifying event and received the Medicaid/CHIP denial from the state agency outside of OE or after their qualifying life event window ended.

Helpful Tips (Cont.)

- In this scenario, once individuals have received their Medicaid or CHIP denial from the state agency, they should update their Marketplace application, including checking the box to indicate they have received a Medicaid or CHIP denial in the past 90 days and attest that they haven't had any income or household changes, if applicable, and answer related questions to see if they are eligible for an SEP.
- Consumers should never click the box on the Marketplace application stating they have received a Medicaid or CHIP denial before they actually receive notice of the denial. This is to ensure the consumer or the consumer's family member are not later determined eligible for and enrolled in Medicaid or CHIP and dually enrolled in Marketplace coverage.

Applying the Rules to Joanne's Situation

- Joanne could request to have her son added to her original application for a QHP, which was effective January 1, 2024, but she will be liable for any outstanding premiums from January 1, 2024, to May 1, 2024.
- If she can pay the outstanding premiums from January, February, March, and April, the effective date can be changed to January 1, 2024, through the Marketplace casework system, and her son's hospitalization may be covered. Joanne's son would be eligible for APTC for January through April, if all other eligibility requirements were met.

Knowledge Check #3

Individuals who receive a Medicaid or CHIP denial outside of OE are eligible for an SEP based on the denial of Medicaid or CHIP eligibility ONLY if they applied for coverage during OE or during another previous SEP window and were denied Medicaid or CHIP coverage after OE or their original SEP window ended (but they may still qualify for the Medicaid Unwinding SEP). How long do these consumers have to sign up for a Marketplace plan after they receive their denial?

A. 30 days

B. 45 days

C. 60 days

D. 90 days

Knowledge Check #3 Answer

Answer: **C. 60 days.**

The SEP eligibility period for most qualifying events is 60 days. This includes post-enrollment period Medicaid or CHIP denials.

Knowledge Check #4

Consumers who qualify for an SEP to purchase a Marketplace plan due to a post-OE (or post-SEP) Medicaid/CHIP denial are not eligible to receive Marketplace coverage back to the effective date they would have received based on the date of their original Marketplace application.

A. True

B. False

Knowledge Check #4 Answer

Answer: **B. False**

If they originally applied at the Marketplace during OE or during a SEP window, consumers who qualify for an SEP to purchase a Marketplace plan due to a post-OE (or post-SEP) Medicaid/CHIP denial may be eligible to receive a retroactive coverage effective date back to the effective date they would have received based on the date of their original Marketplace application.

Knowledge Check #5

In order to receive coverage retroactively, what must the consumer do?

A. Nothing

B. Call the Marketplace Call Center

C. Pay any outstanding premiums

D. Both B and C

Knowledge Check #5 Answer

Answer: **B and C**

B. Call the Marketplace Call Center, AND

C. Pay any outstanding premiums.

Consumers will not get retroactive coverage if they do not first call the Marketplace Call Center to request it. The system will default to coverage that is effective starting the first of the month following their date of plan selection.

Additional Resources

For more information, visit:

- InsureKidsNow.gov
- HealthCare.gov: Getting Medicaid & CHIP Coverage
- Medicaid.gov: Medicaid Eligibility
- Medicaid.gov: CHIP Eligibility

References

1. Enrollment total as of June 2024, from Medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html
2. 45 C.F.R. 155.420(d)(16)
3. Under section 1905(a) of the Social Security Act
4. Section 2303(a)(3) of ACA, amending section 1902(a)(10)(G) of the Social Security Act. See also 1905(a)(4)(C) of the Social Security Act.
5. 42 C.F.R. 435.406 and 42 C.F.R. 457.320(b)(6)
6. For more information, please see new special rules relating to Afghan Evacuees (Health Coverage Options for Afghan Evacuees at Medicaid.gov/medicaid/eligibility/downloads/hlth-cov-option-afghan-evac-fact-sheet.pdf), Certain Ukrainian Nationals (Health Coverage Options for Certain Ukrainian Nationals at Medicaid.gov/medicaid/eligibility/downloads/hlth-cov-opt-fr-cer-ukrainian-natnls.pdf), and COFA migrants (Medicaid.gov/federal-policy-guidance/downloads/sho21005.pdf). Please note that the Consolidated Appropriations Act of 2024 extended coverage in separate CHIPs to COFA migrants.
7. CMS.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf Section 214 of CHIPRA permits States to cover, 2107 of the Social Security Act the Act
8. Medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-childrenpregnant-women
9. ACF.hhs.gov/orr/programs/refugees/medical-screening