



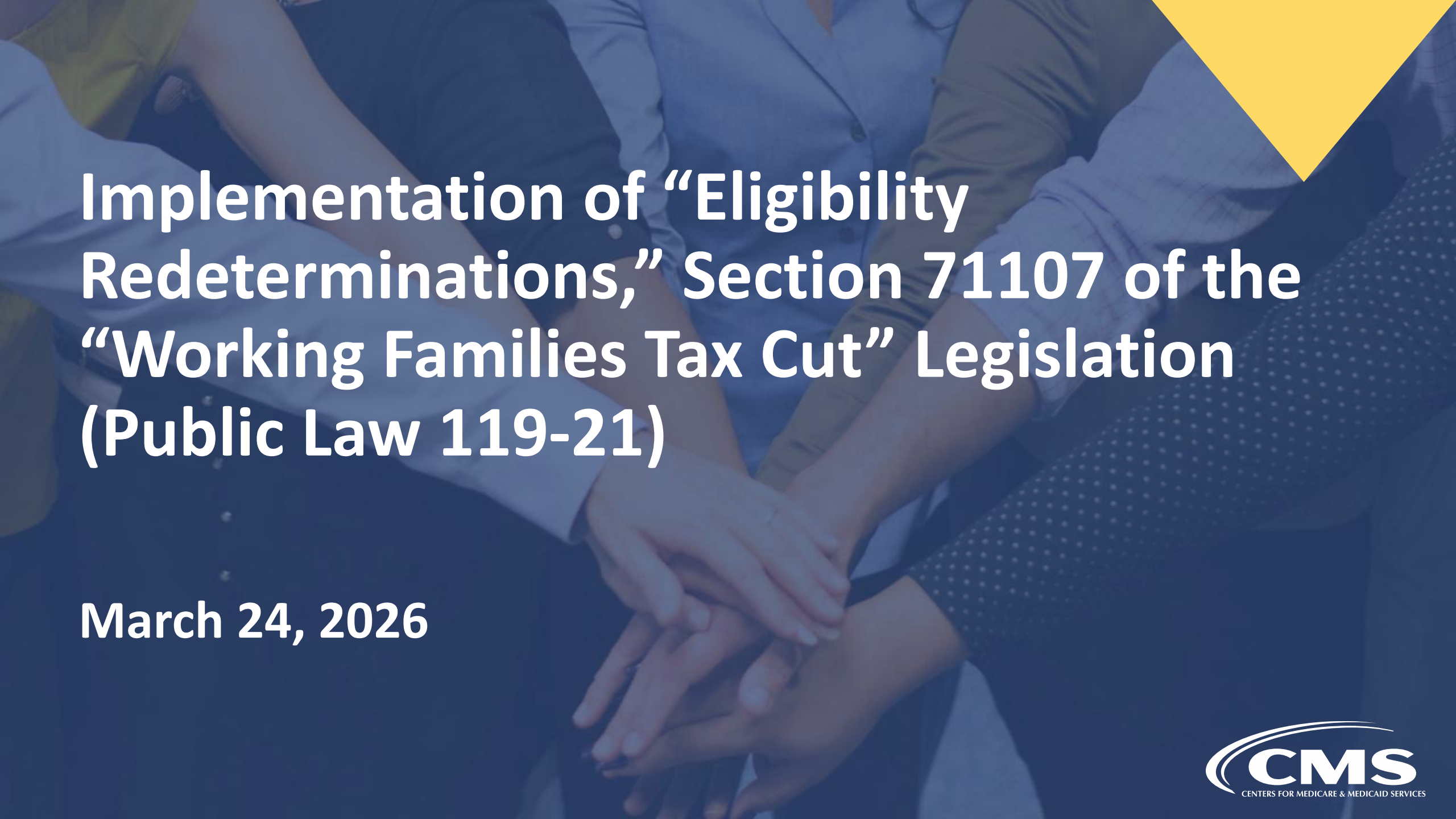
All-State Medicaid and CHIP Call

March 24, 2026



Agenda

- Implementation of “Eligibility Redeterminations,” Section 71107 of the “Working Families Tax Cut” Legislation (Public Law 119-21)
- Implementation of Section 71109, Alien Medicaid Eligibility, of the “Working Families Tax Cut” Legislation (Public Law 119-21)
- Q&A



Implementation of “Eligibility Redeterminations,” Section 71107 of the “Working Families Tax Cut” Legislation (Public Law 119-21)

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Objectives

- These slides are a companion to State Medicaid Director Letter (SMDL) #26-001, Implementation of “Eligibility Redeterminations,” Section 71107 of the “Working Families Tax Cut” Legislation (Public Law 119-21).
- These slides provide an overview of the changes to redeterminations of eligibility made by Section 1107 of Public Law 119-21, which the Centers for Medicare & Medicaid Services (CMS) refers to as the Working Families Tax Cut (WFTC) legislation.
- Section 71107 amends section 1902(e)(14) of the Social Security Act (the Act) to require states to complete eligibility redeterminations once every 6 months for certain individuals.
- The SMDL and deck are part of a series of guidance documents that the Center for Medicaid and CHIP Services (CMCS) expects to issue to support the WFTC legislation implementation.

Content Overview

- **Overview of Section 71107**
- **Transitioning to 6-Month Renewals**
- **Special Considerations**
- **State Next Steps**



Overview of Section 71107



Current Federal Requirements for Certain Medicaid Beneficiaries

- Federal regulations at 42 C.F.R. § 435.916 (2023)¹ outline the requirements for states to conduct periodic renewals of eligibility for all beneficiaries. These regulations require states to redetermine eligibility:
 - once every 12 months, and no more frequently than once every 12 months, for Medicaid beneficiaries whose financial eligibility is determined using methodologies based on modified adjusted gross income (MAGI), and
 - at least once every 12 months for individuals enrolled in non-MAGI based eligibility groups.

1. Section 71102 of the WFTC legislation imposed a moratorium prohibiting CMS from implementing, administering, or enforcing certain amendments made by the CMS 2024 E&E Final Rule that had a compliance date after July 4, 2025. For more, see: November 18, 2025, CMCS Informational Bulletin “Working Families Tax Cut” Legislation,” Public Law 119-21: Summary of Medicaid and Children’s Health Insurance Program (CHIP) Related Provisions.” Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11182025.pdf>.

Populations Subject to 6-Month Renewals

Section 71107 of the WFTC legislation amends section 1902(e)(14) of the Act to add a new subparagraph (L) that requires the 50 states and the District of Columbia to conduct renewals of eligibility once every 6 months, instead of once every 12 months, for two groups of beneficiaries whose financial eligibility is determined using MAGI methodologies beginning with renewals scheduled on or after January 1, 2027:

- Almost all individuals enrolled under the state plan in the Medicaid adult group²
- Individuals enrolled in coverage only through a section 1115 demonstration that provides coverage equivalent to minimum essential coverage (MEC)³ to **all individuals described in the Medicaid adult group**

The SMDL and these slides refer to all individuals subject to 6-month renewals as the “adult expansion group.”

2. Section 1902(a)(10)(A)(i)(VIII) of the Act.

3. This refers to MEC as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations.

Populations Exempt from 6-Month Renewals

- The 6-month renewal requirement in section 1902(e)(14)(L) of the Act does not apply to:
 - Certain American Indians and Alaska Natives⁴ who are enrolled under the state plan in the Medicaid adult group;
 - Certain American Indians and Alaska Natives⁵ “under a waiver” of the state plan that provides coverage equivalent to MEC to all individuals described at section 1902(a)(10)(A)(i)(VIII) of the Act;
 - Individuals enrolled in other MAGI-based eligibility groups; and
 - Individuals enrolled in non-MAGI-based eligibility groups.
- In addition, this requirement does not apply to the territories.

4. American Indians and Alaska Natives exempt from the 6-month renewal requirement are: an Indian or Urban Indian (as such terms are defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act); a California Indian described in section 809(a) of such Act; or those who have otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary. 42 C.F.R. § 435.916 (2023).

5. See Footnote 4

Implications for Requirement for States to Establish Medicaid Community Engagement Requirements

- Many of the individuals who will be required to undergo renewals once every 6 months will also be required to demonstrate community engagement as described in section 1902(xx) of the Act,⁶ beginning January 1, 2027.
- Regardless of whether a member of the “adult expansion group” will be subject to community engagement requirements, all individuals enrolled in the “adult expansion group” will be subject to 6-month renewals unless exempt as noted on slide 9.
- CMS plans to release future guidance to states on how to implement the community engagement requirements and implications of these requirements for renewals of eligibility.

Federal MAGI Medicaid Renewal Requirements

States must continue to complete renewals for all MAGI and non-MAGI beneficiaries as described in requirements at 42 C.F.R. § 435.916 (2023), regardless of whether someone is subject to renewals once every 6 or 12 months. For MAGI-based⁷ eligibility groups, states must:

- ✓ Begin the process by checking available, reliable information to attempt to redetermine eligibility without contacting the beneficiary (an *ex parte* renewal)
- ✓ Send a prepopulated renewal form to beneficiaries whose eligibility cannot be renewed based on available information and request the information needed to complete the redetermination of eligibility at renewal
- ✓ Provide beneficiaries with a minimum of 30 days to return the prepopulated renewal form and any other requested information
- ✓ Consider eligibility on all bases prior to making a determination of ineligibility
- ✓ Provide a minimum of 10 days advance notice and fair hearing rights prior to termination or other adverse action

7. To support states as they implement section 1902(e)(14)(L) of the Act, we focus on MAGI-based groups, including the “adult expansion group” where individuals are subject to the 6-month renewal requirement.



Transitioning to 6-Month Renewals

Establishing Eligibility Periods for New Applicants

- States must provide a 6-month eligibility period for applicants who apply and whose effective date of coverage in the “adult expansion group” is on or after January 1, 2027.
 - An individual’s effective date of coverage (which marks the start of their eligibility period) is determined in accordance with the state plan and may be either the date of application or the first day of the month of application.⁸
- Any months of coverage provided prior to that date under the retroactive eligibility period, per sections 1902(a)(34) and 1905(a) of the Act, would not be included in an individual’s eligibility period.⁹

8. 42 C.F.R. §§ 435.915(b) and (c)

9. Effective for applications made on or after January 1, 2027, section 71112 of the WFTC legislation amends sections 1902(a)(34) and 1905(a) of the Act to shorten the retroactive eligibility period in Medicaid. Notably, individuals enrolled in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act will be limited to a maximum of one month of retroactive eligibility prior to the month of application. CMS expects to issue additional guidance regarding section 71112 of the WFTC legislation.

Transitioning to 6-Month Renewals for Existing Enrollees

- States have two options for implementing the new 6-month renewal requirement for individuals who are already enrolled in a 12-month eligibility period in the “adult expansion group” on January 1, 2027, and whose annual renewals have already been scheduled to occur in 2027.
- Under both options, CMS interprets “scheduled” to refer to the date when the state initiates¹⁰ the renewal process, because the renewal process is not a single moment or day and can take several weeks or months.
 - Under option 1, “scheduled” refers to a renewal initiation date.¹¹
 - Under option 2, “scheduled” refers to the act of setting a future renewal initiation date since when a state determines an individual eligible for Medicaid and grants a new eligibility period, the state is considered to have scheduled the initiation date for the next renewal. .
- States are reminded that regardless of when a beneficiary transitions to a 6-month renewal schedule, the state must redetermine eligibility between regular renewals when someone experiences a change in circumstances that potentially affects eligibility, as further described in 42 C.F.R. § 435.916(d) (2023).

10. CMS considers the key date to be the date on which renewals for the cohort are initiated, rather than the date on which a particular individual’s renewal is completed because the initiated date is known in advanced and established consistently for all individuals with the same eligibility period.

11. When a state determines an individual eligible for Medicaid and grants a new eligibility period, the state is considered to have scheduled the initiation date for the next renewal.

Option 1: Reschedule Renewal Initiation Dates for Beneficiaries Enrolled as of January 1, 2027 (1/2)

- Under this option, states would reschedule previously set 2027 renewal initiation dates to transition beneficiaries already enrolled in the “adult expansion group” before 2027 to as close to a 6-month renewal cadence as possible but would not reschedule these renewal initiation dates to a date before January 1, 2027.
- States implementing this option would need to identify individuals whose renewal initiation dates would need to be rescheduled (and when), initiate a large volume of renewals as early as January 1, 2027, and maintain that renewal schedule into the future.
- States would also need to ensure they did not shorten an individual’s eligibility period in a manner that is inconsistent with Section 1902(e)(14)(L)(i) of the Act by renewing eligibility more frequently than once every 6 months (that is, states should not shorten the previously approved eligibility period of a person enrolled in the “adult expansion group” as of January 1, 2027, so that it is shorter than 6 months).

Option 1: Reschedule Renewal Initiation Dates for Beneficiaries Enrolled as of January 1, 2027 (2/2)

- States will have to weigh several operational considerations if they take this option.
 - Many individuals will be several months into their eligibility period as of January 1, 2027, such that it is impossible to initiate and complete their renewals to give them a 6-month eligibility period. States implementing option 1 would need to reschedule renewal initiation dates for these individuals promptly and shorten their eligibility periods to be as close to 6 months as is practically feasible.
 - Other individuals will have been enrolled for a shorter time on January 1, 2027, but would need to have their previously scheduled 2027 renewal initiations rescheduled to a new date that would give them a 6-month eligibility period.

Option 2: Transition Beneficiaries Enrolled on January 1, 2027, at Their Next Scheduled Renewal

- Under this option, states could retain an individual’s 12-month eligibility period granted before January 1, 2027, and (if applicable) provide a 6-month eligibility period following that already-scheduled 2027 renewal for beneficiaries who remain eligible in the “adult expansion group.”
- Because this option allows states to continue processing renewals in 2027 based on (and without moving) already-scheduled renewal initiation dates, it enables states to avoid a large cluster of renewals in January 2027 due to having to redetermine eligibility for many beneficiaries enrolled in the “adult expansion group” at once and thus would also enable states to retain a more even renewal distribution into the future.



Special Considerations



Households with Different Renewal Schedules

- Section 1902(e)(14)(L) of the Act does not modify states' obligations to determine and redetermine Medicaid eligibility on an individual basis.
 - This will in many instances result in members of the same household having different eligibility periods because they qualify for the program under different eligibility groups that have different eligibility periods (e.g., 6 months versus 12 months).
- States may not shorten nor extend an individual's eligibility period to align renewal dates across members of a household.
- If the beneficiary whose eligibility is being renewed provides information that affects the eligibility of other household members, the state must promptly act on that information for the affected household member and redetermine eligibility.¹²

Movement Between Eligibility Groups at Renewal

- When redetermining eligibility at renewal, states must consider all bases of eligibility prior to making a determination of ineligibility.¹³
- States must account for additional factors of eligibility (e.g., community engagement requirements) that are relevant for the group in which the individual is potentially eligible.¹⁴
- When moving a beneficiary from an eligibility group with a 12-month eligibility period to a group with a 6-month eligibility period, the state must also provide a minimum of 10 days advance notice with fair hearing rights.
- Because the state is granting a new eligibility period following a successful renewal, the state will apply the appropriate eligibility period for the new group.

Coordination with Other Human Services Program Recertifications or Reviews

- For some individuals, a 6-month Medicaid renewal may align with the 6-month review or recertification for another human services program. However, this does not change the new Medicaid renewal requirements.
- While states may include information and questions only needed for other programs on a multi-benefit renewal form, they must ensure multi-benefit renewal forms include clear instructions on which questions must be answered and what information must be provided for purposes of renewing Medicaid eligibility.



State Next Steps



Application and Renewal Processing and Fair Hearing Requests

- CMS recognizes that transitioning to a 6-month renewal schedule will result in a change in state operations and workload.
- States should make every effort now to maintain timely application, renewal, and fair hearing request processing and plan for sufficient capacity to process additional requests or, if needed, resolve application, renewal, and fair hearing request backlogs.
- States that do not resolve existing backlogs or develop new backlogs prior to implementation of section 71107 will have challenges addressing the potential increase resulting from implementation of the eligibility provisions of the WFTC legislation.

State Plan Amendment and Demonstration Changes

- States that cover the adult group under section 1902(a)(10)(A)(i)(VIII) in their Medicaid state plan must submit a state plan amendment (SPA) attesting the state will conduct eligibility redeterminations every 6 months for the relevant population.
 - CMS is developing a MACPro reviewable unit, targeted for release in the second half of 2026, so states may submit this SPA no later than March 31, 2027, to ensure compliance by January 1, 2027.
- States that do not provide coverage to the eligibility groups subject to the 6-month renewal requirement do not need to submit a SPA.
- States with individuals described in 1902(a)(10)(A)(i)(VIII) who are enrolled in coverage “under a waiver” of the state plan that provides coverage equivalent to MEC to all individuals described in section 1902(a)(10)(A)(i)(VIII) should contact their 1115 demonstration project officer.

Medicaid Information Technology (IT) System Costs

- States will need to make process and system changes to operationalize 6-month renewals as well as other eligibility changes made by the WFTC legislation.
- State Medicaid agency IT systems costs necessary to support requirements could be eligible for enhanced FFP.
 - A state may submit an Advanced Planning Document (APD) requesting approval for enhanced FFP for the design, development, and installation of their Medicaid Enterprise Systems (MES) initiatives contributing to the economic and efficient operation of the program, or for the operations of these systems (including maintenance).¹⁵

Next Steps

- CMS is committed to supporting state efforts to complete timely and accurate Medicaid renewals of eligibility and is available to provide ongoing technical assistance and support to states.
- For additional information, please email MedicaidReforms@cms.hhs.gov.



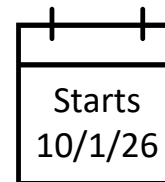
Questions



Implementation of Section 71109, Alien Medicaid Eligibility, of the “Working Families Tax Cut” Legislation (Public Law 119-21)

March 24, 2026

Section 71109. Alien Medicaid Eligibility



Restricts federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related health assistance (CHIP) to the following groups:¹

- 1) U.S. citizens and U.S. nationals
- 2) Lawful Permanent Residents (LPRs or "green card holders")
- 3) Cuban and Haitian entrants
- 4) Compacts of Free Association (COFA) migrants

FFP limitations in section 71109 do not apply to expenditures for:²

- 1) Emergency Medicaid authorized under section 1903(v)(2) of the Act³
- 2) Medicaid and CHIP coverage for lawfully residing children and pregnant women under “the CHIPRA 214 option” in states that have elected this option as authorized under section 1903(v)(4) of the Act⁴
- 3) State-designed Health Services Initiatives (HSIs) authorized under 2105(a)(1)(D)(ii) of the Act

Applicable to all states, DC, and the territories

CMS continues to assess the implications of section 71109 and expects to issue future guidance.

1. Adds new paragraph (5) to section 1903(v) of the Act and amends section 2107(e)(1) of the Act. Section 71109 does not amend the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Public Law 104-193). See “Section 71109. Alien Medicaid Eligibility” on pages 10-11 of the CIB for more information.

2. Section 1903(v)(5) of the Act excepts sections 1903(v)(2) and (4) of the Act from the payment limitations. Section 2107(e)(1)(R) of the Act excepts section 2105(a)(1)(D)(ii) of the Act from the payment limitations. See “Section 71109. Alien Medicaid Eligibility” on pages 10-11 of the CIB for more information.

3. Sections 1903(v)(2) and (3) of the Act; 8 U.S.C. § 1611(b)(2)(A).

4. Section 214 of Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Public Law 111-3).



Questions