

# CMCS All-State Call and Webinar

March 24, 2026,

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**Ryan, Jacquelyn (CMS/CTR)** 0:06

Hello everyone. We will be getting started in about two minutes.

Hello everyone, we will be getting started in about one minute.

Good afternoon, everyone, and thank you for joining today's CMCS Allstate Call and webinar. Today's meeting is being recorded. If you have any objections to being recorded, you may disconnect at this time. And now I would like to turn it over to Nick Wallace to get us started.

Nick.

**Wallace, Nick (CMS/CMCS)** 2:04

Thanks so much, Jacqueline. And hi, everybody. My name is Nick Wallace. I'm an advisor in the Office of the Center Director here at CMCS, and I will be moderating today's Allstate call. And before we run through the agenda, I have the privilege of turning things over to Anne Marie Castello for opening remarks. Anne Marie.

**Costello, Anne Marie (CMS/CMCS)** 2:22

Thanks, Nick, and hi, everyone. For those of you that don't know me, I'm Anne Marie Costello, one of the Deputy Directors here with the Center for Medicaid and CHIP Services, and I'm really happy to be able to join you today. I want to start by acknowledging what we're hearing from states. Since passage of the Work and Families Tax Cut legislation, we've received a steady stream.

Of questions, particularly around topics like community engagement, changes to renewal requirements and immigrant eligibility. That's not surprising. These are significant policy and operational changes that touch core eligibility and enrollment functions.

I'm glad that on today's call we're able to begin answering many of those questions directly. We have guidance out on some provisions, additional materials in development or in close to the clearance process and our eligibility enrollment experts are here today to walk through key issues and respond in real time on community engagement.

The interim final rule, due to be published on June 1st, continues to move through

the federal clearance process. Additionally, we released the second round of government efficiency grants to support implementation of the community engagement requirements and related eligibility systems updates.

Getting that money out the door was important. We know states are actively building and modifying systems, and these funds are intended to support that work with system design and integration to ensure operational readiness. Our goal is to make sure states have both the clarity and resources necessary to implement these requirements successfully.

successfully and on time. Um We've also released guidance on section 71-107, which is the transition to six-month redeterminations for the adult expansion group. This is a meaningful shift from the long-standing 12-month renewal cycle. It has implications

for system logic, workload management, beneficiary communications, and coordination with other eligibility requirements. Our team will walk through that guidance on today's call, highlight key implementation considerations, and respond to questions as you continue planning for the 2027 transition.

Following that, we'll discuss section 71109 titled Alien Medicaid Eligibility. This provision addresses federal financial participation for certain coverage categories and carries important implications for eligibility determinations, verification processes. Processes and financial claiming. While additional guidance is forthcoming, we want to provide a high-level overview today and begin addressing some of the questions we've received. We understand that this is a complex area. We're committed to working closely with states as implementation planning continues.

I also want to take a moment to recognize our entire team, including the Children and Adults Health Programs group. They've been working round the clock, days, nights, weekends to get guidance drafted, cleared and out the door and to respond to the many questions coming from states. That level of engagement reflects how seriously we take our partnership.

CMS is not just here to issue policy, it's also to provide technical assistance, work through operational challenges, and support states as you implement these changes on the ground. Again, we appreciate your engagement, your questions, and your continued partnership. And with that, I'll turn things back to you.

To Nick to walk through today's agenda, Nick.

Thanks, Anne Marie.

Yeah.

So as Ann Marie mentioned, today's call is squarely focused on 2 distinct provisions of the Working Families Tax Cut legislation, particularly as it relates to eligibility and enrollment operations. So we're going to begin by walking through Section 71107 related to eligibility redeterminations. As Ann Marie mentioned earlier this month, we released an.

SMDL letter that provides an overview of the new requirement to conduct eligibility redeterminations every six months for most individuals in the adult expansion group, beginning with renewal scheduled on or after January 1st, 2027.

This letter outlines the federal framework, transition options, and operational considerations, including coordination with upcoming community engagement requirements. My colleagues Caroline Harmon and Maggie Fowler from our Children and Adults Health Program group are going to walk through that guidance and be available to answer your questions following their presentation.

Next, we'll turn to the implementation of a different provision entitled Alien Medicaid Eligibility. This provision makes changes to federal financial participation for certain coverage categories and has implications for eligibility determinations, verification processes and financial.

Systems. Candice Anderson from our Children and Adults Health Program group is going to give a high level overview of this policy, including preliminary policy direction and implementation considerations. And then we have a panel of sorts that is going to go through several questions that we've received.

In advance of this call, as Anne Marie mentioned, this provision is particularly cross-cutting and we have several of our eligibility and enrollment experts here to answer your questions. As Anne Marie mentioned, additional guidance is forthcoming on this provision, we hope very soon, but we wanted to give you some preliminary direction.

And some early visibility into this operational landscape. We've received a number of questions on both of these provisions ahead of this call, but we also encourage folks to use the Q&A function to add additional questions.

And as a reminder, we are going to pause after each distinct presentation. So essentially we're going to divide this state call in half so we can focus our attention and conversation. As a reminder, we're using the webinar platform to share slides today. So if you're not already logged in, we encourage you to do so. And with that, I

am going to turn things over to.

To Caroline and Maggie to walk us through section 71107 and I will turn it to you guys.

**Faller, Margaret (CMS/CMCS) 8:40**

It would help if I unmuted. Hi, everyone. So I'm going to go through the first part of this provision with you all and then I'll turn it over to Caroline. So as Nick mentioned, we're going to start by talking about Section 71107 of the Working Families Tax Cut legislation which deals with new requirements for

redeterminations for most individuals in the adult group. Next slide, please.

So to start with the objective, so these slides are a companion to the state Medicaid director letter that was published earlier this month and I will note at the outset that these

are not released yet, but we are hoping to release them very soon so that they will be available for everyone to review. So in these slides, we're going to provide an overview of the changes of Section 71107, which amends Section 1902 E 14 of the Social Security Act.

To require states to complete eligibility redeterminations once every six months for certain individuals. And this slide deck, as well as the SMDL that was released, is part of a series of guidance that CMS and CMCS specifically expects to issue to assist with the implementation of the WFTC.

legislation. Next slide, please.

So just to give you a brief overview of what we will discuss today, we are going to start with an overview of the requirement at section 71107 and then we'll talk about transitioning to six month renewals and then go through a few special considerations and the next steps for states.

Next slide. Thank you and next slide.

So to start, um.

With respect to the current requirements for renewals, right now with the federal regulations at 42 CFR 435916 outline that for states to or outline the requirements for states to conduct periodic renewals for all beneficiaries and under the current rules.

The regulations require that states renew eligibility once every 12 months, and no more frequently than once every 12 months for Medicaid beneficiaries whose eligibility, or whose financial eligibility specifically is determined using the modified

adjust gross income, or MAGI methodologies.

And then at least once every 12 months for individuals enrolled on a non magi based or in a non magi based eligibility group. And just as a note, the WFTC legislation included a moratorium on certain revisions or amendments made to the regulation, so.

Throughout this slide deck and the SMDL, when we're talking about current regulations, renewal requirements, we are referring to those that were in effect at the end of 2023 prior to the eligibility and enrollment final rule taking effect and those provisions subsequently being part of that moratorium.

Next slide.

So as we briefly touched on Section 71107 of the WFTC legislation amends Section 1902 E 14 of the Social Security Act or the acts by adding a new subparagraph, specifically subparagraph L that requires the 50 states and the.

Columbia to conduct renewals once every six months instead of what is currently required being once every 12 months for two specific groups of beneficiaries whose eligibility is determined using MAGI. So the first is almost all individuals enrolled under the state plan in the Medicaid adult group, and then the second is for individuals enrolled through a section.

1115 demonstration that provides coverage that is equivalent to minimum essential coverage or MEC to all individuals described in the Medicaid adult group. So essentially had the state expanded under the state plan instead of a Section 1115 demonstration and it would have covered all the same people. That is when it applies to Section 11.

11:15 demonstrations and four E's throughout the slide deck and also the SMDL. We are referring to this collectively as the Dole expansion group.

Next slide.

So there are certain populations that are exempt from this new requirement, and that is specifically certain American Indians and Alaska Natives who are enrolled under the state plan in the Medicaid adult group or enrolled under a Section 11T waiver or a waiver of the state plan in coverage equivalent to MEC.

That would cover all the same individuals as those covered in the Medicaid adult group under the state plan. In addition, individuals enrolled in any other MAGI based eligibility group are not subject to six-month renewals, nor does this apply to individuals.

Enrolled in non magi groups and this requirement is also specific to DC in the States

and does not apply to the territories. Next slide.

So as was touched on earlier by Annmarie, I think there is much overlap between this new requirement and the community engagement requirement. So many of the individuals who will be required to undergo renewals once every six months will also be required to demonstrate community engagement as described.

In Section 1902, \*\* of the Act and is in effect as of January 1, 2027. However, regardless of whether a member of the adult expansion group is subject to community engagement, all individuals enrolled in the adult expansion group will be subject to six month renewals unless exempt as noted in slide 9. And again, that is. Generally certain American Indian populations and noting that we do plan to release future guidance on how to implement community engagement and the implications of these requirements for renewals of eligibility.

So another thing to note about this change is while it changes the frequency in which states must conduct renewals, it does not change the steps a state must take when completing that process. So as is required now, states must begin the process by checking available, reliable information and attempt to redetermine eligibility without.

Obtaining information from the beneficiary, as we often refer to as an ex parte renewal. If they're unable to do that, they must send a pre-populated renewal form and provide the beneficiary with a minimum of 30 days to return that form, and then they also must consider eligibility on all bases prior to making a determination of ineligibility.

Eligibility and provide a minimum of 10 days advance notice and fair hearing rights before taking any adverse action.

Next slide. And with that, I'm going to turn it over to Caroline to talk about transitions.

**Haarmann, Caroline (CMS/CMCS) 15:37**

Thank you, Maggie. So as she noted, I'm gonna be walking through the section of guidance that addresses transitioning to the six-month renewal cycle. Next slide, please. So the guidance first covers what this would look like for a person who applies for Medicaid and their effective date of coverage.

Is on or after January 1st, 2027 and they're eligible for the adult expansion group. And so for this group they would receive a six month eligibility period and the state would need to initiate the renewal process so that it is complete before the person's

eligibility period ends.

Next slide. The guidance then moves into discussing implementing the new six month renewal requirements for individuals who are already enrolled in a 12 month eligibility period in the adult expansion group.

On January 1st, 2027 and therefore their annual renewals have already been scheduled to occur at some point in 2027. And because the language in the statute that refers to redetermine redetermination scheduled on or after January 1st, 2027 is ambiguous with respect to.

Eligibility periods that began before 2027 but ends sometime in 2027. There are two options that are available to states for transitioning this group of individuals into a six-month renewal cadence. Next slide.

So option one is to reschedule renewal initiation dates for beneficiaries enrolled as of January 1st, 2027. So under this option, the state would shorten the eligibility period for beneficiaries enrolled in the adult expansion group.

Whose renewal is set to be initiated on or after January 1st, 2027 to provide that person with as close to a six month eligibility period as possible from the effective date of their last eligibility determination.

And I'll just pause here to note that the state would not reschedule these renewal initiation dates to a date that is before January 1st, 2027 and states would need to weigh several operational considerations if they take up this option.

Next slide please.

So um.

There will be a group of individuals who will have been enrolled for a period of time as of January 1st, such that the state would need to reschedule their renewal initiation date and then also promptly initiate and shorten their eligibility period to be as close.

To six months, as is practically feasible. And that's because this is a group of people who have already had at least six months of eligibility in the adult expansion group as of January 1st, 2027. And there are also other people who would have been enrolled for a shorter time as of January 1st, 2027.

But would need to have their eligibility.

Scheduled their previous, excuse me, their previously scheduled 2027 renewal initiation date rescheduled to get them to a six month eligibility period. So from an operational perspective, this means that states implementing this option would need to be able to identify individuals.

Whose renewal initiation dates need to be rescheduled and when they need to be rescheduled for, and then initiate a large volume of renewals as early as January 1st, 2027 and then maintain that schedule into the future, which also will likely result in a cluster of renewals every six months.

Next slide please. Option two is to transition beneficiaries enrolled on January 1st, 2027 at their next scheduled renewal. And so under this option states are able to retain an individual's 12 month eligibility period that was granted before.

Or January 1st, 2027. And then at renewal, the person remains eligible for the adult expansion. If they remain eligible for the adult expansion group, they would be moved into that six month renewal cadence. And this option enables states to retain a more even renewal distribution.

into the future because the state's using the already scheduled renewal initiation dates during the transition period. Next slide, please.

So next, the SMDL addresses certain issues that states are likely to encounter. Next slide please. So under the households with different renewal schedule section, we discussed several issues for states to keep in mind.

Including states obligations to determine and redetermine Medicaid eligibility on an individual basis, and also that states may not shorten or extend an individual's eligibility period in order to align with renewal dates that are across other members of the households.

And also that if a beneficiary who's being renewed provides information that affects the eligibility of other people in the household, the state must act promptly to redetermine the eligibility for those household members. Next slide, please.

So when redetermining eligibility at renewal, we remind states that they must consider all bases of eligibility before making a determination of ineligibility. And as a result of this, Medicaid beneficiaries may be redetermined eligible.

For a different eligibility group than the one that they were previously enrolled in.

And so in some cases this will result in a person moving between eligibility groups where there may be different eligibility periods. So they might be moving from a 12 month renewal cadence from their previous eligibility group into one where there is a six month renewal cadence.

But also because the state is granting a new eligibility period following a successful renewal, the state needs to be able to apply the appropriate eligibility period. Next slide please with regards to coordination with other Human Services programs.

Programs. For some people, a six month Medicaid renewal may align with the six

month renewal or recertification for other for another Human Services program. However, this does not change the new Medicaid renewal requirements. So for example.

States can't delay the completion of a Medicaid renewal if the beneficiary doesn't complete a question on a form that's only needed in order for the state to recertify another program like SNAP for example. And so with that, I will turn the floor back over to Maggie to walk through some state next steps.

**Faller, Margaret (CMS/CMCS)** 22:58

Thank you. Next slide please. So the first thing that states will have to consider or another thing I guess I should say that states will have to consider as we are transitioning to this six month cadence is that.

It is important to maintain timely application renewal and fair hearing request processing and plan for sufficient capacity to process the additional requests or resolve application renewal or fair hearing request backlogs as we recognize that transitioning to the six month renewal schedule will result in a.

Change in state operations and workload. And we note that states that do not resolve existing backlogs or develop new backlogs prior to the implementation of section 71107 will likely have challenges addressing the potential increase resulting from the implementation of not just this eligibility provision, but.

The numerous provisions contained within the WFTC legislation. Next slide.

We also note that there will be some changes with respect to the state plan and demonstrations. So states that cover the adult group in their state plan must submit a state plan amendment attesting that the state will conduct eligibility redeterminations every six months for the affected population.

And we are working on developing A reviewable unit and we are targeting release of that for the second-half of this year. So states will be able to submit the state plan amendment no later than March 31st of 2027 for states that have individuals enrolled in coverage under a waiver.

The state should contact their 1115 demonstration project offer to discuss the specific next steps. And next slide please. We also acknowledge that states will need to process or I'm sorry, make process and system changes to operationalize the six month renewal requirements.

And the various other provisions within the WFTC legislation, state Medicaid agency IT system costs necessary to support these requirements could be eligible for

enhanced FFP. And in order to do that, the state must submit an advanced planning document requesting approval for the enhanced FFP for the design, development, and installation of these system updates. Next slide, please. And then of course, we are always committed to supporting states as they implement these provisions. Again, not just the six-month renewal, but the numerous provisions in the WFTC legislation. So for additional information or questions, you can e-mail [medicaidreforms@cms.hhs.gov](mailto:medicaidreforms@cms.hhs.gov). And I think that brings us to the end of the slides, so we can open it up for questions.

**Wallace, Nick (CMS/CMCS)** 25:57

Thanks, Maggie, and I'll invite Caroline to come back on screen as well. So as a reminder to folks, so we're going to pause here. Thanks so much to Maggie and Caroline. We know this is really complicated and we know that states have been asking a lot of questions about the implementation of this provision. So congratulations on getting the guidance document out.

We are going to pause here for a few minutes for specific questions about this provision. As a reminder, we're going to do our best to answer these questions live, but there's a chance that we have to take them back. And we have received a few questions in advance of this call. So we're going to invite folks to put their questions into the Q&A function, please, because that makes it a little bit easier.

For it to track, but we're going to get started with a few of these FAQ's for Caroline and for Maggie as folks are putting these questions in. The 1st is, is this new six month renewal requirement? Is it a requirement or is it a state option?

**Haarmann, Caroline (CMS/CMCS)** 26:56

I can go ahead and take that. It is a requirement for states that have the Medicaid expansion population.

**Wallace, Nick (CMS/CMCS)** 27:07

And can we?

Can we dive a little bit deeper into who does this requirement apply to? Does the six month renewal apply to all adults in Medicaid?

**Faller, Margaret (CMS/CMCS)** 27:24

So I can start and then Caroline, of course you can jump in as needed. So it does not

apply to all adults in Medicaid. It is very specific to the adult expansion group as we are calling it, which includes adults enrolled under a Medicaid state plan or similarly situated adults.

Adults enrolled under a waiver, and it does not include certain American Indian populations. Adults enrolled in any other MAGI group or non MAGI group like the parent, caretaker, relative or former foster care. Even if they are between the ages that would be applicable, they are not subject to this requirement.

It is very specific to the adult group and the adult expansion group as as we have termed it.

**Wallace, Nick (CMS/CMCS)** 28:14

Thanks, Maggie. What about in terms of renewals for American Indians and Alaska Natives? How often should states conduct renewals for that population enrolled in the adult group?

**Haarmann, Caroline (CMS/CMCS)** 28:30

so they would be subject to the twelve month renewal requirements.

**Wallace, Nick (CMS/CMCS)** 28:39

Thank you.

We have a couple of questions related to the intersection between community engagement and this requirement. Let me start with this one. Can a state begin implementing 6 month renewals earlier than January 1st, 2027 if they choose to elect to go earlier?

With community engagement.

**Faller, Margaret (CMS/CMCS)** 29:03

No. So unlike the portion of the WFTC legislation that outlines community engagement, Section 71107 does not provide a similar option to go early to initiate the six month renewal requirement.

So states cannot begin applying this requirement for any renewals initiated prior to January 1st, 2027.

**Wallace, Nick (CMS/CMCS)** 29:31

Thanks, Maggie.

If someone has an eligibility period that is ending towards the end of 2026, can the state set a six month eligibility period for them at the time if they remain eligible for the adult group?

**Haarmann, Caroline (CMS/CMCS)** 29:53

So if a state is conducting a renewal towards the end of 2026, they would go ahead and continue to use a 12 month eligibility period for that person because the provision has not gone into effect because it is not January 1st, 2027 yet.

2027 yet, so if the state was electing to use option one as early as January 1st, 2027, they could go ahead and adjust that person's eligibility period after 71107 goes into effect.

Yeah.

**Wallace, Nick (CMS/CMCS)** 30:31

Thanks, Caroline. We had a question just come in. Would this affect a woman who is in her postpartum period if that period is currently designated as 12 months?

In a second, sorry, a second question about postpartum.

**Faller, Margaret (CMS/CMCS)** 30:47

Um, so yeah. Oh, sorry, go ahead.

**Wallace, Nick (CMS/CMCS)** 30:52

I was going to say Maggie, it seems like we've gotten multiple questions about the same topic, that's all.

**Faller, Margaret (CMS/CMCS)** 30:56

Got it. Yeah. So for a woman who is in their postpartum continuous eligibility period, the state would continue to provide that 12 month eligibility period and that person would not be subject to the six month renewal requirement.

Depending on how the state handles changes in circumstances, they could, you know, go through the process of the renewal at six months, but would not be able to generally terminate coverage based on what they learned through that renewal process unless there is a specific exception to continuous eligibility and Caroline.

I'm going to pause because you are our continuous eligibility expert, so I want to make sure I didn't miss anything.

**Haarmann, Caroline (CMS/CMCS)** 31:40

I think you've hit on the key points, Maggie. And also I would just flag that there is an example about this in the SMDL about how a state would also operationalize this as the person transit transitions out of their continuous eligibility period at the end of their extended postpartum.

Coverage.

**Wallace, Nick (CMS/CMCS)** 32:01

Thanks to you both. We have just a few more minutes here. I wanted to acknowledge that there are a couple of questions here about the intersection, about further definitions related to community engagement and this provision. And I'll just pause to say that we are working through the interim final rule and so there's more guidance to.

Come on community engagement, but thank you for your questions.

Maggie and Caroline, there's a question here related to noticing periods. CMS is saying a 10 day noticing period needs to happen if they are going from a 12 month renewal to a six month renewal. Is this just once or if they turn between programs, do they need noticing each times? I know that we have.

Separate noticing experts, but I wonder if either of you can provide preliminary guidance related to noticing requirements.

**Faller, Margaret (CMS/CMCS)** 33:00

So I can say at a high level that we consider moving from a 12 month eligibility period to a six month eligibility period as an adverse action and therefore that shift to the six month eligibility period would require that advance notice anytime it is occurring.

But to Nick's point, we certainly have other notice experts. So if there are more specific questions, please submit them and we can have more detailed responses.

**Wallace, Nick (CMS/CMCS)** 33:34

Thanks, Maggie.

And maybe just one final one here. This question is related to a different eligibility in the same household. If someone joins an individual's Medicaid household who has a

different renewal date, but whose income must now be counted towards the entire household to do do their renewal dates.

Need to become aligned. Any additional light we can share on this broader topic about different renewal periods within the same household?

**Haarmann, Caroline (CMS/CMCS)** 34:19

So there's a couple of things that I'll just kind of start by saying. And then, you know, if there's a state that has specific questions, we're happy to kind of work through that and provide technical assistance to them if there is information that the state receives about like.

Other member that impacts other members of the house household. When someone else is applying for the program or undergoing a renewal, the state would need to act promptly on that information and reassess eligibility for other household members if it impacts their eligibility.

I think that that gets at part of the question. Nick, could you repeat? Is there another part of the question that maybe you want to repeat so we can make sure we've addressed the whole thing or know what we need to take back?

**Wallace, Nick (CMS/CMCS)** 35:10

The IT says. For example, a single adult in the expansion population with a renewal date in February gets married and moves in with their spouse, but the spouse has an existing Medicaid with a renewal date in March. This one seems like a very specific example, and so maybe it makes sense to follow up on this one.

OK, I think thanks Caroline. We do have another topic to get into. So I think I we're going to thank Caroline and Maggie for their presentation and for their Q&A and to invite folks that if you do have additional questions on this topic, feel free to put them into the Q&A function. The questions really help us to not only.

**Haarmann, Caroline (CMS/CMCS)** 35:34

I think, yeah.

**Wallace, Nick (CMS/CMCS)** 35:54

Create and inform the guidance, but also as part of our technical assistance. So please go ahead and put those questions in. But in the meantime, we are actually

going to pivot to our next topic of conversation, which is Section 71109, and I'm going to invite Candace Anderson to give our presentation.

**Anderson, Candace (CMS/CMCS)** 36:18

Hey, good afternoon, everyone. I'm going to start with a high-level explanation of Section 7/11/09 entitled Alien Medicaid Eligibility. Today, federal law known as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, or PRORA. Sets out non-citizen eligibility for Medicaid and CHIP. Beginning October 1st, 2026, Section 7/11/09 of the Working Family Tax Cut legislation adds additional restrictions to the availability of federal financial participation or FFP for non-

Citizens eligible for full Medicaid and CHIP benefits, and it is applicable to all states, the District of Columbia and the US territories.

Specifically, Section 71109 restricts, with limited exceptions, FFP for full Medicaid and CHIP benefits to specific groups of individuals who are residents of the United States. This includes U.S. citizens and US nationals.

And sorry, can you go to the next screen? I believe we have a little bit more. Thank you. All right. So this includes U.S. citizens and U.S. nationals and three groups of non-citizens, which are one lawful permanent residents or LPRS, which are commonly known as green card holders.

Two Cuban Haitian entrants and the third group is Compact of Free Association or COFA migrants. This means under section 7/11/09 generally and with limited exceptions.

FFP is no longer available to states for full Medicaid and CHIP coverage of other qualified non-citizens who are not in these three categories that I just listed.

I'll repeat those categories again. That's lawful permanent residents, Cuban Haitian entrants, or COFA migrants. So examples of such qualified non-citizens who will no longer be eligible for full Medicaid or CHIP benefits under Section 7/11/09 include those with statuses such as refugees and asylees.

Again with limited exceptions. So what are these limited exceptions? The specifically Section 7/11/09 lists the following three exceptions. First payment for treatment of an emergency medical condition in Medicaid, often referred to as.

Emergency Medicaid, full Medicaid and CHIP coverage for lawfully residing children and or pregnant women in states that have elected this option in their state plan.

This is commonly referred to as the CHIPRA 214 option, a narrow program under CHIP, a state-designed health.

Services Initiative or HSI to improve the health of low income children. So the FFP limitations under section 7/11/09.

Do not apply to the coverage provided under emergency Medicaid, the CHIPRA 214 option in states that have elected such option or under HSIS, and so FFP will remain available for coverage provided to noncitizens under these exceptions.

Section 7/11/09 is applicable on and after October 1st, 2026 and it does not provide for a grace period to implement these changes. States should implement any necessary system changes and operational changes before October 1st to ensure that only those non-citizens eligible for.

Coverage are provided full Medicaid or CHIP coverage on and after October 1st. I'm going to echo what was said earlier. CMS is continuing to work on detailed guidance for Section 7/11/09 and we hope to issue it soon. I am now going to turn it back to Nick.

Come.

**Wallace, Nick (CMS/CMCS)** 40:23

Thanks, Candace. So now we are going to take questions specific to 7/11/09. And as a reminder, we actually have a team of experts that I will invite to come on screen here, Brady Bunch style, and they're going to try to answer as many of your questions live as possible, but it's possible that we have to take them back and this is a.

Another provision that we have received many questions in advance of the call. So I'm actually going to turn things over to my colleague, Sarah Specter, who is going to moderate this panel of sorts. And as a reminder, folks are welcome to submit additional questions into the Q&A function here as our team starts to address the questions that we have already received on this.

Topic. So Sarah, I will turn it over to you.

**Spector, Sarah (CMS/CMCS)** 41:07

Great. Thanks so much, Nick. I appreciate all of that. I'm glad to be here today with a panel of experts from CAP, who you can see on the screen across our divisions working hard to on this guidance that we hope to issue soon.

Matt Chesnick, Candice Anderson, Kirsten Mickel, Tess Hines and Josh Bougie will bring you as much information as we can as quickly as we can. So turning first to Matt.

After October 1st, 2026, when section 7/11/09 goes into effect, does the five year

waiting period still apply? And what about the exceptions to the five year waiting period?

**Cesnik, Matthew (CMS/CMCS)** 41:53

Yes, states must continue to apply the five-year bar after October 1st, 2026 as the FWTC legislation did not amend for Rora's five-year waiting period requirements. At 8 USC 1613, states also must apply the exceptions to the five-year waiting period described in statute as they do today. Specifically, the five-year bar applies to most lawful permanent residents, LPR.

We note that certain qualified non-citizens who adjust to lawful permanent resident status may continue to be accepted from the five-year bar. For example, a refugee who adjusts to lawful permanent resident status would be considered eligible Full Medicaid and CHIP coverage under Section 711-09 as a lawful permanent resident and would be exempt from the five-year waiting period as they are today. Cuban Haitian entrants and COFA migrants are accepted from the five-year waiting period.

**Spector, Sarah (CMS/CMCS)** 43:13

Thank you. So staying still with with some of the provisions of Purora and some of the intersections between the new provision and Purora after October 1, 2026. Should states still apply the additional Medicaid requirements that some states elect in their state plans under Perora, specifically at 8 USC 1612?

**Cesnik, Matthew (CMS/CMCS)** 43:42

As the WFTC legislation did not amend the additional Medicaid requirements established in Perora at 8 USC 1612B on and after October 1st, 2026. States may continue to apply these requirements to noncitizens who meet all other eligibility requirements for more for full Medicaid benefits to lawful permanent residents, Cuban Haitian entrants and COFA migrants. Specifically, states that have elected in their state plan to restrict Medicaid to lawful permanent residents who can be credited with 40 qualifying work quarters can continue to apply this requirement. To lawful permanent residents, states that have elected in their state plan to limit Medicaid for Cuban Haitians to seven years can continue to apply the seven-year limit for Cuban Haitian entrance.

**Spector, Sarah (CMS/CMCS)** 44:52

Thanks, Matt. So moving to Candace, we understand from everything that you have described that the FFP limitation generally is limiting the full Medicaid coverage to U.S. citizens, nationals and these three immigration statuses you've described. Does this mean that the Section 7/11/09 FFP limitation applies to SSI recipients, including in those states with 1634 agreements?

**Anderson, Candace (CMS/CMCS)** 45:24

Yes, the FFP limitations for Medicaid coverage under Section 7/11/09 applies to Medicaid coverage of SSI recipients. Also note that the Working Families Tax Cut legislation did not change eligibility rules for SSI.

We understand the significant potential impact of Section 7/11/09 on states that have 1634 agreements, as well as the implications for 209 B states and SSI criteria states. We are currently discussing this issue with the Social Security Administration and hope to share more information with states soon.

**Spector, Sarah (CMS/CMCS)** 46:04

Thank you. So one more question about PRWORA and the overlap with Title 19 of the Social Security Act. Um We know that both PRWORA and Title 19 require Medicaid coverage of certain non-citizens, Some of whom, as you've now shared, will not be eligible for FFP in Medicaid. Are states required to cover these noncitizens that are ineligible for FFP with their own local funds?

**Anderson, Candace (CMS/CMCS)** 46:41

No, CMS will not require states to provide coverage to non-citizens using state-only funds when FFP is not available. States continue to have the option to provide state-only funded healthcare coverage to such populations, and should they choose to do so, they must ensure proper FFP.

Claiming and program administration.

**Spector, Sarah (CMS/CMCS)** 47:04

Great. Thanks so much, Candace. So Matt, back to you. We know we've gotten a lot of questions from states who have the CHIPRA 214 option. Can you tell us will

qualified non-citizens, which is defined under Aurora, will they still be eligible for coverage under?

Chipper 214 if the state elects to cover the children or pregnant women who are lawfully residing under that option.

**Cesnik, Matthew (CMS/CMCS)** 47:32

Yes, the WFTC legislation did not change eligibility under the CHIPRA 214 option. Section 71109 exempts expenditures for coverage under the CHIPRA 214 option. From the FFP limitations described in section 7/11/09, therefore in a state that elects the chipper 214 option, a qualified non citizen or a lawfully residing non citizen who is also a child or a pregnant woman.

Will continue to be eligible for full Medicaid or CHIP coverage, depending on the state's election.

**Spector, Sarah (CMS/CMCS)** 48:17

Great. Thanks so much, Matt. So Kirsten, turning to you, we know we've gotten a lot of questions about redeterminations and what are going to be the requirements in order to ensure that eligible individuals continue to be enrolled.

Can you tell us, will active Medicaid beneficiaries be allowed to remain eligible until their next renewal, or will states be required to close active individuals because the match is no longer available?

After October 1st.

**Speaker 1** 48:52

Thanks, Sarah. The answer is no. The statute did not provide for states to redetermine immigration status at a beneficiary's next regular renewal. States should treat this change in policy as a change in circumstance.

And must redetermine eligibility for all potentially affected beneficiaries by October 1, 2026. We note that states would not need to redetermine eligibility for lawful permanent residence, Cuban Haitian entrance.

Or COFA migrants, or for individuals the state covers under its CHIPRA 214 option if elected in the state as their coverage is not changing under Section 1109, as long as the state is able to identify these beneficiaries using information in their system.

**Spector, Sarah (CMS/CMCS)** 49:44

Right. And that leads us right to the next question. So can you talk to us about what steps a state must take prior to termination of Medicaid or CHIP benefits for current beneficiaries if we think the individual is affected by Section 7/11/09 and FFP? Might no longer be available for them.

**Speaker 1** 50:06

Sure. So to act on this change, the state must attempt to re-verify a beneficiary's immigration status using electronic data sources. So SAVE, which is DHS's verification service.

If the state is unable to verify a beneficiary's immigration status, the state must request information from the individual and provide a reasonable period of time to provide the information. If after the the beneficiary responds to the state's request, the state is unable to verify their immigration.

Immigration status. The state must provide the beneficiary with a 90 day reasonable opportunity period if the state determines that the beneficiary no longer has a satisfactory immigration status for the coverage in which they are enrolled.

Or if the beneficiary does not respond to the state's request, the state must consider all bases of eligibility, such as CHIPR 214 if applicable, and emergency Medicaid coverage. Lastly, for Medicaid, the state must provide 10 days advance notice of adverse.

Action or for CHIP timely and adequate written notice and must include the right to a Medicaid Fair Hearing or CHIP review before terminating benefits.

**Spector, Sarah (CMS/CMCS)** 51:29

Thanks so much, Kirsten. So Tess, turning to you, I know we've got a number of questions around how this new provision interacts with children who a state has enrolled under continuous eligibility.

Can you tell us will children under 19 who are currently qualified non-citizens be allowed to retain coverage for the remainder of their continuous eligibility period and if such a child's?

Immigration or citizenship status changes during their renewal period. Would they be allowed to complete the continuous eligibility period or is the qualified non-citizen status an exception?

To the continuous eligibility regulation.

**Hines, Tess (CMS/CMCS)** 52:26

Thanks, Sarah. When Section 7/11/09 requirements take effect on October 1, 2026, some qualified non-citizen children will still be eligible to retain coverage for full Medicaid or CHIP benefits for the remainder of their continuous eligibility period. This applies to children who are FFP eligible non-citizens. So for example, children who are lawful permanent residents and are not subject to the five-year bar, Cuban Haitian entrants and COFA migrants. It also includes children who are covered under state's election of the CHIP report 214 option through Medicaid or CHIP.

These children will remain in the continuous eligibility period and can continue to receive full Medicaid or CHIP coverage for children that are currently enrolled in Medicaid who are not FFP eligible noncitizens and not eligible for CHIPRA 214 in their state.

These children will only be eligible for emergency Medicaid coverage for the remainder of their continuous eligibility period unless they meet an exception to continuous eligibility. And in CHIP, continuous eligibility will no longer apply to qualified non-citizen children enrolled in separate CHIP.

Who are not FFP eligible noncitizens and in states that have not elected CHIPRA 214. So in this situation, states will be expected to follow existing CHIP rules on redeterminations and provide advanced notice for those who are no longer eligible for coverage.

I think you're muted, Sarah.

**Spector, Sarah (CMS/CMCS)** 54:17

Yes, you're right. Apologies, Candace, coming back to you. I know we've gotten a number of questions about changes in the Federal Data Services Hub. Can you tell us, will CMS be making changes to the Hub Verify Lawful Presence Service?

To reflect the changes under the WFTC legislation and where should states look for communication and guidance about the changes in the Hub?

**Anderson, Candace (CMS/CMCS)** 54:45

Yes, CMS has updated the Hub VLP service to help states implement Section 7/11/09. Specifically, the Hub will return a new indicator code that confirms whether the individual is a lawfully lawful permanent resident, a Cuban Haitian entrant, or a COFA migrant, and therefore whether FFP is available for full.

Medicaid or CHIP coverage, but I also want to confirm that the hub will continue to return the same indicators as it does today for the five year bar and for lawful presence. The lawful presence indicator is used for determination of eligibility for the CHIPRA 214 option. There are no changes to the logic or.

Data for these indicators provided by the Hub. The changes are detailed in the Hub's VLP version 37.1 V2 Business Service Definition or BSD, which is published in a technical portal called Zone and accessible by each state's Hub users. CMS is working with states on testing.

and implementation timelines. We will drop a resource e-mail address into the chat for any questions on accessing this portal or other technical questions.

**Spector, Sarah (CMS/CMCS)** 55:59

Great. And I've got one more prepared question, and I see that we're close on time. So turning back to Matt, we've gotten a number of questions about SPAs, about state plan amendments. Matt, can you tell us, are SPAs going to be required for submission for both Medicaid and?

And if so, when will the revised state plan amendments be released?

**Cesnik, Matthew (CMS/CMCS)** 56:26

We are working on the revisions to the Medicaid and CHIP SPA templates to reflect Section 7/11/09. We are working to issue the revised templates as soon as we can for Medicaid. We anticipate all 50 states.

The District of Columbia and the territories will need to submit a SPA for an effective date of October 1st, 2026. States will need to submit the SPA no later than December 31st, 2026 and I'll pass it over to.

To Josh regarding a chip.

**Bougie, Joshua (CMS/CMCS)** 57:05

Thanks Matt. For CHIP, we expect that all states with a separate CHIP that covered targeted low-income children and or pregnant women will need to submit a SPA. For some states, this may be a restriction of eligibility SPA subject to the submission timeframes at 45765B.

Which will require SPA submission by November 30th, 2026.

Otherwise, separate CHIP states that have elected the CHIPA 214 option for all

covered populations will need to submit the SPA by the end of their state fiscal year, in which October 1st, 2026 falls.

**Spector, Sarah (CMS/CMCS)** 57:51

That's great. Really appreciate all of you participating and we work through a lot of the questions that I think we have received at CMS. I think some of some of the questions we've received in the Q&A box, I will say there are a number here which we'll need to take back and we are definitely considering.

Seeing what we're right up on time, Nick, I think maybe I would turn it back to you.

**Wallace, Nick (CMS/CMCS)** 58:18

Thanks, Sarah. And just want to again thank the team for this really robust conversation and to all of the attendees for all of the questions. Again, we are hoping to release guidance on this provision very soon, which means the everything that the team has been talking about will be in writing. So more guidance for.

Coming soon, but we are at time and so we are going to wrap with the March Allstate call. As a reminder, the slides from today's presentation are going to be up on [medicaid.gov](https://www.medicaid.gov) in the next couple of days. The date for the next Allstate call will be Tuesday, April 28th and.

Between now and then, if you have additional questions, feel free to reach out to us, your state leads, or bring questions to the next call. And thank you all for your attendance. Moderator, please adjourn the call.

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