



# New Medicaid & CHIP Eligibility and Enrollment Rule: What Advocates Need to Know

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In April 2024, HHS published a final rule, [Streamlining Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes](#).<sup>1</sup> This rule seeks to reduce complexity in Medicaid, the Children’s Health Insurance Program (CHIP), and the Basic Health Program (BHP) related to eligibility and enrollment.<sup>2</sup> The rule also seeks to ensure that eligible individuals – including children, older adults, and individuals with disabilities – remain enrolled in all insurance affordability programs, including Exchange coverage.

This guide is designed to help advocates understand the changes in the final rule and when they go into effect.

## Background and Current Policy

The Affordable Care Act (ACA) broadened the scope of Medicaid eligibility by allowing states to enroll new categories of eligible individuals and introducing a simplified income formula, called Modified Adjusted Gross Income (MAGI).<sup>3</sup> However, for millions of people who fall in non-MAGI eligibility categories, enrollment remains a challenge. In particular, certain enrollment rules only apply to, and negatively impact, eligibility categories for people with disabilities, older adults, and people in need of intensive medical care or supportive services. As a result of onerous and unnecessary requirements, eligible individuals lose access to coverage.

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<sup>1</sup> 89 Fed. Reg. 22780 (Apr. 2, 2024).

<sup>2</sup> Although this rule also addresses BHP, this brief primarily focuses on the impact of changes on Medicaid and CHIP.

<sup>3</sup> Refer to the [chart below](#) for a full list of MAGI vs. Non-MAGI eligibility categories and populations.

Administrative complexity unnecessarily burdens Medicaid-eligible and Medicaid-enrolled individuals. The final rule addresses the following administrative challenges in current policy:

- **Incongruent MAGI and non-MAGI policies:** States currently impose different eligibility and renewal requirements for non-MAGI and MAGI beneficiaries. This results in different application rules, processing timelines, and in some cases, different due process rights based on the eligibility category of the application. It also drives churn, where individuals lose coverage and need to reenroll.
- **Low enrollment in Medicare Savings Programs:** Some low-income older adults and people with disabilities enrolled in Medicare qualify for Medicaid programs that lower monthly Medicare out-of-pocket costs called Medicare Savings Programs. However, states are not maximizing tools to enroll individuals in these Medicaid programs, which means that the burden falls on eligible individuals to decipher which programs they might qualify for and to submit application information.
- **Institutional bias in spend-down programs:** Individuals with high medical costs, particularly those enrolled in home and community-based services (HCBS) and those who receive institutional or long-term care, often must “spend-down” resources or assets to qualify for Medicaid coverage. The spend-down requirement does not currently allow states to count non-institutionalized, anticipated, regular medical expenses like personal care services or prescription drugs, which means that people may be less likely to qualify for Medicaid.
- **Few attempts to contact enrollees:** States are currently under no obligation to make multiple attempts to contact enrollees whose contact information has changed before initiating termination of coverage or to use certain updated contact information. States must only send one request for information by mail to the last known address.
- **Underutilized available information:** Even though a state likely possesses data about an applicant or enrollee, states do not make full use of that data to facilitate enrollment. For example, an individual’s Medicaid application could be denied for failure to verify income information, even though the state has that information from an active SNAP enrollment. This puts the burden on eligible individuals to provide duplicative information.

## Summary of Changes

HHS first proposed changes to these provisions in a 2022 proposed rule titled [\*Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application\*](#),

*Eligibility Determination, Enrollment, and Renewal Processes*.<sup>4</sup> HHS finalized some of these provisions in a 2023 final rule, *Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment*.<sup>5</sup> The 2023 final rule addressed only the proposed adjustments to Medicare Savings Programs, certain Medicaid programs that help pay Medicare costs for low-income Medicare-enrolled individuals. Information on changes to Medicare Savings Programs are covered in [Appendix B](#).

The April 2024 final rule, *Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes*,<sup>6</sup> further adjusts Medicaid and CHIP enrollment policies by:

- [Facilitating Medicaid Access for People with Disabilities and Chronic Conditions](#);
- [Promoting Continued Enrollment for Eligible Older Adults and People with Disabilities](#);
- [Eliminating CHIP Barriers that Block Enrollment of Eligible Children](#); and
- [Improving Timeliness of Eligibility Determinations and Redeterminations](#).

Unless otherwise stated, all changes in the final rule apply to programs in all 50 states and 5 U.S. territories. For more details on the specific changes made by this rule, click the links above to go to the appropriate section of this paper. For a summary of eligibility and enrollment timelines adjusted or set by the final rule, [click here to view Appendix A, a quick-reference table](#) with citations to the regulation. This is a non-exhaustive summary of the changes in the final rule that focuses on major changes for enrollees.

## Facilitating Medicaid Access for People with Disabilities and Chronic Conditions

People with disabilities and chronic conditions disproportionately rely on Medicaid to pay for intensive services and supports across institutional and home and community-based settings. However, many people who would otherwise be Medicaid-eligible on the basis of age or disability fall outside of the income or resource limit imposed by the state to qualify for Medicaid coverage.

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<sup>4</sup> 87 Fed. Reg. 54760 (Sept. 7, 2022).

<sup>5</sup> 88 Fed. Reg. 65230 (Sept. 21, 2023).

<sup>6</sup> 89 Fed. Reg. 22780 (Apr. 2, 2024).

A separate “medically needy” pathway can help this group access Medicaid coverage after they spend a certain amount of their income and resources on medical expenses (known as a “spend-down”) in a given budget period.<sup>7</sup> Existing rules allow states to count individuals’ projected expenses from institutional care toward the spend-down to determine eligibility earlier in a given budget period, which helps prevent churn. But states cannot consider other projected expenses.

This final rule will facilitate more consistent access to Medicaid for non-institutionalized individuals as well by **giving states the option to expand the use of projected expenses to include certain HCBS benefits, prescription drugs, and other “constant and predictable” expenses** against their spend-down requirement. By factoring in these relatively stable, expected expenses, HHS will enable eligible individuals to enroll sooner and maintain access to coverage in Medicaid, reducing disruptions in coverage that exacerbate health disparities for people with disabilities and chronic conditions. The new option could also prevent unnecessary institutionalization by making it easier for people to access Medicaid services in their homes and communities before they go into a nursing facility. States may adopt this option beginning on the rule’s effective date of June 6, 2024.

**This provision will be codified at 42 C.F.R. §§ 435.831(g)(2) and 436.831(g)(2).**

## Promoting Continued Enrollment for Eligible Older Adults and People with Disabilities

As of April 2024, during the unwinding of Medicaid’s continuous coverage provision, states have disenrolled an estimated [11.6 million people](#) from Medicaid coverage. Approximately 70% of those who lost coverage were terminated solely due to not meeting procedural requirements; for example, missing deadlines or not meeting onerous documentation and verification requirements. These procedural requirements often operate as administrative barriers that block eligible individuals from enrolling or remaining on Medicaid coverage. This final rule targets common administrative barriers in an attempt to decrease the likelihood that eligible individuals lose coverage and increase the likelihood that particularly underserved groups remain covered.

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<sup>7</sup> States can set the budget period at between 1 and 6 months. See NHeLP’s resource [Q&A on Spend-Down](#) for more details.

### 1. Aligning Application and Renewal Procedures between MAGI and Non-MAGI Groups

MAGI is a uniform, tax-based income-counting methodology that states use to determine eligibility for many Medicaid categories, including eligibility based on pregnancy and for infants and children under 19. MAGI, created as part of the Affordable Care Act, reduces the complexity of income determinations and removes some of the administrative barriers associated with eligibility determinations, such as asset tests. Some individuals, including many older adults and people with disabilities, [still use non-MAGI eligibility pathways to qualify for Medicaid](#). Those enrolled in non-MAGI categories often face heightened administrative barriers, including complicated asset tests and income rules that create extra red tape.

What are MAGI and Non-MAGI Medicaid and CHIP Eligibility Categories and Populations?	
MAGI	Non-MAGI
<ul style="list-style-type: none"> <li>• Non-disabled, non-pregnant adults below age 65 (expansion population)</li> <li>• Pregnant people</li> <li>• Parents and caretaker relatives</li> <li>• Children younger than 19</li> <li>• Individuals eligible for CHIP</li> <li>• Individuals eligible for limited scope Medicaid treatment of tuberculosis</li> <li>• Individuals eligible for limited scope family planning services</li> <li>• Certain children receiving means-tested, state-funded foster care, kinship guardian assistance, or adoption assistance</li> </ul>	<ul style="list-style-type: none"> <li>• Individuals who are Aged (65+), Blind, or Disabled (ABD, including SSI recipients and working disabled individuals)</li> <li>• Dually eligible individuals (including those enrolled in MSPs)</li> <li>• Medically needy (spend-down)</li> <li>• People receiving Long-Term Services and Supports (LTSS), HCBS, or services through other Medicaid waiver programs</li> <li>• Children with severe disabilities</li> <li>• Newborns of Medicaid-eligible mothers</li> <li>• Individuals determined eligible through Express Lane Agency findings (<i>e.g.</i>, TANF or SNAP)</li> <li>• Children receiving federal Title IV-E and other foster care, adoption assistance, or kinship guardianship assistance, as well as former foster youth</li> <li>• Individuals eligible through the Breast and Cervical Cancer Treatment Program (BCCTP)</li> </ul>

**For greater detail on MAGI and non-MAGI Medicaid eligibility pathways, see NHELP’s resource [The Advocates Guide to MAGI](#).**

With this final rule, HHS has attempted to reduce the likelihood that Medicaid- and CHIP-eligible individuals will lose access to coverage due to these administrative barriers. HHS extends certain protections that already apply to individuals in MAGI eligibility categories to those in non-MAGI eligibility categories. These protections include clear timelines for responding to renewal or recertification requests, removal of in-person interview requirements, and requirements that agencies use already available information to verify eligibility.<sup>8</sup>

Within 36 months of the effective date of the rule (June 6, 2027), states must implement the following changes:

- **Application:** Individuals must have at least **15 calendar days** to respond to requests for additional information although individuals awaiting a Medicare Savings Program (MSP) determination have **30 calendar days** to supply additional information.
- **Renewal:** An enrollee or household has a minimum of **30 calendar days** to respond to requests for information or return a renewal form. The 30 days begins to run from the date the renewal request is postmarked or sent electronically.
- **Post-Termination:** States that receive a renewal form or other requested eligibility verification information from an enrollee within **90 calendar days of termination** must treat receipt of this information as a new application and **reconsider** the individual's eligibility.

For both application and renewal processes, states must:

- **not renew eligibility any more frequently than 12 months**, barring a change in circumstances; exception: for individuals enrolled in QMB, states may require recertification every 6 months but even then, states have the option to perform less frequent renewals (see [Appendix B](#) for more information on QMB and other Medicare Savings Programs);
- **accept applications** and other information provided by applicants and enrollees **through any modality** available, including phone, electronic notice, mail, in person, and any other method the state offers;

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<sup>8</sup> States may still require asset tests for those in non-MAGI eligibility categories. See 42 U.S.C. § 1396a(e)(14)(C).

- **not require an in-person interview** to complete an application or renewal (this includes a phone or electronic interview that is intended to meet an in-person interview requirement);
- **provide a pre-populated form** that has been completed with information already in the possession of the state, to aid enrollees with renewal; the pre-populated form must include information available to the state from reliable sources including: SNAP, WIC, or TANF databases; state DMV records; Medicaid Managed Care Organization plan information; and the USPS's Notice of Change of Address database (note: States must indicate in verification plans what sources they consider reliable for this purpose);
- **review information from the above reliable sources, and, if applicable, use that information to make a determination of eligibility** before contacting an applicant or enrollee (also known as "ex parte"); if a determination of eligibility is made ex parte, the state must provide notice to the individual of the determination and the basis on which the decision was made, as well as an opportunity to correct the information;
- use vital statistics data and citizenship information from the state's vital statistics records or the Department of Homeland Security SAVE databases to **verify citizenship and identity without contacting the applicant or enrollee** (this provision takes effect in June, 2026); and
- **not require an individual to apply for other available benefits** as a pre-condition to enrollment in Medicaid or CHIP; however, states may still require applicants and beneficiaries to apply for Medicare as a condition of eligibility (note: states must adopt this provision 6 months after the effective date).

These changes will not affect MAGI eligibility, as they already apply to MAGI. Rather, the changes are made to non-MAGI renewals to better align Medicaid eligibility and enrollment requirements across MAGI and non-MAGI pathways.

**These provisions will be codified at 42 C.F.R. §§ 435.907(c)(4) and (d), 435.916 (non-MAGI application and renewal procedures); 435.608, and 436.608 (requirement to apply for other benefits).**

## **2. Simplifying Change in Circumstances Verifications to Reduce Terminations of Eligible Enrollees**

When a state receives information that indicates an individual's eligibility for an insurance affordability program such as Medicaid or CHIP has changed, the state must take action to

verify the individual's continued eligibility. This is known as a "change in circumstances" review.

Many enrollees lose access to coverage for purely procedural reasons during a change in circumstances review or annual redetermination. For example, if an individual does not respond to a request for information within the timeline given by the Medicaid agency, the individual may be terminated from the program not because they are ineligible but because they did not meet a procedural requirement. This results in a high level of "churn", a break in coverage resulting from being disenrolled and then re-enrolled within a short period of time.

The final rule creates a uniform set of procedural requirements for Medicaid and CHIP to reduce churn between regular renewals. Within 36 months after the effective date (June 6, 2027), states must:

- **promptly redetermine eligibility when the state receives reliable information about a change in circumstances;**<sup>9</sup>
- review information in its "**verification plan**" before requiring the enrollee to provide information;
- **give the enrollee a minimum of 30 calendar days** from the date a request for information is postmarked to respond (this aligns Medicaid renewal and change in circumstances policies);
- **limit the scope of the request** to information related to the change in circumstance;
- **accept information from enrollees via any mode permitted** for submission of applications under the state plan (*e.g.*, phone, electronic, in person, or otherwise);
- if a reported change will result in **additional medical assistance** (*e.g.*, lower premiums or cost sharing charges) and it was reported by the enrollee, verify the change pursuant to the verification plan; conversely, if the change is obtained from a third party data source, the state may but is not required to verify changes with the enrollee;
- **not terminate the enrollee for failure to respond** to the request for information, **if the change would result in more beneficial coverage**; the state must keep the enrollee in the same eligibility group or category for the duration of the eligibility period;

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<sup>9</sup> Examples of reliable information include mail returned by the USPS, information from the USPS National Change of Address (NCOA) database and Medicaid Managed Care Plans, or other data sources that have been identified by the agency and approved by CMS before contacting the enrollee to provide information on change of circumstances or renewal.



- when third party data shows a change would **adversely impact eligibility**, give the enrollee an opportunity to provide additional information to confirm or dispute the information; the state may take action after the 30 calendar day response period has expired; and
- **allow a 90-day reconsideration period** for individuals who have been terminated for failure to return change in circumstances information; if the state receives this information within the 90-day reconsideration period following termination, the state must reopen the individual's case and process eligibility within the normal timelines (45 or 90 calendar days).

When adopting information from a reliable source to update an individual's eligibility, the agency must accept the information as reliable, update the individual's record, and notify the individual of the update. If an agency has enough information available to renew an individual's eligibility without requiring additional information, the agency may begin a new eligibility period.

**These provisions will be codified at 42 C.F.R. §§ 435.919, 457.344 (change in circumstances reviews); and 435.407 (verification of citizenship and identity information).**

### **3. Placing Affirmative Obligations on States to Update Address Information and Act on Returned Mail**

States are required to establish processes to regularly check, and act on information from, reliable data sources to update an individual's contact information. Where an individual's address cannot be confirmed via a reliable data source, the final rule adds specific requirements for how states must contact enrollees before taking adverse action.

Within 18 months of the effective date of the rule (December 6, 2025), states must make "a good faith effort" to contact an individual that includes:

- making **at least two attempts**;
- using **two different modalities** such as phone, mail, email, or electronic notification;
- leaving a **"reasonable period of time" between contact attempts** (note: a "reasonable" amount of time is not defined); and
- giving at least **30 calendar days** for the individual to respond and confirm their updated contact information.

If a state does not have sufficient information to meet these requirements, the state must document the insufficiency in the individual's file.

In addition, if the state agency receives **returned mail or information that an individual's address has changed** from the individual's last known address, the state must take specific action depending on whether it receives a forwarding address. Within 18 months of the effective date of the rule (December 6, 2025), the state must adopt the following procedures depending on whether the forwarding address is in- or out-of-state or no address is provided.

### **In-State Forwarding Address**

If the returned mail shows an in-state forwarding address from a **reliable source**, the state must update the individual's record and notify the individual of the change. The state may not terminate the individual's Medicaid simply because the mail was returned.

If the returned mail shows an address from a source that is **not considered reliable**, the state must:

- check their Medicaid Enterprise System and review other reliable sources according to their verification plan;<sup>10</sup>
- update the address without further verification if the address is confirmed;
- if the state is unable to confirm the new address information, make a "good faith effort" to contact the individual and allow the individual **30 calendar days to respond**;
- **not terminate** the individual for failing to respond to a request to update their in-state address; and
- if the individual fails to respond, **cannot use the information to update the individual's case record** because it is not reliable nor verified by the individual.

### **Out-of-State Forwarding Address**

If the returned mail shows an out-of-state forwarding address, the state must:

- **check reliable sources** to confirm the updated address information;
- **make a "good faith effort"** to contact the individual;

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<sup>10</sup> Medicaid Enterprise Systems (MES) are state-run data systems that store information related to eligibility, verification, and claims processing.

- allow the individual **30 calendar days to respond**; and
- if the individual does not respond, **provide an advance termination notice** and fair hearing rights after the allotted 30 calendar day response time.

### No Forwarding Address

If the returned mail contains no forwarding address, the state must:

- **check the Medicaid Enterprise System and reliable sources** to confirm updated address information;
- if updated information cannot be obtained, **make a “good faith effort”** to contact the individual, as described above; and
- move the individual to fee-for-service coverage OR take steps to terminate or suspend coverage; if the state chooses to terminate coverage, it **must provide a notice via last-known address or via electronic method of the enrollee’s fair hearing rights**; if the whereabouts of the enrollee become known before the eligibility period expires, the state must reinstate coverage without requiring additional verification of eligibility.

As with other change in circumstances, if the state has sufficient information available to it to renew eligibility without asking for more information from the enrollee, the state has the option to begin a new eligibility period.

**These changes will be codified at 42 C.F.R. § 435.919 (Medicaid) and 42 C.F.R. § 457.344 (CHIP).**

### 4. Transfers Between Medicaid and CHIP

An enrollee or household that becomes ineligible for one insurance affordability program may be eligible for another program. For example, children who become ineligible for Medicaid due to an increase of household income may be eligible for CHIP. Despite an existing requirement to transfer individuals from one program to another, individuals frequently lose coverage when transitioning, particularly children. This leads to churn and disruptions in care. The final rule attempts to address these inconsistencies by requiring states to create a plan **to facilitate seamless eligibility determinations and transitions from one program to another** to ensure continued enrollment.

Starting on the effective date of June 6, 2024, Medicaid agencies **must make eligibility determinations** on behalf of separate CHIPs, and separate CHIPs must use available information to make Medicaid eligibility determinations.<sup>11</sup> State Medicaid agencies are not required to accept Medicaid eligibility determinations from CHIP that are not based on MAGI, such as determinations of eligibility on the basis of disability. However, the programs are required to send information to the appropriate agency to complete the eligibility determination if they determine the individual is likely eligible. The state must create a plan to facilitate transitions between programs that accounts for these requirements. These changes will help ensure individuals retain coverage and access to care despite transitioning between programs.

Final rules also require Medicaid and separate CHIPs to provide a **combined notice** to all members of the household with information about each person's eligibility status. This is intended to reduce the confusion of receiving multiple notices and the burden of having to figure out for which programs an individual might be eligible.

**These changes will be codified at 42 C.F.R. §§ 431.10 and 435.1200 (Medicaid agency responsibility for coordinating eligibility and enrollment in other programs); 457.65, 457.340, 457.348, 457.350, and 600.330 (responsibilities of separate CHIP agency to facilitate enrollment in other programs).**

## Eliminating CHIP Barriers that Block Enrollment of Eligible Children

Currently, states are allowed to use lock-outs to determine a period of time that a child must wait after non-payment of premiums before re-enrolling in CHIP. On the rule's effective date of June 6, 2024, **states cannot have premium lock-out periods**. Also beginning on the rule's effective date of June 6, 2024, **states must not implement "waiting periods,"** periods where the child is uninsured, prior to allowing the child to enroll in a separate CHIP plan after being disenrolled from a group health plan.<sup>12</sup> Eliminating waiting periods and lock-outs will help prevent gaps in children's coverage and simplify the enrollment process. These

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<sup>11</sup> States have the option to operate Medicaid and CHIP as one program under a single state agency; however, several states opt to operate a separate CHIP program. See [this chart from KFF](#) for more details about which states have separate CHIP programs.

<sup>12</sup> States sunsetting existing lock-out periods and waiting periods will have 12 months after the effective date to implement the prohibition.

changes are particularly important because children who miss periods of insurance lose access to preventive care and risk meeting developmental milestones.

HHS also finalized a prohibition on annual and lifetime limits on CHIP benefits that states must implement 12 months from the effective date of the final rule (June 6, 2025). Annual and lifetime limits are barriers to care that perpetuate inequities for children with higher medical needs. This prohibition aligns CHIP with Medicaid, the Health Insurance Exchange, and private group health plans.

## Improving Timeliness of Eligibility Determinations and Redeterminations

States must already abide by timelines set by HHS to process new applications. These timelines are set to encourage states to process information in a way that facilitates access to coverage for applicants and enrollees – not to limit applicants and enrollees from gaining access to coverage. The final rule establishes clearer processing timelines for changes in circumstances, transfers between programs, and redeterminations of eligibility, in addition to new applications.

### 1. Eligibility Determinations

The final rule seeks to enhance program integrity by codifying existing timeframes for eligibility determinations. Within 36 months of the effective date of the final rule (June 6, 2027), states must adopt, if they have not already, the following maximum time periods for processing **initial applications and transfers** between programs (*i.e.*, between Medicaid and CHIP or Medicaid and the Exchange):

- 90 calendar days for individuals who apply for Medicaid on the basis of disability or who are transferred to Medicaid and must undergo a disability determination; and
- 45 calendar days for individuals who apply for or are transferred to any program (Medicaid, CHIP, or BHP) on any other basis.

In addition, if a state needs information from an applicant that cannot be obtained from reliable data sources, the state must provide no less than 15 calendar days for an individual to respond to a request for that eligibility information before issuing a determination. The determination must be issued within the 45 or 90 calendar day timeline, inclusive of the 15 calendar day window for any request for information.

If the state issues a determination denying the individual's application for coverage, the individual may appeal the determination within at least 90 calendar days of the date the determination is postmarked or sent electronically.<sup>13</sup> However, if the individual responds with new information after the determination but within the 90 calendar day reconsideration window, receipt of that information is treated as a new application. The state must reconsider eligibility and make coverage effective the date the information was received. For instance, if an individual applied for Medicaid on February 1 and was denied but then provided requested information on April 1, the date of effective coverage would be April 1 and retroactive coverage would begin January 1.

### Codifying PHE Flexibilities

Many of the requirements in the final rule are similar to—but not always the same as—flexibilities that were allowed via temporary waivers during the Public Health Emergency. Check each state's [waiver approvals here](#) to see which states adopted policies that maximize enrollment.

## 2. Redeterminations and Renewals

Within 36 months of the effective date of the final rule (June 6, 2027), states will be required to implement new timelines for redeterminations and renewals of eligibility. States must process redeterminations no later than the end of the enrollee's eligibility period if the state has all information needed at least 30 calendar days before the end of the eligibility period. For example, for an eligibility period ending April 30, if the state has all information by March 31, it must process the renewal by April 30.

If the state receives all information to process the renewal with less than 30 calendar days before the renewal period ends, the state has until the end of the month following the end of the eligibility period. Using the same example, if the state received a renewal form from the enrollee on April 25 the state must complete the renewal process and make a determination by the end of May. Coverage cannot be terminated or interrupted during this time.

In cases where an individual is no longer eligible under their current eligibility category but may be eligible under another category (*e.g.*, if a child turns 18 and moves from eligibility as a child to eligibility through expansion), the state must process that eligibility determination

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<sup>13</sup> States may elect a longer reconsideration period than 90 calendar days if they so choose, but the minimum time period provided must be 90 calendar days.

within 45 calendar days from the date the agency determines the individual is not eligible on the current basis. There is one exception to this rule – if the person is newly considered for eligibility on the basis of disability, the agency has 90 calendar days to process that eligibility determination.

### 3. Changes in Circumstances

Finally, within 36 months of the effective date of the rule (June 6, 2027), the state must implement updated timelines for completing change of circumstances reviews. If the state initiates a change in circumstances review, the final rule imposes timeliness standards on the state based on whether the state has all of the information to complete the redetermination or whether it needs information from the enrollee.

If the state has all the information it needs to determine eligibility based on the change in circumstances, the state must complete the eligibility redetermination **by the end of the month that occurs 30 calendar days after the date the state received additional info**. For example, if the state receives information that indicates a change in circumstances on March 15, the state has until the end of April to make the eligibility determination.

If the state needs to request additional information from the enrollee to complete the change in circumstances review, the state has to process the redetermination **by the end of the month that occurs 60 calendar days after the date the information is received** from the enrollee. As a reminder, the state must review available reliable sources of information before contacting the enrollee to provide additional information. Using the same example, if the state requests information from the enrollee on March 15, and the enrollee provides that information on April 10, the state has until the end of June (60 calendar days after April 10, when the state received the information, is June 10, and the state has until the end of that month) to process the redetermination. The individual remains covered until the state makes a determination of eligibility.

Where the state anticipates a change in circumstances or eligibility, such as an individual who turns 18, the state typically has until the end of the month in which the change occurs to make a determination of eligibility. However, if the state needs more information from the enrollee, the state has more time to process the redetermination. Where the enrollee submits the information less than 30 calendar days prior to when the change occurred, the maximum amount of time that the state can take to make the determination becomes the end of the following month. To illustrate this concept: the state typically has until March 31 to determine eligibility for an individual who turns 18 on March 15. However, after checking the Medicaid Enterprise System and reliable sources, the state determines that it needs updated address

information from the individual. The state requests that information and the individual provides that information on March 20. The state has until the end of April to complete the eligibility determination and the individual remains covered until the determination is made.

In any of the above scenarios, if the state deems the enrollee ineligible for the current program in which they are enrolled, the state must consider eligibility for all other insurance affordability programs. The state must abide by the application processing timelines of 90 calendar days for eligibility on the basis of disability and 45 calendar days for all other programs even when those transfers between programs occur.<sup>14</sup>

**These changes will be codified at 42 C.F.R. §§ 435.907 and 435.912 (application, renewal, and change in circumstances timeliness standards for Medicaid); 457.340, 457.1170 (conforming amendments in CHIP); 435.919 (change in circumstances timeframes and protections); 457.344 (conforming changes in CHIP).**

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<sup>14</sup> A state may not necessarily keep an individual covered under their current program while considering eligibility for a different insurance affordability program, if the individual has already been determined ineligible. For example, a state determines an individual is ineligible for CHIP, but may be eligible for Medicaid. The state does not necessarily need to keep that individual covered under CHIP until it issues a Medicaid eligibility determination. However, states must abide by timeliness standards set by the new rule that include making efforts to determine eligibility before the end of each period, creating a plan to transfer individuals between programs if they may be eligible, and issuing a combined notice of eligibility.



## Appendix A: Summary of Timelines

The below chart lists all timelines set by the new final rule and the effective date of the change in regulations.

<b>Summary of Eligibility &amp; Enrollment Timelines Set or Changed by the Rule</b>			
<b>Application Timelines</b>			
Application processing timeline (non-disability)	The state has 45 calendar days to make the eligibility determination, including any requests for information.	435.912(c)(3)(ii) (Medicaid) 457.340(d)(1) (CHIP)	June 6, 2027
Application processing timeline (disability)	The state has 90 calendar days to make the eligibility determination, including any requests for information.	435.912(c)(1)(i) (Medicaid); 457.340(d) (CHIP)	June 6, 2027
Request for information to complete application	The applicant has 15 calendar days from the date the notice requesting information is postmarked or sent electronically.	435.907(d)(1)(i) (Medicaid); 457.330 (CHIP)	June 6, 2027
Reconsideration	If the applicant provides requested information within 90 calendar days of the date of denial, the state must treat it as a new application and restart the eligibility determination.	435.907(d)(1)(iii)	June 6, 2027
<b>Change in Circumstances Timelines</b>			
Request for Information	The enrollee has 30 calendar days from the date the request is sent to respond.	435.919(c)(1)(i)	June 6, 2027
Eligibility processing where anticipated change in eligibility	The state has until the end of the month in which the anticipated change occurs.	435.912(c)(6) (Medicaid); 457.340(d)(1)	June 6, 2027

occurs	However, if an enrollee submits all needed information less than 30 calendar days before the change, the state has until the end of the month following the anticipated change.	(CHIP)	
Eligibility processing where change is reported and no further information is needed from the enrollee	The state has until the end of the month that occurs 30 calendar days after the report of change to determine whether the enrollee remains eligible.	435.912(c)(5) (Medicaid); 457.340(d)(1) (CHIP)	June 6, 2027
Eligibility processing, where more information is needed from the enrollee	The state has until the end of the month that is 60 calendar days after the date the information is reported to determine whether the enrollee remains eligible.	435.912(c)(5) (Medicaid); 457.340(d)(1) (CHIP)	June 6, 2027
<b>Renewal Timelines</b>			
Submit renewal form or submit additional information to process renewal	Enrollees have 30 calendar days from the date the form is postmarked or electronically sent to return a renewal form or requested renewal information.	435.916(b)(2)(i)(B) (Medicaid); 457.343 (CHIP)	June 6, 2027
Renewal processing (non-disability, same eligibility category)	<p>If the state has all information needed to process the renewal, the state must complete the renewal before the start of the next eligibility period.</p> <p>If the state needs information from the enrollee to process the renewal, the state has until the end of the month following receipt of the information to process the enrollment.</p>	435.912(c)(4), (e) (Medicaid); 457.340(d)(1) (CHIP)	June 6, 2027
Renewal processing (non-disability,	The state has 45 calendar days to complete the renewal	435.912(c)(4), (e) (Medicaid);	June 6, 2027

different eligibility category not based on disability)	determination. This timeline includes any requests for information the state might make to the enrollee.	457.340(d)(1) (CHIP)	
Renewal processing (disability or moving from another eligibility category to eligibility on the basis of disability)	The state has 90 calendar days to process the renewal determination. This timeline includes any requests for information the state might make to the enrollee.	435.912(c)(4), (e) (Medicaid); 457.340(d)(1) (CHIP)	June 6, 2027
Reconsideration period for procedural terminations	If an enrollee is terminated based on a failure to respond to a request for information within the allotted timeline, the enrollee has 90 calendar days from the date of termination to provide the requested information. Once the state receives that information, it must reopen the individual’s case and process the redetermination according to the 45 or 90 calendar day timeline.	435.916(b)(2)(iii) (Medicaid); 457.343 (CHIP)	June 6, 2027
Renewal frequency	State may not process renewals more frequently than every 12 months.	435.916(a) (Medicaid); 457.343 (CHIP)	June 6, 2027
Contact attempts	If the state receives returned mail or otherwise becomes aware that the individual’s address has changed, the state must make at least 2 attempts to contact the enrollee via 2 different methods if additional information is needed. There must be “a reasonable period of time” between the first attempt and the final attempt.	435.916 (Medicaid); 457.343 (CHIP)	December 6, 2025

## Appendix B: Helping Eligible Seniors and People with Disabilities Enroll in Medicare Savings Programs (MSP)

Some individuals who receive Medicare are eligible for Medicare Savings Programs (MSP), which are limited scope Medicaid programs that help pay for Medicare premiums and costs. MSPs provide critical financial assistance to low-income older adults and people with disabilities. However, the number of eligible but unenrolled individuals in MSPs remains unacceptably high. For example, a [2017 Urban Institute study](#) showed less than half of Medicare enrollees eligible for MSPs were enrolled.

<b>What are Medicare Savings Plans?</b>			
<b>Program</b>	<b>Paid by Medicaid</b>	<b>Income eligibility</b>	<b>Resource eligibility</b>
Qualified Medicare Beneficiary (QMB)	Part A and Part B premiums, deductibles, & coinsurance	Countable income at or below 100% FPL	Must not exceed 2x SSI resource eligibility standard (\$4,000 if single/\$6,000 if married)
Specified Low Income Medicare Beneficiaries (SLIMB)	Part B premiums	Countable income between 101-120% FPL	Must not exceed 2x SSI resource eligibility standard
Qualified Individual (QI)	Part B premiums	Countable income between 121-135% FPL	Must not exceed 2x SSI resource eligibility standard
<b>Medicare Subsidies</b>			
Low Income Subsidy (LIS), aka "Extra Help"*	Part D premiums, co-pays, & deductibles	Countable income at or below 150% FPL (new for 2024)	\$15,720 (single) or \$31,360 (married); additional if some resources will be used for burial expenses.

\*The above income and asset thresholds are federal. The effective eligibility thresholds for MSPs vary by state because they have flexibility to disregard certain income or assets for MSP categories. Individuals are deemed eligible for LIS if receiving SSI and/or Medicaid (including if they are enrolled in an MSP). Under prior rules, individuals may be automatically enrolled in LIS if they receive QMB, SLIMB or QI, but were not automatically enrolled in QMB, SLIMB, or QI if they receive LIS. The final rule requires states to automatically enroll individuals receiving one MSP in **all** other MSPs they may be eligible for.

In September 2023, HHS released a final rule on [Streamlining Eligibility for MSPs](#).<sup>15</sup> This rule requires states to act when they receive information from the Social Security Administration (SSA) that indicates that an individual may qualify for one of these programs.

No later than October 1, 2024, states must **automatically enroll certain SSI beneficiaries in the Qualified Medicare Beneficiary (QMB)** program when they are enrolled in Medicaid, **without** asking the individual to submit a separate application for QMB. Additionally, the rule allows 14 “group payer” states the option to directly initiate Medicare Part A enrollment for SSI recipients who do not qualify for premium-free Medicare Part A by deeming them QMB eligible.<sup>16</sup> This option avoids a catch-22 for such individuals who would otherwise have to pay their first month of Part A premiums (and associated late penalties) to enroll before they could enroll in QMB. QMB pays for Part A and B premiums and Medicare cost-sharing for eligible beneficiaries.

**This provision is codified at 42 C.F.R. § 435.909.**

Many people who receive Medicare Low-Income Subsidies (LIS), which helps lower out-of-pocket costs for the Medicare Part D Prescription Drug Program, are also eligible for MSP supports that cover Medicare Part A and Part B costs. Unfortunately, many LIS enrollees are not enrolled in these MSPs. This rule attempts to close this gap by **codifying the statutory requirement that states initiate an MSP application when they receive data for individuals who applied for LIS through the Social Security Administration (SSA).**

<sup>15</sup> 88 Fed. Reg. 65230 (Sept. 21, 2023).

<sup>16</sup> These states are Alabama, Arizona, California, Colorado, Illinois, Kansas, Kentucky, Missouri, Nebraska, New Jersey, New Mexico, North Carolina, Utah, and Virginia.

The final rule also proscribes the following steps to lower enrollment barriers. Beginning on April 1, 2026, states must:

- treat receipt of SSA eligibility data as an MSP application and promptly evaluate the individual's eligibility for **all** MSPs based on the information available to the state;
- accept SSA data as verified unless the state has other reliable information that is not reasonably compatible;
- if the state needs further information to determine eligibility, first collect data from available sources, such as SNAP, TANF, and WIC systems, state motor vehicle database records, the USPS's Change of Address database, and other reliable third-party sources, before reaching out to the individual for additional information;<sup>17</sup>
- when requesting additional information from an individual, send a notice indicating their potential eligibility for MSP, a request for what additional information is required, and give the individual a minimum of 30 calendar days to respond;
- accept an individual's self-attestation of some types of income and assets to determine initial eligibility such as interest and dividend income, non-liquid resources, disregardable burial funds, and the cash value of life insurance policies; the state may require post-enrollment verification of these attestations, but must allow an individual 90 calendar days to provide that documentation and help individuals obtain information on the cash value of life insurance policies to facilitate eligibility determination; and
- evaluate individuals under **all** Medicaid eligibility groups, including for full Medicaid benefits, once they initiate this application.

**This provision is codified at 42 C.F.R. § 435.911(e).**

Finally, this rule requires states to **use LIS methodology for calculating household size for the purposes of MSP eligibility determinations.** Prior to this rule, states set their own rules for determining size of household for the purposes of MSP eligibility, which led to different methodologies being used and varying eligibility results from state to state. No later than April 1, 2026, states must use the definition of family size found in 42 C.F.R. § 423.772

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<sup>17</sup> This standard is different from the definition of "reliable information" defined in the preamble to 42 C.F.R. § 435.919. States are allowed to use available third-party data from any "other third-party sources consistent with current regulations," and as clarified in the revisions to 42 C.F.R. § 435.952(c).

as a minimum when determining household size.<sup>18</sup> A state can choose to adopt MSP household rules that are more inclusive than this definition, but not less inclusive.

**This provision is codified at 42 C.F.R. § 435.601.**

**For a basic overview of Medicare Savings Program eligibility and coverage, see NHeLP’s resource [Medicaid and Medicare: Aging, Access, and Affordability](#).**

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<sup>18</sup> Family size as defined by LIS regulations includes the applicant, the applicant’s spouse (if the spouse is living in the same household with the applicant), and all other individuals living in the same household who are related to the applicant and dependent on the applicant or applicant’s spouse.