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# Medicaid Continuous Enrollment Condition Unwinding Marketplace Frequently Asked Questions (FAQ)

*This document describes flexibilities for individuals and Marketplaces with regard to Medicaid Continuous Enrollment Condition unwinding operations (Medicaid unwinding) for plan years 2023 and 2024. The guidance referenced in this document is applicable to all Marketplaces on the federal eligibility and enrollment platform and provides specific operational details for enrollees in Marketplaces using the federal platform. State-based Marketplaces (SBMs) using their own platforms have different operational details but can implement applicable changes and policy flexibilities described in this document. This document does not replace or revise previously issued guidance, and references current federal regulations and law, including the recently enacted Section 5131 of the Consolidated Appropriations Act of 2023 (CAA, 2023) and CMS guidance on this provision in the Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) published January 5, 2023, and State Health Official Letter (SHO# 23-002) published January 27, 2023. Additional guidance related to Medicaid unwinding can be found at Medicaid.gov/Unwinding.*

Since the onset of the novel coronavirus disease of 2019 (COVID-19) Public Health Emergency (PHE), state Medicaid agencies made policy, programmatic, and system changes to respond effectively to the pandemic. State Medicaid agencies also made changes to qualify for the temporary Federal Medical Assistance Percentage (FMAP) increase under Section 6008 of the Families First Coronavirus Response Act (FFCRA).[1] As a condition of receiving the increased FMAP, state Medicaid agencies were required to maintain continuous enrollment for most Medicaid (and in some cases, the Children's Health Insurance Program (CHIP))[1] beneficiaries who were enrolled on or after March 18, 2020. Under the CAA, 2023, the expiration of the Medicaid continuous enrollment condition and receipt of the temporary FMAP increase is no longer linked to the end of the COVID-19 PHE. The continuous enrollment condition ended on March 31, 2023, and the FFCRA's temporary FMAP increase will be gradually reduced and phased down, which began April 1, 2023 and will end on December 31, 2023.

[1] States have flexibility with respect to the design of CHIP in their state. The FFCRA 6008(b)(3) continuous enrollment condition does not apply to individuals enrolled in a separate CHIP, but does apply to individuals enrolled in a "Medicaid expansion CHIP" program (wherein the state has expanded Medicaid eligibility to optional targeted low-income children and meets the requirements of the CHIP program, rather than operating the program separately from Medicaid). However, some states, using state only funds, opted to maintain eligibility for individuals determined ineligible for separate CHIP. States have the option to submit a COVID-19 Section 1115 demonstration application for CMS consideration requesting expenditure authority to enable the state to claim federal financial participation (FFP) for such CHIP beneficiaries through the end of the Medicaid continuous enrollment condition unwinding period, or until a redetermination is conducted during the Medicaid continuous enrollment condition unwinding period.

The March 31, 2023 end of the continuous enrollment condition meant that state programs began to return to normal eligibility and enrollment operations, including processing Medicaid terminations for individuals who are determined no longer eligible; this return to normal operations is known as Medicaid unwinding.[2]

States have up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid, CHIP, and the Basic Health Program (BHP) following the end of the continuous enrollment condition.[3] Beginning April 1, 2023, states claiming the temporary FMAP increase under the FFCRA have been able to terminate enrollment for ineligible individuals enrolled in Medicaid, following a redetermination.

During Medicaid unwinding, some individuals will lose their current Medicaid or CHIP coverage and need to transition to other health insurance, such as coverage through a Health Insurance Marketplace.[4] The earliest date that impacted individuals could lose Medicaid/CHIP coverage was April 1, 2023. CMS is conducting a multi-pronged effort to help facilitate continuity of coverage for impacted individuals as they transition from Medicaid or CHIP to Marketplace coverage.

**Q1: What is CMS announcing today?**

**A1:** Today, CMS is announcing changes and policy flexibilities that Marketplaces that use the federal platform are taking to prepare for Medicaid unwinding. These include:

- Updating account transfer-related notices
- Modifying the Marketplace application
- Implementing flexibilities related to data matching issues (DMI) or inconsistencies

CMS will update this FAQ with additional information on the changes and policy flexibilities that Marketplaces that use the federal platform are taking to prepare for Medicaid unwinding, as necessary. CMS guidance and tools related to Medicaid unwinding are available here: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.

[2] For more information, see the January 5, 2023 CMS Informational Bulletin (CIB) on the provisions included in the CAA, 2023, related to the Medicaid continuous enrollment condition: https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf and SHO #23-002: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

[3] While the requirements of section 6008 of the FFCRA do not apply to separate CHIPs or the BHP, CMS recognizes some states elected to apply certain provisions of section 6008 to their separate CHIP program or BHP. In those circumstances, subject to exceptions noted and other federal requirements, guidance related to Medicaid unwinding from the Medicaid continuous enrollment condition also applies to CHIP and BHP.

[4] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

CMS has also released an FAQ on the Marketplace Unwinding Special Enrollment Period, which can be found here: https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.

*Coverage Transitions: State and Marketplace Coordination*

**Q2: How and when do Marketplaces using the federal platform get information on individuals who lose Medicaid or CHIP coverage or who apply for and are denied Medicaid or CHIP coverage by the state Medicaid agency?**

**A2:** Under certain circumstances, a state Medicaid or CHIP agency sends an individual's application information via secure electronic file to the Marketplace in a process referred to as an inbound account transfer. The inbound account transfer process is triggered if one of the following occurs:

- An individual *not currently enrolled in Medicaid or CHIP* applies for Medicaid or CHIP coverage at the state agency and the state agency denies the coverage application but assesses that the individual might be eligible for Marketplace coverage, including:
    - Applicants who are found ineligible on a categorical and/or income basis (*e.g.*, having a household income that exceeds Medicaid or CHIP eligibility threshold in their state).
    - Children determined ineligible for CHIP during a "waiting period." A waiting period is a period of uninsurance following disenrollment from coverage under a group health plan; it's required by certain states before a child who is otherwise eligible for CHIP may enroll in CHIP coverage.
    - Applicants who are lawfully present but ineligible for Medicaid or CHIP based on immigration status (*e.g.*, applicants within 5-year waiting period).
    - Individuals only eligible for Medicaid coverage that is not Minimum Essential Coverage (MEC), such as coverage limited to family planning services or other limited-benefit programs.
- A *current Medicaid or CHIP beneficiary* loses coverage after being found ineligible for Medicaid/CHIP for a non-procedural reason (*e.g.*, having a household income that exceeds Medicaid or CHIP eligibility criteria) following a state redetermination and the state assesses they might be eligible for Marketplace coverage.

States with Marketplaces that use the federal platform should not send inbound account transfers for individuals whose coverage has been terminated for procedural or administrative reasons, such as a failure to respond to a request for additional information to verify eligibility.[5] For Medicaid individuals whose coverage has been terminated for failure to return their renewal form or necessary information, the state Medicaid agency must reconsider the eligibility of the

[5] 2016 CMCS Informational Bulletin, "Coordination of Eligibility and Enrollment between Medicaid, CHIP, and the Federally Facilitated Marketplace (FFM or "Marketplace")" https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf.

individual, if the individual submits the renewal form within 90 days after the date of termination of coverage or a longer period elected by the state, without requiring a new application.

In preparation for Medicaid unwinding, CMS has analyzed different streams of administrative data submitted by state Medicaid agencies. The analyses suggest that, for a number of reasons, inbound account transfers do not specifically identify individuals losing or ineligible for coverage and include individuals who remain enrolled in Medicaid or CHIP. CMS is working on a number of data strategies to specifically identify individuals who lose Medicaid or CHIP coverage or who apply for and are denied Medicaid or CHIP coverage by the state Medicaid agency.

**Q3: Do the Marketplaces that use the federal platform conduct outreach to individuals who are found ineligible for Medicaid or CHIP due to an eligibility-related factor (and not for procedural reasons)?**

**A3:** Yes. When a state Medicaid agency finds someone ineligible for Medicaid or CHIP due to an eligibility-related factor(s) such as having household income over the Medicaid or CHIP eligibility limit, either at the time they apply or during the renewal process, and sends the application through an inbound account transfer to a Marketplace that uses the federal platform *(see Q2 for more details)*, the Marketplace mails a notice (Marketplace Inbound Account Transfer Notice) to the individual informing them that their state referred them to the Marketplace and encourages them to apply for Marketplace coverage. The Marketplace also may try to reach the individual through additional communication methods to remind them about the availability of Marketplace coverage based on the contact information the state provided to the Marketplace in the account transfer.

To ensure individuals receive their notices from their state and potentially from the Marketplace if their account is transferred, it's important for new applicants and existing beneficiaries to provide their state Medicaid agency with current contact information, including:

- Mailing address
- Home address (if different from the mailing address)
- Email address
- Home and/or cell phone numbers

The Marketplace Inbound Account Transfer Notice encourages the individual to complete and submit a new Marketplace application, and describes the steps they need to take. The notice also tells the individual that they'll get eligibility results right away explaining:

- If they (or others in their household) qualify for health coverage through the Marketplace.
- Any financial help that might be available to help lower their costs.
- Other actions they may need to take to confirm their information.

For enrollment deadlines, including information about Special Enrollment Periods following

the Marketplace Inbound Account Transfer Notice, the Marketplace sends additional notifications encouraging the individual to apply for and enroll in Marketplace coverage.

Individuals don't need to wait for a notice from the Marketplace to apply for Marketplace coverage. If someone in a state with a Marketplace that uses the federal platform receives notice from their state Medicaid agency that they will soon lose, or were denied coverage through Medicaid or CHIP, they should immediately visit HealthCare.gov to apply for coverage through the Marketplace to avoid gaps in coverage.

For help completing a Marketplace application, individuals can visit HealthCare.gov, or call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). They can also visit LocalHelp.HealthCare.gov to make an appointment with someone in their area who can help.

**Q4: How has CMS changed the Marketplace Inbound Account Transfer Notice?**

**A4:** CMS updated the Marketplace Inbound Account Transfer Notice to simplify the information about the Marketplace application process for people who lost, will soon lose, or were denied coverage through Medicaid or CHIP. For example, application instructions in the notice were updated to make them clearer and more user friendly. The updated notice was implemented in February 2022, and CMS continues to make further notice improvements to help individuals take the next step towards Marketplace coverage.

**Q5: How has CMS changed the Eligibility Determination Notice (EDN)?**

**A5:** CMS implemented a new design to improve the usability of the eligibility notice, which is generated when an individual submits a new or updated application to a Marketplace that uses the federal platform. The improvements rely on research-based information design and plain language best practices. The improved notice provides clear, actionable information in a single table to help individuals understand their eligibility and required next steps. The redesigned eligibility notice was implemented in October 2022.

*Reporting Recent or Upcoming Loss of Medicaid or CHIP Coverage on the Marketplace Application on HealthCare.gov*

**Q6. How should an individual answer the Medicaid or CHIP coverage questions on the Marketplace application on HealthCare.gov?**

**A6:** The Marketplace application asks all applicants if they have Medicaid or CHIP coverage that recently ended or will end soon.

- Individuals who have recently lost or are about to lose Medicaid or CHIP coverage should respond "Yes" to this question, and then enter the last date of their Medicaid or CHIP coverage when prompted. If the individual doesn't know the exact date, they should enter their best estimate.

- Individuals who did not already have Medicaid or CHIP coverage and recently applied for Medicaid or CHIP (either directly through their state Medicaid or CHIP agency or indirectly through a referral to their state when they applied for Marketplace coverage) but were denied, should respond "No" to this loss of coverage question. (See content below starting with question Q10 for next steps for individuals who were denied Medicaid).

Next, if the individual answered "Yes," the application asks if the individual's household income or size has changed since they lost Medicaid or CHIP coverage.

- If the individual answers "Yes," the Marketplace will evaluate the individual's eligibility for Marketplace coverage with financial assistance (also known as Advance Payments of the Premium Tax Credit (APTC) and Cost Sharing Reductions (CSRs)), AND re-evaluate the individual for Medicaid and CHIP coverage. If the individual answers "No," the Marketplace will only evaluate the individual for Marketplace coverage with possible financial assistance.

**Note:** Websites of direct enrollment entities approved to use the Enhanced Direct Enrollment (EDE) Pathway will also ask individuals about their loss of Medicaid or CHIP coverage and denial of Medicaid or CHIP coverage. However, the wording of the questions on those websites may differ slightly from the Marketplace application questions on HealthCare.gov that are used to determine eligibility for a special enrollment period.

**Q7: Will individuals losing Medicaid or CHIP coverage qualify for a Special Enrollment Period (SEP) through the Marketplace?**

**A7:** Yes. In accordance with 45 CFR §155.420(d)(1), individuals who lose Medicaid or CHIP coverage are eligible for a SEP to enroll in a Marketplace plan. Typically, these individuals can report their loss of Medicaid or CHIP coverage and select a Marketplace plan up to 60 days before or 60 days after their loss of coverage. Additionally, on January 27, 2023, CMS announced a temporary Marketplace Special Enrollment Period (SEP) that is available in Marketplaces that use the federal platform for qualified individuals and their families who are losing Medicaid or CHIP coverage because of Medicaid unwinding. This SEP, hereinafter referred to as the "Unwinding SEP," allows individuals and families in states with Marketplaces served by the HealthCare.gov platform to enroll in Marketplace health insurance coverage. CMS has updated HealthCare.gov so that qualified individuals losing Medicaid or CHIP coverage and who: 1) submit a new application or update an existing application between March 31, 2023 and July 31, 2024 and, 2) attest to a last day of Medicaid or CHIP coverage during the same time period are eligible for an Unwinding SEP. Individuals who are eligible for the Unwinding SEP will then have 60 days ***after the date they submit or update their application*** to select a plan with coverage that starts the first of the month after they select a plan.

To minimize gaps in coverage, CMS recommends that current Medicaid or CHIP beneficiaries impacted by Medicaid unwinding submit a new application (or update an existing application) on HealthCare.gov as soon as they receive their Medicaid or CHIP coverage termination notice. They do not have to wait for their Medicaid or CHIP coverage to end before they can apply for Marketplace coverage and can attest to a last day of Medicaid or CHIP up to 60 days before their last day of Medicaid or CHIP coverage.

More information on the Marketplace Unwinding Special Enrollment Period can be found here: https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.

**Q8: If an individual loses their Medicaid or CHIP coverage, and they have an offer of health coverage through an employer, can that individual still apply for Marketplace coverage and be determined eligible for financial assistance or an SEP, such as the Unwinding SEP?**

**A8:** It depends. Having an offer of health coverage through an employer does not affect an individual's eligibility to enroll through the Marketplace or access an SEP, including the Unwinding SEP, but it can affect their eligibility for financial assistance.

An individual who has an offer of employer coverage doesn't qualify for APTC or CSRs for Marketplace coverage if the offer is considered affordable and provides "minimum value."[6] In 2023, an employer plan is considered affordable for the employee if the premium the employee must pay for self-only employer coverage is less than 9.12% of their household income. Beginning in 2023, an employer plan is considered affordable for the employee's family members if the premium the employee must pay for family employer coverage is less than 9.12% of their household income. When an individual applies for coverage through the Marketplace, the application will collect the relevant employer coverage premium amounts to determine whether their employer coverage is considered unaffordable. Individuals whose employer coverage is unaffordable (or does not provide minimum value) qualify for APTC and CSRs, if otherwise eligible. An individual also doesn't qualify for APTC or CSRs if they are enrolled in employer coverage, regardless of whether that employer coverage is affordable or provides minimum value.

*Reporting Denial of Medicaid or CHIP Coverage on the Marketplace Application*

**Q9: How do individuals who recently applied for Medicaid or CHIP but were found ineligible (denied) indicate this on the application for coverage in a Marketplace that uses the federal platform?**

[6] See 45 CFR 156.145 for more information.

**A9:** As noted earlier in this document, individuals who did not already have Medicaid or CHIP coverage and recently applied for Medicaid or CHIP (either directly through their state Medicaid or CHIP agency or indirectly through a referral to their state when they applied for Marketplace coverage) but were denied, should respond "No" to the Marketplace application question that asks applicants whether they have Medicaid or CHIP coverage that recently ended or will end soon. There is a subsequent Medicaid or CHIP coverage question on the Marketplace application that asks applicants if they recently applied for Medicaid or CHIP and were determined ineligible by the state Medicaid or CHIP agency. Individuals who were **not enrolled** in Medicaid or CHIP and submitted an application for Medicaid and CHIP coverage, but were told in the last ninety days by the state Medicaid or CHIP agency that they don't qualify for Medicaid and CHIP, should respond "Yes" to this question about a recent application and determination of ineligibility. This ensures that the Marketplace only evaluates these individuals for Marketplace coverage with possible financial assistance.

**Q10: If an individual is denied Medicaid or CHIP coverage after initial application, is that a qualifying life event for a Special Enrollment Period (SEP) through the Marketplace?**

**A10:** It depends. Per regulation at 45 CFR 155.420(d)(11), individuals may be eligible for an SEP due to their Medicaid or CHIP denial if:

1. The individual applies for Marketplace or Medicaid/CHIP coverage during Open Enrollment Period or with a different SEP, like a move, and their account information is sent by the Marketplace to the state because they are found to be potentially eligible for Medicaid or CHIP; **or**
2. The individual applies for Medicaid or CHIP coverage directly with their state during Open Enrollment.

In either of the above cases, if the applicant finds out from their state Medicaid or CHIP agency that they are **ineligible for Medicaid or CHIP** after Open Enrollment Period or their SEP ended, they qualify for an SEP due to this Medicaid or CHIP denial. This SEP is available up to 60 days after their denial date.

In order to access this SEP, individuals in Marketplaces that use the federal platform can answer "Yes" to the application question that asks applicants about a recent Medicaid or CHIP denial. Individuals should check the boxes of everyone applying who was found ineligible for Medicaid or CHIP and provide the date listed in their state Medicaid or CHIP agency denial letter.

**Q11: In the situation described in Q10, when would Marketplace coverage start for individuals with a Medicaid or CHIP denial SEP and can individuals request a retroactive coverage start date?**

**A11:** Marketplace coverage in Marketplaces that use the federal platform is effective the first of the month following plan selection with the Medicaid or CHIP denial SEP. For example, if an individual selects a plan on June 1, Marketplace coverage would start on July 1. Additionally, individuals may request an earlier coverage effective date, specifically the coverage effective

date they would have received if the Marketplace had originally determined them eligible for Marketplace coverage following application. They can do this by calling the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) and requesting an earlier coverage effective date.

**Q12. If an individual is granted retroactive Marketplace coverage, will that coverage pay for medical expenses incurred by the individual during the retroactive period?**

**A12:** Qualified health plan (QHP) enrollees enrolled with retroactive effective dates must make premium payments by the issuer's due date for all months of retroactive coverage through the first prospective month of coverage in order to receive the retroactive date; or pay at least one month's premium to receive a prospective effective date (as described in 45 CFR 155.400(e)(1)(iii)). Payment or reimbursement of any claims incurred by the enrollee during the retroactive period would be processed according to the contract of insurance and applicable state law, and would require the QHP enrollee to work with their QHP issuer to submit the claims. As an example, if an individual applied for 2023 Marketplace coverage on 12/5/22 and was referred to the state agency for Medicaid or CHIP coverage, and the state agency found them ineligible on 1/20/23, the individual should update their Marketplace application to indicate that the state agency recently found them ineligible for Medicaid and CHIP. The Marketplace system will by default give them a 2/1/23 coverage effective date for their Marketplace plan (if eligible and they select a plan on or before 1/31/23), but if the individual calls the Marketplace Call Center, they can adjust the effective date to 1/1/23. If the individual timely pays the January and February premiums, then medical expenses incurred in January may be reimbursed or paid by the plan if the insurance policy would otherwise cover those expenses given the plan's deductible, provider network rules, etc.

*Data Matching Issues*

**Q13: Will individuals be notified of Medicaid or CHIP data matching issues during unwinding?**

**A13:** No, in Marketplaces that use the federal platform, the Medicaid and CHIP data matching issue (DMI) process is paused during Medicaid unwinding. An individual typically receives notice of a Medicaid or CHIP DMI when data from a state Medicaid agency shows that the individual is currently enrolled in Medicaid or CHIP at the time of Marketplace application. In those cases, an individual must submit documents to confirm that they are no longer enrolled in Medicaid or CHIP.

However, timing issues with enrollment and data availability from state Medicaid or CHIP agencies may result in erroneous Medicaid DMIs for some individuals disenrolled from Medicaid. For instance, individuals coming to the Marketplace to enroll prior to Medicaid termination would generate a Medicaid DMI, since data would show the individual as still enrolled in Medicaid. In addition, in some cases, available Medicaid data lags behind enrollment,

causing Medicaid or CHIP DMIs for those recently disenrolled. False positive DMIs create unnecessary administrative burdens and can prevent enrollment with financial assistance.

To support continuous coverage during Medicaid unwinding, the Marketplaces on the federal platform do not require individuals with Medicaid DMIs to submit documents confirming no current Medicaid enrollment. Pausing Medicaid and CHIP DMIs until Medicaid unwinding is over prevents these timing issues during a time of high-volume coverage transitions as CMS works with states and contractors to improve Medicaid and CHIP DMI processes.

**Q14: What should an individual do if they sign up for Marketplace coverage and are notified that they need to resolve a DMI?**

**A14:** Individuals should follow the instructions outlined in the notice they receive and submit the requested document(s) as soon as possible. As noted above, individuals in Marketplaces that use the federal platform will not be notified of a Medicaid/CHIP DMI during the Medicaid unwinding period. However, they may be notified of the following types of DMIs: Annual Income, Citizenship, Immigration, American Indian/Alaskan Native, and Social Security.

**Q15: Can an individual request more time to resolve their DMI?**

**A15:** On a case-by-case determination that an extension is warranted, individuals can contact the Marketplace call center at 1-800-318-2596 (TTY users can call 1-855-889-4325) and request more time to resolve their DMI.

**Q16: During Medicaid unwinding, will an individual in a Marketplace that uses the federal platform lose Marketplace coverage if they don't submit documents to resolve their DMI?**

**A16:** If an individual doesn't submit documentation to resolve a DMI for which documentation has been requested, they may lose Marketplace coverage and/or financial assistance. Individuals should follow the instructions outlined in the notice they receive and submit the requested document(s) as soon as possible. While CMS is not currently generating any new Medicaid or CHIP DMIs during Medicaid unwinding, individuals can generate other DMIs that require documents to be submitted, such as to verify income or lawful presence.

*Help Applying for Marketplace Coverage*

**Q17: How can an individual get help applying for Marketplace coverage?**

**A17:** There are several ways that individuals can get help applying for Marketplace coverage:

- Visit HealthCare.gov.
  - HealthCare.gov will direct individuals to their state-based Marketplace, as applicable.
- Call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

- Visit https://localhelp.healthcare.gov/ to make an appointment with someone in their area who can help.