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CMCS Informational Bulletin

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SUBJECT: "Working Families Tax Cut" Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Enrollment-Related Provisions

The Center for Medicaid and CHIP Services (CMCS) is issuing this CMCS Informational Bulletin (CIB) to accompany the attached slide deck, "'*Working Families Tax Cut' Legislation, Public Law 119-21: Summary of Medicaid and CHIP Enrollment-Related Provisions.*" The slide deck provides an overview of selected changes made by Public Law 119-21 to Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment processes. This CIB and the attached deck are part of a series of guidance documents discussing implementation of Medicaid and CHIP changes made by Public Law 119-21, which CMS refers to as the "Working Families Tax Cut" (WFTC) legislation.

The slide deck highlights selected WFTC eligibility and enrollment provisions with implementation dates beginning January 1, 2027, and identifies the applicable actions for states in implementing these provisions. These provisions include:

- **Section 71103, Reducing Duplicate Enrollment under the Medicaid and CHIP Programs:** Beginning no later than January 1, 2027, each of the 50 states and the District of Columbia (D.C.) must establish a process to regularly obtain address information for beneficiaries enrolled in Medicaid and, where applicable, separate CHIP from the following "reliable data sources":
    - mail returned to the state by the U.S. Postal Service with a forwarding address;
    - the U.S. Postal Service National Change of Address Database;
    - managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case managers (PCCMs) that have contracts under the state plan, if the address information was provided directly by, or verified directly with, the individual; and
    - other data sources identified by the state and approved by the Secretary.

  Based on address information obtained from these sources, the attached slide deck describes the applicable actions for states with respect to resulting address changes for beneficiaries enrolled under the state plan (or a waiver of such plan). Section 71103 also requires CMS to establish, by October 1, 2029, a system to be used by CMS and states,

including D.C. and the territories, to prevent individuals from being simultaneously enrolled in Medicaid or separate CHIP programs in multiple states. This CIB and the attached slide deck do not provide additional guidance concerning the October 2029 system. CMS expects to provide states with additional guidance in the future.

- **Section 71104, Ensuring Deceased Individuals Do Not Remain Enrolled:** Each of the 50 states and D.C. must check the Social Security Administration's Death Master File (DMF) or a successor system on at least a quarterly basis to determine whether Medicaid beneficiaries are deceased. States are required to treat such information as "factual" and disenroll such beneficiaries from Medicaid, with notice and fair hearing rights provided no later than the date of action consistent with 42 CFR part 431 subpart E, without requesting additional information from the household or authorized representative. If a state determines that an individual was misidentified as deceased based on DMF information and was erroneously disenrolled, the state must immediately reenroll the individual retroactive to the date of disenrollment.

- **Section 71112, Reducing State Medicaid Costs:** Effective for applications made on or after January 1, 2027, the retroactive eligibility period for individuals enrolled in the state plan in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act will be limited to one month prior to the month in which the application was made. For most individuals enrolled in the state plan in other eligibility groups, the retroactive eligibility period will be limited to two months prior to the month in which the application was made. In either case, medical assistance is available only for care and services furnished when the individual was (or upon application would have been) eligible for such assistance. Section 71112 also makes similar amendments to the CHIP statute, at section 2102(b)(1)(B) of the Act, by adding a new paragraph (vi), under which states retain the option to provide retroactive child health assistance or pregnancy-related assistance. If a state elects to provide such assistance, however, the assistance may not be made available for items and services furnished before the second month preceding the month in which the application was made.

CMS is committed to working with states, D.C., and the territories to support implementation of the changes in the eligibility and enrollment provisions of the WFTC legislation and is available to provide technical assistance. Questions regarding the Medicaid and CHIP policies discussed in this deck may be directed to MedicaidReforms@cms.hhs.gov.

“Working Families Tax Cut” Legislation, Public Law 119-21: Summary of Medicaid and CHIP Enrollment-Related Provisions

November 2026

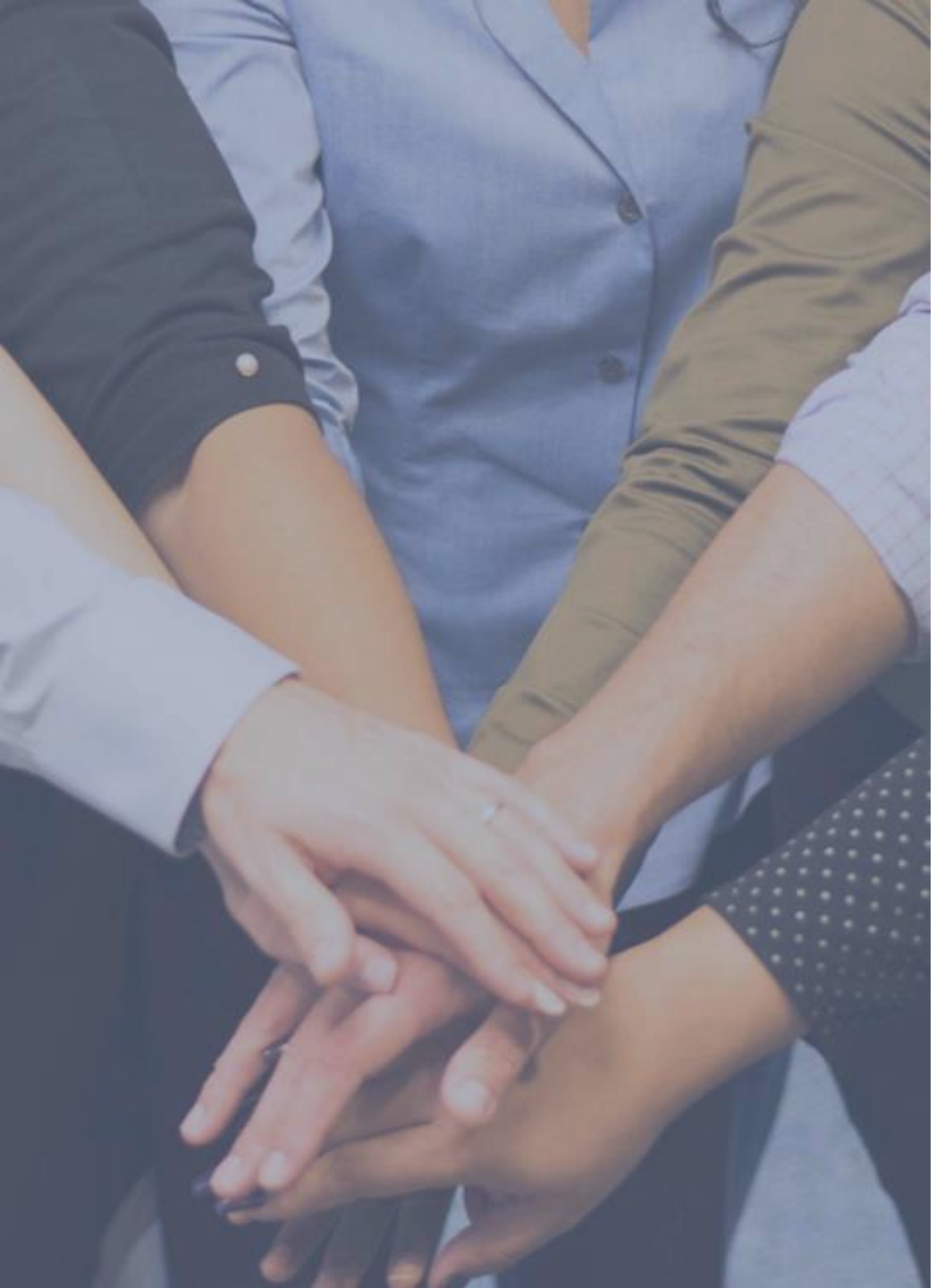
This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

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Background

- On July 4, 2025, President Trump signed into law Public Law No. 119-21, which the Centers for Medicare & Medicaid Services (CMS) refers to as the Working Families Tax Cut (WFTC) legislation.
- This slide deck provides an overview of selected changes to Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment processes made by the WFTC legislation that are effective beginning January 1, 2027, including changes that:
    - Require states to use reliable data to update Medicaid and CHIP beneficiary address information (Section 71103)
    - Require states to check the Death Master File (DMF) quarterly to identify Medicaid beneficiaries who are deceased (Section 71104)
    - Affect the availability of retroactive eligibility in Medicaid and CHIP (Section 71112).

This slide deck is part of a series of guidance documents that the Center for Medicaid and CHIP Services (CMCS) expects to issue to support WFTC legislation implementation.



Content Overview

- Section 71103: Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs (Updating Beneficiary Address Information)
- Section 71104: Ensuring Deceased Individuals Do Not Remain Enrolled (Quarterly Checks of the Death Master File)
- Section 71112: Reducing State Medicaid Costs (Changes to Retroactive Eligibility)
- Next Steps for States

Section 71103: Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs

Overview of Section 71103

- Section 71103 of the WFTC legislation added section 1902(a)(88), 1902(uu), and 1902(vv) to the Social Security Act (the Act). Section 1902(a)(88) applies to Medicaid and is also made applicable to separate CHIP programs through section 2107(e)(1)(H) of the Act. Section 71103 requires:
  - Beginning **no later than January 1, 2027**, states and the District of Columbia (D.C.) must have a process to regularly obtain address information for beneficiaries enrolled under the state Plan (or a waiver of such plan) from reliable data sources and take the actions specified by the Secretary with respect to address changes based on that information.[1]
  - By **October 1, 2029**, the Secretary must establish a system to be used by CMS and the states, including D.C., and the territories, to prevent a beneficiary from being simultaneously enrolled under the state plans, or waivers of such plans, of multiple states.
- This section of this slide deck describes the January 2027 process to regularly obtain address information and the applicable actions for states when information obtained from a reliable data source indicates a change in a beneficiary's address.
- CMS intends to release future guidance addressing the requirement for states, beginning no later than October 1, 2029, to use the CMS-established system to prevent simultaneous enrollment under the Medicaid and separate CHIP state plans of multiple states.

1. The address information process required under section 1902(a)(88)(A), including the requirements described in section 1902(vv) of the Act, does not apply to the territories. This limitation also applies to separate CHIP through section 2107(e)(1)(H) of the Act

Why Accurate Address Information Matters for Medicaid and CHIP

- Applicants and beneficiaries must meet state residency requirements to qualify for Medicaid and CHIP.
  - An individual is generally considered a resident of the state if the individual is living in the state and intends to reside there.[1]
  - Individuals are not required to have a fixed address to be considered state residents.
  - Although an individual may have separate mailing and physical addresses, the state of residence generally is the state where the individual is living.
  - NOTE: Beneficiaries may be temporarily absent from the state (e.g., for education, medical treatment, or because of a disaster) and still maintain residency in their home state.
- Maintaining current contact information helps states meet federal notice and information requirements, including:
  - Providing timely eligibility and benefit notices.
  - Furnishing information about eligibility requirements, available services, and beneficiaries' rights and responsibilities.

42 C.F.R. §§ 435.403, 435.905, 435.917, 457.320

1. Generally, individuals under 21 years of age are considered residents in the state where they reside, or the state of residence of the parent or caretaker

Relevant Federal Requirements Impacting Address Changes

- States must have procedures in place to ensure beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility.
- States must promptly redetermine eligibility between regular renewals whenever they receive information about a change in a beneficiary's circumstances that may affect eligibility, such as a change in state residency.
    - States must promptly evaluate information received from the beneficiary or obtained from other reliable sources, including data sources.
    - Except as otherwise provided by statute or regulations, states may not deny or terminate eligibility or reduce benefits based on information received through data sources unless the state has requested information from the beneficiary and provided appropriate notice and hearing or review rights under the applicable Medicaid or CHIP requirements.
    - A change of in-state address is not a change in circumstances that affects eligibility because the beneficiary continues to be a state resident.
- Specific to Medicaid, states may send a notice no later than the date of action if a beneficiary's whereabouts are unknown and the post office returns agency mail directed to the beneficiary with no forwarding address.

42 C.F.R. § § 435.201, 435.403, 435.905, 435.917, 457.320

Reliable Data Sources for Obtaining Beneficiary Address Information

- Sections 1902(a)(88) and 1902(vv) of the Act, with section 1902(a)(88) made applicable to separate CHIP through section 2107(e)(1)(H) of the Act, require all states and D.C. to begin by January 1, 2027, to regularly obtain Medicaid and CHIP beneficiary address information from the following "reliable data sources:"
  - The National Change of Address (NCOA) Database maintained by the United States Postal Service (USPS);[1]
  - Mail returned to the state by the USPS with a forwarding address; and
  - Information from managed care entities and plans, including managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) and primary care case managers (PCCMs) that have contracts under the state plan, if the address information was provided directly by, or verified directly with, the individual.
    - Effective January 1, 2027, each applicable contract with a managed care entity or plan must provide that the entity or plan will promptly transmit such address information to the state.
  - States may identify additional data sources and seek approval from the Secretary for those sources to be treated as a reliable data source for regularly obtaining enrollee address information.[2]

1. NCOA is a secure dataset of approximately 160 million permanent change-of-address records constructed from names and addresses of individuals, families, and businesses who have filed a change-of-address with the Postal Service.
2. Examples of additional sources a state might identify and submit to CMS for approval include Program of All-Inclusive Care for the Elderly (PACE) organizations, enrollment brokers, and commercial products that may pull from NCOA or other sources.

Processes for Using Reliable Data Sources for Addresses

- Section 71103 amended the Act to require the states and D.C. to have a process to regularly obtain address information for beneficiaries enrolled in Medicaid and CHIP.
- While the statute does not define “regularly,” states must establish a process and frequency that reasonably implements the requirement to obtain address information from reliable data sources discussed on slide 8. States should document these policies in their state policy manuals. CMS will provide additional information to states regarding any future considerations related to documenting state procedures.
    - Considerations for such a process include:
        - Frequency for checking reliable data sources to obtain updated address information (e.g., monthly, quarterly, or prior to initiating the individual's renewal).
        - How the state will check reliable data sources when it is attempting to verify address updates it has received (e.g., batch checks at certain intervals versus one-off data checks).

Process for Using Reliable Data Sources for Addresses (Continued)

- When states request approval to consider additional data sources as “reliable,” CMS will consider factors including whether the data source obtains address information directly from, or verifies it directly with, beneficiaries and the state’s ability to routinely access the data source.

- The following slides describe the applicable actions for states when information from a reliable data source indicates:

    - An in-state address change; or

    - An out-of-state address change.

- The guidance also describes the processes that may apply when mail sent to a beneficiary is returned by the USPS with no forwarding address, which may indicate the beneficiary’s whereabouts are unknown.

In-State Address Changes

When a “reliable data source” (described on slide 8) provides an in-state address that differs from the address the state has on file, the state must process the address information and may use either of the following options to do so. Regardless of the option selected, states may not terminate a beneficiary's coverage based solely on an in-state change of address because the beneficiary continues to be a state resident.

Option 1	Option 2
Verify the address change with the beneficiary before updating the address. If Option 1 is elected: • The state sends a request for information at least to the address on file to verify the address change with the beneficiary and provide a reasonable period of time for the beneficiary to respond. • If the beneficiary responds, the state accepts the address information confirmed by the beneficiary. • If the beneficiary does not respond, the state may update the case file using the address returned by the reliable data source. If the state updates the address, it should notify the beneficiary of the address change in their case file.	Update the address using information from the reliable data source without first requesting information from the beneficiary. If Option 2 is elected: • The state updates the beneficiary's case file using the address returned by the reliable data source; and • The state should notify the beneficiary of the address change in their case file.

Out-of-State Address Changes

- When a “reliable data source” (described on slide 8) provides an out-of-state address, this suggests a possible change in state residency, which is a potential change in circumstances that may affect a beneficiary’s eligibility.
- The state must promptly act on information from the "reliable data source" indicating a potential change in residency and must request information from the individual prior to denying or terminating coverage based on that information.
- The state must:
  - First check whether more recent information is available to the state before requesting information from the beneficiary.
  - Send a request for information at least to the address on file and provide a reasonable period of time for the beneficiary to confirm that they continue to be a resident of the state, including whether they meet temporary absence requirements.
    - States are encouraged to use multiple modalities to reach out to the beneficiary (e.g., telephone, email, or text).
- If the beneficiary does not respond to the request for information, or if the information provided by the individual does not establish continued state residency, the state must provide advance notice of adverse action and applicable Medicaid fair hearing rights or CHIP review rights before terminating the individual’s Medicaid eligibility or CHIP enrollment.

42 C.F.R. §§ 435.916, 435.952(d)

Returned Mail

Returned Mail With a Forwarding Address

- Mail returned to the state by the USPS with a forwarding address is a “reliable data source” under section 1902(vv)(2)(A) of the Act.
- States must process the forwarding address using the applicable procedures for address information obtained from a reliable data source:
  - In-state address: the state may use either of the procedures described on Slide 11.
  - Out-of-state address: the applicable procedures described on Slide 12 apply.

Returned Mail *Without* a Forwarding Address

- When mail is returned to the state by the USPS without a forwarding address, the state may take additional steps to determine whether updated address information is available or may determine that the individual’s whereabouts are unknown. If the state elects to take these additional steps:
  - The state checks other “reliable data sources” for updated address information.
  - If an updated address is identified through another reliable data source, the applicable procedures described on the preceding slides for an in-state or out-of-state address apply.
  - If the other reliable data sources do not identify updated address information, the state may determine that the individual’s whereabouts are unknown and take the applicable actions described on the following slide.

Whereabouts Unknown

- When a state has returned mail with no forwarding address and no other available information about the beneficiary, it may take the following applicable actions:
  - The state may determine that the beneficiary's whereabouts are unknown and terminate their Medicaid eligibility.
  - If the state terminates eligibility, it must provide notice no later than the date of the action, including applicable Medicaid fair hearing rights.
- If the beneficiary's whereabouts become known within their eligibility period, the state must reinstate coverage retroactive to the date of termination without requiring additional information to verify eligibility in Medicaid, unless the state has other information indicating that they may no longer meet all eligibility requirements.

Address Update Comparison Table

Address Update Indicates a Change That Is:	In-State		Out-of-State		Whereabouts Unknown	
State actions:	Must	May	Must	May	Must	May
Promptly act on information from the "reliable data source" indicating a potential address change.	●		●		N/A	
Accept the information from the "reliable data source" and update the in-state address without requesting information from the beneficiary first.[1]		●[2]	N/A		N/A	
Send a request for information to the address on file to verify the address change with the beneficiary and provide a reasonable period of time for the beneficiary to respond.		●[2]	●			●
The state uses multiple modalities to reach out to the beneficiary (e.g., telephone, email, text).		●		●		●
Disenroll the beneficiary from Medicaid if they do not respond to the request for information or if the state determines their whereabouts are unknown, following the provision of notice of action with fair hearing rights as described at 42 C.F.R. §§435.917-918 and 42 C.F.R. 431, subpart E.	N/A		●[3]			●[4]

1. The state also has the option to request information from the individual prior to updating the beneficiary's in-state address
2. For In-State address changes, states can choose between options 1 and 2 outlined on Slide 11.
3. The state must also disenroll a beneficiary from a separate CHIP if the beneficiary does not respond to a request for information when there is an address update indicating an out-of-state change and provide notice of action and CHIP review rights as a part of this process as required under 42 C.F.R. 457.340(e).
4. If the state elects to terminate eligibility, it must provide notice of action and fair hearing rights to the beneficiary.

Section 71104: Ensuring Deceased Individuals Do Not Remain Enrolled

Overview of Section 71104

- Section 71104 of the WFTC legislation established section 1902(a)(89) of the Act, requiring all states and D.C. to check the Social Security Administration's (SSA) Death Master File (DMF) or a successor system on at least a quarterly basis and disenroll beneficiaries identified as deceased beginning January 1, 2027.[1]
- Data received from the DMF must be treated as factual, and deceased individuals must be disenrolled from the state plan without further verification.
- States must discontinue any payments for medical assistance other than for items or services furnished prior to death.
- If an individual was misidentified as deceased, the state must retroactively enroll the individual back to the date of disenrollment.

1. The requirements under section 71104 of the WFTC legislation does not apply to the territories

Checking the DMF Quarterly

- States must establish a reasonable process to check the DMF on a quarterly basis beginning January 1, 2027, and disenroll beneficiaries that it indicates are deceased.
- States must begin and complete their first check in the first quarter of 2027 (between January 1, 2027, and March 31, 2027).
- States must establish a regular cadence for review of the file quarterly after the first check, or at least once in any 3-month period. States will follow the processes outlined in slides 19-21 when using the DMF beginning January 1, 2027, but states will continue to treat information from other data sources that indicate a beneficiary is deceased as a potential change in circumstances, seek additional information from the beneficiary's household or authorized representative to confirm the death per 42 C.F.R. 435.952(d), and redetermine eligibility in accordance with 42 C.F.R. 435.916(d).

Treating Information Returned by the DMF as Factual

- If a state receives information from the DMF, it must treat the information as factual, meaning it is confirmation that the beneficiary is deceased.
  - States shall not seek additional information from the household or authorized representative to confirm the individual is deceased.
  - As a reminder, Section 1902(a)(89) of the Act only applies to information states receive from the DMF and does not apply to death information states receive from other data sources.
- Beneficiaries that appear on the DMF must be disenrolled prospectively, from date of processing, if found to be deceased based on such data.
- If the state has factual information confirming the death of the beneficiary, it may send notice no later than the date of action with fair hearing rights.
- The state must discontinue any payments for medical assistance other than payments for items or services furnished prior to death.

Correcting Erroneous Disenrollment

- If a state determines an individual was misidentified as deceased based on information from the DMF and erroneously disenrolled, the state must immediately reenroll the individual, retroactive to the date of disenrollment.
- The state must notify the individual that their coverage is reinstated and explain how they can have bills paid for services received while they were disenrolled.
- The individual's eligibility period remains the same when they are reinstated:
    - If the misidentified individual is reinstated within their original eligibility period, the state maintains the individual's renewal date.
    - If the misidentified individual is reinstated after their original eligibility period ends, the state must conduct the individual's renewal as soon as practical.

Accessing the DMF

- In order to comply with section 1902(a)(89) of the Act, states will need to establish a connection with the DMF if the state does not already use the data source to identify deceased beneficiaries.
- States may access the DMF through any data service that provides the complete discrete DMF data file.
- States may continue to use other electronic data sources in addition to the DMF, such as vital statistics data on deaths available through state Health Departments, and act on information returned from these data sources indicating a beneficiary is deceased as a change in circumstances as described on the second bullet of slide 22.
- States that already use the DMF to identify deceased beneficiaries will need to ensure they update their processes to check the data source quarterly and act on returned information consistent with the guidance described on slides 17-20.

Federal Requirements for Identifying Deceased Beneficiaries Using Other (Non-DMF) Data Sources

- States may also periodically check additional data sources to identify Medicaid and CHIP beneficiaries who may be deceased, must seek additional information to confirm any reported deaths, and if applicable, must redetermine eligibility due to a change in circumstances per 42 C.F.R. 435.916(d).
- When acting on information obtained from a non-DMF data source, such as state vital statistics, a state must not terminate eligibility unless the state has first sought additional information from the household or authorized representative to confirm the beneficiary is deceased.
- States must provide advance notice of termination with fair hearing rights unless the state has factual information confirming the beneficiary's death, in which case notice may be provided no later than the date of the action.
- Under current CMS guidance for non-DMF data sources, confirmation from the beneficiary's household or authorized representative constitutes the factual information confirming the beneficiary’s death.

42 C.F.R. §§ 431.213(a), 435.912, 435.916, 435.952(d), 457.343, 457.380

Section 71112: Reducing State Medicaid and CHIP Costs

Federal Medicaid Requirements for Retroactive Eligibility Prior to Jan 1, 2027

- For Medicaid:
  - Section 1902(a)(34) of the Act provides that if an individual "has been **determined to be eligible for medical assistance** under the [state] plan," states must make such medical assistance available to that individual for care and services included under the plan and furnished in or after the **third month** before the month in which the individual made application (or application was made on their behalf in the case of a deceased individual) if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished.
  - Section 1902(a)(34) does not expressly require that an individual must be "determined to be eligible for medical assistance under the [state] plan" in the application month; indeed, it expressly contemplates that applications may be made on behalf of deceased individuals who may not be eligible at the time of that application.
  - Therefore, an individual may be eligible for coverage of Medicaid-covered services received during the retroactive eligibility period even if the person is not eligible for coverage in the month of application.

Section 1902(a)(34) of the Act, 42 C.F.R. § 435.915

Federal CHIP Requirements for Retroactive Eligibility Prior to Jan 1, 2027

- For Separate CHIP:
  - States must specify a method for determining the effective date of eligibility for separate CHIP, which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between CHIP and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage.
  - Due to the flexibility of CHIP effective date rules, retroactive eligibility is permissible; however, states are not required to provide retroactive eligibility in CHIP.[1]

42 C.F.R. § 457.340(g)

1. States with separate child health assistance programs may elect to provide retroactive eligibility in CHIP. Under retroactive eligibility, states may use title XXI funds to pay costs of CHIP coverage for a period prior to the application date, for children and/or pregnant women applying for CHIP.

Overview of Section 71112 – Medicaid Requirements

- Section 71112 amends section 1902(a)(34) of the Act to change the retroactive eligibility period in Medicaid for applications made on or after January 1, 2027. Under those amendments, the maximum retroactive eligibility periods are as follows:
  - Section 1902(a)(34)(A): Individuals enrolled in the Medicaid adult group[1] under the state plan are limited to **one month** of retroactive eligibility prior to the month of application.
  - Section 1902(a)(34)(B): Individuals not described in subparagraph (A) (and for whom retroactive eligibility applies[2]) are limited to **two months** of retroactive eligibility prior to the month of application.
    - In states that have included a retroactive eligibility period as part of their medically needy budget period, individuals subject to a spenddown are limited to **two months** of retroactive eligibility prior to the month of application.
- States must implement the changes made to section 1902(a)(34) of the Act. To aid state implementation efforts, CMS is releasing this slide deck to provide states with early notice regarding the changes to 42 CFR 435.915 that CMS intends to propose to align the regulations with section 1902(a)(34) of the Act. If a final rule on this topic is not effective before January 1, 2027, CMS anticipates that it would not take enforcement action against a state that applied the implementing policies discussed in this deck.
- These changes apply to all 50 states, D.C., and the territories.

1. Under section 1902(a)(10)(A)(i)(VIII) of the Act and 42 C.F.R. 435.119
2. Sections 1902(e)(8) and 1905(A) of the Act limit the medical assistance for Qualified Medicare Beneficiaries, as defined in section 1905(p)(1) of the Act.

Overview of Section 71112 – Separate CHIP Requirements

- Section 71112 amends section 2102(b)(1)(B) of the Act to add a new paragraph (vi), which limits the period for which a state may elect to provide retroactive child health assistance or pregnancy-related assistance for individuals whose eligibility for such assistance is based on an application made on or after January 1, 2027 (the same applicability date as Medicaid).
- Section 2102(b)(1)(B)(vi) specifies that, *if* a state elects to provide child health assistance or pregnancy-related assistance for a period before the month of application, such assistance may not be made available for items and services furnished before the second month preceding the month of application.
- States are required to provide retroactive coverage in Medicaid. Unlike Medicaid, section 71112 continues to make retroactive coverage optional for states under a separate CHIP. If a State elects to provide such coverage, the retroactive period may not extend beyond the second month preceding the month of application.

Impact of Section 71112 on Section 1115 Demonstrations

- Under longstanding section 1115 demonstration special terms and conditions (STCs), all requirements of the Medicaid program expressed in federal laws, regulations, and policy statements that are not waived or identified as not applicable apply to the demonstration (consistent with 42 CFR 431.420(a)(1)).Thus, CMS has long interpreted 1902(a)(34) to apply to populations eligible only under section 1115(a)(2) expenditure authority unless it is expressly made not applicable to that population in the demonstration authorities.
- CMS will continue to interpret 1902(a)(34) as applying to populations eligible only under section 1115(a)(2) expenditure authority unless made non-applicable in the demonstration authorities. Because such populations are not eligible under the state plan in the adult group, CMS will consider the two-month retroactive eligibility period in 1902(a)(34)(B) to apply to such populations unless it is expressly made not applicable.
- Some states are authorized through a section 1115 demonstration to waive the requirement to provide retroactive eligibility or to limit the length of the statutory retroactive eligibility period for a state plan population.
    - The changes made by section 71112 of the WFTC legislation do not newly require states that waive retroactive eligibility to begin providing retroactive coverage or end existing demonstration authority.

Determining Which Medicaid Beneficiaries are Eligible for One Month of Retroactive Eligibility

- States must rely on the individual's eligibility status and, if applicable, eligibility group for the month in which the application is made to determine whether an individual could receive one or two months of retroactive eligibility. In either case, medical assistance is available for care and services furnished during the retroactive eligibility period only if the individual was (or upon application would have been) eligible for such assistance when the care and services were furnished.
- Section 1902(a)(34)(A) of the Act applies to individuals who are enrolled in the adult group under the state plan.[1]
    - CMS interprets "enrolled" in section 1902(a)(34)(A) of the Act to mean that the individual has been granted an eligibility period for prospective coverage that is consistent with the renewal time frames in section 1902(e)(14)(L) of the Act or 42 CFR 435.916, based on eligibility in the month in which the application is made.
- Therefore, individuals enrolled (as that term is interpreted above) in the adult group under the state plan may receive up to 1 month of retroactive eligibility prior to the month of application if the individual was eligible for medical assistance when the care or services were furnished.

1. Under section 1902(a)(10)(A)(i)(VIII) of the Act and 42 C.F.R. § 435.119

Determining Which Medicaid Beneficiaries are Eligible for Two Months of Retroactive Eligibility

- Section 1902(a)(34)(B) of the Act applies to individuals not described in 1902(a)(34)(A); that is, individuals not enrolled in the adult group under the state plan for whom retroactive eligibility applies.[1]
- These individuals may receive up to 2 months of retroactive eligibility prior to the month of application if the individual was eligible for medical assistance when the care or services were furnished.
- Because section 1902(a)(34)(B) does not specify that an individual must be eligible or enrolled in the month of application to receive retroactive coverage, section 1902(a)(34)(B) applies to any individuals for whom retroactive eligibility applies, but who are not eligible for prospective coverage based on their eligibility in the month of application.
- This includes individuals who are not eligible for prospective coverage but received Medicaid-covered services and were eligible in the adult group during one or both months of the retroactive eligibility period. As noted on slide 29, these individuals are not considered enrolled in the adult group for purposes of retroactive eligibility because they were not enrolled based on eligibility in the month of application and granted an eligibility period.

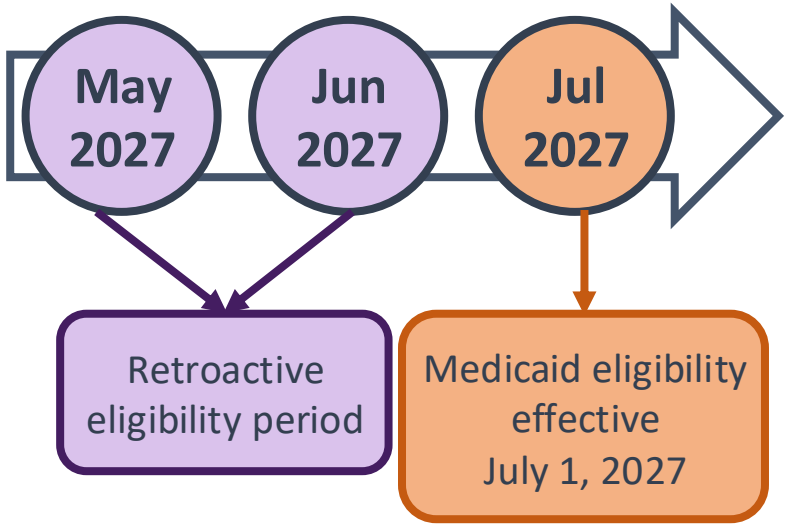
1. Section 1902(e)(8) of the Act specifies a prospective effective date of coverage for Qualified Medicare beneficiaries as defined in section 1905(p)(1) of the Act, which precludes retroactive eligibility for such coverage

Applying a Two-Month Retroactive Eligibility Period

Individuals who are not enrolled in the adult group at application may receive up to 2 months of retroactive eligibility if they were (or upon application would have been) eligible when the services were furnished.

Scenario 1

At Application	Joanna applies for Medicaid on **July 1, 2027,** and indicates she needs help paying past medical bills. Joanna is determined **eligible for medical assistance and enrolled in Medicaid under the state plan pregnant women** eligibility group, effective **July 1, 2027.**
Retroactive Eligibility Period	Because Joanna is enrolled in the state plan pregnant women eligibility group effective July 1, 2027, Joanna may receive **up to two months of retroactive eligibility, covering qualifying medical care and services** for **May and June**, if she was (or upon application would have been) eligible for such assistance during those months.

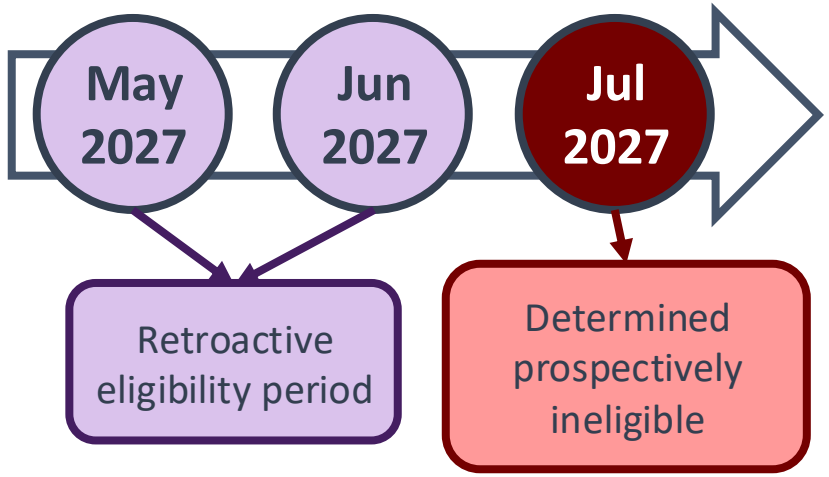


Applying a Two-Month Retroactive Eligibility Period

Individuals who are not enrolled in the adult group at application, including those who are **not** eligible on a prospective basis, may receive up to 2 months retroactive eligibility if they were (or upon application would have been) eligible when the services were furnished.

Scenario 2

At Application	Carla applies for Medicaid on **July 1, 2027,** and indicates she needs help paying past medical bills. Carla is determined **ineligible** for Medicaid in July 2027 because her income was above the applicable threshold.
Retroactive Eligibility Period	Although Carla is not eligible on a prospective basis, she may receive up to **two months** of retroactive eligibility if she was eligible at the time she received qualifying care and services. The state determines that Carla would have been eligible for medical assistance under the Parents and other Caretaker Relatives group when the applicable care and services were furnished. Carla may receive retroactive coverage for qualifying care and services furnished in **May and June 2027.**



Community Engagement and Retroactive Eligibility (1/2)

- Under section 1902(xx)(1)(A) of the Act, an applicable individual who has filed an application must, as a condition of eligibility, demonstrate community engagement for at least 1 but not more than 3 consecutive months (as specified by the state) immediately preceding the month of application.
- Under section 1902(xx)(1)(B) of the Act, an applicable individual must, as a condition of eligibility, demonstrate community engagement for one or more months (as specified by the state) during the period between the individual's most recent determination or redetermination of eligibility and the next regularly scheduled redetermination of eligibility (or, if the state has elected to verify compliance with community engagement more frequently, between the most recent and next such verification).
- Section 1902(xx) requires a demonstration of community engagement only at these two moments. It does not directly require an applicable individual to demonstrate community engagement as a condition of eligibility for coverage in the retroactive eligibility period or provide clear direction regarding the application of a community engagement requirement in the retroactive eligibility period.

Community Engagement and Retroactive Eligibility 2/2

- Because the community engagement statute applies at two distinct points as described on slide 33, CMS does not interpret section 1902(xx)(1)(A) or (B) to apply when determining whether an individual is eligible for coverage during the retroactive eligibility period.
- CMS reminds states that retroactive eligibility is available only for month(s) in which an individual received Medicaid covered services.
- Retroactive eligibility would be prohibited for any month in which an applicant filed an application but was found ineligible for any reason, including due to noncompliance with community engagement.[1]
- CMS expects states to regularly audit the retroactive eligibility determination process and ensure determinations are made appropriately. We will monitor state implementation of the retroactive eligibility policy.

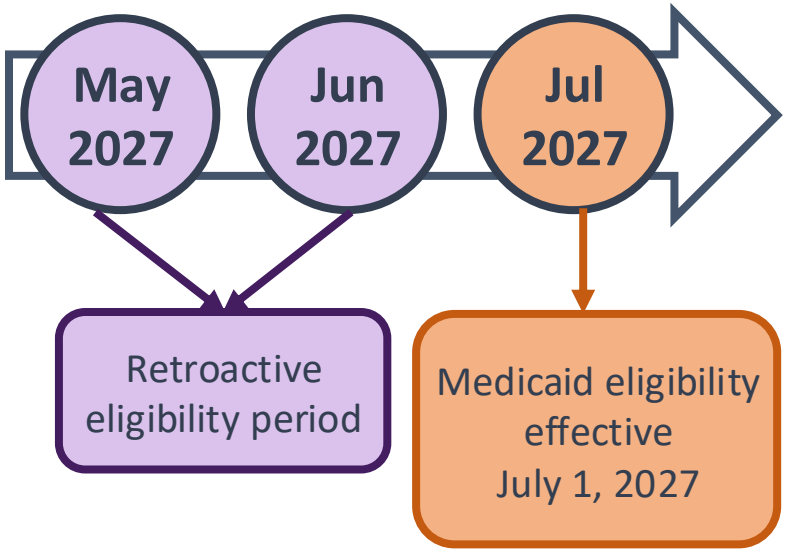
1. This prohibition would ensure the "proper and efficient operation of the [state plan]" under section 1902(a)(4) of the Actand "assure that eligibility for care and services will be determined . . . in a manner consistent with simplicity of administration" under section 1902(a)(19) of the Act.

Applying a Two-Month Retroactive Eligibility Period

Scenario 3

Individuals who are not enrolled in the adult group at application may receive up to 2 months of retroactive eligibility if they were (or upon application would have been) eligible when the services were furnished.

At Application	John applies for Medicaid on **July 1, 2027,** and indicates he needs help paying past medical bills. John is determined eligible for medical assistance and enrolled under the state plan **Parents and other Caretaker Relatives** eligibility group, effective **July 1, 2027**.
Retroactive Eligibility Period	Because John is enrolled under the Parents and other Caretaker Relatives eligibility group effective July 1, 2027, John may receive **up to two months of retroactive eligibility**. The state assesses John's eligibility during May and June 2027 and determines that John would have been eligible for the adult group when the care and services were furnished. John may receive retroactive coverage for qualifying care and services furnished in **May and June 2027.**[1]



1. The requirements established at section 1902(a)(xx)(1) to establish a community engagement requirement for applicable individuals do not apply to the retroactive eligibility requirements established at section 1902(a)(34) of the Act.

Next Steps for States

State Plan Amendments - Medicaid

- All 50 states and D.C. must submit two Medicaid state plan amendments (SPAs) to come into compliance with the two provisions:
  - 71103: The requirement under sections 1902(a)(88)(A) and 1902(vv) of the Act to regularly obtain address information for enrolled individuals from "reliable data sources." If the state would like to use data sources other than those listed as being “reliable data sources” in statute, the SPA must also identify any additional data sources that the state seeks to have approved by the Secretary as reliable.
  - 71112: Changes to retroactive eligibility under section 1902(a)(34) of the Act
  - Territories must also submit a SPA to adopt the changes to retroactive eligibility. The territories do not have to submit a SPA for using "reliable data sources" to update beneficiary contact information.
- Consistent with 42 C.F.R. § 430.20(a)(1) and (b)(3) and to reflect the January 1, 2027, statutory applicability date, Medicaid SPAs for both provisions must be submitted in MACPro no later than March 31, 2027.
- CMS developed new reviewable units in MACPro for these requirements.

71103 State Plan Amendments - CHIP

- All states and D.C. with a separate CHIP must submit a SPA attesting that the state has established the address information process required by sections 1902(a)(88)(A) and 1902(vv) of the Act, as applied to separate CHIP through section 2107(e)(1)(H) of the Act. The SPA must also identify any additional data source that the state seeks to have approved by the Secretary as reliable.
    - CMS expects to issue a revised paper CHIP state plan template in Fall of 2026.

71112 State Plan Amendments - CHIP

- Separate CHIP states that currently provide retroactive child health assistance or pregnancy-related assistance to any of their state plan populations must submit a SPA to reflect the requirements of section 2102(b)(1)(B)(vi) of the Act.
  - CMS is creating a CHIP eligibility SPA template that will be available Fall of 2026.
  - States that *do not* provide retroactive child health assistance or pregnancy-related assistance to *any* of their separate CHIP state plan populations need not submit a SPA.
  - If a state elects in the future to provide retroactive child health assistance or pregnancy-related assistance to any portion of their CHIP population, it must submit a SPA.
- Separate CHIP states that currently provide a retroactive period that is longer than the new 2-month limit will need to submit a CHIP SPA no later than March 1, 2027, to establish a January 1, 2027, effective date as this change will restrict existing benefits and is subject to the restrictive SPA requirements at 2106(b)(3)(B)(ii) of the Act and 42 C.F.R. 457.65(b). All other CHIP SPAs will be due to CMS by the end of the state's 2027 state fiscal year and should follow SPA submission rules at 42 C.F.R. 457.65.

71104 Documenting Verification Policies

- States must clearly document usage of the Death Master File (DMF) on a quarterly or more frequent basis in the state's verification policies and procedures for staff training and audit purposes.
- While states must document usage of the DMF in their verification policies, states do not need to submit an updated MAGI-based verification plan to CMS only for purposes of documenting use of the DMF at this time.

Next Steps

- CMS is committed to working with states, D.C., and the territories to make the policy and operational changes necessary to implement the eligibility and enrollment provisions of the WFTC legislation, and we are available to provide technical assistance.
- For additional information on the WFTC legislation, please visit https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation.
- Questions regarding the Medicaid and CHIP policies discussed in this deck may be directed to MedicaidReforms@cms.hhs.gov.
- Questions about SPAs or verification plan updates may be directed to your Medicaid State Lead or CHIP State Project Officer.