DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

Center for Consumer Information and Insurance Oversight

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The guidance referenced in this document is applicable to all Marketplaces and provides specific operational details for consumers in Marketplaces using the federal eligibility and enrollment platform. This guidance replaces and revises guidance, "Medicaid/CHIP Periodic Data Matching (PDM) - External Frequently Asked Questions (FAQ)" which referenced regulations at 45 CFR 155.330, published on December 29, 2020.

Medicaid/CHIP Periodic Data Matching (PDM) - External Frequently Asked Questions (FAQ)

Consumers who are determined eligible for, or are enrolled in, coverage through Medicaid or the Children's Health Insurance Program (CHIP) that counts as qualifying health coverage (also known as minimum essential coverage, or MEC) are ineligible for advance payments of the premium tax credit (APTC), and for cost-sharing reductions (CSRs) to help pay for the cost of their Exchange coverage premium and covered services.

The Federally-facilitated Exchanges and State-based Exchanges that use the federal eligibility and enrollment platform (Exchange)[1] conduct periodic data matches with state Medicaid and CHIP agencies to determine whether consumers who are enrolled in Exchange coverage with APTC or CSRs are also enrolled in Medicaid or CHIP that counts as qualifying coverage (referred to as "dually enrolled consumers"). The Exchange sends an initial warning notice to the primary contact for each dually enrolled consumer, requesting that they take immediate action. The notice includes the names of those consumers who have been identified as dually enrolled, and instructions to either inform the Exchange that they're not enrolled in Medicaid/CHIP or to end APTC/CSRs with the option to end Exchange coverage as well. Typically, the Exchange also sends a final warning notice to consumers dually enrolled in Medicaid or CHIP and Exchange coverage with APTC/CSRs who do not take action, and (if they continue to take no action) it ends APTC/CSRs for them consistent with 45 CFR 155.330. When the Exchange ends APTC/CSRs, consumers remain enrolled in their Exchange coverage without APTC/CSRs and are responsible for paying the full cost for their share of the Exchange coverage premium and covered services. Consumers also have the option of ending their Exchange coverage.

CMS worked with states in the leadup to Medicaid unwinding process to improve real-time data submitted to the FFE and incorporated a new data source to launch a new, and improved periodic data matching (PDM) process. Pursuant to this new process, notwithstanding the above, CMS is modifying the Medicaid/CHIP PDM process for 2024, consistent with 45 CFR 155.330.

[1] References to the Exchange refer throughout to the Federally-facilitated Exchanges and State-based Exchanges using the federal platform.

For the 2024 coverage year only, Medicaid/CHIP PDM will only include one warning notice to make consumers aware of their dual coverage, and request that they take action. Notices will be sent via U.S. Postal Mail only and will be sent to the primary contact for the affected dually enrolled consumers. The Exchange will not send a final notice, nor will it terminate APTC and CSR eligibility for consumers who appeared dually enrolled at the time of issuance. Using the new data and process, CMS will resume sending final notices and eligibility terminations in 2025.

General Questions about Medicaid/CHIP PDM

Q1: What is Medicaid/CHIP PDM?
A1: Consumers who are eligible for Medicaid or CHIP are not eligible for APTC/CSRs through the Exchange per 26 CFR 1.36B-2(a)(2). As described in Health Insurance Exchange regulations at 45 CFR 155.330(d)(1)(ii), Medicaid/CHIP PDM is the process in which the Exchange periodically examines available data sources to determine whether consumers who are enrolled in Exchange coverage with APTC/CSRs are also determined eligible for or enrolled in Medicaid or CHIP that counts as qualifying coverage.[2] As described in 45 CFR 155.330(e), the Exchange notifies these consumers that they are not eligible for APTC/CSRs for their share of Exchange coverage premium and covered services if they are dually enrolled and should immediately end their APTC/CSRs or terminate their Exchange coverage. If consumers choose to remain enrolled in full-cost Exchange coverage, they should notify their state Medicaid/CHIP agency of their Exchange enrollment as they may no longer be eligible for CHIP.

Q2: What is different about Medicaid/CHIP PDM in 2024?
A2: In 2024, consumers identified as having Exchange coverage with APTC/CSRs and Medicaid or CHIP coverage will receive a single notice through U.S. Postal Mail notifying them of their dual enrollment. Dually enrolled consumers will be asked to take action to either inform the Exchange that they are not enrolled in Medicaid/CHIP or to end APTC/CSRs with the option to end Exchange coverage, as well. Unlike in prior years, consumers will not receive subsequent notices related to their dual coverage. CMS expects to resume Medicaid/CHIP PDM with termination of APTC/CSRs in 2025.

Consistent with Exchange regulations at 45 CFR 155.330(d)(3)(iii), CMS will temporarily pause ending APTCs/CSRs to mitigate consumer harm due to potentially inaccurate Medicaid/CHIP data. CMS designed this notice-only effort for 2024 only to reduce any potential negative impact on consumers living in states that are in the process of resuming routine Medicaid eligibility and enrollment operations, a process often referred to as "Unwinding." Some states will still be completing Unwinding-related renewals throughout 2024. CMS is aware that states completing Unwinding activities will lack current documentation about Medicaid/CHIP enrollment, which could impact the accuracy of Medicaid/CHIP enrollment data used in the PDM process. In 2025,

[2] The state data that is accessed through the Medicaid/CHIP PDM check includes Medicaid and CHIP enrollment data, not data regarding eligibility.

CMS will resume full Medicaid/CHIP PDM operations, and will resume ending APTC/CSRs for Medicaid/CHIP dual enrollees.

Q3: What if a consumer isn't sure if they have Medicaid or CHIP or is currently going through a Medicaid or CHIP eligibility review in 2024?
A3: If a consumer is not sure if they have Medicaid or CHIP, they should contact their state Medicaid or CHIP agency to confirm. For Medicaid, consumers can visit HealthCare.gov/medicaid-chip/getting-medicaid-chip to find their state's contact information. For CHIP, consumers can visit insurekidsnow.gov, or call 1-877-543-7669.

Many states are in the process of redetermining Medicaid and CHIP eligibility following the end of the continuous enrollment condition on March 31, 2023.[3] If a consumer is enrolled in Exchange coverage with APTC/CSRs and believes they are also enrolled in Medicaid or CHIP (or vice versa) but has not received a confirmation of Medicaid or CHIP enrollment or Exchange coverage enrollment, or a Medicaid/CHIP PDM warning notice, they should contact their state Medicaid/CHIP agency or the Exchange, as applicable, to verify their eligibility for or enrollment in Medicaid or CHIP, or Exchange coverage.

If a consumer is enrolled in both Medicaid or CHIP and Exchange coverage with APTC/CSRs, the consumer should visit HealthCare.gov/medicaid-chip/cancelling-marketplace-plan/ or contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) for instructions on how to end their APTC/CSRs or terminate their Exchange coverage. Consumers who are enrolled in full-cost Exchange coverage and Medicaid or CHIP should notify their state Medicaid/CHIP agency of their Exchange enrollment. Those consumers who choose to remain enrolled in full-cost Exchange coverage may no longer be eligible for Medicaid or CHIP.

Q4: What if a consumer who receives the Medicaid/CHIP PDM notice believes they are not enrolled in, or not eligible for, Medicaid or CHIP?
A4: If a consumer receives a Medicaid/CHIP PDM notice but does not think that they are enrolled in, or eligible for, Medicaid or CHIP, the consumer should contact their state Medicaid/CHIP agency as soon as possible to confirm their eligibility and enrollment status. If the consumer learns from the state Medicaid/CHIP agency that they are not eligible for or enrolled in Medicaid or CHIP, the consumer does not need to take any future action at this time. If the consumer learns from the state Medicaid/CHIP agency that they are eligible for or enrolled in Medicaid or CHIP, they should end their APTC/CSRs or terminate their Exchange coverage immediately. Consumers who choose to remain in full-cost Exchange coverage and Medicaid or CHIP should notify their state Medicaid/CHIP agency of their Exchange enrollment because consumers who choose to remain enrolled in full-cost Exchange coverage may no longer be eligible for Medicaid or CHIP.

A consumer who is enrolled in Exchange coverage with APTC/CSRs and Medicaid or CHIP may believe they are eligible to remain enrolled in Exchange coverage with APTC/CSRs if they

[3] In March 2020, the Families First Coronavirus Response Act (FFCRA) established the continuous enrollment condition, which gave states extra federal Medicaid funding on the condition that they maintained enrollment for most individuals (among other conditions).

experience a change in household composition or income that makes them no longer eligible for Medicaid or CHIP. The consumer should contact the state Medicaid/CHIP agency to inform them of these circumstances. If the State Medicaid/CHIP agency informs the consumer that they are no longer eligible for Medicaid or CHIP, the consumer should update their Exchange application to state that they are not enrolled in Medicaid or CHIP; they can remain in their Exchange coverage with APTC/CSRs, if otherwise eligible.

Q5: How often is Medicaid/CHIP PDM conducted?
A5: Per the Exchange Program Integrity Rule (CMS-9922-F) published in the Federal Register on December 27, 2019 (84 FR 71674), all Exchanges are required to conduct Medicaid/CHIP PDM at least twice per year beginning on January 1, 2021. The Exchange typically conducts Medicaid/CHIP PDM twice during the coverage year and sends notices accordingly. However, the frequency will depend on various factors, including evaluations of previous rounds of Medicaid/CHIP PDM. CMS has also revised regulations at § 155.330(d)(3)(iii) to grant the Secretary authority to temporarily suspend the PDM requirement during certain situations to be able to reduce the risk of inaccuracies in PDM due to limited availability of data or documentation (89 FR 26310). In 2024, the Exchange will conduct a single notice-only Medicaid/CHIP PDM, as permitted under § 155.330(d)(3)(iii). We anticipate increasing the number of rounds per year in subsequent years.

Q6: What types of Medicaid and CHIP coverage are considered qualifying coverage?
A6: Most Medicaid is considered qualifying coverage; some forms of Medicaid that cover limited benefits (like Medicaid that only covers emergency care, family planning or pregnancy-related services) are not considered qualifying coverage. For more information on what Medicaid programs are considered qualifying coverage, visit: https://www.healthcare.gov/medicaid-limited-benefits/. CHIP coverage is considered qualifying coverage. For PDM, only consumers enrolled in Medicaid or CHIP coverage that is considered MEC will be notified as outlined in Question 2 of this FAQ.

Q7: What functionality is being used between the Exchange and states to conduct Medicaid/CHIP PDM?
A7: Medicaid/CHIP PDM verifies eligibility for or enrollment in Medicaid or CHIP coverage using the existing synchronous Non-ESI MEC service to check whether a consumer who is enrolled in Exchange coverage with APTC/CSRs is also eligible for or enrolled in Medicaid or CHIP coverage. Since the Exchange utilizes existing functionality to conduct the data match, there should be no additional technological burden on the state Medicaid or CHIP agencies.

Q8: Other than the Medicaid/CHIP PDM notices, how else does the Exchange inform consumers that they should end their APTC/CSRs or terminate Exchange coverage if they are also enrolled in Medicaid or CHIP?
A8: The Exchange informs consumers as follows:

- When selecting Exchange coverage with APTC/CSRs, consumers must attest that they understand their responsibility to end their APTC/CSRs if they become eligible for other MEC (including Medicaid or CHIP).

- The Exchange Eligibility Determination Notice (EDN) that consumers receive after submitting their application for coverage includes clear language regarding consumer responsibility to actively end APTC/CSRs upon becoming eligible for other MEC.
- Information on HealthCare.gov at Healthcare.gov/medicaid-chip/cancelling-marketplace-plan/.

Q9: How will consumers identify the Medicaid/CHIP PDM notices, and what do the notices say?
A9: The subject of the initial warning notice reads ***"Members of your household may have both Health Insurance Marketplace® and Medicaid or CHIP health coverage."*** The notice lists the dually enrolled consumers and provides instructions to either end their APTC/CSRs or update their Exchange application to indicate that they are not enrolled in Medicaid or CHIP. The notice informs consumers who choose to remain enrolled in full-cost Exchange coverage that they should notify their state Medicaid/CHIP agency of their Exchange enrollment. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, who are not sure if their Medicaid or CHIP coverage counts as qualifying coverage, or who are not sure whether they are enrolled in, or have been determined eligible for, CHIP.

Q10: Can a consumer who is eligible for or enrolled in Medicaid or CHIP coverage keep their Exchange coverage?
A10: Yes, if otherwise eligible for Exchange coverage, a consumer may keep their Exchange coverage, but they will not be eligible for any APTC/CSRs to reduce the cost of their Exchange coverage and must pay the full cost. Consumers who choose to remain in full-cost Exchange coverage should notify their state Medicaid/CHIP agency of their Exchange enrollment. Those consumers who choose to remain enrolled in full-cost Exchange coverage may no longer be eligible for Medicaid or CHIP.

Q11: If a consumer is enrolled in Exchange coverage with APTC/CSRs and is eligible for Medicaid medically-needy coverage with a spend down, do they need to end their Exchange coverage with APTC/CSRs?
A11 Individuals who qualify for comprehensive medically-needy Medicaid coverage only after they meet a spend down amount are not considered to have qualifying coverage. Individuals who meet a state's comprehensive medically-needy income level without a spend down requirement will have comprehensive coverage that is recognized as qualifying coverage. In states that do not provide medically-needy coverage that is comprehensive, individuals enrolled in non-comprehensive medically-needy coverage are not considered to have qualifying coverage, regardless of whether they have to meet a spend down amount. Consumers who are enrolled in Exchange coverage with APTC/CSRs and Medicaid that does not count as qualifying coverage do not need to end their APTC/CSRs.

Q12: What obligation do consumers have to notify their state Medicaid/CHIP agency of changes in circumstances mid-year?
A12: Consumers enrolled in Medicaid or CHIP coverage are required to report any material changes that have affected their eligibility for Medicaid or CHIP, and States have an obligation to act on reported changes in a timely manner. Different states have different ways of effectuating this policy. The regulations regarding reporting of changes in circumstances can be

found at 42 CFR 435.919. In addition, consumers who choose to remain in full-cost Exchange coverage and Medicaid or CHIP that counts as qualifying coverage should notify their state Medicaid/CHIP agency of their Exchange enrollment. Those consumers who choose to remain enrolled in full-cost Exchange coverage may no longer be eligible for CHIP.

Q13: Do coordination of benefits and third-party liability (COB/TPL) apply during the time that the consumer was dually enrolled in Medicaid and Exchange coverage with APTC/CSRs?
A13: State Medicaid or CHIP agencies should follow their normal COB/TPL practices for Medicaid. Medicaid should generally remain the payer of last resort.

Q14: Will consumers who are notified that they are dually enrolled be able to retroactively terminate their Exchange coverage with APTC/CSRs?
A14: The Exchange generally will not retroactively terminate Exchange coverage for dually enrolled consumers. Since consumers who are eligible for Medicaid/CHIP, or other minimum essential coverage (MEC), are not eligible for a Marketplace plan with APTC/CSRs, CMS recommends that consumers who are determined eligible for, or enrolled in, Medicaid or CHIP end their APTC/CSRs immediately.

Consumers who are dually enrolled in Medicaid or CHIP and Exchange coverage with APTC/CSRs for a period of time will not need to pay back the amount of APTC they received during that period. See here for IRS guidance on this matter: IRS.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.

Q15: Will Medicaid/CHIP PDM detect dual enrollment in Exchange coverage with APTC/CSRs and Medicare that counts as qualifying coverage?
A15: No. Medicaid/CHIP PDM does not check for dual enrollment in Exchange coverage with APTC/CSRs and Medicare that counts as MEC (that is, Medicare Part A (Hospital Insurance) or Part C, otherwise known as Medicare Advantage). Dual enrollment in Exchange coverage and Medicare that counts as qualifying coverage would also make an enrollee ineligible for APTC/CSRs through the Exchange; this issue is addressed periodically during the year through a separate Medicare PDM process.

Q16: What should a consumer do if they are dually enrolled in Medicaid or CHIP coverage and Exchange coverage with APTC/CSRs but will soon qualify for Medicare due to age or disability?
A16: Consumers who are dually enrolled in Medicaid or CHIP coverage and Exchange coverage with APTC/CSRs, including those who will soon also be eligible for Medicare, should follow the directions provided at healthcare.gov/medicaid-chip/cancelling-marketplace-plan/ or contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to end their APTC/CSRs or terminate their Exchange coverage. Consumers who will soon turn 65 and will be eligible for Medicare generally should enroll in Medicare as soon as they can. Note that consumers who are getting Social Security benefits at least 4 months prior to their 65th birthday will be automatically enrolled in premium-free Medicare Part A and Part B starting the first day of the month they turn age 65 (unless their birthday is the first of the month; if their birthday is the first of the month, Medicare coverage will start the month before their birthday). Consumers not

receiving Social Security benefits should sign up for Medicare Part A and Part B coverage with the Social Security Administration during the 7-month Initial Enrollment Period that begins 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after they turn 65. Please note that consumers who delay enrollment in Medicare Part A or Part B may have to pay late enrollment penalties and pay higher premium costs if they do not enroll in Medicare when first eligible.

For more information on Medicare eligibility and enrollment, refer to Medicare.gov/basics/get-started-with-medicare/.

Note that Medicare enrollees who have limited income and resources or need nursing home care and personal care services may get extra help paying for their premium and out-of-pocket medical expenses from Medicaid. For more information on Medicare and Medicaid dual eligibility, refer to Medicare.gov/basics/costs/help/medicaid.