



# Medicaid Eligibility and Enrollment Rule Explainer

by Tricia Brooks and Alexa Gardner

On April 2, 2024, the Centers for Medicare & Medicaid Services published the second part of a two-part final rule that simplifies the eligibility and enrollment processes for Medicaid, the Children’s Health Insurance Program (CHIP), and the Basic Health Program (BHP).<sup>1</sup> The rule eliminates certain access barriers for children enrolled in CHIP; makes transitions between programs easier; aligns and strengthens enrollment and renewal requirements for most individuals in Medicaid; establishes beneficiary protections related to returned mail; creates timeliness requirements for redeterminations of eligibility; addresses other outdated barriers to coverage; and modernizes record-keeping requirements. The regulations become effective on June 3, 2024, although states will have between 12 and 36 months to implement most changes.

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## Strengthening CHIP Coverage for Children

Since the inception of CHIP in 1997, states with separate CHIP programs had been allowed to impose certain restrictions on eligibility or covered benefits. States currently have the option to establish waiting periods prior to enrollment, a lockout period for non-payment of premiums, and lifetime or annual dollar-based limits on services covered. These policies are prohibited in Medicaid, including for CHIP-eligible children in states that cover some or all children in Medicaid using CHIP funds (known as M-CHIP). The final rule eliminates each of these practices, thereby aligning CHIP policies with longstanding Medicaid policies and removing barriers to CHIP enrollment and coverage.

### ► Eliminates CHIP Waiting Periods (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)

Waiting periods are a period of uninsurance states may require prior to CHIP enrollment. Waiting periods were historically used to deter families from dropping group insurance to enroll in CHIP, known as “crowd-out.” But with no clear evidence of crowd-out and the availability of temporary coverage through the health insurance marketplaces, any deterrent effect that waiting periods may have had is largely diminished. Moreover, the forced uninsurance period creates gaps in coverage and hinders a child’s ability to access routine care for healthy growth and development. Current rules have allowed states to impose waiting periods in separate CHIP for up to 90 days, although previously there were no limits on waiting periods. A decade ago, 38 states imposed waiting periods of up to 12 months,<sup>2</sup> but that number has declined to 11 states, with eight of those states imposing the maximum 90 days.<sup>3</sup>



The final rule eliminates waiting periods for children enrolling in CHIP and CHIP premium assistance programs, which allow states to use CHIP funds to help purchase family coverage for an eligible child who is not enrolled if it is cost-effective. However, children must be uninsured to be eligible for CHIP, and states must continue to monitor substitution of coverage. States are prohibited from adopting a new waiting period as of June 2024, but states that currently have waiting periods have until June 2025 to come into compliance by removing existing waiting periods.<sup>4</sup> Eliminating waiting periods allows children to have access to healthcare immediately, rather than experiencing gaps in coverage that can be harmful to their healthy development and put families at financial risk.

► **Removes Annual and Lifetime Dollar Limits on Covered Services (§ 457.480)**

The Affordable Care Act (ACA) prohibits most types of health insurance, including individual and small group plans, from setting annual or lifetime dollar limits on essential benefits.<sup>5</sup> Medicaid has never allowed annual or lifetime limits. However, separate CHIP programs have been permitted to impose annual or lifetime dollar limits, which has largely been done through limits to specific CHIP benefits, most often dental care.<sup>6</sup> There are eighteen states that place either an annual or a lifetime dollar limit on at least one benefit in CHIP, though no state has a limit on all CHIP benefits.<sup>7</sup>

With the final rule, annual and lifetime dollar limits on any medical or dental services are prohibited in CHIP. Aggregate annual and lifetime dollar limits can act as barriers to children in CHIP receiving necessary care, which may delay treatment and exacerbate medical conditions. CMS explained in the proposed version of the rule that non-monetary limits on benefits, like limitations on the number of physical therapy visits, are still allowable.<sup>8</sup> Annual and lifetime dollar limits on benefits must be phased out by June 2025.

► **Prohibits Lockouts for Non-Payment of Premiums (§§ 457.570 and 600.525)**

Under Medicaid and CHIP rules, states may charge premiums and cost-sharing up to five percent of total family income. (Medicaid does not permit premiums for enrollees with incomes less than 150 percent of the federal poverty level.) In separate CHIP, states have also had the option to lock out children for non-payment of premiums by preventing reenrollment for a specific period of time. Lockout periods are allowed for up to 90 days following disenrollment.<sup>9</sup> During the time children are locked out of CHIP, they are likely to experience disruptions to care and their families may incur medical debt. Twelve states currently institute a lockout period in CHIP and most impose them for the maximum 90 days.<sup>10</sup>

With the new regulations, CHIP lockout periods are no longer permitted. While states may disenroll individuals for unpaid premiums at the end of the 12-month continuous eligibility period, they may not impose a specified period that individuals must wait to reenroll in CHIP coverage. Additionally, the final rule prohibits states from requiring payment of past due premiums or enrollment fees before a family can reenroll in CHIP coverage. As a result, families will be able to immediately reapply following disenrollment for non-payment of premiums, minimizing potential periods of uninsurance. The prohibition on premium lockout periods will also apply to states with a Basic Health Program (BHP) that allow continuous open enrollment throughout the year. As of June 2024, no state will be allowed to add a lockout period. States that currently have a premium lockout will have 12 months from the effective date to sunset the policy.<sup>11</sup>



## Transitions between Medicaid and CHIP

(§§ 431.10, 435.1200, 457.340, 457.348, 457.350, and 600.330)

Although the Affordable Care Act (ACA) envisioned seamless, coordinated coverage across the Insurance Affordability Programs (IAP), one in five children experience a gap when transitioning between Medicaid and CHIP.<sup>12</sup> The current rules did not go far enough to ensure that eligible children were transitioned seamlessly across programs, even when data available to the state verified eligibility for the other program. The new rule is intended to improve transitions by requiring Medicaid and separate CHIP programs to make determinations of eligibility on behalf of the other program, transfer files when appropriate, and accept determinations made by the other program.

While Medicaid agencies and separate CHIP programs must accept eligibility determinations from the other program, they have options in how the requirements are implemented. This will work most seamlessly in states that use, or choose to adopt, a shared eligibility system or service between

Medicaid and CHIP, as many states do.<sup>13</sup> Without a shared eligibility system, Medicaid agencies and separate CHIP programs may use the same MAGI-based eligibility rules and accept the determination from the other program, delegate determination authority to the other program, or adopt other procedures approved by the Secretary.

To facilitate seamless transitions, Medicaid and separate CHIP programs will generally be required to provide a single, combined notice to all enrollees in the household with information about each individual's eligibility status for Medicaid and CHIP, and potential eligibility for other IAPs. Although the new rules governing Medicaid and CHIP transitions are effective on June 3, 2024, states without a shared eligibility system will need time to make changes to meet these requirements.

## Reasonable Classifications of Children Under Age 21

(§§ 435.223)

Under the Medicaid statute, states have the flexibility to extend Medicaid coverage to all children under age 21, 20, 19, or 18, and/or reasonable classifications thereof, using any of the many eligibility pathways under section 1902(a)(10)(A)(ii). States commonly have adopted reasonable classifications to meet the needs of specific populations of children, for

example, children who are in the custody of the state. However, the current rule only describes two MAGI-based categories of eligibility. The addition of § 435.223 makes it clear that states have other options for structuring their children's coverage groups using these flexibilities.



# Updating Renewal and Changes in Circumstances Processes

Since implementation of the Affordable Care Act (ACA) in 2014, states have been required to apply streamlined application and renewal processes for applicants and enrollees whose eligibility is based on Modified Adjusted Gross Income (MAGI). At that time MAGI was a new methodology for counting income and household size for children, pregnant individuals, parents/caretakers, and ACA expansion adults, which largely aligns with financial eligibility for premium tax credits to subsidize coverage in the Health Insurance Marketplaces.<sup>14</sup>

The new rule does not change how financial eligibility is determined for non-MAGI groups, but it extends the MAGI renewal and redetermination requirements to non-MAGI enrollees, including people with disabilities and low-income seniors with both Medicare and Medicaid coverage (dual eligibles). In aligning MAGI and non-MAGI processes, CMS has rewritten the renewal rules at § 435.916 with new references to timeliness standards described below.

Of note, current rules require states to first attempt to renew eligibility using data available to the state through ex parte processes for both MAGI and non-MAGI groups. If ongoing eligibility at renewal can be established through available data sources, the states must accept the information and redetermine eligibility without requiring a signature. While all states can make improvements in their ex parte processes, the unwinding revealed that ex parte processes for non-MAGI groups were particularly lagging. If ex parte processes are inadequate, states have been required to implement time-consuming and less-effective mitigation strategies to comply with federal renewal requirements and qualify for enhanced federal funding throughout 2023. Going forward, states will need to phase out those mitigation strategies in addition to implementing these new redetermination provisions to be fully compliant with all federal renewal requirements.<sup>15</sup>

## ► Aligns Renewal Processes for Non-MAGI Groups with Existing MAGI Rules (§§ 435.907 and 435.916)

States must now renew eligibility for non-MAGI groups once, and only once, every 12 months. The only exception is that states have the option to conduct renewals for qualified Medicare enrollees every six months, but not

more often. States are no longer allowed to require in-person interviews for non-MAGI enrollees as part of the renewal process. If ongoing eligibility for non-MAGI enrollees at renewal can be established through available data sources, the states must accept the information and redetermine eligibility without requiring a signature. If they are unable to confirm ongoing eligibility using reliable data available to the agency through automated ex parte processes, they must send out a pre-populated renewal form and allow at least 30 days for individuals to respond. States may only request information needed to verify eligibility and must be able to accept renewal forms through all four modes: online, phone, mail, or in-person. If an individual submits the renewal form or needed information within 90-days after they have been disenrolled for not responding on time, the state must review, verify, and act on the information without requiring a new application. States have 36 months, until June 2027, to come into compliance with the updated renewal requirements after the rule becomes effective.

## ► Changes in Circumstances (§§ 435.916, 435.919, 457.344 and 457.960)

Previously, the rules applying to changes in circumstances were included in renewals regulations with no specific requirements for enrollee response times or standards for timely redetermination of eligibility. The new section on changes in circumstances specifies that the state must ensure that enrollees understand the importance of reporting changes accurately and on a timely basis and that the agency must accept reports of changes through any of the four modes. The rules apply to changes in circumstances that affect an individual's eligibility, as well as changes impacting the amount of medical assistance or the enrollee's premiums or cost sharing.

The updated rule specifies that if a change is identified by a third-party data source, the state may verify the change with the enrollee. If the change is reported by the enrollee, the agency must first attempt to verify the change through available data. If the state is unable to verify the change through electronic sources, it may only request information relating to the change.



If the agency is unable to verify a reported change that would result in either additional medical assistance or lower premiums or cost-sharing, the agency may not terminate coverage if the enrollee does not respond to a request to verify the change. If a change results in adverse action, the agency must follow the same rules required at renewal, including reviewing eligibility for other bases, and determining potential eligibility for other IAPs before terminating coverage and providing advance notice and fair hearing rights.

► **Beneficiary Response Times and 90-Day Reconsideration Period (§ 435.919(c) and (d))**

In general, the state must allow at least 30 days from the date the agency sends a request for information for the enrollee to respond. The state must accept such information through all four modes and redetermine

eligibility within the time standards described below. If an individual whose coverage is terminated for not providing requested information submits the information within 90 days after being disenrolled (or for a longer period at state option), the state must reconsider eligibility without requiring a new application. A state may also initiate a new eligibility period if it has enough information to review eligibility with respect to all eligibility criteria. Given the complex system changes needed to implement the new rules regarding changes in circumstance and associated response timelines, states will have until June 2027 to comply with the requirements.

## Updating Address Information

Maintaining up-to-date address and contact information for Medicaid enrollees has been a longstanding challenge for states and many fell further behind during the COVID-related three-year pause on Medicaid disenrollments. In the 2023 Consolidated Appropriations Act, Congress required states to take proactive steps to update contact information as one of several conditions for receiving enhanced federal Medicaid funding as the states began the process of unwinding the Medicaid continuous enrollment requirement. The new rule permanently adopts similar requirements and incorporates certain flexibilities for states to accept updated contact information from reliable sources without further verification. Most states (43) adopted section 1902(e)(14) waivers during the unwinding to implement these processes for updating addresses using information from one or more of the reliable sources identified in the rule.<sup>16</sup> States will have until December 2025 to put in place all of the processes described below.

► **Updating Addresses Received from Reliable Sources (§§ 435.919(f)(1) and 457.344(f)(1))**

States must implement (or retain) processes to regularly obtain information and to act on address changes from reliable sources without further verification. If information is received from a reliable source, the state must accept

the information as reliable, update the case record, and notify the enrollee of the change. The rule establishes that reliable data sources include mail returned by the United States Postal Service (USPS) with a forwarding address; the USPS National Change of Address (NCOA) database; contracted managed care organizations, prepaid health plans, and primary care case management entities (PCCM); and other data sources identified by the agency and approved by the Secretary.

► **Updating In-State Addresses from Other Data Sources (§§ 435.919(f)(2)(ii) and 457.344(f)(2)(ii))**

The regulation spells out how states must treat in-state address changes from a data source other than one of the reliable data sources noted above. States must first check the Medicaid Enterprise System (MES)<sup>17</sup> and the most recent information received from the reliable sources to confirm the accuracy of the information. If confirmed, the address is updated without further verification. If not confirmed, the state must make a good-faith effort to contact the beneficiary to confirm the information. However, the state may not update the address or terminate coverage if the individual does not respond to a request to confirm their address or state residency.



► **Updating Out-of-State Address Changes (§§ 435.919(f)(3) and 457.344(f)(3))**

For returned mail or information received from one of the reliable sources with an out-of-state address, the agency must make a good-faith effort (described below) to contact the beneficiary or obtain other information to determine if the individual continues to be a state resident. If unable to verify residency, the state must provide advance notice of termination and fair hearing rights.

► **Actions When Mail is Returned with No Forwarding Address (Whereabouts Unknown) (§§ 435.919(f)(4) and 457.344(f)(4))**

If mail is returned with no forwarding address, the state must check the agency's MES and the most recent information received from the reliable sources. If updated in-state address information is found, the agency must accept the information as reliable, update the case record, and notify the enrollee. If the updated information cannot be confirmed, the agency must make a good faith effort to contact the enrollee.

After making a good-faith effort when the enrollee's whereabouts remain unknown, the agency must take appropriate steps to move the enrollee to a fee-for-service

delivery system or to terminate or suspend coverage. If the agency chooses to terminate or suspend coverage, they must send notice to the last known address or via electronic notification no later than the date of termination or suspension. If the whereabouts of an enrollee whose coverage was terminated or suspended become known, the agency must reinstate coverage back to the date of termination without requiring additional information to verify their eligibility unless the agency has other information that the enrollee may not meet all eligibility requirements. As with other changes in circumstances, if the state has sufficient information available to it to renew eligibility without requesting information from the enrollee, it has the option to begin a new eligibility period.

► **Good-Faith Effort to Contact Beneficiary (§§ 435.919(f)(5) and 457.344(f)(5))**

A good-faith effort includes at least two attempts to contact the enrollee, using two or more modalities (mail, phone, email) with a reasonable amount of time between contact attempts, and providing at least 30 days for the enrollee to respond. If contact information for two or more modalities is not available, the state must make a note in the case record.

## Removing Barriers to Coverage

The new rules include several additional provisions that remove barriers to coverage.

► **Verifying U.S. Citizenship through State Vital Statistics Records and the Department of Homeland Security (§435.407)**

All states must verify citizenship or qualified immigration status in determining Medicaid eligibility. Under current rules, if states are unable to confirm U.S. citizenship or nationality through a data match with the Social Security Administration (SSA), they must verify the applicant's citizenship through alternative sources, including a match with the state's vital statistics records or with the U.S. Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) program. Use of alternative reliable data sources also requires states to obtain proof of personal identity. The new rule establishes that verification through a state's vital statistics records

or DHS SAVE system, like the match with SSA, provides both proof of U.S. citizenship or nationality and reliable documentation of personal identity. As such, once U.S. citizenship is verified through a state's vital statistics records or through DHS SAVE, a state may not require an individual to provide additional proof of identity. Once U.S. citizenship or nationality is verified, it does not have to be re-verified at renewal or when changes in circumstances are reported. States must implement the new verification process by June 2026.

► **No Requirement to Apply for Other Benefits (§§435.608 and 436.608)**

Outdated rules in Medicaid going back nearly 50 years established standards for evaluating which income and resources are "available" to Medicaid applicants or enrollees, including pensions, annuities, retirement funds, or disability benefits. The current rule requires individuals



to apply for other “available” benefits as a condition of eligibility. The new rule redefines “available” to mean only such income and resources that are within the individual’s immediate control, thereby eliminating the requirement to apply for other benefits in order to be eligible for Medicaid. This change must be implemented by June 2025, and applies to states and territories.

► **Prospective Deduction of Expenses for Medically Needy Programs (§§435.831 and 436.831)**

Medically needy programs are often called spenddown programs because they cover Medicaid services after an individual has incurred medical expenses that reduce or “spenddown” their income to the applicable eligibility level. Individuals must submit documentation of expenses

incurred during a specified budget period, ranging from one to six months, before Medicaid pays for additional care. As a result, individuals can churn in and out of coverage depending on their health care needs during the budget period, and the administrative cost for states to verify financial eligibility repeatedly is significant. The new rule allows states to project medical expenses that are constant and predictable with reasonable certainty, allowing individuals to remain continuously enrolled while their medical expenses remain predictable. States and territories will be able to adopt this option for calculating spenddown as of June 2024.

## Timeliness and Performance Standards Requirements

(§§ 435.907, 435.912, 457.340, and 457.1170)

Current timeliness and performance standards only reference applications, although some standards also apply to renewals and changes in circumstances. The new rule ensures that states complete determinations and redeterminations of eligibility within a reasonable timeframe at application, renewal, and following changes in circumstances. Going forward, states are required to include renewals and changes in circumstances in the performance and timeliness standards in their state Medicaid plans. All of the standards described below must be fully implemented by June 2027.

Performance standards are overall standards for determining, renewing, and redetermining eligibility in an efficient and timely manner for a pool of applicants or enrollees. These standards must include accuracy and consumer satisfaction, although not on an individual basis. Timeliness standards refer to the maximum periods of time (with certain exceptions) in which every individual is entitled to an eligibility determination or redetermination at application, renewal, and following a change of circumstance.

To promote accountability and a consistent, high quality consumer experience, the timeliness and performance standards included in the state Medicaid plan must address systems and technologies capabilities and cost; availability of data matching and use of reliable electronic data; time

needed to evaluate data received from other sources; reporting of timeliness and performance standards; the needs and preferences of applicants and enrollees; and the requirement for advance notice of adverse actions. Standards must be established for the following:

► **Applications and Account Transfers Received from Another Insurance Affordability Program**

This standard covers the period from the date the state receives a new application or account transfer from another IAP to the date the agency notifies the applicant of its decision or transfers the account to another IAP. The maximum period allowable is 90 days for applicants who apply for Medicaid on the basis of disability; and 45 days for all other applicants.

► **Regularly Scheduled Renewals**

This standard covers the period from the date the state initiates an ex parte review using available data to the date the state notifies the individual of its decision or terminates eligibility and transfers the individual’s account to another IAP. Redeterminations for regularly scheduled renewals must be processed by the end of the eligibility period unless the renewal form is received less than 30 days before the end of the eligibility period, in which case the redetermination may not exceed the end of the next month.



### ▶ Reported Changes in Circumstances

This standard covers the period from the date the state receives the information about a change to the date the state notifies the individual of its decision or terminates eligibility and transfers the individual's account to another IAP. The redetermination may not exceed the end of the next month that occurs 30 days after the change is reported by the enrollee or received from a third party (e.g., periodic check of a reliable data source) or 60 days after the reported change if the state needs additional information from the enrollee.

### ▶ Anticipated Changes in Circumstances

This standard covers the period from the date the state begins the redetermination of eligibility to the date the state notifies the individual of its decision or terminates eligibility and transfers the individual's account to another IAP. The redetermination of eligibility may not exceed the end of the month following the month in which the anticipated change occurs.

### ▶ Additional Time for Consideration of Other Basis of Eligibility

If the enrollee is ineligible for their current eligibility group at renewal or when a change occurs and the state is considering eligibility on another basis, the determination on the new basis may not exceed 90 days for enrollees who may qualify for a disability group and 45 days for all other enrollees.

### ▶ Exceptions to Standards

States must determine or redetermine eligibility within the standards described unless the agency cannot reach a decision because the individual, or an examining physician, delays or fails to take a required action or there is an administrative or other emergency beyond the state's control. Delays must be documented in the case record.

### ▶ Prohibitions

The agency may not use timeliness standards as a waiting period or as a reason for denying or terminating eligibility or benefits because the state is experiencing processing delays. Likewise, standards may not be used as reason for delaying termination or taking other adverse action.

## Maintenance of Records

(§§ 431.17, 435.914, and 457.965)

For the first time since 1986, CMS has updated recordkeeping regulations which are critical to ensuring appropriate and effective oversight to identify errors in state policies and operations. In fact, about two-thirds of improper payments in 2023 were the result of insufficient documentation.<sup>18</sup> Over the years, digital recording keeping and the ability of eligibility, enrollment, and claims payment systems to capture and report transaction details have evolved significantly.

The rule reaffirms that state Medicaid agencies are responsible for maintaining (or supervising the maintenance of) the records necessary for “the proper and efficient operation of the Medicaid program.” These include both records of individual applicants and enrollees as well as statistical, fiscal, and other records. The rule details the specific information that state agencies must include in each individual record to support their decisions with respect applicant or enrollee.

Individual records must include all nine of the following elements of applicant or enrollee information. Most of these relate to eligibility, but one relates to services received (if any).

- All information on the initial application submitted through any modality;
- The electronic account and any information or documentation received from another IA.
- The date, basis for, and all documents or other evidence to support decisions made at application, renewal, and following a change in circumstances (i.e., determinations, denials, or other adverse actions) including all information provided by the applicant, enrollee, or from third-party sources.
- Any changes in circumstances reported by the individual and any actions taken by the agency.





- All renewal forms and associated documentation submitted through all modalities, including the signature on the form and date received.
- Details on payment for all services, including the services or items provided, relevant diagnoses, the date of service, the provider or practitioner providing the service; and the full amount paid or reimbursed.
- All notices provided to individuals.
- The disposition of income and eligibility verification information received, including evidence that no information was returned from an electronic data source.
- All records pertaining to fair hearings (or CHIP reviews).

States must retain all records with required information for the entire period a case is active plus a minimum of three years afterwards in an electronic format. Records must be made available to the Secretary, federal and state auditors, and other parties who request and are authorized to review such records within 30 days of the request. States must also provide adequate safeguards to restrict the use or disclosure of information contained in the records. Compliance with the new requirements is required by June 2026.

## Applicability of Changes to Separate CHIP Programs

The majority of provisions established under the new regulation for Medicaid generally apply to separate CHIP programs as well. States must follow the same timeliness standards and procedures for acting on changes in circumstances except for the consideration of all other basis of eligibility (which is not a requirement for CHIP) and different standards for account transfers from other programs. The new requirements for verifying citizenship and updating addresses are consistent across Medicaid and CHIP. States must also retain the same records for individuals on CHIP, for

the same minimum period, as for Medicaid, though CHIP programs must keep information on state reviews requested by individuals rather than records pertaining to fair hearings (another policy not required in CHIP). Provisions solely affecting non-MAGI populations—spenddown for medically needy programs, requirement to apply for other benefits, and alignment of non-MAGI renewals—are not applicable to CHIP.

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## Endnotes

<sup>1</sup> “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Process, 89 FR 22780 (published April 2, 2024; effective June 3, 2024), available at <https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health>.

<sup>2</sup> T. Brooks, “Making Kids Wait for Coverage Makes No Sense in a Reformed Health System,” Georgetown University Center for Children and Families, February 2015, available at <https://ccf.georgetown.edu/wp-content/uploads/2015/03/Making-Kids-Wait-for-Coverage-Makes-No-Sense-in-a-Reformed-Health-System-2015.pdf>.

<sup>3</sup> T. Brooks et al., “Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey,” Kaiser Family Foundation, March 26, 2020, available at <https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey-tables/>. Illinois and Maine previously imposed 90-day waiting periods, but have moved to a Medicaid expansion CHIP (M-CHIP) program where waiting periods are not allowed.

<sup>4</sup> States will have 24 months to sunset existing waiting periods in cases where legislative action is required to implement the changes and the state has a biennial legislature.

<sup>5</sup> “Essential Health Benefits,” Healthcare.gov, available at <https://www.healthcare.gov/glossary/essential-health-benefits/>; Information on Essential Health Benefits (EHB) Benchmark Plans, available at <https://www.cms.gov/marketplace/resources/data/essential-health-benefits>.

<sup>6</sup> Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Process, 87 FR 54760 (proposed September 7, 2022) (to be codified at 42 CFR parts 431, 435, 457, and 600), pg. 54816.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> States were allowed to disenroll individuals for non-payment of premiums at any point of their eligibility period as long as individuals were given a minimum 30-day premium grace period. After the Consolidated Appropriations Act of 2023 made 12-month continuous eligibility mandatory for Medicaid and CHIP, however, states are no longer allowed to disenroll for non-payment of premiums during the continuous eligibility period. See “Mandatory Continuous Eligibility for Children in Medicaid and CHIP Frequently Asked Questions”, Center for Medicaid and CHIP Services, October 27, 2023.

<sup>10</sup> T. Brooks et al., 2020, pg. 67.

<sup>11</sup> States will have 24 months to sunset existing premium lockout periods in cases where legislative action is required to implement the changes and the state has a biennial legislature.

<sup>12</sup> L. Jennings & R. Nelb, “Updated Analyses of Churn and Coverage Transitions,” Medicaid and CHIP Payment and Access Commission, April 7, 2022, available at <https://www.macpac.gov/wp-content/uploads/2022/04/Churn-and-Coverage-Transitions.pdf>.

<sup>13</sup> T. Brooks et al., “Table 6: Integration of MAGI-Medicaid Eligibility Systems with Marketplace Systems, Non-MAGI Medicaid, and Non-Health Programs, January 2023,” Kaiser Family Foundation, April 4, 2023, available at <https://files.kff.org/attachment/Table-6-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf>.

<sup>14</sup> “Medicaid Eligibility,” Center for Medicare and Medicaid Services, available at <https://www.medicaid.gov/medicaid/eligibility/index.html>.

<sup>15</sup> “Summary of State Mitigation Strategies for Complying with Medicaid Renewal Requirements Described in the Consolidated Appropriations Act, 2023” Center for Medicaid and CHIP Services, available at <https://www.medicaid.gov/media/159651>.

<sup>16</sup> “COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals,” Center for Medicare and Medicaid Services, available at <https://www.medicaid.gov/media/164611>.

<sup>17</sup> Medicaid Enterprise Systems (MES) refers to a collection of information technology used to administer Medicaid, including but not limited to, eligibility and enrollment systems, claims payment systems (also known as Medicaid management information systems (MMIS)), immunization registries, and electronic clinical quality data, among others.

<sup>18</sup> Department of Health and Human Services, Agency Financial Report, Fiscal Year 2023, available at <https://www.hhs.gov/sites/default/files/fy-2023-hhs-agency-financial-report>.