



# Notice Issues Related to OBBBA's Shift of Medicaid Expansion Enrollees to 6 Month Redeterminations

[Katy DeBriere](#)

## Overview

The so-called "One Big Beautiful Bill Act," or "OBBBA," reverses longstanding CMS guidance that helped reduce eligibility churn.<sup>1</sup>

Under the Affordable Care Act, renewals for Medicaid expansion enrollees were to occur no more than once every 12 months, except when there was a change in circumstances.<sup>2</sup> However, beginning January 1, 2027, OBBBA requires that states redetermine eligibility for most Medicaid expansion enrollees once every 6 months.<sup>3</sup> This provision applies to all states as well as to Washington, D.C.

This new law will cause harm. Research shows that increased eligibility checks lead to higher procedural disenrollments and disrupting coverage.<sup>4</sup> Since full redeterminations are effectively doubled, administrative costs will increase and administrative systems will need to be redesigned. Disruptions in coverage may also result in worse health outcomes, delays in accessing health care, unmet health needs and financial insecurity.<sup>5</sup>

On March 6, 2026, CMS released guidance that details 2 options for states to implement the 6-month renewal period:

- Under Option 1, states can shift renewals currently scheduled to be initiated on or after January 1, 2027 to a schedule that will align with, or be closer to, a 6-month renewal period from the effective date of their last eligibility determination.<sup>6</sup> This would mean individuals currently covered within a 12-month renewal period could be renewed earlier than they expected. Anyone last renewed in April through August 2026 would have their 12-month period of coverage shortened.

### Example

Maria had her Medicaid eligibility renewed on September 1, 2026. Under the previous 12-month renewal cycle, her next renewal would be scheduled for September 1, 2027. However, if her state adopts Option 1, the state could move her renewal up to align with a 6-month schedule—meaning Maria would need to be renewed before March 1, 2027, six months earlier than she anticipated. As a result, Maria's coverage period is effectively shortened, and she will need to complete the renewal process sooner than originally planned.

- Under Option 2, states can apply the 6-month renewal period as an individual comes due for their already scheduled 2027 renewal. This option is strongly preferred. Federal guidance is interpreted to mean that 6-month renewals can be first applied to renewals “initiated” in 2027, so conceivably, a state could delay starting 6-month renewals until March 2027 renewals that are initiated in January 2027.

### Example

On February 1, 2026, the state renewed James’ Medicaid eligibility. Prior to OBBBA implementation, this put his next scheduled renewal on February 1, 2027. Under Option 2, the state would keep his existing renewal date intact and simply apply the new 6-month renewal period when his 2027 renewal comes due. Unlike Option 1, James's current coverage period is not cut short—the 6-month rule only kicks in going forward.

Additionally, because federal guidance ties the 6-month rule to renewals “initiated” in 2027, a state could further delay implementation. For instance, if the state begins processing James's February 2027 renewal in December 2026, that renewal would technically be “initiated” before 2027 starts—potentially allowing the state to keep him on the standard 12-month cycle for one more round.

## Notice Issues

1. Altering renewal periods is agency action.

If states elect Option 1, federal guidance expressly directs states to provide written notice to those individuals previously granted a 12-month eligibility period.<sup>7</sup> This is because CMS considers this a “reduction” that constitutes agency “action.” As such, CMS additionally requires states to issue a notice 10 days before a reduction in the eligibility period and provide full appeal rights.<sup>8</sup> Because it is considered a reduction, this would include continuation of

benefits pending appeal.<sup>9</sup> No such requirement attaches to states who elect Option 2. It is currently largely unknown which states will elect Option 1, so advocates should track this state policy decision closely.

In addition, when a state shifts an individual from another eligibility category to the expansion group, states must notify individuals that this will reduce their eligibility period to 6-months.<sup>10</sup> The content of that notice must conform to 42 C.F.R. §§ 435.917 and 431.210.<sup>11</sup> And, because this reduction in eligibility period constitutes agency “action,” the state must provide full appeal rights, including 10-day prior notice and continuation of benefits.<sup>12</sup>

## 2. Those entitled to continuous eligibility must remain enrolled.

As discussed above, the 6-month renewal period applies only to the Medicaid expansion group. Households that have members who are children, people who receive Medicaid based on pregnancy or disability, or individuals over age 64, need to be aware that their individual Medicaid renewals are not subject to increased renewals. However, if the state undertakes a 6-month renewal for a household member enrolled in Medicaid expansion but determines other, non-expansion members are ineligible due to a change in circumstance, the state can generally act on that change.<sup>13</sup>

There is an exception to the state’s ability to act on a change in circumstance. Regardless of a change that would otherwise negatively affect eligibility, states **cannot** terminate Medicaid for non-expansion household members enrolled in a category entitled to continuous eligibility. The two Medicaid categories entitled to continuous eligibility are children and pregnant women. Specifically, continuous eligibility applies to all children in the household age 18 and under.<sup>14</sup> It also applies to people who are pregnant or in the postpartum coverage period elected by the state.<sup>15</sup>

States will need to ensure that, when they act on a change of circumstances for the household (*e.g.*, an increase in household income that renders individuals ineligible), the notice of adverse action clearly articulates that those individuals entitled to continuous eligibility will remain enrolled until the expiration of that protection.

### Example

A 14-year-old Medicaid beneficiary lives with his father, who also receives Medicaid as an expansion enrollee. During the father's new 6-month renewal period, it is determined that an increase in earned income has put the household over the applicable income limits for the father and the child. The state's notice of adverse action must adequately notify the father of his ineligibility while also informing the household about the child's continued eligibility until his 12-month continuous eligibility period has run. Importantly, the state must undertake another eligibility review process at the end of the child's 12-month eligibility period before acting on the information obtained during the father's renewal.

## Conclusion

OBBBA imposes significant harms on Medicaid applicants and enrollees in the expansion population. Being aware of the notice requirements and due process protections accompanying the shift to 6-month redeterminations is essential for advocates and enrollees alike. States must ensure that renewal notices are timely, accurate, and clearly communicate appeal rights—including continuation of benefits—particularly when reducing eligibility periods or acting on changes in household circumstances.

## ENDNOTES

<sup>1</sup> See, e.g., Medicaid and CHIP Payment and Access Comm'n, *An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP* (Oct. 2021), <https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churnand-Continuous-Coverage-in-Medicaid-and-CHIP.pdf>.

<sup>2</sup> See 42 C.F.R. §§ 435.916, 435.919.

<sup>3</sup> An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No. 119-21, § 71107, 139 Stat. \_\_\_\_ (2025) [hereinafter OBBBA] (codified at 42 U.S.C. § 1396a(e)(14)(L)). (certain American Indian and Alaska Native expansion enrollees are exempted from this provision); see also Ctr. for Medicare & Medicaid Servs. (CMS), Dear State Medicaid Director Letter, SMD #26-001, Implementation of "Eligibility Redeterminations," Section 71107 of the "Working Families Tax Cut" Legislation (Public Law 119-21), at 1, 4 (Mar. 6, 2026), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd26001.pdf> [hereinafter CMCS, SMD #26-001].

<sup>4</sup> *Supra* note 1; see also Matthew Buettgens, Jameson Carter, & Fernando Hernandez-Lepe, *OBBBA's Six-Month Redetermination Could Reduce Medicaid Expansion Enrollment by 2.0 to*

3.1 Million in 2028, Urban Institute (March 25, 2026), <https://www.urban.org/sites/default/files/2026-03/OBBBAsSixMonthRedeterminationCouldReduceMedicaidExpansionEnrollmentby2.0to3.1Millionin2028.pdf>.

<sup>5</sup> Buettgens et al., *supra* note 4, at 2.

<sup>6</sup> See CMCS, *SMD #26-001* at 9-10; see also Kinda Serafi & Elizabeth Dervan, *New CMS Guidance on Six-Month Renewals in Medicaid*, State Health & Value Strategies (March 12, 2026), <https://shvs.org/new-cms-guidance-on-six-month-renewals-in-medicaid/>.

<sup>7</sup> CMCS, *SMD #26-001* at 9.

<sup>8</sup> *Id.*

<sup>9</sup> See 42 C.F.R. § 431.230(a).

<sup>10</sup> CMCS, *SMD #26-001* at 11-12.

<sup>11</sup> *Id.* at 11.

<sup>12</sup> *Id.*; see also 42 C.F.R. §§ 431.211, .220, .230(a).

<sup>13</sup> 42 C.F.R. § 435.916(d) (2023); see also CMCS, *SMD #26-001* at 11.

<sup>14</sup> 42 U.S.C. § 1396a(e)(12); 42 C.F.R. § 435.926; see also CMS, *Dear State Health Official, SHO #25-001, Section 5112 Requirement for all State to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023* (Jan. 15, 2025); CMS, *Mandatory Continuous Eligibility for Children in Medicaid and CHIP, Frequently Asked Questions* (Oct. 27, 2023), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq102723.pdf>; CMS, *Dear State Health Official Letter, SHO No. 23-004, Section 5112 Requirement for all States to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023* (Sept. 29, 2023), <https://www.medicaid.gov/sites/default/files/2023-09/sho23004.pdf>.

<sup>15</sup> States must cover pregnant women, including 60 days postpartum regardless of a change in circumstance. See 42 U.S.C. § 1396a(e)(5), (6); 42 C.F.R. §§ 435.170; CMS, *State Medicaid Manual* §§ 3306-3306.3. States have the option to extend the continuous eligibility period to 12 months postpartum. See 42 U.S.C. § 1396a(e)(16) (added by American Rescue Plan Act of 2021 (ARPA), Pub. L. No. 117-2, § 9812, 135 Stat. 4, 212-13 (March 11, 2021) and amended by Consolidated Appropriations Act, 2023 (CAA), Pub. L. No. 117-328, § 5113, 136 Stat. 4459, 5940 (Dec. 29, 2022)). See CMS, *CMCS Informational Bulletin, Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Related Provisions in the American Rescue Plan Act of 2021* (June 3, 2021), <https://www.medicaid.gov/sites/default/files/2021-11/cib060321.pdf>. See also CMS, *Dear State Health Official Letter, SHO No. 21-007, Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP)* (Dec. 7, 2021), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>. As of May 2024, 47 states have implemented the 12-month postpartum coverage extension. See *Medicaid Postpartum Coverage Extension Tracker*, Kaiser Fam. Found., <https://www.kff.org/medicaid/medicaid-postpartum-coverage-extension-tracker/> (last visited May 15, 2024).