



CMCS Informational Bulletin

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FROM: Dan Brillman, Deputy Administrator and Director of the Center for Medicaid and CHIP Services (CMCS)

SUBJECT: Ensuring Medicaid Eligibility Integrity by Addressing Concurrent Medicaid and Children’s Health Insurance Program (CHIP) Enrollment Across States¹

In 2024, an average of 1.2 million Americans each month appeared to be enrolled in Medicaid or the Children’s Health Insurance Program (CHIP) in more than one state.² These concurrent Medicaid and CHIP enrollments represent millions in excess state and federal dollars spent annually on managed care capitation rates and other costs for individuals who may no longer be eligible in one or more of the states in which they are enrolled. The Centers for Medicare & Medicaid Services (CMS) aims to ensure, as expeditiously as possible and within the bounds of the law, that individuals who are otherwise Medicaid- or CHIP-eligible are enrolled **only** in the Medicaid program or CHIP of their state of residence, not in multiple states’ programs. CMS is also committed to ensuring that Medicaid- and CHIP-eligible individuals are not improperly enrolled concurrently in Medicaid or CHIP and in subsidized Health Insurance Exchange coverage with advance payments of the premium tax credits (APTC) or cost-sharing reductions (CSR). CMS is committed to working with states to eliminate Medicaid and CHIP fraud, waste, and abuse, and ensuring that federal dollars are expended to provide only eligible individuals with health coverage.

Section 1902(a)(8) of the Social Security Act (“the Act”) requires that states furnish Medicaid with reasonable promptness to eligible individuals. Section 2102(b) of the Act limits CHIP payments to states that provide benefits to individuals in a manner consistent with statutory eligibility requirements. With rare exception,³ in both Medicaid and CHIP, individuals are

¹ This document cites and describes statutes and regulations that contain applicable legal requirements, and such statutes and regulations are controlling. This document does not independently impose legally binding requirements on any entity.

² CMS Press Release. “CMS Finds 2.8 Million Americans Potentially Enrolled in Two or More Medicaid/ACA Exchange Plans.” July 17, 2025. Available at: <https://www.cms.gov/newsroom/press-releases/cms-finds-28-million-americans-potentially-enrolled-two-or-more-medicaid/aca-exchange-plans>.

³ Exceptions may apply in certain circumstances (e.g., Medicaid beneficiaries who are displaced from their home state to another state due to a disaster or leave the state for reasons such as education or military service may retain eligibility in their home state, pursuant to 42 C.F.R. § 435.403(j)(3)). CHIP regulations at 42 C.F.R. § 457.320(e) cross-reference Medicaid requirements at 42 C.F.R. § 435.403(h) and (i).

eligible only in the state in which they reside,⁴ and states must promptly redetermine eligibility whenever the state receives information about a change in a beneficiary's circumstances that may impact their eligibility, including a change to their state of residence.⁵

In light of recent analyses demonstrating apparent widespread concurrent enrollment of Medicaid and CHIP beneficiaries in multiple states,⁶ this CMCS Informational Bulletin (CIB) reminds states of their obligation to act timely on changes in circumstances with respect to residency and provides guidance on steps needed to identify and redetermine eligibility for concurrently enrolled beneficiaries.

As described in more detail below, CMS will soon provide each state with a one-time file on Medicaid and CHIP beneficiaries identified as potentially also enrolled in another state, based on state-provided data from T-MSIS. States should review the information provided and, as appropriate, promptly redetermine eligibility for the identified beneficiaries and take necessary action to terminate coverage for those whom the state determines are no longer eligible based on residency.

Additionally, in 2025, the Federally-facilitated Exchange (FFE), conducted two rounds of the Medicaid/CHIP Periodic Data Matching (PDM) process required by federal regulations.⁷ This process consists of notifying individuals who appear to be enrolled in both Medicaid or CHIP and an Exchange plan with APTC or CSRs. If the enrollee does not contest the information in the notice within 30 days after the date of the notice, the FFE ends APTC or CSRs for individuals who still appear to be enrolled in Medicaid or CHIP based on state data.⁸ CMS also provided State-based Exchanges (SBEs) with information on individuals who are potentially enrolled in the state's Medicaid program or CHIP and an Exchange plan with APTC and asked SBEs to determine whether these individuals are concurrently enrolled, and if so, direct them to implement a process, similar to the FFE, to redetermine eligibility as required under regulation. CMS continues to engage SBEs and provide technical assistance, leveraging existing oversight and monitoring activities to ensure compliance with the PDM requirements.

⁴ 42 C.F.R. § 435.403(a). Note: we refer to Medicaid and CHIP **eligibility** in contrast to other situations where Medicaid payment may be required, such as payment, under certain circumstances, for services rendered to a Medicaid beneficiary out-of-state from their state of residence. 42 C.F.R. § 431.52(b).

⁵ 42 C.F.R. §§ 435.916(d)(1) (2023) and 457.343. Section 71102 of Pub. L. 119-21 (July 4, 2025) imposed a moratorium on several provisions in the "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" final rule (89 Fed. Reg. 22,780 (April 2, 2024)) (the "2024 E&E Final Rule"). The 2024 E&E Final Rule amended several Medicaid and CHIP regulations governing eligibility and enrollment requirements, including amending 42 C.F.R. § 435.916 for renewal processes and creating new 42 C.F.R. §§ 435.919 and 457.344 to describe requirements related to state obligations to act on changes in circumstances. The moratorium prohibits CMS from implementing, administering, or enforcing many of the amendments made by the 2024 E&E Final Rule, including changes made to 42 C.F.R. §§ 435.916, 435.919 and 457.344, from July 4, 2025 through September 30, 2034. In light of the moratorium, CMS expects to issue further guidance regarding the moratorium's effects in the near future.

⁶ Similar issues have previously been identified; see, *ee. e.g.,* *OIG, Nearly All States Made Capitation Payments For Beneficiaries Who Were Concurrently Enrolled In A Medicaid Managed Care Program In Two States (A-05-20-00025, Sept. 2022)*.” <https://oig.hhs.gov/documents/audit/7881/A-05-20-00025-Complete%20Report.pdf> (Sept. 2022).

⁷ 45 CFR § 155.330(d)(1)(ii) and (d)(3). *See also* Medicaid/CHIP Periodic Data Matching (PDM) External Frequently Asked Questions <https://www.cms.gov/files/document/external-faqs-mcpdmfinal-07142025508-compliant.pdf>

⁸ 45 C.F.R. § 155.330(e)(2).

States are generally expected to conduct regular data matching through the Public Assistance Reporting Information System (PARIS) to identify individuals concurrently enrolled in public assistance programs, including Medicaid and CHIP, in multiple states and to take action to verify beneficiaries' state residency, when appropriate.⁹ Nevertheless, as CMS' recent analysis demonstrates, concurrent Medicaid and CHIP enrollment across states continues to occur.

Public Law No. 119-21, or H.R. 1, enacted on July 4, 2025, includes new statutory requirements for both CMS and states designed to reduce duplicate Medicaid and CHIP enrollments. Public Law No. 119-21 requires states to establish a process to regularly obtain address information by January 1, 2027. It also requires CMS to establish a system that states and CMS will utilize to prevent concurrent enrollment by no later than October 1, 2029. States shall, consistent with standards established by CMS, be required to submit information about individuals enrolled or seeking to enroll in their state to the system established by CMS at least once per month. Using the information from the system, CMS shall, at least monthly, transmit information to the states identifying whether individuals enrolled or seeking to enroll are identified as also being enrolled in another state.¹⁰ CMS is working expeditiously to comply with these requirements.

The resource described in this Informational Bulletin supports states' current obligations to ensure that individuals are enrolled in the appropriate state's Medicaid program or CHIP – not in multiple states' programs – in advance of Public Law 119-21's implementation and to ensure that eligible beneficiaries retain coverage only in the state in which they reside. CMS will provide information in forthcoming data files to help states prioritize action for those individuals most likely to be ineligible in the given state.

CMS also emphasizes that we expect all states to comply with federal requirements intended to maximize retention for eligible individuals and minimize inappropriate coverage loss, including providing advance notice of termination that includes the right to a Medicaid fair hearing or a CHIP review.¹¹ To ensure individuals do not inadvertently lose coverage for procedural reasons, CMS strongly encourages states to deploy outreach efforts, including reminders through multiple modalities (e.g., phone, mail, electronic notices), when requesting information from beneficiaries to verify residency. States may also wish to engage with managed care plans, providers, and other key partners to support outreach to beneficiaries. For example, managed care plans may have recent address confirmations from individuals, which states can use to verify whether an individual continues to be a state resident.

Overview of Federal Requirements

Applicants and beneficiaries must meet state residency requirements to qualify for Medicaid and CHIP coverage, consistent with the state plan. Any time a state receives information that indicates a beneficiary may no longer be a resident of the state, including information about enrollment in another state's Medicaid program or CHIP, it must consider this information as a potential change in circumstances and redetermine the beneficiary's eligibility consistent with

⁹ 42 C.F.R. 435.945(d). *See also* CMS SMDL #10-009. "Re: Public Assistance Reporting Information System (PARIS)." June 21, 2010, available at <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD10009.pdf>.

¹⁰ Pub. L. No. 119-21, P.L. 119-21, § 71103. July 4, 2025

¹¹ 42 C.F.R. §§ 435.917 and 435.918, 42 C.F.R. part 431 subpart E, and 42 C.F.R. §§ 457.340(e)(1)(ii) and 457.1180 (2023).

federal regulations. We note that in some narrow situations, it may be appropriate for an individual to be enrolled in two states, such as when an individual has temporarily relocated to another state due to a natural disaster.¹²

Acting on Change in Circumstances in Medicaid and CHIP

As required in 42 C.F.R. §§ 435.916 (2023) and 457.343, states must promptly act on information indicating a potential change that may affect a beneficiary's eligibility that the state receives, such as from an electronic data source or other information available to the state, (e.g., such as information from other human services programs). When a state receives such information, the state must determine whether the beneficiary continues to meet the eligibility criterion to which the change relates. The state must redetermine eligibility based on available information, if possible. When needed information is not available, the agency must request such information from the beneficiary in accordance with 42 C.F.R. § 435.952(b) and (c) (2023) (cross-referenced for separate CHIP programs at 42 C.F.R. § 457.380(f)) and give the person a reasonable period of time to provide information or other documentation to establish that the information received by the agency is not correct and the individual continues to meet the eligibility criterion at issue prior to taking adverse action. When acting on such information, the state must limit any requests for information to information regarding the change in circumstances that may affect the beneficiary's eligibility.

If the beneficiary responds, the state must consider all information and documentation submitted by the beneficiary as it redetermines eligibility.¹³ If the information or documentation provided by the beneficiary confirms that they continue to meet the eligibility requirements, the beneficiary retains their coverage, and the state should notify the beneficiary that their eligibility remains unchanged. If the beneficiary responds and the information or documentation provided results in a determination of ineligibility for Medicaid or CHIP, or if the beneficiary does not respond to the request within the time specified, the state must comply with the requirements at 42 C.F.R. §§ 435.916(f) (2023) and 457.350 (2023), considering all bases of eligibility and potential eligibility for other insurance affordability programs before providing advance notice of termination. The advance notice of termination must include the right to a Medicaid fair hearing or a CHIP review, as required by 42 C.F.R. §§ 435.917 and 435.918, 42 C.F.R. part 431 subpart E, and 42 C.F.R. §§ 457.340(e)(1)(ii) and 457.1180 (2023). The effective date of the termination must be prospective from the date the state sends notice of the adverse action.¹⁴ Because states must send advance notice of adverse action, states may not retroactively terminate a beneficiary's coverage.

¹² See, e.g., 42 C.F.R. § 435.403(j). For example, CMS has permitted states to cover nonresidents and to continue covering residents of the state who evacuate or are otherwise absent from the state. See items A.4 and A.5 in the CMS Medicaid disaster relief SPA for the COVID-19 national emergency, available at <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-template.docx>.

¹³ See 42 C.F.R. §§ 435.952(a) and 457.380(f).

¹⁴ 42 C.F.R. §§ 431.211, 431.213 (2023), and 431.214.

The Effect of Change in Circumstances Requirements on the Eligibility of Other Members in a Household

States should keep in mind that any time they act on a change in circumstances for one member of a household, there could be implications for other Medicaid- and/or CHIP-enrolled members of the household.¹⁵ Should a change in circumstances directly affect more than one household member, a state may send a single request for information applicable to all affected household members.

Should a change in circumstances apply to just one individual in the household, the state must seek additional information to confirm only whether that individual continues to be eligible.¹⁶ The state may not terminate the coverage of other household members solely because the individual to whom the change in circumstance applies responds with information or documentation confirming they are no longer eligible or fails to respond to the request for information within the specified time.¹⁷ However, in some circumstances, the information or documentation provided in response to a request for information may indicate other household members also experienced a change in circumstance that the state must act on, such as information suggesting a change in household size potentially affecting income eligibility or changes in residency for other beneficiaries in the household.¹⁸

Overview of the Concurrent Enrollment Files

As noted above, CMS will soon provide each state with a unique file that lists individuals who were enrolled in Medicaid or CHIP in their state and at least one other state between June and August 2025, according to T-MSIS data. Files will include beneficiary information, enrollment dates, and states of potential concurrent enrollment. CMS will also provide additional information to help states prioritize working through the file. Supporting information will include the individuals' most recent state of enrollment and the delivery system in which they are enrolled (e.g., comprehensive managed care or fee-for-service). States are encouraged to supplement the concurrent enrollment file with other data to further prioritize their reviews and casework. For example, states may wish to link the records in the file with claims data to first assess cases where services have not been recently utilized in their state.

The criteria states use for prioritization should be fact-based and neutral with respect to protected characteristics.

Steps to Act on the Information in the Concurrent Enrollment File

Each state can review the concurrent enrollment file that CMS will provide, consider this information as a potential change in circumstances, and promptly redetermine eligibility, as needed, consistent with all applicable federal requirements, including, but not limited to, the procedures described above as well as advance notice of termination and fair hearing rights.

¹⁵ 42 C.F.R. §§ 435.916(d)(2) (2023) and 457.343.

¹⁶ 42 C.F.R. §§ 435.916(d) (2023), 435.916(e) (2023) and 457.343.

¹⁷ 42 C.F.R. § 435.911(c) (2023).

¹⁸ 42 C.F.R. §§ 435.916(d) (2023) and 457.343.

States are expected to process changes in circumstances for the cases identified in the concurrent enrollment file as follows:

- **Compare the data in the concurrent enrollment file from CMS to current information in the state’s eligibility and enrollment system.** Because of the lag in T-MSIS data, states should first determine if the individuals listed in the file provided to the state continue to be enrolled in the state’s Medicaid program or CHIP. States do not need to take further action if the individual is no longer enrolled in Medicaid or CHIP. For individuals who are enrolled, states should consider whether the state has reliable data that are more recent than the concurrent enrollment file, such as a recently reported change in the beneficiary’s address. States need not act on the information in the file and redetermine eligibility if the state has reverified the individual’s state residency since August 2025.

If the state does not have information that is more recent and reliable than the data provided by CMS, the state must take steps to act on the potential change in circumstances for the individual in the concurrent enrollment file who is identified as being concurrently enrolled in another state Medicaid program or CHIP.

- **Follow the required steps for acting on a change in circumstances for those individuals for whom the state does not have more recent data.** For individuals in the concurrent enrollment file who remain enrolled in the state and for whom the state does not have more recent and reliable information, the state must redetermine eligibility based on a potential change in state residency in accordance with the policies described above. When a state does not have information available that verifies an individual is still a state resident, it must reach out to the individual and request the needed information before determining the individual is ineligible. States must verify state residency in accordance with state policies and the state’s verification plan.¹⁹

CMS encourages states to work the cases in the file in an order that mitigates duplicative payments to states providing coverage to the same person. As such, states should consider prioritizing redeterminations for individuals enrolled in managed care as the state is paying capitated payments (regardless of whether the individual is receiving covered services) before redetermining eligibility for someone enrolled in fee-for-service. States should also consider prioritizing action based on the number of months of potentially duplicative coverage.

Individuals due for renewal - CMS recognizes that some individuals on the list will be due for regularly scheduled renewals while the state is working through the file. The state may address a potential change in residency for an individual during the renewal process if the individual’s renewal is in progress or will be initiated at the same time the state is processing the information in the file. When processing the renewal, unless the state checks and obtains reliable information from data sources to reverify residency, the state

¹⁹ There may be cases where two or more states disagree over an individual’s state of residence. In these cases, the state of residence will be the state where the individual is physically located. 42 C.F.R. §§ 435.403(m) and 457.320(e)(4).

will need to send a renewal form to request additional information to verify state residency.

- **Follow federal notice and termination requirements.** In instances where information returned by the beneficiary confirms that they remain a state resident, the state must not terminate the beneficiary's Medicaid or CHIP coverage. Depending on the state's election under 42 C.F.R. § 435.916(d)(1)(ii) (2023) or 42 C.F.R. § 457.343 and the other information available to the state, the state would retain the individual's current eligibility period or start a new eligibility period. If retaining the beneficiary's current eligibility period, the state is encouraged, but not required, to notify the beneficiary that their eligibility remains unchanged. If starting a new eligibility period, the state must send notice of approved eligibility to the beneficiary in accordance with 42 C.F.R. §§ 435.917 and 435.918 and 42 C.F.R. § 457.340(e). If the beneficiary confirms they are no longer a resident or the beneficiary does not respond to the state's request for information, the state must comply with the requirements at 42 C.F.R. §§ 435.916(f) (2023) and 457.350 (2023) to consider all bases of eligibility and potential eligibility for other insurance affordability programs before providing advance notice of termination and Medicaid fair hearing or CHIP review rights consistent with 42 C.F.R. §§ 435.917 and 435.918, 42 C.F.R. part 431 subpart E, and 42 C.F.R. §§ 457.340(e)(1)(ii) and 457.1180 (2023), as applicable. Consistent with guidance provided in a July 25, 2016, CMCS Informational Bulletin, states should not transfer accounts for individuals whose eligibility has been terminated for procedural reasons.²⁰

Additional Considerations for States When Acting on Information on Potential Concurrent Enrollments

Returned mail containing a request to verify residency

We recognize that when states reach out to beneficiaries to request information verifying residency based on data in the concurrent enrollment file, some of the requests for information will result in returned mail. To ensure consistent handling of returned mail and minimize or avoid the need for duplicative requests for information, we clarify that states should take the following actions when a notice requesting information to verify residency is returned to the state.

- **If the returned mail contains an in-state forwarding address:** The state should consider the address on the returned mail as new information verifying that the individual remains in the state and there has not been a change in circumstance that may affect eligibility. In other words, the state may consider the returned mail with an in-state forwarding address as verification the beneficiary continues to reside in the state and therefore does not need to take further action to confirm residency. However, the state may need to make an additional attempt to contact the beneficiary to update the

²⁰ CMS, CIB, "Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace")," July 25, 2016, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf>.

beneficiary's contact information. The state may not terminate the beneficiary's coverage for failure to respond to the state's request to update their contact information.

- **If the returned mail contains an out-of-state forwarding address:** Ordinarily when a state receives returned mail with an out-of-state forwarding address, the state must follow up with the individual to verify the change in residency before taking adverse action because the out-of-state address is considered information indicating a potential change affecting the beneficiary's eligibility.²¹ In the case where the original request for information related to verification of a change in residency results in returned mail, the state is considered to have already satisfied the requirement to reach out to the individual regarding the potential change in residency required by 42 C.F.R. §§ 435.952 (2023) and 457.380 and no additional follow-up is necessary. The state may conduct additional outreach in an effort to locate the individual or the state may proceed with terminating coverage without taking further steps if the individual does not provide proof of continued state residency by the end of the period provided by the state. The state must send advance notice of termination to the most recent address in the beneficiary's record, including the right to a Medicaid fair hearing or CHIP review, consistent with 42 C.F.R. §§ 435.917 and 435.918, 42 C.F.R. part 431 subpart E, and 42 C.F.R. §§ 457.340(e)(1)(ii) and 457.1180 (2023), prior to terminating coverage.
- **If the returned mail does not include a forwarding address (“whereabouts unknown”):** The state may, but is not required to, make further attempts to locate the beneficiary. If the state is unable to locate the beneficiary, the state may terminate coverage for whereabouts unknown when the state has returned mail and no forwarding address. In this circumstance, the state must send notice of adverse action to the most recent address in the beneficiary's record by no later than the date of termination, in accordance with 42 C.F.R. § 431.213(d) (2023) and 42 C.F.R. §§ 457.340(e)(1)(ii) and 457.1180 (2023).

State options for how to treat populations that have continuous eligibility.

There may be some individuals in the concurrent enrollment file who are in a continuous eligibility period (i.e., children receiving 12 months continuous eligibility or pregnant and postpartum women in states that provide 12 months of extended postpartum coverage). While generally such individuals remain continuously eligible regardless of most changes in circumstances, that does not apply when the individual is no longer a state resident. Because no longer being a state resident is an exception to continuous eligibility under sections 1902(e)(12), 1902(e)(16), 2107(e)(1)(K), and 2107(e)(1)(J) of the Act, states must reach out to the family or individual concerning the potential change in residency.

Whether, and when, a state may effectuate a termination with respect to a change in state residency for someone within a continuous eligibility period depends on when a state determines

²¹ 42 C.F.R. §§ 435.916(d) (2023) and 457.343. See also CMS, SHO, “Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency,” March 3, 2022, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.

someone subject to continuous eligibility ceases to be a state resident. Should the family or beneficiary respond and confirm the individual is no longer a state resident, the state must send advance notice and terminate eligibility. If the state does not receive a response from the individual or family confirming continued residence, the state may either 1) maintain eligibility for the remainder of the continuous eligibility period unless and until the state confirms the individual ceases to be a state resident (at which point it would then be required to send advance notice and terminate eligibility) or 2) follow the procedures set forth in federal regulations for acting on a change in circumstances and returned mail and, if still unable to reach the individual or family, provide appropriate notice of termination and fair hearing rights and terminate coverage. For states that maintain eligibility for the remainder of the continuous eligibility period, the state must conduct a renewal at the appropriate time and ensure it addresses the residency inconsistency during the renewal process.

Closing

States and the federal government have a shared interest in ensuring the fiscal integrity of the Medicaid program and CHIP. This letter outlines steps for states and represents an opportunity for collaborative work among states and the federal government to prevent erroneous payment associated with individuals concurrently enrolled in more than one state. In support of this, CMS may conduct additional oversight activities aimed at reducing payment errors associated with concurrent enrollment and confirming that federal financial participation (FFP) is paid according to the statute.

For technical assistance or additional questions about this bulletin, please contact CMSEligEnrollSupport@cms.hhs.gov.