DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 435, 436, 447, 457, and 600

[CMS–2421–F2]

RIN 0938–AU00

Medicaid Program; 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), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This is the second part of a two-part final rule that simplifies the eligibility and enrollment processes for Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP). This rule aligns enrollment and renewal requirements for most individuals in Medicaid; establishes beneficiary protections related to returned mail; creates timeliness requirements for redeterminations of eligibility; makes transitions between programs easier; eliminates access barriers for children enrolled in CHIP by prohibiting premium lock-out periods, benefit limitations, and waiting periods; and modernizes recordkeeping requirements to ensure proper documentation of eligibility determinations.

DATES: These regulations are effective on June 3, 2024.

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

SUPPLEMENTARY INFORMATION:

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 meet the diverse health care needs of children, pregnant individuals, parents, older adults, and people with disabilities. For over 25 years, the Children's Health Insurance Program (CHIP) has stood on the shoulders of Medicaid with the goal of ensuring that all children have health insurance. Together these programs play a major role in making health care available and affordable to millions of Americans.

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 can provide affordable health coverage to individuals whose household income is greater than 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.

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. We issued implementing regulations on March 23, 2012, 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 July 15, 2013, titled ''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 (78 FR 42160) (referred to hereafter 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 issuance of these regulations. The dynamic online applications developed by States and the Federally Facilitated Marketplace, which ask only those questions needed to determine eligibility, have reduced burden on applicants. Of the 48 States that reported application processing time data for the April 2023–June 2023 period, over half (57 percent) of all MAGI-based eligibility determinations at application were processed in under 24 hours.[1] By comparison, for the February 2018–April 2018 period, of the 42 States reporting application processing time data, only 31 percent of all MAGI-based eligibility determinations at application were processed in under 24 hours. 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[2] 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.

The critical role of Medicaid and CHIP in providing timely health care access was highlighted as the coronavirus disease 2019 (''COVID–19'') spread across our country beginning in early 2020. Medicaid and CHIP ensured people who may have lost their jobs or been exposed to COVID–19, or both, had access to coverage, playing a critical role in the national response. States were

[1] MAGI Application Processing Time Snapshot Report: April 2023–June 2023; accessed on 11/17/2023 at *https://www.medicaid.gov/sites/default/files/2023-10/magi-app-process-time-snapshot-rpt-apr-jun-2023.pdf.*

[2] MAGI Application Processing Time Snapshot Report: April 2023–June 2023; accessed on 1/18/2024 at *https://www.medicaid.gov/sites/default/files/2020-04/magi-application-time-report.pdf.*

eligible for a temporary increase in the Federal Medical Assistance Percentage (FMAP) throughout the COVID–19 public health emergency (PHE), if they met certain conditions specified in section 6008 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116–127, March 18, 2020), amended by section 5131 of Division FF of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117–328, December 29, 2022). One such condition was the continuous enrollment condition described at section 6008(b)(3) of the FFCRA. This condition required States to maintain enrollment, through March 31, 2023, for all Medicaid beneficiaries who enrolled on or after March 18, 2020, with limited exceptions.

Under the CAA, 2023, the FFCRA's temporary FMAP increase was extended through December 31, 2023, at a gradually reducing rate, for States that continued to meet the conditions specified in subsections 6008(b)(1), (2), and (4) of the FFCRA, along with new conditions at subsection 6008(f) of the FFCRA.[3] Among the new conditions for enhanced FMAP were requirements to (a) complete eligibility redeterminations in accordance with all applicable Federal requirements (or alternative processes and procedures approved by CMS), (b) update beneficiary contact information, and (c) make a good faith effort to contact beneficiaries whose mail was returned to the State. Since early 2023, States have been engaged in an effort to unwind their continuous enrollment policies and return to normal eligibility and enrollment operations (this process has commonly been referred to as ''unwinding''). CMS worked actively with States during this period to review their redetermination processes, approve alternatives when needed, and ensure that the enrollment protections established by the ACA were available to all applicants and beneficiaries during the unwinding period. This final rule builds upon these protections to promote enrollment and reduce churn.

The Biden-Harris Administration is committed to protecting and strengthening Medicaid and CHIP and has demonstrated this commitment through multiple executive actions. For example, on January 20, 2021, President Biden issued Executive Order 13985 on advancing racial equity and support for underserved communities.[4] It charged Federal agencies with identifying potential barriers that underserved communities may face to enrollment in programs like Medicaid and CHIP. 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 for coverage but remain uninsured.[5] In April 2022, President Biden issued another Executive order, building on progress and reflecting new Medicaid and CHIP flexibilities established by the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117–2). 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.[6] It calls upon Federal agencies to examine policies and practices that make it easier for individuals to enroll in and retain coverage. Building on 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 pandemic, 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 interested parties that certain policies continue to result in unnecessary administrative burden and create barriers to enrollment and retention of coverage for eligible individuals. For example:

- Individuals whose eligibility is not based on MAGI (non-MAGI individuals)—such as, 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). This left such individuals at greater risk of being denied or losing coverage due to procedural reasons, including, for example, failure to return paperwork,[7] than their MAGI-based counterparts, even though we believe many are likely to continue to meet the substantive Medicaid eligibility criteria due to low likelihood of changes in their income or other circumstances.[8]
- 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 delays in processing applications and renewals and some individuals being denied increased assistance for which they have become eligible.
- 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 improper Medicaid 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.

Through the proposed rule that appeared in the **Federal Register** on September 7, 2022, entitled ''Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes'' (87 FR 54760) (referred to hereafter as the ''September 2022 proposed rule''), we proposed policies designed to address these and other gaps, thereby streamlining Medicaid and CHIP eligibility and enrollment processes, reducing

[3] See the January 2023 State Health Official (SHO) #23–002, ''RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023, for additional information on the ''unwinding period.'' Available online at *https://www.medicaid.gov/sites/default/files/2023-08/sho23002.pdf.*

[4] 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/.*

[5] 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/.*

[6] 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/.*

[7] Procedural reasons include instances where a beneficiary fails to provide the information necessary to complete a Medicaid or CHIP renewal. This many include a renewal form with information about the individual's continued eligibility or documentation to verify continued eligibility.

[8] Assistant Secretary for Planning and Evaluation (ASPE) (2019). Loss of Medicare-Medicaid dual eligible status: Frequency, contributing factors and implications. Accessed on August 4, 2023, at *https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//189201/DualLoss.pdf.*

administrative burden on States and enrollees, and increasing enrollment and retention of eligible individuals. We also sought to improve the integrity of Medicaid and CHIP. Through the Payment Error Rate Measurement (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 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 finalized in this rule will further these 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 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 of eligibility determinations, and effective communications with providers, beneficiaries, and the public. 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.

On September 21, 2023, the ''Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment'' final rule (88 FR 65230) (referred to hereafter as the ''2023 Streamlining MSP Enrollment final rule'') appeared in the **Federal Register**, which finalized provisions of our September 2022 proposed rule that were specific to individuals dually eligible for both Medicaid and Medicare. This rule addresses the remaining provisions of the September 2022 proposed rule. It is focused on aligning enrollment and renewal requirements for most individuals in Medicaid; improving access for medically needy individuals; establishing expectations for timely renewals and redeterminations of eligibility for individuals experiencing a change in circumstances; streamlining transitions between Medicaid and CHIP; eliminating access barriers for children enrolled in CHIP; removing unnecessary administrative barriers; and modernizing recordkeeping requirements to ensure proper documentation of eligibility determinations.

If any provision of this final rule is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, it shall be severable from this final rule and not affect the remainder thereof or the application of the provision to other persons not similarly situated or to other, dissimilar circumstances.

II. Summary of the Proposed Provisions and Analysis of and Responses to Public Comments

We received a total of 7,055 timely comments from State Medicaid and CHIP agencies, advocacy groups, health care providers and associations, health insurers and plans, and the general public.

Comment: We received many comments supporting the September 2022 proposed rule. Commenters supported the changes proposed to reduce barriers to coverage, make the eligibility and enrollment process easier and faster, and help eligible individuals to retain coverage. The commenters highlighted the benefits our proposed policies would have on individuals, families, providers, States, and communities. On the individual level, commenters stated that the proposed rule would reduce individual burdens and worries, save money, and even make people happier. The commenters noted that it would help families by removing some of the barriers to accessing health care services during periods of great stress and economic insecurity, and that it would ensure their children have access to the health care services they need. Commenters noted that a reduction in churning will not only improve the health of beneficiaries, but it will also protect individual beneficiaries, and their families, from medical debt and associated stressors. Maximizing coverage for individuals, these commenters stated, will not only ensure better outcomes for the people enrolled in Medicaid and CHIP but may even save lives. Several commenters described the proposed changes as a long-term complement to our current efforts to minimize inappropriate coverage losses during the unwinding period following the end of the continuous enrollment condition.

Commenters also stated that these regulations would reduce burdens on States, save taxpayer dollars, and serve as a practical step toward ensuring the long-term sustainability of Medicaid and CHIP. Some commenters noted their belief that the current rules place an outsized emphasis on preventing the enrollment of ineligible individuals and that this rule will balance that interest with the ultimate goal of ensuring coverage for those who *are* eligible.

From the provider perspective, commenters explained that the reduction in enrollment churn resulting from the proposed streamlining of Medicaid and CHIP eligibility and enrollment processes would reduce administrative burdens on physicians and their practices. One commenter stated that it would help providers to maintain continuity of care and trust in their relationships with their patients. Another commenter stated that the September 2022 proposed rule would diminish the harmful consequences of churning, including disruptions in physician care and medication adherence; increased administrative costs for providers, Medicaid managed care plans, and States; and higher health costs when delayed care forces more expensive interventions. One commenter noted that eliminating barriers to enrollment in Medicaid and CHIP could lead to an increase in the number of Medicaid and CHIP beneficiaries and a reduction in uncompensated care costs, thereby protecting the viability of the medical safety net. Hospitals also commented that reduced churn from the policies proposed in the September 2022 proposed rule would lessen the workload for hospital staff who assist patients with program and financial assistance applications.

At the broader community level, commenters supported the proposed steps to promote health equity by eliminating barriers to initial and continuing enrollment in Medicaid (that is, form submission requirements rather than reliance on electronic data and verification). The commenters explained that because people of color are disproportionately likely to be enrolled in Medicaid and CHIP for health

coverage, lowering administrative burdens to make it easier to enroll in coverage and to reduce coverage disruptions could be critical to advancing health and racial equity. One commenter noted that by enabling low-income households to access the benefits to which they are entitled under law, the September 2022 proposed rule would effectively result in a transfer of funding (spending described in the regulatory impact analysis) from the Federal Government to Medicaid and CHIP beneficiaries through additional health care spending by those programs. The commenter explained that this transfer will not only enhance the health of the United States' low-income population but will also likely improve their financial well-being. Commenters also supported the proposal to address institutional bias by allowing for the projection of predictable costs in the community for home and community-based services.

Response: We appreciate commenters' support for the September 2022 proposed rule. As discussed in the background section of this final rule, Medicaid and CHIP play a key role in the United States health care system. While Medicaid and CHIP coverage can have a huge impact on the individuals served by these programs, we agree that the full value of the programs goes well beyond the individual beneficiaries.

We agree with commenters that the streamlined eligibility and enrollment processes established by this rule will help to reduce the churning of eligible individuals on and off Medicaid and CHIP. We agree with commenters that reduced churn has the potential to reduce administrative burdens for beneficiaries and their health care providers, improve the ability of beneficiaries and their providers to form lasting relationships, reduce the need for high-cost interventions that can result from delayed care, and protect beneficiaries from medical debt and providers from non-payment. We also agree with comments on the broader community impact of this rule. After completing the upfront investment in systems and training needed to implement the changes in this final rule, States should begin to see savings from the reduced administrative burden. In addition, we believe that healthier beneficiaries can be more productive in their homes, their work, and their communities.

Recognizing the benefits of this rule, we are finalizing (with some modifications) the changes included in the September 2022 proposed rule that were not included in the 2023 Streamlining MSP Enrollment final rule. Some of the proposed changes are modified in response to comments, and all modifications are discussed in the comment responses that follow.

Comment: We also received many comments that generally opposed the September 2022 proposed rule and urged CMS to withdraw the rule in its entirety. Commenters opposing the rule cited concerns about increased enrollment of ineligible individuals, increased program costs, reduced program integrity, and reduced flexibility for States. Other concerns raised were that the proposed rule would increase doctors' and hospitals' profits, take away individuals' choices, and decrease the quality of health care.

Some commenters stated that this rule would prohibit critical program integrity protections. These commenters expressed concern that changes proposed to streamline the enrollment process would permit ineligible individuals to enroll in Medicaid and CHIP, and they recommended tighter controls to protect the integrity of these programs. The commenters stated that loopholes in existing eligibility and enrollment processes, particularly with respect to the verification of eligibility, would be expanded by this rule, making it difficult for States to effectively verify Medicaid and CHIP eligibility.

Commenters opposing the proposals noted the increase in State costs described in the regulatory impact analysis and expressed concern that Medicaid and CHIP costs would increase. One commenter expressed concern that these changes were coming at the expense of State flexibility, taxpayers, and the truly needy who rely on the sustainability of Medicaid.

A few commenters stated that the proposed rule gives more control to the Federal Government at the expense of States. They believe the proposed rule weakens State flexibility to administer enrollment determinations. One commenter stated that they opposed the proposed changes noting that States are best positioned to set eligibility, renewal, and retention requirements for Medicaid and CHIP. Another commenter explained that because issues of health care vary from State to State, they believe it is wrong for CMS to establish a ''one size fits all'' approach.

Response: We appreciate commenters' concerns about protecting the integrity of the Medicaid and CHIP programs. As stewards of Federal funding for Medicaid and CHIP, we take program integrity very seriously. We maintained a focus on reducing the rate of improper payments as we developed the proposals finalized in this rule. For example, we expect the new requirements finalized in this rule for electronic recordkeeping will help ensure that State and Federal auditors can more easily verify the accuracy of eligibility determinations and payments made to providers. We also expect that establishing clear timeliness standards for acting on changes in circumstances and completing renewals will ensure that States do not continue to provide coverage to ineligible individuals for an extended period. These provisions will also ensure that States do not improperly deny coverage for a beneficiary who is eligible for Medicaid or CHIP. Accurate eligibility determinations in both situations are an important part of program integrity.

We disagree with comments suggesting that streamlining eligibility and enrollment processes and eliminating unnecessary administrative requirements will increase the enrollment of ineligible individuals. To the contrary, the focus of many of the proposed provisions is to reduce enrollment errors caused when *eligible* individuals are unable to overcome administrative barriers to enrollment. For example, by removing the requirement to apply for other benefits that do not impact an individual's eligibility for Medicaid or CHIP, this rule eliminates a burdensome step in the eligibility process that increases potential for caseworker- or system error. Additionally, this final rule increases State reliance on electronic data sources, such as States' asset verification programs, to verify eligibility, thereby reducing the burden for States, as well as applicants and beneficiaries, of submitting copies of paper documents that must be reviewed by a caseworker.

Regarding commenters' concerns about the increased costs associated with this rule, this final rule does not expand Medicaid or CHIP eligibility criteria to include new populations (for example, individuals with higher incomes or in categories not currently eligible for coverage under these programs). It simply removes barriers that prevent individuals who satisfy existing financial and other eligibility criteria from enrolling and remaining enrolled in these programs. We recognize that many of the provisions will require States to change their eligibility systems and their enrollment processes, and that these changes will generate upfront costs. However, as discussed in the regulatory impact analysis and collection of information sections, we believe these changes will create administrative savings that will continue to accrue in the future, and

that these savings will far outweigh the initial administrative costs. In addition, we note that enhanced Federal funding for design, implementation, and operation of State eligibility and enrollment systems is available in accordance with § 433.112(b)(14) for changes to support accurate and timely processing of eligibility determinations.

Finally, we understand commenters' concerns that some of the changes finalized in this rule will reduce the flexibility currently available to States. As we considered the comments submitted regarding each specific provision in this final rule, we looked for opportunities to provide States with more flexibility in achieving the policy goals of the September 2022 proposed rule. Revisions finalized in this rulemaking, which improve State flexibility, are discussed in detail in the responses to comments that follow.

A. Facilitating Medicaid Enrollment

1. Facilitate Enrollment by Allowing Medically Needy Individuals To Deduct Prospective Medical Expenses (42 CFR 435.831 and 436.831)

We proposed to amend § 435.831(g)(2) to permit States additional flexibility to project the incurred medical expenses of noninstitutionalized individuals who seek to establish eligibility for Medicaid as medically needy. Generally, 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 and who attain income eligibility by reducing their countable income to their State's medically needy income level (MNIL) by deducting the uncovered medical and remedial care expenses they, their family members, and financially responsible relatives have incurred (a process referred to as a ''spenddown''). When an individual qualifies as medically needy, the individual's eligibility lasts only as long as the State's medically needy budget period, which, under § 435.831(a), can be no longer than 6 months (and can be as short as 1 month), at which point the individual will need to meet their spenddown amount again with different incurred medical or remedial expenses to reestablish eligibility. This process causes frequent disruptions in medically needy-based Medicaid coverage and can pose administrative challenges to States.

In 1994, we amended § 435.831 to add a new paragraph (g)(1), under which we permitted States to *project* the costs of medical institutional expenses, at the Medicaid reimbursement rate, that individuals seeking eligibility as medically needy will incur in a budget period (59 FR 1659, 1673 (January 12, 1994)). As we explained in section II.A.5. of the preamble of the September 2022 proposed rule, ''projecting'' expenses means that a State deducts from the individual's countable income the medical expenses that it anticipates an individual will incur during a budget period. This can expedite eligibility because the individual does not have to first incur the anticipated expenses. As we explained, our rationale for permitting the projection of institutional expenses has been that such expenses are by their nature constant and predictable, and allowing their projection at the Medicaid rate offers States a simplified approach to determining the eligibility of institutionalized individuals as medically needy with a high degree of certainty of the accuracy of the determinations.

We believe that allowing projection of only institutional expenses, while not also allowing projection of predictable and constant services incurred by community-based individuals, fosters an institutional bias, and we therefore proposed to amend § 435.831(g)(2) to allow States to project the expenses of other services that are also reasonably constant and predictable. Our proposed regulation identified examples of services that we believe meet this criterion, including home and community-based services (HCBS) reflected in a person-centered service plan in accordance with § 441.301(b)(1)(i), § 441.468(a)(1), § 441.540(b)(5), or § 441.725 (relating to the HCBS authorized under section 1915(c), (i), (j) and (k) of the Act), and prescription drugs. We explained that features of these services create a high degree of likelihood of their continued receipt from month to month. We also proposed that States use the Medicaid reimbursement rate for the costs of the services they would project under proposed § 435.831(g)(2). We invited comment on other types of services that may meet the reasonably constant-and-predictable criteria, which we would consider including in the regulatory text.

In drafting the September 2022 proposed rule, we inadvertently failed to include a revision to § 436.831(g)(2) that mirrors the change proposed at § 435.831(g)(2) to permit Guam, Puerto Rico, and the Virgin Islands (collectively, the ''436 territories'') to make the same elections with respect to medically needy eligibility. This omission was unintentional, as most of the provisions of the proposed rule that are adopted in this final rule are applicable to the 436 territories as a result of incorporation by reference in existing regulations (as noted elsewhere throughout this final rule). The same reasons for adopting this option in § 435.831 also apply in the 436 territories, and we note that reference to the effects of such changes on all five U.S. territories was included in the discussion of information collection requirements in the proposed rule (87 FR 54820). We are including § 436.831(g)(2) in this final rule and note that all references to § 435.831(g) also apply to § 436.831(g).

We received the following comments on this provision in the proposed rule, and below are our responses.

Comment: Most commenters strongly supported the proposed regulation, with nearly all such commenters stating that the proposal would do one or more of the following: help reduce Medicaid's institutional bias; further the integration mandates of the Americans with Disabilities Act (ADA) and section 504 of the Rehabilitation Act; reduce eligibility churn and ensure greater continuity of coverage; and reduce administrative burden and complexity. A couple of commenters specifically noted that the proposed regulation will improve health equity.

Response: We appreciate the commenters' support. As explained in the following comment and response, we are finalizing the regulation as proposed.

Comment: We received many comments in response to our invitation for the identification of other types of services that are reasonably constant and predictable, and which could be considered for inclusion in the regulatory text. Commenters suggested a very broad variety of services, and many commenters recommended that we include the services they identified in the regulation text. Examples of the additional expenses which were suggested to us by commenters include personal care services, Program of All-Inclusive Care for the Elderly (PACE) services, additional drug-related costs, behavioral health services, durable medical equipment (DME), health insurance premiums, and laboratory tests.

Response: We appreciate the very thorough and thoughtful responses to our request. We agree that many of the expenses suggested by commenters, including health insurance premiums (such as, but not limited to, Medicare or PACE premiums paid by the individual), could meet the reasonably constant-and-predictable standard. However, we have decided to finalize the rule as proposed, in which the

examples of projectable services that will appear in the final regulation text will be those that were included in the proposed rule—that is, the services in plans of care for the section 1915-related HCBS benefits and prescription drugs. We note that the list of specific services included in the regulation text is illustrative, not exhaustive, and have concluded that, given the variety and volume of expenses which could meet the reasonably constant-and-predictable standard, the addition of all or most of such services to the regulation text would be too cumbersome. Additionally, we are concerned that a longer list may actually heighten the potential that someone would incorrectly conclude that the specifically identified services are the only permissible ones that States may project as reasonably constant and predicable.

Although we are not including additional examples in the final regulation, we confirm that the services in the regulation text are not exclusive, and that States are authorized to project services not specifically identified in the regulation which they determine to be reasonably constant and predicable. The language in the final rule (as in the proposed rule) provides that States may project expenses that they have determined to be reasonably constant and predictable ''including, *but not limited to,*'' the services in a person-centered service plan for section 1915-related HCBS and prescription drugs. (Emphasis added.)

We agree that many of the services identified by commenters could be reasonably constant and predictable. However, we decline to individually evaluate each service identified against that standard here. Under the final rule, discretion is left to each State to evaluate whether, and under what circumstances, a given service is considered reasonably constant and predictable. We believe that the services we have included in the regulation reflect practical examples of the reasonably-constant-and-predictable principle that will guide the type of services States may choose to project.

Comment: One commenter suggested removing all examples from the regulation text, expressing concern that the inclusion of examples may be inadvertently interpreted to limit the projection of expenses to those contained within a Medicaid-approved plan of care, which would make the option available only to individuals who have already established Medicaid eligibility and have an approved plan of care. The commenter suggested that CMS explicitly provide States with the option to expand prospective HCBS-related deductions to individuals with private-pay receipts or who have received support from a qualified entity (such as an Aging and Disability Resource Center) to develop a service plan.

Response: As explained previously in this final rule, we believe that adding other services to the regulation could increase the possibility that the list may be read as an exclusive one, in contrast to our intent. We disagree, however, that it is necessary to omit all examples from the regulatory text, because we believe, as also noted previously in this final rule, that the examples we include offer a useful gauge of our expectation on what may be considered reasonably constant and predictable. We also believe it is clear that the list of examples is illustrative but not exhaustive.

Comment: A commenter suggested that we replace specific HCBS references with a blanket reference to HCBS authorized under all authorities.

Response: As noted previously in this final rule, we believe that the specific services identified in the regulation offer a useful gauge of our expectations of what may be considered reasonably constant and predictable. The proposed regulation identified examples of services that we believe meet these criteria, including HCBS reflected in a person-centered service plan pursuant to § 441.301(b)(1)(i), § 441.468(a)(1), § 441.540(b)(5), or § 441.725 (relating to the HCBS authorized under section 1915(c), (i), (j) and (k) of the Act). While we agree that HCBS that are not reflected in a person-centered service plan pursuant to one of the authorities listed in proposed § 435.831(g)(2) could potentially include services that help an individual remain in the community (such as transportation), our goal is to provide clear examples of reasonably constant and predictable expenses in the regulation text. We believe that the proposed regulation text accomplishes that goal, since HCBS provided pursuant to a person-centered service plan necessarily meet that standard, whereas HCBS not reflected in such a plan may not, depending on the service and circumstances. We reiterate, however, that States are authorized to project services not specifically identified in the regulation which they determine to be reasonably constant and predictable, including HCBS that are not included in a person-centered service plan.

Comment: We received several comments that either requested clarification on whether this proposal would be optional for States or that implied the commenters believed it not to be optional. One commenter stated that the subsection heading for this proposal in the preamble is presented as an individual option instead of a State option, and the commenter recommended that we confirm that States do not have to elect this option. Another commenter indicated that this proposal would reduce State discretion. A few other commenters shared that the proposal would impose a burden on States (that is, additional staff training and system changes), and that, given the complexity of the proposal, the timeline for State implementation should be relaxed. One commenter stated that the proposal might possibly increase medically needy caseloads.

Response: We confirm that the authority to project noninstitutional expenses that we proposed and are finalizing at § 435.831(g)(2) in this final rule is a State option, not a mandate. We agree that the language of the heading in the preamble to the September 2022 proposed rule suggests an individual option instead of a State option, and we have revised it in this final rule preamble. We note, however, that we did not propose, nor did we make, a change to the paragraph heading of § 435.831(g) in which this new State authority is inserted (''Determination of deductible incurred medical expenses: *Optional deductions.*'') (Emphasis added). Given the optional nature of this provision, we disagree that it will impose a burden on States or that the timeline for State implementation should be longer (as there is not an implementation timeline for the election of this option). Although we believe that adopting the option will ease administrative burden, a State that believes negative outcomes that may possibly stem from permitting the projection of noninstitutional expenses would outweigh the benefits would not have to elect this option.

Comment: Many commenters took the position that, for HCBS participants, CMS *should* require States to project noninstitutional medical and remedial expenses, rather than making it optional. The commenters indicated that making it mandatory would streamline the process and reduce unnecessary burden on how people with extensive health care needs receiving HCBS must demonstrate their eligibility.

Response: As we explained in section II.A.5. of the preamble of the September 2022 proposed rule, our proposal to allow States to project noninstitutional expenses builds on the preexisting State regulatory option to project institutional expenses, a primary rationale of which

was to increase State flexibility. While we agree that expanding States' authority to project additional types of expenses will help streamline eligibility processes and offer important advantages to applicants and beneficiaries, we did not propose to eliminate State discretion in applying this policy. Doing so would be a substantial departure from the flexibility principles on which the proposed rule was based. Therefore, we are finalizing § 435.831(g)(2) as proposed. The projection of reasonably constant and predictable medical expenses in determining whether a medically needy individual has met their spenddown will be a State option under this final rule.

Comment: Several commenters requested that the regulation be extended to a broader range of people beyond those receiving services under the specific HCBS authorities included in the regulation text. One commenter noted that because use of services in an HCBS plan of care may vary greatly over the course of multiple budget periods, States may not be able to reasonably predict the individual's services costs in a forthcoming budget period.

Response: States are permitted under this regulation to project the cost of noninstitutional services for all medically needy individuals, regardless of whether such individuals are eligible for HCBS authorized under section 1915 of the Act, so long as the projected services are reasonably constant and predictable. States are also not limited to projecting the specific services identified in the regulation.

Comment: One commenter stated that proposed § 435.831(g)(2) would not eliminate Medicaid's institutional bias. The commenter indicated that individuals who become hospitalized and then apply for Medicaid are typically discharged by hospitals to nursing facilities instead of the community due to the higher degree of likelihood that they will establish Medicaid eligibility in the former. The commenter further stated that individuals who are thus discharged to a nursing facility and become Medicaid-eligible will likely choose to remain there, as a return to the community, with different financial eligibility rules, may pose a threat to their retaining Medicaid.

Response: We appreciate the concerns raised by the commenter. We have acknowledged in the past the challenges faced by Medicaid-eligible institutionalized individuals seeking to return to the community, and the proposed rule did not purport to eliminate all barriers individuals receiving institutional care may face in returning to the community. We previously issued a State Medicaid Director Letter on strategies that States may utilize to facilitate transitions from institutions to the community and connecting such individuals to HCBS. (Olmstead Update No. 3, July 25, 2000). We believe that the option provided under § 435.831(g)(2) of this final rule complements these strategies to further assist States in their rebalancing [9] efforts.

Comment: Two commenters stated that a plan of care may only be developed for an individual who has established Medicaid eligibility, with one of the commenters indicating that, as a result, projection of the plan-of-care costs would not assist a prospective medically needy individual in need of the HCBS.

Response: We disagree with the commenters. The eligibility group described in § 435.217, which covers individuals who are eligible for and will receive section 1915(c) services and who would be eligible if institutionalized, requires that section 1915(c) services be authorized before the individual may be enrolled in the group. This requires the completion of the plan of care as a condition precedent; for example, for individuals seeking coverage under this group, a State must complete a plan of care for section 1915(c) services *prior* to determining them eligible for Medicaid. Similarly, States are specifically authorized under sections 1915(c)(3) and 1915(i)(3) of the Act to apply special financial eligibility deeming rules for medically needy individuals seeking coverage for section 1915(c) or (i) services. This means that States electing to cover section 1915(c) or (i) services must confirm the need for such services as part of the underlying Medicaid eligibility determination. A State could develop a plan of care for the individual as part of this process; indeed, it often will make sense for the State to do so.

Comment: We received many comments relating to retroactive coverage for HCBS, with nearly all such commenters suggesting that retroactive HCBS coverage should be available to the same extent it is for institutional services. Some of the commenters claimed that the misalignment is biased toward institutional services or discriminatory.

Response: While not specifically stated by the commenters, we assume the comments on this point refer to the ''medical assistance'' definition in section 1915(c)(1) of the Act, which defines HCBS services as services that are provided ''pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such [HCBS waiver] services, the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.'' We further believe that the commenters are proposing that if an individual is otherwise eligible for Medicaid coverage of other services, that the services that are in a section 1915(c) waiver participant's plan of care, but which are received by the individual before the plan of care is actually developed and the level-of-care determination has been made, also be eligible for Medicaid coverage. We appreciate the commenters' interest in this issue; however, it is beyond the scope of this rule. We note, however, that individuals who are eligible for HCBS are not categorically excepted from retroactive medical assistance coverage authorized under section 1902(a)(34) of the Act, and Medicaid beneficiaries may receive retroactive coverage for HCBS-related State plan services such as personal care services and home health care services.

Comment: A couple of commenters stated that requiring use of the Medicaid rate for noninstitutional expense projection is too prescriptive and requested that CMS provide flexibility for States to determine the appropriate rate.

Response: We do not agree that the requirement to use the Medicaid rate is overly prescriptive. Use of the Medicaid rate is appropriate to achieve the highest level of certainty that an individual will incur the liability that the regulation permits States to anticipate prior to the actual receipt of services. Use of a different rate increases the possibility that, upon reconciliation at the end of the budget period, an individual will be found not to have met their spenddown obligation (and thus to have been erroneously granted eligibility). Limiting the expenses projected to the Medicaid rate strikes an appropriate balance between preventing medically needy individuals from having to establish or reestablish eligibility based on a spenddown prior to receiving services and ensuring that individuals who are not reasonably certain to meet

[9] ''Rebalancing'' is defined in this context as achieving a more equitable balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care.

their spenddown obligation are not erroneously granted eligibility.

Comment: Some commenters recommended including community expenses that are not currently available to meet a spenddown, such as housing expenses (that is: rent, mortgage, and property taxes), utilities, and food.

Response: Expenses that are used to meet an individual's spenddown, whether they are projected or not, must meet the requirements of § 435.831(e) (''Determination of deductible incurred expenses: Required deductions based on kinds of services''). Changes to § 435.831(e) are beyond the scope of this regulation.

Comment: One commenter urged CMS to include in the regulation as projectable expenses those that are significant in cost but not necessarily predictable month-to-month.

Response: We are not permitting in the regulation the projection of expenses that are not reasonably constant and predicable. As explained in the preamble, the rationale for the projection of expenses is that the individual has expenses that the State can be reasonably certain the individual will actually incur the cost of during a budget period. We do not believe that intermittent or sporadic expenses, regardless of whether their cost is expected to be high, meet the standard needed to predict with reasonable certainty that the individual will incur them within a budget period. While we are not authorizing the projection of expenses that do not meet a reasonably-constant-and-predictable standard, we note that an individual's actually incurred medical and remedial expenses that meet the requirements of § 435.831(e) must be deducted during a budget period.

Comment: A couple of commenters requested that CMS specifically include section 1115 waivers in the HCBS authorities that are included in the regulation.

Response: As noted previously in this final rule, we are not adding additional services to the regulation beyond those that we originally proposed, and we reiterate that the services listed in the regulation text are not exhaustive. We confirm that a State that has received authority under section 1115(a)(2) of the Act to provide to State-plan eligible individuals coverage for services for which the State is not otherwise eligible for Federal Financial Participation (FFP) could project the cost of such services for individuals seeking to qualify as medically needy, provided that such services are reasonably constant and predictable.

Comment: One commenter inquired about whether a State would be required to define which non-institutional expenses it has determined meet the criteria and will be projected.

Response: States that elect to project institutional expenses are currently required to confirm their election in their Medicaid State plan. States that elect to project non-institutional expenses in accordance with § 435.831(g) of this final rule similarly will be required to confirm this election in their Medicaid State plan. States also should document each of the non-institutional expenses the State has determined will be projected in accordance with the State's election under § 435.831(g)(2) of this final rule, and the circumstances in which such expenses will be projected, in their policies and procedures.

Comment: Several commenters requested that CMS require States to revisit and modernize their MNILs to ensure that individuals have enough income available to meet their needs in the community.

Response: Changes to State MNILs are beyond the scope of this rule.

Comment: One commenter requested that the regulation include a requirement that if a determination is made that an individual no longer has reasonably constant and predictable medical expenses that meet his or her spenddown obligations, the individual should receive timely and advance notice after the renewal, with appeal and aid-paid-pending rights.

Response: The circumstances in which Medicaid's notice and fair hearing rights apply are set forth in 42 CFR part 431, subpart E. If a State's determination that an individual's medical or remedial care expenses are no longer constant and predictable implicates one of the circumstances described in part 431, subpart E (that is, as a result the individual is no longer eligible for the medically needy group), the individual will be entitled to advance notice and an opportunity for a fair hearing. The requirement for States to provide advance notice and fair hearing rights for individuals losing medically needy eligibility is not impacted by this final rule.

Comment: A couple of commenters urged CMS to include a longer period for projection of noninstitutional medical expenses, up to 12 months.

Response: The projection of expenses is made for the duration of the medically needy budget period elected by the State, which, under § 435.831(a)(1), cannot be longer than 6 months.

Comment: A few commenters objected to the expectation described in the preamble that States conduct reconciliations at the end of each budget period; for example, that they confirm that medically needy individuals actually incurred the amounts projected at the beginning of the budget periods. One commenter indicated that reconciliation is burdensome and could pose a barrier to enrollment. Another commenter stated that the reconciliations should occur at renewal instead of the end of budget periods.

Response: We believe reconciliation is necessary to ensure the projection process does not result in erroneous grants of eligibility. Reconciliation is also required for States that project institutional services. We disagree that conducting reconciliation at the point of an eligibility renewal is appropriate. It will be important for States to identify as quickly as possible medically needy beneficiaries whose projected expenses are not actually being incurred to (1) minimize the financial burden on the individual at the point of reconciliation, and (2) prevent further payment of medical assistance exceeding the amount for which the individual is eligible.

Comment: One commenter requested that CMS include language in the regulatory text that prohibits the termination of coverage retroactively when individuals are found not to have met spenddown obligations after reconciliation.

Response: Under § 431.211, States generally are not permitted to terminate an individual's Medicaid eligibility sooner than 10 days after providing notice that the individual is no longer eligible for Medicaid. While there are exceptions to this limitation, described in § 431.213, none of those exceptions relate to a circumstance in which an individual may have received an erroneous grant of Medicaid eligibility based on the projection of their medical or remedial care expenses. Section 431.211 applies equally to individuals eligible for medically needy coverage, and we do not consider it necessary or appropriate to repeat this requirement in § 431.831.

Comment: One commenter recommended that the regulation require only documentation of the predictability of prospective bills without requiring proof of payment during the budget period in which expenses are projected, as there is often a lag in billing times.

Response: Such an addition to the regulation would not be consistent with Federal policy. Expenses for incurred medical or remedial care services are

counted in meeting an individual's spend down amount under § 435.831, regardless of whether or not the individual actually pays the provider for the services. The regulation at § 435.831(f)(5) identifies the particular circumstance in which an actual *payment* must also be deducted (specifically, *payments* made during a current budget period for services incurred previous to the budget period and which were not deducted as *expenses* in a previous budget period). In these circumstances, States may verify that the payment was made. However, we note that the past consistency of *payments* made by an individual seeking to qualify as medically needy by projecting the cost of an expense that is reasonably constant and predictable may not be a factor in determining the amount to be projected.

Comment: One commenter inquired about how the new authority to project noninstitutional expenses will work in conjunction with the ''hypothetical spenddown'' process used by States that determine eligibility for HCBS through the medically needy eligibility pathway.

Response: As mentioned previously in this final rule, the eligibility group described in § 435.217 (generally referred to as ''217 group'' beneficiaries) serves individuals who are eligible for and will receive section 1915(c) services and who would be eligible if institutionalized. While individuals in this group are, as required under §§ 435.726 and 435.735, subject to post-eligibility treatment-of-income (PETI) rules, many States allow 217 group beneficiaries to keep all of their income to meet their community needs. This is effectuated by a State setting the maintenance allowance used in the PETI calculation for 217 group beneficiaries at the income eligibility standard for the State's 217 group. For example, if 300 percent of the supplemental security income (SSI) benefit rate is the income eligibility standard for the State's 217 group, the State would elect 300 percent of the SSI benefit rate as the maintenance allowance. However, individuals who need section 1915(c) services but who have incomes in excess of the 217 group income standard commonly must qualify as medically needy to access such services, which requires them to reduce their income to the State's MNIL, which is typically an amount well below the State's maintenance allowance for the 217 group.

The hypothetical spenddown policy enables States, at their option, to project the costs of institutional expenses that would be incurred by an otherwise medically needy individual if that individual were institutionalized. If the individual would meet their spenddown if they were actually in an institution, a State electing this policy could deem the individual to be one who *would be eligible if institutionalized,* thereby enabling the individual to be eligible under the 217 group. This allows the individual to keep the amount of their income equal to the State's section 1915(c) maintenance allowance for the 217 group, instead of having to spend down all of their income in order to establish eligibility while remaining in the community.

This option is not impacted by the policy finalized in this rulemaking at § 435.831(g), which enables States to project reasonably predictable and constant non-institutional medical expenses an individual expects to incur. However, we note that there is now a more versatile option available to States. As described in ''State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services'' (SMD #21–004, December 7, 2021), States can adopt income and resource disregards targeted at individuals who need HCBS, which includes the authority to target disregards at the 217 group, which also enables States to provide HCBS through the 217 group to individuals at higher income levels. We are available to provide technical assistance to any State interested in either of these options.

After considering the comments received, we are finalizing the regulation text at § 435.831(g)(2) as proposed without modification. We note that because the effect of this change is specific to the computation of medical expenses of noninstitutionalized individuals who seek to establish eligibility for Medicaid as medically needy, it operates independently from the other provisions of this final rule.

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

We proposed revisions to clarify that the regulations at § 435.952, regarding the use of information to verify an individual's eligibility, apply not only to verification of income and non-financial information, but also to the verification of resources. The language of § 435.952 is written broadly to encompass all factors of eligibility, including income and resource criteria, when applicable. However, because § 435.952(b) applies 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. Therefore, we proposed revisions to paragraphs (b) and (c) of § 435.952 to clarify that this provision applies to any information obtained by the State, including resource information. Since § 435.952 applies to resource information obtained from electronic data sources, such as an asset verification system (AVS) described under section 1940 of the Act, we also proposed a corresponding technical change to add section 1940 of the Act to § 435.940 (regarding the basis and scope of the verification regulations). As a reminder, when implementing a reasonable compatibility standard for resources, States should continue to evaluate resources on an individual basis (subject to existing regulations under § 435.602) and not on a household basis.

We received the following comments on these proposed provisions:

Comment: Commenters overwhelmingly supported the proposed changes clarifying that States should, to the extent possible and when reasonably compatible, rely on electronic data for verifying resources to streamline eligibility processes and alleviate the administrative burden for States and individuals. Further, commenters expressed that clarifying that the reasonable compatibility standards also apply to the verification of resources would increase the efficiency of the eligibility determination process for individuals who are age 65 or over, are blind, or have a disability (referred to herein as ABD individuals), as these individuals generally are required to have resources under a certain threshold in order to be eligible for Medicaid. Multiple commenters also supported the proposed changes because they would reduce churn, where eligible individuals lose eligibility (generally for a procedural reason such as not returning requested documentation) and then reapply and are determined eligible again.

Response: We appreciate the overwhelming support for the proposed revisions at § 435.952. We agree with commenters that applying a reasonable compatibility standard will increase the efficiency and reduce administrative burden for States when determining eligibility for individuals for whom a resource standard is required. States are already required to apply a reasonable compatibility standard for income for all

populations under existing regulations at § 435.952. As commenters noted and we agree, our proposed policy will also streamline the eligibility process for consumers, because individuals will not be required to provide additional paper documentation of resources when electronic data sources provide information that is reasonably compatible with the individual's attestation. This streamlining will facilitate enrollment of eligible individuals. For example, if the resource threshold for non-MAGI eligibility is $2,000, the individual attests to $1,700 in financial assets from two sources and the AVS returns a resource amount of $1,850, the attested resource information and the resource information returned from the AVS both would be below the relevant threshold of $2,000, and therefore considered reasonably compatible, and no additional information from the individual would be needed. This is true regardless of the other data elements returned by the AVS such as the type or name of an asset which differs from the two sources listed in the attestation, or if the $1,850 includes a third source that was not included in the attestation.

Comment: A few commenters raised concerns that the proposal would increase fraud in the Medicaid program and divert health care dollars and services from the neediest Americans. One commenter suggested that the rule should require individuals to provide verification of their resources rather than comparing self-attested information to data from electronic sources. The commenter stated that the proposed changes would increase Medicaid enrollment of ineligible individuals. This commenter suggested that the rule require individuals to verify their financial information, because such a policy would combat intentional fraud and remove middle and upper-income individuals from the Medicaid program.

Response: We disagree that the proposed changes will increase fraud in the Medicaid program. The proposal would not limit States' statutory obligation to verify factors of an individual's eligibility. States currently must verify resources using an AVS described in section 1940 of the Act for individuals whose eligibility is subject to a resource test, and nothing in this rulemaking changes that requirement. As clarified in this final rule, § 435.952(c)(2) requires States to seek additional information, which may include documentation, if attested information is not reasonably compatible with information obtained through the AVS or other electronic data match. This means that if the resource information to which the individual attests is not reasonably compatible with information obtained through an electronic data match, and thus could affect whether the individual would be eligible for Medicaid, the State must seek additional information from the individual. If electronic data verifies an individual's attestation, there is no need for a State to require additional proof. Doing so would only add burden for both the State and the individual and diminish program integrity by potentially preventing the enrollment of an individual who is eligible for the program. In the final rule, we have made minor modifications to § 435.952(c)(1) to make sure it is clear that the policy described above is the same for income and resources (meaning that resource information must be considered reasonably compatible if the resource information obtained electronically and the information provided by or on behalf of the individual is either at or below the applicable standard or other relevant threshold). Thus, we are finalizing the revisions at § 435.952(b) and (c)(1) as proposed with minor clarifying modifications to paragraph (c)(1).

Comment: One commenter suggested that CMS make our proposed modifications to § 435.952(b) and (c)(1) optional for States until more extensive work has been done to ensure that electronic data sources have sufficient information to verify resources. The commenter noted that verification of many types of resources may not be available through electronic data sources such as an AVS, for example, non-homestead real property, automobiles and other vehicles, equipment, investments, annuities, and retirement assets.

Response: We disagree that application of the regulations at § 435.952 to verification of resources should be at State option. The State must attempt to verify and determine eligibility in accordance with its verification plan, which may include requesting additional information and documentation from the individual in appropriate circumstances. Documentation from the individual may be sought to verify an individual's assets when electronic data is inconsistent with attested asset information as well as when electronic data are not available (that is for non-financial assets) and establishing a data match would not be effective in accordance with § 435.952(c). The verification rules at § 435.952, including the reasonable compatibility requirements, reduce burden on both individuals and States and thus further the effective and efficient administration of the State plan and best interests of beneficiaries. Further, the current regulation at § 435.952 is written broadly to encompass all factors of eligibility, including resource criteria when applicable. The current regulations apply to verification of resources; this final rule clarifies the regulations to explicitly reflect as much. Finally, all 50 States, the District of Columbia, and Puerto Rico are required to implement an AVS to verify financial assets under section 1940 of the Act. States would be required to access other electronic data sources for asset verification only to the extent that such sources are available and would be effective in accordance with § 435.952(c)(2)(ii).

Comment: A few commenters expressed concerns about operational and technological challenges in implementing this provision within the timeframe described in the September 2022 proposed rule, including some States that operate an AVS as a separate portal that is not integrated into the State's Medicaid eligibility system. Some commenters shared that applying a reasonable compatibility standard to resources would require a manual process until the State is able to make systems changes. Some commenters stated that system enhancements to make a reasonable compatibility determination for evaluation of resources would require the development of a new interface and new system rules, which would be difficult to complete within the 12-month implementation timeframe proposed.

Response: We appreciate the operational concerns expressed by commenters and understand that this provision may lead States to implement operational changes and system enhancements. It is our understanding that if a State is using an AVS through a separate portal, there is already a manual process in place. Modification of the manual process requires re-training, but not a new interface. If a State is using an AVS through an automated interface, it may undertake modification of comparison logic and rules, but no new interface and/or rules need to be implemented. Because this is an existing requirement, and because this final rule does not add any new or additional burden, we are not providing additional time for State compliance with this provision. We recognize that some States are in the midst of other significant system changes and we will continue to work with them to ensure compliance with this requirement as soon as possible.

Comment: A few commenters expressed concerns about the data quality and timeliness of responses from an AVS, which can delay eligibility determinations and prevent States from meeting application and renewal processing deadlines. Some of these commenters also raised concerns that not all financial institutions participate in AVS. A number of commenters requested additional technical assistance from CMS on details about how AVS programs should be operationalized. For example, due to the frequency of the AVS returning missing information or delayed information from smaller banks, one commenter requested clarification on the timeframe in which the AVS verification is considered complete and when to apply the reasonable compatibility standard.

Response: We appreciate the comments regarding data quality and the timeliness of the information returned from the AVS. We understand that not all asset information available from financial institutions participating in the AVS is returned in real time. States may establish a reasonable timeframe to review information that is returned from an AVS. We understand that most financial institutions respond to AVS requests within 5 days, which a State could consider a reasonable amount of time to wait for information to be returned before the State applies the reasonable compatibility standard. If the State determines that the information returned from the AVS is incomplete, or if the AVS does not return information within the reasonable timeframe established by the State, the State must attempt to determine eligibility in accordance with its verification plan, which may include requesting additional information and documentation from the individual. We continue to be available to provide additional technical assistance to States regarding operationalizing of AVS and the application of verification rules at § 435.952 to electronic information obtained from an AVS.

Comment: One commenter requested clarification on how reasonable compatibility would interact with resource assessments and 90-day asset transfers to community spouses.

Response: We interpret this comment as requesting feedback on how resource-related reasonable compatibility would operate in the context of the spousal impoverishment rules described in section 1924 of the Act (''Treatment of Income and Resources for Certain Institutionalized Spouses''), both at the underlying eligibility and redetermination phases. Reasonable compatibility, as explained immediately below, is sometimes, but not always, relevant under the spousal impoverishment rules.

Section 1924(c)(2) of the Act requires that a State determine the amount of countable resources an institutionalized spouse and community spouse own, jointly or separately, at the time of the institutionalized spouse's Medicaid application. This amount, minus the community spouse resource allowance (CSRA) determined under section 1924(f)(2) of the Act, is the amount deemed available to the institutionalized spouse and compared to the resource standard of the eligibility group for which the institutionalized spouse is being evaluated. Effectively, the resource standard for the institutionalized spouse is the CSRA plus the resource standard for the relevant eligibility group.

Consider, for example, an institutionalized spouse who is being evaluated for the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act (relating to individuals who have been in medical institutions for at least 30 consecutive days) in a State in which the CSRA is $70,000. The resource standard for the eligibility group is $2,000, which effectively means the institutionalized spouse will be resource-eligible if the resources owned by the couple are equal to or less than $72,000. Reasonable compatibility could be applied in making this determination. If the institutionalized spouse self-attests that the spouses have $60,000 in a savings account and no other countable resources, and the data returned on the couple's resources by the State's AVS is $65,000, the State would consider the amounts reasonably compatible and determine the institutionalized spouse resource-eligible without requiring additional documentation.

Section 1924(f)(1) of the Act permits the institutionalized spouse to transfer their interest in any resources to the community spouse as soon as practicable after being determined eligible, as any resources still in the institutionalized spouse's name at their first renewal will be deemed available to the institutionalized spouse, including resources that were considered to be part of the CSRA at application. In other words, while each spouse's ownership of resources is not relevant at the determination of the institutionalized spouse's eligibility, it *is* relevant at the institutionalized spouse's redetermination. Reasonable compatibility would not serve a role in the verification of whether the institutionalized spouse maintains *ownership* of resources that were included in the initial calculation of resource eligibility.

We note that section 1924(c)(1) of the Act also requires that a State determine the resources owned by the institutionalized spouse and community spouse at the former's first continuous period of institutionalization. However, while this amount may be relevant in determining the CSRA under section 1924(f)(2) of the Act, it is not compared to a resource-eligibility standard, which means that reasonable compatibility would not apply to a State's verification of this figure.

Comment: One commenter suggested this September 2022 proposed rule may be a good opportunity to modernize the MAGI and non-MAGI verification plan submission and review process and move towards a web-based submission process instead of submitting verification plans via email.

Response: We appreciate the comment to improve the verification plan submission and review process. The comment is outside the scope of this rule. However, we will consider the comments for future enhancements of the verification plan review process.

After considering the comments, we are finalizing the revisions at §§ 435.940 and 435.952(b) and (c)(1) as proposed. We note that because the effect of this change is specific to clarifying current regulations regarding States' use of electronic data for verification of assets, it operates independently from the other provisions of this final rule.

3. Verification of Citizenship and Identity (42 CFR 435.407 and 457.380)

A State must verify an applicant's U.S. Citizenship under section 1902(a)(46)(B) of the Act, implemented at §§ 435.406 and 435.956(a). When a State has not been able to verify an applicant's U.S. citizenship through an electronic data match with the Social Security Administration (SSA), it must verify the applicant's U.S. citizenship using alternative methods described under §§ 435.407 and 435.956(a)(1). Under current regulations, individuals whose citizenship is verified based on any of the sources identified in § 435.407(b)—which include 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. Verification with a State's vital statistics records or DHS SAVE system, like the data match with SSA, provides both proof of U.S. citizenship or nationality and reliable documentation of personal identity. Once U.S.

citizenship is verified via a State's vital statistic records or DHS SAVE, a State may not require an individual to provide additional proof of identity as a condition of eligibility. As such, in the September 2022 proposed rule, we proposed to move verification of birth with a State's vital statistics records and U.S. citizenship with DHS SAVE system to the list of primary verifications of U.S. citizenship that do not require additional proof of identity, at § 435.407(a)(7) and (8) respectively. These changes are incorporated into CHIP through an existing cross-reference at § 457.380(b)(1)(i). We also proposed to remove the phrase ''at State option'' from § 435.407(b)(2), as use of such data match with a vital statistics agency is not voluntary if it is available and effective in accordance with § 435.952(c)(2)(ii).

We received the following comments on these proposed provisions:

Comment: The majority of commenters were in support of the proposed changes to allow verification of birth with a State vital statistics agency and verification of citizenship with DHS SAVE system, or any other process established by DHS, as stand-alone evidence of citizenship. Commenters agreed the changes would provide additional efficiencies in the eligibility determination process and limit the burden on applicants to provide documentation of citizenship without increasing the risk of erroneous eligibility determinations.

Response: We appreciate the support for the proposed changes at § 435.407(a)(7) and (8). We agree that allowing States to electronically verify birth with a State vital statistics agency or to verify citizenship with DHS SAVE system will create administrative efficiencies for States and eliminate the need for applicants to provide unnecessary additional information without an increased risk of erroneous eligibility determinations. In section II.A.7. of the September 2022 proposed rule, we provided details on the efficacy of these data sources, both of which serve as primary information sources, one for evidence of U.S. birth (State vital statistics) and the other for naturalized U.S. citizenship (DHS SAVE system).

Comment: A few commenters noted that some States do not have systems alignment with vital statistics, so these system changes could be costly and time consuming for States to implement.

Response: We considered these comments and acknowledge that not every State may have an existing electronic system that matches an applicant's or beneficiary's data with the State vital statistics agency. It is optional for Medicaid and CHIP agencies to have a data match established with their State vital statistics agency. We note that the proposed changes to allow birth verification through an electronic match to a State's vital statistics agency, if use of such match is available and effective (considering such factors as associated costs to the data match, cost of reliance on paper documentation, and impact on program integrity) in accordance with § 435.952(c)(2)(ii), is not a new requirement for States in this final rule. Establishing such a data match with State vital statistics agencies also promotes data integrity in the Medicaid and CHIP programs. Once such a data match is established, the State must utilize it to verify U.S. citizenship when the information from the applicant is not able to be verified with SSA or DHS, rather than requesting paper documentation from the individual.

If a State does need to make changes to its eligibility system, FFP is available at the 90 percent rate (enhanced FFP or enhanced match), in accordance with § 433.112(b)(14), for changes to support accurate and timely processing of eligibility determinations, like data matching with a State's vital statistics agency, other States' vital statistics agencies, or DHS SAVE system. Approval for enhanced FFP or enhanced match requires the submission of an Advanced Planning Document (APD). A State may submit an APD requesting approval for a 90/10 enhanced match for the design, development, and implementation of their Medicaid Enterprise Systems (MES) initiatives that contribute to the economic and efficient operation of the program, including the electronic data exchanges discussed here. Interested States should refer to 45 CFR part 95, subpart F (Automatic Data Processing Equipment and Services—Conditions for Federal Financial Participation (FFP)), for the specifics related to APD submission. States may also request a 75/25 enhanced match for ongoing operations of CMS approved systems. Interested States should refer to 42 CFR part 433, subpart C (Mechanized Claims Processing and Information Retrieval Systems), for the specifics related to systems approval.

For some States, this rulemaking may require some eligibility and enrollment systems changes, changes to operational eligibility processes, and/or potential verification plan revisions, at the same time when States are facing a significant workload following the unwinding of the continuous enrollment condition. Therefore, we are providing States with 24 months following the effective date of this final rule to demonstrate compliance with the changes. We urge all States to comply as soon as possible.

Comment: One commenter recommended CMS require States to accept birth certificates (paper or electronic) issued by the State's vital statistics agency as stand-alone evidence of U.S citizenship.

Response: We thank the commenter for this comment to consider allowing a paper copy or electronic version (that is, a PDF obtained via email) of a birth certificate from a State's vital statistics agency as stand-alone evidence of U.S. citizenship. However, with such documentation, it may be difficult for the State to know what, if any, set of identifiable information was used to obtain such birth certificate or if a data match of such information was required to obtain the paper or electronic version of the birth certificate. A paper or electronic copy of a birth certificate could be altered, causing potential concern for program integrity. By contrast, data matching for identity occurs when the State agency uses a set of personally identifiable information from the applicant to check against the State vital statistics agency for a match, enabling electronic verification of birth or U.S. citizenship. As such, we believe this provision will enhance program integrity. Evidence of identity as specified in § 435.407 would still need to be verified if a paper copy or electronic version of a U.S. birth certificate is provided, without evidence that verification with a State vital statistics agency was completed.

Comment: One commenter requested that REAL IDs be included in the list of documents providing stand-alone evidence of citizenship, since they are verified with the State's vital statistics agency.

Response: This comment is outside the scope of the proposed rule. However, it should be noted that if a State requires proof of U.S. citizenship for issuing a valid State-issued driver's license, this document can serve as stand-alone evidence of citizenship under existing regulations at § 435.407(a)(4).

Comment: Some commenters were concerned that the proposed regulation would prohibit States from verifying eligibility, could lead to increased fraud and waste in Medicaid and CHIP, and could result in ineligible individuals being enrolled in coverage.

Response: We do not believe this proposal would cause ineligible individuals to be enrolled in coverage. In fact, we believe it may reduce potential fraud and waste in the

Medicaid and CHIP programs, thereby improving program integrity. First, verifying U.S. citizenship directly through an electronic interface with a State vital statistics agency or through DHS SAVE system decreases reliance on paper documentation which may be more difficult for the individual to obtain, take longer to verify, or have a higher chance of being altered. Second, verification of U.S. citizenship with a State vital statistics agency or DHS SAVE system requires a robust data matching process. The 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) before a response is provided. Similarly, DHS SAVE system reviews a set of identifiable information to verify identity before providing a response that verifies U.S. citizenship, and in some cases, the DHS SAVE system requires additional information or paper documentation from the individual to complete the verification. Third, State vital statistics agencies record and maintain evidence of birth in the State, making them the primary source of evidence of U.S. citizenship for many individuals. Likewise, DHS is the agency that makes decisions to grant U.S. citizenship for individuals who are naturalized U.S. citizens. Thus, the DHS SAVE system is the primary Federal data source that is able to verify an individual's attestation that they are a naturalized U.S. citizen.

Comment: A few commenters indicated that only U.S. citizens, not noncitizens, should receive government benefits.

Response: This comment is outside the scope of this proposed rule. Changes proposed at § 435.407 apply only to individuals who have declared to be U.S. citizens; they do not apply to noncitizens. We note that Federal law, such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), governs eligibility of noncitizens for Federal means-tested public benefits, including Medicaid and CHIP.

After consideration of the public comments we received, we are finalizing without modification our proposal to move verification through a match with a State's vital statistics records or with the DHS SAVE program from paragraph (b) to paragraph (a) of § 435.407 as proposed. We are also finalizing without modification our proposal to remove the phrase ''at State option'' from § 435.407(b)(2), as use of such data match with a vital statistics agency is not voluntary if it is available and effective in accordance with § 435.952(c)(2)(ii). We note that because the effect of this change is specific to simplifying verification procedures to allow verification of citizenship with a state vital statistics agency or SAVE without separate identity verification, it operates independently from the other provisions of this final rule.

B. Promoting Enrollment and Retention of Eligible Individuals

1. Aligning Non-MAGI Enrollment and Renewal Requirements With MAGI Policies (§§ 435.907(c)(4) and (d) and 435.916)

Since the passage of the ACA, States have been required to apply streamlined application and renewal processes to applicants and beneficiaries whose financial eligibility is based on MAGI. Despite their potential benefit, these procedures have been optional for individuals excepted from use of the MAGI-based methodologies at § 435.603(j) (''non-MAGI'' individuals). As discussed in section II.B.1. of the September 2022 proposed rule, we proposed to revise requirements at §§ 435.907 and 435.916 to require that States adopt many of the streamlined application and renewal procedures currently required for MAGI applicants and beneficiaries for non-MAGI individuals as well. We believe these changes promote equity across all populations served by Medicaid.

As noted in the proposed rule, States are currently 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), although this is not expressly stated in the regulations. Therefore, we proposed to codify in regulation at new § 435.907(c)(4) the requirement that any MAGI-exempt applications and supplemental forms must be accepted through all modalities currently allowed for MAGI beneficiaries. We also proposed at § 435.916(a)(1) to require that States conduct regularly-scheduled eligibility renewals once, and only once, every 12 months for all non-MAGI Medicaid beneficiaries with one narrow exception (discussed below). Next, we proposed to require that States provide MAGI-excepted beneficiaries whose eligibility cannot be renewed based on information available to the State with: § 435.916(b)(2)(i), (1) a pre-populated renewal form that contains information available to the agency; and (2) a minimum of 30 calendar days from the date the agency sends the renewal form to return the signed renewal form along with any required information; and at § 435.916(b)(2)(iii), (3) a 90-day reconsideration period for individuals who return their renewal form after the end of their eligibility period and following termination for failure to return the form. We also proposed at § 435.916(b)(2)(iv) to eliminate the State option to require an in-person interview as part of the application and renewal processes for non-MAGI beneficiaries. States currently are required to comply with each of these policies for MAGI-based individuals.

Lastly, in the September 2022 proposed rule, we proposed several technical changes, on which we did not receive any comments, including: (1) at proposed § 435.916(b)(2)(i)(B) to clarify that the 30 calendar days that States must provide beneficiaries to return their pre-populated renewal form begins on the date the State sends the form; (2) at proposed § 435.916(b)(2)(iii) to specify explicitly 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; (3) at proposed § 435.916(d)(2) 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); and (4) at proposed § 435.912(c)(4), with a cross reference in proposed § 435.916(c), to establish time standards for States to complete renewals of eligibility.

This final rule redesignates several provisions from § 435.916 to the new § 435.919 rule, as discussed in section II.B.2. of this preamble. As a result, several paragraphs of § 435.916 are renumbered in this final rule. For example, § 435.916(g) (relating to accessibility of renewal forms and notices) is redesignated to § 435.916(e) of this final rule. We did not receive any comments on this change. However, as a reminder, this provision requires State Medicaid programs to ensure that any renewal form or notice be accessible to persons who have limited English proficiency and persons with disabilities, consistent with § 435.905(b). Further, State Medicaid

programs are separately required under Federal civil rights laws to conduct their programs and activities in an accessible manner. State agencies that receive Federal financial assistance must take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include provision of language assistance services (section 1557 of the ACA, 42 U.S.C. 18116; Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d *et seq.*). States are also required to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services (section 1557; section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794; and Title II of the Americans with Disabilities Act, 42 U.S.C. 12131 *et seq.*).[10] Nothing in this final rule changes these requirements.

We note that the requirements in part 435, subpart J, apply specifically to the 50 States, the District of Columbia, the Northern Mariana Islands, and American Samoa and through a cross reference at § 436.901 they also apply to Guam, Puerto Rico, and the Virgin Islands (with the exception of § 435.909). The revisions to §§ 435.907 and 435.916, and all other revisions to part 435, subpart J, included in this rule, apply equally to the 50 States, the District of Columbia, and all territories.

We received the following comments on these proposed provisions:

Comment: Commenters generally supported the alignment of the non-MAGI with MAGI processes proposed under §§ 435.907 and 435.916, including allowing non-MAGI individuals to apply and renew through all modalities, renewing eligibility no more frequently than every 12 months, providing a pre-populated renewal form, giving enrollees 30 days to respond, and allowing a 90-day reconsideration period. Commenters noted that these proposed requirements, which originated in the ACA for the MAGI-based populations, have all proven possible to implement and effective at reducing churn of beneficiaries on and off Medicaid. Furthermore, non-MAGI populations tend to have fixed, routine sources of income, and so tend to stay consistently eligible, and yet, commenters asserted, States have not been allowed to extend to them the simplified enrollment and renewal processes available to MAGI populations that would help prevent churn. Therefore, commenters support now extending these policies to the non-MAGI groups as proposed in the September 2022 proposed rule.

Other commenters pointed out that the proposed changes to align renewal requirements for MAGI and non-MAGI individuals would reduce administrative burdens on State Medicaid agencies, by creating one simplified set of renewal rules for State eligibility and enrollment call center workers, enrollees, assisters, and other interested parties to understand and implement. One commenter also highlighted that the September 2022 proposed rule would extend some of the requirements for applications to renewals, such as at proposed § 435.916(b)(2)(iii), which, via cross reference to § 435.912(c)(3) of the current regulation, would require that States determine eligibility at renewal within the same timeliness standards applicable to processing applications; this would allow States to consolidate eligibility and enrollment information for each applicant or beneficiary in one case record.

Response: We agree with these commenters that aligning these application and renewal procedures will promote continuity of coverage, decrease churn, 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. We note that this alignment will be particularly beneficial to individuals in households in which some individuals are eligible based on MAGI and others are eligible on a non-MAGI basis, as non-MAGI household members may otherwise be subject to more burdensome administrative requirements. We also believe alignment will reduce administrative burden for States. We want to clarify that, under the current regulations, States are permitted, at their option, to apply to their non-MAGI populations the application and renewal procedures we proposed to require in this rulemaking. The proposed revisions at §§ 435.907(c)(4) and 435.916(a)(1) and (b)(2)(i), (iii), and (iv), which we are finalizing as proposed in this final rule, will make it mandatory for States to do so.

Comment: One commenter noted that the proposal at § 435.907(c)(4), requiring that States accept all MAGI-exempt applications and supplemental forms provided by applicants seeking coverage on a non-MAGI basis through all the modalities allowed for MAGI individuals, would require substantial systems changes to implement, as currently non-MAGI renewals are processed in a separate system from MAGI renewals, and such updates would take longer than 12–18 months given States' unwinding priorities.

Response: We understand that State system updates needed to accept applications and supplemental as well as renewal forms via additional modalities will take time and resources. However, as this is a longstanding policy being codified through rulemaking, we find this to be a reasonable investment given the reduction in beneficiary burden that will result from being able to submit required information in whatever modality best fits the needs of the applicant or beneficiary. CMS has been working with States to enforce this requirement, and those not already in compliance now have a mitigation plan approved by CMS to come into compliance.

Additionally, while encouraged, there is no requirement for States to integrate non-MAGI with MAGI systems but rather to make non-MAGI applications and renewals possible through the same modalities—for example, paper, phone, web-based—as MAGI applications and renewals. We do recognize the operational challenges States face and are finalizing these requirements so that they are effective upon the effective date of this rule, except as otherwise required (such as by the CAA, 2023). However, States will have 36 months after the effective date of this rule to complete all system and operational changes necessary for compliance. This implementation timeframe will permit States to complete most unwinding and mitigation-related activities and then have adequate time to complete any additional system changes needed for full compliance with the requirements to align non-MAGI application and renewal requirements with those applicable to MAGI beneficiaries.

We remind States that enhanced FFP is available, in accordance with § 433.112(b)(14), at a 90 percent matching rate for the design, development, or installation of improvements to Medicaid eligibility determination systems, in accordance with applicable Federal requirements. Enhanced 75 percent FFP is also available for operations of such systems, in accordance with applicable Federal requirements.

Comment: Some commenters specifically supported the proposed limitation on renewals to no more than once every 12 months at § 435.916(a)(1),

[10] For more information, *see* U.S. Dept of Health & Human Servs., Re: Ensuring Language Access for Limited English Proficient (LEP) Individuals and Effective Communication for Individuals with Disabilities During the States' Unwinding of the Medicaid Continuous Enrollment Condition (Apr. 4, 2023), *https://www.hhs.gov/sites/default/files/medicaid-unwinding-letter.pdf.*

stating this would help improve health equity by ensuring that vulnerable populations maintain their Medicaid coverage. Commenters stated that more frequent renewals increase the number of eligible individuals who lose coverage, while conducting eligibility determinations only once every 12 months will reduce churn and provide non-MAGI beneficiaries with greater stability of coverage. While generally supporting the proposal requiring States to conduct regularly scheduled renewals once, and only once, every 12 months, some commenters requested that the Medically Needy population be excluded from this requirement, because the determination of medical expenses that individuals must incur to establish eligibility must be completed more frequently than once every 12 months.

Response: We appreciate the support for this proposed provision. With respect to the request to exempt medically needy beneficiaries from the limitation on renewals to once every 12 months, we note that a State's medically needy budget period and its renewal schedule do not need to be identical. Under § 435.831(a)(1) of the current regulations, States can adopt a budget period between 1 and 6 months. While States need to verify that individuals have met their spenddown every budget period, they do not need to recalculate their spenddown amount every budget period. The spenddown amount will remain constant until the next renewal unless the individual experiences a change in circumstances that might impact their eligibility. For example, a number of States currently limit renewals for their medically needy populations to once every 12 months, regardless of the length of their budget periods. Likewise, we do not know of any States with a 1-month budget period that conduct a full renewal of eligibility for medically needy beneficiaries every month on the same timeline. Therefore, we do not agree that alignment of regular renewals with the budget period is needed, and we are finalizing the requirement at § 435.916(a)(1) as proposed to permit renewals no more frequently than once every 12 months, with the limited exception discussed later in this final rule.

Comment: A number of commenters supported our proposal at §§ 435.907(d)(2) and 435.916(b)(2)(iv) to eliminate in-person interviews for non-MAGI eligible enrollees. They noted that the proposed change would reduce burden on enrollees, especially those with difficulties with activities of daily living, disabilities, behavioral health issues, and any individuals who are hampered by work schedules, inability to obtain childcare, or lack of transportation.

Response: We agree and appreciate the support for this proposed provision. We believe in-person interview requirements create a barrier for eligible individuals to obtain and maintain coverage without yielding any additional information that cannot be obtained through other modalities, particularly for individuals without access to reliable transportation or a consistent schedule.

Comment: A few commenters requested that CMS extend the proposed prohibition on mandatory in-person interviews at §§ 435.907(d) and 435.916(b) to include all interviews, including phone and video interviews, for both non-MAGI and MAGI beneficiaries, because they create significant barriers. These commenters explain that a phone or video interview is no more necessary than an in-person interview. One commenter explained that, in States that currently require interviews as a condition of eligibility, individuals are allowed to complete the interview by phone, so unless the interview requirement is eliminated completely, this proposed change is unlikely to reduce procedural denials based on failure to complete the interview.

Response: We appreciate and share the commenters' desire to remove unnecessary barriers to retaining enrollment for non-MAGI beneficiaries. We are finalizing our proposal to prohibit in-person interviews for non-MAGI beneficiaries as proposed. If any States use phone or video interviews to fulfill the requirement of an in-person interview, these interview types are also prohibited.

Comment: One commenter stated their support for requiring that States provide non-MAGI beneficiaries with prepopulated renewal forms at § 435.916(b)(2)(i)(A), which should assist many individuals who have difficulties with eyesight, cognition, and language barriers that interfere with understanding complex instructions. One commenter supported CMS requiring a prepopulated form because it will reduce the burden on people with disabilities, their families, and service providers and will also reduce burden on legal services and other assisters who assist individuals seeking coverage across the different Medicaid eligibility pathways. Another commenter supported CMS requiring States to give beneficiaries a prepopulated renewal form, which would make it much easier for beneficiaries to complete the forms and reduce risk of errors. Another commenter proposed that CMS should make the proposal to require a prepopulated renewal form for non-MAGI beneficiaries a State option. This commenter stated that if CMS were to finalize the requirement as proposed, States would need funding to support system changes as well as significant technical assistance with implementation.

Response: We appreciate the support and agree that using a prepopulated form will reduce burden and the risk of errors both when a beneficiary completes the form and when the State enters information into its system. We understand that system updates needed to implement the form will take time and resources. However, we find this to be a reasonable investment given the reduction in both beneficiary and State burden that will result, as beneficiaries will no longer be required to gather and resubmit, and State workers will not need to re-enter, information already available to the State or already in the system. Again, we remind States that enhanced FFP is available, in accordance with § 433.112(b)(14), at a 90 percent matching rate for the design, development, or installation of improvements to Medicaid eligibility determination systems, in accordance with applicable Federal requirements. Enhanced FFP is also available at a 75 percent matching rate, in accordance with § 433.116, for operations of such systems, in accordance with applicable Federal requirements. Receipt of these enhanced funds is conditioned upon States meeting a series of standards and conditions to ensure investments are efficient and effective.

For the reasons noted, we are finalizing § 435.916(b)(2)(i)(A), which requires States to send a prepopulated renewal form when the State needs additional information to renew a beneficiary's eligibility, as proposed.

Comment: One commenter indicated their support for the determination of Medicaid eligibility to be done through various State applications, including the use of the Supplemental Nutrition Assistance Program (SNAP) benefits assessment, to automatically supplant the renewal process and use that data to determine eligibility renewals.

Response: Although we support the development of integrated applications that enable individuals to apply for multiple programs using a single application, we did not propose to permit States to use the applications used by SNAP or any other program in lieu of a Medicaid application or renewal form. Accordingly, this comment is outside the scope of this rulemaking. For more information about

States' ability to integrate SNAP and Medicaid applications, see the August 31, 2015, SHO letter (SHO #15–001) ''RE: Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies.'' [11]

Comment: Some commenters expressed concern that States with integrated eligibility systems would be challenged to implement the policies proposed at § 435.916(b)(2)(i)(B) and (C), to require that States provide non-MAGI beneficiaries with at least 30 calendar days to return the prepopulated renewal form and other requested information, as well as a 90 calendar day reconsideration period following termination due to failure to return the renewal form or requested information, because these timelines do not align with the time frames for SNAP and Temporary Assistance for Needy Families (TANF). Commenters believe that lack of alignment with these programs could lead to beneficiary confusion and increase the risk of a higher rate of procedural denials. Other commenters encouraged CMS to find a solution to the different timeframes between Medicaid and SNAP for beneficiaries to return required additional information and offer a waiver or other option to States that jointly administer their Medicaid and SNAP programs to adjust this requirement. Lastly, some commenters opposed the proposal to apply the renewal processes at current § 435.916(a)(3) to non-MAGI beneficiaries due to concerns that States with integrated eligibility systems would have trouble implementing a prepopulated renewal form for Medicaid when the same form is used for other programs like SNAP and TANF that use different income counting methodologies.

Response: We acknowledge the important work that many States have undertaken to establish integrated eligibility systems and simplified notices across their health and human service programs, like Medicaid, CHIP, SNAP, and TANF. However, we believe it is equally important to provide the same streamlined renewal processes for all Medicaid beneficiaries, regardless of the financial methodologies used to determine their eligibility. This is particularly important for households with both MAGI and non-MAGI Medicaid beneficiaries, for whom unaligned processes could increase confusion and result in increased procedural terminations.

Further, we have worked with other human service programs, including SNAP, to better understand their requirements and to identify areas for potential alignment. While we recognize the challenges that States face in developing integrated eligibility and enrollment systems serving multiple programs, we do not believe that the processes proposed in § 435.907(c)(4) or § 435.916 of the September 2022 proposed rule increase the challenges States face in aligning their Medicaid and CHIP renewal processes with other human service programs like SNAP. CMS is available to provide technical assistance to States attempting to develop such an integrated system.

Comment: A few commenters urged CMS to consider extending the time period for all beneficiaries to provide requested information at renewal from a minimum of 30 calendar days to 45 or 60 calendar days. Others also supported potentially increasing the timeframe available to non-MAGI beneficiaries to 75 calendar days. These commenters were concerned that 30 calendar days may not be enough time for current beneficiaries to gather requested information. Commenters were concerned that while individuals who may not respond within the 30 days will have a reconsideration period after termination, they may still experience gaps in coverage that could potentially be avoided if they had more time initially to provide requested information.

Response: We appreciate commenters' concerns to ensure that current beneficiaries have sufficient time to respond and prevent interruptions to coverage. We note that States continue to retain the ability to allow additional time beyond the required minimum of 30 calendar days for both MAGI and non-MAGI beneficiaries. However, our goal is to align requirements for non-MAGI beneficiaries with those currently applicable for MAGI beneficiaries. We believe the benefits of aligning the renewal requirements for all beneficiaries will operationally simplify the process for States and reduce confusion for beneficiaries. We did not propose any changes to the amount of time required for MAGI beneficiaries to return requested information at renewal at § 435.916(a)(3)(i)(B) but may consider extending the minimum timeframe beyond 30 calendar days for both MAGI and non-MAGI beneficiaries in future rulemaking. We are finalizing 30 calendar days for non-MAGI beneficiaries as proposed.

Comment: While most commenters supported requiring a reconsideration period after the date of termination, a few believed that 90 calendar days for the reconsideration period proposed at § 435.916(b)(2)(i)(C) is too long and could lead to increased recoupments from providers. Instead, they suggested 60 calendar days to ensure beneficiaries have adequate time to receive notices and reply as well as to align with the Marketplaces' special enrollment period (SEP) timeframes.

Response: In proposing 90 calendar days for the reconsideration period, our goal was to provide an equitable experience for all Medicaid beneficiaries, regardless of the financial methodologies used to determine their eligibility, and to eliminate the confusion that may result from different renewal timeframes for different household members who are subject to different methodologies. The 90 calendar days for the reconsideration period proposed for non-MAGI beneficiaries would achieve alignment with the current requirement that provides a 90-day reconsideration period for MAGI beneficiaries.

We do not believe that requiring States to provide non-MAGI beneficiaries who have been terminated for procedural reasons with 90 calendar days for the reconsideration period to return their renewal form and any additional documentation needed will have any impact on recoupment from providers. Indeed, because a reconsideration period increases the number of terminated individuals who successfully reenroll in the program relatively quickly, provider reimbursement is likely to benefit.

The reconsideration period after termination should not be confused with the amount of time individuals have to return a renewal form and other needed documentation before their eligibility period expires, which we proposed to be 30 days at § 435.916(b)(2)(i)(B). We appreciate the suggestion to align with the Marketplace, but in this case, we believe the Medicaid standard is preferable. We do not believe that lack of alignment between Medicaid's reconsideration period and the 60-day Special Enrollment Period (SEP) poses a significant problem for coordination between these programs and are not aware of any challenges that the current 90 calendar days for the reconsideration period for MAGI beneficiaries poses for coordination between the Marketplace and Medicaid.

After considering these comments, we are finalizing §§ 435.907(c)(4) and (d) and 435.916 as proposed. We note that

[11] *https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SHO-15-001.pdf.*

these changes to eligibility determination processes for non-MAGI populations require States to: conduct renewals no more than once every 12 months; use prepopulated renewal forms; provide a minimum 90-day reconsideration period after termination for failure to return information needed to redetermine eligibility; eliminate mandatory in-person interviews at application and renewal; and limit requests for information on a change in circumstances to information on the change, operate independently from the other provisions of this final rule. Because each of these changes individually serves to reduce the burden on applicants and beneficiaries associated with eligibility determinations, we believe they also operate independently from one another.

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

In the September 2022 proposed rule, we proposed to add a new § 435.919 to clearly define States' responsibility to act on changes in circumstances. We proposed to revise and redesignate § 435.916(c) (related to procedures for reporting changes) and (d) (related to promptly acting on changes in circumstances and scope of redeterminations based on changes in circumstances) of the current regulations to new § 435.919. In addition to modifying these existing requirements, we proposed to describe the steps that States must take when reevaluating eligibility based on changes in circumstances reported by beneficiaries and when reevaluating eligibility based on changes in circumstances received from a third-party data source. We also proposed that States must provide beneficiaries with at least 30 calendar days to respond to requests for additional information and 90 calendar days for the reconsideration period during which beneficiaries who failed to provide requested information related to a change in circumstances can still do so and have their eligibility reinstated if eligible. Finally, we modified existing language at § 435.916(d)(2), redesignated to proposed § 435.919(b)(3), to clarify that States must act on anticipated changes at an appropriate time (instead of *the* appropriate time). Generally, these proposed provisions were incorporated into the CHIP regulations at new § 457.344.

We received the following comments on these proposals:

Comment: One commenter requested clarification regarding proposed § 435.919(a) for States ''to ensure that beneficiaries understand the importance of making timely and accurate reports of changes in circumstances that may affect their eligibility'' and CMS' expectations for States to meet these requirements. The commenter expressed concern that States that currently provide information regarding reporting requirements via the rights and responsibilities to which individuals agree when submitting their initial application, and which are repeated in the notice informing individuals of their eligibility, may not provide sufficient notice.

Response: As discussed in section II.B.2. of the September 2022 proposed rule, we proposed redesignating current requirements at § 435.916(c) related to procedures for reporting changes to proposed §§ 435.919(a) and 457.344(a). It was not our intent to apply new requirements about the procedures States must have in place to communicate with Medicaid and CHIP beneficiaries on accurate and timely reporting for changes in circumstances that may affect their eligibility. Providing clear information about this responsibility in the description of the rights and responsibilities provided to applicants and individuals determined eligible for coverage can satisfy this requirement. States continue to have flexibility to communicate this information through other avenues as well.

Comment: We received many comments regarding the proposed processes for acting on changes in circumstances at §§ 435.919(b) and 457.344(b). Although commenters supported the alignment between Medicaid and CHIP when States act on changes in circumstances, commenters generally opposed the proposed approach as being overly prescriptive and complex for State eligibility workers to implement. Some commenters raised concerns that the number of decision points, such as when a request for additional information may be needed and what actions States must take in the different scenarios, would increase the likelihood of errors. Others expressed concerns that the proposed process would increase administrative burden by requiring States to evaluate each reported change to determine whether it might impact eligibility prior to processing the information. Commenters recommended applying a single process to all changes in circumstances rather than differentiating based on the source that reports the change.

Response: We appreciate the feedback from commenters about the potential administrative challenges of implementing §§ 435.919(b) and 457.344(b) as proposed. As discussed in section II.B.2. of the September 2022 proposed rule, our intent in establishing a new section in part 435 (§ 435.919) (and a corresponding new section in part 457 (§ 457.344)) was not to create a set of new requirements that States must follow when they receive information about a change in circumstances. Our intent was to clarify existing requirements to ensure that States act on changes timely and in a manner that protects the coverage of beneficiaries who remain eligible (thereby, reducing unnecessary procedural terminations). Rather than increasing administrative burden by requiring States to establish a host of new actions and decision points within their process for redetermining eligibility based on changes in circumstances, the clear set of required actions described in this final rule is intended to help States to streamline their processes and reduce errors.

We agree with commenters that the structure of proposed § 435.919(b), differentiating between changes reported by a beneficiary and changes reported by a third-party data source, with additional requirements for anticipated changes known to the agency, appears to create varied and potentially conflicting requirements for different types of changes and may cause confusion. Therefore, in this final rule, we revise § 435.919(b) to streamline these requirements and establish a single set of actions that are required when a State receives reliable information about a change in circumstances that may impact a beneficiary's eligibility.

In this final rule, we combined proposed § 435.919(b)(1)(i), requiring the State to evaluate whether a beneficiary-reported change may impact that beneficiary's eligibility, with the requirement proposed at § 435.919(b)(2)(i) that the State evaluate whether the information received from a third-party data source was accurate and if accurate, whether it may impact a beneficiary's eligibility. As such, we are finalizing § 435.919(b) to require States to promptly redetermine eligibility between regularly scheduled renewals, whenever they have obtained or received reliable information about a change in a beneficiary's circumstances that may impact the beneficiary's eligibility for Medicaid, the amount of medical assistance for which the beneficiary is eligible, or the beneficiary's premiums or cost sharing charges. Reliable information includes changes reported by beneficiaries or

their authorized representatives, as well as information obtained from third-party data sources identified in States' verification plans that the State has determined to be accurate.

At § 435.919(b)(1) we are finalizing the requirement (proposed in the same paragraph) that in redetermining eligibility based on a change in circumstances, the agency must complete the redetermination based on available information, whenever possible. If the State does not have all information needed to complete a redetermination, it must request needed information from the beneficiary in accordance with § 435.952(b) and (c).

At § 435.919(b)(2) and (3) of this final rule, we combine the requirements proposed at § 435.919(b)(1)(iii) and (b)(2)(iii), to describe the requirements when a reported change may result in additional medical assistance (including lower premiums and/or cost sharing charges). If the change was reported by the beneficiary, as described at § 435.919(b)(2)(i) of this final rule, prior to furnishing additional medical assistance, the State must verify the change in accordance with its verification plan. However, if the change was obtained from a third-party data source, as described at § 435.919(b)(2)(ii) of this final rule, the State may verify the information with the beneficiary prior to completing the determination. States are not required to verify such changes with the beneficiary. Proposed § 435.919(b)(1)(iii) and (b)(2)(iii) also included a prohibition against terminating the coverage of a beneficiary who fails to respond to a request for information to verify their eligibility for increased medical assistance. This requirement is finalized at § 435.919(b)(3).

We are finalizing, at § 435.919(b)(4), the requirement proposed at § 435.919(b)(2)(ii) when third-party data indicates a change that would adversely impact a beneficiary's eligibility. Prior to taking adverse action based on information from a third-party data source, the State must provide the beneficiary with an opportunity to furnish additional information to verify or dispute the information received. An adverse action, as defined at § 431.201, includes a termination, suspension, or reduction in covered benefits, services, or eligibility, or an increase in premiums or cost sharing charges. At § 435.919(b)(5), we are finalizing the required actions proposed at § 435.919(b)(4), when a State determines that a reported change in circumstances results in an adverse action. These include compliance with the requirements to consider eligibility on other bases, determine potential eligibility for other insurance affordability programs, and provide advance notice and fair hearing rights.

We complete the revisions to § 435.919(b) with a requirement at paragraph (b)(6) regarding anticipated changes. This requirement is finalized as proposed at § 435.919(b)(3), except we added a cross-reference to paragraphs (b)(1) through (5) to clarify that the same steps apply when States are reevaluating a beneficiary's eligibility based on an anticipated changes in circumstances. Lastly, in this final rule, we revise the CHIP regulations at § 457.344 to correspond with the modifications at § 435.919, as discussed previously in this final rule, and ensure continued alignment between Medicaid and CHIP. However, we note that there are some minor differences at § 457.344 to account for Medicaid requirements that do not apply to CHIP, such as considering eligibility on all other bases.

Comment: One commenter sought clarification on what would be considered ''additional medical assistance'' for purposes of acting on changes in circumstances under proposed § 435.919(b). Some commenters also had questions about whether moving individuals between eligibility groups, when the move results in no change to the benefits to which the individual is entitled, should be considered ''additional medical assistance'' when acting on changes in circumstances.

Response: The term ''additional medical assistance'' at § 435.919(b)(2), as well as the term ''additional child or pregnancy-related assistance'' at § 457.344(b)(2), mean any practical change to an individual's coverage that is beneficial to the individual. For example, an individual moving from an eligibility group provided with limited benefits (for example, the eligibility group limited to family planning and related services at § 435.214) to another eligibility group that receives a comprehensive benefit package (for example, the eligibility group for parents and other caretaker relatives at § 435.110) would be considered to be receiving ''additional medical assistance'' because the individual is now entitled to more benefits. Another example would be a reduction or elimination of cost sharing or premiums, applied to a beneficiary who experienced a reduction in income. We also consider movement between eligibility groups that does not result in a practical change in benefits to be included within the term ''additional medical assistance'' for the purposes of meeting the requirements under proposed §§ 435.919(b)(2) and 457.344(b)(2).

Comment: Some commenters had questions about what States should do under proposed § 435.919 when a reported change could result in an individual moving to a different eligibility group, particularly when the movement between eligibility groups may not impact benefits. Commenters sought clarification on whether States should reach out to beneficiaries regarding changes in circumstances that would result in a beneficiary changing eligibility groups and what to do if the beneficiary fails to respond to requests for additional information. One commenter recommended that States be allowed to move the individual between eligibility groups even if the individual does not respond to requests for information.

Response: States are required, as described at §§ 435.919(b) and 457.344(b) of this final rule, to redetermine eligibility whenever they receive information about a change in circumstances that may impact a beneficiary's eligibility. We recognize that some changes in circumstances result in an adverse action, making the beneficiary ineligible or eligible for less medical assistance (that is, fewer benefits or higher cost sharing), some changes in circumstances result in eligibility for additional medical assistance, and other changes in circumstances necessitate a change from one eligibility group to another without impacting the medical assistance available to the beneficiary. In cases where a change in circumstances has no practical impact on a beneficiary's coverage, for example, eligibility for a different group with no change in coverage, the requirements described at §§ 435.919(b)(2) and 457.344(b)(2) of this final rule apply. The State must attempt to act on the change, if reported by the beneficiary, consistent with applicable verification requirements (§§ 435.940 through 435.960 for Medicaid and § 457.380 for CHIP) and the State's verification plan. If the State is able to verify the information, then the beneficiary would be moved to the new group. If the change was provided by a third-party data source, the State may verify the change with the beneficiary. If the State elects to verify information with the beneficiary and the beneficiary confirms that the change is correct, then the beneficiary would also be moved to the new group. However, if the State is unable to verify the information with the beneficiary, the individual must remain in their current eligibility group; consistent with

§§ 435.919(b)(3) and 457.344(b)(3), the individual's eligibility may not be terminated for failure to respond to a request for additional information.

Comment: Some commenters noted a lack of clarity in the proposed rule about when information from a third-party data source would be considered ''reliable'' consistent with proposed § 435.919(b)(2)(i) and encouraged CMS to provide additional guidance on the data sources or types of information that could be considered reliable.

Response: We expect States to make eligibility determinations for Medicaid and CHIP based on the most current and reliable information available to them. Information available in a beneficiary's case record or other more recent information available to the State, including information from electronic data sources or other agencies such as SNAP, would be considered reliable for this purpose. For example, if a State receives information from a third-party data source, such as Equifax, indicating a change in a beneficiary's income, but that information is older than other income information the State received from another agency, such as TANF, the State should not act on the older information from the third-party data source. See the December 2020 Center for Medicaid and CHIP Services (CMCS) Informational Bulletin ''Medicaid and CHIP Renewal Requirements'' for additional information.[12]

Comment: One commenter expressed concern about how the proposed changes in circumstances requirements would interact with the reasonable opportunity period for individuals otherwise eligible for full Medicaid or CHIP benefits who do not respond to requests for additional information to resolve discrepancies about their declared satisfactory U.S. citizenship or satisfactory immigration status. The commenter provided an example when an individual is receiving limited Medicaid benefits for the treatment of an emergency medical condition who later declares to have a change in immigration status which makes them eligible for full Medicaid benefits.

Response: Sections 1137(d)(3), 1902(a)(46)(B), 1902(ee) and 2105(c)(9) of the Act require that States verify that an individual is a U.S. citizen or has a satisfactory immigration status when determining eligibility for Medicaid and CHIP. If States are unable to verify a beneficiary's U.S citizenship or satisfactory immigration status or a reported change in such status, existing regulations at §§ 435.956(b) and 457.380(b)(1) require States to provide individuals with a reasonable opportunity period to verify such information. During this reasonable opportunity period, States must provide the individual with benefits that they would otherwise be eligible for consistent with §§ 435.956(a)(5)(ii) and 457.380(b)(1)(ii).

In this scenario, in which an individual is eligible only for the treatment of an emergency medical condition in Medicaid due to not having U.S. citizenship or satisfactory immigration status, but the individual reports a change by declaring to be a U.S. citizen, U.S. national, or having satisfactory immigration status, we would expect the State to attempt to verify the information consistent with § 435.919(b)(1), which cites to existing citizenship/immigration verification requirements at § 435.956. If the State is unable to verify the declared U.S. citizenship or satisfactory immigration status promptly, the State must provide the individual with a reasonable opportunity period and must continue efforts to complete the verification of the individual's citizenship or satisfactory immigration status, or request documentation if necessary. Once the reasonable opportunity period is provided, the State may begin to furnish full Medicaid benefits provided the individual is otherwise eligible (that is, the individual satisfies all other eligibility criteria). At that time, such State would be expected to follow the reasonable opportunity requirements at § 435.956(b), including providing proper notice to the individual about when the reasonable opportunity period begins and ends. If, by the end of the reasonable opportunity period, the individual's U.S. citizenship or satisfactory immigration status has not been verified, States would be expected to terminate the individual's full Medicaid benefits within 30 days. At that point coverage would revert back to limited coverage for the treatment of an emergency medical condition as described in section 1903(v)(2)(A) of the Act.

Comment: Many commenters did not support proposed § 435.919(b)(2)(iii), which would allow States to verify information received from a third-party data source with the beneficiary before providing additional medical assistance or lowering cost sharing. Commenters indicated that currently at renewal States are required to act on reliable information from a third-party data source that results in eligibility for additional medical assistance or lower cost sharing without verifying the information with the individual. The commenters believe that States similarly should be required to act on reliable information received from a third-party data source that indicates a change in circumstances resulting in eligibility for additional medical assistance or lower cost sharing without verifying the change with the beneficiary.

Response: We appreciate commenters' concerns. The intent of our proposal was to codify existing policy. States currently have the option to act on information obtained from a third-party data source without verifying the information with the individual prior to providing the additional benefits. Because we did not propose to change this policy, we are finalizing this policy as proposed but will take the comments into consideration in the future. At §§ 435.919(b)(2)(ii) and 457.344(b)(2)(ii), we are finalizing the option for States to confirm third-party information with a beneficiary, prior to providing additional medical assistance or reducing premiums and/or cost sharing. However, we retain the requirement at §§ 435.919(b)(3) and 457.344(b)(3) that States may not terminate a beneficiary's eligibility if they do not respond to a request for additional information to verify such third-party information.

Comment: Some commenters supported the requirement at § 435.919(b)(1)(iv) to require States to send a notice to a beneficiary who reports a change that does not ultimately impact their eligibility. However, many other commenters believe that requiring a notice in this situation would be administratively burdensome for States and could create confusion for beneficiaries. Commenters were particularly concerned about the potential for confusion following the end of the continuous enrollment condition.

Response: While we believe that communication with beneficiaries is critical, we appreciate commenters' concerns that this requirement both imposes additional burden on States and could cause unnecessary confusion for beneficiaries. Therefore, we are not finalizing the requirement at proposed §§ 435.919(b)(1)(iv) and 457.344(b)(1)(iv) that States must send a notice to beneficiaries that the information they reported was received but did not impact their eligibility. However, we encourage States to develop clear notices, at their option, to acknowledge such reported changes and assure beneficiaries that there is no impact on their eligibility or coverage.

Comment: Many commenters supported the proposed requirement at

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

§§ 435.919(b)(1)(iii) and (b)(2)(iii) that would prohibit a State from disenrolling a beneficiary who does not respond to requests for additional information to verify a change in circumstance that would result in a beneficial change, such as more medical assistance or lower cost sharing.

Response: We appreciate commenters' support of our proposal to keep individuals enrolled in Medicaid and CHIP when they do not respond to requests that would potentially result in more beneficial coverage, such as additional benefits or lower cost sharing. We are finalizing § 435.919(b)(1)(iii) and (b)(2)(iii), redesignated at § 435.919(b)(3) for Medicaid, as proposed. In addition, we are finalizing the corresponding CHIP provisions, proposed at §§ 457.344(b)(1)(iii) and (b)(2)(iii), and redesignated here as § 457.344(b)(3) of this final rule, as proposed.

Comment: Many commenters were supportive of proposed § 435.919(c)(1) to require that States provide beneficiaries with at least 30 calendar days to respond to requests for additional information related to a change in circumstances, which would align with the current policy to provide MAGI-based beneficiaries with at least 30 days to return a renewal form. Commenters noted that beneficiaries often have significant difficulty in responding to requests for additional information, particularly when documentation is needed. However, some commenters expressed concern that this requirement would have a significant fiscal impact on States. These commenters noted that the policy would require States to maintain coverage for at least two additional months for individuals who may ultimately be determined ineligible for Medicaid. They stated that this additional time could have a considerable fiscal impact on States, especially in the case of beneficiaries enrolled in a managed care delivery system. Commenters also sought clarification from CMS on how proposed § 435.919(c)(1) interacts with the minimum 10-day advance notice currently required prior to taking an adverse action (§ 431.211).

Response: We appreciate commenters' support for alignment of beneficiary response timeframes at renewal and following a change in circumstances for Medicaid and CHIP. We also appreciate commenters' concerns about maintaining coverage for individuals who may be determined ineligible, and we recognize the fiscal constraints that may incentivize speedy disenrollment of potentially ineligible beneficiaries. However, the benefits of providing individuals with adequate time to collect needed information and respond to a request from their State Medicaid or CHIP agency are clear. As discussed earlier, maintaining enrollment and reducing enrollment churn has the potential to improve beneficiary health; reduce the need for high-cost interventions that can result from delayed care; reduce administrative burdens for individuals, health care providers, and State agencies; improve the ability of beneficiaries and their providers to form lasting relationships; and protect beneficiaries from medical debt and providers from non-payment.

Current § 435.930(b) requires States to continue to furnish Medicaid to beneficiaries until they are found to be ineligible, and States cannot complete a finding of ineligibility without giving the beneficiary an adequate opportunity to explain, disprove, or verify information received from a third party. We believe a minimum 30-day response period provides adequate time for beneficiaries to respond and does not create undue burden on States. In addition, we agree with comments that support aligning policies between renewals and changes in circumstances to make administration simpler for States and reduce beneficiary confusion in terms of the expectations regarding their response to requests for additional information. As such, we are finalizing the 30-day response period at § 435.919(c)(1) for Medicaid and § 457.344(c)(1) for CHIP as proposed.

We appreciate the question about how the requirement at § 431.211, to provide a minimum of 10 days advance notice prior to taking an adverse action, fits together with the 30-day response period finalized in this rule, when a beneficiary's eligibility must be terminated for failure to provide the requested information and will provide additional guidance on this question in the future.

Comment: While many commenters viewed requiring a minimum timeframe for beneficiaries to respond to requests for additional information as a helpful way to combat churn, one commenter suggested that approach was not effective. Instead, this commenter highlighted the importance of providing States with additional flexibility to be able to gradually end Medicaid benefits for individuals who may appear to be no longer eligible rather than applying additional rules to States.

Response: This comment is beyond the scope of this rulemaking. We note that medical assistance can only be provided to individuals who meet all eligibility requirements under a State plan or demonstration project authorized under section 1115 of the Act. While States are required to continue to furnish benefits until an individual has been found ineligible, consistent with § 435.930 of the current regulations, Federal financial participation is not available for individuals determined to no longer meet eligibility criteria.

Comment: Commenters were also generally supportive of the requirement at proposed § 435.919(c)(1)(ii) that would require States to allow beneficiaries to respond to requests for information through any modality specified in § 435.907(a), but a few commenters expressed concerns at being able to ensure that all methods were available given that changes in circumstances happen frequently and that it would be challenging for States to track all modalities of submission.

Response: We appreciate commenters' raising their concerns about challenges States may face when developing procedures for beneficiaries to report changes or provide additional information regarding changes in circumstances consistent with §§ 435.919 and 457.344. However, we note that these are not policy changes. They simply codify existing policies. States are currently required to allow beneficiaries to report information about changes through all modalities that are also available to individuals submitting a new application under existing § 435.916(c), which is redesignated at § 435.919(a) for Medicaid and § 457.344(a) for CHIP in this final rule. Therefore, we are finalizing §§ 435.919(c)(1)(ii) and 457.344(c)(1)(ii) as proposed.

Comment: The majority of commenters supported the redesignation of existing requirements at § 435.916(d), which limit the scope of requests for additional information to only those related to the reported change in circumstance, to new § 435.919(e).

Response: We appreciate commenters' support of our proposal. We are finalizing § 435.919(e) and the corresponding CHIP regulation at § 457.344(e) as proposed.

Comment: Similar to the existing 90-day reconsideration period at application, many commenters expressed support for providing a reconsideration period for individuals who return requested information relating to a change in circumstances after their coverage has been terminated. Many commenters noted that this policy would reduce the burden of processing new applications and simplify implementation by applying a

consistent policy for renewals and changes in circumstances. However, some commenters urged CMS to consider removing the language in proposed § 435.919(d) that limited the requirement to provide a 90-day reconsideration period to only individuals who are terminated for procedural reasons (that is, because they did not respond to the State's request for additional information). Commenters stated that providing a reconsideration period for individuals whose coverage is terminated for cause, such as individuals with fluctuating income whose coverage is terminated when their income increases only to become eligible again shortly thereafter, could be very beneficial and prevent unnecessary churn.

Response: We appreciate commenters' general support of our proposal. We agree that aligning policies between renewals and changes in circumstances simplifies requirements for States. We appreciate commenters' suggestions to remove the language in proposed § 435.919(d) that limits the proposed 90-day reconsideration period to only terminations as a result of not providing requested information. Since we did not propose expanding the scope of the reconsideration period in this way, we are not including this as a requirement in this final rule. We may consider the suggestion in future rulemaking and encourage States to consider existing flexibilities available to protect individuals whose coverage may be terminated as they experience frequent changes in circumstances. In the specific scenario raised by the commenter, we note that States have the flexibility under §§ 435.603(h)(3) and 457.315(a) to take into account reasonably predictable changes in income when determining current monthly income, and that this can help reduce churn for individuals whose income fluctuates over the course of the year.

Comment: One commenter appeared to raise concerns about the current requirement that States must obtain a signature for any additional information received at renewal. The commenter noted that it may not always be possible to obtain a signature depending on how information is submitted and that it is very common for beneficiaries to forget to sign when they return additional information at renewal. Second, the commenter stated that if a similar policy is applied to reconsideration periods as a result of a change in circumstance, States will likely face the same challenges as they currently do in obtaining signatures at renewal. Because of those challenges, they recommended removing the requirement at § 435.919(d)(2) that States be required to obtain a signature from the beneficiary to confirm the accuracy of any information provided to redetermine eligibility during a reconsideration period following a change in circumstances. They believe allowing this flexibility will reduce administrative burden.

Response: We appreciate the commenter's concerns about some of the challenges States may face when attempting to obtain the necessary signatures during renewal. As a best practice, we encourage States to continue to reach out to beneficiaries that are missing information on a returned renewal form. We believe this additional outreach is particularly important when individuals have provided all of the information necessary to complete an eligibility determination but have forgotten to include their signature.

The intent of proposed §§ 435.919(d)(2) and 457.344(d)(2) was to align the policies for the reconsideration period specific to a change in circumstance with the existing policies for a reconsideration period provided at renewal. Currently, if a beneficiary provides additional information during the 90-day reconsideration period at renewal, States must treat the information as a new application as described at §§ 435.916(b)(2)(iii) and 457.343. As such under § 435.907(f), the individual must provide a signature to be able to consent to enrollment (or reenrollment) in Medicaid and CHIP and verify the accuracy of the additional information or provide correct information, consistent with section 1137(d)(1)(A) of the Act. In order to continue to meet these requirements, we are finalizing §§ 435.916(d)(2) and 457.344(d)(2) with references to § 435.907(f) as proposed. Additionally, we note that treating additional information received during the 90-day reconsideration period as a new application entitles eligible individuals to up to 3 months of retroactive coverage under Medicaid consistent with § 435.915.

Comment: Some commenters expressed concern that it would not be possible for States with an integrated eligibility system that also determines eligibility for other programs, such as SNAP and TANF, to comply with protections for Medicaid beneficiaries proposed at § 435.919(c)(1), requiring at least 30 calendar days for beneficiaries to respond to requests for information related to a change in circumstances, because these protections are not required under the other programs.

Response: We acknowledge the important work that many States have undertaken to establish integrated eligibility systems and simplified notices across their health and human service programs, like Medicaid, CHIP, SNAP, and TANF. However, the eligibility requirements and processes between those programs continue to differ, so we believe that providing a minimum beneficiary response period to Medicaid and CHIP beneficiaries is appropriate to ensure that individuals who are actually eligible have time to provide the necessary information and reduce the likelihood of churn within Medicaid and CHIP.

We have worked with other human service programs, including SNAP, to identify areas for potential alignment. While we recognize the challenges that States face in developing integrated eligibility and enrollment systems serving multiple programs, we do not believe that the processes proposed in §§ 435.919(c)(1) and 457.344(c)(1) of the September 2022 proposed rule increase the challenge States face in aligning their Medicaid and CHIP beneficiary response timeframes with other human service programs like SNAP. We are available to provide technical assistance to States attempting to develop such an integrated system.

Comment: Some commenters sought clarification on when States could or could not act on information if individuals did not respond to requests for additional information.

Response: Generally, the intent of proposed §§ 435.919 and 457.344 was to outline in more detail the existing requirements States must follow under § 435.952 when considering information received by the State and when additional information may be requested from the beneficiary. For example, proposed §§ 435.919(b)(2)(ii) and 457.344(b)(2)(ii), redesignated at §§ 435.919(b)(4) and 457.344(b)(4) of this final rule respectively, require States to provide individuals with the opportunity to dispute third-party information prior to taking an adverse action, such as terminating a beneficiary's coverage or their benefits; this is a current requirement at § 435.952(d) for Medicaid and also applies to CHIP as referenced at § 457.380.

However, in addition to the existing requirements under §§ 435.952 and 457.380, we proposed to clarify at § 435.919(b)(1)(iii) and (b)(2)(iii), redesignated at § 435.919(b)(3) of this final rule, that States would not be permitted to terminate a beneficiary's existing coverage if they do not respond to the State's request for additional

information about a change in circumstances (either from the beneficiary or a third party data source) that may make the individual eligible for additional medical assistance or lower premiums or cost sharing charges. We proposed the same requirement for CHIP at § 457.344(b)(1)(iii) and (b)(2)(iii), which we redesignate at § 457.344(b)(3) in this final rule. We believe it is important to affirm this protection in the regulations to ensure that individuals who otherwise remain eligible for Medicaid or CHIP retain their current level of benefits, even if they may have been eligible for additional coverage if they had responded to the State's request.

After considering the comments regarding requirements for acting on changes in circumstances, we are finalizing §§ 435.919 and 457.344, as well as the changes proposed to § 435.916 with the modifications discussed. We note that because the effect of these changes is specific to the steps States are required to take to process changes in circumstances, including processing timeframes, the a minimum number of days States must provide for beneficiaries to return information to verify eligibility, and the reconsideration period (without requiring a new application) for beneficiaries who return needed information after being terminated for failure to respond, they operate independently from the other provisions of this final rule. Because each of these changes individually serves to protect beneficiaries during eligibility determinations based on changes in circumstances, we believe they also operate independently from one another.

3. Timely Determination and Redetermination of Eligibility (§§ 435.907, 435.912, 457.340(d), and 457.1170)

Current requirements at § 435.912 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, only reference applications, although certain provisions also apply at renewal and when a beneficiary experiences a change in circumstances. We proposed changes to § 435.912 to ensure that States complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances. We also proposed to add a new paragraph at § 435.907(d)(1), requiring that if a State is unable to determine an applicant's eligibility based on information provided on the application and verified through electronic data sources and it must obtain additional information from the applicant, the State must provide the applicant with a reasonable period of time to furnish the information.

At § 435.912(b), we proposed to require that States include renewals and changes in circumstances within the performance and timeliness standards described in their State plans. Additionally, we proposed at § 435.912(c)(1) to clarify the actions that begin and end the period of time that is considered under a State's timeliness standards at application, and to specify the actions that begin and end the period of time that is considered under a State's timeliness standards at renewal and changes in circumstances. Proposed § 435.912(c)(2) expands the criteria that States need to consider when developing their performance and timeliness standards. We also proposed a new requirement at § 435.912(g)(3) that prohibits States from using the timeliness standards to delay terminating a beneficiary's coverage or taking other adverse actions. Finally, we proposed standards to specify the maximum amount of time States may take to complete renewals and redeterminations based on changes in circumstances (proposed § 435.912(c)(4) through (6)).

The changes to §§ 435.907(d) and 435.912 apply equally to CHIP through existing cross-references at §§ 457.330 and 457.340(d)(1), respectively. We proposed minor changes to § 457.340(d) to clarify when certain Medicaid requirements were not applicable to CHIP when States consider eligibility on other bases. We also modified the title of § 457.340(d) to include a reference to timely redeterminations of CHIP eligibility. We are finalizing all changes proposed at §§ 435.907(d), 435.912, and 457.340(d), except as described in the following discussions. Additionally, we note that we revised the references to Medicaid requirements at § 457.340(d)(1)(i), which were redesignated as § 435.912(c)(4)(ii), (c)(5)(iii), and (c)(6)(ii) in this final rule.

For reference, Table 1 provides an overview of the timeframes for (1) applicants or beneficiaries to provide additional information, (2) States to complete a timely determination, and (3) individuals to submit information for reconsideration at application, when a change in circumstances occurs, and at renewal. The information provided in Table 1 is offered for ease of reference but does not contain in full detail the information needed to understand the application of the regulations summarized within. Additional information on the specific changes illustrated in Table 1 can either be found in the discussion that follows or in sections II.B.1. and II.B.2. of this final rule. Readers should refer to the regulation text and to the text discussion in this preamble to understand the requirements summarized in Table 1.

BILLING CODE 4120–01–P

TABLE 1: Enrollment-related Timeframes in this Final Rule

	Minimum Period for Individual to Provide Additional Information	**Maximum Period for State to Complete Timely Determination**	**Minimum Period for Individual to Submit Information for Reconsideration**
Application	A reasonable period of at least 15 calendar days §§ 435.907(d)(1)(i); 457.330	● 90 calendar days for applications based on disability ● 45 calendar days for all other applications §§ 435.912(c)(3)(i) and (ii); 457.340(d)(1)	90 calendar days §§ 435.907(d)(1)(iii); 457.330
Change in Circumstances – Reported Change	30 calendar days §§ 435.919(c)(1)(i); 457.344(c)(1)(i)	● End of month that occurs 30 calendar days following report of change, or ● End of month that occurs 60 calendar days following report of change, if additional information needed §§ 435.912(c)(5)(i), (ii), and (iii)*; 457.340(d)(1) introductory text and (d)(1)(i)	90 calendar days §§ 435.919(d); 457.344(d)
Change in Circumstances – Anticipated Change	30 calendar days §§ 435.919(c)(1)(i); 457.344(c)(1)(i)	● End of month in which anticipated change occurs, or ● End of month following anticipated change, if all needed information submitted ***less than*** 30 calendar days before change §§ 435.912(c)(6)(i) and (ii)*; 457.340(d)(1) and (d)(1)(i)	90 calendar days §§ 435.919(d); 457.344(d)
Renewal	30 calendar days §§ 435.916(b)(2)(i)(B); 457.343	● End of eligibility period, or ● End of month following end of eligibility period, if all needed information submitted with ***less than*** 30 calendar days in eligibility period §§ 435.912(c)(4)(i) and (ii)*; 457.340(d)(1) introductory text and (d)(1)(i)	90 calendar days §§ 435.916(b)(2)(iii); 457.343

*If Medicaid eligibility must be newly determined on another basis at renewal or following a change in circumstances, the clock for a timely redetermination of eligibility on another basis begins again on the date the individual is found ineligible on the current basis, and the State must redetermine eligibility within 90 calendar days for determinations based on disability and 45 calendar days for determinations on all other bases.

BILLING CODE 4120–01–C

a. At Application

Current § 435.912(c)(3) requires States to determine eligibility within 90 calendar days for new applicants whose eligibility is being determined on the basis of disability and within 45 calendar days for all other applicants. We did not propose any changes to this requirement. However, we did propose to establish a minimum timeframe for applicants to provide additional information when needed to determine eligibility. Specifically, we proposed new language at § 435.907(d)(1)(i) that would require the State to provide the applicant with no less than 30 calendar days to respond to a request for additional information when eligibility is being considered on the basis of a disability, and no less than 15 calendar days to respond when eligibility is being considered on all other bases. We proposed at § 435.907(d)(1)(ii) to require that States accept additional information through any of the modes by which an application may be submitted. We also proposed that when a notice of ineligibility is sent for failure to respond, States must provide a reconsideration period of at least 30 calendar days, during which the State

would be required to accept requested information and reconsider the individual's eligibility without requiring a new application (proposed § 435.907(d)(1)(iii)(A)), similar to the minimum 90-day reconsideration currently required at § 435.916(a)(3) for individuals terminated at a periodic renewal for failure to return a renewal form or other information needed to renew their eligibility. When a reconsideration period is applied, we proposed at § 435.907(d)(1)(iii)(B) that the 45 calendar-day clock for completing an eligibility determination timely as described at § 435.912(c)(3) (or 90 calendar days for a determination based on disability) would restart on the date the requested information is submitted. In addition, at proposed § 435.907(d)(1)(iii)(C), the effective date of coverage for individuals determined eligible would be based upon the original application date (that is, the date the application was submitted or the first day of the month of submission, in accordance with the State's election).

We received the following comments related to timely determinations at application:

Comment: While many commenters agreed that it was important to provide additional time to individuals who may need to provide documentation for their disability, they were concerned that applying different timeframes—30 calendar days for those whose eligibility is being determined on the basis of disability (proposed § 435.912(d)(1)(i)(A)) and 15 calendar days for those being determined eligible on all other bases (proposed § 435.912(d)(1)(i)(B))—would create confusion about what response deadline was applicable to a specific applicant. Commenters sought clarification about whether the additional time under proposed § 435.912(d)(1)(i)(B) was available only to individuals being considered for categorical eligibility based on disability or available to any applicant with a disability.

Commenters also raised concerns regarding the operational and administrative burden of applying two separate timeframes for applicants. They explained that different timeframes may be particularly challenging when multiple household members are included on a single application and only one is applying on the basis of disability, or when an individual applicant is being considered for eligibility in both a disability-related and non-disability-related eligibility group. In addition, several commenters expressed concerns that States with integrated eligibility systems, which may include SNAP, TANF, and other State-specific programs, would not be able to provide the same timeframes for applicants to provide additional information needed across programs. For example, if additional income information was needed to verify financial eligibility for both Medicaid and SNAP, SNAP requires States to give households at least 10 days for the individual to return the information, while the Medicaid agency would be required to provide more time. Commenters expressed concern that different deadlines would add complexity and confuse applicants who may be receiving requests for the same information from each program with different timeframes to respond, and both requests may be included within the same notice or separate notices sent from each program.

Some commenters recommended providing additional response time to other groups of applicants, such as individuals who are subject to an asset test or who are required to provide a level of care determination. Other commenters also suggested that for individuals who need language assistance or are experiencing homelessness, 15 calendar days was not sufficient.

Many commenters agreed that 15 calendar days would be sufficient for the majority of applicants, with some commenters citing CMS' September 2022 Application Processing Time Snapshot report that indicates the vast majority of MAGI applications are completed within either the first 24 hours or within days of receipt. However, other commenters did not agree with that timeframe and provided a range of suggestions for minimum response times between 15 to 60 calendar days.

Some commenters did not support the establishment of specific timeframes for any applicants and instead recommended that we continue to provide flexibility for States to set their own timeframes that best meet the needs of specific types of applicants and/or are appropriate for the type of information being requested. Other commenters opposed a 30-calendar day minimum timeframe for applicants to respond to requests for additional information because it would be challenging for States to determine eligibility timely for non-disability applications (within 45 calendar days) while others asked for clarity regarding the interaction between the minimum beneficiary response period and the maximum timeframe for a timely eligibility determination.

In section II.B.3. of the preamble to the September 2022 proposed rule, we requested comment on an alternative option providing a 30-calendar day response period with a new exception to the timeliness standard. The exception would provide States with up to 15 additional calendar days if needed to process information provided by an applicant at or near the end of the applicant's 30-day response period. Some commenters supported a new exception to the timeliness standard to ensure that both applicants and States had sufficient time in the application process; other commenters were concerned that adding a new exception provided States with too much time that would result in additional delays for otherwise eligible applicants to be determined eligible for coverage and obtain access to needed care, because many States already struggle to meet the current timeliness standards. Some commenters also were concerned that restarting the clock for completing a timely determination of eligibility during the reconsideration period, as proposed at § 435.907(d)(1)(iii)(B), provided too much time for States.

Response: We appreciate commenters' support for maximizing response timeframes to ensure that applicants have sufficient time to respond to requests for additional information, especially when information about disability, assets, or level of care may be needed. However, we also understand commenters' concerns about States' ability to meet application timeliness standards and the need for continued flexibility to address different types of situations. We agree with commenters that requiring two separate timeframes for disability-related and non-disability-related application types may be administratively burdensome and could create confusion for both applicants and eligibility workers, depending on how they are implemented. In States with integrated eligibility systems, a third timeframe could also be needed if the Medicaid timeframes cannot align with other programs like SNAP. At the same time, we remain concerned that requiring a single, minimum of 30 calendar days for all applicants would make it challenging for States to process non-disability-related applications timely (within 45 days). In order to balance these opposing concerns, we are eliminating the different standards at proposed § 435.907(d)(1)(i)(A) and (B) and finalizing a single minimum standard for all applicants. As described at § 435.907(d)(1)(i) of this final rule, States will be required to provide all applicants with a reasonable amount of time that is no less than 15 calendar days to respond to any request for

additional information needed to determine their eligibility at application. This flexibility will permit States to elect to create a single minimum timeframe for all requests for information at application, including a 15 or 30 calendar day timeframe, that provides the best balance for a State's specific circumstances. Alternatively, a State may tailor the timeframes at application to reasonable periods (no less than 15 calendar days) depending on the circumstances and may vary the timeframes depending on the circumstances of the request.

Further, to support applicants in States with integrated operations, we consulted with the U.S. Department of Agriculture (USDA) to explore options for aligning response periods across Medicaid and SNAP. As a result of this consultation, USDA anticipates releasing guidance outlining available flexibilities for States to align their SNAP processes with Medicaid. Through these flexibilities, a minimum 15 calendar day response period will permit States with integrated eligibility systems to establish a single response period for SNAP and Medicaid. This will also support individuals applying for both programs simultaneously and help to minimize confusion when information is requested to determine eligibility. CMS and USDA's Food and Nutritional Service (FNS) are working in close collaboration to permit alignment of these allied programs wherever possible and will develop coordinated technical assistance to support state implementation.

We believe modifying § 435.907(d)(1)(i) to require a reasonable period of time (at least 15 calendar days) strikes an appropriate balance between applicants' need for sufficient time to gather necessary information and States' need for sufficient time to complete the determination, while also considering administrative burden. We believe that the reasonable response period (minimum of 15 calendar days) coupled with the reconsideration period proposed and finalized at § 435.907(d)(1)(iii) for applicants who are denied eligibility for failure to provide requested information timely alleviates any adverse impact on individuals who may need more time.

The minimum amount of time that a State may consider reasonable for an applicant to respond with additional information is 15 calendar days. Consistent with the revisions at 435.907(d)(1)(i) of this final rule, a State could consider that it is reasonable to provide only 15 calendar days for an applicant to obtain and submit a recent pay stub demonstrating income eligibility. However, for an applicant acquiring documentation of certain assets in order to verify resource eligibility for a non-MAGI group, the same State may also determine that more time may be reasonable. There is a limited exception to the 15-day minimum for certain MSP determinations based on Low Income Subsidy (LIS) application data (LIS leads data). If the LIS leads data does not support a determination of Medicare Savings Program (MSP) eligibility and the State requires additional information for the MSP determination, § 435.911(e)(8) requires States to provide individuals with a minimum of 30 days to furnish such information.

Finally, although we are not making changes to the existing 45 and 90 calendar day application timeliness standards at § 435.912(c)(3), we clarify that these standards represent the maximum amount of time a State may take to complete an eligibility determination. Recognizing that operational flexibilities and limitations differ in each State, we believe States are in the best position to establish reasonable timeframes for beneficiary responses that will permit the State to complete application processing timely, subject to the timeframes required under this final rule. Consistent with existing requirements at § 435.912(g)(1), we expect States to complete their initial eligibility determinations as quickly as possible and not use the timeliness standards to delay coverage for individuals who would otherwise be eligible.

Comment: Almost all commenters were supportive of the reconsideration period proposed at § 435.907(d)(1)(iii) for applicants who are denied eligibility for failure to provide requested information and who subsequently submit the information within the period allowed by the State.

Some of these commenters supported a 30-day reconsideration period, while others recommended providing a 90-day period at application to be consistent with the reconsideration periods at renewal and when an individual experiences a change in circumstances.

Many commenters did not support our proposal at § 435.907(d)(1)(iii)(B) and (C) to require States to provide a retroactive effective date of coverage back to the original date of application if an individual provided information during their reconsideration period. Some expressed concern that this policy would incentivize applicants to not respond timely and would be unfair to individuals who do provide the necessary information by the requested deadline. Other commenters noted that providing the retroactive effective date for coverage was an important beneficiary protection from harmful outcomes, like debt from unpaid medical bills. Some commenters suggested applying the same effective date rules for reconsideration periods at application, renewal, and changes in circumstances, such that the provision of additional information would be treated like a new application and the effective date of eligibility would be based on the new application date.

We received only one comment expressing concern about the burden of implementing a new reconsideration period for applicants. The commenter explained that they did not believe this would create any improvement since most application errors are resolved during the application review process.

Response: We agree with commenters that applying the same policies across all reconsideration periods, whether at application, renewal, or changes in circumstances, would promote consistency and reduce complexity for States and individuals who need to provide additional information at application, at renewal, or following a change in circumstances. Therefore, we are modifying proposed § 435.907(d)(1)(iii) in this final rule to increase the reconsideration period at application from 30 to a minimum of 90 calendar days, and requiring the effective date of coverage to be based on the date the requested information is received to align with the policies for reconsideration periods at renewal and following a change in circumstances. We do not believe it is reasonable to require States to provide retroactive coverage based on the original application date because applicants now have a longer period of time to respond without having to provide a new application. Additionally, States are required to provide eligible Medicaid applicants with retroactive coverage consistent with § 435.915(a).[13] We believe that this retroactive coverage will help address the impact of potential gaps in coverage for applicants who provide requested information during the reconsideration period. We note that States also have the option to provide retroactive coverage to individuals applying for CHIP under § 457.340(g).

Therefore, we are removing the provisions proposed at § 435.907(d)(1)(iii)(B) and (C) regarding the timeliness standard and effective date of eligibility. We are finalizing a

[13] Unlike other Medicaid eligibility groups, qualified Medicare beneficiary (QMB) benefits are not retroactive. Coverage begins the first day of the month following the month in which the individual is determined to qualify for this eligibility group.

single paragraph at § 435.907(d)(1)(iii) that (1) requires States to accept information submitted by an applicant within 90 calendar days of the date of denial and (2) specifies that States must treat the additional information like a new application and reconsider eligibility consistent with the current timeliness standards at § 435.912(c)(3). Because this information will be treated like a new application, the effective date of eligibility will be based on the date the information is returned consistent with current § 435.915.

Comment: A few commenters urged CMS to revise § 435.912(e) to limit the scope of the exceptions to the timeliness standards in § 435.912. Current § 435.912(e) provides that States must determine or redetermine eligibility within established timeliness standards except in unusual circumstances. One commenter was concerned that the example described at § 435.912(e)(2) for an administrative or other emergency beyond the agency's control is too broad and recommended removing the reference to ''administrative.'' Another commenter recommended that States be required to notify applicants and beneficiaries when they are taking advantage of the exceptions provided at § 435.912(e).

Response: We appreciate the commenters' concerns about protecting access to timely eligibility determinations. We believe the timeliness standards are critically important for ensuring that applicants and beneficiaries have timely access to the coverage and services to which they are entitled. At the same time, we believe it is important that the language in the example described at § 435.912(e)(2) remain sufficiently broad to account for a variety of unusual circumstances. As the introductory language at § 435.912(e) states, the situations described in paragraphs (e)(1) and (2) are simply examples of the types of circumstances that may require an exception to the timely determination of eligibility. We have, and will continue to, work with States when they experience unusual circumstances like natural disasters and other emergencies to determine whether a timeliness exception is warranted and to implement workarounds to ensure that individuals continue to have access to the benefits they need during this time. We also note that States are required to document the reason for the delay in the individual's case record in accordance with § 435.912(f).

Comment: We sought comment about whether States should be afforded additional time to determine CHIP eligibility for applicants seeking coverage under a separate CHIP for children with special health care needs (CSHCN), similar to the additional time provided at § 435.912(c)(3)(i) for States to make a final determination of eligibility for Medicaid coverage based on disability. Commenters indicated that it was not appropriate to provide States with extra time to make an eligibility determination for the separate CHIP for CSHCN because these children still have to meet the financial eligibility criteria for CHIP. Also, commenters were concerned that delaying a child's enrollment into CHIP for the sake of enrolling the child into CHIP for CSHCN, which offers an enhanced benefit package, could potentially be harmful. Instead, commenters believed it would be reasonable for States to continue to work with these children post-enrollment into CHIP if additional information is necessary to determine their eligibility for the State's CSHCN program, and to transition them to such program at a later time if appropriate.

Response: We agree with commenters that providing additional time for a determination of eligibility for a CSHCN program within CHIP is not necessary and could potentially delay the receipt of necessary care. Therefore, we are finalizing § 457.340(d)(1) as proposed.

b. At Renewal

At § 435.912(c)(4) of the proposed rule, we proposed requirements for timeliness standards for States to complete renewals conducted under § 435.916. We proposed three timeframes for completing timely renewals depending on the circumstances of the case. First, if a beneficiary's eligibility can be renewed based on available information or the beneficiary returns a renewal form with at least 25 days remaining in the eligibility period, we proposed that a State would be required to complete the renewal prior to the end of the individual's eligibility period. Second, if the State is redetermining eligibility on the basis for which a beneficiary has been enrolled and the beneficiary returns a renewal form less than 25 calendar days before the end of the eligibility period, we proposed that the State must complete the renewal by the end of the following month. Finally, if the State must redetermine eligibility on another basis other than disability, we proposed that the State would have an additional 25 calendar days to complete the eligibility determination. However, if the State is redetermining eligibility on the basis of disability, the State would have up to 90 additional calendar days from the date the individual is determined ineligible on their current basis.

Comment: Many commenters supported the clarity of the timeliness standards for renewals proposed at § 435.912(c)(4), including our proposal to provide States with additional time to complete a renewal when renewal forms are received near the end of a beneficiary's eligibility period. However, other commenters stated that the proposed timeliness standards were too prescriptive, and that additional flexibility is necessary for States to be able to effectively manage their processes.

Response: We appreciate commenter support for our proposal to ensure that States have sufficient time to complete a timely eligibility determination, particularly when beneficiaries provide all necessary information close to the end of their eligibility period. We also agree with commenters that flexibility is important for States to effectively administer their Medicaid and CHIP programs, although we believe our proposal at § 435.912(c)(4) provides more flexibility than currently is available to States. As discussed in section II.B.3. of the September 2022 proposed rule, § 435.930(b) currently requires States to continue furnishing Medicaid benefits to eligible individuals until they are found to be ineligible. This means a State must maintain the eligibility of a beneficiary who submits all needed information at the end of their eligibility period, until the State can complete a redetermination, and if the beneficiary is no longer eligible, provide advance notice and fair hearing rights. However, current regulations do not provide for an extension of the renewal process beyond the end of a beneficiary's eligibility period, even if additional information is not provided to the State in a timely manner and even when the State is required to evaluate eligibility on other bases. Proposed paragraphs (c)(4)(ii) and (iii) of § 435.912 address this tension in the current regulations, by accounting for those situations in which States will need additional time to complete an eligibility determination in order to comply with § 435.930(b) without running afoul of the requirement in § 435.916 to renew eligibility once every 12 months. Therefore, we are finalizing the proposed policy to permit States to extend the redetermination process beyond the end of a beneficiary's eligibility period when information is received late in the process or eligibility needs to be determined on another basis, but we are making some modifications to the standards

themselves as described in the comment responses that follow.

We note that the timeliness standards described at § 435.912(c)(4) represent the maximum amount of time that States may take to complete renewals. States maintain significant flexibility when establishing their timelines to process renewals and are not required to take the maximum amount of time described in the regulation to complete a renewal. In establishing standards for timely renewals, § 435.912(c)(2) which we are finalizing as proposed, requires States to demonstrate that their timeliness standards address certain criteria, including prior State experience, availability of information, the needs of beneficiaries, and advance notice requirements.

Comment: Many commenters expressed concern about the variety of timeliness standards proposed for different circumstances at renewal, which could require completion of the renewal at the end of the beneficiary's eligibility period (§ 435.912(c)(4)(i)), the end of the month following the end of the beneficiary's eligibility period (proposed § 435.912(c)(4)(ii)), and 90 or 25 calendar days following a determination of ineligibility on the current basis when eligibility on another basis must be determined (proposed § 435.912(c)(4)(iii)). Some commenters also expressed confusion about the maximum timeliness standard applicable under proposed § 435.912(c)(4)(iii) when eligibility is being determined on a different basis. There also was concern that requiring several different timeframes for completion of renewals depending on when information is returned to the agency would be challenging to implement. Several commenters indicated that these changes, and the variety of timeframes associated with them, would require complex systems changes and extensive training for eligibility workers.

Response: We appreciate commenters' concern that the variety of different timeframes proposed for timely renewals, which differ from the current timeframes for application and the proposed timeframes for changes in circumstances, would add unnecessary complexity and confusion and would require complex systems changes and significant training for eligibility workers. In this final rule, we simplify the maximum timeframes for timely renewals at § 435.912(c)(4) to align more closely with the existing timeframes for timely eligibility determinations at application and the timeframes for processing changes in circumstances.

The September 2022 proposed rule included three maximum timeliness standards for renewals: (1) the end of the eligibility period for renewals that can be completed using available information and those for which all necessary information is returned to the State at least 25 or more calendar days prior to the end of the eligibility period (proposed § 435.912(c)(4)(i)); (2) the end of the month following the end of the eligibility period for renewals for which needed information is returned with no less than 25 calendar days prior to the end of the eligibility period (proposed § 435.912(c)(4)(ii)); and (3) following a determination of ineligibility, 90 calendar days for eligibility determined based on disability or 25 calendar days when eligibility must be determined on a different basis (proposed § 435.912(c)(4)(iii)). At § 435.912(c)(4) of this final rule, we are finalizing the requirement to complete all renewals by the end of the eligibility period with two exceptions.

The first exception, at § 435.912(c)(4)(i), occurs when additional information needed to determine eligibility is not returned timely. We proposed a threshold of 25 calendar days, meaning if the beneficiary returned the renewal form at least 25 calendar days before the end of the eligibility period, the State must process the renewal before the end of the eligibility period. If the beneficiary returns the renewal form with less than 25 calendar days before the end of the eligibility period, the proposed rule would have required that the State process the renewal by the end of the month following the end of the eligibility period. In this final rule, we are increasing this threshold to 30 calendar days before the end of the eligibility period, such that if a beneficiary returns their renewal form at least 30 calendar days before the end of their eligibility period, the State must process the renewal before the end of the eligibility period. If less than 30 calendar days remain before the end of the eligibility period, the State must process the renewal by no later than the end of the following month.

The second exception, finalized at § 435.912(c)(4)(ii), permits States to establish a separate timeliness standard when eligibility must be determined on another basis. We proposed at § 435.912(c)(4)(iii) to provide States with an additional 90 calendar days to complete a renewal when the other basis requires a disability determination and 25 calendar days when the other basis does not require a disability determination. In this final rule, we are maintaining the 90 calendar day threshold for disability-related determinations and increasing the timeframe for all other determinations to 45 calendar days to be consistent with the existing timeliness standards at application.

Again, we clarify that the standards described at § 435.912(c)(4) are the maximum standards that a State may establish for timely eligibility renewals. States retain flexibility to complete renewals requiring a determination on other bases more quickly, provided that the State provides beneficiaries with at least 30 calendar days consistent with § 435.916(b)(2)(i)(B) as well as the minimum 10 days advance notice and fair hearing rights required under 42 CFR part 431, subpart E.

Comment: Many commenters raised concerns that the proposed thresholds for renewals, as well as changes in circumstances, would need to be tracked and reported to CMS, which would require extensive modifications to their systems.

Response: We are not establishing new reporting requirements for States to report on the timeliness thresholds established in this final rule. Section 435.912(b) requires States to establish timeliness and performance standards in their State plan. However, we recognize that States may find tracking this information important for purposes of their own internal audits or external reviews, such as PERM and MEQC reviews and other CMS eligibility audits.

Comment: Many commenters were concerned that the changes proposed at § 435.912(c)(4)(ii) and (iii), which permit States to establish renewal timeliness standards that extend beyond the end of an individual's eligibility period, would result in many renewals being completed after a beneficiary's eligibility period ends. Commenters were concerned about the fiscal impact of that policy if States are required to keep beneficiaries enrolled in coverage while they complete their renewal and then the beneficiary is ultimately found to be ineligible. Some commenters also sought clarification on whether States could continue to receive enhanced funding based on a beneficiary's current eligibility group during the additional time available to States to redetermine eligibility based on information provided less than 25 calendar days prior to the end of the beneficiary's eligibility period consistent with proposed § 435.912(c)(4)(ii).

Response: Current regulations at § 435.930(b) require States to continue furnishing Medicaid benefits to all eligible individuals until the State completes a redetermination and finds

an individual to be ineligible. The timeliness standards proposed at § 435.912(c)(4) do not modify those requirements. States are still expected to complete redeterminations prior to the end of a beneficiary's eligibility period whenever possible. What the renewal timeliness standards finalized at § 435.912(c)(4) recognize is that sometimes it is not possible for a State to complete a renewal by the end of a beneficiary's eligibility period because the State received requested information from that beneficiary too close to the end their eligibility period or the State needs to evaluate eligibility on other bases. If a State concludes that an individual is ineligible with less than 10 days remaining in the eligibility period, the State will be unable to provide the required advance notice and terminate eligibility before the eligibility period ends. In such cases, the State must continue eligibility beyond the end of the eligibility period, and if the State has elected to extend coverage through the end of the month, that beneficiary would remain enrolled until the end of the month following the month in which the eligibility period ends. Under § 435.912(c)(4)(i) of this final rule, this would be considered a timely renewal.

Section 435.912(c)(4) of this final rule recognizes that a beneficiary remains eligible until determined ineligible, and States must continue providing benefits until the determination is complete. As such, as long as the eligibility determination is conducted in accordance with the timeliness standards for renewals outlined in § 435.912(c)(4), States may continue to claim the same match rate for such beneficiaries, until they are determined ineligible, without the potential risk of eligibility-related improper payments or other negative audit findings due to this requirement. For increased clarity of existing policy, we modify § 435.912(g)(2) in this final rule by adding a cross-reference to § 435.930(b) to ensure that States may not use the timeliness standards as a reason to stop furnishing benefits if they are unable to complete eligibility determinations in a timely manner.

c. At Changes in Circumstances

We proposed two different timeliness standards at § 435.912(c)(5) and (6) for redeterminations based on changes in circumstances that may impact eligibility. First, we proposed at § 435.912(c)(5)(i) that States must complete redeterminations based on a reported change by the end of the month in which 30 calendar days from the date the agency becomes aware of the change falls, unless the State needs to request additional information from the beneficiary. In that case, we proposed that the State must complete the redetermination by the end of the month in which 60 calendar days from the date that the agency received the reported change in circumstances falls, as described at proposed § 435.912(c)(5)(ii).

Second, for anticipated changes of circumstances, we proposed at § 435.912(c)(6) to use the same general standard proposed for renewals based on whether all necessary information is available at least 25 calendar days before the change occurs. Anticipated changes are those that the State knows will occur in the future, like a beneficiary turning 65 and becoming eligible for Medicare or aging out of the eligibility group for children under age 19. As described at proposed § 435.912(c)(6)(i), if all information needed to redetermine eligibility is available with 25 or more calendar days before the date of the change, a State would be required to redetermine eligibility by the date (or at State option, the end of the month) the anticipated change will occur. Per proposed § 435.912(c)(6)(ii), if the State receives needed information with less than 25 calendar days remaining before the anticipated change occurs, the State must complete the redetermination by the end of the month following the anticipated change. Finally, we proposed at § 435.912(c)(6)(iii) that if a State must redetermine eligibility on another basis following an anticipated change in circumstances, they must complete the redetermination within either 25 calendar days (or, if on the basis of disability, 90 calendar days) from the date it determines the individual is ineligible based on their current basis.

Comment: While some commenters were supportive of the proposed timeliness standards for reported changes in circumstances at § 435.912(c)(5), others suggested that CMS adopt a simplified approach. One commenter recommended including language to specify that the timeliness standard begins once all necessary information is received.

Response: We appreciate commenters' support of proposed § 435.912(c)(5). We believe the proposal clearly outlines the applicable standards based on whether States seek additional information or not, so we will not modify those requirements in this final rule. However, in order to provide alignment across all changes in circumstance timeliness standards, we have added a new § 435.912(c)(5)(iii) in this final rule to clarify that as a result of a change in circumstances, States must redetermine eligibility on another basis within 90 calendar days for determinations based on disability or 45 calendar days for all other determinations. The additional 90 or 45 calendar days begins on the day the State determines the individual is no longer eligible on their current basis of eligibility.

Comment: Many commenters did not support the proposed timeliness standards for anticipated changes at § 435.912(c)(6). Similar to renewals, commenters raised concerns regarding the complexity of implementing and tracking a 25-calendar day cutoff to know when additional time would be available to complete a redetermination due to an anticipated change in circumstances. Another commenter did not agree with proposed § 435.912(c)(6)(iii)(B), stating that 25 calendar days was not enough time to redetermine eligibility on other bases for an individual who was found ineligible on their current basis due to the anticipated change in circumstances and instead recommended applying the same timeliness standard proposed for reported changes in § 435.912(c)(5).

Response: We understand the commenters' concerns about the complexity of the maximum timeliness standards proposed for anticipated changes in circumstances. Similar to the changes made to streamline the maximum timeliness standards at renewal at § 435.912(c)(4), we are streamlining the requirements for the timeliness of redeterminations related to anticipated changes in eligibility. Specifically, we are establishing a single standard for timely redeterminations regarding anticipated changes in circumstances and creating two exceptions. As described at § 435.912(c)(6) of this final rule, a redetermination of eligibility based on an anticipated change may not exceed the end of the month in which the change occurs, except in cases where the beneficiary returns needed information late in the process or the State needs to complete a determination of eligibility on another basis. In section § 435.912(c)(6)(i) of this final rule, we increase the 25-calendar day threshold to 30 calendar days, such that if a beneficiary returns requested information less than 30 days prior to the end of the month in which the anticipated change occurs, the State must complete the redetermination by the end of the following month. At § 435.912(c)(6)(ii) of this final rule, we apply the existing timeliness standards for new applications when a State must consider eligibility for a beneficiary on another basis following a change in

circumstances. This provides States with a maximum of 45 additional calendar days that begins when States make the determination of ineligibility on the original basis, to complete an eligibility determination on a new basis for beneficiaries whose eligibility is not being redetermined based on a disability. If a disability determination is required, the State may take up to an additional 90 calendar days to complete the eligibility determination.

d. Overarching Comments and CHIP-Specific Considerations

In addition to the comments discussed previously in this final rule, we received several general comments that relate to the proposed beneficiary response requirements or timeliness standards, including CHIP-specific changes, as follows.

Comment: In the September 2022 proposed rule, we sought comment on whether the 30-day beneficiary response timeframes proposed at §§ 435.907(d)(1)(i), 435.916(b)(2)(i)(B), and 435.919(c)(1)(i) should be calculated using calendar days or business days. Additionally, we sought comment on whether the timeliness standards for States to complete a redetermination of eligibility at a regularly-scheduled renewal or based on a change in circumstances at proposed § 435.912(c)(4) through (6) should be based on calendar or business days. The majority of commenters supported a timeframe based on calendar days to maintain consistency with existing standards and minimize differences across States based on recognizing different holidays. However, a few commenters supported using business days or giving States flexibility to use the most appropriate approach, because in some cases using business days would provide applicants with more time in which to submit requested information.

Response: We appreciate commenters' feedback in this area and agree that continuing to adhere to current practices, which define the response period based on calendar days, would maintain consistency and minimize confusion among both eligibility workers and beneficiaries. Therefore, we are finalizing §§ 435.907(d)(1)(i) and 435.916(b)(2)(i)(B) as proposed and modifying §§ 435.919(c)(1)(i) and 457.344(c)(1)(i) to specify ''calendar days'' to describe applicant and beneficiary response periods consistently throughout this final rule. Finally for increased clarity of current policy at application, we are making a technical change to specify ''calendar days'' at § 435.912(c)(3) and modifying proposed § 435.912(c)(4) through (6) to also specify that States must redetermine an individual's Medicaid eligibility on another basis using timeliness standards based on ''calendar days.''

Comment: Many commenters supported CMS clarifying in this final rule that the 30-day response period begins on the date a request for additional information is sent, which we defined in the September 2022 proposed rule as the date the request was postmarked. Commenters believed that this would help to reduce the impact of delays on the amount of time available to an applicant or beneficiary if the State or the mail system is delayed in sending requests for additional information in a timely manner. However, commenters were concerned that it would not be practical to base the response period on the day the request was postmarked due to operational challenges. For example, one commenter explained that in many cases it would not be possible for States to know the exact date the request was postmarked, and they would have to rely on beneficiaries keeping the original envelopes to determine the 30-calendar day response timeframe at renewal. Commenters were concerned that this approach would also not allow States to include a specific deadline for response within the request for additional information, and that they would have to rely on beneficiaries to determine their own deadline based on the postmarked date. Another commenter indicated that requiring States to postmark all requests could increase mailing costs if their current process does not include postmarked envelopes.

Response: At §§ 435.916(b)(2)(i)(B), and 435.919(c)(i), we proposed to require States to begin an applicant or beneficiary's 30-day response timeframe on the date the agency sends the notice or form. As discussed in the September 2022 proposed rule, our expectation is that States will base the beginning of the beneficiary response window on the date the request is postmarked, when applicable. If the required notice or form is not sent through U.S. mail with a postmark, then the 30 calendar days would be calculated based on the date the required notice or form is sent electronically or submitted to the post office for mailing.

While we appreciate commenters' concerns that it may be difficult to always know the specific date that a notice is postmarked or sent, we believe the benefit of a consistent policy across States outweighs the challenges. In a State that uses a contractor for mailing, we would expect the agreement between the State and the contractor to include details about the timeliness of mailings, and the 30-calendar day response period would be based on that agreement. For example, if the contract specifies that all mailings are completed within 2 days of receipt from the State, the return date specified in the notice would be 32 days after the notice is sent out for mailing. We agree that it would be inappropriate to notify a beneficiary that they must return needed information within 30 days of the postmark date and then expect the beneficiary to calculate the due date. This would also make it difficult for the State to include a deadline in the eligibility system for receipt of the needed information. We believe that proposed §§ 435.907(d)(1)(i), 435.916(b)(2)(i)(B), and 435.919(c)(i) will ensure that all Medicaid beneficiaries are provided with sufficient time to respond to requests for additional information at application, renewal, or a change in circumstances. Therefore, we are finalizing these provisions as proposed.

Comment: Many commenters supported the technical changes throughout § 435.912 to clarify that timeliness standards are applicable at application, renewal, and changes in circumstances, including the proposed changes at § 435.912(c)(1) to further clarify the period covered when calculating a State's timeliness standards. Commenters also supported expanding the criteria at § 435.912(c)(2), that States need to consider when developing their performance and timeliness standards, such as accounting for time needed to evaluate information obtained from electronic data sources and to provide required advance notice when the agency makes a determination that results in an adverse action. Finally, commenters supported the requirement at proposed § 435.912(g)(3), which specifies that States may not use the timeliness standard to delay an adverse action, including termination of an individual's coverage.

Response: We appreciate commenters' support of these specific changes as well as the technical changes throughout § 435.912 to clarify that timeliness standards are now applicable at application, renewal, and changes in circumstances. We are finalizing as proposed § 435.912(c)(1) (period covered by the timeliness and performance standards), (c)(2) (criteria for establishing timeliness and performance standards), and (g)(3) (prohibition on using the timeliness standards to delay adverse action), as well as the technical changes extending

existing requirements at § 435.912 to renewals and redeterminations based on changes in circumstances. We note that references to requirements for changes in circumstances within § 435.912(b)(4) and (c)(1)(iii) and (iv) were revised consistent with the redesignation of those requirements in this final rule as discussed in section II.B.2. of this final rule.

Comment: Some commenters recommended that CMS engage in stronger oversight and enforcement of timeliness requirements. While commenters agreed that new timeliness standards at renewal and changes in circumstances were important, they remained concerned that States will struggle to meet these new timeliness standards, because they continue to struggle to meet the existing timeliness standards at application. For example, one comment suggested including State reporting requirements at § 435.912 for the timeliness standards as a condition to receive FFP, because it would not be difficult to expand the current Performance Indicator data set, where States currently report application timeliness data, to incorporate reporting elements specific to timeliness for renewals and changes in circumstances. Others urged CMS to consider imposing sanctions on States that have a high percentage of determinations that are not completed within the required timeliness standards.

Response: We appreciate commenters' concerns regarding State compliance with timeliness standards, and we agree that it is critical for States to complete all eligibility determinations as quickly as possible. We believe oversight and enforcement are important components of our role with respect to Medicaid, CHIP, and the BHP. As such, this final rule includes important regulatory requirements for States and protections to ensure that eligible applicants and beneficiaries can enroll and stay enrolled as long as they continue to meet the requirements of their program. In this final rule, we are not including reporting requirements for the timeliness standards at § 435.912. Processes are already in place at both the State and Federal levels to ensure that applications, renewals, and redeterminations are processed timely. We note that States that do not comply with these requirements may be cited for improper payments identified during PERM reviews, MEQC reviews, other CMS eligibility audits, or State-level audits. Consistent with existing program requirements, improper payments identified by PERM and MEQC may be subject to recoveries.

Comment: The comments we received with respect to modifying §§ 457.1140, 457.1170(a), and 457.1180 supported these changes, which (1) require States to provide an opportunity for review if States fail to make a timely CHIP eligibility determination at application or renewal and (2) emphasize that continuation of enrollment under § 457.1170 includes continued provision of benefits pending a review.

Response: We are finalizing §§ 457.1140, 457.1170, and 457.1180 as proposed.

After considering all comments received, we are finalizing the proposals described above in this section with the modifications discussed. We note that these changes revising timeliness standards to expressly apply at application, renewal, and when a change in circumstance occurs, requiring States to provide a minimum number of days for individuals to return information needed to verify eligibility, providing specific timeframes for conducting Medicaid and CHIP renewals, including when beneficiaries return information late and when the State needs to consider eligibility on other bases, and establishing a 30-day reconsideration period for applicants who return needed information after being determined ineligible for failure to respond, operate independently from the other provisions of this final rule.

4. Agency Action on Updated Address Information (§§ 435.919 and 457.344)

As we discussed in section II.B.2. of this final rule, in order to ensure that Medicaid and CHIP beneficiaries continue to meet applicable eligibility requirements, States must have a process to obtain information about changes in circumstances that may impact eligibility and to redetermine eligibility when appropriate. A change in address represents such a change. Beneficiaries who have moved out of State will no longer meet eligibility requirements for coverage in the original State (unless the State has suspended its State-residency requirement or has extended Medicaid and/or CHIP eligibility to individuals who are not residents of the State). Beneficiaries who have moved to a new in-State address are at risk of procedural termination at a regularly-scheduled renewal, if they rely on mailed paper notices and the State does not have their updated address. Indeed, our experience in working with States and beneficiary advocacy organizations indicates that returned mail historically has resulted in a significant number of beneficiaries losing their coverage, because their continued eligibility cannot be confirmed by the State. As such, it is critical for States to take reasonable steps to locate and update the contact information of beneficiaries who may have moved, prior to terminating their coverage or taking any other adverse action.

In the September 2022 proposed rule, we included new paragraphs (f) and (g) at proposed § 435.919 for Medicaid and § 457.344 for CHIP to specify the steps States must take when beneficiary mail is returned to the agency by the United States Postal Service (USPS) (paragraph (f)) or when the agency obtains updated mailing information from third-party data sources (paragraph (g)). For brevity, in the following discussion we provide only the Medicaid references at § 435.919(f) and (g). When reading these references please note that the policy includes both the Medicaid requirements at § 435.919(f) and (g) and the CHIP requirements at § 457.344(f) and (g) unless otherwise stated.

We proposed the following three-step process when the State receives returned beneficiary mail:

- Step 1 would require the State to check available data sources for updated beneficiary contact information (proposed § 435.919(f)(1));
- Step 2 would require the State to (1) conduct outreach via mail to the original address on file, the forwarding address (if provided on the returned mail), and all addresses obtained in Step 1; and (2) make at least two additional attempts through one or more modalities other than mail, such as phone, text or email, to locate the beneficiary and verify their address (proposed § 435.919(f)(2) and (3));
- Step 3 describes the actions a State would be required to or would have the option to take when a beneficiary's new address could not be verified, and mail was returned with an in-State forwarding address (proposed § 435.919(f)(4)), an out-of-State forwarding address (proposed § 435.919(f)(5)), or no forwarding address at all (proposed § 435.919(f)(6)). We also proposed conforming changes to §§ 431.213(d) and 431.231(d) regarding returned mail with no forwarding address.

At proposed § 435.919(g), we described the steps a State would have to take to verify the accuracy of information obtained from a third-party data source other than the USPS. Specifically, at § 435.919(g)(1), we proposed that States that obtain updated in-State mailing information from USPS National Change of Address (NCOA)

database or managed care plans [14] may treat such information as reliable, provided that the State completes the same basic actions described in Step 2 for returned mail (for example, attempt to contact the beneficiary at the original address on file and the new address provided by the third-party data source, and complete at least 2 additional attempts to contact the individual to verify their new address through one or more modalities other than mail). At § 435.919(g)(2), we proposed that, with Secretary approval, States may treat updated in-State information from other trusted data sources in accordance with proposed paragraph (g)(1), and at § 435.919(g)(3), we proposed that for all other third-party updates, the State must follow the actions described in steps 2 and 3 for returned mail. For additional information on the requirements and State options in proposed § 435.919(f) and (g), see section II.B.4. of the September 2022 proposed rule.

We received the following comments on these provisions:

Comment: Many commenters supported the three-step process proposed for responding to returned mail. They noted that Medicaid beneficiaries may move frequently; parents and other caregivers, especially those experiencing housing instability, are often under extreme amounts of stress, and updating their address may not be a high-enough priority to take care of immediately; and some beneficiaries maintain non-traditional residences that cannot receive mail. These commenters noted that returned mail can be a particular problem for people who are housing insecure.

Many commenters stated that the proposed processes represent a reasonable approach that would promote retention of eligible individuals, reduce procedural disenrollments, avoid churn, and accelerate the pace at which States adopt non-traditional modes of beneficiary communication, which can be more efficient, cost-effective, and timely. The commenters asserted that clear guidance and commonsense tactics to better locate beneficiaries in the event of returned mail would help to mitigate unnecessary coverage losses and will be particularly important as millions of notices requiring a response are physically mailed to program enrollees during the unwinding period.

While most commenters supported increasing requirements for States to confirm the accuracy of beneficiary contact information and obtain updated address information when mail is returned, some of these same commenters also opposed the specific requirements included in the September 2022 proposed rule. These commenters described the proposed requirements for returned mail and other address updates as overly complicated and burdensome, particularly for States that already exercise reasonable diligence in handling returned mail and attempting to locate enrollees who have moved. They raised concerns about potential negative, unintended consequences for beneficiaries; requirements not reflecting on-the-ground realities; and increased risk of negative audit findings.

A number of commenters expressed concern that the proposed returned mail requirements are unduly prescriptive, weaken or remove State flexibility, include an unprecedented level of detail that is likely to become outdated over time, and lack the flexibility for simple solutions, like calling a beneficiary to get an updated address. Specific operational challenges raised by commenters include: the need to implement significant system updates across multiple enrollment systems; challenges in reconfiguring timeframes for timed processes; increased workload for outreach and imaging staff; increased mailing costs, including the cost of paper, postage, and mail vendors; and the need for new legislative and budget authority. Some of these commenters urged CMS not to finalize the proposed changes, but instead to work directly with States to better understand the operational realities, and to support the development of State-specific strategies that meet local needs.

Response: We appreciate the support for requirements that protect coverage for eligible individuals, particularly those who may be housing insecure, by establishing reasonable solutions to the problems posed by returned mail. At the same time, we also appreciate the concerns and challenges raised by commenters about States' ability to implement the specific steps set forth in the September 2022 proposed rule, and we recognize that the same approach may not be best for all States. As such, we are finalizing a simplified set of requirements for returned mail and address updates.

The September 2022 proposed rule included separate requirements for agency action when mail is returned by the USPS (paragraph (f)) and when updated address information is obtained from sources other than returned mail (paragraph (g)). We are combining paragraphs (f) and (g) of proposed § 435.919 into one paragraph at § 435.919(f) (Agency action on updated address information) in this final rule that establishes a single set of requirements for all types of address changes. Then we are streamlining the requirements at § 435.919(f), such that paragraph (f)(1) describes the requirements for obtaining updated address information from third-party data sources, paragraphs (f)(2) through (4) describe the actions required by the State depending on the type of address information received, and paragraph (f)(5) describes the good-faith effort requirements for contacting beneficiaries as needed to confirm updated information.

Within § 435.919(f), we are also making changes to provide greater State flexibility, such as by removing some of the details for operationalizing the regulatory requirements. This will permit continued use of existing strategies for addressing returned mail, such as those established during the COVID–19 PHE under the waiver authority of section 1902(e)(14)(A) of the Act, which have proven very effective with updating beneficiary contact information without any notable adverse impact on beneficiaries. These changes are detailed in the succeeding discussion.

Comment: We received many comments about the use of third-party data sources for updating beneficiaries' mailing addresses. Many commenters supported the requirement proposed at § 435.919(f)(1) that States check data sources, including the agency's Medicaid Enterprise System and the agency's contracted managed care plans, if applicable, when mail is returned to the State. They noted that obtaining updated, accurate information from reliable outside sources will help to reduce disenrollment of otherwise eligible beneficiaries and ensure that they continue to receive important information about their coverage. Other commenters supported the use of electronic data sources but were opposed to the specific requirements proposed. A few commenters noted the cost implications for building new interfaces and establishing data sharing agreements with multiple managed care plans, and with other entities like SNAP, TANF, or the State's department of motor vehicles (DMV).

Many commenters specifically supported the proposed requirement at § 435.919(f)(1)(ii) and option at § 435.919(g)(1) for States to obtain updated beneficiary contact information from their contracted managed care

[14] Throughout this document, the use of the term ''managed care plan'' includes managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs) and primary care case management entities (PCCM entities).

plans. A number of commenters flagged managed care plans as one of the best sources for updated address information. The commenters stated that plans are more likely than States to have recently updated contact information, since beneficiaries typically engage with their managed care plans more frequently than they engage with the State Medicaid agency. Managed care plans often have multiple points of contact with their members, including hospital admissions, provider relationships, care management programs, disease management programs, and other health plan activities.

A number of commenters also highlighted the nationwide reliability of the NCOA database and recommended that all States be required to use it. Commenters stated that forwarding addresses and updated contact information from the NCOA database are almost always accurate. One State reported that it had never received a member report of an incorrect address update based on the NCOA database. Another commenter explained that the NCOA database includes safeguards to ensure accuracy of change requests, making it a readily accessible and reliable source of information.

Several commenters stated that CMS should give States the option to accept updated addresses from managed care plans and the NCOA database without first having to contact beneficiaries to reverify the information. The commenters recognized that this strategy is proving effective under waiver authority granted under section 1902(e)(14)(A) of the Act to assist States in returning to normal operations during the unwinding period. As such, they indicated that the strategy should be made permanent.

Some commenters recommended going beyond a State option and requiring States to obtain updated contact information from their contracted managed care plans and the NCOA database. They noted that despite the availability of waiver authority under section 1902(e)(14)(A) of the Act and CMS' guidance highlighting its use as a best practice, some States have not established the necessary data exchange protocols to obtain updated contact information from their contracted managed care plans. Many commenters supported a requirement that States use both the NCOA database and information obtained from contracted managed care plans. One commenter suggested that without a requirement across all States, CMS would effectively be authorizing States to reject reliable sources of information and to increase procedural terminations; and such policies would disproportionately affect eligible people of color.

Many commenters supported the use of automatic, electronic data matches to the greatest extent possible because they not only mitigate churn, but also reduce administrative burden on beneficiaries and States. Other commenters recommended caution when using updated contact information and addresses obtained from sources other than the beneficiary, when they have not been directly confirmed by the State agency with the beneficiary. Finally, one commenter recommended that States be required to give notice to beneficiaries and provide them with an opportunity to verify the information obtained from these data sources.

Response: We appreciate commenters' support for State use of available, reliable data sources to identify updated beneficiary addresses and other contact information. We agree that the use of outside data sources will improve States' ability to maintain contact with beneficiaries and will reduce unnecessary procedural terminations. We also appreciate the feedback regarding the cost and burden required to establish new connections with outside data sources.

As described in section II.B.4. of the September 2022 proposed rule, we proposed to require, at § 435.919(f)(1), that States check their Medicaid Enterprise System, their contracted managed care plans (if applicable), and at least one other data source such as the NCOA database, for updated mailing address information whenever beneficiary mail is returned by the USPS. At § 435.919(g)(1), we proposed that independent of the returned mail processes, States that obtain updated in-State mailing information from the NCOA database or contracted managed care plans may, at their option, treat that information as reliable, provided they contact beneficiaries and provide them with an opportunity to review the information as specified at proposed § 435.919(g)(1)(i). We also requested comment on whether States should be required, or permitted, to update beneficiary contact information based on information obtained from a managed care plan, the NCOA database, or other reliable sources, without first attempting to contact the beneficiary to verify the information.

We received significant support from commenters for a requirement that States obtain and act on updated address information provided by contracted managed care plans (when such information has been verified by the beneficiary) and the NCOA database, without requiring the State Medicaid or CHIP agency to complete additional verification. Commenters also supported the use of forwarding information provided by USPS without additional beneficiary verification. Based on this feedback, at § 435.919(f)(1)(i), we are revising and redesignating proposed § 435.919(f)(1) and (g)(1) to require that States establish a process to regularly obtain updated address information from reliable third-party data sources for use in updating beneficiaries' addresses in their case records. At § 435.919(f)(1)(iii), we define four types of data sources as always reliable for this purpose: (1) mail that is returned to the State agency by USPS with a forwarding address: (2) the NCOA database; (3) managed care plans under contract with the State, provided that the managed care plan received the information directly from the beneficiary or verified it with the beneficiary; and (4) other data sources identified by the State agency and approved by the Secretary. Hereafter in this preamble, we will refer to the sources described in § 435.919(f)(1)(iii) as ''reliable data sources.'' We also clarify at § 435.919(f)(1)(iii)(C) that for the purpose of this rule, managed care plans include MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities as defined in § 438.2 of the subchapter.

In returning to normal operations during the unwinding period, the vast majority of States requested (and were granted) waiver authority under section 1902(e)(14)(A) of the Act to accept updated contact information from contracted managed care plans and/or the NCOA database, without separately verifying the information with beneficiaries. We did not receive any feedback from commenters suggesting that this practice was, or would, harm beneficiaries or their access to coverage. We agree with commenters that implementing this process nationwide would result in more equitable treatment of beneficiaries across States and improved access for all Medicaid and CHIP beneficiaries nationwide. Therefore, we are finalizing a requirement at § 435.919(f)(2)(i) that when a State receives information regarding an in-State change of address from a reliable data source, the State must accept the information as reliable, update the beneficiary's case record with the new information, and notify the beneficiary of the update.

We recognize that some States will incur new costs as they establish data sharing agreements, create new electronic exchanges with the NCOA database and/or contracted managed care plans, and train staff in the use of

reliable, third-party information. However, we believe States will also see a reduction in the volume of returned mail as a result of this new policy. The benefits of maintaining up-to-date contact information for all beneficiaries should outweigh these upfront costs.

Comment: We received many comments supporting the use of data sources other than the NCOA database and contracted managed care plans, such as the examples described in proposed § 435.919(f)(1)(iii): SNAP, TANF, DMV, and other sources identified in the State's verification plan. Many commenters supported allowing States to accept updated address and contact information from a more expansive list of third-party sources. Suggested data sources include: medical providers and health clinics; Indian health care providers; essential community providers such as Federally Qualified Health Centers (FQHCs); community service providers such as a homeless shelters, homeless services providers or reentry programs; organizations that support managed care delivery systems, such as enrollment brokers; pharmacies and prescription drug plans; commercial third-party data providers; State and health plan contractors such as non-emergency medical transportation providers; schools; legally authorized representatives and/or emergency contacts; and other partners. One commenter supported crosschecking beneficiaries' addresses across State programs. Another commenter recommended that CMS more flexibly define reliable data sources and allow States to utilize additional sources that have proven to be credible (such as credit reporting agencies and utility companies).

Many commenters recommended State flexibility with respect to the data sources to be used, and two commenters specifically opposed requirements to create new electronic data exchanges with sources a State has determined not to be helpful. One commenter stated that requiring States to check data sources with which they do not already have electronic connections will require eligibility workers to manually review a long list of data sources before acting on information, even when third-party information may not be reliable. Another commenter expressed support for an explicit requirement that the State Medicaid Agency select the third-party source that is believed to be the most comprehensive.

Finally, many commenters expressed support for the provision at proposed § 435.919(g)(2) authorizing States to use updated in-State address information from other trusted data sources with approval from the Secretary and further supported permitting such sources to be deemed ''reliable'' such that the information does not need to be reverified by the State. Some recommended permitting other reliable data sources, at State option, since the quality of data and the feasibility of accepting updated addresses varies between States and data sources.

Response: We believe updated address information available from the NCOA database and updated address information verified by contracted managed care plans should always be considered reliable. As discussed, we are requiring at § 435.919(f)(1)(i) of this final rule that States must establish processes to regularly obtain and act on information from these reliable data sources. We appreciate that other outside sources of information may also be efficient and effective for this purpose; however, we do not have enough information to conclude that any other such sources are sufficiently reliable to permit States to accept updated beneficiary contact information from them without separately verifying the information with the beneficiary or to require their use by all States.

In this final rule, proposed § 435.919(g)(2) is redesignated at § 435.919(f)(1)(iii)(D), permitting States to request authority to utilize other data sources as reliable data sources, provided they can demonstrate that the data source provides reliable, up-to-date address information that has been verified with the beneficiary or an individual described at § 435.907(a) who is permitted to submit information on behalf of the beneficiary. At § 435.919(f)(1)(ii) of this final rule, we also revise and redesignate proposed § 435.919(g)(3), permitting States to establish a process to obtain information from other third-party data sources as well and to act on such information following additional verification by either a reliable data source or the beneficiary.

Additional verification is required for two types of address changes: in-State address changes obtained from a third-party data source other than those considered reliable for this purpose and out-of-State address changes received from any source. Section 435.919(f)(2)(ii) of this final rule provides that when an in-State address change is provided by a data source not described in § 435.919(f)(1)(iii), the State must check their Medicaid Enterprise System, along with the most recent information obtained from reliable data sources, before taking any further action. In the September 2022 proposed rule, we did not include a check of other data sources at proposed § 435.919(g)(3) for verification of these types of address updates, but we sought comment on whether we should require States to check available data sources. We did not receive any comments opposing this action, and we are including this requirement in this final rule because we believe it is in the best interests of beneficiaries for all States to check reliable data sources that would permit the immediate update of beneficiary contact information. Section § 435.919(f)(2)(ii)(A) of this final rule requires that if the in-State change of address is consistent with information from the State's Medicaid Enterprise System or a reliable data source, the State must update the beneficiary's case record and notify the beneficiary of the change. In such cases no further action is required. However, if the State is unable to confirm the new address information through the State's Medicaid Enterprise System or other reliable data source, under § 435.919(f)(2)(ii)(B) of this final rule, the State must make a good-faith effort to contact the beneficiary to verify the new address information. The requirements for making a good-faith effort are discussed later in this section.

In the September 2022 proposed rule, we proposed that when a State is unable to confirm an in-State change of address with a beneficiary, the State may not terminate the beneficiary's eligibility for failure to respond to a request to confirm the change (proposed § 435.919(f)(4)(i)); additionally, if the in-State change of address was provided by a reliable data source, the State must accept it and update the beneficiary's case record (proposed § 435.919(f)(4)(ii)). In this final rule, we revise and redesignate proposed § 435.919(f)(4)(i) and (ii) at § 435.919(f)(2)(ii)(C), which prohibits a State from terminating the coverage of an individual for failure to respond to a request from the State to confirm the information. Section 435.919(f)(2)(ii)(C) of this final rule also prohibits the State from using the information to update the beneficiary's case record, because the information subject to this provision was not obtained from a reliable data source, and it was not verified by the beneficiary.

The other type of address change requiring additional verification is an out-of-State address change. In the September 2022 proposed rule, at § 435.919(f)(2) and (3), we proposed to require States to contact a beneficiary by mail and using at least one alternative modality to verify an out-of-State forwarding address provided by USPS

when mail is returned to the State. Then at § 435.919(g)(3), we proposed to apply these same beneficiary contact requirements (proposed § 435.919(f)(2) and (3)) to out-of-State address changes provided by third-party data sources other than the NCOA database and contracted managed care plans. We did not receive any comments specific to beneficiary contacts required to confirm out-of-State address changes. In this final rule, at § 435.919(f)(3)(i) we revise and redesignate the requirements proposed at § 435.919(f)(2) and (3) and (g)(3) that States contact a beneficiary by mail and through at least one alternative modality to verify an out-of-State address update. As finalized, § 435.919(f)(3)(i) requires the State to make a good-faith effort to contact the beneficiary to confirm an out-of-State address change received from any third-party data source. The good-faith effort requirement is discussed in detail later in this section.

When a State is unable to reach a beneficiary to confirm the accuracy of updated out-of-State address information or to obtain additional information demonstrating that the beneficiary continues to meet State residency requirements, we proposed at § 435.919(f)(5) that the State must provide advance notice of termination and fair hearing rights consistent with 42 CFR part 431, subpart E. We are finalizing this policy as proposed; to do so, we revise and redesignate the language proposed at § 435.919(f)(5) at § 435.919(f)(3)(ii) of this final rule.

While the use of data sources other than USPS and contracted managed care plans does require a State to complete additional verification, we encourage States to continue existing data exchanges to obtain updated beneficiary address information and to test the reliability of existing data sources and other data sources identified by commenters. As CMS and States' experience with other sources of beneficiary contact information increases, we may learn of other sources that are also extremely reliable. If a State demonstrates that another such source of updated beneficiary contact information is reliable, § 435.919(f)(1)(iii)(D) of this final rule provides flexibility for the State, subject to approval by the Secretary, to treat updated contact information from such source in the same manner as other reliable data sources (§ 435.919(f)(1)(iii)(A) through (C)) are treated.

Comment: Several commenters encouraged CMS to either require or to encourage States to use all available data sources to verify addresses and contact information prior to terminating eligibility when a beneficiary's whereabouts cannot be confirmed. These commenters explained that requesting States to select only one data source, as proposed at § 435.919(f)(1)(iii), may be insufficient, as not all beneficiaries will, for example, receive benefits from a specified State agency or have a driver's license. Utilizing all available data sources would minimize unnecessary Medicaid coverage loss.

Response: We understand commenters' concerns about ensuring that States take sufficient action to attempt to locate a beneficiary whose whereabouts are unknown. In the September 2022 proposed rule at § 435.919(f)(1), we proposed to require that when a State receives returned mail with no forwarding address, the State must check its Medicaid Enterprise System, contracted managed care plans (if applicable), and at least one third-party data source for an updated address. We recognize that a single data source may not be sufficient, depending on the source, to locate a beneficiary whose whereabouts are unknown. However, as discussed previously, in this final rule we are requiring all States to utilize the reliable data sources described in § 435.919(f)(1)(iii). We believe these data sources will provide not only the greatest reliability but also include information on the largest number of Medicaid and CHIP beneficiaries of any available third-party data sources. While we are not requiring the use of additional data sources, we encourage States to use all available resources to locate a beneficiary whose whereabouts are unknown.

At § 435.919(f)(4)(i) and (ii) of this final rule, we are revising and redesignating the requirements proposed at § 435.919(f)(1), along with the requirements proposed at § 435.919(f)(2) and (3), for mail that is returned without a forwarding address. We require at § 435.919(f)(4)(i) of the final rule that when a State receives returned mail with no forwarding address, the State must check its Medicaid Enterprise System and the most recently available information from reliable data sources for additional contact information. If updated address information cannot be obtained and confirmed as reliable, then § 435.919(f)(4)(ii) requires the State to make a good-faith effort (as discussed later) to contact the beneficiary to obtain updated information. If a State is unable to identify and confirm a beneficiary's current address, the State must either move the beneficiary to a fee-for-service delivery system or take the necessary steps to terminate or suspend the beneficiary's coverage. At § 435.919(f)(4)(iii) of this final rule, we redesignate and finalize the requirements proposed at § 435.919(f)(6).

Comment: One commenter requested clarity on what would constitute a check of a third-party data source such as a contracted managed care plan. The commenter questioned whether a process, for example, in which the State obtains updated beneficiary contact information from its managed care plans on a recurring basis, would satisfy the requirement at proposed § 435.919(f)(1)(ii) to check managed care plans for updated address information whenever beneficiary mail is returned. Similarly, commenters recommended that requests for beneficiary contact information be sent to managed care plans in batch files, rather than individually, since responding to individual requests would require a significant amount of time and resources from the plans. One commenter recommended that States establish new processes to ensure that they do not accidentally override updated enrollee information received from managed care plans.

Response: We recognize that submitting an individual request to a managed care plan each time the State receives updated beneficiary address information may be unnecessarily burdensome, particularly if the process is not automated. We also understand that many States have established processes with contracted managed care plans to obtain updated beneficiary contact information on a regular basis, such as a daily, weekly, or monthly data exchange. We believe any of these options satisfies the requirement to check data sources for updated address information, which was proposed at § 435.919(f)(1) and is finalized at § 435.919(f)(1)(i) (establishing a process to obtain updated address information from reliable sources) and at § 435.919(f)(2)(ii) (checking reliable data sources to verify in-State address updates) and (f)(4)(i) (checking reliable data sources to obtain updated address information when whereabouts are unknown). A State may satisfy the requirement to verify in-State address updates (§ 435.919(f)(2)(ii)) and the requirement to obtain new address information when whereabouts are unknown (§ 435.919(f)(4)(i)), by making individual data requests to reliable data sources or by sending a batch of individual requests to a reliable data source on a regular basis, such as at the end of each day or week. Alternatively, States may satisfy this requirement by

establishing a process to receive regular updates (that is, daily, weekly, or monthly) from reliable data sources. We believe that establishing a process to receive regular updates strikes the best balance between minimizing the burden on States (as well as their contracted managed care plans) and ensuring that States have up-to-date beneficiary contact information when needed to contact a beneficiary, such as the beneficiary's next renewal or redetermination of eligibility following a change in circumstances.

Comment: We received many comments on the requirements proposed for contacting beneficiaries to confirm a change of address. At § 435.919(f)(2) and (g)(1)(ii), we proposed to require States to send the beneficiary a notice by mail at: the current address in the beneficiary's case record; the forwarding address, if provided for returned mail, or the new address obtained from a third-party data source; and any address identified by checking other data sources (required for returned mail only). Some commenters supported these proposed requirements, describing the requirement to send notices to both (or multiple) addresses as a critical step to protect the beneficiary's right to ensure that the information is correct before it becomes permanent.

While some commenters were supportive, many other commenters expressed concerns about the requirements for mailing notices to beneficiaries. Commenters were particularly concerned about the proposed requirement to send a notice to the address on file after mail sent to that address has been returned. They stated that such an approach would not be effective or efficient, and that it would add unnecessary time, and administrative and financial burden. A couple of commenters were concerned that the proposed approach would do the opposite of streamlining eligibility and enrollment, and one suggested that it contradicts the intent of the Paperwork Reduction Act of 1995, because it will generate twice as much mail to be processed when it is returned again to the agency undelivered.

Commenters reported concerns that ongoing paper and envelope shortages would be exacerbated by a requirement to send multiple paper notices, that it would increase the backlog of returned mail processing, that it would have a negative environmental impact, and that it would compound confusion and burden on beneficiaries who already receive a large volume of notices. In addition, several States reported that their systems do not have the functionality to hold (or send mail to) more than one beneficiary address; that manual intervention by workers would be necessary to add a second address; and that this process would significantly increase the risk of data input errors and lead to more misdirected notices. One State commenter explained that due to system limitations, they have developed a different process that is not consistent with CMS' proposed change, but they believe to be comparably effective.

At § 435.919(f)(3) and (g)(1)(iii), we proposed to require States to send at least two additional notices using one or more modalities besides mail, such as text message or email. Many commenters supported the proposed requirement for States to contact beneficiaries through other modalities, such as phone, email, or text message, when mail is returned, since this may increase their ability to reach eligible individuals. Several commenters noted that use of additional modalities puts greater protections in place to ensure that States are doing their due diligence to follow up when mail is returned. One commenter noted that traditional mail has proven to be vastly ineffective due to changes in address and delays in mail delivery, and one State commenter stated that they already attempt outreach to beneficiaries by telephone, in addition to sending a notice by mail, when mail is returned.

Other commenters expressed concerns about the financial, administrative, and time burden of contacting beneficiaries through multiple modalities. Several commenters stated that their States would require significant personnel resources for compliance, since possible automation of notices provided through other modalities would be limited and would likely require complex modifications to multiple systems. Some States reported that they would need to procure a Customer Relationship Management system, which would require years and significant State funds to implement. Other commenters were concerned that it may be impossible to send a beneficiary at least two additional notices by one or more modalities other than mail. The commenters stated that States may not have enough available contact information for a phone call, electronic notice, email, and/or text message, particularly if they only maintain email addresses for individuals who have elected to receive their notices electronically, which may result in a low contact success rate with a high cost.

A number of commenters recommended more State flexibility for contacting beneficiaries about returned mail and updated mailing addresses. Others suggested specific alternative approaches. Some supported a requirement for States to investigate other available addresses and send notice to those addresses. Others recommended limiting the total number of required attempts to two, for example, by sending one notice to the updated address and another notice through an additional modality other than mail. We also received comments recommending that the second notice be a State option or best practice, particularly in light of the reliability of forwarding addresses. Finally, some commenters recommended that CMS not mandate any specific outreach, but instead encourage States to make additional attempts to contact beneficiaries through additional modalities.

Response: We agree that when new address information is obtained from outside sources, which may not have verified the information in advance, it is important for States to take adequate steps to contact the beneficiary and ensure that the information is correct. We also understand the barriers and challenges raised by commenters regarding the proposed approaches for contacting beneficiaries by mail and through other modalities, and we recognize that some approaches will be easier to implement in some States than others. In this final rule, we seek to balance the likelihood of reaching a beneficiary with the significant increase in burden that multiple mailings and the use of multiple modalities would place on State Medicaid and CHIP agencies.

As discussed previously in this final rule, we believe updated addresses provided by the NCOA database and States' contracted managed care plans (when verified by the beneficiary) are extremely reliable. Therefore, we are finalizing a requirement at § 435.919(f)(2)(i) that States must accept in-State address updates from these sources as reliable, use the information to update the contact information in a beneficiary's case record without attempting to contact the beneficiary for additional verification, and notify the beneficiary of the update. We believe this change will reduce the number of additional beneficiary communications that are needed. However, we believe there are still a number of situations in which it is important for States to attempt to contact a beneficiary to confirm a change of address before updating the beneficiary's case record.

This includes situations in which the reliable third-party data indicates a potential change of State residency (that is, an out-of-State forwarding address), the change of address was provided by a third-party data source other than those considered reliable under § 435.919(f)(1)(iii) of this final rule, or mail is returned to the State without a forwarding address. Therefore at § 435.919(f)(2)(ii)(B), (f)(3)(i), (f)(4)(ii), and (f)(5) of this final rule, we revise and redesignate the beneficiary contact requirements proposed at § 435.919(f)(2) and (3) and (g)(1)(ii) and (iii). For the purpose of this final rule, we refer to these beneficiary contact requirements as a good-faith effort to contact beneficiaries to confirm address changes, and we define a good-faith effort at § 435.919(f)(5). The discussion that follows describes § 435.919(f)(5) in detail, including the redesignation and revisions to proposed § 435.919(f)(2) and (3) and (g)(1)(ii) and (iii).

In the September 2022 proposed rule, at § 435.919(f)(2), we proposed to require that whenever beneficiary mail is returned to the State by USPS, the State must attempt to contact the beneficiary by mail to either confirm the forwarding address or to obtain a new address. This included requirements to send a notice to the address currently on file in the beneficiary's case record, the forwarding address (if provided) and any other addresses identified by the agency. We proposed the same requirement at § 435.919(g)(1)(ii) for updated in-State address information obtained from the NCOA database or from a contracted managed care plan (provided the information was verified by the beneficiary), except the requirement to send a notice to other addresses identified by the agency. Finally, we proposed to apply the requirements at § 435.919(f)(2) to in-State address changes received from data sources other than USPS and contracted managed care plans and to out-of-State address changes received from any outside data source through a cross reference at proposed § 435.919(g)(3).

At § 435.919(f)(3) and (g)(1)(iii) we proposed to require that States send the beneficiary at least two notices, by one or more modalities other than mail, such as phone, electronic notice, email, or text message, to either confirm the forwarding address or to obtain a new address. Consistent with the requirements for mailing notices, we proposed to apply these requirements when beneficiary mail is returned, when the State obtains an updated in-State address from the NCOA database, and to other address updates through a cross-reference at § 435.919(g)(3).

In this final rule, we combine these requirements into a good-faith effort requirement to contact the beneficiary, which must include, at a minimum, at least two attempts to contact the beneficiary, using at least two different modalities, with a reasonable period of time between contact attempts. To permit a swift and seamless transition, we modelled the good-faith effort required by this final rule on the requirements established under section 6008(f)(2)(C) of the FFCRA, as amended by the CAA, 2023. As a condition for receiving the FFCRA's temporary FMAP increase, States were required to undertake a good-faith effort to contact beneficiaries using more than one modality before terminating eligibility on the basis of returned mail. In a State Health Official letter issued on January 27, 2023 (SHO# 23–002), we defined a good-faith effort to mean that the State (1) has a process in place to obtain up-to-date mailing addresses and additional contact information for all beneficiaries, and (2) attempts to reach a beneficiary whose mail is returned through at least two modalities using the most up-to-date contact information the State has for the individual.[15]

The September 2022 proposed rule would have required States to mail notices to all available beneficiary addresses, including the address currently on file, the forwarding address, and any other addresses obtained from other data sources. We agree with commenters that this proposed requirement was unnecessarily burdensome. In this final rule, we have eliminated the specific requirements for mailing notices to the old address, new address, and any other available to the agency. Instead, § 435.919(f)(5)(i)(A) requires the State to make at least two attempts to contact the beneficiary, and § 435.919(f)(5)(i)(B) requires the State to use at least two different modalities (such as mail, phone, email). For many beneficiaries, a mailed paper notice continues to be the best method of communication, and when the State receives an out-of-State forwarding address or obtains an updated in-State address, we would generally expect the State to mail a notice to that address as part of their good-faith effort, in accordance with this final rule. This approach provides States with flexibility, for example, to tailor their approach to specific types of beneficiaries and to utilize modalities that have proven most effective in reaching their beneficiaries.

We recognize that every individual's situation is different, and some beneficiaries may respond best to text messaging, internet-based messaging, or other electronic communication, while others may be more likely to respond to a phone call or a letter. We proposed to require, at § 435.919(f)(3)(i) that for a beneficiary who elected to receive electronic notices and communications in accordance with § 435.918, at least one communication attempt must be electronic, and any additional attempts must occur through a different modality. We are not finalizing this requirement; removing this proposed requirement from the final rule increases State flexibility, and current § 435.918(b) already requires States to communicate electronically, by posting notices to an individual's electronic account, when an individual elects to receive their notices electronically. We expect States to utilize the modalities that match individual beneficiary preferences as much as possible. For those beneficiaries who have requested electronic communications, we would generally expect at least one of the attempts to contact the beneficiary, as required at § 435.919(f)(5)(i), to be made using this modality unless the electronic communication is undeliverable. If the electronic communication is undeliverable, the State must utilize other modalities, if available, to fulfill this requirement.

Further, we proposed at § 435.919(f)(3)(ii) and (iii) that notices must be sent first to contact information in the beneficiary's case record, if available, and then using other contact information, but that the State may utilize any combination or order of modalities. To increase flexibility and permit States to establish the most effective processes given their unique circumstances, we are not finalizing these requirements. However, in making a good-faith effort to contact a beneficiary, we expect States to utilize the most up-to-date information available. For example, if a State receives a piece of returned mail with no forwarding address, and the contact information in the beneficiary's case record includes a mailing address and cell phone number provided 10 months ago, plus an email address that was updated one month ago, the State would be expected to attempt to contact the beneficiary by email and by phone or text.

We believe this requirement to make a good-faith effort to contact the beneficiary, with at least two attempts through two or more modalities, strikes

[15] *https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf.*

the best balance of protecting coverage for eligible individuals without overburdening State agencies. We also recognize that States will not always have sufficient information to make two or more attempts through different modalities. At § 435.919(f)(5)(ii), we revised and redesignated the requirement proposed at § 435.919(f)(3)(v) that if the State does not have the necessary contact information to full the requirements of § 435.919(f)(5)(i) for a good-faith effort, the State must make a note of that fact in the beneficiary's case record.

Comment: One commenter supported the proposed requirement that when a State sends notice to a beneficiary to update their address, or confirm an updated address, the individual be provided with a reasonable period of time of 30 calendar days from the date the notice is sent to the beneficiary to verify the accuracy of the new contact information. Another commenter disagreed with the requirement to wait 30 calendar days to hear back from a beneficiary before acting on a change. One commenter reported that States often receive address changes that at are least six months old, creating very little risk that the individual incorrectly updated their address and did not realize the error in the intervening six months; in these cases, giving the beneficiary 30 days to respond would significantly delay the State's ability to update the address and not meaningfully increase the accuracy of the agency's contact information.

Response: We believe it is important to provide beneficiaries with adequate time to receive and respond to a request from the State. In this final rule, we revise and redesignate the requirement to provide beneficiaries with at least 30 days to verify the accuracy of new contact information, proposed at § 435.919(f)(3)(i) and (g)(1)(v), at § 435.919(f)(5)(i)(D) of this final rule. Section 435.919(f)(5)(i)(D) provides that when a State makes a good-faith effort to contact a beneficiary to confirm their updated address, the State must provide the beneficiary with at least 30 calendar days to respond to the request and either provide updated contact information or confirm the updated contact information obtained by the State. We note that when beneficiaries themselves provide updated contact information to the State, or when the State receives updated, in-State contact information from a reliable data source described in § 435.919(f)(1)(iii), the State is not required to separately verify the change with the beneficiary.

Comment: We received several comments regarding the use of data in States with combined eligibility systems, which may include Medicaid, SNAP, TANF, and other public benefit programs. One commenter questioned whether use of a combined eligibility system would automatically satisfy the requirement at proposed § 435.919(f)(1)(iii) to check at least one outside data source. Two commenters expressed concern about the use of other data sources in States with combined eligibility systems. One commenter noted that while the NCOA database, for example, may be an acceptable source for address verification for Medicaid, it may conflict with other programs' requirements and could have a significant impact on eligibility for other benefit programs.

Response: We recognize that utilizing a combined eligibility system requires navigating among different programs' eligibility requirements. Prior to this final rule, policy differences already existed between CMS programs and other State-administered health and human services programs, and States have reconciled differences over time to administer multiple programs together through a single system. States have a number of options for reconciling different program requirements for this purpose. They may, for example, adopt options or flexibilities that permit alignment of program rules, establish separate processes to allow separate rules to be applied to each program, or determine that information collected, or decisions made, by one program can be applied to the other program. The options available will differ by program, by State and Federal requirements, and by the specific nature and design of State processes.

In this rule, we are finalizing a requirement that States must obtain data from sources defined as reliable for updating beneficiary contact information. At § 435.919(f)(1)(iii), we define the following four data sources as reliable: mail returned to the State agency by the USPS, the NCOA database, managed care plans, and other entities under contract with the State, and other data sources identified by the State and approved by the Secretary. States may seek approval from the Secretary to deem data provided by SNAP, TANF, or another public benefit program or agency as reliable for updating beneficiary contact information. In such cases, the State must demonstrate that the information was received directly from, or verified by, the beneficiary whose contact information will be updated or by an individual with authority to provide information to the State on the beneficiary's behalf. Such individuals would include an adult who is in the applicant's household, as defined in § 435.603(f), family, as defined at 26 U.S.C. 36B(d)(1), or an authorized representative. Additional information on obtaining Secretarial approval for this purpose will be made available through subregulatory guidance.

We are not finalizing the requirement at proposed § 435.919(f)(1)(iii) to check at least one outside data source, so the commenter's question about whether use of a combined eligibility system would automatically satisfy the requirement to check an outside data source is no longer relevant for this rule. However, States are permitted, as described at § 435.919(f)(1)(ii) to establish processes to obtain updated address information from data sources other than those identified as reliable and described in § 435.919(f)(1)(iii), including data provided by SNAP, TANF, or other public benefit programs. States must act on information obtained from these data sources in accordance with § 435.919(f)(2) and (3).

Comment: Several commenters opposed the proposed requirement that when sending notices through one or more modalities, the notices be issued a minimum of 3 days apart. The commenters stated that this would be operationally difficult for States to monitor and track and would create significant additional work without a clear added benefit. The commenters recommended State flexibility with respect to the timing of the communications. Other commenters supported the requirement to schedule at least 3 business days between the first and the last attempt to contact a beneficiary, explaining that such additional time may permit some beneficiaries to overcome challenges they experienced in responding to the first attempt.

Response: We appreciate the input. We agree that it is important to provide a reasonable period of time for a beneficiary to respond between the first and the last contact attempts. However, we also understand commenters' concerns that 3 days may not be the best timeframe for all situations and that such a specific timeframe may be difficult to implement. While we believe 3 days is a reasonable period of time, we believe other timeframes may also be considered reasonable. As such, we are revising and redesignating proposed § 435.919(f)(3)(iv) at § 435.919(f)(5)(i)(C), which requires that a good-faith effort to contact a beneficiary includes a reasonable period of time between contact attempts.

Comment: One commenter recommended that before updating a

mailing address based on secondary information, States use the new address as an alternative address or consider communicating only non-sensitive information at the new address until the beneficiary has been successfully contacted and has confirmed the update. The commenter explained that such an approach would mitigate privacy concerns if personal health information was inadvertently sent to the individual at an incorrect address.

Response: We agree that protecting the privacy of Medicaid and CHIP beneficiaries is critical. That is why we proposed at § 435.919(f)(2) and (3) and (g)(1) to require that States contact beneficiaries prior to making updates to their contact information based on information provided by an outside data source that has not been determined to be extremely reliable. We note that the reliable data sources identified in § 435.919(f)(1)(iii) of this final rule all provide information that was either obtained from or confirmed by the beneficiary. Except in the case of updated in-State address information received from a reliable data source, we are finalizing the requirement that the State attempt to contact a beneficiary to confirm an in-State change of address (§ 435.919(f)(2)(ii)(B)) and an out-of-State change of address (§ 435.919(f)(3)(i)) provided by a third-party data source.

Comment: One commenter expressed concern that States would not be permitted to send electronic notices to individuals who do not expressly consent to receive their notices electronically.

Response: States are required to provide timely and adequate written notice to beneficiaries of any decisions affecting their eligibility, as described at current § 435.917. If an individual elects to receive such notices electronically, the use of electronic notices must comply with § 435.918(b). This regulatory requirement does not prohibit a State from attempting to reach a beneficiary through a secure electronic communication when the State is unable to deliver the notice by mail because a beneficiary's mailing address is no longer correct.

Comment: One commenter expressed concerns surrounding managed care plans' ability to utilize two different effective contact modalities given current restrictions under the Telephone Consumer Protection Act (TCPA). The commenter requested clear guidance on the role of managed care plans in these outreach efforts.

Response: We believe managed care plans are a particularly effective source of reliable contact information for beneficiaries. That is why we are finalizing the requirement proposed at § 435.919(f)(1)(ii), revised and redesignated at § 435.919(f)(1)(i) that States establish a process to obtain and act on updated information available through contracted managed care plans. While managed care plans are important partners to State Medicaid and CHIP agencies, the regulatory requirement finalized at § 435.919(f) does not require action by contracted managed care plans. State agencies must make a good-faith effort to contact their beneficiaries to verify a change of address. While § 435.919(f)(1)(i) requires States to work with contracted managed care plans to obtain updated beneficiary contact information, the managed care plans themselves are not obligated to conduct any outreach under these requirements. Because the requirements established by the TCPA fall outside our purview, we are not able to provide guidance on this statute or compliance with its terms. For additional information on the TCPA and its implications for Medicaid and CHIP agencies, we refer readers to guidance issued by the Federal Communications Commission at *https://www.fcc.gov/document/fcc-provides-guidance-enable-critical-health-care-coverage-calls.*

Comment: Many commenters noted the importance of using multiple modalities to reach beneficiaries in different types of situations. Several commenters expressed concerns about States' ability to contact beneficiaries who may be housing insecure and do not maintain a consistent address, because reliance on mailed notices will have a disproportionately negative impact on such individuals, particularly individuals experiencing homelessness. One commenter explained that text messages and email are likely preferred methods of contact for Medicaid beneficiaries due to the high prevalence of smartphone use among this population. Other commenters noted that beneficiaries have varied access to different modes of communication, and they are likely to have different levels of ability and levels of comfort utilizing various communication modalities. Examples provided by commenters include beneficiaries in rural areas who may have limited broadband access and cellphone coverage, older adults and people with disabilities who may temporarily lose access to mail while they are hospitalized or receiving skilled nursing care in a facility, and individuals with disabilities who may have unique accessibility issues across different modes of communication.

One commenter recommended that beneficiary preferences be considered when determining the best contact method for a given beneficiary, as some may prefer electronic notices, some may opt for paper, and others may prefer to speak to a caseworker, especially if they have questions. Another commenter recommended that applications and renewal forms include options to indicate when an individual is experiencing unstable housing and must be contacted through methods other than mail. A third commenter suggested that we provide States with resources and technical assistance to ensure they are equipped to communicate with beneficiaries experiencing homelessness, including via text messaging.

Response: We agree that different modes of communication are likely to be more effective for some beneficiaries than others and that access to alternative forms of communication is particularly important for individuals who may not receive mail regularly, such as those who are housing insecure. The model, single streamlined application described at § 435.907(b)(1) permits applicants to leave the home address field blank if they are experiencing unstable housing, and applicants and beneficiaries are always permitted to provide an alternative mailing address, such as the address of a relative, friend, community-based organization, or post office, among others. In addition, every applicant and beneficiary currently have the right under existing regulations (see § 435.918) to elect to receive communications electronically. We will continue to consider additional opportunities, including potential changes to the single, streamlined application, to assist States in communicating with different types of individuals who may have different communication needs. We remind States that communications with individuals with limited English proficiency and individuals with disabilities must be accessible, as discussed previously.

Comment: One commenter requested clarification about whether States are required to act on address changes reported by third-party entities that are not considered by the State to be reliable.

Response: Other than the data sources identified as reliable in § 435.919(f)(1)(iii) of this final rule—the agency's contracted managed care plans, the NCOA database, USPS returned mail, and any other source identified by the State and approved by the Secretary—States are not required to establish processes for obtaining updated address information from any

other specific data sources. Each State agency has flexibility to determine which data sources will be most effective for use in their own State. Address information obtained from any data source other than those identified as reliable in § 435.919(f)(1)(iii) must be verified by the beneficiary.

Comment: Most commenters supported the proposed requirement at § 435.919(f)(4)(i) that when beneficiary mail is returned to the State and the State is unable to confirm a beneficiary's in-State forwarding address, the State may not terminate the beneficiary's eligibility for failure to respond.

Response: We agree that failure to respond to a request to confirm a change of address is not a valid reason for terminating a beneficiary's eligibility. We are finalizing this requirement as proposed, except that we have moved the proposed provision to § 435.919(f)(2)(ii)(C) of this final rule and applied it only to in-State address updates from third-party sources other than those defined as reliable at § 435.919(f)(1)(iii). When the State receives an in-State address change from the USPS, either via returned mail or from the NCOA database, or from a contracted managed care plan that obtained the information directly from the beneficiary or verified it with the beneficiary, § 435.919(f)(2)(i) requires the State to accept the change, update the beneficiary's case record with the information and then notify the beneficiary of the change. A beneficiary does not need to respond to reconfirm the information provided by a reliable data source.

Comment: One commenter requested clarification about the prohibition on terminating Medicaid eligibility when a beneficiary fails to respond to a request to confirm an in-State forwarding address. The commenter was unclear about whether this requirement was limited to only circumstances in which the change of address is the only change or whether it also applies when a State attempts to contact a beneficiary to request information about a change that does impact the individual's eligibility, such as income.

Response: Section § 435.919(f)(2)(ii)(C) of this final rule, prohibits a State from terminating an individual's coverage for failure to respond to a request from the State to confirm their address or State residency. This requirement applies only to the request to confirm the change of address. For example, a State receives notification through a monthly data exchange with SNAP that a beneficiary's address has changed to a new in-State address. In accordance with § 435.919(f)(2)(ii)(A) of this final rule, the State checks reliable data sources but is unable to confirm the beneficiary's updated address. The State therefore mails a notice to the beneficiary and calls the beneficiary at the phone number in the beneficiary's case record to request confirmation of the change of address. If the beneficiary does not respond to either request, the State may not terminate the beneficiary's eligibility in accordance with § 435.919(f)(2)(ii)(C) of this final rule. However, if the State receives information from the SNAP agency both that the beneficiary has moved and that their income has increased beyond the income standard for Medicaid, the outcome may be different. In this case, the State would need to contact the beneficiary in accordance with § 435.919(f)(2)(ii) to confirm the change of address, and in accordance with § 435.919(b)(4) to verify or dispute the income information. After following these steps, if the beneficiary does not respond the State's outreach, then the State may send advance notice of termination and fair hearing rights, in accordance with § 435.917 and 42 CFR part 431, subpart E, because it cannot confirm that the beneficiary remains income eligible.

Comment: We received one comment urging CMS to require States to provide advance notice, at a beneficiary's last known address or through electronic means, before suspending or terminating eligibility because a beneficiary's whereabouts are unknown.

Response: The circumstances in which Medicaid's notice and fair hearing rights apply are set forth in 42 CFR part 431, subpart E. Section 431.213 provides for a series of exceptions to the requirement to provide advance notice; current § 431.213(d) permits a State to send notice of an adverse action not later than the date of the action when a beneficiary's whereabouts are unknown and the post office returns mail with no forwarding address. It also refers to current § 431.231(d) for the procedure for when beneficiaries whereabouts become unknown. In the preamble to the September 2022 proposed rule, we proposed to revise and redesignate § 431.231(d) at proposed § 435.919(f)(6) and to update the reference to § 431.231(d) in current § 431.213(d). However, we did not carry these changes over to the proposed regulatory text correctly, and the references to §§ 431.213(d) and 431.231(d) were switched. The requirement for States to provide advance notice and fair hearing rights, and the existing exception at § 431.213(d) permitting the State to send notice no later than the date of termination or suspension when a beneficiary's whereabouts are unknown, are not impacted by this final rule. However, we are finalizing the proposed change to revise and redesignate § 431.231(d). In this final rule, we remove and reserve paragraph (d) of § 431.231, which requires that any discontinued services be reinstated if a beneficiary's whereabouts become known during the time that beneficiary would have remained eligible for services. Paragraph (f)(4)(iii) of this final rule describes the procedures a State must follow when a beneficiary's whereabouts are unknown, including the requirement to reinstate coverage if the beneficiary's whereabouts become known.

We understand the commenter's concerns about ensuring that beneficiaries receive advance notice of any adverse actions. We believe the changes finalized in this rule will reduce the number of beneficiaries whose whereabouts remain unknown and who cannot be reached for notification. While we are not making any policy changes to the exception at § 431.213(d), we will continue to seek new alternatives and will consider making a change in future rulemaking.

Comment: We received several comments on proposed § 435.919(f)(5), which would require States to terminate the eligibility of a beneficiary if they are unable to contact the beneficiary following the return of mail with an out-of-State forwarding address. Several commenters specifically supported this proposed requirement. They noted that beneficiaries must first be given proper notice and the opportunity to verify or dispute the out-of-State address, and the State must provide advance notice of termination and fair hearing rights. Two commenters recommended that no disenrollment action be taken due to returned mail, since it does not necessarily indicate that a beneficiary has moved. Another commenter recommended that in lieu of disenrollment, States be given the option to retain eligibility for such beneficiaries and transition them to fee-for-service care as opposed to keeping them enrolled in a managed care plan and continuing to make capitation payments.

Response: We believe it is appropriate for States to terminate the eligibility of beneficiaries when the State has information indicating that the beneficiary no longer meets all eligibility requirements, in this case State residency, and the beneficiary does not respond to requests from the State to verify continued eligibility. At

§ 435.919(f)(3)(ii) of this final rule, we are finalizing the requirement proposed at § 435.919(f)(5) to terminate eligibility in such cases; States must provide advance notice and fair hearing rights in accordance with § 435.917 and 42 CFR part 431, subpart E.

We appreciate commenters' interest in keeping beneficiaries enrolled. However, we do not believe it is appropriate to maintain the eligibility of a beneficiary when the State has information indicating that the individual no longer meets the State's residency requirement, regardless of the delivery system in which the individual is enrolled. An individual cannot have a different eligibility determination in a managed care versus a fee-for-service delivery system. We believe the commenter's recommendation to transition beneficiaries from managed care to fee-for-service was intended to permit States to keep beneficiaries enrolled, in case they respond later to confirm continued State residency, while at the same time protecting the State from paying for medical assistance while their eligibility status is unclear. Changing the delivery system through which a beneficiary receives medical assistance is not an appropriate way to resolve an eligibility issue. However, we note that States may achieve a similar result through use of a reconsideration period. As described at § 435.919(d) of this final rule, when the State receives information indicating that a beneficiary experienced a change in circumstances that impacts eligibility, and the beneficiary fails to respond to the State with information indicating continued eligibility, the State must move forward to terminate eligibility and provide the individual with a reconsideration period of at least 90 days. If the individual subsequently submits information indicating continued eligibility within 90 days after the date of termination, or a longer period elected by the State, the State must reconsider the individual's eligibility without requiring a new application.

Comment: We received a number of comments opposing proposed § 457.344(f)(5). In States in which CHIP coverage is not provided statewide, we proposed to apply the requirements for out-of-State returned mail when mail is returned with an out-of-county forwarding address and CHIP coverage is not available in the county to which the enrollee's mail is being forwarded. Commenters were concerned that such individuals' eligibility would be terminated without considering whether the individual may be eligible for other Medicaid or CHIP coverage or for assistance purchasing a qualified health plan through the State's Marketplace. They recommended that the State proceed with determining eligibility for other insurance affordability programs, sending a combined notice, and transferring the individual's account in accordance with §§ 435.1200 and 457.350.

Response: We appreciate the points raised by commenters about protecting access to coverage for CHIP enrollees who move but continue to reside within the same State. We also recognize that while States are permitted to limit their CHIP coverage to specific geographic areas within the State, only a very small number of States have chosen to limit the program's Statewide availability. As such, we do not believe it is necessary to establish a special requirement for handling mail returned with an in-State address in the limited cases in which CHIP is not available Statewide. The requirement finalized at § 457.344(f)(2) for handling an in-State change of address will apply to all CHIPs. When a change of address is provided by a reliable data source, § 457.344(f)(2) of this final rule requires the State to accept and update the address in the enrollee's case record. When applying this requirement in a State that does not provide Statewide coverage, if the change would impact an individual's CHIP eligibility, we would expect the State to first attempt to contact the beneficiary to confirm the change of address as they would with any other reported change impacting eligibility. If the State is unable to reach the enrollee to confirm the change, the State must act on the change. In cases where a change of address would result in ineligibility for CHIP, before terminating enrollment, the State must screen the individual for eligibility for other Medicaid or CHIP coverage, and if the individual is no longer eligible for CHIP and is not eligible for Medicaid, the State must consider the individual's potential eligibility for assistance through the State's Marketplace in accordance with § 457.350. If the individual is potentially eligible for coverage through the Marketplace, their account must be transferred to the Marketplace in accordance with § 457.350.

Comment: One commenter expressed concern that the changes proposed with respect to returned mail will likely lead to prolonged delays in assessing enrollees' eligibility. Another commenter stated that from a member perspective, the increased outreach requirements that must be performed by the agency, such as the requirement to perform outreach using at least two modalities, may impact timely receipt of notifications, increasing unnecessary churn.

Response: We do not agree that the proposed returned mail changes will lead to delays in assessing enrollees' eligibility. In fact, we believe these requirements will facilitate better communication with beneficiaries and reduce delays in redetermining their eligibility at regular renewals or when the State receives information regarding a change in circumstances that may impact a beneficiary's eligibility. We believe that returned mail results in a significant number of beneficiaries being terminated from coverage, even though they continue to meet all eligibility requirements, because many States historically have not taken reasonable steps to locate them. Returned mail with an in-State forwarding address does not indicate a potential change that may result in ineligibility. While an out-of-State or no forwarding address does indicate a potential change in circumstances with respect to State residency, it is critical to maintaining continuity of coverage for eligible individuals that States attempt to confirm the accuracy of the information before acting on it, including efforts to locate the individual to obtain or confirm their new address.

After considering the comments, we are finalizing the returned mail requirements with modification as discussed. Because the effect of this change is specific to updating beneficiaries' case files with updated address information, primarily for the purpose of contacting beneficiaries with information about their case, we note that this provision operates independently from the other provisions of this final rule.

5. Transitions Between Medicaid, CHIP and BHP Agencies (42 CFR 431.10, 435.1200, 457.340, 457.348, 457.350, and 600.330)

We proposed to revise Medicaid regulations at §§ 431.10 and 435.1200 and CHIP regulations at §§ 457.340, 457.348, and 457.350 to improve coverage transitions between Medicaid and separate CHIPs. The proposed changes seek to reduce and prevent unnecessary gaps in coverage for individuals transitioning between these programs, and to make the transitions process more seamless for families. The proposed changes would require Medicaid and separate CHIPs to make determinations of eligibility on behalf of the other program; to accept determinations of eligibility made by these programs; to transition individuals to the insurance affordability program for which they are determined eligible

or potentially eligible based on available data; and for Medicaid and separate CHIP agencies to provide a single, combined notice to all members of a household with information about each individual's eligibility status for each applicable insurance affordability program. We proposed technical changes to BHP regulations at § 600.330, to maintain the current policy for that program. We sought comment on whether it is appropriate and feasible to apply the proposed changes for seamless transitions between Medicaid and separate CHIPs to coverage transitions between Medicaid, separate CHIPs, and BHPs, but we did not receive any specific comments on the appropriateness or feasibility of applying the specific transitions requirements to BHPs. Therefore, we are not making changes to § 600.330, and are finalizing this section as proposed. BHPs must continue to fulfill the requirements of § 435.1200(d), (e)(1)(ii), and (e)(3) and, if applicable, § 600.330(c).

Comment: Many commenters provided overall support for the provisions in the September 2022 proposed rule to improve transitions in coverage between Medicaid and separate CHIPs. Commenters indicated that the proposed changes would help to prevent unnecessary churn between insurance affordability programs; reduce gaps in coverage as beneficiaries move between programs; improve timeliness for State agencies to transition beneficiaries' coverage; and reduce burden for families throughout the renewal and transition processes.

Response: As noted by commenters, we believe these changes will help to ensure a more streamlined process for transitioning beneficiaries between insurance affordability programs, reduce gaps in coverage during these transitions, and improve the renewal and transitions experience for beneficiaries. As such, we are finalizing as proposed the changes as set forth in proposed §§ 435.1200, 457.340, 457.348, and 600.330 without revision. We are making one change to proposed § 457.350, in paragraph (b)(1)(ii) of that section, to include new language that clarifies that information provided on the application or renewal form by or on behalf of the beneficiary includes information obtained through trusted electronic data sources. Aside from this change to paragraph (b)(1)(ii) of the section, we are finalizing § 457.350 as proposed.

Comment: Numerous commenters expressed support for provisions in § 435.1200(e) of the September 2022 proposed rule to require Medicaid agencies to make determinations of eligibility for their State's separate CHIP and proposed § 457.348 to require separate CHIPs to accept determinations of eligibility made by their State's Medicaid agency. Commenters noted that these changes will ensure continuity of coverage for individuals transitioning from Medicaid to a separate CHIP. Some commenters provided suggestions for CMS on how to implement these changes in order to minimize barriers to accessing care when individuals are transitioned from Medicaid to a separate CHIP. Several commenters encouraged CMS to require States to effectuate separate CHIP coverage immediately after an eligibility determination is made by Medicaid, and permit plan-selection and collection of premiums and enrollment fees (if imposed) for the separate CHIP post-enrollment. Similarly, other commenters suggested that CMS require States to apply a 30-day premium grace period for the first month of enrollment after a transition in coverage from Medicaid to a separate CHIP. Another commenter requested that CMS encourage States to develop a gradual phase-out of benefits from Medicaid and graduated co-payments in separate CHIPs when individuals are transitioned from Medicaid to a separate CHIP.

Response: We appreciate commenters' support of our proposal to require Medicaid agencies to make eligibility determinations on behalf of separate CHIPs and agree that this change will help to ensure beneficiaries retain coverage and access to care through transitions from Medicaid to a separate CHIP. We are finalizing §§ 435.1200(e) and 457.348 as proposed to effectuate this requirement. We thank commenters for offering suggestions for implementation of this requirement. We acknowledge that adopting the recommendations to require a 30-day premium grace period; collect initial premiums and enrollment fees post-enrollment; and initiate graduated copayments in separate CHIPs would reduce barriers for individuals to access care as they transition to a separate CHIP from Medicaid. We note that the current regulation at § 457.340(g), which is not revised in this final rule, requires States to develop a method for determining the effective date of separate CHIP eligibility. This provision provides States with the flexibility to select any reasonable method that supports coordinated transitions of children between a State's separate CHIP and other insurance affordability programs without creating gaps or overlaps in coverage. We believe States with premiums and enrollment fees in their separate CHIPs could prevent potential gaps in coverage and delays in effectuating separate CHIP coverage for individuals transitioning from Medicaid by leveraging the flexibility afforded under existing authority at § 457.340(g). For example, to address commenters' concerns about enrollment fees and premiums creating potential gaps in coverage as individuals transition from Medicaid to a separate CHIP, we encourage States to waive premiums for the first month of separate CHIP coverage. We also acknowledge that post-enrollment plan-selection for separate CHIPs would help to reduce delays for individuals to access care as they are transitioned to a separate CHIP from Medicaid. Several States with managed care delivery systems in their separate CHIP provide services to newly enrolled individuals through fee-for-service arrangements temporarily before their managed care plan selection/assignment is finalized. This strategy helps to ensure that newly enrolled individuals can receive needed care before they have been assigned to a specific managed care plan. We encourage States with managed care delivery systems in their separate CHIP to consider this or a similar approach to ensure newly enrolled beneficiaries are able to access needed separate CHIP services prior to plan-assignment.

Comment: Numerous commenters expressed support for the requirements for separate CHIP agencies to make eligibility determinations on behalf of Medicaid as outlined in § 457.350(b) of the September 2022 proposed rule, and for Medicaid to accept determinations of eligibility made by the separate CHIP agency as proposed at § 435.1200. Commenters noted that these changes would improve coordination between Medicaid and separate CHIPs in conducting eligibility determinations and transitioning individuals between programs. A few commenters expressed concern that inaccurate or incomplete eligibility determinations could be made by separate CHIPs that use different methodologies to assess eligibility than Medicaid. A commenter also recommended that CMS require Medicaid programs to supervise separate CHIPs and other insurance affordability programs in determining Medicaid eligibility in States that do not use a shared eligibility service for Medicaid, their separate CHIP, and other insurance affordability programs.

Response: We thank commenters for their support of the proposed requirements to permit separate CHIPs to make determinations of eligibility on

behalf of Medicaid and agree that these changes will support alignment in separate CHIPs and Medicaid to conduct eligibility determinations and transitions between insurance affordability programs as seamlessly as possible. We appreciate commenters' recommendations to ensure that accurate Medicaid eligibility determinations are made by separate CHIPs. We note that State Medicaid agencies are not required to accept eligibility determinations that are not made on the basis of MAGI and that proposed § 435.1200(b)(4) provides Medicaid agencies with several options for accepting determinations of eligibility based on MAGI that are made by separate CHIPs, which we are finalizing without revision. We believe this approach provides the State Medicaid agency with the ability to exercise appropriate oversight over MAGI-based eligibility determinations for Medicaid. For instances when separate CHIPs do not have sufficient information to make determinations of eligibility for Medicaid, such as Medicaid eligibility on a non-MAGI basis, proposed § 457.350(e) directs separate CHIPs to make a determination of potential Medicaid eligibility and transfer the account to the State Medicaid agency to make a final determination.

Comment: Another commenter indicated that potential increases in Medicaid enrollment as a result of permitting separate CHIPs to determine eligibility on behalf of Medicaid could strain dental provider capacity to care for additional children in Medicaid and urged CMS to expand dental provider participation in Medicaid to meet the oral health care needs of a larger eligible Medicaid population.

Response: We acknowledge commenters' request for us to expand dental provider participation in Medicaid to ensure adequate provider capacity to administer oral health care services to a potentially larger Medicaid population as a result of these changes. However, changes related to Medicaid provider participation requirements are outside the scope of this final rule. Therefore, we are finalizing requirements at § 435.1200 for Medicaid and § 457.350(b) for separate CHIPs as proposed.

Comment: Many commenters offered support for the proposed requirements in §§ 435.1200(h)(1) and 457.340(f) that State Medicaid and separate CHIP agencies provide households with a single combined notice to indicate changes in beneficiaries' eligibility and coverage under Medicaid, separate CHIPs, BHPs, and an Exchange. Commenters noted that the use of a combined notice for all insurance affordability programs will ensure a more seamless and less burdensome process for renewals and transitions between programs for States and beneficiaries.

Response: We thank the commenters for their support to require Medicaid and separate CHIP agencies to provide a single combined notice with information about Medicaid, separate CHIP, BHP, and Exchange coverage. We agree that issuing one notice to families about eligibility and ineligibility information for all insurance affordability programs would simplify the process to inform families about changes in coverage.

Comment: A few commenters recommended that CMS explicitly require the content of combined notices to include information about additional steps for individuals to effectuate coverage, such as plan selection and premium requirements.

Response: We appreciate commenters' concerns about combined notices including detailed information for families about what they need to do to effectuate their Medicaid or separate CHIP coverage. We are maintaining current requirements for content of eligibility notices to applicants and beneficiaries outlined in existing § 435.917(b) for Medicaid and § 457.340(e) for separate CHIP, which include information about obtaining benefits and cost sharing requirements.

Comment: One commenter encouraged CMS to make conforming changes to the definition of combined notices for Medicaid in § 435.4, and to § 457.340(f) for separate CHIPs to align these sections with the changes for combined notices included in proposed § 435.1200(h)(1).

Response: We agree with commenters' recommendation that the definition of combined notices in § 435.4 be consistent with proposed changes for combined notices in § 435.1200(h)(1). We note that the proposed § 435.1200(h)(1) cross-references the definition of combined eligibility notices in § 435.4 for Medicaid. Additionally, corresponding changes for separate CHIPs in § 457.340(f) cross-reference the definition of combined eligibility notices in § 457.10. We believe the existing definitions of combined eligibility notices in current §§ 435.4 and 457.10 adequately account for changes in proposed §§ 435.1200(h)(1) and 457.340(f), and these current definitions will be maintained without revision. In response to comments about making conforming changes to § 457.340(f) to align with proposed changes for combined notices in § 435.1200(h)(1), we note that conforming changes were proposed in § 457.340(f) for separate CHIPs to align with changes proposed in § 435.1200(h)(1) for Medicaid. As such, we are finalizing §§ 435.1200(h)(1) and 457.340(f) as proposed to require State Medicaid and separate CHIP agencies to use a single, combined notice to provide information about Medicaid, separate CHIP, BHP, and Exchange eligibility and ineligibility determinations.

Comment: Some commenters requested that CMS specify scenarios when a combined notice for a full family would not be required.

Response: In response to commenter questions about situations when a single combined notice for a full family will not be required, we clarify that current § 435.1200(h)(1), redesignated as § 435.1200(h)(1)(ii) in this final rule, requires States to issue a single combined notice to the maximum extent feasible for all members of a household that are included on the same application or renewal form, regardless of individual member differences in program eligibility. A situation that could result in multiple notices for a single household is when multiple members of a household are included on an application for coverage, and one or more individuals are determined to be potentially eligible for different programs for which a final eligibility determination is needed. In this scenario, individuals that are assessed as potentially eligible may receive an additional, separate notice once the program they are potentially eligible for makes a final eligibility determination. For example, a parent and their child who are members of the same household submit one application for health coverage. A notice is provided to the household, indicating that the child is eligible for Medicaid, while the parent is potentially eligible for Exchange coverage. The parent's information is sent to the Exchange to make a final eligibility determination. The household would then receive a second, separate notice with information about the parent's final eligibility determination made by the Exchange.

Comment: Several commenters responded to CMS' request for comment in section II.B.5. of the September 2022 proposed rule about the appropriateness of requiring BHP agencies and Exchanges to issue single combined notices. These commenters encouraged CMS to require that combined notices be provided by all insurance affordability programs and that the combined notices include information

pertaining to eligibility and ineligibility for Medicaid, separate CHIP, BHP, and Exchange coverage. CMS also sought comment about the feasibility for BHP agencies and Exchanges to implement the combined notice requirements proposed for Medicaid and separate CHIPs. However, comments did not address CMS' question about the feasibility for BHPs and Exchanges to implement the combined notice requirements.

Response: While we acknowledge the recommendation of some commenters to require BHP agencies and the Exchanges to issue combined eligibility notices, we are concerned about the feasibility of State implementation, a point on which we did not receive any comments. Additionally, requirements for Exchange notices are outside of the scope of this rulemaking. Therefore, while we encourage State BHP agencies with the capability to issue combined notices to do so, we decline commenters' suggestion to require this of BHPs and Exchanges in the final rule.

Comment: Another commenter requested that CMS permit individuals transitioning from Medicaid to an Exchange to seamlessly transition to an Exchange plan that is affiliated with the individual's existing Medicaid plan, to promote continuity of care.

Response: We agree with commenters that maintaining continuity of care is an important element to ensure seamless transitions between insurance affordability programs. However, this rule does not address plan selection through the Exchanges. We understand that some States may have agreements with the same health plans across all insurance affordability programs. However, this is not always the case. To the extent that health plans do align across insurance affordability programs in a State, we encourage States to assign individuals to health plans in Medicaid or a separate CHIP that are affiliated with the individual's existing health plan to ensure continuity of care, as long as they follow the rules for plan enrollment in §§ 438.54 and 457.1210(a).

After considering all comments, we are finalizing the proposed changes to Medicaid regulations at §§ 431.10 and 435.1200 and CHIP regulations at §§ 457.340, 457.348, and 457.350 with modifications as discussed previously in this final rule. Because the effect of this change is specific to the process to prevent termination of eligible beneficiaries who should be transitioned between Medicaid and CHIP, we note that this provision operates independently from the other provisions of this final rule.

6. Optional Group for Reasonable Classification of Individuals Under 21 Who Meet Criteria for Another Optional Group (§§ 435.223 and 435.601)

We proposed to add a new regulation at § 435.223, ''Other optional eligibility for reasonable classifications of children under 21,'' to codify in the regulations the option for States to provide coverage to individuals under age 21, 20, 19, or 18, or to reasonable classifications of such individuals, who meet the requirements of any clause of section 1902(a)(10)(A)(ii) of the Act. We further confirmed in the proposed rule (87 FR 54800) that States, in determining eligibility under the proposed § 435.223, could except from MAGI financial eligibility methodologies those individuals who are described in § 435.603(j). We explained that the current section of our regulations for optional categorically needy coverage of reasonable classifications of children at § 435.222 does not reflect the full scope of authority States have under section 1902(a)(10)(A)(ii) of the Act to cover different groups of individuals under age 21 or reasonable classifications of such individuals, as the terms of § 435.222 apply only to individuals who are eligible under section 1902(a)(10)(A)(ii)(I) (relating to individuals who meet the eligibility requirements for, but are not receiving, cash assistance) or (IV) of the Act (relating to individuals who meet the eligibility requirements for cash assistance or would but for their institutionalization) and whose financial eligibility is determined using MAGI-based methodologies.

We also proposed changes to § 435.601(f)(1) to provide that, in the case of individuals for whom the cash assistance program most closely categorically-related to the individual's status is Aid to Families and Dependent Children (AFDC) (that is, individuals under age 21, pregnant individuals and parents and other caretaker relatives who are exempt from MAGI-based methodologies and to whom, as we explained in the proposed rule, AFDC methodologies generally still apply), the agency may apply either (1) the financial methodologies of the AFDC program, or (2) the MAGI-based methodologies defined in § 435.603, except to the extent that MAGI-based methods conflict with the terms of § 435.602 (relating to financial responsibility of relatives and other individuals).

We also proposed to change the heading of § 435.222, to reflect that it would no longer be the exclusive regulation relating to reasonable classifications of children and proposed certain additional technical changes to § 435.601(b)(2) and (d)(1) in accordance with our proposed amendment to § 435.601(f).

Comment: We received several comments on these proposals, all of which expressed support. Commenters noted that the proposals would increase State flexibility and add an eligibility pathway for non-MAGI individuals under age 21.

Response: We appreciate the commenters' support, and we are finalizing §§ 435.223 and 435.601(b)(2), (d), and (f)(1)(i) and (ii) as proposed.

We are making an additional change to the heading of § 435.222. We proposed to change the existing heading of § 435.222 from ''Optional eligibility for reasonable classifications of individuals under age 21'' to ''Optional eligibility for reasonable classifications of individuals under age 21 with incomes below a MAGI-equivalent standard.'' As we explained in section II.B.6 of the preamble of the September 2022 proposed rule, part of the rationale for proposing a new § 435.223 was to confirm the authority of States to extend eligibility to reasonable classifications of individuals under age 21 who are excepted from the mandatory use of MAGI-based methodologies. We further explained that, while the proposed § 435.223 would not be exclusive to non-MAGI reasonable classifications of individuals under age 21, we believed, as a practical matter, States would utilize the proposed § 435.223 only for non-MAGI reasonable classifications, because § 435.222 already permitted MAGI-based reasonable classifications of individuals under age 21.

Upon further review, however, we recognize that the current terms of § 435.222 only permit the creation of MAGI-based reasonable classifications of individuals under age 21 within two particular eligibility categories: section 1902(a)(10)(A)(ii)(I) (relating to individuals who are eligible for, but are not receiving, cash assistance); and section 1902(a)(10)(A)(ii)(IV) (relating to individuals who would be eligible for cash assistance but for their institutionalization). Because § 435.222 limits States' ability to create MAGI-based reasonable classifications of individuals under age 21, we are further modifying our proposed heading of § 435.222 to read ''Optional eligibility for reasonable classifications of individuals under age 21 with income below a MAGI-equivalent standard in specified eligibility categories,'' to better reflect the limited reach of § 435.222.

Neither the heading to the proposed § 435.223, nor the terms of the

September 2022 proposed rule, limited eligibility to individuals eligible on a non-MAGI basis. Therefore, our change to the heading to § 435.222 does not require a corresponding change to § 435.223 (which, as noted above, we are finalizing as proposed). We also confirm that States may offer eligibility under § 435.223 to MAGI-based reasonable classifications of individuals under age 21 who are eligible under categories separate from section 1902(a)(10)(A)(ii)(I) and (IV).

We also note that the proposed regulation text to § 435.601 noted paragraph (f)(2) as ''[Reserved.]'' This was inadvertent. Current § 435.601(f)(2) contains certain rules relating to a State's election of less restrictive financial methodologies. No change was intended to be proposed or is being made to this provision.

Comment: One commenter specifically encouraged CMS to evaluate any cost-sharing requirements that a State might apply to this new pathway which could in turn create a barrier to coverage.

Response: We thank the commenter for raising this concern about cost-sharing requirements. We have considered possible financial barriers to coverage under § 435.223 in the context of cost-sharing requirements. Specifically, we reviewed our premiums and cost-sharing rules under 42 CFR 447.50 through 447.90, to identify any standard limitations that apply to individuals under 21 or reasonable classifications of such individuals. Currently, under § 447.56(a)(1)(v), States may exempt from premiums and cost-sharing ''individuals under age 19, 20, or age 21, eligible under § 435.222.''

As we explained in the September 2022 proposed rule, proposed § 435.223 is derived from the same statutory provisions that supports § 435.222. With the addition of a new § 435.223, there would be no statutory directive or logical reason to limit the discretion in § 447.56(a)(1)(v) to individuals eligible under § 435.222 and not include those eligible under § 435.223. In this final rule, therefore, we are making a technical amendment to § 447.56(a)(1)(v) to add ''and § 435.223'' after ''42 CFR 435.222.''

After consideration of the public comments we received, we are finalizing §§ 435.223 and 435.601(b)(2), (d), and (f)(1)(i) and (ii) as proposed (with certain minor stylistic changes to cross-references therein that do not affect the substance), and are making modifications, as described previously in this final rule, to §§ 435.222 (the heading) and 447.56(a)(1)(v). Because the effect of this change is specific to allowing states to establish an optional eligibility group for all or a reasonable classification of individuals under age 21 whose eligibility is excepted from use of the MAGI-based methodology (that is, those living with a disability), or whose MAGI-based eligibility is not otherwise described, and for which such coverage is not already permitted in regulation, we note that this provision operates independently from the other provisions of this final rule.

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), 1903(x)(4), and 1137(d)(4)(A) of the Act, set forth the requirement for States to provide a reasonable opportunity period (ROP) for individuals who have declared U.S. citizenship or satisfactory immigration status, for whom the State is unable to promptly verify citizenship or satisfactory immigration status, and who meet all other eligibility requirements. During the ROP, the State furnishes benefits to the individual while continuing efforts to complete verification. Current § 435.956(b)(4) provides 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. As we have no information indicating the availability of multiple ROPs poses significant risks to program integrity, in the September 2022 proposed rule, we proposed to revise § 435.956(b)(4) to remove the option for States to impose limits on the number of ROPs that an individual may receive. This Medicaid requirement is applicable to CHIP through an existing cross-reference at § 457.380(b)(1)(ii).

We received the following comments on this proposed change:

Comment: The overwhelming majority of commenters supported the proposed change to remove the State option to place a limitation on the number of reasonable opportunity periods an individual may receive. Supportive comments included statements that allowing States to limit the number of ROPs would make it harder for eligible individuals to enroll, which could disproportionately impact certain vulnerable groups, that there is no indication that the availability of multiple ROPs poses significant risks to program integrity, and that limitations on the number of ROPs are unnecessary and act as barriers to eligible immigrants' enrollment. One commenter shared that removing the option to limit ROPs is consistent with sections 1902(a)(46)(B), 1902(ee)(1)(B)(ii), 1903(x)(4), and 1137(d)(4)(A) of the Act, which do not include any limitation on the number of ROPs.

Response: We agree with these comments. Under section 1902(a)(8) of the Act and § 435.906, State agencies must afford individuals the opportunity to apply for Medicaid without delay. The ROP is an integral piece of the Medicaid application and enrollment process when the State is not able to promptly verify an individual's citizenship or satisfactory immigration status. By removing the option for States to limit the number of ROPs, we aim to reduce barriers to enrollment and to ensure that U.S. citizens and immigrants and their families applying for or renewing their coverage have prompt access to the benefits to which they are entitled while they complete the process of verifying their citizenship or satisfactory immigration status. We agree that the statute does not expressly limit the number of ROPs an individual may receive, nor does it expressly provide discretion for States to establish such a limit. We note that only one State has elected the option to limit the number of ROPs, as a pilot program, and that State removed the requirement from its State Plan as data revealed there were no program integrity issues.

Comment: One commenter shared that an applicant's immigration status can change over time and that the removal of the ROP limitations better accommodates circumstances in which such a change may occur.

Response: We understand that an individual's immigration status may change as their life circumstances change, including when an individual has applied for an adjustment of status to Lawful Permanent Resident (LPR, or ''green card'' holder). By removing the State option to limit the number of ROPs, we intend to allow for the possibility that an individual's immigration status may have changed since the individual was last determined eligible for Medicaid or CHIP, or that new information or evidence regarding their satisfactory immigration status may be available. We agree that individuals who submit a new application after they are procedurally terminated or terminated for another reason should be afforded another ROP if their citizenship or immigration status cannot be promptly verified, including when their citizenship or immigration status changed from the status on their previous application.

Comment: Many commenters shared that some applicants such as survivors of domestic abuse and individuals experiencing homelessness are more likely to have difficulty with electronic data matches to verify their U.S. citizenship or satisfactory immigration status. The challenging circumstances some vulnerable individuals face can make it harder for them to be determined eligible for Medicaid. These commenters noted that noncitizens, such as Compact of Free Association (COFA) migrants or those with visas under the Violence Against Women Act (VAWA) or trafficking victims (T visa holders), may have particular difficulty having their immigration status verified timely or providing paper documentation. The commenters shared that allowing States to limit the number of ROPs could disproportionately impact these communities, widening health disparities. These individuals are more likely to need an ROP to ensure the individual can immediately enroll in Medicaid if they have attested to U.S. citizenship or satisfactory immigration status and meet all other eligibility requirements, so that they can receive benefits during delays in the verification process.

Response: We agree that individuals experiencing domestic abuse and homelessness, or survivors of trafficking, may have greater difficulty with verification of citizenship or immigration status, because without stable and permanent housing, individuals often do not have access to the documentation that includes the information needed by States to begin verification of satisfactory immigration status with DHS SAVE system. For example, an individual who is a Victim of Trafficking may need to provide paper documentation, specifically a letter issued by the HHS' Office of Refugee Resettlement, demonstrating evidence of satisfactory immigration status, when such status is not verifiable through the Federal Data Services Hub or DHS SAVE system. For many other noncitizens, to initiate DHS SAVE system verification, an individual must provide an ''Alien number'' or I–94 number. We note that while most COFA migrants' immigration status can be verified electronically through the Hub or DHS SAVE system, there are some COFA migrants who may have to provide additional paper documentation to verify COFA status. The ROP is intended to account for delays in the verification process, such that individuals can receive coverage while waiting for verification of their citizenship or satisfactory immigration status. There may be operational challenges or delays with the verification process, including for noncitizens with the DHS SAVE system or if an individual's citizenship is not verified with the SSA. We believe that ROPs should not be limited, given the possibility of individuals, especially vulnerable individuals, needing additional time for their citizenship or satisfactory immigration status to be verified.

Comment: A few commenters encouraged CMS to engage in oversight of States' implementation of this provision to ensure that individuals are afforded a ROP and receive benefits during that time.

Response: We provide oversight of States' Medicaid and CHIP eligibility determination and enrollment processes through multiple avenues. We offer technical assistance to States on various eligibility issues, including citizen and noncitizen eligibility requirements and verification processes, through monthly Eligibility Technical Assistance Group (E–TAG) meetings, Center for Medicaid and CHIP Services (CMCS) all-State calls, and one-on-one calls with State agency staff. We also conduct oversight of State's eligibility policies and processes through the PERM and MEQC programs and other CMS eligibility audits, through which eligibility cases are sampled and reviewed for compliance with all eligibility criteria and enrollment processes, including those related to citizenship and satisfactory immigration status. Finally, we make extensive eligibility policy resources available on Medicaid.gov to assist States in making accurate eligibility determinations. When we learn that a State is out of compliance with Federal statutes that CMS has been charged with implementing or CMS regulations, we immediately begin working with the State to address the issue—providing technical assistance, requesting corrective action when needed, and then withholding Federal funding when noncompliance cannot otherwise be resolved.

Comment: One commenter suggested clarification that in prohibiting a limitation on ROPs, CMS is not requiring States to accept self-attestation and thereby approve an application that has not been electronically verified for citizenship status. Another commenter expressed concern that without a limitation on ROPs, the State may be forced to accept other information on the application that is no longer accurate.

Response: A State must comply with the statutory requirements for verification of U.S. citizenship and satisfactory immigration status prior to completing an applicant's eligibility determination. Section 1902(a)(46)(B) of the Act requires Medicaid agencies to verify the U.S. citizenship of applicants who have attested to being U.S. citizens; verification may occur through a data match with the SSA under section 1902(ee) of the Act, or an alternative method of verification under section 1903(x) of the Act. States must verify an applicant's declaration of satisfactory immigration status through an electronic system set up by DHS under section 1137(d) of the Act. If an individual has declared to be a U.S. citizen or to have satisfactory immigration status but the State has been unable to complete verification of such status, and the individual meets all other Medicaid and CHIP eligibility requirements, the agency must provide an ROP and make benefits available during the ROP. Federal statute and regulations specify that if verification of citizenship or satisfactory immigration status is not completed by the end of the ROP, except in specific cases, benefits must be terminated within 30 days.

We do not agree that, by removing the limit on the number of ROPs, State Medicaid and CHIP agencies will have to accept application information that is no longer accurate. For each application that is submitted, the individual would be required to provide a declaration of satisfactory citizenship or immigration status and updated information regarding U.S. citizenship or satisfactory immigration status. Such information would be verified by the State Medicaid or CHIP agency in accordance with sections 1902(a)(46), 1902(ee)(2)(B), 1903(x) and 1137(d)(3) of the Act, §§ 435.407, 435.945, and 435.956, and the State's approved verification plan. Finally, under 42 CFR 435.907(f), all applications must be signed under penalty of perjury.

Comment: One commenter recommended that CMS amend the proposed rule to require States to close a case, for which citizenship or immigration status has not been electronically verified, that is more than 90 days old. The commenter further noted that this would not prohibit an individual from submitting a new application.

Response: This comment is outside the scope of this regulation. However, we note that § 435.956(b)(3), implementing sections 1902(ee)(1)(B)(ii)(III) and 1137(d)(5) of the Act, requires State Medicaid and CHIP agencies to terminate benefits within 30 days of the end of the 90-day ROP, while providing notice and fair hearing rights under 42 CFR 431,

subpart E, if the individual's U.S. citizenship or satisfactory immigration status has not been verified. States have an option (described at § 435.956(b)(2)(ii)(B)) to extend the ROP beyond 90 days for individuals declaring to be in a satisfactory immigration status, if the agency determines that the individual is making a good-faith effort to obtain any necessary documentation, or the agency needs more time to verify the individual's status through other available electronic data sources or to assist the individual in obtaining documents needed to verify their status. This option, which must be elected through a State plan amendment, is not impacted by this final rule. Some States have also provided for a similar extension for individuals who have declared to be U.S. citizens under section 1115 demonstration authority during the unwinding period.

After consideration of the public comments we received, we are finalizing without modification our proposal at § 435.956(b)(4) to remove the optional limitation on the number of reasonable opportunity periods. Because the effect of this change is specific to removing the option to limit the number of ROPs during which otherwise eligible applicants receive Medicaid while they complete verification of their U.S. citizenship or satisfactory immigration status, we note that this provision operates independently from the other provisions of this final rule.

2. Remove Requirement To Apply for Other Benefits (§§ 435.608 and 436.608)

In the September 2022 proposed rule, we proposed to remove the requirement at § 435.608 that State Medicaid agencies require Medicaid applicants and beneficiaries, as a condition of their eligibility, to take all necessary steps to obtain other benefits to which they are entitled, such as annuities, pensions, retirement and disability benefits, unless they can show good cause for not doing so. This requirement presently applies to all Medicaid applicants and beneficiaries, without regard to the basis of their eligibility or the financial methodology used to determine their eligibility.

In section II.B.2. of the September 2022 proposed rule, we explained that current § 435.608 was established in 1978, under the authority of section 1902(a)(17)(B) of the Act, which authorizes the Secretary to prescribe the standards for evaluating which income and resources are *available* to Medicaid applicants or beneficiaries. Through this proposed change, we would redefine ''available'' in section 1902(a)(17)(B) of the Act to mean only such income and resources as are actually within a Medicaid applicant's or beneficiary's immediate control. We indicated in the proposed rule, however, that we were also considering maintaining the requirement with modifications.

In drafting the September 2022 proposed rule, we inadvertently failed to include the removal of § 436.608 consistent with the change proposed to remove § 435.608. Similar to the proposed revisions to § 435.831(g), this omission was unintentional, as most of the provisions of the proposed rule that are adopted in this final rule are applicable to the 436 territories as a result of incorporation by reference in existing regulations (as noted elsewhere throughout this final rule). The same reasons for rescinding § 435.608 also apply in the 436 territories. We are including the recission of § 436.608 in this final rule to make the same simplification available to applicants in Guam, Puerto Rico, and the Virgin Islands and the Medicaid agencies in these territories. All references to § 435.608 in the September 2022 proposed rule and this final rule also apply to § 436.608.

We received the following comments on this proposal:

Comment: Most commenters supported the proposal to eliminate § 435.608 in its entirety. Numerous commenters, including beneficiary advocacy organizations and State Medicaid agencies, stated that the current rule is outdated, burdensome, and impedes access to medical care. Several commenters identified the administrative challenges posed by the current rule and welcomed eliminating the work involved in applying the rule in their eligibility determinations. Two commenters specifically mentioned the communications with applicants and beneficiaries made necessary by § 435.608, with one reporting that multiple contacts are commonly required and the other reporting that they are time consuming. Multiple commenters stated that compliance with § 435.608 does not commonly result in applicants or beneficiaries receiving income that affects eligibility, and several commenters noted challenges related to specific benefits. One commenter stated that this change would help veterans by eliminating the burden of applying for veterans' benefits to which they may not be entitled. Other commenters noted that this requirement can frequently result in individuals being forced to elect early retirement benefits from Social Security, which provides a lower monthly benefit. One commenter stated this choice is particularly harmful for women because, the commenter wrote, women are more likely than men to rely on Social Security but receive lower average benefits than men, and, as women and particularly women of color, as further shared by the commenter, are at greater risk of poverty as they age, a reduction in their Social Security benefit could represent a serious loss at a financially precarious time. Additionally, one commenter stated that, as CHIP, BHP, and the Marketplace do not impose a requirement to apply for other benefits, the Medicaid requirement creates misalignment across programs, which is a counter-objective of the September 2022 proposed rule itself.

Many commenters expressly opposed the alternatives we presented, under which CMS would maintain the rule but with modifications. These comments noted that only reducing the scope of the rule would have little practical value, because a modified requirement to apply for other benefits would still leave many individuals subject to the rule, and a modified form of the rule would possibly be more complex for States to administer.

Response: We appreciate this support and commenters' explanations about specific impacts of our proposal. We are finalizing our proposal to remove and reserve § 435.608.

Comment: Some commenters suggested that CMS consider ways to encourage States to educate beneficiaries about the other benefits to which they may be entitled, including public benefit programs, by engaging in partnerships with other entities, and that CMS should consider using its resources to help facilitate the timely enrollment of Medicaid beneficiaries in such programs. The commenters mentioned the SNAP as an example of a program that could help meet the needs of Medicaid beneficiaries. Another commenter stated that individuals should pursue income and benefits for which they are potentially eligible, as it is in their best interest to do so, even if receipt of such benefits would not be counted for Medicaid eligibility.

Response: We agree generally that the receipt of other benefits to which Medicaid applicants and beneficiaries are entitled could help such individuals meet their needs. The purpose of this rulemaking to eliminate § 435.608 is focused on our role in establishing the parameters for Medicaid eligibility rather than assessing whether applying for other benefits serves the best interests of Medicaid applicants and beneficiaries. We did not originally

promulgate § 435.608 based on our judgment of what actions taken by Medicaid applicants and beneficiaries, even if unrelated to their Medicaid eligibility, might produce the best outcomes for them. Instead, as noted above, we promulgated § 435.608 in order to align a procedural requirement of the AFDC and SSI programs with Medicaid, at a time when eligibility for Medicaid was predominantly based on eligibility for these cash assistance programs.

Removing the Medicaid requirement that applicants and beneficiaries apply for other benefits does not prohibit, and is not intended to discourage, States from educating Medicaid applicants and beneficiaries about their potential eligibility for other such benefits or facilitating their application for them. While we do not intend to directly inform Medicaid applicants and beneficiaries of other benefits for which they may be eligible, we have engaged in efforts to facilitate their eligibility for other programs, such as working with States to establish multi-benefit applications (that is, Medicaid, SNAP, and TANF) and partnering with the Food and Nutrition Service (FNS) to promote and expand demonstration projects aimed at qualifying children for free and reduced-price school meals. We expect to continue working on initiatives such as these and encourage States to continue educating beneficiaries about other benefits for which they may be eligible.

Comment: One commenter supported maintaining § 435.608 and applying the rule in circumstances in which applicants and beneficiaries will receive income countable in their Medicaid eligibility determinations. Another commenter indicated that States should maintain the discretion to apply the rule for individuals who apply for Medicaid on the basis of being 65 years old or older, or having blindness or a disability.

Response: We decline to maintain the rule in circumstances involving countable income or for discrete populations. As noted above, most commenters supported the removal of the provision in its entirety, and numerous commenters noted that only reducing the scope of the rule would have little practical value, because a modified requirement to apply for other benefits would still leave many individuals subject to the rule, and a modified form of the rule would possibly be more complex for States to administer. We did not receive comments suggesting that certain categories of beneficiaries are not as acutely affected by the rule as others, which means that maintaining the rule in limited form will perpetuate the challenges to beneficiaries and States that commenters noted in their input. We are persuaded that maintaining the rule even in limited circumstances would not reduce the delays in access to coverage experienced by applicants or the administrative burden States experience in enforcing it.

Comment: We received several comments relating to the potential costs of eliminating the requirement to apply for other benefits. One commenter expressed concern that an increase in State costs could be an unintended consequence of the elimination of the requirement, which, the commenter indicated, States commonly address by reducing eligibility, benefits, and employing other mechanisms that create barriers to timely access to health care. The commenter suggested that CMS take steps to minimize possible negative ramifications of the proposal. Other commenters stated that removing § 435.608 could increase Long-Term Services and Supports (LTSS) costs, with one commenter specifically noting that, if veterans do not pursue Veteran Aid and Attendance benefits, which are includable in the PETI calculation, State and Federal liability would be affected. The commenter questioned if this had been taken into consideration.

Response: We appreciate the commenters' concern about unintended consequences, in the form of possible increased State costs that might stem from the elimination of the requirement. However, based on the comments we received, we do not share the concern. States commented that imposing the requirement does not commonly produce countable income for Medicaid applicants and beneficiaries. Therefore, we do not expect this change to result in increased State costs. Additionally, as noted above, numerous States, in commenting in support of eliminating § 435.608, reported that the staff time necessary to contact applicants and beneficiaries to confirm compliance with the existing regulation has imposed an administrative burden on them, and that the operational complexity of implementing the requirement outweighs any benefit to them in terms of saved payments for medical assistance. Accordingly, it is possible that this change will result in fewer costs for States by making eligibility determinations more efficient without an offsetting increase in benefit costs.

We interpret the generalized comment about the increase in LTSS costs that might result from the removal of § 435.608 as being related to PETI, which is the subject of the specific comment relating to Veteran Aid and Attendance benefits.

The PETI calculation described in §§ 435.700 through 435.735 (relating to the categorically needy) and 435.832 (relating to the medically needy) generally requires the inclusion of all income, including income that is disregarded or excluded in the underlying income eligibility determination. However, nearly all of the examples of benefits specifically identified in § 435.608 for which Medicaid applicants and beneficiaries have historically been required to apply—annuities, pensions, retirement and disability benefits, Old-Age, Survivors, and Disability Insurance (OASDI) and railroad retirement benefits, unemployment compensation—are generally sources of countable income for individuals whose eligibility is determined using non-MAGI income eligibility methodologies and who therefore could be subject to PETI. While there may be some benefits within the scope of § 435.608 that might produce income not countable in a non-MAGI income eligibility determination, but which could be countable in a PETI calculation (that is, a certain portion of Veterans Affairs Administration (VA) Aid and Attendance benefits), the instances are few. Therefore, we do not anticipate that the elimination of § 435.608 would have a disproportionate impact on State LTSS costs compared to non-LTSS expenditures, nor an impact that would persuade us to make § 435.608 a post-enrollment activity.

Comment: One commenter requested clarification about whether removal of § 435.608 means that Medicaid applicants and beneficiaries will not be required to apply for Social Security benefits or for retirement distributions, but that they may still be required to apply for Medicare as a condition of Medicaid eligibility.

Response: We confirm that the removal of § 435.608 means that Medicaid applicants and beneficiaries will no longer be required, as a condition of their Medicaid eligibility, to apply for Social Security benefits or retirement distributions. However, States may still require applicants and beneficiaries to apply for Medicare as a condition of Medicaid eligibility.

We have historically permitted, as a State plan option, the requirement that applicants and beneficiaries apply for Medicare as a condition of Medicaid eligibility, subject to certain limitations (described below). This authority is not derived from § 435.608, but instead from *New York State Department of Social*

Services v. *Dublino,* 413 U.S. 405 (1973), the holding of which generally provides support for States to impose collateral conditions of eligibility in Federal programs which further the objectives of the particular program and are not otherwise prohibited by the authorizing statute.

As we have historically noted, Medicaid is the payor of last resort (*see* section 3900.1 of the State Medicaid Manual), and Medicaid regulations prohibit FFP for coverage of any services that would have been covered by Part B of the Medicare program had the individual been enrolled in Part B (section 1903(b)(1) of the Act; § 431.625(c)(3)). Given these precepts and in the absence of any statutory prohibition, consistent with the *Dublino* holding, we have permitted States to require Medicaid applicants and beneficiaries who may be eligible for Medicare to apply for Medicare Parts A, B, and/or D as a condition of Medicaid eligibility. When electing this authority, a State must agree to pay any premiums and cost-sharing (except those applicable under Part D) that such individuals would otherwise incur based on their Medicare enrollment. States continue to have this authority notwithstanding the removal of § 435.608.

Comment: A few commenters noted that States rely on disability determinations made by the SSA for Social Security Disability Insurance (SSDI) benefits and expressed concern that eliminating applications for SSDI as a Medicaid eligibility requirement could increase the workloads of State disability units. The commenters further expressed concern that those who forego applying for SSDI may ultimately forego their Medicare entitlement, which SSDI beneficiaries attain after receiving benefits for 24 months; this would result in Medicaid providing coverage for services such individuals would otherwise receive from Medicare.

Response: It is not clear to us how the removal of the requirement in § 435.608 would increase the workload of State disability units or create circumstances in which they will become newly responsible for making disability determinations. Section § 435.541(c) requires States to conduct a disability determination for individuals who apply for Medicaid on the basis of disability in several different circumstances. These include, but are not limited to, the circumstances in which such a Medicaid applicant has not yet filed an application for disability benefits with SSA, or has filed an application for disability benefits with SSA but is not expected to receive a determination from SSA within sufficient time for the State to comply with the time limit in § 435.912(c)(3)(i) for disability-based Medicaid applications (that is, within 90 days of the filing of the Medicaid application).

An individual who applies for Medicaid on the basis of disability and has not filed a disability claim with SSA, but then does so pursuant to the historical requirement in § 435.608 to apply for other benefits, would most typically still be an individual for whom a State, per § 435.541(c), would conduct a disability determination. This is because the State, in order to comply with § 435.912(c)(3)(i) to determine disability-related eligibility within 90 days of the date of Medicaid application, would most practically proceed with its own determination, instead of first waiting during this period for the outcome of the SSA's determination, as the latter course would present a risk to the State of having insufficient time to make its own determination consistent with § 435.912(c)(3)(i) if it were to become clear that SSA's determination would not be completed before the 90th day of the Medicaid application. In most other situations in which a State is required under § 435.541(c) to determine disability, the relevant individual has already applied for disability-related benefits with SSA.

We appreciate the commenters' additional concern about the possibility of individuals who forego SSDI applications not eventually attaining entitlement to Medicare as a result. However, we generally did not receive comments suggesting that individuals are likely to forego applying for other benefits for which they may be eligible as a result of the removal of § 435.608. As such, it is not clear to us that eliminating § 435.608 will correlate into Medicaid applicants and beneficiaries choosing not to apply for SSDI and, possibly as a result, not attaining entitlement to Medicare. Further, as we explained earlier, States may still advise individuals of their possible eligibility for other benefits.

In addition, as discussed previously, we did receive a comment noting that requiring individuals to apply for Social Security *retirement* benefits before their full retirement age forces them to accept a lower benefit. However, individuals who might now delay filing for Social Security retirement benefits as a result of the removal of § 435.608 would not be Medicare-eligible if they applied for their retirement benefits before the age of 65. At the age of 65, whether they have applied for Social Security retirement benefits or not, they will be Medicare-eligible. As we explained previously, States may still require such individuals, independent of § 435.608, to file an application for Medicare as a condition of Medicaid eligibility. We are therefore not persuaded that eliminating § 435.608 will translate into Medicaid applicants and beneficiaries choosing to forego applying for SSDI or applying for retirement benefits and ultimately requiring States to provide Medicaid coverage for services that could have been covered by Medicare.

Comment: One commenter who supported removal of § 435.608 also recommended that CMS consider eliminating the requirement in §§ 433.145(a)(2) and 435.610(a)(2)(i) that Medicaid applicants and beneficiaries (subject to the ''good cause'' exception) cooperate in establishing the identity of a child's parents and obtaining medical support payments. The commenter believes the requirement is a barrier to coverage.

Response: We appreciate the comment; however, the suggestion is beyond the scope of this regulation.

Comment: One commenter supported the elimination of § 435.608 and suggested that income and resource standards can have the effect of discouraging Medicaid-eligible individuals who have disabilities from working. The commenter noted that Medicaid's working disability eligibility groups allow such individuals to work and maintain their Medicaid coverage, given the higher income and resource standards that generally apply to these groups. The commenter encouraged CMS to issue Federal guidance supporting State adoption of the working disability groups, and allowing States to smoothly transition individuals to other eligibility groups when they experience a change in their health or work status.

Response: We agree on the importance of Medicaid's working disability eligibility groups. While the commenter's suggestions are outside the scope of this regulation, we appreciate this feedback.

Comment: One State indicated that it requires individuals to pursue assets as a condition of receiving certain State-funded cash payments and questioned whether the elimination of § 435.608 would affect this requirement.

Response: Eliminating § 435.608 will only prohibit States from requiring that Medicaid applicants and beneficiaries, as a condition of their Medicaid eligibility, apply for other benefits for which they may be entitled. A similar requirement imposed by a State in the context of its State-funded programs would not be affected.

After consideration of the public comments we received, we are finalizing our proposal to eliminate § 435.608 in its entirety. Because the effect of this change is specific to eliminating the requirement to apply for other benefits as a condition of Medicaid eligibility, we note that this provision operates independently from the other provisions of this final rule.

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

As we explained in section II.D. of the September 2022 proposed rule, State Medicaid agencies must maintain records needed to justify and support all decisions made regarding applicants and beneficiaries. These records must include sufficient information to substantiate an eligibility determination made by the State. They must also be made available for review purposes, such as review by applicants and beneficiaries prior to a fair hearing and review by State and Federal auditors conducting oversight. Because current recordkeeping regulations are both outdated and lacking in needed specificity, we proposed revisions at §§ 431.17 and 435.914 for Medicaid and at § 457.965 for CHIP to require that State agencies maintain their records in an electronic format and to clarify the specific information to be retained, the minimum retention periods, and the requirements for making records available outside the agency.

We note that § 431.17 applies to States, the District of Columbia, and all Territories, as does § 435.914 through a cross-reference at § 436.901.

We received the following comments on these proposed provisions:

Comment: Many commenters noted their support for the proposed changes, including standardized timeframes for record retention and clarification of the specific records and documentary evidence that must be maintained by States to support eligibility determinations. They supported the alignment of requirements between Medicaid and CHIP and agreed that proposed changes would advance the integrity of these programs. Commenters explained that proper documentation would not only reduce improper payments identified by PERM due to insufficient documentation, but more importantly, actual eligibility and coverage errors that could negatively impact Medicaid and CHIP beneficiaries. Additionally, commenters reported that some States' systems and processes are already in alignment with these proposals.

Response: We thank the commenters for their support. We are finalizing proposed changes to § 431.17 (regarding the format, content, and availability of records, as well as the minimum retention period in Medicaid), changes to § 435.914 (regarding documentation of agency decisions at application, redetermination, and renewal in Medicaid), and corresponding changes at § 457.965 for CHIP with some modifications, which are explained in the following discussion.

Comment: Most commenters supported the proposal at §§ 431.17(d)(1) and 457.965(d)(1) to require States to maintain records in an electronic format. They noted both long-term operational efficiencies and ease of sharing documents. Several commenters raised concerns about the significant technology, time, and resource investment that would be required to transition from paper to electronic records, including the eligibility system interfaces, scanning technology, and staff training that will be required. Some States reported that they have already transitioned completely to electronic records, while others reported that they are in the process of moving to an electronic format. Commenters also noted that implementation may be especially challenging for States with non-MAGI legacy systems, integrated eligibility systems, eligibility offices in smaller, more rural areas, and county-based eligibility systems.

Response: We appreciate these concerns and recognize that States are currently facing competing demands on their time, resources, and eligibility systems. At the same time, we believe it is critically important for States to modernize their recordkeeping processes and implement comprehensive electronic records to address HHS Office of Inspector General (OIG) audits and PERM, MEQC, and other CMS eligibility reviews that have historically identified documentation inadequacies. Accordingly, we are finalizing as proposed the requirements at §§ 431.17(d)(1) and 457.965(d)(1) that Medicaid and CHIP agencies must maintain all required records in an electronic format.

Comment: We received a number of comments regarding standardization. A couple of commenters recommended that CMS work with States to adopt a standardized format across all Medicaid and CHIP agencies. Another commenter expressed concern that implementation of the proposed requirements would necessitate universal definitions for all records both within States and across States. Several commenters recommended that CMS partner with State agencies to ensure that any system changes made to support electronic recordkeeping are completed in a standardized and secure way, including proper testing and training for agency staff. One commenter urged CMS to clarify that States must retain sensitive claims information separately from eligibility and enrollment information. Finally, one commenter requested clarification on the funding available to support the changes needed to comply with these new electronic recordkeeping requirements.

Response: While we recognize the benefits of standardization across States, in this final rule, we do not require States to adopt a single standardized format. We do, however, encourage States to implement a standardized format for records across their systems as much as possible. While each of the records and documentary evidence described in §§ 431.17(b)(1) and 457.965(b)(1) for Medicaid and CHIP respectively are considered part of the case record, we did not propose that these records must be stored in a single system, and this final rule does not require that States maintain all required case records in a single system.

Federal funding may be available for systems development, subject to conditions for enhanced funding (CEF) outlined at § 433.112 and Medicaid program standards, laws, regulations, and industry best practices, including certification under the Streamlined Modular Certification process. As described at § 95.621, State agencies are responsible for the security of all automated data processing systems involved in the administration of Department of Health and Human Services' programs and must establish a security plan that outlines how software and data security will be maintained. This section further requires that State agencies conduct a review and evaluation of physical and data security operating procedures and personnel practices on a biennial basis. Additionally, as specified in part 11 of the State Medicaid Manual, State agencies are required to be in compliance with the security and privacy standards contained in Public Law 104–191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and adopted in 45 CFR 164, subparts C and E, as follows: The security standards require that measures be taken to secure protected heath information that is transmitted or stored in electronic format. The privacy standards apply to protected health information that may be in electronic, oral, and paper form. Furthermore, State agencies are bound by the requirements in section 1902(a)(7) of the Act, as further implemented in our regulations

at §§ 431.300 through 431.307. These provisions require that use or disclosure of information concerning applicants and recipients is permitted only when directly connected to administration of the State plan and provide additional safeguards to protect applicant and beneficiary data. Conducting a risk analysis, pursuant to HIPAA and implementing regulations at 45 CFR 164.308(a)(1)(ii)(A), should be the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications of HIPAA. Therefore, a risk analysis can be foundational and must be completed to assist organizations in identifying and implementing the most effective and appropriate administrative, physical, and technical safeguards of PII/PHI.

Comment: One commenter suggested that we provide an option for States to store records in non-electronic format in special circumstances, such as when a beneficiary expresses safety concerns that an individual may have unauthorized access to State systems.

Response: We appreciate this comment and agree that maintaining the safety and privacy of Medicaid beneficiaries is of critical importance. We acknowledge that storing records electronically may pose new challenges to ensuring beneficiary records are secure from unauthorized access. However, we note that any recordkeeping system will have security vulnerabilities and that there are safeguards that States can implement to minimize this risk. We believe that electronic storage of records is necessary to align with industry standards and that the advantages of modernizing Medicaid recordkeeping standards outweigh the risks inherent with electronic systems. We are finalizing the electronic format requirements at §§ 431.17(d)(1) and 457.965(d)(1) as proposed. We expect States to implement privacy and security measures in accordance with all Federal and State laws regarding privacy, security, and confidentiality. Compliance with these laws will help to ensure that records are not improperly accessed. To comply with the privacy protections under section 1902(a)(7) of the Act and 42 CFR part 431, subpart F, States must have policies in place that specify for what purposes data will be used within the organization and to whom and for what purposes the agency will disclose data. While States are required to establish electronic recordkeeping as finalized in this rule, States also have flexibility to develop additional protection processes for applicants and beneficiaries who need or request them. For example, a State could place a security freeze on the beneficiary's records at the request of the beneficiary, which would prevent the records from being accessed on the user-end, such as through an applicant or beneficiary user portal, while still allowing the State Medicaid agency to utilize the data as appropriate. Such a process could also include restricting access to records to a limited number of State employees. Additionally, States could implement a policy of requiring identity proofing to validate that an individual attempting to access records on the user-end is the applicant or beneficiary.

Comment: Several commenters supported the specific types of information and documentation that we proposed must be included in beneficiary case records, as described at proposed §§ 431.17(b)(1) and 457.965(b)(1). Another commenter expressed concern about the specific content requirements included in the proposed rule, describing them as rigid and administratively taxing. The commenter expressed appreciation for the historic flexibility in this area and concern that the specificity of the new requirements will lead to increased audit citations.

Response: We appreciate commenters' support of the content requirements proposed at §§ 431.17(b)(1) and 457.965(b)(1) for individual applicant and beneficiary records. We proposed to require such records to include applications, renewal forms, and changes submitted by the individual or household; information transferred from another insurance affordability program; evidence returned regarding the disposition of income and eligibility verification; documentation supporting any decisions made regarding the individual's eligibility; all notices provided to the individual; records pertaining to any appeals or fair hearings; and information on all medical assistance provided. We developed these requirements to assist State Medicaid and CHIP agencies in maintaining records that can be used to justify and support decisions made regarding the eligibility of applicants and beneficiaries and the coverage available to them, defend these decisions when challenged by an applicant or beneficiary, and enable State and Federal auditors and reviewers to conduct appropriate oversight. As discussed in section II.D. of the proposed rule, insufficient documentation was the leading cause of eligibility-related improper payments in the most recent cycles of review in the PERM program, MEQC program, and other CMS eligibility audits. As such, we do not agree with the comment that flexibility in this area has benefited State agencies or that increased specificity related to recordkeeping will increase audit citations. Based on the PERM, MEQC, and other CMS eligibility audit findings and recent OIG findings citing insufficient documentation to evaluate the accuracy of States' eligibility determinations, we anticipate a reduction in audit citations once States fully implement these requirements. We are finalizing the content requirements at §§ 431.17(b)(1) and 457.965(b)(1) as proposed.

Comment: One commenter expressed support for our proposal to expand the Medicaid case documentation requirements at § 435.914 to include agency decisions at renewal, in addition to agency decisions at application. One commenter suggested further amendment to add redeterminations in addition to renewals.

Response: We appreciate the support for the changes proposed at § 435.914, which would require State Medicaid agencies to include in each applicant's case record, the facts and documentation necessary to support a decision of eligibility or ineligibility at application and at renewal. We did not intend to exclude redeterminations based on changes in circumstance from these recordkeeping requirements. Accordingly, we are adding ''redetermination'' to § 435.914(b) in this final rule to ensure that records related to redeterminations made in response to changes in circumstances are maintained in the same way and to the same extent as records related to applications and annual renewals.

Comment: Commenters requested clarification of the level of detail required to be maintained in each individual's case record, particularly with respect to data received through electronic data sources, when to document data that is not useful to the eligibility determination, and whether to document a lack of data received through data sources.

Response: State Medicaid and CHIP agencies are expected to maintain an appropriate level of detail to permit the individual or other authorized reviewer to understand how and why the agency made a determination of eligibility or a coverage decision. Data received by the State Medicaid or CHIP agency that is related to a condition of eligibility and therefore relevant to the determination made by the State must be maintained. For example, if a State pings an electronic data source to verify income when income is relevant to the eligibility determination, the State must

maintain the income data received, even if the agency subsequently determines that the income data was not useful in making the eligibility determination. In this case, the State Medicaid agency should document that the State found the income information to not be useful to determining or verifying eligibility. This income data as well as documentation that the State reviewed it and determined it to be irrelevant to their determination is necessary context 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.

Comment: One commenter recommended that we require collection of demographic information on all program applicants. They explained that collection of demographic information at application facilitates interactions with individuals who may need language access services or other communication services to enroll in coverage, and it removes the need for entities further down the line to request duplicative information. It also allows programs to track disparities not just in access to services, but in the eligibility and redetermination processes, in retention of eligible individuals and families, and in utilization of services.

Response: We support efforts to collect demographic information for purposes of States providing language access, streamlining communications with applicants and beneficiaries, and supporting retention efforts. However, we believe that *requiring* provision of certain demographic information on the application would increase applicant burden and act as a barrier to enrollment. The requirements regarding certain demographic information collected on the application are outside the scope of this rulemaking, and we decline to require collection of specific demographic information from all program applicants through the requirements for the content of records at § 431.17(b). However, we urge States to continue to explore methods of encouraging applicants to provide demographic information, which can be used to improve access and retention, such as providing help text on the application explaining how demographic information will be used or requesting the information after the person has been enrolled.

Comment: Most commenters supported the proposed requirement at §§ 431.17(d)(2) and 457.965(d)(2) that States must make records available to the Secretary and to Federal and State auditors within 30 days of the request. One commenter specifically supported beneficiary access to case records within 30 calendar days. However, many commenters were concerned by the inclusion of ''other parties, who request, and are authorized to review, such records'' within the requirement. Commenters expressed concerns about applicant and beneficiary privacy, specifically regarding access to sensitive information such as diagnoses and services used, as well as immigration status, that may be used for purposes outside the provision of health care through Medicaid and CHIP. Commenters recommended that we strengthen this requirement by more narrowly defining the specific parties that have a legitimate program integrity purpose or research purpose for accessing beneficiary records. Others recommended that records only be made available to parties authorized under Federal law so that Federal privacy protections clearly apply. One commenter stated that it is important to reassure immigrants that it is safe to apply for health coverage because their information will only be used for purposes of administering the program and not for immigration enforcement purposes. Some commenters suggested that we use this opportunity to clarify CMS policy on information sharing with the DHS or other similar authorities.

Response: We appreciate this comment and agree that safeguarding confidential information concerning Medicaid applicants and beneficiaries is of critical importance. Section 1902(a)(7) of the Act and implementing regulations at 42 CFR part 431, subpart F, require State Medicaid agencies to provide safeguards that restrict the use or disclosure of information concerning Medicaid applicants and beneficiaries to uses or disclosures that are directly connected with the administration of the Medicaid State plan. The same requirements also apply to separate CHIPs under § 457.1110(b), which provides that separate CHIPs must comply with part 431, subpart F. Accordingly, we are clarifying this existing requirement by adding a new paragraph (e) to § 431.17 of this final rule, which specifies that records maintained pursuant to § 431.17 must be safeguarded in accordance with the requirements of part 431, subpart F.

Section 431.302 sets forth the ''purposes directly related to State plan administration,'' which include: Establishing eligibility; determining the amount of medical assistance; providing services for beneficiaries; and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan. Under longstanding policy, sharing information with DHS about an applicant or beneficiary's Medicaid or CHIP coverage for purposes of a public charge determination is generally not directly related to administration of the State plan,[16] and therefore the circumstances in which such information can be shared with DHS are quite limited. Some examples of permissible disclosure of applicant and beneficiary information include: providing the information needed to verify eligibility under section 1137 of the Act and §§ 435.940 through 435.965, such as verifying immigration status through the DHS SAVE Program; sharing information with a beneficiary's enrolled Medicaid or CHIP providers as needed to provide services; and sharing information with a beneficiary's Medicaid or CHIP managed care plan as needed to provide services.

Comment: Several commenters raised concerns about States' ability to meet the 30-day timeframe for making records available upon request. They noted challenges that may be outside the agency's control, such as a high volume of requests during a specific timeframe or competing demands from other programs in States with integrated or county-based eligibility systems, which may make it difficult to provide all records within the requirement timeframe. Commenters suggested we provide a process for States to request an extension to this timeframe.

Response: At §§ 431.17(d)(2) and 457.965(d)(2) we proposed to require that States make records available within 30 calendar days of the receipt of a request. We thank commenters for the suggestion to permit a process through which States could request an extension of the timeframe for making records available. We understand that there may be limited circumstances in which a State is unable to make records available within 30 days following a request, such as in the case of natural disasters. However, we believe that a process for States to request an extension in such cases is impractical, as States in such circumstances may be unable to take necessary steps to request an extension. In lieu of an extension process, we have revised §§ 431.17(d)(2) and 457.965(d)(2) in this final rule to permit an exception to the 30-day timeframe when there is an

[16] CMCS Informational Bulletin, ''Public Charge and Safeguarding Beneficiary Information'' (issued July 22, 2021), available at: *https://www.medicaid.gov/federal-policy-guidance/downloads/cib072221.pdf.*

administrative or other emergency beyond the agency's control. This exception is modeled on the eligibility determination timeliness exception found at § 435.912(e)(2). States will not be required to seek our approval that use of the exception is appropriate but may want to seek our concurrence for audit or other oversight purposes. Additionally, we are making a technical revision to §§ 431.17(d)(2) and 457.965(d)(2) to clarify that parties may specify in their request a longer period of time for States to provide the requested records.

Comment: We received a number of comments in support of our proposal that the Medicaid and CHIP State plans provide for retention of records for the period during which an applicant or beneficiary's case is active and a minimum of 3 additional years thereafter. One commenter stated that this proposal strikes a good balance between the preservation of necessary information and administrative efficiency. We also received many comments recommending that States be required to maintain applicant and beneficiary records for longer than 3 years. The majority of these comments recommended retention of records during the period in which a case is active and 10 years thereafter. They explained that it is not unusual for an individual to reapply after a break in coverage for 3 or more years, and a longer retention policy would make it possible for the State to utilize verification of citizenship or immigration status and other eligibility factors that do not change when such an individual reapplies for coverage. Commenters also noted that a 10-year retention period would align with the policy for Medicaid MCOs under § 438.3(u) and for drug manufacturers participating in the Medicaid Drug Rebate Program under § 447.510(f).

Response: We appreciate commenters' support for the proposed policy, at §§ 431.17(c) and 457.965(c), which would require State Medicaid and CHIP agencies to retain records while an individual's case is active plus a minimum 3 years thereafter. We also understand commenters' concerns that 3 years will not be sufficient in all cases. A longer retention period may be particularly beneficial for certain citizens and certain qualified non-citizens whose eligible immigration status is unlikely to change and cannot be verified electronically. If such an individual disenrolls and then reapplies, we agree that the enrollment process would be streamlined significantly if the State still had the individual's case record with documentation of their citizenship or satisfactory immigration status.

In proposing a 3-year retention timeframe, we considered the administrative burden of maintaining documentation with a large file size, like a recording of a telephonic signature, along with the different actions for which beneficiary case records may be needed. While we appreciate that retention for just 3 years will not be long enough to help every applicant who reapplies for coverage after a period of disenrollment, we also recognize that no standard will protect everyone. We are also concerned that the burden of maintaining all required documentation for all beneficiaries for at least 10 years may cause some States to take actions to reduce case record size, which could negatively impact applicants' and beneficiaries' user experiences if data is lost or rendered unreadable.

While we appreciate the drawbacks to a 3-year retention period raised by commenters, we still believe that requiring State Medicaid and CHIP agencies to retain records for 3 years after an individual's case is no longer active strikes the best balance between the advantages of a longer retention period and administrative burden on States. Therefore, we are finalizing a 3-year retention requirement at §§ 431.17(c)(1) and 457.965(c), as proposed, with one exception at § 431.17(c)(2) specific to Medicaid, which is described in a subsequent comment response. We note that the requirement to retain records during the period that an individual case is active, plus 3 years thereafter, is the *minimum* requirement for State retention of records. Recognizing the benefits of retaining records for a longer period of time, particularly records related to factors of eligibility that will not change, we encourage all States to consider instituting a longer record retention period. We also note that, as discussed in section II.D. of the September 2022 proposed rule, a case remains active for any applicant or beneficiary who has a fair hearing appeal pending. In addition, in the event that an individual submits a new application prior to expiration of the 3-year period, the records retention clock would restart, and the State would need to retain the case record until 3 years after eligibility is terminated or the individual otherwise disenrolls from coverage.

Comment: One commenter pointed out that State and Federal statute does not allow estate recovery until after a Medicaid recipient dies, or if they are survived by a spouse, after their spouse dies. Therefore, in cases when estate recovery is required, the commenter noted that records may need to be maintained for longer than the proposed 3-year period. This commenter suggested that we amend the minimum record retention period to require records to be maintained for at least 15 years.

Response: We thank the commenter for raising this issue and agree that the proposed minimum retention period may be insufficient in cases where estate recovery is required after the death of a surviving spouse. We also note that in some situations, States may need to delay estate recovery if the deceased beneficiary is survived by someone other than their spouse, such as a minor or child with a disability. We recognize States need to maintain records for use in the estate recovery process, when such a process is required under section 1917(b) of the Act. However, requiring a minimum record retention period of 15 years, even if narrowly tailored to cases where estate recovery is required, may be longer than necessary in some cases and not long enough in other cases. Therefore, we are including an exception to our proposed language at § 431.17(c) when estate recovery is required. As described at § 431.17(c)(2) of this final rule, States must maintain records for individuals whose estates are subject to recovery until they have satisfied their statutory obligations under section 1917(b) of the Act for the estate at issue (that is, the State completed recovery from the estate through a legal proceeding or other means, waived recovery against the estate on the basis of undue hardship, or determined that the estate has insufficient property from which to recover).

Comment: Several commenters requested that CMS amend the proposed record retention period to align with other programs such as SNAP and TANF.

Response: While we acknowledge there may be benefits to aligning the record retention period with other programs, particularly in States with an integrated eligibility system that includes other programs like SNAP and TANF, we decline to make this a requirement. We do not believe that all other programs have the same record retention requirements, and our rule does not preclude a State from maintaining records for a longer period of time if, for example, the State determines it would be administratively convenient to align the period with longer periods used by other programs. Similarly, we do not believe that States are precluded from retaining records

from other programs for a longer period if needed to align with Medicaid's retention period. We believe that our proposed retention period of the time that the case is active plus an additional 3 years for most records, as described at §§ 431.17(c)(1) and 457.965(c), will ensure that applicant and beneficiary records will be available for the majority of circumstances in which such records may be needed. Some programs calculate the retention period only from the date of initial determination, without taking into account the time period a case is active. If we were to impose a minimum retention period that did not take into account the length of time that a case is active, States would not be required to maintain evergreen verification data, for example, which continues to demonstrate a beneficiary's current eligibility even if received more than 3 years prior. Additionally, beneficiaries who enrolled more than 3 years prior may be unable to access all of their records. Therefore, we are finalizing the length of the retention period for most records at §§ 431.917(c)(1) and 457.965(c) as the period when the applicant or beneficiary's case is active, plus a minimum of 3 years thereafter.

Comment: One commenter recommended that the proposed retention policy apply not only to an individual's record while that individual's case is active plus 3 years thereafter, but also while that individual is part of another case that is active, plus 3 years thereafter. Another commenter recommended that the retention period relate to the individual, rather than the active case. One commenter further recommended clarification that States must maintain separate case records for parents and their dependent children.

Response: We appreciate the comments flagging differences in how States maintain applicant and beneficiary records. The regulatory provisions related to recordkeeping in this final rule, at §§ 431.17, 435.914, and 457.965 are specific to individual applicants and beneficiaries. We recognize that applications often include multiple household members, and these household members may remain together in a State's beneficiary case records. However, applicants and beneficiaries receive their own individual determination of eligibility at application, at renewal and when they experience a change in circumstances. Most services are provided at the individual beneficiary level as well. As such, the Medicaid and CHIP regulations regarding maintenance of records are applied at the individual applicant and beneficiary level. This does not preclude a State from maintaining the records of individual household members together for recordkeeping purposes, but in such cases, the household record must be retained while every individual member's case is active and for at least 3 years after the last household member has disenrolled.

Comment: One commenter requested that CMS clarify its expectations for disposition of records after the mandatory retention period ends. Another commenter suggested adding a provision to hold States harmless during audits for documentation omissions that would not have made a difference in determining eligibility for an applicant or beneficiary or in authorizing coverage of a specific service. And one commenter recommended that CMS provide guidance on how States can help applicants and beneficiaries understand how to gain access to their case records.

Response: We decline to prescribe specific regulatory standards in these areas. State Medicaid and CHIP agencies have flexibility to adopt record disposition procedures consistent with their State law, rules, and policies. After the mandatory retention period under this final rule ends, States may choose to maintain records for a longer period of time, archive, or destroy records. With respect to the information that must be made available to auditors, we agree that applicant and beneficiary case records must include the information needed to support the decisions made regarding eligibility and benefits, but the specific details about what types of information may, or may not, be considered in an audit are outside the scope of this rule. Finally, we agree that every State must establish a clear process, that is not burdensome, for individuals to request and access copies of their case records. We will consider including more information on these topics in future subregulatory guidance.

After considering all comments, we are finalizing the recordkeeping requirements proposed at §§ 431.17, 435.914, and 457.965 with some modifications as discussed. Because the effect of this change is specific to clearly defining the types of eligibility determination documentation to be maintained, defining the time required to retain Medicaid and CHIP records and case documentation, removing references to outdated technology, and defining when records must be made available upon request, we note that this provision operates independently from the other provisions of this final rule.

E. Eliminating Access Barriers in CHIP and BHP

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

We proposed to revise CHIP regulations at § 457.570 and BHP regulations at § 600.525(b)(2) to prohibit premium lock-out periods in CHIP and BHP. Premium lock-out periods have permitted States to specify a period of time that an individual must wait after non-payment of premiums until being allowed to reenroll in the CHIP or BHP.

In order to improve continuity of care and align with Medicaid rules in this area, we proposed that States with a separate CHIP or BHP that terminate enrollees for non-payment of premiums or enrollment fees may not condition re-enrollment in CHIP or BHP on the payment of past-due premiums or enrollment fees. This is in accordance with our CHIP statutory authority at section 2101(a) of the Act to ''expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner'' and BHP authority at section 1331(c)(4) of the Act to ''coordinate the administration of, and provision of benefits with the State Medicaid program under title XIX of the SSA, the State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.'' We also sought comment on an alternative proposal to provide States with an option to implement a 30-day premium lock-out period.

Comment: We received numerous comments in support of our proposal to prohibit premium lock-out periods in CHIP. Several commenters indicated that eliminating premium lock-outs would improve access and continuity of care for children and reduce barriers to care. One commenter noted their support for this change in BHP, citing it will simplify BHP premium rules. In addition, a few commenters indicated that even short gaps in coverage can create a barrier to care and stated that CMS should not permit a premium lock-out period of 30 days.

Response: We thank the commenters for supporting our proposal to eliminate premium lock-out periods. We are finalizing this provision as proposed at § 457.570 for CHIP and § 600.525(b)(2) for BHP. As discussed in section II.F.1. of the September 2022 proposed rule, we agree that removing lock-out periods will increase access to care, reduce gaps in coverage, and limit financial barriers to care for low-income families. This final rule will support continuity of care

to ensure enrollees in CHIP and BHP receive and maintain coverage.

Comment: A few commenters requested technical clarifications related to eliminating premium lock-out periods. One commenter requested clarification on whether the enrollee's services will be expected to be covered in the month of termination. Another commenter requested clarification on whether a State can require payment of past-due premiums as a condition of re-enrollment. Another commenter questioned whether States will be able to terminate for non-payment of premiums.

Response: We appreciate the commenters request for clarity on these issues. Under the final rule, once an individual's coverage is terminated, States will not be required to cover services (unless the individual re-enrolls in coverage). Further, as discussed in the September 2022 proposed rule, under the final rule, States cannot require families who were disenrolled to repay past-due premiums as a condition of reenrollment. Because States will 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, and could re-enroll without paying any past due premiums. However, the family could be required to pay a new premium or enrollment fee associated with new enrollment prior to re-enrollment. Finally, while the final rule prohibits lock-out periods for individuals with unpaid premiums or enrollment fees, it does not address whether States may still terminate coverage for nonpayment of premiums, an issue that is beyond the scope of the final rule.

Comment: Two commenters opposed prohibiting premium lock-out periods. One commenter expressed concerns that States could experience administrative and budgetary challenges with removing the premium lock-out period.

Response: We acknowledge the commenters' concerns related to potential administrative and budgetary challenges associated with States eliminating premium lock-out periods. To improve administrative simplicity, we encourage States to consider other options for facilitating timely premium payments, such as charging a single, but affordable, annual enrollment fee. As discussed in the September 2022 proposed rule, requiring an affordable enrollment fee may improve retention, reduce disenrollment rates, and simplify program administration by reducing the cost of monthly bill collection. As with premiums, States could consider varying enrollment fees based on family income level to ensure that they are affordable. Some States have reported that the costs associated with managing premium lock-out periods and frequent churn have resulted in greater administrative burden and higher costs compared to premium payment offsets.

Comment: A few commenters requested that CMS delay the effective date of this provision to ensure States have adequate time to make necessary changes in State laws or updates to information technology systems.

Response: We recognize that certain changes proposed in this rule, including the elimination of premium lock-out periods, may require States to make changes to their statutes and/or regulations, as well as systems changes prior to implementation, and that this process can take time. States will no longer be permitted to adopt a new premium lock-out period when this provision becomes effective. However, we are providing States with existing premium lock-out periods with 12 months from the effective date of this final rule to implement the necessary changes to discontinue this policy. States with biennial legislatures that require legislative action to implement these requirements can request an extension of up to 24 months following the effective date of this final rule.

After considering the comments, we are finalizing as proposed. Because the effect of this change is specific to preventing States from disenrolling or locking-out CHIP beneficiaries for failure to pay premiums, we note that this provision operates independently from the other provisions of this final rule.

2. Prohibition on Waiting Periods in CHIP (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)

CHIP regulations at § 457.805(b) have permitted States to institute a 90-day ''period of uninsurance,'' or ''waiting period,'' for individuals who have disenrolled from a group health plan, prior to allowing them to enroll in a separate CHIP. We proposed to revise §§ 457.805(b) and 457.810(a) to eliminate the use of a waiting period for any length of time as a substitution procedure under either CHIP direct state plan coverage or premium assistance. We also proposed conforming amendments to remove references to waiting periods by revising § 457.65(d), removing § 457.340(d)(3), and revising § 457.350(i) (which is redesignated as § 457.350(g) in this final rule). Then we proposed to remove specified limitations in § 457.805(b)(2) and (3) that are no longer relevant without waiting periods.

We sought comment on an alternative proposal to provide States with an option to implement a 30-day waiting period if a high rate of substitution of group coverage could be demonstrated. We are finalizing the change we proposed, to prohibit the use of waiting periods altogether.

Comment: The majority of commenters supported the proposal to prohibit waiting periods in separate CHIPs. Commenters expressed the view that elimination of waiting periods would help reduce potential gaps in children's coverage and simplify the enrollment process for families. In addition, several commenters explicitly opposed permitting a waiting period of any length, including a 30-day waiting period, in favor of eliminating waiting periods altogether.

Response: We thank commenters for their support of the proposal to eliminate CHIP waiting periods. We agree with commenters that permitting a waiting period for any length of time would not sufficiently address the access barriers that waiting periods pose for children and families. In addition, a 30-day waiting period would provide less time for children to obtain coverage in another insurance affordability program during the waiting period. The purpose of these changes is to mitigate gaps in coverage for children that may occur during a waiting period and to align with other insurance coverage such as Medicaid and private insurance plans that do not permit waiting periods prior to individuals being enrolled. The proposal to eliminate separate CHIP waiting periods is also consistent with Executive Order 14070 of April 5, 2022, titled ''Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage,'' which instructs agencies to identify policy changes to ensure that enrollment and retention in coverage can be more easily navigated by consumers.

Comment: A commenter expressed concern that prohibiting States' use of waiting periods in our regulations would be more restrictive on State plans than the existing title XXI statutory requirements. A few commenters expressed concern that the proposed changes removed some of the State flexibility needed to design their separate CHIPs.

Response: We appreciate the commenters' request for further clarification on these issues. No provision of the Act expressly authorizes waiting periods. As we explained in the preamble to our original CHIP final regulations (66 FR

2490), CMS had previously interpreted section 2102(b)(3)(C) of the Act, which requires the State child health plan to ''include a description of procedures to be used to ensure that the insurance provided under the State child health plan does not substitute for coverage under group health plans,'' to permit States to adopt a waiting period as one possible method to prevent substitution.[17] When CHIP began in 1997, group health plans were the main alternative sources of coverage for children who would otherwise have been eligible for CHIP. Because waiting periods historically involved a period of uninsurance, requiring a waiting period before a child could enroll in CHIP was considered a possible deterrent to families who wanted to change coverage from group health plans to CHIP. CMS therefore permitted waiting periods as one potential route to ensure that CHIP ''does not substitute for coverage under group health plans.''

Since 1997, circumstances have changed significantly. As explained in section II.F.2. of the September 2022 proposed rule preamble, after the passage of the Affordable Care Act, families waiting to enroll in CHIP can receive health coverage through an Exchange, greatly diminishing any deterrent effect that may have resulted from a waiting period. There is little to no evidence that waiting periods effectively reduce substitution of coverage.[18] By contrast, the evidence has shown that waiting periods can impose significant costs on children. There is an abundance of evidence showing that waiting periods reduce program enrollment and utilization of health care services and increase the number of children without insurance.[2] [19] [20] Children are particularly vulnerable to waiting periods because a period of uninsurance can compromise child health and development and access to preventive and primary health care during childhood and adolescence.[21] [22] [23]

Even though sections 2102(b)(1)(B)(iii), 2102(b)(1)(B)(iv), and 2112(b)(5) of the Act prescribe limitations on the use of waiting periods, these restrictions on their usage do not automatically authorize waiting periods. Rather, these provisions—which were included in the statue when it was first enacted in 1997—reflect the fact that waiting periods were, at the time, contemplated as one potential strategy States could use to prevent substitution of coverage, consistent with section 2102(b)(3)(C) of the Act. As explained, because the health coverage landscape has changed since 1997, waiting periods are no longer a viable method to ensure that CHIP does not substitute for coverage under group health plans.

Further, CMS regulations at § 457.805(a) require that States employ ''reasonable procedures'' to ensure that CHIP does not substitute for coverage. For the reasons stated above, as well as those reasons discussed in section II.F.2. of the preamble to the September 2022 proposed rule, waiting periods no longer constitute a ''reasonable procedure'' for preventing or addressing substitution of coverage. States will continue to be required to monitor for substitution of coverage. In addition, States will also have the flexibility to propose a procedure other than a waiting period to reduce substitution of coverage if monitoring shows that substitution of coverage exceeds the acceptable threshold determined by the State in its CHIP state plan. For example, States may implement a CHIP premium assistance program for children enrolled in group health plan coverage, and/or improve public outreach about the range of health coverage options that are available in that State.

We believe this approach appropriately meets the requirements outlined in relevant statute and regulations, while minimizing adverse impacts for children and families that are often a result of implementing waiting periods.

After considering the comments, we are finalizing as proposed. Because the effect of this change is specific to ensuring that CHIP coverage does not substitute for coverage under group health plans, we note that this provision operates independently from the other provisions of this final rule.

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

Annual and lifetime limits are not permitted on Essential Health Benefits in any individual, group, or employer health plans, or on any benefits in Medicaid. However, CHIP regulations have been silent on the use of annual and lifetime limits except for banning annual and aggregate dollar limits on mental health and substance use disorder benefits. Recognizing that these limits may present barriers to CHIP enrollees receiving necessary health care services and exacerbate unmet treatment needs, we proposed to prohibit any annual, lifetime or other aggregate dollar limitations on any medical or dental services that are covered under the CHIP State plan. This prohibition was included in the September 2022 proposed rule at § 457.480.

We received the following comments on this provision:

Comment: The majority of commenters supported the proposal to prohibit annual and lifetime limits on all covered CHIP benefits. In particular, commenters expressed support for the provision as important to eliminating barriers to care, preventing discrimination against children with higher medical needs, and providing CHIP children improved access to dental and orthodontia care. A few commenters highlighted the positive benefit of aligning State Medicaid programs and CHIP that this provision would achieve. One commenter also noted that States still have the flexibility to design their benefit package, which creates an appropriate balance between utilization management and assuring access to critical services.

Response: We appreciate the support from commenters for our proposal to remove annual and lifetime limits. We are finalizing changes as proposed at § 457.480. As discussed in section II.F.3. of the September 2022 proposed rule, we agree that such limits create barriers for families to access health coverage, particularly for children with the greatest medical needs. States have frequently reported that alignment across Medicaid and CHIP creates administrative simplification, and we

[17] See section II.G.2 of (66 FR 2490), State Child Health; Implementing Regulations for the State Children's Health Insurance Program.

[18] Gruber, J. and Simon, K. (2008) Crowd-out 10 years later: Have recent public insurance expansions crowded out private health insurance? Journal of Health Economics, 27(2):201–217. *https://doi.org/10.1016/j.jhealeco.2007.11.004.*

[19] Reinbold, G.W. (2021). State Medicaid and CHIP options and child insurance outcomes: An investigation of 83 state options with state-level panel data. World Medical & Health Policy, 1–15. *https://doi-org.ezproxyhhs.nihlibrary.nih.gov/10.1002/wmh3.465.*

[20] Medicaid and CHIP Payment and Access Commission, Transitions Between Medicaid, CHIP, and Exchange Coverage, July 2022. Accessed at: *https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf.*

[21] DeVoe, J.E., Graham, A., Krois, L., Smith, J., & Fairbrother, G.L. (2008). ''Mind The Gap'' in Children's Health Insurance Coverage: Does the Length of a Child's Coverage Gap Matter?. Ambulatory Pediatrics, 8(2), 129–134. *https://doi.org/10.1016/j.ambp.2007.10.003.*

[22] Leininger, L.J. Partial-Year Insurance Coverage and the Health Care Utilization of Children. Medical Care Research and Review. 2009;66:49–67. *https://doi.org/10.1177/1077558708324341.*

[23] Buchmueller, T., Orzol, S.M., & Shore-Sheppard, L. (2014). Stability of children's insurance coverage and implications for access to care: evidence from the Survey of Income and Program Participation. International journal of Health Care Finance and Economics, 14(2), 109–126. *https://doi.org/10.1007/s10754-014-9141-1.*

agree that this is an important area for alignment. We also recognize, as noted by commenters, that States continue to have flexibility in designing their benefit package, as long as they adhere to the relevant requirements in part 457, subpart D.

Comment: One commenter expressed support for the September 2022 proposed rule and recommended that removing limits should be factored into rate setting to ensure actuarial soundness in States with managed care plans.

Response: We agree with the point raised by the commenter. States that remove lifetime and annual limits in a CHIP managed care delivery system should ensure that such changes are accounted for in rate development. States must adhere to the Federal standards for rate development in CHIP managed care at § 457.1203, including using payment rates in CHIP managed care that are consistent with actuarially sound principles. We recommend that States coordinate closely with their actuaries to ensure the application of generally accepted actuarial principles and practices in CHIP managed care rate setting.

Comment: Two commenters opposed removing annual and lifetime limits. Specifically, one commenter expressed concern related to prohibiting annual and lifetime limits due to the potential cost impact to State CHIPs.

Response: We recognize that the potential cost associated with eliminating annual and lifetime limitations in CHIP is an important consideration for States and health plans. We note that one study found that the cost of eliminating lifetime limits is minimal because only a small number of people exceed them.[24] In addition, improving overall access to dental care services, for example, helps families avoid emergency room visits that may increase financial burden for both States and families. We also note that CHIP has been an outlier in terms of permitting these types of limitations. Following implementation of the ACA, neither Medicaid, Exchange, nor private group health plans allow annual, lifetime or other aggregate dollar limitations. Thus, higher income children in the Exchange have been protected from these types of limitations whereas lower income children in CHIP continued to be subject to dollar limitations. We also note that States and health plans have extensive experience in using other types of cost containment mechanisms.

For the above reasons, we are finalizing these changes to § 457.480 as proposed. Because the effect of this change is specific to prohibiting annual and/or lifetime limits on benefits in CHIP, we note that this provision operates independently from the other provisions of this final rule.

F. Compliance Timelines

In the September 2022 proposed rule, we did not specify the date(s) by which States would be required to demonstrate compliance with the proposed requirements, but we requested comment on appropriate compliance timeframes. We received the following comments on the amount of time States will need to implement each provision as proposed:

Comment: Many comments regarding the timeline for implementing this rule focused on the benefits of the streamlined eligibility and enrollment processes included in the September 2022 proposed rule and the likelihood that these changes would reduce erroneous disenrollments when States begin to terminate the coverage of ineligible individuals at the end of the continuous enrollment condition. Timeframes recommended by these commenters ranged from promptly or as soon as practicable to specific timeframes of 30 to 60 days, 90 days, and no more than 6 or 12 months following publication of this final rule. Some commenters supported our proposed approach to make all changes effective 30-days after publication, with compliance required within 12 months. Others recommended prioritizing some provisions for earlier implementation, or phasing them in, based on different factors, including whether the provisions (1) would help to mitigate coverage losses; (2) required fewer resources; (3) posed a smaller technological burden or required fewer system changes; or (4) simply clarified existing requirements. Many commenters recognized the need to balance State resources and the amount of work required to implement a change with the needs of beneficiaries and the potential positive impact on coverage. They urged CMS to afford States sufficient time to implement, but not more time than would be necessary.

At the other end of the spectrum, many commenters focused on the vast resources States were currently directing toward unwinding from the PHE and returning to regular operations at the end of the continuous enrollment condition. They described how that work was already stretching States' limited resources, and that States could not simultaneously manage that work and implement this rule within the proposed timeframe. Many commenters expressed concern that the significant time and resources needed to implement this rule would take time and funding away from unwinding work and that instead of mitigating coverage losses, speedy implementation would put States at risk for implementation errors. Commenters described many changes that States will need to make as they implement this rule, including: developing new State legislative and regulatory constructs; revising budget requests to obtain needed funding; implementing system updates, which will be much greater in States that still utilize legacy systems for eligibility and enrollment that is not based on MAGI; designing new procedures and implementing workflow changes; hiring and training staff to implement the new processes and requirements; and obtaining CMS approval of changes to their State plans. None of these commenters believed our proposed timeframe for compliance was adequate. They recommended timeframes for compliance ranging from at least 6 to 12 months following the end of unwinding to 2, 3, or 5 years following publication of this final rule. One commenter suggested that CMS pause this rulemaking and refile it after States have returned to regular operations following the continuous enrollment condition. Several commenters also recommended that we provide States with an option to request an extension when specific barriers could not be overcome during a required compliance timeframe.

Response: We agree that the provisions in the September 2022 proposed rule will help eligible individuals to enroll in Medicaid and CHIP and to stay enrolled as long as they remain eligible. At the same time, implementing many of the provisions in this final rule will require complex systems changes that will take time for States to make. We are sympathetic to States' assertions that they are currently devoting all available resources toward protecting the enrollment of eligible individuals as they unwind from the continuous enrollment condition, and we believe that requiring States to divert resources away from this work will likely do more harm than good. We also agree that an early effective date, combined with phased-in compliance, strikes the best balance between making the streamlined processes in this final rule available as soon as possible and giving States the time needed to implement these changes correctly. We

[24] PricewaterhouseCoopers. ''The Impact of Lifetime Limits.'' March 2009. Prepared for the National Hemophilia Foundation on behalf of the Raise the Caps Coalition.

appreciated the many suggestions for criteria to assist us in developing a phase-in plan for compliance.

After considering all of the factors suggested for phase-in and all of the challenges that States may need to overcome as they implement these changes, we are finalizing this rule with an effective date 60 days after publication and will phase-in compliance with each provision as described in Table 2, with full compliance required no more than 36 months after this final rule becomes effective.

BILLING CODE 4120–01–P

TABLE 2: Compliance Timeframes

Provision	Compliance Date
Facilitate enrollment by allowing medically needy individuals to deduct prospective medical expenses (§§ 435.831 and 436.831)	Option available upon effective date
Establish new optional eligibility group for reasonable classification of individuals under 21 who meet criteria for another group (§ 435.223)	Option available upon effective date
Improve transitions between Medicaid and CHIP (§§ 431.10, 435.1200, 457.340, 457.348, 457.350, 600.330)	Upon effective date
Remove optional limitation on the number of reasonable opportunity periods (§§ 435. 956 and 457.380)	Upon effective date
Apply primacy of electronic verification and reasonable compatibility standard for resource information (§§ 435.952 and 435.940)	Upon effective date
Remove requirement to apply for other benefits (§§ 435.608 and 436.608)	12 months after effective date
Prohibit premium lock-out periods (§§ 457.570 and 600.525)	Upon effective date; 12 months after effective date for States sunsetting existing lock-out periods [1,2]
Prohibition on waiting periods in CHIP (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)	12 months after effective date [2,3]
Prohibit annual and lifetime limits on benefits (§ 457.480)	12 months after effective date[2, 4]
Agency action on returned mail (§§ 435.919 and 457.344)	18 months after effective date
Recordkeeping (§§ 431.17, 435.914, and 457.965)	24 months after effective date
Verification of Citizenship and Identity (§ 435.407)	24 months after effective date
Align non-MAGI enrollment and renewal requirements with MAGI policies (§§ 435.907 and 435.916)	36 months after effective date
Establish specific requirements for acting on changes in circumstances (§§ 435.916, 435.919, 457.344, and 457.960)	36 months after effective date
Establish timeliness requirements for determinations and redeterminations of eligibility (§§ 435.907, 435.912, 457.340, and 457.1170)	36 months after effective date

[1] The policy will be effective 60 days after publication of this final rule. At that time, States will no longer be permitted to adopt a new premium lock-out period. States with an existing lock-out period will have 12 months to remove it.

[2] States with biennial legislatures that require legislative action to implement these requirements can request an extension of up to 24 months following the effective date of this final rule.

[3] The policy will be effective 60 days after publication of this final rule. At that time, States will no longer be permitted to adopt a new waiting period. States with an existing waiting period will have 12 months to remove the waiting period and establish a substitution monitoring strategy.

[4] The policy will be effective 60 days after publication of this final rule. At that time, States will no longer be permitted to adopt new annual or lifetime limits. States with existing annual or lifetime limits will have 12 months to remove the limits.

BILLING CODE 4120–01–C

In establishing a compliance date for each provision in this final rule, we first considered whether the provision established a new State option or a requirement, and whether the provision clarified the policy for existing processes or would require new processes. For those provisions that create new options, are expected to require little to no change in State processes, or clarify existing requirements, compliance is required

when the rule becomes effective. Next, we considered those provisions that were expected to reduce State administrative burden and have the least extensive statutory or system implications. Recognizing that some of these provisions may require State legislative action or have budget implications, States will have 12–18 months following the effective date of this final rule to implement these provisions and demonstrate compliance with the new requirements. States with biennial legislatures that require legislative action to implement these requirements can request an extension of up to 24 months following the effective date of this final rule. The last set of provisions are expected to require the greatest change to State systems and workflow processes. To ensure that States have adequate time to adopt the system and policy changes needed to implement these requirements, to ensure that eligibility workers are properly trained in the new policies and procedures, and to ensure that implementation does not interfere with the completion of State unwinding work and mitigations, we are providing States with 24 to 36 months following the effective date of this final rule to demonstrate compliance with these requirements. We encourage all States to work within these timeframes to prioritize completion of these changes as quickly as possible.

Comment: We received a number of comments recommending specific implementation timeframes for specific provisions. Recommended timeframes included:

- Agency action on returned mail as soon as possible, 30 days, and 90 days after the effective date;
- Align non-MAGI enrollment and renewal requirements with MAGI policies 60 days, 90 days, and at least 3 years after the effective date;
- Apply primacy of electronic verification and reasonable compatibility standard for resource information 60 days after effective date;
- Establish specific requirements for acting on changes in circumstances—18–24 months and 3 years after the effective date;
- Prohibiting access barriers in CHIP—as soon as possible;
- Remove requirement to apply for other benefits 90 days after effective date; and
- Transitions between Medicaid and CHIP 90 days after the effective date.

Response: We took each of these recommendations into account when developing the compliance timeframes described in Table 2. In some cases, the specific recommendation was consistent with our final compliance timeframe. For example, commenters recommended between 18 and 36 months to implement the requirements for acting on changes in circumstances. We believe this provision will require significant system changes, particularly in States that are still using legacy eligibility systems, and we are requiring compliance with the requirements at §§ 435.919, 457.344, and 457.960 no later than 36 months after this final rule becomes effective. In other cases, the specific recommendation informed our compliance timeframe even though it is not the same. For example, one commenter recommended making removal of the requirement to apply for other benefits effective 90 days after the effective date. We agree that this is a low-complexity system change that is likely to improve beneficiary access and reduce State administrative burden, and as such, it should happen quickly. However, we are providing States with up to 12 months following the effective date of this final rule to comply with this requirement as we believe some States may require additional time to get the necessary system changes in the queue and to effectuate them.

III. Collection of Information Requirements

In the September 2022 proposed rule, we projected both new burden and savings based on how the rule would change respondents' efforts relative to the status quo. However, the proposed rule referenced Office of Management and Budget (OMB) control numbers that we now believe do not cover certain longstanding provisions of the Medicaid and CHIP programs related to eligibility and enrollment. Specifically, because the Medicaid program predates the enactment of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), and because we viewed many longstanding basic Medicaid requirements as exempt from the PRA, burden for the following requirements were not historically subjected to the requirements of the PRA and therefore are not covered by the OMB control numbers referenced in the September 2022 proposed rule: application (burden on State in processing the application and burden on individual in filling out application); requests for additional information (burden on State in assessing application and burden on individual in responding to State); making eligibility determinations and providing appeal rights (burden on State in making determinations and burden on individual if filing appeal); verifying information in the application (burden on State in conducting verifications and burden on individual in supplying supporting documentation); and renewal process (burden on State in conducting renewals and burden on individual in responding to State). We are addressing that oversight by moving our burden and savings estimates to the Regulatory Impact Analysis (RIA) section of this final rule. We will be bringing the longstanding Medicaid requirements and what was thought to be exempt into compliance with the PRA outside of this rulemaking. That effort will include the publication of **Federal Register** notices with 60- and 30-day comment periods to allow for public comment on the estimates of this final rule's impact.

In addition to the above-mentioned restructuring of the burden estimates from the proposed rule to final rule, the finalization of certain proposed collection of information requirements were separately addressed in the 2023 Streamlining MSP Enrollment final rule. The provisions were specific to individuals dually eligible for both Medicaid and Medicare and include: Information Collection Requests (ICRs) Regarding Facilitating Enrollment Through Medicare Part D Low-Income Subsidy ''Leads'' (§§ 435.601, 435.911, and 435.952), 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), and ICRs Regarding Automatically Enrolling Certain SSI Recipients Into the Qualified Medicare Beneficiaries Group (§ 435.909).

IV. Regulatory Impact Analysis

We received one public comment on the RIA section of the September 2022 proposed rule, which we summarize and respond to here.

Comment: One commenter recommended that CMS include in its RIA more qualitative estimates of the positive impacts of this final rule, in addition to quantitative estimates of administrative spending and spending due to increased enrollment as well as savings to States and beneficiaries. Specifically, the commenter suggested that we highlight the improved health and economic outcomes for beneficiaries of increased enrollment and decreased churn. Likewise, the commenter urged CMS to describe the distributive impacts of the rule as well as the positive effects on health equity.

Response: We agree that we anticipate unquantified positive impacts on beneficiaries as a result of States implementing the policies in this final rule. As discussed in the background section of this final rule and in response

to similar comments in section II. of this preamble, Medicaid and CHIP play a key role in the United States health care system. These programs make it possible for tens of millions of Americans to access the health care services they need. While Medicaid and CHIP coverage can have a huge impact on the individuals served by these programs, we agree that the full value of the programs goes well beyond the individual beneficiaries.

Again, we agree with commenters that the streamlined eligibility and enrollment processes established by this rule will reduce the enrollment churn of eligible individuals on and off Medicaid and CHIP. Commenters noted that a reduction in enrollment churn will not only improve the health of beneficiaries, but it will also protect individual beneficiaries, and their families, from medical debt and associated stressors. We agree with commenters that reduced enrollment churn has the potential to reduce administrative burdens for beneficiaries and their health care providers, improve the ability of beneficiaries and their providers to form lasting relationships, and reduce the need for high-cost interventions that can result from delayed care. We also agree with comments on the broader community impact of this rule. We believe that healthier beneficiaries can be more productive in their homes, their work, and their communities.

We also received one comment specifically related to the rule's collection of information requirements. The comment and our response can be found below.

Comment: One commenter questioned whether the cost savings that CMS claimed that States should achieve once automation is in place are meaningful, since, in many States, most of the Medicaid operations are automated other than the non-MAGI caseloads. According to the commenter, the system, policy, and procedural updates required to implement this rule will need to be prioritized and developed over several years. For example, a small to medium build can take up to 12 months, while a significant build can take 24–36 months, depending on the complexity of the systems and the number of competing priorities. States' challenges include staff turnover and competing priorities, and any administrative savings from this rule would take additional years to realize.

Response: We understand that State system updates, such as those needed to accept applications and supplemental forms via additional modalities, will take time and resources. However, we find this to be a reasonable investment given the reduction in beneficiary burden that will result from being able to submit required information in whatever modality best fits the needs of the applicant or beneficiary. Additionally, while encouraged, there is no requirement for States to integrate non-MAGI with MAGI systems but rather to make non-MAGI renewals possible through the same modalities—for example, paper, phone, web-based—as MAGI renewals. We do recognize the operational challenges States face and are finalizing these requirements so that they are effective using a phased approach (see section II.F for a list of compliance dates for each provision in this final rule).

We remind States that enhanced FFP is available, in accordance with § 433.112(b)(14), at a 90 percent matching rate for the design, development, or installation of improvements to Medicaid eligibility determination systems, in accordance with applicable Federal requirements. Enhanced FFP is also available at a 75 percent matching rate for operations of such systems, in accordance with applicable Federal requirements.

A. Statement of Need

We have learned through our experiences in working with States and other interested parties 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 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 final rule will 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 Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 on Modernizing Regulatory Review (hereinafter, the Modernizing E.O.) (April 6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 on Regulatory Planning and Review and 13563 on Improving Regulation and Regulatory Review 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). The Modernizing E.O. amends section 3(f)(1) of Executive Order 12866. The amended 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 $200 million or more in any 1 year (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (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) raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

OIRA must be prepared for major rules with significant regulatory action(s) or with economically significant effects ($200 million or more in any 1 year). Based on our estimates,

the OIRA has determined this rulemaking is significant per section 3(f)(1) as measured by the $200 million or more in any 1-year threshold, and hence is also a major rule under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act). 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 final rule is estimated to be $45.15 billion (in real FY 2024 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 $37.39 billion paid by the Federal Government and $23.20 billion paid by the States, and a reduction of $15.44 billion in Federal Marketplace subsidies.

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 $9.0 million to $47.0 million in any one year. Individuals and States are not included in the definition of a small entity. Since this final rule would only impact States and individuals, we do not believe that this final rule will have a significant economic impact on a substantial number of small businesses.

In addition, section 1102(b) of the Act requires us 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 604 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 final 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 final rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act (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 2024, that is approximately $183 million. We believe that this final rule would have such an effect on spending by State, local, or tribal governments but not by private sector entities.

C. 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 2024 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. We have assumed that the effective date of the rule would be October 1, 2024, with provisions being effective on the schedule described in this rule. In addition, we have relied on the data sources and assumptions described in the next section to develop estimates for specific provisions of this final rule.

D. Anticipated Effects

To derive average administrative burdens for each provision in this rule, we used data from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates (*https://www.bls.gov/oes/2022/may/oes_nat.htm*). Table 3 presents BLS' mean hourly wage along with our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary) and our adjusted hourly wage.

TABLE 3: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	40.04	40.04	80.08
Computer Programmer	15-1251	49.42	49.42	98.84
Database and Network Administrator and Architect	15-1240	53.08	53.08	106.16
Eligibility Interviewers, Government Programs	43-4061	24.05	24.05	48.10
General and Operations Mgr.	11-1021	59.07	59.07	118.14
Interpreter and Translator	27-3091	29.68	29.68	59.36
Management Analyst	13-1111	50.32	50.32	100.64
Procurement Clerks	43-3061	22.38	22.38	44.76

States: To estimate State costs, it was important to take into account the Federal Government's contribution to the cost of administering the Medicaid and CHIP programs. The Federal Government provides funding based on a 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 in this final rule, 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 and CHIP 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.

Beneficiaries: We believe that the cost for beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $21.98/hr. While we used BLS wage data to estimate the cost of our proposed provisions, this final rule uses the Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices,[25] which identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for beneficiaries, we used a measurement of the usual weekly earnings of wage and salary workers of $1,059 [26] for 2022, divided by 40 hours to calculate an hourly pre-tax wage rate of $26.48/hr. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent or $4.50/hr ($26.48/hr × 0.17), resulting in the post-tax hourly wage rate of $21.98/hr ($26.48/hr − $4.50/hr). Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs, since the individuals' activities, if any, would occur outside the scope of their employment.

Total Administrative Burden and Savings: As outlined in Table 4, in total, we expect this rule will result in a one-time administrative burden of 53,409 labor hours for States and savings of minus 7,207,971 labor hours for beneficiaries, as well as $2,589,410 in one-time spending for States and one-time savings of minus $158,431,203 for beneficiaries. However, we also expect the rule to result in annual reductions in administrative burden of minus 3,048,036 labor hours for States and minus 21,859,547 labor hours for beneficiaries, as well as an annual reduction of minus $66,014,177 in spending by States and minus $480,472,849 by beneficiaries.

BILLING CODE 4120–01–P

[25] *https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//176806/VOT.pdf.*

[26] *https://fred.stlouisfed.org/series/LEU0252881500A.*

TABLE 4: Total Annual and One-Time Administrative Burden and Savings for States and Individuals

	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)
State Total - Annual	56	44,313,473	Varies	(3,048,036)	Varies	$(139,751,180)	$(66,014,177)	n/a	$ 7,722,826
Individual Total - Annual	56	13,312,392	Varies	(21,859,547)	$ 21.98	n/a	n/a	$(480,472,849)	$ (27,883,860)
State Total – One-Time	56	730	Varies	53,409	Varies	$ 5,178,502	$ 2,589,410	n/a	n/a
Individual Total - One-Time	56	3,603,986	Varies	(7,207,971)	$ 21.98	n/a	n/a	$ (158,431,203)	n/a

BILLING CODE 4120–01–C

1. Facilitating Enrollment by Allowing Medically Needy Individuals To Deduct Prospective Medical Expenses (§ 435.831(g))

The amendments under § 435.831(g) will permit States to project medical expenses of noninstitutionalized individuals that the State can determine with reasonable certainty will be constant and predictable 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 individual or State agency. Over time, this will reduce the burden on the State by making the spenddown process much more predictable for many noninstitutionalized individuals in the medically needy group. This will also reduce the burden on the individual who will not need to wait for coverage until they've reached their spenddown each budget period but instead will remain continuously enrolled while their medical expenses remain predictable. However, there will 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 reconsider financial eligibility each budget period once the spenddown amount is reached.

This provision is only relevant to the 36 States that have opted to cover the medically needy or are 209(b) States, and it is optional for those States. Assuming all 36 States take up the option, we estimate that 36 States will 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 reconsider financial eligibility each month once the spenddown amount is reached. We estimate it will take an average of 200 hours per State to develop and code the changes to utilize projected noninstitutional expenses when determining financial eligibility for medically needy individuals. Of those 200 hours, we estimate it will take a Database and Network Administrator and Architect 50 hours at $106.16/hr and a Computer Programmer 150 hours at $98.84/hr. Therefore, we estimate a one-time burden of 7,200 hours (36 States × 200 hr) at a cost of $724,824 (36 States × [(50 hr × $106.16/hr) + (150 hr × $98.84/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 will be $362,412 ($724,824 × 0.5).

We estimate that under new § 435.831(g), each of all 36 States will no longer need to collect information each budget period on the incurred medical expenses for 25 beneficiaries in the medically needy or mandatory 209(b) groups annually. We estimate it currently takes an Eligibility Interviewer, Government Programs, 2 hours at $48.10/hr and an Interpreter and Translator 1 hour at $59.36/hr to review the incurred medical expenses submitted for 6 months per year per beneficiary. Therefore, each State will save minus 450 hours (−3 hr × 6 months/year × 25 beneficiaries) and minus $23,334 (6 months/year × −25 beneficiaries × [(2 hr × $48.10/hr) + (1 hr × $59.36/hr)]) annually by not processing such incurred expenses each budget period for each individual in the medically needy or mandatory 209(b) groups. In aggregate, we estimate this provision will save all 36 States minus 16,200 hours (−450 hr × 36 States) and minus $840,024 (−$23,334 × 36 States). When taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings will be minus $420,012 (−$840,024 × 0.5).

Likewise, we estimate that under new § 435.831(g), those same 25 beneficiaries will no longer need to submit evidence of the incurred medical expenses that their States have designated as being reasonably constant and predictable but instead will remain continuously enrolled and reconcile actual expenses with projected expenses periodically, thus reducing the burden on the individuals. We estimate that it currently takes a beneficiary 2 hours at $21.98/hr to submit information each budget period in an average of 6 months per year. Therefore, beneficiaries in each State will save a total of minus 300 hours (−2 hr × 6 months/year × 25 beneficiaries/State) and minus $6,594 (−300 hr × $21.98/hr) annually. In aggregate, under this provision, beneficiaries across all 36 States will save minus 10,800 hours (−300 hr × 36 States) and minus $237,384 (−$6,594 × 36 States) annually.

When taking into account the Federal contribution, we estimate a one-time State savings of minus $57,600 ($362,412 − $420,012).

TABLE 5: Administrative Burden and Savings for States and Individual from Changes to § 435.831(g)

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.831(g)	36	900	(12)	(10,800)	$ 21.98	n/a	n/a	$ (237,384)	n/a	Annual
§ 435.831(g)	36	900	(18)	(16,200)	Varies	$ (840,024)	$ (420,012)	n/a	n/a	Annual
§ 435.831(g)	36	36	200	7,200	Varies	$724,824	$362,412	n/a	n/a	One-Time
§ 435.831(g) - Individual Subtotal	***36***	***900***	***(12)***	***(10,800)***	***$ 21.98***	***n/a***	***n/a***	***$ (237,384)***	***n/a***	***Annual***
§ 435.831(g) - State Subtotal	***56***	***936***	***Varies***	***(9,000)***	***Varies***	***$ (115,200)***	***$ (57,600)***	*n/a*	*n/a*	***Both***

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

States have inquired about 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 under §§ 435.952 and 435.940 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 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 changes to §§ 435.952 and 435.940, we estimate that the States will save an Eligibility Interviewer 1 hour per beneficiary at $48.10/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 minus 510,000 hours (51 States × 10,000 individuals/State × −1 hr) and minus $24,531,000 (−510,000 hr × $48.10/hr). When taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings will be minus $12,265,500 (−$24,531,000 × 0.5).

Under the changes to §§ 435.952 and 435.940, we estimate that 10,000 individuals per State will save on average 1 hour each at $21.98/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 $11,209,800 (−510,000 hr × $21.98/hr).

TABLE 6: Administrative Burden and Savings for States and Individual from Changes to §§ 435.952 and 435.940

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.952 and 435.940 - Individual Subtotal	51	510,000	(1)	(510,000)	$ 21.98	n/a	n/a	$ (11,209,800)	n/a	Annual
§§ 435.952 and 435.940 - State Subtotal	51	510,000	(1)	(510,000)	$ 48.10	$ (24,531,000)	$ (12,265,500)	n/a	n/a	Annual

3. Verification of Citizenship and Identity (§ 435.407)

The amendments under § 435.407 will simplify eligibility verification procedures by considering verification of birth with a State vital statistics agency or verification of citizenship with DHS SAVE as stand-alone evidence of citizenship. Likewise, under this provision, separate verification of identity will not be required. This 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 will apply to the roughly 100,000 applicants per year for whom States cannot verify U.S. citizenship with SSA.

We estimate that the amendments under § 435.407 will take a Management Analyst 15 minutes (0.25 hr) per applicant at $100.64/hr to check with the State's vital statistics agency for verification of U.S. citizenship of an applicant. In aggregate for all 56 States, this provision will add a burden of 25,000 hours (0.25 hr × 100,000 applicants) at a cost of $2,516,000 (25,000 hr × $100.64/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $1,258,000 ($2,516,000 × 0.5).

In contrast, we estimate that the amendments under § 435.407 will save an Eligibility Interviewer 45 minutes (0.75 hr) at $48.10/hr by no longer needing to request and process paper documentation to verify identity. In aggregate, all 56 States will save minus 75,000 hours (0.75 hr × − 100,000 applicants) and minus $3,607,500 (− 75,000 hr × $48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings will be minus $1,803,750 (− $3,607,500 × 0.5).

When taking into account the Federal contribution, we estimate a total annual State savings of minus $545,750 ($1,258,000 − $1,803,750).

For individuals, we estimate that the amendments under § 435.407 would save each applicant 1 hour at $21.98/hr plus an average of approximately $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 to verify identity. In aggregate, all 100,000 applicants would save 100,000 hours (1 hr × − 100,000 applicants) and minus $2,198,000 (− 100,000 hr × $21.98/hr) in labor and minus $1,000,000 ($10.00 × − 100,000 applicants) in non-labor related costs.

TABLE 7: Administrative Burden and Savings for States and Individual from Changes to § 435.407

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.407	56	100,000	(1)	(100,000)	$ 21.98	n/a	n/a	$ (2,198,000)	($1,000,000)	Annual
§ 435.407	56	100,000	(1)	(75,000)	$ 48.10	$ (3,607,500)	$ (1,803,750)	n/a	n/a	Annual
§ 435.407	56	100,000	0	25,000	$ 100.64	$ 2,516,000	$ 1,258,000	n/a	n/a	Annual
§ 435.407 - Individual Subtotal	***56***	***100,000***	***(1)***	***(100,000)***	***$ 21.98***	***n/a***	***n/a***	***$ (2,198,000)***	***(1,000,000)***	***Annual***
§ 435.407 - State Subtotal	***56***	***200,000***	***Varies***	***(50,000)***	***Varies***	***$ (1,091,500)***	***$ (545,750)***	n/a	n/a	***Annual***

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

The amendments under § 435.916(a) will 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. Section 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. Section 435.916(b)(2) will require States to provide all beneficiaries, including non-MAGI beneficiaries, whose eligibility cannot be renewed without contacting the individual in accordance with § 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. Section 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) had 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 conducted 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 § 435.916(a), we estimate it will 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 will take a Database and Network Administrator and Architect 50 hours at $106.16/hr and a Computer Programmer 150 hours at $98.84/hr. In aggregate, we estimate a one-time burden of 1,200 hours (6 States × 200 hr) at a cost of $120,804 (6 States × [(50 hr × $106.16/hr) + (150 hr × $98.84/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 will be $60,402 ($120,804 × 0.5).

We also estimate that 21 States do not pull available non-MAGI beneficiary information to prepopulate a renewal form.[27] Under § 435.916(b)(2), we estimate it will 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 will take a Business Operations Specialist 50 hours at $80.08/hr and a Management Analyst 150 hours at $100.64/hr. In aggregate, we estimate a one-time burden of 4,200 hours (21 States × 200 hr) at a cost of $401,100 (21 States × [(50 hr × $80.08/hr) + (150 hr × $100.64/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 will be $200,550 ($401,100 × 0.5).

While we do not have evidence of how many States currently require an in-person or telephone 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[28] for whom States will no

[27] 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.*

[28] Major Eligibility Group Information for Medicaid and CHIP Beneficiaries by Year, accessed

Continued

longer need to conduct an in-person interview as part of the renewal process. Under § 435.916(b)(2), we estimate that an Eligibility Interviewer will save on average 0.5 hours per beneficiary at $48.10/hr. In aggregate, we estimate this will save States minus 1,344,193 hours (0.5 hr × −2,688,386 beneficiaries) and minus $64,655,683 (−1,344,193 hr × $48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings will be minus $32,327,842 (−$64,655,683 × 0.5).

In total for the burdens related to § 435.916, taking into account the Federal contribution, we estimate an annual State savings of minus $32,327,842 with a one-time cost of $260,952 ($200,550 + $60,402).

We estimate that in the aforementioned six States 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 [29] who would no longer need to submit a renewal under § 435.916(a). Assuming impacted beneficiaries are evenly distributed across these six States, and assuming it currently takes each beneficiary 1 hour at $21.98/hr to submit a renewal form, in aggregate, beneficiaries across these six States will save minus 2,688,386 hours (−2,688,386 non-MAGI beneficiaries × 1 hr) and minus $59,090,724 (−2,688,386 hr × $21.98/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 [30] who will no longer need to travel to a Medicaid office to complete an in-person interview in order to maintain coverage under § 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 will save minus 2,688,386 hours (−2,688,386 beneficiaries × 1 hr) and minus $59,090,724 (−2,688,386 hr × $21.98/hr) in labor and minus $26,883,860 (−2,688,386 non-MAGI beneficiaries × $10.00) in non-labor related costs for a total savings of minus $85,974,584 (−$59,090,724 − $26,883,860).

Under § 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 [31] 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.[32] Therefore, we estimate 74,603 beneficiaries (2,688,386 beneficiaries/56 States × 0.042 × 37 States) will newly not need to complete a full application to reenroll in coverage because they will be in a 90-day reconsideration period under § 435.916(b)(2). Assuming impacted beneficiaries are evenly distributed across the 37 States and assuming it currently takes each beneficiary 1 hour at $21.98/hr to submit a new full application, this provision will save, in aggregate, beneficiaries across these 37 States a total of minus 74,603 hours (−74,603 beneficiaries × 1 hr) and minus $1,639,774 (−74,603 hr × $21.98/hr).

For beneficiaries, we estimate a total burden reduction of minus 5,451,375 hours (−2,688,386 hr −2,688,386 hr −74,603 hr) and minus $146,705,082 (−$59,090,724 − $85,974,584 −$1,639,774).

BILLING CODE 4120–01–P

from: *https://data.medicaid.gov/dataset/267831f3-56d3-4949-8457-f6888d8babdd.*

[29] Ibid.

[30] Ibid.

[31] Ibid.

[32] 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/.*

TABLE 8: Administrative Burden and Savings for States and Individual from Changes to § 435.916

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.916	37	74,603	(1)	(74,603)	$ 21.98	n/a	n/a	$ (1,639,768)	n/a	Annual
§ 435.916	6	2,688,386	(1)	(2,688,386)	$ 21.98	n/a	n/a	$ (59,090,724)	n/a	Annual
§ 435.916	56	2,688,386	(1)	(2,688,386)	$ 21.98	n/a	n/a	$ (59,090,724)	- $26,883,860	Annual
§ 435.916	56	2,688,386	(1)	(1,344,193)	$ 48.10	$ (64,655,683)	$ (32,327,842)	n/a	n/a	Annual
§ 435.916	21	21	200	4,200	Varies	$401,100	$200,550	n/a	n/a	One-Time
§ 435.916	6	6	200	1,200	Varies	$120,804	$60,402	n/a	n/a	One-Time
§ 435.916 - Individual Subtotal	***56***	***5,451,375***	***(1)***	***(5,451,375)***	***$ 21.98***	n/a	n/a	***$ (119,821,216)***	***$ (26,883,860)***	***Annual***
§ 435.916 - State Subtotal	***56***	***2,688,413***	***Varies***	***(1,338,793)***	***Varies***	***$ (64,133,779)***	***$ (32,066,890)***	n/a	n/a	***Both***

BILLING CODE 4120–01–C

5. Acting on Changes in Circumstances (§§ 435.916, 435.919, and 457.344)

The amendments under § 435.919 will, 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 will 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 requirements under §§ 435.912, 435.919, and 457.344 will result in more time for beneficiaries to respond to the State's request for additional information, it is likely that fewer beneficiaries will lose eligibility as a result of this provision. As well, because the amendments will, 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) [33] to submit additional information to maintain their eligibility, it is likely that beneficiaries will not need to complete and States will 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.[34]

Assuming the 40 States with a separate CHIP agency can adapt language from the Medicaid notice for their purposes, we estimate it will 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 at least 30 calendar days to respond. Therefore, we estimate it will 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 will take a Business Operations Specialist 4 hours (and 2 hr for CHIP) at $80.08/hr and a Management Analyst 2 hours (and 1 hr for CHIP) at $100.64/hr. We estimate one-time burden of 306 hours for Medicaid (51 Medicaid States [35] × 6 hr) and 120 hours for CHIP (40 CHIP States × 3 hr) at a cost of $26,602 for Medicaid (51 States × [(4 hr × $80.08/hr) + (2 hr × $100.64/hr)]) and $10,432 for CHIP (40 States × [(2 hr × $80.08/hr) + (1 hr × $100.64/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 shares will be $13,301 for Medicaid ($26,602 × 0.5) and $5,216 for CHIP ($10,432 × 0.5).

We also estimate it will 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

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

[34] 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/.*

[35] 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.*

to include language allowing the beneficiary a 90-day reconsideration period. Of those 6 hours, we estimate it will take a Business Operations Specialist an average of 4 hours at $80.08/hr and a Management Analyst 2 hours at $100.64/hr. In aggregate, we estimate a one-time burden of 336 hours (56 States × 6 hr) at a cost of $29,210 (56 States × [(4 hr × $80.08/hr) + (2 hr × $100.64/hr)]) for revising the termination notice. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $14,605 ($29,210 × 0.5).

We also estimate that it will save each State 50 hours to process full applications annually for beneficiaries who will no longer lose coverage and later reenroll. Specifically, we estimate it will save an Eligibility Interviewer 40 hours at $48.10/hr and an Interpreter and Translator 10 hours at $59.36/hr. In aggregate, we estimate an annual savings of minus 2,800 hours (56 States × −50 hr) and minus $140,986 ([(40 hr × $48.10/hr) + (10 hr × $59.36/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 will be minus $70,493 (−$140,986 × 0.5).

When taking into account the Federal contribution, we estimate a total State savings of minus $37,371 ($13,301 + $5,216 + $14,605 − $70,493).

We estimate that it will save each beneficiary who is disenrolled after a change in circumstance 2 hours at $21.98/hr to no longer submit a full application. As stated above under burden #4, approximately 4.2 percent of beneficiaries are disenrolled from coverage and reenroll within 90 days.[36] 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),[37] we estimate approximately 3,603,986 beneficiaries (85,809,179 beneficiaries × 0.042) will save this time not reapplying after a change in circumstance. In aggregate, we estimate that this provision will save beneficiaries minus 7,207,972 hours (−3,603,986 beneficiaries × 2 hr) and minus $158,431,225 (−7,207,972 hr × $21.98/hr).

BILLING CODE 4120–01–P

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

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

TABLE 9: Administrative Burden and Savings for States and Individual from Changes to §§ 435.916, 435.919, and 457.344

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.916, 435.919, and 457.344	56	3,603,986	(2)	(7,207,971)	$ 21.98	n/a	n/a	$ (158,431,203)	n/a	Annual
§§ 435.916, 435.919, and 457.344	56	56	(50)	(2,800)	$ 48.10	$ (140,986)	$ (70,493)	n/a	n/a	Annual
§§ 435.916, 435.919, and 457.344	40	40	3	120	$ 80.08	$10,432	$5,216	n/a	n/a	One-Time
§§ 435.916, 435.919, and 457.344	51	51	6	306	$ 80.08	$26,602	$13,301	n/a	n/a	One-Time
§§ 435.916, 435.919, and 457.344	56	56	6	336	$ 80.08	$29,210	$14,605	n/a	n/a	One-Time
§§ 435.916, 435.919, and 457.344 - Individual Subtotal	***56***	***3,603,986***	***(2)***	***(7,207,971)***	***$ 21.98***	***n/a***	***n/a***	***$ (158,431,203)***	***n/a***	***One-Time***
§§ 435.916, 435.919, and 457.344 - State Subtotal	***56***	***203***	***Varies***	***(2,038)***	***Varies***	***$ (74,742)***	***$ (37,371)***	n/a	n/a	***Both***

6. Timely Determination and Redetermination of Eligibility in Medicaid (§ 435.912) and CHIP (§ 457.340)

a. State Plan Changes

The amendments in this section will 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 amendments will apply the current requirements that apply at application to redeterminations either at renewal or based on changes in circumstances. 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 amendments will 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 amendments will 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 under § 435.912 will for the first time establish set timeframes for when States must complete existing requirements related to acting on change in circumstances. The amendments will require States to process a redetermination by the end of month that occurs 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 by the end of month that occurs 60 calendar days if the State needs to request additional information from the individual.

We estimate that it will take each State 3 hours to update their Medicaid State plans via a State plan amendment (SPA) to establish timeliness standards for the State to process redeterminations. Of those 3 hours per SPA, we estimate it will take a Business Operations Specialist 2 hours at $80.08/hr and a General Operations Manager 1 hour at $118.14/hr to update and submit each SPA to us for review. In aggregate, we estimate a one-time burden of 168 hours (56 States × 3 hr) at a cost of $15,585 (56 responses × ([2 hr × $80.08/hr] + [1 hr × $118.14/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 will be $7,792 ($15,585 × 0.5).

b. Updating Notices and Systems

We estimate that it will 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 for the State to process their redeterminations. Of those 6 hours, we estimate it will take a Business Operations Specialist 4 hours at $80.08/hr and a Computer Programmer 2 hours at $98.84/hr. In aggregate, we estimate a one-time burden of 336 hours (56 States × 6 hr) at a cost of $29,008 (56 States × ([4 hr × $98.84/hr] + [2 hr × $80.08/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 will be $14,504 ($29,008 × 0.5).

We also estimate it will take an average of 200 hours per State to develop and code the changes to each State's system to update the timeframes for beneficiaries to return additional information and to implement a reconsideration process for beneficiaries who are disenrolled for failure to return information within the newly established timeframes but who return the information within the reconsideration period. Of those 200 hours, we estimate it will take a Business Operations Specialist 50 hours at $80.08/hr and a Management Analyst 150 hours at $100.64/hr. In aggregate, we estimate a one-time State burden of 11,200 hours (56 States × 200 hr) at a cost of $1,069,600 ([(50 hr × $80.08/hr) + (150 hr × $100.64/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 will be $534,800 ($1,069,600 × 0.5).

c. Total State Cost

When taking into account the Federal contribution, we estimate a total one-time State cost of $557,096 ($7,792 + $14,504 + $534,800).

TABLE 10: Administrative Burden and Savings for States and Individual from Changes to §§ 435.912 and 457.340

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.912 and 457.340	56	56	6	336	$ 80.08	$29,008	$14,504	n/a	n/a	One-Time
§§ 435.912 and 457.340	56	56	200	11,200	$ 80.08	$1,069,600	$534,800	n/a	n/a	One-Time
§§ 435.912 and 457.340	56	56	3	168	Varies	$15,585	$7,792	n/a	n/a	One-Time
§§ 435.912 and 457.340 - State Subtotal	***56***	***168***	***209***	***11,704***	***Varies***	***$ 1,114,193***	***$ 557,096***	***n/a***	***n/a***	***One-Time***

7. Agency Action on Updated Address Information (§§ 435.919 and 457.344)

This rule establishes the steps States must take when beneficiary mail is returned to the agency. All States must establish a data exchange to obtain updated beneficiary contact information from the USPS and contracted managed care plans. When updated in-State contact information is found, States must accept that information as reliable, update the beneficiary's case record, and notify the beneficiary of the change. If an in-State change of address is obtained from other data sources and

cannot be confirmed as reliable by information available from USPS or contracted managed care plans, then the State must make a good-faith effort (at least two attempts to contact the beneficiary through at least two different modalities) to confirm the change. When updated out-of-State contact information is obtained from any source, the State must always make a good-faith effort to contact the beneficiary. If the State is unable to confirm that the beneficiary continues to meet State residency requirements, the State must terminate the beneficiary's eligibility, subject to notice and fair hearing rights. When mail is returned with no forwarding address, and the State is unable to obtain a new address (after making a good-faith effort), the State must suspend or terminate the beneficiary's enrollment, or move the beneficiary from a managed care program to fee-for-service Medicaid.

In the September 2022 proposed rule, we estimated that, to implement this provision, States with managed care delivery systems in their Medicaid and CHIP programs would need to update their contracts to enter into regular data sharing arrangements with their managed care plans to obtain up-to-date beneficiary contact information. However, we know now that all States with managed care delivery systems have already done this as a part of their activities to unwind from the COVID–19 PHE, and so we are omitting this burden estimate from this final rule.

In the same September 2022 proposed rule, we estimated, using our 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, the NCOA database, etc., we estimated that it would take 28 States each 40 hours to establish these data-sharing agreements. Through ongoing monitoring of States' activities to unwind from the COVID–19 PHE, we now know that 37 States have waiver authority under section 1902(e)(14)(A) of the Act to check the NCOA database and update beneficiary contact information based on that information without checking with the beneficiary first, and so we no longer need to use a proxy here. We are updating our estimate that the additional burden of implementing this provision will apply to only 19 States (56 States − 37 States with waiver authority) instead of 28, thus reducing the burden. Of those 40 hours, we estimate it will take a Procurement Clerk 10 hours at $44.76/hr and a Management Analyst 30 hours at $100.64/hr. In aggregate, we estimate a one-time burden of 760 hours (40 hr × 19 States) at a cost of $65,869 ([(10 hr × $44.76/hr) + (30 hr × $100.64/hr)] × 19 States). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $32,935 ($65,869 × 0.5).

In the September 2022 proposed rule, we also assumed that 15 percent [38] of all Medicaid beneficiaries (12,871,377 beneficiaries = 85,809,179 beneficiaries × 0.15) [39] generate returned mail each year, and so we estimated that it will 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. However, in this final rule we are amending our proposal, as described in detail in section II.B.4. of this preamble, to only require that States send a single notice by mail to the forwarding address. Therefore, we revise our estimate here to omit the burden for mailing an additional notice to the original address on file. We estimate that it will take a Management Analyst in each State 0.0083 hr/notice at $100.64/hr to program the sending of one extra notice for a total of 106,832 hours (0.0083 hr × 12,871,377 beneficiaries) at a cost of $10,751,616 (106,832 hr × $100.64/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $5,375,808 ($10,751,616 × 0.5). We also estimate this amendment will create additional burden in postage costs for all States totaling $7,722,826 ($0.60/notice [40] × 12,871,377 [41]). When taking into account the 50 percent Federal contribution, the estimated State share will be $3,861,413 ($7,722,826 × 0.5). In aggregate for the above burdens, taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $9,237,221 ($5,375,808 + $3,861,413).

We estimate that it will take an Eligibility Interviewer an average of 5 minutes (0.083 hr) per beneficiary at $48.10/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. Because this final rule permits States to automatically update in-State changes of address when they can be verified by USPS or a contracted managed care plan, we do not believe States will need to conduct additional outreach to all 12.9 million beneficiaries. However, until we have a better understanding of the volume of returned mail that will require such follow-up outreach, we are maintaining our proposed estimate here. In aggregate, we estimate this will add 1,068,324 hours (0.083 hr × 12,871,377 beneficiaries) at a cost of $51,386,398 (1,068,324 hr × $48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $25,693,199 ($51,386,398 × 0.5).

In total, for the burden related to §§ 435.919 and 457.344, when taking into account the 50 percent Federal contribution, we estimate a total State cost of $34,963,355 ($32,935 + $9,237,221 + $25,693,199).

We estimate that current State policies on returned mail may have contributed to a drop of approximately 2.125 percent in enrollment.[42] Applying that change, we estimate that 273,517 beneficiaries in total (12,871,377 beneficiaries × 0.02125), or 5,363 beneficiaries in each of 51 States, will no longer be disenrolled after non-response to a State notice generated by returned mail and will no longer need to reapply to Medicaid. Therefore, we estimate that these amendments will lead to a reduction in burden for 273,517 beneficiaries who will otherwise be disenrolled after generating returned mail. We estimate that these beneficiaries will each save 2 hours of time not needed to reapply for Medicaid at $21.98/hr. In aggregate, we estimate this amendment will save beneficiaries in all States minus 547,034

[38] 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/*.

[39] 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*.

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

[41] 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*.

[42] 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/*.

hours (−273,517 beneficiaries × 2 hr) and minus $12,023,807 (−547,034 hr × $21.98/hr).

TABLE 11: Administrative Burden and Savings for States and Individual from Changes to §§ 435.919 and 457.344

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.919 and 457.344	51	273,517	(2)	(547,034)	$ 21.98	n/a	n/a	$ (12,023,797)	n/a	Annual
§§ 435.919 and 457.344	51	12,871,377	n/a	n/a	n/a	n/a	$ 3,861,413	n/a	$7,722,826	Annual
§§ 435.919 and 457.344	19	19	40	760	$ 44.76	$65,869	$ 32,935	n/a	n/a	One-Time
§§ 435.919 and 457.344	51	12,871,377	0	106,832	$ 100.64	$ 10,751,616	$ 5,375,808	n/a	n/a	Annual
§§ 435.919 and 457.344	51	12,871,377	0	1,068,324	$ 48.10	$ 51,386,398	$ 25,693,199	n/a	n/a	Annual
§§ 435.919 and 457.344 - Individual Subtotal	***51***	***273,517***	***(2)***	***(547,034)***	***$ 21.98***	***n/a***	***n/a***	***$ (12,023,797)***	***n/a***	***Annual***
§§ 435.919 and 457.344 - State Subtotal	***51***	***38,614,150***	***Varies***	***1,175,917***	***Varies***	***$ 62,203,883***	***$ 34,963,354***	n/a	***$ 7,722,826***	***Both***

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

In States with separate Medicaid and CHIP programs, § 435.1200 will require both the Medicaid and CHIP agencies to make system changes to transition the eligibility of individuals more seamlessly 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 § 435.1200 will 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 will take a Procurement Clerk 10 hours at $44.76/hr and a Management Analyst 30 hours at $100.64/hr. In aggregate, we estimate a one-time burden of 1,600 hours (40 hr × 40 States) at a cost of $138,672 [(10 hr × $44.76/hr) + (30 hr × $100.64/hr) × 40 States]. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $69,336 ($138,672 × 0.5).

We estimate that it will 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. Of those 42 hours, we estimate it will take a Business Operations Specialist 22 hours at $80.08/hr and a Management Analyst 20 hours at $100.64/hr. In aggregate, we estimate a one-time burden of 1,680 hours (40 States × 42 hr) at a cost of $150,982 [[(22 hr × $80.08/hr) + (20 hr × $100.64/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 will be $75,491 ($150,982 × 0.5).

We estimate that it will 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 an 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 will take a Business

Operations Specialist 50 hours at $80.08/hr and a Management Analyst 150 hours at $100.64/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 $764,000 ([(50 hr × $80.08/hr) + (150 hr × $100.64/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 will be $382,000 ($764,000 × 0.5).

We estimate that 25 percent of States with a separate CHIP (40 States × 0.25 = 10) are already using combined notices and will 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 will 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 will take a Business Operations Specialist 14 hours at $80.08/hr and a Management Analyst 32 hours at $100.64/hr. In aggregate, we estimate a one-time burden of 1,380 hours (30 States × 46 hr) at a cost of $130,248 ([(14 hr × $80.08/hr) + (32 hr × $100.64/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 will be $65,124 ($130,248 × 0.5).

For the burden related to §§ 435.1200, 457.340, 457.348, 457.350, and 600.330, when taking into account the Federal contribution, we estimate a total cost of $591,951 ($69,336 + $75,491 + $382,000 + $65,124).

We also estimate that this provision will 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 $56,582,586 (−2,574,276 hr × $21.98/hr).

We estimate that it will save each beneficiary 4 hours previously spent reapplying for coverage. Assuming 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 $18,860,862 (−858,092 hr × $21.98/hr).

For beneficiaries, we estimate a total savings of minus $75,443,448 (−$56,582,586 − $18,860,862).

BILLING CODE 4120–01–P

TABLE 12: Administrative Burden and Savings for States and Individual from Changes to §§ 435.1200, 457.340, 457.348, 457.350, and 600.330

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.1200, 457.340, 457.348, 457.350, and 600.330	56	858,092	(3)	(2,574,276)	$ 21.98	n/a	n/a	$ (56,582,586)	n/a	Annual
§§ 435.1200, 457.340, 457.348, 457.350, and 600.330	56	214,523	(4)	(858,092)	$ 21.98	n/a	n/a	$ (18,860,862)	n/a	Annual
§§ 435.1200, 457.340, 457.348, 457.350, and 600.330	40	40	40	1,600	Varies	$138,672	$69,336	n/a	n/a	One-Time
§§ 435.1200, 457.340, 457.348, 457.350, and 600.330	30	30	46	1,380	Varies	$130,248	$65,124	n/a	n/a	One-Time

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.1200, 457.340, 457.348, 457.350, and 600.330	40	40	42	1,680	Varies	$150,982	$75,491	n/a	n/a	One-Time
§§ 435.1200, 457.340, 457.348, 457.350, and 600.330	40	40	200	8,000	Varies	$764,000	$382,000	n/a	n/a	One-Time
§§ 435.1200, 457.340, 457.348, 457.350, and 600.330 - Individual Subtotal	***56***	***1,072,615***	***Varies***	***(3,432,368)***	***$ 21.98***	n/a	n/a	***$ (75,443,449)***	n/a	***Annual***
§§ 435.1200, 457.340, 457.348, 457.350, and 600.330 - State Subtotal	***40***	***150***	***Varies***	***12,660***	***Varies***	***$ 1,183,902***	***$ 591,951***	n/a	n/a	***One-Time***

BILLING CODE 4120–01–C

9. Eliminating Requirement To Apply for Other Benefits (§ 435.608)

This rule removes 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.[43] 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 applied for a benefit solely to obtain or keep Medicaid coverage.

If we estimate that, in a year, 5 percent of beneficiaries need to apply for another benefit, that will be 2,300,000 people who are no longer required to apply due to the removal of 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 we did not estimate the burden reduction for Medicaid and CHIP.

We estimate it will 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 will take a Database and Network Administrator and Architect 50 hours at $106.16/hr and a Computer Programmer 150 hours at $98.84/hr. For States, we estimate a total one-time burden of 11,200 hours (56 States × 200 hr) at a cost of $1,127,504 ([(50 hr × $106.16/hr) + (150 hr × $98.84/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 will be $563,752 ($1,127,504 × 0.5).

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

TABLE 13: Administrative Burden and Savings for States and Individual from Changes to § 435.608

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.608 - State Subtotal	*56*	*56*	*200*	*11,200*	*Varies*	*$1,127,504*	*$563,752*	*n/a*	*n/a*	*One-Time*

10. 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. We are finalizing the proposal to revise § 435.956(b)(4) to remove the option for States to establish limits on the number of ROPs. Under revised § 435.956(b)(4), all 56 States will be prohibited from imposing limitations on the number of ROPs that an individual may receive.

Since the option was established, 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, we have not received any inquiries about establishing such a limitation. Therefore, we estimate that the amendments to § 435.956(b)(4) will not lead to any change in burden on States.

11. Eliminating Requirement To Apply for Other Benefits (§§ 435.608 and 436.608)

We anticipate a reduction in administrative burden for States resulting from the elimination of the requirement to apply for other benefits outlined in the preamble of this final rule. Specifically, we estimate that this provision would save State Eligibility Interviewers on average 1 hour per enrollee at $48.10/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 $110,630,000 (2,300,000 hrs × $48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $55,315,000.

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 $21.98/hr. In aggregate, we estimate that enrollees in all States would save minus 4,600,000 hours (2 hrs × 2,300,000 enrollees) and minus $101,108,000 (4,600,000 hrs × $21.98/hr) annually.

BILLING CODE 4120–01–P

TABLE 14: Administrative Burden and Savings for States and Individual from Changes to §§ 435.608 and 436.608

Regulation Section(s)	# of Respondants (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total Labor Cost ($)	Total State Share ($)	Total Beneficiary Time (Hours)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.608 and 436.608	56	2,300,000	1	(2,300,000)	$ 48.10	$ (110,630,000)	$ (55,315,000)	n/a	n/a	n/a	Annual
§§ 435.608 and 436.608	56	56	200	11,200	$ 98.84	$ 1,127,504	$ 563,752	n/a	n/a	n/a	One-Time
§§ 435.608 and 436.608 - Individual Subtotal	56	2,300,000	2	(4,600,000)	$ 21.98	n/a	n/a	(4,600,000)	$ (101,108,000)	n/a	Annual
§§ 435.608 and 436.608 - State Subtotal	56	2,300,056	Varies	(2,288,800)	Varies	(109,502,496)	(54,751,248)	(4,600,000)	$ (101,108,000)	n/a	Both

BILLING CODE 4120–01–C

12. Recordkeeping (§§ 431.17 and 457.965)

The amendments under §§ 431.17 (Medicaid) and 457.965 (CHIP) 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 final rule clearly defines the records, such as the date and basis of any determination and the notices provided to the applicant/beneficiary. Sections 431.17(c) and 457.965(c) establish a minimum records retention period of 3 years, and §§ 431.17(d) and 457.965(d) 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 §§ 431.17(c) and 457.965(c), we estimate it will take an average of 20 hours per State for a Management Analyst at $100.64/hr to update each State's policies and procedures to retain records electronically for 3 years minimum as well as the other changes finalized in this rule. In aggregate, we estimate a one-time burden of 1,120 hours (56 States × 20 hr) at a cost of $112,717 (1,120 hr × $100.64/hr) for completing the necessary updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $56,358 ($112,717 × 0.5).

TABLE 15: Administrative Burden and Savings for States and Individual from Changes to §§ 431.17 and 457.965

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 431.17 and 457.965 - State Subtotal	56	56	20	1,120	$ 100.64	$112,717	$56,358	n/a	n/a	One-Time

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

a. CHIP State Plan Changes

The amendments to §§ 457.570 and 600.525(b)(2) will 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 § 457.570, we estimate it will take a Management Analyst 2 hours at $100.64/hr and a General and Operations Manager 1 hour at $118.14/hr in all 14 States that currently impose lock-out periods to amend their CHIP State plans to remove the lock-out period and submit in the Medicaid Model Data Lab (MMDL) portal for review. We estimate an aggregate one-time burden of 42 hours (14 States × 3 hr) at a cost of $4,472 (([2 hr × $100.64/hr] + [1 hr × $118.14/hr]) × 14 States). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share will be $2,236 ($4,472 × 0.5).

b. BHP Blueprint Changes

Our amendments will require BHP States to revise their BHP Blueprints to remove the premium lock-out period. Under § 600.525(b)(2), in the one BHP State that imposes a lock-out period, we estimate it will take a Management Analyst 2 hours at $100.64/hr and a General and Operations Manager 1 hour at $118.14/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 $319 (([2 hr × $100.64/hr] + [1 hr × $118.14/hr]) × 1 State).

c. Total State Cost

In total for the burden related to §§ 457.570 and 600.525(b)(2), taking into account the Federal contribution for the CHIP-related changes, we estimate a total one-time cost for the State of $2,555 ($2,236 + $319).

TABLE 16: Administrative Burden and Savings for States and Individual from Changes to §§ 457.570 and 600.525(b)(2)

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 457.570 and 600.525(b)(2)	14	14	3	42	Varies	$4,472	$2,236	n/a	n/a	One-Time
§§ 457.570 and 600.525(b)(2)	1	1	3	3	Varies	$319	$319	n/a	n/a	One-Time
§§ 457.570 and 600.525(b)(2) - State Subtotal	14	15	3	45	Varies	$ 4,791	$ 2,555	n/a	n/a	One-Time

14. Prohibition on Waiting Periods in CHIP (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)

The amendments to §§ 457.65, 457.340, 457.350, 457.805, and 457.810 in the September 2022 proposed rule will 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 amendments will 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 will need to update their applications to eliminate the question requesting attestation of recently lost coverage and all related follow-up questions evaluating 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 will need to update the application to remove the trigger to query the data source.

We estimate it will 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 will take a Database and Network Administrator and Architect 50 hours at $106.16/hr and a Computer Programmer 150 hours at $98.84/hr. In aggregate, we estimate a one-time burden of 2,200 hours (11 States × 200 hr) at a cost of $221,474 ([(50 hr × $106.16/hr) + (150 hr × $98.84/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 will be $110,737 ($221,474 × 0.5).

We estimate it will take an average of 3 hours in each of 11 unique States to update each State's CHIP SPAs in MMDL to eliminate the waiting period and to document the other strategies the States will use to monitor substitution of coverage. We estimate it will take a General and Operations Manager 1 hour at $118.14/hr and a Business Operations Specialist 2 hours at $80.08/hr. In aggregate, we estimate a one-time burden for all States of 33 hours (11 States × 3 hr) and $3,061 ([(1 hr × $118.14/hr) + (2 hr × $80.08/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 will be $1,531 ($3,061 × 0.5).

In total for the burden 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 will be $112,268 ($110,737 + $1,531).

BILLING CODE 4120–01–P

TABLE 17: Administrative Burden and Savings for States and Individual from Changes to §§ 457.65, 457.340, 457.350, 457.805, and 457.810

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total State Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 457.65, 457.340, 457.350, 457.805, and 457.810	11	11	200	2,200	varies	$221,474	$110,737	n/a	n/a	One-Time
§§ 457.65, 457.340, 457.350, 457.805, and 457.810	11	11	3	33	Varies	$3,061	$1,531	n/a	n/a	One-Time
§§ 457.65, 457.340, 457.350, 457.805, and 457.810 - State Subtotal	11	22	Varies	2,233	Varies	$ 224,535	$ 112,268	n/a	n/a	One-Time

BILLING CODE 4120–01–C

15. Prohibiting Annual and Lifetime Limits on Benefits (§ 457.480)

a. Programming Changes to Annual and Lifetime Limits

The amendments to § 457.480 will 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 six 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 amendments will require 13 States to update their systems and their CHIP SPAs to eliminate annual or lifetime benefit limits.

We estimate it will 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 will take a Database and Network Administrator and Architect 5 hours at $106.16/hr and a Computer Programmer 15 hours at $98.84/hr. In aggregate, we estimate a one-time burden across all 13 States of 260 hours (20 hr × 13 States) and $26,174 ([(5 hr × $106.16/hr) + (15 hr × $98.84/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 will be $13,087 ($26,174 × 0.5).

b. Updating CHIP SPAs

The amendments to § 457.480 will require States to submit updated CHIP SPAs. We estimate it will take an average of 3 hours in each of 13 unique States to update each State's CHIP SPAs in MMDL to remove each of 21 different limits on annual and/or lifetime benefits (calculated as 21/13, or approximately 1.62, limits per State if distributed evenly). Of those 3 hours, we estimate it will take a General and Operations Manager 1 hour at $118.14/hr and a Business Operations Specialist 2 hours at $80.08/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 × 3 hr × 1.62 limits/State) and $5,844 ([(1 hr × $118.14/hr) + (2 hr × $80.08/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 will be $2,922 ($5,844 × 0.5).

c. Total State Cost

In total for the burden related to § 457.480, taking into account the 50 percent Federal contribution, we estimate a total one-time State cost of $16,009 ($13,087 + $2,922).

BILLING CODE 4120–01–P

TABLE 18: Administrative Burden and Savings for States and Individual from Changes to § 457.480

Regulation Section(s)	# of Respondents (States)	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Total Labor Cost ($)	Total State Share ($)	Total Beneficiary Time (Hours)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 457.480	13	13	20	260	Varies	$26,174	$13,087	n/a	n/a	n/a	One-Time
§ 457.480	13	21	3	65	Varies	$5,844	$2,922	n/a	n/a	n/a	One-Time
§ 457.480 - State Subtotal	***13***	***34***	***23***	***325***	***Varies***	***$ 32,019***	***$ 16,009***	-	***$ -***	***n/a***	***One-Time***

BILLING CODE 4120–01–C

16. Provisions To Facilitate Medicaid Enrollment

For provisions that would facilitate Medicaid enrollment (including the electronic verification and reasonable compatibility standard; facilitating enrollment by allowing medically needy individuals to deduct prospective medical expenses; 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 2028.

TABLE 19: Impact of Provisions to Facilitate Enrollment on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2024	2025	2026	2027	2028
Enrollment	0.02	0.02	0.02	0.02	0.02
Total Spending	460	460	480	490	500
Federal Spending	260	270	280	280	290

17. 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 final 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, we 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 890,000 person-year equivalents by 2028.

TABLE 20: 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)

	2024	2025	2026	2027	2028
Enrollment	0.12	0.43	0.70	0.88	0.89
Total Spending	1,180	5,210	8,670	11,220	11,450
Federal Spending	720	3,170	5,270	6,820	6,960

18. Eliminating Barriers to Access in Medicaid

We assumed that removing or limiting 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 420,000 person-year equivalents by 2028.

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 21: 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)

	2024	2025	2026	2027	2028
Enrollment	0.20	0.41	0.40	0.41	0.42
Total Spending	2,040	4,080	4,160	4,230	4,320
Federal Spending	1,300	2,570	2,630	2,680	2,740

19. CHIP Changes and Eliminating Access Barriers in CHIP

We estimated that 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 130,000 person-year equivalents by 2028.

TABLE 22: 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)

	2024	2025	2026	2027	2028
Enrollment	0.03	0.09	0.11	0.13	0.13
Total Spending	90	320	380	420	430
Federal Spending	60	220	260	300	310

20. 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 final 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.

To estimate the impacts this final rule would have on Marketplace expenditures, we started by calculating the cost of care and Federal subsidy payments for different households shifting from Medicaid and CHIP to Marketplace coverage. 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 programs was 10 percent—this also considers that some beneficiaries receive all or part of their care outside of managed care delivery systems. 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 Medicaid and CHIP to Marketplace coverage 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 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 this final 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 this final rule. To project costs for future years that would be affected by this final 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 final rule.

TABLE 23: Projected change in Federal Marketplace subsidy expenditures (in millions of 2024 dollars)

	2024	2025	2026	2027	2028
Federal Marketplace subsidies	-1,070	-2,740	-3,490	-4,040	-4,100

There is a wide range of possible savings due to this effect of this final 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 less than estimated here. This uncertainty is addressed in the high and low range estimates provided in the accounting statement (see section IV.F. of this final rule).

21. Total

In total, we project that these provisions would increase Medicaid enrollment by 1.33 million by 2028 and would increase total Medicaid spending by $58,950 million from 2024 through 2028. Of that amount, we estimate that $36,240 million would be paid by the Federal Government and $22,710 million would be paid by the States. We also estimate that CHIP enrollment would increase by 0.13 million by 2028, and that total CHIP expenditures would increase by $1,640 million from 2024 to 2028 ($1,150 Federal and $490 million State costs). Table 24 shows the net impacts for Medicaid and for CHIP.

TABLE 24: Impact of Provisions on Medicaid and CHIP Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

Medicaid	2024	2025	2026	2027	2028	2024-2028
Enrollment	0.34	0.86	1.12	1.32	1.33	
Total Spending	3,680	9,750	13,310	15,940	16,270	58,950
Federal Spending	2,280	6,010	8,180	9,780	9,990	36,240
State Spending	1,400	3,740	5,130	6,160	6,280	22,710
CHIP	2024	2025	2026	2027	2028	2024-2028
Enrollment	0.03	0.09	0.11	0.13	0.13	
Total Spending	90	320	380	420	430	1,640
Federal Spending	60	220	260	300	310	1,150
State Spending	30	100	120	120	120	490

In addition to the effects on Medicaid and CHIP, we have also estimated impacts on the Federal subsidies for Marketplace coverage. Table 25 shows the net impact on Federal spending for Medicaid, CHIP, and Federal Marketplace subsidies.

TABLE 25: Estimated Impacts of the Medicaid and CHIP Eligibility Rule on Federal Spending [Millions of 2024 dollars]

	2024	2025	2026	2027	2028	2024-2028
Medicaid Federal Spending	2,280	6,010	8,180	9,780	9,990	36,240
CHIP Federal Spending	60	220	260	300	310	1,150
Federal Marketplace Subsidies Federal Spending	-1,070	-2,740	-3,490	-4,040	-4,100	-15,440
Total Federal Spending	1,270	3,490	4,950	6,040	6,200	21,950

E. Alternatives Considered

In developing this final rule, the following alternatives were considered:

1. Not Proposing the Rule

We considered not finalizing this rule and maintaining the status quo. However, we believe this final 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 final 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. 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 in section IV.D. of this final rule, as a one-time cost of $56,358) and sought comment on whether States should retain flexibility to maintain records in paper or other formats that reflect evolving technology.

F. Limitations of the Analysis

There are several 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 (and to a lesser extent, CHIP) has 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 final 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 spending in the entire Medicaid program ($839 billion in FY 2022), this is still a relatively narrow range.

G. 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 10 showing the classification of the transfer payments with the provisions of this final 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 IV.D. of this final rule. To address the significant uncertainty related to these estimates, we have assumed that the costs could be 50 percent greater than or less 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 less 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 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 outlooks 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 26.

TABLE 26: Accounting Statement (Millions of 2024 dollars)

Category	Primary estimate	Low estimate	High estimate	Units		
				Year dollars	Discount rate	Period covered
Annualized Monetized Transfers from Federal Government to beneficiaries	$4,220	$2,110	$6,331	2024	7%	2024-2028
	$4,316	$2,158	$6,474	2024	3%	2024-2028
Annualized Monetized Transfers from States to beneficiaries	$4,471	$2,235	$6,706	2024	7%	2024-2028
	$4,566	$2,283	$6,850	2024	3%	2024-2028

H. Waiver Fiscal Responsibility Act Requirements

The Director of OMB has waived the requirements of section 263 of the Fiscal Responsibility Act of 2023 (Pub. L. 118-5) pursuant to section 265(a)(2) of that Act.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on February 27, 2024.

List of Subjects

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 436

Aid to families with dependent children, Grant programs-health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), Virgin Islands.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

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 amends 42 CFR chapter IV as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 1. The authority citation for part 431 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 2. Section 431.10 is amended by—
■ a. Redesignating paragraphs (c)(1)(i)(A)(*2*) and (*3*) as paragraphs (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;

* * * * *

■ 3. 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 chapter 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 chapter.

(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 chapter, 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 chapter.

(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 chapter, 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—

(1) Except as provided in paragraph (c)(2) of this section, 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.

(2) For beneficiaries described in section 1917(a)(1)(B), (b)(1)(B) and (b)(1)(C) of the Act, provide that the records required under paragraph (b) of this section will be retained until the State has satisfied the requirements of section 1917(b) of the Act (relating to estate recovery).

(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) Consistent with paragraph (e) of this section, and to the extent permitted under Federal law, 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 (or longer period specified in the request), except when there is an administrative or other emergency beyond the agency's control.

(e) *Release and safeguarding information.* The agency must provide safeguards that restrict the use or disclosure of information contained in the records described in paragraph (b) of this section in accordance with the requirements set forth in subpart F of this part.

■ 4. Section 431.213 is amended by revising paragraph (d) to read as follows:

§ 431.213 Exceptions from advance notice.

* * * * *

(d) The beneficiary's whereabouts are unknown, and the post office returns mail directed to him indicating no forwarding address (see § 435.919(f)(4) of this chapter for procedures if the beneficiary's whereabouts become known);

* * * * *

§ 431.231 [Amended]

■ 5. Section 431.231 is amended by removing and reserving paragraph (d).

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

■ 6. The authority citation for part 435 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 7. 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 in specified eligibility categories.

* * * * *

■ 8. Section 435.223 is added to read 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.

■ 9. 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 (10) and (12) through (18) as paragraphs (b)(2) through (16), respectively; and

■ d. In newly redesignated paragraph (b)(16), removing the reference ''(17)'' and adding in its place the reference ''(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 (DHS) Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by DHS to verify that an individual is a citizen.

* * * * *

■ 10. Section 435.601 is amended by—

■ a. In paragraph (b)(2), 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 or as permitted under paragraph (f)(1)(ii)(B) of this section, in determining'';

■ b. In paragraph (d)(1) introductory text, 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''; and

■ c. Revising paragraph (f)(1).

The revision reads as follows:

§ 435.601 Application of financial eligibility methodologies.

* * * * *

(f) * * *

(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.

* * * * *

§ 435.608 [Removed and Reserved]

■ 11. Section 435.608 is removed and reserved.

■ 12. 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 of this chapter and expenses for prescription drugs, projected to the end of the budget period at the Medicaid reimbursement rate;

* * * * *

■ 13. 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 paragraph (a) of this section.

(d) *Requesting information from applicants.* (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 applicants with a reasonable period of time of no less than 15 calendar days, measured from the date the agency sends the request, to respond and provide any necessary information;

(ii) Allow applicants to provide requested information through any of the modes of submission specified in paragraph (a) of this section; and

(iii) If the applicant subsequently submits the additional information within 90 calendar days after the date of denial, or a longer period elected by the agency, treat the additional information as a new application and reconsider eligibility in accordance with the application time standards at § 435.912(c)(3) without requiring a new application; and

(2) The agency may not require an in-person interview as part of the application process.

* * * * *

■ 14. Section 435.911 is amended by removing the heading from paragraph (a) and revising paragraph (c) introductory text 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—

* * * * *

■ 15. 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, promptly and without undue delay, for:

(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 in accordance with § 435.919(b)(1) through (5), 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)(6), 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)(1) through (5), cover the period from the date the agency receives information about the reported change, 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)(6), 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 chapter when the agency makes a determination resulting in termination or other action as defined in § 431.201 of this chapter.

(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) 90 calendar days for applicants who apply for Medicaid on the basis of disability; and

(ii) 45 calendar days for all other applicants.

(4) *Standard for renewals.* The redetermination of eligibility at a beneficiary's regularly scheduled renewal may not exceed the end of the beneficiary's eligibility period, except as provided in paragraphs (e) and (c)(4)(i) and (ii) of this section.

(i) In the case of a beneficiary who returns a renewal form less than 30 calendar days prior to the end of the beneficiary's eligibility period, the redetermination of eligibility may not exceed the end of the month following the end of the beneficiary's eligibility period.

(ii) In the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid (the applicable modified adjusted gross income standard described in § 435.911(b)(1) and (2) or another basis) and for whom the agency is considering eligibility on another basis, the eligibility determination on the new basis may not exceed—

(A) 90 calendar days for beneficiaries whose eligibility is being determined on the basis of disability; and

(B) 45 calendar days for all other beneficiaries.

(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) 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;

(ii) 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; or

(iii) In the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid (the applicable modified adjusted gross income standard described in § 435.911(b)(1) and (2) or another basis) and for whom the agency is considering eligibility on another basis—

(A) 90 calendar days following the determination of ineligibility on the current basis, for beneficiaries whose eligibility is being determined on the basis of disability; and

(B) 45 calendar days following the determination of ineligibility on the current basis for all other beneficiaries.

(6) *Standard for redeterminations based on anticipated changes.* The redetermination of eligibility for a beneficiary based on an anticipated change in circumstances may not exceed the end of the month in which the anticipated change occurs, except as provided in paragraphs (e) and (c)(6)(i) and (ii) of this section.

(i) In the case of a beneficiary who returns information or documentation requested pursuant to § 435.919(b)(6) less than 30 calendar days prior to the end of the month in which the anticipated change occurs, the redetermination of eligibility may not exceed the end of the month following the month in which the anticipated change occurs.

(ii) In the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid (the applicable modified adjusted gross income standard described in § 435.911(b)(1) and (2) or another basis) and for whom the agency is considering eligibility on another basis, the eligibility determination on the new basis may not exceed—

(A) 90 calendar days for beneficiaries whose eligibility is being determined on the basis of disability; and

(B) 45 calendar days 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 or benefits as required under § 435.930(b) (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]

■ 16. Section 435.914 is amended by–

■ a. In paragraph (a), 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 chapter''; and

■ b. In paragraph (b) introductory text, removing the phrase ''by a finding of eligibility or ineligibility'' and adding in its place the phrase ''and renewal or redetermination by a finding of eligibility or ineligibility''.

■ 17. 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 chapter, 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).

■ 18. 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 has reliable information about a change in a beneficiary's circumstances that may impact the beneficiary's eligibility for Medicaid, the amount of medical assistance for which the beneficiary is eligible, or the beneficiary's premiums or cost sharing charges. Such redetermination must be completed in accordance with this paragraph (b) and paragraph (e) of this section.

(1) The agency must redetermine eligibility based on available information, if possible. When needed

information is not available, the agency must request such information from the beneficiary in accordance with § 435.952(b) and (c).

(2) Prior to furnishing additional medical assistance or lowering applicable premiums or cost sharing charges based on a reported change:

(i) If the change was reported by the beneficiary, the agency must verify the information in accordance with §§ 435.940 through 435.960 and the agency's verification plan developed under § 435.945(j).

(ii) If the change was provided by a third-party data source, the agency may verify the information with the beneficiary.

(3) If the agency is unable to verify a reported change that would result in additional medical assistance or lower premiums or cost sharing, the agency may not terminate the beneficiary's coverage for failure to respond to the request to verify such change.

(4) Prior to taking an adverse action, as defined in § 431.201 of this chapter, based on information received from a third-party, the agency must request information from the beneficiary to verify or dispute the information received, consistent with § 435.952(d).

(5) If the agency determines that a reported change results in an adverse action, the agency must—

(i) Comply with the requirements at § 435.916(d)(1) (relating to consideration of eligibility on other bases) and (2) (relating to determining potential eligibility for other insurance affordability programs) prior to terminating a beneficiary's eligibility in accordance with this section.

(ii) 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.

(6) If the agency has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, the redetermination of eligibility must be initiated at an appropriate time based on such changes consistent with paragraphs (b)(1) through (5) of this section and the timeliness standards at § 435.912(c)(6).

(c) *Beneficiary response times*—(1) *In general.* The agency must—

(i) Provide beneficiaries with at least 30 calendar 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) *90-day reconsideration period.* If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 calendar 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 updated address information*—(1) *Updated address information received from a third party.* (i) The agency must have a process in place to regularly obtain updated address information from reliable data sources and to act on such updated address information in accordance with paragraphs (f)(2) and (3) of this section.

(ii) The agency may establish a process to obtain updated address information from other third-party data sources and to act on such updated address information in accordance with paragraphs (f)(2) and (3) of this section.

(iii) For purposes of paragraph (f)(1)(i) of this section, reliable data sources include:

(A) Mail returned to the agency by the United States Postal Service (USPS) with a forwarding address;

(B) The USPS National Change of Address (NCOA) database;

(C) The agency's contracted managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs), and PCCM entities as defined in § 438.2 of this chapter, provided the MCO, PIHP, PAHP, PCCM, or PCCM entity received the information directly from or verified it with the beneficiary; and

(D) Other data sources identified by the agency and approved by the Secretary.

(2) *In-State address changes.* The following actions are required when the agency receives updated in-State address information for a beneficiary.

(i) If the information is provided by a reliable data source described in paragraph (f)(1)(iii) of this section, the agency must—

(A) Accept the information as reliable;

(B) Update the beneficiary's case record; and

(C) Notify the beneficiary of the update.

(ii) If the information is provided by a data source not described in paragraph (f)(1)(iii) of this section, the agency must check the agency's Medicaid Enterprise System (MES) and the most recent address information received from reliable data sources described in paragraph (f)(1)(iii) of this section to confirm the accuracy of the information.

(A) If the updated address information is confirmed, the agency must accept the information as reliable in accordance with paragraph (f)(2)(i) of this section.

(B) If the updated address information is not confirmed by the MES or a reliable data source, the agency must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the beneficiary to confirm the information.

(C) If the agency is unable to confirm the updated address information, the agency may not update the beneficiary's address in the case record or terminate the beneficiary's coverage for failure to respond to a request to confirm their address or State residency.

(3) *Out-of-State address changes.* The following actions are required when the agency receives updated out-of-State address information for a beneficiary through the processes described in paragraph (f)(1) of this section.

(i) The agency must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the beneficiary to confirm the information or obtain

information on whether the beneficiary continues to meet the agency's State residency requirement.

(ii) If the agency is unable to confirm that the beneficiary continues to meet State residency requirements, the agency must provide advance notice of termination and fair hearing rights consistent with part 431, subpart E, of this chapter.

(4) *Whereabouts unknown.* The following actions are required when beneficiary mail is returned to the agency with no forwarding address.

(i) The agency must check the agency's MES and the most recently available information from reliable data sources described in paragraph (f)(1)(iii) of this section for additional contact information. If updated in-State address information is available from such a reliable data source, then accept the information as reliable in accordance with paragraph (f)(2)(i) of this section.

(ii) If updated address information cannot be obtained and confirmed as reliable in accordance with paragraph (f)(4)(i) of this section, the agency must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the beneficiary to obtain updated address information.

(iii) If the agency is unable to identify and confirm the beneficiary's address pursuant to paragraph (f)(4)(i) or (ii) of this section and the beneficiary's whereabouts remain unknown, the agency must take appropriate steps to move the beneficiary to a fee-for-service delivery system, or to terminate or suspend the beneficiary's coverage.

(A) If the agency elects to terminate or suspend coverage in accordance with this paragraph (f)(4)(iii), 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, no later than the date of termination or suspension and provide notice of fair hearing rights in accordance with part 431, subpart E, of this chapter.

(B) If whereabouts of a beneficiary whose coverage was terminated or suspended in accordance with this paragraph (f)(4)(iii) become known within the beneficiary's eligibility period, as defined in § 435.916(b), the agency—

(*1*) 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.

(*2*) 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.

(5) *A good-faith effort to contact a beneficiary.* (i) For purposes of this paragraph (f), a good-faith effort includes:

(A) At least two attempts to contact the beneficiary;

(B) Use of two or more modalities (such as, mail, phone, email);

(C) A reasonable period of time between contact attempts; and

(D) At least 30 calendar days for the beneficiary to respond to confirm updated address information, consistent with paragraph (c)(1) of this section.

(ii) If the agency does not have the information necessary to make at least two attempts to contact a beneficiary through two or more modalities in accordance with paragraph (f)(5)(i) of this section, the agency must make a note of that fact in the beneficiary's case record.

■ 19. Section 435.940 is revised to read 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 chapter, 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 chapter and section 1902(a)(19) of the Act.

■ 20. Section 435.952 is amended by revising paragraphs (b), (c) introductory text, and (c)(1) 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 information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual, and resource information obtained through an electronic data match shall be considered reasonably compatible with resource information provided by or on behalf of an individual, if both the information obtained electronically and the information provided by or on behalf of the individual are either above or at or below the applicable standard or other relevant threshold.

* * * * *

■ 21. 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.

* * * * *

■ 22. Section 435.1200 is amended by—

■ a. Revising the heading for paragraph (b) and paragraph (b)(1);

■ b. Revising and republishing paragraph (b)(3);

■ c. Adding paragraph (b)(4);

■ d. Revising paragraphs (c) and (e)(1);

■ e. Adding paragraph (e)(4);

■ f. Revising paragraph (h)(1) and the introductory text of the first paragraph (h)(3)(i); and

■ g. Redesignating the second paragraph (h)(3)(i) 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) Enter into and, upon request, provide to the Secretary one or more agreements with the Exchange, Exchange appeals entity and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to—

(i) Minimize burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for enrollment in a QHP or for one or more insurance affordability programs;

(ii) Ensure compliance with paragraphs (c) through (h) of this section;

(iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under § 435.912, based on the date the application is submitted to any insurance affordability program;

(iv) Provide for a combined eligibility notice and opportunity to submit a joint fair hearing request, consistent with paragraphs (g) and (h) of this section;

(v) If the agency has delegated authority to conduct fair hearings to the Exchange or Exchange appeals entity under § 431.10(c)(1)(ii) of this chapter, provide for a combined appeals decision by the Exchange or Exchange appeals entity for individuals who requested an appeal of an Exchange-related determination in accordance with 45 CFR part 155, subpart F, and a fair hearing of a denial of Medicaid eligibility which is conducted by the Exchange or Exchange appeals entity; and

(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 the requirement of this paragraph (b)(4), 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 this chapter, 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 (c) 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) of this section.

* * * * *

(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 (h)(1)(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 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

■ 23. The authority citation for part 436 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§ 436.608 [Removed and Reserved]

■ 24. Section 436.608 is removed and reserved.

■ 25. Section 436.831 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:

§ 436.831 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 of this chapter and expenses for prescription drugs, projected to the end of the budget period at the Medicaid reimbursement rate;

* * * * *

PART 447—PAYMENTS FOR SERVICES

■ 26.The authority citation for part 447 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1396r–8.

■ 27. Section 447.56 is amended by revising paragraph (a)(1)(v) to read as follows:

§ 447.56 Limitations on premiums and cost sharing.

(a) * * *

(1) * * *

(v) At State option, individuals under age 19, 20 or age 21, eligible under § 435.222 or § 435.223 of this chapter.

* * * * *

PART 457—ALLOTMENTS AND GRANTS TO STATES

■ 28. The authority citation for part 457 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 29. 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, enrollment caps or closed enrollment periods is considered an amendment that restricts eligibility and must meet the requirements in paragraph (b) of this section.

* * * * *

■ 30. Section 457.340 is amended by—

■ a. Revising the heading for paragraph (d) and paragraph (d)(1);

■ b. 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)(ii), (c)(5)(iii), and (c)(6)(ii) 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.

* * * * *

■ 31. 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) of this chapter, as cross-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 has reliable information about a change in an enrollee's circumstances that may impact the enrollee's eligibility for CHIP, the amount of child or pregnancy-related health assistance for which the enrollee is eligible, or the enrollee's premiums or cost sharing charges. Such redetermination must be completed in accordance with paragraph (e) of this section.

(1) The State must redetermine eligibility based on available information, if possible. When needed information is not available, the State must request such information from the enrollee in accordance with § 435.952(b) and (c) of this chapter as referenced in § 457.380(f).

(2) Prior to furnishing additional child or pregnancy-related assistance or lowering applicable premiums or cost sharing charges based on a reported change:

(i) If the change was reported by the enrollee, the State must verify the information in accordance with §§ 435.940 through 435.960 of this chapter and the State's verification plan as referenced in § 457.380.

(ii) If the change was provided by a third-party data source, the State may verify the information with the enrollee.

(3) If the State is unable to verify a reported change that would result in additional child or pregnancy-related health assistance or lower premiums or cost sharing, the State may not

terminate the enrollee's coverage for failure to respond to the request to verify such change.

(4) Prior to taking an action subject to review, as defined in § 457.1130, based on information received from a third-party data source, the State must request information from the enrollee to verify or dispute the information received consistent with § 435.952(d) of this chapter as referenced in § 457.380(f).

(5) If the State determines that a reported change results in an action subject to review, the State must:

(i) 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) Provide notice and State review rights, in accordance with the requirements of § 457.340(e), and subpart K of this part, prior to taking any action subject to review resulting from a change in an enrollee's circumstances.

(6) 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 paragraphs (b)(1) through (5) of this section and the requirements at § 435.912(c)(6) of this chapter as referenced in § 457.340(d)(1).

(c) *Enrollee response times*—(1) *State requirements.* The State must—

(i) Provide enrollees with at least 30 calendar 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.

(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)(1); States must document the reason for delay in the individual's case record.

(d) *Ninety-day reconsideration period.* If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 calendar 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)(1).

(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 updated address information*—(1) *Updated address information received from a third party.* (i) The State must have a process in place to regularly obtain updated address information from reliable data sources and to act on such updated address information in accordance with paragraphs (f)(2) and (3) of this section.

(ii) The State may establish a process to obtain updated address information from other third-party data sources and to act on such updated address information in accordance with paragraphs (f)(2) and (3) of this section.

(iii) For purposes of paragraph (f)(1)(i) of this section, reliable data sources include:

(A) Mail returned to the State by the United States Postal Service (USPS) with a forwarding address;

(B) The USPS National Change of Address (NCOA) database;

(C) The State's contracted MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities as defined in § 457.10, provided the MCO, PIHP, PAHP, PCCM, or PCCM entity received the information directly from or verified it with the enrollee; and

(D) Other data sources identified by the State and approved by the Secretary.

(2) *In-State address changes.* The following actions are required when the State receives updated in-State address information for an enrollee.

(i) If the information is provided by a reliable data source described in paragraph (f)(1)(iii) of this section, the State must—

(A) Accept the information as reliable;

(B) Update the enrollee's case record; and

(C) Notify the enrollee of the update.

(ii) If the information is provided by a data source not described in paragraph (f)(1)(iii) of this section, the State must check the State's Medicaid Enterprise System (MES) and the most recent address information received from reliable data sources described in paragraph (f)(1)(iii) of this section to confirm the accuracy of the information.

(A) If the updated address information is confirmed, the State must accept the information as reliable in accordance with paragraph (f)(2)(i) of this section.

(B) If the updated address information is not confirmed by the MES or a reliable data source, the State must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the enrollee to confirm the information.

(C) If the State is unable to confirm the updated address information, the State may not update the enrollee's address in the case record or terminate the enrollee's coverage for failure to respond to a request to confirm their address or State residency.

(3) *Out-of-State address changes.* The following actions are required when the State receives updated out-of-State address information for an enrollee through the processes described in paragraph (f)(1) of this section.

(i) The State must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the enrollee to confirm the information or obtain information on whether the enrollee continues to meet the State's residency requirement.

(ii) If the State is unable to confirm that the enrollee continues to meet State residency requirements, the State must provide advance notice of termination and individual's rights to a CHIP review consistent with § 457.340(e)(1).

(4) *Whereabouts unknown.* The following actions are required when enrollee mail is returned to the State with no forwarding address.

(i) The State must check the State's MES and the most recently available information from reliable data sources described in paragraph (f)(1)(iii) of this section for additional contact information. If updated in-State address information is available from such a reliable data source, then accept the information as reliable in accordance with paragraph (f)(2)(i) of this section.

(ii) If updated address information cannot be obtained and confirmed as reliable in accordance with paragraph (f)(4)(i) of this section, the State must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the enrollee to obtain updated address information.

(iii) If the State is unable to identify and confirm the enrollee's address pursuant to paragraph (f)(4)(i) or (ii) of this section and the enrollee's whereabouts remain unknown, the State must take appropriate steps to move the enrollee to a fee-for-service delivery system, or to terminate or suspend the enrollee's coverage.

(A) If the State elects to terminate or suspend coverage in accordance with this paragraph (f)(4)(iii), 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).

(B) If whereabouts of an enrollee whose coverage was terminated or suspended in accordance with this paragraph (f)(4)(iii) become known within the enrollee's eligibility period, as defined in § 435.916(b) of this chapter as referenced in § 457.343, the State—

(*1*) Must reinstate coverage back to the date of termination without requiring the individual to provide additional information to verify their eligibility, unless the State has other information available to it that indicates the enrollee may not meet all eligibility requirements.

(*2*) 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.

(5) *A good-faith effort to contact an enrollee.* (i) For purposes of this paragraph (f), a good-faith effort includes:

(A) At least two attempts to contact the enrollee;

(B) Use of two or more modalities (such as, mail, phone, email);

(C) A reasonable period of time between contact attempts; and

(D) At least 30 calendar days for the enrollee to respond to confirm updated address information, consistent with paragraph (c)(1) of this section.

(ii) If the State does not have the information necessary to make at least two attempts to contact an enrollee through two or more modalities in accordance with paragraph (f)(5)(i) of this section, the State must make a note of that fact in the enrollee's case record.

■ 32. Section 457.348 is amended by—

■ a. In paragraph (a)(4), 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. Adding paragraph (a)(6);

■ c. Revising paragraph (b);

■ d. In paragraph (c)(3), removing the reference to ''§ 457.350(i)'' and adding in its place the reference ''§ 457.350(g)''; and

■ e. 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 (b) 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 the requirement in this paragraph (e), the agency may:

(1) Apply the same modified adjusted gross income (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 this chapter, 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.

■ 33. 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, the Basic Health Program (BHP) in accordance with § 600.305(a) of this chapter, 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, including information obtained by the agency from other trusted electronic data sources.

(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) Disenroll 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.

■ 34. 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.

* * * * *

■ 35. Section 457.570 is amended by revising and republishing paragraph (c) to read as follows:

§ 457.570 Disenrollment protections.

* * * * *

(c) The State must ensure that disenrollment policies, such as policies related to non-payment of premiums, do not present barriers to the timely determination of eligibility and

enrollment in coverage of an eligible child in the appropriate insurance affordability program. A State may not—

(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.

* * * * *

■ 36. 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 into CHIP an eligible individual who has been disenrolled from group health plan coverage, Medicaid, or another insurance affordability program. States must conduct monitoring activities to prevent substitution of coverage.

■ 37. 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 waiting periods.* A State may not, under this section, impose a waiting period before enrolling into CHIP premium assistance coverage an eligible individual who has access to, but is not enrolled in, group health plan coverage.

* * * * *

§ 457.960 [Removed]

■ 38. Section 457.960 is removed.

■ 39. 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 all of the following:

(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(b) and (c).

(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 a result of a change in circumstance, 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.

(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.

(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 an electronic format; and

(2) To the extent permitted under Federal law, 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 (or longer period specified in the request), except when there is an administrative or other emergency beyond the agency's control.

(e) *Release and safeguarding information.* The State must provide safeguards that restrict the use or disclosure of information contained in the records described in paragraph (b) of this section in accordance with the requirements set forth in § 457.1110.

■ 40. 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.

■ 41. Section 457.1170 is revised to read as follows:

§ 457.1170 Program specific review process: Continuation of enrollment.

A State must ensure the opportunity for continuation of enrollment and benefits pending the completion of review of the following:

(a) A suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing; and

(b) A failure to make a timely determination of eligibility at application and renewal.

■ 42. 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.

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILIATION

■ 43. 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).

■ 44. 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 Children's Health Insurance Program (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 § 435.1200(d), (e)(1)(ii), and (e)(3) of this chapter and, if applicable, paragraph (c) of this section for BHP eligible individuals.

* * * * *

■ 45. 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.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2024–06566 Filed 3–27–24; 8:45 am]

BILLING CODE 4120–01–P