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CMS
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CMCS Informational Bulletin

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SUBJECT: **Notice of Technology and Process Upgrades for Account Transfer Functionality for States Served by Marketplaces on the Federal Platform**

Purpose

The purpose of this CMCS Informational Bulletin (CIB) is to announce that the Centers for Medicare & Medicaid Services (CMS) intends to replace the technology and processes supporting the coordination of eligibility and enrollment among insurance affordability programs[1], as required under section 1943 of the Social Security Act and added by section 2201 and section 1413 of the Affordable Care Act (ACA). This CIB provides information to the Medicaid and Children's Health Insurance Program (CHIP) agencies in states that utilize Marketplaces on the federal platform (hereafter referred to as the "Marketplace")[2] for eligibility and enrollment. This CIB reminds states of their ongoing responsibility to ensure state systems and technology are upgraded as needed to support seamless coordination and integration between the Medicaid and CHIP agency and the Marketplace[3]. It also highlights opportunities for state engagement in the design and development process of these system changes and outlines expectations for states to align with future CMS technical and process specifications.

Introduction

The expiration of the Medicaid continuous enrollment condition and the subsequent return to regular Medicaid and CHIP eligibility renewal operations[4] (hereafter generally referred to as

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[1] As defined in 45 CFR § 155.300(a); 42 CFR § 435.4.
[2] Marketplaces on the Federal platform include State-Based and Federal Marketplaces that utilize the Federal platform. This CIB references upcoming changes to the account transfer service for Marketplaces on the Federal platform only.
[3] As required by 42 CFR § 433.112(b)(16), Federal Financial Participation (FFP) is available for design, development, installation, or enhancement of mechanized processing and information retrieval systems. The system must support seamless coordination and integration with the Marketplace, the Federal Data Services Hub, and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services as applicable.
[4] Under section 6008 of the Families First Coronavirus Response Act (FFCRA), states were able to claim a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) during the COVID-19 Public Health Emergency (PHE), under certain conditions. As one of the conditions of receiving this temporary FMAP increase, states were required to maintain continuous enrollment for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020. On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) de-linked the end of the

"unwinding") underscored the importance of effective coordination between state Medicaid programs, CHIPs, and the Marketplace. It also highlighted the shortcomings of the existing technology and processes intended to facilitate individuals' transition between these programs. Throughout unwinding, CMS worked extensively with states to improve the quality of data sent to CMS from states. The partnership between CMS and states has been critical to ensuring Medicaid and CHIP eligible individuals retain their coverage, and in helping individuals who are no longer eligible for Medicaid and CHIP to find coverage elsewhere, whether through the Marketplace or an employer.

As CMS looks ahead, ensuring eligible individuals maintain a source of quality, affordable health coverage, whether through Medicaid, CHIP, Medicare, or a Marketplace, remains an ongoing, long-term priority. The "No-Wrong-Door" mandate envisioned by the ACA requires effective coordination between state Medicaid and CHIP agencies and the Marketplace to ensure that eligible individuals have a seamless path to coverage in the program for which they are eligible. Throughout unwinding, it became evident that CMS and states must address the need for significant technology infrastructure improvements beyond regular system maintenance and updates, with the goal of facilitating seamless coverage transitions for eligible individuals in the manner required by the ACA. This presents a unique opportunity for states and the Marketplace to collaboratively define and build a new account transfer service that replaces existing infrastructure. Rather than a routine upgrade, these new services built by CMS will support better coverage outcomes for individuals and families and reduce costs for state eligibility and enrollment systems.

Background

The ACA and implementing regulations require coordination of eligibility and enrollment among insurance affordability programs, including Marketplace coverage with financial assistance, Medicaid, CHIP, and the Basic Health Program (BHP). Eligible individuals must be able to submit a single, streamlined application for coverage either to the Marketplace serving their state or the state Medicaid or CHIP agency, receive an eligibility determination, and be enrolled in the appropriate program. To operationalize the ACA and implementing regulations[5], CMS established the Account Transfer (AT) service to facilitate the secure, bidirectional, electronic transfer of account information between the Marketplace and state Medicaid and CHIP agencies. This service (hereafter called "legacy AT") ensures that an individual's account information is appropriately transferred between the Marketplace and the state agency regardless of where the individual's initial application was received.

Regulations outline the conditions under which state Medicaid and CHIP agencies and the Marketplace must transfer accounts electronically, application information that must be included in the transfers, as well as the actions each program must take when the transfers are received.

COVID-19 PHE from the continuous enrollment condition in the FFCRA. As a result, the Medicaid continuous enrollment provision ended on March 31, 2023, requiring states to restart renewals of Medicaid and CHIP eligibility for all individuals who were enrolled in their Medicaid program as of March 31, 2023. Consistent with federal requirements, individuals who are no longer eligible for Medicaid must be disenrolled. For these individuals, states must assess eligibility for other insurance affordability programs and then appropriately transfer the individual's account.

[5] Described in 42 CFR § 435.1200, 42 CFR § 457.348, and 45 CFR § 155.345.

- When an individual submits an application to a state Medicaid or CHIP agency, or the agency is processing a current beneficiary's renewal or a potential change in circumstance that may affect eligibility between regular renewals, if the agency determines the individual is not eligible for Medicaid or CHIP, the agency must promptly assess the individual's potential eligibility for other insurance affordability programs and transfer the individual's account to the Marketplace as outlined at 42 CFR § 435.1200(e) and § 457.350(b). CMS currently refers to this process as an "Inbound Account Transfer." Regulations at 45 CFR § 155.345 outline the responsibilities of the Marketplace to determine applicants' eligibility for enrollment in a QHP and advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) upon receipt of an Inbound AT from a state Medicaid or CHIP agency.

- When an individual submits an application to the Marketplace and is subsequently assessed or determined eligible for Modified Adjusted Gross Income (MAGI)-based Medicaid or CHIP, their account information must be transferred to the state Medicaid or CHIP agency as outlined at 45 CFR § 155.302(b), § 155.305(c), and § 155.345. The Marketplace also includes additional information in this account transfer, including if individuals should be screened for eligibility on a basis other than MAGI. CMS currently refers to this process as an "Outbound Account Transfer." Regulations at 42 CFR §§ 435.1200(c), 435.1200(d) and 457.348(c) also outline the responsibilities of state Medicaid and CHIP agencies upon receipt of an Outbound AT from the Marketplace.

- After the state receives an account from the Marketplace and the state makes a final determination of eligibility for Medicaid or CHIP, the state must send back a response to the Marketplace that contains information about whether the individual was determined eligible or ineligible for Medicaid and CHIP by the state. CMS currently refers to this process as an "Outbound Response Account Transfer."[6]

For individuals who initially apply for coverage at the Marketplace, states may either delegate authority to the Marketplace to make final MAGI-based determinations of Medicaid and CHIP eligibility[7] (known as determination states) or choose to have the Marketplace make an initial assessment only of MAGI-based Medicaid and CHIP eligibility (known as assessment states).

- For determination states, the Marketplace makes the final MAGI-based Medicaid and/or CHIP eligibility determination when no verification issues are present. Outstanding verification issues include situations in which the Marketplace cannot verify an individual's attestation of income, residency, U.S. citizenship, immigration status, and/or Social Security Number (SSN) because the attestation is inconsistent with information contained in certain records or electronic data sources used by the Marketplace. If an individual's eligibility information was not fully verified by the Marketplace[8], their information must be sent to the state to resolve any inconsistencies identified by the Marketplace. The state must promptly

[6] The Outbound Response Account Transfer is a deferred response, as it is not sent until the state has made a final determination regarding the individual's eligibility for Medicaid and CHIP.

[7] Per 42 CFR § 431.10(c)(1)(i)(A)(5)

[8] As outlined in 42 CFR § 435.948 and § 435.956(c). Verification issues in the Marketplace related to Medicaid or CHIP eligibility may occur when an individual's income, Social Security Number (SSN), residency, and/or citizenship/immigration status is unverified or if the Marketplace finds that information obtained by data source are not consistent with the individual's attestation. States must ensure that any pending or inconsistency-related verification issues are resolved prior to a final Medicaid and CHIP eligibility determination.

enroll an individual if that individual's eligibility information was fully verified by the Marketplace. If individuals are determined eligible, the state must enroll them in the appropriate eligibility group in a timely manner. Determination state status can provide a more seamless eligibility experience for the consumer in such states, in addition to reducing burden on state eligibility workers and systems. There are currently eight determination states.

- For assessment states, the state uses the Marketplace's preliminary assessment of MAGI-based Medicaid and/or CHIP eligibility to make a final determination of eligibility. The state must complete any necessary verifications and conduct a final Medicaid and CHIP eligibility determination[9].If individuals are determined eligible, the state must enroll them in the appropriate eligibility group in a timely manner. There are currently twenty-four assessment states.

- In all states served by the Marketplace (that is, in both determination and assessment states), the state Medicaid or CHIP agency must make final eligibility determinations for all non-MAGI referrals[10]. If individuals are determined eligible, the state must enroll them in the appropriate eligibility group in a timely manner.

Prior to the launch of the Federal Marketplace in 2013, state Medicaid and CHIP agencies underwent system changes to integrate with the legacy AT service to comply with CMS regulations. The legacy AT service is still in use today to share account information between state agencies and the Marketplace. In the legacy AT service, states and the Marketplace transmit account information in accordance with a prescribed data model (also known as a payload). The payload of account information passes through the Federal Data Services Hub (Hub) for validation before it is received by either the state or the Marketplace for processing.

Despite several enhancements since its inception, the legacy AT service has some technical challenges and operational gaps, which can lead to an often-complicated process for individuals transitioning between Medicaid, CHIP, and Marketplace coverage. Specifically, the legacy AT service utilizes a rigid Extensible Markup Language (XML)-based data model with insufficient data quality controls, leading to incomplete and inaccurate data. This results in individuals having to fill out a new application with the Marketplace to receive an eligibility determination for Marketplace coverage. Further, while account information can be transferred between the states and the Marketplace, there is variation among states regarding the circumstances and timing in which ATs are sent to the Marketplace. Finally, while the Marketplace and states routinely verify information prior to transferring an account, verification information is not consistently reused by the entity receiving the account, leading to potential unnecessary re-verification of information. Collectively, these challenges serve as a barrier to continuous coverage, which in turn impacts eligible individuals' access to care. As a result, the legacy AT service falls short of the ACA's envisioned "No-Wrong-Door" mandate.

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[9] As outlined in 42 CFR § 435.948 and § 435.956(c). Verification issues at the Marketplace may occur when an individual's income, Social Security Number (SSN), residency, and/or citizenship/immigration status is unverified or if the Marketplace finds that data sources are not aligned with the individual's attestation. States must ensure that any pending or inconsistency-related verification issues are resolved prior to a final Medicaid and CHIP eligibility determination.

[10] Accounts are automatically sent via Outbound AT from the Marketplace to the state Medicaid and CHIP agency for a non-MAGI Medicaid determination if an individual attests to certain screening questions, is receiving Title II income related to disability, or is at least 65 years old.

Account Transfer (AT) 2.0

To address these challenges, CMS is working on a multi-year effort to overhaul the legacy AT service to ensure that eligible individuals have a greater chance of maintaining continuous coverage as they move between Medicaid, CHIP, and the Marketplace. Termed Account Transfer (AT) 2.0, these services aim to streamline the individuals' experience, modernize technology associated with the AT process, and enhance technical assistance to states. New AT 2.0 services are envisioned as an eventual replacement for the legacy AT service.

To improve our communications and clarity in documentation regarding AT 2.0, CMS is updating how account transfer is described to plain language descriptions, as seen in the table below.

Legacy AT	AT 2.0
Inbound AT	State-initiated AT
Outbound AT	Marketplace-initiated AT
Outbound Response AT	State Response AT

Below are some planned improvements for these new AT 2.0 services:

- *Modernized Data Format*: The AT 2.0 data model will use a JavaScript Object Notation (JSON)-based data model. This update not only ensures that the data model is flexible and easy to update, it also aligns the AT data format with the Marketplace's eligibility system. This alignment is anticipated to speed up the time to make an eligibility determination and improve the experience for individuals.

- *Enhanced Data Quality*: The AT 2.0 data model will have a core set of well-defined data elements that are consistently formatted. This core set of data will be accompanied by a robust set of data quality controls to ensure that data is consistent. Operationally, this means that the Marketplace and states will be able to reliably reuse AT data, where appropriate, to support business and process needs. For example, the Marketplace and states will be able to perform the required reuse of verification information as outlined under 42 CFR § 435.1200(d)(2) and 45 CFR § 155.345(g)(3), thereby minimizing redundant verification processing and requests for documentation.[11]

- *Streamlined Eligibility*: CMS is planning for improved eligibility processes at the Marketplace to effectively reuse data received from states through the AT process. The robust and consistent data received as a result of the new AT 2.0 data quality controls will support

[11] Per 42 CFR § 435.945(j) and § 457.380(j), state Medicaid and CHIP agencies must develop, and update as modified, a verification plan that describes verification policies adopted by the State agency to implement the provisions outlined in § 435.940 - 435.956. Additionally, as noted above, states must resolve all pending or inconsistency-related verification issues prior to a final Medicaid and CHIP eligibility determination. CMS encourages states to share feedback on how AT 2.0 services can better support state reuse of verification data.

accurate and streamlined eligibility determinations. Reliable data from the Marketplace may also provide information that states can leverage as part of their verification procedures, as applicable.

- *Reduced Burden on Individuals*: AT 2.0 services will support smooth coverage transitions for eligible individuals. When AT data is reliable and reusable, CMS expects that individuals will be able to review and submit a pre-populated Marketplace application and enroll in Marketplace coverage without resubmitting information that was previously provided to the state. States may seek to adopt similar streamlined processes to ease the burden on individuals transitioning to Medicaid and CHIP coverage from the Marketplace. This process will result in a highly streamlined application review and submission process for individuals.

- *Improved Traceability*: AT 2.0 services will support clearer traceability of individuals moving between Medicaid, CHIP, and the Marketplace coverage. Incorporating key lessons from unwinding, AT 2.0 services are anticipated to help prevent coverage overlaps, reduce coverage gaps for populations that disproportionately experience churn, and generally improve data analysis. AT 2.0 will include new data that will enhance the ability of CMS and states to track coverage and individuals' applications across programs. Greater traceability will allow CMS and states to craft messaging and user experiences tailored to individuals' specific circumstances, as well as to analyze coverage trends. Additionally, CMS is committed to providing clear guidelines and scenarios for when states and the Marketplace are expected to send ATs.

State Engagement

Feedback from state Medicaid and CHIP agencies is a cornerstone of the AT 2.0 initiative. Given that AT 2.0 services will be used by all states that utilize the Marketplace on the Federal platform, robust state engagement ensures that CMS accounts for varying levels of state Medicaid and CHIP system modernization. In that vein, in 2024, CMS convened a group of six volunteer states – Alaska, Hawaii, Iowa, New Hampshire, South Carolina, and Tennessee – to gather early input on AT 2.0 services from both assessment and determination states. CMS is working directly with these states and their systems vendors to gather their initial and ongoing input to ensure that draft specifications for the AT 2.0 services are as responsive to state Medicaid and CHIP agency needs as possible.

Specifically, these volunteer states will help inform the AT 2.0 data model early in the design process, by reviewing and offering early input to the draft AT 2.0 data model. This first round of volunteer state review will include a focus on draft data elements, associated definitions, and data quality controls for both State-initiated and Marketplace-initiated AT. These six states and their systems vendors will also review draft technical documentation. In addition, these states will provide feedback on CMS' notional timing for launching AT 2.0 services.

CMS is also planning additional opportunities to gather state perspectives on AT 2.0 and welcomes all states to participate in refining AT 2.0 materials. This multipronged engagement approach ensures that state feedback on feasibility, development, and implementation is woven into the structure and rollout of AT 2.0 services.

- In late 2025, CMS plans to release the full draft AT 2.0 data model for review by all states and their systems vendors. This second round of review prior to finalization will be focused on clarity and usability of AT 2.0 documentation. Input from all-state review will be taken into consideration as CMS finalizes the data model.

- Beginning in 2027, states who have chosen to serve as early adopters will connect to and test AT 2.0 services. CMS will work closely with these states as they modernize their IT systems, conduct testing, and fully onboard to AT 2.0 services. These states will offer critical feedback regarding AT 2.0 timelines and will inform onboarding expectations for all states.

State Medicaid and CHIP Agency Responsibilities

CMS anticipates that the AT 2.0 initiative can make meaningful improvements to individuals' experience when they transition between the Marketplace and Medicaid and CHIP by ensuring that AT data is reliable and usable for eligibility and verification purposes. The AT 2.0 initiative will also ultimately reduce burden on state systems and workers. CMS acknowledges that states are working hard to comply with various regulatory requirements that require systems changes. To support a successful adoption of technical and process changes, CMS will offer in-depth technical assistance to states as they align with new AT 2.0 services. As technical data and process specifications for AT 2.0 services are finalized and shared, states can anticipate the following:

- States should plan to include AT 2.0 and related system changes as part of their multi-year IT plans, including the possibility of supporting legacy AT and AT 2.0 services simultaneously. States will be expected to continue use of legacy AT until they can fully migrate to AT 2.0 services.

- States may need to identify whether AT 2.0 specifications require updates to state eligibility systems, processes, and/or state applications, including any funding needs. As a reminder, state Medicaid agency IT System costs may be eligible for enhanced federal financial participation (FFP). Approval for enhanced match requires the submission of an Advanced Planning Document (APD). A state may submit an APD requesting approval for a 90/10 enhanced match for the design, development and implementation of their Medicaid Enterprise Systems (MES) initiatives that contribute to the economic and efficient operation of the program and ensure compliance with the requirements reiterated in this CIB including the maintenance and operations of these services. Interested states should refer to 45 CFR Part 95 Subpart F – Automatic Data Processing Equipment and Services-Conditions for FFP for the specifics related to APD submission. States may also request a 75/25 enhanced match for ongoing operations of CMS approved systems. Interested states should refer to 42 CFR Part 433 Subpart C – Mechanized Claims Processing and Information Retrieval Systems for the specifics related to systems approval.

- All states will be required to test and onboard to all AT 2.0 services. CMS will outline minimum requirements and deadlines in the future. Following state cutover to AT 2.0 services, CMS will continue monitoring AT data quality and processing.

Conclusion

Achieving the ACA's "No-Wrong-Door" mandate will require continued close collaboration between CMS, state Medicaid and CHIP agencies, health insurance issuers, advocates, and others. Collectively, AT 2.0 services will embrace modernized technology, bolster systems efficiency, and reduce burden on eligible individuals, especially those who are disproportionately burdened by administrative processes of applying and maintaining coverage through Medicaid, CHIP, or the Marketplace. CMS values state Medicaid and CHIP agencies as trusted partners in creating seamless coverage transitions for eligible individuals between insurance affordability programs. CMS encourages states to share any initial questions or feedback by emailing CMS at **AT2.0Feedback@cms.hhs.gov**.