



COMBINED MEDICAID 104-1

Retroactive Medicaid

Supersedes: CMA 05/01/2017

Reference: ARM 37.82.101, .204, .704, .904, .1111, 37.83.202; 42 CFR 435.914; 42; CFR 435.915; P.L. 119-21

Overview: Effective 1/1/2027, Medicaid coverage may be provided for up to one month immediately preceding the month of application or a new coverage request for ACA Adult Expansion programs and up to two months for all other Medicaid programs (excluding HMK programs). The request can be made any time after initial application or new coverage request as long as the requested retroactive month is within the 365 days that the provider has to bill. For pregnancy related coverage, retroactive Medicaid cannot be established prior to the month of conception.

If Medicaid is already open on a case and a new Medicaid request is received for an individual not currently receiving Medicaid, the retroactive month or months are from the coverage request date for that individual.

Retroactive coverage is available to clients who would have been eligible for Medicaid at the time services were received if they had applied or requested coverage.

A system notice, either approving or denying retroactive coverage is sent any time retroactive coverage is requested. This information is included in the application approval/denial notice if retroactive coverage is processed at the same time. If retroactive coverage is requested on the application (the applicant indicates that he/she has medical bills for any allowable retroactive month(s) prior to application), the eligibility staff member must process that coverage request timely. If retroactive coverage is denied, a denial notice must be sent that provides the eligibility determination for all requested months.

For SSA (Social Security Administration) applicants, see Disability Determination Overview ABD 105-1 Disability Determination.

FINANCIAL ELIGIBILITY:

Retroactive Medicaid coverage may be provided for one month for ACA Adult Expansion programs or up to two months for other programs immediately prior to the application or coverage request date. The client must meet all financial and non-financial eligibility requirements for each retroactive month. Actual income for the retro month(s) is required, and resources must be verified for ABD related programs.

NOTE: HMK and QMB do not allow retro

The applicant does not need to be eligible in the application month to be eligible for retroactive Medicaid coverage. As long as they were eligible in the retroactive months, coverage for those month(s) is provided. Use actual income received and expenses incurred in the retroactive month or months when determining retroactive eligibility. For programs with a resource limit, if the applicant is resource eligible any day of the month, he/she is considered resource eligible for the entire month.

NOTE: Citizenship/immigration status and identity verification is required when processing retroactive Medicaid requests.

NOTE: For clients requesting ACA Adult or ACA Adult-Medicaid retroactive coverage, the individual must have met a community engagement requirement or have a temporary exclusion in the month prior to the requested retroactive month. This is called the 1-month lookback. If the individual qualifies for an exclusion in the eligibility month, they are not subject to community engagement requirement.

CONTINUED BENEFITS:

A retroactive month cannot be used to create an ongoing span if the client was not eligible in the application month or the month after.

RETROACTIVE COVERAGE FOR SSI RECIPIENTS:

For SSA applicants, see Disability Determination Overview, ABD 201-1 Disability Determination.

Effective Date: 07/01/2026