DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 435, 457, and 600

[CMS–2421–P]

RIN 0938–AU00

Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This rulemaking proposes changes to simplify the processes for eligible individuals to enroll and retain eligibility in Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program. This proposed rule would remove barriers and facilitate enrollment of new applicants, particularly those dually eligible for Medicare and Medicaid; align enrollment and renewal requirements for most individuals in Medicaid; establish beneficiary protections related to returned mail; create timeliness requirements for redeterminations of eligibility in Medicaid and CHIP; make transitions between programs easier; eliminate access barriers for children enrolled in CHIP by prohibiting premium lock-out periods, waiting periods, and benefit limitations; and modernize recordkeeping requirements to ensure proper documentation of eligibility and enrollment.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 7, 2022.

ADDRESSES: In commenting, please refer to file code CMS–2421–P.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2421–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2421–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Stephanie Bell, (410) 786–0617, *Stephanie.Bell@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that website to view public comments.

I. Background

Since 1965, Medicaid has been a cornerstone of America's health care system. The program provides free or low-cost health coverage to low-income individuals and families and helps to meet the diverse health care needs of children, pregnant individuals, parents and other caretaker relatives, older adults, and people with disabilities. For 25 years, the Children's Health Insurance Program (CHIP) has served as a bridge from Medicaid to private insurance for somewhat higher-income children. As of May 2022, the most recent month for which enrollment data are available, nearly 89 million individuals were enrolled in Medicaid and CHIP.[1]

Access to health coverage expanded significantly in 2010 with enactment of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010), together referred to as the Affordable Care Act (ACA). The ACA expanded Medicaid eligibility to low-income adults under age 65 without regard to parenting or disability status, simplified Medicaid and CHIP enrollment processes, and established health insurance Marketplaces where individuals without access to Medicaid, CHIP, or other comprehensive coverage could purchase coverage in a Qualified Health Plan (QHP). Many individuals with household income above the Medicaid and CHIP income standards became eligible for premium tax credits and/or cost-sharing reductions to help cover the cost of the coverage. In addition, the ACA provided States with the option of establishing a Basic Health Program (BHP), which provides affordable health coverage to individuals whose household income exceeds 133 percent but does not exceed 200 percent of the Federal Poverty Level (FPL) (that is, lower income individuals who would otherwise be eligible to purchase coverage through the Marketplaces with financial subsidies). BHPs allow States to provide more affordable coverage for these individuals and to improve the continuity of care for those whose income fluctuates above and below the Medicaid and CHIP levels. To date, two States, New York and Minnesota, have established BHPs, covering over 1 million people.[2]

In addition to coverage expansion, the ACA also required the establishment of a seamless system of coverage for all insurance affordability programs (that is, Medicaid, CHIP, BHP, and the insurance affordability programs available through the Marketplaces). In accordance with sections 1943 and 2107(e)(1)(T) of the Social Security Act (the Act) and sections 1413 and 2201 of the ACA, individuals must be able to apply for, and enroll in, the program for which they qualify using a single application submitted to any program. In the March 23, 2012 **Federal Register**, CMS issued implementing regulations titled ''Medicaid program; Eligibility Changes Under the Affordable Care Act of 2010'' final rule, (77 FR 17144) (referred to hereafter as the ''2012 eligibility final rule''), and the ''Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment'' final rule titled in July 2013 (78 FR 42160) (referred to hereafter

[1] May 2022 Medicaid & CHIP Enrollment Data Highlights—*https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.*

[2] *https://www.cms.gov/files/document/health-insurance-exchanges-2022-open-enrollment-report-final.pdf.*

as the ''2013 eligibility final rule''). These regulations focused on establishing a single streamlined application, aligning financial methodologies and procedures across insurance affordability programs, and maximizing electronic verification in order to create a streamlined, coordinated, and efficient eligibility and enrollment process for eligibility determinations based on Modified Adjusted Gross Income (MAGI).

Significant progress has been made in simplifying eligibility, enrollment, and renewal processes for applicants and enrollees, as well as reducing administrative burden on State agencies administering Medicaid, CHIP, and BHP, since the promulgation of these regulations. The dynamic online applications developed by States and the Federally Facilitated Marketplaces, which ask only those questions needed to determine eligibility have reduced burden on applicants. Greater reliance on electronic verifications has reduced the need for individuals to find and submit, and for eligibility workers to review, copies of paper documentation, decreasing burden on both States and individuals and increasing program integrity. Renewals completed using electronic information available to States have increased retention of eligible individuals, while also decreasing the administrative burden on both States and enrollees.

Following a period of steady growth attributed to the ACA, enrollment in Medicaid and CHIP declined from 2017 through 2019. Evidence suggests that the economy was the primary driver of this decline. However, we also know that more restrictive State enrollment policies contribute to coverage disruptions and create churning as people lose their Medicaid or CHIP coverage and then re-enroll within a short period of time.[3] The Georgetown University Center for Children and Families estimated that 4.4 million children were uninsured in 2019, an increase from 2016 of 726,000 uninsured children. Looking at uninsurance among children by income, those with household income below 138 percent of the FPL (133 percent of the FPL is the minimum income standard that States may establish for children in Medicaid, plus a 5 percentage point disregard), the percentage of Medicaid-eligible children who did not have any health insurance coverage increased from 6.8 percent in 2016 to 7.7 percent in 2019.[4] Based on the most recently available data from the American Community Survey, children in poverty continued to experience an increase in uninsurance from 2018 through 2020 as the uninsurance rate increased by 1.6 percentage points to 9.3 percent.[5] The raw numbers represented by these percentage changes correspond to a large number of individual children who were uninsured despite having a household income low enough to be eligible for Medicaid and who may have deferred or foregone needed health care as a result.

Additionally, enrollment in Medicare Savings Programs (MSPs), through which Medicaid provides coverage of Medicare premiums and/or cost-sharing for lower income Medicare beneficiaries, has remained relatively low. The MSPs are essential to the health and economic well-being of those enrolled, promoting access to care and helping free up individuals' limited income for food, housing, and other of life's necessities. Yet a 2017 study conducted for Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that only about half of eligible Medicare beneficiaries were enrolled in MSPs.[6]

The critical role of Medicaid and CHIP providing timely health care access to the most vulnerable individuals was highlighted as the Novel Coronavirus 2019 (''COVID–19'') spread across our country beginning in 2020. Medicaid and CHIP helped to provide a lifeline for those who may have lost their jobs or been exposed to COVID–19, or both, and they played a critical role in the national pandemic response. The Families First Coronavirus Response Act (Pub. L. 116–127) (FFCRA) conditioned a temporary increase in Federal Medicaid funding on State compliance with several conditions, including maintaining enrollment for beneficiaries enrolled in Medicaid through the end of the month in which the COVID–19 public health emergency (PHE) ends (''continuous enrollment condition''). Additionally, the FFCRA, along with the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; Pub. L. 116–135) and the American Rescue Plan Act of 2021 (ARP; Pub. L. 117–2), also ensured Medicaid and CHIP coverage of COVID–19 testing, treatment, and vaccines, as well as vaccine administration.

The Biden-Harris Administration is committed to protecting and strengthening Medicaid and CHIP both during and following the COVID–19 PHE. On January 20, 2021, President Biden issued an Executive Order on advancing racial equity and support for underserved communities. It charged Federal agencies with identifying potential barriers that underserved communities may face to enrollment in programs like Medicaid and CHIP.[7] This was followed on January 28, 2021, by Executive Order 14009 with a specific call to strengthen Medicaid and the ACA and remove barriers to obtaining coverage for the millions of individuals who are potentially eligible but remain uninsured.[8] In April 2022, President Biden issued another Executive Order, building on progress from the first and reflecting new Medicaid and CHIP flexibilities established by the ARP. The April 5, 2022 Executive Order 14070, ''Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage'' charges Federal agencies with identifying ways to help more Americans enroll in quality health coverage.[9] It calls upon Federal agencies to examine policies and practices that make it easier for individuals to enroll in and retain coverage. Following this charge, we reviewed the improvements made to implement the ACA, examined States' successes and challenges in enrolling eligible individuals, considered the changes brought about by the COVID–19 PHE, and looked for gaps in our regulatory framework that continue to impede access to coverage.

We have learned through our experiences working with States and other stakeholders that certain policies continue to result in unnecessary administrative burden and create barriers to enrollment and retention of

[3] Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID–19 Pandemic; accessed on 8/30/21 at *https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.*

[4] Alker, Joan and Corcoran, Alexandra. 2020. ''Children's Uninsured Rate Rises by Largest Annual Jump in More than a Decade.'' Accessed on 03/16/2022 at *https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf.*

[5] Katherine Keisler-Starkey and Lisa N. Bunch, U.S. Census Bureau Current Population Reports, P60–274, Health Insurance Coverage in the United States: 2020, U.S. Government Publishing Office, Washington, DC, September 2021.

[6] *Medicare Savings Program Enrollees and Eligible Non-Enrollees,* Kyle J. Caswell, Timothy A. Waidmann, The Urban Institute, June 2017: *https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.*

[7] E.O. 13985, 86 FR 7009. Accessed online on July 19, 2022 at *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.*

[8] E.O. 14009, 86 FR 7793. Accessed online on July 19, 2022 at *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/.*

[9] E.O. 14070, 87 FR 20689. Accessed online on July 19, 2022 at *https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/.*

coverage for eligible individuals. For example:

- There are no regulations to facilitate enrollment in the MSPs. In particular, CMS does not have regulations to link enrollment in other Federal programs with the MSPs, despite the high likelihood that individuals in such programs are eligible for the MSPs. This hinders States' ability to enroll those known to be eligible. Additionally, stakeholders report that burdensome documentation requirements substantially impede eligible individuals from enrolling in the MSPs.[10]
- Individuals whose eligibility is not based on MAGI (non-MAGI individuals)—for example, those whose eligibility is based on being age 65 or older, having blindness, or having a disability—generally were not included in the enrollment simplifications established under the ACA or our implementing regulations (the 2012 and 2013 eligibility final rules), leaving such individuals at greater risk of being denied or losing coverage due to procedural reasons than their MAGI-based counterparts, even though, we believe, many are more likely to remain Medicaid eligible due to lower likelihood of changes in their income or other circumstances.
- Current regulations do not consistently provide clear timeframes for applicants and enrollees to return information needed by the State to make a determination of eligibility or for States to process and act upon information received. This may lead to unnecessary delay in processing applications and renewals, some ineligible individuals retaining coverage, and some individuals being denied increased assistance for which they have become eligible.
- Our recordkeeping regulations, which are critical to ensuring appropriate and effective oversight to identify errors in State policies and operations, were last updated in 1986 and are both outdated and lacking in needed specificity. We believe these outdated requirements have contributed to inconsistent documentation policies across States, which may have furthered the incidence of Medicaid improper payments.
- Barriers to coverage that are not permitted under any other insurance affordability program—including lock-outs for individuals terminated due to non-payment of premiums, required periods of uninsurance prior to enrollment, and annual or lifetime caps on benefits—remain a State option in separate CHIPs.

In this rulemaking, we seek to close these and other gaps, thereby streamlining Medicaid and CHIP eligibility and enrollment processes, reducing administrative burden on States and enrollees, and increasing enrollment and retention of eligible individuals. We also seek to improve the integrity of Medicaid and CHIP. Through the PERM program, the Medicaid Eligibility Quality Control (MEQC) program, and other CMS eligibility reviews, we have regular opportunities to work with States in reviewing their eligibility and enrollment processes. As a result of these reviews, and other internal program integrity efforts, States are continually making improvements to their eligibility and enrollment systems both to enhance functionality and to correct any newly identified issues. We believe the changes proposed in this rule will further these program integrity efforts, and we will continue to work closely with States throughout implementation.

Current regulations at 42 CFR 433.112 establish conditions that State eligibility and enrollment systems must meet in order to qualify for enhanced Federal matching funds. Among these conditions, § 433.112(b)(14) requires that each State system support accurate and timely processing and adjudications/eligibility determinations. As States submit proposed changes to their eligibility and enrollment systems and implement new and/or enhanced functionality, we will continue to provide them with technical assistance on the policy requirements, conduct ongoing reviews of both the State policy and State systems, and ensure that all proposed changes support more accurate and timely processing of eligibility determinations.

We will also continue to explore other opportunities for reducing the incidence of beneficiary eligibility-related improper payments, including leveraging the enhanced funding available for design, implementation, and operation of State eligibility and enrollment systems, as well as mitigation and corrective action plans that address specific State challenges. Our goal is to ensure that eligible individuals can enroll and stay enrolled without unnecessary burden and that ineligible individuals are redirected to the appropriate coverage programs as quickly as possible.

Finally, we recognize that the COVID–19 PHE and the continuous enrollment condition have disrupted routine eligibility and enrollment operations for Medicaid, CHIP, and BHP. As States look ahead toward the eventual end of the PHE and the resumption of routine operations, they are faced with providing coverage for a significantly larger pool of enrollees than they have ever had to manage in the past. From February 2020 through May 2022, enrollment in Medicaid and CHIP increased by 25.9 percent, or 18.3 million individuals, and new applications continue to be submitted. In May 2022, about 2.1 million new applications for Medicaid and CHIP were submitted to States. At the same time, many States report a shortage of eligibility workers.

CMS is actively engaged with States as they plan for initiating eligibility and enrollment work over the course of a 12-month unwinding period when the COVID–19 PHE ends (hereinafter referred to as the ''unwinding period''). A March 2022 report by the Urban Institute projected that as many as 15.8 million people could lose their Medicaid coverage when the PHE ends and the continuous enrollment requirement is no longer in effect.[11] It is a CMS priority to ensure that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage.

As we consider the challenges faced by States during the unwinding period, we seek comment on reasonable implementation timelines for the provisions in this proposed rule, which would allow States to move these important protections forward without negatively impacting the resumption of routine eligibility and enrollment operations. Certain provisions designed to improve the retention of eligible individuals, such as the prospective deduction of medical expenses for medically needy individuals, agency actions on returned mail, and transitions between coverage programs, could reduce the likelihood of eligible individuals losing health coverage during unwinding. However, if implementing such provisions early would divert needed resources away

[10] In October 2020, CMS engaged with 55 stakeholders across four States to better understand experiences when applying for the MSPs. One of the main findings was that burdensome documentation requirements substantially impede eligible individuals from enrolling in the MSPs and that easing these requirements is a critical step to ensuring individuals can obtain and retain these critical benefits.

[11] Buettgens, M. and Green, A. 2022. *What will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency*. Washington, DC: Urban Institute. Accessed on July 19, 2022 at *https://www.urban.org/research/publication/what-will-happen-medicaid-enrollees-health-coverage-after-public-health-emergency*.

from critical unwinding-related activities, then a compliance date following the unwinding period may be preferred.

We recognize that each State faces a unique set of challenges related to the unwinding period, with differing needs and opportunities. As we contemplate the timing of a final rule, we are considering adopting an effective date of 30 days following publication and a separate compliance date, which may vary by requirement, with full compliance no later than 12 months following the effective date of the final rule. This approach would provide States with immediate access to new options, like the option to establish an earlier effective date for coverage provided to individuals eligible in the QMB group. This approach also would allow States to immediately extend temporary options authorized under section 1902(e)(14)(A) of the Act as they prepare for unwinding, like the option to rely on certain third-party information to update a beneficiary's mailing address. And it would permit States with greater capacity to implement new system changes to immediately adopt simplifications like removal of the requirement to apply for other benefits as a condition of Medicaid eligibility.

At the same time, we recognize that certain changes proposed in this rule may require States to make changes to their own statute and/or regulations, as well as systems changes prior to implementation, and this process can take time. For example, if the proposed prohibition on premium lock-out periods, which delay a child's ability to re-enroll in a separate CHIP following termination of coverage due to the family's failure to pay premiums, is finalized, we would provide CHIPs that currently impose such lockout periods with the time needed to comply with the new prohibition. At the same time, by making the final rule effective 30 days following enactment, States could not newly adopt a premium lock-out period.

We seek comment on whether an effective date of 30 days following publication would be appropriate when combined with a later date for compliance for most provisions. We seek comment on the timeframe that would be most effective for compliance with each provision and whether the compliance date should vary by provision. We believe compliance with the proposed provision implementing current statutory requirements (the requirement to utilize Medicare Part D Low-Income Subsidy ''leads'' data from SSA to initiate an MSP application) should be required 30 days following publication of the final rule, because we do not have flexibility to delay what is required under the statute. New State options established under the final rule would be effective 30 days following publication, but do not require a compliance date, since States are not required to adopt optional policies. We would encourage States to come into compliance with all other new requirements as expeditiously as possible, not only because they would improve access for new applicants and improve retention of eligible enrollees, but also because they would streamline eligibility and enrollment processes and promote the overall integrity of Medicaid and CHIP. However, for proposed provisions that do not create State options and are not implementing statutory requirements, we are considering compliance dates of 90 days, 6 months, and/or 12 months following the effective date of the final rule. We seek comment on the appropriate compliance timeframe for each provision, and request that commenters explain why they believe finalizing a shorter or longer compliance timeframe is most appropriate.

II. Provisions of the Proposed Regulations

A. Facilitating Medicaid Enrollment

1. Facilitate Enrollment Through Medicare Part D Low-Income Subsidy ''Leads'' Data (§§ 435.4, 435.601, 435.911, and 435.952)

The MSPs consist of several mandatory Medicaid eligibility groups that cover Medicare Part A and/or B premiums and, in some cases, cost-sharing. State Medicaid agencies receive applications and adjudicate eligibility for full Medicaid, as well as MSP-only benefits. Currently, the MSP eligibility groups cover over 10 million low-income individuals. There are three primary MSP eligibility groups: [12] the Qualified Medicare Beneficiary (QMB) group, which pays all of an individual's Medicare Parts A and B premiums and assumes liability for most associated Medicare cost-sharing charges for people with income that does not exceed 100 percent of the FPL; the Specified Low-Income Medicare Beneficiary (SLMB) group, which pays the Part B premium for people with income that exceeds 100 percent, but is less than 120 percent, of the FPL; and the Qualifying Individuals (QI) group, which pays Part B premiums for people with income at least 120 percent but less than 135 percent of the FPL. Individuals also must meet corresponding resource criteria in order to be eligible for an MSP. The income and resource requirements for coverage under the MSPs, and the benefits to which eligible individuals are entitled, are set forth at sections 1905(p)(1) and 1902(a)(10)(E) of the Act. Among other things, section 1905(p) of the Act directs that the income and resource methodologies applied by the Social Security Administration (SSA) in determining SSI eligibility per sections 1612 and 1613 of the Act be used to determine financial eligibility for the MSPs, except that States may employ less restrictive income and/or resource methodologies than those applied in determining SSI eligibility under the authority of section 1902(r)(2) of the Act.

The MSPs are essential to the health and economic well-being of low-income Medicare enrollees, helping to free up limited income for food, housing, and other life necessities. For example, in 2022, the Part B premium is $170.10 a month, which is more than 10 percent of the income of individuals who qualify for the QI group, and an even higher percentage of income for those who qualify for the QMB or SLMB groups. Despite the importance of the MSPs, a 2017 study conducted for MACPAC estimated that only about half of eligible individuals enrolled in Medicare were also enrolled in the MSPs.[13] This means that millions of Medicare enrollees living in poverty are paying over 10 percent of their income to cover Medicare premiums alone. Complex MSP enrollment processes contribute to this low participation

[12] There is a separate and fourth MSP eligibility group generally referred to as the ''Qualified Disabled Working Individuals (QDWI) group,'' or QDWI group. As described in 1902(a)(10)(E)(ii), eligibility in the QDWI group is limited to individuals whose incomes do not exceed 200 percent of the FPL; whose resources do not exceed twice the relevant SSI resource standard (that is, for a single individual or couple); and who are eligible to enroll in Part A under section 1818A of the Act. Section 1818A of the Act permits individuals who became entitled to Part A on the basis of their receipt of Social Security disability insurance (SSDI) and who subsequently lose SSDI after returning to work (and, hence, entitlement to Part A) to enroll in Part A contingent on paying the Part A premiums. The medical assistance available to QDWIs is the coverage of the Part A premiums. The QDWI group is not included in this proposal, because the income limits of the QDWI group are significantly higher than LIS and there does not exist the flexibility to disregard resources that are available for the other MSPs.

[13] Medicare Savings Program Enrollees and Eligible Non-Enrollees, Kyle J. Caswell, Timothy A. Waidmann, The Urban Institute, June 2017: *https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.*

rate.[14] [15] In order to address the barriers to accessing MSP coverage, in 2008 Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110–275). MIPPA included new requirements for States to leverage the Medicare Part D Low-Income Subsidy (LIS) program to help enroll likely-eligible individuals in MSPs.

The Medicare Part D LIS program, also sometimes referred to as ''Extra Help,'' is administered by SSA and pays Medicare Part D prescription drug premiums and cost-sharing for over 13 million individuals with low income. Full premium subsidy LIS (or ''full LIS'') generally pays the Part D premiums and deductibles in full and sets co-payments for drugs at between $0 and $9.85 (in 2022) for people with incomes below 135 percent of the FPL [16] [17] who also meet certain resource criteria. To receive this benefit, individuals complete an application and submit it to SSA. Once received, SSA verifies the information provided on the LIS applications and determines eligibility. Income, resources and other eligibility criteria for the LIS program are defined at section 1860D–14 of the Act. Under section 1860D–14(a)(3)(C)(i) of the Act, income shall be determined in the manner described in section 1905(p)(1)(B) of the Act, without regard to the application of section 1902(r)(2) of the Act and except that support and maintenance furnished in kind shall not be counted as income. Section 1860D–14 of the Act provides that, for purposes of determining eligibility for the LIS program, applicants' resources be calculated ''as determined under section 1613 of the Act for the purposes of the supplemental security income (SSI) program subject to a life insurance exclusion policy.'' The SSA has also adopted several other regulatory and sub-regulatory methodological simplifications for the LIS program that deviate from SSI rules. These include the exclusion of interest and dividend income and non-liquid resources and burial funds.

The MSP and LIS programs both assist individuals with incomes below 135 percent of the FPL [18] in accessing the Medicare benefits to which they are entitled and, as illustrated above, generally use a common methodology to determine income and resource eligibility. Current regulations at 42 CFR 423.773(c) require that individuals enrolled in MSPs be automatically enrolled in LIS, but the reverse is not true, and many people enrolled in the LIS program are not enrolled in an MSP, despite likely being eligible. As mentioned above, MIPPA included several provisions to promote the enrollment of LIS applicants into the MSPs. In addition, section 112 of MIPPA amended section 1905(p)(1)(C) of the Act to increase the resource limit for the QMB, SLMB, and QI MSP eligibility groups to the same resource limit applied for full LIS established at section 1860D–14(a)(3) of the Act. The resource standard for the full LIS program and the QMB, SLMB, and QI eligibility groups for 2022 is $8,400 for a single individual and $12,600 for a couple.

Section 113 of MIPPA amended section 1144 of the Act to further eliminate barriers to enrollment in the MSP and LIS programs. Section 1144(c)(3) of the Act requires SSA to transmit data from LIS applications (''leads data'') to State Medicaid agencies. Section 1144(c)(3) of the Act also provides that the electronic transmission from SSA ''shall initiate'' an MSP application. MIPPA section 113 also added a new paragraph at section 1935(a)(4) of the Act that, beginning January 1, 2010, required States to accept leads data and ''act upon such data in the same manner and in accordance with the same deadlines as if the data constituted'' an MSP application submitted by the individual. As such, under § 435.912, States have 45 days to make an MSP eligibility determination based on the LIS data. The date of the MSP application is defined as the date of the individual's application for LIS under section 1935(a) of the Act.

Despite these statutory requirements, not all States initiate an MSP application upon receipt of leads data from SSA. CMS data reflect that over a million individuals enrolled in full LIS are not enrolled in an MSP. Given near alignment of MSP and LIS eligibility criteria, most of these individuals are likely eligible for an MSP eligibility group (See November 1, 2021 Center for Medicaid and CHIP Services Informational Bulletin, ''Opportunities to Increase Enrollment in Medicare Savings Programs'').[19]

The January 28, 2021 Executive Order on Strengthening Medicaid and the ACA directs agencies to address policies and practices that may present unnecessary barriers to individuals and families attempting to access Medicaid coverage,[20] the April 5, 2022 Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage charges Federal agencies with identifying ways to help more Americans enroll in quality health coverage,[21] and the December 13, 2021 Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government supports streamlining State enrollment and renewal processes and removing barriers to ensure eligible individuals are automatically enrolled in and retain access to critical benefit programs.[22] As such, we have evaluated CMS's regulatory authority to reduce barriers to enrollment of eligible individuals into the MSPs. Under the authority in section 1902(a)(4) of the Act to specify ''methods of administration'' that the Secretary finds to be ''necessary for the proper administration'' of State plans, we propose several regulatory changes to promote efficient enrollment in the MSPs by maximizing State use of LIS leads data. We believe these proposals will also have a positive impact on health equity by helping to provide more low-income individuals with access to additional health coverage consistent with the January 20, 2021 Executive Order.[23]

Accepting LIS leads data as an MSP application. As noted above, under section 1935(a)(4) of the Act, SSA must

[14] Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors, and Implications, Office of the Assistant Secretary for Planning and Evaluation, 2019. *https://aspe.hhs.gov/basic-report/loss-medicare-medicaid-dual-eligible-status-frequency-contributing-factors-and-implications.*

[15] Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment, Government Accountability Office, 2012. *https://www.gao.gov/assets/gao-12-871.pdf.*

[16] Section 1860D–14 of the Act [42 U.S.C. 1395w–114].

[17] Partial premium subsidy LIS (or ''partial LIS'') generally pays for premiums on a sliding scale, from 100 percent to 25 percent paid, and sets deductibles and co-payments for drugs at a reduced level for people with income below 150 percent of the FPL who meet certain resource criteria.

[18] Section 11404 of the Inflation Reduction Act of 2022 (Pub. L. 117–169, enacted on August 16, 2022) increases the income limit for the full LIS program to income below 150 percent of the FPL and increases the resource limit to the same resource limit as applied for partial LIS program at section 1860D–14(a)(3)(E) of the Act beginning January 1, 2024.

[19] Available at *https://www.medicaid.gov/federal-policy-guidance/downloads/cib11012021.pdf.*

[20] *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/.*

[21] *https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/.*

[22] *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/12/13/executive-order-on-transforming-federal-customer-experience-and-service-delivery-to-rebuild-trust-in-government/.*

[23] *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.*

transmit the LIS leads data to States, and States must use that data to initiate an application for the MSPs. On February 18, 2010, CMS issued a State Medicaid Director Letter (SMDL #10–003), ''Medicare Improvements for Patients and Providers Act of 2008 (MIPPA),'' explaining that, ''starting January 1, 2010, the State is directed to treat the [leads] data as an application for MSP benefits, as if it had been submitted directly by the applicant.'' Additionally, the guidance explained, ''States must act on the data as an application for MSP benefits, even if the LIS application was denied by SSA.'' [24] We reiterated the 2010 guidance in 2020 through updates to the Manual for the State Payment of Medicare Premiums.[25]

In this rulemaking, we propose to codify in regulation the statutory requirements for States to maximize the use of leads data to establish eligibility for Medicaid and the MSPs. We anticipate that codifying these requirements will lead to more eligible individuals enrolling in MSPs because we believe that some States may have been unaware or unclear of the steps required to meaningfully use the leads data to streamline eligibility and enrollment in the MSPs.

Currently, all States receive leads data from SSA each business day. This data includes information on the individual's address, income, resources and household size that SSA has verified.[26] Per section 113 of MIPPA, States must accept, via secure electronic transfer, the SSA leads data and process that information to initiate an MSP application. However, we are aware that several States do not use the leads data to begin the application process. For example, upon receipt of the leads data, some States simply send the individual a letter that encloses a blank application or instructions on how to apply for the MSPs. Such practices fall short of States' statutory obligation to treat receipt of leads data as an application and to evaluate individuals' eligibility using the leads data.

We propose to add a definition of LIS leads data at § 435.4 and a new paragraph (e) to § 435.911 of the regulations to clearly delineate the steps States must take upon receipt of leads data from SSA. We propose to define LIS leads data to mean data from an individual's application for low-income subsidies under section 1860D–14 of the Act that the SSA electronically transmits to the appropriate State Medicaid agency as described in section 1144 (c)(1) of the Act. Proposed § 435.911(e)(1) requires States to accept, via secure electronic interface, the SSA LIS leads data. Proposed paragraph (e)(2) requires that States treat receipt of the leads data as an application for Medicaid and promptly and without undue delay, consistent with the timeliness standards at § 435.912, determine MSP eligibility without requiring submission of a separate application.

We recognize that State Medicaid agencies generally will need to request additional information in order to make a determination of eligibility, as some differences remain in income and resource counting methodologies between the LIS and MSPs. In addition, the leads data transmitted to the State does not include information on an individual's citizenship or immigration status, and therefore, States will need to ask individuals for their status, which must be verified in accordance with sections 1137(d), 1902(ee) or 1903(x) of the Act and §§ 435.956(a) and (b), 435.406 and 435.407, if such information is not already in the casefile and has been verified in a previous application. As such, we propose at paragraph (e)(3) of § 435.911 that States must request additional information in order to make a determination of eligibility for MSPs. We also recommend that when States request additional information from individuals, they include information on how to contact the local State Health Insurance Assistance Program (SHIP) for assistance.

However, consistent with existing regulations at §§ 435.907(e) and 435.952(c), we propose at paragraph (e)(4) of § 435.911 that States may only require that individuals provide information needed to complete an eligibility determination if information needed for such determination is not available to the agency or if information available to the agency through an electronic data match or other means is not reasonably compatible with information provided by or on behalf of the individual. Thus, under the proposed rule, States may not request that individuals attest or otherwise provide documentation to establish information contained in leads data, which SSA has already verified and confirmed for the LIS eligibility determination.

Note that a State is not in compliance with the statutory requirement in section 1935(a)(4) of the Act to initiate an application based on leads data or with the proposed regulation if it requires the individual to file a new application for MSP, since the leads data already provides much of the information that would otherwise be requested on an application. Further, as discussed in more detail below, States have the flexibility under section 1902(r)(2) of the Act to align the methodologies applied in determining MSP eligibility with the methodologies for determining eligibility for LIS. Additionally, we highly recommend completely aligning financial methodologies for determining LIS and MSP eligibility as a program integrity best practice. If a State chooses such complete alignment in financial methodologies between the LIS and MSP programs, under the proposed rule the State may not require additional financial information from an individual for whom the State has received leads data in order to make a determination of MSP eligibility.

The LIS leads data that is transferred to State agencies has been verified by the SSA. Thus, we believe that State verification of this data prior to adjudicating eligibility is duplicative and inefficient. Consistent with the Secretary's authority under section 1902(a)(4) of the Act (relating to establishment of such methods of administration as the Secretary determines ''necessary for proper and efficient administration'' of the Medicaid program) and section 1902(a)(19) of the Act (relating to simplicity of administration and the best interests of recipients), we also propose at § 435.911(e)(5) that States accept the information verified by SSA and provided through the leads data as verified, provided that the information provided through the LIS leads data supports a determination of eligibility under section 1902(a)(10)(E) of the Act.

The Computer Matching and Privacy Protection Act at 5 U.S.C. 522a(p)(1) requires States to take actions to independently verify information that SSA provides before the State may terminate, suspend, reduce, deny, or take other adverse action against an individual. Therefore, in instances in which the leads data would not support a determination of eligibility for MSPs, we propose at § 435.911(e)(7) to require that States use the attested information provided by the applicant to SSA through the LIS application process and separately verify the individual's eligibility for Medicaid in accordance with the State's verification policies.

[24] State Medicaid Director Letter, #10–003, ''Medicare Improvements for Patients and Providers Act of 2008 (MIPPA),'' page 2. Available at *https://www.medicaid.gov/federal-policy-guidance/downloads/smd10003.pdf*.

[25] Chapter 1, section 1.11.

[26] The leads data also includes information on the LIS subsidy amount and denial reasons, which States can use to immediately identify if the individual is ineligible for MSPs.

Specifically, under proposed § 435.911(e)(7), the State would be required to (1) determine whether additional information is needed to make a determination of eligibility for an MSP; (2) if additional information is needed, notify the individual that they may be eligible for assistance with their Medicare premium and/or cost sharing charges, but that additional information is needed for the agency to make a determination of such eligibility; (3) provide the individual with a minimum of 30 days to furnish any information needed by the agency to determine MSP eligibility; and (4) verify the individual's eligibility for an MSP in accordance with the State's verification plan developed in accordance with § 435.945(j). We note that, in the case of an applicant who has attested to income or assets over the applicable income or resource standard, States can, but are not required to, request additional information from the individual to confirm ineligibility for coverage.

We note that, under our proposal, States may continue to request from the individual information necessary to make an eligibility determination but that is missing from the leads data or other third-party sources. Pursuant to § 435.952(c), States may also seek information from the individual if the State has other information that is not reasonably compatible [27] with the leads data; however, we anticipate such circumstances with respect to financial eligibility will be extremely rare since SSA generally relies on the same sources for financial eligibility data also relied upon by States and the data from SSA will in most instances be the most current.

Finally, individuals eligible for the LIS program may be eligible for full Medicaid benefits, in addition to the assistance with Medicare premiums and cost-sharing available under the MSPs. Under the current regulations at § 435.911, for individuals who submit the single streamlined application used for individuals applying for Medicaid on the basis of MAGI, but who may be eligible on a basis other than MAGI, States are required to collect any additional information that is needed to make a determination on a non-MAGI basis, and to make such determination if the individual provides the needed information. Consistent with sections 1902(a)(4) and (a)(19) of the Act, we propose a similar requirement with respect to individuals whose application was initiated by receipt of LIS leads data. Specifically, under proposed § 435.911(e)(6), States would be required to collect such additional information as may be needed to determine whether such individuals are eligible for Medicaid in any other eligibility groups (that is, other than the MSPs), including other non-MAGI groups and MAGI-based groups as well. We believe this proposal would codify a pathway for efficient enrollment of LIS enrollees into both the appropriate MSP eligibility group, as well as into a full-benefit group if eligible without imposing undue administrative burdens on States. We believe this would also promote program integrity. We note that individuals can be eligible for both an MSP and an eligibility group that confers full Medicaid benefits. Therefore, the requirement under proposed § 435.911(e)(6) is in addition to the requirement to determine the individual's eligibility for an MSP.

Streamlining Methodologies. As mentioned previously, the income standard for the LIS program and the highest income standard for the MSPs is similar, the resource standard for all MSPs and the LIS is the same until January 1, 2024, and the methodologies for both programs are very closely aligned. However, the differences in income and resource methodologies prevent LIS enrollees from being seamlessly enrolled into the MSPs unless the State has elected to align the MSP methodologies with LIS methodologies by adopting certain income and resource disregards under section 1902(r)(2) of the Act.

As discussed above, the two methodologies differ slightly in that several types of income and resources that are counted in determining MSP eligibility are not counted in determining LIS eligibility.[28] States have the flexibility to achieve full alignment of the MSP and LIS methodologies. Specifically, under section 1902(r)(2) of the Act, codified in regulation at § 435.601(d), States have the option to use less restrictive income and resource methodologies in making eligibility determinations for most non-MAGI eligibility groups, including the MSPs. States can use this authority to align MSP methodologies with LIS methodologies by adopting less restrictive methodologies to disregard income and resources that are counted in determining MSP but not LIS eligibility. These include: (1) the following types of income: in-kind support and maintenance, dividend income, and interest income; and (2) the value of the following types of resources: non-liquid resources, burial funds, and life insurance. We expect that States have not maximized this opportunity due to competing priorities and the complexity of eligibility policy.

Under proposed § 435.911(e), States that adopt less restrictive MSP eligibility methodologies to completely align with the LIS methodologies would be able to use leads data to make a determination of MSP financial eligibility without requesting additional information from the individual (as noted above, information on citizenship and immigration status would still be needed), thus reducing administrative burden for the State and relieving LIS recipients of the need to navigate a complex application process.

States that have not fully aligned methodologies must continue to request the additional information needed to determine financial eligibility which is not provided through the leads data. In addition, as noted above, States must request information relating to U.S. citizenship and immigration status in order to verify such status in accordance with the State's usual processes. In accordance with § 435.406(a) and section 1137(d) of the Act, individuals must first make a declaration of U.S. citizenship or satisfactory immigration status in accordance with § 435.406(a). After the declaration is made, per regulations at § 435.956, States must attempt to electronically verify U.S. citizenship or satisfactory immigration status and, if such status cannot be promptly verified, the State must provide the individual with a reasonable opportunity period to provide documentation or other information needed to verify their status. During the reasonable opportunity period, the State must furnish benefits to individuals who otherwise meet all eligibility requirements and must itself continue efforts to verify the individual's status. These requirements apply equally to individuals being determined for eligibility in the MSPs following the State's receipt of leads data from SSA.

However, in accordance with the authority at section 1902(a)(4) of the Act to promote the administrative efficiency of the program and section 1902(a)(19) of the Act relating to simplicity of administration and the best interests of beneficiaries, we propose to add a new

[27] Under 42 CFR 435.952(c)(1), income information obtained through an electronic data match shall be considered ''reasonably compatible'' with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.

[28] For example, section 116 of MIPPA directs SSA not to count in-kind support and maintenance as income, and not to count the cash surrender value of life insurance policies as a resource, when determining eligibility for LIS. These statutory disregards apply only to LIS eligibility determinations and not to MSP eligibility groups.

paragraph (e) to § 435.952 to require that States adopt a number of enrollment simplification policies related to the income and resources that are counted in determining MSP, but not LIS, eligibility that would enable State agencies to use the leads data more efficiently, reduce burden on applicants and States, and increase the number of LIS enrollees successfully enrolled in the MSPs. We also anticipate these policies would have a positive health equity impact by increasing access to Medicare coverage for low-income individuals and increasing the financial security of those who successfully enroll consistent with the January 20, 2021 Executive Order.[29]

Finally, we anticipate that these enrollment simplifications will help reduce the high rate of churn that dually eligible individuals experience, largely due to administrative reasons such as providing documentation of certain income and assets to demonstrate their continued eligibility. Analysis by the Assistant Secretary for Planning and Evaluation (ASPE) for the Department of Health and Human Services in 2019 examined data from years 2007 through 2009 and found that 29.1 percent of individuals lost Medicaid eligibility for at least 1 month during the first year of transitioning to full-benefit dual eligibility and 21.1 percent lost Medicaid eligibility for at least 3 months following the transition despite dually eligible individuals' relatively stable income and assets over time.[30] Experts interviewed noted that dually eligible beneficiaries most often lost coverage because of failing to comply with administrative requirements as opposed to changes in income, assets, or functional status. In 2021, CMS performed similar analysis on data from years 2015 through 2018 and found similar results: 29.1 percent of individuals lost Medicaid eligibility for at least 1 month during the first year of transitioning to full-benefit dual eligibility and 24.1 percent lost Medicaid eligibility for at least 3 months following the transition.[31] The proposed simplifications for each source of income and resource are discussed below.

We note that our proposals would not change the income and resource rules for individuals applying for non-MAGI eligibility groups other than the MSPs. We propose simplifying income and resource policies for the MSP eligibility groups given the narrow scope of assistance available under these groups (limited to assistance with Medicare premiums and/or cost-sharing assistance), their smaller numbers of eligible and enrolled individuals relative to other non-MAGI eligibility groups, and MIPPA provisions which closely align them with the LIS program, which does not count these types of income and resources. We seek comment on extending the proposals below to all individuals seeking eligibility on a non-MAGI basis. We also seek comment on extending the proposal relating to verification of dividend and interest income to individuals seeking eligibility based on MAGI, as well as whether there are additional income or resource types to which the proposals below could be extended for all individuals.

Interest and Dividend Income. Regulations governing LIS eligibility determinations at 20 CFR 418.3350(d) exclude all interest and dividend income earned on resources owned by the applicant or their spouse. However, under the SSI income methodologies applicable to MSP determinations, States must count interest and dividend income, unless they have elected to disregard such income using the authority provided under section 1902(r)(2) of the Act and 42 CFR 435.601(d).

Based on stakeholder reports and program experience, we believe that the vast majority of individuals likely to qualify for an MSP eligibility group do not have significant interest or dividend income, whereas the requirement to timely obtain and furnish acceptable statements from financial institutions, sometimes extending back over a lengthy period of time, to document interest and dividend income earned is unduly burdensome for applicants and provides negligible program integrity value. Therefore, consistent with section 1902(a)(19) of the Act, in order to minimize undue administrative burden on applicants, we are proposing at § 435.952(e)(1)(i) and (ii) to prohibit States from requesting documentation of dividend and interest income prior to making a determination of MSP eligibility, except when the agency has information that is not reasonably compatible with the applicant's attestation. Under the proposed rule, States would be required to accept self-attestation of dividend and interest income for MSP applicants and their spouse, but would retain the option to verify such income after the individual has been enrolled (a process, currently available at State option with respect to most eligibility criteria, which we refer to as ''post-enrollment verification''), including the option to require the individual to provide documentation of interest or dividend income if electronic verification is not available.

We seek comment on the utility of post-enrollment verification and whether it results in unnecessary procedural denials of eligible individuals. If a State chooses to conduct post-enrollment verification checks, under proposed § 435.952(e)(1)(iii) it must allow individuals at least 90 calendar days to respond to requests for documentation. We seek comment on the proposal to require that States provide individuals with at least 90 calendar days to respond to requests for additional information in this situation and whether States should be required to provide, at a minimum, a shorter period of time, such as at least 30 or 60 calendar days. If a State found that an individual has income exceeding the income standard during the post-enrollment verification process, the State would take appropriate action consistent with regulations at § 435.916(d) (redesignated and revised at proposed regulations at § 435.919 in this rulemaking), including determining eligibility on other potential bases and, if not eligible on any basis, providing advance notice and fair hearing rights prior to terminating MSP coverage. Section 435.952(e)(1)(ii) clarifies that States must request documentation prior to making an initial determination to deny eligibility if they have information that is not reasonably compatible with the applicant's attestation in accordance with § 435.952(c)(2).

As discussed above, under section 1902(r)(2) of the Act, States also have the ability to disregard interest and dividend income entirely, which would bring treatment of interest and dividend income in determining eligibility for MSPs into alignment with the LIS program. We encourage States to consider adoption of such an income disregard, as it is unlikely that an applicant could have both investments large enough to generate significant interest or dividend income and resources and still satisfy the resource test for the LIS or MSP benefits.

Non-liquid resources. For LIS eligibility determinations, under 20 CFR 418.3405, SSA only counts liquid

[29] *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/*.

[30] Assistant Secretary for Planning and Evaluation (ASPE) (2019). Loss of Medicare-Medicaid dual eligible status: Frequency, contributing factors and implications. *https://aspe.hhs.gov/system/files/pdf/261716/DualLoss.pdf*.

[31] CMS completed an updated internal analysis of ASPE's study in 2021 using data from 2015–2018 that shows that dually eligible individuals continue to lose Medicaid at a high rate in their first year due to administrative reasons.

resources, which it defines as cash, financial accounts, and other financial instruments that can be converted to cash within 20 workdays. Non-liquid resources, such as an automobile, are not counted for LIS eligibility.[32] However, SSI rules in section 1613 of the Act, which apply to MSP determinations, have a broader definition of countable resources that includes non-liquid resources; for example, while SSI excludes one automobile for resource-eligibility purposes, a second automobile is countable. This can be onerous for MSP applicants because it can be difficult to timely determine, and furnish acceptable documentation of, the value of something that cannot easily be sold. Similar to interest and dividend income, consistent with section 1902(a)(19) of the Act and in order to minimize administrative burdens on individuals, we are proposing at § 435.952(e)(2)(i) to require that States accept applicants' attestation of the value of any non-liquid resources, except, as described at proposed § 435.952(e)(2)(ii), when the State has information that is not reasonably compatible with the individual's attestation. However, as with dividend and interest income, as described at proposed § 435.952(e)(2)(iii), States would retain the option to conduct post-enrollment verification, including the option to require the individual to provide documentation of non-liquid resources if electronic verification is not available, and to take appropriate action, consistent with regulations at § 435.916(d) (redesignated and revised at proposed regulations at § 435.919 in this rulemaking), if the State determines the individual greatly undervalued or failed to disclose resources. If the agency elects to conduct verifications post-enrollment, and documentation is requested, the agency must provide the individual with at least 90 calendar days from the date of the request to respond and provide any necessary information requested. As with dividend and interest income, § 435.952(e)(2)(ii) clarifies that States must request documentation prior to making an initial determination denying eligibility if they have information that is not reasonably compatible with the applicant's attestation in accordance with § 435.952(c)(2). Finally, States also may use authority at section 1902(r)(2) of the Act to disregard the value of all non-liquid resources.

Burial funds. Under section 1613(d)(1) of the Act, which applies to both LIS and MSP determinations, up to $1,500 in burial fund are to be excluded for the applicant (and an additional $1,500 for their spouse) so long as the burial fund is ''separately identifiable and has been set aside.'' The statute does not, however, prescribe how the funds must be separately identifiable. Current SSA policy allows LIS applicants to attest to having $1,500 in burial funds, which may be co-mingled with other funds in a single account (see SSA Program Operations Manual Systems [POMS] HI 03030.020 Resource Exclusions Section B.3.). However, consistent with section 1905(p)(1)(C) of the Act, which directs that SSI's resource methodologies be used to determine MSP-related resource eligibility, States typically require applicants to provide documentation that their burial funds are set aside in a separate account, as provided under SSI's burial fund-related methodology described in 20 CFR 416.1231(b). This creates a misalignment between LIS and MSP methodologies and imposes additional burdens on MSP applicants.

We propose in § 435.952(e)(3)(i) to require that States, when determining eligibility for the MSPs, allow individuals to self-attest that up to $1,500 of their resources, and up to $1,500 of their spouse's resources, are set aside as burial funds in a separate account and therefore are not countable as resources for MSP determinations. Proposed § 435.952(e)(3)(ii) clarifies that States must request documentation prior to making an initial determination of ineligibility if they have information that is not reasonably compatible with the applicant's attestation in accordance with § 435.952(c)(2). As in the proposed provision for interest and dividend income and non-liquid resources, and described at § 435.952(e)(3)(iii), States would retain the option to conduct post-enrollment verification, including obtaining documentation of resources in burial funds, and taking appropriate action, consistent with regulations at § 435.916(d) (redesignated and revised at proposed regulations at § 435.919 in this rulemaking). If the agency elects to conduct verifications post-enrollment, and documentation is requested, the agency must provide the individual with at least 90 calendar days from the date of the request to respond and provide any necessary information requested. Again, we seek comment on the 90-day response period in this situation and whether States should be required to provide, at a minimum, a shorter period of time, such as least 30 or 60 calendar days. Finally, States may also use authority at section 1902(r)(2) of the Act to disregard all or a greater amount of burial funds or to not require that the burial funds be held in a separate set-aside account.

Life Insurance Policies. Section 116 of MIPPA, codified at section 1860D–14(a)(3)(G) of the Act, eliminated the value of life insurance policies as a countable resource for LIS determinations. However, under the SSI resource methodologies described in section 1613(a) of the Act, which, as noted above, apply to MSP-related resource eligibility determinations per section 1905(p)(1)(C) of the Act, the cash surrender value of life insurance with a total face value exceeding $1,500 is countable. Term life insurance policies do not have a cash surrender value and are not a countable resource under SSI methodologies described in 20 CFR 416.1230(a). Because term life insurance is not relevant to the Medicaid eligibility determination, States are not permitted to request information about the face value of such policies.

We have received reports from advocates that obtaining documentation of a life insurance policy's cash surrender value is highly burdensome for applicants. A life insurance policy's cash surrender value depends on the market, the length of time the policyholder has paid premiums, and other factors. Further, the cash surrender value is not knowable solely from the documents a policyholder is likely to have. To obtain the current cash surrender value of a policy, an applicant generally must contact the company that has issued the policy, request a statement of the current cash surrender value and then submit that statement to the State agency once obtained. This can pose a significant hurdle to applicants, leading to denials for otherwise eligible applicants.

To reduce this burden on applicants, we encourage States to use their authority under section 1902(r)(2) of the Act to disregard a higher face value of life insurance policies or to disregard the cash surrender value of life insurance policies altogether. A few States currently disregard policies with face values of at least up to $10,000, which eliminates administrative hurdles for most individuals, while ensuring that those comparatively few applicants who own substantial policies have the value of those policies counted in their eligibility determinations.

Under proposed § 435.952(e)(4)(i), if an individual attests to having a life insurance policy with a face value

[32] The exception to this rule is that the equity value of any real property than an individual owns other than the individual's primary place of residence is counted as a resource.

below $1,500, States must accept the attested face value for purposes of making an initial eligibility determination for MSP coverage, unless the State has information that is not reasonably compatible with attested information. If the total face value of all of an individual's life insurance policies does not exceed $1,500, the cash surrender value of the individual's policies is not counted in determining MSP eligibility pursuant to sections 1613(a)(16) and 1905(p)(1)(C) of the Act. As with attested interest and dividend income, non-liquid assets, and burial funds, States would be required, as specified at proposed § 435.952(e)(4)(ii), to request additional information if they have information not reasonably compatible with the attested value prior to enrolling the individual in coverage in accordance with § 435.952(c)(2). Per current § 435.952(c)(2), the agency may accept a reasonable explanation from the applicant or require documentation.

Under proposed § 435.952(e)(4)(i)(A), if an individual attests to having a life insurance policy with a face value in excess of $1,500, consistent with current regulations at § 435.948, States may accept the attested cash surrender value. If the State has information that is not reasonably compatible with the attested value of the policy, we propose, at § 435.952(e)(4)(ii), that the State must seek additional information from the individual in accordance with § 435.952(c)(2). Per current § 435.952(c)(2), the agency may accept a reasonable explanation from the applicant or require documentation.

Per proposed § 435.952(e)(4)(iii), States would have the option to conduct post-enrollment verification for individuals enrolled based on an attested value. In conducting post-enrollment verification, if a State determines that the face value of the policy exceeds $1,500, then the State must redetermine the cash surrender value, consistent with regulations relating to changes in circumstances at § 435.916(d) (redesignated and revised at § 435.919 in this proposed rule), as described above and seek the cash surrender value on behalf of the individual consistent with § 435.952(e)(4)(iv)(A). If, in redetermining eligibility, including the cash surrender value of the policy, once obtained, the State determines the individual to be ineligible for an MSP, the State would need to consider eligibility on other potential bases and provide advance notice and fair hearing rights in accordance with part 431 subpart E of the regulations prior to terminating MSP coverage.

We also propose at § 435.952(e)(4)(iv)(A) that when documentation of the cash surrender value of a life insurance policy is required, the State must assist the individual with obtaining this information and documentation by requesting that the individual provide the name of the insurance company and policy number and authorize the State to obtain such documentation on the individual's behalf, similar to the assistance that SSA provides SSI applicants, in which SSA obtains from the applicant basic information about the policy and authorization to contact the insurer, and then confirms the cash surrender value directly with the life insurance company itself.[33] The agency may also request, but may not require, additional information from the applicant to assist the agency in obtaining documentation of the cash surrender value, such as the name of an agent. If the individual does not provide basic information about the policy and an authorization, under proposed § 435.952(e)(4)(iv)(B), the State may require that the individual provide documentation of the cash surrender value. Under proposed § 435.952(e)(4)(iv)(C), the State must provide the individual with at least 15 calendar days to provide such documentation if required pursuant to paragraph (e)(4)(i) or (ii) of this section (that is, if documentation of the cash surrender value is needed prior to the agency's making a determination of eligibility) and at least 90 calendar days if required pursuant to paragraph (e)(4)(iii) of this section (that is, post-enrollment). We note that the minimum of 15 calendar days in proposed § 435.952(e)(4)(iv)(C) for applicants to provide documentation of cash surrender value of a life insurance policy is consistent with the minimum 15 calendar days that we propose States must generally provide applicants to provide required documentation under proposed at § 435.907(d), discussed in section II.B.3 of this proposed rule. We seek comment on whether 15 calendar days or a longer minimum period, such as 20 calendar days or 30 calendar days, appropriately balances the complexity of determining and obtaining documentation of the cash surrender value with the 45-day limit for States to complete Medicaid eligibility determinations for individuals applying on a basis other than disability status under § 435.912(c)(3). The 90 calendar days proposed for individuals to obtain documentation of the cash surrender value of a life insurance policy during a post-enrollment verification process is consistent with the 90 calendar days in proposed paragraphs (e)(1)(iii), (e)(2)(iii), and (e)(3)(iii) of § 435.952.

We recognize this proposal would represent a significant change for a number of States and could present some administrative challenges to implement. However, documenting the cash surrender value of life insurance is a considerable hurdle for many applicants. Because the cash surrender value of most applicants' policies is likely very modest, the value of any life insurance policy likely will have a minimal impact on their financial eligibility for coverage, whereas obtaining documentation of the cash surrender value may pose a substantial administrative barrier to access. We believe it is in the interest of efficient administration of the program, consistent with section 1902(a)(4) of the Act, to implement a process that places fewer burdens on applicants. We also believe that States are better able to navigate obtaining such documentation when needed. We seek comment on whether the burden shifted to States under the proposed rule is appropriate, or whether an alternative approach would be preferable.

In-Kind Support and Maintenance. In-kind support and maintenance is assistance an applicant receives that is paid for by someone else, such as groceries or utilities paid for by an adult child. Section 1860D–14(a)(3)(C)(i) of the Act, added by section 116 of MIPPA, excludes in-kind support and maintenance as countable income for LIS determinations. Under SSI methodologies at 20 CFR 416.1131, which apply to MSP determinations, the value of in-kind support and maintenance, if both food and shelter are received by an applicant, is presumed to be one-third of the Federal benefit rate (FBR) ($841 per month in 2022 for a single person), unless the applicant provides documentation demonstrating a different amount. While documenting the amount of actual in-kind support and maintenance can be difficult for applicants, we do not believe it is common for applicants to attempt to rebut the one-third FBR presumption, and therefore, it is rare that applicants are faced with providing documentation of this type of income.

Under the proposed rule, States would continue to be permitted to require documentation from individuals who seek to rebut the one-third FBR presumption. However, we seek comment on if obtaining documentation to rebut the one-third presumption

[33] See SSA POMS SI 01130.300.D., Developing Life Insurance Policies at *http://policy.ssa.gov/poms.nsf/lnx/0501.130300*.

poses a barrier to eligibility and whether we should require States to accept self-attestation from individuals who seek to rebut a presumption of the amount of in-kind support and maintenance they receive subject to post-enrollment verification as discussed above. Alternatively, States can, and are encouraged to, further streamline the MSP eligibility and enrollment process for individuals with in-kind maintenance and support by disregarding in-kind support and maintenance entirely under section 1902(r)(2) of the Act.

2. Define ''Family of the Size Involved'' for the Medicare Savings Program Groups Using the Definition of ''Family Size'' in the Medicare Part D Low-Income Subsidy Program (§ 435.601)

To further facilitate alignment of methodologies used to determine eligibility for the Medicare Part D LIS and MSP groups and facilitate enrollment in the MSPs based on LIS data, we propose to amend § 435.601 (''Application of financial eligibility methodologies'') to create a new paragraph (e), in which we propose to define ''family size'' for purposes of MSP eligibility.

Each year, the U.S. Department of Health and Human Services (HHS) issues the Federal poverty guidelines (often referred to as the Federal poverty level or FPL), a measure of poverty used as an eligibility criterion by Medicaid and a number of other Federal programs. The FPL is a dollar amount that increases with the family size of an individual. For example, in 2022, in terms of annual income, the FPL is $13,590 for a single person, $18,310 for a couple, and $23,030 for a family of three.

Under section 1905(p)(2)(A) and (B) of the Act, QMB-eligible individuals have incomes that do not exceed 100 percent of the FPL ''applicable to a family of the size involved.'' Section 1905(s)(2) of the Act similarly directs that Qualified Disabled Working Individual (QDWI)-eligible individuals have incomes that do not exceed 200 percent of the FPL ''applicable to a family of the size involved.'' Section 1902(a)(10)(E)(iii) and (iv) of the Act also direct that the income standards for the SLMB and QI eligibility groups be percentages of the FPL ''applicable to a family of the size involved.'' As described above, SLMBs have incomes greater than 100 percent of the FPL and less than 120 percent of the FPL, and QIs have incomes at least equal to 120 percent of the FPL and less than 135 percent of the FPL. The statute does not define the phrase ''family of the size involved'' and CMS has historically permitted States to apply their own reasonable definition of this phrase.[34]

However, in light of the various statutory provisions to facilitate enrollment of LIS recipients into MSPs and vice versa, we believe it is appropriate to establish Federal standards governing the phrase ''family of the size involved.''

Specifically, we propose for purposes of determining eligibility for the MSP groups, consistent with our authority under section 1902(a)(4) of the Act to facilitate methods of administration that promote the proper and efficient administration of the Medicaid program, that ''family of the size involved'' be defined to include at least the individuals included in the definition of ''family size'' in the LIS program. Under § 423.772 (''Definitions'' relating to the LIS program), ''family size'' is defined to include the applicant, the applicant's spouse (if the spouse is living in the same household with the applicant), and all other individuals living in the same household who are related to the applicant and dependent on the applicant or applicant's spouse for one-half of their financial support.

By proposing that a State's definition of ''family of the size involved'' include ''at least'' the individuals described in § 423.772 for purposes of the MSP groups, States would retain flexibility to include other individuals who are not described in § 423.772. Additionally, this proposal would not affect the States' ability to adopt a different reasonable definition of the phrase for purposes of other eligibility groups. For example, in order to be eligible under section 1902(a)(10)(A)(ii)(XIII) of the Act (providing coverage for working individuals with disabilities), an individual must have income that is less than 250 percent of the FPL for a ''family of the size involved.'' States would not be required to adopt the definition at proposed § 435.601(e) for purposes of determining income eligibility for this eligibility group. We seek comment on this proposal to define ''family of the size involved'' for purposes of the MSP groups.

[34] Memorandum from Director, Center for Medicaid and State Operations, to Regional Administrator, Re: Medicaid Eligibility—Policy Governing Family Size in Determining Eligibility for Qualified Medicaid Beneficiaries and Specified Low-Income Beneficiaries. Oct. 2, 1997. Available at *https://www.medicaid.gov/sites/default/files/2019-12/medicaid-eligibilty-memo.pdf.*

3. Automatically Enroll Certain SSI Recipients Into the Qualified Medicare Beneficiaries Group (§ 435.909)

SSI is a Federal cash assistance program that serves low-income individuals who are age 65 or older, or have blindness or a disability. SSI recipients typically qualify for other Federal and State programs. For example, many SSI recipients are entitled to Medicare under 42 CFR 406.5(a) and (b). Additionally, in most States, the receipt of SSI is a mandatory basis for Medicaid eligibility pursuant to section 1902(a)(10)(A)(i)(II)(aa) of the Act, implemented at § 435.120 (''Individuals receiving SSI group,'' hereafter the ''mandatory SSI group''). Thirty-three States and the District of Columbia (DC) that cover the mandatory SSI group have an agreement with SSA under section 1634(a) of the Act under which SSA completes the determination of eligibility for the mandatory SSI group, and the Medicaid agency automatically enrolls the individual in Medicaid following a data exchange with SSA. These States commonly are referred to as ''1634 States.'' A minority of States that cover the mandatory SSI group apply the SSI program's income and resource methodologies and disability criteria but require individuals to submit a separate application to the State Medicaid agency (''criteria States'').

Eight States do not cover the mandatory SSI group. Instead, these States have elected the authority provided under section 1902(f) of the Act to apply financial methodologies and/or disability criteria more restrictive than the SSI program in determining eligibility for individuals 65 years old or older or who have blindness or a disability, subject to certain conditions. These States are referred to as ''209(b) States,'' after the provision of section 209(b) of the Social Security Act Amendments of 1972 (Pub. L. 92–603), which enacted what became codified at section 1902(f) of the Act. The eligibility group authorized by section 1902(f) of the Act is implemented at § 435.121 (''Individuals in States using more restrictive requirements for Medicaid than the SSI requirements,'' hereafter ''mandatory 209(b) State group'').

Most Medicare-eligible SSI recipients also meet the eligibility requirements for the QMB eligibility group described in sections 1902(a)(10)(E) and 1905(p) of the Act, which provides Medicaid coverage of Medicare premiums (both Part A, if applicable, and Part B) and cost- sharing (copayments, coinsurance, and deductibles).

Section 1905(p)(1) of the Act provides that, to be eligible under the QMB group, an individual must be entitled to Medicare Part A or enrolled in Medicare Part B for coverage of immunosuppressive drugs under section 1836(b) of the Act, have income that does not exceed 100 percent of the FPL for the applicable family size, and have resources that do not exceed the limits for the full-subsidy LIS program. As described at section 1860D–14(a)(3)(D) of the Act, the full-subsidy LIS resource limit is three times the SSI resource limit, adjusted annually based on changes to the Consumer Price Index.[35] (See section II.A.1. of this proposed rule for discussion of the LIS program.) The income standard for SSI (that is, SSI's maximum Federal benefit rate) is typically 74 percent of the FPL for an individual and 83 percent of the FPL for married individuals. Thus, because the income and resource standards for the QMB group exceed the income and resource standards for SSI, individuals entitled to Medicare Part A who meet the income and resource requirements for the mandatory SSI group or mandatory 209(b) group will always meet the income and resource requirements for the QMB group and be eligible for the QMB group.

Most individuals enrolled in Medicare qualify for Part A without paying a premium (premium-free Part A). SSA automatically enrolls these individuals in premium-free Part A if they are age 65 or over and receive Social Security or Railroad Retirement Board (RRB) retirement benefits under title II of the Act or are under age 65 and have received Social Security or RRB disability benefits for 24 months under title II of the Act. See 42 CFR part 406 subpart A. In 2021, approximately 2.6 million individuals (approximately one third) of SSI recipients were entitled to premium-free Part A.[36]

Under § 406.20, many individuals who are not eligible for premium-free Part A may still enroll in Part A by applying for benefits at SSA and paying a premium (''premium Part A''). In 2022, the premium for Medicare Part A was $499; however, based on prior work history, some individuals may qualify for a reduced rate of $274. Individuals who are not eligible for premium-free Part A are not automatically enrolled in premium Part A and they must enroll in Part B prior to or at the same time as they enroll in Part A. All Medicare beneficiaries must pay a monthly premium for enrollment in Part B, which is subject to an adjustment based on income. In 2022, the minimum Part B premium was $170.10.

All States currently have a buy-in agreement with the Secretary under section 1843 of the Act which requires them to pay the Part B premiums for certain Medicaid beneficiaries, including individuals enrolled in the QMB group and those receiving SSI (known as ''Part B buy-in'') as described in the Medicare regulations at § 407.42. A buy-in agreement permits States to directly enroll eligible individuals in Medicare Part B at any time of the year (without regard for Medicare enrollment periods or late enrollment penalties if applicable) and to pay the Part B premiums on the individual's behalf. In 1634 States, when SSA determines an individual eligible for both the mandatory SSI group and Medicare Part B, CMS automatically initiates Part B buy-in for the individual through a joint data exchange among CMS, the State Medicaid agency, and SSA (''buy-in data exchange'').[37] In SSI criteria and 209(b) States, SSA notifies both the State and CMS that an individual has been determined eligible for SSI and Medicare Part B; however, because such individuals must submit a separate Medicaid application for determinations of eligibility, CMS does not automatically initiate Part B buy-in. Rather, once the State determines an individual eligible for the mandatory SSI or 209(b) group, the State must initiate Part B buy-in for the individual pursuant to its buy-in agreement through its daily exchange of enrollment data with CMS. See 42 CFR 407.40(c)(4) and 407.42; CMS Manual for the State Payment of Medicare Premiums, chapter 2, section 2.5.1.

While individuals enrolled in the mandatory SSI or 209(b) group receive full Medicaid benefits, enrollment in the QMB group provides these individuals with additional protection from out-of-pocket health care costs—specifically Medicare premiums and cost-sharing charges. Moreover, Federal law prohibits all Medicare providers and suppliers, not just those participating in Medicaid, from charging QMBs for Medicare cost-sharing. Since 2018, CMS has notified Medicare providers and suppliers when an individual is enrolled in the QMB group and protected from Medicare cost-sharing liability.

Maximizing the number of Medicaid beneficiaries who are also enrolled in Medicare is not only advantageous to the individual, but it can also result in cost savings for States. As a third-party payer, Medicare pays primary to Medicaid for Medicare Part A (inpatient hospital and skilled nursing facility services) and Medicare Part B (outpatient medical care). In addition, Medicaid beneficiaries who are enrolled in both Medicare Parts A and B may join Medicare-Medicaid integrated care plans, which provide more coordinated care across the two payers and may generate savings to the State by helping beneficiaries avoid institutional placement and by providing supplemental benefits, such as dental, transportation, hearing, or other benefits that otherwise would have been covered by Medicaid.

Despite the potential benefits for Medicaid beneficiaries and State agencies, CMS data from 2022 indicates that over 500,000 or 16 percent of SSI recipients who are eligible to enroll in Medicare are not enrolled in the QMB eligibility group. We believe a major driver of eligible but unenrolled QMBs is that many States require SSI recipients to file a separate application with the State Medicaid agency in order to be evaluated for eligibility for the QMB group, even though they have been determined eligible for the mandatory SSI or 209(b) groups, and all SSI recipients who are entitled or able (with a premium) to enroll in Part A necessarily meet the requirements for QMB eligibility.

To facilitate the enrollment of SSI recipients into the QMB eligibility group we propose, consistent with section 1902(a)(4) of the Act to promote the proper and efficient administration of the Medicaid program, the January 28, 2021 Executive Order on Strengthening Medicaid and the Affordable Care Act, the April 5, 2022 Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage, and the December 13, 2021 *Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government,* to add a new paragraph (b) at § 435.909 that generally would require States to deem an individual enrolled in the mandatory SSI or 209(b) group eligible for the QMB group the

[35] The resource limit for LIS is three times the SSI limit with yearly updates since January 1, 2010 to reflect to reflect Consumer Price Index (CPI). Note that the MSP resource test is determined without regard to the life insurance policy exclusion for Part D LIS, in accordance with section 1902(p)(1)(C).

[36] *SSI Monthly Statistics, September 2021,* Social Security Office of Retirement and Disability Policy 2021. *https://www.ssa.gov/policy/docs/statcomps/ssi_monthly/2021-09/table01.html.*

[37] States with buy-in agreements must exchange buy-in enrollment data with CMS on a daily basis under § 407.40(c)(4), and CMS also exchanges buy-in data with SSA on a daily basis. CMS collectively refers to these data exchange processes as the ''buy-in data exchange.'' See Manual for the State Payment of Medicare Premiums, chapter 2, sections 2.0 and 2.1.

month the State becomes responsible for paying the individual's Part B premiums under its buy-in agreement pursuant to § 407.47(b). We also propose technical changes to remove reserved paragraph (a) at § 435.909, redesignate § 435.909 paragraph (b) as (a) and add a new header to new § 435.909(a).

We note that under section 1902(e)(8) of the Act, QMB eligibility is effective the month following the month in which the determination of eligibility for the QMB group is made. Thus, under our proposal, QMB coverage would start the month following the month the State deems (that is, determines) an individual eligible for the QMB group and starts paying the individual's Part B premiums under the buy-in agreement. For example, if an individual is first enrolled in both the mandatory SSI or 209(b) Medicaid group and entitled to Part A in January 2025, the State would start paying the individual's Part B premiums under the buy-in agreement and deem the individual eligible for the QMB group in January 2025. The individual's QMB coverage would start February 1, 2025.

SSI Recipients Who Have Premium-Free Medicare Part A

As noted above, SSA automatically enrolls individuals who receive Social Security or RRB retirement benefits or disability benefits for 24 months into premium-free Part A. SSA data for States (including those with a 1634 agreement and those without a 1634 agreement) indicates whether an SSI recipient is entitled to premium-free Part A. As discussed above, because all SSI recipients meet the financial eligibility requirements for the QMB group, proposed § 435.909(b)(1)(i) would require all States to deem SSI recipients who are determined eligible for either the mandatory SSI group at § 435.120 or the mandatory 209(b) group at § 435.121 as eligible for the QMB group if they are entitled to premium-free Medicare Part A. Under the proposed rule, when a 1634 State (which has delegated authority to SSA to make Medicaid eligibility determinations for SSI recipients) receives from CMS the Part B buy-in enrollment for an SSI recipient who is entitled to premium-free Medicare Part A, the State would automatically enroll the individual in both the mandatory SSI group and the QMB group; such individuals would not be required to submit a separate application to the Medicaid agency to determine eligibility for the QMB group.

Criteria States and 209(b) States also obtain from CMS information that an SSI recipient is Medicare-eligible and entitled to premium-free Medicare Part A. However, in these States SSI recipients must submit a separate application to the Medicaid agency which determines eligibility for either the mandatory SSI or the 209(b) group. Under proposed § 435.909(b)(1)(i), once the State has determined an SSI recipient eligible for the mandatory SSI or the 209(b) group, the State also would start paying the Part B premiums for the individual the first month they are entitled to Part A and receiving SSI-based Medicaid and start QMB group coverage the first day of the following month.

From time to time, individuals enrolled in the mandatory SSI or 209(b) group become retroactively entitled to premium-free Medicare Part A based on a retroactive award of Social Security Disability Insurance (SSDI). Under the Medicare regulations at § 407.47(b), States generally become responsible for retroactive Part B premiums for such individuals dating back to the first month they were enrolled in the mandatory SSI or 209(b) group and eligible for Part B.[38] In an April 27, 2022 proposed rule entitled, ''Implementing Certain Provisions of the Consolidated Appropriations Act and other Revisions to Medicare Enrollment and Eligibility Rules'' (87 FR 25090) (referred to hereafter as the ''2022 Medicare eligibility and enrollment proposed rule''), we proposed adding a new paragraph (f) at § 407.47 to limit State liability for retroactive Part B premiums for full-benefit Medicaid beneficiaries, including individuals receiving SSI-based Medicaid, to a period of no greater than 36 months prior to the date of the Medicare enrollment determination. At 87 FR 25114 through 25115 of the proposed rule, we noted that this time limit would reduce burden on providers, help State Medicaid programs and the Medicare program run more efficiently, be consistent with a legal ruling in favor of States in at least one Federal court, and not harm Medicaid beneficiaries since Medicaid would have covered any medical costs the beneficiary incurred for periods in the past.

To align with that change, under § 435.909(b)(3), we propose that retroactive QMB coverage for individuals in the mandatory SSI or 209(b) group be limited to the same period for retroactive Part B premium liability proposed at § 407.47(f) in the 2022 Medicare eligibility and enrollment proposed rule. For example, if SSA determines an individual enrolled in the mandatory SSI or 209(b) group eligible for premium-free Part A in January 2025 with an effective date back to January 2023, the State would deem the individual eligible for the QMB group retroactive to January 2023. Because coverage under the QMB group begins the month after the month of the eligibility determination, QMB coverage in this example would be effective February 1, 2023. Alternatively, if SSA determines an individual enrolled in the mandatory SSI or 209(b) group eligible for premium-free Part A in January 2025 with an effective date back to January 2021, the State would deem the individual eligible for the QMB group retroactive to January 2022, with QMB coverage effective February 1, 2022. We invite comment on this limit on retroactive QMB eligibility.

Additionally, we remind States that individuals deemed eligible for Medicaid are not exempt from regularly-scheduled renewals of Medicaid eligibility in accordance with § 435.916. However, for an individual eligible under both the mandatory SSI and QMB groups, the State need only verify that the individual still receives SSI and is entitled to Medicare Part A in order to renew their eligibility in both groups. States can do this verification electronically by confirming receipt of SSI in the State Verification Exchange System or State Online Query System, and we encourage them to do so to minimize burden. When a beneficiary no longer meets the eligibility requirements for the eligibility group under which they have been receiving coverage, the State must determine eligibility on all bases before terminating eligibility.

SSI Recipients Eligible for Premium Part A

As mentioned above, individuals age 65 and over who lack the sufficient work history for premium-free Part A may qualify to pay, or have paid on their behalf, a monthly premium to receive Medicare Part A benefits.[39] To meet the requirements for premium Part A at § 406.20(b), the individual must be: age 65 or older, a U.S. resident, not otherwise entitled to Part A, entitled to Part B or in the process of enrolling in it, and a U.S. citizen or lawful permanent resident who has resided in the U.S. continuously during the 5 years immediately preceding the month they enrolled in Medicare.

[38] Individuals who are entitled to premium-free Part A are eligible to enroll in Medicare Part B under § 407.10(a)(1).

[39] Note that all individuals receiving title II benefits based on disability who have met the 24-month waiting period to enroll in Medicare are entitled to premium-free Part A.

All States must pay the Part A premium for individuals who are enrolled in the QMB eligibility group. However, States can choose one of two methods to pay the Part A premium for QMBs.[40] First, States can expand their buy-in agreement with CMS under section 1818(g) of the Act to include enrollment and payment of Part A premiums for QMBs who do not have premium-free Part A. Currently, 36 States and the District of Columbia have chosen this option. States that include payment of Part A premiums for QMBs in their buy-in agreements are called ''Part A buy-in States.'' In Part A buy-in States, individuals determined eligible for the QMB group can enroll in premium Part A at any time of the year and without regard to late enrollment penalties. Fourteen States do not include Part A in their buy-in agreements and instead pay the Part A premiums for QMBs using a group payer arrangement, which allows certain third parties (for example, States) to pay the Part A premiums for a class of beneficiaries.[41] States that use a group payer arrangement for QMBs are known as Part A ''group payer States.''

As previously noted, in order to qualify for the QMB eligibility group under section 1905(p)(1) of the Act, an individual must be entitled to hospital insurance benefits under Part A of title XVIII. Being ''entitled to'' Part A means that if an individual receives Part A-covered services, the costs of those services will be covered by Medicare. See 42 CFR 406.3. In general, an individual becomes so entitled to Part A if—(1) they are eligible for premium-free Part A based on payment of a payroll tax; or (2) are eligible to enroll in Premium Part A and do enroll (creating a Part A premium obligation). The premium payment is due for each month beginning with the first month of coverage. 42 CFR 406.32(f).

Further, section 1905(a) of the Act specifies that payments of Medicare cost-sharing for QMBs (including Part A premiums) are ''medical assistance'' for purposes of FFP, if made in the month following the month in which the individual becomes a QMB. (Per the introductory paragraph of section 1905(a) of the Act, payments for Medicare premiums and cost sharing only qualify as medical assistance in the case of Medicare cost-sharing with respect to a QMB described in section 1905(p)(1) of the Act, if provided after the month in which the individual becomes such a beneficiary). Thus, under a literal reading of the words of the statute, a State cannot claim FFP under the QMB group until the month after the month in which the individual is ''entitled to Part A,'' which requires first that a Part A premium be paid. This creates a ''catch 22'' in which low-income individuals can only be eligible for QMB coverage that makes Part A enrollment affordable if they first became liable for its premium.

This result would eviscerate the purpose of sections 1843 and 1818(g) of the Act (''buy-in statute''). Under a literal read, States with a Part A buy-in agreement could theoretically use State-only funds to pay Part A premiums the first month to allow the individual to become entitled to Part A and start QMB coverage the next month. However, in *Harris* v. *McCrae,* 448 U.S. 297 (1980), the U.S. Supreme Court held that States cannot be required to provide Medicaid using only State funds. Further, while individuals can enroll in Part A at any time of the year without regard for Medicare enrollment periods or late enrollment if the State pays their Part A premium under its buy-in agreement, this is not the case for individuals who are paying the premium themselves. Individuals who must pay the Part A premium themselves must wait until a Medicare enrollment period to enroll in Part A and may be subject to late enrollment penalties. Thus, a literal read of the statute would defeat the purpose of buy-in statute—to avoid delays in QMB enrollment by allowing QMB-eligible individuals who reside in Part A buy-in States to enroll in Part A at any time of the year, without regard to Medicare enrollment penalties.

Recognizing that a literal read of the statute would produce a result that essentially nullifies the impact of the QMB and buy-in statutory provisions, CMS instituted a policy approximately 30 years ago under which States can receive FFP for paying an individual's Part A premium the first month of entitlement, thereby triggering both Part A entitlement and QMB coverage. Under this policy, Part A buy-in States can determine an individual eligible for QMB status, and thus for their Part A premiums to be paid, if they are enrolled in Part B but not yet entitled to Part A.[42] Group payer States similarly can approve eligibility for individuals under the QMB eligibility group if SSA has determined them conditionally eligible for premium Part A, through a process known as ''conditional enrollment.'' The conditional enrollment process enables low-income individuals to apply at SSA for premium Part A on the condition that they will only be enrolled in Part A if the State determines they are eligible for the QMB group.[43] Most group payer States recognize conditional enrollment in Part A for purposes of determining QMB eligibility, but they are not required to do so.

Individuals who lack premium-free Part A are more likely to have worked in the informal economy in low wage jobs.[44] Internal analysis by CMS from 2017 found that, as compared to their QMB-eligible counterparts with premium-free Part A, QMB-eligible individuals who qualify for premium Part A tend to be poorer and more likely to be non-native English speakers. For multiple decades, the conditional enrollment policy has helped hundreds of thousands of individuals obtain essential assistance with Medicare premiums and cost-sharing by allowing States to pay the first month's premium needed to trigger Medicare Part A entitlement. Without this policy, the subsidies available under the QMB group to make Part A affordable would only be available to individuals who somehow found a way to pay the initial Part A premium (including a late enrollment penalty if applicable) themselves. We estimate that precluding coverage of Part A premium payments under the QMB group until the month after an individual has become entitled to Part A would prevent over 78,000 individuals each year from enrolling in Part A with State payment of Part A premiums.[45]

We believe that we should implement the statute in a manner that gives full effect to what we believe to be Congress' intended policy in this rare instance in which implementing the plain meaning of the words of the statute would produce a result that is at odds with this statutory purpose. In *United States* v.

[40] See chapter 1, section 1.2 of the CMS Manual for the State Payment of Medicare Premiums.

[41] See Program Operations Manual System (POMS) HI 01001.230 Group Collection-General at *http://policynet.ba.ssa.gov/poms.nsf/lnx/0601001230.*

[42] Chapter 1, section 1.10 of the CMS Manual for the State Payment of Medicare Premiums and SSA Program Operations Manual System (POMS) HI 00801.140.C Premium Part A Enrollments for Qualified Medicare Beneficiaries (QMBs)—Part A Buy-In States and Group Payer States at *http://policynet.ba.ssa.gov/poms.nsf/lnx/0600801140.*

[43] The conditional enrollment process is described in chapter 1, section 1.11 of the CMS Manual for the State Payment of Medicare Premiums and in SSA Program Operations Manual System (POMS) HI 00801.140 Premium Part A Enrollments for Qualified Medicare Beneficiaries (QMBs)—Part A Buy-In States and Group Payer States at *http://policynet.ba.ssa.gov/poms.nsf/lnx/0600801140.*

[44] *Streamlining Medicare and QMB Enrollment for New Yorkers: Medicare Part A Buy-In Analysis and Policy Recommendations,* Medicare Rights Center, February 2011. *https://www.medicarerights.org/pdf/Part-A-Buy-In-Analysis.pdf.*

[45] Based on internal CMS data from 2015–2019.

Ron Pair Enterprises, Inc., 489 U.S. 235 (1989), the U.S. Supreme Court found, ''The plain meaning of legislation should be conclusive, except in the 'rare cases [in which] the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters.' *Griffin* v. *Oceanic Contractors, Inc.,* 458 U.S. 564, 571 (1982). In such cases, the intention of the drafters, rather than the strict language, controls. *Ibid.*''

More recently, in *Donovan* v. *First Credit, Inc.,* 983 F.3d 246, 254 (6th Cir. 2020) the Sixth Circuit reformulated this concept as follows: ''Thus, the absurd-results doctrine sanctions the use of extra-textual sources to contravene statutory text only if there is no alternative and reasonable interpretation available that, consistent with legislative purpose, would avoid the absurd result.'' *See id.; In re Corrin,* 849 F.3d 653 at 657 ('When the language is ambiguous or leads to an absurd result, the court may look at the legislative history of the statute to help determine the meaning of the language.').''

We note that there is precedent, in the Medicare Part D context, for not applying the plain meaning of the words of the statute when it leads to what we believe to be an absurd result contrary to the purpose of the statute. The following language from the preamble to the January 28, 2005 final rule implementing Medicare part D explains:

> Section 1860D–1(b)(1)(C) of the Act requires CMS to auto-enroll into PDPs an individual ''who is a full benefit dual eligible individual'' who ''has failed to enroll in a prescription drug plan or an MA–PD plan.'' Although this statutory provision specifically references the statutory definition of ''full-benefit dual eligible individual'' under section 1935(c)(6) of the Act, if interpreted literally, section 1860D–1(b)(1)(C) of the Act would require CMS to auto-enroll into Part D plans only individuals receiving full-benefits under Medicaid who are already enrolled in Part D but who have ''failed to enroll in'' a Part D plan, a patently absurd result. We have an obligation to interpret the statute so as to avoid an absurd result and give full effect to the Congress' intended policy. We think it is clear that the Congress required CMS to establish an auto-enrollment process to ensure that individuals who currently receive coverage for Part D drugs under Medicaid continue to receive coverage for such drugs through enrollment in Part D beginning in 2006.[46]

For the reasons set forth above, we believe that in this case also, reading the statute literally to require an individual to pay their first month's Part A premium in order to become eligible to receive coverage of Part A premiums under the QMB group would be contrary to the fundamental purpose of the QMB statutory provisions: to enable low-income individuals to gain Medicare benefits they could not otherwise afford. A literal read of the statute is also at odds with the intent of the buy-in statute to avoid undue delays in QMB enrollment. Therefore, we propose to incorporate in the regulations our longstanding practice of providing FFP for State payments of the first month of an individual's Part A premium for individuals who are eligible for the QMB group based on conditional enrollment in Part A. This also will facilitate enrollment into the QMB group for SSI recipients who need to pay a premium to enroll in Part A.

According to internal CMS estimates, in 2022 approximately 800,000 SSI recipients were eligible for Part A by paying a premium. When an individual age 65 or older is determined eligible for SSI and Medicare Part B but lacks sufficient work history for premium-free Part A, SSA transmits the individual's record to CMS. In 1634 States, CMS automatically initiates Part B buy-in (that is, enrollment in Part B with the State paying the Part B premium); in criteria and 209(b) States, CMS alerts the State that the individual is eligible for SSI and Medicare. As described above, States must pay the Part B premiums for individuals once they are eligible for Part B and have been determined eligible for the mandatory SSI or 209(b) group under §§ 407.42 and 407.47(b). Once the SSI recipient is enrolled in Part B buy-in, CMS notifies SSA, which also updates its SSI records to reflect Part B buy-in for the individual.

As mentioned above, in Part A buy-in States, CMS considers enrollment in Part B sufficient to treat the individual as meeting the requirement that the individual be entitled to Part A for the purposes of the State's QMB eligibility determination. Because the SSI income and resource standards are below the standards for eligibility under the QMB group, individuals eligible for the mandatory SSI or 209(b) group will meet the financial eligibility requirements for the QMB group. Thus, in Part A buy-in States, when an SSI recipient who lacks sufficient work history for premium-free Part A has been determined eligible for the mandatory SSI or 209(b) group and is enrolled in Part B, the State can determine the individual eligible for the QMB eligibility group and enroll the individual in Part A buy-in.

To streamline QMB enrollment for SSI recipients who must pay a premium to enroll in Part A, we propose at § 435.909(b)(1)(ii) to require Part A buy-in States to deem those individuals who are determined eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group and initiate their enrollment into Medicare Part A, pursuant to their buy-in agreement, the month they are enrolled in Part B buy-in.

As noted, in States that have a 1634 agreement with SSA, when SSA determines an individual eligible for the mandatory SSI group, SSA also notifies CMS that an individual eligible for Medicare Part B has been determined eligible for the mandatory SSI group. CMS initiates the individual's enrollment in Medicare Part B buy-in and notifies the State after doing so. In Part A buy-in States with a 1634 agreement, once the State receives the automated Part B buy-in enrollment from CMS for an SSI recipient who lacks a sufficient work history for premium-free Part A, under proposed § 435.909(b)(1)(ii) the State would enroll the individual in the mandatory SSI group, deem the individual eligible for the QMB group, and effectuate enrollment in Medicare Part A through the buy-in agreement.

As discussed above, in criteria and 209(b) States, when CMS receives information from SSA that an individual is eligible for SSI and Medicare Part B, CMS does not automatically initiate Part B enrollment, which is a prerequisite for entitlement to Part A for individuals subject to a Part A premium. In a Part A buy-in State without a 1634 agreement (that is, a criteria or 209(b) State), once the individual applies to the Medicaid agency, some States currently only determine eligibility for the mandatory SSI or 209(b) group, as applicable, and initiate Part B enrollment per their buy-in agreement. Under proposed § 435.909(b)(1)(ii), these Part A buy-in States also would be required to deem any individuals determined by the State to be eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group and initiate enrollment in both Medicare Part A and Part B buy-in.

In the 14 group payer States, it is more challenging for SSI recipients to enroll in Medicare Part A and the QMB eligibility group. Unlike in Part A buy-in States, individuals determined eligible for the mandatory SSI or 209(b) group in group payer States who are enrolled in Part B pursuant to the State's buy-in agreement will not necessarily satisfy the eligibility requirement for the QMB group that the individual be entitled to Part A. Even though the State will initiate enrollment of the

[46] 70 FR 4194 at 4370 and 4371 (January 28, 2005). *https://www.govinfo.gov/content/pkg/FR-2005-01-28/pdf/05-1321.pdf.*

individual in Part B, pursuant to its buy-in agreement, it will not cover the individual's Part A premium or initiate Part A enrollment under the buy-in agreement. Instead, the individual must separately apply for premium Part A at SSA using the conditional enrollment process.

Although the conditional enrollment process provides a way for individuals to enroll in the QMB eligibility group without paying their own Part A premiums upfront, the process is administratively burdensome for both individuals and the State, and the vast majority of individuals fail to complete the process unless an eligibility worker or other application assistor provides hands on assistance through every step of the process.[47] Two other challenges currently make QMB enrollment harder for SSI recipients without premium-free Part A in group payer States. First, group payer States can only enroll individuals in premium Part A during the general Medicare enrollment period that runs from January through March each year. Second, group payer States are required to pay late enrollment penalties, if applicable, for those Medicaid beneficiaries who did not timely enroll in Medicare Part A when they first became eligible to do so.

To streamline QMB enrollment for SSI recipients without premium-free Part A in group payer States, we propose to add a State option for deeming individuals eligible for the QMB group. Specifically, proposed § 435.909(b)(2) would allow, but not require, group payer States to directly initiate Medicare Part A enrollment for individuals who are not entitled to premium-free Part A without first sending them to SSA to apply for conditional Part A enrollment. Under this proposed option, once the State has determined the individual eligible for the mandatory SSI or 209(b) group and become liable for paying their Part B premiums under the buy-in agreement pursuant to § 407.42, the State would also deem them eligible for the QMB group.

We are aware that State-specific variables can impact a State's decision to either enter into a Part A buy-in agreement or to remain a group payer State. By allowing, but not requiring, group payer States to adopt the same streamlined QMB enrollment procedures used in Part A buy-in States, we preserve the current statutory option for group payer States to operate differently than Part A buy-in States while still enabling them to modernize their processes and facilitate enrollment of these very low-income individuals into Medicare Part A and the QMB group. However, we seek comments on the administrative and fiscal impacts of our proposal and of other approaches, such as requiring group payer States to deem individuals determined eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group once they have completed the conditional enrollment process at SSA.

4. Clarifying the Qualified Medicare Beneficiary Effective Date for Certain Individuals (§ 406.21)

In the above section, we seek to facilitate enrollment for SSI recipients into QMB. Here, we propose to clarify the effective date of coverage under the QMB group for individuals who must pay a premium to enroll in Part A and reside in a group payer State in order to provide individuals with protection from Medicare premiums and cost-sharing costs on the earliest possible date.

The first opportunity individuals have to enroll in premium Part A is during their initial enrollment period (IEP). For most individuals who become eligible for Medicare on or after 1966, under section 1837(d) of the Act, the IEP begins on the first day of the third month before the month the individual turns 65 and ends 7 months later.

Eligible individuals who do not enroll in premium Part A during their IEP, or who disenroll from premium Part A and wish to re-enroll, must generally do so during the general enrollment period (GEP). The GEP is established under section 1837(e) of the Act, and is the period beginning on January 1 and ending on March 31 of each year. For individuals who enroll in Medicare under the GEP in a month before January 1, 2023, Part A entitlement would begin the first of July following their enrollment, as provided in sections 1838(a)(2)(D)(i) and (ii) and (a)(3)(B)(i) and (ii) of the Act. Section 120 of the Consolidated Appropriations Act, 2021 (CAA) revised the Part A entitlement effective date for individuals who enroll during the GEP in a month beginning on or after January 1, 2023. Specifically, Part A entitlement for individuals who enroll in premium Part A during the GEP would begin with the first day of the month following the month in which they enroll.

In the 2022 Medicare eligibility and enrollment proposed rule at 87 FR 25094, we proposed to revise § 406.21(c) to implement the GEP effective dates outlined in section 120 of the CAA. Specifically, § 406.21(c)(3)(i) would require that for individuals who enroll or reenroll during a GEP prior to January 1, 2023, entitlement would begin July 1 following their enrollment, while § 406.21(c)(3)(ii) would require that for individuals who enroll or reenroll during a GEP on or after January 1, 2023, entitlement would begin on the first day of the month after the month of enrollment, consistent with section 1838(a)(2)(D)(ii) of the Act (incorporated for premium Part A beneficiaries by reference in section 1818(c) of the Act).

To align with that change, we propose to clarify the applicable effective date of QMB coverage for an individual who resides in a group payer State and enrolls in conditional Part A during the GEP. As discussed above in section II.A.3 of this preamble, in a Part A buy-in State, CMS considers enrollment in Part B sufficient to meet the requirement that an individual be entitled to Part A for the purposes of the QMB eligibility determination. However, in a group payer State, enrollment in QMB for individuals who need to pay a premium to enroll in Part A is always a two-step process. The State cannot determine individuals eligible for QMB and enroll them in Part A buy-in until SSA establishes actual or conditional Part A enrollment. With respect to QMB enrollment under a buy-in agreement under § 406.26, Medicare Part A coverage begins the first month an individual is entitled to Part A under § 406.20(b) and has QMB status. We consider a conditional Part A filing to be sufficient to fulfill the requirement for entitlement to Part A as applicable for QMB coverage.[48]

Specifically, in this rule we propose in new § 406.21(c)(5) to codify existing policy for individuals who enroll in actual or conditional Part A during the GEP. Beginning on or after January 1, 2023, the effective date of Medicare coverage for individuals who enroll in Medicare during the GEP is the month following the month of enrollment under section 1838(a)(2)(D)(1) and (a)(3)(B)(i) of the Act. For such individuals, QMB coverage starts the month premium Part A entitlement begins (if the State determines the individual has met the eligibility requirements for QMB coverage in the same month that Part A enrollment occurs), or a month later than the month of Part A entitlement (if the individual is determined eligible for QMB the month Part A entitlement begins or later).

[47] *Streamlining Medicare and QMB Enrollment for New Yorkers: Medicare Part A Buy-In Analysis and Policy Recommendations,* Medicare Rights Center, February 2011. *https://www.medicarerights.org/pdf/Part-A-Buy-In-Analysis.pdf.*

[48] See CMS Manual for the State Payment of Medicare Premiums, chapter 1, section 1.11.

This proposal would clarify that individuals who reside in group payer States and enroll in actual or conditional Part A during the GEP can obtain QMB as early as the month Part A entitlement begins.

5. Facilitate Enrollment by Allowing Medically Needy Individuals To Deduct Prospective Medical Expenses (§ 435.831)

The current medically needy income eligibility regulation at 42 CFR 435.831 permits institutionalized individuals to deduct their anticipated medical and remedial care expenses from their income. We propose to amend the regulation to allow noninstitutionalized individuals, under certain circumstances, to do the same for purposes of medically needy eligibility determinations. This proposal is designed to eliminate the institutional bias inherent in only permitting projection of the cost of care for institutionalized individuals.

Section 1902(a)(10)(C) of the Act provides States the option to extend Medicaid eligibility to ''medically needy'' individuals. Implementing regulations are codified at 42 CFR part 435, subpart D. The medically needy are individuals who have incomes too high to qualify in a categorically needy group described in section 1902(a)(10)(A) of the Act, but who have certain significant and costly health needs. Consistent with section 1902(a)(10)(C)(i)(III) of the Act and regulations at § 435.811(a), States establish a separate income standard to determine the income eligibility of medically needy individuals (referred to as the ''medically needy income level,'' or ''MNIL''). As directed by section 1903(f)(2) of the Act and § 435.831(d), a State's determination of a prospective medically needy individual's income eligibility includes the deduction of the uncovered medical and remedial expenses incurred by the individual, the individual's family members, or the individual's financially responsible relatives, from the individual's countable income. This process of deducting incurred medical and remedial expenses from an individual's countable income is referred to as a ''spenddown.''

To determine income eligibility for medically needy coverage, a State first determines an individual's countable income in accordance with § 435.831(b), including application of any disregards imposed under the methodology appropriate for the individual (for example, a $20 monthly income disregard for an individual whose Medicaid is based on SSI methodologies), or approved under the State's Medicaid plan under the authority of section 1902(r)(2) of the Act and § 435.601(d).

If the individual's remaining countable income is at or below the MNIL, they are income-eligible for the medically needy group. If the remaining countable income exceeds the MNIL, the individual will need to meet a spenddown; that is, the individual will need to reduce the amount of their income above the MNIL by the amount of their outstanding medical and remedial care expense liability, from bills the individual incurs during their current budget period, and, in some circumstances, previous to it (for example, under 42 CFR 435.831(f), bills incurred in previous budget periods that were not used to meet a spenddown because the individual had other bills that were sufficient to meet the spenddown in the previous budget periods may be used in the current budget period). As required by § 435.831(a)(1), States must choose a budget period of between 1 and 6 months to be used for medically needy individuals. The State multiplies the amount that an individual's countable income exceeds the MNIL for a single month by the number of months in the budget period. The product is the amount of medical or remedial care expenses for which the individual must document being liable—the spenddown—to establish eligibility during the budget period. Once the individual confirms having the necessary medical expense liability to the State agency, the individual is eligible for the remainder of the budget period.

For example, if an individual's countable monthly income is $1,200 in a State in which the MNIL is $700, the individual's spenddown amount, based on monthly income, would be $500 ($1,200 − $700 = $500). If the budget period elected by the State is 3 months, the State multiplies $500 by 3, and the individual's spenddown is $1,500 for the budget period. If the individual's budget period begins on January 1st, and the individual incurs unpaid medical expenses that are equal to or greater than $1,500 on February 15th, the individual will be eligible for Medicaid from February 15th through March 31st. To reestablish Medicaid eligibility in the next budget period, the individual will have to incur separate medical or remedial care expenses for $1,500. The individual will not become eligible for Medicaid again until the expenses have been incurred. This results in the individual consistently cycling on and off Medicaid, with eligibility starting at some point after the new budget period begins, causing a gap in coverage for the individual and additional administrative work for the State.

Separately, section 1902(f) of the Act and regulations at § 435.121 authorize States to apply criteria more restrictive than the SSI program criteria in determining eligibility under the mandatory eligibility group for individuals seeking Medicaid on the basis of being 65 years old or older or having blindness or disabilities, provided that they offer Medicaid to any such individual who would have been eligible under the State's 1972 Medicaid plan. (States electing this option are referred to as ''209(b) States,'' after the provision in the Social Security Amendments of 1972, Public Law 92–603, that enacted section 1902(f) of the Act). In determining whether any such individual is income-eligible, section 1902(f) of the Act and § 435.121(f)(1)(iii) also require that uncovered medical expenses incurred by the individual, the individual's family, or individual's financially responsible relatives, be deducted from countable income, and that a spenddown be calculated for individuals with income exceeding the income limit for the mandatory 209(b) State group in generally the same manner it is calculated for the medically needy.

In 1994, based on the authority granted to the Secretary under sections 1102 and 1902(a)(4) of the Act to create rules necessary for the efficient operation of the Medicaid program, and under section 1902(a)(17) of the Act to prescribe the extent to which costs of medical care may be deducted from income, we established, under § 435.831(g)(1), that States have the option to ''include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate'' in calculations [49] (59 FR 1659, January 12, 1994 referred to hereafter as the ''1994 rulemaking''). We further confirmed in the preamble to the 1994 rulemaking that 209(b) States are authorized to implement the authority established in the rule relating to the projection of medical institutional expenses.

''Projecting'' expenses means that a State includes in incurred medical expenses those costs that it anticipates an individual will incur during a budget period, which can make eligibility effective on the first day of an

[49] ''Medicaid Program; Deduction of Incurred Medical Expenses (Spenddown)'' Final Rule with Comment Period; *https://www.govinfo.gov/content/pkg/FR-1994-01-12/html/94-547.htm.*

individual's budget period, if the anticipated expenses equal or exceed the individual's spenddown. In promulgating the 1994 regulation, we reasoned that institutional services are, by their nature, constant and predictable, which supported a simplified approach for States to determine that an institutionalized individual will meet their spenddown amount each budget period. As required by regulations in § 435.831(i)(2), States must reconcile the projected amounts with the actual amounts incurred at the end of the budget period in order to confirm that the individual's incurred expenses were at least equal to the individual's spenddown.

For example, consider an individual in an institution on the first day of a month with a spenddown amount of $3,000 in a State in which the medically needy budget period is 1 month. The Medicaid rate for the facility is $4,500 ($150 daily), the private rate is $6,000 ($200 daily), and the State does not project institutional expenses. Until eligibility for Medicaid is established, the individual will be charged the private daily rate, which would mean that, in a month in which the individual does not receive any services not included in the daily rate, the individual will incur $3,000 in expenses as of the 15th of the month (3,000 ÷ 200 = 15), at which point the individual will be eligible for Medicaid, for the remainder of the month. If the individual does, however, receive any uncovered services beyond the basic services included in the daily rate, the individual would become eligible earlier in the month, although again only for the remainder of the month. The result is that the individual is consistently cycling on and off Medicaid, with an eligibility start date each budget period that is not predictable to either the institutionalized individual or State agency.

On the other hand, if the State elects to project the individual's institutional expenses under the authority of § 435.831(g)—that is, determine that the individual *will* incur the Medicaid rate of $4,500 for the month—the State can establish that the individual is eligible for Medicaid, and grant eligibility effective the first day of the month. No further eligibility-related determination is necessary. Projecting expenses can benefit both parties, by reducing administrative costs for the State and providing continuity of coverage for the beneficiary.

We explained that we considered use of the Medicaid reimbursement rate in the projection of expenses necessary to achieve the highest level of certainty that an individual will incur the liability that the regulation was permitting States to anticipate prior to the actual receipt of the services (see 59 FR 1661). For example, if a State projects the private rate for the services for an institutionalized individual, and the private rate for a particular month exceeds the individual's spenddown and the individual is consequently deemed Medicaid eligible on the first day of the month, the individual will not be charged the private rate for any of the services that month, but instead will be charged the Medicaid rate, as the provider would have to accept the Medicaid reimbursement rate for the Medicaid-covered services. If, however, the individual's spenddown amount exceeds the cost of the Medicaid rate, the individual possibly will not end up incurring in the month the expenses necessary to meet his or her spenddown. Therefore, to avoid possible erroneous grants of eligibility, we determined that the use of the Medicaid reimbursement rate in the projection of expenses was more appropriate.

The projection of expenses can have the effect of accelerating eligibility. However, only permitting projection of the cost of care for institutionalized individuals creates an inherent institutional bias. Further, we believe that there are noninstitutional services that may be similarly constant and predictable such that States could project them for individuals who must meet a spenddown to become income-eligible. Permitting projection of such noninstitutional services would reduce some of the complexity that both State agencies and individuals seeking coverage of home and community-based services (HCBS) currently experience and reduce institutional bias. Projecting noninstitutional expenses would reduce administrative costs associated with disenrolling and reenrolling individuals, as well as lead to better outcomes for individuals who would no longer cycle on and off Medicaid and experience disruptions to their continuity of care.

We propose to amend § 435.831(g) to permit States to project certain additional services that the State can determine with reasonable certainty will be constant and predictable. Similar to the explanation provided for institutional expenses in the preamble to the 1994 rule, the projection of expenses for noninstitutional services is limited to those that are reasonably certain to be received by the individual, since only the amounts for which the individual is ultimately liable can be used to reduce income. Like the reconciliation process required for projected institutional expenses, under the proposed revisions to § 435.831(g), States will have to reconcile actual noninstitutional services received with those projected at the end of budget periods to address erroneous grants of spenddown-related eligibility. Note that this proposal does not change the requirement that a State continue to apply any eligible expenses actually incurred by the individual in determining whether individuals have met the spend down amount, regardless of whether the expense was projected.

We propose to include in the regulatory language examples of specific types of expenses that we believe meet this standard, while providing additional flexibility for States to identify additional expenses that meet the criteria of being constant and predictable. Specifically, we propose to allow projection of medical or remedial expenses for the HCBS that are included in a plan of care (care plan) for an individual receiving a section 1915(i), 1915(j), or 1915(k) benefit or participating in a section 1915(c) HCBS waiver. We believe these medical and remedial expenses are generally constant and predictable because States are required to develop a care plan that identifies the services, and the frequency with which they will be received, for individuals eligible for section 1915(c), (i), (j), and (k) services, as set forth in section 1915(c)(1), (i)(1)(E) and (G), (j)(1), (5)(C), and (k)(1)(A)(i) of the Act, and §§ 441.301(b)(1)(i), 441.468(a)(1), 441.540(b)(5), 441.720, and 441.725. States could reasonably calculate, and deduct, the anticipated cost, based on the Medicaid reimbursement rate, of the services in an individual's care plan. We believe this proposal would also have the effect of eliminating the institutional bias that is fostered by the existing regulation's allowance for the projection of only institutional expenses.

The same may be true of individuals who have significant expenses related to high-cost drugs that treat a chronic condition. Pharmacies routinely keep a patient medication profile (''pharmacy profile'') for a patient, which could be used to determine which medications are for chronic conditions and which are for acute treatment. A State could, for example, use a pharmacy profile to review the 3-, 6-, or 12-month history of the prescriptions that an individual has been prescribed, and use that information to project expenses that are reasonably expected to be incurred in the current budget period.

We recognize that the projection of institutional expenses is often a straightforward calculation, as it involves only one provider, with a fixed and easily identifiable rate. By contrast, the feasibility of projecting expenses for individuals receiving section 1915(c) or (i) services or prescriptions for chronic conditions will depend on the individual's specific circumstances. For example, it is possible that a section 1915(c) participant will not receive a service that is part of their care plan during a month, or that the frequency with which the individual receives one of the services, or multiple services, in the care plan varies on a periodic basis. For such HCBS beneficiaries who need a spenddown to qualify, it may take time before a State develops a reasonable degree of certainty regarding the predictable costs the individual incurs each month. For HCBS beneficiaries whose use of services in their care plan varies greatly over the course of multiple budget periods, a State may be unable to reasonably predict the individual's service costs in a forthcoming budget period. Therefore, we propose to expressly permit States to project the expenses of section 1915(c), (j), (k) and (i) services and prescription drug services, as well as other expenses in calculating whether an individual meets their spenddown, where the State has determined that such services are constant and predictable.

For both the expenses for services expressly permitted under the examples in the proposed regulation text and for any other expenses for services that the agency has determined are reasonably constant and predictable, States would need to develop processes to evaluate the likelihood of an individual receiving the services in an upcoming budget period and the anticipated cost of the services. Discrepancies between a State's projections and the cost of services actually received inevitably will exist. Under proposed § 435.831(g)(2), States would be required to project expenses to the end of the budget period with reasonable certainty. Consistent with current regulations at § 435.831(i)(2), States would need to reconcile the projected amounts with the actual amounts incurred at the end of the budget period. Individuals who the State determines as a result of reconciliation did not actually meet their spenddown during the budget period may not have eligibility terminated retroactively. The State should use the findings made during reconciliation to prospectively determine whether the individual can be expected to incur reasonably constant and predictable expenses in the next budget period, and adjust the projection accordingly.

We invite comment to identify any other types of services that individuals may receive on a constant and predictable basis, and for which a State could project, with a degree of relative certainty, consistent costs for an individual over the course of a prospective budget period. Such services would be considered for inclusion in the regulatory text in the final rule as specific examples of services that a State can determine with reasonable certainty to be constant and predictable.

We propose to amend § 435.831 to replace the current text in paragraph (g)(2) with the proposed State option to project noninstitutional expenses. Current paragraphs (g)(2) and (3) in § 435.831 will be redesignated at paragraphs (g)(3) and (4). Note that the proposed changes to § 435.831(g) that would enable States to project reasonably certain noninstitutional expenses for medically needy individuals would also apply in projecting noninstitutional expenses in 209(b) States.

6. Application of Primacy of Electronic Verification and Reasonable Compatibility Standard for Resource Information (§§ 435.952 and 435.940)

All 50 States and the District of Columbia are required to implement an asset verification system (AVS) under section 1940 of the Act to verify certain financial resources for all individuals applying for or receiving Medicaid as an aged, blind, or disabled (ABD) individual. An AVS enables States to verify assets held in virtually any financial institution in the United States through an electronic data matching process, although not all information returned through an AVS occurs in real time; information from smaller financial institutions may take as long as 30 days or more to be returned to the Medicaid agency. In our work with States implementing the AVS requirement, many States have asked whether they are permitted to request additional documentation from applicants and beneficiaries related to resources that can be verified through the State's AVS, or if they can apply a reasonable compatibility standard for resources when resource information returned from an electronic data source is comparable to the information provided by the applicant or beneficiary.

The current regulation at § 435.952(b) provides that, if information provided by or on behalf of an individual is ''reasonably compatible'' with information obtained by the State in accordance with §§ 435.948, 435.949 or 435.956, that the State must determine or renew eligibility based on such information. Current § 435.952(c) provides that an individual must not be required to provide additional information or documentation unless information needed by the State in accordance with §§ 435.948, 435.949 or 435.956 cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual. Section 435.952(c)(1) provides that States must consider income information obtained through an electronic data match to be reasonably compatible with attested income information if either both are above or both are at or below the applicable income standard or other relevant income threshold. Current § 435.952(c)(2) requires the agency to seek additional information, which may include documentation, if attested information is not reasonably compatible with information obtained through an electronic data match. However, documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective. In determining effectiveness, States must consider such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved, as well as for eligible individuals to be denied coverage. We seek comment from States on potential implementation challenges, including any systems integration considerations or challenges, under this proposal which could impact the effectiveness and usefulness of such a data match.

The language of § 435.952 is written broadly to encompass all factors of eligibility, including income and resource criteria, when applicable. However, at the time § 435.952 was promulgated in the 2012 eligibility final rule, no State had implemented the AVS requirement and Federal requirements relating to verification of resources were not included in the regulations. Because § 435.952(b) and (c) apply specifically to information needed by the State to verify an individual's eligibility in accordance with §§ 435.948 (relating to income), 435.949 (relating to information received through the

Federal Data Services Hub), or 435.956 (relating to non-financial eligibility requirements), some have interpreted this requirement not to apply to verification of resources. This interpretation is not consistent with our intent. The language in § 435.952 is not specific to income. Indeed, the reasonable compatibility policies described in § 435.952(b) and (c) also apply to verification of non-financial eligibility criteria, for example, State residency which can also be verified electronically (for example, through a data match with the State's department of motor vehicles). Applying §§ 435.952(b) and (c) to resources will help streamline enrollment for individuals applying for Medicaid on a non-MAGI basis, such as on the basis of age, blindness, or disability, and decrease burden for both States and beneficiaries. If attested resource information is found to be reasonably compatible with the resource information returned from the AVS, then these resources are considered verified and no further actions from the State or from the beneficiary are needed. Therefore, we propose to revise paragraphs (b) and (c) of § 435.952 to clarify that these provisions apply also to verification of resources. Specifically, we propose to make clear that paragraphs (b) and (c) apply to any information obtained by the State—not just information obtained in accordance with § 435.948, 435.949 or 435.956. We also propose to insert the words ''and resource'' after ''income'' in paragraph (c)(1) and to delete the word ''income'' where it appears before ''standard'' and ''threshold'' to require that States consider resource information obtained through an electronic data match to be reasonably compatible with attested resource information if both are either above or at or below the applicable standard or other relevant threshold.

This proposal is intended to clarify that States are not permitted to request additional resource information from the beneficiary to determine eligibility if the resource information provided by an individual is reasonably compatible with the information received from an electronic data source, such as the AVS. If information provided by an individual is not reasonably compatible with the information received from the electronic data source, States must resolve any discrepancies per § 435.952(c)(2), which is not revised in this rulemaking.

Under the proposed regulations, resource information obtained from an electronic data source, such as an AVS, must be considered reasonably compatible with resource information provided by the applicant or beneficiary if both are either above or at or below the applicable resource standard or other applicable resource threshold. Further, while not required, States could establish a reasonable compatibility threshold, such that electronic data would be considered reasonably compatible with attested resources if the electronic data is no higher than attested resources plus the State's elected threshold amount (expressed as either a percentage or dollar amount). Some States, for example, apply a reasonable compatibility threshold of 5 or 10 percent of attested income in verifying income eligibility. States would not be required to establish the same reasonable compatibility threshold for income and resources, and may apply different reasonable compatibility thresholds for different eligibility groups, provided that the State has a reasonable rationale for doing so.

We also propose a corresponding technical change to amend § 435.940 to add section 1940 of the Act as a basis for the income and eligibility verification requirements. The proposed changes to § 435.952 in this rulemaking include resource information obtained from electronic data sources, such as an asset verification program described under section 1940 of the Act.

7. Verification of Citizenship and Identity (§ 435.407)

In 2016, we revised the Medicaid and CHIP regulations governing the verification of citizenship and identity to require States to rely primarily on electronic verification to effectuate the streamlined and coordinated approach required by the ACA to reduce burden on individuals and increase administrative efficiency. These regulatory changes were issued by CMS in a November 2016 final rule titled, ''Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP'' (81 FR 86453, November 30, 2016) (referred to hereafter as the ''2016 eligibility and enrollment final rule''). Under the regulations, all States must first attempt to verify citizenship electronically using data from the SSA, and most States rely on a match through the Federal Data Services Hub (FDSH) for this data. In that final rule, we also streamlined and simplified the list of documents and other acceptable means of verification that can be used when citizenship cannot be verified electronically with SSA. One such alternative source of citizenship verifications, codified at § 435.407(b), is a data match with the State's (or another State's) vital statistics system. We explained in the preamble to the 2016 eligibility and enrollment final rule that if citizenship verification cannot be completed through an electronic data match with SSA, the State must attempt to verify citizenship through an electronic data match with the State's (or another State's) vital statistics system, before requesting paper documentation from the individual, if such match is available within the meaning at § 435.952(c)(2)(ii).

Under current regulation, individuals whose citizenship is verified based on any of the sources identified in § 435.407(b)—which includes, under the current regulations, a match with a State's vital statistics records or with the U.S. Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) Program—must also provide proof of identity. The documentary evidence identified in section 1903(x)(3)(B) of the Act, codified through the 2016 eligibility and enrollment final rule at § 435.407(a), in contrast, provides ''stand-alone'' proof of citizenship; separate proof of identity is not required. Section 1903(x)(3)(B)(vi) of the Act authorizes the Secretary to specify that other documents in addition to those specified in the statute, must be accepted as stand-alone satisfactory documentation of citizenship if they determine that such documents provide both proof of United States citizenship or nationality, as well as reliable documentation of personal identity. As explained below, verification with a State's vital statistics records or SAVE, like the data match with SSA, which provides both proof of U.S. citizenship or nationality and reliable documentation of personal identity, meets this standard.

In this rule, we are proposing to further simplify the verification procedures by moving verification of citizenship with a State vital statistics agency or SAVE from paragraph (b) to paragraph (a) of § 435.407 for Medicaid, which is incorporated into CHIP regulations through existing cross-references at §§ 457.380(b)(1)(i) and 435.956(a). This change would mean that verification of birth with a State vital statistics agency or verification of citizenship with SAVE would be considered stand-alone evidence of citizenship; separate verification of identity would not be required, similar to the treatment afforded to verification of citizenship with SSA. This proposed change would reduce burden on

individuals and State Medicaid agencies and increase administrative efficiency.

Turning first to citizens whose status can be verified with DHS' SAVE Program, SAVE can provide electronic verification of U.S. citizenship for individuals who have a DHS record of naturalized or derived citizenship, usually documented with a Certificate of Naturalization or Certificate of Citizenship. Any SAVE program requestor (for example, the Medicaid or CHIP agency or other benefit granting or licensing agency) that requests verification of U.S. citizenship or immigration status through the SAVE program must provide the SAVE program with the individual's biographic information (first name, last name, and date of birth) and a personalized numeric identifier (such as an Alien Number; Form I–94, Arrival/Departure Record Number; Student and Exchange Visitor Information System (SEVIS) ID number; or unexpired foreign passport number) unique to that individual. DHS verifies identity prior to providing a SAVE program response verifying citizenship or immigration status, reviewing multiple records and in some cases requiring additional information from the requestor. If an individual's immigration status is confirmed by SAVE, the State's verification of immigration status is complete under current regulations, whereas separate proof of identity is required if SAVE confirms the individual's citizenship. Because the process followed by SAVE is identical, we do not believe that the extra step required for citizens is justified. Therefore, we propose revisions to § 435.407 to provide for comparable processes for individuals whose status is verified by SAVE, regardless of whether they are a citizen or non-citizen. Specifically, we propose to remove verification of citizenship with SAVE currently at § 435.407(b)(11) (which requires separate proof of identify) and to add such verification at proposed § 435.407(a)(8) (which would not require separate proof of identity) for Medicaid, which is incorporated into CHIP regulations through existing cross-references at §§ 457.380(b)(1)(i) and 435.956(a).

Verification of U.S. citizenship with a State vital statistics agency provides a similarly robust data matching process because a State Medicaid or CHIP agency must provide the State vital statistics agency with a minimum set of identifiable information including the name, date of birth, and Social Security Number (SSN). Some States also use additional identifiers if they are available, such as the individual's birth county, the parents' names or the mother's maiden name. Based on State feedback, CMS understands that the process and data fields used to verify citizenship with a State vital statistics agency are similar across States. Conducting a data match with specific identifiers like date of birth and SSN is the same process that could be used to provide evidence of identity, thereby making a requirement to separately verify identity redundant. Therefore, we propose revisions to § 435.407 under which verification of citizenship with a State vital statistics agency would serve as stand-alone proof of U.S. citizenship and no separate proof of identify would be required. Specifically, we propose to remove verification of citizenship with a State vital statistic's agency currently at § 435.407(b)(2) (which requires separate proof of identify) and to add such verification at proposed § 435.407(a)(7) (which would not require separate proof of identity) for Medicaid, which is incorporated into CHIP regulations through an existing cross-references at §§ 457.380(b)(1)(i) and 435.956(a). However, we recognize that different State Medicaid and CHIP agencies and vital statistics agencies may employ different processes and seek comment on what processes Medicaid and CHIP agencies use to verify citizenship with a State vital statistics agency, including what information and identifiers are used to complete verification, whether the data matching process with all State vital statistics agencies is sufficiently robust to appropriately apply this proposed change in policy to verification of citizenship in all States, or limit this change in policy only to States in which the vital statistic agency's processes are comparable to those of the SAVE program.

We note that, if citizenship cannot be verified through an electronic match with SSA, States are required to verify citizenship using an electronic match prior to requesting other forms of documentation, if such match is available and effective in accordance with § 435.952(c)(2)(ii). Inasmuch as State vital statistics agencies generally can provide electronic data matching, we are also proposing to delete the words ''at State option,'' which are included in existing § 435.407(b)(2), from proposed § 435.407(a)(7) for Medicaid, which is incorporated into CHIP regulations through an existing cross-reference at § 457.380(b)(1)(i) to § 435.956(a). Use of such match with a vital statistics agency is not voluntary if it is available and effective in accordance with § 435.952(c)(2)(ii). This proposed revision does not necessarily require a State to develop a match with its vital statistics agency. However, States that do not currently perform such electronic matches must develop that capacity if such match is available and would be effective in accordance with the standard set forth in § 435.952(c)(2)(ii). If a State already has established a match with a State vital statistics agency or it would be effective to establish such capability in accordance with the standard set forth in § 435.952(c)(2)(ii), the State must utilize such match before requesting paper documentation.

B. Promoting Enrollment and Retention of Eligible Individuals

1. Aligning Non-MAGI Enrollment and Renewal Requirements With MAGI Policies (§§ 435.907 and 435.916)

The 2012 and 2013 eligibility final rules established a number of eligibility and enrollment simplifications for MAGI-based Medicaid and CHIP beneficiaries. Among these were streamlined processes that made it easier for eligible individuals to apply and remain enrolled in Medicaid and CHIP. However, beneficiary advocates raised concerns that these simplifications have not been afforded to Medicaid beneficiaries excepted from use of MAGI-based methodologies, which is particularly problematic given that individuals over age 65 and those who are eligible based on blindness or a disability are likely to have more stable eligibility. Therefore, in this proposed rule, we propose changes to both the application and renewal requirements for MAGI-excepted applicants and beneficiaries to align with the requirements for populations based on MAGI.

Beginning with the application process, individuals must be permitted to submit the single streamlined application developed by the Secretary, or an alternative single streamlined application described at § 435.907(a)(2) of the current regulations, through all modalities specified at § 435.907(a) (online, by telephone, by mail, or in person). Although not expressly stated in the regulations, States also are expected to accept applications and supplemental forms needed for individuals to apply for coverage on a non-MAGI basis via all modalities identified in § 435.907(a). In addition, § 435.907(d) prohibits States from requiring an in-person interview as part of the application process, when determining eligibility based on MAGI, whereas States are still permitted to

require an in-person interview for MAGI-excepted applicants.

At renewal, current § 435.916(a) requires States to conduct renewals of Medicaid eligibility on an annual basis for individuals whose financial eligibility is determined using MAGI-based methodologies. However, for individuals excepted from use of the MAGI-based methodologies, § 435.916(b) of the current regulations permits States to conduct regularly-scheduled renewals more frequently (for example, every 6 months). States must renew eligibility for all Medicaid beneficiaries without requiring information from the individual if able to do so consistent with regulations at §§ 435.916(a)(2) and (b). However, when a beneficiary's eligibility cannot be renewed based on available information, States must follow a set of streamlined procedures for MAGI-based beneficiaries, which are not required for those excepted from MAGI. The procedures for requesting information from MAGI-based beneficiaries are described at § 435.916(a)(3) of the current regulations and include: (1) using a pre-populated renewal form; (2) providing the individual a minimum of 30 calendar days to sign and return the form along with any requested information; and (3) reconsidering eligibility for an individual terminated for failure to return the renewal form or other needed information if the form or other information is returned within 90 calendar days after the date of termination. The procedures for requesting information from MAGI-based beneficiaries are described at § 435.916(a)(3) of the current regulations and include: (1) using a pre-populated renewal form; (2) providing the individual a minimum of 30 calendar days to sign and return the form along with any requested information; and (3) reconsidering eligibility for an individual terminated for failure to return the renewal form or other needed information if the form or other information is returned within 90 calendar days after the date of termination. In addition, States may not require a MAGI beneficiary to complete an in-person interview as part of the renewal process under § 435.916(a)(3)(iv) of the current regulations. States may, but are not required to, adopt the procedures at § 435.916(a)(3) for individuals whose eligibility is determined on a basis other than MAGI, per § 435.916(b) of the current regulations.

While almost all States adopt at least one of the optional processes for renewals of non-MAGI beneficiaries,[50] the differences in renewal requirements for MAGI and non-MAGI beneficiaries result in a less streamlined and more burdensome process for beneficiaries who qualify for Medicaid on a non-MAGI basis, such as being age 65 or older or having blindness or a disability. As a result of these differences, individuals who are Medicaid eligible on one of these bases may be required to spend more time completing renewal paperwork if their renewal form is not prepopulated. They may be provided less time to return their renewal form and requested information, even if the individual must provide information related to additional factors of eligibility associated with non-MAGI eligibility groups as compared to MAGI eligibility groups, such as asset information.

CMS finds this to be problematic for several reasons. First, individuals who are Medicaid eligible based on being age 65 or older or having blindness or a disability are more likely to live on a fixed income and, therefore, are more likely to remain financially eligible for coverage than the non-disabled beneficiaries under age 65 who qualify for Medicaid based on MAGI.[51] We are concerned that, despite the generally greater stability of their income, and therefore, eligibility, a larger proportion of non-MAGI beneficiaries who lose coverage do so for procedural reasons. Indeed, as noted in section II.A.1. of this proposed rule, dually eligible for Medicaid and Medicare who lose Medicaid coverage within the first year of enrollment likely lose such coverage for reasons that are administrative in nature.[52] Also, individuals who are Medicaid eligible based on being age 65 or older or having blindness or disability status may experience additional barriers related to document retention, communication (for example, limited English proficiency and low health literacy), technology (for example, printing costs, access to a computer or internet) and limited access to transportation, among others. Processes that provide greater flexibility, such as reduced documentation requests and more time for returning information, can reduce these barriers.[53] [54] As a result, we believe that when States do not use available streamlined renewal procedures for this population, there is a greater risk of terminations for procedural reasons.

Using the authority provided in sections 1902(a)(4)(A) and (a)(19) of the Act to ensure the proper and efficient administration of the program and that eligibility is determined in a manner consistent with simplicity of administration and best interests of beneficiaries, we propose to revise current renewal regulations at § 435.916 to require States to apply the same renewal procedures for MAGI and non-MAGI beneficiaries. Specifically, we propose, by removing the reference in § 435.916(a)(1) to MAGI beneficiaries, to require that States conduct regularly-scheduled renewals of eligibility once, and only once, every 12 months for all Medicaid beneficiaries, including non-MAGI beneficiaries with limited exception, discussed below. We believe aligning the frequency of renewals for non-MAGI beneficiaries with the current requirement for MAGI beneficiaries is appropriate given that circumstances related to eligibility are generally more stable for non-MAGI beneficiaries and will reduce beneficiary burden, consistent with sections 1902(a)(4) and (a)(19) of the Act. In addition, we believe this proposal promotes equity across enrolled populations since non-MAGI beneficiaries, whose income tends to be more stable, would no longer be subject to more frequent requests to return renewal forms or provide documentation to verify continued eligibility than other beneficiaries. We also note that over 40 States currently conduct renewals only once every 12 months for all Medicaid beneficiaries.

[50] Kaiser Family Foundation (2019). Medicaid financial eligibility for seniors and people with disabilities: Findings from a 50-State survey, p. 19–20. *https://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/*.

[51] Ku, L. & Steinmetz, E. (2013). Bridging the Gap: Continuity and Quality of Coverage in Medicaid. *https://ccf.georgetown.edu/wp-content/uploads/2013/09/GW-Continuity-Report-9-10-13.pdf*; Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (2021). Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID–19 Pandemic. *https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf*.

[52] Assistant Secretary for Planning and Evaluation (2019). Loss of Medicare-Medicaid dual eligible status: Frequency, contributing factors and implications. *https://aspe.hhs.gov/system/files/pdf/261716/DualLoss.pdf*. CMS also recently completed an updated internal analysis of ASPE's study using data from 2015–2018 that shows that dually eligible individuals continue to lose Medicaid at a high rate in their first year due to administrative reasons.

[53] CMS Office of Burden Reduction & Health Informatics (April 2022). Navigating the Medicare Savings Program (MSP) Eligibility Experience. *https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf*.

[54] CMS Office of Burden Reduction & Health Informatics (April 2022). Navigating the Medicare Savings Program (MSP) Eligibility Experience. *https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf*.

We seek comment on this proposal at § 435.916(a)(1) to align the frequency of renewals for all beneficiaries, except as noted below. We are particularly interested in comments from State agencies on the administrative impact of conducting eligibility only once every 12 months for non-MAGI beneficiaries and whether or not State agencies that currently conduct renewals only once every 12 months for all Medicaid beneficiaries have experienced more stable coverage among non-MAGI beneficiaries or any program integrity concerns after shifting from a shorter renewal cycle to a 12-month renewal cycle. We are also interested in data regarding coverage losses among non-MAGI beneficiaries due to procedural reasons, such as failure to return renewal paperwork timely, versus changes to specific factors of eligibility, such as income or disability status. We are also interested in hearing from stakeholders and beneficiaries on the impact of more frequent renewals on maintaining coverage.

Section 1902(e)(8) of the Act provides an option for States to renew eligibility for QMBs described in section 1905(p)(1) of the Act more frequently than once every 12 months, but no more frequently than once every 6 months. Thus, we cannot, propose to limit renewals for QMBs to once every 12 months, and proposed § 435.916(a)(2) continues to allow States to conduct more frequent renewals of Medicaid eligibility for QMBs consistent with section 1902(e)(8) of the Act. However, States are permitted under current regulations at § 435.916(b) to conduct renewals once every 12 months for QMBs and would remain able to do so under proposed § 435.916(a)(2). We encourage States to exercise their flexibility to schedule renewals only once every 12 months for QMBs to mitigate churn and ease administrative burden on beneficiaries and States that is associated with more frequent renewals of eligibility.

Proposed § 435.916(b)(3) also requires States to adopt the renewal processes at § 435.916(a)(3) of the regulations, as revised at redesignated § 435.916(b)(2), for non-MAGI beneficiaries when a State is unable to renew eligibility for an individual based on information available to the agency. Proposed § 435.916(b)(2) and (3) would require States to provide all beneficiaries, including non-MAGI beneficiaries, whose eligibility cannot be renewed in accordance with proposed § 435.916(b)(1): (1) a renewal form that is pre-populated with information available to the agency; (2) a minimum of 30 calendar days to return the signed renewal form along with any required information; and (3) a 90-day reconsideration period for individuals terminated for failure to return their renewal form but who subsequently return their form within the reconsideration period. We believe aligning these renewal procedures would promote continuity of coverage and simplify the renewal process for non-MAGI beneficiaries in a manner that is in the best interest of beneficiaries, consistent with section 1902(a)(19) of the Act, including those in households with individuals enrolled on both a MAGI and non-MAGI basis who otherwise may be subject to more burdensome administrative requirements at renewal. In addition, we believe States will also experience reduced administrative burden associated with churn if individuals face fewer administrative barriers to maintaining coverage.

We also propose to eliminate the option States have under current regulations at §§ 435.907(d) and 435.916(b) to require an in-person interview as part of the application and renewal process for non-MAGI beneficiaries. Stakeholder feedback on the beneficiary experience navigating State application and renewal processes indicate that it can be challenging for individuals who are Medicaid eligible based on being age 65 or older or having blindness or a disability status to coordinate, prepare for, and participate in an interview and missing and/or having to reschedule an interview, particularly when the process is not flexible for the individual, can result in determinations of ineligibility and/or terminations based on procedural reasons.[55] We believe in-person interview requirements create a barrier for eligible individuals to obtain and maintain coverage without yielding any additional information than can be obtained through other modalities, particularly for individuals without access to reliable transportation or a consistent schedule.

In addition to eliminating the option to require an in-person interview, we propose to codify longstanding policy to align enrollment requirements in the best interest of all applicants. Proposed § 435.907(c)(4) codifies longstanding policy that States accept all MAGI-exempt applications and supplemental forms provided by applicants seeking coverage on a non-MAGI basis, through all the modalities listed in current regulations at § 435.907(a). Eliminating the in-person interview requirement and codifying the requirements for accepting MAGI-exempt applications and supplemental forms through all modalities would further align eligibility and enrollment procedures for MAGI and non-MAGI applicants and beneficiaries and reduce applicant and beneficiary burden, consistent with sections 1902(a)(4) and (a)(19) of the Act.

We propose removing the introductory language at the current § 435.916(b) related to the frequency of and process for renewals of eligibility for non-MAGI beneficiaries. We propose redesignating current regulations at § 435.916(b)(1) and (2) (related to the agency's option to consider blindness and disability as continuing at renewal) at proposed § 435.916(b)(3)(i) and (ii).

In addition to the policy changes proposed to align application and renewal processes for MAGI and non-MAGI populations whenever possible, we propose several additional changes to current § 435.916 to ensure that the renewal requirements are clear and consistent. We propose to redesignate current regulations at § 435.916(a)(2) (related to renewals based on information available to the agency) and § 435.916(a)(3) (related to renewals that require information from beneficiaries) to § 435.916(b)(1) and (b)(2), respectively. States will continue to be required to attempt to renew eligibility for all Medicaid beneficiaries (MAGI and non-MAGI) based on available information before requesting information from the individual, as required at current § 435.916(a)(2) and (b), and to send a renewal form to, and request information from, beneficiaries for whom the State does not have sufficient information to redetermine eligibility, and accept the renewal form through all modalities required at application at § 435.907(a). (online, by telephone, by mail, or in person). We propose to modify the header in proposed § 435.916(b)(2) from ''use of a pre-populated renewal form'' to ''renewals requiring information from the individual'' since the current regulations describe the steps States must take when conducting renewals that require information from the individual, which includes, but is not limited to, the use of pre-populated renewal forms.

At § 435.916, we also propose to revise current paragraph (a)(3)(i)(B), redesignated at proposed paragraph (b)(2)(i)(B), to clarify that the 30 calendar days that States must provide beneficiaries to return their pre-

[55] CMS Office of Burden Reduction & Health Informatics (April 2022). Navigating the Medicare Savings Program (MSP) Eligibility Experience. *https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf.*

populated renewal form begins on the date the State sends the form. This would mean that beneficiaries have 30 calendar days from the date a form is postmarked or, for beneficiaries who elected to receive electronic notices, the date the electronic is sent. We believe starting the 30-day period from the date the State sends the form, instead of the date on the form, will ensure beneficiaries do not lose time to respond if the form is postmarked or sent after it is dated.

We propose clarifying revisions to current § 435.916(a)(3)(i)(B) (related to renewal form signatures), redesignated at proposed § 435.916(b)(2)(i)(B), by including a technical change to explicitly state that beneficiaries must sign their pre-populated renewal form under penalty of perjury; current regulations at § 435.916(a)(3)(i)(B) includes this requirement only by cross reference to § 435.907(f).

We propose to revise current § 435.916(a)(3)(iii) (related to timely processing of renewal forms and information returned during the reconsideration period), redesignated at proposed § 435.916(b)(2)(iii), to specify explicitly in regulation our current policy that the returned renewal form and information received during the reconsideration period serve as an application and require, via cross reference to § 435.912(c)(3) of the current regulation, that States determine eligibility within the same timeliness standards applicable to processing applications, that is, 90 calendar days for renewals based on disability status and 45 calendar days for all other renewals. Treatment of renewal forms returned during the 90-day reconsideration period as an application means that the availability of retroactive eligibility at § 435.915 can close the gap in coverage that such beneficiaries otherwise would experience. Adherence to the timeliness standards applicable to applications will ensure eligible individuals are furnished coverage with reasonable promptness, consistent with sections 1902(a)(4) and 1902(a)(8) of the Act and will minimize the likelihood that individuals will forgo needed care. As revised, proposed § 435.916(a)(3)(iii) is also consistent with guidance described in the December 4, 2020, CMCS Informational Bulletin ''Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements'' (2020 Renewal CIB) that a renewal form returned within the reconsideration period serves as an application for the purposes of adherence to timeliness standards to make determinations of eligibility.[56] [57]

We propose to redesignate and revise current regulations at § 435.916(c) and (d), related to redeterminations based on changes in circumstances, at the new proposed § 435.919. Proposed revisions to these regulations are discussed in section II.B.2. of this proposed rule.

With the redesignation of current § 435.916(c) and (d) to proposed § 435.919, we also propose to redesignate current § 435.916(e) (related to requesting only information from beneficiaries needed to renew eligibility) at proposed § 435.916(b)(2)(v). We propose to redesignate current § 435.916(f) (related to determining eligibility on all bases and transmission of data pertaining to individuals no longer eligible for Medicaid) and § 435.916(g) (relating to accessibility of renewal forms and notices) to proposed § 435.916(d) and (e), respectively. Additionally, we modify current § 435.916(f)(2), redesignated at § 435.916(d)(2) in this proposed rule, to ensure that, prior to terminating coverage for an individual determined ineligible for Medicaid, States determine eligibility for CHIP and potential eligibility for other insurance affordability programs (that is, BHP and insurance affordability programs available through the Exchanges) and transfer the individual's account in compliance with the procedures set forth in § 435.1200(e), including proposed changes described in section II.B.5. of this proposed rule. We believe requiring that these actions be completed prior to termination is necessary to limit gaps in coverage for individuals transitioning between Medicaid and other insurance affordability programs, consistent with sections 1902(a)(4) and 1902(a)(19) of the Act. We add a paragraph heading at proposed § 435.916(e) to format the provision consistent with other provisions in § 435.916.

Finally, as discussed in section II.B.3. of this proposed rule, we propose to establish time standards for States to complete renewals of eligibility in proposed § 435.912(c)(4) and add a cross reference to these proposed time standards in proposed § 435.916(c).

2. Acting on Changes in Circumstances Timeframes and Protections (§§ 435.916, 435.919, and 457.344)

Section 1902(a)(10) of the Act authorizes States to make medical assistance available under the State plan to individuals who meet certain eligibility criteria. Once an applicant has been determined eligible for coverage, Federal regulations include two basic requirements to ensure that individuals receiving medical assistance continue to be eligible. First, as described in section II.B.1. of this proposed rule, States are required to conduct regular renewals of eligibility per § 435.916(a) and (b) of the current regulations. Second, per § 435.916(c) and (d) of the current regulations, States must have a process to obtain information about changes in circumstances that may impact a beneficiary's eligibility and redetermine eligibility in between regular renewals when appropriate.

Current regulations at § 435.916(c) require that States have procedures designed to ensure that beneficiaries make timely and accurate reports of any changes in circumstances that may affect their eligibility and that such changes may be reported through any of the modes for submission of applications described in § 435.907(a). Current regulations at § 435.916(d) specify that the agency must promptly redetermine eligibility between regular renewals of eligibility whenever it receives information about a change in beneficiary circumstances that may affect eligibility, such as a change in income or the death of a beneficiary. The regulation does not define ''promptly.''

We are concerned that a number of States are not taking appropriate steps to follow up on reported or detected changes in beneficiaries' circumstances within a reasonable period of time or in a manner that promotes continuity of coverage for eligible beneficiaries. There is a potential risk to beneficiaries if a State delays processing a change in circumstances that may entitle a beneficiary to additional assistance or lower premiums or cost-sharing, as well as risk that beneficiaries may lose coverage for procedural reasons if States do follow up with a beneficiary to request additional information but do not provide sufficient time for the beneficiary to respond. Moreover, recent U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) reports, as well as CMS audits and data analyses have cited cases in which States continued to provide coverage for many months after a change impacting eligibility was identified that should have prompted a redetermination based on a change in circumstances and other instances in which States continued to make

[57] CMCS Informational Bulletin: Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements (2020). Available at *https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.*

capitated payments to managed care plans for deceased beneficiaries.[58]

Consistent with section 1902(a)(4) of the Act, to promote the proper and efficient administration of the Medicaid program, we propose to add a new § 435.919 to clearly define the responsibilities States have to act on changes in circumstances. We propose to revise and redesignate § 435.916(c) of the current regulations (related to procedures for reporting changes) to new § 435.919(a). We propose to revise and redesignate current § 435.916(d) (related to promptly acting on changes in circumstances) to proposed § 435.919(b) and (c).

Proposed § 435.919(a)(1) would specify that States must have procedures for beneficiaries to make timely and accurate reports of changes in circumstances that may affect eligibility. Proposed § 435.919(a)(2) specifies that States must accept both reported changes in circumstances that may affect eligibility and any other beneficiary reported information through the same modes for submission of application at § 435.907(a). We believe this is an important update that would ensure that beneficiaries can easily report information that supports continued enrollment in Medicaid, such as updating contact information or reporting an in-state address change, even if the information would not constitute a change in circumstances that affects eligibility.

Proposed § 435.919(b)(1) describes the steps that we believe States should be required to take in processing changes in circumstances reported by a beneficiary in between renewals of eligibility. Under the proposed regulation, States must first evaluate whether the reported change may result in ineligibility for Medicaid or a change in the amount of medical assistance for which the beneficiary is eligible (for example, a change in benefits or higher or lower premiums or cost sharing charges). If additional information is needed to determine whether the beneficiary remains eligible, the agency must redetermine eligibility based on available information, if able to do so, and if the additional information is not available to the agency, request such information from the beneficiary. When the agency requests information from the beneficiary to determine whether a change in circumstances results in coverage that is more beneficial to the individual (for example, additional benefits or lower premiums or cost sharing charges), the agency may not take adverse action if the beneficiary does not respond. In this situation, the agency would not provide the more beneficial coverage but would instead continue to provide the less beneficial coverage for which eligibility was already established. The agency must send the beneficiary written notice of this decision consistent with 42 CFR 435.917(b)(1), which must include information on the beneficiary's right to appeal their eligibility status or level of benefits and services approved.

If the reported change adversely impacts the beneficiary's eligibility for Medicaid such that termination may be necessary, the State must consider whether the beneficiary may remain eligible on any other basis, as currently required under current regulations at § 435.916(f)(1), which is redesignated at § 435.916(d)(1) in this proposed rule. If the beneficiary is determined to be ineligible for Medicaid on any basis, proposed § 435.919(b)(1), cross-referencing to proposed § 435.919(b)(4), provides that the State must provide advance notice of termination and fair hearing rights, consistent with 42 CFR part 431, subpart E of the regulations. Prior to making a determination of ineligibility, the State also must determine potential eligibility for other insurance affordability programs and transfer the individual's account, as appropriate, consistent with existing regulations at § 435.916(f)(2), redesignated at proposed § 435.916(d)(2). If the agency finds that the reported change results in other adverse action, such as higher premiums or cost sharing charges or a reduced benefit package, the State must provide advance notice of the adverse action and fair hearing rights, consistent with the requirements of 42 CFR part 431, subpart E. We note that, in accordance with 42 CFR 431.230, if the beneficiary requests a fair hearing prior to the date of action provided in the advance notice (for example, the date the individual's eligibility will be terminated), the State may not implement the adverse action until a fair hearing decision is rendered.

If a beneficiary-reported change may result in an increase in the amount of assistance a beneficiary is entitled to, for example, a reduction in premiums or cost sharing, or additional benefit, the State must verify the reported information in accordance with §§ 435.940 through 435.960 and the State's verification plan prior to granting additional coverage or assistance. Such verification may include electronic data or other information available to the agency, attested information, or documentation from the beneficiary. States may not terminate the beneficiary's coverage or take other adverse action if the individual does not respond to requests for additional information to verify the beneficiary-reported change. If the reported change has no impact on eligibility or coverage, consistent with section 1902(a)(4) and (a)(19) of the Act, we propose at § 435.919(b)(1)(iv) that the agency must acknowledge the reported change by providing the beneficiary with notice acknowledging receipt of the information and explaining that there is no impact on eligibility or coverage.

The process we are proposing for States to act on information obtained from a third party, such as information obtained through an electronic data match or from another program such as the Supplemental Nutrition Assistance Program (SNAP), is described at proposed § 435.919(b)(2). This process largely mirrors that described in proposed § 435.919(b)(1), discussed above. Under proposed § 435.919(b)(2), the agency will need to evaluate the reliability of the information obtained and, if reliable information from a third party may result in an adverse action, the State must give the beneficiary an opportunity to provide information disputing the accuracy of the third-party information in accordance with § 435.952(d). If the beneficiary does not respond with the requested information or the information provided does not establish the beneficiary's continued eligibility or entitlement to the same level of assistance, the State must: (1) provide advance notice of termination or other adverse action and fair hearing rights consistent with part 431, subpart E; and (2) before terminating the beneficiary's coverage, assess eligibility for other insurance affordability programs in accordance with proposed revisions to current § 435.916(f)(2), redesignated at § 435.916(d)(2) in this rulemaking, and transfer the individual's account, as appropriate.

If a change identified by reliable third-party data may result in an increase in the amount of coverage or assistance a beneficiary is entitled to (for example, additional benefits or lower premiums or cost sharing), States retain flexibility under the proposed rule either to act on the third-party information without additional follow up or to contact the beneficiary to determine whether the information received is accurate. However, States that choose to contact the beneficiary to verify the accuracy of information prior

[58] *https://www.lla.la.gov/PublicReports.nsf/1CDD30D9C828608286258340065E5F6/$FILE/0001ABC3.pdf* and *https://oig.hhs.gov/oas/reports/region7/71604228.pdf*; *https://oig.hhs.gov/oas/reports/region5/51800026.pdf*; *https://oig.hhs.gov/oas/reports/region4/41806220.pdf*; and *https://oig.hhs.gov/oas/reports/region5/51700008.pdf.*

to furnishing additional assistance may not terminate the beneficiary's coverage or take other adverse action if the individual does not respond to the request for information. Additionally, if States choose to contact the beneficiary and the beneficiary does not respond to the request for information, the State may act on the third-party information. If third-party information is not reliable (for example, information is older than other information available to or obtained by the State or is incomplete) or does not impact the beneficiary's eligibility, there is no requirement for the agency to take further action or to provide notice to the beneficiary. Additionally, States may not take adverse action based on unreliable information.

At § 435.919(c)(1), we propose that States provide a minimum of 30 calendar days from the date a request for information is sent, which is the date the request is postmarked or the date the notice is sent electronically if the beneficiary elected to receive electronic notices, for a beneficiary to obtain and submit information needed in order for the State to redetermine eligibility based on a change in circumstances. We believe specifying a minimum timeframe will ensure all States provide beneficiaries a reasonable time to respond to requests for information to demonstrate ongoing eligibility and mitigate churn that would otherwise occur when beneficiaries do not have sufficient time to respond to such requests. We believe the 30-day timeframe also provides beneficiaries consistency across program requirements as this aligns with the minimum timeframe MAGI beneficiaries are provided to return their renewal form in the current regulations § 435.916(a)(3)(i)(B) and proposed timeline for all beneficiaries to return their renewal form at § 435.916(a)(2)(i)(B) of this proposed rule. As discussed in section II.B.3. of this proposed rule, we propose to establish time standards for States to promptly act on changes in circumstances and standards for acting on anticipated changes in circumstances in proposed § 435.912(c)(5) and (6), and we cross reference to these proposed time standards in proposed § 435.919(c)(2).

At § 435.919(d), we propose that States provide beneficiaries whose coverage was terminated due to failure to provide information requested in accordance with proposed § 435.919(b)(1)(i) and (ii) with a 90-day reconsideration period. Under the proposal, if a beneficiary returns requested information within 90 calendar days of termination, the State would be required to redetermine the individual's eligibility without requiring a new application. While States may not require individuals to complete a new application within the reconsideration period, States may need to request additional information from the individual that is required at application, such as additional information needed to determine eligibility or a signature under penalty of perjury that information provided is accurate. Consistent with § 435.915(a) of the current regulations, retroactive coverage during the 90-day period generally would be available, including for MSP eligibility groups described in section 1902(a)(10)(ii), (iii) and (iv)[59] of the Act, to help fill any gap in coverage for eligible individuals for whom retroactive eligibility may apply. Similar to the 90-day reconsideration period provided to individuals terminated for failure to complete a regularly-scheduled renewal under § 435.916(a)(3)(iii) of the current regulations, we believe this proposed policy is important to reduce gaps in coverage as well as the administrative burden associated with churn, when beneficiaries terminated from coverage reapply within a few months thereafter, particularly beneficiaries enrolled in managed care. We propose that the application timeliness standards provided under § 435.912(c)(3) would apply to redeterminations initiated during the 90-day reconsideration period proposed at § 435.919(d). Application of the timeliness standards at § 435.912(c)(3) in this situation aligns with the proposed revision of current regulations at § 435.916(a)(3)(iii), redesignated at proposed § 435.916(b)(2)(iii), to apply the timeliness standards to redeterminations initiated during the 90-day reconsideration period afforded beneficiaries under current regulations to return renewal forms. Proposed revisions to current § 435.916(a)(3)(iii), redesignated at proposed § 435.916(b)(2)(iii), are discussed in section II.B.1. of this proposed rule.

Proposed § 435.919(e) includes the requirements in § 435.916(d)(1)(i) and (ii) of current regulation (relating to the limitation on requests for information to necessary information and the circumstances under which States may begin a new eligibility period, which is the period of time between application and renewal or regularly scheduled renewals, following a change in circumstances). We propose revisions to current § 435.916(d)(1)(i), redesignated at § 435.919(e)(1) in this proposed rule, to remove the reference to MAGI beneficiaries in order to apply the requirement that States evaluating a change in circumstances must limit requests for additional information to such change in circumstances to both MAGI and non-MAGI beneficiaries. We believe this change is necessary to ensure non-MAGI beneficiaries are not subject to a full renewal of eligibility more frequently than once every 12 months, consistent with proposed § 435.916(a). We redesignate current § 435.916(d)(1)(ii), which allows States to begin a new 12-month eligibility period if the agency has enough information to renew eligibility with respect to all eligibility criteria when processing a change in circumstances, to proposed § 435.919(e)(2). We also make technical changes to current § 435.916(d)(1)(ii), redesignated at proposed § 435.919(e)(2), to use the term ''eligibility period'' rather than ''renewal period'' and to remove the reference to the ''12-month'' eligibility period to align the length of the new eligibility period the State may begin for an individual consistent with the eligibility periods described in proposed § 435.916(a).

Finally, we propose to redesignate and modify § 435.916(d)(2), which requires that States act on anticipated changes in circumstances at the appropriate time as proposed at § 435.919(b)(3), as this provision also relates to changes in beneficiary circumstances. In proposed § 435.919(b)(3), we modify language in the current regulations at § 435.916(d)(2) to require that States act on anticipated changes at an appropriate time (instead of *the* appropriate time) and clarify that this means that the State would need to initiate a redetermination consistent with timeliness standards for processing anticipated changes in circumstances at proposed § 435.912(c)(6). While CMS does not define for each State the appropriate time to act on an anticipated change in circumstances, we expect States to begin the process early enough in order to reasonably complete the redetermination prior to the anticipated change occurring. As discussed in section II.B.3. of this proposed rule, we propose to establish timelines for States to redetermine eligibility based on anticipated changes in circumstances in proposed § 435.912(c)(6). In proposed

[59] Retroactive eligibility is not available to individuals who qualify for coverage under the QMB group described in section 1902(a)(10)(E)(i) of the Act. Per section 1902(e)(8) of the Act, coverage under the QMB group is effective the month following the month in which the QMB eligibility determination is made.

§ 435.919(c)(2), we require States to redetermine eligibility for a beneficiary with an anticipated change in circumstances within the time standards established in proposed § 435.912(c)(6). We believe including the cross reference to proposed § 435.912(c)(6) will ensure States determine the appropriate time to act based on their processes prior to the anticipated change in circumstances occurring such that the State can complete the redetermination according to the time standards in proposed § 435.912(c)(6).

With the proposed creation of § 435.919 and the proposed re-designation of § 435.916(d), with revisions, to new § 435.919(b), we also propose technical changes at §§ 435.911(c) and 435.1200(e)(1). Current § 435.911(c) applies to individuals who submit an application described in § 435.907 or whose eligibility is being renewed in accordance with § 435.916. We propose to add a new clause to extend the application of this paragraph to individuals whose eligibility is being redetermined in accordance with § 435.919. At § 435.1200(e)(1), we propose to replace the reference to § 435.916(d) with a reference to proposed § 435.919(b). Changes to § 435.1200 are discussed in further detail in section II.B.5. of this preamble. Additionally, the application of the proposed requirements of § 435.919 to CHIP is discussed in section II.E.2. of this preamble.

3. Timely Determination and Redetermination of Eligibility (§§ 435.907 and 435.912)

Several regulatory requirements, currently codified in subpart J of part 435, establish parameters to ensure that applications for coverage are not unduly burdensome and that new applicants receive a timely determination of eligibility. Other provisions protect current beneficiaries from needlessly onerous renewal requirements and ensure that States keep individuals enrolled while they review potential Medicaid eligibility on other bases. Section 435.907 of the current regulations describes the requirements for States to make available an application for Medicaid, the limitations on the information that may be requested at application, and the modalities through which individuals must be able to apply. Similarly, § 435.916 (discussed in section II.B.1. of this preamble) describes the requirements for States to conduct renewals and limitations on the information that may be requested from beneficiaries at renewal, and proposed § 435.919 (discussed in section II.B.2 of this preamble) would redesignate and revise current § 435.916(c) and (d) with respect to redeterminations based on changes in circumstances.

The requirements related to the timely determination of eligibility, including the maximum time period in which individuals are entitled to a determination of eligibility, exceptions to timeliness requirements, and considerations for States in establishing performance standards are found at § 435.912. As described at current § 435.912(c)(3), States are required to determine the eligibility of new applicants within 90 calendar days if they apply on the basis of disability and within 45 calendar days for applicants applying on all other bases. These longstanding timeframes are important for ensuring eligible applicants receive timely access to coverage. However, the current regulations do not establish standards to ensure that applicants have enough time to gather and provide additional information and documentation requested by a State in adjudicating eligibility. In addition, the timeframes provided in current § 435.912(c) expressly apply only to new applications; they do not expressly apply to redeterminations either at renewal or based on changes in circumstances.

Current regulations at § 435.930(b) require that States continue furnishing Medicaid benefits to eligible individuals, until they are found to be ineligible. Under this provision, a beneficiary may not be disenrolled if the State has not completed a redetermination of eligibility, even after the end of an individual's scheduled renewal date. This provision is critical to ensuring that eligible beneficiaries are not inappropriately terminated from coverage. However, if completing a renewal is delayed, ineligible individuals may remain inappropriately enrolled.

Ensuring the integrity of Medicaid and CHIP—both to prevent inappropriate enrollments and to protect the enrollment of eligible individuals—is an important component of CMS's work. From a program integrity perspective, both termination of coverage without an accurate determination of ineligibility and the extension of coverage beyond a beneficiary's period of eligibility would constitute an error. Through PERM, the MEQC program, and other CMS eligibility reviews, we partner with States to review their eligibility and enrollment processes and conduct case reviews to ensure that eligible individuals can enroll and stay enrolled without undue burden and that ineligible individuals are redirected to the appropriate coverage programs. Through this work, as well as our ongoing work with States prior to the COVID–19 PHE, we have become aware that in certain situations, redeterminations can remain incomplete for several months following the end of a beneficiary's eligibility period. For example, this may happen when a beneficiary does not timely return documentation or when a determination on another basis is required. While we recognize the challenges States may face in completing redeterminations by the end of a beneficiary's eligibility period or as quickly as possible when they become aware of a potential change in circumstances, it is important that States act promptly once all information and other documentation requested from the individual is received.

Consistent with sections 1902(a)(4) and (19) of the Act to ensure the proper and efficient administration of the program and that eligibility is determined in a manner consistent with simplicity of administration and best interests of beneficiaries, we propose changes to § 435.907 and § 435.912 to ensure that applicants and beneficiaries have adequate time to furnish all requested information and that States complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances.

With respect to new applicants, we propose to revise § 435.907 first to redesignate § 435.907(d) (relating to a prohibition on requiring in-person interviews) as § 435.907(d)(2). As discussed in section II.B.1 of this preamble, we also propose to revise newly redesignated paragraph (d)(2) of § 435.907 to remove the clause that states, ''for a determination of eligibility using MAGI-based income'' such that the prohibition on requiring in-person interviews applies to both the MAGI-based and non-MAGI application processes. Then we propose to establish a new paragraph (d)(1) at § 435.907, which would require that, if the State agency is unable to determine an applicant's eligibility based on the information provided on the application and verified through electronic data sources, and it must obtain additional information from the applicant, specified requirements would need to be met. This may occur, for example, if an applicant fails to complete a section of the application before signing and submitting it, or if an applicant provides information on the application that is not reasonably compatible with the

information available through electronic data sources.

Proposed § 435.907(d)(1)(i)(B) would require the agency to provide most applicants with at least 15 calendar days, from the date the request is postmarked or the electronic request is sent, to respond with the additional information. For applicants whose Medicaid eligibility is being considered on the basis of a disability, such as individuals under age 65 who may be eligible for the age and disability-related poverty level group described at section 1902(a)(10)(A)(ii)(X) of the Act, proposed § 435.907(d)(1)(i)(A) would require the agency to provide the applicant with at least 30 calendar days, from the date the request is postmarked or the electronic request is sent, to respond. Additionally, as described at proposed § 435.907(d)(1)(ii), applicants must be permitted to provide additional information through any of the modes by which an application may be submitted at current § 435.907(a). This is current policy that we are proposing to codify through this proposed rule.

As discussed in sections II.B.1 and II.B.2 of this preamble, current § 435.916(a)(3)(i)(B), redesignated at proposed § 435.916(b)(2)(i)(B), and proposed § 435.919(c)(3) would require the agency to provide current beneficiaries with at least 30 calendar days from the date the request is postmarked or the electronic request is sent to submit requested information, beginning on the date the State sends the request for additional information, which is the date the request is postmarked or the date the electronic request is sent. This is longer than the minimum timeframe of 15 calendar days that we propose for most applicants to furnish additional information or documentation. We considered establishing a 30-day requirement for all applicants, consistent with the timeframe proposed at redetermination, but we believe that a 15-day response period for most applicants is appropriate for several reasons. First, in determining eligibility for an applicant, the agency will have recently received information from the applicant (or a person acting responsibly on their behalf) who is newly seeking coverage, and we believe the applicant (or such other person) will typically be expecting a communication from the agency. By contrast, at renewal and when the agency is acting on information it has received from other sources, a beneficiary may be less likely to expect any communication from the State, and therefore, may be less prepared to respond. Second, while States are required to make eligibility effective on the date of application, or up to 3 months prior if the individual would have been eligible retroactively, applicants may be reluctant to access covered services before the eligibility determination is completed. Requiring the agency to make a final determination on applications within the maximum 45 calendar days permitted for individuals applying on a basis other than disability status while also providing the individual with at least 30 calendar days to respond to a request for additional information is unreasonable. However, to permit States more than 45 calendar days to complete applications when additional information is required also could result in eligible individuals delaying needed care. We believe that a minimum 15 calendar days strikes an appropriate balance for most applicants and we seek comment on whether States, beneficiaries, and other interested parties agree that this timeframe is appropriate.

As noted above, we are proposing that States must provide applicants applying on the basis of disability with at least 30 calendar days, from the date the request is postmarked or the electronic request is sent, to return additional information or documentation required by the agency. We believe the longer timeframe is appropriate because some individuals with disabilities may need more time to gather documentation related to their disability determination and since States have up to 90 calendar days to make a final determination of eligibility on disability-based applications, the additional time will not undermine States' ability to make a timely determination.

We are considering aligning the minimum time that States must provide all applicants to submit additional information or documentation requested by the State, as well as finalizing a longer timeframe for all applicants. Timeframes under consideration include 15 calendar days, 20 calendar days, 25 calendar days, and 30 calendar days. We are also considering a minimum requirement of 30 calendar days for all applicants, accompanied by a change to the timeliness requirements for application processing, which would establish an exception to the 45-day requirement at current § 435.912(c)(3)(ii) and provide an additional 15 calendar days for a State to complete application processing when additional information is needed. We seek comment on the appropriate minimum timeframe for applicants to submit requested information at proposed § 435.907(d) that will provide the greatest balance between ensuring that a State determines eligibility as quickly as possible and that applicants have adequate time to gather any information or documentation needed by the State to complete the determination. We also seek comment on whether the final rule should align the timeframe for all applicants or provide a longer period for individuals applying on the basis of disability, and whether a corresponding exception to the 45-day timeliness requirement at § 435.912(c)(3)(ii) should accompany a longer timeframe. In addition, we request comment on whether calendar days or business days would provide a more appropriate measure of timeliness here.

Finally, when the State agency cannot determine an applicant's eligibility for Medicaid without additional information and the agency denies eligibility because the applicant does not timely respond to a request for additional information, per current regulations at § 435.917, the State must provide the individual with notice of the agency's decision. We propose at § 435.907(d)(1)(iiii)(A) that, if the individual subsequently submits the requested information within 30 calendar days of the date the notice of ineligibility is sent (or a longer period established by the State), the State must reconsider the individual's eligibility without requiring the individual to complete and submit a new, full application. This is similar to the reconsideration periods provided at current § 435.916(a)(3)(iii) (redesignated at proposed § 435.916(b)(2)(iii) in this proposed rule) for individuals whose eligibility is terminated at their regularly-scheduled renewal and proposed § 435.919(d) for individuals whose eligibility is terminated following a change in circumstances due to failure to provide additional information requested by the agency.

To ensure that a State has adequate time to complete the determination of eligibility when requested information is submitted during the reconsideration period, we propose at § 435.907(d)(1)(iii)(B) to begin a new clock for determining timeliness. This would provide the State with an additional 45 calendar days (or 90 calendar days for disability-related determinations) to complete the eligibility determination in accordance with proposed § 435.912(c)(3), beginning on the date that the requested information is submitted. In addition, to protect the needs of applicants, the effective date of coverage would continue to be determined in accordance with the date upon which the application was submitted as described at proposed

§ 435.907(d)(1)(iii)(C). We believe this would provide the best balance for both the applicant and the State agency, by protecting the applicant's access to coverage while providing additional time for the State to complete a timely determination. We seek comment on whether the effective date of coverage should be determined in accordance with the application date or whether, consistent with the reconsideration period at renewal and the proposed reconsideration period following a change in circumstances (described in section II.B.2. of this preamble), the return of additional information would effectively constitute a new application with a new effective date of coverage.

We are proposing a 30-day reconsideration period at application, rather than a 90-day reconsideration period similar to the 90-day period proposed at redetermination, because we believe applicants will generally be expecting a communication from the State regarding the status of the submitted application and will be less likely than current beneficiaries to miss requests for additional information. We also are concerned that a longer reconsideration period for applicants would mean that a longer period of time will have elapsed between the date the applicant has attested to information provided on the application and the date a determination is ultimately made. However, recognizing that a consistent 90-day period for all reconsiderations—at application, at renewal, and following a change in circumstances—may be clearer, we seek comment on whether the length of reconsideration period at application should align with the 90-day reconsideration period currently provided at renewal and proposed for redeterminations based on changes in circumstances in this rulemaking, or whether the reconsideration period for applicants should be somewhat longer than 30 calendar days (for example, 45 calendar days or 60 calendar days) but still less than 90 calendar days.

With respect to redeterminations, we propose revisions to § 435.912 to clearly specify expectations for the maximum time States have to complete redeterminations at regular renewals, as well as when the State learns of a change in circumstances that may impact an individual's eligibility. Current § 435.912 requires States to establish timeliness and performance standards. Paragraph (a) of § 435.912 of the current regulations defines ''timeliness standards'' as the maximum period of time in which an individual is entitled to a determination of eligibility and ''performance standards'' as the overall standards for timely determinations of eligibility. Current § 435.912(b) lists the types of eligibility determinations for which States must establish standards, while § 435.912(c) sets forth criteria which the agency must account for in establishing these standards. Paragraphs (d) through (g) of current § 435.912 require the agency to inform individuals of the timeliness standards, to provide for exceptions to the timeliness standards for determining eligibility, and to document any delays in completing the required actions, as well as prohibiting the agency from using the application time standards either as a waiting period or as a reason to deny eligibility.

We propose first to revise the definition of ''timeliness standards'' in § 435.912(a) to specify that these standards must include not only the maximum time period in which every applicant is entitled to a determination of eligibility at application in accordance with § 435.907, but also the maximum period of time in which the agency must redetermine eligibility at renewal in accordance with § 435.916 and when an anticipated or known change in circumstances occurs in accordance with proposed § 435.919(b)(3). The ''performance standards'' defined in current § 435.912(a) would also be revised to clearly include standards for renewing and redetermining eligibility in a timely and efficient manner across a pool of beneficiaries. Section 435.911(c) of the regulations currently requires, in pertinent part, that agency must, promptly and without undue delay consistent with timeliness standards established under § 435.912, provide coverage to individuals who have submitted an application described in § 435.907 or whose eligibility is being renewed in accordance with § 435.916. We propose a conforming amendment to the introductory language in § 435.911(c) to include a cross reference to proposed § 435.919 to make clear that the terms of § 435.911(c) apply also to individuals whose eligibility is being redetermined following a change in circumstances.

Second, we propose to add a paragraph heading for § 435.912(b) that states, ''State plan requirements'' and expand upon the activities described in § 435.912(b) for which States would be required to establish timeliness and performance standards in their State plan. Specifically, we propose to expand the requirement in current § 435.912(b)(2) to establish timeliness and performance standards to include not only determinations of eligibility for Medicaid and assessments of potential eligibility for other insurance affordability programs, as currently required, but also final determinations of eligibility for CHIP consistent with changes proposed at § 435.1200(e) and described in section II.B.5. of this preamble. We also propose to incorporate current paragraph (b)(2) of § 435.912, which requires States to establish timeliness and performance standards for determining potential eligibility for and transferring an individual's electronic account to another insurance affordability program, into current paragraph (b)(1), such that proposed § 435.912(b)(1) would require the agency to establish performance and timeliness standards for determining Medicaid eligibility for individuals who submit an application to the Medicaid agency, as well as determining eligibility for CHIP when an individual is determined ineligible for Medicaid (in accordance with proposed changes discussed in section II.B.5. of this preamble) and determining potential eligibility for insurance affordability programs available through the Exchanges as described at proposed § 435.1200(e).

We propose to redesignate current § 435.912(b)(3) (regarding determining Medicaid eligibility for individuals transferred from other insurance affordability programs) as proposed § 435.912(b)(2) and to add new paragraphs (b)(3), (4), and (5) to § 435.912 as follows:

- Proposed § 435.912(b)(3) would require States to establish specific standards for redetermining eligibility at renewal in accordance with § 435.916;
- Proposed § 435.912(b)(4) would require the establishment of specific standards for redeterminations of eligibility related to changes in circumstances reported by a beneficiary or received from a third party as described at proposed § 435.919(b)(1) and (b)(2) respectively; and
- Proposed § 435.912(b)(5) would require the establishment of specific standards for redeterminations of eligibility at the time of an anticipated change in circumstances in accordance with proposed § 435.919(b)(3).

Third, current § 435.912(c)(1) provides that the timeliness and performance standards adopted by the agency must cover the period from the date of application, or transfer from another insurance affordability program, to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program. We would revise this to specify that they also include the periods of time covered by the timeliness and performance standard adopted by the

agency for renewals and redeterminations of eligibility.

Preliminarily, we propose to redesignate the requirement at current § 435.912(c)(1) (providing that the standards for these activities cover the period from the date of application or transfer to the Medicaid agency through the date that the agency notifies the applicant of its decision or transfers the account to another insurance affordability program) as proposed § 435.912(c)(1)(i). Proposed § 435.912(c)(1)(ii) would provide that timeliness and performance standards adopted by the agency for conducting regularly-scheduled renewals must cover the period from the date that the agency initiates the steps required to renew eligibility on the basis of information available to the agency, as required under § 435.916(a)(2) (redesignated as § 435.916(b)(1) in this proposed rule), to the date that the agency sends the beneficiary notice regarding their continued eligibility for coverage, or as applicable, terminates eligibility and transfers the individual to another insurance affordability program in accordance with § 435.1200(e).

Proposed § 435.912(c)(1)(iii) would provide that timeliness and performance standards adopted by the agency for conducting redeterminations of eligibility based on a change in a beneficiary's circumstances must cover the period from the date that the agency receives information indicating a potential change in circumstances that may affect eligibility to the date that the agency sends the individual a notice regarding their continued eligibility for coverage, or as applicable, terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e).

Finally, proposed § 435.912(c)(1)(iv) would provide that timeliness and performance standards adopted by the agency for conducting redeterminations of eligibility based on an anticipated change in a beneficiary's circumstances must cover the period from the date the agency begins the redetermination of eligibility based on an anticipated change, as described at § 435.919(b)(3) of this subpart, to the date the agency notifies the individual of its decision or, as applicable the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e). We also propose to add a heading to paragraph (c) that reads, ''Timeliness and performance standard requirements.''

Current § 435.912(c)(1) also requires States to comply with the requirements of paragraph (c)(2) (relating to criteria that States must consider in establishing their timeliness and performance standards) so as ''to promote accountability and consistency of high-quality consumer experience among States and between insurance affordability programs.'' We propose to incorporate this requirement into proposed § 435.912(c)(2) and to expand the criteria that States must take into account to reflect the broader scope of activities for which States must account for in establishing their timeliness and performance standards.

Current § 435.912(c)(2) requires that, in establishing their timeliness and performance standards, States must account for the capabilities and cost of available systems and technology, the general availability of electronic data matching and ease of connections to authoritative sources of information to determine and verify eligibility, the demonstrated performance and timeliness experience of other State Medicaid, CHIP and other insurance affordability programs, and the needs of individuals, including their preferred mode of application submission and the relative complexity of adjudicating their eligibility. Proposed revisions to § 435.912(c)(2) would add to these criteria the time needed by the agency to evaluate information obtained from electronic data sources and the time needed to provide advance notice to beneficiaries when the agency makes a determination that would result in the denial or termination of eligibility or another adverse action, since an adverse action cannot be effective until the end of the advance notice period (generally advance notice must be sent 10 days prior to the date of the action, in accordance with §§ 431.211, 431.213 and 431.214). Proposed § 435.912(c)(2) also would provide that States account for the needs of beneficiaries, as well as applicants and the complexity of their cases in establishing their timeliness and performance standards.

Paragraph (c)(3) of § 435.912 provides parameters for States in setting a standard for the timely determination of Medicaid eligibility at application and when an account transfer is received from another insurance affordability program. The parameters in current § 435.912(c)(3), of no more than 90 calendar days for determining eligibility on the basis of disability and no more than 45 calendar days for determining eligibility on all other bases, remain unchanged in this proposed rule. However, we propose several technical changes to § 435.912(c)(3), including the addition of a paragraph heading and additional references to the application and account transfer activities described in proposed paragraphs (b)(1) and (2) of this section.

We also propose to add new paragraphs (c)(4), (5), and (6) to § 435.912 to establish separate parameters within which States must establish timeliness standards for the completion of regularly scheduled renewals, redeterminations based on changes in circumstances, and redeterminations based on anticipated changes. In establishing the maximum timeframes in proposed § 435.912(c)(4) within which the agency must complete a regularly scheduled renewal, we take into account the additional time that States may need to complete a redetermination of eligibility when beneficiaries return needed information near the end of their eligibility period, as well as when the State may need to make a determination of eligibility on another basis, as required under § 435.916(f)(1) of the current regulations, redesignated at § 435.916(d)(1) in this proposed rule.

Based on our experience in working with States, we believe that once the agency has received all information needed to complete a redetermination of eligibility, 25 calendar days is ample time for the agency to process the redetermination and provide the minimum 10 days of advance notice of termination or other adverse action, if needed. Therefore, in the case of an individual whose eligibility can be renewed based on available information or who returns all needed information at least 25 calendar days or more prior to the end of the eligibility period, we propose at § 435.912(c)(4)(i) that the agency be required to complete a redetermination by the end of the eligibility period.

Recognizing that in certain cases, a State will not receive all of the information needed to redetermine eligibility until closer to the end of the eligibility period, proposed § 435.912(c)(4)(ii) would provide additional time in such cases. If information is returned before the end of the eligibility period, but with less than 25 calendar days remaining, proposed § 435.912(c)(4)(ii) would provide the agency with one additional month to complete a timely redetermination of eligibility. In such cases, the agency would be required to complete the redetermination, on the basis on which the beneficiary was last determined eligible, by no later than the end of the month following the month in which the individual's eligibility period ends.

For example, suppose a beneficiary's 12-month eligibility period is scheduled to end on March 31st, but the individual does not return all information needed to redetermine eligibility until March 20th. This is less than 25 days prior to the end of the eligibility period, so in this example, the State would need to complete the renewal by no later than April 30th (the end of the month following the month in which the individual's eligibility period ends). We seek comment on whether proposed § 435.912(c)(4)(i) and (ii) strike the right balance between maximizing completion of timely renewals and providing States with sufficient time to not only complete a renewal but also to provide advance notice of termination when necessary.

Proposed § 435.912(c)(4)(iii) addresses timelines for renewals in which eligibility must be considered on another basis. Current § 435.916(f) (redesignated at proposed § 435.916(d)) requires the agency, when it determines that an individual is no longer eligible on the basis upon which he or she has been receiving coverage, to consider eligibility on all bases prior to completing a determination of ineligibility for Medicaid. When information in the individual's case record or renewal form indicates that the beneficiary may be eligible on another basis or bases (for example, an individual determined ineligible based on MAGI may be eligible based on disability), we recognize that additional time may be required for States to obtain the additional information needed to make a determination on such other basis. Proposed § 435.912(c)(4)(iii)(B) provides the agency with 25 days to make a determination of eligibility for most beneficiaries and to send advance notice of termination if the individual is ineligible. However, if a new determination based on disability is necessary, we propose in § 435.912(c)(4)(iii)(A) a maximum of 90 days for States to complete a redetermination of eligibility on the basis of disability. The applicable time period (25 or 90 days) is measured in calendar days from the date the agency determines the individual not eligible on the basis on which he or she had been receiving coverage. We believe that a longer 90-day period is appropriate when a determination of disability is required because of the additional complexity in making a disability determination. This is consistent with the maximum 90 days provided for States making a determination of eligibility based on disability at initial application as described at current § 435.912(c)(3)(i). Regulations governing determinations of disability are found at § 435.541.

These timeliness standards for regularly scheduled renewals are cross-referenced in proposed § 435.916(c), which requires that a renewal be completed by the end of the beneficiary's eligibility period in accordance with proposed § 435.912(c)(4)(i). If an individual returns the renewal form with less than 25 calendar days remaining before the end of their eligibility period, proposed § 435.912(c)(4)(ii) would permit the State to complete the renewal by the end of the month following the month in which the individual's eligibility period ends. This would be compliant with both the renewal requirement at proposed § 435.916(c) and the timeliness requirement at proposed § 435.912(c)(4)(ii). As noted previously, when a determination of eligibility is completed after the end date of a beneficiary's eligibility period, current § 435.930(b) requires the agency to continue furnishing Medicaid to the individual while the determination of eligibility is pending. This permits the State to continue providing medical assistance to the individual until the renewal is completed, and if the individual is no longer eligible for Medicaid, it provides the State with adequate time to provide advance notice and fair hearing rights in accordance with part 431 subpart E of the regulations.

Under proposed § 435.912(c)(5), States must complete redeterminations based on changes in beneficiary circumstances reported by an individual or third party no later than the end of the month that occurs 30 calendar days from the date the State receives information indicating a potential change in circumstances, if the State has sufficient information to evaluate any potential impact and to redetermine eligibility without requesting additional information from the individual. Because most States continue coverage through the end of the month, we propose to extend the requirement to the end of the month in which the 30th day occurs. If additional information from the beneficiary is needed, we propose at § 435.912(c)(5)(ii) that States have through the end of the month that occurs 60 calendar days from the date the State receives information indicating a change in circumstances that may impact eligibility to make a redetermination of eligibility. We note that proposed § 435.919(c)(3) would require States to provide beneficiaries with at least 30 calendar days from the date the request is postmarked or the electronic request is sent to provide the information and that the State enable beneficiaries to do so through any of the modes of submission specified in § 435.907(a). This aligns with the 30 calendar days which States must provide beneficiaries to return a pre-populated renewal form and any needed documentation at renewal under current regulation at § 435.916(a)(3)(i)(B), redesignated at proposed § 435.916(b)(2)(i)(B).

Proposed § 435.912(c)(6) establishes requirements for redeterminations of eligibility based on anticipated changes in circumstances. As described in § 435.916(d)(2) (redesignated as proposed § 435.919(b)(3)), anticipated changes are events that the agency knows about in advance, like a beneficiary's birthday, and States must act on such changes at an appropriate time such that the State completes the redetermination prior to the anticipated change occurring. Thus, while CMS does not specify when a State must begin the redetermination process for an anticipated change in circumstances, under our proposal, the agency must determine the amount of time it needs to act on such changes and to begin the redetermination process with sufficient time to complete processing the redetermination prior to the change occurring. As such, we propose to apply the same basic requirements at proposed § 435.912(c)(6) for States establishing standards for redeterminations based on anticipated changes in circumstances as those described at proposed § 435.912(c)(4) for regularly scheduled renewals. At proposed § 435.912(c)(6)(i), the agency would be required to complete a redetermination of eligibility based on an anticipated change in circumstances on or before the date of the anticipated change or the last day of the month in which the anticipated change occurs.

When an individual is determined ineligible for Medicaid, States have flexibility to terminate coverage either on the date on which the individual becomes ineligible (provided that advance notice has been provided and other bases of eligibility have been considered) or at the end of the month. In States that have elected the option to continue coverage through the end of the month, the redeterminations described at proposed § 435.912(c)(4), (c)(5), and (c)(6) must be completed prior to the end of the month. In all other States, the redetermination must be completed prior to the date specified.

For example, suppose a State has a higher income standard for younger children in the eligibility group for children under age 19, and a beneficiary

whose household income exceeds the standard for children aged 6 through 18 will be turning 6 years old on October 3rd in the middle of their eligibility period. This beneficiary lives in a State that continues coverage through the end of the month in which an individual becomes ineligible. If the State receives all information needed to determine the individual's continued eligibility (in either the eligibility group for children under age 19 or another eligibility group) on or before October 6th (25 days before the end of the month in which the change occurs), then the agency would be required to complete a timely redetermination of eligibility by no later than October 31st.

If the State receives the information needed to complete a redetermination, but does not have at least 25 calendar days to process the information, then as described at proposed § 435.912(c)(6)(ii), the State would have 1 additional month to complete a timely redetermination of eligibility. Using the example above, suppose the State receives all information needed to determine the individual's eligibility on or after October 7th, then the agency would be required to complete a timely redetermination of eligibility by no later than November 30th. Proposed § 435.912(c)(6)(iii) establishes the same standards for completing a determination of another basis as that proposed at § 435.912(c)(4)(iii) for regularly scheduled renewals.

We seek comment on the amount of time provided for States to complete a redetermination of eligibility at a regularly-scheduled renewal or based on changes in circumstances at proposed § 435.912(c)(4), (c)(5), and (c)(6), whether the regulations should allow for a longer or shorter period of time, and whether the use of business days rather than calendar days would be more appropriate.

Each of the standards proposed in paragraphs (c)(3) through (6) provides for an exception to the timeliness standards, which is described in current § 435.912(e), when the agency cannot comply with the regulatory timelines due to an administrative or other emergency beyond the agency's control. States that use the timeliness exception § 435.912(e) must document the reason for delay in the case record in accordance with § 435.912(f). It is also important to note that, while the proposed timeliness standards provide maximum timeframes for completion of redeterminations at renewal or based on changes in circumstances, they do not constitute additional grace periods for States or beneficiaries to delay completion of redeterminations. States are, and will continue to be, expected to process redeterminations as expeditiously as possible, and additional time is only authorized beyond the prescribed eligibility period if a beneficiary responds to a request for information after the date required by the agency but prior to the date of termination or other adverse action identified in the beneficiary's advanced notice of termination or other adverse action.

Finally, we propose a number of technical amendments to paragraphs (d), (e), (f), and (g) of this section to clearly specify that these provisions apply to applicants and applications as well as beneficiaries and redeterminations of eligibility. Because we are specifying that the timeliness standards in section § 435.912 include both applications and redeterminations, we also propose a related change to current § 435.912(g). The current provision prohibits States from using the timeliness standards as a waiting period for new applicants or as a reason for denying eligibility because it is not determined within the required timeframe. We propose to add a new paragraph (g)(3) to § 435.912 that would prohibit States from using the timeliness standards as a reason for delaying termination of an individual's coverage or delaying an adverse action.

We propose to apply the same requirements to separate CHIPs through an existing reference to § 435.912 of the Medicaid regulations in § 457.340(d)(1). Changes to §§ 457.340(d) are discussed in further detail in section II.E.1. of this preamble.

4. Agency Action on Returned Mail (§§ 435.919 and 457.344)

Section 1902(a)(10) of the Act requires States to make medical assistance available under the State plan to individuals who meet certain eligibility criteria and provides States with the option to provide medical assistance to certain other individuals. To ensure that individuals receiving such assistance continue to meet applicable eligibility requirements, States must have a process to obtain information about changes in circumstances and redetermine eligibility when appropriate, including at annual renewal. In this rulemaking, we propose at § 435.919(f) certain actions that States must take when mail sent to a beneficiary is returned to the agency, regardless of whether the returned mail signals potential ineligibility.

The United States Postal Service (USPS) returns mail sent to beneficiary when the address used is incorrect, or the individual has moved and USPS has no record of a forwarding address, or the time-limited mail forwarding service has expired. That a beneficiary has moved does not necessarily mean the individual is no longer a State resident or ineligible on that basis. However, we are concerned that when a beneficiary's mail is returned to the agency, some States rely on that information to conclude that the individual cannot be located and terminate coverage without taking reasonable steps to ascertain the accuracy of the information received or attempting to locate the beneficiary and update their address. Additionally, if a State attempts to contact the beneficiary to verify a new in-state address received from USPS and the individual does not respond, many States continue to use the original address in the beneficiary's case record. If the new address from USPS is correct, the beneficiary has not elected to receive electronic notices, and an *ex parte* renewal based on information available to the agency is not successful, this will result in termination at the individual's regular renewal because such beneficiaries will not receive a mailed notice or renewal form and will be unable to respond as required.

We believe that returned mail may result in a significant number of beneficiaries who continue to meet all eligibility requirements being terminated from coverage, and that it is critical for States to take reasonable steps to locate beneficiaries who may have moved and to update their address prior to taking any adverse action. Therefore, consistent with section 1902(a)(4) of the Act, to promote the proper and efficient administration of the Medicaid program, and section 1902(a)(19) of the Act, to provide such safeguards as may be necessary to assure simplicity of administration and the best interests of beneficiaries, we propose adding new paragraph (f) at proposed § 435.919 to specify the steps States must take when beneficiary mail is returned to the agency.

States rely heavily on communicating with beneficiaries by mail to facilitate essential eligibility and enrollment actions, such as renewals and requests for additional information. Returned mail with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to State residency, but without additional follow up by the State, the receipt of returned mail alone is not sufficient to make a definitive determination as to whether beneficiaries no longer meet State residency requirements because they have moved out of State. Returned mail with an in-state forwarding address is not an indication of a change affecting

eligibility, but it nonetheless is important for the State to confirm the accuracy of the information to ensure future ability to contact the beneficiary, for example, so that the individual can receive and return a renewal form or other information needed by the State to renew their eligibility or can receive critical program information.

Under proposed § 435.919(f), when States receive returned beneficiary mail, they must take proactive steps to verify any forwarding address provided or to otherwise locate the individual. For all returned beneficiary mail, including returned mail with an in-state, an out-of-state, or no forwarding address, we propose at §§ 435.919(f)(1) through 435.919(f)(3), that States conduct a series of data checks and outreach attempts to locate the beneficiary and verify their address. If the State is unable to locate or verify a beneficiary's address after this series of outreach attempts, proposed § 435.919(f)(4) through (f)(6) outlines required and permissible State actions based on the location of the address, if any, provided on the returned mail (that is, in-state or out-of-state). The proposed steps which States must or may take whenever beneficiary mail is returned are discussed in more detail, below.

Step 1: Check Available Data Sources for Updated Contact Information

Under proposed § 435.919(f)(1), whenever beneficiary mail is returned, the State must first check data sources available to the agency to identify any potential updated mailing address information available to the State prior to reaching out to the individual. At a minimum, a State must check for updated mailing contact information from the following sources: (1) the agency's Medicaid Enterprise System (MES); (2) the agency's contracted managed care plans, if applicable in the State; and (3) one or more other third-party data sources, discussed below.

Updated beneficiary contact information from managed care plans, enrollment brokers, claims data, and in the case of integrated eligibility systems, other State administered public benefit systems may be available in the State's MES, and for this reason we believe it is critical that States check for potential updated address information that may be in this system, as reflected at proposed § 435.919(f)(1)(i). Many States have told CMS that individuals enrolled in a managed care plan are more likely to provide their plan, which generally has more frequent contact with their beneficiaries than the State agency, with updated address information. We therefore propose at § 435.919(f)(1)(ii) that the State must obtain and check the address on file with the plan for any individual enrolled in a managed care plan. Finally, there are other third-party data sources available to State Medicaid agencies, and we propose at § 435.919(f)(1)(iii) that the State must obtain and check at least one of the following: the State agency that administers SNAP, the State agency that administers TANF, the Department of Motor Vehicles, the USPS National Change of Address (NCOA) database, and other sources specified in the State's verification plan to determine if a different and more recent address is available.

Discussed in more detail below, under proposed § 435.919(f)(2) and 435.919(g), when a State receives a forwarding address on a piece of returned mail, the State must attempt to contact the individual to verify the forwarding address and provide them with an opportunity to confirm or dispute the information.

Step 2: Conduct Outreach Using at Least Two Different Modalities

In verifying a forwarding address provided by USPS under the proposed rule, States must attempt to contact the beneficiary by both mail (at proposed § 435.919(f)(2)), as well as a modality other than mail (at proposed § 435.919(f)(3)), such as by phone, electronic notice, email, or text message. States have flexibility as to the order in which they attempt to contact the beneficiary through the different modalities.

In attempting to contact the beneficiary by U.S. mail, we propose at § 435.919(f)(2) that the State must send notices to both the current address on file, the forwarding address (if one is provided by USPS), and any address more recent than that in the beneficiary's case records obtained pursuant to proposed § 435.919(f)(1). The notice must request that the individual confirm their current address. The State must provide the individual with a reasonable period of time to verify the accuracy of the new contact information. Consistent with proposed § 435.919(c)(1), we propose that § 435.919(f)(2)(i) define this reasonable period of time as 30 calendar days from the date the notice is sent to the beneficiary. Sending mail to the current address on file represents a key beneficiary protection to ensure that initial piece of returned mail was not incorrectly returned.

We propose at § 435.919(f)(3) that, in attempting to contact the beneficiary using a modality other than mail, the State must make at least two attempts with at least three business days between the first and last attempt. In implementing this requirement, States have flexibility to use any combination of available electronic or telephonic modalities. Such communications, initiated either directly by the State agency or through a State contractor or partner, must be compliant with Federal communications laws such as the Telephone Consumer Protection Act (47 U.S.C. 227).

If it is not feasible to conduct outreach via an alternative modality, for example because there is no phone or other electronic contact information in the case record or obtained from third-party sources, the State must note that in the case record. For outreach conducted by electronic or telephonic modalities, States must use the contact information available on file. States also may leverage the electronic or telephonic contact information obtained by the State through data checks pursuant to § 435.919(f)(1) and reach out to the beneficiary through other modalities pursuant to § 435.919(f)(3).

We note that, under § 435.918, beneficiaries must be provided a choice to receive notices via mail or in an electronic format. If a beneficiary has elected to receive notices and communications electronically, the State must send a notice via the individual's preferred electronic format and such notice must provide at least 30 calendar days from the date the agency sends the notice to verify the accuracy of the new contact information. Regardless of the notice format a beneficiary elects, under the proposed rule States must attempt to contact individuals for whom they have received returned mail via both mail and an alternative electronic modality in an effort to confirm the beneficiary's correct current address. For a beneficiary who elected to receive electronic notices and communications in accordance with § 435.918, if a previous electronic communication attempt failed, the agency cannot use that same electronic modality as the alternative modality to satisfy the requirement at proposed § 435.919(f)(3). States have flexibility under the proposed rule as to the order in which they attempt to contact the beneficiary through the different modalities.

Step 3: State Agency Action Based on Address or No Forwarding Address if Beneficiary Does Not Respond

If a State agency has exhausted all outreach efforts described in §§ 435.919(f)(1) through (f)(3), then the proposed actions that a State must or may take depend on whether USPS

returns an in-state forwarding address, an out-of-state forwarding address or no forwarding address.

Returned mail with an in-state forwarding address reflects a potential change in circumstances that does not affect eligibility. Accordingly, if the beneficiary does not respond to the State's request to confirm their current address in a reasonable period after the State has taken the steps required under proposed §§ 435.919(f)(1) through (f)(3), we propose at § 435.919(f)(4)(i) that, consistent with current Federal policy, the State may not terminate the beneficiary's coverage if the State does not receive a response to its requests that the individual confirm their correct current address. However, while USPS may occasionally return mail sent to a beneficiary with an erroneous forwarding address, we believe that the USPS information generally is accurate, and certainly is accurate far more often than it is inaccurate. This accuracy is buoyed by controls implemented by USPS, which include charging a fee by credit card to validate online change of address (COA) requests, requiring individuals submitting a hardcopy COA request to verify that they understand an unauthorized COA order is a Federal offense, and sending two confirmation letters (to the new and old address) to authenticate the order. Therefore, we propose at § 435.919(f)(4)(ii) that, if the State does not receive a response from the beneficiary that an in-state forwarding address provided by USPS is incorrect, the State must accept the new in-state address and update the beneficiary's account accordingly.

Similarly, the USPS NCOA database includes the permanent change-of-address records maintained by the USPS. Every time an individual or family moves and submits a change-of-address form to their local post office, their new address is recorded in the NCOA database. States can establish agreements with USPS to gain access to the NCOA database in order to utilize these address changes. Therefore, we propose at § 435.919(f)(4)(iv) that, if the State does not receive a response from the beneficiary that an in-state address provided by NCOA is incorrect, the State must accept the new in-state address and update the beneficiary's account accordingly. Additionally, we believe that updated in-state address information obtained from managed care plans may be treated as reliable data, provided that the updated contact information was received by the plan directly from, or was verified with, the beneficiary. Therefore, we propose at § 435.919(f)(4)(iii) that, if the State does not receive a response from the beneficiary that an in-state address obtained from a managed care plan is incorrect, the State must accept the new in-state address and update the beneficiary's account accordingly. We seek comment on whether States should be required to update a beneficiary's in-state address using more recent contact information reflected in a forwarding address from USPS or an address provided by NCOA or a managed care plan in this situation, when the beneficiary has not responded to the State's request to verify their current address.

We note that CMS provided some States with authority under section 1902(e)(14)(A) of the Act to rely on updated contact information from a reliable third-party source, such as an MCO, without first attempting to contact the individual and providing them with a reasonable period of time to verify the accuracy of the new contact information, in accordance with the State Health Official Letter, ''Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID–19 Public Health Emergency,'' published on March 2, 2022 (SHO letter #22–001). We seek comment on whether States should be permitted or should be required to update beneficiary contact information based on information obtained from an MCO, from the USPS NCOA, or other reliable data sources without first attempting to contact the beneficiary to provide them with an opportunity to verify or dispute the new information, because such third-party data is reliable, and, if so, which data sources should States be permitted to rely upon without attempting to contact beneficiaries. We are especially interested in comments from States that received authority under section 1902(e)(14)(A) of the Act to update beneficiary contact information based on information received from a reliable third party without first attempting to contact the individual, as described in SHO letter #22–001. We also seek comment on the efficacy of the requirement to send a notice to a beneficiary's address on file to ensure that initial piece of returned mail was not incorrectly returned.

Returned mail with an out-of-state forwarding address indicates a potential change in circumstances (State residency) that may impact eligibility. Consistent with current requirements under § 435.916(d), we propose at § 435.919(f)(5) that, if a beneficiary does not respond to the State's requests per proposed § 435.919(f)(1) through (f)(3) for information to verify their current address, or if information provided does not establish that the beneficiary continues to satisfy the State residency requirement, the State must provide advance notice of termination and fair hearing rights consistent with 42 CFR part 431 subpart E.

Returned mail with no forwarding address. Current regulations at § 435.916(d) require termination of the eligibility of a beneficiary for whom an out-of-state forwarding address has been received if the beneficiary does not respond with information establishing continued State residency, current regulations at § 431.213(d) provide for an exception to advance notice in the case of a beneficiary whose ''whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address'' and current regulations at § 431.231(d) provide for reinstatement of beneficiaries whose benefits were discontinued due to whereabouts unknown (''as evidenced by the return of unforwardable agency mail'') if their whereabouts subsequently become known. However, the current regulations are unclear with respect to what actions States must take in the case of beneficiaries who did not respond to the State's attempts to contact them to confirm their address and for whom the State has received no forwarding address and was unable to obtain an updated address from a reliable third-party source.

While it is important that beneficiaries who remain in-state are not inappropriately terminated, continued enrollment of individuals whose State residency is unknown, particularly those enrolled in a managed care plan for whom the State pays a monthly capitation payment, may result in unnecessary expense to State Medicaid program and Federal government. To balance these two interests and provide clear requirements for such situations, we propose revising and redesignating current regulation at § 431.231(d) at proposed § 435.919(f)(6) to require that, when a State receives returned beneficiary mail with no forwarding address, the State must first take reasonable steps to locate the beneficiary consistent with proposed §§ 435.919(f)(1) through (f)(3). If, after taking such steps, the State is unable to locate the beneficiary, we propose at § 435.919(f)(6)(i) that States must take appropriate steps to terminate coverage, suspend coverage, or move the beneficiary into a fee-for-service delivery system.

Under § 431.231(d) of the current regulations, redesignated at proposed

§ 435.919(f)(6), States are not required to provide advance notice of termination in the case of a beneficiary whose whereabouts remain unknown after the efforts required to locate the individual have been taken, but are required to provide notice of fair hearing rights. However, consistent with current regulations at § 431.231(d), redesignated at proposed at § 435.919(f)(6)(ii)(A), if the beneficiary's whereabouts become known prior to the beneficiary's originally-scheduled renewal date, the State must reinstate their coverage. We propose adding a requirement at § 435.919(f)(6)(ii)(A) that States must reinstate coverage back to the date of termination if the individual's whereabouts become known before their next regularly-scheduled renewal, without the need to verify eligibility. For example, suppose a beneficiary's eligibility is terminated in April 2023 on the basis of their whereabouts being unknown. In July 2023, the individual seeks care, but is told by the provider that their Medicaid coverage was terminated. If the individual contacts the agency before their next regularly-scheduled renewal, the agency must immediately reinstate their coverage retroactive to April 2023. Consistent with current § 435.916(d)(1)(ii), redesignated at proposed § 435.919(e)(2), we are adding the option at proposed at § 435.919(f)(6)(ii)(B) for States to begin a new eligibility period (defined in current regulations at § 435.916(a), redesignated and revised at § 435.916(b) in this proposed rule) for a beneficiary whose whereabouts become known if the agency has enough information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the beneficiary.

Proposed § 435.919(g), describes the steps a State may take if it obtains updated mailing information from third-party sources other than returned mail from the USPS. Specifically, we propose at § 435.919(g)(1) that States that obtain updated in-state mailing information from NCOA or managed care plans may treat such information as reliable, provided that the State conducts the following outreach. When updated address information is obtained by the State from NCOA or from a managed care plan that has a contract with the State, the State must send a notice to the current address on file with the State and provide the individual with a reasonable period of time to verify the accuracy of the new contact information. Consistent with proposed § 435.919(c)(1), we propose that § 435.919(g)(1)(v) define this reasonable period of time as 30 calendar days from the date the notice is sent to the beneficiary.

States must also contact the beneficiary through other modalities, such as via telephone, electronic notice, email, or text message, where feasible, and must send information to the new address. We propose at § 435.919(g)(1)(iii) that, in attempting to contact the beneficiary using a modality other than mail, the State must make at least two attempts with at least 3 business days between the first and last attempt. In implementing this requirement, States have flexibility to use any combination of available electronic or telephonic modalities. Such communications, initiated either directly by the State agency or through a State contractor or partner, must be compliant with Federal communications laws such as the Telephone Consumer Protection Act (47 U.S.C. 227). If it is not feasible to conduct outreach via an alternative modality, for example because there is no phone or other electronic contact information in the case record or obtained from third-party sources, the State must note that in the case record. For outreach conducted by electronic or telephonic modalities, States must use the contact information available on file. If the beneficiary does not respond, the State may update the beneficiary record with the new contact information. If the beneficiary responds and confirms the new address, the State must update the beneficiary record with the new contact information. Critically, States should ensure that managed care plans only provide updated contact information received directly from or verified by the beneficiary, and not from a third party or other source. We remind States that the rules at §§ 435.919(b) and 435.952(d) apply for out-of-state address information obtained under § 435.919(g).

At § 435.919(g)(2), we propose that States may treat updated in-state address information from other trusted data sources in accordance with proposed paragraph (g)(1) if the State obtains approval from the Secretary. At § 435.919(g)(3), we propose the process that States must follow when obtaining any address information from any sources not listed in paragraph (g)(1) or (2) of this section. Under § 435.919(g)(3), the agency must follow the steps outlined in § 435.919(f)(2) through (6), related to returned mail in order to confirm the address change with the beneficiary. We seek comment on whether States either should be permitted or should be required to update beneficiary contact information based on information obtained from an MCO, from the USPS NCOA, or other reliable data sources, such as Indian Health Care Providers, Federally Qualified Health Centers, Rural Health Clinics, Program of All-inclusive Care for the Elderly providers, Primary Care Case Managers, Accountable Care Organizations, Patient Centered Medical Homes, Enrollment Brokers, or other State Human Services Agencies (for example, SNAP), without first attempting to contact the individual to provide them with an opportunity to verify or dispute the new information, because such third-party data is reliable, and, if so, which data sources should States be permitted to rely upon without attempting to contact beneficiaries. We are especially interested in comments from States that received authority under section 1902(e)(14)(A) of the Act to update beneficiary contact information based on information received from a reliable third party without first attempting to contact the beneficiary, as described in SHO letter #22–001. We also seek comment on the efficacy of the requirement to send a notice to a beneficiary's address on file to ensure that initial piece of returned mail was not incorrectly returned, and on the efficacy of the requirement to conduct at least two outreach attempts to the beneficiary using a modality other than mail. We also seek comment on the requirements in proposed § 435.919(g)(3) paragraphs (f)(2) through (6), related to processing out-of-state address information or address information from a source not identified in § 435.919(g)(1), including whether CMS should consider including a requirement that a State check the available data sources outlined in § 435.919(f)(1)(i) and § 435.919(f)(1)(ii).

Finally, we make a conforming amendment to § 431.213(d), which currently cross references § 431.231(d), to instead reference § 435.919(f). Proposed changes to § 457.344 regarding the responsibilities of States administering a separate CHIP in the event of returned mail and when they receive information from a third party about a change in address for individuals enrolled in a separate CHIP are discussed in further detail in section II.E.3 of this preamble.

5. Transitions Between Medicaid, CHIP and BHP Agencies (§§ 431.10, 435.1200, 600.330)

Section 1943 of the Act requires Medicaid agencies to collaborate with separate CHIP and BHP agencies, if such agencies exist in the State, and with the Exchanges to establish a coordinated

eligibility and enrollment process. Through this process, most applicants, as well as beneficiaries whose eligibility is being redetermined, are evaluated for eligibility for each of these insurance affordability programs and may enroll in the program for which they are eligible without having to complete separate applications. The requirements to coordinate eligibility and enrollment among insurance affordability programs were established in the 2012 eligibility final rule at § 435.1200. State experience in implementing § 435.1200 has revealed some weaknesses in the requirements, which permit eligible individuals to experience unnecessary gaps in coverage and periods of uninsurance. Through this proposed rule, we seek to correct those weaknesses and reduce coverage gaps wherever possible.

One weakness in the current requirements occurs when an agency has information indicating that a beneficiary is no longer Medicaid eligible and likely eligible for another insurance affordability program, but the individual does not respond to confirm this information. As discussed in sections II.B.1. and II.B.2. of this preamble, when the agency receives information reported by a beneficiary or from a reliable third-party source which may affect eligibility, the agency must promptly redetermine the individual's eligibility. If the third-party information would result in an adverse action, the agency must contact the beneficiary and request additional information to verify or dispute the information. Similarly, when a State accesses available information in attempting to renew an individual's eligibility during a regularly-scheduled renewal and obtains information indicating the individual may no longer be eligible, it must send the beneficiary a renewal form (which must be prepopulated for MAGI-based beneficiaries under the current regulations) and provide sufficient time for the individual to return the form and any other information or documentation needed to establish continued eligibility (at least 30 calendar days for MAGI-based beneficiaries under the current regulations). When a beneficiary or a beneficiary's representative does not respond to such requests, the agency must provide the individual with advance notice of termination and fair hearing rights, consistent with part 431 subpart E of the regulations.

For most individuals determined ineligible for Medicaid, current § 435.1200(e) requires the agency to determine potential eligibility for other insurance affordability programs and, as appropriate, transfer the individual's electronic account to the appropriate program. However, because this requirement applies only to a beneficiary who ''submits an application or renewal to the agency which includes sufficient information to determine Medicaid eligibility,'' the agency is not required to transfer an individual's account in all cases. When a beneficiary does not submit a required renewal form or other information needed to redetermine or renew eligibility, the Medicaid agency must send such advance notice of termination but is not required to transfer the individual's account to another insurance affordability program.

These terminations, without a resulting transfer to another insurance affordability program, can create major disruptions in health insurance coverage for otherwise eligible individuals. For example, a family may receive notification of potential income ineligibility for Medicaid, but may not respond because the information described in the notification is correct, and the family does not understand that they need to confirm their increased income so their account will be transitioned to CHIP, BHP, or the Exchange in their State in accordance with current § 435.1200(e).

Disenrollment from health insurance coverage without a corresponding transition to enrollment in another insurance affordability program is a troubling outcome, particularly since regulatory requirements at § 435.1200 for Medicaid, §§ 457.348 and 457.350 for CHIP, § 600.330 for BHP, and 45 CFR 155.302 for Exchanges were designed to ensure coordination of coverage and smooth transitions between insurance affordability programs. Losses of coverage are even more troubling when different programs share an eligibility system and a determination of eligibility for one program could be completed seamlessly as the individual is determined ineligible for another program.

When developing the coordination requirements currently published at §§ 435.1200, 457.348 and 457.350, and 600.330, and 45 CFR 155.302, we recommended, but did not require States to utilize a shared eligibility system or service for all insurance affordability programs. Today, we believe every State with separate programs for Medicaid and CHIP [60] utilizes a single eligibility system or shared eligibility service for eligibility determinations based on MAGI. As such, when a Medicaid beneficiary is determined ineligible due to an increase in household income, and the individual is screened for potential CHIP eligibility, the system effectively makes a determination of financial eligibility for CHIP. We believe the Medicaid agency could complete the determination of CHIP eligibility based on available information, so the individual does not need to be screened and then transferred to the separate CHIP agency before a determination of CHIP eligibility can be completed.

Additionally, while Medicaid and CHIP are separate programs, both use MAGI-based methodologies described at section 1902(e)(14) of the Act, further detailed at §§ 435.603 for Medicaid and cross-referenced at § 457.315 for CHIP, to determine financial eligibility. Further, States can, and often do, utilize the same policies and procedures to verify MAGI-based income eligibility for Medicaid and CHIP. In fact, current § 435.1200(d)(4) requires the Medicaid agency to accept findings related to eligibility criteria made by a separate CHIP agency without further verification if that program applies the same verification policies as those used by the Medicaid agency. A similar requirement applies to CHIP at § 457.348(c)(4). Because the same financial methodologies are used for each program, if the same verification requirements apply, a determination of financial eligibility used to determine CHIP eligibility must be accepted by the Medicaid agency in determining financial eligibility for Medicaid and vice versa.

Through this rule, we propose changes to § 435.1200 to improve transitions between Medicaid and a separate CHIP; corresponding changes to CHIP are described in section II.E.5 of this preamble. We note that these changes would apply only to transitions between Medicaid and a separate CHIP. They would not apply to transitions between title XIX funding and title XXI funding within Medicaid in States that implement CHIP through a Medicaid expansion, either in whole or in part.

Current § 435.1200 implements the ACA requirements established at section 1943(b) of the Act relating to the coordination of enrollment among insurance affordability programs. The general requirements for coordination are described at § 435.1200(b). Paragraph (b)(1) requires the Medicaid agency to fulfill the general responsibilities described in later paragraphs, while paragraph (b)(2) requires the agency to certify, for the

[60] As of June 1, 2022, 40 States have a separate CHIP; this includes 2 States with only a separate CHIP and 38 States with both a Medicaid expansion and a separate CHIP.

other insurance affordability programs, the criteria for determining Medicaid eligibility. Current § 435.1200(b)(3) requires the agency to enter into an agreement with the agency or agencies administering a separate CHIP, BHP, and the Exchange operating in the State; such agreement(s) must include a clear delineation of the responsibilities of each program with respect to eligibility determinations, notices, and fair hearings. Paragraphs (c) and (d) describe the Medicaid agency's responsibilities for eligibility and enrollment when an individual has been determined Medicaid eligible (paragraph (c)) or assessed as potentially Medicaid eligible (paragraph (d)) by a separate CHIP, BHP, or Exchange. Paragraph (e) of current § 435.1200 describes the responsibilities of the Medicaid agency to evaluate an individual's eligibility for CHIP, BHP, and coverage through the Exchanges when an individual is determined not eligible for Medicaid (§ 435.1200(e)(1)) or is undergoing a Medicaid eligibility determination on a non-MAGI basis (§ 435.1200(e)(2)). Paragraphs (f) through (i) of current § 435.1200 describe the coordination requirements for an enrollment website, appeals, and notices.

Among the requirements for enrollment simplification and coordination described in section 1943(b) of the Act, paragraph (b)(1)(F) specifically requires outreach and enrollment of underserved populations eligible for Medicaid. One of the populations called out for focused outreach and enrollment is children, including subsets of particularly underserved children, as well as racial and ethnic minorities, rural populations, and individuals with mental health and/or substance use disorders. While the increase in uninsurance among children known to be eligible for Medicaid or another insurance affordability program has leveled off since 2020 when the PHE went into effect, likely due in large measure to the continuous enrollment condition under the FFCRA discussed in the background section of this preamble, in order to reduce the likelihood of future increases in uninsurance, we propose a new approach to implementing the coordination requirements in section 1943(b) of the Act.

Section 1902(a)(19) of the Act requires that the Medicaid State plan include safeguards to ensure that eligibility is determined in a manner that is consistent with the simplicity of administration and the best interests of beneficiaries. We believe the language and requirements in § 435.1200, which do not require transition of otherwise eligible individuals from one program to another when beneficiaries have failed to provide requested information to confirm or dispute third-party data indicating a change in eligibility, have contributed to an increase in uninsurance among individuals losing coverage under Medicaid and CHIP, even though they meet the eligibility requirements for another one of those programs. This result is inconsistent with both the simplicity of administration of the Medicaid program and the best interest of Medicaid beneficiaries.

Utilizing the authority provided in sections 1902(a)(19) and 1943(b)(1)(F) of the Act, we propose to revise paragraphs (b), (c), (e), and (h) of § 435.1200 to improve enrollment of underserved populations and to reduce unnecessary administrative barriers to coverage by requiring Medicaid agencies, in States with a separate CHIP, to:

- Provide for an agreement with the separate CHIP agency to seamlessly transition the eligibility of beneficiaries between Medicaid and CHIP when their eligibility status changes;
- Accept determinations of MAGI-based Medicaid eligibility made by a separate CHIP;
- Establish procedures to receive determinations of Medicaid eligibility completed by a separate CHIP;
- Complete determinations of eligibility for a separate CHIP for individuals who are determined ineligible for Medicaid based on reliable third-party data; and
- Issue a combined notice indicating ineligibility for Medicaid and eligibility for CHIP when appropriate.

In section II.E.4. of this preamble, we discuss proposed changes to the CHIP regulations that correspond with these proposed requirements for Medicaid agencies. When proposed changes to the Medicaid and CHIP regulations are read together, they would ensure that (1) when an individual is determined ineligible for Medicaid, the individual would receive a determination of CHIP eligibility (from the Medicaid agency) and, if eligible for CHIP, the individual's electronic account would be transferred from the Medicaid agency to the separate CHIP agency, with the separate CHIP agency completing any enrollment-related activities such as collection of an applicable enrollment fee or premium and/or plan selection; and (2) when CHIP determines that an enrollee has become ineligible for CHIP, the individual would receive a determination of MAGI-based Medicaid eligibility, and, if eligible for Medicaid, the individual's electronic account would be transferred from the separate CHIP agency to the Medicaid agency, with the Medicaid agency completing any enrollment related activities such as issuing a Medicaid card.

We believe these changes could address potential declines in enrollment that may result from eligible individuals not being seamlessly transitioned to Medicaid from CHIP and from Medicaid to CHIP when available information indicates eligibility for the other program. We propose the following specific revisions to the coordination requirements for States with a separate CHIP.

Preliminarily, we propose to add a new requirement to the list of requirements in current § 435.1200(b)(3) that must be addressed in agreements between the Medicaid agency and other insurance affordability programs. Proposed § 435.1200(b)(3)(vi) would require the Medicaid agency to include in its agreement with the State's separate CHIP agency, procedures for seamlessly transitioning the eligibility of individuals from Medicaid to CHIP when they are determined ineligible for Medicaid and eligible for CHIP. The agreement would also include procedures for seamlessly transitioning the eligibility of individuals from CHIP to Medicaid when they are determined ineligible for CHIP by that program and eligible for Medicaid. The agreement required under § 435.1200(b)(3) would describe the responsibilities for each State agency administering Medicaid and CHIP to effectuate the required coordination.

We propose to add a requirement at § 435.1200(b)(4) that the Medicaid agency must accept a determination of MAGI-based Medicaid eligibility made by the State agency administering a separate CHIP (See section II.E.5. of this preamble for a discussion of the proposed requirements for agencies administering a separate CHIP to determine MAGI-based Medicaid eligibility.). There are a number of different options that the Medicaid agency could use to effectuate this requirement in compliance with the single State agency's responsibility to determine Medicaid eligibility described at § 431.10(b)(3).

- If the separate CHIP is administered by the single State agency that administers the Medicaid program, then the single State agency itself can determine Medicaid eligibility at the same time as it is determining CHIP ineligibility.
- If the separate CHIP is not part of the single State agency, then as described at proposed § 435.1200(b)(4)(i), the Medicaid and

CHIP agencies could agree to utilize the same MAGI-based methodologies under §§ 435.603 and 457.315, and verification policies and procedures under §§ 435.940 through 435.956 and 457.380, such that the Medicaid agency would accept any finding relating to a criterion of eligibility made by a separate CHIP agency without further verification in accordance with current regulations at § 435.1200(d)(4).

- As described at proposed § 435.1200(b)(4)(ii), the agency may use a shared eligibility service that allows the Medicaid agency to maintain responsibility for the rules and requirements used to determine Medicaid eligibility, while permitting the separate CHIP agency to determine Medicaid eligibility by running the rules in the shared eligibility service maintained by the Medicaid agency when ineligibility for CHIP is determined. In such cases, any functions performed by the separate CHIP agency would be solely administrative in nature, and not reflective of a delegation of authority to make Medicaid eligibility determinations.
- If the separate CHIP agency does not use the same MAGI-based methodologies and verification procedures as those used by Medicaid, and the two programs do not share an eligibility service with the Medicaid agency, we propose at § 435.1200(b)(4)(iii) that the Medicaid agency may enter into an agreement in accordance with § 431.10(d) of the regulations, as amended in this proposed rule, and § 431.10(c) under which the Medicaid agency delegates authority to make final Medicaid eligibility determinations to the entity that makes eligibility determinations for a separate CHIP agency. To effectuate this option, we propose to add the State agencies that administer the separate CHIP and BHP programs to the list of entities in § 431.10(c)(1)(i)(A) to which the Medicaid agency may delegate authority to make determinations of Medicaid eligibility. A separate BHP agency is added to the list of entities to which Medicaid may delegate eligibility determinations to accommodate either an option or a requirement for a State's BHP to complete determinations of Medicaid eligibility.
- Finally, at proposed § 435.1200(b)(4)(iv), we would provide States with the option to utilize a different policy or procedure approved by the Secretary.

We request comment on whether there are different ways that States with a separate CHIP agency should be permitted to effectuate a seamless transition of eligibility into Medicaid for individuals determined ineligible for CHIP.

We also propose to expand the scope of paragraph (c) of § 435.1200, which provides for the provision of Medicaid to individuals determined eligible by another insurance affordability program. Current § 435.1200(c) applies only to States that have entered into an agreement under which the Exchange or another insurance affordability program makes final determinations of Medicaid eligibility. We propose to amend § 435.1200(c) to require Medicaid agencies, which must accept final determinations of Medicaid eligibility completed by a separate CHIP agency in accordance with proposed paragraph (b)(4), to do so in accordance with the requirements of paragraph (c), as described below.

Current § 435.1200(c)(1) through (c)(3) require the Medicaid agency to establish procedures to receive electronic accounts from another insurance affordability program; comply with the requirements of § 435.911 (relating to determinations of Medicaid eligibility) to the same extent as if the Medicaid agency had received the application in an account transferred to it; and maintain proper oversight of the Medicaid program. We propose to redesignate the responsibilities described at current § 435.1200(c)(1) through (c)(3) as paragraphs (c)(1)(i) through (iii), to delete the current introductory language in § 435.1200(c), and to add a new paragraph (c)(2) to describe the individuals who would be subject to the requirements set out in proposed paragraph (c)(1).

Specifically, proposed § 435.1200(c)(2)(i) describes the individuals currently subject to the requirements in § 435.1200(c)—that is, individuals determined Medicaid eligible by the Exchanges or other insurance affordability programs (for example, a BHP), including as a result of a decision made by the appeals entity for such program, if the agency has entered into an agreement under which the Exchange or other insurance affordability program may make final determinations of Medicaid eligibility. Proposed § 435.1200(c)(2)(ii) describes individuals who are determined Medicaid eligible by a separate CHIP agency, including as the result of a decision made by a CHIP review entity in accordance with proposed 435.1200(b)(4).

Because we propose to require all States with a separate CHIP to fulfill the responsibilities of proposed § 435.1200(c), not just those States that choose to enter into an agreement with another insurance affordability program, we also propose to revise the general requirement at § 435.1200(b)(1) (which currently provides that the Medicaid agency fulfill the requirements set forth in § 435.1200(d) through (h)) to include paragraph (c) in the list of requirements in § 435.1200 which the Medicaid agency must fulfill. Similarly, we propose to revise § 435.1200(b)(3)(ii), which provides that the agreements established between the Medicaid agency and other insurance affordability programs must ensure compliance with § 435.1200(d) through (h), to include paragraph (c) of § 435.1200.

We do not propose to make any changes to § 435.1200(d) in this proposed rule. Paragraph (d) requires the Medicaid agency to accept a determination of potential Medicaid eligibility made by another insurance affordability program. Because this rule would not require the Medicaid agency to enter into an agreement to accept eligibility determinations made by a BHP or Exchange or to make determinations of eligibility for BHP or for insurance affordability programs available through the Exchanges, we believe this paragraph will continue to be necessary in these cases. In addition, we recognize that there may be cases in which a separate CHIP agency does not have access to all information needed to determine eligibility for Medicaid (for example, on a non-MAGI basis), but may be able to complete a determination of potential eligibility and transfer the individual's electronic account to the Medicaid agency to request the additional information and complete the determination.

The proposed revisions to § 435.1200(c) aim to improve the seamless transition of individuals from a separate CHIP *to Medicaid.* We also propose changes to § 435.1200(e) to improve the seamless transitioning of individuals *from Medicaid* to a separate CHIP. Current § 435.1200(e)(1) describes the requirements that, for individuals determined ineligible for Medicaid, the Medicaid agency determine potential eligibility for and, as appropriate, transfer via a secure electronic interface the individual's electronic account to another insurance affordability program (that is, CHIP, BHP or Exchange).

As mentioned previously, current § 435.1200(e)(1) does not require the agency to transfer an individual's account to another insurance affordability if the individual fails to submit a ''renewal to the agency which includes sufficient information to determine Medicaid eligibility[.]'' We propose to remove reference to submission of a renewal form, such that

the Medicaid agency would be required to transfer the account of an individual who, during a regularly-scheduled renewal or redetermination based on a change in circumstances, has been determined ineligible for Medicaid and determined eligible, or potentially eligible, for another insurance affordability program based on available information. We note that this does not change the agency's obligation to provide individuals with an opportunity to dispute the information obtained by the agency indicating Medicaid ineligibility before the agency terminates their Medicaid eligibility, as required at current § 435.952(d), or to provide advance notice of termination and fair hearing rights in accordance with part 431 subpart E of the regulations.

We also propose to revise § 435.1200(e)(1) by breaking it into two paragraphs—paragraphs (e)(1)(i) and (ii)—establishing separate requirements for situations in which the Medicaid agency completes a determination of eligibility for a separate CHIP agency and situations in which the Medicaid agency makes a determination of *potential* eligibility for BHP or for insurance affordability programs available through the Exchanges.

At proposed § 435.1200(e)(1)(i), we would require that in a State that operates a separate CHIP, when the Medicaid agency determines an individual to be ineligible for Medicaid, it must also determine whether the individual is eligible for CHIP using information available to the agency. Information on the individual's financial eligibility will already be available in the eligibility system, along with certain non-financial eligibility factors such as State residency and citizenship or eligible immigration status. Other eligibility criteria which may be applicable to determining eligibility for CHIP, which are not relevant in a Medicaid determination, include enrollment in other insurance coverage and access to State employee health insurance. We believe State Medicaid agencies have access to other reliable data sources from which they can obtain any additional information that may be needed about these criteria. State Medicaid agencies have information on other insurance coverage that a beneficiary may have, which States are required to obtain from insurers for purposes of third-party liability and coordination of benefits per section 1902(a)(25)(I) of the Act. State Medicaid agencies also can access information on the availability of State employee health coverage from the State agency which administers such coverage. We believe it is consistent with simplicity of administration and the best interests of beneficiaries for the agency to be expected to access these data sources to make a determination of eligibility for CHIP.

We recognize that it may be easier for some States to identify access to State employee health coverage than others. For example, in some States, a single State agency may administer the employee health plan for all State employees, and the plan may be available only to State employees and their dependents. While in other States, particularly those in which the government is more decentralized or in which local government agencies also participate in State employee health coverage, we believe it may be more difficult to access such information. We seek comment on State Medicaid agencies' ability to collect information on access to State employee health coverage, particularly if a child is not already enrolled in such coverage, without requiring additional information from the family.

Ideally, an individual's enrollment in CHIP would be effectuated at the same time the State terminates coverage in Medicaid so the individual would not experience a period of uninsurance. However, we recognize that the separate CHIP agency may require payment of an enrollment fee or premium or other action, like plan selection, before enrollment can be completed. A combined notice, discussed later in this section, may mitigate some risk of a coverage gap by notifying the individual about the CHIP enrollment fee or premium requirement at the same time advance notice of Medicaid termination is issued, providing some additional time for families to make the required CHIP payment before Medicaid coverage ends. We seek comment on challenges States may face in smoothly transitioning enrollment from Medicaid to CHIP and processes that could be implemented to address these challenges. We also seek comment on whether there are situations in which the Medicaid agency would be able to complete only a determination of potential eligibility for CHIP, such that the final regulation would need to allow for situations in which the Medicaid agency would transfer the individual's electronic account to the agency administering a separate CHIP to finalize the determination for its own program.

Proposed § 435.1200(e)(1)(ii) would require that when the Medicaid agency determines an individual to be ineligible for both Medicaid and CHIP, the agency must determine potential eligibility for BHP if the State operates a BHP and if ineligible for BHP, the agency must determine potential eligibility for insurance affordability programs available through the Exchanges. This is consistent with the current regulatory requirement at § 435.1200(e)(1).

As important as it is to transition an individual from one insurance affordability program to another when eligibility changes, it is equally important to ensure that such individual receives clear and consistent information about the transition, both before the change is effectuated and when the transition occurs. It can be very confusing for individuals to receive separate notices from the Medicaid program and CHIP, particularly when they arrive at different times. Accordingly, we propose to require that individuals be provided with a combined eligibility notice when either the Medicaid agency determines the individual ineligible for Medicaid and eligible for CHIP or the separate CHIP agency determines the individual eligible for Medicaid and ineligible for CHIP.

A ''combined eligibility notice'' is defined at current § 435.4 as an eligibility notice that informs an individual or multiple family members of a household of eligibility for each of the insurance affordability programs, for which a determination or denial of eligibility was made, as well as any right to request a fair hearing or appeal related to the determination made for each program. A combined notice must meet the general requirements described at § 435.917(a), along with the more specific requirements at §§ 435.917(b) (relating to required content) and 435.917(c) (relating to pursuing eligibility on a non-MAGI basis), except that information described in §§ 435.917(b)(1)(iii) (relating to medically needy coverage) and 435.917(b)(1)(iv) (relating to covered benefits and services) may be included either in a combined notice issued by another insurance affordability program or in a supplemental notice provided by the agency. A combined eligibility notice must be issued in accordance with the agreement(s) between the agency and other insurance affordability program(s) per § 435.1200(b)(3).

Current § 435.1200(h)(1) requires that, to the maximum extent feasible, individuals and households receive a single notice rather than separate notices from each applicable insurance affordability program, communicating the determination of eligibility as required under §§ 435.917 and 457.340. In the preamble to the 2016 final rule,

we noted concerns from a number of commenters about the ability of State systems to issue a combined notice and described several considerations when looking at the feasibility of issuing combined notices. These considerations included whether the State uses a shared eligibility service, whether the State relies on a Federally-facilitated Exchange to make determinations of Medicaid eligibility, and the maturity of the State's systems with greater use of combined eligibility notices expected as systems mature. In the 2016 final rule, we explained that it should be feasible to issue a combined notice when a single eligibility system or shared eligibility service is making determinations for multiple programs. As such, we believe that when the agency is enrolling an individual in Medicaid based on a determination of eligibility completed by another program, or vice versa, issuance of a combined eligibility notice should always be feasible.

Therefore, we propose to revise § 435.1200(h)(1) to require in all cases that individuals determined ineligible for Medicaid and eligible for CHIP in States with separate CHIP and Medicaid agencies in accordance with proposed § 435.1200(e)(1)(i) receive a combined eligibility notice informing them that: (1) they have been determined no longer eligible for Medicaid; and (2) they have been determined eligible for CHIP. Similarly, we propose to require the Medicaid agency to ensure that an individual determined eligible for Medicaid by a separate CHIP agency also receives a combined notice. We propose to effectuate this requirement through a new paragraph (h)(1)(i) at § 435.1200, which would require that the Medicaid agency include in its agreement with a separate CHIP agency (as described in § 435.1200(b)(3) and revised in this rulemaking), that either the Medicaid agency or the CHIP agency will provide such combined eligibility notice explaining both the termination of eligibility for Medicaid and the determination of eligibility for CHIP or vice versa. States that operate its CHIP and Medicaid programs under the same agency and eligibility system that already provide a seamless, combined Medicaid and CHIP notice, may not need to make any changes. Note that regardless of which entity sends the combined notice, per the definition of combined notice in § 435.4 of the current regulations, the Medicaid content of the notice must comply with the requirements set forth in § 435.917.

Proposed § 435.1200(h)(1)(ii) would maintain the requirement in current § 435.1200(h)(1) that, to the maximum extent feasible, a combined eligibility notice be issued in all other cases (that is, situations not described at proposed § 435.1200(h)(1)(i)), consistent with current regulations. This provision would apply to situations in which the Medicaid agency has determined an individual to be potentially eligible for a BHP or insurance affordability programs available through the Exchanges, and to situations in which an Exchange, CHIP or BHP has made an assessment of potential Medicaid eligibility, including on a non-MAGI basis, but not a final determination. In addition, as currently required, when more than one individual is included on an application or renewal, Medicaid and the other insurance affordability programs would be expected to provide a single combined notice for all household members to the extent possible, even if members are eligible for different programs.

We recognize that State eligibility systems still continue to mature and many States are still working through a backlog of system changes to correct issues arising from changes made in response to earlier rulemaking. We seek comment on the feasibility of implementing a combined notice for Medicaid and CHIP eligibility determinations, as well a combined notice with determinations of BHP and insurance affordability programs available through the Exchanges, both in States using a fully integrated eligibility system or shared system and in States utilizing separate systems. We also seek comment on the time that would be required for States to implement these changes if they are not already issuing combined eligibility notices.

Finally, we propose one overarching policy change and several technical amendments to § 435.1200. With respect to the policy change, we propose to clarify that the requirements at proposed § 435.1200(e)(1) (related to determining eligibility or potential eligibility for other insurance affordability programs) apply not only to individuals who have been determined ineligible for Medicaid on all bases, but also to individuals who have been determined ineligible for Medicaid coverage that is considered minimum essential coverage as defined at § 435.4. We would effectuate this requirement through a new paragraph (e)(4) at § 435.1200. Consider for example, an individual covered under the eligibility group for children under age 19 (described at § 435.118), which provides minimum essential coverage. If the agency determines that the individual's MAGI-based household income has increased such that it exceeds the income standard for that eligibility group and the only group for which that individual is eligible is the eligibility group in which coverage is limited to family planning and family planning-related services (described at § 435.214), which does not provide minimum essential coverage, then in accordance with proposed § 435.1200(e)(1), the agency would be required to determine that individual's eligibility for a separate CHIP. If the State either does not offer a separate CHIP, or the individual does not meet the eligibility requirements for that program, then the agency would need to determine that individual's potential eligibility for BHP and for insurance affordability programs available through the Exchanges and transfer the individual's account in accordance with proposed § 435.1200(e)(1)(iii).

Regarding the technical amendments, first we propose to remove ''and definitions'' from the title of § 435.1200(b), as definitions are currently included in § 435.1200(a), and we propose to correct the spelling of ''programs'' in § 435.1200(b)(3)(i). Second, we propose a technical change to 435.1200(e)(1) to replace the reference to § 435.916(d) with a reference to proposed § 435.919 to reflect the re-designation of current § 435.916(d) at § 435.919 in this proposed rule. And third, we propose to correct a numbering error in § 435.1200(h). The paragraph following § 435.1200(h)(3)(i)(B) was incorrectly numbered as (i), and we propose to renumber this paragraph as § 435.1200(h)(3)(ii).

In summary, the proposed changes to § 435.1200 would require the Medicaid agency to:

- Ensure that the agreement between the agency and the separate CHIP agency includes procedures for the seamless transition of eligibility between programs;
- Accept determinations of Medicaid eligibility made by a separate CHIP agency;
- Make determinations of CHIP eligibility and transfer eligible individuals to the separate CHIP agency; and
- Provide for the issuance of a combined notice to an individual who is determined ineligible for Medicaid and eligible for CHIP or eligible for Medicaid and ineligible for CHIP.

We considered applying these same changes to BHP agencies. Currently, the BHP regulation at § 600.330(a) requires the BHP agency to establish eligibility and enrollment mechanisms and procedures to maximize coordination with the Exchange, Medicaid, and CHIP.

Additionally, it requires a State BHP agency to fulfill the requirements of § 435.1200(d) and (e), and if applicable, paragraph (c) for BHP eligible individuals. In this proposed rule, we propose to revise § 600.330(a) to limit the Medicaid requirements that a BHP agency must fulfill to those in § 435.1200(d), (e)(1)(ii) and (e)(3). Paragraph (c) of § 435.1200 would still be required when applicable (that is, when the BHP agency has entered into an agreement with another insurance affordability program to make final determinations of BHP eligibility).

We seek comment on whether it is appropriate to apply the changes designed to create seamless transitions between Medicaid and a separate CHIP to BHP as well. This would include maintaining the current language in § 600.330(a) and revising paragraphs (b), (c), (e), and (h) of § 435.1200 to require the Medicaid agency to amend its agreement with the BHP agency to seamlessly transition eligibility between programs, to accept determinations of Medicaid eligibility made by the BHP agency, to make determinations of BHP eligibility, and to provide for the issuance of a combined Medicaid and BHP eligibility notice. or to maintain current coordination requirements, such that BHPs are required only to evaluate potential eligibility for Medicaid and CHIP and to accept determinations of potential BHP eligibility made by a Medicaid or separate CHIP agency. This would not prohibit a BHP from entering into an agreement with Medicaid and/or CHIP in which each agency completes determinations of eligibility for the other. These changes would require the State Medicaid agency to make a determination of eligibility for BHP based on information available through electronic or other data sources. We seek comment on whether it is possible for the Medicaid agency to gather the information necessary to complete such a determination, specifically, information on other affordable insurance coverage available to an individual.

6. Optional Group for Reasonable Classification of Individuals Under 21 Who Meet Criteria for Another Optional Group (§ 435.223)

Section 1902(a)(10)(A)(ii) of the Act authorizes States to provide Medicaid to one or more of the categorical populations described in section 1905(a) of the Act who also meet the requirements described in section 1902(a)(10)(A)(ii) of the Act (which lists the optional categorically needy eligibility groups). With specific regard to the categorical population described in section 1905(a)(i) of the Act—individuals under age 21 or, at State option, under age 20, 19 or 18—the introductory language in section 1902(a)(10)(A)(ii) of the Act permits States to extend medical assistance to ''reasonable categories'' of such individuals. Section 435.222 implemented optional coverage of individuals under the age of 21, 20, 19, or 18, or a reasonable category of such individuals (referred to as ''reasonable classifications'' in the regulations) who meet the AFDC income and resource requirements, as described in section 1902(a)(10)(A)(ii)(I) of the Act. Prior to January 1, 2014, and the implementation of MAGI-based methodologies under the ACA, States also were permitted to raise the effective income standard for eligibility for coverage under this group through adoption of income disregards under section 1902(r)(2) of the Act and § 435.601(d) of the regulations. Many States used a combination of these authorities to provide Medicaid to all individuals under age 21, as well as to various State-defined reasonable classifications of such individuals up to varying income standards under their State plan.

Revisions finalized in the 2016 eligibility and enrollment final rule reflect the adoption of MAGI-based methodologies in determining financial eligibility for most individuals under Medicaid, including individuals under age 21 eligible under § 435.222. The elimination of income disregards under MAGI-based methodologies (see § 435.603(g)) also effectively limits the flexibility States previously had to raise the effective income standard for coverage under § 435.222 to meet the needs of new reasonable classifications of individuals under age 21 who are not eligible under the mandatory group for children at § 435.118 or, in the case of 19 and 20-year-olds, under the adult group at § 435.119. Other flexibilities, however, are provided in the statute which States may wish to employ to meet the coverage needs of reasonable classifications of children who are excepted from mandatory application of MAGI-based methods under the statute and regulations or otherwise fall outside the scope of § 435.222 (for example, individuals under age 21 seeking coverage on the basis of a disability or blindness or who meet a specified level-of-care need).

As noted above, States have the flexibility to provide coverage to individuals under age 21 (or, at State option, under age 20, 19 or 18) or to reasonable classifications of such individuals who meet the requirements of *any* subparagraph of section 1902(a)(10)(A)(ii) of the Act, which includes, but is not limited to, clause (I) of such section. For example, a State that has selected the eligibility category described in section 1902(a)(10)(A)(ii)(I) of the Act for individuals who meet AFDC requirements could define a reasonable classification of individuals under age 21 to include individuals who meet a level-of-care need for HCBS. A State that has not selected the eligibility category described in section 1902(a)(10)(A)(ii)(I) of the Act but has instead selected the eligibility category described in section 1902(a)(10)(A)(ii)(X) of the Act, relating to individuals who have disabilities or are 65 years old or older, could similarly define a reasonable classification of individuals who are under 21 and meet an HCBS-related level of care.

The terms of the current § 435.222, however, do not accommodate the adoption of such reasonable classifications, either because the regulation requires application of an income test that is based on ''household income,'' which generally is defined in § 435.4 to mean MAGI-based income, or limits inclusion of ''reasonable classifications'' to the eligibility categories described in section 1902(a)(10)(A)(ii)(I) and (IV) of the Act (or both).

To reflect the flexibility that we believe States are afforded under the statute, we are proposing to add a new § 435.223 under which States may provide coverage to all individuals under age 21, 20, 19, or 18, or to a reasonable classification of such individuals, who meet the requirements of any clause of section 1902(a)(10)(A)(ii) of the Act (as implemented in subpart C of part 435 of the regulations to the extent to which a given clause is so implemented).

While coverage under proposed § 435.223 is not expressly limited to individuals excepted from MAGI under § 435.603(j), we believe that, as a practical matter, this will most typically be the case, as coverage for a reasonable classification of individuals under age 21 who are not excepted from the mandatory use of MAGI-based methodologies is already permitted by § 435.222. Considering this and the need to distinguish § 435.222 and the proposed § 435.223, we propose to change the heading for § 435.222 to read, ''Optional eligibility for reasonable classifications of individuals under 21 with income below a MAGI-equivalent standard.''

For individuals excepted from the mandatory use of MAGI-based methodologies, § 435.601 generally

requires that States apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's status. In the case of individuals who are under age 21 and who have blindness or disabilities, this generally means application of SSI-related financial methodologies. In the case individuals under age 21 who do not have blindness or disabilities, this means application of the financial methodologies in the State's former AFDC program.

Because of the elimination of the AFDC program in 1996 and the replacement of AFDC-based methodologies with MAGI-based methodologies for determining financial eligibility for individuals not excepted from MAGI-based methods under the ACA, in the 2012 eligibility final rule, we provided States with flexibility under § 435.831(b)(1)(ii) to apply either AFDC-based methodologies or MAGI-like methodologies, with limited exception, in determining eligibility for medically needy individuals under age 21, pregnant individuals, and parents and other caretaker relatives. Without this flexibility, States would be required to apply AFDC-based methodologies to these medically needy populations, even though the AFDC program ceased to exist over 25 years ago and those methodologies have no other applicability. Proposed § 435.601(f)(1)(i) and (ii) similarly provides States with flexibility to apply, at State option, either AFDC-based methods or MAGI-like methods in determining income eligibility for individuals under age 21, for whom the most closely categorically related cash assistance program is AFDC.

The limited exception to application of ''true'' MAGI-based methodologies described in § 435.603 of the regulations to medically needy individuals under § 435.831(b)(1)(ii) stems from section 1902(a)(17)(D) of the Act. This statutory provision, implemented at § 435.602 of the regulations, prohibits States from taking into account the financial responsibility of any individual in determining eligibility for any applicant or beneficiary under the State plan unless such applicant or recipient is the individual's spouse or the individual's child who is under age 21, or with blindness or disability. This limitation continues to apply to all individuals excepted from mandatory application of MAGI-based methods under section 1902(e)(14)(D) of the Act, implemented at § 435.603(j). Therefore, similar to the limitation on the flexibility afforded States under § 435.831(b)(1)(ii) to apply MAGI-based methodologies for otherwise AFDC-related medically needy individuals, proposed § 435.601(f)(1)(ii)(B) requires that, in applying MAGI-based methodologies, States must ensure that there is no deeming of income or attribution of financial responsibility that would conflict with the requirements of section 1902(a)(17)(D) of the Act; that is, in determining eligibility under proposed § 435.223 for an individual under age 21 who is described in § 435.603(j) as exempt from the MAGI methodologies set forth in § 435.603, no income other than the income of the individual or his or her parent(s) and/or spouse, would be counted, even if the income of someone else would be counted under the MAGI-based methods defined in § 435.603.

We also propose two technical changes related to the amendment of § 435.601(f). In paragraphs (b)(2) and (d)(1) of § 435.601, we replace the cross reference to § 435.831(b)(1) (which provides an exception to the general rule to use the methods of the most closely categorically related cash assistance program) with a reference to the new subparagraph (f)(1)(ii)(B), which provides for the same exception. Note that, under section 1902(r)(2) of the Act and § 435.601(d), a State also could apply less restrictive methodologies than either AFDC or the MAGI-like methodologies adopted in accordance with the option at proposed § 435.601(e), including application of income disregards. By disregarding all resources, States, at their option, also could effectively eliminate application of an asset test for individuals excepted from MAGI-based methods in accordance with § 435.603(j) who are seeking coverage under an optional coverage group adopted in accordance with proposed § 435.223.

C. Eliminating Barriers to Access in Medicaid

1. Remove Optional Limitation on the Number of Reasonable Opportunity Periods (§§ 435.956 and 457.380)

Sections 1902(a)(46)(B), 1902(ee)(1)(B)(ii), 1903(x)(4), and 1137(d)(4)(A) of the Act, implemented at § 435.956(b) for Medicaid and through a cross-reference at § 457.380(b)(1)(ii) for CHIP, set forth the requirement for States to provide a reasonable opportunity period (ROP) for individuals who have attested to citizenship or satisfactory immigration status, and for whom the State is unable to verify citizenship or satisfactory immigration status when the individual meets all other eligibility requirements, in accordance with § 435.956(a).

During the ROP, the State agency must continue efforts to complete verification of the individual's citizenship or satisfactory immigration status, or request documentation, if necessary. In accordance with § 435.956(b)(2), during the ROP, the State agency must furnish Medicaid benefits to individuals who meet all other eligibility requirements, and may elect to do so effective as of the date of application or the first day of the month of application, consistent with § 435.915(b).

In the November 30, 2016 **Federal Register**, we issued the ''Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP'' Final Rule [61] (81 FR 86382) (referred to hereafter as the ''2016 eligibility and enrollment final rule''), which set forth regulations governing the ROP at § 435.956. At § 435.956(b)(4), we provided an option for States to limit the number of ROPs that a given individual may receive, if the State demonstrates that the lack of limits jeopardizes program integrity and receives approval of a State plan amendment (SPA) prior to implementing such limits. This option to limit an individual's number of ROPs applies to individuals who re-apply for coverage after they have been determined to be ineligible for Medicaid due to failure to verify citizenship, U.S. national status, or satisfactory immigration status during the ROP provided in connection with a prior application.

We finalized this State option in the 2016 eligibility and enrollment final rule in response to public comments that we received on the ''Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing'' proposed rule that published in the January 22, 2013, **Federal Register** (78 FR 4593).[62] In particular, one commenter stated that

[61] Accessed from: *https://www.federalregister.gov/documents/2016/11/30/2016-27848/medicaid-and-childrens-health-insurance-programs-eligibility-notices-fair-hearing-and-appeal.*

[62] *https://www.federalregister.gov/documents/2013/01/22/2013-00659/medicaid-childrens-health-insurance-programs-and-exchanges-essential-health-benefits-in-alternative.*

the proposed rule could be interpreted to allow multiple (and unlimited) ROPs through the submission of subsequent applications despite the failure of verification of the individual's citizenship or immigration status. Another commenter questioned whether CMS considered limiting the number of ROPs that can be provided. In response to these comments, § 435.956(b)(4) of the final rule established the State option to limit the number of ROPs, provided that before the State implements such a limitation, the State: (1) demonstrates that the lack of limits jeopardizes program integrity; and (2) receives approval of a SPA electing the option.

Since the option was finalized, only one State has submitted a SPA requesting to implement this option, which we approved as a one-year pilot program to provide the State with an opportunity to demonstrate that not limiting the number of ROPs jeopardized program integrity in the State. The State's pilot program limited individuals to two ROPs during the 12-month pilot period. During the pilot, the State monitored requests for multiple ROPs, and collected data on the frequency and characteristics of individuals who re-applied after failing to complete verification of their status during their first ROP. From its data analysis of the pilot period, the State observed that the number of repeat ROPs provided by the State was minimal and concluded that the availability of multiple ROPs posed negligible risk to program integrity. Following the pilot, the State suspended the policy of limiting the ROP period and removed the policy from its State Plan. Other than the one State, CMS has not received any inquiries about establishing such a limitation or raising program integrity concerns related to ROPs.

Sections 1902(a)(46)(B), 1902(ee)(1)(B)(ii), 1903(x)(4), and 1137(d)(4)(A) of the Act do not expressly limit the number of ROPs an individual may receive, nor do these provisions expressly provide discretion for States to establish such a limit. In light of the absence of any indication that the availability of multiple ROPs poses significant risks to program integrity, we believe that removing the option for States to impose limits on the number of ROPs that an individual may receive is warranted. Therefore, we are interpreting the ambiguity in 1902(a)(46)(B), 1902(ee)(1)(B)(ii), 1903(x)(4), and 1137(d)(4)(A) of the Act with respect to this question of limiting the number of ROPs to remove the State option to limit the number of ROPs an applicant may receive after re-applying for benefits. We also find this proposal to be consistent with both section 1902(a)(19) of the Act, which requires that States provide safeguards as necessary to ensure that eligibility for care and services under the State plan are provided in a manner consistent with simplicity of administration and the best interests of the recipients, and section 1902(a)(8) of the Act, which requires that all individuals who wish to apply for Medicaid have the opportunity to do so. The ROP is integral to the Medicaid application process and ensuring prompt access to services for eligible individuals who have attested to U.S. citizenship, national, or satisfactory immigration status, but whose status cannot be promptly verified electronically. We note that an individual's status may change between the filing of applications or new information or evidence regarding U.S. citizenship/national status or satisfactory immigration status may become available. This policy revision supports the health and well-being of immigrants and their families in accordance with Executive Order 13993 ''Revision of Civil Immigration Enforcement Policies and Priorities'' and provides access to health coverage in Medicaid and CHIP for U.S. citizens and immigrants who are eligible to receive such coverage during a Reasonable Opportunity Period in accordance with Executive Order 14070 ''Continuing To Strengthen Americans' Access to Affordable, Quality Health Coverage.''

Therefore, we propose to revise § 435.956(b)(4) to remove the option for States to establish limits on the number of ROPs. Under proposed § 435.956(b)(4) for Medicaid and the existing cross-reference at § 457.380(b)(1)(ii) for CHIP, States would be prohibited from imposing limitations on the number of ROPs that an individual may receive.

2. Remove or Limit Requirement To Apply for Other Benefits (§ 435.608)

Under § 435.608(a) (relating to ''Applications for other benefits''), State Medicaid agencies must require that all Medicaid applicants and beneficiaries, as a condition of their eligibility, take all necessary steps to obtain other benefits to which they are entitled, unless they can show good cause for not doing so. Paragraph (b) of § 435.608 describes such benefits to include, but not be limited to, annuities, pensions, retirement, and disability benefits. (Veterans' compensation and pensions, Social Security disability insurance and retirement benefits, and unemployment compensation are specifically identified as examples). This requirement applies to all Medicaid applicants and beneficiaries, without regard to the basis of their eligibility or the financial eligibility methodology used to determine their eligibility.

This provision was originally promulgated in 1978 (see 43 FR 9810) and codified at the time at 42 CFR 448.3(b)(1)(ii) and 448.21(a)(2)(i)(C). It was redesignated later in 1978 at § 435.603 (see 43 FR 45204), and redesignated again in 1993 at § 435.608 (see 58 FR 4931). When the rule was established in 1978, we noted that: ''Section 1902(a)(17) of the Act requires that available income and resources must be considered in determining eligibility, except for amounts that would be disregarded (or set aside for future needs) by the AFDC [Aid to Families with Dependent Children] or SSI programs. Those programs require applicants and recipients to accept other cash benefits which are available to them; see: section 407(b)(2) of the Act and 45 CFR 233.20(a)(3)(ix) regarding AFDC; and section 1611(e)(2) of the Act and 20 CFR 416.230 and 416.1330 regarding SSI. Thus, this amendment conforms Medicaid requirements to those of the AFDC and SSI programs.'' (43 FR 9812).

Section 1902(a)(17)(B) of the Act directs that a State plan ''must provide for taking into account only such income and resources as are, as determined *in accordance with standards prescribed by the Secretary,* available to the applicant or recipient and . . . as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance or benefits'' under various Federal cash assistance programs, including the SSI program and the former AFDC program (emphasis added). This statutory language prohibits State Medicaid agencies from taking into account income and resources not counted in determining eligibility for various Federal cash assistance programs described in section 1902(a)(17)(B) of the Act. However, section 1902(a)(17)(B) of the Act does not mandate that States must take into account all types or sources of income and resources that *are* counted in the eligibility determinations for those programs. Instead, the language specifically provides discretion to the Secretary to establish the standards under which income and resources not disregarded by the various Federal cash assistance programs should be considered ''available,'' that is, taken into account, in determining an individual's Medicaid eligibility.

Thus, while section 1902(a)(17)(B) of the Act *authorizes* the Secretary to consider as ''available'' income or resources Medicaid applicants and beneficiaries might receive if they applied for certain benefits, section 1902(a)(17)(B) of the Act does not require the Secretary to do so. Nor does section 1902(a)(17)(B) of the Act compel the Secretary to apply either the requirement in section 1611(e)(2) of the Act (that individuals seeking SSI apply for other benefits) or the requirement in former section 407(b)(2) of the Act (that individuals seeking AFDC benefits apply for AFDC) to individuals seeking Medicaid.

Adoption of the rule imposed in the SSI and AFDC programs to Medicaid was reasonable in 1978, given that the primary path to Medicaid eligibility at the time was receipt of SSI or AFDC benefits; the Medicaid eligibility pathways available for individuals not receiving assistance from a Federal cash assistance program, or deemed to be receiving assistance from such programs, were very limited.

However, Medicaid has significantly changed in the intervening years. For example, Medicaid eligibility was ''de-linked'' from cash assistance for a significant portion of the Medicaid population when the AFDC program was repealed and replaced with the Temporary Assistance for Needy Families (TANF) program in section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Pub. L. 104–193). Unlike AFDC, eligibility for TANF does not confer automatic eligibility for Medicaid. Additionally, numerous eligibility groups have since been authorized under the statute, including groups for children, pregnant individuals, parents and caretaker relatives, and other adults with income higher than the income standard for cash assistance programs and eligibility groups that have no income test, such as the mandatory eligibility group for former foster care children described in section 1902(a)(10)(A)(i)(IX) of the Act (implemented in the regulations at § 435.150), and the optional group serving individuals in need of breast or cervical cancer treatment described in section 1902(a)(10)(A)(ii)(XVIII) of the Act (implemented in the regulations at § 435.213).

Further, whereas financial eligibility for all eligibility groups previously had been based on the financial methodologies applied by a cash assistance program (primarily AFDC or SSI), effective January 1, 2014, the ACA directed States to apply an entirely different financial methodology in determining eligibility for most individuals seeking Medicaid coverage, based on Federal income tax rules in the Internal Revenue Code. This methodology, based on MAGI as defined under section 36B(d)(2) of the Internal Revenue Code, generally considers only amounts actually received by an individual and the individual's household members, and does not consider other amounts or benefits that the individual or other household members could receive if proactive steps were taken. Thus, there is no statutory mandate for the rule in § 435.608(a) that currently requires application for other benefits by Medicaid applicants and beneficiaries.

We have received a number of inquiries from States about the requirement to apply for other benefits. Some States specifically have requested flexibility to avoid applying this requirement to individuals otherwise eligible for the eligibility group for former foster care children which, as noted above, does not have an income test. These States noted that individuals who otherwise meet all requirements to be enrolled or remain enrolled in this group were losing Medicaid coverage due to failure to provide information on application for other benefits, such as unemployment compensation. Some States received beneficiary complaints related to the burden of this requirement and the impact on individuals who are required to apply for Social Security benefits before reaching their full retirement age. These States, in turn, reached out to CMS for guidance.

Given that the Medicaid program has largely outgrown the foundation upon which § 435.608 was based—that is, a close connection between Medicaid and cash assistance programs—and the barrier to coverage the requirement poses for some individuals, we believe it is appropriate to revisit this regulation. Specifically, we propose to reinterpret the meaning of ''such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient'' in section 1902(a)(17)(B) of the Act to encompass only the actual income and resources within the applicant's or beneficiary's immediate control, but not to encompass such income and resources that might be available if such individuals applied for, and were found eligible for, other benefits. This means that eligibility for Medicaid would no longer require that applicants and beneficiaries apply for benefits for which they may be entitled. We believe this interpretation is consistent with section 1902(a)(19) of the Act, which provides that eligibility be determined in a manner consistent with simplicity of administration and the best interests of recipients.

In developing our proposal, we are considering several alternative options to address the requirement to apply for other benefits. These alternatives are not mutually exclusive and could be used in combination with one another.

- We are considering revising the requirement in § 435.608 to include benefits that would count as income under the financial methodology used to determine the applicant or beneficiary's income. Individuals whose financial eligibility is determined using MAGI-based methodologies would not be required to apply for other benefits that would not count as income. For example, such a person would not be required to apply for benefits such as TANF or veterans' benefits as a condition of Medicaid eligibility because those benefits are not counted as income under MAGI-based methodologies. Additionally, individuals who are eligible for, or applying for coverage under, a Medicaid eligibility group that does not include an income test, would not be required to apply for other benefits, as receipt of other benefits would not impact an individual's income for purposes of Medicaid eligibility because it would not impact their eligibility. This would be true of, for example, individuals who are eligible for the former foster care children eligibility group and the eligibility group serving individuals in need of breast or cervical cancer treatment. This would also be true of individuals who are eligible for Medicaid on the basis of their receipt of assistance under title IV–E of the Act (see § 435.145). Under this option, however, individuals seeking coverage under an eligibility group applying the financial methodologies of the SSI program would be required, as a condition of eligibility, to apply for benefits that count as income in determining eligibility for SSI. For some individuals, in the course of processing an application, States must apply both the MAGI and non-MAGI methodologies before the most appropriate outcome is determined (see § 435.911(c)); eliminating the requirement to apply for other benefits for MAGI-based individuals but maintaining the requirement for non-MAGI individuals could be administratively burdensome for States. Therefore, we consider a proposal to eliminate the requirement for all Medicaid applicants and beneficiaries to be the better approach.
- We also are considering exempting SSI beneficiaries from the requirement

to apply for other benefits, including SSI beneficiaries in States that have elected their option under section 1902(f) of the Act to apply eligibility criteria more restrictive than the SSI program for individuals who seek eligibility on the basis of being 65 years old or older or who have blindness or disabilities (that is, 209(b) States), but not other applicants and beneficiaries whose financial eligibility is based on SSI financial methodologies. As mentioned above, Federal law requires SSI applicants and beneficiaries to apply for other benefits for which they may be eligible. This means that an SSI beneficiary who applies for Medicaid will have already applied for other benefits for which the individual may be eligible, except where the SSA itself has determined: (a) that it does not believe that there are other benefits for which the individual may be eligible; or (b) that, even if there are potentially other such benefits, receipt of such benefits would not affect the individual's underlying SSI eligibility or payment amount (see 20 CFR 416.210 and SI 00510.001 (''Overview of the Filing for Other Program Benefits Requirement'') in the SSA POMS). With this in mind, we believe that imposing the requirement in § 435.608(a) on SSI recipients would be duplicative. We acknowledge that it may be theoretically possible that, in non-1634 States (that is, criteria States and 209(b) States, as described above), there could be an SSI beneficiary who may be eligible for a benefit for which the SSA ultimately did not require the individual to apply but which could potentially affect the individual's Medicaid eligibility. However, we believe that such circumstances would be rare and do not outweigh the interests of the vast majority of individuals in 209(b) and criteria States, or simplicity of administration, consistent with section 1902(a)(19) of the Act, or efficiency of administration, consistent with section 1902(a)(19) of the Act. Even so, if the requirement were eliminated for all SSI beneficiaries, in addition to MAGI-based individuals, but preserved for non-SSI beneficiaries whose eligibility is based on either SSI methodologies or a 209(b) State's more restrictive methodologies, this approach could similarly create administrative burden for States. Therefore, we believe that a proposal to eliminate the requirement for all Medicaid populations is superior to this option as well.

We invite comment on these possible alternatives. If CMS were to adopt an alternative to the proposal to eliminate the requirement to apply for other benefits in its entirety, we would consider making several modifications to such requirement, as follows:

For those for whom we would maintain the requirement to apply for other benefits as a condition of eligibility, we are considering making the operation of the requirement a post-enrollment activity. Such a policy would be similar to, for example, the requirement that applicants attest that they will cooperate, while beneficiaries must cooperate, with identifying liable third parties under section 1902(a)(25) of the Act, as implemented at § 435.610(a)(2). Thus, applicants would need to attest to their agreement to apply for other benefits for which they may be eligible at application unless, consistent with the current regulation at § 435.608(a), they can show good cause for not doing so. States would follow up with the individual on compliance with the requirement post-enrollment, and non-cooperation by a beneficiary without good cause would be grounds for termination (subject to requirements for advance notice and fair hearing rights in 42 CFR part 431, subpart E).

We are considering revising the ''good cause'' exception at § 435.608(a) to incorporate language included in the ''good reason'' exception in the SSI regulations at 20 CFR 416.210(e)(2). Specifically, we are considering including two examples of situations satisfying the good cause exemption that are in the SSI provision: (a) where an individual is incapacitated; or (b) where it ''would be useless'' for an individual to apply for other benefits because the individual has previously applied for the other benefits and been denied and has not experienced a relevant change in circumstances since that time. Additionally, the SSI policy also excuses compliance with the requirement to apply for other benefits where an individual will not receive a benefit that will affect eligibility. Therefore, we are considering adding these specific examples in the reference in the ''good cause'' exception in § 435.608.

We are considering requiring States to provide written notice to each individual who is subject to the requirement in § 435.608 of the benefits for which the State believes the individual may be eligible and that the individual's Medicaid eligibility may be affected by the individual's failure to apply for such benefits. This is the SSA's approach in requiring that SSI applicants and beneficiaries file for other benefits, as described in 20 CFR 416.210(c), and we would consider this to be a reasonable condition precedent to imposing the requirement.

We seek comment on this proposal related to § 435.608 and how CMS can update the regulation to reduce unnecessary barriers to enrollment and to reduce burden on individuals and States. We are interested, for example, in whether or not it is the experience of State agencies that imposition of the existing rule commonly results in applicants or beneficiaries receiving additional eligibility-altering income. We are also interested in the experiences of applicants and beneficiaries in their compliance with this rule, such as whether it commonly delays favorable eligibility determinations, and, by extension access to care. We are mindful that the requirement imposed by § 435.608(a) is not similarly imposed in eligibility determinations for CHIP, the BHP, or insurance affordability programs available through the Exchanges, and we are interested in comments on the whether the approach of the latter programs is more practical. We also welcome comments on each of the alternatives we are considering that might be adopted in a final rule based on comments received.

In consideration of the foregoing analysis, we propose in this rulemaking to remove the requirement at § 435.608 entirely for all Medicaid applicants and beneficiaries to apply for other benefits to which they are entitled.

D. Recordkeeping (§§ 431.17, 435.914, and 457.965)

Comprehensive recordkeeping is essential to the proper and efficient administration of any State Medicaid program, consistent with section 1902(a)(4) of the Act. State Medicaid agencies must maintain records needed to justify and support the decisions made regarding all applicants and beneficiaries, defend decisions challenged by an applicant or beneficiary who requests a fair hearing, enable State and Federal auditors and reviewers to conduct appropriate oversight, and support the State's own quality control processes. Applicants and beneficiaries (or their authorized representative) must also be able to review the content of their case record prior to a fair hearing challenging an agency's decision.

Regulations at §§ 431.17 and 435.914 currently require that State Medicaid agencies' records for applicants and beneficiaries include sufficient content to substantiate the eligibility determination made by the State. However, these regulations are largely outdated and unclear. In many instances, the requirements lack the specificity reflective of the range of

records and information used by today's Medicaid programs. The requirements do not reflect modern technology, specifically the use of electronic data, and do not specify how long applicant and beneficiary case records must be retained, resulting in a range of retention periods across States. Over the years, we have received questions from Medicaid agencies requesting clarification on record retention policy, storage modalities, and retention periods.

HHS OIG reports also raise concerns about the adequacy of the case records maintained across State Medicaid agencies.[63] The HHS OIG reports identified case records that lack documentation of income, citizenship, or immigration status verification and found case records in which auditors could not access documents needed to evaluate the accuracy of a State's determination of eligibility. Additionally, PERM eligibility reviews in the FYs 2019, 2020, and 2021 cycles found that insufficient documentation was a leading cause of eligibility errors.[64]

To help States meet the requirement to maintain appropriate, comprehensive, and accessible records, consistent with section 1902(a)(4) of the Act, we propose to revise § 431.17 to more clearly delineate the types of information State Medicaid agencies must maintain in case records and to prescribe a minimum retention period. Reflecting modern forms of technology, we also propose to revise the regulations to require that States store their case records in an electronic format.

We propose revisions to § 431.17(b)(1) to detail the specific records and documentary evidence that must be retained as part of each applicant's and beneficiary's case record to support the determinations made by State Medicaid agencies. These records, which are critical to demonstrating that States are providing the proper amount of medical assistance to eligible individuals, include:

- All information provided on the initial application submitted by, or on behalf of, an applicant regardless of the modality through which a person applies for Medicaid (for example, online, by phone, in person or through the Exchange), including the signature and date of application;
- The electronic account and any information or documentation received from another insurance affordability program in accordance with § 435.1200(c) and (d);
- Any changes in circumstances reported by the individual and any actions taken by the agency in response to such reports;
- All renewal forms and information returned by or on behalf of the beneficiary to the agency in accordance with § 435.916, including the signature on any returned renewal form and the date the form was received;
- The date of and basis for any determination, denial, or other adverse action, including decisions made at application, at renewal, and as a result of a change in circumstance, affecting an applicant or beneficiary, as well as all documents or other evidence to support such action, including all information provided by, or on behalf of, the applicant or beneficiary and all information obtained electronically or otherwise by the agency or third-party sources. This includes information received from data sources as described in the regulations at §§ 435.940 through 435.960.
- The provision of, and payment for, services, items and other medical assistance. This includes services or items provided and dates that the services or items were provided; diagnoses related to services or items provided; names of the providers rendering or referring/prescribing the services or items (as applicable), including their National Provider Identifier; the full amounts billed and paid or reimbursed for the services or items; and any liable third party and the amount of such liabilities;
- All notices provided to the applicant or beneficiary under §§ 431.206, 435.917 or 435.918;
- All records pertaining to any fair hearings requested by, or on behalf of, the applicant or beneficiary, including each request submitted and the date of such request, the complete record of the hearing decision, as described in § 431.244(b), and the final administrative action taken by the agency following the hearing decision and date of such action; and
- The disposition of information received by the agency when conducting verifications per regulations at §§ 435.940 through 435.960, including evidence that no information was returned from a given data source. In documenting the disposition of information received through this process, the disposition of information received by the agency includes documentation that the agency determined that information received was not useful to verifying eligibility.

Neither the statute nor current regulations specify how long Medicaid records must be maintained. We believe that the length of record retention also is a critical factor to effective administration of the State plan and propose to revise § 431.17(c) to require that States maintain all records described in this regulation for the period that the applicant or beneficiary's case is active, plus a minimum of 3 years thereafter. In establishing this minimum time period, we assessed the areas of the Medicaid program for which there are time limits that would impact record retention, such as the PERM program, which operates on a 3-year cycle, and Medicaid timely filing, described at section 1132(a)(2) of the Act, which requires that States file any claim for payment no later than 2 years from the calendar quarter of the expenditure. We consider 3 years to be a reasonable minimum based on these factors. We consider a case to be active starting at the date of application. For applicants determined ineligible (that is, the application is denied), the case would be active through the date that a determination of ineligibility is made. For applicants determined eligible (that is, the application is approved), the case would be active until their eligibility is terminated or coverage otherwise ends. A case would also remain active for any applicant or beneficiary who has a pending fair hearing or appeal. In the event that a case becomes active again prior to the expiration of the 3-year period, the records retention clock would restart. In this case, under the proposed rule, the State would need to retain all prior records until 3 years after the individual's eligibility is again terminated or their coverage otherwise ends. For example, if a beneficiary, who initially applied for coverage in 2020, is terminated in 2022 due to an increase in income and in 2024 (2 years later) reapplies and is determined eligible, the case would become active again. The records retention clock would restart, and all of the individual's records from

[63] California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements, Office of Inspector General, 2018. Available at *https://oig.hhs.gov/oas/reports/region9/91702002.pdf*; New York Did Not Correctly Determine Medicaid Eligibility for Some newly Enrolled Beneficiaries, Office of Inspector General, 2018. Available at *https://oig.hhs.gov/oas/reports/region2/21501015.pdf*; Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance with Federal and State Requirements, Office of Inspector General, 2017. Available at *https://oig.hhs.gov/oas/reports/region4/41608047.pdf*; Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries, Office of Inspector General, 2019. Available at *https://oig.hhs.gov/oas/reports/region7/71604228.pdf*.

[64] Fiscal Year 2019 Agency Financial Report, US Department of Health and Human Services, 2019. Available at *https://www.hhs.gov/sites/default/files/fy2019-hhs-agency-financial-report.pdf*.

his or her initial application and enrollment from 2020 to 2022 must be retained during the new retention period.

We believe that tying the retention period to the period of time that the case is active plus an additional 3 years will ensure that applicant and beneficiary records will be available for all circumstances in which such records may be needed, including after an individual is no longer enrolled in the Medicaid program. For example, if a formerly enrolled applicant reapplies to Medicaid 2 years after they lost coverage, States should rely on previously verified citizenship and immigration status unless the State has reason to believe something has changed. In order to rely on information previously verified, that information must be retained in the case record. Additionally, under the estate recovery program authorized by section 1917(b)(1) of the Act, States may recover payments for all Medicaid covered services. Therefore, States may need to access claims data in order to tally the cost of covered services for extended periods, depending on the length of the applicant's enrollment. We seek comment on the proposed retention period, as well as on whether a shorter or longer retention period should be required for certain types of records, including those pertaining to the provision of, and payment for, services, items and other medical assistance, or whether a shorter or longer period should be required for all records—for example, a period of 10 years for all records, similar to our policy regarding enrollee records for Medicare,[65] as well as the record retention policy applied to managed care organizations under § 438.3(u). We also seek comment on whether the retention period should be tied to the individual or the active case.

Current § 431.17(d) contains outdated regulation text that references obsolete or rarely used technology, including microfilm systems. We propose to update this paragraph to require that State Medicaid agencies store records in an electronic format and that the State Medicaid agency make records available to the Secretary or other appropriate parties, such as State and Federal auditors, within 30 calendar days of the date records are requested, if not otherwise specified. We seek comment on whether States should retain flexibility to maintain records in paper or other formats that reflect evolving technology. While each of the records and documentary evidence described in this section are considered part of the case record, we do not propose that these records must be stored in a single system.

Finally, we propose conforming revisions to § 431.17(a), relating to basis and purpose of § 431.17. We also propose revisions to § 435.914 of the current regulations, which also relates to case documentation, to reflect the full scope of records required under the proposed rule for both applicants and beneficiaries. Section 435.914(a) currently requires that States include in each applicant's case record facts to support the agency's decision on the application. Section 435.914(b) currently requires States to dispose of each application by either: (1) making a finding of eligibility or ineligibility; (2) documenting in the case record that the applicant voluntarily withdrew the application, and documenting that the agency sent a notice confirming such withdrawal; or (3) including an entry in the case record that the applicant has died or cannot be located. We propose to revise § 435.914(a) to apply to both applicant and beneficiary case records and to provide that the records maintained in each individual's case record include all those described in § 431.17(b)(1), as revised in this proposed rule. We propose to revise § 435.914(b) to provide that States must dispose of all applications and renewals by a finding of eligibility or ineligibility unless one of the three circumstances described above applies. The applicability of these requirements to a separate CHIP, including proposed changes to § 457.965, is discussed further in section II.E.5 of this preamble.

E. CHIP Proposed Changes—Streamlining Enrollment and Promoting Retention and Beneficiary Protections in CHIP

Current CHIP regulations adopt many of the Medicaid eligibility regulations, which require that States have methods of establishing and continuing eligibility, including coordinated and streamlined eligibility and enrollment processes between CHIP and other insurance affordability programs. In order to retain the alignment with Medicaid and other insurance affordability programs, we propose to adopt the same proposed policies for CHIP as are proposed for Medicaid in this proposed rule, except where otherwise noted. We discuss each of these proposed changes as they apply to CHIP below. We seek comment on whether there are any special considerations applicable to CHIP that warrant adoption of a different policy for CHIP than the proposed alignments with Medicaid requirements, which would include the various policies on which we specifically seek comment in the preamble discussing the proposed revisions to the Medicaid regulations.

1. Timely Determination and Redetermination of Eligibility and Related Reviews (§§ 457.340 and 457.1170)

As discussed in section II.B.3 of this proposed rule, we propose changes to §§ 435.907(d) and 435.912 of the Medicaid regulations to ensure applicants are provided a meaningful opportunity to provide additional information needed by the State to make an eligibility determination and to establish specific timeliness standards for completion of regularly-scheduled renewals and redeterminations of eligibility due to changes in circumstances, including when a State receives information needed to redetermine eligibility too close to the end of an enrollee's eligibility period to complete a redetermination of eligibility prior to the end of the eligibility period.

To ensure continued coordination between Medicaid and CHIP enrollment and renewal processes, as required by section 2102(b)(2)(E) of the Act, we propose to apply these changes equally to CHIP, except where otherwise noted. As discussed in section II.B.3 of this proposed rule, we propose revisions at § 435.907(d) to require that, if a State cannot determine Medicaid eligibility based on the information provided on the application and the State needs additional information from the applicant, the State must: (1) give applicants for whom a disability determination is not needed at least 15 calendar days from the date the request is postmarked or electronic request is sent to provide the requested information and 30 calendar days from the date the request is postmarked or electronic request is sent for applicants whose eligibility is being determined on the basis of disability; (2) allow applicants to respond through any of the modes of submission that must be available for submission of the application; and (3) reconsider the eligibility of individuals whose application is denied for failure to provide needed information if the individual provides the needed information within 30 calendar days from the date the denial notice is postmarked or electronic notice is sent without requiring the individual to submit a new application. The terms of § 435.907(d) are applicable to CHIP through an existing reference in § 457.330 to § 435.907. Therefore, these

[65] *CMS Records Schedule.* Available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/CMSRecordsSchedule/index.html.*

proposed changes would apply equally to CHIP, except as noted below with regard to a determination of disability, and no additional revisions to the CHIP regulations are needed.

We note that, unlike Medicaid, there are no distinct eligibility groups in CHIP for which a determination of disability is needed. Some States, however, have established a separate CHIP for children with special health care needs (CSHCN). We seek comment on whether the longer time to return additional information requested by the State at application at proposed § 435.907(d)(1)(i)(A) for individuals applying for Medicaid based on disability (a minimum of 30 calendar days), should be applied to children applying for a separate CHIP if a determination that the child qualifies as a CSHNC is required, as these families may similarly need more time to provide additional documentation or other information needed by the State to make a final determination on their application. We also seek comment on whether a minimum of 15 calendar days from the date the State's request for additional information is postmarked or electronically sent is sufficient for applicants generally (that is, regardless of any need for a determination of CSHCN status) or whether a longer timeframe, such as 20, 25, or 30 calendar days from the date the request is postmarked or electronically sent, similar to the longer time (30 calendar days) proposed for individuals applying for Medicaid on the basis of disability, is appropriate. As discussed in section II.B.3 of this proposed rule, we are also considering a minimum requirement of 30 calendar days from the date the request is postmarked or electronically sent for all applicants to provide additional information, along with an exception to the 45-day requirement at current § 435.912(c)(3)(ii) to provide States with an additional 15 calendar days to complete application processing if the State requested additional information from the applicant, which would apply to CHIP by existing references at § 457.340(d). We also seek comment regarding whether States should be afforded additional time to make a determination of eligibility for applicants seeking coverage under a separate CHIP for CSHCN, similar to the additional time (maximum of 90 calendar days) provided at § 435.912c)(3)(i)) for States to make a final determination of eligibility for individuals applying for Medicaid coverage based on disability and, if so, whether an a maximum of 60, 75, or 90 calendar days is appropriate for determining eligibility for a separate CHIP for CSHCN. Additionally, we seek comment on whether calendar or business days would be better suited as an appropriate timeliness measure. Finally, we also seek comment on whether a longer reconsideration period of 45 calendar days, or 90 calendar days, would be appropriate, similar to the proposed 90-day reconsideration period discussed in section II.B.1 and II.B.2 of this preamble if a beneficiary provides the requested information within 90 calendar days of termination without requiring a new application.

As also discussed in section II.B.3 of this proposed rule, we propose revisions to § 435.912 to specify that States must establish timeliness and performance standards for conducting regularly-scheduled renewals, as well as redeterminations of eligibility due to changes in enrollee circumstances, including maximum timeframes within which States must complete these actions. Proposed revisions to § 435.912 also specify the minimum timeframes that States must provide to enrollees to respond to requests for information when completing renewals. Similar to Medicaid, we also seek comment on the amount of time provided for States to complete a redetermination of eligibility at a regularly-scheduled renewal or based on changes in circumstances at proposed § 435.912(c)(4), (c)(5), and (c)(6), whether the regulations should allow for a longer or shorter period of time, and whether the use of business days rather than calendar days would be more appropriate. Section 435.912 of the Medicaid regulations is applicable to CHIP through an existing reference at § 457.340(d). Therefore, these proposed changes would apply equally to CHIP, except that we propose to revise § 457.340(d)(1) to exclude application of certain Medicaid requirements that are not applicable to CHIP. The Medicaid requirements not applicable to CHIP include § 435.912(c)(4)(iii) and (c)(6)(iii) (relating to timelines for completing renewals and redeterminations when States must consider other bases of eligibility per § 435.916(f)(1), which is redesignated as § 435.916(d)(1) in this proposed rule). We also propose to revise the title of § 457.340(d) to clarify that the timeliness standards apply both at application and renewal.

Finally, in order to support effective and efficient eligibility procedures, consistent with sections 2101(a) and 2102(b)(2) of the Act, we propose to modify section § 457.1170 to require that States ensure the opportunity for continued enrollment in CHIP during a review of a State's failure to make a timely determination of eligibility. Currently, States using a program specific review process for separate CHIP must only provide the opportunity for continued enrollment in CHIP pending the completion of a review for a suspension or termination of CHIP eligibility. We believe this proposed change to § 457.1170 will support a CHIP enrollee's rights during a review if a State fails to meet the proposed timeliness standards at both application and renewal consistent with proposed changes in § 435.912, as referenced in § 457.340(d).

Additionally, we propose to modify § 457.1170 to clarify that continuation of enrollment includes the continued provision of health benefits during the review period. Currently, § 457.1170 provides that States must ensure the opportunity for continuation of enrollment pending the completion of review of a suspension or termination of enrollment. While we acknowledge that, consistent with our definition of ''enrollee'' at § 457.10, coverage of health benefits is intrinsic to enrollment, we propose to add explicit reference to benefits at § 457.1170 to emphasize that continued enrollment without provision of benefits pending completion of a review of a termination or suspension of coverage does not satisfy the requirement at § 457.1170. Finally, we propose to make explicit references to continuation of benefits in §§ 457.1140 and 457.1180 when describing the process for continuation of enrollment or referencing in notices.

As discussed above in section II.B.3 of the preamble, we seek comment for both Medicaid and CHIP on whether proposed § 435.912(c)(4)(ii) (incorporated in CHIP through § 457.340(d)) balances maximizing the completion of timely renewals prior to the end of an enrollee's eligibility period and providing States with sufficient time to complete redeterminations and provide notice for enrollees who return needed documentation or other information prior to the end of their eligibility period, but not by the date requested by the agency to ensure completion of a timely renewal. The notice requirements for CHIP are located at § 457.340(e)(1).

2. Changes in Circumstances (§§ 457.344 and 457.960)

As discussed in sections II.B.2 of this proposed rule, we propose to revise and redesignate paragraphs (c) and (d) of current § 435.916, related to changes in circumstances, to a new § 435.919 that is devoted specifically to State and enrollees' responsibilities for acting on changes in circumstances. Proposed § 435.919 includes procedures for

enrollees to report changes to the Medicaid agency and specific steps States must take in promptly processing such changes.

We propose at § 435.919(c)(1) that States must provide a minimum of 30 calendar days for beneficiaries to respond to a request for additional information needed to determine eligibility based on a change in circumstances. We also propose at § 435.919(d) that State Medicaid agencies provide beneficiaries whose coverage is terminated due to failure to provide information needed to redetermine eligibility following a change in circumstances with a 90-day reconsideration period. During this 90-day period, if a beneficiary returns the requested information, the agency would be required to redetermine the individual's eligibility without requiring a new application.

Consistent with section 2102(b) of the Act related to a State's eligibility standards and methodologies, we propose to apply the changes at proposed § 435.919 to CHIP. Regulations governing changes in circumstances for CHIP beneficiaries are currently found in § 457.960. For greater transparency, we propose to remove § 457.960 in its entirety and incorporate the terms of proposed § 435.919 into a new § 457.344. Some of the provisions in current § 435.916 (redesignated at proposed § 435.919) are not applicable to CHIP and we are not proposing to adopt them through proposed changes to § 457.344. Specifically, we propose to not incorporate into § 457.344 the requirement proposed at § 435.919(b)(4)(i) (currently at § 435.916(f)(1)) related to determining eligibility upon all other bases. We do not believe this requirement is relevant for CHIP because the eligibility of all CHIP beneficiaries is based on MAGI, but we seek comment on whether it should be applied to CHIP in cases where a State has more than one separate CHIP population and an enrollee could transition between populations. For example, some States have a separate CHIP program specific to CSHCN or elect to provide coverage to other eligibility groups in CHIP, such as targeted low-income pregnant women.

Currently § 457.343 references § 435.916, in its entirety as applicable. For example, the current regulations specify where noted that other CHIP regulations regarding verification and noticing requirements apply in place of Medicaid regulations referenced in § 435.916. Outside the redesignation of § 435.916 (c) and (d) to § 435.919, as discussed above, the remaining changes to the regularly-scheduled renewal requirements at proposed § 435.916 will also apply to CHIP through this cross-reference. However, there are several proposed revisions to § 435.916 that would not be applicable to CHIP populations, such as proposed §§ 435.916(a)(2) related to Medicare beneficiaries, 435.916(b)(3) related to non-MAGI determinations, and 435.916(d)(1) (a redesignation of current § 435.916(f)(1)) related to considering eligibility on all bases prior to terminating a beneficiary.

3. Returned Mail (§ 457.344)

As discussed in section II.B.4 of the preamble, we propose requirements at § 435.919(f) describing the actions that States must take to verify an individual's address when the State receives returned mail, including the minimum amount of time States must provide to individuals to respond to such requests. Under this proposed rule, in addition to sending notices to the current address on file and the new address provided by USPS, the State must also attempt to contact the individual using other means, such as by telephone, email, text, or other electronic notice. Proposed §§ 435.919(f)(1), (2), and (3) specify the actions States must take to verify an individual's address, and proposed §§ 435.919(f)(4), (5) and (6) describe the actions States must take if an individual fails to confirm their address based on whether the forwarding address is in-state or out-of-state or there is no forwarding address. This rule also re-designates existing Medicaid requirements at § 431.231(d) as proposed § 435.919(f)(6). Under these requirements, States must reinstate coverage if an individual's whereabouts become known before their next renewal date. Finally, this rule proposes § 435.919(g), which describes the actions States may and must take when they receive updated in-state address information from the USPS NCOA database or the State's contracted managed care entities as well as requirements when they receive updated address information from other third-party sources, regardless of whether those data sources have or have not been approved by the Secretary.

Consistent with the section II.E.2 of the preamble, we are proposing that CHIP adopt the substance of proposed § 435.919 as § 457.344 with some exceptions. We also propose to apply the Medicaid provisions related to receipt of updated address information from returned mail, the USPS NCOA, a State's contracted managed care plans, and other third-party sources under § 435.919(f) and (g) equally to CHIP. Additionally, we clarify at § 457.344(f)(5) and (g)(1)(vii) that if any separate CHIP population is not available Statewide and the updated address lies outside of the specific geographic areas in which the State's separate CHIP provides coverage, the State is required to treat the newly identified address as out-of-state and take the appropriate actions when trying to verify an enrollee's address, regardless of whether the address is obtained due to returned mail or obtained from another third-party data source.

We seek also comment on several requirements in proposed § 457.344(f) and (g). Similar to the request for comments on proposed § 435.919(f), we seek comment with respect to proposed § 457.344(f) on whether States should be required to update an enrollee's in-state address using more recent contact information reflected in a forwarding address from USPS or an address provided by NCOA or a managed care plan in this situation, when the enrollee has not responded to the State's request to verify their current address. Additionally, we seek comment on whether States should be permitted or should be required to update enrollee contact information based on information obtained from an MCO, from the USPS NCOA, or USPS forwarding without first attempting to contact the enrollee to provide them with an opportunity to verify or dispute the new information, because such third-party data is reliable, and, if so, which data sources should States be permitted to rely upon without attempting to contact enrollees. We are especially interested in comments from States that received authority under section 1902(e)(14)(A) of the Act (which applies to CHIP through section 2107(e)(1)(I) of the Act) to update enrollee contact information based on information received from a reliable third party (for example, an MCO, USPS NCOA or USPS forwarding address) without first attempting to contact the individual, as described in SHO letter #22–001. States that received such authority were temporarily permitted to accept updated enrollee contact information from designated reliable sources without first contacting the individual in an effort to verify the accuracy of the new contact information. We also seek comment on the efficacy of the requirement to send a notice to an enrollee's address on file to ensure that initial piece of returned mail was not incorrectly returned.

We also seek comment on whether all States have a Medicaid Enterprise

System that encompasses both Medicaid and CHIP, as we have assumed under proposed § 457.344(f)(1)(i). Finally, inasmuch as proposed § 435.919(f)(6) (relating to individuals whose whereabouts become known) includes regulation text from an existing Medicaid regulation at § 431.231(d), we seek comment on whether any provisions of § 435.919(f)(6) should not be applied to CHIP at proposed § 457.344(f)(6). We believe there may be operational challenges States may face when implementing these provisions and we seek further comment on the potential impact of these provisions.

Finally, similar to Medicaid, we seek comment on whether under proposed § 457.344(g) States either should be permitted or should be required to update enrollee contact information based on information obtained from an MCO, from the USPS NCOA, or other reliable data sources, such as Indian Health Care Providers, Federally Qualified Health Centers, Rural Health Clinics, Program of All-inclusive Care for the Elderly providers, Primary Care Case Managers, Accountable Care Organizations, Patient Centered Medical Homes, Enrollment Brokers, or other State Human Services Agencies (for example, SNAP), without first attempting to contact the individual to provide them with an opportunity to verify or dispute the new information, because such third-party data is reliable, and, if so, which data sources should States be permitted to rely upon without attempting to contact enrollees.

We are especially interested in comments from States that received authority under section 1902(e)(14)(A) of the Act (which applies to CHIP through section 2107(e)(1)(I) of the Act) to update enrollee contact information based on information received from a reliable third party without first attempting to contact the enrollee, as described in SHO letter #22–001. We also seek comment on the efficacy of the requirement to send a notice to an enrollee's address on file to ensure that initial piece of returned mail was not incorrectly returned, and on the efficacy of the requirement to conduct at least two outreach attempts to the enrollee using a modality other than mail. We also seek comment on the requirements in proposed § 457.344(g)(3) cross referencing § 457.344(f)(2) through (6), related to processing out-of-state address information or address information from a source not identified in § 457.344(g)(1) or (2).

4. Transitions Between CHIP and Medicaid (§§ 457.340, 457.348, and 457.350)

As discussed in section II.B.5. of this preamble, every State with separate programs for Medicaid, CHIP, and BHP, and many States with a State-based Marketplace utilize a single eligibility system or shared eligibility service. As such, when an enrollee is determined ineligible for one program, and the individual is screened for potential eligibility in another program, the system is effectively making a determination of eligibility for the other program. An individual who applies at the Medicaid agency does not need to be screened and then transferred to the CHIP agency before a determination of CHIP eligibility can be completed, even if the CHIP agency operates separately from the Medicaid agency in the State. To improve transitions between programs and reduce the likelihood of individuals experiencing gaps in coverage, we proposed changes to the Medicaid transition requirements at § 435.1200. As discussed in detail in section II.B.5., these changes would require the Medicaid agency to determine eligibility for CHIP when an individual is determined ineligible for Medicaid, and seamlessly transition the individual's electronic account to the separate CHIP agency when determined eligible for CHIP; these changes would also require the Medicaid agency to accept determinations of MAGI-based Medicaid eligibility made by separate CHIP agencies and enroll those eligible individuals into Medicaid, through one of the mechanisms described in § 435.1200(b)(4). We also propose changes to the Medicaid regulations at § 435.1200(h)(1) to require States to provide a combined eligibility notice to individuals determined ineligible for Medicaid and eligible for separate CHIP. We similarly propose changes to § 457.340 to require the use of a combined notice for transitions between separate CHIP and Medicaid. Additionally, we propose changes to §§ 457.340, 457.348, and 457.350 to improve transitions between separate CHIP and Medicaid, as described below.

To help prevent children who are eligible for CHIP from becoming uninsured when their Medicaid eligibility is terminated, we propose to make several changes to current § 457.348, which establishes requirements for the State to coordinate transitions of eligibility between and with other insurance affordability programs. First, we propose to add a new paragraph to § 457.348 regarding agency responsibilities for transitioning eligibility. Paragraph (a) of current § 457.348 requires the State to enter into agreements with the agencies administering other insurance affordability programs to fulfill a number of requirements in this section, such as minimizing burden on individuals during the eligibility process, and ensuring prompt determination of eligibility and enrollment in the appropriate program without undue delay. We propose to revise § 457.348(a) to require that these agreements provide for not only coordination of notices, but also for a combined eligibility notice with other insurance affordability programs. We also propose to add a new paragraph (a)(6) to § 457.348, which would require the State to have an agreement with the Medicaid agency which clearly describes the responsibilities of each agency for ensuring a seamless transition between separate CHIP and Medicaid when an individual is determined ineligible for one program and eligible for another program. This is consistent with the proposed Medicaid revision at § 435.1200(b)(3)(vi).

Second, we propose to modify § 457.348(b) to require the CHIP agency to accept determinations of separate CHIP eligibility made by Medicaid. Current § 455.348(b) describes the responsibilities of the CHIP agency for individuals found CHIP eligible by another insurance affordability program, if the agency has elected to accept eligibility determinations made by other programs. We propose to require that the agency accept eligibility determinations made by Medicaid but retain the option to enter into an agreement with a BHP or Marketplace operating in the State to accept eligibility determinations made by those entities. To effectuate this change in regulation, and to improve clarity of existing regulations, we propose to delete the introductory language in current paragraph (b) and redesignate the requirements in current § 457.348(b)(1) through (3) at proposed § 457.348(b)(1)(i) through (iii). We propose to add a new paragraph (b)(2) to describe the individuals who are subject to the requirements in proposed paragraph (b)(1). Specifically, proposed § 457.348(b)(2)(i) describes the individuals who are subject to the requirements in paragraph (b) in the current regulations—that is, individuals determined eligible for CHIP by the Marketplace or another insurance affordability program (including as a result of a decision made by a Marketplace appeals entity), if the agency has entered into an agreement

under which the Exchange makes final determinations of CHIP eligibility. Proposed § 457.348(b)(2)(ii) describes individuals who are determined CHIP eligible by a separate Medicaid (including as the result of a decision made by a Medicaid appeals entity). We also propose to add new introductory language at proposed § 457.348(b)(1) to explain that the requirements in proposed paragraph (b)(1) apply to individuals described in proposed paragraph (b)(2).

Paragraph (c) of current § 457.348(c) describes the CHIP agency's responsibilities when individuals are transferred from other insurance affordability programs based on their potential eligibility for CHIP. We are not proposing any revisions to these requirements, since they will continue to apply in States that do not elect to accept determinations of eligibility made by BHP or the Marketplace. Similarly, we do not propose any changes to current § 457.384(d), which specifies that a State must certify for the Exchange and other insurance affordability programs the criteria applied in determining CHIP eligibility.

Third, we propose to add a new paragraph (e) to § 457.348 to clarify that the State must accept a determination of CHIP eligibility made by a separate Medicaid program. Similar to the proposed changes to the Medicaid regulations discussed in section II.B.5. of this rule, in order to comply with this requirement, we propose that the agency may: (1) apply the same MAGI-based methodologies without further verification as Medicaid; (2) enter into an agreement under which the State delegates authority to the Medicaid agency to make final determinations of CHIP eligibility; or (3) adopt other procedures approved by the Secretary. These options are described at proposed § 457.348(e)(1), (2), and (3) respectively. We seek comment on whether these options encompass the full range of processes that a State may establish to accept determinations of eligibility made by Medicaid.

When accepting a determination of CHIP eligibility made by Medicaid, we expect States to enroll the individual in separate CHIP as quickly and seamlessly as possible. Any action the State requires the individual to take prior to enrollment, such as payment of an enrollment fee or selection of a plan, should be described in the combined notice provided to the individual and the individual should be given adequate time to respond to prevent or minimize a gap in coverage. We request comment on the challenges a State may face in seamlessly transitioning eligibility from another program, as well as strategies to mitigate those challenges.

Next, we propose changes to § 457.350, which currently focuses on screening individuals for potential eligibility for other insurance affordability programs. We propose to require separate CHIP agencies to complete MAGI-based eligibility determinations for Medicaid and to screen for potential non-MAGI Medicaid, as well as eligibility for BHP and insurance affordability programs available through the Exchanges. As proposed, when a CHIP enrollee is determined ineligible due to a decrease in household income, the separate CHIP agency would also complete a determination of eligibility for Medicaid. The individual would no longer be screened for potential MAGI Medicaid eligibility, transferred to the Medicaid agency, and then receive a determination of Medicaid eligibility, as required by current § 457.350(b). The separate CHIP agency must utilize the option the Medicaid agency has elected to accept determinations of MAGI-based Medicaid eligibility made by a separate CHIP. The options for the Medicaid agency to accept a CHIP eligibility determination and continue to comply with Medicaid single State agency responsibilities are discussed in section II.B.5 of the Medicaid preamble. We are proposing to add a new paragraph (b)(3) at 457.350 to require the State to ensure that Medicaid eligibility determinations are conducted in accordance with the option elected by the Medicaid agency at proposed § 435.1200(b)(4) and that this be reflected in the agreement between the State and the Medicaid agency that is required at § 457.348(a). We seek comment on the feasibility of a contractor for the separate CHIP agency having the ability to conduct the Medicaid determination in accordance with the options specified at § 435.1200(b)(4).

These changes correspond with the changes proposed to the Medicaid regulations at § 435.1200(e). In addition to the changes related to Medicaid eligibility determinations, we also propose to restructure § 457.350 in order to improve the clarity of both existing and proposed requirements for separate CHIP agencies evaluating eligibility for other insurance affordability programs. These proposed changes are effectuated as follows. Specifically, we propose:

- To amend § 457.350(a)(2) to clarify that the State plan must describe how enrollment is facilitated for applicants found either potentially eligible for another insurance affordability program (that is, BHP or insurance affordability programs available through the Exchanges) or eligible for Medicaid in accordance with this section.
- To revise § 457.350(b) to require States to determine an applicant's eligibility for MAGI Medicaid and to determine potential eligibility for non-MAGI Medicaid, BHP, or insurance affordability programs available through the Exchanges for individuals who are not eligible for MAGI-based Medicaid. Current § 457.350(b) requires a State to identify potential eligibility for other insurance affordability programs (specifically MAGI-based Medicaid, non-MAGI Medicaid, and other insurance affordability programs), promptly and without undue delay and consistent with the State's timeliness standards, when an individual is determined ineligible for separate CHIP at application, at renewal, based on a change in circumstances, or following a review. At § 457.350(b)(1) we propose to retain the introductory language at current § 457.350(b) that a State act promptly and without undue delay, consistent with the timeliness standards established by the State, but we would add a new paragraph (b)(1)(i) requiring the State to determine eligibility for MAGI-based Medicaid. At proposed § 457.350(b)(1)(ii), we would require a State, if unable to make a determination of eligibility for MAGI-based Medicaid to determine potential eligibility for non-MAGI Medicaid, BHP, or insurance affordability programs available through the Exchanges. Proposed § 457.350(b)(2) would apply the requirements of proposed paragraphs (b)(1)(i) and (ii) to applicants, enrollees whose eligibility is being redetermined at renewal or based on a change in circumstances, and to individuals determined ineligible for separate CHIP as a result of a review conducted in accordance with subpart K of this part. This is consistent with the application of current paragraph (b) of § 457.350, as described in the current introductory language.
- Technical changes to paragraph (c) of this section. Current § 457.350(c) describes the income eligibility test that States must apply when determining an individual's eligibility for MAGI-based Medicaid, or potential eligibility for BHP or insurance affordability programs available through the Exchanges. We propose to revise the references to paragraph (b) to reflect the change at proposed § 457.350(b)(1)(i) requiring the State to determine eligibility for MAGI-based Medicaid and the redesignation of the requirement to determine potential eligibility for BHP and insurance affordability programs available through the Exchanges at proposed § 457.350(b)(1)(ii).

• To redesignate current paragraph (f) at proposed § 457.350(d), which is currently reserved. Current § 457.350(f) applies to individuals determined by the separate CHIP agency to be potentially eligible for Medicaid based on MAGI and requires the State to transfer the individual's account to the Medicaid agency, find the applicant provisionally ineligible for CHIP until the Medicaid determination is completed, and redetermine CHIP eligibility if the individual is found ineligible when the Medicaid agency completes the determination. Because we propose to require States to complete determinations, rather than potential determinations, of eligibility for Medicaid based on MAGI, we propose several changes to § 457.350(f) (redesignated at proposed § 457.350(d)). First, we propose to modify the title for proposed § 457.350(d) to clarify that this provision applies to actions that States must take when determining an individual eligible for Medicaid based on MAGI, rather than actions the State must take for individuals found potentially eligibility for Medicaid. Next, we propose to amend the citation in the introductory language to reflect the changes proposed at paragraph (b)(1) of this section. We propose to revise § 457.350(f)(2) (redesignated at § 457.350(d)(2)) to require that the State find the applicant ineligible for CHIP (as opposed to provisionally ineligible for CHIP until the Medicaid determination is completed). Finally, we propose to delete current paragraph (f)(3), which requires the State to determine or redetermine eligibility when the Medicaid agency returns a determination of ineligibility for an individual whom the separate CHIP agency screened as potentially Medicaid eligible, since under proposed § 457.350(b) the CHIP agency will have completed a determination of eligibility for MAGI-based Medicaid and proposed § 435.1200(c) would require the Medicaid agency to accept the determination of eligibility made by the separate CHIP agency.

• To redesignate current § 457.350(j), describing the requirements for individuals determined potentially eligible for non-MAGI Medicaid, as proposed § 457.350(e). Current § 457.350(j) requires the State to transfer the individual's account to the Medicaid agency, complete a determination of CHIP eligibility and evaluate eligibility for other insurance affordability programs if ineligible for CHIP, include coordinated content in the CHIP eligibility notice, and disenroll the individual from CHIP if they ultimately are determined eligible for Medicaid. We propose several technical changes to paragraph (j) (redesignated as proposed paragraph (e)). We propose to revise the title to clarify that this paragraph applies not only to applicants but also to individuals whose eligibility is being redetermined at renewal or based on a change in circumstances and to individuals who are determined ineligible for CHIP upon review; we note that this is not a change in policy but simply a correction to the title. Then we propose to revise existing cross-references to align with proposed changes to paragraphs (b), (e), and (g) in § 457.350.

• To redesignate, at § 457.350, current paragraph (e) as paragraph (f). Current § 457.350(e) applies only to States that use a screening procedure other than a full Medicaid eligibility determination and requires the State to provide certain information to the family when a child is found potentially ineligible for Medicaid. We propose to revise the title of § 457.350(e) (redesignated at § 457.350(f)) to clarify that, in accordance with other changes proposed to this section, this paragraph would apply to individuals who are determined ineligible for MAGI-based Medicaid and found potentially ineligible for Medicaid on a basis other than MAGI. We also propose to update the existing cross-reference in this paragraph to reflect the redesignation of current paragraph (e) as new paragraph (f).

• To delete current paragraph (g) of § 457.350 in its entirety and to redesignate current § 457.350(i) at proposed § 457.350(g). Currently, paragraph (g) describes information States must provide to help families make informed decisions about applying for Medicaid coverage. We believe that the separate CHIP agency is already required to provide similar information to families of children that may potentially be eligible for Medicaid on a non-MAGI basis in § 457.350(e) (redesignated as proposed § 457.350(f)). Therefore, we propose to eliminate the current requirements at § 457.350(g). Current § 457.350(i) (which is revised in this rulemaking to remove references to individuals subject to a period of uninsurance, as discussed in section II.F.2 of this proposed rule) sets forth procedures that the State must undertake when an individual is found potentially eligible for another insurance affordability program, including transferring the individual's electronic account to the other program. We propose to revise § 457.350(i) of the current regulations (redesignated as proposed § 457.350(g)) as discussed in section II.F.2. of this preamble.

• To redesignate requirements at current § 457.350(k) and (h) as proposed § 457.350(h) and (i) respectively. Current paragraph (k) (redesignated at proposed paragraph (h)) permits the separate CHIP agency to make determinations of eligibility for advance payments of the premium tax credit and cost sharing reductions on behalf of the Exchange; we are not proposing any changes to this paragraph. Current § 457.350(h) (redesignated at proposed § 457.350(i)) describes procedures for waiting lists, enrollment caps, and closed enrollment; we propose only a technical change to this section to update the cross-reference to reflect other changes proposed in this section.

Similar to Medicaid, we seek comment on information that the separate CHIP agency would not be able to access through electronic or other data sources when determining MAGI-based eligibility for Medicaid and for which it may need to contact the individual before completing a determination of eligibility. Additionally, we seek comment on whether there are cases in which the separate CHIP agency would be able to complete only a determination of potential MAGI-based eligibility for Medicaid, types of situations that would result in only a determination of potential eligibility, and whether the separate CHIP agency may need the option to transfer the individual's electronic account to the separate Medicaid agency to finalize the determination.

Similar to the proposed changes for coordination of notices in the Medicaid regulations at § 435.1200(h), discussed in section II.B.5 of this proposed rule, we propose changes to § 457.340(f) related to coordination of notices with other programs. These changes correspond with Medicaid changes at § 435.1200(h) to ensure that individuals receive a combined notice regardless of the agency that completes the eligibility determination or transfers the individual's electronic account to another insurance affordability program for a final eligibility determination. Providing individuals with a combined notice will be critical to ensuring that they understand the changes in coverage that are occurring and any additional obligations that may be imposed by the program to which their coverage is being transitioned. As previously mentioned above in the section related to transitions from Medicaid to CHIP, States that operate its CHIP and Medicaid programs under the same agency and eligibility system that

already provide a seamless, combined Medicaid and CHIP notice, may not need to make any changes.

To effectuate this change to the combined notice requirements, we propose changes to § 457.340(f)(1). Current § 457.340(f)(1) requires States to provide combined notices, to the maximum extent feasible, to individuals and to multiple members of the same household who are included on the same application or renewal form; this paragraph also requires the State to include coordination of notices in its agreement with other insurance affordability programs as described at § 457.348(a). We propose to separate current § 457.340(f)(1) into three separate requirements—proposed paragraphs (f)(1)(i), (ii) and (iii)—each of which must be included in the agreement into which the State enters into, in accordance with § 457.348(a). Proposed § 457.340(f)(1)(i) would establish a new requirement for the State to ensure that individuals are provided with a combined notice when their Medicaid eligibility is determined by the separate CHIP agency, or their CHIP eligibility is determined by the agency administering Medicaid. Proposed § 457.340(f)(1)(ii) and (iii) would restate the requirements currently described in paragraph (f)(1)—that is, at proposed § 457.340(f)(1)(ii) to provide a combined notice to individuals transferred between the State and another insurance affordability program to the maximum extent feasible; and at proposed § 457.340(f)(1)(iii) to require a combined notice for multiple members of the same household to the maximum extent feasible. We do not propose to make any changes to § 457.340(f)(2). We seek comment on States' ability to issue a combined notice in accordance with proposed § 457.340(f)(1)(i).

Consistent with these changes to § 457.350, we propose a conforming change to § 457.348(a), which describes the agreements that States must establish with other insurance affordability programs. We propose to revise § 457.348(a) to require that these agreements provide for not only coordination of notices, but also for a combined eligibility notice with other insurance affordability programs.

5. Recordkeeping (§ 457.965)

As discussed in section II.D of this preamble, we propose to revise § 431.17(b) to clearly detail the specific types of information that Medicaid agencies must retain as part of each applicant and/or enrollee's case records. We also propose changes to § 431.17(c) to specify the minimum duration of time that the information that should be retained for both applicant and enrollee files. Finally proposed revisions at § 431.17(d) would provide that States must be able to provide stored information within 30 calendar days after a request has been made if not otherwise specified. Additionally, we clarified in section II.D. of this preamble that we do not propose that all of the information that could be considered part of the case record be stored in a single system.

To ensure effective and efficient administration of the CHIP program, consistent with section 2101(a) of the Act, we propose to modify existing CHIP documentation requirements at § 457.965 by adopting the same requirements as we are proposing for Medicaid at § 431.17, except that cross-references to other Medicaid regulations in proposed § 431.17 are replaced with corresponding cross-references to existing CHIP regulations. As with Medicaid, we seek comment regarding whether 3 years is an appropriate minimum duration of time for States to retain case records after the case is active; additionally, we seek comment whether any longer or shorter duration would be appropriate for certain types of information, such as those related to payment and provision of child health assistance, to remain in the case records. We are also particularly interested in comments on whether the retention period should be tied to the individual or the active case. Finally, we seek comment whether States should retain flexibility to maintain records in paper or other formats that reflect evolving technology.

F. Eliminating Access Barriers in CHIP

Following passage of the ACA, CMS focused on aligning methodologies and procedures in order to create a streamlined, coordinated eligibility and enrollment process across insurance affordability programs. In such rulemaking, we left in place certain flexibilities available to States in administering separate CHIPs which are not permitted in Medicaid, including the option to specify a period of time that CHIP beneficiaries whose families fail to pay required premiums are not permitted to reenroll in CHIP coverage or ''lock out'' such beneficiaries; the option to impose a waiting period prior to enrollment for beneficiaries previously enrolled in other coverage; and the option to impose annual and lifetime limits on benefits. Each of these policies, if adopted by a State, poses a barrier to obtaining and retaining coverage for CHIP beneficiaries who otherwise meet the eligibility requirements for the State's program. As discussed further below, we propose to eliminate each of these State options.

1. Prohibit Premium Lock-Out Periods (§§ 457.570 and 600.525(b)(2))

Premium payment policies can directly influence the difficulty, or ease, eligible children and pregnant individuals face when enrolling in and retaining CHIP coverage. Under section 2103(e)(3)(C) of the Act, States must provide enrollees with a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the child or targeted low-income pregnant woman's coverage is terminated. If the premium remains unpaid at the end of the grace period, States must also offer the family an opportunity to show their income has decreased such that the CHIP enrollee may qualify for a lower premium payment in CHIP or be eligible for Medicaid. States also currently have the option under § 457.570 to impose a premium lock-out period, which is a specified period that a child or a pregnant individual must wait until being allowed to reenroll in the CHIP program after non-payment of premiums. There is no statutory provision expressly requiring CMS to provide States with the option to institute a premium lock-out period after non-payment of premiums.

Under Medicaid, premiums are authorized under sections 1902(a)(14), 1916, and 1916A of the Act, and implementing regulations at 42 CFR 447.50 through 447.57. Medicaid permits disenrollment for failure to pay premiums is at 447.55(b)(2), but does not permit premium lock-out periods.

Premium lock-out periods, by design, require children or pregnant individuals to go without coverage for a specified period. While not focused on the CHIP beneficiary populations specifically, a review of the literature on Medicaid lock-out periods previously authorized under section 1115 demonstrations indicates that premium lock-out periods pose a barrier to coverage and hinder access to care. Research on the impact of premium lock-out periods on access to care for Medicaid

beneficiaries authorized under section 1115(a) of the Act also shows that Medicaid beneficiaries who experience lock-outs are more likely to skip or delay provider visits, not fill prescriptions, and report financial barriers to accessing care.[66] One study found that individuals who experienced interruptions in coverage had higher hospitalization rates for conditions, such as asthma and diabetes, that could have been managed in outpatient settings with consistent access to treatment.[67] Gaps in coverage also make it less likely that families establish sustained relationships with health care providers, which also can undermine the quality of care they receive.[68] The literature also shows that premium lock-out periods disproportionately affect non-White populations compared to White populations, which may further exacerbate existing disparities in health outcomes. Additionally, there is no evidence to demonstrate that lock-out periods incentivize families to comply with requirements.

In order to improve continuity of care and align with Medicaid rules in this area, we propose to eliminate premium lock-out periods in CHIP. Section 2101(a) of the Act requires States to provide access to health care in an effective and efficient manner that is coordinated with other sources of health benefits coverage. In addition, the April 5, 2022 Executive Order 14070, ''Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage'' requires agencies to identify ways to expand the availability of affordable health coverage, improve quality of coverage, and to strengthen benefits. Specifically, we propose to revise § 457.570(c)(1) to prohibit States from imposing premium lock-out periods; to remove current paragraph (c)(2), and to redesignate and revise paragraph (c)(3) at paragraph (c)(2) to prohibit States from requiring collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment once a lock-out period is over if an individual was terminated for failure to pay premiums.

There are a multitude of promising practices described in the literature for helping to prevent late or missed premium payments, thereby avoiding even short-term disruptions to coverage,[69] such as:

- Conducting new member calls to ensure that families understand their payment obligations and options.
- Ensuring eligibility staff who work directly with families are trained and knowledgeable about payment policies and procedures, and can explain them to people, particularly those experiencing a language or cultural barrier.
- Generating frequent payment notices and reminders.
- Providing multiple and convenient options for paying premiums.
- Providing advance payment incentives (such as pay for a certain number of months and permitting 1 free month).

Another possible approach for States to reduce the disruptive effect of non-payment of premiums is to apply an affordable annual enrollment fee or provide families with the choice between paying monthly premiums or an annual enrollment fee. Similar to premiums, States may provide varying fees based on family income level to ensure that families at a lower income can afford the enrollment fee. We note that an annual enrollment fee would need to meet the conditions specified at section 2103(e)(3)(A)(i) of the Act relating to limitations on premiums and enrollment fees for children under 150 percent of the FPL, section 2103(e)(3)(B) of the Act for all other children, and section 2112(b)(6) of the Act for targeted low-income women. To be affordable, an annual fee would likely need to be substantially lower than the equivalent of 12 monthly premium payments.[70] For example, some States with a separate CHIP charge an annual enrollment fee of $50 for one child or $100 for a family with two or more children. Requiring a single affordable annual payment may improve retention, reduce disenrollment rates, and simplify program administration, for example, by reducing the cost of billing, collecting and processing premium payments.[71] We solicit comments on the potential parameters for ensuring that an annual fee is affordable.

States will continue to have the option to disenroll children or targeted low-income pregnant women from coverage due to non-payment of premiums, including enrollment fees, as long as the State provides families a minimum 30-day premium grace period, which is required under 2103(e)(3)(C) of the Act. States must inform an individual, seven days after the first day of the grace period, that failure to make a payment within the premium grace period will result in termination of coverage, and of the individual's right to challenge the termination. Because States would no longer be able to require collection of past due premiums or enrollment fees as a condition of eligibility, a family could re-apply for coverage immediately following disenrollment. States retain the flexibility to determine whether families will be required to complete a new application in order to reenroll in coverage after disenrollment. Other States allow a period of time after disenrollment for families to make a payment and have coverage reinstated without requiring the submission of a new application.

We note that, under 42 CFR 600.320(d), States that operate a BHP have the option to enroll eligible individuals in their BHP during enrollment and special enrollment periods that are no more restrictive than those required for an Exchange at 45 CFR 155.410 and 155.420 or follow the Medicaid and CHIP rules to permit continuous open enrollment throughout the year. Under § 600.525(b)(2), States that elect to allow continuous open enrollment throughout the year must comply with the reenrollment standards set forth in the CHIP regulations at § 457.570(c). Thus, by eliminating the State option to impose a premium lock-out period in CHIP, we effectively would be eliminating the premium lock-out period for States with a BHP that allows continuous open enrollment throughout the year.

As such, we propose to remove the requirement at § 600.525(b)(2) for a BHP State to define the length of the

[66] Ku, L., & Ross, D.C. (2002). *Staying covered: the importance of retaining health insurance for low-income families.* Commonwealth Fund, Task Force on the Future of Health Insurance. *https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_dec_staying_covered__the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586_pdf.pdf.*

[67] Bindman, A.B., Chattopadhyay, A., & Auerback, G.M. (2008). Interruptions in Medicaid coverage and risk for hospitalization for ambulatory care–sensitive conditions. *Annals of internal medicine, 149*(12), 854–860.

[68] Ku, L., & Ross, D.C. (2002). *Staying covered: the importance of retaining health insurance for low-income families.* Commonwealth Fund, Task Force on the Future of Health Insurance. *https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_dec_staying_covered__the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586_pdf.*

[69] Brooks, T. (2013). Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters. *Georgetown University Center for Children and Families. https://ccf.georgetown.edu/wp-content/uploads/2013/12/Handle-with-Care-How-Premiums-Are-Administered.pdf.*

[70] Ku, L., & Ross, D.C. (2002). *Staying covered: the importance of retaining health insurance for low-income families.* Commonwealth Fund, Task Force on the Future of Health Insurance. *https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_dec_staying_covered__the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586_pdf.*

[71] Ibid.

premium lock-out period in its BHP Blueprint, as premium lock-out periods will no longer be permissible. We propose this change using our authority in section 1331(c)(4) of the ACA, which requires a State that operates a BHP to coordinate the administration of, and provision of benefits under its BHP with the State Medicaid, CHIP, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care. We request comment regarding whether BHPs should be allowed to continue operating a premium lock-out period.

We are also considering the option of permitting a 30-day lock-out period and invite comments on this option.

2. Prohibit Waiting Periods (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)

Currently, the CHIP regulations permit States to impose a ''period of uninsurance,'' or ''waiting period,'' on individuals who have recently disenrolled from a group health plan prior to allowing them to enroll in a separate CHIP. Section 457.805 provides some limitations on the use of waiting periods. Our experience in implementing the ACA provisions designed to increase access for families under Medicaid and CHIP and expand coverage through the Exchanges calls into question whether the use of waiting periods in CHIP continues to be appropriate. Waiting periods are a State option unique to CHIP programs, as waiting periods are not permitted in Medicaid, BHP, and individual market Exchange plans.[72] Historically, we have interpreted section 2102(b)(3)(C) of the Act, which requires States to ensure that coverage provided under CHIP does not substitute for (or ''crowd out'') coverage under group health plans, to permit States to adopt a waiting period. Corresponding regulations at § 457.805 specify that State plans must include a description of ''reasonable procedures'' to prevent substitution.

Currently, 11 States use a waiting period in CHIP as a mechanism for preventing substitution. Children are denied eligibility under CHIP if they recently had group health coverage, within a State-prescribed waiting period, and have not qualified for a Federal or State-specified exception. Currently, States impose waiting periods that range from one month to 90 days. CHIP regulations at § 457.805 provide that a waiting period may not exceed 90 days.

At the inception of CHIP in 1997, employer-sponsored health insurance was the main alternative source of coverage for children in families within the CHIP income range. With passage of the ACA, coverage in a QHP through the Exchanges became available, and families may now qualify for premium tax credits to purchase coverage from the Exchange for their children while they wait for CHIP coverage during a waiting period.

Waiting periods, which have historically resulted in a period of uninsurance between the end of private health coverage and the beginning of CHIP enrollment, were seen as a deterrent to families dropping private coverage in order to enroll their children in CHIP. However, the availability of coverage through the Exchanges during a waiting period warrants reconsideration of the use of waiting periods in CHIP.[73]

The availability of Exchange coverage increases the complexity of implementing CHIP waiting periods, as coordinating coverage between the Exchanges and CHIP creates challenges that can lead to loss of coverage when affected children must transition from Exchange coverage to CHIP.[74] As noted, families with children who are ineligible for CHIP during a waiting period are eligible for advance payments of the premium tax credit to enroll the child in a QHP through the Exchange, if they meet other applicable requirements. However, after a child is determined eligible for enrollment in a QHP, additional time is needed for the family to select and enroll in a health plan. By the time a child is enrolled in a health plan through the Exchange, the CHIP waiting period often will have expired, or be close to expiring, at which point the child is eligible for CHIP, and the CHIP agency and family must act to move the child from Exchange coverage to the State's CHIP program. Under current regulations at § 457.350(i), the CHIP agency is expected to notify both the Exchange and family of the child's potential eligibility for CHIP at the end of the waiting period. The complexities of tracking waiting periods, sending notices to families, and requiring families to take additional steps to transition coverage likely result in children who are eligible for CHIP being unenrolled.[75] [76] [77] Furthermore, health policy experts in a number of States that continue to implement waiting periods indicate that the burden imposed on families in some cases prevents them from seeking public coverage again, even once the children are eligible after the waiting period is over.[78] [79]

Even for families that successfully navigate the administrative hurdles of moving from Exchange to CHIP coverage, coverage transitions create care complexities. A move from the Exchange to CHIP may necessitate a change of providers and/or managed care plans, which interrupt care. These potential changes in coverage may limit a child's access to needed services following a waiting period.

The 2013 eligibility final rule amended CHIP regulations at § 457.805(b)(1) to impose some limitations on waiting periods, including a 90-day maximum as mentioned above. Subsequent to this rule, the majority (23 of 36) of States elected to eliminate their CHIP waiting period. No state that has eliminated a waiting period has reported a substitution problem to CMS through their monitoring efforts. Eleven states still implement CHIP waiting periods; nine States have a 90-day waiting

[72] U.S. Department of Health and Human Services. (2016, May). Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards. Retrieved from: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Waiting-period-FAQ-05262016-Final-.pdf.*

[73] Under current Treasury regulations, some children may not qualify for Exchange premium tax credits if they are deemed eligible for affordable health coverage through a family member's employer, based on whether the cost of self-only coverage for the family member is affordable. The Treasury Department has published a Notice of Proposed Rulemaking that would change this rule. 87 FR 20354 (Apr. 7, 2022).

[74] Brooks, Tricia. Now is the time to remove CHIP waiting periods and welcome kids into coverage. April 17, 2020. Retrieved from *https://ccf.georgetown.edu/2020/04/17/now-is-the-time-to-remove-chip-waiting-periods-and-welcome-kids-into-coverage/.*

[75] Medicaid and CHIP Payment and Access Commission. March 2017. ''Chapter 1: The Future of CHIP and Children's Coverage'' in *Report to Congress on Medicaid and CHIP.* Retrieved from *https://www.macpac.gov/wp-content/uploads/2017/03/The-Future-of-CHIP-and-Childrens-Coverage.pdf.*

[76] Foster, Leslie. January 2016. ''Research Brief 3: Stakeholder perspectives from Texas'' in *Health Care Coverage and Access for Children in Low-income Families.* Mathematica Policy Research, funded by the David & Lucile Packard Foundation.

[77] Bruce, Giles. February 13, 2020. ''Why Do Some States Still Require Long Waits Before Kids Can Get Health Insurance?'' in *Children's Health Matters.* University of Southern California, Center for Health Journalism. Retrieved from *https://centerforhealthjournalism.org/2020/01/30/why-do-some-states-still-require-long-waits-kids-can-get-health-insurance.*

[78] Medicaid and CHIP Payment and Access Commission. March 2017. ''Chapter 1: The Future of CHIP and Children's Coverage'' in *Report to Congress on Medicaid and CHIP.* Retrieved from *https://www.macpac.gov/wp-content/uploads/2017/03/The-Future-of-CHIP-and-Childrens-Coverage.pdf.*

[79] Foster, Leslie. January 2016. ''Research Brief 3: Stakeholder perspectives from Texas'' in *Health Care Coverage and Access for Children in Low-income Families.* Mathematica Policy Research, funded by the David & Lucile Packard Foundation.

period, one State has a 2-month waiting period, and one State has a one month waiting period. In the 2013 final rule, we also amended § 457.805(b)(3) to require that States adopt certain exemptions to any waiting period. Under this regulation, States may not apply a waiting period if:

- The premium paid by the family for coverage of the child under the group health plan exceeds 5 percent of household income;
- The child's parent is determined eligible for advance payments of the premium tax credit for enrollment in a QHP through the Exchange because the employer-sponsored insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B–2(c)(3)(v);
- The cost of family coverage that includes the child exceeds 9.5 percent of the household income;
- The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;
- A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);
- The child has special health care needs; or
- The child lost coverage due to the death or divorce of a parent.

In addition to the Federally required exemptions to CHIP waiting periods listed above, the majority of States apply other State-specific exemptions to the waiting period. Requirements at § 457.810 apply the same 90-day maximum and Federal exceptions to waiting periods for CHIP premium assistance programs. As a result of these exceptions, States have anecdotally reported that few children are subject to waiting periods.

Sections 2102(b)(1)(B)(iii), 2102(b)(1)(B)(iv) and 2112 (b)(5) of the Act reference circumstances in which waiting periods may not be applied to CHIP populations or coverage. These provisions, included in the statute when it was first enacted in 1997, place certain limitations on the use of waiting periods, which were implicitly recognized at the time as one of the potential strategies states could use to fulfill the requirement at section 2102(b)(3)(C) of the Act to address substitution of coverage. Since the inception of CHIP, the health coverage landscape has significantly changed, including the addition of the Exchange coverage option. Any gap in coverage created by a waiting period or the administrative process to transfer children between different coverage options, such as the Exchange, can compromise child health and development and access to preventive and primary health care during childhood and adolescence. As noted above, waiting periods have never been allowed under Medicaid and are not permitted in the Exchanges, either. Nor are waiting periods permitted in the private insurance market, for example, for individuals with pre-existing conditions. These changes call into question the appropriateness of waiting periods as a tool to address substitution of coverage.

In addition, Executive Order 14070 of April 5, 2022 titled ''Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage'' instructs agencies to identify policy changes to ensure that enrollment and retention in coverage can be more easily navigated by consumers. The navigation of waiting periods for families is challenging, and CHIP is now an outlier among insurance providers compared to Medicaid and private insurance plans providing EHB coverage in allowing waiting periods to be applied before individuals can enroll in coverage. In addition, moving children between CHIP and the Exchange is not an efficient or effective use of State and Federal resources. In order to align with other programs, and consistent with the requirement in section 2101(a) of the Act to provide access for children to health care in an effective and efficient manner that is coordinated with other sources of health benefits coverage, as well as Executive Order number 14070 of April 5, 2022, we are proposing to eliminate all waiting periods in separate CHIPs. States will be required to continue monitoring efforts to prevent substitution of coverage in accordance with section 2012(b)(3)(c) of the Act.

Specifically, we propose to revise § 457.805(b) to provide that States may not impose a waiting period before enrolling eligible individuals in CHIP. We also propose the following conforming changes to other regulatory provisions to remove language referring to waiting periods.

- Revise § 457.65 to remove references to State plan amendments that implement or extend the length of a required period of uninsurance.
- Remove § 457.340(d)(3) (relating to facilitating enrollment in CHIP after a State-required period of uninsurance).
- Revise § 457.350(i) (redesignated at proposed § 457.350(g) as discussed in section II.E.4. of this proposed rule) to remove references to individuals subject to a State-required period of uninsurance, and to remove paragraphs (2) and (3) of § 457.350(i) (redesignated at proposed § 457.350(g)) relating to State notices for individuals found eligible for other insurance affordability programs during the waiting period).
- Remove § 457.805(b)(2) and (b)(3) (relating to Federal exceptions to waiting periods).
- Amend § 457.810(a) to specify that waiting periods may not be applied to CHIP premium assistance programs and remove paragraphs (a)(1) and (2) (relating to the 90-day limit for, required exemptions from, waiting periods applied to CHIP premium assistance programs).

Under the proposed rule, States would be required to continue to monitor the prevalence of substitution of coverage, consistent with requirements at § 457.805, and to report annually to CMS on the effectiveness of strategies used to prevent substitution of coverage pursuant to § 457.750(b)(2). In the preamble of the July 15, 2013 final rule (78 FR 42159), we explained that effective January 1, 2014, monitoring of substitution is a sufficient approach for addressing substitution at all income levels. There are a number of ways States monitor substitution of coverage, such as matching applicants to a database that identifies sources of other coverage, including questions on the single streamlined application about private and group health coverage, and tracking the number of applicants that reported other coverage and are later enrolled in CHIP. We expect that if this monitoring demonstrates a high rate of substitution, a State will consider strategies such as offering premium assistance to children enrolled in group health plan coverage, and improving public outreach about the range of health coverage options that are available in that State. We are available to provide technical assistance to develop additional strategies to reduce crowd out if it is determined through monitoring activities that substitution of coverage exceeds an acceptable threshold determined by the State.

We invite comments on our proposal to eliminate waiting periods to effectively balance the goal of preventing coverage gaps for children while ensuring that CHIP coverage does not substitute for coverage available under group health plans. We are also considering the option of permitting a 30-day waiting period for States that are able to demonstrate that high rates of substitution are a problem, and invite comments on this proposal.

3. Prohibit Annual and Lifetime Limits on Benefits (§ 457.480)

Section 1001 of the ACA added section 2711 to the Public Health Service Act (PHS Act), which prohibits annual and lifetime limits on the provision of essential health benefits (EHBs), as defined in section 1302(b) of the ACA, by group health plans and health insurance issuer. As such, annual and lifetime limits are not permitted for individuals enrolled in QHPs through the Exchanges. Medicaid also does not permit annual or lifetime limits. However, the CHIP regulations do not prohibit annual or lifetime limits, and a number of States have implemented annual and lifetime limits on CHIP benefits. Specifically, 12 States place an annual dollar limit on at least one CHIP benefit, and six States place a lifetime dollar limit on at least one benefit. Most commonly, annual and lifetime benefits are placed on dental, or specifically orthodontia, coverage. Ten States limit dental coverage to $500–$2,000 annually, and four States limit lifetime orthodontia coverage to $725–$1,250. These limits may present barriers to children receiving necessary dental and orthodontia care. Research on childhood oral health care indicates that dental care is the most common unmet treatment need in children.[80] Many low-income families face barriers such as accessibility and costs that deter them from seeking oral care services, leading to increased risk of dental diseases or dental emergencies.[81] Children in low-income families, including those covered by Medicaid and CHIP, are twice as likely to have untreated tooth decay compared to children with higher incomes.[82] Thus, annual and lifetime limits further exacerbate unmet treatment needs for CHIP children by placing a financial burden on low-income families.

While many States limit specific benefits to an annual or lifetime dollar amount, currently, no State imposes an aggregate annual or lifetime limit on all CHIP benefits. However, some States did impose such limits in previous years. Section 2103(f)(2) of the Act requires that coverage offered under a separate CHIP comply with the requirements of subpart 2 of part A of Title XXVII of the PHS Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage. Because section 2711 of the PHS Act is in subpart 2 of part A of Title XXVII of the PHS Act, which applies to separate CHIPs (by cross-reference in section 2103(f)(2) of the Act), States cannot impose annual or lifetime limits in the provision of any EHBs covered under a separate CHIP.

Under section 2103(a) of the Act, States may elect to provide benchmark coverage, benchmark-equivalent coverage, existing comprehensive State-based coverage, or Secretary-approved coverage to their separate population (where applicable). Regardless of the type of coverage provided, there are several required benefit categories that States must offer, including well-baby and well-child visits; dental benefits; mental health and substance use disorder services; testing, treatment, and vaccination for COVID–19; and age-appropriate immunizations.

In accordance with section 2101(a) of the Act, which calls for the provision of CHIP in a manner that is effective and efficient and coordinated with other sources of health benefits coverage for children, and section 2103(f)(2) of the Act which generally prohibits annual and lifetime limits on EHBs, we are proposing to revise the regulations at § 457.480 to prohibit all annual and lifetime dollar limits on all benefits in CHIP. Although title XXI of the Act does not apply EHB rules under a separate CHIP, the services which must be covered under title XXI also are EHBs. Specifically, pediatric services (including dental and vision services) and maternity and newborn care are EHBs. Because we believe that all of the benefits provided to children or targeted low-income pregnant women under a CHIP State plan are inherently pediatric, maternity, or newborn care services, we believe it is appropriate—indeed, the better application of the incorporated requirements in section 2711 of the PHS Act to separate CHIPs—to prohibit annual and lifetime limits on all covered CHIP benefits.

We propose that this prohibition be applied both to aggregate annual and lifetime limits on all benefits, as well as annual and lifetime limits on specific benefits (for example, dental services). Such limits construct barriers for families to access health coverage and result in a lack of coverage for children with the greatest medical needs. Additionally, these limits create a financial hardship on low-income families and/or an increase in uncompensated care that could raise costs for all health coverage payers. We note that the proposed prohibition on annual and lifetime dollar limits would not apply to non-monetary annual or lifetime limits on specific benefits. For example, a State could still implement a limitation on the number of physical therapy visits or eyeglasses that will be covered each year, provided such limitations are in compliance with all other Federal requirements. We encourage States to maintain processes that allow beneficiaries to exceed these non-financial limitations when medically necessary.

We propose to redesignate current paragraphs (a) and (b) of § 457.480, as paragraphs (b) and (c) respectively, and to add a new paragraph (a) to prohibit annual and lifetime dollar limits in the provision of all CHIP medical and dental benefits.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*) we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a ''collection of information'' requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purposes of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this rule that contain information collection requirements. Comments, if received, will be responded to within the subsequent final rule.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics'

[80] Newacheck, P. W., Hughes, D. C., Hung, Y. Y., Wong, S., & Stoddard, J. J. (2000). The unmet health needs of America's children. *Pediatrics, 105*(4 Pt 2), 989–997.

[81] U.S. Department of Health and Human Services.(2004,October). *Guide to children's dental care in Medicaid*. Centers for Medicare and Medicaid Services. Retrieved from: *https://www.medicaid.gov/sites/default/files/2019-12/child-dental-guide.pdf*.

[82] Dye, B. A., Mitnik, G. L., Iafolla, T. J., & Vargas, C. M. (2017). Trends in dental caries in children and adolescents according to poverty status in the United States from 1999 through 2004 and from 2011 through 2014. *Journal of the American Dental Association (1939), 148*(8), 550–565.e7. Retrieved from: *https://doi.org/10.1016/j.adaj.2017.04.013*.

May 2021 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, the following table presents the BLS' mean hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
All Occupations	00-0000	28.01	n/a	n/a
Business Operations Specialist	13-1000	38.64	38.64	77.28
Computer Programmer	15-1251	46.46	46.46	92.92
Database and Network Administrator and Architect	15-1240	49.25	49.25	98.50
Eligibility Interviewers, Government Programs	43-4061	23.35	23.35	46.70
General and Operations Mgr.	11-1021	55.41	55.41	110.82
Interpreter and Translator	27-3091	28.08	28.08	56.16
Management Analyst	13-1111	48.33	48.33	96.66
Procurement Clerks	43-3061	21.60	21.60	43.20

Wages for State Governments. As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Cost to State Governments. To estimate State costs, it was important to take into account the Federal government's contribution to the cost of administering the Medicaid, CHIP, and BHP programs. The Federal government provides funding based on a Federal Medical Assistance Percentage (FMAP) that is established for each State, based on the per capita income in the State as compared to the national average. FMAPs range from a minimum of 50 percent in States with higher per capita incomes to a maximum of 76.25 percent in States with lower per capita incomes. States receive an ''enhanced'' FMAP for administering their CHIP programs, ranging from 65 to 83 percent. For Medicaid, all States receive a 50 percent FMAP for administration. As noted previously, States also receive higher Federal matching rates for certain services and now for systems improvements or redesign, so the level of Federal funding provided to a State can be significantly higher. As such, in taking into account the Federal contribution to the costs of administering the Medicaid, CHIP, and BHP programs for purposes of estimating State burden with respect to collection of information, we elected to use the higher end estimate that the States would contribute 50 percent of the costs, even though the burden will likely be much smaller.

Wages for Individuals. For enrollees, we believe that the burden will be addressed under All Occupations (at $28.01/hr) since the group of individual respondents varies widely from working and nonworking individuals and by respondent age, location, years of employment, and educational attainment, etc. Unlike our State adjustment to the respondent hourly wage, we did not adjust this figure for fringe benefits and overhead since the individuals' activities will occur outside the scope of their employment.

B. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding Facilitating Enrollment Through Medicare Part D Low-Income Subsidy ''Leads'' (§§ 435.601, 435.911, and 435.952)

With the exception of the proposed changes under § 435.952(e)(4), the following changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410), regarding the collection of eligibility data from State Medicaid and CHIP agencies. The proposed § 435.952(e)(4) changes will be submitted to OMB under control number 0938–0467 (CMS–R–74), regarding the collection of information for income verification.

OMB Control Number 0938–1147 (CMS–10410)

Proposed § 435.911(e) focuses on using the SSA data from processing LIS applications ''leads data'' to streamline MSP eligibility determinations. Section 435.911(e)(1) would require States to accept, via secure electronic interface, the SSA LIS leads data, while § 435.911(e)(2) would require that States treat receipt of the leads data as an application for Medicaid and promptly and without undue delay determine MSP eligibility without requiring submission of a separate application. Section 435.911(e)(4) would require States to refrain from requesting information from individuals already provided through leads data unless information available to the agency is not reasonably compatible with information provided by or on behalf of the individual, while § 435.911(e)(5) requires States to accept information provided through the leads data relating to a criterion of eligibility without further verification.

We estimate that States would be able to adjudicate over 90 percent of MSP applications for LIS enrollees without gathering additional documentation from the applicants. Therefore, if there are about 400,000 new LIS applicants

approved annually in 51 States,[83] we estimate that 90 percent of those applicants or 360,000 (400,000 × 0.9) would be able to enroll in an MSP without providing additional income and resource related documentation, and without the State receiving and adjudicating such data.

The provisions in § 435.911(e) are associated with a reduction in burden for States and beneficiaries associated with application completion and eligibility determinations or redeterminations at the State Medicaid agency, including: reduced verification work for States that do not need to adjudicate the leads data for approximately 360,000 new LIS applicants; reduced paperwork to submit for the LIS enrollees applying to MSPs in 51 States; reduced time and costs for enrollees who were previously expended to obtain, print, copy, mail and fax documents to the State to support the State's verification of income and resources; and reduced enrollee burden related to the need for public transportation and cell phone usage in relation to said document activities (obtaining, printing, copying, mailing and faxing).

We estimate that the provisions in § 435.911(e) would save an Eligibility Interviewer 25 minutes (0.42 hr = 25 min/60 min) per eligibility determination at $46.14/hr for the 360,000 new LIS applicants from reduced paperwork to review because of the proposed self-attestation requirements and reduced verification work due to considering the leads data as verified. In aggregate, we estimate an annual savings of minus 151,200 hours (360,000 applicants × 0.42 hr) and minus $6,976,368 (151,200 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $3,488,184.

We estimate these provisions would reduce the time needed for LIS enrollees applying to MSPs to submit paperwork from 4 hours to 15 minutes, for a savings of 3.75 hours per enrollee per year across all 51 States. In aggregate, we estimate an annual savings of minus 1,350,000 hours (360,000 applicants × 3.75 hr) and minus $37,813,500 (1,350,000 hr × $28.01/hr). We also estimate enrollee non-labor savings from the changes to § 435.911(e) from public transportation, printing, copying, postage, and fax expenses to be about $10 [($4.50 postage for small package or $1.75/page for faxing) + $4 roundtrip bus ride (from home to printing/copying place to post office and back home) + $0.13/page for printing/copying)] per LIS enrollee per year for all 51 States. In aggregate, we estimate an annual non-labor savings of minus $3,600,000 (360,000 enrollees × $10/enrollee).

Under proposed § 435.952(e)(1) through (e)(4), States would be required to accept self-attestation of certain income and resources for MSP applicants and beneficiaries, including dividend and interest income, burial funds of spouse and individual, and the face value of life insurance policy. Because 10 States (about 20 percent of all States) do not have asset tests and do not require documentation to complete an eligibility determination or redetermination at the State Medicaid agency, we expect the savings from the self-attestation proposals would only apply to approximately 8.4 million individuals (80 percent of 11 million applications/renewals[84] minus 400,000 individuals who applied to LIS counted above) in the other 41 States. We estimate that under proposed § 435.952(e)(1) through (e)(4), these 8.4 million individuals would see a reduction from 4 hours to 2 hours, for a savings of 2 hours per individual, to complete an application/renewal in all 41 States. In aggregate, we estimate an annual savings of minus 16,800,000 hours (8,400,000 individuals × 2 hr) and minus $470,568,000 (16,800,000 hr × $28.01/hr). We estimate the non-labor savings under proposed § 435.952(e)(1) through (e)(4) derived $10 [($4.50 postage for small package or $1.75/page for faxing) + $4 roundtrip bus ride (to/from post office, printing/copying place and home) + $0.13/page for printing/copying)] per MSP applicant/renewal per year for all 51 States. In aggregate, we estimate an annual non-labor savings of minus $84,000,000 (8,400,000 beneficiaries × $10/beneficiary).

We also estimate that the proposal under § 435.952(e)(1) through (e)(4) would save an Eligibility Interviewer 15 minutes (0.25 hr) per eligibility determination or renewal for these 8,400,000 applicants/beneficiaries. In aggregate, we estimate an annual labor savings for States of minus 2,100,000 hours (8,400,000 applicants × 0.25 hr) and minus $96,894,000 (2,100,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $48,447,000.

OMB Control Number 0938–0467 (CMS–R–74)

We are also proposing to revise § 435.952(e)(4) to require States to develop a verification process to determine the cash surrender value of life insurance policies over $1,500. We anticipate this proposal would be a change for 10 States in their process for verifying the cash surrender value of life insurance policies over $1,500. We do not anticipate an impact in the following 16 States because they are using authority in section 1902(r)(2) of the Act to disregard the cash surrender value of life insurance in whole or part: Alabama, Arizona, California, Connecticut, Delaware, Louisiana, Mississippi, Nevada, New Mexico, New York, North Carolina, Oregon, South Carolina, Vermont, Wyoming, and Washington, DC. Seventy percent of the remaining States would choose to use authority in section 1902(r)(2) of the Act to disregard the cash surrender value of life insurance rather than opting to verify the cash surrender value of life insurance. As such, we expect that this change would only impact 20 percent of all 50 States and Washington, DC (or 10 States).[85] Based on enrollment in past years, we anticipate that all States would adjudicate 1,000,000 new MSP applications a year plus 10 million renewals. However, we anticipate this policy would only affect 2 percent of applicants and beneficiaries across 10 States because of the small number of people who could both afford this type of life insurance (which is much more expensive than term life insurance) and also likely to apply for MSPs (which tends to be lower-income individuals) 44,000 individuals [(11,000,000 individuals × 0.02 × 0.2].

The burden associated with proposed changes to § 435.952(e)(4) would consist of the time and effort for eligibility workers in 10 States to collect information regarding the cash surrender value of life insurance from 44,000 applicants; eligibility workers in 10 States not having to spend time coaching 44,000 applicants how to gather and find information on the cash surrender value of life insurance; and eligibility workers in 10 States not having to review life insurance documents for individuals with life insurance less than $1,500.

We estimate that under proposed § 435.952(e)(4) it would take an

[83] Over the past 5 years (2017–2021), SSA approved an average of 394,025 LIS applications annually. *https://www.ssa.gov/open/data/Data-about-Extra-Help-with-Medicare-Prescription-Drug-Plan-Cost.html.*

[84] Based on States adjudicating 1.5 million new applications and 10 million for redetermination annually.

[85] We are not including impacts for territories in these estimates because territories do not have any enrollment in MSPs.

Eligibility Interviewer about 1 hour at $46.14/hr to verify the cash surrender value of each life insurance policy over $1,500. In aggregate, we estimate an annual burden of 44,000 hours (1 hr × 44,000 individuals) at a cost of $2,030,160 (44,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $1,015,080.

We estimate the proposal under proposed § 435.952(e)(4) would save Eligibility Interviewers an average 45 minutes (0.75 hr) per applicant from not needing to coach applicants on how to gather and find information on the cash surrender value of life insurance. In aggregate, we estimate an annual savings of minus 33,000 hours (44,000 applicants × 0.75 hr) and $1,522,620 (33,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $761,310.

We also estimate State *savings* under proposed § 435.952(e)(4) from eligibility workers not having to review life insurance documents for individuals with life insurance less than $1,500. We anticipate it would take an eligibility worker about 10 minutes (0.167 hr) to review a life insurance document and that this savings would affect 3 percent of applicants and beneficiaries or individuals (66,000 individuals = 11,000,000 individuals × 0.03 × 0.2) across 10 States. In aggregate, we estimate an annual savings of minus 11,022 hours (66,000 individuals × −0.167 hr) and minus $508,555 (−11,022 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $254,278.

In total, taking into account the Federal contribution, we estimate a State annual burden reduction of minus $51,935,692 (−$3,488,184 + −$48,447,000 + $1,015,080 + −$761,310 + −$254,278).

For individuals, we estimate an annual burden reduction of minus 18,150,000 hours (-1,350,000 + −16,800,000 hr) and minus $595,981,500 (−$37,813,500 + −$3,600,000 + −470,568,000 + −$84,000,000).

2. ICRs Regarding Defining ''Family of the Size Involved'' for the Medicare Savings Program Groups using the Definition of ''Family Size'' in the Medicare Part D Low-Income Subsidy Program (§ 435.601)

The following proposed changes will be submitted to OMB for review under control numbers 0938–1188 (CMS–10434 #15) regarding the submission of a State plan amendment (SPA) and 0938–1147 (CMS–10410) regarding Medicaid application changes.

OMB 0938–1188 (CMS–10434 #15)

Proposed § 435.601 would align the definition of ''family size'' for purposes of MSP eligibility with that of the LIS program. Specifically, ''family of the size involved'' would be defined to include *at least* the individuals included in the definition of ''family size'' in the LIS program: the applicant, the applicant's spouse, and all other individuals living in the same household who are related to and dependent on the applicant or applicant's spouse. While some States either already define family size to match the LIS definition or use a family size that is less restrictive than this definition, we estimate that 10 States use SSI methodologies to determine family size, which means that these States only use an individual or couple and any other deemed individuals as part of the family size. As such, we estimate that 10 States would need to submit a SPA to change their definition of family size for MSP eligibility groups to comply with this regulation.

We estimate that it would take each State 3 hours to submit a SPA to update the definition of ''family size'' in their Medicaid State plans. Of those 3 hours, we estimate it would take a Business Operations Specialist 2 hours at $77.28/hr and a General Operations Manager 1 hour at $110.82/hr to update and submit each SPA to CMS for review. In aggregate, we estimate a one-time burden of 30 hours (10 States × 3 hr) at a cost of $2,654 (10 States × ([2 hr × $77.28/hr] + [1 hr × $110.82/hr]) for completing the necessary SPA updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State cost would be $1,327.

OMB 0938–1147 (CMS–10410)

We estimate that it would take each State 200 hours to develop and code the changes to its Medicaid application to add questions to identify other third parties in prospective MSP group households. We note that these changes do not create additional burden on beneficiaries as the new questions would be in lieu of prior questions. As such, the changes require the programming change reflected here with a neutral impact on applicants. Of those 200 hours, we estimate it would take a Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. In aggregate, we estimate a one-time burden of 2,000 hours (10 States × 200 hr) at a cost of $188,630 (10 States × [(50 hr × $98.50/hr) + (150 hr × $92.92/hr)]) for completing the necessary updates to the Medicaid application. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State cost would be $94,315.

In total, taking into account the Federal contribution, we estimate a one-time State cost of $95,642 ($1,327 + $94,315).

3. ICRs Regarding Automatically Enrolling Certain SSI Recipients Into the Qualified Medicare Beneficiaries Group (§ 435.909)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

The proposal under § 435.909 would require that States deem certain individuals who are eligible for Medicare Part A and SSI eligible for QMB without requiring an application. In particular, we propose that: (1) States with 1634 agreements must deem Supplemental Security Income (SSI) recipients who are entitled to premium-free Medicare Part A; (2) all other States must deem SSI recipients who are entitled to premium-free Medicare Part A and have been determined eligible for Medicaid under either § 435.120 or § 435.121; and (3) Part A buy-in States must deem if the individual is determined eligible for Medicaid under either § 435.120 or § 435.121, entitled to SSI, only qualifies for premium Part A, and is enrolled in Part B. To implement these new requirements, States would need to identify Medicare-eligible SSI recipients in order to enroll them in the MSPs. States would also need to trigger deeming of Medicare-eligible SSI recipients to QMB by making eligibility systems changes to trigger QMB enrollment once the SSI-individual is Medicare eligible. Current regulations do not allow State Medicaid agencies to forgo an eligibility determination for Medicaid beneficiaries who are eligible for SSI when they become newly eligible for Medicare Part A and B. Therefore, this new requirement would mean system changes for all 50 States and the District of Columbia, (altogether, 51 ''States'').

While these deeming provisions are intended to enroll more SSI recipients in QMB, this rulemaking would not reach all SSI recipients eligible for QMB. We estimate currently 16 percent or 566,556 (3,540,975 × 0.16) SSI recipients are eligible but not enrolled

in QMB, and nearly 500,000 new SSI recipients who are enrolled in Medicaid under either § 435.120 or § 435.121 would enroll in QMB as a result of the proposal under § 435.909. As discussed in section II.A.3. of this proposed rule, in the 34 States with a 1634 agreement, the Medicaid agency automatically enrolls the SSI recipients in Medicaid following a data exchange with SSA and then CMS automatically initiates Part B buy-in for the individual through the ''buy-in data exchange.'' In the remaining States, individuals must submit a separate application to the State Medicaid agency to be determined eligible for Medicaid. CMS does not automatically initiate Part B buy-in for SSI individuals who live in SSI criteria and 209(b) States; rather, States must initiate Part B buy-in once the SSI recipient has separately applied for and been determined eligible for the mandatory SSI or 209(b) group. Additionally, SSI recipients who live in group payer States and are eligible for premium Part A are still required to go through a complicated two-step application process to establish QMB eligibility once an individual is determined eligible for the mandatory SSI or 209(b) groups and has been enrolled in Part B pursuant to the State's buy-in agreement. Under the proposed rule, the application process for SSI recipients who live in criteria and 209(b) States would remain the same and so would the two-step application process to establish QMB eligibility for SSI recipients living in group payer States and having premium part A.

Based on SSA data and internal CMS analysis of the 566,556 SSI recipients eligible for QMB but not enrolled, we estimate almost 83 percent (469,820) were likely eligible for premium-free Part A while approximately 17 percent (96,736) were eligible for premium Part A. Of the 469,820 who were eligible for premium-free Part A, we estimate 405,963 reside in States with 1634 agreements, and 63,857 reside in 209(b) or SSI criteria States. Because Medicaid is automatic in States with 1634 agreements, we estimate that 405,963 individuals (all of the above-mentioned SSI recipients in 1634 States) would be automatically enrolled in QMB under this new provision.

In contrast, we estimate that only 65 percent of the above-mentioned 63,857 SSI recipients in 209(b) or SSI criteria States, or 41,507 individuals, would be enrolled under the new provision. This is because it is unlikely that all SSI recipients who live in SSI or 209(b) States would complete the Medicaid application process in their State. Of the 96,736 eligible for premium Part A, we estimate 33 percent (31,923) are in Part A buy-in States and 67 percent (64,813) of those eligible for premium Part A are in group payer States, where deeming would be optional. We estimate that 95 percent (30,327) of individuals in Part A buy-in States who are eligible for premium Part A would enroll as a result of the new provision because we estimate that all of those individuals live in States with 1634 agreements. However, for the individuals eligible for premium Part A in group payer States where deeming would be optional, we expect some more populous States to use this option, so we are estimating 33 percent (21,388 = 64,813 × 0.33) of all individuals with premium Part A living in group payer States would newly enroll.

Therefore, we estimate a total of 499,185 individuals (405,963 + 41,507 + 30,327 + 21,388) would newly enroll without the need to complete an application. We estimate that those individuals would each save 2 hours from not filling out Medicaid applications and compiling associated documentation (going from 2 to zero hours) at $28.01/hr. We estimate an annual savings of minus 998,370 hours (499,185 individuals × 2 hr) and minus $27,964,344 (998,370 hr × $28.01/hr).

All 51 States would need to make eligibility systems changes to deem an SSI individual in QMB once they are eligible for Medicare. We estimate it would take a Computer Programmer an average of 180 hours per State at $92.92/hr to make systems changes to set their systems to search for Medicare eligibility in Federal systems and then enroll that individual in QMB. In aggregate, we estimate a one-time burden of 9,180 hours (51 States × 180 hr) at a cost of $853,006 (9,180 hr × $92.92/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $426,503.

We also estimate that this provision would result in an annual *reduction* of burden for the State to no longer review and adjudicate QMB applications from SSI recipients. We estimate that this proposal would *save* an Eligibility Interviewer 1 hour (going from 1 hour to zero) per QMB determination at $46.14/hr. We also estimate that States conduct QMB eligibility determinations for approximately 250,000 SSI individuals across 51 States, which would no longer be necessary. In aggregate, we estimate an annual burden savings of minus 250,000 hours (250,000 individuals × −1 hr/response) and minus $11,535,000 (−250,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $5,767,500.

In total, for the ICRs related to § 435.601 under OMB control number 0938–1147 (CMS–10410), taking into account the Federal contribution, we estimate an annual State burden *reduction* of minus $5,340,997 ($426,503 + −$5,767,500).

4. ICRs Regarding Facilitating Enrollment by Allowing Medically Needy Individuals To Deduct Prospective Medical Expenses (§ 435.831)

The following proposed changes will be submitted to OMB for review under control 0938–TBD (CMS–10819). At this time, the control number is to be determined (TBD). OMB will assign the control number upon their clearance of the proposed rule's new information collection request. The new control number will be set out in the final rule.

The amendments proposed under § 435.831(g) would permit States to project certain additional services that the State can determine with reasonable certainty will be constant in order to prevent those in the medically needy group from cycling on and off Medicaid, and preventing the occurrence of an eligibility start date each budget period that is not predictable to either the institutionalized individual or State agency. Over time, this would reduce the burden on the State by eliminating the need to process a new application or renewal each month for each individual in the medically needy group. This would also reduce the burden on the individual who would not need to reapply each month but instead would remain continuously enrolled. However, there would be an up-front cost to the States to program their eligibility systems to project the cost of care for the medically needy group and to remove the triggers to renew eligibility each month once the spenddown amount is reached.

We estimate that all 56 States (50 States, 5 territories, and the District of Columbia; hereinafter ''56 States'') would need to make system changes to program their eligibility systems to project the cost of care for the medically needy group and to remove the triggers to renew eligibility each month once the spenddown amount is reached. We estimate it would take an average of 200 hours per State to develop and code the changes to each State's system to reschedule renewals for medically needy beneficiaries no more frequently than once every 12 months. Of those 200 hours, we estimate it would take a

Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. Therefore, we estimate a one-time burden of 11,200 hours (56 States × 200 hr) at a cost of $1,056,328 (56 States × [(50 hr × $98.50/hr) + (150 hr × $92.92/hr)]) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $528,164.

We estimate that under proposed § 435.831(g), each of all 56 States would no longer need to process a new application or renewal each month for 25 individuals in the medically needy group annually. We estimate it currently takes an Eligibility Interviewer, Government Programs, 2 hours at $46.14/hr and an Interpreter and Translator 1 hour at $56.16/hr to help process a new application or renewal each month for 6 months per year per beneficiary. Therefore, each State would save 450 hours (3 hr × 6 months/year × 25 beneficiaries) and $22,266 (6 months/year × 25 beneficiaries × [(2 hr × $46.14/hr) + (1 hr × $56.16/hr)]) annually by not processing a new application or renewal each month for each individual in the medically needy group. In aggregate, we estimate this provision would save all States minus 25,200 hours (450 hr × 56 States) and minus $1,246,896 ($22,266 × 56 States). When taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $623,448.

Likewise, we estimate that under proposed § 435.831(g), those same 25 beneficiaries would no longer need to reapply each month but instead would remain continuously enrolled, thus reducing the burden on the individuals. We estimate that it currently takes a beneficiary 2 hours at $28.01/hr to reapply each month in an average of 6 months per year. Therefore, beneficiaries in each State would save a total of 300 hours (2 hr × 6 months/year × 25 beneficiaries/State) and $8,403 (300 hr × $28.01/hr) annually. In aggregate, under this provision, beneficiaries across all 56 States would save 16,800 hours (300 hr × 56 States) and $470,568 ($8,403 × 56 States) annually.

In total, for the ICRs related to § 435.831 under OMB control number 0938–TBD (CMS–10819), taking into account the Federal contribution, we estimate a one-time State cost of minus $95,284 ($528,164 + −$623,448).

5. ICRs Regarding Application of Primacy of Electronic Verification and Reasonable Compatibility Standard for Resource Information (§§ 435.952 and 435.940)

The following proposed changes will be submitted to OMB for review under control number 0938–0467 (CMS–R–74).

States have asked whether they are permitted to request additional documentation from applicants and beneficiaries related to resources that can be verified through the State's asset verification system (AVS), or if they can apply a reasonable compatibility standard for resources when resource information returned from an electronic data source is compared to the information provided by the applicant or beneficiary. We believe the requirements at § 435.952(b) and (c), which require States to apply a reasonable compatibility test to income determinations, apply to resource determinations as well. We believe that clearly applying the requirements at § 435.952(b) and (c) to resources will help streamline enrollment for individuals applying for Medicaid on a non-MAGI basis, such as on the basis of age, blindness, or disability, and decrease burden for both States and beneficiaries.

The amendments proposed under §§ 435.952 and 435.940 would clarify that, if information provided by an individual is reasonably compatible with information returned through an AVS, the State must determine or renew eligibility based on that information. They would also clarify that States must consider asset information obtained through an AVS to be reasonably compatible with attested information if either both are above or both are at or below the applicable resource standard or other relevant resource threshold.

Under the proposed changes to §§ 435.952 and 435.940, we estimate that the States would save an Eligibility Interviewer 1 hour per beneficiary at $46.70/hr to no longer reach out to 10,000 individuals per State for additional information to verify their resources. In aggregate, we estimate a *savings* for all States of 510,000 hours (51 States × 10,000 individuals/State × 1 hr) and $23,531,400 (510,000 hr × $46.14/hr). When taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $11,765,700 ($23,531,400 × 0.5).

Under the proposed changes to §§ 435.952 and 435.940, we estimate that 10,000 individuals per State would save on average 1 hour each at $28.01/hr to no longer need to submit additional information to verify their resources. In aggregate for individuals in all States, we estimate a savings of minus 510,000 hours (1 hr × 10,000 individuals/State × 51 States) and minus $14,285,100 (510,000 hr × $28.01/hr).

6. ICRs Regarding Verification of Citizenship and Identity (§ 435.407)

The following proposed changes will be submitted to OMB for review under control number 0938–0467 (CMS–R–74).

The amendments proposed under § 435.407 would simplify eligibility verification procedures by considering verification of birth with a State vital statistics agency or verification of citizenship with SAVE as stand-alone evidence of citizenship. Likewise, under this provision, separate verification of identity would not be required. This proposed revision is not intended to require a State to develop a match with its vital statistics agency if it does not already have one in place. However, if a State already has established a match with a State vital statistics agency or it would be effective to establish such capability in accordance with the standard set forth in § 435.952(c)(2)(ii), the State must utilize such match before requesting paper documentation from the applicant. We estimate this provision would apply to the roughly 100,000 applicants per year for whom States cannot verify U.S. citizenship with SSA.

We estimate that the amendments proposed under § 435.407 would take a Management Analyst 15 minutes (0.25 hr) per applicant at $96.66/hr to check the State's vital statistics agency for verification of U.S. citizenship of an applicant. In aggregate for all 56 States, this provision would add a burden of 25,000 hours (0.25 hr × 100,000 applicants) and $2,416,500 (25,000 hr × $96.66/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $1,208,250.

In contrast, we estimate that the amendments proposed under § 435.407 would *save* an Eligibility Interviewer 45 minutes (0.75 hr) at $46.70/hr by no longer needing to request and process paper documentation of citizenship. In aggregate, all 56 States would save minus 75,000 hours (0.75 hr × 100,000 applicants) and minus $3,460,500 (75,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated

State savings would be minus $1,730,250.

In total for the ICRs related to § 435.407 under OMB control number 0938–0467 (CMS–R–74), taking into account the Federal contribution, we estimate an annual State savings of minus $522,000 ($1,208,250 + −$1,730,250). For individuals, we estimate that the amendments proposed under § 435.407 would save each applicant 1 hour at $28.01/hr plus an average of $10 in miscellaneous costs [($4.50 postage for small package or $1.75/page for faxing) + $4 roundtrip bus ride (from home to printing/copying place to post office and back home) + $0.13/page for printing/copying], to no longer need to gather and submit paper documentation of citizenship. In aggregate, all 100,000 applicants would save 100,000 hours (1 hr × 100,000 applicants) and $2,801,000 (100,000 hr × $28.01/hr) in labor and + $1,000,000 ($10.00 × 100,000 applicants) in non-labor related costs.

7. ICRs Regarding Aligning Non-MAGI Enrollment and Renewal Requirements With MAGI Policies (§ 435.916)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

The amendments proposed under § 435.916(a) would align the frequency of renewals for non-MAGI beneficiaries with the current requirement for MAGI beneficiaries, which allows for renewals no more frequently than every 12 months. Proposed § 435.916(b) also requires States to adopt the existing renewal processes required for MAGI beneficiaries for non-MAGI beneficiaries when a State is unable to renew eligibility for an individual based on information available to the agency. Proposed § 435.916(b)(2) would require States to provide all beneficiaries, including non-MAGI beneficiaries, whose eligibility cannot be renewed without contacting the individual in accordance with proposed § 435.916(b)(1), a renewal form that is pre-populated with information available to the agency, a minimum of 30 calendar days to return the signed renewal form along with any required information, and a 90-day reconsideration period for individuals terminated for failure to return their renewal form but who subsequently return their form within the reconsideration period. Proposed § 435.916(b)(2) no longer permits States to require an in-person interview for non-MAGI beneficiaries as part of the renewal process.

We estimate that in 2021, six States—Minnesota, New Hampshire, Texas, Utah, Washington, and West Virginia—have policies in place to conduct regularly-scheduled renewals for at least some non-MAGI beneficiaries more frequently than once every 12 months. One other State conducts more frequent renewals for non-MAGI populations during normal operations, but elected to conduct renewals only once every 12-months for all beneficiaries during the COVID–19 PHE. We excluded the State from these estimates as it would have needed to make changes for the temporary authority in effect as of 2021 during the PHE.

Under proposed § 435.916(a), we estimate it would take an average of 200 hours per State to develop and code the changes to each State's system to reschedule renewals for non-MAGI beneficiaries no more frequently than once every 12 months. Of those 200 hours, we estimate it would take a Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. In aggregate, we estimate a one-time burden of 1,200 hours (6 States × 200 hr) at a cost of $113,178 (6 States × [(50 hr × $98.50/hr) + (150 hr × $92.92/hr)]) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $56,589.

We also estimate that 21 States do not pull available non-MAGI beneficiary information to prepopulate a renewal form.[86] Under proposed § 435.916(b)(2), we estimate it would take an average of 200 hours per State to develop and code the changes to each State's system to pull the existing non-MAGI beneficiary information to prepopulate a renewal form. Of those 200 hours, we estimate it would take a Business Operations Specialist 50 hours at $77.28/hr and a Management Analyst 150 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 4,200 hours (21 States × 200 hr) at a cost of $385,592 (21 States × [(50 hr × $77.25/hr) + (150 hr × $96.66/hr)] for completing the necessary system changes and designing the form. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $192,796.

While we do not have evidence of how many States currently require an in-person interview, to calculate this burden, we will assume all 56 States do so, with the understanding that the actual State savings will be much less. In 2020, there were about 2,688,386 non-MAGI beneficiaries[87] for whom States would no longer need to conduct an in-person interview for non-MAGI beneficiaries as part of the renewal process. Under proposed § 435.916(b)(2), we estimate that an Eligibility Interviewer would save on average 0.5 hours per beneficiary at $46.14/hr. In aggregate, we estimate this would save States minus 1,344,193 hours (0.5 hr × 2,688,386 beneficiaries) and minus $62,021,065 (1,344,193 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $31,010,533.

In total for the ICRs related to § 435.916 under OMB control number 0938–1147 (CMS–10410), taking into account the Federal contribution, we estimate a one-time State savings of minus $30,761,148 ($56,589 + $192,796 − $31,010,533) with an annual savings of minus $31,010,533. We estimate that in the six States—Minnesota, New Hampshire, Texas, Utah, Washington, and West Virginia—that currently have policies to conduct regularly-scheduled renewals for non-MAGI beneficiaries more frequently than once every 12 months during normal operations, in 2020, there were about 2,688,386 non-MAGI beneficiaries[88] who would no longer need to submit a renewal under proposed § 435.916(a). Assuming impacted beneficiaries are evenly distributed across these six States, and assuming it currently takes each beneficiary 1 hour at $28.01/hr to submit a renewal form, in aggregate, beneficiaries across these six States would save minus 2,688,386 hours (2,688,386 non-MAGI beneficiaries × 1 hr) and minus $75,301,692 (−2,688,386 hr × $28.01/hr).

While we do not have evidence of how many States currently require an in-person interview, to calculate this burden, we will assume all 56 States do so, with the understanding that the actual individual burden will be much less. In 2020, there were about 2,688,386 non-MAGI beneficiaries[89] who would

[86] Kaiser Family Foundation. *Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey*. Available at: *https://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey*.

[87] Major Eligibility Group Information for Medicaid and CHIP Beneficiaries by Year, accessed from: *https://data.medicaid.gov/dataset/267831f3-56d3-4949-8457-f6888d8babdd*.

[88] Ibid.

[89] Ibid.

no longer need to travel to a Medicaid office to complete an in-person interview in order to maintain coverage under proposed § 435.916(b)(2). Assuming impacted beneficiaries are evenly distributed across these 56 States and assuming it currently takes each beneficiary 1 hour to travel to and participate in an in-person interview, plus on average $10/person in travel expenses, in aggregate, beneficiaries across these 56 States would save minus 2,688,386 hours (2,688,386 beneficiaries × 1 hr) and minus $75,301,692 (2,688,386 hr × $28.01/hr) in labor and minus $26,883,860 (2,688,386 non-MAGI beneficiaries × $10.00) in non-labor related costs.

Under proposed § 435.916(b)(2), we estimate 37 States will need to establish a reconsideration period for non-MAGI beneficiaries or extend the timeframe of their existing reconsideration period for non-MAGI beneficiaries to 90 calendar days. In 2020, there were up to 2,688,386 non-MAGI beneficiaries in 56 States [90] who would newly not need to complete a new application to regain coverage after being terminated for coverage for failure to return their renewal form under this provision. Approximately 4.2 percent of beneficiaries are disenrolled from coverage and reenroll within 90 days.[91] Therefore, we estimate 74,603 beneficiaries (2,688,386 beneficiaries/56 States × 0.042 × 37 States) would newly not need to complete a full application to reenroll in coverage because they would be in a 90-day reconsideration period under proposed § 435.916(b)(2). Assuming impacted beneficiaries are evenly distributed across the 37 States and assuming it currently takes each beneficiary 1 hour at $28.01/hr to submit a new full application, this provision would save, in aggregate, beneficiaries across these 37 States a total of minus 74,603 hours (74,603 beneficiaries × 1 hr) and minus $2,089,630 (74,603 hr × $28.01/hr).

For beneficiaries, we estimate a total burden reduction of minus $179,576,874 (−$75,301,692 −$102,185,552 −$2,089,630).

8. ICRs Regarding Acting on Changes in Circumstances (§§ 435.916, 435.919, and 457.344)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

The amendments proposed under § 435.919 would, if the State cannot redetermine the individual's eligibility after a change in circumstance using third party data and information available to the agency, allow beneficiaries at least 30 calendar days from the date the State sends a request for additional information to provide such information. In addition, the amendments would require States to provide beneficiaries terminated due to failure to provide information requested after a change in circumstance with a 90-day reconsideration period.

Because the proposed requirements under §§ 435.912, 435.919, and 457.344 would result in more time for beneficiaries to respond to the State's request for additional information, it is likely that fewer beneficiaries would lose eligibility as a result of this provision. As well, because the proposed amendments would, for the first time, provide a 90-day reconsideration period after a change in circumstance for all approximately 85,809,179 Medicaid and CHIP beneficiaries (in the 51 States that reported enrollment data for November 2021),[92] to submit additional information to maintain their eligibility, it is likely that beneficiaries would not need to complete and States would not need to process full applications for 4.2 percent of those individuals or 3,603,986 beneficiaries (85,809,179 beneficiaries × 0.042) who lose coverage and later reenroll.[93]

Assuming the 40 States with a separate CHIP agency can adapt language from the Medicaid notice for their purposes, we estimate it would not take as long for those 40 States to revise the notice requesting additional information from beneficiaries regarding their eligibility after a change in circumstance to include language allowing the beneficiary 30 calendar days to respond. Therefore, we estimate it would take an average of 6 hours per State Medicaid agency and 3 hours per separate CHIP agency to complete this task. Of the 6 Medicaid hours, we estimate it would take a Business Operations Specialist 4 hours (and 2 hr for CHIP) at $77.28/hr and a Management Analyst 2 hours (and 1 hr for CHIP) at $96.66/hr. We estimate an aggregate, one-time burden of 426 hours [(51 Medicaid States [94] × 6 hr) + (40 CHIP States × 3 hr)] at a cost of $35,673 (51 States × [(4 hr × $77.28/hr) + (2 hr × $96.66/hr)] + (40 States × [(2 hr × $77.28/hr) + (1 hr × $96.66/hr)]) for revising the notice requesting additional information. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $17,837.

We also estimate it would take each State 6 hours to revise the termination notice to beneficiaries who did not respond to the State's request for additional information regarding their eligibility after a change in circumstance to include language allowing the beneficiary a 90-day reconsideration period. Of those 6 hours, we estimate it would take a Business Operations Specialist an average of 4 hours at $77.28/hr and a Management Analyst 2 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 336 hours (56 States × 6 hr) at a cost of $28,137 (56 States × [(4 hr × $77.28/hr) + (2 hr × $96.66/hr)] for revising the termination notice. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $14,068.

We also estimate that it would save each State 50 hours to process full applications annually for beneficiaries who would no longer lose coverage and later reenroll. Specifically, we estimate it would save an Eligibility Interviewer 40 hours at $46.14/hr and an Interpreter and Translator 10 hours at $56.16/hr. In aggregate, we estimate an annual savings of minus 2,800 hours (56 States × 50 hr) and minus $134,803 ([(40 hr × $46.14/hr) + (10 hr × $56.16/hr)] × 56 States) for processing fewer full applications. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $67,402.

In total, for ICRs related to § 435.919 under OMB control number 0938–1147 (CMS–10410), taking into account the Federal contribution, we estimate a total State savings of minus $35,497 ($17,837 + $14,068 − $67,402).

[90] Ibid.

[91] Kaiser Family Foundation (2021). Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. *https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.*

[92] CMS, *November 2021 Medicaid & CHIP Enrollment.* Available at *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.*

[93] Kaiser Family Foundation. (2021). Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. *https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.*

[94] While this provision applies to all States, Washington, DC, and the 5 territories, we are only estimating the burden for the 51 States for which we have current enrollment data, per the November 2021 CMS enrollment snapshot, available at *https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-november-2021-medicaid-chip-enrollment-trend-snapshot.pdf.*

We estimate that it would *save* each beneficiary who is disenrolled after a change in circumstance 2 hours at $28.01/hr to no longer submit a full application. As stated above, approximately 4.2 percent of beneficiaries are disenrolled from coverage and reenroll within 90 days.[95] Because this provision applies to all beneficiaries, which numbered approximately 85,809,179 individuals for Medicaid and CHIP (in the 51 States that reported enrollment data for November 2021),[96] we estimate approximately 3,603,986 beneficiaries (85,809,179 beneficiaries × 0.042) would save this time not reapplying after a change in circumstance. In aggregate, we estimate that this provision would save beneficiaries minus 7,207,972 hours (3,603,986 beneficiaries × 2 hr) and minus $201,895,296 (7,207,972 hr × $28.01/hr).

9. ICRs Regarding Timely Determination and Redetermination of Eligibility in Medicaid (§ 435.912) and CHIP (§ 457.340)

The following proposed changes will be submitted to OMB for review under control number 0938–1188 (CMS–10434 #15) for the State plan changes and 0938–1147 (CMS–10410) for the remaining burden related to updating notices and systems.

OMB Control Number 0938–1188 (CMS–10434 #15)

The amendments in this section would establish standards to ensure that applicants have enough time to gather and provide additional information and documentation requested by a State in adjudicating eligibility. In addition, the proposed amendments would apply to redeterminations either at renewal or based on changes in circumstances, the current requirements which apply at application. To address the current situation where redeterminations remain unprocessed for several months following the end of a beneficiary's eligibility period due to the beneficiary failing to return needed information to the State, these proposed amendments would require States to establish timeliness standards for both beneficiaries to return requested information to the State, as well as for the State to complete a redetermination of eligibility when the beneficiary returns information too late to process before the end of the eligibility period. In addition, these proposed amendments would require States to establish performance and timeliness standards for determining Medicaid eligibility, as well as determining eligibility for CHIP and BHP when an individual is determined ineligible for Medicaid.

Lastly, the amendments proposed under § 435.912 would for the first time establish set timeframes for when States must complete existing requirements related to acting on change in circumstances. The amendments would require States to process a redetermination within 30 calendar days from the date the State receives information indicating a potential change in a beneficiary's circumstance if no information is needed from the individual to redetermine eligibility and within 60 calendar days if the State needs to request additional information from the individual.

We estimate that it would take each State 3 hours to update their Medicaid State plans via a SPA to establish timeliness standards for the State to process redeterminations. Of those 3 hours per SPA, we estimate it would take a Business Operations Specialist 2 hours at $77.28/hr and a General Operations Manager 1 hour at $110.82/hr to update and submit each SPA to CMS for review. In aggregate, we estimate a one-time burden of 168 hours (56 States × 3 hr) at a cost of $14,861 (56 responses × ([2 hr × $77.28/hr] + [1 hr × $110.82/hr])) for completing the necessary SPA updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $7,431.

OMB Control Number 0938–1147 (CMS–10410)

We estimate that it would take each State 6 hours to update their notices to inform beneficiaries of the newly established timeframes within which they must return requested additional information in order for the State to process their redeterminations. Of those 6 hours, we estimate it would take a Business Operations Specialist 4 hours at $77.28/hr and a Computer Programmer 2 hours at $92.92/hr. In aggregate, we estimate a one-time burden of 336 hours (56 States × 6 hr) and $27,718 (56 States × ([4 hr × $92.92/hr] + [2 hr × $77.28/hr])) for all States to update the notices. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $13,859.

We also estimate it would take an average of 200 hours per State to develop and code the changes to each State's system to remove the edit to disenroll those beneficiaries who fail to return additional information within the newly established timeframes. Of those 200 hours, we estimate it would take a Business Operations Specialist 50 hours at $77.28/hr and a Management Analyst 150 hours at $96.66/hr. In aggregate, we estimate a one-time burden for all States of 11,200 hours (56 States × 200 hr) at a cost of $1,028,244 ([(50 hr × $77.25/hr) + (150 hr × $96.66/hr)] × 56 States) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $514,122.

In total for the ICRs related to §§ 435.912 and 457.340 under OMB control number 0938–1188 (CMS–10434 #15) and 0938–1147 (CMS–10410), taking into account the Federal contribution, we estimate a total one-time State cost of $535,412 ($7,431 + $13,859 + $514,122).

10. ICRs Regarding Returned Mail (§§ 435.919 and 457.344)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

This rule proposes to specify the steps States must take when beneficiary mail is returned to the agency. States would be required to first conduct a series of data checks to identify updated beneficiary contact information, including the State's Medicaid Enterprise System (MES), managed care plans, enrollment brokers, claims data, and other State administered public benefit systems, like TANF, SNAP, the DMV, as well as the NCOA. If updated contacted information is found, States must send a notice to that new address. Second, based on this information available to the State agency, the State must attempt to contact the beneficiaries by both mail, as well as a modality other than mail, such as by phone, electronic notice, email, or text message, as permissible. This provision also requires the State to send notices to both the current address on file and the forwarding address, if one is provided on the returned mail, requesting that the beneficiary confirm the new address. Third, only after the above has occurred with no response may the State take action, including updating the beneficiary's in-state address, terminating or suspending the

[95] Kaiser Family Foundation (2021). Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. *https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.*

[96] CMS, *November 2021 Medicaid & CHIP Enrollment.* Available at *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.*

beneficiary's enrollment, or moving the beneficiary from managed care to fee-for-service Medicaid.

We estimate that it would take all 42 Medicaid managed care States (and 34 States with managed care in separate CHIP) 40 hours to update their managed care contracts to enter into regular data-sharing arrangements with their MCOs to obtain up-to-date beneficiary contact information. While some of these States have both Medicaid and CHIP managed care and may even contract with the same plans for both programs, we assume there is no overlap for purposes of this estimate. Of those 40 hours, we estimate it would take a Procurement Clerk 10 hours at $43.20/hr and a Management Analyst 30 hours at $96.66/hr. In aggregate, we estimate this would create a one-time burden for States of 3,040 hours [40 hr × (42 Medicaid States + 34 CHIP States] at a cost of $253,217 [(10 hr × $43.20/hr) + (30 hr × $96.66/hr) × 76 State agencies]. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $126,609.

We estimate, using CMS' own analysis, that about half of all States (56 States/2 = 28 States) currently check DMV data for updated beneficiary information, such as contact information, as a part of their routine verification plans. Using this as a proxy for whether the State has an agreement with third-party sources, for example, NCOA, DMV, etc., we estimate that it would take 28 States each 40 hours to establish these data-sharing agreements. Of those 40 hours, we estimate it would take a Procurement Clerk 10 hours at $43.20/hr and a Management Analyst 30 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 1,120 hours (40 hr × 28 States) at a cost of $93,290 ([(10 hr × $43.20/hr) + (30 hr × $96.66/hr)] × 28 States). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $46,645.

Assuming 15 percent [97] of all Medicaid beneficiaries (12,871,377 beneficiaries = 85,809,179 beneficiaries × 0.15) [98] generate returned mail each year, we estimate that it would take 51 States each 30 seconds (approximately 0.0083 hr) per notice to send one additional notice by mail not only to the current address on file, but also to the forwarding address, if one is provided. We estimate that it would take a Management Analyst in each State 0.0083 hr/notice at $96.66/hr to program the sending of these extra notices for a total of 106,832 hours (0.0083 hr × 12,871,377 beneficiaries) at a cost of $10,326,381 (106,832 hr × $96.66/hr). We also estimate this amendment would create additional burden in postage costs for all States and all beneficiaries totaling $7,722,826 ($0.60/notice [99] × 12,871,377 [100]). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $9,024,603.

We estimate that it would take an Eligibility Interviewer an average of 5 minutes (5/60 = approximately 0.083 hr) per beneficiary at $46.14/hr to make one additional outreach attempt using a modality other than mail to the estimated 12,871,377 beneficiaries per year for whom the State receives returned mail. In aggregate, we estimate this would add a burden of 1,068,324 hours (0.083 hr × 12,871,377 beneficiaries) at a cost of $49,292,469 (1,068,324 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $24,646,235.

In total for the ICRs related to §§ 435.919 and 457.344 under OMB control number 0938–1147 (CMS–10410), and taking into account the 50 percent Federal contribution, we estimate a total State cost of $33,844,092 ($126,609 + $46,645 + $9,024,603 + $24,646,235).We estimate that current State policies on returned mail may have contributed to approximately 2.125 percent drop in enrollment.[101] Applying that change, we estimate that 273,517 beneficiaries (12,871,377 beneficiaries × 0.02125) would no longer be disenrolled after non-response to a State notice generated by returned mail and would no longer need to reapply to Medicaid. Therefore, we estimate that these amendments would lead to a reduction in burden for 273,517 beneficiaries who would otherwise be disenrolled after generating returned mail. We estimate that these beneficiaries at $28.01/hr would each save 2 hours of time not needed to reapply for Medicaid. In aggregate, we estimate this amendment would save beneficiaries in all States minus 547,034 hours (273,517 beneficiaries × 2 hr) and minus $15,322,422 (547,034 hr × $28.01/hr).

11. ICRs Regarding Improving Transitions Between Medicaid and CHIP (§§ 435.1200, 457.340, 457.348, 457.350, and 600.330)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

In States with separate Medicaid and CHIP programs, proposed § 435.1200 would require both the Medicaid and CHIP agencies to make system changes to more seamlessly transition the eligibility of individuals from one program to the other. We have not included a burden estimate for changes to the BHP regulations, since revisions to the Medicaid cross-references are intended to maintain current BHP policies.

We estimate that proposed § 435.1200 would take each of the 40 States with a separate CHIP 40 hours to execute a delegation agreement between the Medicaid and CHIP agencies to implement more seamless coverage transitions. Of those 40 hours, we estimate it would take a Procurement Clerk 10 hours at $43.20/hr and a Management Analyst 30 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 1,600 hours (40 hr × 40 States) at a cost of $133,272 [(10 hr × $43.20/hr) + (30 hr × $96.66/hr) × 40 States]. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $66,636.

We estimate that it would take all 40 States with a separate CHIP an average of 42 hours each to review any policy differences between their Medicaid and CHIP programs and make any necessary administrative actions to permit coordination of enrollment, such as a delegation of eligibility determinations or alignment of financial eligibility requirements between the two programs approximately. Of those 42 hours, we estimate it would take a Business Operations Specialist 22 hours at $77.28/hr and a Management Analyst 20 hours at $96.66/hr. In aggregate, we

[97] KHN, November 9, 2019, ''Return to Sender: A Single Undeliverable Letter Can Mean Losing Medicaid.'' Available at *https://khn.org/news/tougher-returned-mail-policies-add-to-medicaid-enrollment-drop/*.

[98] Centers for Medicare & Medicaid Services, ''October and November 2021 Medicaid and CHIP Enrollment Trends Snapshot,'' March 28, 2022. Available at *https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-november-2021-medicaid-chip-enrollment-trend-snapshot.pdf*.

[99] This amount is based on the current USPS postage rate for standard letters.

[100] While this provision applies to all States, Washington, DC, and the 5 territories, we are only estimating the burden for the 51 States for which we have current enrollment data, per the November 2021 CMS enrollment snapshot available at *https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-november-2021-medicaid-chip-enrollment-trend-snapshot.pdf*.

[101] KHN, November 9, 2019, ''Return to Sender: A Single Undeliverable Letter Can Mean Losing Medicaid.'' Available at *https://khn.org/news/tougher-returned-mail-policies-add-to-medicaid-enrollment-drop/*.

estimate a one-time burden of 1,680 hours (40 States × 42 hr) at a cost of $145,334 ([(22 hr × $77.28/hr) + (20 hr × $96.66/hr)] × 40 States) to review and make necessary policy changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $72,667.

We estimate that it would take all 40 States with a separate CHIP 200 hours to make changes to their shared eligibility system or service to determine, based on available information, whether the individual is eligible for Medicaid or CHIP when determined ineligible for the other program and before a notice of ineligibility is sent. Of those 200 hours, we estimate it would take a Business Operations Specialist 50 hours at $77.28/hr and a Management Analyst 150 hours at $96.66/hr. In aggregate, we estimate a one-time burden for all 40 States of 8,000 hours (40 States × 200 hr) at a cost of $734,520 ([(50 hr × $77.28/hr) + (150 hr × $96.66/hr)] × 40 States) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $367,260.

We estimate that 25 percent of States with a separate CHIP (40 States × 0.25 = 10) are already using combined notices and would see no additional burden from this provision. For the 30 of the 40 States with separate CHIPs who do not currently use a combined notice, we estimate that it would take 6 hours to develop or update a combined eligibility notice for individuals determined ineligible for Medicaid and eligible for CHIP or vice versa and 40 hours to make the system changes necessary to implement it. Of those 46 hours, we estimate that it would take a Business Operations Specialist 14 hours at $77.28/hr and a Management Analyst 32 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 1,380 hours (30 States × 46 hr) at a cost of $125,251 ([(14 hr × $77.28/hr) + (32 hr × $96.66/hr)] × 30 States) to develop the notice. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $62,626.

In total for the ICRs related to §§ 435.1200, 457.340, 457.348, 457.350, and 600.330 under OMB control number 0938–1147 (CMS–10410), and taking into account the Federal contribution, we estimate a total cost of $1,138,377.60 ($66,636 + $72,667 + $367,260 + $62,626).We also estimate that this provision would *save* each beneficiary on average 3 hours to no longer submit a renewal form once they have been determined ineligible for one program and determined potentially eligible for another insurance affordability program based on available information. Assuming 1 percent of beneficiaries (85,809,179 beneficiaries × 0.01 = 858,092 beneficiaries) currently submit a Medicaid renewal for this reason, in aggregate, we estimate an annual saving for beneficiaries in all States of minus 2,574,276 hours (3 hr × 858,092 individuals) and minus $72,105,471 (2,574,276 hr × $28.01/hr).

We estimate that it would *save* each beneficiary 4 hours previously spent reapplying for coverageAssuming 0.25 percent of beneficiaries (214,523 beneficiaries = 85,809,179 beneficiaries × 0.0025) currently lose coverage for failure to return a renewal form when no longer eligible, instead of being transitioned to the program for which they are eligible, we estimate an annual saving for beneficiaries in all States of minus 858,092 hours (4 hr × 214,523 individuals) and minus $24,035,157 (858,092 hr × $28.01/hr).

For beneficiaries, we estimate a total savings of minus $96,140,628 (−$72,105,471 − $24,035,157).12. ICRs Regarding Eliminating Requirement to Apply for Other Benefits (§ 435.608)

With regard to the burden associated with developing and coding the changes to each State's application system to eliminate the trigger for the Medicaid applicant to apply for other benefit programs, the proposed requirement and burden will be submitted to OMB for review under control number 0938–TBD (CMS–10819). At this time, the control number is to be determined (TBD). OMB will assign the control number upon their clearance of the proposed rule's new information collection request. The new control number will be set out in the final rule.

This rule proposes to remove the requirement at § 435.608 that State Medicaid agencies must require all Medicaid applicants and beneficiaries, as a condition of their eligibility, to take all necessary steps to obtain any benefits to which they are entitled. The requirement applies to adults only, which equates to approximately 46,000,000 Medicaid applicants.[102] Most individuals already apply for other benefits such as Veterans' compensation and pensions, Social Security disability insurance and retirement benefits, and unemployment compensation, because they want to receive them. As such, the requirement only impacts those individuals who only applied for a benefit because they had to in order to get or keep Medicaid.

If we estimate that, in a given year, 5 percent of beneficiaries need to apply for another benefit, that would be 2,300,000 people to whom the requirement would no longer apply by removing this provision. However, the burden of this requirement on beneficiaries with respect to the collection of information relates to the application requirements of other agencies, and therefore an estimate of burden reduction is not reflected in this section.

We estimate it would take an average of 200 hours per State to develop and code the changes to each State's application system to eliminate the trigger for the Medicaid applicant to apply for other benefit programs. Of those 200 hours, we estimate it would take a Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. For States, we estimate a total one-time burden of 11,200 hours (56 States × 200 hr) at a cost of $1,056,328 ([(50 hr × $98.50/hr) + (150 hr × $92.92/hr)] × 56 States) to complete the necessary system changes.

Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $528,164.

13. ICRs Regarding Removing Optional Limitation on the Number of Reasonable Opportunity Periods (§ 435.956)

This provision does not create any new or revised reporting, recordkeeping, or third party disclosure requirements or burden. The requirements and burden are addressed as part of the single streamlined application that is approved by OMB under control number 0938–1191 (CMS–10440).

We propose to revise § 435.956(b)(4) to remove the option for States to establish limits on the number of ROPs. Under proposed § 435.956(b)(4), all 56 States would be prohibited from imposing limitations on the number of ROPs that an individual may receive.

Since the option was finalized, only one State submitted a SPA requesting to implement this option, and implemented via a 12-month pilot. Following the pilot, the State suspended the policy of limiting the ROP period and removed the option from its State Plan. Other than the one State, CMS has not received any inquiries about establishing such a limitation. Therefore, we estimate that the

[102] CMS, *November 2021 Medicaid & CHIP Enrollment.* Available at *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.*

proposed amendments to § 435.956(b)(4) will not lead to any change in burden on States.

14. ICRs Regarding Recordkeeping (§§ 431.17 and 457.965)

The following proposed changes will be submitted to OMB for review under control number 0938–TBD (CMS–10819). At this time, the control number is to be determined (TBD). OMB will assign the control number upon their clearance of the proposed rule's new information collection request. The new control number will be set out in the final rule.

The amendments proposed under §§ 431.17 (Medicaid) and 457.965 (CHIP) would clearly delineate the types of information that States must maintain in Medicaid and CHIP case records while the case is active in addition to the minimum retention period of 3 years. This proposal clearly defines the records, such as the date and basis of any determination and the notices provided to the applicant/beneficiary. While current regulations do not include a timeframe for records retention, proposed §§ 431.17(c) and 457.965(c) would establish a minimum retention period of 3 years, and proposed §§ 431.17(d) and 457.965(d) would require that records be stored in an electronic format and that such records be made available to appropriate parties within 30 days of a request if not otherwise specified.

We recognize that States are in various stages of electronic recordkeeping today and that a portion of non-MAGI beneficiary case records are currently stored in a paper-based format, along with a small portion of MAGI-based beneficiary case records. Therefore, under proposed §§ 431.17(c) and 457.965(c), we estimate it would take an average of 20 hours per State for a Management Analyst at $96.66/hr to update each State's policies and procedures to retain records electronically for 3 years minimum. In aggregate, we estimate a one-time burden of 1,120 hours (56 States × 20 hr) at a cost of $108,259 (1,120 hr × $96.66/hr) for completing the necessary updates.

Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $54,130 ($108,259 × 0.5).

15. ICRs Regarding Prohibiting Premium Lock-Out Periods and Disenrollment for Failure To Pay Premiums (§§ 457.570 and 600.525(b)(2))

The following proposed CHIP State plan changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410). The BHP Blueprint changes will be submitted to OMB for review under control number 0938–1218 (CMS–10510).

OMB Control Number 0938–1147 (CMS–10410)

The amendments proposed to §§ 457.570 and 600.525(b)(2) would eliminate the option for States to impose premium lock-out periods in CHIP and in States with a BHP that allows continuous open enrollment throughout the year.

Under proposed § 457.570, we estimate it would take a Management Analyst 2 hours at $96.66/hr and a General and Operations Manager 1 hour at $110.82/hr in all 15 States that currently impose lock-out periods to amend their CHIP State plans to remove the lock-out period and submit in MMDL for review. We estimate an aggregate one-time burden of 45 hours (15 States × 3 hr) at a cost of $4,562 (([2 hr × $96.66/hr] + [1 hr × $110.82/hr]) × 15 States). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $2,281.

OMB Control Number 0938–1218 (CMS–10510)

Our proposed amendments would require BHP States to revise their BHP Blueprints to remove the premium lock-out period. Under proposed § 600.525(b)(2), in the one BHP State that imposes a lock-out period, we estimate it would take a Management Analyst 2 hours at $96.66/hr and a General and Operations Manager 1 hour at $110.82/hr to revise their BHP Blueprints to remove the premium lock-out period. We estimate an aggregate one-time burden of 3 hours (1 State × 3 hr) at a cost of $304 (([2 hr × $96.66/hr] + [1 hr × $110.82/hr]) × 1 State).

In total for the ICRs related to §§ 457.570 and 600.525(b)(2) under OMB control numbers 0938–1147 (CMS–10410), and OMB Control Number 0938–1218 (CMS–10510), taking into account the Federal contribution for the CHIP-related changes, we estimate a total one-time cost for the State of $2,585 ($2,281+ $304).

16. ICRs Regarding Prohibiting Waiting Periods in CHIP (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

The amendments proposed to §§ 457.65, 457.340, 457.350, 457.805, and 457.810 would eliminate the State option to impose a waiting period for families with children eligible for CHIP who were recently enrolled in a group health plan. Currently, 11 States with a separate CHIP program impose waiting periods between 1 month and 90 days. We estimate that the proposed amendments would require these 11 States to process CHIP applications earlier than under current rules and without evaluating whether the applicant just lost coverage through a group health plan. Therefore, these States would need to update their applications to eliminate the question asking for attestation of recently lost coverage and all related follow-up questions, such as to evaluate whether the person falls into an exception for a waiting period. If the State uses a data source to check for other coverage, the State would need to update the application to remove the trigger to query the data source.

We estimate it would take an average of 200 hours in each of these 11 States to develop and code the changes to each State's application to remove all questions and queries related to recently lost coverage. Of those 200 hours, we estimate it would take a Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. In aggregate, we estimate a one-time burden of 2,200 hours (11 States × 200 hr) at a cost of $207,493 ([(50 hr × $98.50/hr) + (150 hr × $92.92/hr)] × 11 States) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $103,747.

We estimate it would take an average of 3 hours in each of 11 unique States to update each State's CHIP SPAs in MMDL to document the other strategy(ies) the states will use to monitor substitution of coverage. We estimate it would take a General and Operations Mgr. 1 hour at $110.82/hr and a Business Operations Specialist 2 hours at $77.25/hr for a per State total of $265. In aggregate, we estimate a one-time burden for all States of 33 hours (11 States × 3 hr) and $2,915 ([(1 hr × $110.82/hr) + (2 hr × $77.25/hr)] × 11 States) for completing the necessary SPA updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $1,458.

In total for the ICRs related to §§ 457.65, 457.340, 457.350, 457.805,

and 457.810, and taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $105,205 ($103,747 + $1,458).

17. ICRs Regarding Prohibiting Annual and Lifetime Limits on Benefits (§ 457.480)

The following proposed CHIP State plan changes will be submitted to OMB for review under control number 0938–1148 (CMS–10398 #17) as they relate to updating CHIP SPAs and under control number 0938–TBD (CMS–10819) as they relate to programming in necessary system changes. At this time, the control number for CMS–10819 is to be determined (TBD). OMB will assign the control number upon their clearance of the proposed rule's new information collection request. The new control number will be set out in the final rule.

OMB Control Number 0938–TBD (CMS–10819)

The amendments proposed to § 457.480 would prohibit annual and lifetime dollar limits in the provision of all CHIP medical and dental benefits. Currently, 13 unique States place either an annual or lifetime dollar limit on at least 1 CHIP benefit. Twelve of the 13 States place an annual dollar limit on at least one CHIP benefit (AL, AR, CO, IA, MI, MS, MT, OK, PA, TN, TX, and UT), and 6 of the 13 States place a lifetime dollar limit on at least one benefit (CO, CT, MS, PA, TN, and TX). We estimate that the proposed amendments would require 13 States to update their systems and their CHIP SPAs to eliminate annual or lifetime benefit limits.

We estimate it would take an average of 20 hours to develop and code the changes to remove just 1 limit on either an annual or lifetime benefit. Of those 20 hours, we estimate it would take a Database and Network Administrator and Architect 5 hours at $98.50/hr and a Computer Programmer 15 hours at $92.92/hr. In aggregate, we estimate a one-time burden across all 13 States of 260 hours (20 hr × 13 States) and $24,522 ([(5 hr × $98.50/hr) + (15 hr × $92.92/hr)] × 13 States) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $12,261.

OMB Control Number 0938–1148 (CMS–10398 #17)

The amendments proposed to § 457.480 would require States submit updated CHIP SPAs. We estimate it would take an average of 3 hours in each of 13 unique States to update each State's CHIP SPAs in MMDL to remove 21 different limits on annual and/or lifetime benefits (calculated as 21/13, or approximately 1.62, limits per State). Of those 3 hours, we estimate it would take a General and Operations Mgr. 1 hour at $110.82/hr and a Business Operations Specialist 2 hours at $77.25/hr for a per State total of 5 hours (3 hr/limit × 1.62 limits). In aggregate, we estimate a one-time burden for all States of 65 hours (13 States × 5 hr) and $5,573 ([(1 hr × $110.82/hr) + (2 hr × $77.25/hr)] × 21 limits) for completing the necessary SPA updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $2,786.

In total for the ICRs related to § 457.480 under control numbers 0938–TBD (CMS–10819) and 0938–1148 (CMS–10398 #17), taking into account the 50 percent Federal contribution, we estimate a total one-time State cost of $15,047 ($12,261 + $2,786).

C. Summary of Proposed Burden Estimates

In Table 2, we present a summary of the proposed requirements and burden estimates.

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TABLE 2: Summary of Proposed Burden Estimates

Regulation Section(s)	OMB Control No. (CMS ID No.)	# of Respondents	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.407	0938-0467 (CMS-R-74)	56	1,786	-1	n/a	28.01	n/a	n/a	-2,801,000	-1,000,000	Annual
§ 435.407	0938-0467 (CMS-R-74)	56	1,786	-0.75	(75,000)	46.14	-3,460,500	-1,730,250	n/a	n/a	Annual
§ 435.407	0938-0467 (CMS-R-74)	56	1,786	0.25	25,000	96.66	2,416,500	1,208,250	n/a	n/a	Annual
§§ 435.952 and 435.940	0938-0467 (CMS-R-74)	51	10,000	-1	(510,000)	46.14	-23,531,400	-11,765,700	n/a	n/a	Annual
§§ 435.952 and 435.940	0938-0467 (CMS-R-74)	51	10,000	-1	n/a	28.01	n/a	n/a	-14,285,100	n/a	Annual
Subtotal	***0938-0467 (CMS-R-74)***	***270***	***25,358***	Varies	***(560,000)***	Varies	***-22,487,400***	***-11,243,700***	***-17,086,100***	***-1,000,000***	***Annual***
§ 435.1200	0938-1147 (CMS-10410)	56	15,323	-3	n/a	28.01	n/a	n/a	-72,105,471	n/a	Annual
§ 435.1200	0938-1147 (CMS-10410)	56	3,831	-4	n/a	28.01	n/a	n/a	-24,035,157	n/a	Annual
§ 435.1200	0938-1147 (CMS-10410)	40	1	40	1,600	Varies	133,272	66,636	n/a	n/a	One-Time
§ 435.1200	0938-1147 (CMS-10410)	40	1	42	1,680	Varies	145,334	72,667	n/a	n/a	One-Time
§ 435.1200	0938-1147 (CMS-10410)	40	1	200	8,000	Varies	734,520	367,260	n/a	n/a	One-Time
§ 435.1200	0938-1147 (CMS-10410)	30	1	46	1,380	Varies	125,251	62,626	n/a	n/a	One-Time
§ 435.601	0938-1147 (CMS-10410)	10	1	200	2,000	Varies	188,630	94,315	n/a	n/a	One-Time
§ 435.909	0938-1147 (CMS-10410)	51	9,788	-2	n/a	28.01	n/a	n/a	-27,964,344	n/a	Annual
§ 435.909	0938-1147 (CMS-10410)	51	1	180	9,180	92.92	853,006	426,503	n/a	n/a	One-Time
§ 435.909	0938-1147 (CMS-10410)	51	4,902	-1	(250,000)	46.14	-11,535,000	-5,767,500	n/a	n/a	Annual

Regulation Section(s)	OMB Control No. (CMS ID No.)	# of Respondents	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.916	0938-1147 (CMS-10410)	6	448,064	-1	n/a	28.01	n/a	n/a	-75,301,692	n/a	Annual
§ 435.916	0938-1147 (CMS-10410)	56	48,007	-1	n/a	28.01	n/a	n/a	-75,301,692	-26,883,860	Annual
§ 435.916	0938-1147 (CMS-10410)	37	2,016	-1	n/a	28.01	n/a	n/a	-2,089,630	n/a	Annual
§ 435.916	0938-1147 (CMS-10410)	6	1	200	1,200	Varies	113,178	56,589	n/a	n/a	One-Time
§ 435.916	0938-1147 (CMS-10410)	21	1	200	4,200	Varies	385,623	192,812	n/a	n/a	One-Time
§ 435.916	0938-1147 (CMS-10410)	56	48,007	-0.5	(1,344,193)	46.14	-62,021,065	-31,010,533	n/a	n/a	Annual
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	51	5,363	-2	n/a	28.01	n/a	n/a	-15,322,422	n/a	Annual
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	76	1	40	3,040	Varies	253,217	126,608	n/a	n/a	One-Time
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	28	1	40	1,120	Varies	93,290	46,645	n/a	n/a	One-Time
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	51	252,380	0.0083	106,832	96.66	10,326,422	9,024,603	n/a	7,722,826	Annual
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	51	252,380	0.083	1,068,324	46.14	49,292,469	24,646,235	n/a	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	51	7,059	-3.75	n/a	46.14	n/a	n/a	-62,289,000	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	51	7,059	0	n/a	n/a	n/a	n/a	n/a	-3,600,000	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	41	204,878	-2	n/a	28.01	n/a	n/a	-470,568,000	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	41	204,878	0	n/a	n/a	n/a	n/a	n/a	-84,000,000	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	51	7,059	-0.42	(151,200)	46.14	-6,976,368	-3,488,184	n/a	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	41	204,878	-0.25	(2,100,000)	46.14	-96,894,000	-48,447,000	n/a	n/a	Annual

Regulation Section(s)	OMB Control No. (CMS ID No.)	# of Respondents	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	10	4,400	1	44,000	46.14	2,030,160	1,015,080	n/a	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	10	4,400	-0.75	(33,000)	46.14	-1,522,620	-761,310	n/a	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	10	6,600	-0.167	(11,022)	46.14	-508,555	-254,278	n/a	n/a	Annual
§§ 435.912 and 457.340	0938-1147 (CMS-10410)	56	1	6	336	Varies	27,718	13,859	n/a	n/a	One-Time
§§ 435.912 and 457.340	0938-1147 (CMS-10410)	56	1	200	11,200	Varies	1,028,244	514,122	n/a	n/a	One-Time
§§ 435.916 and 435.919	0938-1147 (CMS-10410)	56	64,357	-2	n/a	28.01	n/a	n/a	-201,895,296	n/a	Annual
§§ 435.916, 435.919, and 457.344	0938-1147 (CMS-10410)	51	1	6	306	Varies	25,624	12,812	n/a	n/a	One-Time
§§ 435.916, 435.919, and 457.344	0938-1147 (CMS-10410)	40	1	3	120	Varies	10,049	5,024	n/a	n/a	One-Time
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	56	1	6	336	Varies	28,137	14,068	n/a	n/a	One-Time
§ 435.919	0938-1147 (CMS-10410)	56	1	-50	(2,800)	Varies	-134,803	-67,402	n/a	n/a	Annual
§§ 457.65, 457.340, 457.350, 457.805, and 457.810	0938-1147 (CMS-10410)	11	1	200	2,200	Varies	207,493	103,747	n/a	n/a	One-Time
§§ 457.65, 457.340, 457.350, 457.805, and 457.810	0938-1147 (CMS-10410)	11	1	3	33	Varies	$2,915	$1,458	n/a	n/a	One-Time
Subtotal	***0938-1147 (CMS-10410)***	***1563***	***1,805,647***	Varies	***(2,625,128)***	Varies	***-113,587,859***	***-56,793,930***	***-1,026,872,704***	***-106,711,034***	Varies
§ 457.480	0938-1148 (CMS-10398 #17)	13	2	3	63	Varies	5,573	2,786	n/a	n/a	One-Time
§§ 457.570 and 600.525(b)(2)	0938-1148 (CMS-10398 #17)	15	1	3	45	Varies	4,562	2,281	n/a	n/a	One-Time
Subtotal	***0938-1148 (CMS-10398 #17)***	***28***	***3***	***3***	***108***	Varies-	***10,135***	***5,067***	***n/a***	***n/a***	**One-Time**

Regulation Section(s)	OMB Control No. (CMS ID No.)	# of Respondents	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.601	0938-1188 (CMS-10434 # 15)	10	1	3	30	Varies	2,654	1,327	n/a	n/a	One-Time
§§ 435.912 and 457.340	0938-1188 (CMS-10434 # 15)	56	1	3	168	Varies	14,861	7,431	n/a	n/a	One-Time
Subtotal	***0938-1188 (CMS-10434 # 15)***	***66***	***2***	***3***	***198***	***Varies***	***17,515***	***8,758***	***n/a***	***n/a***	***One-Time-***
§ 435.956	0938–1191 (CMS–10440)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
§§ 457.570 and 600.525(b)(2)	0938-1218 (CMS-10510)	1	1	3	3	Varies	304	304	n/a	n/a	One-Time
Subtotal	***0938-1218 (CMS-10510)***	***1***	***1***	***3***	***3***	***Varies***	***304***	***304***	***0***	***0***	***One Time***
§ 435.608	0938-TBD (CMS-10819)	56	1	200	11,200	Varies	1,056,328	528,164	n/a	n/a	One-Time
§ 435.831(g)	0938-TBD (CMS-10819)	56	25	-12	n/a	28.01	n/a	n/a	-470,568	n/a	Annual
§ 435.831(g)	0938-TBD (CMS-10819)	56	1	200	11,200	Varies	1,056,328	528,164	n/a	n/a	One-Time
§ 435.831(g)	0938-TBD (CMS-10819)	56	25	-18	(25,200)	Varies	-1,246,896	-623,448	n/a	n/a	Annual
§ 457.480	0938-TBD (CMS-10819)	13	1	20	260	Varies	24,522	12,261	n/a	n/a	One-Time
§§ 431.17 and 457.965	0938-TBD (CMS-10819)	56	1	20	1,120	96.66	108,259	54,130	n/a	n/a	One-Time
Subtotal	***0938-TBD (CMS-10819)***	***293-***	***54***	***Varies***	***(1,420)***	***Varies***	***998,541***	***499,271***	***-470,568***	***n/a***	***Varies***
§ 406.21	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
§ 435.223	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
				Total - Annual	**(3,258,259)**		**(143,765,656)**	**(71,882,828)**	**(828,744,076)**	**(107,761,034)**	
				Total – One-Time	**72,020**		**6,628,892**	**3,314,598**	**n/a**	**n/a**	

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit the CMS website at *www.cms.hhs.gov/PaperworkReductionActof1995*, or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** section of this proposed rule and identify the rule (CMS–2421–P), the ICR's CFR citation, and OMB control number.

IV. Response to Comments

Because of the large number of public comments, we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

We have learned through our experiences in working with States and other stakeholders that there are gaps in our regulatory framework related to Medicaid, CHIP, and BHP eligibility and enrollment. While we have made great strides in expanding access to coverage over the past decade, certain policies continue to result in unnecessary burdens and create barriers to enrollment and retention of coverage. In response to the President's Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage, we reviewed existing regulations to look for areas where access could be improved.

In this rulemaking, we seek to eliminate obstacles that make it harder for eligible people to remain enrolled, particularly those individuals who are exempted from MAGI and did not benefit from many of the enrollment simplifications in our 2012 and 2013 eligibility final rules. We seek to streamline enrollment for individuals known to be Medicaid eligible, like current enrollees who are also eligible for but not enrolled in the MSPs. We seek to remove coverage barriers, like premium lock-out periods and waiting periods that are not permitted under other insurance affordability programs, and to reduce coverage gaps as individuals transition from one insurance affordability program to another. Together, the changes in this proposed rule would streamline Medicaid, CHIP and BHP eligibility and enrollment processes, reduce administrative burden on States and enrollees, expand coverage of eligible applicants, increase retention of eligible enrollees, and improve health equity.

B. Overall Impact

We have examined the impacts of this rule as required by E.O. 12866 on Regulatory Planning and Review (September 30, 1993), E.O. 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 (March 22, 1995; Pub. L. 104–4), E.O. 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) (having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action(s) or with economically significant effects ($100 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is ''economically significant'' as measured by the $100 million threshold. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The aggregate economic impact of this proposed rule is estimated to be $61.93 billion (in real FY 2023 dollars) over 5 years. This represents additional health care spending made by the Medicaid and CHIP programs on behalf of Medicaid and CHIP beneficiaries, with $41.41 billion paid by the Federal government and $20.52 billion paid by the States.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $8.0 million to $41.5 million in any one year. Individuals and States are not included in the definition of a small entity. Since this proposed rule would only impact States and individuals, therefore, we do not believe that this proposed rule will have a significant economic impact on a substantial number of small businesses. We seek comment on the relevant impact.

In addition, section 1102(b) of the Act requires CMS to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. This proposed rule applies to State Medicaid and CHIP agencies and would not add requirements to rural hospitals or other small providers. Therefore, we are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the UMRA also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation.

In 2022, that is approximately $165 million. We believe that this proposed rule would have such an effect on spending by State, local, or tribal governments but not by private sector entities.

Overall Assumptions

In developing these estimates, we have relied on several global assumptions. All estimates are based on the projections from the President's FY 2023 Budget. We have assumed that new enrollees would have the same average costs as current enrollees by eligibility group, unless specified in the description of the estimates (for example, some enrollees only would receive Medicare premium assistance). We have assumed that the rule would be effective on April 1, 2023. In addition, we have relied on the data sources and assumptions described in the next section to develop estimates for specific provisions of this proposed rule.

C. Anticipated Effects

1. Facilitate Enrollment Through Medicare Part D LIS Leads Data

To calculate the impact of easing enrollment for persons already receiving the LIS benefit, we analyzed data from the Medicare Integrated Data Repository (IDR) from July 2020. We determined the number of people who were enrolled in the LIS program by: (1) State; (2) the category of LIS benefit they received; and (3) whether or not they were also enrolled in Medicaid. We identified 13.1 million persons receiving the Part D LIS, of which 11.1 million were enrolled in Medicaid and 2.0 million were not.

We developed a regression using the percentage of LIS enrollees who were also enrolled as dual eligibles as the dependent variable, and used several policy factors as independent variables: State use of MIPPA applications; verification policies and procedures; grace period for providing verifications after initial denial; redetermination grace period; counting children towards income; income disregard; and asset disregard. While the latter three policies would not change under the proposed rule, we believed that they may explain some of the variation in the percentage of LIS recipients who are dual eligibles. We found that this model explained some amount of the variation in the percentage of LIS enrollees who are enrolled as dual eligibles, and that the most significant variable was the State use of MIPPA applications. Other policies appeared to have weak correlations. The model suggested that the use of these policies—and in particular the use of the Part D LIS leads data—would result in an average increase in the percentage of LIS recipients who are dual eligible enrollees from 84.6 percent to 88.0 percent (an increase of 3.4 percentage points). We estimated that about 0.44 million additional persons would have been enrolled in Medicaid as a result of these changes, had they been made in 2020.

We assumed these enrollees, as QMBs, would receive payment for the Medicare Part B premium. The premium is $170.10 per month in 2022.

To calculate future impacts to enrollment, we assumed that the increase in enrollment due to this provision would grow at the same rate as Medicaid enrollment among aged persons and persons with disabilities. We estimate that this would increase enrollment by about 0.52 million persons by FY 2027, and would increase total Medicaid spending by $4.84 billion from FY 2023 through FY 2027. Detailed estimates are shown in Table 3.

TABLE 3: Impact of Facilitating Medicaid Enrollment through Medicare Part D LIS Leads Data on Medicaid expenditures and enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.24	0.48	0.49	0.51	0.52
Total Spending	510	1,040	1,060	1,100	1,130
Federal Spending	290	600	620	640	660

2. Automatically Enroll Certain SSI Recipients Into QMB Program

To calculate the impact of automatically enrolling SSI recipients into QMB Medicaid coverage, we examined data on SSI recipients and their health care coverage.[103] As of 2017, about 17 percent of all SSI recipients had Medicare coverage but were not dually enrolled in Medicaid.

First, we estimated how many persons would enroll who already receive Medicare Part A without paying a premium. We estimated that there are 2.6 million people enrolled in SSI who are enrolled in Part A and do not pay the premium. Of these, we estimated about 67 percent reside in ''1634 States'' (about 1.7 million) and therefore are automatically enrolled in Medicaid. Of the remaining 0.9 million, we have assumed that 90 percent would enroll in the QMB group and receive Medicare Part B premium and cost-sharing assistance. We estimated those benefits to be about $5,000 per enrollee per year for 2022.

Second, we estimated how many persons would enroll who receive Medicare Part A but have to pay a premium. We estimate that there are 5.2 million such people enrolled in SSI. We estimated that 27 percent of this population lives in States that do not automatically enroll these individuals in the QMB group. Of States that do not automatically enroll these individuals in the QMB group, we assumed that about 20 percent of States would use the option provided in this proposed rule, and that about 50 percent of this population would be enrolled in the QMB group as a result. In total, this would result in an increase of about 0.15 million enrollees in the QMB group. We assumed these beneficiaries would receive Medicare Part B premium and cost-sharing assistance as well as Medicare Part A premium assistance. We estimated those benefits would be about $11,000 per enrollee per year in 2022.

[103] *https://www.census.gov/content/dam/Census/library/publications/2021/demo/p70br-171.pdf.*

TABLE 4: Impact of Automatically Enrolling Certain SSI Recipients into QMB Program on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.47	0.94	0.96	0.97	0.98
Total Spending	2,810	5,660	5,700	5,740	5,790
Federal Spending	1,640	3,280	3,300	3,320	3,350

3. Other Provisions To Facilitate Medicaid Enrollment

For other provisions that would facilitate Medicaid enrollment (including the definition of family size; making the QMB effective date earlier; the electronic verification and reasonable compatibility standard; and the verification of citizenship and identity), we assumed that these provisions would increase enrollment by about 0.1 percent among aged enrollees and enrollees with disabilities, and would have a negligible impact on other categories of enrollees. We estimated that this would increase enrollment by about 20,000 person-year equivalents by 2027.

TABLE 5: Impact of Other Provisions to Facilitate Enrollment on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.01	0.02	0.02	0.02	0.02
Total Spending	220	440	460	460	480
Federal Spending	130	260	260	270	280

It is likely that those SSI enrollees newly gaining Medicaid coverage would also have higher Medicare costs following enrollment. Primarily, receiving cost-sharing assistance for Medicare would lead to these individuals seeking out more care that may have been difficult to afford previously, also known as induction.

To estimate these impacts, we reviewed research on the effects of changing out of pocket costs on total health care costs, and specifically on Medicare. In general, we have historically estimated that reductions in out of pocket costs would increase total spending by $0.60 to $1.30 for every $1.00 reduction in out of pocket costs. Among research on health care costs, we relied primarily on research that examined the impacts on changing Medicare out of pocket costs.[104]

This research is useful, particularly because of the analysis reviewing cost-sharing among those Medicare enrollees without any other coverage, those with supplemental coverage (such as ''Medigap'' plans or retiree health benefits), and those with Medicaid. First, the analysis found that Medicare enrollees without other coverage had an average of $13,693 in costs, of which $2,399 was paid out of pocket (18 percent). Among those with supplemental coverage, average costs were $14,349, with $594 paid out of pocket (4 percent) and $2,095 paid through supplemental coverage (15 percent). Enrollees with Medicaid coverage had $26,181 in average costs, with $209 paid out of pocket (1 percent) and $3,190 paid by Medicaid (12 percent). A significant amount of cost differences is likely due to health status. Most notably, those with Medicaid coverage are on average older and more likely to have a disability or chronic condition, which would result in higher costs regardless of who pays for care.

The analysis also examines the effect of changing Medicare cost-sharing structures on total, Medicare, and out of pocket spending. While the specific proposed benefit changes are not related to this proposed rule, it does provide the relative magnitude of changes between Medicare and out of pocket costs. The analysis found a larger change in costs for those without any other coverage than those with supplemental coverage. For those without other coverage, out of pocket costs decreased by $428 while total costs increased by $764 (or $1.80 for every $1.00 reduction in out of pocket costs). For those with supplemental coverage, there was a decrease of $158 in out of pocket costs and an increase of $130 in total costs (or $0.80 for every $1.00 reduction in out of pocket costs).

We also reviewed how many Medicare enrollees have supplemental coverage or Medicaid. Research from the Kaiser Family Foundation recently looked at this.[105] This analysis found that 26 percent of Medicare beneficiaries had annual income of less than $20,000 (which is reasonably close to the SSI income limit of $1,767 monthly, which would be $21,204 annually). Of these beneficiaries, 37 percent had Medicaid and 11 percent had supplemental coverage. Excluding those with Medicaid and assuming the two groups are mutually exclusive, 17 percent of low-income beneficiaries without Medicaid had supplemental coverage. We believe it is reasonable to assume that very few beneficiaries had both Medicaid and other supplemental coverage.

We estimated the impact assuming that the overall increase in total costs would be $0.80 for every $1.00 reduction in out of pocket costs. For

[104] B Garrett, A Gangopadhyaya, A Shartzer, and D Arnos, ''A Unified Cost-Sharing Design for Medicare: Effects on Beneficiary and Program Spending,'' The Urban Institute, July 2019. *https://www.urban.org/sites/default/files/publication/100528/a_unified_cost-sharing_design_for_medicare_effects_on_beneficiary_an_1.pdf.* [Accessed August 3 2022].

[105] W Koma, J Cubanski, and T Neuman, ''A Snapshot of Coverage Among Medicare Beneficiaries in 2018,'' Kaiser Family Foundation, March 23 2021. *https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018/.* [Accessed August 3 2022].

those without supplemental coverage, this would be expected to result in an increase of 14 percent in total costs and 20 percent in Medicare costs, and for those without supplemental coverage, increases of 3 percent for total costs and 10 percent for Medicare costs. Using the analysis on SSI enrollees and coverage, this is a weighted average of an 18 percent increase in Medicare costs for those newly gaining Medicaid.

To calculate the annual impacts, we multiply the Medicare per enrollee costs each year by 18 percent and by the number of SSI enrollees newly receiving Medicaid, and then adjust for cost-sharing to calculate the Federal Medicare spending amounts. Using total Medicare per enrollee costs (as projected in the 2022 Trustees Report),[106] we project that this would increase Medicare spending by $11.1 billion over 2023 to 2027 under this proposed rule. Annual impacts are shown in Table 6.

TABLE 6: Projected change in Medicare expenditures from additional SSI enrollees receiving Medicaid (in millions of 2023 dollars)

	Medicare expenditures
2023	1,200
2024	2,400
2025	2,400
2026	2,500
2027	2,600
Total	11,100

There is a wide range of possible costs due to this effect of the proposed rule. Most notably, and described previously in this section, is that the impact of reducing out of pocket costs could have different impacts than estimated here. Thus, individuals could use greater or lesser levels of additional services, resulting in different levels of Medicare spending changes than estimated here. This uncertainty is addressed in the high and low range estimates provided in the accounting statement (see section V.F. of this proposed rule).

4. Promoting Enrollment and Retention of Eligible Individuals

These provisions are expected to increase coverage by assisting persons with gaining and maintaining Medicaid coverage. We have considered several effects of the provisions in this proposed rule.

First, we estimated the impacts of aligning non-MAGI enrollment and renewal requirements with MAGI policy. We anticipate that this provision would increase the number of member months of coverage among enrollees eligible based on non-MAGI criteria (older adults and persons with disabilities). In an analysis of dually eligible enrollees from 2015 to 2018, CMS found that about 29 percent of new dually eligible enrollees lost coverage for at least 1 month in the first year of coverage, and about 24 percent lost coverage for at least 3 months. While some of this loss of coverage is likely due to enrollees no longer being eligible, we expect that many enrollees may still be eligible despite losing coverage, and that this provision would assist enrollees in continuing coverage. We assumed that this provision would increase enrollment among aged enrollees and enrollees with disabilities by about 1 percent.

For all other provisions under this section, we assumed that they would increase coverage for children by about 1 percent and for all other enrollees by about 0.75 percent. In particular, we assumed that provisions for acting on changes in circumstances, timely eligibility determinations and redeterminations, and action on returned mail would all contribute to modest increases in enrollment (mostly through continuing coverage for persons already enrolled) and that the provision to improve transitions between Medicaid and CHIP would further increase Medicaid enrollment.

In total, we estimated these provisions would increase enrollment by about 880,000 person-year equivalents by 2027.

TABLE 7: Impact of Provisions to Promote Enrollment and Retention on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.43	0.86	0.86	0.87	0.88
Total Spending	5,120	10,480	10,650	10,870	11,090
Federal Spending	3,140	6,440	6,550	6,660	6,800

[106] ''2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.'' *https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.* [Accessed August 3 2022].

5. Eliminating Barriers To Access in Medicaid

We assumed that removing or limit requirements to apply for other benefits as a condition of Medicaid enrollment would lead to an increase in Medicaid coverage. We have not assessed the impacts across different benefits (that is, SSI, TANF, etc.). We assumed that this would increase overall enrollment by about 0.5 percent, or about 410,000 person-year equivalents by 2027.

We have assumed that removing optional limitations on the number of reasonable opportunity periods would have a negligible impact on Medicaid enrollment and expenditures.

TABLE 8: Impact of Provisions to Eliminate barriers to access in Medicaid on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.20	0.40	0.40	0.41	0.41
Total Spending	1,960	4,020	4,080	4,170	4,250
Federal Spending	1,240	2,580	2,600	2,660	2,710

6. CHIP Proposed Changes and Eliminating Access Barriers in CHIP

We estimated that proposed changes to CHIP enrollment (including timely determinations and redeterminations, acting on changes in circumstances, acting on returned mail, and improving transitions between CHIP and Medicaid) would increase CHIP enrollment by about 1 percent. These are comparable to the impacts on Medicaid children of the comparable Medicaid provisions.

For prohibitions on premium lockout periods and waiting periods, there are currently 14 States that have such lockout periods and 11 States that have waiting periods for CHIP enrollment. We assumed that in those States, removing these barriers to coverage would increase enrollment by about 1 percent. We assumed that prohibiting annual and lifetime limits on benefits in CHIP would have a negligible impact.

In total, we estimate these provisions would increase enrollment by about 120,000 by 2027.

TABLE 9: Impact of Provisions to Promote Enrollment and Retention in CHIP and Reduce Barriers to Coverage on CHIP Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.06	0.12	0.12	0.12	0.12
Total Spending	180	370	370	380	390
Federal Spending	120	250	260	260	280

7. Impacts on the Marketplaces

We anticipate that many of the enrollees that would either be gaining Medicaid or CHIP coverage or retaining Medicaid or CHIP coverage as a result of this proposed rule would have had other coverage under current policies. In particular, we expect that many of the children and adults would have enrolled in the Marketplace and been eligible for subsidized care (excluding those age 65 or older and those with disabilities who are enrolled in Medicare).

To estimate the impacts this proposed rule would have on Marketplace expenditures, we started by calculating the cost of care and Federal subsidy payments for different households shifting from Marketplace coverage to Medicaid and CHIP. We made the following assumptions. We estimated that health care prices are 30 percent higher in Marketplace plans than in Medicaid and CHIP, and that the average percentage of costs for non-benefit costs in managed care was 10 percent—this also considers that some beneficiaries receive all or part of their care outside of managed care. Next, we assumed that individuals would reduce health spending by 10 percent in the Marketplace due to increased cost sharing requirements. We used an actuarial value of 70 percent, consistent with silver level plans on the Marketplace, and assumed that the average percentage of non-benefit costs in Marketplace plans was 20 percent. Finally, we assumed that the average income of persons shifting from Marketplace coverage to Medicaid and CHIP would be 125 percent of the Federal poverty level (FPL) and that the premium tax credits would be calculated assuming that they would not have to pay any contribution in 2023, 2024, and 2025 under the Inflation Reduction Act of 2022, and that they would have to pay 2 percent of income for coverage for 2026 and beyond.

We calculated the amount of Federal subsidies (measured by premium tax credits) for households of one adult, two adults, one adult and one child, one adult and two children, and two adults and two children, and then calculated the total Federal cost of Marketplace coverage to be consistent with the distribution of projected enrollment change in Medicaid and CHIP under the proposed rule. We made a final assumption that 60 percent of individuals would have enrolled in Marketplace coverage, and the remaining 40 percent would have either received other coverage or become uninsured.

We estimated that Marketplace costs would have decreased by $3.8 billion in 2022 under the policies in the proposed rule. To project costs for future years that would be affected by the proposed rule, we assumed that per capita costs,

premiums, and Federal subsidies would increase consistent with the projected growth rates in the President's Budget with adjustments to account for the impacts of the Inflation Reduction Act of 2022, and that enrollment would increase consistent with the projections made for the Medicaid and CHIP provisions of this proposed rule.

TABLE 10: Projected change in Federal Marketplace subsidy expenditures (in millions of 2023 dollars)

	Federal Marketplace subsidy expenditures
2023	–1,930
2024	–3,940
2025	–3,980
2026	–3,940
2027	–4,000
Total	–17,790

There is a wide range of possible savings due to this effect of the proposed rule. For these estimates, participation in the Marketplace and health care costs and prices may vary from what we assumed here. Thus, actual savings could be greater or lesser than estimated here. This uncertainty is addressed in the high and low range estimates provided in the accounting statement (see section V.F. of this proposed rule).

8. Total

In total, we project that these provisions would increase Medicaid enrollment by 2.81 million by 2027, and would increase total Medicaid spending by $99,290 million from 2023 through 2027. Of that amount, we estimate that $60,280 million would be paid by the Federal government and $39,010 million would be paid by the States. We expect the majority of the additional enrollment and cost to be provided for older adults and persons with disabilities. We also estimate that CHIP enrollment would increase by 0.12 million by 2027, and that total CHIP expenditures would increase by $1,690 million from 2023 to 2027 ($1,170 Federal and $520 million State costs). Table 11 shows the net impacts for Medicaid and for CHIP.

TABLE 11: Impact of Proposed Provisions on Medicaid and CHIP Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

Medicaid	2023	2024	2025	2026	2027	2023-2027
Enrollment	1.34	2.70	2.74	2.78	2.81	
Total Spending	10,620	21,640	21,950	22,340	22,740	99,290
Federal Spending	6,440	13,160	13,330	13,550	13,800	60,280
State Spending	4,180	8,480	8,620	8,790	8,940	39,010
CHIP	2023	2024	2025	2026	2027	2023-2027
Enrollment	0.06	0.12	0.12	0.12	0.12	
Total Spending	180	370	370	380	390	1,690
Federal Spending	120	250	260	260	280	1,170
State Spending	60	120	110	120	110	520

TABLE 12: Estimated Impacts for the Medicaid and CHIP Eligibility Rule [Millions of 2023 dollars]

	2023	2024	2025	2026	2027	Total
Total costs	10,800	22,010	22,320	22,720	23,130	100,980
Federal costs	6,560	13,410	13,590	13,810	14,080	61,450
State costs	4,240	8,600	8,730	8,910	9,050	39,530

In addition to the effects on Medicaid and CHIP, we have also estimated impacts on Medicare and the Federal subsidies for Marketplace coverage. Table 13 shows the net impact on Federal spending for Medicaid, CHIP, Medicare, and Federal Marketplace subsidies.

TABLE 13: Estimated Impacts of the Medicaid and CHIP Eligibility Rule on Federal Spending [Millions of 2023 dollars]

Medicare	2023	2024	2025	2026	2027	2023-2027
Medicaid Federal Spending	6,440	13,160	13,330	13,550	13,800	60,280
CHIP Federal Spending	120	250	260	260	280	1,170
Medicare Federal Spending	1,200	2,400	2,400	2,500	2,600	11,100
Federal Marketplace Subsidies Federal Spending	–1,930	–3,940	–3,980	–3,940	–4,000	–17,790
Total Federal Spending	5,830	11,870	12,010	12,370	12,680	54,760

9. Administrative Burden

We anticipate a reduction in administrative burden for States resulting from the proposed elimination of the requirement to apply for other benefits outlined in the preamble of this proposed rule. Specifically, we estimate that this provision would save State Eligibility Interviewers on average 1 hour per enrollee at $46.70/hr from no longer needing to prepare and send notices and requests for additional information about applying for other benefits, or to process requests for good cause exemptions. In aggregate for all States, we estimate an annual savings of minus 2,300,000 hours (1 hr × 2.3M enrollees) and minus $106,122,000 (2,300,000 hrs × $46.70/hr).

We also estimate that this provision would save each enrollee who otherwise meets all requirements to be enrolled or remain enrolled in Medicaid but who, absent this provision, would lose Medicaid coverage due to failure to provide information on application for other benefits on average 2 hours at $28.01/hr. In aggregate, we estimate that enrollees in all States would save minus 4,600,000 hours (2 hrs × 2,300,000 enrollees) and $128,846,000 (4,600,000 hrs × $28.01/hr) annually.

D. Alternatives Considered

In developing this proposed rule, the following alternatives were considered:

1. Not Proposing the Rule

We considered not proposing this rule and maintaining the status quo. However, we believe this proposed rule will lead to more eligible individuals gaining access to coverage and maintaining their coverage across all States. In addition, we believe that provisions in this proposed rule, such as updates to the recordkeeping requirements, will reduce the incidence of improper payments and improve the integrity of the Medicaid program and CHIP.

2. Providing States With Discretion Regarding the Date of Application for QMBs

Section 406.26 describes enrollment in Medicare Part A through the buy-in process. We considered proposing modifications to § 406.26(b) to provide States with discretion to use the Part A conditional enrollment filing date as the date of the Medicaid application for QMB eligibility. As background, the QMB eligibility group covers Part A premiums for individuals who do not qualify for premium-free Part A. However, to apply for the QMB eligibility group, an individual must be entitled to Part A—and many cannot afford the monthly premium ($499 in 2022). Such individuals have to navigate a complex two-step process where they first apply for conditional enrollment in Part A at SSA, then go to the State Medicaid agency to apply for the QMB eligibility group. Providing States the option to use the date of application at SSA for conditional enrollment as the date of application for a QMB application could permit States to offer an earlier effective date for QMB. We chose not to propose a regulatory change at this time because we do not have enough information to accurately assess its impact. However, we seek comments on this alternative considered that might be adopted in the final rule based on comments received.

3. Maintaining Records in Paper Format

We considered allowing States, which have not yet transitioned their enrollee records into an electronic format, to continue to maintain a paper-based record keeping system. As documented by the OIG and PERM eligibility reviews, many existing enrollee case records lack adequate information to verify decisions of Medicaid eligibility. A move to electronic recordkeeping will not only help States to ensure adequate documentation of their eligibility decisions, but will also make it easier to report such information to State auditors and other relevant parties. Therefore, we proposed to require State Medicaid agencies to store records in electronic format (estimated above, in the Collection of Information section, as a one-time cost of $108,260) and sought comment on whether States should retain flexibility to maintain records in paper or other formats that reflect evolving technology.

E. Limitations of the Analysis

There are a number of caveats to these estimates. Foremost, there is significant uncertainty about the actual effects of these provisions. Each of these provisions could be more or less effective than we have assumed in developing these estimates, and for many of these provisions we have made assumptions about the impacts they would have. In many cases, determining the reasons why a person may not be enrolled despite being eligible for Medicaid or CHIP is difficult to do in an analysis such as this. Therefore, these assumptions rely heavily on our judgment about the impacts of these provisions. While we believe these are reasonable estimates, we note that this could have a substantially greater or lesser impact than we have projected.

Second, there is uncertainty even under current policy in Medicaid and CHIP. Due to the COVID–19 pandemic and legislation to address the pandemic, Medicaid enrollment (and to a lesser extent, CHIP enrollment) have experienced significant increases in enrollment since the beginning of 2020. Actual underlying economic and public health conditions may differ than what we assume here.

In addition to the sources of uncertainty described previously, there are other reasons the actual impacts of these provisions may differ from the estimates. There may be differences in the impacts of these provisions across eligibility groups or States that are not reflected in these estimates. There may also be different costs per enrollee than we have assumed here—those gaining coverage altogether or keeping coverage for longer durations of time may have different costs than those who were already assumed to be enrolled in the program. Lastly, to the extent that States have discretion in provisions that are

optional in this proposed rule or in the administration of their programs more broadly, States' efforts to implement these provisions may lead to larger or smaller impacts than estimated here.

To address these limitations, we have developed a range of impacts. We believe that the actual impacts would likely fall within a range 50 percent higher or lower than the estimates we have developed. While this is a significant range, we would note that in the context of the entire Medicaid program ($743 billion in FY 2021), this is still a relatively narrow range.

F. Accounting Statement

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement in Table 14 showing the classification of the transfer payments with the provisions of this proposed rule. These impacts are classified as transfers, with the Federal government and States incurring additional costs and beneficiaries receiving medical benefits and reductions in out-of-pocket health care costs.

This provides our best estimates of the transfer payments outlined in the ''Section C. Detailed Economic Analysis'' above. To address the significant uncertainty related to these estimates, we have assumed that the costs could be 50 percent greater than or lesser than we have estimated here. We recognize that this is a relatively wide range, but we note several reasons for uncertainty regarding these estimates. First, there are numerous provisions that affect Medicaid and CHIP in this rule. For several provisions, we have limited information, analysis, or comparisons to prior experience to use in developing our estimates. Thus, the range reflects that impacts of these provisions could be greater or lesser than we assume. In addition, given the number of provisions, there may be cases where multiple provisions would help an individual maintain coverage. This could lead to these estimates ''double counting'' some effects. We also note that there are expected impacts on Medicare and the Marketplace subsidies; we believe this range adequately accounts for the potential variation in costs or savings to those programs as well. Finally, given the significant effects of the COVID–19 pandemic and legislation intended to address this, the current outlook for Medicaid and CHIP are less certain than typically. We provide this wider range to account for this uncertainty as well. This range provides the high cost and low cost ranges shown in Table 14.

TABLE 14: Accounting Statement [Millions of 2023 dollars]

Category	Primary estimate	Low estimate	High estimate	Units		
				Year dollars	Discount rate	Period covered
Annualized Monetized Transfers from Federal Government to beneficiaries	$10,755	$5,378	$16,133	2023	7%	2023-2027
	$10,867	$5,434	$16,301	2023	3%	2023-2027
Annualized Monetized Transfers from States to beneficiaries	$7,768	$3,884	$11,652	2023	7%	2023-2027
	$7,847	$3,923	$11,770	2023	3%	2023-2027

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on August 25, 2022.

List of Subjects

42 CFR Part 406

Diseases, Health facilities, Medicare.

42 CFR Part 431

Grant programs—health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs—health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Health insurance, Reporting and recordkeeping requirements.

42 CFR Part 600

Administrative practice and procedure, Health care, Health insurance, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

■ 1. The authority citation for part 406 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1395i–2, 1395i–2a, 1395p, 1395q and 1395hh.

■ 2. Section 406.21 is amended by adding paragraph (c)(5) to read as follows:

§ 406.21 Individual enrollment.

* * * * *

(c) * * *

(5) If an individual resides in a State that pays premium hospital insurance for Qualified Medicare Beneficiaries under § 406.32(g) and enrolls or reenrolls during a general enrollment period after January 1, 2023, QMB coverage is effective the month entitlement begins (if the individual is determined eligible for QMB before the month following the month of enrollment), or a month later than the month entitlement begins (if the individual is determined eligible for QMB the month entitlement begins or later).

* * * * *

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 3. The authority citation for part 431 is revised to read as follows:

Authority: 42 U.S.C. 1302.

■ 4. Section 431.10 is amended by—

■ a. Redesignating paragraphs (c)(1)(i)(A)(*2*) and (*3*) as (c)(1)(i)(A)(*4*) and (*5*), respectively; and

■ b. Adding new paragraphs (c)(1)(i)(A)(*2*) and (*3*).

The additions read as follows:

§ 431.10 Single State agency.

* * * * *

(c) * * *

(1) * * *

(i) * * *

(A) * * *

(*2*) The separate Children's Health Insurance Program agency;

(*3*) The Basic Health Program agency;

* * * * *

■ 5. Section 431.17 is revised to read as follows:

§ 431.17 Maintenance of records.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes the kinds of records a Medicaid agency must maintain, the minimum retention period for such records, and the conditions under which those records must be provided or made available.

(b) *Content of records.* A State plan must provide that the Medicaid agency will maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the plan. The records must include all of the following—

(1) Individual records on each applicant and beneficiary that contain all of the following:

(i) All information provided on the initial application submitted through any modality described in § 435.907 of this subchapter by, or on behalf of, the applicant or beneficiary, including the signature on and date of application.

(ii) The electronic account and any information or other documentation received from another insurance affordability program in accordance with § 435.1200(c) and (d) of this subchapter.

(iii) The date of, basis for, and all documents or other evidence to support any determination, denial, or other adverse action, including decisions made at application, renewal, and as a result of a change in circumstance, taken with respect to the applicant or beneficiary, including all information provided by, or on behalf of, the applicant or beneficiary, and all information obtained electronically or otherwise by the agency from third-party sources.

(iv) The provision of, and payment for, services, items and other medical assistance, including the service or item provided, relevant diagnoses, the date that the service or item was provided, the practitioner or provider rendering, providing or prescribing the service or item, including their National Provider Identifier, and the full amount paid or reimbursed for the service or item, and any third-party liabilities.

(v) Any changes in circumstances reported by the individual and any actions taken by the agency in response to such reports.

(vi) All renewal forms and documentation returned by, or on behalf of, a beneficiary, to the Medicaid agency in accordance with § 435.916 of this subchapter, regardless of the modality through which such forms are submitted, including the signature on the form and date received.

(vii) All notices provided to the applicant or beneficiary in accordance with § 431.206 and §§ 435.917 and 435.918 of this subchapter.

(viii) All records pertaining to any fair hearings requested by, or on behalf of, the applicant or beneficiary, including each request submitted and the date of such request, the complete record of the hearing decision, as described in § 431.244(b), and the final administrative action taken by the agency following the hearing decision and date of such action.

(ix) The disposition of income and eligibility verification information received under §§ 435.940 through 435.960 of this subchapter, including evidence that no information was returned from an electronic data source.

(2) Statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

(c) *Retention of records.* The State plan must provide that the records required under paragraph (b) of this section will be retained for the period when the applicant or beneficiary's case is active, plus a minimum of 3 years thereafter.

(d) *Accessibility and availability of records.* The agency must—

(1) Maintain the records described in paragraph (b) of this section in an electronic format; and

(2) Make the records available to the Secretary, Federal and State auditors and other parties who request, and are authorized to review, such records within 30 calendar days of the request, if not otherwise specified, and to the extent permissible by Federal law.

§ 431.213 [Amended]

■ 6. Section 431.213 is amended by removing and reserving paragraph (d).

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

■ 7. The authority citation for part 435 is revised to read as follows:

Authority: 42 U.S.C. 1302.

■ 8. Section 435.4 is amended by adding a definition for ''Low Income Subsidy Application data (LIS leads data)'' in alphabetical order to read as follows:

§ 435.4 Definitions and use of terms.

* * * * *

Low-Income Subsidy Application data (LIS leads data) means data from an individual's application for low-income subsidies under section 1860D–14 of the Act that the Social Security Administration electronically transmits to the appropriate State Medicaid agency as described in section 1144 (c)(1) of the Act.

* * * * *

■ 9. Section 435.222 is amended by revising the section heading to read as follows:

§ 435.222 Optional eligibility for reasonable classifications of individuals under age 21 with income below a MAGI-equivalent standard.

* * * * *

■ 10. Section 435.223 is added as follows:

§ 435.223 Other optional eligibility for reasonable classifications of individuals under age 21.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18) or to one or more reasonable classifications of individuals under age 21 who meet the requirements described in any clause of section 1902(a)(10)(A)(ii) of the Act and implementing regulations in this subpart, if any.

■ 11. Section 435.407 is amended by—

■ a. Adding paragraphs (a)(7) and (8);

■ b. Removing paragraphs (b)(2) and (11);

■ c. Redesignating paragraphs (b)(3) through (b)(10) as paragraphs (b)(2) through (b)(9), and paragraphs (b)(12) through (b)(18) as paragraphs (b)(10) through (b)(16), respectively; and

■ d. In newly redesignated paragraph (b)(16), removing the reference to paragraph ''(17)'' and adding in its place a reference to paragraph ''(15)''.

The additions read as follows:

§ 435.407 Types of acceptable documentary evidence of citizenship.

(a) * * *

(7) Verification with a State vital statistics agency documenting a record of birth.

(8) A data match with the Department of Homeland Security Systematic Alien Verification for Entitlements (SAVE) Program or any other process

established by DHS to verify that an individual is a citizen.

* * * * *

■ 12. Section 435.601 is amended—

■ a. In paragraph (b)(2) by removing the phrase ''specified in paragraphs (c) and (d) of this section or in § 435.121 or as permitted under § 435.831(b)(1), in determining'' and adding in its place the phrase ''specified in paragraphs (c) through (e) of this section or in § 435.121 of this part or as permitted under (f)(1)(ii)(B) of this paragraph, in determining'';

■ b. In paragraph (d)(1) introductory text by removing the phrase ''permitted under § 435.831(b)(1) in determining eligibility'' and adding in its place the phrase ''permitted under paragraph (e) or (f)(1)(ii)(B) of this section in determining eligibility'';

■ c. By adding paragraph (e); and

■ d. By revising paragraph (f).

The addition and revision read as follows:

§ 435.601 Application of financial eligibility methodologies.

* * * * *

(e) *Procedures for determining eligibility for the Medicare Savings Program groups.* When a State determines eligibility for a Medicare Savings Program group, for income eligibility the agency must include at least the individuals described in § 423.772 in determining family of the size involved.

(f) *State plan requirements.* (1)(i) The State plan must specify that, except to the extent precluded in § 435.602, in determining financial eligibility of individuals, the agency will apply the cash assistance financial methodologies and requirements, unless the agency chooses the option described in paragraph (f)(1)(ii)(B) of this section, or chooses to apply less restrictive income and resource methodologies in accordance with paragraph (d) of this section, or both.

(ii) In the case of individuals for whom the program most closely categorically-related to the individual's status is AFDC (individuals under age 21, pregnant individuals and parents and other caretaker relatives who are not disabled, blind or age 65 or older), the agency may apply—

(A) The financial methodologies and requirements of the AFDC program; or

(B) The MAGI-based methodologies defined in § 435.603, except that, the agency must comply with the terms of § 435.602.

(2) [Reserved]

§ 435.608 [Removed and Reserved]

■ 13. Section 435.608 is removed and reserved.

■ 14. Section 435.831 is amended by—

■ a. Redesignating paragraphs (g)(2) and (3) as paragraphs (g)(3) and (4), respectively; and

■ b. Adding new paragraph (g)(2).

The addition reads as follows:

§ 435.831 Income eligibility.

* * * * *

(g) * * *

(2) May include expenses for services that the agency has determined are reasonably constant and predictable, including, but not limited to, services identified in a person-centered service plan developed pursuant to § 441.301(b)(1)(i), § 441.468(a)(1), § 441.540(b)(5), or § 441.725 and expenses for prescription drugs, projected to the end of the budget period at the Medicaid reimbursement rate.

* * * * *

■ 15. Section 435.907 is amended by adding paragraph (c)(4) and revising paragraph (d) to read as follows:

§ 435.907 Application.

* * * * *

(c) * * *

(4) Any MAGI-exempt applications and supplemental forms must be accepted through all modalities described at 435.907(a).

(d)(1) If the agency needs to request additional information from the applicant to determine and verify eligibility in accordance with § 435.911, the agency must—

(i) Provide the applicant with no less than the following number of days, measured from the date the agency sends the request, to respond and provide any necessary information:

(A) Thirty (30) calendar days for applicants who apply for Medicaid on the basis of disability, and

(B) Fifteen (15) calendar days for all other applicants;

(ii) Allow applicants to provide requested information through any of the modes of submission specified in paragraph (a) of this section; and

(iii)(A) In the case of an individual who is denied eligibility for failure to submit requested information and who subsequently submits the requested information within the period allowed by the agency in accordance with paragraph (d)(1)(ii) of this section, reconsider eligibility without requiring a new application;

(B) For purposes of the application timeliness standards at § 435.912(c)(3) of this subpart, the date of application for individuals described in paragraph (d)(1)(iv)(A) of this section is considered the date upon which the individual submits the additional information requested by the agency; and

(C) For purposes of the effective date of eligibility under § 435.915 of this subpart, the date of application for individuals described in paragraph (d)(1)(iiii)(A) of this section is date on which the original application was submitted.

(2) The agency may not require an in-person interview as part of the application process.

* * * * *

■ 16. Section 435.909 is revised to read as follows:

§ 435.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

(a) *Automatic enrollment of certain individuals in Medicaid.* The agency must not require a separate application for Medicaid from an individual, if the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act for determining Medicaid eligibility; and—

(1) The individual receives SSI;

(2) The individual receives a mandatory State supplement under either a federally-administered or State-administered program; or

(3) The individual receives an optional State supplement and the agency provides Medicaid to beneficiaries of optional supplements under § 435.230.

(b) *Automatic enrollment of SSI recipients in the Qualified Medicare Beneficiary group.* (1) The agency must deem individuals eligible for the Qualified Medicare Beneficiary group as described in § 400.200 of this chapter if the individual receives SSI and is determined eligible for medical assistance under § 435.120 or § 435.121 and—

(i) The individual is entitled to Part A under part 406, subpart B of this chapter; or

(ii) The individual is entitled to Part A under § 406.20 of this chapter and the agency has a State buy-in agreement authorized under section 1843 of the Act and modified under section 1818(g) of the Act.

(2) The agency may deem individuals eligible for the Qualified Medicare Beneficiary group as described in § 400.200 of this chapter if the individual receives SSI and is determined eligible for medical assistance under § 435.120 or § 435.121; and—

(i) The individual is entitled to Part A under § 406.5(b) of this chapter; and

(ii) The agency uses the group payer arrangement under § 406.32(g) of this chapter to pay Part A premiums for Qualified Medicare Beneficiaries.

(3) The automatic enrollment of SSI recipients in the Qualified Medicare

Beneficiaries group described in paragraphs (b)(1) and (2) of this section is effective no earlier than the effective date of coverage under a buy-in agreement for individuals described in § 407.47(b) of this chapter.

■ 17. Section 435.911 is amended by revising paragraph (c) introductory text and adding paragraph (e) to read as follows:

§ 435.911 Determination of eligibility.

* * * * *

(c) For each individual who has submitted an application described in § 435.907, whose eligibility is being renewed in accordance with § 435.916, or whose eligibility is being redetermined in accordance with § 435.919 and who meets the non-financial requirements for eligibility (or for whom the agency is providing a reasonable opportunity to verify citizenship or immigration status in accordance with § 435.956(b)), the State Medicaid agency must comply with the following—

* * * * *

(e) The agency must—

(1) Accept, via secure electronic interface, Low Income Subsidy application data (LIS leads data) transmitted to the agency from the Social Security Administration;

(2) Treat received LIS leads data relating to an individual as an application for eligibility under section 1902(a)(10)(E) of the Act and, promptly and without undue delay, consistent with timeliness standards established under § 435.912, determine the eligibility of the individual under such section, without requiring submission of another application;

(3) Request additional information needed by the agency to make a determination of eligibility for the Medicare Savings Programs;

(4) Not request information or documentation from the individual already provided to SSA through the LIS application and included in the transmission to the agency by the Social Security Administration; and

(5) Accept any information verified by SSA, without further verification, if the information provided through the LIS leads data supports a determination of eligibility under section 1902(a)(10)(E) of the Act.

(6) Collect such additional information as may be needed—

(i) Consistent with § 435.907(b), to determine whether such individual is eligible for Medicaid on the basis of the applicable modified adjusted gross income standard, and furnish Medicaid on such basis;

(ii) Consistent with § 435.907(c), to determine whether such individual is eligible for Medicaid benefits on any basis other than the applicable modified adjusted gross income standard or under section 1902(a)(10)(E) of the Act, and furnish Medicaid on such basis; and

(iii) Consistent with § 435.956, to verify an individual's U.S. citizenship or satisfactory immigration status, including providing the required reasonable opportunity period under 435.956(b).

(7) If any of the LIS leads data does not support a determination of eligibility under section 1902(a)(10)(E) of the Act, the agency must—

(i) Determine whether additional information is needed to make a determination of eligibility under section 1902(a)(10)(E) of the Act;

(ii) If such information is needed, notify the individual that they may be eligible for assistance with their Medicare premium and/or cost sharing charges, but that additional information is needed for the agency to make a determination of such eligibility;

(iii) Provide the individual with a minimum of 30 days to furnish information any information needed by the agency to make such determination of eligibility; and

(iv) Verify the individual's eligibility under section 1902(a)(10)(E) of the Act in accordance with the agency's verification plan developed in accordance with § 435.945(j).

■ 18. Section 435.912 is revised to read as follows:

§ 435.912 Timely determination and redetermination of eligibility.

(a) *Definitions.* For purposes of this section—

Performance standards are overall standards for determining, renewing and redetermining eligibility in an efficient and timely manner across a pool of applicants or beneficiaries, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination, renewal, or redetermination of eligibility.

Timeliness standards refer to the maximum periods of time, subject to the exceptions in paragraph (e) of this section and in accordance with § 435.911(c), in which every applicant is entitled to a determination of eligibility, a redetermination of eligibility at renewal, and a redetermination of eligibility based on a change in circumstances.

(b) *State plan requirements.* Consistent with guidance issued by the Secretary, the agency must establish in its State plan timeliness and performance standards for, promptly and without undue delay—

(1) Determining eligibility for Medicaid for individuals who submit applications to the single State agency or its designee in accordance with § 435.907, including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to § 435.1200(e);

(2) Determining eligibility for Medicaid for individuals whose accounts are transferred from other insurance affordability programs, including at initial application, as well as at a regularly-scheduled renewal or due to a change in circumstances;

(3) Redetermining eligibility for current beneficiaries at regularly-scheduled renewals in accordance with § 435.916, including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to 435.1200(e);

(4) Redetermining eligibility for current beneficiaries based on a change in circumstances reported by the beneficiary in accordance with § 435.919(b)(1) or received from a third party in accordance with § 435.919(b)(2), including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to 435.1200(e); and

(5) Redetermining eligibility for current beneficiaries based on anticipated changes in circumstances in accordance with § 435.919(b)(3), including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to 435.1200(e).

(c) *Timeliness and performance standard requirements*—(1) *Period covered.* The timeliness and performance standards adopted by the agency under paragraph (b) of this section must—

(i) For determinations of eligibility at initial application or upon receipt of an account transfer from another insurance affordability program, as described in paragraphs (b)(1) and (2) of this section, cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e);

(ii) For regularly-scheduled renewals of eligibility under § 435.916, cover the period from the date that the agency initiates the steps required to renew eligibility on the basis of information available to the agency, as required under § 435.916(b)(1), to the date the agency sends the individual notice required under § 435.916(b)(1)(i) or (b)(2)(i)(C) of its decision to approve their renewal of eligibility or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e);

(iii) For redeterminations of eligibility due to changes in circumstances under § 435.919(b), cover the period from the date the agency receives information reported by the beneficiary, as described at § 435.919(b)(1)(i), or received from the third party, as described at § 435.919(b)(2)(i), to the date the agency notifies the individual of its decision or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e); and

(iv) For redeterminations of eligibility based on anticipated changes in circumstances under § 435.919(b)(3), cover the period from the date the agency begins the redetermination of eligibility, to the date the agency notifies the individual of its decision or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e).

(2) *Criteria for establishing standards.* To promote accountability and a consistent, high quality consumer experience among States and between insurance affordability programs, the timeliness and performance standards included in the State plan must address—

(i) The capabilities and cost of generally available systems and technologies;

(ii) The general availability of electronic data matching, ease of connections to electronic sources of authoritative information to determine and verify eligibility, and the time needed by the agency to evaluate information obtained from electronic data sources;

(iii) The demonstrated performance and timeliness experience of State Medicaid, CHIP and other insurance affordability programs, as reflected in data reported to the Secretary or otherwise available;

(iv) The needs of applicants and beneficiaries, including preferences for mode of application and submission of information at renewal or redetermination (such as through an internet website, telephone, mail, in-person, or other commonly available electronic means), the time needed to return a renewal form or any additional information needed to complete a determination of eligibility at application or renewal, as well as the relative complexity of adjudicating the eligibility determination based on household, income or other relevant information; and

(v) The advance notice that must be provided to beneficiaries in accordance with §§ 431.211, 431.213, and 431.214 of this subchapter when the agency makes a determination resulting in termination or other action as defined in § 431.201 of this subchapter.

(3) *Standard for new applications and transferred accounts.* Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant or individual whose account was transferred from another insurance affordability program may not exceed—

(i) Ninety (90) days for applicants who apply for Medicaid on the basis of disability; and

(ii) Forty-five (45) days for all other applicants.

(4) *Standard for renewals.* Except as provided in paragraph (e) of this section, the redetermination of eligibility for a beneficiary at a regularly-scheduled renewal may not exceed—

(i) The end of the beneficiary's eligibility period, in the case of a beneficiary whose eligibility can be renewed based on information available to the agency as described at § 435.916(b)(1) or in the case of a beneficiary whose renewal requires additional information and who returns a renewal form 25 or more calendar days prior to the end of the eligibility period described in § 435.916(a);

(ii) The end of the month following the end of the beneficiary's eligibility period, in the case of a beneficiary whose eligibility is being redetermined on the basis for which the beneficiary has been receiving Medicaid (the applicable modified adjusted gross income standard described in § 435.911(b)(1) and (2) or another basis) and who returns a renewal form less than 25 calendar days prior to the end of the beneficiary's eligibility period; and

(iii) The following time periods, in the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid and for whom the agency is considering eligibility on another basis—

(A) Ninety (90) calendar days from the date the agency determines the beneficiary is not eligible on the current basis, if eligibility is being determined on the basis of disability;

(B) Twenty-five (25) calendar days from the date the agency determines the beneficiary is not eligible on the current basis, for all bases of determination other than the basis of disability.

(5) *Standard for redeterminations based on changes in circumstances.* Except as provided in paragraph (e) of this section, the redetermination of eligibility for a beneficiary based on a change in circumstances reported by the beneficiary or received from a third party may not exceed the end of the month that occurs—

(i) Thirty (30) calendar days following the agency's receipt of information related to the change in circumstances, unless the agency needs to request additional information from the beneficiary; and

(ii) Sixty (60) calendar days following the agency's receipt of information related to the change in circumstances if the agency must request additional information from the beneficiary.

(6) *Standard for redeterminations based on anticipated changes.* Except as provided in paragraph (e) of this section, the redetermination of eligibility for a beneficiary based on an anticipated change in circumstances, may not exceed—

(i) The date of the anticipated change, or at State option the last day of the month in which the anticipated change occurs, in the case of a beneficiary who returns requested information or documentation 25 or more calendar days prior to the date of the change (or the last day of the month if elected by the State);

(ii) The end of the month following the month in which the anticipated change occurs, in the case of a beneficiary whose eligibility is being redetermined on the basis for which the beneficiary has been receiving Medicaid (the applicable modified adjusted gross income standard described in § 435.911(b)(1) and (2) or another basis, as described in § 435.911(c)(2)) and who returns requested information or documentation less than 25 calendar days prior to the date of the change (or the last day of the month if elected by the State); and

(iii) The following time periods, in the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid and for whom the agency is considering eligibility on another basis—

(A) Ninety (90) calendar days from the date the agency determines the beneficiary is not eligible on the current basis, if eligibility is being determined on the basis of disability;

(B) Twenty-five (25) calendar days from the date the agency determines the beneficiary is not eligible on the current basis, for all other beneficiaries.

(d) *Availability of information.* The agency must inform individuals of the timeliness standards adopted in accordance with this section.

(e) *Exceptions.* The agency must determine or redetermine eligibility within the standards except in unusual circumstances, for example—

(1) When the agency cannot reach a decision because the applicant or beneficiary, or an examining physician, delays or fails to take a required action, or

(2) When there is an administrative or other emergency beyond the agency's control.

(f) *Case documentation.* The agency must document the reason(s) for delay in the applicant's or beneficiary's case record.

(g) *Prohibitions.* The agency must not use the timeliness standards—

(1) As a waiting period before determining eligibility;

(2) As a reason for denying or terminating eligibility (because it has not determined or redetermined eligibility within the timeliness standards); or

(3) As a reason for delaying termination of a beneficiary's coverage or taking other adverse action.

§ 435.914 [Amended]

■ 19. Section 435.914 is amended—

■ a. In paragraph (a), by removing the phrase ''case record facts to support the agency's decision on his application'' and adding in its place the phrase ''and beneficiary's case record the information and documentation described in § 431.17(b)(1) of this subchapter''; and

■ b. In paragraph (b) introductory text, by removing the phrase ''by a finding of eligibility or ineligibility'' and adding in its place the phrase ''and renewal by a finding of eligibility or ineligibility''.

■ 20. Section 435.916 is revised to read as follows:

§ 435.916 Regularly-scheduled renewals of Medicaid eligibility.

(a) *Frequency of renewals.* Except as provided in § 435.919:

(1) The eligibility of all Medicaid beneficiaries not described in paragraph (a)(2) of this section must be renewed once every 12 months, and no more frequently than once every 12 months.

(2) The eligibility of qualified Medicare beneficiaries described in section 1905(p)(1) of the Act must be renewed at least once every 12 months, and no more frequently than once every 6 months.

(b) *Renewals of eligibility.* (1) Renewal on basis of information available to agency. The agency must make a redetermination of eligibility for all Medicaid beneficiaries without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information through any data bases accessed by the agency under §§ 435.948, 435.949, and 435.956. If the agency is able to renew eligibility based on such information, the agency must, consistent with the requirements of this subpart and subpart E of part 431 of this subchapter, notify the individual—

(i) Of the eligibility determination, and basis; and

(ii) That the individual must inform the agency, through any of the modes permitted for submission of applications under § 435.907(a), if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(2) Renewals requiring information from the individual. If the agency cannot renew eligibility for beneficiaries in accordance with paragraph (b)(1) of this section, the agency —

(i) Must provide the individual with—

(A) A pre-populated renewal form containing information, as specified by the Secretary, available to the agency that is needed to renew eligibility.

(B) At least 30 calendar days from the date the agency sends the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 435.907(a), and to sign the renewal form under penalty of perjury in a manner consistent with § 435.907(f);

(C) Notice of the agency's decision concerning the renewal of eligibility in accordance with this subpart and subpart E of part 431 of this chapter;

(ii) Must verify any information provided by the beneficiary in accordance with §§ 435.945 through 435.956;

(iii) If the individual subsequently submits the renewal form or other needed information within 90 calendar days after the date of termination, or a longer period elected by the State, must treat the renewal form as an application and reconsider the eligibility of an individual whose coverage is terminated for failure to submit the renewal form or necessary information in accordance with the application time standards at § 435.912(c)(3) without requiring a new application;

(iv) Not require an individual to complete an in-person interview as part of the renewal process.

(v) May request from beneficiaries only the information needed to renew eligibility. Requests for non-applicant information must be conducted in accordance with § 435.907(e).

(3) Special rules related to beneficiaries whose Medicaid eligibility is determined on a basis other than modified adjusted gross income.

(i) The agency may consider blindness as continuing until the reviewing physician under § 435.531 determines that a beneficiary's vision has improved beyond the definition of blindness contained in the plan; and

(ii) The agency may consider disability as continuing until the review team, under § 435.541, determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

(c) *Timeliness of renewals.* The agency must complete the renewal of eligibility in accordance with this section by the end of the beneficiary's eligibility period described in paragraph (a) of this section and in accordance with the time standards in § 435.912(c)(4).

(d) *Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for Medicaid.* (1) Prior to making a determination of ineligibility, the agency must consider all bases of eligibility, consistent with § 435.911.

(2) Prior to terminating coverage for individuals determined ineligible for Medicaid, the agency must determine eligibility or potential eligibility for other insurance affordability programs and comply with the procedures set forth in § 435.1200(e).

(e) *Accessibility of renewal forms and notices.* Any renewal form or notice must be accessible to persons who are limited English proficient and persons with disabilities, consistent with § 435.905(b).

■ 21. Section 435.919 is added to read as follows:

§ 435.919 Changes in circumstances.

(a) *Procedures for reporting changes.* The agency must:

(1) Have procedures designed to ensure that beneficiaries understand the importance of making timely and accurate reports of changes in

circumstances that may affect their eligibility; and

(2) Accept reports made under paragraph (a)(1) of this section and any other beneficiary reported information through any of the modes permitted for submission of applications under § 435.907(a);

(b) *Agency action on information about changes.* Consistent with the requirements of § 435.952, the agency must promptly redetermine eligibility between regularly-scheduled renewals of eligibility required under § 435.916(a) whenever it receives information about a change in a beneficiary's circumstances.

(1) *Changes reported by the beneficiary.* When a beneficiary reports information about a change in circumstances, the agency must:

(i) Evaluate whether the reported change may impact the beneficiary's eligibility for Medicaid or the amount of medical assistance for which the beneficiary is eligible, premiums or cost sharing charges. If additional information is needed to determine whether the beneficiary is no longer eligible due to the reported change, the agency must redetermine eligibility based on available information, if able to do so, and if the additional information is not available to the agency, request such information from the beneficiary;

(ii) If the agency determines that the reported change results in an adverse action, as defined in § 431.201 of this subchapter, take appropriate action in accordance with paragraph (b)(4) of this section.

(iii) If the agency finds that the reported change may result in eligibility for additional medical assistance or lower premium or cost sharing charges, the agency must verify the reported change in accordance with §§ 435.940 through 435.960 and the agency's verification plan developed under § 435.945(j) prior to furnishing additional assistance or lowering applicable premiums or cost sharing charges. The agency may not terminate the beneficiary's coverage if the beneficiary does not respond to agency requests for additional information under this paragraph;

(iv) If the agency's evaluation pursuant to paragraph (b)(1)(i) of this section indicates that the reported change has no impact on eligibility, the agency must provide the beneficiary with notice acknowledging receipt of the information from the beneficiary and explaining that the beneficiary's eligibility is not impacted.

(2) *Information received from a third party.* If the agency receives information regarding a beneficiary's change in circumstances from a third party, the agency must:

(i) Evaluate the reliability of the information received and determine whether, if accurate, the information received would impact the beneficiary's eligibility, the amount of medical assistance for which the beneficiary is eligible, premiums or cost sharing charges;

(ii) If the agency finds that the third-party information is reliable and may adversely impact the beneficiary, the agency must request information from the beneficiary to verify or dispute the information received, consistent with § 435.952. If the agency determines that the reported change results in an adverse action, take appropriate action in accordance with paragraph (b)(4) of this section.

(iii) If the agency determines that the third-party information is reliable and results in eligibility for additional medical assistance or lower premium or cost sharing charges, the agency must notify the beneficiary of such determination. Prior to providing such notice or additional medical assistance or lowering premium or cost sharing charges, the agency may verify third-party information with the beneficiary; the agency may not terminate the beneficiary's coverage if the beneficiary does not respond to the agency's request for additional assistance under this paragraph (b). The agency may accept the third-party information if the beneficiary does not respond to agency requests for additional information under this paragraph (b);

(iv) Except as provided in paragraphs (f) and (g) of this section, if the agency determines that the third-party information is not reliable or does not impact the beneficiary's eligibility, no action is required.

(3) *Anticipated changes.* If the agency has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, it must initiate a redetermination of eligibility at an appropriate time based on such changes consistent with the timeliness standards at § 435.912(c)(6).

(4) *Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for Medicaid.* (i) The agency must comply with the requirements at § 435.916(d)(1) (relating to consideration of eligibility on other bases) and § 435.916(d)(2) (relating to determining potential eligibility for other insurance affordability programs) prior to terminating a beneficiary in accordance with this section.

(ii) The agency must provide advance notice of adverse action and fair hearing rights, in accordance with the requirements of part 431, subpart E of this chapter, prior to taking any adverse action resulting from a change in a beneficiary's circumstances.

(c) *Response times and time standards*—(1) *Beneficiary response times.* The agency must—

(i) Provide beneficiaries with at least 30 days from the date the agency sends the notice requesting the beneficiary to provide the agency with any additional information needed for the agency to redetermine eligibility.

(ii) Allow beneficiaries to provide any requested information through any of the modes of submission specified in § 435.907(a).

(2) *Time standards for redetermining eligibility.* The agency must redetermine eligibility within the time standards described in § 435.912(c)(5) and (6), except in unusual circumstances, such as those described in § 435.912(e); States must document the reason for delay in the individual's case record.

(d) *Ninety (90)-day reconsideration period.* If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 days after the date of termination, or a longer period elected by the State, the agency must—

(1) Reconsider the individual's eligibility without requiring a new application in accordance with the application timeliness standards established under § 435.912(c)(3).

(2) Request additional information needed to determine eligibility consistent with § 435.907(e) and obtain a signature under penalty of perjury consistent with § 435.907(f) if such information or signature is not available to the agency or included in the information described in this paragraph (d).

(e) *Scope of redeterminations following a change in circumstance.* For redeterminations of eligibility for Medicaid beneficiaries completed in accordance with this section—

(1) The agency must limit any requests for additional information under this section to information relating to a change in circumstance that may impact the beneficiary's eligibility.

(2) If the agency has enough information available to it to renew eligibility with respect to all eligibility criteria, the agency may begin a new eligibility period, as defined in § 435.916(a).

(f) *Agency action on returned mail:* Whenever beneficiary mail is returned

to the agency by the United States Postal Service (USPS), the agency—

(1) Must check the following sources for updated mailing address and other contact information—

(i) The agency's Medicaid Enterprise System;

(ii) The agency's contracted managed care plans, if applicable; and

(iii) One or more of the following: the State agency that administers Supplemental Nutrition Assistance Program; the State agency that administers Temporary Assistance for Needy Families; the State Department of Motor Vehicles; the USPS National Change of Address (NCOA) database; or other sources specified in the State's verification plan described in § 435.945(j).

(2) Must send the beneficiary a notice by mail to the address currently on file in the beneficiary's case record, the forwarding address (if provided on the returned mail), and any address identified by the agency per paragraph (f)(1) of this section.

(i) Consistent with paragraph (c)(1) of this section, the agency must provide beneficiaries with at least 30 days from the date the agency sends the notice to verify the accuracy of the new contact information.

(ii) [Reserved]

(3) Must send the beneficiary at least two notices, by one or more modalities other than mail, such as by phone, electronic notice, email or text messaging.

(i) For a beneficiary who elected to receive electronic notices and communications in accordance with § 435.918, at least one communication attempt must use the beneficiary contact information on file via the preferred electronic format and such notice must provide at least 30 days from the date the agency sends the notice to verify the accuracy of the new contact information. If there is a failed electronic communication attempt then the agency cannot use that same electronic modality as the alternative modality to satisfy this proposed requirement and may use telephonic or electronic contact information obtained in (f)(1) of this section, as feasible.

(ii) The notices required under this paragraph must be sent to the contact information in the beneficiary's case record, if available, and may be sent to other contact information obtained by the agency per paragraph (f)(1) of this section.

(iii) The agency may elect to utilize any combination or order of other modalities.

(iv) The first and last such notice must be separated by no less than 3 business days.

(v) If the agency does not have contact information for any alternative modality, the agency must make a note of that fact in the beneficiary's case record.

(4) In the case of beneficiary mail returned with an in-state forwarding address, whose current address the agency is unable to confirm pursuant to paragraphs (f)(1) through (3) of this section—

(i) May not terminate a beneficiary's coverage for failure to respond to a request to confirm their address or State residency.

(ii) Must accept and update the beneficiary's case record with—

(A) The in-state forwarding address provided on the returned beneficiary mail;

(B) An in-state address obtained from the managed care organization pursuant to paragraph (f)(1)(i) or (ii) of this section, provided that such address was received by the plan directly from, or was verified with, the beneficiary; or

(C) The in-state address obtained from the USPS NCOA database pursuant to paragraph (f)(1)(iii) of this section.

(5) In the case of a beneficiary mail returned with an out-of-state address, whose current address the agency is unable to confirm pursuant to paragraphs (f)(1) through (3) of this section, the agency must provide advance notice of termination and fair hearing rights consistent with 42 CFR part 431, subpart E.

(6) If a beneficiary's whereabouts are unknown, as indicated by the return of beneficiary mail with no forwarding address and the beneficiary's failure to respond to the notices described in paragraphs (f)(2) and (3) of this section, and the agency has not updated the beneficiary's address based on a reliable third-party source pursuant to paragraph (f)(1) of this section, the agency must take appropriate steps to terminate or suspend the beneficiary's coverage or move the beneficiary to a fee-for-service delivery system.

(i) If the agency elects to terminate or suspend coverage in accordance with this paragraph, the agency must send notice to the beneficiary's last known address or via electronic notification, in accordance with the beneficiary's election under § 435.918 of this subpart, no later than the date of termination or suspension and provide notice of fair hearing rights in accordance with 42 CFR part 431 subpart E.

(ii) If whereabouts of a beneficiary whose coverage was terminated or suspended in accordance with this paragraph become known within the beneficiary's eligibility period, as defined in § 435.916(b), the agency—

(A) Must reinstate coverage back to the date of termination without requiring the individual to provide additional information to verify their eligibility, unless the agency has other information available to it that indicates the beneficiary may not meet all eligibility requirements.

(B) May begin a new eligibility period, consistent paragraph (e)(2) of this section, if the agency has sufficient information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the beneficiary.

(g) *Agency action on updated address information from other sources.* (1) Whenever the agency obtains updated in-state mailing address information from the United States Postal Service National Change of Address (NCOA) or agency's contracted managed care plans, the agency—

(i) In the case of updated mailing address information from a contracted managed care plan, must ensure that an address was received by the plan directly from, or was verified with, the beneficiary;

(ii) Must send the beneficiary a notice by mail to both the address currently on file in the beneficiary's case record and the new in-state address and provide the individual with a reasonable period of time to verify the accuracy of the new contact information;

(iii) Must send the beneficiary at least two notices, by one or more modalities other than mail, such as by phone, electronic notice, email or text messaging consistent with paragraph (f)(3) of this section;

(iv) May not terminate a beneficiary's coverage for failure to respond to a request to confirm an in-state change of address;

(v) May accept the in-state address as the beneficiary's new address and update the beneficiary's case record accordingly, if the beneficiary does not respond to a request to confirm their address or State residency, provided the beneficiary is given at least 30 days from the date the agency sent the notice; and

(vi) Must accept the in-state address as the beneficiary's new address and update the beneficiary's case record accordingly, if the beneficiary confirms their address or State residency.

(2) Upon approval from the Secretary, the agency may treat updated in-state address information from other trusted data sources in accordance with paragraph (g)(1) of this section.

(3) Whenever the agency obtains updated mailing address information

from any source not listed in paragraph (g)(1) or (2) of this section, including out-of-state mailing address information, the agency must follow the steps outlined in paragraphs (f)(2) through (6) of this section.

■ 22. Section 435.940 is revised as follows:

§ 435.940 Basis and scope.

The income and eligibility verification requirements set forth in this section and §§ 435.945 through 435.960 are based on sections 1137, 1902(a)(4), 1902(a)(19), 1902(a)(46)(B), 1902(ee), 1903(r)(3), 1903(x), 1940, and 1943(b)(3) of the Act, and section 1413 of the Affordable Care Act. Nothing in the regulations in this subpart should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits, consistent with parts 431 and 455 of this subchapter, or its obligation to provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the plan, consistent with § 431.15 of this subchapter and section 1902(a)(19) of the Act.

■ 23. Section 435.952 is amended by revising paragraphs (b) and (c) and adding paragraph (e) to read as follows:

§ 435.952 Use of information and requests for additional information from individuals.

* * * * *

(b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency, including information obtained in accordance with § 435.948, § 435.949, or § 435.956, the agency must determine or renew eligibility based on such information.

(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948, § 435.949, or § 435.956 cannot be obtained electronically or information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j), with information provided by or on behalf of the individual.

(1) Income and resource information obtained through an electronic data match shall be considered reasonably compatible with income and resource information provided by or on behalf of an individual if both are either above or at or below the applicable standard or other relevant threshold.

(2) [Reserved]

* * * * *

(e) When determining eligibility for individuals applying for the Medicare Savings Programs specified in sections 1902(a)(10)(E)(i), (iii), and (iv) and 1905(p) of the Act, the agency must accept attestation (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) of the following income and asset information without requiring further information (including documentation) from the individual:

(1) *Income and interest income.* (i) Except as provided in paragraph (e)(1)(ii) of this section, the agency must accept an applicant's attestation of the value of any dividend and interest income earned on resources owned by the applicant or the applicant's spouse.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify interest and dividend income after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(2) *Non-liquid resources.* (i) Except as provided in paragraph (e)(2)(ii) of this section, the agency must accept an applicant's attestation of the value of any non-liquid resources owned.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify the value of non-liquid resources after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(3) *Burial funds.* (i) Except as provided in paragraph (e)(3)(ii) of this section, the agency must accept an applicant's attestation that up to $1,500 of their resources, and up to $1,500 of their spouse's resources, are set aside in a separate account and are not countable as resources when determining eligibility for the Medicare Savings Programs.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify resources in burial funds after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(4) *Life insurance policies.* (i) Except as provided in paragraph (e)(4)(ii) of this section, the agency must accept an applicant's attestation of the face value of life insurance.

(A) If an individual attests to a face value of life insurance policy that is above $1,500, the State may accept an attestation of the cash surrender value of the life insurance policy for the purpose of determining resource eligibility for the Medicare Savings Programs.

(ii) If the agency has information about either the face value or the cash surrender value that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section, which may include a reasonable explanation of the discrepancy or documentation.

(iii) The agency may verify the face value of a life insurance policy after the agency has determined that an applicant is eligible for a Medicare Savings Program, in accordance with paragraph (c) of this section.

(iv)(A) When an individual must provide documentation of the cash surrender value of a life insurance policy, the agency must assist the individual with obtaining this information and documentation by requesting that the individual provide

the name of the insurance company and policy number and authorize the agency to obtain such documentation from the issuer of the policy on the individual's behalf. The agency may also request, but may not require, additional information from the applicant to assist the agency is obtaining the needed documentation, such as the name of an agent.

(B) If the individual does not provide the information and authorization in paragraph (e)(4)(iv)(A), the agency may require that the individual provide documentation of the cash surrender value.

(C) The agency must allow the individual to submit documentation through any of the modalities described in § 435.907(a) and provide the individual with at least 15 days to provide information or documentation described in this paragraph if such information or documentation is requested pursuant to paragraph (e)(4)(i) or (ii) of this section and at least 90 days if required pursuant to paragraph (e)(4)(iii) of this section.

■ 24. Section 435.956 is amended by revising paragraph (b)(4) to read as follows:

§ 435.956 Verification of other non-financial information.

* * * * *

(b) * * *

(4) The agency may not limit the number of reasonable opportunity periods an individual may receive.

* * * * *

■ 25. Section 435.1200 is amended—

■ a. By revising the heading for paragraph (b) introductory text;

■ b. By revising paragraph (b)(1);

■ c. In paragraph (b)(3)(i), by removing the phrase ''one or more insurance affordability program'' and adding in its place the phrase ''one or more insurance affordability programs'';

■ d. By revising paragraph (b)(3)(ii);

■ e. By adding paragraphs (b)(3)(vi) and (b)(4);

■ f. By revising paragraphs (c) and (e)(1);

■ g. By adding paragraph (e)(4);

■ h. By revising paragraphs (h)(1) and (h)(3)(i) introductory text; and

■ i. By redesignating the ''(i)'' paragraph following (h)(3)(i)(B) as paragraph (h)(3)(ii).

The revisions and additions read as follows:

§ 435.1200 Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs.

* * * * *

(b) *General requirements.* * * *

(1) Fulfill the responsibilities set forth in paragraphs (c) through (h) of this section.

* * * * *

(3) * * *

(ii) Ensure compliance with paragraphs (c) through (h) of this section;

* * * * *

(vi) Seamlessly transition the eligibility of beneficiaries between Medicaid and the Children's Health Insurance Program (CHIP) when an agency administering one of these programs determines that a beneficiary is eligible for the other program.

(4) Accept a determination of eligibility for Medicaid made using MAGI-based methodologies by the State agency administering a separate CHIP in the State. In order to comply with this requirement, the agency may:

(i) Apply the same MAGI-based methodologies in accordance with§ 435.603, and verification policies and procedures in accordance with §§ 435.940 through 435.956 as those used by the separate CHIP in accordance with §§ 457.315 and 457.380 of subchapter D, such that the agency will accept any finding relating to a criterion of eligibility made by a separate CHIP without further verification, in accordance with this paragraph (d)(4);

(ii) Utilize a shared eligibility service through which determinations of Medicaid eligibility are governed exclusively by the Medicaid agency and any functions performed by the separate CHIP are solely administrative in nature;

(iii) Enter into an agreement in accordance with § 431.10(d) of this chapter under which the Medicaid agency delegates authority to the separate CHIP in accordance with § 431.10(c) of this chapter to make final determinations of Medicaid eligibility; or

(iv) Adopt other procedures approved by the Secretary.

(c) *Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program.* (1) For each individual determined Medicaid eligible in accordance with paragraph (c)(2) of this section, the agency must—

(i) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;

(ii) Comply with the provisions of § 435.911 to the same extent as if an application had been submitted to the Medicaid agency; and

(iii) Comply with the provisions of § 431.10 of this chapter to ensure it maintains oversight for the Medicaid program.

(2) For purposes of paragraph (c)(1) of this section, individuals determined eligible for Medicaid in this paragraph include:

(i) Individuals determined eligible for Medicaid by another insurance affordability program, including the Exchange, pursuant to an agreement between the agency and the other insurance affordability program in accordance with § 431.10(d) of this chapter (including as a result of a decision made by the program or the program's appeals entity in accordance with paragraph (g)(6) or (g)(7)(i)(A) of this section); and

(ii) Individuals determined eligible for Medicaid by a separate CHIP (including as the result of a decision made by a CHIP review entity) in accordance with paragraph (b)(4) of this section.

* * * * *

(e) * * *

(1) *Individuals determined not eligible for Medicaid.* For each individual who submits an application to the agency which includes sufficient information to determine Medicaid eligibility or whose eligibility is being renewed in accordance with § 435.916 (regarding regularly-scheduled renewals of eligibility) or § 435.919 (regarding changes in circumstances) and whom the agency determines is ineligible for Medicaid, and for each individual determined ineligible for Medicaid in accordance with a fair hearing under subpart E of part 431 of this chapter, the agency must promptly and without undue delay, consistent with timeliness standards established under § 435.912:

(i) Determine eligibility for a separate CHIP if operated in the State, and if eligible, transfer the individual's electronic account, via secure electronic interface, to the separate CHIP agency and ensure that the individual receives a combined eligibility notice as defined at § 435.4; and

(ii) If not eligible for CHIP, determine potential eligibility for BHP (if offered by the State) and coverage available through the Exchange, and if potentially eligible, transfer the individual's electronic account, via secure electronic interface, to the program for which the individual is potentially eligible.

* * * * *

(4) *Ineligible individuals.* For purposes of paragraph (e)(1) of this section, an individual is considered ineligible for Medicaid if they are not eligible for any eligibility group covered by the agency that provides minimum essential coverage as defined at § 435.4. An individual who is eligible only for

a limited benefit group, such as the eligibility group for individuals with tuberculosis described at § 435.215, would be considered ineligible for Medicaid for purposes of paragraph (e)(1).

* * * * *

(h) * * *

(1) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that a combined eligibility notice, as defined in § 435.4, will be provided:

(i) To an individual, by either the agency or a separate CHIP, when a determination of Medicaid eligibility is completed for such individual by the State agency administering a separate CHIP in accordance with paragraph (b)(4) of this section, or a determination of CHIP eligibility is completed by the Medicaid agency in accordance with paragraph (e)(1)(i) of this section; and

(ii) To the maximum extent feasible to an individual who is not described in paragraph (i) of this section but who is transferred between the agency and another insurance affordability program by the agency, Exchange, or other insurance affordability program, as well as to multiple members of the same household included on the same application or renewal form.

* * * * *

(3) * * *

(i) Provide the individual with notice, consistent with § 435.917, of the final determination of eligibility on all bases, including coordinated content regarding, as applicable.

* * * * *

PART 457—ALLOTMENTS AND GRANTS TO STATES

■ 26. The authority citation for part 457 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 27. Section 457.65 is amended by revising paragraph (d) to read as follows:

§ 457.65 Effective date and duration of State plans and plan amendments.

* * * * *

(d) *Amendments relating to enrollment procedures.* A State plan amendment that institutes or extends the use of waiting lists, enrollments caps or closed enrollment periods is considered an amendment that restricts eligibility and must meet the requirements in paragraph (b) of this section.

* * * * *

■ 28. Section 457.340 is amended by—

■ a. Revising the paragraph (d) heading;

■ b. Revising paragraph (d)(1);

■ c. Removing paragraph (d)(3); and

■ d. Revising paragraph (f)(1),

The revisions read as follows:

§ 457.340 Application for and enrollment in CHIP.

* * * * *

(d) *Timely determination and redetermination of eligibility.* (1) The terms in § 435.912 of this chapter apply equally to CHIP, except that—

(i) The terms of § 435.912(c)(4)(iii) and (c)(6)(iii) of this chapter (relating to timelines for completing renewals and redeterminations when States must consider other bases of eligibility) do not apply; and

(ii) The standards for transferring electronic accounts to other insurance affordability programs are pursuant to § 457.350 and the standards for receiving applications from other insurance affordability programs are pursuant to § 457.348.

* * * * *

(f) * * *

(1) Include in the agreement into which the State has entered under § 457.348(a) that, a combined eligibility notice, as defined in § 457.10, will be provided:

(i) To an individual, by the State agency administering a separate CHIP or the Medicaid agency, when a determination of CHIP eligibility is completed for such individual by the State agency administering Medicaid in accordance with § 457.348(e), or a determination of Medicaid eligibility is completed by the State in accordance with § 457.350(b)(1);

(ii) To the maximum extent feasible, to an individual who is not described in paragraph (f)(1)(i) of this section but who is transferred between the State and another insurance affordability program in accordance with § 457.348 or § 457.350; and

(iii) To the maximum extent feasible, to multiple members of the same household included on the same application or renewal form.

* * * * *

■ 29. Section 457.344 is added to read as follows:

§ 457.344 Changes in circumstances.

(a) *Procedures for reporting changes.* The State must:

(1) Have procedures designed to ensure that enrollees understand the importance of making timely and accurate reports of changes in circumstances that may affect their eligibility; and

(2) Accept reports made under paragraph (a)(1) of this section and any other enrollee reported information through any of the modes permitted for submission of applications under § 435.907(a), as referenced at § 457.330.

(b) *State action on information about changes.* Consistent with the requirements of § 457.380(f), the State must promptly redetermine eligibility between regularly-scheduled renewals of eligibility required under § 457.343, whenever it receives information about a change in an enrollee's circumstances.

(1) *Changes reported by the enrollee.* When an enrollee reports information about a change in circumstances, the State must:

(i) Evaluate whether the reported change may impact the enrollee's eligibility for CHIP or the amount of child health assistance or pregnancy-related assistance for which the enrollee is eligible, premiums or cost sharing charges. If additional information is needed to determine whether the enrollee is no longer eligible due to the reported change, the State must redetermine eligibility based on available information, if able to do so, and if the additional information is not available to the State, request such information from the enrollee;

(ii) If the State determines that the reported change results in an adverse action, take appropriate action in accordance with paragraph (b)(4) of this section.

(iii) If the State finds that the reported change may result in eligibility for additional child health or pregnancy-related assistance or lower premium or cost sharing charges, the State must verify the information in accordance with § 457.380 and the State's verification plan prior to furnishing additional assistance or lowering applicable premiums or cost sharing charges. The State may not terminate the enrollee's coverage if the enrollee does not respond to agency requests for additional information under this paragraph (b).

(iv) If the State's evaluation pursuant to paragraph (b)(1)(i) of this section indicates that the reported change has no impact on eligibility, the State must provide the enrollee with notice acknowledging receipt of the information from the enrollee and explaining that the enrollee's eligibility is not impacted.

(2) *Information received from a third party.* If the State receives information regarding an enrollee's change in circumstances from a third party, the State must:

(i) Evaluate the reliability of the information received and whether, if accurate, the information received would impact the enrollee's eligibility for CHIP, the amount of child health assistance or pregnancy-related

assistance for which the enrollee is eligible, premiums or cost sharing charges.

(ii) If the State finds that the third-party information is reliable and may adversely impact the enrollee, the State must request information from the enrollee to verify or dispute the information received, consistent with § 457.380(f). If the State determines that the reported change results in an adverse action, take appropriate action in accordance with paragraph (b)(4) of this section.

(iii) If the State determines that the third-party information is reliable and results in eligibility for additional child health assistance or pregnancy-related assistance or lower premium or cost sharing charges, the State must notify the enrollee of such determination. Prior to providing such notice or additional child health assistance or pregnancy-related assistance or lowering premium or cost sharing charges, the State may verify third-party information with the enrollee; the State may not terminate the enrollee's coverage if the enrollee does not respond to the State's request for additional or pregnancy-related assistance under this paragraph.

(iv) Except as provided paragraphs (f) and (g) of this section, if the State determines that the third-party information is not reliable or does not impact the enrollee's eligibility, no action is required.

(3) *Anticipated changes.* If the State has information about anticipated changes in an enrollee's circumstances that may affect his or her eligibility, it must initiate a determination of eligibility at the appropriate time based on such changes consistent with the requirements at § 435.912(c)(6) of this chapter as referenced in § 457.340(d)(1).

(4) *Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for CHIP.* (i) The State must comply with the requirements at § 435.916(d)(2) of this chapter as referenced in § 457.343 (relating to determining potential eligibility for other insurance affordability programs), prior to terminating an enrollee's eligibility in accordance with this section.

(ii) The State must provide notice of adverse action and State review rights, in accordance with the requirements of § 457.340(e), § 457.1260 (if enrolled in managed care), and subpart K of this part, prior to taking any adverse action resulting from a change in an enrollee's circumstances.

(c) *Enrollee response times*—(1) *State requirements.* The State must—

(i) Provide enrollees with at least 30 days from the date the State sends the notice requesting the enrollee to provide the State with any additional information needed for the State to redetermine eligibility.

(ii) Allow enrollees to provide any requested information through any of the modes of submission specified in § 435.907(a) of this chapter as referenced in § 457.330 of this subpart.

(2) *Time standards for redetermining eligibility.* The State must redetermine eligibility within the time standards described in § 435.912(c)(5) and (6) of this chapter, except in unusual circumstances, such as those as described in § 435.912(e) of this chapter, as referenced in § 457.340(d); States must document the reason for delay in the individual's case record.

(d) *Ninety (90)-day reconsideration period.* If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 days after the date of termination, or a longer period elected by the State, the State must—

(1) Reconsider the individual's eligibility without requiring a new application in accordance with the timeliness standards described at § 435.912(c)(3) of this chapter as referenced in § 457.340(d).

(2) Request additional information needed to determine eligibility and obtain a signature under penalty of perjury consistent with § 435.907(e) and (f) of this chapter respectively as referenced in § 457.330 if such information or signature is not available to the State or included in the information described in this paragraph (d).

(e) *Scope of redeterminations following a change in circumstances.* For redeterminations of eligibility for CHIP enrollees completed in accordance with this section—

(1) The State must limit any requests for additional information under this section to information relating to change in circumstances which may impact the enrollee's eligibility.

(2) If the State has enough information available to it to renew eligibility with respect to all eligibility criteria, the State may begin a new eligibility period under § 457.343.

(f) *State action on returned mail.* Whenever beneficiary mail is returned to the State by the United States Postal Service (USPS), the State—

(1) Must check the following sources for updated mailing address and other contact information—

(i) The State's Medicaid Enterprise System;

(ii) The State's contracted managed care plans, if applicable; and

(iii) One or more of the following: the State agency that administers Supplemental Nutrition Assistance Program; the State agency that administers Temporary Assistance for Needy Families; the State Department of Motor Vehicles; the USPS National Change of Address (NCOA) database; or other sources specified in the State's verification plan described in § 457.380(j).

(2) Must send the enrollee a notice by mail to the address currently on file in the enrollee's case record, the forwarding address (if provided on the returned mail), and any address identified by the State per paragraph (f)(1) of this section;

(i) Consistent with paragraph (c)(1) of this section, the State must provide beneficiaries with at least 30 days from the date the State sends the notice to verify the accuracy of the new contact information.

(ii) [Reserved]

(3) Must send the enrollee at least two notices, by one or more modalities other than mail, such as by phone, electronic notice, email or text messaging.

(i) For an enrollee who elected to receive electronic notices and communications in § 457.110, at least one communication attempt must use the enrollee contact information on file via the preferred electronic format and such notice must provide at least 30 days from the date the agency sends the notice to verify the accuracy of the new contact information. If there is a failed electronic communication attempt then the State cannot use that same electronic modality as the alternative modality to satisfy this proposed requirement and may use telephonic or electronic contact information obtained in paragraph (f)(1) of this section, as feasible.

(ii) The notices required under this paragraph must be sent to the contact information in the enrollee's case record, if available, and may be sent to other contact information obtained by the State per paragraph (f)(1) of this section.

(iii) The State may elect to utilize any combination or order of other modalities.

(iv) The first and last such notice must be separated by no less than 3 business days.

(v) If the State does not have contact information for any alternative modality, the State must make a note of that fact in the enrollee's case record.

(4) In the case of enrollee mail returned with an in-state forwarding address, whose current address the State is unable to confirm pursuant to

paragraphs (f)(1) through (3) of this section, a State—

(i) May not terminate an enrollee's coverage for failure to respond to a request to confirm their address or State residency.

(ii) Must accept and update the enrollee's case record with—

(A) The in-state forwarding address provided on the returned enrollee mail;

(B) An in-state address obtained from the managed care organization pursuant to paragraph (f)(1)(i) or (ii) of this section, provided that such address was received by the plan directly from, or was verified with, the enrollee; or

(C) The in-state address obtained from the USPS NCOA database pursuant to paragraph (f)(1)(iii) of this section.

(5) In the case of an enrollee whose mail is returned with an out-of-state address (or an address outside of the geographic area for separate CHIPs that are not Statewide) and whose current address the State is unable to confirm pursuant to paragraphs (f)(1) through (3) of this section, the State must provide sufficient notice of termination including information describing an individual's right to a CHIP review process, consistent with § 457.340(e)(1).

(6) If an enrollee's whereabouts are unknown, as indicated by the return of enrollee mail with no forwarding address and the enrollee's failure to respond to the notices described in paragraphs (f)(2) and (3) of this section, and the State has not updated the enrollee's address based on a reliable third-party source pursuant to paragraph (f)(1) of this section, the State must take appropriate steps to terminate coverage, suspend coverage, or move the individual to the fee-for-service delivery system, if available.

(i) If the State elects to terminate or suspend coverage in accordance with this paragraph, the State must send notice to the enrollee's last known address or via electronic notification, in accordance with the enrollee's election under § 457.110, no later than the date of termination or suspension and provide notice of an individual's rights to a CHIP review in accordance with § 457.340(e).

(ii) If whereabouts of a beneficiary whose coverage was terminated or suspended in accordance with this paragraph become known within the beneficiary's eligibility period, as defined in § 435.916(b) of this chapter as referenced in § 457.343, the State—

(A) Must reinstate coverage back to the date of termination without requiring the individual to provide additional information to verify their eligibility, unless the agency has other information available to it that indicates the enrollee may not meet all eligibility requirements.

(B) May begin a new eligibility period, consistent paragraph (e)(2) of this section, if the State has sufficient information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the enrollee.

(g) State action on updated address information from other sources. (1) Whenever the State obtains updated in-state mailing address information from the United States Postal Service National Change of Address (NCOA) or the State's contracted managed care plans, if applicable, the State—

(i) In the case of updated mailing address information from a contracted managed care plan, must ensure that an address was received by the plan directly from, or was verified with, the enrollee;

(ii) Must send the enrollee a notice by mail to both the address currently on file in the enrollee's case record and the new in-state address and provide the individual with a reasonable period of time to verify the accuracy of the new contact information;

(iii) Must send the enrollee at least two notices, by one or more modalities other than mail, such as by phone, electronic notice, email or text messaging consistent with paragraph (f)(3) of this section;

(iv) May not terminate an enrollee's coverage for failure to respond to a request to confirm an in-state change of address;

(v) May accept the in-state address as the enrollee's new address and update the enrollee's case record accordingly, if the enrollee does not respond to a request to confirm their address or State residency, provided the beneficiary is given at least 30 days from the date the agency sent the notice; and

(vi) Must accept the in-state address as the enrollee's new address and update the beneficiary's case record accordingly, if the enrollee confirms their address or State residency.

(vii) For separate CHIPs that are not Statewide, if the address obtained from NCOA or the State's managed care plans are outside of the State's specific geographic area for its separate CHIP, the requirements of paragraphs (f)(1) through (3) of this section to verify out-of-state addresses are applicable.

(2) Upon approval from the Secretary, the State may treat updated in-state address information from other trusted data sources in accordance with paragraph (g)(1) of this section.

(3) Whenever the State obtains updated mailing address information from any source not listed in paragraph (g)(1) or (2) of this section, including out-of-state mailing address information, the State must follow the steps outlined in paragraphs (f)(2) through (6) of this section.

■ 30. Section 457.348 is amended—

■ a. In paragraph (a)(4), by removing the phrase ''Provide for coordination of notices with other insurance'' and adding in its place the phrase ''Provide for a combined eligibility notice and coordination of notices with other insurance'';

■ b. By adding paragraph (a)(6);

■ c. By revising paragraph (b);

■ d. In paragraph (c)(3), by removing the reference to ''§ 457.350(i)'' and adding in its place the reference ''§ 457.350(g)''; and

■ e. By adding paragraph (e).

The additions and revision read as follows:

§ 457.348 Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs.

(a) * * *

(6) Seamlessly transition the enrollment of beneficiaries between CHIP and Medicaid when a beneficiary is determined eligible for one program by the agency administering the other.

(b) *Provision of CHIP for individuals found eligible for CHIP by another insurance affordability program.* (1) For each individual determined CHIP eligible in accordance with paragraph (b)(2) of this section, the State must—

(i) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of CHIP eligibility and notify such program of the receipt of the electronic account;

(ii) Comply with the provisions of § 457.340 to the same extent as if the application had been submitted to the State; and

(iii) Maintain proper oversight of the eligibility determinations made by the other program.

(2) For purposes of paragraph (b)(1) of this section, individuals determined eligible for CHIP in this paragraph include:

(i) Individuals determined eligible for CHIP by another insurance affordability program, including the Exchange, pursuant to an agreement between the State and the other insurance affordability program (including as a result of a decision made by the program or the program's appeal entity in accordance with paragraph (a) of this section)); and

(ii) Individuals determined eligible for CHIP by the State Medicaid agency (including as the result of a decision made by the Medicaid appeals entity) in

accordance with paragraph (e) of this section.

* * * * *

(e) *CHIP determinations made by other insurance affordability programs.* The State must accept a determination of eligibility for CHIP from the Medicaid agency in the State. In order to comply with this requirement, the agency may:

(1) Apply the same MAGI-based methodologies in accordance with§ 457.315, and verification policies and procedures in accordance with § 457.380 as those used by the Medicaid agency in accordance with §§ 435.940 through 435.956 of subchapter C, such that the agency will accept any finding relating to a criterion of eligibility made by a Medicaid agency without further verification;

(2) Enter into an agreement under which the State delegates authority to the Medicaid agency to make final determinations of CHIP eligibility; or

(3) Adopt other procedures approved by the Secretary.

■ 31. Section 457.350 is revised to read as follows:

§ 457.350 Eligibility screening and enrollment in other insurance affordability programs.

(a) *State plan requirement.* The State plan shall include a description of the coordinated eligibility and enrollment procedures used, at an initial and any follow-up eligibility determination, including any periodic redetermination, to ensure that:

(1) Only targeted low-income children are furnished CHIP coverage under the plan; and

(2) Enrollment is facilitated for applicants and enrollees found to be eligible or potentially eligible for other insurance affordability programs in accordance with this section.

(b) *Evaluation of eligibility for other insurance affordability programs.* (1) For individuals described in paragraph (b)(2) of this section, promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), the State must:

(i) Determine eligibility for Medicaid on the basis of having household income at or below the applicable modified adjusted gross income standard, as defined in § 435.911(b) of this chapter (''MAGI-based Medicaid''); and

(ii) If unable to make a determination of eligibility for MAGI-based Medicaid, identify potential eligibility for other insurance affordability programs, including Medicaid on a basis other than MAGI, eligibility for the Basic Health Program (BHP) in accordance with 42 CFR 600.305(a), or insurance affordability programs available through the Exchange as indicated by information provided on the application or renewal form provided by or on behalf of the beneficiary.

(2) Individuals to whom paragraph (b)(1) of this section applies include:

(i) Any applicant who submits an application to the State which includes sufficient information to determine CHIP eligibility;

(ii) Any enrollee whose eligibility is being redetermined at renewal or due to a change in circumstance per § 457.343; and

(iii) Any enrollee whom the State determines is not eligible for CHIP, or who is determined not eligible for CHIP as a result of a review conducted in accordance with subpart K of this part.

(3) In determining eligibility for Medicaid as described in paragraph (b)(1) of this section, the State must utilize the option the Medicaid agency has elected at § 435.1200(b)(4) of this chapter to accept determinations of MAGI-based Medicaid eligibility made by a separate CHIP, and which must be detailed in the agreement described at § 457.348(a).

(c) *Income eligibility test.* To determine eligibility as described in paragraph (b)(1)(i) of this section and to identify the individuals described in paragraph (b)(1)(ii) of this section who are potentially eligible for BHP or insurance affordability programs available through an Exchange, a State must apply the MAGI-based methodologies used to determine household income described in § 457.315 or such methodologies as are applied by such other programs.

(d) *Individuals found eligible for Medicaid based on MAGI.* For individuals identified in paragraph (b)(1) of this section, the State must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), transfer the individual's electronic account to the Medicaid agency via a secure electronic interface; and

(2) Except as provided in § 457.355, find the applicant ineligible for CHIP.

(e) *Individuals potentially eligible for Medicaid on a basis other than MAGI.* For individuals identified as potentially eligible for Medicaid on a non-MAGI basis, as described in paragraph (b)(1)(ii) of this section, the State must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), transfer the electronic account to the Medicaid agency via a secure electronic interface.

(2) Complete the determination of eligibility for CHIP in accordance with § 457.340 or evaluation for potential eligibility for other insurance affordability programs in accordance with paragraph (b) of this section.

(3) Include in the notice of CHIP eligibility or ineligibility provided under § 457.340(e), as appropriate, coordinated content relating to—

(i) The transfer of the individual's electronic account to the Medicaid agency per paragraph (e)(1) of this section;

(ii) The transfer of the individual's account to another insurance affordability program in accordance with paragraph (g) of this section, if applicable; and

(iii) The impact that an approval of Medicaid eligibility will have on the individual's eligibility for CHIP or another insurance affordability program, as appropriate.

(4) Dis-enroll the enrollee from CHIP if the State is notified in accordance with § 435.1200(d)(5) of this chapter that the applicant has been determined eligible for Medicaid.

(f) *Children found ineligible for Medicaid based on MAGI, and potentially ineligible for Medicaid on a basis other than MAGI.* If a State uses a screening procedure other than a full determination of Medicaid eligibility under all possible eligibility groups, and the screening process reveals that the child does not appear to be eligible for Medicaid, the State must provide the child's family with the following in writing:

(1) A statement that based on a limited review, the child does not appear eligible for Medicaid, but Medicaid eligibility can only be determined based on a full review of a Medicaid application under all Medicaid eligibility groups;

(2) Information about Medicaid eligibility rules, covered benefits, and restrictions on cost sharing; and

(3) Information about how and where to apply for Medicaid under all eligibility groups.

(4) The State will determine the written format and timing of the information regarding Medicaid eligibility, benefits, and the application process required under this paragraph (f).

(g) *Individuals found potentially eligible for other insurance affordability programs.* For individuals identified in paragraph (b)(1)(ii) of this section who have been identified as potentially eligible for BHP or insurance affordability programs available through the Exchange, the State must promptly and without undue delay, consistent

with the timeliness standards established under § 457.340(d), transfer the electronic account to the other insurance affordability program via a secure electronic interface.

(h) *Evaluation of eligibility for Exchange coverage.* A State may enter into an arrangement with the Exchange for the entity that determines eligibility for CHIP to make determinations of eligibility for advance payments of the premium tax credit and cost sharing reductions, consistent with 45 CFR 155.110(a)(2).

(i) *Waiting lists, enrollment caps and closed enrollment.* The State must establish procedures to ensure that—

(1) The procedures developed in accordance with this section have been followed for each child applying for a separate child health program before placing the child on a waiting list or otherwise deferring action on the child's application for the separate child health program;

(2) Children placed on a waiting list or for whom action on their application is otherwise deferred are transferred to other insurance affordability programs in accordance with paragraph (h) of this section; and

(3) Families are informed that a child may be eligible for other insurance affordability programs, while the child is on a waiting list for a separate child health program or if circumstances change, for Medicaid.

■ 32. Section 457.480 is amended by—

■ a. Revising the section heading;

■ b. Redesignating paragraphs (a) and (b) as paragraphs (b) and (c), respectively; and

■ c. Adding a new paragraph (a).

The revision and addition read as follows:

§ 457.480 Prohibited coverage limitations, preexisting condition exclusions, and relation to other laws.

(a) *Prohibited coverage limitations.* The State may not impose any annual, lifetime or other aggregate dollar limitations on any medical or dental services which are covered under the State plan.

* * * * *

■ 33. Section 457.570 is amended by—

■ a. Revising paragraph (c)(1);

■ b. Removing paragraph (c)(2);

■ c. Redesignating paragraph (c)(3) as paragraph (c)(2); and

■ d. Revising newly redesignated paragraph (c)(2).

The revisions read as follows:

§ 457.570 Disenrollment protections.

* * * * *

(c) * * *

(1) Impose a specified period of time that a CHIP eligible targeted low-income child or targeted low-income pregnant woman who has an unpaid premium or enrollment fee will not be permitted to reenroll for coverage in CHIP.

(2) Require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment if an individual was terminated for failure to pay premiums.

* * * * *

■ 34. Section 457.805 is amended by revising paragraph (b) to read as follows:

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

* * * * *

(b) *Limitations.* A State may not, under this section, impose a waiting period before enrolling an eligible individual in CHIP that has been disenrolled from group health plan coverage. States should conduct monitoring activities to prevent substitution of coverage.

■ 35. Section 457.810 is amended by revising paragraph (a) to read as follows:

§ 457.810 Premium assistance programs: Required protections against substitution.

* * * * *

(a) *Prohibition of imposing a waiting period.* A State may not, under this section, impose a waiting period before enrolling an eligible individual who has, but is not enrolled in, group health plan coverage into CHIP premium assistance coverage.

* * * * *

§ 457.960 [Removed]

■ 36. Section 457.960 is removed.

■ 37. Section 457.965 is revised to read as follows:

§ 457.965 Documentation.

(a) *Basis and purpose.* This section, based on section 2101 of the Act, prescribes the kinds of records a State must maintain, the minimum retention period for such records, and the conditions under which those records must be provided or made available.

(b) *Content of records.* A State plan must provide that the State will maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the plan. The records must include all of the following—

(1) Individual records on each applicant and enrollee that contain—

(i) All information provided on the initial application submitted through any modality described in § 435.907(a) of this chapter as referenced in § 457.330, by, or on behalf of, the applicant or enrollee, including the signature on and date of application;

(ii) The electronic account and any information or other documentation received from another insurance affordability program in accordance with § 457.348(c) and (d);

(iii) The date of, basis for, and all documents or other evidence to support any determination, denial, or other adverse action taken with respect to the applicant or enrollee, including all information provided by the applicant or enrollee, and all information obtained electronically or otherwise by the State from third-party sources;

(iv) The provision of, and payment for, services, items and other child health assistance or pregnancy-related assistance, including the service or item provided, relevant diagnoses, the date that the item or service was provided, the practitioner or provider rendering, providing or prescribing the service or item, including their National Provider Identifier, and the full amount paid or reimbursed for the service or item, and any third-party liabilities;

(v) Any changes in circumstances reported by the individual and any actions taken by the State in response to such reports;

(vi) All renewal forms returned by, or on behalf of, a beneficiary, to the State in accordance with § 457.343, regardless of the modality through which such forms are submitted, including the signature on the form and date received.

(vii) All notices provided to the applicant or enrollee in accordance with §§ 457.340(e) and 457.1180; and

(viii) All records pertaining to any State reviews requested by, or on behalf of, the applicant or enrollee, including each request submitted and the date of such request, the complete record of the review decision, as described in subpart K of this part, and the final administrative action taken by the agency following the review decision and date of such action; and

(ix) The disposition of income and eligibility verification information received under § 457.380, including evidence that no information was returned from an electronic data source.

(2) Statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

(c) *Retention of records.* The State plan must provide that the records required under paragraph (b) of this section will be retained for the period when the applicant or enrollee's case is active, plus a minimum of 3 years thereafter.

(d) *Accessibility and availability of records.* The agency must—

(1) Maintain the records described in paragraph (b) of this section in paper in an electronic format; and

(2) Make the records available to the Secretary, Federal and State auditors and other parties who request, and are authorized to review, such records within 30 calendar days of the request if not otherwise specified, and to the extent permissible by Federal law.

■ 38. Section 457.1140 is amended by revising paragraph (d)(4) to read as follows:

§ 457.1140 Program specific review process: Core elements of review.

* * * * *

(d) * * *

(4) Receive continued enrollment and benefits in accordance with § 457.1170.

■ 39. Section 457.1170 is revised to read as follows:

§ 457.1170 Program specific review process: Continuation of enrollment.

(a) A State must ensure the opportunity for continuation of enrollment and benefits pending the completion of review of the following:

(1) A suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing and;

(2) A failure to make a timely determination of eligibility at application and renewal.

(b) [Reserved]

■ 40. Section 457.1180 is revised to read as follows:

§ 457.1180 Program specific review process: Notice.

A State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under § 457.1130 that includes the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment and benefits may continue pending review.

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■ 41. The authority citation for part 600 continues to read as follows:

Authority: Section 1331 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, 124 Stat 1029).

■ 42. Section 600.330 is amended by revising paragraph (a) to read as follows:

§ 600.330 Coordination with other insurance affordability programs.

(a) *Coordination.* The State must establish eligibility and enrollment mechanisms and procedures to maximize coordination with the Exchange, Medicaid, and CHIP. The terms of 45 CFR 155.345(a) regarding the agreements between insurance affordability programs apply to a BHP. The State BHP agency must fulfill the requirements of 42 CFR 435.1200(d), (e)(1)(ii), and (e)(3) and, if applicable, paragraph (c) of this section for BHP eligible individuals.

* * * * *

■ 43. Section 600.525 is amended by revising paragraph (b)(2) to read as follows:

§ 600.525 Disenrollment procedures and consequences for nonpayment of premiums.

* * * * *

(b) * * *

(2) A State electing to enroll eligible individuals throughout the year must comply with the reenrollment standards set forth in § 457.570(c) of this chapter.

Dated: August 29, 2022.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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