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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 407, 430, 431, 433, 435, and 457

[CMS-2334-F2]

RIN 0938-AS27

Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP

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

ACTION: Final rule.

SUMMARY: This final rule implements provisions of the Affordable Care Act that expand access to health coverage through improvements in Medicaid and coordination between Medicaid, CHIP, and Exchanges. This rule finalizes most of the remaining provisions from the “Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule” that we published in the January 22, 2013, **Federal Register**. This final rule continues our efforts to assist states in implementing Medicaid and CHIP eligibility, appeals, and enrollment changes required by the Affordable Care Act.

DATES: These regulations are effective on January 20, 2017.

FOR FURTHER INFORMATION CONTACT: Sarah deLone, (410) 786-0615.

Executive Summary

This final rule implements provisions of the Patient Protection and Affordable Care Act of

2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), and the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This final rule codifies in regulation certain statutory eligibility provisions set forth in the Affordable Care Act; changes regulatory requirements to provide states more flexibility to coordinate Medicaid and the Children’s Health Insurance Program (CHIP) eligibility notices, appeals, and other related administrative procedures with similar procedures used by other health coverage programs authorized under the Affordable Care Act; modernizes and streamlines existing rules, eliminates obsolete rules, and updates provisions to reflect the various Medicaid eligibility pathways; and codifies certain CHIPRA eligibility-related provisions, including eligibility for newborns whose mothers were eligible for and receiving Medicaid or CHIP coverage at the time of birth.

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Acronyms and Terms

Because of the many organizations and terms to which we refer by acronym in this final rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

ABP	Alternative Benefit Plans
ACF	U.S. Department of Health and Human Services, Administration for Children and Families
[the] Act	The Social Security Act
AFDC	Aid to Families with Dependent Children
Affordable Care Act	The Affordable Care Act of 2010, which is the collective term for 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)
APTC	Advanced Payment of the Premium Tax Credit
BCCEDP	Breast and Cervical Cancer Early Detection Program
BHP	Basic Health Program
CDC	Centers for Disease Control and Prevention
CE	Continuous Eligibility
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CNMI	Commonwealth of the Northern Mariana Islands
COI	Collection of Information
CSEA	Child Support Enforcement Agency
CSR	Cost-Sharing Reductions

DHS	Department of Homeland Security
DOJ	Department of Justice
DSH	Federal Data Services Hub
EDL	Enhanced Driver's License
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FFE	Federally Facilitated Exchange
FFP	Federal Financial Participation
FPL	Federal Poverty Level
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
ICR	Information Collection Requirements
INA	Immigration and Nationality Act
IRC	Internal Revenue Code of 1986
IRS	Internal Revenue Service
LTSS	Long-Term Care Services and Supports
MAGI	Modified Adjusted Gross Income
MNIL	Medically Needy Income Level
MOE	Maintenance of Effort
MOU	Memorandums of Understanding
MSIS	Medicaid Statistical Information System
OACT	Office of the Actuary
OMB	Office of Management and Budget
PE	Presumptive Eligibility
PRA	Paperwork Reduction Act of 1995

PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
QHP	Qualified Health Plan
RIA	Regulatory Impact Analysis
SAVE	Systematic Alien Verification for Entitlements
SBA	Small Business Administration
SHO	State Health Official
SMD	State Medicaid Director
SPA	State Plan Amendment
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
TAG	Technical Advisory Groups
TMA	Transitional Medical Assistance

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), was amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010). These laws are collectively referred to as the Affordable Care Act. The Affordable Care Act extends and simplifies Medicaid eligibility and, in the March 23, 2012, **Federal Register**, we issued a final rule entitled “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010” (referred to as the “March 23, 2012, Medicaid eligibility final rule”) addressing certain key Medicaid eligibility issues.

In the January 22, 2013 **Federal Register**, we published a proposed rule entitled “Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and

Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing” (78 FR 4594) (hereinafter referred to as “January 22, 2013 proposed rule”), that addressed a number of Medicaid eligibility provisions not addressed in the March 23, 2012, Medicaid eligibility final rule. This proposed rule included additional requirements related to the statutory eligibility provisions created by the Affordable Care Act; proposed changes to provide states more flexibility to coordinate Medicaid and the Children’s Health Insurance Program (CHIP) procedures related to eligibility notices, appeals, and other related administrative actions with similar procedures used by other health coverage programs authorized under the Affordable Care Act.

In the July 15, 2013 **Federal Register**, we issued the “Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; final rule” (78 FR 42160) (referred to as the “July 15, 2013 Medicaid and CHIP final rule”) that finalized certain key Medicaid and CHIP eligibility provisions included in the January 22, 2013 proposed rule. In this final rule, we are addressing most of the remaining provisions of the January 22, 2013 proposed rule. We will not be finalizing in this rule the definition of “lawfully present” in §435.4, or provisions finalizing the option states have to cover lawfully residing children and pregnant women in Medicaid and CHIP under section 214 of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) at §435.406(b) and §457.320, or the provision relating to benefits for those individuals who are non-citizens proposed at §435.406(c). We will consider addressing these provisions in future guidance. We also are not finalizing proposed technical changes to the introductory text in §435.201(a).

We discuss below only those public comments associated with the provisions addressed in

this final rule. For a complete and full description of the proposed Medicaid and CHIP eligibility and expansion provisions as required by the statute, see the January 22, 2013 proposed rule.

II. Provisions of the Proposed Rule and Responses to Comments

We received a total of 741 timely comments to the proposed rule from individuals, state Medicaid agencies, advocacy groups, health care providers, employers, health insurers, and health care associations. The comments ranged from general support or opposition to the proposed provisions to very specific questions or comments regarding the proposed changes.

After careful consideration of the comments received we are revising some of the proposed regulations and finalizing other regulations as proposed. Many comments were addressed in the July 15, 2013 Medicaid and CHIP final rule Part I. Some comments were outside the scope of the proposed rule. In some instances, commenters raised policy or operational issues that will be addressed through future regulatory and subregulatory guidance to be provided subsequent to this final rule. Therefore, some, but not all, comments are addressed in this final rule.

Brief summaries of the provisions that are being finalized in this rule, a summary of the public comments we received on those provisions (except specific comments on the paperwork burden or the economic impact analysis), and our responses to the comments follows. Comments related to the paperwork burden and the impact analyses are addressed in the “Collection of Information Requirements” and “Regulatory Impact Analysis” sections in this final rule.

A. Appeals

1. Coordination of Appeals

Consistent with sections 1413 and 2201 of the Affordable Care Act, we proposed regulations to promote coordination of Medicaid fair hearings under section 1902(a)(3) of the Social Security Act (the Act) with appeals of eligibility determinations for enrollment in a

Qualified Health Plan (QHP) and for advance payment of the premium tax credit (APTC) and cost-sharing reductions (CSR) under section 1411(f) of the Affordable Care Act, as well as appeals related to other insurance affordability programs. We proposed revisions to the CHIP regulations to achieve similar coordination of CHIP reviews under 42 CFR part 457 subpart K with Exchange-related appeals, as well as appeals related to other insurance affordability programs. In this final rule, we refer to an Exchange operating in the state in which the applicant has applied for coverage as “an Exchange.” We use the term “Exchange-related appeal” to refer both to an appeal of a determination of ineligibility to enroll in a QHP through an Exchange as well as an appeal of eligibility for, or an amount awarded of, APTC or CSRs. The terms “Medicaid appeal” and “Medicaid fair hearing” have the same meaning in this final rule. The terms “CHIP appeal” and “CHIP review” have the same meaning in this final rule.

To ensure the coordination of appeals when both an Exchange-related and a Medicaid appeal are pending, we proposed to permit Medicaid agencies to delegate authority to conduct fair hearings of eligibility denials for individuals whose income eligibility is based on the applicable modified adjusted gross income (MAGI) standard, to an Exchange or Exchange appeals entity (provided that an Exchange or Exchange appeals entity is a governmental agency, which maintains personnel standards on a merit basis). This proposal was finalized in revisions to §431.10 and §431.206(d) in the July 2013 Eligibility final rule, along with conforming changes to §431.205(b)(1). Consistent with section 1902(a)(3) of the Act and §431.10(c)(1)(ii), if the agency does delegate such authority to an Exchange or Exchange appeals entity, individuals must be given the choice to have their Medicaid appeal conducted by the Medicaid agency. As we explained in the proposed rule, states currently have broad flexibility under §457.1120 to delegate the CHIP review process to other entities; thus, no revision of the CHIP regulations was needed to permit delegation of review authority to an Exchange or Exchange appeals entity.

We proposed several other revisions to regulations in 42 CFR part 431 subpart E that were not finalized in the July 2013 Eligibility final rule. These revisions would maximize coordination of appeals involving different insurance affordability programs and minimize burden on consumers and states, regardless of whether the Medicaid or CHIP agency has delegated such authority to an Exchange or Exchange appeals entity, including:

- To avoid the need for individuals to request multiple appeals related to a MAGI-based eligibility determination, we proposed at §431.221(e) that, whenever an individual who has been determined ineligible for Medicaid requests an appeal related to his eligibility for the APTC or CSR level, this Exchange-related appeal will automatically be treated as an appeal of the Medicaid denial, without the individual having to file a separate fair hearing request with the Medicaid agency. We proposed a similar provision for CHIP at §457.1180.

- For simultaneous Exchange-related and Medicaid appeals in which an Exchange appeals entity is not adjudicating the Medicaid appeal, we proposed at §431.244(f)(2) that the agency must take final administrative action on a Medicaid fair hearing request within 45 days from the date an Exchange appeals entity issues its decision relating to eligibility to enroll in a QHP and for APTC and CSRs. The purpose of proposed §431.244(f)(2) was to enable the Medicaid agency to defer conducting the Medicaid fair hearing until an Exchange-related appeal had been decided, which could significantly reduce the burden on both consumers and states, particularly in the case of Medicaid fair hearing requests automatically triggered for individuals with income significantly above the applicable Medicaid income standard, many of whom would not likely choose to appeal their Medicaid denial or be found Medicaid eligible by the hearing officer. Recognizing the competing interests of consumers in different situations, we set forth several alternatives – including not modifying the 90-day timeframe at all – and solicited comments on the different approaches. Because there is broad flexibility under title XXI for

reviews of CHIP determinations, we did not propose similar provisions for CHIP.

- We proposed revisions to the definition of “electronic account” in §§435.4 and 457.10 (to include information collected or generated as part of Medicaid fair hearing or Exchange appeals processes) and to §431.242(a)(1)(i) (to ensure individuals would have access to the information in their electronic account, as well as the information in their “case record”). (Current §457.1140(d)(2) ensures individuals have the right to review their files and all other “applicable information” relevant to their eligibility or coverage for CHIP, which would include information in the individual’s electronic account.)

- In situations in which the Medicaid agency has delegated to an Exchange or an Exchange appeals entity authority both to make eligibility determinations and to conduct Medicaid fair hearings, we proposed revisions at §435.1200(c) to clarify that the Medicaid agency must receive and accept a decision of an Exchange appeals entity finding an individual eligible for Medicaid, just as it accepts a determination of Medicaid eligibility made by an Exchange. We also proposed revisions at §435.1200(c)(3) to provide that, if an Exchange appeals entity has adjudicated both an Exchange-related and Medicaid appeal, an Exchange or Exchange appeals entity would issue a combined appeals decision. We proposed similar revisions for CHIP at §457.348(c).

- For states that have not delegated authority to an Exchange to determine Medicaid eligibility, we proposed revisions at §435.1200(d) (introductory text) to require that the agency treat an assessment of eligibility by an Exchange appeals entity in the same manner as an assessment of eligibility by an Exchange and, at §435.1200(d)(4), to require that the Medicaid agency accept findings relating to a criterion of eligibility made by another insurance affordability program’s appeals entity, if such findings were made in accordance with the same policies and procedures as those applied or approved by the Medicaid agency. We proposed similar revisions

for CHIP at §457.348(d).

- We proposed revisions to §435.1200(e)(1) to provide that the agency must assess individuals for potential eligibility for other insurance affordability programs when they have been determined ineligible for Medicaid in the course of a fair hearing conducted by the Medicaid agency in the same manner as is required for individuals determined ineligible for Medicaid at initial application or renewal. We proposed similar revisions for CHIP at §457.350(b) (introductory text).

- We proposed to add a new paragraph (g) to §435.1200, to ensure coordination between appeals entities. Proposed paragraph (g)(1) requires that the Medicaid agency establish a secure electronic interface through which an Exchange appeals entity can notify the Medicaid agency of a Medicaid fair hearing request and can transfer the individual's electronic account and information contained therein between programs or appeals entities. Proposed §435.1200(g)(2) requires that, in conducting a Medicaid fair hearing under part 431 subpart E, the Medicaid agency not request information or documentation from the individual already included in the individual's electronic account or provided to an Exchange or Exchange appeals entity. Proposed §435.1200(g)(3) requires that the Medicaid agency transmit to an Exchange a Medicaid fair hearing decision issued by the agency when necessary to ensure an appellant is not enrolled in both programs (that is, when the appellant either had been denied Medicaid by an Exchange, or by the agency and transferred to an Exchange for a determination of eligibility for enrollment in a QHP and for APTC and CSRs). Similar provisions for CHIP were proposed at §457.351.

- In addition, we proposed conforming amendments to §435.1200(b)(1) related to the coordination of appeals between the Medicaid agency and an Exchange and Exchange appeals entity to incorporate new paragraph (g) in the delineation of general requirements that the Medicaid agency must meet to effectuate a coordinated eligibility system. We proposed revisions

to §435.1200(b)(3) to specify that the goal of minimizing burden on consumers through coordination of insurance affordability programs also relates to coordination of appeals processes and that the agreement entered into between the Medicaid agency and an Exchange per §435.1200(b)(3) must also ensure compliance with new paragraph (g). We proposed similar revisions for CHIP at §457.348(b).

We received the following comments on these proposed provisions, which are summarized below. We respond to comments and describe the provisions included in this final rule related to coordination of appeals processes across insurance affordability programs as they relate to coordination between Medicaid and Exchange-related appeals or appeals related to other insurance affordability programs. The policies discussed in this section and reflected in the final rule for Medicaid also apply to coordination between CHIP and Exchange-related appeals or appeals related to other insurance affordability programs.

Comment: Commenters generally supported the goal of coordinating the appeals processes across insurance affordability programs to reduce burden on consumers, states and the Exchanges. Several commenters noted particular support for the proposed revisions at §435.1200(b)(3) that require the agreement(s) between the agency and other insurance affordability programs to delineate the responsibilities of each program to achieve a coordinated appeals process. One commenter supported the proposed revisions at §435.1200(c) specifying that the Medicaid agency must accept a decision of an Exchange appeals entity finding an individual eligible for Medicaid to the same extent as it accepts determination of Medicaid eligibility made by an Exchange. Another commenter commended the clarifications at proposed §435.1200(d)(2), precluding duplicative information requests, and at proposed §435.1200(d)(4), requiring the Medicaid agency to accept findings relating to a criterion of eligibility made by another insurance affordability program's appeals entity if such findings were made in accordance

with the same policies and procedures as those applied or approved by the Medicaid agency.

Some commenters also supported the requirement at proposed §431.221(e) to automatically consider an Exchange-related appeal to trigger a Medicaid fair hearing request when a determination of Medicaid ineligibility has been made by either an Exchange or the Medicaid agency (referred to below as the proposed “auto-appeal” provision). These commenters believed that this provision is important (1) to reduce burden and confusion for consumers, who otherwise would have to request two separate appeals of what they may perceive as a single adverse action, and (2) to ensure that consumers don’t miss the deadline to appeal a denial of Medicaid. One commenter suggested technical revisions to proposed §431.221(e) to ensure that an appeal to “an Exchange” (as well as to “an Exchange appeals entity”) and an appeal involving eligibility for “enrollment in a QHP” (as well as an appeal related to eligibility for the “advanced payment of premium tax credit or cost sharing reductions”) be treated as a request for a Medicaid fair hearing under this provision.

Other commenters cautioned against requiring a high degree of coordination, which they believed would not be consistent with existing state capacity and resources. Some of these commenters also stated that such coordination would be difficult given the variation in state laws, policies and operations. For example, one commenter stated that a high degree of coordination was unrealistic because Medicaid fair hearings are subject not only to federal law and regulations, but also to state administrative procedures acts, thereby creating differences in the rules applicable to appeals in each state. Accordingly, these commenters strongly opposed the “auto appeal” provision at proposed §431.221(e). The commenters believe that the provision would result in a substantial increase in the number of Medicaid fair hearings that state agencies will have to conduct, adding further pressure on state Medicaid budgets, even though many applicants would not have been interested in having a Medicaid hearing, and in many cases the hearings would not

likely result in a reversal of the Medicaid denial. The commenters noted that states do not have resources to expand their capacity to handle such an increased volume of appeals and recommended that the provision be removed from the final rule. A few commenters also believed that proposed §431.221(e) would be inconsistent with the ability of states to retain responsibility for all Medicaid fair hearing requests (rather than delegating authority to an Exchange to decide any Medicaid appeals); the commenters suggested that in states that do not delegate fair hearing authority to an Exchange or Exchange appeals entity, requiring submission of a separate request to the Medicaid agency would be appropriate. Several commenters recommended that if we finalize §431.221(e) as proposed, we delay implementation until January 1, 2015, or later. One commenter believed that such a delay also would allow states to gather experience in how administrative efficiencies can be achieved through technical efficiencies using the shared case file and the informal resolution process at an Exchange.

Some commenters recommended that an Exchange appeals entity be required to offer applicants an opportunity to request a fair hearing of a Medicaid denial. Another commenter suggested that only applicants and beneficiaries appealing an Exchange-related determination who were found to have income within a specified threshold of the applicable Medicaid standard be treated as automatically having requested a fair hearing of their Medicaid denial. In other situations, the commenter suggested that, if an Exchange appeals entity, in conducting the Exchange-related appeal, determines the appellant to be eligible for Medicaid, the Medicaid agency could accept such determination effective as of the date of application.

Response: The Affordable Care Act requires coordination between insurance affordability programs in determining eligibility. We interpret this statutory requirement to apply when simultaneous appeals related to eligibility for multiple programs are pending. The goal of such coordination is to reduce the burden on consumers, state agencies, and Exchanges that administer

the programs; achieving the optimal balance requires that we take into consideration the interests and capacity of all parties.

We agree with commenters who voiced concerns, similar to those that we raised in the proposed rule, that proposed §431.221(e) could result in a substantial increase in the volume of fair hearing requests that Medicaid agencies would be responsible for adjudicating, even though in many cases it would be unlikely that the appellant would have independently requested a Medicaid hearing in the absence of the “auto-appeal provision” or be found eligible for Medicaid as a result of the hearing. As stated in the proposed rule, our intent was to reduce the need for an individual to submit multiple appeal requests. To address the concerns of commenters, we have decided not to include proposed §431.221(e) in the final rule. We provide instead an alternative simple mechanism for individuals appealing an Exchange-related appeal to also request a Medicaid fair hearing,

We are not accepting the commenter’s suggestion that an Exchange-related appeal should trigger an automatic Medicaid fair hearing request when the appellant has income within a specified threshold of the applicable Medicaid standard. We do not believe it is feasible to establish an appropriate income threshold for all applicants and beneficiaries in light of the many factors that apply in determining income eligibility depending on each individual’s circumstances. Instead, consistent with the policy objectives we identified in the proposed rule, this final rule provides that applicants and beneficiaries requesting an Exchange-related appeal who also want to appeal a Medicaid denial may do so by making a single “joint fair hearing request” to an Exchange or Exchange appeals entity when an Exchange has provided a combined eligibility notice which includes a Medicaid denial, as well as a determination of eligibility for enrollment in a QHP with (or without) an award of APTC. This policy is effectuated through the following provisions:

- We provide a definition of a “joint fair hearing request” in §431.201 to mean a request for a Medicaid fair hearing that is included in an appeal request submitted to an Exchange or Exchange appeals entity under 45 CFR 155.520. We also add a cross-reference to the definition of “joint fair hearing request” in §431.201 at §435.1200(a)(2)(ii) of the final rule. Note that a “joint fair hearing request” may be made both in states that have elected and states that have not elected to delegate authority to conduct Medicaid fair hearings to an Exchange or Exchange appeals entity. Note also that a joint fair hearing request does not constitute a request for the Medicaid and Exchange-related appeals to both be heard by an Exchange appeals entity in states which have delegated Medicaid fair hearing authority. The joint fair hearing request simply allows applicants and beneficiaries to request a Medicaid fair hearing at the same time as they file an Exchange-related appeal with an Exchange or Exchange appeals entity. If a joint fair hearing request is submitted and authority to conduct the Medicaid fair hearing has been delegated to an Exchange or Exchange appeals entity, the individual must be provided with a choice to have the Medicaid fair hearing conducted by the Medicaid agency, consistent with §431.10(c)(1)(ii) and §431.10(d)(4) of the July 2013 final eligibility rule.

- Revisions at paragraph (g)(1) of §435.1200 of the final rule provide that the agency must include in the agreement consummated per §435.1200(b)(3) that, if an Exchange (or other insurance affordability program) provides an applicant or beneficiary with a combined eligibility notice which includes a denial of Medicaid eligibility, an Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity) will (1) provide the applicant or beneficiary with an opportunity to submit a joint fair hearing request, including an opportunity to request expedited review of his or her fair hearing request consistent with §431.221(a)(1)(ii) of the final rule; and (2) notify the Medicaid agency of the request for a Medicaid fair hearing, unless the hearing will be conducted by an Exchange appeals entity in accordance with a

delegation of Medicaid fair hearing authority under §431.10(c)(1)(ii). Section 431.221(a)(1)(ii) (relating to requests for expedited review of a fair hearing request) is discussed in section I.A.(b) of this final rule.

Under the final regulation, if a combined eligibility notice, including a Medicaid denial, is not provided by an Exchange, but instead it is the Medicaid agency that provides notice of the Medicaid denial, the Medicaid agency is responsible for providing notice of fair hearing rights in accordance with existing regulations at §435.917 and part 431 subpart E, and the individual would need to submit a fair hearing request to the agency in accordance with §431.221. Note that, as discussed in section II.B. of this final rule, while states are permitted to implement a system of combined eligibility notices in coordination with an Exchange operating in the state at any time, we do not expect that states and Exchanges will be able to provide combined notices in all situations immediately, but will phase in increased use of single coordinated eligibility notices over time as systems mature and resources become available. Because provision of a joint fair hearing request is contingent upon issuance of a combined eligibility notice by an Exchange, the requirement to permit individuals to make a joint fair hearing request is effective only to the extent that a combined eligibility notice is provided. In some instances, an Exchange already may be providing a combined eligibility notice of a Medicaid denial together with notice of eligibility to enroll in a QHP and receive APTC and CSRs, even in the absence of a requirement that it do so. Where combined eligibility notices are being provided, the Medicaid agency must work with an Exchange operating in the state to ensure that the Exchange provides individuals receiving a combined notice with an opportunity to request a Medicaid fair hearing using a joint fair hearing request. In states that have delegated authority to make MAGI-based Medicaid eligibility determinations to the Federally-facilitated Exchange (FFE), for example, the FFE currently provides a combined eligibility notice to individuals who submit their application to the FFE and

accepts joint fair hearing requests from individuals determined by the FFE to be ineligible for Medicaid based on MAGI.

- We add new paragraph §435.1200(g)(3) to provide that the agency must accept and act on a joint fair hearing request submitted to an Exchange or Exchange appeals entity in the same manner as a request for a fair hearing submitted to the agency in accordance with §431.221.

- Section 435.1200(g)(1)(i) of the proposed rule provided for the establishment of a secure electronic interface through which an Exchange or Exchange appeals entity would notify the Medicaid agency whenever an Exchange-related appeal is filed, because under the proposed rule, this would have triggered an automatic Medicaid appeal, as well as providing a mechanism through which the individual's electronic account could be transmitted. We are revising proposed §435.1200(g)(1)(i), redesignated at §435.1200(g)(2)(i) of the final rule, instead to provide that the state agency establish a secure electronic interface through which an Exchange or Exchange appeals entity can notify the agency that it has received a joint fair hearing request. Per §435.1200(g)(2)(ii) of this final rule, the secure electronic interface also must support transmission of the individual's electronic account and other information relevant to conducting an appeal between the agency and an Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity). Discussed in more detail below, §435.1200(g)(2) is subject to a delayed compliance date, 6 months after the date we publish a **Federal Register** notice alerting states of the compliance date for paragraph (g)(2).

For individuals determined ineligible for Medicaid who have requested only an Exchange-related appeal, it also is critical to prevent any possibility of an “appeals gap,” if an Exchange appeals entity issues a decision finding an individual eligible for Medicaid. To prevent such a gap, §435.1200(g)(6) of the final rule provides that, if an Exchange made the initial determination of Medicaid ineligibility in accordance with a delegation of authority under

§431.10(c)(1)(i)(A)(3), the agency must accept a decision made by an Exchange appeals entity that an appellant is eligible for Medicaid in the same manner as if the determination of Medicaid eligibility had been made by an Exchange. Per §435.915 of the current regulations, the effective date of eligibility will be based on the date the application was filed. If the Medicaid agency made the initial determination of Medicaid ineligibility, §435.1200(g)(7) of the final rule provides the Medicaid agency with an option either to accept determinations of Medicaid eligibility made by an Exchange appeals entity in accordance with §435.1200(c), or to accept such determinations as an assessment of potential Medicaid eligibility and to then re-determine the individual's Medicaid eligibility in accordance with §435.1200(d). If the agency opts to re-determine the individual's eligibility, it must take into account any additional information obtained by an Exchange appeals entity in conducting an Exchange-related appeal. Such information should be provided by an Exchange appeals entity to the Medicaid agency, via the secure electronic interface established per §435.1200(g)(2), in accordance with the agreement described in paragraph (b)(3) to minimize burden on consumers. However, if an Exchange appeals entity does not transmit or otherwise furnish information relevant to the agency's redetermination, the agency must attempt to obtain the information directly from the individual. We are finalizing proposed revisions to §435.1200(d) (introductory text) and §435.1200(d)(2), accordingly, to provide that, in making a determination of eligibility for an individual transferred from another insurance affordability program, the agency may not request information or documentation from the individual that is in the individual's electronic account or that has been provided to the agency by another insurance affordability program or appeals entity. Section 435.1200(d)(4) of the proposed rule, also finalized without revision in this final rule, similarly requires that the agency accept any finding relating to a criterion of eligibility made by another insurance affordability program or appeals entity, without further verification, if such finding was made in accordance

with policies and procedures which are the same as those applied by the agency or approved by it in the agreement consummated with the other program or appeals entity described in §435.1200(b)(3). Paragraphs (g)(4) and (g)(5) of §435.1200 of the final rule are discussed below.

Note that the option provided in paragraph (g)(7) applies when the Medicaid agency has made the determination of ineligibility, regardless of whether or not the agency has authorized an Exchange to make Medicaid eligibility determinations in accordance with a delegation of authority under §431.10(c)(1)(i)(A)(3). States must apply the option they elect consistently to all individuals in the situation described. Regardless of the option elected, for individuals ultimately approved for Medicaid in accordance with §435.1200(g)(7), the effective date of eligibility is based on the date the application was filed, consistent with §435.915.

We proposed revisions to the introductory text of §435.1200(c) to require the agency to accept a determination of Medicaid eligibility by an Exchange appeals entity in adjudicating a Medicaid fair hearing in accordance with a delegation of fair hearing authority under §431.10(c)(1)(ii). We did not receive comments on these proposed revisions, which are included in the final rule. We also include a cross-reference to new paragraphs (g)(6) and (7) in the introductory text of §435.1200(c) to reflect the additional circumstances in which the agency must or may accept a determination of Medicaid eligibility by an Exchange appeals entity.

We note that in a state that has not delegated authority to make Medicaid eligibility determinations to an Exchange, if an Exchange assesses the individual as ineligible for Medicaid and the individual elects to withdraw his or her Medicaid application in accordance with §155.302(b)(4), there is no possibility of a Medicaid fair hearing to be heard (by either the agency or an Exchange appeals entity) because there has been no determination of Medicaid ineligibility by an Exchange. Under the proposed revisions to the introductory text of §435.1200(d), finalized as proposed, the Medicaid agency must accept and treat an assessment of Medicaid eligibility

made by an Exchange appeals entity in the same manner as if the assessment had been made by an Exchange. Per §435.907(h), finalized in the July 2013 Medicaid and CHIP eligibility final rule, if an Exchange appeals entity assesses such an individual as eligible for Medicaid, the individual's application is automatically reinstated and transferred to the Medicaid agency to make a final determination. If the agency denies Medicaid eligibility at that point, notice of fair hearing rights would be provided by the agency.

For consumers who request both a Medicaid and an Exchange-related appeal, coordination of the appeals processes can be achieved when an Exchange or Exchange appeals entity is able to conduct both appeals together in accordance with a delegation of authority under §431.10(c)(1)(ii). However, in some cases, the Medicaid agency and Exchange appeals entity each will be responsible for adjudicating separate appeals. We appreciate the commenters' concern regarding the significant practical challenges to achieving the degree of coordination required under the proposed regulations. We therefore are revising the proposed §435.1200(g)(2), redesignated at paragraph (g)(4) in the final rule, to require that, in conducting a fair hearing in accordance with subpart E or part 431, the agency must minimize, to the maximum extent possible consistent with guidance issued by the Secretary, any requests for information or documentation from the individual that is already included in the individual's electronic account or otherwise provided to the agency by an Exchange or Exchange appeals entity. Over time, as state system capabilities increase, we anticipate that the degree of coordination possible between the state and an Exchange or Exchange appeals entity will increase, and we will issue additional guidance on coordination procedures as appropriate.

To address potentially conflicting decisions issued by the two appeals entities, current Exchange regulations at §155.345(h) provide that an Exchange and Exchange appeals entity must accept a fair hearing decision issued by the Medicaid agency regarding the appellant's Medicaid

eligibility, even if it conflicts with the decision reached by an Exchange appeals entity.

We did not receive any comments on proposed revisions to the introductory text in §435.1200(c), which is finalized without revision in this final rule.

We remind states that, while the decision to delegate appeals authority to an Exchange or Exchange appeals entity means that the agency must accept a decision regarding eligibility issued by an Exchange appeals entity under a delegation of authority, it does not relieve the agency of its responsibility to conduct any fair hearings requested by Medicaid applicants and beneficiaries in the state. For example, notwithstanding a delegation of appeals authority, per current §431.10(c)(1)(ii), individuals who request a fair hearing are entitled to request that their hearing be conducted by the agency, and not by the delegated entity. In addition, Medicaid agencies are not required to delegate appeals authority to an Exchange or Exchange appeals entity and the Exchanges and Exchange appeals entities respectively are not obligated to accept such delegations. Per current §431.10(c)(3)(ii), agencies that enter into an agreement with an Exchange or Exchange appeals entity to do so must exercise appropriate oversight over, and ultimately remain responsible for, the Medicaid fair hearing process.

As provided under §435.1200(g)(4) of the final rule, in conducting a fair hearing in accordance with subpart E or part 431 of the regulations, the agency must minimize any requests for information or documentation from the individual which already are included in the individual's electronic account or otherwise provided to the agency by an Exchange or Exchange appeals entity. However, in the event that the Medicaid agency has not received information from an Exchange or Exchange appeals entity needed to conduct a fair hearing, the agency would need to obtain such information directly from the individual, and would be authorized under the regulations to do so.

Commenters did not raise concerns with the following proposed revisions to

§435.1200(d) (introductory text), §435.1200(d)(4) or §435.1200(e)(1) (introductory text), which are finalized as proposed. Revisions to §435.1200(d) require that the agency treat findings, assessments and decisions made by an Exchange appeals entity in the same manner and to the same extent as eligibility determinations made by an Exchange or Medicaid agency for the purposes of the coordination described in §435.1200(d). Revisions to §435.1200(e) require that the agency treat fair hearing decisions made by the Medicaid appeals entity the same as determinations made by the Medicaid agency for purposes of the coordination described in §435.1200(e). We also are finalizing as proposed conforming revisions to §435.1200(b) relating to the basic responsibilities of the agency to minimize burden on consumers who have requested appeals related to more than one insurance affordability program and to address such coordination in an agreement between the agency and other applicable appeals entities.

The proposed revision at §435.1200(c)(3) providing for a combined appeals decision when an Exchange or Exchange appeals entity adjudicates a fair hearing request in accordance with a delegation of authority is moved to a new paragraph (b)(3)(v) of §435.1200. Consistent with the proposed rule, under §435.1200(b)(3)(v) of the final rule, if the agency has delegated authority to conduct fair hearings to an Exchange or Exchange appeals entity, the agreement between the entities must provide for a combined appeals decision by an Exchange or Exchange appeals entity in the case of individuals whose fair hearing is conducted by an Exchange or Exchange appeals entity. Note that this requirement applies regardless of whether the Medicaid agency or Exchange made the underlying determination of Medicaid ineligibility.

The policies relating to coordination of appeals across insurance affordability programs previously discussed and codified in the final rule also apply to states' separate CHIP programs, except that the right to have to an appeal adjudicated by the state agency even if the agency has delegated authority to an Exchange or Exchange appeals entity does not apply in the case of any

delegation of authority to conduct appeals of a CHIP determination. Table 1 provides a cross walk between the provisions of the final rule which accomplish the application of these policies to Medicaid and CHIP.

TABLE 1: Crosswalk between the policies to Medicaid and CHIP

Medicaid final regulation	CHIP final regulation
§431.201 (Definition of “joint fair hearing request”)	§457.10 (Definition of “joint review request”)
§431.242	No comparable provision
§435.4 (Definition of “electronic account”)	§457.10 (Definition of “electronic account”)
§435.1200(b)(3)	§457.348(a)
§435.1200(c) and (d)	§457.348(b) and (c)
§435.1200(e)	§457.350(b) (introductory text)
§435.1200(g)	§457.351(a)

Proposed revisions to §457.1180, which would have provided for an automatic review of a CHIP denial based on a request for an Exchange-related appeal, are not included in this final rule for the same reason that proposed changes to §431.221(e) are not finalized.

Comment: A commenter requested clarification regarding whether an assessment of Medicaid ineligibility by an Exchange is considered to be a Medicaid denial and, if so, whether an appeal of an Exchange-related determination to an Exchange appeals entity would trigger an automatic request for a Medicaid fair hearing when an Exchange had assessed the individual as not eligible for Medicaid. The commenter questioned how the Medicaid agency could conduct a fair hearing when it had not made an initial determination of ineligibility.

Response: As noted, we are not finalizing the auto-appeal provision at §431.221(e) of the proposed rule. Therefore, no “Exchange related appeal” requests will result in automatic requests for Medicaid fair hearings. For assessments, we agree that, in a state that has not delegated authority to make Medicaid eligibility determinations to an Exchange, an assessment of Medicaid ineligibility by the Exchange does not constitute a denial of Medicaid subject to appeal. Per §155.302(b)(4), an individual who has been assessed ineligible for Medicaid by an Exchange has

the option either to accept that assessment and withdraw his or her Medicaid application or request that his or her Medicaid application be transferred to the Medicaid agency to make a final eligibility determination. If an individual who requests a final determination by the Medicaid agency is denied eligibility by the Medicaid agency, he or she at that point would have the right to request a fair hearing of the agency's denial. If an individual who chooses to withdraw his or her Medicaid application files an appeal relating to his or her eligibility for APTC and the Exchange appeals entity finds that the individual's income is at or below the applicable MAGI standard for Medicaid, per §435.1200(d) the agency would accept such finding as an assessment of Medicaid eligibility and make a final determination of eligibility, in the same manner as if an Exchange had assessed the applicant as Medicaid eligible based on the initial application. The same result would ensue for CHIP per §457.348(c).

Comment: A few commenters recommended that CMS clarify whether the regulatory requirements at §435.1200 require only coordination of eligibility and enrollment between Medicaid and CHIP, or also require coordination of eligibility and enrollment between Medicaid and other insurance affordability programs, including the Basic Health Program (BHP) and APTC and CSRs for coverage through the Marketplace.

Response: At §435.1200, which set forth the Medicaid agency's responsibilities to establish a seamless and coordinated system of eligibility and enrollment with respect both to an initial determination of eligibility and to any appeals of such initial determinations, we require Medicaid coordination with all other insurance affordability programs, including CHIP, BHP and APTCs and CSRs for coverage in a QHP. Similarly, the CHIP regulations at §§457.348 through 457.351, as revised in this final rule, provide for the coordination of eligibility determinations and appeals between CHIP and all other insurance affordability programs, not just for coordination between the CHIP and Medicaid programs.

Comment: A commenter believed that the establishment of an electronic interface between an Exchange appeals entity and the Medicaid eligibility system could take considerable time in some states, which would delay the ability of these states to come into full compliance with the policy reflected in the proposed rule.

Response: As noted in the proposed rule, the secure electronic interface required for use in exchanging information between the Medicaid agency and an Exchange appeals entity under proposed §435.1200(g)(1) (redesignated at §435.1200(g)(2) in this final rule) can be the same interface as that established between the Medicaid agency and Exchange for exchange of information related to the initial determination of eligibility; a separate secure interface directly between the Medicaid agency and Exchange appeals entity may be established, but is not required. Due to the considerable work which is ongoing in many states relating to multiple aspects of their eligibility and enrollment systems, we agree that a delay in the compliance date of this requirement is appropriate. Thus, we are providing for a delayed compliance date of the requirement in §435.1200(g)(2) to establish a secure electronic interface between the Medicaid agency and the Exchange appeals entity, which is incorporated at §457.351(a) for CHIP. Under §435.1200(i), states will be required to establish a secure interface for electronic transfer of information between insurance affordability programs and appeals entities within 6 months from the date of a published **Federal Register** notice alerting states of the compliance date for paragraph (g)(2).

Comment: In situations involving simultaneous Exchange-related and Medicaid appeals, no commenters supported the policy at proposed §431.244(f)(2) to give state Medicaid agencies up to 45 days from the date an Exchange appeals entity issues an Exchange-related appeals decision to decide a Medicaid fair hearing. Some commenters were concerned that 45 days from the date of the Exchange appeals decision would not provide the Medicaid agency adequate time

to conduct the Medicaid fair hearing. To meet the 45-day timeframe, the commenters stated that fair hearings may need to be scheduled prior to the issuance of a decision by an Exchange appeals entity, thereby undermining the goal to prevent duplication of effort. One commenter added that, if following the initiation of the Medicaid fair hearing process, the appellant withdraws his fair hearing request upon receiving an Exchange appeal decision, the State will have incurred unnecessary expense; this commenter recommended that CMS allow up to 90 days from the date of an Exchange appeal decision for the Medicaid agency to issue a decision on the fair hearing request. One commenter recommended that the timeframe generally permitted for fair hearing decisions be extended from 90 to 120 days, with the Medicaid agency receiving an Exchange's decision relating to eligibility for other insurance affordability programs no less than 60 days before the expiration of the 120-day period.

Others commenters were concerned that proposed §431.244(f)(2) would result in excessive delays in fair hearing decisions for many individuals who were wrongfully denied Medicaid. Some of these commenters believed that the Medicaid fair hearing often should go first. Other commenters recommended that consumers should be given a choice as to whether their Exchange appeal or Medicaid fair hearing is conducted first. In support of a Medicaid-first policy, a few commenters pointed to the requirement at §155.345(h) of the Exchange regulations that the Medicaid fair hearing decision must be accepted by an Exchange even if it conflicts with a decision rendered by an Exchange appeals entity.

Response: Proposed §§431.244(f)(2) and 431.221(e) represented two integral components of an overarching policy to achieve coordinated appeals processes across insurance affordability programs, in particular between Medicaid fair hearings and Exchange-related appeals. Because we were concerned that the automatic Medicaid appeals that would be generated under proposed §431.221(e) would overwhelm the resources of Medicaid agencies' fair hearing processes, we

proposed to permit Medicaid agencies to defer acting on such Medicaid fair hearing requests until the resolution of an Exchange-related appeal. Since we are not adopting the automatic appeal provision at proposed §431.221(e) in this final rule, we do not believe this accommodation is necessary. Under this final regulation, a Medicaid fair hearing will be conducted only for individuals who affirmatively request such hearing – either through submission of a joint fair hearing request to an Exchange or directly to the agency. In this context, the potential harm to applicants and beneficiaries of delaying fair hearings as proposed at §431.244(f)(2), outweighs the value of any potential administrative efficiencies gained. Accordingly, we are not finalizing proposed §431.244(f)(2). Rather, this final rule, at §431.244(f)(1)(ii), applies the standard 90 day time frame for taking final administrative action on all fair hearing requests, regardless of whether a simultaneous Exchange-related appeal has been filed, unless an expedited decision (discussed below) is required under §431.244(f)(2). This overall time frame does not preclude the Medicaid agency and an Exchange from agreeing on the sequencing of related simultaneous appeals to maximize efficiency and reduce the burden on the agency and consumers. Protocols for sequencing of appeals can be included in the agreement between the two programs under §435.1200(b)(3) of the final regulation, provided that the 90-day time frame for taking final administrative action in §431.244(f) is met. As noted, because there is broad flexibility under CHIP regarding the timing of appeals decisions, we had not proposed similar changes in the CHIP regulations.

Comment: A commenter believed that the existence of two levels of the Exchange appeals process would make coordination of appeals between Medicaid and the Exchange difficult; the commenter believed that the Medicaid and Exchange appeal processes inevitably will diverge, and that expecting too much coordination could create confusion and the potential for someone to miss their opportunity to appeal, particularly in households in which one member

has an appealable Exchange-related adverse action and another an appealable Medicaid-related adverse action. Another commenter recommended that we clarify that the informal review process runs concurrently with the timeframe for issuing a fair hearing decision, unless the appellant withdraws his request for a fair hearing. A third commenter sought clarification that the informal review process at the Exchange appeals entity may not interfere with an applicant's right to timely request a separate Medicaid appeal.

Response: The Exchange appeals process provides for an informal resolution process prior to the Exchange appeals entity engaging in a formal hearing process. Appellants who are not satisfied with the result of the informal resolution process are entitled to a hearing. (See §155.535.)

We do not agree that the existence of such an informal resolution process will undermine coordination of the appeals process, or jeopardize individuals' right to request a Medicaid fair hearing. If an Exchange or Exchange appeals entity is conducting a Medicaid fair hearing in accordance with a delegation of authority under §431.10(c)(1)(ii), the Exchange or Exchange appeals entity may choose to provide an informal resolution process for individuals appealing a Medicaid eligibility determination made by the Exchange. If an Exchange or Exchange Appeals Entity is providing an opportunity for informal resolution prior to a fair hearing, the process must be conducted consistent with Medicaid fair hearing rights and timeframes in accordance with part 431, subpart E, as required under the requirements of a delegation at §431.10(c)(3)(i)(A). Thus, the time permitted to render a final decision (measured from the date of the appeal request) would not be affected. Appellants who are not satisfied with the result from the informal process at an Exchange or Exchange appeals entity would have the right to proceed to a formal hearing, as required under the Exchange regulations at §155.535(a)(2). Appellants satisfied with the result of the informal resolution process would need to withdraw their request for a Medicaid fair

hearing in accordance with §431.223(a); if the appellant is not satisfied, the Exchange appeals entity would proceed with a hearing. If the state has not delegated authority to conduct fair hearings to the Exchange or Exchange appeals entity, the informal resolution process established by the Exchange appeals entity will not be relevant, as the Medicaid agency will conduct the fair hearing in accordance with the processes established by the state agency.

We understand that a number of state Medicaid agencies employ informal resolution processes prior to holding a fair hearing. While not required, we believe informal resolution processes reflect an efficient mechanism to resolve appeals without incurring the cost or time needed for a formal hearing process. Whether employed by an Exchange or Exchange appeals entity or the Medicaid agency, use of an informal resolution process does not affect (1) the timeliness requirements set forth in §431.244(f) for issuance of a final fair hearing decision, measured against the date the fair hearing is requested; or (2) individuals' right to request that their fair hearing be conducted by the Medicaid agency, despite a delegation of fair hearing authority under §431.10(c)(1)(ii).

Comment: Some commenters were concerned about an inconsistency in the period of time states must provide individuals to request a Medicaid fair hearing and the period of time permitted for individuals to file an Exchange-related appeal with an Exchange appeals entity. Commenters pointed to the regulation at §431.221(d), which provides flexibility for state Medicaid agencies to allow applicants and beneficiaries “a reasonable time, not to exceed 90 days” to request a fair hearing, whereas under the proposed Exchange regulation at §155.520(b), individuals are given 90 days to appeal an Exchange-related determination. Several commenters recommended that language be added at the end of proposed §431.221(a)(5) to require that, for individuals receiving both a Medicaid and Exchange-related determination, any request for a Medicaid hearing be deemed timely if made within 90 days of the date of the notice

relating to the individual's Exchange-related determination, regardless of the State's deadline for requesting a Medicaid hearing.

Response: In this final rule, we refer to the period of time individuals are provided to request an Exchange-related appeal or a Medicaid fair hearing as the "appeals period." Current §431.221(d) requires only that the agency establish an appeals period not to exceed 90 days. The 90-day Exchange appeals period provided at proposed §155.520(b) was finalized, with revision, in the Exchange appeals final regulation which was published on August 30, 2013. Under §155.520(b)(2) of that regulation, an Exchange or Exchange appeals entity may align the appeals period for an Exchange-related determination with the appeals period for a Medicaid fair hearing, provided that such period is not less than 30 days. This flexibility will enable, although not require, an Exchange appeals entity and Medicaid agency to adopt the same appeals period for both programs. States also have broad flexibility under §457.1180 of the CHIP regulations to establish a reasonable appeal period, making alignment across all insurance affordability programs possible.

As previously discussed, we are not finalizing proposed §431.221(e), which would have required the Medicaid agency to treat an Exchange-related appeal as automatically triggering a Medicaid fair hearing request in certain circumstances. Conversely, we agree that vastly different appeals periods could cause confusion, particularly for individuals who receive a single combined eligibility notice relating to their eligibility for multiple programs. However, we did not propose revisions to §431.221(d) in the January 22, 2013 proposed rule. Therefore, to promote alignment between the appeals period permitted by all insurance affordability programs, we propose elsewhere in this **Federal Register**, revisions to §431.221(d) under which the agency would be required to provide individuals with no less than 30 days nor more than 90 days to request a fair hearing. We also are proposing elsewhere in this **Federal Register** a similar requirement at a

new §457.1185(a)(3)(i) of the CHIP regulations.

We also agree with commenters that, when a combined eligibility notice including a Medicaid denial is issued, enabling the individual to submit a joint fair hearing request to an Exchange or Exchange appeals entity in accordance with §435.1200(g)(1) of the final rule, a shorter appeals period for requesting a Medicaid fair hearing than that permitted for requesting an Exchange-related appeal could create confusion and result in someone inadvertently missing the deadline for requesting a Medicaid fair hearing. Therefore, we also are proposing elsewhere in this **Federal Register** a new paragraph (d)(2) in §431.221, under which the Medicaid agency, whether or not it has delegated fair hearing authority to an Exchange or Exchange appeals entity, must accept as timely a request for a Medicaid fair hearing submitted to an Exchange or Exchange appeals entity (or to another insurance affordability program or appeals entity) as part of a joint fair hearing request within the time frame permitted for filing a timely appeal of an Exchange-related determination under §155.520(b) (or for filing a timely appeal with such other insurance affordability program or appeals entity); a similar provision is proposed elsewhere in this **Federal Register** as a new §457.1185(a)(3)(ii) of the CHIP regulations.

Comment: Several commenters supported the proposed regulation at §431.221(a) to enable applicants and beneficiaries to request a Medicaid fair hearing via all the same modalities as are available for individuals to submit an application per §435.907(a). Other commenters believed that requiring additional modalities (that is, other than by mail) for fair hearing requests was unnecessary, would impose undue burden on states, and should be available only at state option. A few noted their concern, in particular, about states' ability to track telephone requests, as well as the additional staff time required to gather information from individuals requesting a fair hearing in person or over the phone. They recommended that CMS eliminate the requirement that states accept hearing requests by phone or in person in favor of providing states with

flexibility to determine their own capacity to offer these modalities for consumers to request hearings.

Some commenters suggested CMS include a requirement that the Medicaid agency be required to document and confirm all telephonic hearing requests in writing and that such confirmation occur within one business day of receipt of the telephonic hearing request. Some of these commenters believed that states should provide all individuals with confirmation of their fair hearing request, regardless of the modality through which the request was made. One commenter (mistakenly) stated that the Exchange regulations at §155.520 do not allow individuals to submit a Medicaid hearing request via the Internet. The commenter, concerned that reliance on the Federally-facilitated Exchange might affect the permissibility of Medicaid fair hearing requests via the internet, encouraged CMS to amend the Exchange regulations to provide for appeal requests via the internet for both programs.

Response: We believe that facilitating consumers' ability to exercise their fair hearing rights through modernizing the means by which a fair hearing request can be made is as important as, and no more inherently burdensome to states than, modernizing the means by which an application can be filed. While individuals will be afforded an opportunity to request a fair hearing through the same modalities that can be used to submit an application, states retain flexibility in the mechanisms available to appellants to provide documentation supporting their position. For example, supporting documentation could be provided in connection with an informal resolution process, if applicable, or during the evidentiary hearing conducted by the hearing officer. Thus, we disagree with some commenters' concern regarding the particular burden of telephonic or in-person requests. Given the broad availability and use of the Internet for filing applications, we believe that this modality also should be available for appeals in all states. Therefore, we are finalizing the policy as proposed at §431.221(a)(1) through (5) in the

final rule. However, inasmuch as the modalities identified for submission of a fair hearing request at proposed §431.221(a)(1) through (5) mirror the modalities that states must make available to applicants under §435.907(a), we have revised proposed §431.221(a)(1) through (5), redesignated at §431.221(a)(1)(i) in the final rule, to instead provide a cross-reference to the modalities described in §435.907.

We are aware that states will need time to upgrade their systems to accept fair hearing requests through these additional modalities. Thus, we are adding a delayed effective date for the new modalities for fair hearing requests required under the final rule. Per §§431.221(a)(1)(i) and 435.1200(i) of the final rule, telephonic and online fair hearing requests, as well as requests via other commonly available electronic means (if any) will not be required until 6 months from the date of the publication of the **Federal Register** notice requiring their implementation.

We note that our expectation is that the same modalities for requesting an appeal be available also in CHIP. However, we did not propose revisions to the CHIP regulations requiring that individuals applying for or receiving CHIP be able to request a review under subpart K of the CHIP regulations via all modalities available to individuals seeking to apply for CHIP. Therefore, we propose elsewhere in this **Federal Register** a new §457.1185(a) to require that states must provide individuals with the opportunity to request a review of a denial or termination of CHIP or other CHIP-related matter via all such modalities. The proposed regulation at §457.1185(a)(1)(ii) also includes a right to request an expedited completion of a review in accordance with current §457.1160, similar to the right provided Medicaid applicants and beneficiaries at §431.221(a)(1)(ii) of this final rule. Under the broad authority states currently have to establish a review process under part 457 subpart K, the option for states to accept review requests of CHIP-related matters through all modalities already is available.

We did not propose that the state Medicaid or CHIP agency provide confirmation of fair

hearing requests and therefore we are not including such a requirement in this final rule.

However, we agree that confirmation of fair hearing requests, which we note is required under the Exchange regulations at §155.520(d), would strengthen the procedural protections afforded beneficiaries. Therefore, we propose elsewhere in this **Federal Register** further revisions to §431.221(a) and a new §457.1185(a)(2) to include this requirement.

Comment: A few commenters requested clarification regarding the ability of individuals to request a fair hearing through “other commonly available electronic means.” One commenter believed that the proposed regulation fails to address commonly available social media, which some might reasonably conclude are included in the definition of “commonly available electronic means,” which would be burdensome for states to accommodate. Another commenter recommended that §431.221(a)(4) be revised to insert “designated by the state” after “through other commonly available electronic means” to make clear that it is states, not consumers, that have authority to designate what is considered to be a “commonly available electronic means” through which a fair hearing may be requested. Another commenter supported the requirement to make fair hearing requests available through other commonly available electronic means, but recommended delaying implementation of the requirement to allow time for the state to make the necessary systems changes to support such requests.

Response: We appreciate commenters’ concern that the phrase “commonly available electronic means” may be interpreted differently by different states, consumers and other stakeholders. As noted, in proposing §431.221(a), we intended to propose that the same modalities available for submission of applications under §435.907 also be made available for individuals to request a fair hearing, and we have revised the final rule at §431.221(a)(1)(i) to instead cross-reference the modalities listed in §435.907. Since we did not propose revisions to the identical existing language in the regulations at §435.907(a)(5) (requiring that agencies accept

applications “through other commonly available electronic means”), we are not revising the language we proposed in §431.221(a)(4) pertaining to the modalities applicable to fair hearing requests in this rulemaking. However, we will take the comments under advisement in future rulemaking.

Comment: One commenter requested CMS to clarify its expectations regarding how states should ensure that requests made via telephone, the Internet or other commonly available electronic means are made only by the affected applicant beneficiary or a properly designated authorized representative.

Response: To ensure that fair hearing requests are submitted only by the affected applicant or beneficiary or person authorized to act on their behalf, states are expected to employ the same policies and practices regarding the authority of the individual submitting a fair hearing request as those applied by the state regarding the submission of applications and renewal forms by authorized representatives, under §435.923. We believe it is important that a person or entity is not submitting an appeal request form on behalf of the individual without the consent of the individual. For example, it would not be permissible for a nursing home provider to submit an appeal request form on behalf of a beneficiary if no consent has been obtained from the individual. We also note that an individual serving in the role of an authorized representative under §435.923 may limit the scope of his or her representation. For example, such an individual could be an attorney and only represent the individual in conducting the fair hearing or any informal resolution of that issue, but not receive an individual’s notices or otherwise be responsible for filing change reporting or a renewal form. We have revised the introductory text of proposed §431.221(a), redesignated at §431.221(a)(1) of the final rule, to cross-reference the definition of “authorized representative” in §435.923 for clarity.

Comment: Section 431.223 provides that a request for a hearing may be withdrawn in

writing. One commenter sought clarification regarding whether a request to withdraw a fair hearing request can be effectuated in the same manner as a request for a fair hearing, as provided at proposed §431.221(a). A number of commenters recommended that §431.223 be revised to provide additional protection against inadvertent or erroneous dismissals, similar to those provided in §155.530(b) and (d), which requires an Exchange appeals entity to provide notice of dismissal, including information about how a dismissal may be vacated. The commenters believed that, given the inevitable complexity of states' hearing systems and changes that are being made to achieve greater coordination with an Exchange, there is a significant possibility that confusion on the part of individuals, as well as on the part of the navigators and insurance brokers helping them, will result in erroneous withdrawals. The commenters believed that individuals with both Exchange-related and Medicaid appeals pending would be particularly vulnerable to erroneous withdrawal. The commenters also recommended that dismissals not be accepted for individuals who have a disability and may therefore qualify in a category to which MAGI does not apply.

Response: In the proposed rule, we indicated our expectation that withdrawal of a Medicaid fair hearing request would be permitted through all of the modalities identified in §435.907 (related to submission of an application); these modalities mirror those at proposed §431.221(a) relating to a request for a Medicaid fair hearing. We provide in this final rule at §431.223(a) that states must offer individuals who have requested a fair hearing the ability to withdraw their request via any of the modalities available in accordance with §431.221(a)(1)(i). Under the regulation, the requirement to accept telephonic, online, or other electronic withdrawals is effective at the same time as the requirement to make those modalities available to individuals to make a fair hearing request. Under §431.223(a), telephonic hearing withdrawals must be recorded, including the appellant's statement and telephonic signature. We expect the agency to

retain as part of the individual's electronic file the voice signature recording along with either a voice recording of the appellant's complete statement requesting the withdrawal, a written transcript of the appellant's statement, or a summary statement indicating that the appellant requested his or hearing be withdrawn. For telephonic, online, and other electronic withdrawals, the agency must send the appellant a written confirmation of such withdrawal, via regular mail or electronic notification in accordance with the individual's election under §435.918(a) of this chapter. We propose elsewhere in this **Federal Register** that such confirmation must be provided within 5 business days of the agency's receipt of a telephonic withdrawal. Appellants always will retain the right to request a withdrawal in writing, regardless of other modalities available.

States currently have the flexibility under subpart K of the CHIP regulations to accept withdrawal of a request for review via multiple modalities. We did not discuss our expectation in the proposed rule that states necessarily would be required to do so. Therefore, we propose a new §457.1185(b) elsewhere in this **Federal Register** that states must accept a withdrawal of a request for review under CHIP via all modalities that are available to submit a request for review, and that the state provide the individual with written confirmation of such request within 5 business days.

Comment: A commenter sought clarification regarding the continuation of benefits pending an appeal when an individual is denied or terminated from Medicaid and transferred to an Exchange.

Response: The extent to which an individual is entitled to continued receipt of Medicaid pending the outcome of an appeal depends on whether the individual has been denied Medicaid eligibility at initial application or terminated from Medicaid during a regular renewal or eligibility redetermination triggered by a change in circumstance in accordance with regulations at §435.916. Current §§431.230 and 431.231 provide for continuation of Medicaid benefits for beneficiaries who timely request a fair hearing of a termination of coverage or other action.

Individuals who appeal a denial of Medicaid at initial application are not entitled to benefits pending the outcome of their hearing. Nothing in the Affordable Care Act affected the policies reflected in these existing regulations, and we did not propose any modifications in the January 22, 2013 proposed rule.

Codified at §155.305(f)(1)(ii)(B) and (g)(1)(i)(B), individuals who are eligible for Medicaid are not eligible for APTCs or CSRs. Under §155.345(h), an Exchange must adhere to an eligibility determination or fair hearing decision made by the Medicaid agency. There is no difference under the Exchange regulations between the treatment of individuals receiving Medicaid benefits pending the outcome of their fair hearing and the treatment of Medicaid beneficiaries generally.

Applicants determined ineligible for Medicaid and CHIP generally will be eligible for enrollment in a QHP (provided that they meet all requirements for QHP enrollment), and will be eligible for a determination of eligibility for APTCs and CSRs in accordance with Exchange regulations at 45 CFR part 155, subpart D. Per §435.1200(e)(1) of the regulations (revised in this final rule), the agency must transfer to an Exchange the electronic account of applicants determined ineligible for Medicaid (irrespective of whether they appeal that determination) whom the agency determines potentially eligible for Exchange financial assistance, so that the Exchange can make a final determination of eligibility to enroll in a QHP and receive APTC and CSRs. Eligible applicants who appeal their Medicaid denial may enroll in a QHP and receive APTC and CSRs pending the outcome of their Medicaid appeal. Proposed §435.1200(g)(3), redesignated at §435.1200(g)(5) of this final rule, requires that the agency notify the Exchange or Exchange appeals entity operating in the state of the fair hearing decision for individuals transferred to the Exchange following a denial or termination of Medicaid. This requirement is retained in the final rule at §435.1200(g)(5)(i)(C). If the Medicaid fair hearing results in approval of Medicaid

eligibility, under the Exchange regulations, the individual no longer would be eligible for APTC or CSRs.

A different result ensues for Medicaid beneficiaries who appeal their Medicaid termination and are eligible for continuation of Medicaid benefits pending the outcome of their appeal. Per §435.1200(e), the agency must transfer the electronic account of a beneficiary terminated from coverage to an Exchange for a determination of eligibility for enrollment in a QHP with APTC and CSRs. If the beneficiary makes a timely request for a fair hearing on his or her Medicaid termination, resulting in continued eligibility for Medicaid benefits pending the outcome of the fair hearing in accordance with §431.230, the beneficiary will not be eligible for APTC or CSR unless and until the Medicaid termination is upheld following the conclusion of the Medicaid fair hearing.

Proposed §435.1200(g)(3), redesignated at §435.1200(g)(5) of this final rule, requires that the agency notify the Exchange or Exchange appeals entity operating in the state of the fair hearing decision for individuals transferred to the Exchange following a denial or termination of Medicaid. This requirement is retained in the final rule at §435.1200(g)(5)(i)(C). However, to ensure that Medicaid beneficiaries who are entitled to continued Medicaid coverage pending the outcome of their fair hearing are not inappropriately determined eligible for Exchange financial assistance, §435.1200(g)(5) of the final rule also requires at clauses (g)(5)(i)(A) and (B) that the Medicaid agency notify the Exchange operating in the state (1) that an individual who has been transferred to the Exchange has requested a fair hearing and (2) whether or not such individual is entitled to Medicaid coverage pending the outcome of the hearing. If the individual's termination from Medicaid is upheld, per §435.1200(e)(1) and (g)(5)(i)(C), the agency must notify the Exchange of the decision and that the individual has been terminated from Medicaid, at which point the Exchange would proceed with a determination of eligibility for enrollment in a QHP

with APTC and CSRs.

Comment: A commenter was concerned that the proposed rules on the timing and sequencing of appeals could lead to overlapping program eligibility, resulting in confusion about payment responsibilities. The commenter recommended that CMS issue guidance about how administrative costs and payment of services will be handled during the appeal process when overlapping eligibility between programs occurs.

Response: As previously discussed, we are not finalizing proposed §431.221(e) which would have facilitated, although not required, a sequencing of hearings. When an individual requests both an Exchange-related and Medicaid-related (or CHIP-related) appeal, there will be times when two appeals affecting the same individual will be pending before different appeals entities (because an Exchange appeals entity has not been delegated authority to hear the Medicaid or CHIP-related appeal or, because the individual requests that the Medicaid agency conduct the fair hearing when an Exchange appeals entity has been delegated authority to conduct certain Medicaid-related appeals). In such situations, each entity will bear its own costs of adjudicating the appeal before it. Payment for services provided to an individual pending the outcome of an appeal generally is borne by the program in which the individual is enrolled. However, because Medicaid eligibility may be retroactively effective as far back as the third month prior to the month of application, for any period of time involving dual coverage under Medicaid and a QHP, Medicaid would pay secondary to the QHP for any unpaid bills. Thus, if an applicant denied Medicaid elects to enroll in a QHP pending the outcome of his Medicaid fair hearing, the QHP will pay claims for covered services unless and until the individual is disenrolled from the QHP, subject to any applicable deductions or cost sharing charges associated with the QHP coverage. If the Medicaid fair hearing ultimately results in a determination of Medicaid eligibility, Medicaid coverage would be available to cover any unpaid medical expenses

furnished by Medicaid providers back to the date or month of application, as well as during the 3 months prior to the month of application consistent with §435.915.

In situations involving simultaneous Medicaid and Exchange-related appeals being adjudicated separately, there also could be a gap in time between the issuance of the two appeals decisions. As noted, under §§435.1200(g)(5)(i)(C) and 457.351(a), the Medicaid or CHIP agency must notify an Exchange of the Medicaid or CHIP appeals decision and if the decision results in approval of Medicaid or CHIP eligibility, per §§155.305(f)(1)(ii)(B), 155.305(g)(1)(i)(B), and 155.345(h), an Exchange must terminate APTC and CSR for the individual's enrollment in the QHP – regardless of the outcome of any Exchange-related appeal. (Individuals are responsible for termination of their enrollment in the QHP, which is requested through the Exchange. While we assume that individuals found Medicaid or CHIP eligible as a result of their appeal will not opt to continue their QHP enrollment without an APTC or CSR, they may do so.) If, as a result of the fair hearing, the individual is determined eligible for Medicaid, under §435.915, Medicaid eligibility would be effective no later than the date of initial application (with up to 3 months of retroactive eligibility prior to the month of application, if the conditions specified in §435.915 are met). For the period of time prior to disenrollment from the QHP, Medicaid would serve as a secondary payer, subject to general coordination of benefits requirements at section 1902(a)(25) of the Act. The Medicaid program will pay for services or costs covered under the state plan that were furnished by Medicaid providers and not covered by the QHP, including unpaid beneficiary cost-sharing amounts exceeding Medicaid limitations. Medicaid would have no liability to reimburse the QHP for any payments made or benefits provided for the individual pending the outcome of the fair hearing decision. If the individual chooses to remain enrolled in the QHP despite termination of the APTC and CSR, Medicaid would continue to serve as a secondary payer consistent with section 1902(a)(25) of the Act. If the individual had not elected to enroll in

a QHP pending the outcome of the Medicaid fair hearing, no coordination of benefits would be required, and Medicaid would be available for payment for covered services received pending the outcome of the appeal, back to the date or month of application (or up to 3 months before the month of application if the conditions set forth at §435.915(a) are met). If, as a result of a CHIP appeal, the individual is determined eligible for CHIP, eligibility for CHIP would be effective under the policy adopted by the state in its CHIP state plan per §457.340(f). Reflected in §457.310(b)(2)(ii), individuals are not eligible for CHIP if they are enrolled in other coverage; therefore, an individual cannot be enrolled in a separate CHIP until QHP enrollment is terminated.

Per §435.1200(e)(1)(i) and §457.351(a) of this final rule, if the Medicaid or CHIP appeals entity upholds the initial denial, the agency is required to assess the appellant's eligibility for other insurance affordability programs and transfer the individual's account to the appropriate program. If assessed as eligible for enrollment in a QHP through an Exchange, per §§435.1200(g)(5)(i)(C) and 457.351(a), the agency must notify the Exchange or Exchange appeals entity of the outcome of the appeal. Per §155.345(h) of the Exchange regulation, an Exchange and Exchange appeals entity must accept the Medicaid or CHIP appeals decision.

Comment: A commenter believed that the proposed rule assumes that all applicants will submit an online application to an Exchange. The commenter questioned whether that is the expectation and, if not, how applications filed with the Medicaid agency will be coordinated with an Exchange. The commenter also questioned whether there would be circumstances where the application will go to the Medicaid agency first, especially if the individual is just initially applying for Medicaid.

Response: Per §435.907, as stated in the final eligibility regulation published on March 23, 2012, states must accept paper, electronic and telephonic single streamlined applications filed

with the Medicaid agency via an internet web site, mail, telephone or in person. The responsibilities of the agency to coordinate eligibility and enrollment with the Exchange and other insurance affordability programs – set forth in §435.1200, as revised in the July 2013 final eligibility rule as well as this rulemaking – are the same regardless of the modality through which an individual applies for coverage. We would expect that applications not submitted online will be converted by the agency into an electronic format so that it can become part of the individual's electronic account and the agency can fulfill the requirements set forth in §435.1200. Similar provisions for CHIP are found at §§457.330, 457.348 and 457.350.

(2) Related Changes to Medicaid Fair Hearing Rules

We proposed various modifications to our fair hearing regulations at current §431.200, et seq. to modernize our regulations and to clarify certain provisions for consistency with the March 23, 2012, Medicaid eligibility final rule. We also proposed to add a new regulation at §431.224, “Expedited Appeals,” to provide for an expedited fair hearing process similar to the expedited process currently provided at §§431.244(f)(2), 438.408, and 438.410 (related to managed care). This would permit individuals who have urgent health needs to have their eligibility and fee-for-service related appeals addressed under expedited timeframes. Under the proposed rule, an expedited appeal process would be required if the time otherwise permitted under §431.244(f)(1) could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function. We proposed to revise §431.244(f)(2) to require that the agency take final administrative action within 3 working days when the standard for expedited review is met, the same timeframe provided for expedited appeals in the managed care context at §431.244(f)(2). The proposed revisions are discussed in greater detail in section I.B.1(b) of the January 22, 2013 proposed rule. We received the following comments on these proposed provisions:

Comment: We proposed revisions at §431.244(f)(1)(ii) to clarify that the 90-day

timeframe to issue a decision after an individual files an appeal applies broadly to appeals decisions, not only to managed care appeals decisions. The application of the 90-day timeframe allowed for Medicaid fair hearing decisions generally (including fair hearings related to eligibility and fee-for-service matters) was inadvertently removed in a previous rulemaking.

Response: We received no comments on this provision and are finalizing the policy to apply the same standard 90-day timeframe for state Medicaid agencies to issue all types of fair hearing decisions (other than those which must be decided on an expedited basis). However, following publication of the January 22, 2013 proposed rule, we finalized other revisions to §431.244(f)(1) in the “Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule,” published in the May 6, 2016, **Federal Register** (hereinafter referred to as “May 6, 2016 managed care final rule”). The revisions to §431.244(f)(1) finalized in that rulemaking also are reflected in §431.244(f)(1) of this final rule.

Comment: We proposed revisions at §431.220(a)(1) to clarify that a hearing is required (if requested) when the Medicaid agency has denied eligibility, level of benefits, services, or has failed to act with reasonable promptness, as required under section 1902(a)(3) of the Act, and to specify that a determination of eligibility may include a determination of a spend down liability or a determination of income used for purposes of premiums, enrollment fees, or cost-sharing under part 447 of this chapter. To align with the modification of §431.220, we also proposed revisions at §431.201 (definition of “action”) and §431.206(c)(2) (when information in §431.206(b) must be provided to applicants and beneficiaries). We also proposed cross-referencing §431.220(a)(1) at §431.241(a) (the issues to be considered at a hearing) for further alignment. We proposed to add a definition of “local evidentiary hearing” to §431.201 and to add reference to section 1943 of the Act and section 1413 of the Affordable Care Act in §431.200 (Basis and Scope).

Commenters overwhelmingly supported these proposed revisions and no commenters opposed our proposed revisions in these sections. However, some commenters recommended a few changes to our proposals that were technical or intended to further clarify the regulation text of our proposed modifications. A few commenters recommended that we adopt the same language used to describe income determinations for premium and cost-sharing purposes in §431.220(a)(1)(ii) as that in proposed §431.241(a)(3). Another commenter requested clarification regarding the term “claim,” which appeared in both §§431.220(a)(1) and 431.241(a). The commenter questioned if “claim” refers to a claim made on an application (that is, disability, blindness etc.), or to a claim for payment submitted by a provider. Some commenters were concerned that the revised definition of “action” does not include denials of eligibility, services, or benefits, and sought clarification that such denials do provide a basis for a fair hearing request. A few commenters also recommended a technical revision to the definition of “action” to insert the words, “termination or suspension of, or” prior to “reduction in the level of benefits and services;” the commenters believed this was important to ensure our revised definition is not read as excluding termination or suspension of a service or benefit. We did not receive any comments on the proposed definition of “local evidentiary hearing” or on the addition of section 1943 of the Act and section 1413 of the Affordable Care Act to §431.200.

Response: We appreciate the support for the proposed revisions at §431.220(a)(1), §431.206(c)(2), §431.241(a) and (b), and the definition of “action” in §431.201, which we are finalizing as proposed with a few minor revisions. Specifically, we are streamlining the language in §431.220(a)(1)(iii) to provide a cross-reference to the definitions of “premiums” and “cost sharing” in §447.51 and are making revisions for clarity in §§431.206(c)(2), 431.220(a)(1) (introductory text) and 431.241(a). In §431.220(a)(1), we are replacing the word “applicant” with “individual” to apply this provision to applicants and beneficiaries, when applicable. We are

moving the content of current §431.221(a)(2) (relating to beneficiaries) to paragraph (a)(1), removing paragraph (a)(2), and redesignating paragraphs (a)(3) to (a)(7) at paragraphs (a)(2) to (a)(6). Similarly, for clarity we have removed paragraph (b) of §431.241 and placed the content regarding changes in type or amount of benefits and services in §431.220(a)(1)(iv). We have also redesignated paragraphs (c) and (d) at paragraphs (b) and (c). We revise for clarity the reference to “any determination of income for the purposes of imposing any premiums, enrollment fees or cost-sharing under subpart A of part 447” in the definition of “action” in §431.201 to apply if a beneficiary “is subject to an increase in premiums or cost-sharing charges under subpart A of part 447 of this chapter” and have added the phrase “an increase in beneficiary liability” to clarify the language related to spend down liability, premiums and cost-sharing amount. We are accepting commenters’ suggestion to insert the words “termination or suspension of, or” prior to the phrase “reduction in the level of benefits or services” in the definition of “action” in §431.201.

We note that we have added the term “benefits” to encompass items or other Medicaid benefits for which individuals have a right to a fair hearing if a state terminates, suspends, reduces, denies, or delays such a benefit. Examples of “benefits” include prescription drugs, prosthetic devices or cost-sharing, which would not be ordinarily considered a “service.” Accordingly, the term “benefit” has been added to the following regulations §431.201 (definition of action), §431.206(c)(2) (informing applicants and beneficiaries), §431.220(a)(when a hearing is required) and §431.241 (matters to be considered at a hearing) (through cross-reference to §431.220(a)(1)). Further, “covered benefits and services” as described in §431.201, include any covered benefits or services provided for in the state plan or under a state’s approved waiver. We note that we have also removed the term “in the level of” which we proposed as it relates to “benefits” as unnecessary and confusing, from the same regulations. We have made conforming modifications to align the language described above in §§431.206(c)(2) and 431.220(a)(1). We

also clarify in §§431.206(c)(2), 431.220(a)(1)(v) and 431.241(a) (through cross-reference to §431.220(a)(1)) that a denial of a request for exemption from mandatory enrollment in an Alternative Benefit Plan provides a basis for a fair hearing request. We finalize the definition of “local evidentiary hearing” in §431.201 and the revisions to the basis and scope at §431.200, as proposed.

The reference to a “claim” in §§431.220(a)(1) and 431.241(a) (through cross-reference to §431.220(a)(1)) refers broadly to any claim by an applicant or beneficiary for Medicaid, whether such claim be for eligibility for coverage in general, or for a particular benefit or service, consistent with use of the term in section 1902(a)(3) of the Act. The definition of “action” does not include denials because beneficiaries are entitled to 10 days advance notice of an “action” under §431.211 and, in the event a beneficiary requests fair hearing of an “action,” benefits must be continued in the circumstances described in §431.230 and may be reinstated in the circumstances described in §431.231. Because denials of eligibility for new applicants and denials of a particular service or benefit for beneficiaries do not require advance notice, nor does a request for a fair hearing of such denials result in a continuation or reinstatement of benefits or services, it would be erroneous to include denials in the definition of “action”. Under §431.220 and §431.241(through cross-reference to §431.220(a)(1)), as revised in this rulemaking, we clearly specify that individuals are entitled to request a fair hearing of denials of eligibility, benefits and services. The term ‘denial of a claim’ in §431.220(a)(1) includes situations in which the agency authorizes an amount, duration or scope of a service which is less than that requested by the beneficiary or provider. For example, if the individual has requested 20 physical therapy visits and the state denies the individual’s coverage of 20 visits, covering instead only 10 visits – this is considered a denial of a service, which could be appealed under §431.221(a)(1).

We had proposed revisions to the introductory text in §431.206(b) (relating to information

that must be provided to applicants and recipients) to add “or entity” after “the agency.” We did not receive any comments on this proposed revision. However, we are not including this proposed revision in the final regulation as it is unnecessary; generally, the Medicaid agency is responsible for providing information described in §431.206. To the extent that responsibility is delegated to another entity, the delegated entity would be required to comply with all Medicaid rules in accordance with §431.10(c)(3)(i)(A), including providing this information. If the Medicaid agency and the delegated entity agreed to have the Medicaid agency provide certain information, that would be specified in the agreement effectuating a delegation of fair hearing authority in accordance with §431.10(d).

Comment: Several commenters supported our proposed regulation at §431.205(e) to require that the hearing system be accessible to individuals who are limited English proficient and individuals with disabilities, in accordance with §435.905(b). A few commenters raised concerns that phone hearings may be an inadequate hearing forum, particularly for individuals with certain disabilities. The commenters recommended that for such individuals, reasonable accommodations, including video conferencing, should be provided without cost to the appellant. These commenters recommended that our regulation specify that the agency shall not abridge an individual’s right to confront and cross-examine adverse witnesses, or request an individual to waive any provisions of federal or state fair hearing regulations because of a request for a reasonable accommodation. They recommended our rules clarify that a request for reasonable accommodation cannot be used to limit the application of any other protections provided to individuals requesting a fair hearing under the regulations or otherwise alter the state’s fair hearing rules, except as needed to accommodate the request for accommodation.

A number of commenters strongly recommended the addition of a new paragraph (f) to §431.205 specifying that the hearing process may not discriminate on the basis of race, color,

national origin, language, sex, sexual orientation, gender identity, age or disability and must comply with the relevant federal statutes, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act, the Americans with Disabilities Act, and section 1557 of the Affordable Care Act.

Response: We appreciate the support for our proposed addition of §431.205(e), which we are finalizing as proposed. Under §431.205(e) of the final rule, states must ensure accessibility to their fair hearing process for individuals with disabilities (including, but not limited to use of auxiliary aids) and for individuals with limited English proficiency through language assistance services, consistent with §435.905(b). For states relying on telephonic hearings, the provision of video conferencing or an in-person hearing, use of which is common in states today, could be used to ensure access to effective communication for those individuals needing auxiliary aids and services. We are not accepting the commenters recommendation to add regulation text relating to protections for individuals requesting a reasonable accommodation, because we do not believe it is necessary. The rules do not provide a mechanism for states to waive any protections or to otherwise limit such protections for any reason. Moreover, we understand that the current regulations issued under Title II of the Americans with Disabilities Act, which apply to the state hearing system, address this issue. See 28 CFR 35.130(b)(1). For additional information on reasonable modifications and auxiliary aids and services to ensure accessibility of state and local government activities and services for individuals with disabilities, we direct readers to regulations at 28 CFR 35.101 et seq. An adverse action based on a request for a reasonable modification would violate the Title II regulations, as would setting aside or limiting the applicability of any protections provided in part 431, subpart E or in accordance with the state's fair hearing procedures. See 28 CFR 35.134 for more detail.

We are accepting the comment to add a new paragraph (f) to §431.205, clarifying that the

hearing system established under section 1902(a)(3) of the Act and part 431 subpart E must be conducted in a manner that complies with all applicable federal statutes and implementing regulations, including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act. This is consistent with the technical revisions, discussed in section D of this final rule, which we are making at §435.901, that the state's eligibility standards and methods are consistent with the rights of individuals under all of these statutes and implementing regulations. We also note that, for individuals who believe they have been discriminated against in the appeals and hearings process, these individuals can use the grievance process established by each state agency operating a Medicaid program or CHIP. This grievance process must operate in accordance with Section 1557 of the Affordable Care Act and implementing regulations, among other existing Federal civil rights authorities. These individuals may also file complaints of discrimination directly with the HHS Office for Civil Rights at www.HHS.gov/OCR.

Comment: Several commenters supported our proposed addition of paragraph (e) to §431.206 to require that information provided to applicants and beneficiaries be accessible to individuals who are limited English proficient and individuals with disabilities, consistent with section §435.905(b) of this chapter. A number of commenters suggested that more detailed requirements be added at paragraph (e) related to accessibility of information for individuals who are limited English proficient and individuals with disabilities.

Response: We appreciate the support for proposed paragraph (e) to require that information be provided accessibly, which we are finalizing as proposed. We note that we added paragraph (e) to §431.206 in the July 2013 final eligibility rule to authorize states to provide electronic notices in accordance with §435.918. Section 431.206(e) of this final rule amends

paragraph (e) to also require that states provide information (whether in electronic or paper form) in a manner that is accessible to individuals who are limited English proficient and to individuals with disabilities. We also are making a technical modification to this provision, replacing the word “section” with “subpart” to apply the accessibility requirements as well as the permissibility of electronic notices under paragraph (e) to all appeals notices described in part 431, subpart E, as intended. We address the comment to add more specific requirements related to accessibility in section D of this final rule, relating to accessibility of program information under §435.905(b).

Comment: A number of commenters recommend amending §431.220(a) to add the specific phrase “de novo” to the regulation to specify that the state agency must grant an opportunity for a de novo hearing before the agency, consistent with Goldberg v. Kelly and constitutional due process principles, as all individuals have the right to a de novo hearing.

Response: The comment is beyond the scope of this rulemaking. However, we agree all applicants and beneficiaries who request a fair hearing are entitled to a de novo hearing, which must take place either before the agency or an entity to which fair hearing authority has been delegated under §431.10(c)(1)(ii) or an ICA waiver. This is consistent with current regulations at §§431.240 through 431.244, which require that hearings be conducted by an impartial official; that individuals be afforded an opportunity to submit evidence and arguments without interference; and that hearing decisions be based only on evidence introduced at the hearing. Together, these provisions effectively require a de novo hearing. However, to further clarify the current policy, we propose elsewhere in this **Federal Register** to add the words “de novo” before hearing in §431.205(b) to clarify that the fair hearing provided by the state’s hearing system must be a “de novo” hearing, which is defined in current regulations at §431.201.

Comment: A few commenters were concerned about individuals being denied fair hearing rights when there is a change in law or policy, even if the individual may have a factual or other

issue that should be considered at a fair hearing. The commenters suggested that we modify the regulation (1) to clarify that cases can only be dismissed if there can be no disagreement regarding the application of that change to the appellant; (2) to permit only an impartial, independent hearing officer or administrative law judge to determine that a fair hearing can be denied under §431.220(b); and (3) to require that an appellant be provided an opportunity to orally oppose the dismissal of the appeal.

Response: The comment is beyond the scope of this final rule. Please see proposed modification of §431.220 elsewhere in this **Federal Register** for more discussion on this issue.

Comment: Several commenters supported proposed §§431.224 and 431.244(f)(3) to establish an expedited fair hearing process that aligns with Exchange appeals regulations at §155.540 as well as with a similar process provided for Medicaid managed care enrollees at §438.410. Commenters supported establishing an expedited fair hearing process that would provide applicants and fee-for-service beneficiaries the same right to an expedited hearing process of a Medicaid denial or other adverse action (as defined in §431.201) when there is an urgent health need, as is provided under Exchange regulations at §155.540, as well as to Medicaid beneficiaries enrolled in managed care and CHIP beneficiaries for whom coverage of a service is limited or denied in accordance with §§438.408(b)(3), 438.410 and 457.1160(b)(2). Several commenters supported this provision, which they believe was critical to ensuring the request is acted upon promptly. Many other commenters expressed concern about states' ability to implement an expedited fair hearing process within 3 working days, as required at proposed §431.244(f)(3). These commenters disagreed that existing processes for expedited managed care appeals would make compliance with the proposed expedited appeals process easy, stating that Medicaid appeals entities generally do not possess the medical expertise needed to evaluate if an expedited hearing should be granted. Some commenters were also concerned that an appeals

entity wouldn't be able to obtain sufficient information on which to base a fair hearing decision in a 3-day timeframe. One commenter supported the language at proposed §431.244(f)(3) that expedited decisions be made "as expeditiously as the individual's health condition requires," but expressed concern that 3 days may not allow time for the individual or agency to prepare properly for the hearing. Others commenters were concerned that a 3-day timeframe also may pose a burden on individual appellants to gather information necessary to prepare for the hearing. One commenter suggested that requiring a hearing within 3 working days and a decision 3 working days after that would be more reasonable. Another commenter recommended that the expedited timeframe for taking final action if the expedited hearing is granted, be changed from 3 days to at least 45 days. A few commenters were concerned that the proposed expedited fair hearing process will require extensive staffing increases, including skilled medical personnel, as well as updates to current tracking mechanisms. One commenter recommended eliminating the proposed expedited fair hearing process.

One commenter requested clarification regarding the relationship between (1) the 2 days at proposed §431.224(b) for the state to determine if an individual meets the standard for an expedited review and to inform the individual if his or her request for expedited review is denied, and (2) the 3-day timeframe to take administrative action on an expedited fair hearing. Some commenters also suggested that CMS require data reporting on the timeliness of Medicaid fair hearing decisions, and to make this information available to the public. We did not receive any comments regarding §431.242(f), which adds the request of an expedited review to the procedural rights that must be afforded to individuals requesting a fair hearing.

Response: Exchange appeals regulations at §155.540 provide for an expedited appeals process for individual eligibility appeals of determinations for coverage through the Marketplace, APTC, and CSRs. Medicaid regulations at §§431.244(f)(2), 438.408(b)(3) and 438.410 currently

provide for an expedited appeals process when a beneficiary has been denied coverage of, or payment for, a benefit or service by a managed care organization and allowing the time generally permitted to resolve enrollee grievances could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. Current CHIP regulations at §457.1160(b)(2) provide for similar expedited review of health services matters, as defined at §457.1130(b). The current regulations, however, do not apply to Medicaid applicants and beneficiaries who are denied eligibility or terminated from coverage, whose coverage is reduced, or for whom coverage of a benefit or service by the agency in a fee-for-service context is denied, terminated, reduced, or delayed. We agree with commenters supporting the proposed regulation that having an expedited review process is an important consumer protection for applicants and beneficiaries with urgent health care needs, regardless of the nature of the appeal or the type of delivery system employed. Therefore, we are including at §431.224 of the final rule a requirement that states establish an expedited fair hearing process for individuals with appeals of eligibility determinations and fee-for service beneficiaries similar to the regulations currently in place for individuals enrolled in coverage through the Marketplace, as well as Medicaid managed care and CHIP. We note that such an expedited fair hearing process could be included in the delegation of fair hearings at §431.10(c)(1)(ii) and addressed in an agreement between the agencies that would include responsibilities of the parties described at §431.10(d).

At the same time, we appreciate the concerns raised regarding the operational challenges to implementing the proposed time frames and are revising proposed §§431.224 and 431.244(f)(3) to provide states with more flexibility in notifying individuals whether their request for an expedited hearing has been granted and in establishing a reasonable time frame for conducting expedited hearings. Under §431.224(a)(1) of the final rule, states must establish and maintain an expedited fair hearing process for individuals who request an expedited fair hearing if

the agency determines that the standard time permitted for resolution of an appeal in §431.244(f)(1) could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function. We do not propose specific criteria which states may or must take into account in determining whether this standard is met. However, we note that, in addition to the medical urgency of an individual's situation, we believe appropriate considerations also could include whether the individual currently is enrolled in health insurance that will cover most of the costs of the requested treatment, whether or not the individual has a needed procedure or treatment scheduled, or whether the individual is unable to schedule a procedure or treatment due to lack of coverage. Paragraph (a)(2) of §431.224 provides that states must take final administrative action within the time period established under §431.244(f)(3) if the individual meets the urgent health standard described in §431.224(a)(1). Under §431.224(b) of the final regulation, the agency must inform individuals whether their request for an expedited fair hearing is granted or denied as expeditiously as possible, orally or through electronic means in accordance with the individual's election under §435.918 (relating to receipt of electronic notices). If oral notice is provided, the state must follow up with written notification, which may be through electronic means if consistent with the individual's election under §435.918. For individuals whose expedited fair hearing request is approved, the state must provide notice of a hearing date that allows adequate time for the individual to participate, consistent with current §431.240(a)(2). States can inform the individuals that their request for expedited fair hearing has been granted and the date of such hearing in the same notice. Note that we propose elsewhere in this **Federal Register** further modification of §431.224(b) regarding expedited fair hearing notices.

Section 431.244(f)(3)(i) of the final rule provides that, for individuals whose request for an expedited fair hearing related to an eligibility matter described in §431.220(a)(1) or to any matter described in §431.220(a)(2) or (3) is approved, the agency must take final administrative

action as expeditiously as possible. Effective no earlier than 6 months after the release of a **Federal Register** notice described in §435.1200(i) of the final rule, final administrative action for such hearings under §431.244(f)(3)(i) must be taken as expeditiously as possible, but no later than 7 working days from the date the agency receives the expedited fair hearing request. Section 431.244(f)(3)(ii) of the final rule provides that, for individuals whose request for an expedited fair hearing related to a services or benefits matter described in §431.220(a)(1) is approved, the agency must take final administrative action as expeditiously as possible. Effective no earlier than 6 months after the release of a **Federal Register** notice described in §435.1200(i) of the final rule, final administrative action for such hearings under §431.244(f)(3)(ii) must be taken as expeditiously as possible and within the timeframe specified in §431.244(f)(2) of the current regulations (that is, within 3 working days from the date the agency receives the expedited hearing request). In §431.244(f)(3)(iii), we provide that for individuals whose request for an expedited fair hearing of a claim related to a services or benefits matter described in §431.220(a)(4) through (6) is granted, the agency must take final administrative action in accordance with §431.244(f)(2).

We believe that the 7 working days timeframe provided (with a delayed effective date) under §431.244(f)(3)(i) of the final rule results in comparable treatment for individuals appealing eligibility-related and managed care appeals. Individuals appealing a decision of a managed care plan are required in some states to exhaust their plan level appeal before requesting a fair hearing of the plan's decision before the agency. Under current §438.408(b)(3), managed care plans must resolve expedited appeals of an adverse action taken by the plan within 72 hours. Under current §431.244(f)(2), the agency has 3 working days to take final administrative action if the individual appeals the plan's decision to the agency. Allowing for one working day for transmission of the case file from the plan to the agency, this results in a 7-day time frame for reaching final

administrative action on expedited appeals filed by enrollees in a managed care plan who are appealing an action taken by the plan. In §431.244(f)(3)(ii), we have aligned the timeframe to take final administrative action in an expedited fair hearing request between managed care and fee-for-service delivery systems (3 working days), so that all individuals appealing a service-related appeal will be able to get a resolution from at least a first-level review in 3 working days when there is an urgent health need, whether such review is at the level of the managed care plan or, for a fee-for-service appeal, before the agency. We believe that these timeframes strike a reasonable balance between needed consumer protections and state administrative concerns. Because we recognize that some claims (both those that meet the standard for expedited hearing in §431.224(a)(1) and those that do not), are more urgent than others, elsewhere in this **Federal Register**, we also are proposing that states establish more detailed timeliness and performance standards for both expedited and non-expedited fair hearings. We also note that states may, within the limits provided at §431.10 and subject to other legal requirements regarding the use of contractors by the single state agency, use contractors to perform clerical duties, such as receiving and tracking expedited hearing requests and preparing case files for hearing, which may help the state to meet applicable time frames.

Finally, we are finalizing the addition of new paragraph (f) in §431.242, providing for the right of applicants and beneficiaries to request an expedited hearing; we have removed the words “if appropriate” from §431.242(f) in the final rule, as there are no conditions which constrain an individual’s right to request an expedited fair hearing. We also (1) add a conforming revision at §431.221 (related to requests for hearing) to require that individuals be provided an opportunity to include a request for an expedited hearing in their request for a fair hearing; and (2) make similar conforming revisions in §431.206(b) – revising §431.206(b)(1) and adding paragraph (b)(4) – to provide that individuals must be informed of the opportunity to request an expedited review of

their fair hearing request and of the time frames upon which the state will take final administrative action in accordance with §431.244(f). We expect that the process established by a state under §431.224(a)(1) for an individual to request an expedited fair hearing would include providing the opportunity for an individual to make such a request after the individual has requested their fair hearing, if the individual has not indicated a request for an expedited fair hearing in the initial fair hearing request in §431.221(a)(1). No additional hearing would be required in response to a subsequent request for an expedited hearing, if a hearing on the initial request already had been held.

Comment: Some commenters recommended that CMS require data reporting on the timeliness of Medicaid fair hearing decisions, and that this information be made available to the public.

Response: We will take this suggestion, which is beyond the scope of this rulemaking, into future consideration.

Comment: Several commenters expressed concern about the proposed standard for when an expedited fair hearing would be required, that is, whenever the time otherwise permitted to take final administrative action on a fair hearing request would jeopardize the individual's ability to attain, maintain or regain maximum function. These commenters indicated that this standard is overbroad and would encompass many conditions.

Response: This standard for an expedited fair hearing is aligned with the standard used for Exchange eligibility appeals at §155.540 and similar to the standard currently used in our managed care appeals rules at §438.410. To maintain consistency and alignment across insurance affordability program eligibility appeals and similar treatment between FFS beneficiaries and managed care enrollees, we finalize the standard in §431.224(a) as proposed.

Comment: A few commenters requested clarification regarding implementation of the

expedited fair hearing process. One commenter questioned whether there needs to be an intermediate level of review of the expedited hearing request. Additionally, the commenter sought clarification about whether appeals staff would have to be available on an “on-call” basis. Another commenter questioned if individuals may appeal an adverse decision related to granting an expedited fair hearing request.

Response: There is no specific requirement for states to establish an intermediate level of review for an expedited fair hearing request, or to have staff on call at all times to receive requests for expedited review of a fair hearing. There is flexibility under the regulations for each state to establish policies and procedures best tailored to its own situation, provided that such policies and procedures comply with the requirements set forth in the regulations, including meeting the timeframe consistent with §431.244(f)(2). Section 431.224(b) of the final regulation requires states to inform individuals whether the state is granting or denying their request for an expedited review, but does not require that the individual be given an opportunity to appeal the agency’s denial of their request. We note that a denial of a request for an expedited hearing is not required under the definition of “action” at §431.201 nor identified as a basis for requesting a fair hearing under §431.220.

Comment: A few commenters recommended that we require individuals to provide medical evidence justifying the need for an expedited fair hearing process, which they believed would minimize the burden on states. One commenter requested clarification whether individuals can be required to submit the medical records as part of the expedited hearing request or whether self-attestation must be accepted.

Response: States have flexibility under the regulations to establish policies and procedures for an expedited review process, and we neither require nor preclude submission of medical documentation as may be appropriate. We note that elsewhere in this **Federal Register**,

we propose that states will be required to establish an expedited appeals plan, which must discuss when an individual requesting an expedited fair hearing would need to provide medical documentation of their urgent health need.

Comment: A few commenters requested clarification about the individuals for whom the expedited fair hearing process applies. One commenter requested clarification regarding whether the expedited fair hearing process would only apply to beneficiaries, and only when there is a denial of services, not when an adverse eligibility determination has been made. Another commenter questioned whether the requirement for expedited fair hearing process applies also to non-MAGI populations whose Medicaid eligibility may be based upon multiple criteria such as assets, disability status, and functional level of care, many of which may be difficult to verify or adjudicate on an expedited basis.

Response: The expedited review process established in §431.224 is available when warranted based on an urgent health need for all individuals who can request a fair hearing of an action, as defined in §431.201, or when a hearing is required under §431.220 (which includes denials of eligibility, benefits or services, as well as when a claim is not acted upon with reasonable promptness). The expedited review process is available both to those enrolled in, or seeking coverage under, a MAGI-related eligibility category and to those enrolled in, or seeking coverage under, a non-MAGI based category.

Comment: Several commenters supported our proposed revisions to §431.232 to provide that the agency must inform an applicant or beneficiary that he or she has 10 days from the notice of an adverse decision of a local evidentiary hearing to appeal that decision to the state agency and to adopt language similar to that proposed at §§431.231 and 435.956 and finalized in the July 2013 eligibility final rule, regarding the date an individual is considered to receive a notice sent by the agency.

Response: We appreciate the support for our proposed regulation at §431.232(b) which we are finalizing as proposed, except for a grammatical revision for clarity to move reference to the requirement that the notice required be “in writing.”

Comment: We received many comments in support of our proposed modification to §431.242(a)(1) that gives an appellant access to the content in his or her electronic account, in addition to his or her case file.

Response: We appreciate the commenters’ support and are finalizing §431.242(a)(1) as proposed. We note that access to this content could be provided in a variety of methods, including providing electronic access to this information or mailing copies of the information contained in the electronic account to an appellant or other authorized individual who requests it.

Comment: We proposed revisions to the definition of “electronic account” in §435.4 to include information collected or generated as part of a fair hearing process. One commenter suggested that the specific data elements that will be added to the electronic account be defined so that states can build or modify their systems accordingly.

Response: There are many data elements that must or may be included in an electronic account, and we do not believe that this level of specificity is appropriate for inclusion in the regulations. Specific data elements for inclusion in an electronic account are discussed in relevant technical documents related to account transfers of eligibility determinations between Exchanges and state agencies.

Comment: Several commenters recommended adding language in §431.244(g), to require that the public must have “free” access to all hearing decisions. The commenters also suggested clarifying that the agency may satisfy this requirement by making hearing decisions available through a free indexed and searchable database posted online.

Response: The comment is beyond the scope of this final rule. However, elsewhere in

this **Federal Register**, we propose revisions to §431.244(g) relating to public access to hearing decisions. We also note that, because hearing decisions may contain confidential information about the appellant, any disclosure would need to adhere to privacy protections and disclosure rules at section 1902(a)(7) of the Act and part 431 subpart F. We understand that a number of states redact Personally Identifiable Information (PII) and information otherwise subject to privacy and disclosure protections to provide public access to hearing decisions in accordance with current §431.244(g).

Comment: A commenter suggested that CMS identify areas in which requirements could be established to promote greater consistency in state Medicaid appeals processes for beneficiaries and permit Medicaid health plans to maintain efficient systems to provide beneficiary appeal rights across the country.

Response: We appreciate the comment suggesting consistency in Medicaid fair hearings rules across states. Section 431.205 sets out broad requirements that fair hearing procedures must be consistent with Goldberg v. Kelly, and federal authorities including the Civil Rights Act of 1964, Americans with Disabilities Act, and section 1557 of the Affordable Care Act and implementing regulations. Although there are areas of state flexibility in operationalizing and implementing the fair hearing process (for example, flexibility regarding how to organize hearing functions within the state agency or to delegate appeals functions to an Exchange or Exchange appeals entity per §431.10(c) or another state agency through an Intergovernmental Cooperation Act of 1968 waiver), much of the regulations in part 431 subpart E reflect standard definitions and requirements that must be applied across states, including a common definition of “action” in §431.201; when a hearing is required at §431.220; requirements relating to the procedural protections during a hearing at §431.242; and standards governing various aspects of hearing decisions at §431.244. In revising the regulations in part 431 subpart E, we also have worked to

establish, to the extent possible, consistency and coordination with the regulations for Exchange-related appeals, as well as comparability between the protections afforded to Medicaid beneficiaries in a FFS and managed care environment.

Comment: A commenter suggested that we include a cross-reference in §431.221(a) to §435.923 (added to the regulations in the July 2013 final rule) to clearly define who can request a fair hearing on behalf of another person as their “authorized representative.”

Response: We are accepting the comment and adding the recommended cross-reference to §431.221(a). We also make a technical revision to §457.340(a) to add a cross-reference to §435.923 (relating to authorized representatives) to the list of Medicaid regulations which apply equally to the state in administering a separate CHIP. Application of the regulations to authorized representatives was inadvertently excluded from the January 22, 2013 Eligibility and Appeals proposed rule and the July 15, 2013 Medicaid and CHIP final rule Part I.

B. Notices

1. Content Standards (§§435.917 and 431.210)

Effective notices must be clear and understandable to consumers and deliver appropriate, comprehensive eligibility information that enables the reader to understand the action being taken, the reason for the action, any required follow-up, and the process to appeal. Such notices are a key component of a coordinated and streamlined eligibility and enrollment process required under section 1943 of the Act and 1413 of the Affordable Care Act. Therefore, we proposed (1) to revise §431.210(b) to provide that notices must contain a clear statement of the specific reasons supporting an intended adverse action; and (2) to revise §435.913, redesignated at proposed §435.917, to clarify the agency’s responsibilities to communicate specific content in a clear and timely manner to applicants and beneficiaries when issuing notices affecting their eligibility, benefits or services, including notices involving the approval, denial or suspension of eligibility

and the denial or change in benefits and services.

We proposed at §435.917(a) that eligibility notices must be written in plain language, be accessible to individuals who are limited English proficient and individuals with disabilities consistent with §435.905(b), comply with regulations relating to notices in part 431 subpart E and, if the notice is provided in electronic format, comply with §435.918(b). Proposed paragraph (b) sets forth the specific content required for notices. Proposed paragraph (c) provides that eligibility notices relating to a determination of eligibility based on the applicable MAGI standard include a plain language description of other potential bases of eligibility (for example, eligibility based on being aged, blind or disabled or eligibility for medically needy coverage based on incurred medical expenses), and how to request a determination on such other bases. Under proposed paragraph (d), the agency's responsibility to provide notice is satisfied by a combined eligibility notice (defined in proposed §435.4 and discussed in section II.B.2 of this final rule) provided by another insurance affordability program, provided that the agency provide supplemental notice of certain information required under §435.917(b)(1) if the information is not included in the combined notice provided by the other program. Similar policies were proposed for CHIP through proposed revisions to §457.340(e). We are also finalizing as proposed the removal of §§435.913 and 435.919 pertaining to timely and adequate notice concerning adverse actions and moved the provisions therein to §435.917. We also make a conforming technical revision in §435.945(g) to remove the cross reference to §435.913.

The provisions, except as noted below, are finalized as proposed. We received the following comments on these proposed provisions:

Comment: A commenter stated that detailed information on out-of-pocket costs across insurance affordability programs should be included in the eligibility notice. Another commenter noted that states should be given flexibility in terms of additional benefit and cost-sharing

information that could be included in the eligibility notice and the format in which such information can be provided, such as in a brochure.

Response: States need to customize eligibility notices to deliver sufficient information on benefits and cost sharing, without creating overly-complex and lengthy notices. We are revising proposed §435.917(b)(1)(iv) to clarify that eligibility notices must contain basic information regarding the level of benefits available and the cost-sharing obligations associated with the eligibility status that has been determined, as well as how the individual can receive more detailed information, which could be provided in another format, such as a brochure. We also are revising §435.917(b)(1)(iv) in this final rule to provide that a notice of eligibility also include, if applicable, basic information regarding the differences in coverage available to individuals enrolled in benchmark or benchmark-equivalent coverage or in an Alternative Benefit Plan as opposed to coverage available to individuals described in §440.315 (relating to exemptions from mandatory enrollment in benchmark or benchmark-equivalent coverage). The agency could provide more detailed information in a brochure included with the eligibility notice or make it available online, through a supplemental mailing or upon request.

Comment: A commenter noted that the information on potential eligibility on non-MAGI bases which must be included in notices involving a determination of eligibility or ineligibility based on MAGI under proposed §435.917(c) should explain the eligibility rules for these other groups, including any applicable resource test, so that individuals can know whether to pursue eligibility under these categories or seek coverage elsewhere. The commenter recommended that eligibility notices for individuals found eligible under the new adult group described in §435.119 should explain that the individual may be eligible for different benefits based on their healthcare condition and how they should request a review of their status.

Response: We agree with the commenter that eligibility notices approving eligibility based on MAGI need to include information regarding other bases of eligibility. However, the amount of detail provided must also take into account the need to provide a clear and understandable notice. We believe that proposed §435.917(c), which is finalized as proposed, strikes the right balance. A notice of approval, denial, or termination of eligibility based on MAGI must contain basic information sufficient to enable the individual to pursue a determination on a non-MAGI basis, without undermining the goal of clarity and simplicity.

Through our efforts to provide support and technical assistance to states in modernizing eligibility notices, we developed Medicaid and CHIP model notices to include content depicting how information on non-MAGI bases of eligibility could be written and displayed. Our model notices, while not required, include information describing non-MAGI eligibility criteria and suggest that individuals who believe they are potentially eligible on a non-MAGI basis contact the state Medicaid agency for further information. These model notices can be obtained at <http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Learning-Collaborative-State-Toolbox/State-Toolbox-Expanding-Coverage.html>.

Comment: A commenter recommended that approval notices should be required to include a clear explanation of any restrictions based on the availability of medical treatment that may be in place if the individual is in a managed care plan, including utilization control mechanisms and whether the plan has stated any moral or religious exceptions. The commenter requested that CMS further clarify a state's responsibility to notify all potential enrollees of these limits and provide information about how to access covered services.

Response: Due to the variation which may exist between managed care plans, we do not believe such detailed plan-specific information should be included in eligibility notices. This

information is more appropriate to include in a subsequent notice regarding the individual's enrollment options, which is the subject of regulations relating to managed care at §438.10.

Comment: We received a few comments regarding our proposed revisions to §431.210(b) to require that an adverse action notice contain “a clear statement of the specific reason supporting the intended action.” One commenter supported the proposed paragraph, noting that agencies often provide only a regulation citation to justify an action, which is not meaningful to most consumers. Another commenter was concerned that proposed §431.210(b) would lead to litigation because notices would lack the clarity required. No comments were received on proposed revisions at §431.210(a) (replacing reference to “the State” with “the agency” and requiring adverse notices to include the effective date of the action) or §431.210(d)(1) (adding the word “local” before “evidentiary”).

Response: Providing both a clear statement, as well as specific legal authority (required per current §431.210(c)) for an adverse action is critical to enable consumers to understand an agency's decisions regarding their case. Therefore, we are finalizing §431.210(b) as proposed. Current §431.210(c) (which is not revised in this rulemaking) continues to require that a notice of adverse action include specific legal authority supporting the action. Under the regulations, such notices must include both a plain language description and a specific citation supporting why the agency has determined that an individual's eligibility is denied or terminated, or whose benefits are reduced, suspended or terminated. Sections §431.210(a) and (d)(1) are finalized as proposed. We remind states operating Medicaid and CHIP programs that in addition to the program notice requirements discussed in this final rule, states must comply with other applicable notice requirements, such as those under Section 1557 of the Affordable Care Act and implementing regulation.

2. Combined and Coordinated Notices (§§435.4, 435.917, 435.1200, 457.10, 457.348, and 457.350)

A coordinated system of notices is important to a high quality consumer experience and a coordinated eligibility and enrollment system, as provided for under section 1413 of the Affordable Care Act and section 1943 of the Act. We proposed a coordinated system of notices across all insurance affordability programs to maximize the extent to which individuals and families receive a single notice communicating the determination or denial of eligibility for all applicable insurance affordability programs and for enrollment in a QHP through the Exchange. This is regardless of where the individual initially submits an application or renews eligibility or whether the Exchange is authorized to make Medicaid and CHIP eligibility determinations or for which program an individual ultimately is approved eligible. In support of this policy objective, we proposed to add definitions in §435.4 of “combined eligibility notice” (to mean an eligibility notice that informs an individual, or household of his or her eligibility for multiple insurance affordability programs) and “coordinated content” (to refer to information included in an eligibility notice relating to the transfer of an individual’s or household’s electronic account to another program). We explained that coordinated content is needed when the eligibility determination for all programs cannot be finalized for inclusion in a single combined eligibility notice. Definitions of “combined eligibility notice” and “coordinated content” were proposed for CHIP in §457.10.

We proposed various revisions to §435.1200 specifying the circumstances in which a coordinated eligibility notice or coordinated content would be required for Medicaid determinations and similar revisions at §457.348 and §457.350 for CHIP. In §435.1200, we proposed to redesignate paragraph (a) at paragraph (a)(1) and to add a new paragraph (a)(2) to provide cross-references to the definitions added at §435.4. We proposed a new paragraph

§435.1200(b)(3)(iv) to provide that the agreements between the Medicaid agency and other insurance affordability programs delineate the responsibilities of each program to provide combined eligibility notices (including a combined notice for multiple household members to the extent feasible) and coordinated content, as appropriate. At §435.1200(b)(4) we proposed that if a combined eligibility notice cannot be provided for all members of the same household, the coordinated content must be provided about the status of other members. Proposed §435.1200(c)(3) provides that when an Exchange or other insurance affordability program makes a final determination of Medicaid eligibility or ineligibility, the agreement between the agency and Exchange or other program consummated under §435.1200(b)(3) must stipulate that the Exchange or other program will provide the applicant with a combined eligibility notice including the Medicaid determination. Similar provisions for CHIP were proposed at §457.348(a), (b)(3)(i) and (ii), and (c)(3).

We proposed incorporating, for clarity, the content of §435.1200(d)(5) (relating to notification of the receipt of an electronic account transferred to the agency) into §435.1200(d)(1). We proposed to add new language at §435.1200(d)(3)(i) specifying that, when an individual is assessed by an Exchange or other program as potentially Medicaid eligible and the account is transferred to the Medicaid agency for a final determination, if the Medicaid agency approves eligibility, the Medicaid agency will provide the combined eligibility notice for all applicable programs. We proposed revisions to §435.1200(e) to provide a new paragraph (e)(1)(ii) and (e)(1)(iii)(B) that, effective January 1, 2015, or earlier, at state option, the Medicaid agency include in the agreement consummated under §435.1200(b)(3) that the Exchange or other program will issue a combined eligibility notice, including the Medicaid agency's denial of Medicaid eligibility, for individuals denied eligibility by the agency at initial application (or terminated at renewal) and assessed and transferred to the Exchange or other insurance

affordability program as potentially eligible for such program. Per proposed §435.1200(e)(1)(iii)(A), prior to January 1, 2015, the agency would provide notice of a Medicaid denial or termination and coordinated content relating to the individual's transfer to another insurance affordability program if such other program would not be providing a coordinated eligibility notice containing such denial or determination. Finally, under proposed §435.917(d) the agency's responsibility to provide notice of an eligibility determination, as required under §431.210 or proposed §431.917, is satisfied by a combined notice provided by an Exchange or another insurance affordability program in accordance with an agreement between the agency and the Exchange or such program. Similar revisions were proposed for CHIP at §§457.348(d)(1) and (d)(3)(i), 457.350(i)(2) and (3).

The proposed policy of a single combined eligibility notice would not apply in the case of individuals determined ineligible for Medicaid on the basis of MAGI but being evaluated for eligibility on a non-MAGI basis, because the Medicaid agency typically would be continuing its evaluation of the individual's eligibility on the non-MAGI bases at the same time that the individual was being evaluated for, and potentially enrolled in, another insurance affordability program. In this situation, under proposed §435.1200(e)(2)(ii), the Medicaid agency would provide notice to the individual explaining that the agency has determined the individual ineligible for Medicaid on the basis of MAGI and that the agency is continuing to evaluate Medicaid eligibility on other bases. This notice also would contain coordinated content advising the applicant that the agency has assessed the individual as potentially eligible for, and transferred the individual's electronic account to, the other program. Proposed §435.1200 (e)(2)(iii) requires the agency to provide the individual with notice of the final eligibility determination on the non-MAGI bases considered. If the individual is later determined eligible for Medicaid on a basis other than MAGI, proposed paragraph (e)(2)(iii) provides that that agency include coordinated

content in the notice of eligibility on the non-MAGI basis that the agency has notified the applicable insurance affordability program of the Medicaid determination, as well as the impact that the Medicaid determination will have on the individual's eligibility for the other program. For CHIP, we proposed to redesignate §457.350(j)(3) at §457.350(j)(4) and to add a new paragraph (j)(3) providing for the coordination of notices for individuals assessed by the CHIP agency as not eligible for Medicaid based on having income below the applicable MAGI standard, but as potentially eligible for Medicaid on a non-MAGI basis.

Comment: We received many comments regarding our proposed policy to establish a coordinated system of notices across insurance affordability programs. Commenters generally supported the policy goal as an important part of a coordinated eligibility and enrollment system and we received no comments recommending specific revisions to the proposed regulations. Many commenters, however, were concerned about current systems capabilities to coordinate single combined notices between different insurance affordability programs. One commenter was concerned that the need to provide a combined eligibility notice could undermine provision of timely notice. Commenters also found the proposed regulations confusing and were unsure of exactly when a combined eligibility notice is required.

Response: We appreciate commenters' support of the goal of achieving a coordinated system of notices, as well as the concerns about the ability of multiple programs to provide a single combined eligibility notice to the extent envisioned in the proposed rule, particularly in states that do not operate a shared service for determining eligibility for all programs, including all states which rely on the FFE to determine eligibility for enrollment in a QHP and for APTC and CSRs. We also agree with commenters that the regulatory provisions implementing a coordinated system of notices proposed in §435.1200, which were spread across several paragraphs of that section, are confusing. We make two basic changes in the final rule to address

commenters' concerns. First, we are not finalizing the key provisions relating to coordinated notices as proposed at paragraphs (b)(4), (c)(3), (d)(3)(i), (e)(1)(ii) and (e)(1)(iii) in §435.1200. Instead, the final rule anticipates that states and Exchanges will phase in increased use of single coordinated eligibility notices, to be provided by the last entity to “touch” an application or renewal, more gradually over time, as provided in a new paragraph §435.1200(h) of the final rule. Specifically, §435.1200(h)(1) of the final rule provides that the agency include in the agreements with other programs, under §435.1200(h)(1) that, to the maximum extent feasible, the agency, Exchange or other insurance affordability program will provide a combined eligibility notice to individuals, as well as to multiple members of the same household included on the same application or renewal form. Section 435.1200(h)(2) provides that, for individuals and other household members who will not receive a combined eligibility notice, the agency must include appropriate coordinated content in the notice it provides under §435.917. To ensure that applicants and beneficiaries are fully informed of the status of their application or renewal, we clarify in the definition at §435.4 of the final rule that, in addition to information relating to the transfer of an individual's or household's electronic account to another program, coordinated content also includes, if applicable, any notice sent by the agency to another insurance affordability program regarding an individual's eligibility for Medicaid, the ways in which eligibility for the different programs may impact each other, and the status of household members on the same application or renewal form whose eligibility is not yet determined.

For example, because applicants and current beneficiaries determined ineligible for Medicaid have different rights – both in terms of the continuation of benefits pending an appeal of the Medicaid agency's determination, as well as the right to a special enrollment period in the Exchange – we do not expect that states necessarily will be able to provide for a combined notice right away for individuals determined ineligible for Medicaid by the Medicaid agency and

transferred to an Exchange that does not share a common eligibility system. As systems mature, and the communication between the programs can differentiate individuals denied eligibility by the agency at initial application from those being terminated at renewal or due to a change in circumstances, a combined notice would be required under §435.1200(h)(1).

Rather than finalize the amendments to §435.1200(e)(2) pertaining to notices as proposed, existing §435.1200(e)(2) remains unchanged and we have specifically accounted for one particularly complex situation, involving the need for multiple notices, in the final regulation at §435.1200(h)(3). We did not finalize as proposed §§435.1200(e)(2)(ii) and 435.1200(e)(2)(iii), but added §435.1200(h)(3), which describes the notice requirements for individuals determined ineligible for Medicaid based on having household income above the applicable MAGI standard (at initial application or renewal), but who are undergoing a determination on a basis other than MAGI. Section 435.1200(h)(3) directs the agency to first provide notice to the individual, consistent with §435.917, that the agency has determined that the individual is not eligible for Medicaid based on MAGI, but is continuing to evaluate eligibility on other bases. This notice must include a plain language explanation of the other bases being considered and coordinated content that the agency has transferred the individual's electronic account to the Exchange or other insurance affordability program (as required under §435.1200(e)(2)) and an explanation that eligibility for or enrollment in the other program will not affect the determination of Medicaid eligibility on a non-MAGI basis. Once the agency has made a final determination of eligibility on all bases, per §435.1200(h)(3)(ii), the agency must provide the individual with notice of the final determination of eligibility on all bases, consistent with §435.917. The notice must also contain coordinated content that the agency has notified the Exchange or other program of its final determination (required under §435.1200(e)(2)(ii)) and, if applicable, an explanation of any impact that the agency's approval of Medicaid eligibility may have on the individual's eligibility

for the other program or the transfer of the individual's electronic account to the Exchange or other program (required under §435.1200(e)(1) if the agency ultimately denies or terminates the individual's eligibility).

Initially, under the standard established at §435.1200(h)(1) of this final rule, we expect that states that have delegated authority to the FFE to make MAGI-based eligibility determinations will provide in the agreement entered into per §435.1200(b) that the FFE will provide a combined eligibility notice for all applicants it determines are eligible for Medicaid, as well as applicants that it determines are ineligible for Medicaid based on MAGI whose account is not transferred to the Medicaid agency for a full determination of eligibility including non-MAGI bases. States currently operating a state-based Exchange in which all insurance affordability programs access shared services for determining eligibility are expected to provide a single combined eligibility notice in all instances. As systems mature, we expect that all states, including both assessment and determination states using the FFE, as well as states operating a state-based Exchange both with and without a shared eligibility service, will develop more integrated notices capabilities able to provide combined eligibility notices in a wider range of circumstances. Enhanced federal match is available for Medicaid agencies to develop such capabilities and we will work with states through the Advance Planning Documents associated with obtaining federal match for systems development to achieve this goal.

Finally, we make conforming revisions in the final rule at §435.1200(b)(3)(ii) to cross-reference paragraphs (d) through (h) (rather than (d) through (g)) and to streamline the language in proposed §435.1200(b)(3)(iv) (relating to the general requirement that the agreements between insurance affordability programs provided for a combined eligibility notice and opportunity to submit a joint fair hearing request consistent with the regulations). Proposed §435.917(d) is finalized as proposed, with a non-substantive modification replacing "through" with "and".

We note that in proposing new §435.1200(c)(3) in the proposed rule, we neglected to propose that current §435.1200(c)(3) (relating to the responsibility of an agency electing to delegate eligibility determination authority to maintain oversight of the Medicaid program) be redesignated at §435.1200(c)(4). We did not intend to remove current §435.1200(c)(3), which is retained (without revision or redesignation) in this rulemaking.

We have made similar revisions to the proposed provisions relating to establishment of a coordinated system of notices in CHIP, as well as similar reorganizational changes. Thus, we revise the definitions of “combined eligibility notice” and “coordinated content” at §457.10 to align with the definitions finalized at §435.4. Proposed §457.348(b)(3)(i) and (ii) (relating to the requirement that the agreements between the state and other insurance affordability programs delineate the responsibilities of each to effectuate a coordinated system of notices) are finalized at §457.348(a)(4) of the final rule. We are not finalizing the addition of proposed §457.348(a) or revisions to current regulations proposed at §457.348(b)(3)(i) and (ii), (c)(3) and (d)(3)(i) and §457.350(i)(2) and (3) and (j)(3). Instead, we are adding a new paragraph at §457.340(f) adopting the same coordinated policy for CHIP as is adopted for Medicaid at §435.1200(h)(1) and (2) of the final rule.

Similar to §435.1200(h)(3) of the final rule, we are revising §457.350(i)(3) (redesignated at §457.350(i)(2) in this final rule) to provide that, in the case of individuals subject to a period of uninsurance under §457.805, the state must (1) notify the Exchange or other insurance affordability program to which the individual was referred in accordance with §457.350(i) of the date on which the individual’s required period of uninsurance ends and the individual will be eligible to enroll in CHIP; and (2) provide the individual with an initial notice that the individual is not currently eligible to enroll in CHIP (and why); the date on which the individual will be eligible to enroll in the CHIP; and that the individual’s account has been transferred to another

insurance affordability program for a determination of eligibility to enroll in such program pending eligibility to enroll in CHIP. Such notice also must contain coordinated content informing the individual of the notice provided to an Exchange or other program to which the individual's account was sent and the impact that the individual's eligibility to enroll in the CHIP will have on the individual's eligibility for the other program. Prior to the end of the period of uninsurance, the state must send a second notice reminding the individual of the information contained in the first notice, as appropriate. The notice must be sent sufficiently in advance of the date the individual is eligible to enroll in CHIP such that the individual is able to disenroll from the insurance affordability program to which the individual's account was transferred prior to that date. We also make a technical revision to redesignated §457.350(i)(2) to add a cross-reference to §457.805 (relating to periods of uninsurance as a strategy to ameliorate substitution of coverage) and to clarify that the state must transfer individuals subject to a period of uninsurance to the Exchange or other insurance affordability program (that is, the BHP, in a state which has implemented a BHP).

In the case of individuals identified as potentially eligible for Medicaid on a non-MAGI basis, we are revising §457.350(j)(3) of the final rule to provide that states must include in the notice of CHIP eligibility or ineligibility provided by the state coordinated content relating to (1) the transfer of the individual's electronic account to the Medicaid agency (for a full Medicaid determination); (2) if applicable, the transfer of the individual's account to another insurance affordability program (that is, to the Exchange or BHP if the state determines the individual is not eligible for CHIP); and (3) the impact that an approval of Medicaid eligibility will have on the individual's eligibility for CHIP or the insurance affordability program to which the individual's account was transferred, as appropriate. We make a technical revision at §457.350(j)(2) to reflect the requirement that, if an individual identified as potentially eligible for Medicaid on a non-

MAGI basis is determined not eligible for CHIP, the state must identify whether the individual may be eligible for other insurance affordability programs.

We are not finalizing the proposed redesignation of current §457.350(f)(2) and (3) or the addition of a new paragraph (f)(2) in §457.350, which would have required the Medicaid agency to issue a combined eligibility notice for individuals assessed by the State as eligible for Medicaid based on MAGI and transferred to the Medicaid agency, because such assessments and transfers do not constitute a denial of CHIP. We neglected to include regulation text in the proposed CHIP regulations similar to the proposed provision at §435.917(d), specifying that the provision of a combined eligibility notice including a determination of CHIP eligibility or ineligibility satisfies the state's responsibility to provide such notice under §457.340(e). This proposal was implied in the proposed rule. We are revising §457.340(e)(2) in this final rule to finalize the policy implied in the proposed rule.

Comment: Several commenters supported our proposal to include the content of §435.1200(d)(5) in §§435.1200(d)(1) and 457.348(d)(5) in §457.348(d)(1), respectively.

Response: We are finalizing §§435.1200(d)(1) and 457.348(d)(1) as proposed. Proposed §§435.1200(d)(5) and 457.348(d)(5), finalized in the July 2013 final eligibility rule at §§435.1200(d)(6) and 457.348(c)(6), are redesignated at §§435.1200(d)(5) and 457.348(d)(5) in this final rule, accordingly.

Comment: A number of commenters were concerned about the effective date (January 1, 2015, in the proposed rule) for the requirement to provide combined notices, including an eligibility determination made by another program. The commenters recommended that additional time is needed for the systems builds needed to support this policy.

Response: We appreciate the concerns that combined notices will be challenging to implement in states with a state-based Exchange that do not have a shared eligibility service, as

well as all states using a Federally-Facilitated Exchange and agree that additional time is needed for the development, testing and deployment of the systems needed to support provision of such notices. We are not providing for a delayed effective date of the regulations relating to coordinated notices per se. However, as explained above, §§435.1200(h) and 457.340(f) of the final rule require the use of combined eligibility notices to the extent feasible, taking into account whether the state uses a shared eligibility service or the FFE, whether the FFE is determining or assessing eligibility for Medicaid and CHIP, and the maturity of the eligibility and enrollment systems operated by the state and the Exchange. As state and Exchange systems mature, greater use of combined eligibility notices is required. Under the final regulations, it should be feasible for a state using a shared eligibility service for all insurance affordability programs to provide a single combined eligibility notice, which therefore is required under the final rule. Similarly, when the FFE has been authorized to make and has made a final determination of eligibility for Medicaid or CHIP for applicants who have applied for coverage through the Exchange, the agreement between the state and the FFE must provide for a combined eligibility notice from the FFE. We may revisit these requirements in future rulemakings as states' systems develop and states gain more experience with issuing combined notices.

Comment: While supporting the ability to provide combined eligibility notices to consumers, several commenters, noting the complexity of the policy, recommended that CMS provide guidance and technical assistance to states. Another commenter recommended that notices need to clearly state whom the notice is for, such as for one individual or multiple people in the household. The commenters recommended CMS consult with states and stakeholders to develop guidance on combined and coordinated notices and to conduct consumer testing on model notices.

Response: We agree with the commenters and, since issuing the proposed rule, we have developed a tool kit to provide states with consumer-tested model notices for Medicaid and CHIP, as well as guidance on developing, and a framework for structuring, effective notices in a coordinated and streamlined eligibility and enrollment system. The tool kit also includes resources on key messages based on communication requirements and eligibility scenarios, and consumer tested best practices and tips. In developing these resources, we worked closely with the Medicaid and CHIP Coverage Expansion Learning Collaborative, which includes representatives from a dozen states, and with consumer advocates and other stakeholders. The tool kit can be obtained at <http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Learning-Collaborative-State-Toolbox/State-Toolbox-Expanding-Coverage.html>.

Comment: A commenter noted the importance of providing denial notices in a timely manner to individuals when appropriate, especially in cases where the individuals may be eligible for other insurance affordability programs.

Response: Per §431.210 (revised in this final rule) and §457.340(e), Medicaid and CHIP agencies are required to provide notice whenever an applicant or beneficiary is determined ineligible for coverage and, if such determination is made by the state agency, such applicant or beneficiary must be assessed for eligibility for, and transferred as appropriate to, other insurance affordability programs, consistent with §§435.1200(e) and 457.350. If a coordinated eligibility notice is not provided by another program under an agreement between the agency and such other program, the state agency must provide the notice required under the regulations; per §§435.1200(h)(2) and 457.340(f)(2), such notice must contain coordinated content explaining that the individual's account has been transferred to the other insurance affordability program for consideration. We remind states operating Medicaid and CHIP programs and Exchanges that in addition to the program notice requirements discussed in this final rule, states and Exchanges

must comply with other applicable notice requirements, such as those under Section 1557 of the Affordable Care Act and its implementing regulation.

3. CHIP Notice and Information Requirements (§§457.110 and 457.350)

We proposed to redesignate §457.350(f)(2) at (3) and to revise redesignated §457.350(f)(3) to clarify that the requirement to find an individual ineligible, provisionally ineligible, or suspend the individual's application for CHIP unless and until the Medicaid application for the individual is denied, applies only at application. We proposed revisions at §457.350(g) to clarify that the requirement to provide information sufficient to enable families applying for CHIP to make an informed choice about applying for Medicaid also applies to providing such information about other insurance affordability programs. We proposed to revise §457.350(h)(2) to clarify that the responsibility to inform applicants placed on a waiting list for enrollment in a separate CHIP that, if their circumstances change while on such list, they may be eligible for Medicaid or other insurance affordability programs. Finally, we proposed a technical correction in §457.805(b)(3)(v) to replace "and" with "or".

We received no comments on these proposed provisions and we are revising §§435.350(g), 435.350(h)(2) and 457.805(b)(3)(v) as proposed, except that we are making a technical revision at §457.350(h), as revised in the July 2013 Eligibility final rule, to redesignate paragraph (h)(2) at (h)(3) and add a new paragraph (h)(2), providing that the procedures developed by states which have instituted a waiting list or enrollment cap or otherwise closed enrollment ensure that affected children placed on a waiting list or for whom action on their application is otherwise deferred are transferred to another appropriate insurance affordability program in accordance with §457.350 (i). As discussed above, we are not adding a new paragraph (f)(2) at §457.350 or redesignating current §457.350(f)(2) at (3). We had proposed revisions to current §457.350(f)(2) to clarify that the requirement to find an individual ineligible,

provisionally ineligible, or suspend the individual's application for CHIP unless and until the Medicaid application for the individual is denied, applies only at application in response to concerns expressed by states that at renewal such a requirement could result in a gap in coverage. However, we do not believe that the current §457.350(f)(2), which refers explicitly to "applicants" is unclear, and therefore, we are not revising §457.350(f)(2) in the final rule.

We also are making a technical revisions to §457.110, which was finalized in the July 15, 2013 Medicaid and CHIP final rule. Paragraph (a)(1) is revised to clarify that the state must (instead of "may") provide, at beneficiary option, notices to applicants and beneficiaries in electronic format, as long as the state establishes safeguards in accordance with §435.918 of this chapter.

C. Medicaid Eligibility Changes under the Affordable Care Act

1. Former Foster Care Children (§435.150)

We proposed new §435.150 to implement section 1902(a)(10)(A)(i)(IX) of the Act, added by sections 2004 and 10201(a) and (c) of the Affordable Care Act, under which states must provide Medicaid coverage starting in 2014 to a new eligibility group for "former foster care children." Under proposed §435.150, this mandatory group covers individuals under age 26 who were in foster care under the responsibility of "the State" or Tribe and were enrolled in Medicaid under "the State's" Medicaid State plan or section 1115 demonstration upon attaining either age 18 or a higher age at which an individual will age out of foster care based on the state's or Tribe's election under title IV-E of the Act. We proposed to provide states with the option to cover under this group individuals who aged out of foster care while receiving Medicaid in "any state" at either of the relevant points in time. For additional discussion, see section I.B.3.(a) of the proposed rule. We received no comments on proposed §§435.150 (a) (basis), (b)(1) (age required for coverage), and (b)(2) (limitation on eligibility for individuals eligible for mandatory coverage)

under another group described in part 435 subpart A, other than the adult group described in §435.119), which are finalized as proposed.

Comment: Several commenters suggested we make the “any state” option in proposed §435.150(b)(3) a requirement, so that states would be required to cover individuals under this group if they aged out of foster care while receiving Medicaid in “any state” at either of the relevant points in time. Some commenters were particularly concerned about children in foster care under the responsibility of one state, who were placed in another state and either were enrolled in Medicaid in the receiving state or chose to remain in the receiving state when they aged out of foster care. These commenters believe that former foster youth should be eligible for coverage regardless of changes in state of residence. One commenter recommended that states ensure eligibility in either the state placing the youth in foster care or the state in which the child was placed, whichever is the child’s state of residence upon leaving foster care. A few commenters supported retaining the “any state” option as a state option. Another commenter recognized the challenge of states confirming eligibility for youth who were in foster care in another state.

Response: Section 1902(a)(10)(A)(i)(IX) of the Act provides that, to be eligible under this group, an individual must have been “in foster care under the responsibility of the State” and to have been “enrolled in the State plan under this title or under a waiver of the plan while in such foster care[.]” Because the statute mandates coverage specifically for individuals in foster care in the state – not in a or any state – who were receiving Medicaid under the state plan or waiver of such plan – not a state plan or any state plan – we do not have flexibility to require that states provide coverage to individuals who aged out of foster care while under the responsibility of, or receiving Medicaid in, another state. Based on this specific statutory language, we also do not believe that the statute supports providing states with the option to do so under this eligibility

group. Therefore, we are removing the “any state” option that was proposed. We remain committed to working with states to continue coverage of these individuals. States that wish to continue existing coverage or to extend eligibility to former foster care children from another state may do so through 1115 demonstration authority, and we are releasing concurrently with this final rule subregulatory guidance providing additional detailed information on state flexibility to cover these individuals, including releasing an 1115 waiver template to help states to transition this group to 1115 authority without any gaps in coverage.

To provide state flexibility in other respects, we are revising §435.150(c) in the final rule to provide states with new options to provide coverage under this group. States may elect to provide coverage to individuals who meet the requirements in §435.150(b)(1) and (2), were in foster care under the responsibility of the state or a tribe located within the state, at either of the ages specified in §435.150(b)(3)(i) and (ii), and were:

- Enrolled in Medicaid under the state’s Medicaid state plan or under a section 1115 demonstration project at some time during the period in foster care during which the individual attained such age; or
- Placed by the state or tribe in another state and, while in such placement, were enrolled in the other state’s Medicaid state plan or under a section 1115 demonstration project.

Comment: One commenter believed that requiring that the child be receiving Medicaid at the time he or she turned 18 or aged out of foster care was unnecessarily restrictive. The commenter stated that the statute requires only that the child have been enrolled in Medicaid in the state at some point during his or her receipt of foster care assistance.

Response: We agree that clauses (cc) and (dd) of section 1902(a)(10)(A)(i)(IX) of the Act can be read independently such that, under clause (cc) to be eligible for coverage under the former foster care group, an individual must be in foster care on the date of attaining the age described in

clause (cc), whereas clause (dd) would require only that the individual have been enrolled in Medicaid “while in such foster care,” but not necessarily that the individual have been enrolled in Medicaid at the time of attaining the age described in clause (cc). However, we do not believe it appropriate to finalize this interpretation in this final rule without opportunity for broader public comment. Therefore, we are including the commenter’s suggestion as an option for states in §435.150(c) of this final rule and will consider proposed revised revisions to §435.150 to require only that an individual must have been enrolled in the state’s Medicaid program at some point during the period in foster care which ended upon the individual’s attaining the age described in §435.150(b)(3)(i) or (ii). We note that the option provided states at §435.150(c) of the final rule would extend coverage in the state responsible for foster care placement under §435.150 to former foster care youth who were enrolled in Medicaid when they ran away from a foster care placement. Runaway youth may remain in foster care (receiving child locator services), even though their Medicaid coverage may lapse, and, if remaining in a foster care status upon attaining age 18, they could be eligible for coverage in such state under §435.150 of the final rule provided that the other criteria are met.

Comment: Several commenters requested CMS to issue guidance to assist states in establishing procedures to ensure automatic or passive eligibility verification and enrollment, and to recommend various outreach procedures to identify current and former foster care children. Several specific ways to conduct this outreach were suggested, including establishing a toll-free number for former foster youth to call and ensuring that child welfare agencies are informing youth about their eligibility and assisting with their enrollment during foster care transition planning. One commenter suggested HHS should encourage states to enact procedures to ensure that verification of eligibility and enrollment for former foster youth be as automatic as possible. The commenter included outreach strategies and recommended that state Medicaid agencies take

steps to identify former foster youth and collaborate with child welfare agencies in their state plans and in the healthcare oversight plan that child welfare agencies develop with state Medicaid agencies. Another commenter supported automatic enrollment upon eligibility, continuing until the individual's 26th birthday. Three commenters raised concerns regarding the difficulty states will have in verifying past foster care placements and Medicaid eligibility for youths from another state.

Response: Under §435.916(f)(1) of the current regulations, states may not determine a current beneficiary to be ineligible before considering all bases of eligibility. In the case of individuals aging out of foster care on or after January 1, 2014 (the effective date for coverage under the former foster care group), this means that states cannot terminate Medicaid eligibility of an individual in foster care who attains age 18 or otherwise ages out of their foster care status without determining first whether such individual retains eligibility under another eligibility group. Individuals who age out or leave foster care may be eligible under the mandatory group for children under §435.118, as a disabled individual under §435.120 or §435.121, as a pregnant woman under §435.116, or as a parent or other caretaker relative under §435.110. If the state can determine that an individual who otherwise satisfies the requirements for coverage under the former foster care group at §435.150 is eligible for any of these other mandatory eligibility groups, it should transfer the individual to such group. If the individual is eligible for the former foster care group and either the state determines the individual is ineligible for these other mandatory groups or does not have sufficient information to determine eligibility under the other groups, the state should transition the individual to the former foster care group without interruption in Medicaid coverage or need to submit additional information. If a state does not know whether the individual remains a state resident upon leaving foster care and cannot electronically verify state residency, the state may require attestation and/or documentation of

state residency, consistent with the state's verification plan developed per §435.945(j). We recommend the use of automated transition of individuals to the former foster care group within a state, and we remind states of the availability of enhanced federal funding for Medicaid eligibility and enrollment systems ("90/10" funding) to support such automated systems. If automated transition is not possible, a manual process is acceptable at this time. A manual process may involve caseworker action at the state foster care agency.

Some individuals who may be eligible for coverage under this group may need to apply with a new application – for example, because they left foster care prior to January 1, 2014. For such individuals, states may accept attestation of their former status under §435.945(a). If the state does not accept self-attestation, electronic verification of the individual's former foster care status, as well as his or her receipt of Medicaid while in foster care is required if available or if establishing an electronic data match would be effective within the meaning of §435.952(c)(2)(ii). If electronic verification is not available or establishing a data match would not be effective, states may require that applicants provide documentation of their former status. We note that the verification procedures followed in each state should be set forth in the verification plan developed by the state in accordance with §435.945(j).

Comment: A few commenters recommended that a specific Medicaid benefits package be established for former foster care youth, rather than the adult benefits package, due to their unique health concerns.

Response: While the statute does not authorize us to require a specific Medicaid benefit package for former foster care youth, individuals eligible under the former foster care group are exempt from mandatory enrollment in benchmark or benchmark-equivalent coverage under section 1937(b)(2)(B)(viii) of the Act. Thus, while a state may establish benchmark or benchmark equivalent coverage for individuals enrolled in this group, which the state believes is

better tailored to their needs, the state cannot require enrollment in such coverage. We note also that individuals enrolled in the former foster care group who are under age 21 are entitled to early and periodic screening, diagnosis, and treatment (EPSDT) services under part 441 subpart B.

Comment: Several commenters stated that coverage under this group also should include individuals who at their 18th birthday were receiving Medicaid coverage through an adoption or guardianship subsidy. One commenter stated that eligibility should be expanded to include youth who left foster care at age 16 or older when they were adopted or placed in legal guardianship with kin, and that eligibility requirements for foster care should be universal among states.

Response: Section 1902(a)(10)(A)(i)(IX) of the Act limits eligibility under this group to individuals who were in foster care at the specified ages; therefore, we do not have the authority to expand Medicaid coverage under this group to include individuals who were not in foster care at either of the relevant points in time but were instead receiving adoption or guardianship assistance, nor do we have the authority to require uniform foster care eligibility requirements across all states. Adopted children up to age 26 generally may be covered as dependents under their adoptive parents' insurance.

2. Individuals excepted from MAGI (§§435.601 and 435.602)

We proposed technical amendments to §435.601 and §435.602 necessitated by the Affordable Care Act's requirements that MAGI-based financial methodologies be applied in determining Medicaid eligibility, unless the individual is excepted from application of MAGI-based methods under §435.603(j). We proposed to redesignate §435.601(b) at §§435.601(b)(2) and 435.602(a) at §435.602(a)(2) and to add new paragraphs §435.601(b)(1) and §435.602(a)(1) to clarify that the methodologies set forth in §435.601 (related to application of the methodologies of the most closely-related cash assistance program) and §435.602 (related to financial responsibility of relatives and other individuals) apply only to individuals excepted from

application of MAGI-based methodologies in accordance with §435.603(j). A conforming revision to the heading for redesignated §435.601(b)(2) also was proposed. We also proposed to remove §435.601(d)(1)(i) and (ii) (relating to pregnant women and children, who are not excepted from application of MAGI-based methods) and to redesignate §435.601(d)(1)(iii) through (vi) at §435.601(d)(1)(i) through (iv). We received no comments on these revisions, which are finalized as proposed. We also make a non-substantive revision for clarity in redesignated §435.602(a)(2)(ii) to replace reference to “the State’s approved AFDC plan” with reference to “the State’s approved State plan under title IV-A of the Act in effect as of July 16, 1996.” Discussed in section II.A.3 of this final rule, we make other revisions at redesignated §435.601(b)(2) and (d)(1) related to revisions made to §435.831 related to financial methodologies for medically needy individuals.

Comment: One commenter requested clarification about the rules for post-eligibility treatment of income for an institutionalized individual. The commenter also questioned whether the eligibility requirements for payment of long-term care services will apply to MAGI individuals whose coverage includes long-term care services, such as nursing homes.

Response: On February 21, 2014, we issued State Medicaid Director (SMD) letter #14-001 regarding the application of transfer-of-asset rules and post-eligibility treatment of income rules to individuals eligible for Medicaid on the basis of MAGI. The commenter is directed to this letter, available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-14-001.pdf>.

3. Family Planning (§§435.214, 435.603, and 457.310)

We proposed to add §435.214, codifying a new optional family planning eligibility group for non-pregnant individuals under sections 1902(a)(10)(A)(ii)(XXI) and 1902(ii) of the Act, as added by section 2303 of the Affordable Care Act. Benefits for individuals enrolled in this group

are limited to family planning or family planning-related services under the first clause (XVI) in the matter following section 1902(a)(10)(G) of the Act. Section 1902(ii)(3) of the Act permits states to consider only the income of the individual applying for coverage in determining eligibility for this group, and we proposed to codify that option by adding a new paragraph (k) to §435.603. We also proposed to amend the definition of a targeted low-income child at §457.310(b)(2)(i) to provide that eligibility for limited coverage of family planning services under §435.214 would not preclude an individual from being eligible for CHIP. We received several comments on these provisions.

Comment: Several commenters supported the proposed regulations to codify this new group. Several commenters strongly supported the amendment to §457.310(b)(2)(i) to ensure that eligibility for family planning coverage under Medicaid will not undermine eligibility for comprehensive coverage under CHIP. Other commenters expressed strong support for inclusion of the income eligibility standards for pregnant women under section 1115 demonstration projects in determining the highest income standard for purposes of setting income eligibility for services under this section.

Response: We appreciate the commenters' support and are finalizing §435.214, §435.603(k) and the revisions to §457.310(b)(2)(i) as proposed, with the exception of minor technical revisions. We are revising the section heading and the introductory text in §435.214(b) to reflect that individuals eligible for Medicaid under §435.214 are eligible only for the limited family planning services described in §435.214(d); removing the phrase "meet all of the following requirements;" and adding a parenthetical clarifying that coverage is provided to individuals "of any gender."

Comment: A commenter stated that CMS should finalize the proposed provision so that states can consider only the income of the applicant or recipient when determining eligibility for

coverage under a family planning State Plan Amendment (SPA). Another commenter requested that the final rule provide a detailed explanation as to why eligibility for a particular service should be treated differently than others. The commenter believed that such exceptions result in greater confusion and costs.

Response: Under section 1902(ii)(3) of the Act, states have the option to consider only the individual applicant's or beneficiary's income. The statute thus specifically authorizes, at state option, a deviation from the household composition and household income rules associated with MAGI-based methodologies for this population only, at state option. This option is codified at §435.603(k) of the final rule. In addition, we note that under pre-Affordable Care Act rules, many states applied this methodology under their section 1115 family planning demonstration programs, finding it critical to enable vulnerable populations, such as women experiencing domestic abuse and teens to obtain family planning services based on their own income. We note that states that elect to cover more than one group under §435.214 may exercise the options provided at §435.603(k) differently for each group adopted under §435.214.

Comment: A commenter requested clarification on how coverage under this group will be coordinated between the Medicaid agency and the Exchange, since family planning is not full Medicaid coverage.

Response: We are not certain whether the commenter is questioning about coordination of benefits for individuals who may be eligible for APTC and CSR for enrollment in a QHP and also for Medicaid coverage of family planning benefits under the state plan or whether the commenter is questioning about coordination of the application process to obtain coverage for family planning benefits. We therefore will respond to both questions.

For individuals who are eligible for enrollment in a QHP and also for coverage of family planning benefits under the state plan, Internal Revenue Service (IRS) regulations at

26 CFR 1.5000A-2(b)(ii)(A) provide that coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Act is not minimum essential coverage. Therefore, individuals who are eligible for coverage of family planning services under the optional state plan group per §435.214 may also be eligible to receive APTC and CSR for enrollment in a QHP through the Exchange. For individuals enrolled in both, the rules governing coordination of benefits and third party liability section 1902(a)(25) of the Act and implementing regulations would apply, with Medicaid serving as a secondary payer for covered family planning services furnished by Medicaid-participating providers.

For the application process, to apply for coverage through the Exchange, an individual must submit a single streamlined application. The Exchange regulations at §155.302(b)(1) and §155.305(c) require that, in assessing or determining an applicant's financial eligibility for Medicaid, the Exchange must use the applicable Medicaid MAGI standard, as defined in §435.911(b) of the Medicaid regulations. See the definition of "applicable Medicaid MAGI-based income standard" in §155.300. The applicable MAGI standard under §435.911(b), in turn, represents the highest income standard under which an applicant may be determined eligible for coverage under the MAGI-based eligibility groups for adults under age 65 at §435.119; parents and caretaker relatives at §435.110 or §435.220; pregnant women at §435.116; children at §435.118; or individuals under 65 with income over 133 percent of the FPL at §435.218. The income standard for several optional MAGI-based eligibility groups – including the new family planning group at §435.214 – is not taken into account in establishing the applicable MAGI standard which is used by the Exchange in assessing or determining the Medicaid eligibility of new applicants. Therefore, while the Exchange regulations do not preclude the Exchange from determining or making an assessment of eligibility for coverage under the family planning group, they do not require that it do so.

The FFE is not currently programmed to assess or determine eligibility under the optional family planning group. If the FFE does not assess or determine an applicant as eligible for Medicaid based on the applicable MAGI standard, the applicant can request a full determination by the Medicaid agency per §§155.302(b)(4)(i)(A) and 155.345(c), and if the applicant requests such determination or if the FFE identifies the applicant based on information provided on the application as potentially eligible for Medicaid on a MAGI-exempt basis (that is, based on being aged, blind or disabled or having high medical expenses), the FFE must transfer the applicant to the Medicaid agency under §§155.302(b)(4)(ii) and 155.345(d).

Under §435.911(c)(2), if the Medicaid agency finds that an applicant is not eligible on the basis of the applicable MAGI standard, the agency is directed to evaluate eligibility on bases other than the applicable MAGI standard, which includes not only eligibility on a basis excepted from application of MAGI-based methods per §435.603(j), but also eligibility for MAGI-based groups which are not reflected in the applicable MAGI standard, such as the family planning group. If additional information not collected on the single streamlined application submitted to the FFE is needed, the agency would request such information per §435.911(c)(2).

While the FFE does not have immediate plans to determine or assess eligibility for optional family planning coverage, we encourage states using a State-Based Exchange to do so. But we understand that the experience of states with section 1115 family planning demonstrations indicates that most individuals who are enrolled for family planning coverage were not determined for this coverage following submission of a regular application, but as a result of a referral from clinics and other providers of family planning services, using a designated application. To maximize access to this coverage, we allow the use of a targeted application designed for the family planning group, which can be distributed through providers of family planning services and submitted directly to the state Medicaid agency, regardless of the capacity

of the Exchange to determine eligibility under §435.214. As an alternative to the single streamlined application described in §435.907(b)(1), such targeted applications must be approved by the Secretary per §435.907(b)(2).

4. Determination of eligibility (§435.911)

We proposed several revisions to the regulations at §435.911. We proposed revisions at §435.911(b)(1)(i) to reflect that, in states that have adopted coverage for parents and caretaker relatives under the optional group at §435.220 with an income standard above the standard for coverage under the mandatory group at §435.110, the applicable MAGI standard for parents and caretaker relatives will be the standard adopted for coverage under the optional eligibility group (unless the state also has adopted and phased in coverage of parents and caretaker relatives under the optional group described at §435.218 for individuals with income over 133 percent FPL up to a higher standard, in which case the applicable MAGI standard for parents and caretaker relatives will be the standard applied to coverage under that optional group, as set forth at §435.911(b)(1)(iv), added by the March 23, 2012, Medicaid eligibility final rule).

We also proposed to revise the introductory text in §435.911(b)(1), to add new paragraph (b)(2), and to revise paragraph (c)(1) of §435.911, added by the March 23, 2012, Medicaid eligibility final rule, to extend use of the MAGI screen to elderly adults, as well as adults who are eligible for Medicare and excluded from coverage in the adult group on that basis. Individuals who are age 65 or older may be eligible based on MAGI as a parent or caretaker relative, but were unintentionally excluded from the MAGI screen rules established in the March 23, 2012, Medicaid eligibility final rule. (A proposed technical revision in the introductory text of paragraph (c) relating to the cross-reference to the reasonable opportunity period for documentation of citizenship and immigration status is discussed in section 6(b) of this final rule.) We received the following comments on these proposed provisions which are summarized below.

Comment: Several commenters supported, and no commenters opposed, the proposed revisions. Several commenters expressed support for the requirement that Medicaid agencies furnish Medicaid to eligible individuals consistent with timeliness standards under §435.912 and recommended that we issue guidance explaining this requirement and clarifying the applicability of timely determinations for non-citizen applicants. The commenters also recommended that CMS apply the timeliness standards in §435.912 to individuals undergoing non-MAGI eligibility determinations by adding a cross-reference to §435.912(c)(2).

Response: We appreciate the commenters' support and are finalizing the regulation as proposed, except as noted below. We also agree with the importance of the timeliness requirements for eligibility determinations at §435.912, as added by the March 23, 2012 Medicaid eligibility final rule. The timeliness requirements in §435.912 apply both to determinations of eligibility based on MAGI, as well as to determinations of eligibility for individuals excepted from application of MAGI-based methods. Therefore, we are making a technical revision to include a cross-reference to §435.912 at §435.911(c)(2), as suggested. We note that the single streamlined application generally does not provide sufficient information for states to make a determination of eligibility on a non-MAGI basis. For an applicant to be approved on a non-MAGI basis, the state will need to request, and applicants will need to provide, additional information in accordance with §435.911(c)(2). We will take into consideration the commenters' suggestion that we issue interpretive guidance on the timeliness requirements at §435.912.

Comment: A commenter requested clarification of the relationship between §435.110(c) and §435.911(b)(2). The commenter interpreted §435.911(b) as setting a minimum applicable MAGI income standard floor of 133 percent FPL, whereas §435.110(c) establishes both a minimum and maximum permissible income standard for the mandatory parent and caretaker relative eligibility group, which may be lower than 133 percent FPL.

Response: In addition to establishing a minimum and maximum permissible income standard for mandatory coverage of parents and caretaker relatives §435.110(c) requires that each state adopt in its state plan an income standard between the minimum and maximum levels permitted, and this standard may be – indeed, in most states is – less than 133 percent FPL. As a general rule, the minimum applicable MAGI income standard under §435.911(b) is 133 percent FPL. This will be the case for parents and caretaker relatives who are under age 65 and not eligible for Medicare, who may be eligible under the mandatory group for parents and caretaker relatives at §435.110, the adult group at §435.119 or the optional group for parents and caretaker relatives at §435.220, but for whom the minimum applicable MAGI standard will be the 133 percent FPL standard for coverage under the adult group. For parents and caretaker relatives who are 65 years of age or older or who are eligible for Medicare, the applicable MAGI standard will be the income standard established by the state per §435.110(c) or §435.220(c), if the state has adopted the optional group under §435.220. The proposed addition to the introductory text in §435.911(b)(1) (which reads, “Except as provided in paragraph (b)(2) of this section”) allows for an exception to the general rule that the minimum applicable MAGI standard is 133 percent FPL. This exception is set forth in proposed paragraph (b)(2), which establishes the applicable MAGI standard for adults who are not eligible for coverage under the adult group because they either are eligible for Medicare or they are age 65 or older. For such adults who are parents or caretaker relatives, the applicable MAGI standard per paragraph (b)(2)(ii) is the income standard established by the state under §435.110(c) or, if higher, the standard established by the state under §435.220(c).

Comment: A commenter suggested that the word “and” following the phrase “individuals who are at least 65 and 19” in proposed §435.911(b)(2) should be changed to “or.”

Response: We disagree with the suggestion. The purpose of proposed §435.911(b)(2) is to define an applicable MAGI standard for individuals excluded from application of the MAGI screen in §435.911 because they are ineligible for coverage under the adult group based either on being at least age 65 or eligible for Medicare. Individuals who are under age 19 are eligible for coverage under the MAGI-based eligibility group for children, described in §435.118, regardless of whether or not they are eligible for Medicare, and should not be impacted by the addition of paragraph (b)(2) to §435.911. The commenter's suggestion, if adopted, would result in the applicable MAGI standard for such children being established in paragraph (b)(2) instead of paragraph (b)(1)(iii), as is the case under the current regulations.

Comment: The same commenter also suggested that the word "and" at the end of proposed paragraph (b)(2)(i) should be changed to "or."

Response: We agree with this comment and are replacing "and" with "or" at the end of paragraph (b)(2)(i) in the final regulation.

Comment: A commenter requested that CMS address disabled children in §435.911. The commenter stated that disabled children should first be placed in the MAGI-based eligibility group for children at §435.118, similar to disabled parents and caretaker relatives who may be eligible based on MAGI under §435.110.

Response: We believe that children with disabilities were correctly addressed in the March 23, 2012 Medicaid eligibility final rule and did not make any proposed revisions to the treatment of disabled children in §435.911 in the proposed rule. Children, whether disabled or not, may be eligible under §435.118. A child applying for coverage using the single streamlined application must be evaluated for eligibility using the applicable MAGI standard for children, which is based on the income standard adopted for children of the relevant age group under §435.118(c) (unless the state has adopted the optional eligibility group at §435.218 to a higher

income standard and has phased in coverage of children under that group) and, under §435.911(c)(1), must be promptly enrolled in Medicaid if eligible on that basis. Under §435.911(c)(2), if the child may be eligible on the basis of disability and enrollment on such basis would be better for the child or the family requests such determination, the state must proceed with evaluating the child's eligibility on that basis. We note that, if a disabled child is eligible for mandatory coverage as an SSI recipient under section 1902(a)(10)(A)(i)(II) of the Act and §435.120 or meets the more restrictive criteria applied for mandatory coverage as a disabled individual in a 209(b) state in accordance with section 1902(f) of the Act and §435.121, then the child should be enrolled in the mandatory group for disabled individuals in the state. However, it would be unusual for a child already receiving SSI to apply for coverage using the single streamlined application, and we would not expect that disabled children who do not receive SSI but are determined eligible and enrolled for coverage on the basis of the applicable MAGI standard per §435.911(c)(1) would have any reason to complete a determination based on disability.

Comment: A commenter requested that we clarify that, in accordance with the definition of "applicable MAGI standard" in §435.911(b), some aged and disabled adults will be subject to the MAGI screening process required under §435.911.

Response: We agree that some aged and disabled adults will be determined eligible on the basis of MAGI and the applicable MAGI standard in accordance with the MAGI screen established at §435.911, as revised in this rulemaking. Under §435.911, disabled adults who are not eligible for Medicare and who submit the single streamlined application may be determined eligible and enrolled in Medicaid on the basis of MAGI using the applicable MAGI standard, which will be the 133 percent FPL standard for the new adult group or the higher standard applied under the optional group described in §435.218, if adopted by the state and if adults have been

phased into coverage under that group. In accordance with §435.911(c)(2), for those adult applicants who are identified, based on information in the single streamlined application, as potentially eligible based on disability or who otherwise request such determination, the state must make the disability-based determination, provided that the applicant provides all information necessary and completes the disability determination process. Because of the longer period of time typically required to make a determination based on disability, disabled adults often may be enrolled temporarily in coverage based on MAGI (for example, under the adult group) pending a final determination based on disability. In other cases, such adults may choose not to complete the disability determination or may not be eligible on that basis, in which case they will remain enrolled in coverage based on MAGI. Under the proposed revisions to §435.911, finalized in this final rule, elderly parents and caretaker relatives, as well as disabled parents and caretaker relatives who are eligible for Medicaid similarly may be determined eligible and enrolled in Medicaid on the basis of MAGI using the applicable MAGI standard, which will be the standard applied in the state for mandatory coverage of parents and caretaker relatives under §435.110 or, if adopted by the state, the higher income standard applied to optional coverage of parents and caretaker relatives under §435.220. As with disabled adults not eligible for Medicare, such parents and caretakers may also then be determined eligible on the basis of disability in accordance with §435.911(c)(2).

D. Medicaid Enrollment Changes under the Affordable Care Act needed to achieve coordination with the Exchange: Accessibility for Individuals who are Limited English Proficient (§§435.901 and 435.905)

We proposed to revise regulations relating to the provision of information to persons who are limited English proficient to ensure access to coverage for eligible individuals and to achieve alignment with existing Exchange regulations at §155.205(c). We proposed to specify at

§435.905(b)(1) that providing language services for individuals who are limited English proficient means providing oral interpretation, written translations, and taglines, which are brief statements in a non-English language that inform individuals how to obtain information in their language. We also proposed to apply the accessibility requirements in §435.905(b) to the provision of a hearing system and hearing procedures under §§431.205 and 431.206, to the notices required under proposed §435.917, and to the notice of a reasonable opportunity period required under proposed §435.956(b)(1) by adding a cross-reference to §435.905(b) at proposed §§431.205(e), 431.206(e), 435.917(a)(2), and 435.956(b)(1). We received the following comments concerning our proposed provisions.

Comment: Several commenters supported our proposal to specify certain types of language services that must be provided to individuals who are limited English proficient. Some commenters recommended additional requirements related to providing language services, including requiring that states hire bilingual staff and provide taglines in 15 languages. Several commenters suggested that we add a requirement that, for any individual who the agency knows or should reasonably know is limited English proficient, the agency must provide information in that individual's language. A number of commenters also recommended that we include specific types of services which must be provided to make information accessible to individuals with visual impairments or other disabilities.

Other commenters sought more detailed explanation of what steps states must take to satisfy the general accessibility requirements set forth in the regulation. One commenter requested that we clarify that states are not required to provide written translations of applicable forms in more languages than is their current practice. Some commenters recommended that we provide additional guidance on how to implement this requirement in the future. One commenter

suggested that we refer states to guidance issued by the HHS Office of Civil Rights for federal financial aid recipients.

We received similar comments on other sections of the proposed rule regarding accessibility for individuals with disabilities and individuals who are limited English proficient in §§431.206, 435, 917, 435.918, and 435.956.

Response: We appreciate the support for the proposed revisions to §435.905(b)(1), which are finalized as proposed, except that the requirement to provide taglines proposed in paragraph (b)(1) has been moved to paragraph (b)(3). Individuals who are limited English proficient must be provided information accessibly through language services, which means providing oral interpretation and written translations. The purpose of the proposed rule was to specify the approaches used to provide language services, through oral interpretation and written taglines, and to require that states must inform individuals that such accessible information is available. Our modification to §435.905(b) is consistent with requirements in the Medicaid managed care regulations at §438.10(c) and the Exchange regulation relating to accessibility standards at §155.205(c). We will consider more detailed accessibility requirements in future rulemaking. States should consult the guidance issued on August 8, 2003, by the HHS Office for Civil Rights for recipients of federal financial assistance, which include Medicaid and CHIP agencies, related to provision of services to limited English proficient persons, available at <http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf>, and regulations implementing section 1557 of the Affordable Care Act at 45 CFR 92.201, 92.8(a)(3) and 92.8(d) through (h), regarding meaningful access for individuals with limited English proficiency, language assistance and the use of taglines. The latter regulations were issued by the HHS Office for Civil Rights on May 18, 2016 (81 FR 31375).

Comment: Several commenters supported the inclusion of proposed §435.905(b)(3), which requires individuals be informed of the accessibility services available, in accordance with §435.905(b)(1) and (2), to individuals with disabilities and individuals who are limited English proficient. We received one technical comment recommending that our proposed language at §435.905(b)(3), should be redesignated at paragraph (c) of this section.

Response: We appreciate the support for §435.905(b)(3), which we are finalizing as proposed, except to move the requirement relating to taglines from proposed §435.905(b)(1) to paragraph (b)(3), as discussed above, because taglines are a method to inform individuals of the availability of, and how to access, language services through a brief statement in a non-English language.

Comment: Commenters supported the application of the accessibility requirements described in §435.905(b) to the accessibility and availability of the hearing system, processes, and notices described in §§431.205, 431.206, §435.917 and 435.956(b)(1).

Response: We appreciate the commenters' support and are finalizing inclusion of a cross-reference to §435.905(b) at §§431.205(e), 431.206(e), 435.917(a), and 435.956(g) (redesignated at §435.956(b)), as proposed. We note that the accessibility requirements in §435.905(b), as revised in this rulemaking, also apply to the availability of applications and supplemental forms, renewal forms and notices per the cross cite in current §§435.907(g) and 435.916(g), as well as to the website and any interactive kiosks and other information systems established by the state to support Medicaid information and enrollment activities per the cross-reference to §435.905(b) at §435.1200(f)(2).

Comment: Several commenters recommended inserting a reference to section 1557 of the Affordable Care Act, in addition to the citations to the Civil Rights Act and the Rehabilitation Act

in the regulation, as other federal statutes with which states must comply in administering their programs.

Response: We agree that reference to these federal statutes is appropriate and are revising §435.901 to add reference to the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act and their respective implementing regulations.

Comment: Several commenters also suggested renaming §435.905 as “Accessibility for Individuals who are Limited English Proficient and Individuals with Disabilities,” noting that the scope of §435.905 is broader than accessibility of program information to individuals who are limited English proficient.

Response: Section 435.905 prescribes what information generally must be provided to applicants and beneficiaries in writing (electronically and in paper), and orally as appropriate, as well as the accessibility of that information. Thus, we agree with the commenters to a limited degree and have revised the title to §435.905 to read, “Availability and accessibility of program information.” We do not believe it is appropriate to include reference to individuals with limited English proficiency or to disabled individuals in the title, as this would suggest a narrower scope of the provision than it actually has.

E. Medicaid Eligibility Requirements and Coverage Options Established by other Federal Statutes

1. Coverage of Children and Families

a. Mandatory Coverage of Children with Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E (§435.145)

We proposed to amend §435.145 of the current regulations to reflect that children for whom kinship guardianship assistance payments are made under title IV-E of the Act are entitled

to automatic Medicaid eligibility to the same extent as children for whom an adoption assistance agreement under title IV-E is in effect or for whom foster care maintenance payments under title IV-E are made, in accordance with the statutory requirement under section 473(b)(3)(C) of the Act. Per §435.403(g), such children are eligible for Medicaid in the state where the child resides without regard to whether the child would be eligible for kinship guardianship assistance under title IV-E in that state. For example, if State A provides kinship guardianship payments under title IV-E for a child now living with a relative in State B, State B must automatically enroll the child in its Medicaid program regardless of whether State B has elected to provide title IV-E kinship guardianship assistance payments or it ends such assistance at an earlier age than State A. We also proposed revisions of the description of eligibility for Medicaid based on receipt of adoption assistance under title IV-E, included in current §435.145 and redesignated at §435.145(b)(1) of the proposed rule, for consistency with the statutory language at section 473(b)(3) of the Act. Proposed new §435.145(a) provides the basis for eligibility under this section. No comments were received on the proposed revisions to §435.145, which are finalized without modification.

b. Families with Medicaid Eligibility Extended Because of Increased Collection of Spousal Support (§435.115)

Sections 408(a)(11)(B) and 1931(c)(1) of the Act, implemented at §435.115, require a 4-month Medicaid extension for low-income families eligible under section 1931 of the Act who otherwise would lose coverage due to increased income from collection of child or spousal support under title IV-D of the Act. We proposed to revise §435.115 to eliminate increased income from collection of child support as a reason for a 4-month Medicaid extension because child support is not counted as income under MAGI-based methodologies; to remove obsolete, duplicative, and unnecessary paragraphs; to replace references to eligibility under AFDC with

references to coverage under the regulations implementing section 1931 of the Act; and generally to streamline and simplify the regulatory language.

Comment: One commenter believed that, because states cannot terminate pregnant women from Medicaid due to a change in income under section 1902(e)(6) of the Act, implemented at proposed §435.170, the 4-month extension under §435.115 should not apply to pregnant women.

Response: We agree with the commenter that, under §435.170 and sections 1902(e)(5) and (6) of the Act, pregnant women are covered at least for pregnancy-related services through the end of the month in which their post-partum period ends, regardless of changes in income (including increased spousal support). We are revising §435.115 to remove proposed paragraph (b)(2)(i), accordingly.

Comment: A commenter disagreed with the proposed revision to limit the extension required under §435.115 to individuals losing coverage due to increased spousal support.

Response: We do not agree with the comment. Because child support is not counted in the MAGI-based income used in determining eligibility for coverage under section 1931 of the Act, an increase in child support cannot result in loss of eligibility under section 1931 of the Act, and therefore, can never trigger the 4-month extension available under §435.115.

Comment: A commenter requested guidance on how transitional assistance would work in the case of an adult moving from the section 1931-related group to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, implemented at §435.119, because of an increase in earnings. Specifically, the commenter questioned whether such an individual would be eligible for TMA under section 1925 of the Act, or if the individual would only be eligible if his or her MAGI exceeded the income standard of 133 percent of the FPL for the adult group.

Response: Transitional Medical Assistance under section 1925 of the Act or the 4-month Medicaid extension provided under §435.115 is required only if the individual would otherwise lose Medicaid. For example, if a parent who loses coverage under §435.110 due to an increase in income becomes eligible for coverage under the adult group, TMA would not be required, unless the individual subsequently lost eligibility under the adult group prior to the end of the 12-month TMA period, measured from the point at which the parent lost eligibility under §435.110.

c. Extended and Continuous Eligibility for Pregnant Women (§435.170) and Hospitalized Children (§435.172)

(1) Pregnant Women Eligible for Extended or Continuous Eligibility (§435.170)

Current §435.170 implements section 1902(e)(5) of the Act, relating to extended eligibility for pregnant women postpartum. We proposed revisions to §435.170 to include implementation of section 1902(e)(6) of the Act, relating to continuous coverage of pregnant women for pregnancy-related services until the end of the month that the post-partum period ends, regardless of changes in income. We also proposed new paragraph §435.170(d) to clarify that neither extended nor continuous eligibility applies to pregnant women covered only during a period of presumptive eligibility.

Comment: Several commenters noted that this extended coverage under §435.170 is limited to “pregnancy-related” services, which are defined in §435.116(d)(3), and which means that states could provide benefits less comprehensive than the benefits provided under other categorically needy groups. The commenter recommended that CMS do as much as it can to ensure that pregnant women receive benefits that are at least equal to the services they would be entitled to receive if they were not pregnant. Another commenter recommended that the authority used by CMS under §435.116 to consolidate the eligibility groups for pregnant women into one

group should also be applied to require that a full set of benefits be available in the prenatal and post-partum periods.

Response: Section 1902(e)(5) of the Act expressly provides that women eligible under that section are covered for pregnancy-related and postpartum services and section 1902(e)(6) of the Act provides that women eligible under that section are treated as a pregnant women eligible under section 1902(a)(10)(A)(10)(i)(IV) or 1902(a)(10)(A)(ii)(IX) of the Act; per clause (VII) in the matter following section 1902(a)(10)(G) of the Act, coverage for such pregnant women is limited to pregnancy-related and postpartum services. Therefore, we cannot require states to provide full coverage for pregnant women described in sections 1902(a)(10)(A)(i)(IV) or 1902(a)(10)(A)(ii)(IX) of the Act or eligible under sections 1902(e)(5) or (e)(6) of the Act. However, because the health of a pregnant woman and the fetus are inextricably intertwined, we have made it clear that we expect pregnancy-related services to constitute a robust benefit package (see the discussion in the preamble to March 23, 2012 Medicaid eligibility rule at 77 FR 17144, 17149). We have also made clear at §435.116(d)(1) that states can provide all state plan benefits as “pregnancy-related,” and most states have elected to do so. States that seek approval of limited benefit packages for pregnant women must explain how the services excluded from the benefit are not “pregnancy-related.”

Comment: One commenter expressed strong support for the provisions in §435.170. Another commented that the cross-reference to §435.116(d)(3) in proposed §435.170(b) and (c) does not align with the flexibility states have to provide full Medicaid benefits to all pregnant women.

Response: We agree with the commenter and are revising §435.170 to clarify that if a state elects to provide full coverage for all pregnant women eligible under §435.116, the state would also provide full coverage during an extended or continuous eligibility period for pregnant

women under §435.170. If a state elects to provide pregnancy-related services to pregnant women whose income exceeds the applicable income limit adopted by the state per §435.116(d)(4) for full coverage, it would provide the same pregnancy-related services to women covered during an extended or continuous eligibility period for pregnant women under §435.170. Paragraph (a) (basis) is finalized as proposed. Proposed paragraph (d)(1) (applicability to pregnant women covered during a presumptive eligibility period) is redesignated at §435.170(e) of the final rule.

(2) Continuous Eligibility for Hospitalized Children (§435.172)

We proposed a new regulation of §435.172 implementing section 1902(e)(7) of the Act, which requires states to continue eligibility for children who are eligible under §435.118 when admitted to a hospital through the end of the inpatient stay if they would otherwise lose eligibility due to age.

Comment: One commenter expressed strong support for the provisions in §435.172. Another commented that the cited authority of section 1902(e)(7) of the Act does not authorize continued coverage for children who otherwise would lose eligibility due to household income, because the cited authority requires that the individual would remain eligible “but for attaining such age.” The commenter also requested clarification regarding duration limits and commented that, as written, the regulation would provide that an individual could remain eligible as a hospitalized child for 20 years regardless of age and income.

Response: We agree with the commenter and are removing reference to “household income” from §435.172 of the final rule, which otherwise is finalized as proposed. Under the statute, the duration of this extended eligibility period lasts until the end of the inpatient stay during which the child would have lost Medicaid eligibility under §435.118 solely due to age. We do not have flexibility to limit the extension of eligibility provided under the statute to a

shorter period, though we note that a single inpatient stay for a period as long as that suggested by the commenter seems highly unlikely.

d. Optional Eligibility Groups and Coverage Options

(1) Optional Medicaid Eligibility Groups and Coverage Options (§§435.213, 435.215, §435.220, 435.222, 435.226, 435.227, 435.229, and 435.926)

We proposed to codify new regulations or revise existing regulations for optional Medicaid eligibility to implement statutory requirements, including the use of MAGI effective in 2014 for individuals not excepted from MAGI. We proposed a new regulation §435.213 for individuals needing treatment for breast or cervical cancer (implementing section 1902(a)(10)(A)(ii)(XVIII) of the Act) and clarified that men may be covered under this group if they meet the eligibility requirements. We proposed new §435.215 for individuals infected with tuberculosis who are not eligible for enrollment under a group which covers full Medicaid benefits (including an alternative benefit or benchmark benefits plan); §435.226 for independent foster care adolescents; and §435.926 for states' option to provide continuous eligibility for children. We proposed revisions to §435.220 to replace an obsolete optional group with provisions for an optional eligibility group for parents and other caretaker relatives. We proposed revisions to the following regulations to implement the shift from an AFDC-based net income standard to an equivalent MAGI-based income standard, to revise the language for clarity, and to remove any obsolete language: §435.222 (optional eligibility for individuals under age 21 or for reasonable classifications thereof); §435.227 (state adoption assistance children); and §435.229 (optional targeted low-income children). We also proposed to remove inclusion of pregnant women, "specified relatives" (that is, parents and other caretaker relatives), and individuals under age 21 from the list of categorical populations for whom states may opt to provide coverage under §435.210, since optional coverage of these individuals is provided at current §435.116 (pregnant

women) and §435.220 and §435.222, as revised in this rulemaking. This proposed revision results in §435.210 applying only to optional SSI-related eligibility groups for aged, blind and disabled individuals. We received the following comments on these provisions, which, except as noted below, we are finalizing as proposed without substantive modification. We also make several non-substantive revisions for clarity.

Comment: A commenter believes that the addition of §435.226 for independent foster care adolescents appears unnecessary because such persons will be covered in the new mandatory group for former foster care children under §435.150.

Response: While there is significant overlap, there are also differences between these eligibility groups, which we explained in the proposed rule. While the definition of the optional group described at §435.226 requires that an individual be in foster care upon attaining age 18, the mandatory group requires that an individual be in both foster care and Medicaid upon attaining either age 18 or any higher age adopted by the state for federal foster care assistance under title IV-E of the Act. For the optional group, the individual may have been in foster care in any state, while the mandatory group requires that the individual was in foster care and Medicaid in “the” state where the individual now resides. The optional group covers individuals up to age 19, 20, or 21, as specified by the state; the mandatory group covers individuals up to age 26.

Comment: A commenter noted that proposed §435.226 imposes an income limit on the optional group for independent foster care adolescents, but the governing statutory language provides states with flexibility not to require an income test.

Response: Upon review of the statutory requirements for this group at section 1905(w)(1)(C) of the Act, we agree with the commenter. Therefore, we are revising §435.226 to provide that a state may elect to have no income standard for this group. If the state elects to

establish an income standard, it may be no lower than the state's income standard under §435.110 for the mandatory group of parents and other caretaker relatives under section 1931 of the Act.

Although we did not receive comments on proposed §435.227, we realize that the reference in paragraph (c) to the payment standard in every state under the former AFDC program will never be higher than the highest income standard which would have been applied to children under the state plan as of March 23, 2010 or December 31, 2013. This is because since 1990 the lowest income standard permitted for any age group of children under section 1902(1)(2) of the Act was 100 percent FPL. Therefore, we have removed reference to the AFDC payment standard in §435.227(c) of the final rule. We also have streamlined the regulation text in paragraph (c) for increased readability.

Comment: Several commenters supported applying MAGI-based methodologies to the eligibility group for individuals infected with tuberculosis at proposed §435.215, provided that states convert their current net income standard to a MAGI-equivalent standard. The commenters requested CMS to apply continuous eligibility for tuberculosis patients throughout the course of their treatment, since losing coverage substantially increases the chance of abandoned or interrupted treatment. A few commenters requested clarification on whether a state may continue to apply a resource test for this group, as has historically been required, unless a state chose to disregard all assets under section 1902(r)(2) of the Act.

Response: Because individuals infected with tuberculosis are not included in the list of exceptions from MAGI specified under section 1902(e)(14)(D) of the Act, implemented at §435.603(j), effective January 1, 2014, determinations of financial eligibility under this optional group are subject to MAGI-based methodologies set forth at §435.603, including the elimination of any resource test, as specified at §435.603(g)(1). Each state's previous net income limits for this and other MAGI-related eligibility groups have been converted to a MAGI-equivalent

standard. Because maintenance of effort ended in 2014 for eligibility groups for which being a child is not a condition of eligibility, states may elect to lower their income standard for coverage under §435.215 of the final rule. The statute does not authorize continuous eligibility for this group under the state plan. We are willing to work with states interested in pursuing demonstration authority under section 1115 of the Act to support continuous eligibility for this group.

The statute and proposed regulation provide that individuals eligible for coverage under a mandatory eligibility group are not eligible under this optional group for individuals infected with tuberculosis. We are making a technical revision at §435.215 in the final rule to specify that an individual is only eligible for this group (which only covers treatment for tuberculosis) if the individual is not eligible for full coverage under the state plan, defined as all services which the state is required to cover under §440.210(a)(1) and all services which it has opted to cover under §440.225, or an approved alternative benefits plan under §440.325, whether such full coverage is available through enrollment in a mandatory or optional categorical eligibility group under the state's Medicaid plan. Full coverage necessarily will include the services available to individuals enrolled under §435.215. Therefore, consistent with section 1902(a)(19) of the Act, it will be in beneficiaries' best interests to be enrolled in this limited-scope benefits group only if they are not eligible for full coverage.

We received no comments on proposed §435.229. However, we are making technical revisions at §435.229 in the final rule for consistency with the statute; specifically, the option to cover, under section 1902(a)(10)(A)(ii)(XIV) of the Act, "optional targeted low-income children," as defined in section 1905(u)(2)(B) of the Act. The definition in section 1905(u)(2)(B) of the Act cross-references the definition of a "targeted low-income child" for purposes of a separate CHIP in section 2110(b)(1) of the Act. Per section 2110(b)(1)(B) of the Act, the definition of a

“targeted low-income child,” in turn, incorporates the applicable maximum income standard permitted under a state’s separate CHIP. Thus, the maximum income standard a state may adopt for the optional group of optional targeted low-income children under sections 1902(a)(10)(A)(ii)(XIV) and 1905(u)(2)(B) of the Act is not the net income standard for this optional group under the Medicaid state plan or waiver prior to January 1, 2014, converted to an equivalent MAGI-based standard; rather, if higher, it is the maximum income standard, converted for MAGI, now permitted for eligibility under a separate child health plan in the state. Therefore, we are revising paragraph (c)(3) of §435.229 in the final rule to reference the highest effective income level under a CHIP state plan or 1115 demonstration, in addition to Medicaid, converted to a MAGI-equivalent standard. This revision is key to preserve the option for states to transition children from coverage under a separate CHIP program to coverage under a Medicaid expansion program up to an income level higher than coverage of children under the mandatory children’s group at §435.118.

We also are making technical revisions at §435.213 in the final rule for optional eligibility for individuals needing treatment for breast or cervical cancer. Proposed §435.213(c) provided that an individual is considered to need treatment for breast or cervical cancer if the Centers for Disease Control and Prevention (CDC) screen determines that the individual needs treatment for breast or cervical cancer. Because need for such treatment is a condition for eligibility under this group, we clarify in §435.213(c) of the final rule that an individual is considered to need treatment for breast or cervical cancer if the initial screen by the CDC’s breast and cervical cancer early detection program determines that the individual needs treatment for breast or cervical cancer. For eligibility subsequent to the initial eligibility period, the individual’s treating health professional would determine that the individual needs treatment for breast or cervical cancer.

(2) Continuous eligibility under CHIP (§457.342)

We proposed to adopt a new regulation at §457.342 to codify states' option to elect continuous eligibility for children under their separate CHIP. Consistent with existing policy, we proposed the same policies at §457.342 as those at proposed §435.926, except that states also may elect to terminate CHIP during a continuous eligibility period due to non-payment of a premium or enrollment fee required under the CHIP state plan. In addition, in this final rule, we are clarifying in proposed paragraph (a) that continuous eligibility under CHIP is subject to a child remaining ineligible for Medicaid, as required by section 2110(b)(1) of the Act and §457.310, relating to the definition and standards for being a targeted low-income child, and the requirements of section 2102(b)(3) of the Act and §457.350, relating to eligibility screening and enrollment. Thus, if a state has elected the option of continuous eligibility in CHIP, but during the continuous eligibility period receives information regarding a change in household size or income that would potentially result in eligibility of the child for Medicaid, the state would redetermine eligibility using this information and enroll the child in Medicaid, if found to be eligible.

Comment: Several commenters expressed strong support for proposed §457.342. The commenters also recommended that for children disenrolled due to non-payment of a premium, a new continuous eligibility period begins when the child is reenrolled in CHIP following payment of the unpaid premiums or at the end of a lock-out period.

Response: If a child is subject to requirements for payment of premiums or an enrollment fee at §457.510, the state may terminate the child from CHIP for failure to pay the required amounts at the end of a premium grace period (of at least 30 days), as permitted under section 2103(e)(3)(C) of the Act. States may also impose a premium lock-out period (which may not exceed 90 days per §§457.10 and 457.570) on individuals terminated for failure to pay premiums or enrollment fees. If the state requires a new application following disenrollment due to unpaid

premiums or enrollment fees after payment is made or at the end of a premium lock-out period, and the individual is determined to be eligible for CHIP based on that application, a new continuous eligibility period would begin. However, if the state does not require a new application in these circumstances, then the previous continuous eligibility period would resume, extending through the same date as would have been the case had the individual not been terminated and then reenrolled.

We are clarifying at proposed paragraph (b) that the continuous eligibility period may be terminated for failure to pay premiums or enrollment fees, subject to a premium grace period of at least 30 days and the disenrollment protections at section 2103(e)(3)(C) of the Act and §457.570.

2. Presumptive Eligibility

a. Proposed Amendments to Medicaid Regulations for Presumptive Eligibility

We proposed to revise Medicaid regulations in part 435 subpart L related to basis, definitions, and the option for states to cover services for children during a presumptive eligibility period at §§435.1100 through 435.1102; to add a new §435.1103, implementing the state option to provide presumptive eligibility for pregnant women and individuals needing treatment for breast or cervical cancer, as well as six new options for Medicaid presumptive eligibility provided by the Affordable Care Act; to add a new §435.1110, implementing section 1902(a)(47)(B) of the Act, added by the Affordable Care Act, which gives hospitals the option to make presumptive eligibility determinations for Medicaid; and to revise §§435.1001 and 435.1002 in subpart K, regarding the availability of federal financial participation (FFP) related to presumptive eligibility. In the July 2013 Eligibility final rule, we finalized the proposed revisions to §435.1102, as well as the addition of new §435.1103 and §435.1110. In this final rule, we finalize the proposed revisions at §§435.1001, 435.1002, 435.1100, and 435.1101.

(1) FFP for Administration and for Services (§§435.1001 and 435.1002)

We proposed to amend §§435.1001 and 435.1002 to clarify that, consistent with current policy and federal statutory authority, FFP is available for the necessary administrative costs a state incurs in administering all types of presumptive eligibility and for services covered for individuals determined presumptively eligible for any type of presumptive eligibility, not just for such costs associated with presumptive eligibility for children.

Comment: A commenter requested that for individuals determined presumptively eligible, a state receive 100 percent federal funding for services provided unless and until the individual completes the eligibility determination process for Medicaid. The commenter stated that this is particularly important for states expanding Medicaid to the new adult group under §435.119, as it will be difficult to determine whether the presumptively eligible individual should be claimed at 100 percent federal funding for those “newly eligible” or the state’s regular Medicaid match rate.

Response: There is no federal statutory authority to reimburse states at a higher match rate than the state’s regular Medicaid match under title XIX of the Act for services covered for individuals determined to be presumptively eligible, including those determined presumptively eligible for the adult group at §435.119. However, if the individual submits a regular application and is subsequently determined to be Medicaid eligible, the state may claim the regular or enhanced match, as appropriate, for services provided beginning on the effective date of eligibility based on the regular application, including during any period of retroactive eligibility. For example, if an adult under age 65 is determined presumptively eligible under the adult group, the state would claim services provided during the presumptive eligibility period at the state’s regular match. If, based on a regular application, the individual subsequently is determined to be retroactively eligible during the presumptive eligibility period and is determined to meet the definition of a “newly eligible” individual for purposes of claiming enhanced FFP under part 433, subpart E, the state may adjust its claims to reflect the newly eligible enhanced match for services

provided during the overlapping retroactive and presumptive eligibility periods. Similarly, if the individual is determined retroactively eligible as a Medicaid expansion child meeting the definition of optional targeted low-income child at §435.4, the state may claim the title XXI enhanced match for services provided during the period of retroactive eligibility. No comments were received on proposed §435.1101. We are finalizing both §435.1001 and 435.1002 as proposed.

(2) Basis for Presumptive Eligibility (§435.1100)

We proposed to revise §435.1100 to include the statutory basis for provision of presumptive eligibility for all populations who may receive services during a period of presumptive eligibility under part 435 subpart L, as revised in the July 15, 2013 Medicaid and CHIP eligibility final rule. No public comments were received. We are finalizing §435.1100 as proposed.

(3) Definitions (§435.1101)

We proposed to revise §435.1101 to replace the definition of “application form” with “application” for consistency with terminology used in §435.907 and to clarify that the definition of “qualified entity” includes a health facility operated by the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian Organization.

Comment: One commenter recommended that safety net health plans, defined in section 9010(c)(2)(C) of the Affordable Care Act, be clearly identified in §435.1101 as a type of “qualified entity” eligible to conduct presumptive eligibility determinations.

Response: We are not accepting this comment since safety net health plans are not specifically included in the definition of “qualified entity” in section 1920A of the Act. We note, however, that, as reflected in the current definition of “qualified entity” in §435.1101, and subject to approval by the Secretary, states may designate entities other than those specifically identified

as a qualified entity authorized to make presumptive eligibility determinations in accordance with §§435.1102 and 435.1103. We are finalizing the proposed revisions to the definition in §435.1101 without modification.

b. Proposed Amendments to CHIP Regulations for Presumptive Eligibility (§§457.355 and 457.616)

To align the regulations governing presumptive eligibility for children under CHIP with Medicaid, we proposed to revise §457.355 to specify that presumptive eligibility for children under a separate title XXI CHIP program is determined in the same manner as Medicaid presumptive eligibility for children under §§435.1101 and 435.1102 of this chapter. In addition, we proposed to revise §457.355 and to remove §457.616(a)(3) to implement the amendment to section 2105(a)(1) of the Act that was made by the CHIPRA. Prior to the passage of CHIPRA, states were authorized to claim enhanced federal matching funds under their title XXI allotment for coverage of children during a Medicaid presumptive eligibility period. This authority was implemented in current §§457.355 and 457.616(a)(3). Section 113(a) of CHIPRA, however, amended section 2105(a)(1) of the Act to eliminate this authority and, effective April 1, 2009, states must claim their regular FFP under title XIX for services provided to all children determined presumptively eligible for Medicaid (including those eligible for a Medicaid expansion program) during a presumptive eligibility period. We proposed to implement this change in the federal statute through the deletion of §§457.355(b) and 457.616(a)(3).

Comment: We received no comments on the proposed revisions to §457.355(a), which are finalized at §457.355 with technical revisions for consistency with the Medicaid regulation at §435.1102 of this chapter. Several commenters requested that we revise the proposed §457.355 to clarify that states may claim title XXI funds for children covered during a presumptive eligibility period under either a title XXI-funded Medicaid expansion program or a separate title

XXI child health program. Another commenter requested clarification on whether regular Medicaid match rather than enhanced CHIP match must be claimed for children ages 6 through 18 with income over 100 percent FPL and at or below 133 percent FPL who would have been eligible under the state's separate title XXI CHIP prior to implementation of the expansion of Medicaid for this age group up to 133 percent FPL under the Affordable Care Act.

Response: As previously explained, prior to passage of CHIPRA, states were authorized to claim enhanced federal matching funds under their title XXI allotment for coverage of children during a Medicaid presumptive eligibility period. CHIPRA, however, eliminated this authority and, effective April 1, 2009, states must claim their regular FFP under title XIX for services provided to all children determined presumptively eligible for Medicaid during a presumptive eligibility period. This includes children determined presumptively eligible based on having family income in the range of a state's Medicaid expansion program for optional targeted low-income children. We proposed to implement this change in the federal statute through the deletion of §457.355(b) and §457.616(a)(3), which we finalize in this rulemaking as proposed. If a child, who is determined presumptively eligible for Medicaid and subsequently approved for Medicaid eligibility (based on a regular application), meets the definition of optional targeted low-income child at §435.4, the state may claim enhanced title XXI match for services received on or after the effective date of regular Medicaid eligibility, including during a period of retroactive eligibility described in §435.915. This includes uninsured children covered under the Medicaid state plan effective January 1, 2014, as a result of the expansion of coverage for children ages 6 through 18 up to 133 percent FPL under the Affordable Care Act, but it does not include expanded coverage of insured children, since insured children do not meet the definition of an "optional targeted low-income child" under section 1905(u)(2)(B) of the Act or §435.4.

Section 435.1002(c) of the Medicaid regulations, as revised in this rulemaking and discussed above, is consistent with this policy.

3. Financial Methodologies for Medically Needy (§§435.601 and 435.831)

In determining financial eligibility for medically needy pregnant women, children, parents, and other caretaker relatives, the methodologies of the former AFDC program historically have been applied as the cash assistance program most closely related to these populations. Under section 1902(r)(2) of the Act and current §435.601(d), states also have the flexibility to adopt other reasonable methodologies, provided that for aged, blind and disabled individuals such methodologies are less restrictive than the SSI methodologies applied to medically needy aged, blind and disabled individuals per section 1902(a)(10)(C)(iii) of the Act and §435.601, and for medically needy children, pregnant women, parents and caretaker relatives, such methodologies are less restrictive than the AFDC-based methods. Because of the elimination of the AFDC program in 1996 and the replacement under the Affordable Care Act of AFDC-based methodologies with MAGI-based methodologies for determining financial eligibility for categorically needy pregnant women, children, parents, and other caretaker relatives, we proposed revisions at §435.831 to provide states with flexibility to apply, at state option, either AFDC-based methods or MAGI-based methods for determining income eligibility for medically needy children, pregnant woman, and parents and other caretaker relatives.

However, section 1902(a)(17)(D) of the Act prohibits state plans from taking into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is the individual's spouse or the individual's child who is under age 21, blind or disabled. In requiring the adoption of MAGI-based methodologies for most individuals, section 1902(e)(14)(A) of the Act provides for an exception to the limitations on financial responsibility in section 1902(a)(17)(D) of the Act, and under section

1902(e)(14)(D)(i)(IV) of the Act, medically needy individuals are exempt from the mandatory application of MAGI-based methods. Therefore, the limitation on deeming to an applicant or beneficiary the income of individuals other than the applicant's or beneficiary's spouse or parents under section 1902(a)(17)(D) of the Act continues to apply to the medically needy, and states must ensure that there is no deeming of income or attribution of financial responsibility that would conflict with the requirements of that section of the Act. We suggested possible ways that states could apply MAGI-based methodologies in determining eligibility for the medically needy without violating section 1902(a)(17)(D) of the Act. We suggested, for example, that when application of the MAGI-based methodologies set forth in §435.603 would result in impermissible deeming, the state could subtract from total household income the income of the individual which may not be counted under section 1902(a)(17)(D) of the Act. Alternatively, we suggested that the state could remove the individual whose income may not be counted under section 1902(a)(17)(D) of the Act, from the household altogether, such that the individual's income would not be counted in total household income and the individual himself or herself would not be included in household size. Under the proposed rule, per section 1902(r)(2) of the Act and §435.601(d), states would have the option to apply methodologies to medically needy parents and caretaker relatives, pregnant women and children that are less restrictive than either AFDC-based methods or the MAGI-based methodologies permitted under the proposed revisions at §435.831.

To meet the MOE requirement in section 1902(gg) of the Act, we explained in the proposed rule that states would have to ensure that the application of MAGI-based methodologies to medically needy populations would be no more restrictive than the AFDC-based methodologies applied by the state prior to enactment of the Affordable Care Act. Because the MOE has expired for adults, this requirement currently applies only to the determination of

eligibility of medically needy children until the expiration of the MOE for children in 2019. We explained that, for purposes of the MOE, states may replace current AFDC-based disregards applied to medically needy individuals with a single block-of-income disregard such that in the aggregate the same number of people are covered, which will satisfy the MOE.

Finally, we noted that, under the regulations adopted in the March 23, 2012, Eligibility final rule, eligibility under section 1931 of the Act, like all other bases of eligibility, is determined on an individual basis. For consistency, we proposed to remove the reference to “family” in §435.831(c) so that parents and other caretaker relatives similarly will be evaluated for medically needy eligibility as individuals, as currently is the case for medically needy pregnant women and children.

Nothing in the proposed rule would change the methodologies applied to determining medically needy eligibility for aged, blind, and disabled individuals, when being aged, blind or disabled also is a condition of such eligibility.

Comment: Commenters were generally supportive of states having the option to apply MAGI-based methods in determining eligibility for medically needy children, pregnant women, and parent/caretaker relatives. Commenters also supported the policy in the proposed rule that states must ensure there is no deeming of income or attribution of financial responsibility that would conflict with requirements in section 1902(a)(17)(D) of the Act, but noted that this requirement would complicate development of streamlined systems of eligibility rules and procedures. One commenter expressed concern that AFDC-based rules relating to financial responsibility of relatives would continue to be required, even in states electing to use MAGI-like methods under §435.831(b)(1)(ii).

Response: We appreciate the support, and are finalizing the policy described in the proposed rule. We are making some revisions to proposed §435.831 to more clearly reflect the

policy and options described in the proposed rule. First, as explained in the proposed rule, the revisions to §435.831 were intended to provide states with an option to adopt the financial methodologies used to determine household income for MAGI-based eligibility groups, except where application of the MAGI-based methodologies would violate the limitation on deeming to an applicant or beneficiary income from anyone other than a spouse or, in the case of an individual under age 21, a parent living with the applicant or beneficiary. Proposed §435.831(b)(1) provided only that states could apply the MAGI-based methodologies in §435.603(e), which provides generally for application of the methodologies set forth in section 36B(d)(2)(B) of the IRC in calculating the income attributed to a given individual. The rules governing household composition, family size and household income described in paragraphs (b), (c), (d) and (f) of §435.603 are also integral to the determination of income eligibility using MAGI-based methodologies; indeed, it is household composition and deeming rules in §435.603(d) and (f), not the income methods at §435.603(e), which may conflict with the limits on deeming set forth in section 1902(a)(17)(D) of the Act. Therefore, we are replacing the reference to the “MAGI-based methodologies defined in §435.603(e)” in proposed §435.831(b)(1) with reference to the “MAGI-based methodologies defined in §435.603(b) through (f)” in the final rule.

Also, to ensure compliance with section 1902(a)(17)(D) of the Act, we proposed at §435.831(b)(1) that states electing to apply MAGI-like methodologies to medically needy parents and caretaker relatives, pregnant women and individuals under age 21, also comply with §435.602 (relating to the financial responsibility of relatives and other individuals), as revised in this rulemaking. We agree with the commenter, however, that the reference to all of §435.602 was overly broad.

Under section 1902(a)(17)(D) of the Act, except as provided in paragraphs (e)(14), (l)(3), (m)(3) and (m)(4), in determining an individual's financial eligibility for Medicaid, the state may consider only the income and resources of the individual, the individual's spouse (if living with the individual) and, in the case of individuals under age 21, the individual's parents (if living with the individual). Under §435.602(a)(2)(ii), the income and resources of parents and spouses of individuals under age 21 is considered only if the parent's or spouse's income would have been counted under the state's approved AFDC state plan for a dependent child. Thus, for example, under §435.602(a)(2)(ii), the income of a child's stepparent is considered only to the extent to which stepparent income was counted under AFDC. This is more limiting, however, than the restrictions on deeming provided under section 1902(a)(17)(D) of the Act, which does not prohibit stepparent deeming. Accordingly, we are revising §435.831(b)(1) in the final rule to accurately reflect the terms of the limitation under section 1902(a)(17)(D) of the Act. Under §435.831(b)(1)(ii) of the final rule, if the state exercises the option to apply MAGI-based methodologies defined in §435.603(b) through (f) to certain medically needy individuals, the state must comply with the terms of §435.602, except that in applying §435.602(a)(2)(ii) to individuals under age 21, the agency may, at state option, include in the individual's household all parents as defined in §435.603(b) (including stepparents) who are living with the individual without regard to whether such parent's or stepparent's income and resources would have been counted under AFDC if the individual would be considered a dependent child under the AFDC State plan.

Under the final rule, states may elect to apply more stringent limitations on deeming for individuals under age 21 applied in effect under the state's AFDC program, but are not required to do so. In determining financial eligibility of medically needy parents and caretaker relatives, pregnant women and individuals under 21, this will provide states with greater latitude to adopt either the household composition and deeming rules applied under the state's AFDC state plan or

the MAGI-based household composition and deeming rules set forth in §435.603(b), (c), (d) and (f), subject to the specific limitation on deeming set forth at section 1902(a)(17)(D) of the Act. Thus, under the final regulation, states may not count the income of a child in determining the medically needy eligibility of a parent or another sibling. States may, however, count a stepparent's income in determining the medically needy eligibility of a child if the state elects to apply MAGI-like methodologies to such individuals in accordance with §435.831(b)(1)(ii) of the final rule.

We agree with the commenters that compliance with the deeming provisions in section 1902(a)(17)(D) of the Act adds some complication to the streamlined system of eligibility rules. However, as the commenters noted, this limitation is grounded in statute. For this reason, we suggested two relatively simple approaches (noted above) which we believe states could use to integrate medically needy coverage into a streamlined eligibility system for MAGI-based coverage without running afoul of the deeming restrictions.

We also are making a technical revision to paragraph (b)(2) of §435.601 (relating to application of financial methodologies for individuals excepted from application of MAGI-based methodologies, discussed earlier in this final rule) to cross-reference the state option to apply MAGI-like methodologies to certain medically needy individuals under §435.831.

Comment: For states electing application of MAGI-like methodologies to medically needy pregnant women, parents and caretaker relatives and children, several commenters questioned exactly what methodology we envision states using to convert their current AFDC-based net medically needy income level (MNIL) into MAGI-equivalent standards to comply with the MOE requirement in section 1902(gg) of the Act. Several commenters questioned whether we intend to require application of the guidance we provided to states in the December 28, 2012, State Health Official (SHO) Letter (SHO #12-003 and Affordable Care Act #22) regarding

Conversion of Net Income Standards to MAGI Equivalent Income Standards. The commenters noted that in the proposed rule we stated that states may replace current disregards applied for medically needy eligibility under an AFDC-related group with a block-of income disregard to satisfy the MOE in the aggregate, but the preamble does not require that they do so. The commenters requested clarification that states wishing to take up the option to apply a MAGI-based methodology to medically needy pregnant women, parents and caretaker relatives and children, must convert current AFDC income standards according to approved methodologies, and suggested that we reconsider use of the average disregard method and consider instead a methodology that would minimize the number of persons who would potentially lose eligibility under a MAGI-based standard. One commenter stated that it is unclear how states could calculate the block disregard in a way that would definitively show that it is not more restrictive than the current methodology. Another commenter supported use of a conversion methodology to establish an equivalent MAGI-based MNIL that satisfies the MOE requirement in the aggregate. A few commenters expressed support of the requirement that states must comply with the maintenance of effort requirement for medically needy children.

Response: To comply with the MOE at section 1902(gg) of the Act, which remains applicable to children through September 30, 2019, states that elect to adopt MAGI-based methodologies for medically needy parents and caretaker relatives, pregnant women and children will need to ensure that the application of MAGI-based standards and methodologies to medically needy children will be no more restrictive than the AFDC-based standards and methodologies applied by the state prior to enactment of the Affordable Care Act. As noted, one way for a state to satisfy this provision would be to retain the MNIL currently established in the state plan and replace the disregards applied to children in establishing medically needy eligibility as of the enactment of the Affordable Care Act (or, if less restrictive, applied subsequent to that date) with

a single block-of-income disregard such that, in the aggregate, children are no worse off when the MAGI-based methods are applied. States could also apply this method to medically needy pregnant women, parents and other caretaker relatives (since the MOE for adults has expired, states would not be required to do so for these populations.) Alternatively, a state could raise the MNIL by a conversion factor – as was done in accordance with the December 28, 2012, SHO in converting the pre-Affordable Care Act net income standards for previously AFDC-related categorically needy groups to a MAGI-based equivalent standard – such that children in the aggregate would not be harmed. We note, however, that states cannot adopt a different converted MNIL for each medically needy group: The same MNIL must be applied to the medically needy groups for pregnant women and children and the same MNIL must be applied to the medically needy groups for parents and other caretaker relatives, or aged, blind, and disabled individuals. In addition, under section 1903(f)(1) of the Act, the MNIL cannot exceed 133 $\frac{1}{3}$ percent of the former AFDC payment standard. These limitations likely make the first approach, replacing current disregards with an in-the-aggregate-equivalent block-of-income disregard, though not required, more practical.

The December 28, 2012, SHO was not issued with conversion of the MNIL for medically needy groups in mind, and its terms are not uniformly applicable to the present situation, in which a state may elect to replace current AFDC-based methodologies with MAGI-based methodologies for certain medically needy individuals. However, we believe the basic principles outlined in the SHO are relevant, and that the standardized MAGI conversion methodology described in the SHO can be applied in this situation to yield a converted medically needy income level that satisfies the MOE requirements under section 1902(gg) of the Act, and we have worked with states with medically needy programs to determine an appropriate conversion factor for their medically needy programs using that methodology. We also believe that states should have the option to

suggest an alternative state proposed methodology, as we also had permitted in the December 28, 2012, SHO for converting the income standards applied to categorically needy eligibility groups, and we will work with any state interesting in applying an alternative method to ensure compliance with the MOE set forth in section 1902(gg) of the Act, as well as other applicable provisions of the statute and regulations relating to coverage of medically needy individuals.

Comment: Several commenters requested clarification on whether states may continue to apply a resource test for medically needy eligibility. The commenters state that because other, less vulnerable populations subject to MAGI-based methodologies under the Affordable Care Act will be exempt from asset tests, the same exemption should apply to medically needy populations.

Response: Section 1902(a)(10)(C)(i)(III) of the Act, implemented for resources at §§435.840 through 435.845, provides that states electing to cover medically needy individuals establish a resource standard and methodologies for determining resource eligibility for all medically needy groups. In giving states the option to align the income methodologies used in determining medically needy eligibility for the historically AFDC-related populations of parents and caretaker relatives, pregnant women and children with the new MAGI-based income methodologies now used for determining the categorically-needy eligibility of these same populations, we did not eliminate the ability of states to apply a resource test to all of their medically needy groups, nor could we have done so, as there is nothing in the Affordable Care Act which supersedes section 1902(a)(10)(C)(i)(III) of the Act. Thus, while section 1902(e)(14)(C) of the Act prohibits application of a resource test to any individual for whom the state is required to apply MAGI-based methodologies under section 1902(e)(14) of the Act, providing states with the option to apply MAGI-like income methodologies established per paragraphs (G) and (H) of section 1902(e)(14) of the Act, as implemented in §435.603, to certain medically needy groups does not result in full application of section 1902(e)(14)(C) of the Act or

the elimination of any applicable resource test in states electing that option. As there is no resource test under MAGI, we did not propose any revisions to existing regulations relating to permissible medically needy resource standards and methodologies, and these regulations remain in effect. States may, at their option, elect to effectively eliminate the resource test for any or all medically needy eligibility groups by adopting a less restrictive methodology to disregard all of an individual's resources under section 1902(r)(2) of the Act and §435.601(d).

Similarly, as explained in the proposed rule, a state's election to apply MAGI-like income methodologies under §435.831 does not eliminate the option states currently have under section 1902(r)(2) of the Act and §435.601(d) to adopt less restrictive financial methodologies in determining the financial eligibility of medically needy parents and caretaker relatives, pregnant women and children. In this final rule, we are making a conforming revision to the introductory text of §435.601(d)(1) to reflect the state flexibility available under the statute.

4. Deemed newborn eligibility (§§435.117 and 457.360)

Section 1902(e)(4) of the Act, implemented in current §435.117, provides that babies born to mothers eligible for and receiving covered services under the Medicaid state plan for the date of birth (including during a period of retroactive coverage in accordance with §435.915) be automatically deemed eligible for Medicaid without an application until the child's first birthday. Before the year of deemed newborn eligibility ends, the agency is required, in accordance with §435.916, to determine whether the child remains Medicaid eligible for any other eligibility groups, such as for the mandatory children's group under §435.118. Section 211 of CHIPRA made several revisions to section 1902(e)(4) of the Act and also added a new requirement at section 2112 of the Act, relating to deemed eligibility for babies born to targeted low-income pregnant women covered under CHIP. We proposed to revise §435.117 and to add a new §457.360 implementing the CHIPRA amendments, as follows:

- In accordance with section 1903(x)(5) of the Act, as added by section 211(b)(3)(A)(ii) of CHIPRA, we proposed revisions at §435.117(b) to require that a child born to a mother covered by Medicaid for labor and delivery as an emergency medical service in accordance to section 1903(v)(3) of the Act is automatically eligible until the child's first birthday under §435.117 (in the same manner as any infant born to a mother eligible for and receiving full Medicaid benefits on the date of birth).

- We proposed revisions at §435.117(b) to eliminate the requirement, based on a previous provision of statute, that deemed newborn eligibility continue only as long as the baby is a member of the mother's household and the mother either remained eligible for Medicaid or would remain eligible if still pregnant, as these limitations were removed from section 1902(e)(4) of the Act by section 113(b)(1) of CHIPRA.

- Section 2112(e) of the Act, as added by section 111 of CHIPRA, requires that babies born to pregnant women covered by a state as targeted low-income pregnant women under a separate CHIP similarly be deemed automatically eligible for Medicaid or CHIP, as appropriate. We proposed to amend §435.117(b) and to add a new §457.360 implementing this requirement, based on whether household income at the time of the birth is at or below or above the income standard established by the state for eligibility of infants under §435.118.

- Consistent with section 1902(a)(19) of the Act to promote simplicity of administration and the best interest of beneficiaries, we proposed at §435.117(b)(1)(iii) and (iv) that states be provided with the option to cover as deemed newborns under Medicaid or CHIP, as appropriate based on the mother's household income, babies born to mothers covered for the date of the child's birth as a targeted low-income child under a separate CHIP state plan or to mothers covered under a Medicaid or CHIP demonstration waiver under section 1115 of the Act. The state would have to provide an assurance that, based on the income levels of eligibility, the state

believes that the children would meet the applicable eligibility standard if a full eligibility determination were performed.

- We proposed at §435.117(c) that states be provided with the option to provide deemed newborn eligibility under Medicaid to babies born to mothers receiving Medicaid in another state and at §457.360(c) that states be provided with the option to provide deemed newborn eligibility under CHIP to babies born to mothers receiving CHIP or coverage under a CHIP or Medicaid section 1115 demonstration program in another state.

- Finally, we proposed at §§435.117(d) and 457.360(d) that states be required to use the mother's Medicaid or CHIP identification number for a deemed newborn unless and until the state assigns a separate identification number to the child, as provided at section 1902(e)(4) and section 2112(e) of the Act.

Comment: Several commenters strongly supported the option at §§435.117(b) and 457.360(b) for states to extend automatic enrollment to babies born to mothers covered as a targeted low-income child under a separate CHIP state plan, but recommended that we require states to provide deemed newborn eligibility for such babies, as well as to babies born to mothers who are eligible through a section 1115 demonstration (rather than simply providing states with the option to do so). A few commenters encouraged us to require that states alert women who become pregnant while enrolled under a section 1115 demonstration of the importance of informing the state of their pregnancy to be evaluated for eligibility under the state plan, including the opportunity to receive a year of stable coverage for their newborns. Some commenters stated that states that take up the option to cover targeted low-income pregnant women under a separate CHIP should be required to provide automatic deemed eligibility to the newborns of mothers enrolled in CHIP as targeted-low income children. Two commenters, who supported the option to deem eligibility to a newborn of a mother who was covered as a targeted low-income child

under a separate CHIP, indicated that this option would eliminate the administrative burden that is otherwise involved in the process of enrolling the baby in Medicaid or CHIP if a new application for the newborn is required. One of these commenters maintained that virtually all of these newborns (who are born to a targeted low-income child in a separate CHIP) meet Medicaid eligibility requirements, and should automatically be deemed eligible for Medicaid, while the other took the position that all such newborns should automatically be deemed eligible for CHIP.

Several commenters stated that the proposed §§435.117(c) and 457.360(c) would violate the woman's right to travel because they would not require deemed newborn eligibility when the mother had been enrolled in Medicaid or CHIP in another state. One commenter encouraged CMS to work with states to avoid the disruptions to coverage that may result from leaving this at state option. Another commenter supported making deemed newborn eligibility for infants born in another state optional. The commenter stated that, for such infants, a new application and verification of citizenship is important.

Response: We are finalizing the extension of deemed newborn eligibility beyond the statutory requirements at state option, as proposed. Since eligibility levels for pregnant women and children vary between the states, we are revising proposed §435.117(b)(1)(ii) and (iii) to provide an additional option for states to deem Medicaid eligible a newborn child of a mother covered under another state's CHIP state plan (as a targeted low-income pregnant woman or child) for the date of the child's birth. We also are moving the content of proposed paragraph (c) to §435.117(b)(1)(i), and redesignating paragraph (d) at paragraph (c). In addition, we are revising paragraph (b)(2) to be clearer that newborns who must be deemed under paragraph (b)(1) are not optional for deeming under paragraph (b)(2).

Under §457.360, we are making organizational revisions to be consistent with the changes in Medicaid at §435.117. We are redesignating the proposed paragraph (b)(2) as a new paragraph

(b)(3) and moving the content of the proposed paragraph (c) to a new paragraph at §457.360(b)(2)(i). Also, we are adding a new paragraph at §457.360(b)(2)(ii) to include a requirement that states electing CHIP optional newborn deeming provisions must also elect the comparable options in Medicaid. This clarification is designed to ensure that states deem newborns to the appropriate program and prevent the claiming of enhanced federal matching funds under their title XXI allotment for coverage of newborns who are eligible for Medicaid. We are also redesignating the proposed paragraph (d) regarding the CHIP identification number as paragraph (c).

Comment: A commenter stated that proposed §§435.117(d) and 457.360(d), requiring states to use the mother's Medicaid or CHIP identification number for a deemed newborn unless and until the state assigns a separate identification number to the child, are overly prescriptive and would require change to the states' current functionality. The commenter requested that this requirement be omitted from the final rule.

Response: This provision, which serves to ensure that deemed newborns do not experience any gap in coverage for needed services, is expressly required under sections 1902(e)(4) and 2112(e) of the Act. States are permitted to immediately assign a separate identification number to a deemed newborn, thereby avoiding any need for the mother's identification number to be used temporarily for the baby. We are retaining this provision in both Medicaid and CHIP, although moving the content proposed at §§435.117(d) and 457.360(d) to §§435.117(c) and 457.360(c), respectively, as previously discussed.

Comment: A commenter requested clarification about whether a newborn who was covered under the state's separate CHIP as an unborn child is deemed eligible for one year. The commenter also questioned about the availability of enhanced title XXI funding for postpartum care for the mothers of these newborns.

Response: A newborn who was covered as an unborn child under a separate CHIP, and whose mother was not covered by Medicaid for the date of the child's birth, cannot be deemed eligible for Medicaid or CHIP for the period extending until the child's first birthday, since the mother was not covered for the date of birth. Without coverage of the mother, there is no basis for providing deemed newborn eligibility. If a pregnant woman gives birth to a newborn who was covered as an unborn child under a separate CHIP state plan, and the woman is determined eligible for Medicaid for coverage of the labor and delivery, as authorized under section 401(b)(1) of PRWORA, codified at 8 U.S.C. 1611(b)(1), and sections 1903(v)(2) and 1903(v)(3) of the Act, the baby is entitled to be deemed eligible for Medicaid under §435.117. Given (1) the requirements at §457.626(a)(2) (prohibiting payment for services that can reasonably be expected to be paid under another federally-financed program) and §457.626(a)(3) (specifically prohibiting payment for services that are payable under Medicaid as a service to a pregnant woman), (2) the express requirement added at section 1903(x)(5) of the Act by section 211(b)(3)(A)(ii) of CHIPRA to provide deemed newborn eligibility to infants born to pregnant women covered only for labor and delivery for the child's birth, and (3) the enhanced degree of coordination required between the eligibility and enrollment systems for all insurance affordability programs per §§457.348 and 457.350, we expect states to evaluate whether the pregnant woman of an unborn child covered under a separate CHIP is eligible for Medicaid coverage for the labor and delivery of the baby as treatment of an emergency medical condition, consistent with §435.139. If the woman is determined to be eligible for Medicaid coverage (including during a retroactive eligibility period), the state must deem the baby eligible for Medicaid under §435.117 until the child's first birthday. In cases involving retroactive Medicaid coverage of the labor and delivery of the child and retroactive deemed eligibility for the child, states may make adjustments to claiming through the customary financial management processes. Once determined eligible for

and enrolled in Medicaid, the child's eligibility for CHIP must be terminated. To ensure coordination of coverage and care, consistent with sections 2101(a) and 2102(b)(3)(E) of the Act, the child's eligibility may not be terminated prior to enrollment in Medicaid.

With regard to the coverage of postpartum care for mothers of newborns who had been covered in the state's separate CHIP under the unborn child option, section 2112(f)(2) of the Act permits states to provide postpartum services beginning on the last day of the pregnancy through the end of the month in which the 60-day postpartum period ends, in the same manner as provided in Medicaid, if the mother, except for age, would otherwise satisfy the eligibility requirements of the separate CHIP state plan. If the mother does not meet the eligibility requirements (other than age) for coverage under the CHIP state plan, FFP under title XXI is available to cover postpartum care only if the state usually pays for pregnancy and delivery services through a bundled payment or global fee method which includes postpartum care together with prenatal care, labor and delivery. (Global fees are commonly used in reimbursing for obstetrical care cover all prenatal visits, delivery, and at least one postnatal visit.) FFP similarly is available for capitation rates that reflect the use of bundled payments or global fees by managed care entities. For states that do not pay using such a bundled payment or global fee methodology, FFP is not available for postpartum care. In addition, FFP is not available for post-hospitalization postpartum care that is not included in the bundled or capitated payment. As explained in SHO Letter #02-004 (November 12, 2002), the option to cover unborn children from conception to birth was not meant to alter existing payment methodologies, and states are not permitted to establish a bundled payment methodology applicable only to coverage for unborn children.

Comment: Several commenters did not understand why paragraph (b)(1)(iii) of §435.301, relating to deemed newborns of medically needy mothers, is being deleted from the current rules. The commenters stated that this rule should be left in place, or, it should be clarified that

mothers eligible for Medicaid as medically needy are considered to be covered under the state plan and, therefore, their babies would qualify as deemed newborns under §435.117.

Response: Effective April 1, 2009, CHIPRA eliminated the Medicaid requirement at section 1902(e)(4) of the Act that the baby remains eligible as a deemed newborn only so long as the mother remains eligible for Medicaid (or would remain eligible if still pregnant). Removing this requirement means that all newborns born to women covered by Medicaid for the child's birth, including a mother covered as medically needy, are now covered as mandatory categorically needy deemed newborns. Therefore, all infants born to pregnant women who are eligible for Medicaid for the date of the child's birth, including pregnant women who are eligible as medically needy, are covered under §§435.117 and 435.301(b)(1)(iii) for medically needy deemed newborns no longer is consistent with the statute. SHO Letter 09-009, issued on August 31, 2009, provides additional explanation on the policy changes made by CHIPRA to deemed newborn eligibility, including the change for babies born to medically needy pregnant women (see <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109b.pdf>).

F. Verification Exceptions for Special Circumstances (§435.952)

Under §435.952(c), states are permitted to request additional information from individuals, including documentation, to verify most eligibility criteria if data obtained electronically by the state is not reasonably compatible with attested information or electronic data is not available. However, there are individuals for whom providing documentation even in such limited circumstances would create an insurmountable procedural barrier to accessing coverage. In accordance with section 1902(a)(19) of the Act (relating to simplicity of administration and best interest of individuals), we proposed revisions at §435.952(c)(3) under which states must accept self-attestation (and may not require documentation) if documentation

does not exist or is not reasonably available at the time of application or renewal, for example, as may be the case for victims of domestic violence or natural disasters and homeless individuals.

Under the proposed revisions, this self-attestation policy would not apply, for example, in the case of citizenship or immigration status, when documentation is (or may be) expressly required under the Act.

Comment: A commenter requested clarification as to whether the exception at proposed §435.952(c) requiring that states accept self-attestation in special circumstances applies to all individuals regardless of whether their eligibility is based on MAGI or non-MAGI methodologies.

Response: The regulations relating to verification of eligibility at §§435.940, *et seq.*, including §435.952, as revised in this final rule, applies to all applicants and beneficiaries, regardless of the methodology used to determine financial eligibility. We note that the regulations relating to verification apply equally at application, as well as renewals and redeterminations due to a change in circumstances, and we have revised §435.952(c)(3) in the final rule to clarify that the proposed revision also applies both at application and renewal.

Comment: Several commenters recommended that CMS amend §435.952(c)(3) to permit states to apply the special circumstances exception to allow self-attestation of eligible immigration status and not require states to collect documentary evidence of eligible immigration status. Several commenters also suggested that the final rule require states to accept a photocopy, facsimile, scanned, or other copy of a document used to verify immigration status.

Response: Section 1137 of the Act requires states to verify a written declaration (made under penalty of perjury) of satisfactory immigration status. Section 1902(a)(46)(B) of the Act requires states to verify an attestation of citizenship in accordance with sections 1903(x) or 1902(ee) of the Act. Thus, we do not have authority, even under special circumstances, to permit states to accept self-attestation of these criteria. Neither section 1137 of the Act, DOJ guidance,

the Systematic Alien Verification for Entitlements (SAVE), which is the Department of Homeland Security's (DHS) system of record used by agencies to verify immigration status, nor our regulations require individuals to submit original or certified copies of documents as evidence of satisfactory immigration status, and states may accept copies of documents if necessary to complete the verification of immigration status.

Comment: A commenter recommended CMS clarify that dependents may also qualify for an exception for special circumstances and be able to self-attest in lieu of providing documents at the time of application.

Response: Section 435.952, including the "special circumstance exception" at §435.952(c)(3), does not distinguish between different members of a household or family, but applies to all individuals applying for or renewing coverage. In addition, the legal capacity of dependents who are minors or who have diminished cognitive ability to attest to information (which must be done under penalty of perjury) is a matter of state law. Therefore, we do not believe that further clarification in the regulation text is required. We also note that, under §435.945, other specified individuals can attest to information on behalf of a child (or other individual), including an adult in the child's or other individual's household (as defined in §435.603) or family (as defined in section 36(B)(d)(1) of the IRC), an authorized representative, or if a minor or incapacitated, someone acting responsibly for the individual.

G. Verification Procedures for Individuals Attesting to Citizenship or Satisfactory Immigration Status (§§435.3, 435.4, 435.406, 435.407, 435.911, 435.956, 435.1008, 457.320, 457.380)

In our proposed rule we noted that verification of citizenship and immigration status is governed by sections 1137, 1902(a)(46)(B), 1902(ee), and 1903(x) of the Act, and by section 1943 of the Act, which cites to section 1413(c) of the Affordable Care Act. Sections 1943 and 2107(e)(1)(O) of the Act and section 1413(c) of the Affordable Care Act require that there be a

coordinated eligibility, verification, and enrollment system between Medicaid, CHIP, the Exchanges, and the BHP, if applicable. More specifically section 1413(c) of the Affordable Care Act, which is incorporated into titles XIX and XXI via cross references at sections 1943(b)(3) and 2107(e)(1)(O) of the Act, requires that all insurance affordability programs verify certain information in a manner compatible with the method established under section 1411(c)(4) of the Affordable Care Act, that is by data matches with certain federal agencies, including the Social Security Administration (SSA), DHS, and the Internal Revenue Service (IRS), through an electronic service established by the Secretary (referred to as the “federal data services hub” or “FDSH”). The requirement to use the FDSH is implemented at current §435.949 for Medicaid and §457.380(g) for CHIP. Current §§435.952(c) and 457.380(f) also require state Medicaid and CHIP agencies to rely on electronic data sources to verify eligibility information to the maximum extent possible and limit the instances when paper documentation can be requested.

The verification rules related to citizenship and immigration status as proposed in the January 22, 2013 proposed rule (78 FR 4615) were an extension of the current verification rules and were intended to develop a consistent and cohesive set of verification rules to the greatest extent possible for all factors of eligibility. These rules are part of the streamlined and coordinated eligibility, verification, and enrollment system that will be used among all health insurance affordability programs as required by section 1413 of the Affordable Care Act. In response to public comments, however, we are providing states greater flexibility in using an alternative mechanism to verify citizenship and immigration status under our final rule at §435.956.

Prior to enactment of the Affordable Care Act, section 211 of CHIPRA also had made several important changes to the statute for verification of citizenship. Specifically, CHIPRA section 211 revised section 1902(a)(46) of the Act and added a new section 1902(ee) of the Act to

provide states an option to verify citizenship through an electronic data match between the agency and SSA in lieu of requiring documentation in accordance with section 1903(x) of the Act.

Section 1903(x) was also revised to exempt infants deemed eligible for Medicaid under section 1902(e)(4) of the Act from the requirement to verify citizenship and to require that states provide individuals declaring U.S. citizenship with a “reasonable opportunity period” to provide documentation of their status, similar to the “reasonable opportunity” afforded individuals declaring satisfactory immigration status under section 1137(d) of the Act. Section 211 of CHIPRA also clarified the acceptability of documentation issued by a federally-recognized Indian tribe for purposes of citizenship verification and extended the requirements to verify citizenship to CHIP.

Implementation of the changes made by section 211 of CHIPRA and the establishment of a more streamlined and coordinated verification process through the FDSH for citizenship and immigration status among all insurance affordability programs are not yet addressed in the regulations, and we proposed various revisions and additions to current regulations as follows:

- Consistent with sections 1413(c) and 1411(c)(4) of the Affordable Care Act, and §435.949, we proposed to add paragraph §435.956(a) (reserved in prior rulemaking) to codify the requirement that states must verify citizenship and immigration status with SSA and DHS through the FDSH if available;
- We proposed regulations implementing a 90-day reasonable opportunity period for individuals declaring U.S. citizenship or satisfactory immigration status at §435.956(a)(2) and (g) and a conforming amendment to §435.1008 was proposed providing that states are entitled to receive FFP for benefits provided to individuals declaring citizenship or satisfactory immigration status during the reasonable opportunity period, regardless of whether eligibility ultimately is approved for such period.

- We proposed various revisions to §435.406, §435.407 and §435.956, and a conforming revision at §435.911(c), to streamline and revise the regulations for consistency, reduce administrative burden on states and individuals, and to implement revisions to section 1903(x) of the Act made by CHIPRA. We also proposed to simplify and streamline the regulations governing the documentation of citizenship under section 1903(x) of the Act, eliminating restrictions in the current regulations that are not required under the statute, reducing administrative burden and removing unnecessary barriers to successful documentation, without compromising program integrity.

- We proposed to extend the requirement to verify citizenship or nationality and immigration status to CHIP at §457.320 and §457.380; and

- We proposed to add definitions of “citizenship,” “non-citizen,” and “qualified non-citizen” at §435.4, and to add applicable statutory references to the basis at §435.3.

- We also proposed a technical correction at §435.910(g), to put back the reference to the verification of SSNs with SSA, which was inadvertently removed in the March 2012 eligibility final rule and at §435.911(c) to replace the reference in §435.911(c) to section 1903(x), section 1902(ee) or section 1137(d) of the Act with a cross-reference to §435.956(g), which implements the cited sections of the statute.

A complete description of the proposed revisions to §435.407 and the terms of proposed §435.956(a) and (g) - redesignated in this final rule as paragraph (b) - can be found in section I.B.7 of the January 22, 2013 proposed rule (78 FR 4615). We received the following comments concerning the proposed verification policies for individuals attesting to citizenship or satisfactory immigration status, which we are generally finalizing as proposed except as noted below as well as some technical revisions for clarity.

Comment: Several commenters supported the replacement of the terms “alien(s)” with the

terms “non-citizen(s).”

Response: We appreciate the commenters' support and have finalized the change we proposed from the terms “alien(s)” to the terms “non-citizen(s).” We also are finalizing the proposed definitions of “non-citizen” and “qualified non-citizen,” except to revise the language in the definition of “qualified non-citizen” in this final rule to provide that qualified non-citizen “includes” rather than “has the same meaning as” the term qualified alien, as defined in the Immigration and Nationality Act (INA) at 8 U.S.C. 1641(b) and (c). We are making this change because the Congress has made full Medicaid benefits available to other categories of non-citizens without making conforming changes to include the new categories in the definition of qualified alien in the INA. For instance, under 22 U.S.C. 7105 certain victims of a severe form of trafficking are eligible for Medicaid benefits to the same as extent as refugees (who are included in the definition of qualified alien in the INA) “notwithstanding title IV of the Personal Responsibility and Work Opportunity Act of 1996.” The use of the term “includes” is designed to ensure that the term qualified non-citizen for purposes of the Medicaid program will be broad enough to include all of the non-citizen groups that are expressly addressed in other Federal statutes and who may be eligible for Medicaid even though those groups are not expressly mentioned in 1641(b) and (c). We also are making non-substantive revisions to the proposed definition of “citizenship” in §435.4 of the final rule to eliminate redundant language in the proposed definition.

Comment: One commenter suggested that states should not be required to use the FDSH to verify citizenship and immigration status rather than using an existing interface with the SSA and the DHS, especially since information from the FDSH cannot be used to make eligibility determinations for other human services programs.

Response: We agree with the commenter that states should not be required to use only the FDSH to verify citizenship and immigration status rather than using an existing interface with SSA and DHS. Although our proposed rule stated that the agency must verify citizenship and immigration status through the electronic service established in §435.949 if available, we also recognized alternative approaches that could be used if the FDSH was not available. Moreover, some flexibility is permitted under the current regulations at §§435.949 and 457.380. Those rules generally require use of the FDSH to obtain information from the Social Security Administration (SSA) and the Department of Homeland Security (DHS) which can be used to verify citizenship and immigration status, unless the state has obtained approval from the HHS Secretary to obtain needed information through another mechanism in accordance with §435.945(k) or §457.380(i). We have approved state requests to use other verification mechanisms under those rules. No commenters supported eliminating the flexibility for states to obtain approval to verify citizenship or immigration status through an alternative mechanism and we do not intend to eliminate the flexibility provided under those regulations in this final rule. In response to the comment, we are revising the regulation text to provide at §435.956(a)(1)(i) and (a)(2)(i) of the final rule that states can verify citizenship and immigration status through the FDSH or alternative mechanism authorized in accordance with §435.945(k), so that states would be able to use the existing interfaces with SSA and DHS.

Comment: A few commenters suggested that requiring additional electronic verification of citizenship or immigration status if verification through the FDSH fails is redundant.

Response: We understand the commenters to be raising a situation in which SSA or DHS has been queried, via the FDSH, and has sent a response that it has no information to verify the individual's declared status. SSA and DHS only return a response that the status is verified or that it cannot verify the status; neither will return a response that the individual is not a "citizen"

or not in a satisfactory immigration status. We agree that in such situations, when verification via the FDSH fails, attempting electronic verification again with SSA or DHS would be redundant and is not required. Under §435.956(a)(1)(ii) of the final regulation, if the state already has received a response to an electronic query from SSA through the FDSH, which was unable to verify citizenship based on the applicant's Social Security number, verification in accordance with section 1902(ee) would be redundant, and the state would need to verify citizenship status in accordance with §435.407.

We are also making a change in the final regulation to simplify the language. Inasmuch as section 1902(ee) of the Act provides for verification of citizenship through a data match with SSA, we have replaced the reference to verifying "citizenship in accordance with section 1902(ee) of the Act" in proposed §435.956(a)(1)(i) to refer more plainly to verifying citizenship "through a data match with the Social Security Administration" in §435.956(a)(1)(ii)(A) of the final rule.

Unlike citizenship status, for which states are provided an option under title XIX to verify an individual's status with SSA or based on a number of other forms of documentation, states are required to verify immigration status with DHS in accordance with section 1137(d) of the Act. DHS has developed a service, the "Systematic Alien Verification for Entitlements Program" (SAVE) for states to use for this purpose. SAVE can be accessed electronically, either through the FDSH or via a direct interface with the state. Accordingly, we have revised proposed §435.956(a)(1) for immigration status to provide in §435.956(a)(2)(i) of the final rule that states must verify immigration status, in accordance with section 1137 of the Act, through the service established in accordance with §435.949, or alternative mechanism authorized in accordance with §435.945(k). If SAVE is unable to verify an individual's attested status, the state is not required to query SAVE a second time with the same information; instead, the individual must be provided with an opportunity to provide other documentation of status as discussed further below.

Comment: Several commenters supported requiring states to exhaust all available electronic data sources to verify citizenship and immigration status before requesting for paper documentation. One commenter believed that a data match with the state's vital statistics agency should be optional.

Response: Under section 1411(c) of the Affordable Care Act and section 1943 of the Act, incorporating section 1413 of the Affordable Care Act, states are required to first attempt verification of citizenship and immigration status via the FDSH, or through an alternative mechanism authorized in accordance with §435.945(k) of the current regulations, which implements sections 1411(c)(4)(B) and 1413(c)(1) of the Affordable Care Act (applicable to Medicaid via section 1943(b)(3) of the Act). If such verification is not successful, we believe the cross reference in proposed §435.952(a)(1) to §435.952(c)(2)(ii) to require additional electronic verification before paper documentation is requested was in error, and we have eliminated this cross-reference in the final rule. If verification with SSA via the FDSH or alternative approved mechanism is not successful, states may obtain other evidence of citizenship by other means, as set forth in section 1903(x) of the Act. We do not have authority to nullify the choice provided to states under section 1902(a)(46)(B) of the Act. Thus, while a data match with a state's vital statistics agency is one source of permissible evidence, we agree with the commenter that states are not required to attempt such a match before requesting other types of documentary evidence under the statute. We note that §435.407 of the proposed and final rule, provides a number of electronic evidentiary sources which states may use to obtain evidence of U.S. citizenship, including a data match with DHS (related to an individual's naturalized citizenship). If verification of immigration status with SAVE through the FDSH or alternative mechanism is not successful, states have the option under section 1137(d)(2) of the Act to require other proof of

immigration status issued by DHS or such other documentation as the state determines constitutes reasonable evidence of satisfactory status.

Comment: A commenter questioned whether the FDSH would replace states' current processes to verify immigration status with the SAVE system. The commenter also questioned generally what processes states should follow to verify immigration status.

Response: Before responding to the commenter's questions, it will be helpful to explain the requirements under section 1137(d) of the Act for verification of immigration status. In general, section 1137(d) of the Act requires that non-citizens applying for Medicaid must provide a declaration of satisfactory immigration status and that states, in determining eligibility for Medicaid, must verify such status with DHS. DHS has developed a service, the "Systematic Alien Verification for Entitlements Program" (SAVE) which can be accessed electronically and which is used for this purpose. SAVE includes 3 possible steps to complete verification of immigration status, all of which can be accessed through the FDSH or via a direct interface. The status of most non-citizens can be verified at step 1, which occurs in real-time and is effectuated by the agency sending a query through the FDSH or directly to SAVE. If verification is not obtained in Step 1, the process moves to Step 2, which generally takes 2-3 business days to complete. At the end of SAVE step 2, DHS will return a response to the state either verifying the individual's immigration or naturalized citizen status or indicating that the status was not verified in requiring the state to "submit additional verification." If verification at SAVE step 2 is not successful, at SAVE step 3 the state must provide evidence of the individual's immigration document for DHS to review. Currently this can be done using a pre-populated form developed by DHS, the G845 form, or utilizing the "scan and upload" feature DHS has newly made available for states to initiate SAVE step 3. In May 2018, DHS has indicated that it will no longer accept the paper G845 form or any other paper alternative form at SAVE step 3. SAVE step 3,

which requires a DHS employee to research paper records, generally takes 10 to 21 business days for DHS to complete and return a response to the state.

Prior to implementation of the Affordable Care Act, all states queried the SAVE system through a direct interface with SAVE. A web-based query system is also available. States can now query SAVE through the FDSH's Verify Lawful Presence (VLP) service, which can verify immigration status through all three steps of SAVE, as needed. States are required under §435.949 of the current regulations to use the FDSH VLP service unless we have authorized the state to use an alternative mechanism (such as a pre-existing interface) in accordance with §435.945(k). Over half of all states currently are or have been authorized by us under §435.945(k) to use their own interface to query SAVE. Some states have received authorization to use their own interface for all three steps. Other states have received authorization to use their own interface only for steps 2 and 3; a few have received authorization to use their own interface only for step 3.

If a state uses the FDSH VLP service for all three steps of SAVE, the state could retire its own interface, which effectively would mean that the FDSH has replaced the state's previous connection to SAVE, although the three steps involved remain the same. In a state which receives approval under §435.945(k) to continue to use its pre-existing connection for any step, the FDSH would not replace the state's previous connection. In addition, if the FDSH is down, a state which uses the FDSH but also has maintained a direct connection with SAVE, could use that connection rather than waiting for the FDSH to be available.

Comment: One commenter requested that the rules at proposed §435.956(a), requiring states to use the FDSH to verify citizenship and immigration status if the data is available, and §435.952(c), requiring the use of electronic data sources over documentation, not apply to individuals whose eligibility is determined manually.

Response: We are unclear what the commenter means by “individuals whose eligibility is determined manually.” It may be that the commenter is referring to individuals who have submitted a paper application by mail or in person. Or perhaps the commenter is referring to individuals for whom either DHS or SSA is unable to return a positive match verifying citizenship or immigration status. In either case, we note that the verification rules at §§435.940 through 435.956, apply equally to all applicants and beneficiaries, regardless of the mode through which they submit their application. Per §435.956(a)(1) of the final rule, states first must attempt verification of citizenship or immigration status through the FDSH or alternative mechanism approved by us under §435.945(k), regardless of the mode through which an application was filed. However, the state retains the option to request the individual to submit documentation if that attempt is not successful.

Comment: A commenter disagreed with the policy at proposed §435.406(a)(iv)(E) to exempt individuals who received medical assistance as a deemed newborn in any state from the citizenship verification requirements because it would be more administratively burdensome for states to verify status as a deemed newborn in another state rather than conducting an electronic data match with SSA. The commenter also indicated that only exempting individuals who received eligibility based on such status after July 1, 2006 would represent a change in policy. Another commenter questioned what resources will be available to identify individuals who were deemed eligible as a newborn in other states.

Response: Section 1903(x) of the Act requires states to exempt deemed newborns from the citizenship verification requirements, which we implement at §435.406(a)(1)(iii)(E) of the final rule. Under §435.117(b) of the final rule, states have the option to provide deemed newborn eligibility to a child if the child’s mother was eligible for and receiving Medicaid or CHIP in another state for the date of the child’s birth. However, in response to the concern raised by the

commenter, we are revising §435.406(a)(1)(iii)(E), as redesignated in the final rule, to provide that states have the option to apply the exemption to individuals who were eligible as a deemed newborn in another state provided that the state has verified the individual was eligible as a deemed newborn in the other state. For example, if state A has taken up the option under §435.117(b)(2)(i) of the final rule to provide deemed eligibility to babies born to pregnant women on Medicaid in another state, and accepts self-attestation of the deemed newborn status in the other state (state B), state A must verify the baby's citizenship in accordance with the regulations – for example, via the FDSH or alternative approved mechanism, or based on documentary evidence described in §435.407 of the regulations. FFP at the administrative match (50 percent) is available to verify that an individual was eligible as a deemed newborn in another state.

We do not agree with the commenter that only exempting individuals who received deemed newborn status on or after July 1, 2006 would be a change in policy. As discussed in a SHO Letter issued in December 2009, SHO #09-016, the deemed newborn exemption added to section 1903(x) of the Act by section 211 of CHIPRA, went into effect on July 1, 2006, as if it had been included in the Deficit Reduction Act of 2005. We have consistently maintained that the exemption applies only to individuals deemed eligible under section 1902(e)(4) of the Act on or after July 1, 2006.

Comment: Several commenters supported proposed §435.407 to consolidate and streamline the types of documents required to verify citizenship and identity in the event that citizenship cannot be verified through the FDSH. Several commenters also supported the proposal to allow individuals to present copies of documents rather than originals. One commenter questioned if states can start accepting copies prior to January 1, 2014, to relieve the administrative burden of the current policy.

Response: We are finalizing with slight modification the list of acceptable documents in

§435.407 of the proposed rule, including the requirement that states accept copies of documents an effective date on or after the effective date of this final rule, except when the state has reason to question the validity of the document provided. Originals are not required under the statute and we are not aware of any evidence establishing that this requirement enhances program integrity. In a study conducted by the Government Accountability Office (GAO) in 2007, states overwhelmingly reported that the requirement to obtain original documents was one of two aspects of the current regulations that significantly increased burden on states and beneficiaries (the other was the complexity of the list of acceptable documents provided in the regulations), with the primary result being not increased program integrity but an undue barrier to coverage for eligible individuals. Forty-two of 44 states reported to the GAO that original documents posed a barrier to eligible citizens proving their status. See States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens, Report to Congressional Requesters, United States Government Accountability Office, GAO-07-889, June 2007. Further, requiring original documents effectively results in a requirement to provide documentation in person for individuals who are reluctant to send an original through the mail and undermines achieving a real-time online application process. Many states are able to complete the electronic verification in real-time and notify the individual if documents are needed, which enables applicants to upload documents immediately. Requiring originals would greatly hamper realization of the real-time online application experience which the regulations are designed to facilitate. We note that over 90 percent of electronic queries to SSA result in successful verification, such that paper documentation is only necessary in limited circumstances.

We are making technical changes at §435.407(b)(1), and retaining some of the language in the current rule related to establishing that an individual is a collectively naturalized citizen from

Puerto Rico or CNMI. We had erroneously proposed to remove this language as no longer relevant. We are also making a technical change at §435.407(b)(7) to refer more simply to “A Northern Marianas Identification Card issued by DHS or a predecessor agency,” removing the requirement that the individual have been born in the CNMI before November 4, 1986, because only collectively naturalized citizens who were born in the CNMI before that date will be issued such a card. We also are replacing the word “satisfactory” with “sufficient” in the introductory language in §435.407(a) to be clearer that the documents listed in paragraph (a) are sufficient to document citizenship.

Comment: We solicited comments on whether two affidavits, rather than one as proposed should be required to verify citizenship under §435.407(b)(18). Several commenters supported the proposed rule of requiring just one affidavit. No commenters supported retaining the requirement for two affidavits. Nor did any commenters oppose the other proposed changes to eliminate the administrative barriers to use of affidavits, such as eliminating language indicating that affidavits be used only as a last resort in rare circumstances.

Response: We agree with the commenters and are finalizing without modification the provision at §435.407(b)(18) that only one affidavit is needed to verify citizenship. We also are finalizing the elimination of other limitations currently placed on the use of affidavits as compared to other forms of documentation listed in §435.407. We previously limited states' flexibility to accept affidavits as a reliable source of documentation for individuals who do not have ready access to more common types of citizenship documentation, such as a passport or birth certificate. However, since the 2006 issuance of §435.407 implementing section 1903(x) following passage of the Deficit Reduction Act of 2005, we are aware of no information to support the proposition that one affidavit is any less reliable than two, or that the other restrictions placed on use of affidavits in the current regulations enhance their reliability. Nor did any

commenters point out any such information or concerns. Therefore, we are finalizing the revisions to §435.407(d)(5) of the current regulations which were proposed at redesignated §435.407(b)(18) in this rulemaking.

Comment: A commenter suggested that rules pertaining to the process for verification of citizenship used by the Exchange and Medicaid be consistent.

Response: We agree and believe the rules as finalized at §435.956 do align with the citizenship verification rules applicable to the Exchange to the fullest extent possible. We note, in particular, that Medicaid and CHIP agencies and the Exchange must verify citizenship and immigration status through the FDSH (if available) or an alternative approved approach and provide a reasonable opportunity period (referred to in Exchange regulations as an “inconsistency period”) of up to 90 days, with the provision of benefits pending the opportunity for applicants to resolve any inconsistencies and complete verification of their status. One notable difference is that, to receive Medicaid or CHIP benefits during a reasonable opportunity period, an applicant has to be determined to meet all other eligibility requirements (for example, income), whereas the Exchange regulations provide for APTC and CSR eligibility during a 90-day inconsistency period for other factors of eligibility (such as income), as well. However, this is not a matter of verification processes, but of the extent to which assistance is authorized under the separate statutory authorities governing Medicaid, CHIP and coverage through an Exchange. We note that we are revising the proposed paragraph at §435.956(b)(2)(ii)(B), which provided states the option to extend the reasonable opportunity if the individual is making a good faith effort to provide documentation or the agency needs more time to complete the verification of citizenship or immigration status. In the final rule we are only allowing this option for individuals who declare satisfactory immigration status because we do not have the statutory authority to extend the reasonable opportunity period for citizenship verification beyond 90 days as prescribed in section

1902(ee) of the Act. Under section 1902(ee)(1)(B)(ii)(III) of the Act, individuals who have made a declaration of citizenship must be disenrolled from coverage within 30 days from the end of the 90 day period, if no such documentary evidence is presented or the inconsistency is not resolved. Section 1137 of the Act, which governs verification of immigration status does not prescribe a definitive time period for the reasonable opportunity period, so the flexibility exists for states to provide a good faith extension when necessary beyond the 90-day reasonable opportunity period defined in this rule.

Comment: A commenter questioned whether a state can accept as verification of citizenship and immigration status, information from SSA indicating that the individual provided a declaration of citizenship or lawful presence when the person applied for SSI or low-income subsidies under Medicare Part D.

Response: Under section 1903(x) of the Act and §435.406(a)(1)(v), redesignated at §435.406(a)(1)(iii) of this final rule, individuals receiving SSI as well as individuals entitled to or enrolled in Medicare under title XVIII of the Act are exempt from the Medicaid citizenship verification requirements. Under 8 U.S.C. 1612(a)(2)(F), non-citizens receiving SSI payments are eligible for full Medicaid benefits to the same extent as citizens who are receiving SSI; thus, states do not need to verify the immigration status of non-citizens receiving SSI. The immigration status of non-citizens entitled to or eligible for Medicare, including those receiving low-income subsidies under Medicare Part D, must be verified consistent with the requirements in §435.956.

Comment: A commenter suggested that neither §435.406 nor §435.407 address the verification of lawful presence, though section 1137(d)(2) of the Act appears to require that hard copy documentation of lawful presence be presented. The commenter requested confirmation that

if DHS verifies that the person is lawfully present, the state is not required to obtain other documentation.

Response: “Lawfully present” is not an immigration status *per se*, but rather a term we used in earlier guidance in interpreting the phrase “lawfully residing in the United States” in section 214 of CHIPRA, which added sections 1903(v)(4) and 2107(e)(1)(J) of the Act to provide states with an option to cover otherwise-eligible pregnant women and children who are “lawfully residing in the United States.” See the July 1, 2010 State Health Official Letter (SHO #10-006, CHIPRA #17) and the August 28, 2012 State Health Official Letter (SHO #12-002). Section §435.956(a) addresses verification of immigration status for most non-citizens, regardless of whether they are declaring an immigration status qualifying them for coverage as a qualified non-citizen or as a lawfully present pregnant woman or child. Section 1137(d) of the Act requires that documentary evidence, which may include electronic confirmation of immigration status from DHS, be provided. We agree with the commenter that the proposed rule did not adequately convey that states must attempt to verify immigration status for both qualified non-citizens and other lawfully residing individuals through the FDSH or alternative mechanism approved under §435.945(k). Therefore, we have added a new paragraph §435.406(c) in the final regulation to provide that agency must verify a declaration of satisfactory immigration status in accordance with §435.956; per §435.956(a)(2) of the final rule, that is, through the FDSH or approved alternative mechanism. Under the final regulation, if the state is able to verify an individual is in satisfactory immigration status through SAVE, additional documentation is not required.

We also removed proposed §435.406(a)(1)(ii), requiring that the agency verify a declaration of citizenship, and instead added a new paragraph (c) to consolidate the requirement to verify both a declaration of citizenship and satisfactory immigration status. We redesignated proposed §435.406(a)(1)(iii) and (iv) at §435.406(a)(1)(ii) and (iii) in the final rule accordingly.

Comment: One commenter was concerned that the proposed regulation requires that a 90-day reasonable opportunity period be given to individuals for whom the state is unable to promptly verify citizenship or immigration status, but does not specify that individuals must have first made a declaration that they are a citizen, national or lawfully residing non-citizen.

Response: Sections 1137(d) and 2105(c) of the Act requires individuals seeking coverage under Medicaid or CHIP to provide a declaration of citizenship or satisfactory immigration status under penalty of perjury; such declaration is generally provided on the single streamlined application for Medicaid, CHIP, and the Exchanges, either on paper with a signature in writing, over the phone using a telephonic signature, or online using an electronic signature. Such declaration is required whether an individual is in an immigration status included in the definition of “qualified non-citizen” or in a status which is included in the definition of “lawfully present” in the July 1, 2010 and August 28, 2012 State Health Official Letters. Consistent with the statute and the current regulations, §435.406(a)(1)(i) of the proposed rule requires that individuals make a declaration of status as a citizen or national of the United States, and this requirement is retained in the final rule. The current regulations at §435.406(a)(2)(i) require that qualified non-citizens (referred to in the current regulations as “qualified aliens,” using the term employed by PRWORA) make a declaration that they are in a satisfactory immigration status. Sections 1137(d)(4), 1902(ee)(1) and 1903(x)(1) are clear that individuals must first declare citizenship or satisfactory immigration status before a reasonable opportunity period is provided. However, the proposed regulation did not, as the commenter points out, clearly reflect this requirement. Therefore, we have revised §435.956(b) to clarify that the agency must provide a reasonable opportunity period to otherwise eligible individuals who have made a declaration of citizenship or satisfactory immigration status in accordance with §435.406(a), as revised in this final rule, but

whose status the agency is unable to promptly verify following the process set forth in §435.956(a) of the final rule.

Comment: A commenter questioned if the expectation is for states to check their records to ascertain whether citizenship has already been verified for an individual, and if so, block the citizenship verification request to the FDSH. The commenter is concerned that this would impede the expectation of a streamlined application and real-time eligibility determinations for most applicants.

Response: It is a longstanding policy, currently at §435.407(i)(5) and maintained with slight modifications in the proposed and this final rule at §435.956(a)(4), that verification of citizenship is a one-time occurrence and states should not re-verify citizenship at renewal or subsequent application for Medicaid or CHIP unless later evidence raises a question of the person's citizenship. As part of the state's dynamic online application process, states should check existing records for those who are known to the system and determine whether citizenship has already been verified. For individuals whose citizenship has already been verified, states should suppress sending a new verification request to SSA, unless the individual reports, or the state otherwise has learned of, a change in their citizenship status, in which case the state may act upon the information.

Comment: We solicited comments on the most appropriate procedures for verification of active duty service or veteran status for qualified non-citizens, as well as their spouses and dependents that are exempt from the 5-year waiting period applicable to certain qualified noncitizens on the basis of such service or veteran status. One commenter supported the approach of allowing states to accept self-attestation unless the state has information that is not reasonably compatible with such attestation, subject to the requirements of §435.952. Another commenter

suggested that the FDSH obtain this information from the Department of Defense and Veteran's Administration.

Response: We believe that, if electronic verification of active duty or veteran status becomes available through the FDSH, states should be required first to attempt verification of this status through the FDSH. This is consistent both with the verification requirements for immigration status generally, finalized in §435.956(a)(2) of this final rule, as well as the requirement under §435.952(c) generally to access electronic verification sources before requiring other forms of documentation or additional information from the individual. Until electronic verification is available, we agree with the commenter that state flexibility to accept self-attestation of active duty or veteran status is appropriate, unless the state has information contrary to the individual's attestation. We, therefore, are adding a new paragraph at §435.956(a)(3) to require states to verify through the FDSH (or alternative mechanism authorized under §435.945(k)) that an individual is an honorably discharged veteran or in active military duty status, or the spouse or unmarried dependent child of such person as described in 8 U.S.C. 1612(b)(2), if such verification is available through the FDSH. If verification through the FDSH or alternative authorized mechanism is not available, §435.956(a)(3) provides that states may accept attestation that an applicant, or the spouse or parent of an unmarried dependent child applying for coverage, is in active duty or veteran status for purposes of the exemption from the 5-year waiting period. Consistent with current regulations at §435.952(c), if electronic verification via the FDSH or otherwise is not available, states also retain the flexibility to require documentation of active duty or veteran status.

Comment: A commenter suggested that permitting coverage under Medicaid or CHIP for individuals without an SSN or a verified SSN creates fiscal and program integrity risks. Another commenter opposed the policy that a reasonable opportunity period for verification of citizenship

be triggered when an individual is unable to provide a SSN because a state cannot conduct electronic verifications without a SSN. One commenter recommended amending §435.956(g)(1) to require a 90-day reasonable opportunity period pending verification of an individual's SSN.

Response: We do not agree with the comments and are finalizing the rule as proposed at §435.956(b)(1) with the exception of minor revisions for clarity. While electronic verification with SSA cannot be done without an SSN, citizenship can be verified using other documentation specified in §435.407; income and other eligibility criteria also can be verified without an SSN, in accordance with the state's verification plan. Indeed, section 1902(ee)(2)(C) of the Act specifically requires states to provide a reasonable opportunity period pending verification of citizenship when an individual has not submitted an SSN. Further, the requirement to enroll otherwise eligible individuals in Medicaid or CHIP pending receipt and verification of an SSN reflects longstanding Medicaid policy, codified at §435.910(f), which is also applied to CHIP per §457.340. This policy applies both to individuals whose citizenship or immigration status has been verified as well as to individuals in a reasonable opportunity period. Individuals determined eligible for Medicaid who do not have an SSN, or whose SSN cannot be verified at the time of application, must cooperate with the agency in obtaining an SSN or resolving any inconsistencies with SSA records, with the limited exceptions of those individuals exempt from furnishing an SSN per §435.910(h). The eligibility of individuals whose citizenship or immigration status is verified (electronically or otherwise), but who fail to cooperate in obtaining or verifying their SSN when required may be terminated, provided that advance notice and fair hearing rights are afforded in accordance with part 431 subpart E.

Comment: A commenter questioned whether state agencies that issue drivers' licenses are held to the same standards of verification of citizenship or SSNs that apply to the Medicaid agency, and if so, whether states are required to accept a state-issued driver's license as

documentary evidence of citizenship. Further, the commenter questioned if our regulations refer only to the Enhanced Driver's License (EDL) under the Western Hemisphere Travel Initiative or also to "REAL IDs" established under the REAL ID Act of 2005, and whether there is a standard that all states must use in designating that a driver's license meets the EDL or REAL ID requirements.

Response: Section 1903(x)(3)(B)(iv) of the Act, implemented at current §435.407(a)(4), requires states to accept a driver's license as proof of citizenship if the state issuing the license requires proof of U.S. citizenship, or obtains and verifies a social security number from the applicant who is a citizen before issuing such license. The state Medicaid agency is responsible for determining if the state agency issuing drivers' licenses meets the requirements of §435.407(a)(4), and if so, such licenses must be accepted as proof of citizenship. The DHS has issued regulations governing EDLs and REAL IDs at 8 CFR 235.1 and 6 CFR part 37 respectively. An EDL issued in accordance with the DHS regulations would meet the requirements in §435.407(a)(4). We understand that a REAL ID may be issued to non-citizens and therefore would not constitute evidence of citizenship under §435.407(a)(4).

Comment: A commenter requested that states be allowed to maintain a 45-day timeframe to process applications prior to beginning a 90-day reasonable opportunity period, including the provision of benefits, to resolve inconsistencies and verify citizenship and immigration status. The commenter suggests that requiring states to begin benefits and provide notice to applicants sooner creates administrative burden and expense if the inconsistency is resolved within 45 days. The commenter believes that states should have flexibility to determine when the 90-day reasonable opportunity period should begin. Another commenter opposed the policy to require states to fund benefits for individuals during the reasonable opportunity period pending verification of citizenship and immigration status.

Response: As discussed in previous guidance (SHO #09-016, December 2009), the reasonable opportunity period pending verification of citizenship and immigration status is a statutory requirement that is distinct from the 45-day timeliness standard under §435.912, which refers to the maximum period of time in which most applicants are entitled to an eligibility determination. Per sections 1137(d), 1902(ee) and 1903(x) of the Act, implemented at §435.956(a)(5)(ii), for applicants declaring citizenship or satisfactory immigration status, whose status the state is unable to verify electronically in accordance with §435.956(a)(1), benefits must be furnished as soon as the state determines that the applicant meets all other eligibility requirements; per conforming revisions at §435.1008, which we finalize as proposed, FFP is available for benefits provided during a reasonable opportunity. The determination of such other eligibility requirements is subject to the same timeliness standards as apply to applicants generally under §435.912. Once a state has completed its review of the application, and conducted other relevant verifications-- which often will be much sooner than 45 days—it must promptly enroll applicants who have made a declaration of citizenship or satisfactory immigration status, even if the verification of such status is still pending. Resolution of an inconsistency relating to verification of citizenship or immigration status which takes more than 45 days does not trigger a violation of the timeliness standards provided that benefits are not delayed or denied during the reasonable opportunity period because of such inconsistency. States have the option under current regulations at §435.915(b) to begin furnishing benefits to applicants determined eligible for Medicaid effective the date of application or the first day of the month of application. Reflected at §435.956(a)(5)(iii) of the final rule, the agency must apply the same election made under §435.915(b) to applicants who have been provided a reasonable opportunity to provide citizenship or immigration status once they are determined otherwise-eligible for coverage – that is, the agency must provide benefits during a reasonable opportunity period to applicants

determined otherwise eligible for coverage effective the date of application or the first day of the month of application, consistent with the agency's election under §435.915(b). Retroactive eligibility during the 90 days preceding the month of application is not available to individuals during a reasonable opportunity period, but would be available once their status is successfully verified and the determination of eligibility is complete.

Comment: A commenter questioned whether the electronic data source or paper documentation provided by the applicant takes precedence if the two conflict. Further, the commenter questioned if the paper source can be used to initiate the 90-day reasonable opportunity with provision of benefits so the recipient can attempt to resolve the discrepancy with the federal agency providing the electronic data.

Response: If data obtained through an electronic data match is inconsistent with attested information provided by the individual, §435.952(c)(2) requires that the agency obtain additional information from the individual, including paper documentation. The very purpose of such additional information is to substantiate the individual's claim despite the existence of electronic data to the contrary. In the case of income, for example, if quarterly wage data through an electronic match is not reasonably compatible with an individual's attested wages, pay stubs showing current wages would take precedence over the quarterly wage data (unless the agency had reason to question their authenticity). In the case of citizenship, SSA will never respond to an electronic query with a finding that an individual is not a citizen. Rather, SSA will respond to an electronic query with a response that the individual's citizenship status is verified or that SSA cannot verify citizenship status. Similarly, an electronic query at Step 1 or 2 to SAVE status will never return a finding that a non-citizen is not in a qualified or otherwise lawfully-present status; rather, SAVE will only return a positive verification, or indicate that it cannot verify the individual's status. The reasonable opportunity period is triggered under the statute and

§435.956(a)(5) of the final rule if the individual's status cannot be promptly verified through either the FDSH or alternative mechanism. Paper documentation typically serves to verify the status of an individual once a reasonable opportunity has been triggered, and states may not wait until receipt of paper documentation of citizenship or immigration status to initiate benefits during a reasonable opportunity period.

Comment: We solicited comments on when states should begin the reasonable opportunity period for citizenship and immigration status when inconsistencies arise from an electronic data source. One commenter suggested that states should be allowed to resolve data or process inconsistencies prior to triggering the reasonable opportunity period, including time to verify through SAVE. The commenter also supports an alternative to the proposed policy, in which the reasonable opportunity period would begin after electronic verifications have been exhausted. The commenter also disagreed that a reasonable opportunity should be triggered if the FDSH or SSA or DHS databases are unavailable because technological difficulties should not drive policy decisions, especially if the result may be inappropriate costs to the state. Another commenter stated that a reasonable opportunity period should be allowed when there is a discrepancy with a data source, as well as when electronic verifications are unavailable. Several commenters recommend not allowing states more than 1 or 2 business days to resolve inconsistencies before the reasonable opportunity period is triggered so benefits are not unnecessarily delayed.

Response: Both sections 1137(d) and 1902(ee) of the Act require states to provide a reasonable opportunity period with the provision of benefits to otherwise eligible individuals pending verification of immigration status or citizenship, respectively, if the state is unable to verify the individual's declaration with SSA or DHS. Section 1903(x)(4) of the Act provides that individuals who make a declaration of citizenship or national status be provided at least the

reasonable opportunity to present documentation of citizenship status as is provided non-citizens under section 1137(d) of the Act. At §435.956(g)(1) of the proposed rule, we proposed that notice of such reasonable opportunity period must be provided if the individual's status cannot be "promptly verified" with these data sources through the FDSH or alternative mechanism authorized in accordance with §435.945(k). We explained that we believed this struck the right balance between applicants' interests in accessing coverage in a timely manner and states' interests in not being required to take steps to enroll someone in coverage immediately whenever electronic verification cannot be achieved in real time, if inconsistencies preventing successful verification with SSA or DHS can be quickly resolved.

We are not persuaded by the commenters to change the proposed policy, which is finalized at §435.956(a)(5) of the final rule. We agree that states should be given time to resolve simple inconsistencies preventing successful verification of status with SSA or DHS prior to initiating the reasonable opportunity period, such as correcting inverted numbers in an individual's SSN or immigrant identification number or a misspelled name, and we have moved the text at proposed §435.956(g)(1)(ii) to §435.956(a)(1)(i)(B) and (a)(2)(ii) of the final rule, which makes clear that efforts to resolve inconsistencies through such measures must be done promptly, and that initiation of the reasonable opportunity period occurs after such attempts are made. However, if inconsistencies preventing a successful match cannot be promptly resolved, resolution could take days or even weeks. We do not believe that delaying start of a reasonable opportunity period, including the provision of benefits to otherwise-eligible individuals, while the state continues more time-consuming efforts to verify the individual's status with SSA or DHS is consistent with the intent of the statute, or that such a policy would strike the right balance between administrative efficiency and best interests of beneficiaries.

We also do not believe that it is in the interests of either states or applicants that states be limited to 2-3 days to resolve inconsistencies preventing a successful match. Applicants whose status cannot be promptly verified with SSA or DHS are given 90 days to establish their status. During this time states are required under §435.956(b)(1) to continue its efforts to complete verification of the individual's status, or request documentation if necessary. We agree with the commenter who stated that a reasonable opportunity period should be allowed when there is a discrepancy with a data source, as well as when electronic verifications are unavailable; a reasonable opportunity is provided under proposed §435.956(g)(1), finalized at §435.956(a)(5) of the final rule.

Comment: A commenter was concerned that the proposed rules could be interpreted to allow multiple (and unlimited) reasonable opportunity periods through subsequent applications despite failure by the individual to provide proof of citizenship or immigration status. Another commenter questioned if CMS considered limiting the number of reasonable opportunity periods that can be provided.

Response: The reasonable opportunity period may only be granted based on an attestation by the applicant that he or she is a citizen or in a satisfactory immigration status which cannot be promptly verified because (1) the individual does not have the necessary information to conduct an electronic data match; (2) electronic data is not available and the state must collect additional information from the individual; or (3) there is an inconsistency between the individual's attestation and information from an electronic data source. An attestation that the applicant knows to be untrue could result in criminal or other penalties for fraud. If fraud is suspected, states should rely on the program integrity measures they have in place to deal with such situations. In response to the comment, we are adding §435.956(b)(4) to the final rule to allow states to request approval from CMS to place limitations on the number of reasonable

opportunity periods to verify citizenship and immigration status that a given person may receive if the state can demonstrate a program integrity concern related to applicants receiving multiple reasonable opportunity periods.

Comment: A commenter recommended that CMS allow a reasonable opportunity period for other factors of eligibility beyond citizenship and immigration status to align with the policies of the Exchanges.

Response: We do not have the statutory authority to apply a reasonable opportunity for factors other than citizenship and immigration status.

Comment: A commenter suggested that CMS also allow for self-attestation of membership in a tribe to provide cost sharing and other protections during the 90-day reasonable opportunity period.

Response: The 90-day reasonable opportunity period only applies to verification of citizenship and immigration status and is not relevant to cost sharing protections for American Indians. Cost sharing exemptions are outside the scope of this regulation but are discussed in the July 15, 2013 Medicaid and CHIP final rule.

Comment: A commenter supported proposed §435.956(g)(4), giving states the option whether or not to provide continuation of benefits if an appeal is filed following a termination of eligibility at the end of the reasonable opportunity period because citizenship or immigration status had not been verified. One commenter suggested adding “during any appeal process” to the list of triggers for a reasonable opportunity period.

Response: We are maintaining in the final rule the option, redesignated at §435.956(b)(3), for states to continue to furnish benefits during the appeals process if an individual is terminated due to citizenship or immigration status not being verified before the reasonable opportunity period ends. We do not agree with the commenter that “during any appeal process” should be

added to the list of what triggers a reasonable opportunity period. Generally an appeals process would come after the reasonable opportunity period has been exhausted and a final eligibility determination has been made, so it is not a relevant “trigger” of a reasonable opportunity period.

Comment: We solicited comments on how long states should be expected to retain records indicating that citizenship and immigration status of a given applicant has been previously verified. Several commenters recommended that the records should be kept indefinitely. Several commenters recommended that states be required to retain documentation of citizenship for a period of no less than 10 years. One commenter stated states should not be required to retain records of citizenship indefinitely, but rather for a more limited time period, such as 5 years.

Response: We appreciate the suggestions that verification records for citizenship and immigration status be retained by states for specific periods of time. The suggested comments provided a range of options from 5 years to indefinitely. In light of the diverse opinions concerning the optimal time period, we are finalizing proposed §435.956(a)(3), redesignated at §435.956(a)(4), without revision and are not prescribing a specific length of time for which states must maintain such records. We note that, while a hardcopy of a document verifying citizenship or immigration status need not be retained, states should maintain a notation in their electronic case records of responses received from the FDSH or other electronic sources, or that paper documentation was furnished, verifying citizenship or immigration status, so that the individual’s status will not need to be re-verified following a break in coverage, unless the individual’s particular status is subject to change. States must maintain an electronic record of successful citizenship or immigration status verification in accordance with the record retention policies generally applied by the state in accordance with §431.17.

Comment: Several commenters recommended prohibiting states from re-verifying immigration status at renewal because the status for most lawfully present immigrants does not

change from year to year, and existing change reporting requirements already obligate individuals to report any change in immigration status.

Response: We did not propose and are not finalizing a prohibition on states re-verifying immigration status at renewal for those statuses that are subject to change, such as non-citizens with Temporary Protected Status. States are not required to verify immigration status at renewal if an individual has a permanent status, unless a change is reported.

Comment: Several commenters stated that the additional requirement at proposed §§435.406(a)(3) and 457.320(d) that the application filer attest that he or she has a reasonable basis for making the declaration of citizenship or immigration status on behalf of another applicant is an unnecessary burden. The commenters stated that if someone is “acting responsibly” for the applicant, then by definition he or she would have a reasonable basis for declaring an applicant’s immigration status.

Response: We disagree that someone acting responsibly for a minor or incapacitated individual necessarily is competent to make a sworn declaration of citizenship or immigration status on their behalf. In order to make such declaration on behalf of another person, someone must actually know the person’s status. We therefore are finalizing the provision proposed at 435.406(a)(3). However, we are revising the language in the final rule to be clear that to make a declaration on another person’s behalf, someone must attest to having knowledge of the other person’s status, not merely to having a “reasonable basis” for their status, as proposed. We also are removing the word “family” from §§435.406(a)(3) and 457.320(d), as proposed because it is redundant and are making minor revisions to §457.320(d) to clarify that an individual applying for CHIP must make a declaration of citizenship or immigration status. Examples of individuals who might have knowledge of another person’s citizenship or immigration status on behalf, and could make the declaration permitted under §§435.406(a)(3) and 457.320(d) of the final rule,

include a parent, spouse or other family member, friend or acquaintance who can attest to knowing the individual's status. We would not generally expect application assistors, who are not personally acquainted with the applicant, to have the requisite knowledge to make such a declaration.

Comment: A commenter questioned whether the FDSH will provide verification of domestic violence for applicants who attest to being a qualified alien.

Response: The FDSH will provide responses indicating whether SAVE has verified that the individual has a satisfactory immigration status for purposes of full Medicaid and/or CHIP benefits, whether the individual is subject to the 5-year bar, and whether the 5-year bar has been met. While domestic violence *per se* is not verified, SAVE does verify if the individual meets the criteria as a qualified non-citizen under 8 U.S.C. 1641(c) (relating to treatment of certain "battered aliens" as a qualified non-citizen), or is the spouse or child of such an individual.

Comment: A commenter questioned what type(s) of assistance states are expected to provide under proposed §435.407(e) and how community-based organizations assisting these clients can maximize such assistance. The commenter suggested that states be required to pay for or waive the cost of obtaining documents from federal government agencies or other states needed to verify citizenship. Several commenters suggested the assistance required be limited to persons who are limited English proficient and individuals with disabilities.

Response: We believe it is appropriate to provide states with flexibility to determine when applicants need assistance with securing documentation, as well as the best means for providing that assistance, and we are finalizing §435.407(e) as proposed. Examples of individuals who may need such assistance are discussed in section I.B.7 of the January 22, 2013 proposed rule, which may include, but is not limited to, individuals with limited English

proficiency and individuals with disabilities. We also encourage states to work with community-based organizations to assist individuals in obtaining needed documentation.

Comment: One commenter recommended CMS offer federal assistance to states to ensure that their electronic verification systems are in good working order and able to access the FDSH in a timely manner.

Response: Subject to limitations, enhanced federal funding is available to assist states with the modernizing or building new eligibility systems in accordance with §433.112.

Comment: Several commenters also recommended adding a paragraph at §435.956 to prescribe specific parameters states must follow when providing a notice of reasonable opportunity period to individuals who are limited English proficient and individuals with disabilities.

Response: Proposed §435.956(g)(1) requires that the notice of the reasonable opportunity period be accessible to persons who are limited English proficient and individuals with disabilities consistent with §435.905(b), and we are finalizing that provision at §435.956(b)(1), with minor editorial revision. Accessibility standards under §435.905(b) are discussed in section II.D of this final rule.

Comment: Several commenters recommended requiring states to have Memorandums of Understanding (MOU) with DHS that protect applicants' due process and privacy rights under section 1137(d) of the Act before directly verifying information with DHS in the event verification is not done through the FDSH.

Response: Current statute and regulations already provide safeguards which protect applicants' privacy. Section 1137(d) of the Act requires states to protect an individual's privacy when conducting a match with SAVE. Section 435.945(i) requires Medicaid agencies to execute written agreements with other agencies before releasing data to, or requesting data from, those

agencies. In addition, §431.300 requires safeguards to be in place when agencies exchange information to verify eligibility.

Comment: Several commenters suggested that Medicaid and CHIP agencies and the Exchange be required to establish agreements for sharing information about verified citizenship or immigration status to minimize duplicative verification requirements.

Response: Current §435.1200 requires all insurance affordability programs to transfer all information obtained by the program that is relevant to eligibility for other programs, which would include an individual's verified citizenship or immigration status. Under §§435.1200(d)(4), 457.348, 600.330 and 155.345, findings related to a criterion of eligibility made by one program must be accepted without further verification.

Comment: A commenter recommended that §435.406 be revised to indicate that beneficiaries who are no longer exempt from citizenship verification requirements must make a declaration of citizenship and have it verified, such as former foster care children.

Response: We do not completely agree with the commenter. While we recognize that applicants will need to make a declaration of citizenship, section 1903(x) (2)(C) of the Act exempts individuals from the requirement to present satisfactory documentation of citizenship for whom child welfare services are made available under part B of Title IV, or adoption or foster care assistance is made available under part E of title IV of the Act. We interpret this to mean that such services or assistance was made available at some time, not that the individual must currently be receiving them to qualify for the exemption. However, if the state received information that Title IV-B or E services or assistance was terminated due to citizenship, the exemption would no longer apply and the state would need to verify the individual's status. In contrast, sections 1903(x)(2)(A) and (B) of the Act explicitly require that individuals must be currently entitled to or enrolled in Medicare, or receiving SSI or Title II disability benefits.

Therefore, we believe it would be appropriate for states to verify the citizenship of individuals no longer entitled to or enrolled in Medicare or receiving SSI or Title II disability benefits. We note that per §435.407(d) of the final rule, states may rely on verification of citizenship by a federal agency or another state agency, if such verification was done on or after July 1, 2006.

Comment: Several commenters stated that §435.910 was not clear in describing how states should verify SSNs, or what procedures states must follow in the event that a different SSN is found to have been issued to the individual. The commenters also suggested that the regulations should, but currently do not, require that the agency must provide clear notice to applicants and beneficiaries if there is a problem in verifying their SSN, and that individuals be given a reasonable opportunity period to verify his or her SSN. Finally, the commenters stated the regulations should be revised to require the state to provide clear instructions or assistance to the applicant or beneficiary to correct his or her SSA records in the event of an inconsistency with the attested to SSN.

Response: We did not propose revisions to §435.910, except to remedy the inadvertent deletion in prior rulemaking of the identification of the statute as the source for states to verify SSNs, which identification is restored at §435.910(g) in the final rule. Therefore, the comment is beyond the scope of this rulemaking.

Comment: Several commenters recommended deleting §435.910(g) and conducting future rulemaking that fully addresses the requirements for verification of SSN, in particular what protections and procedures the state is required to provide an applicant or beneficiary in the event of a problem with his or her SSN verification.

Response: We did not propose to remove §435.910(g) and do not agree that any further rulemaking is necessary. Section 435.910, in conjunction with the verification regulations at §§435.940 through 435.956 provides comprehensive guidance on who must present an SSN, the

procedures for verification of an SSN, and the obligations of states to assist individuals who do not have or cannot remember their SSN or to resolve inconsistencies between their attested SSN and information received from SSA.

H. Elimination or Changes to Unnecessary and Obsolete Regulations (§§407.42, 435.113, 435.114, 435.201, 435.210, 435.211, 435.220, 435.223, 435.310, 435.401, §435.510, 435.522, 435.909, and 435.1004)

We proposed to revise or eliminate various regulations, in whole or in part, as obsolete or no longer applicable due to the expansion of Medicaid coverage under the Affordable Care Act to most individuals with income at or below 133 percent FPL, the previous de-linkage of Medicaid eligibility from receipt of AFDC cash assistance, the replacement of AFDC-based with MAGI-based financial eligibility methodologies effective January 1, 2014, the simplification of multiple eligibility groups, and the streamlining of eligibility determinations. We received no public comments on these proposed revisions. We are finalizing these revisions without modification with one exception. We are not finalizing proposed changes to introductory language in §435.201(a) because, in removing the obsolete reference to AFDC cash assistance, we proposed alternative regulation language that is not consistent with the statute. Specifically, we proposed that the agency may choose to cover under an optional eligibility group individuals who are “not eligible and enrolled for mandatory coverage” under state plan. Section 1902(a)(10)(A)(ii) of the Act, however, precludes coverage under an optional group as long as an individual is be eligible for coverage under a mandatory group, whether or not the individual has actually enrolled under the mandatory group. We will address revisions to the introductory language in §435.201(a) in future guidance. We are finalizing revisions to §435.201(a)(4), (5) and (6) as proposed.

J. Electronic Submission of the Medicaid and CHIP State Plan (§§430.12, 457.50 and 457.60)

We proposed to revise §§430.12, 457.50, and 457.60 to reflect our implementation of an automated transmission process for the Medicaid and CHIP state plan amendment (SPA) business process. Historically, we have accepted state plan amendments on paper, using a pre-printed template supplemented by additional state-specific paper submissions. This process was not transparent to states or other stakeholders because it was not easily shared in an increasingly electronic environment. To move to a more modern, efficient and transparent business process, in consultation with states, we are developing the MACPro (Medicaid and CHIP Program) system to electronically receive and manage state plan amendments, as well as other Medicaid and CHIP business documents. The proposed revisions direct states to use the automated format for submission of SPAs, replacing previous paper based state plan pages and documents, and give states a period of time to make the transition to the new system with technical support from CMS. We received the following comments concerning the proposed automated transmission process for the Medicaid and CHIP business process provisions, which are revised in the final rule as indicated:

Comment: Several commenters supported the requirement for the electronic submission of SPAs, as a step toward increased transparency. Commenters encouraged CMS to add a provision to the final rule specifying that Medicaid and CHIP state plans, including amendments, be made available to the public at the time that they are submitted, providing consumers and advocates acting on their behalf, as well as researchers and policy analysts, with access to the basic, descriptive information contained in state plans and amendments as soon as they become available. Commenters further recommended that there be a 30-day public notice and comment period followed by a 15-day period of state review of the comments received.

Response: We appreciate the comment and share the commenters' interest in increased transparency. CHIP State Plans and Medicaid SPAs are currently posted on the Medicaid.gov

website and are available for consumers, advocates, researchers, and others once approved, and we are exploring whether, under the new automated system, the entire approved Medicaid state plan can be made publicly available. Providing public access and an opportunity to comment on SPA submissions prior to approval is outside the scope of this final rule, which narrowly addresses the modality through which SPAs are submitted to CMS.

Comment: Several commenters expressed concern that the requirement for states to convert from approved paper state plans to the automated format in one year would cause undue hardship on the states. The commenters believe that it will take individuals knowledgeable about the program areas to input the state plan, necessarily diverting limited state resources from the many tasks associated with implementing provisions of the Affordable Care Act. While some were not opposed to the conversion of state plans to MACPro, they noted that completion of this target would depend on the availability of timely technical assistance from CMS.

Response: We understand states' concerns about use of limited resources and have removed the specific timelines for implementation of the automated templates described in proposed §§430.12(a)(1) and (2) and 457.50 and 457.60 from the final rule, under which the Secretary will provide further guidance when the MACPro templates are issued. We also have delayed full implementation of the MACPro system as states and we have focused on other priorities related to implementation of the Affordable Care Act, instead employing an interim solution that collects the data for the MAGI-related SPAs in a structured format so that the information can be converted later to MACPro. We also intend to release templates incrementally, to give states time to adapt to the new format. As the system and templates become available, we will provide technical assistance to help states meet applicable deadlines.

Comment: Several commenters recommended that paper state plan formats be allowed until such time that states are required to submit a state plan amendment electronically through MACPro.

Response: As noted above, we have revised the expectations under the final rule for states' transition to use of standardized state plan templates and a fully automated SPA submission process. As the new electronic templates are released, states will be expected to transition from the current to the new formats, consistent with future guidance to be provided by the Secretary. We will provide states with technical support needed to ensure a successful transition.

K. Changes to MAGI (§435.603)

We proposed several revisions to §435.603 in the January 22, 2013, proposed rule. First, we proposed to add definitions of “child,” “parent” and “sibling” in paragraph (b) to include natural, adopted, step and half relationships, and to streamline regulation text throughout §435.603 to use these terms. We finalized inclusion of the definitions of “parent” and “sibling” in §435.603(b) of the July 15, 2013, Eligibility final rule (78 FR 42160), but did not respond to comments on the definitions, nor did we finalize use of the newly-defined terms elsewhere in §435.603. We will do so in this final rule. Second, we proposed to clarify the exception from application of MAGI-based financial methodologies provided in section 1902(e)(14)(D)(iv) of the Act and implemented at paragraph (j)(4) of §435.603 for individuals needing long-term care services. Specifically, we proposed to clarify that the exception from application of MAGI-based methods at §435.603(j)(4) applies only in the case of individuals who request coverage for long-term care services and supports (LTSS) for the purpose of being evaluated for an eligibility group for which meeting a level-of-care need is a condition of eligibility or under which long-term care services not covered for individuals determined eligible using MAGI-based financial methods are

covered. The proposed clarification was to make clear that the exception does not apply to someone who could be determined eligible using MAGI-based methodologies under a MAGI-based eligibility group which covers the needed long-term care services, simply because the individual requests such services.

Although we did not propose specific changes to the regulation text, we also requested comments on whether we should make other revisions to the household composition provisions of the March 23, 2012, Eligibility final rule at §435.603(f) to address potential inequities in situations in which an individual is included as a member of two households for purposes of determining each household's Medicaid eligibility, such that the individual's income is "double counted" as being wholly available to the members in each household, when, in reality, only a portion of the individual's income may actually be available to each household.

Finally, we also had proposed revisions to the application of the 5 percent disregard under section 1902(e)(14)(I) of the Act. Those proposed revisions were finalized in the July 15, 2013, Medicaid and CHIP final rule (78 FR 42160).

Comment: Commenters supported the technical corrections to how parents and siblings are defined in determining households for Medicaid eligibility, noting that the proposed definitions were consistent with the treatment of families under the IRC for purposes of eligibility for the premium tax credits and cost-sharing reductions and that such consistency was important for achieving coordination between all insurance affordability programs. Another commenter stated that changing the definition of parent will impact the assistance unit determinations and budgeting methodologies, requiring changes to systems already in design.

Response: We appreciate the commenters' support and, as noted above, we finalized the definitions of "child," "parent," and "sibling" in the July 15, 2013 Medicaid and CHIP final rule. We are finalizing in this regulation use of these terms in §435.603(f)(2)(i), (f)(3)(ii) and (f)(3)(iii),

as proposed. We neglected to propose a similar use of the word parent in place of reference to the term “natural, adopted or step parent” in §435.603(d)(2)(i) of the March 23, 2012, Medicaid eligibility final rule, but also are making this technical streamlining revision to the regulation text in this final rule.

Comment: Several commenters responded to our request for comment on the situation involving individuals who are included in more than one household.

Response: We have decided not to revise the regulations to address this issue at this time, but will consider this issue again, and the comments received, in subsequent rulemaking.

Comment: We received a few comments on the proposed revisions to the exception from application of MAGI-based methods at proposed §435.603(j)(4). One commenter supported the proposed clarification that an individual who is otherwise eligible under a MAGI-based category is not exempted from MAGI-based methodologies simply because he or she requests certain long-term care services. Another commenter appreciated the clarification, but expressed continued concerns about the clarity of the proposed revision. The commenter requested clarification on: (1) whether and how the exception at proposed §435.603(j)(4) relates to eligibility under sections 1915(i) and 1915(k) of the Act; and (2) the interaction of this exception from application of MAGI-based methods with the spousal anti-impoverishment requirements in section 2404 of the Affordable Care Act.

Response: The revisions to §435.603(j)(4) clarify when MAGI-based financial methodologies may be applied to individuals who will receive certain LTSS. We interpret section 1902(e)(14)(D)(iv) of the Act as providing that seeking coverage for LTSS or meeting a level-of-care need for such services does not necessarily result in the exception of an individual from application of MAGI-based financial methodologies. An exception to MAGI-based methods

applies under the statute based on our analysis only to the extent that an eligibility determination requires that the individual be institutionalized or is made for purposes of receiving LTSS.

Under proposed paragraph §435.603(j)(4), individuals who are eligible under a MAGI-based eligibility group (that is, an eligibility group to which MAGI-based methodologies generally apply, for example, the eligibility groups for parents and other caretaker relatives, pregnant women, children and adults under age 65 at §§435.110, 435.116, 435.118 and 435.119) are not excepted from application of MAGI-based methodologies simply because they require LTSS covered for the MAGI-based group in which they are enrolled. Individuals are excepted from MAGI-based methodologies only if the need for LTSS or institutional status results in application for coverage under a different eligibility group related to that need or status. For example, an individual who meets the requirements for eligibility under the adult group at §435.119 is not excepted from application of MAGI-based methods simply because of a need for LTSS. If the LTSS needed are covered under the ABP adopted by the state for the adult group, and the individual does not have to establish financial eligibility for such services (as would be the case if the state has elected to cover home and community-based services similar to those described in section 1915(i)(1) of the Act under an ABP for individuals enrolled in the adult group), the individual's need for LTSS provided under the ABP does not result in an exception from MAGI for purposes of determining eligibility for coverage generally under the adult group. (Discussed below, determinations of financial eligibility for services described in section 1915(i)(1) of the Act are excepted from mandatory application of MAGI-based methods under §435.603(j)(4)). Similarly, if an individual enrolled in the adult group becomes institutionalized and is eligible for coverage of the institutional services needed through the adult group, she does not become exempt from MAGI-based methods due to her institutionalization. Conversely, if the individual is unable to access needed institutional care or other LTSS through enrollment in the

adult group or could obtain services more appropriate to his needs through enrollment in another eligibility group for which being in an institution or meeting a level-of-care need for LTSS is required, MAGI-based methodologies would not apply for purposes of determining eligibility for such other eligibility group.

We realize that the text of proposed §435.603(j)(4) could be read in a way that would result in application of MAGI-based methodologies to individuals being determined for eligibility under the “Special Income Level” group described in section 1902(a)(10)(A)(ii)(V) of the Act and §435.236 because meeting a level-of-care need is not per se a condition of eligibility for this group (rather, being institutionalized is). Similarly, proposed §435.603(j)(4) could be read to require that eligibility under section 1915(i), implemented at §435.219 of the regulations (relating to optional coverage for individuals meeting an institutional level of care or satisfying defined needs-based criteria for home and community based services) must be determined using MAGI-based methodologies. Such result clearly would be contrary to the exception for LTSS individuals from application of MAGI-based methods provided in section 1902(e)(14)(D)(iv) of the Act as well as the flexibility afforded to states to adopt SSI-related or other financial methodologies, if approved by the Secretary, for coverage under section §435.219(c). Therefore, we are making a technical revision for increased clarity and consistency with the statute in §435.603(j)(4) to include within the scope of the exception from MAGI described therein individuals being evaluated for an eligibility group for which being institutionalized, meeting an institutional level of care, or satisfying needs-based criteria for home and community based services is a condition of eligibility. We note that states typically require that an individual be in a medical institution or nursing facility for at least 30 days to be considered “institutionalized,” which we note is consistent with the standard for institutionalized status under the Supplemental Security Income (SSI) program (see 20 CFR 416.414(a)(1)), as well as the definition of “institutionalized spouse”

in section 1924(h) of the Act (relating to eligibility and post-eligibility treatment of income for certain married individuals who need long-term services and supports).

Section 1915(i) of the Act, implemented in the Home and Community-Based Services final rule (79 FR 2947) published in the January 16, 2014, **Federal Register** (“January 16, 2014 HCBS final rule”), enables states to cover home and community-based services under the state plan instead of through a waiver. First, implemented at §440.182 of the regulations, section 1915(i) of the Act, authorizes states to cover home and community-based services described in section 1915(i)(1) of the Act (“1915(i) services”) to individuals who meet needs-based criteria, are eligible under the Medicaid state plan and have income at or below 150 percent FPL. Notwithstanding the general requirement in section 1902(a)(10)(B) of the Act and §440.240 (relating to comparability of services), states are permitted to cover section 1915(i) services for individuals eligible under one or more categorically needy eligibility groups described in section 1902(a)(10)(A) of the Act and 42 CFR part 435 subparts B and C, without covering the services for individuals eligible under all other categorically needy eligibility groups. (If a state covers section 1915(i) services for medically needy individuals, it must cover such services for all individuals eligible under the state plan, with the exception of individuals eligible for the adult group described in §435.119 who are enrolled in an ABP which does not cover the services in question.) States also can opt to cover section 1915(i) services for a defined subset of individuals eligible under a given eligibility group. In addition, states that elect to cover section 1915(i) services in accordance with §440.182 may also elect to cover individuals in one or both categories described in §435.219. Meeting needs-based criteria is a requirement for coverage under the category described in §435.219(a); meeting a level-of care need is a requirement for coverage under the category described in §435.219(b).

Section 1915(k) of the Act, implemented at §441.500 et seq., authorizes states to cover certain home and community-based services (“section 1915(k) services”) for individuals eligible under the state plan. States exercising the option provided at section 1915(k) of the Act must comply with the comparability of services requirements in section 1902(a)(10)(B) of the Act and §440.240 such that, if section 1915(k) services are covered for individuals eligible under any categorically needy eligibility group, the services must be covered for individuals eligible under all categorically needy eligibility groups which are covered under the state plan. However, under §441.510(b)(2), if an individual is enrolled in an eligibility group for which nursing facility services are not covered, an additional income test is applied, and the individual’s income must be at or below 150 percent FPL to receive coverage of the section 1915(k) services.

If a state has opted to cover section 1915(i) services for a MAGI-based eligibility group that is not restricted to benchmark benefits, or to cover section 1915(i)-like benefits in an ABP provided to an individual in the new adult group, the state would apply MAGI to determine financial eligibility. Similarly, in a state that has opted to cover section 1915(k) services for a MAGI-based eligibility group not restricted to benchmark benefits or to cover section 1915(k)-like services through an ABP for medically frail individuals in a group that is restricted to benchmark benefits, MAGI would apply. Other than eligibility groups which confer only a limited set of benefits (for example, coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Act and §435.214 of this rulemaking), coverage of nursing facility services is mandatory for all MAGI-based eligibility groups. Therefore, as a practical matter, the 150 percent FPL income test for section 1915(k) services provided to individuals eligible for coverage under a group that does not cover nursing facility services (for example, under a group for medically needy individuals) will never be applicable.

We interpret the needs-based criteria which must be met as a condition of eligibility for receipt of section 1915(i) services under §435.219(a) of the January 16, 2014, HCBS final rule to be a level-of-care requirement for purposes of the exception from mandatory application of MAGI-based methodologies in §435.603(j)(4). Accordingly, states are not required to apply MAGI in determining eligibility under either option described in §435.219. We note that under §§435.219(c) and 441.715(d)(2) of the January 16, 2014, HCBS final rule, states have flexibility to apply reasonable income methodologies in determining eligibility under §435.219(a), which could include MAGI-like methodologies, subject to the limitations on deeming income described in section 1902(a)(17)(D) of the Act and Secretarial approval in an approved state plan amendment.

We intend to address in future guidance the interaction of MAGI-based methods, including the exception from application of such methods at §435.603(j)(4), with the spousal impoverishment rules of section 1924 of the Act.

Comment: A commenter believed that the definition of “long-term care services” contained in §435.603(j)(4) is confusing. The commenter noted that section 1902(e)(14)(D)(iv) of the Act, upon which proposed §435.603(j)(4) is based, incorporates, by reference, the services described in section 1917(c)(1)(C)(ii) of the Act, but that the proposed §435.603(j)(4) does not do so. The commenter believes that our proposed definition omits 2 services which should be reflected in the regulation by virtue of the cross-reference to section 1917(c)(1)(C)(ii) of the Act. The commenter suggests that we revise proposed §435.603(j)(4) to explicitly cross-reference section 1917(c)(1)(C)(ii) of the Act, or explain the rationale for excluding some of the services identified therein.

Response: We did not propose revisions to the definition of “long-term care services and supports” contained in §435.603(j)(4), which generally tracks the definition of services provided

in section 1902(e)(14)(D)(iv) of the Act, except that section 1902(e)(14)(D)(iv) of the Act cross-references services described in section 1917(c)(1)(C)(ii) of the Act, whereas the regulatory definition at §435.603(j)(3) refers instead to home health services as described in sections 1905(a)(7) of the Act and personal care services described in sections 1905(a)(24) of the Act. We replaced the statutory reference to section 1917(c)(1)(C)(ii) of the Act for clarity; we did not eliminate any LTSS from inclusion in the definition used for purposes of §435.603(j)(4) in so doing.

The commenter's concern may relate to the omission, from the definition of LTSS in the regulation, of the services described in section 1905(a)(22) of the Act. Section 1905(a)(22) of the Act permits states to include in their definition of "medical assistance" home and community care for "functionally disabled elderly individuals," to the extent described and allowed under section 1929 of the Act. However, inasmuch as FFP for these services under section 1929 of the Act expired at the end of federal fiscal year 1995 per section 1929(m) of the Act, home and community care services are no longer authorized for coverage under section 1905(a)(22) of the Act.

Other optional long-term care services are those that can be covered under section 1915 of the Act and are reflected in the definition contained in §435.603(j)(4). Therefore, we are not accepting the comment. We note, however, that proposed §435.603(j)(4) inadvertently replaced the phrase "Long-term services and supports" at the beginning of the second sentence in §435.603(j)(4) with the phrase "Long-term care services." The first sentence in §435.603(j)(4) uses the phrase "long-term care services and supports." No substantive difference was intended in these different variations and we are making a technical change in this final rule for consistency to use the language contained in the first sentence of §435.603(j)(4) in the second sentence as well.

L. Medical Support and Payments (§§433.138, 433.145, 433.147, 433.148, 433.152 and 435.610)

We proposed to amend §433.148(a)(2) to provide that, consistent with the practice in many states today, individuals (unless exempt per existing regulations) must agree to cooperate in establishing paternity and obtaining medical support at application, but that further action to pursue support, as appropriate, will occur after enrollment in coverage.

We proposed to make technical corrections to §§433.138, 433.145, 433.147, and 435.610 to update references to eligibility of pregnant women under section 1902(a)(10)(A)(i) of the Act with a reference to §435.116 and to update or eliminate references to verification regulations in subpart J of part 435 which were eliminated or revised in the March 23, 2012, Medicaid eligibility final rule.

We proposed to remove §433.152(b)(1) because 45 CFR part 306 no longer exists. We also proposed to revise §433.147(c)(1) and remove §433.147(d) to eliminate references to factors applicable to waiving the cooperation requirement contained in 45 CFR part 232 because 45 CFR part 232 was removed from the regulations following with the passage of the PRWORA. Finally, we proposed to remove §435.610(c) as no longer necessary.

We received a number of comments concerning the proposed changes to the medical support and payments provisions, which are finalized as proposed except as indicated below.

Comment: Many commenters recommended that the requirement to cooperate with establishing paternity not apply in situations where the child was conceived through assisted reproduction by a donor or that a good cause exception be provided. Further, the commenters recommended leaving “assisted reproduction” undefined, and that the language of these provisions be made gender neutral by referring to the child’s other “parent” rather than the “father” because they believe this language creates confusion about whether this requirement is

met by establishing the maternity of another mother rather than the child's father when the child has same-sex female parents.

Response: We agree with the recommendation that gender-neutral language should be used and are revising §§433.145(a)(2), 433.147 and 433.148 in the final rule, accordingly. In addition, we note that state law applies in determining who meets the definition of parent under federal Medicaid regulations, including in instances of assisted reproduction.

Comment: One commenter was concerned with the requirement that states must determine whether a parent is cooperating with child support enforcement only after determining eligibility. The commenter believed this post-eligibility requirement could create a churning effect whereby a parent who is enrolled and then subsequently terminated from Medicaid for failing to cooperate with the state child support enforcement agency, subsequently reapplies for Medicaid, requiring that the state must enroll the parent again, creating a repeating cycle. The commenter recommended that when there is a previous finding of non-cooperation, the applicant be determined ineligible for Medicaid if they reapply.

Response: We appreciate the concern raised by the commenter, but are finalizing the rule as proposed. As discussed in the January 22, 2013 proposed rule, states must align the eligibility rules for all insurance affordability programs to the maximum extent possible, to achieve a highly coordinated and streamlined eligibility and enrollment system. Because all insurance affordability programs will use the same streamlined application and eligibility determinations and enrollment will be coordinated, an eligibility determination for Medicaid should not be delayed by the cooperation requirements. Parents must only be required to agree to cooperate with medical support enforcement during the application process. States may pursue administrative and operational solutions to expedite the determination of noncooperation with

child support enforcement or to suspend, rather than terminate, eligibility of an individual who refuses to cooperate without cause, until the required cooperation is offered.

Comment: One commenter questioned what is considered a concerted effort by the state to establish paternity, and whether states must document written and verbal attempts to communicate with the parent in attempting to establish paternity. The commenter also requested clarification on how often the state must attempt to contact the absent parent. The commenter suggested that states should be able to define what constitutes a concerted effort to establish paternity.

Response: Rules governing establishment of paternity are outside the scope of the proposed regulations. We note, however, that states have been required to implement laws regarding paternity establishment beginning with the Family Support Act of 1988. HHS' Administration for Children and Families (ACF) regulations address state programs for establishment of paternity. Under §433.152, as revised in this final rule, agreements between the state Medicaid agency and the child support enforcement agency in the state must provide for the Medicaid agency to reimburse the state CSEA for those child support services that are not reimbursable by the federal Office of Child Support Enforcement and which are necessary for the collection of medical support for the state Medicaid program.

Comment: One commenter was concerned that any change in policy to deny or terminate Medicaid coverage of a child for parental non-cooperation without good cause would violate MOE requirements for children.

Response: Children cannot be denied or terminated from coverage under the statute due to lack of parental cooperation in obtaining medical child support. This prohibition is reflected at §433.148(b)(1) and (b)(2), under which the agency must provide Medicaid to any individual who cannot legally assign his or her own rights to medical support payments and who would otherwise

be eligible for Medicaid but for the refusal of another person to assign the individual's rights or to cooperate in obtaining medical support.

III. Provisions of the Final Regulations

We are finalizing the provisions of the January 22, 2013 proposed rule as proposed with the following exceptions:

Change to §407.42.

- Remove the reference to §435.114, which is an obsolete regulation.Changes to §430.12
- Revised to reflect changes to the Medicaid state plan template.

Changes to §431.201

- Provided definition of a “joint fair hearing request.”
- Revised for clarity the definition of “action.”

Change to §431.205

- Added a new paragraph (f), clarifying that the hearing system established under section 1902(a)(3) of the Act and part 431 subpart E, must be conducted in a manner that complies with applicable federal statutes and implementing regulations.

Changes to §431.206

- Revised paragraph (b)(1) and added paragraph (b)(4) to provide that individuals must be informed of the opportunity to request an expedited review of their fair hearing request, and informed of the timeframes upon which the state will take final administrative action.
- Made non-substantive revisions for clarity in paragraph (c)(2).

Changes to §431.220

- Revised paragraph (a)(1) to allow an individual to request a fair hearing if an agency takes an action erroneously.

- Added a cross-reference to the definitions of “premiums” and “cost sharing” in §447.51.
- Added paragraph (a)(1)(v) to clarify that a hearing is required when an individual’s request for exemption from mandatory enrollment in an Alternative Benefit Plan is denied or not acted upon with reasonable promptness.
- Added paragraph (a)(1)(iv) to clarify that a change in the amount or type of benefits or services is another basis on which the agency must grant a hearing.
- Made other non-substantive revisions for clarity in paragraph (a)(1).

Changes to §431.221

- Redesignated and combined proposed paragraphs (a)(1) through (5) at paragraph (a)(1)(i).
- Revised paragraph (a)(1)(ii) to provide that a fair hearing request made in any modality under §431.221(a)(1) must include an opportunity to request an expedited review of such a request.
- Paragraph (e) is not included in the final rule.

Change to §431.223

- Revised this section to reflect that states must offer a withdrawal of a fair hearing in all modalities that it offers a request for a fair hearing in accordance with §431.221(a). When a state offers a telephonic hearing withdrawal, it must record appellant’s statement and telephonic signature. For telephonic, online and other electronic withdrawals, the agency must send the individual written confirmation, via regular mail or electronic notification in accordance with the individual’s election.

Changes to §431.224

- Revised paragraph (a) with minor revisions for clarity on the expedited appeals standard.

- Revised paragraph (b) to provide clarity that the state must inform an individual whether an expedited review will be granted as expeditiously as possible and shall do so orally or through electronic means in accordance with §435.918.

Change to §431.232

- Made minor revisions for clarity in paragraph (b).

Changes to §431.241

- Made revisions to cross-reference §431.220(a)(1) for clarity in paragraph (a).
- Removed changes to paragraph (b) and placed content regarding changes in the amount or type of benefits or services in §431.220(a)(1)(iv).

Change to §431.244--

- Made revisions to paragraph (f)(1) to incorporate changes to this paragraph finalized in the May 6, 2016 managed care final rule.

- Added paragraph (f)(3) to provide that –

++ For individuals whose request for expedited appeal is based on an eligibility issue, the state must take final administrative action as expeditiously as possible, but no later than 7 working days from the date the agency receives the expedited fair hearing request;

++ For individuals whose request for an expedited appeal is based on a benefits or services related fee-for-service issue, the state must take final administrative action in accordance with the time frame at current (f)(2) (which is 3 working days);

++ For individuals whose request for an expedited appeal is based on a managed care appeal, the state must take final administrative action, in accordance with current rules at paragraphs (f)(2) of this section.

- The expedited time frame in paragraph (f)(3)(i) and (f)(3)(ii) are subject to a delayed effective date in accordance with the policy described in §435.1200(i) of this rule.

- Proposed paragraph (f)(2) is not being finalized in this rule.

- Added paragraph (f)(4) to discuss exceptional circumstances when the agency does not have to take the final action within the required time frame.

Change to §433.145

- Amended paragraph (a)(2) to reflect that medical support and payments may be obtained or derived from the non-custodial parent of the child, regardless of the gender of the non-custodial parent.

Changes to §435.4

- Modified the definitions of “non-citizen” and “qualified non-citizen,” to use the word “includes” rather than the phrase “has the same meaning as” to further simplify the regulation text.

- Modified the definition of “citizenship” to eliminate repetitive language.

Change to §435.115

- Removed paragraph (b)(2)(i) concerning pregnant women because they retain Medicaid eligibility until the end of the postpartum period through §435.170.

Changes to §435.117

- Redesignated paragraph (b)(2) as (b)(3) and redesignated and revised paragraphs (b)(1)(iii) and (iv) as (b)(2)(ii), including revised introductory language in (b)(2).

- Added at paragraph (b)(2)(ii)(B) the state option to cover as a deemed newborn the child of a mother covered under another state’s CHIP state plan for the date of birth.

- Redesignated paragraph (c) as paragraph (b)(2)(i).

- Redesignated paragraph (d) as (c).

Change to §435.150

- Revised paragraph (b)(3) to clarify the requirements.
- Removed the parenthetical in paragraph (b)(3) with the state option to determine an individual eligible under this group if in foster care and/or Medicaid in any state upon attaining either age 18 or any higher age that title IV-E foster care ends in the state.
- Revised paragraph (c) to provide additional state options for coverage under the former foster care group.

Change to §435.170

- Revised this section to reference §435.116(d)(2) and (4), rather than just §435.116(d)(3) to clarify that if a state elects to provide full coverage for all pregnant women eligible under §435.116, it would also provide full coverage during an extended or continuous eligibility period for pregnant women.

Change to §435.172

- Removed “or household income” from paragraph (b)(1), for consistency with the requirements at section 1902(e)(7) of the Act.

Changes to §435.213

- Revised paragraph (c) to clarify that a screen based on which an individual is determined to need treatment for breast or cervical cancer is either an initial screen under the Centers for Disease Control and Prevention breast and cervical cancer early detection program or a subsequent screen by the individual’s treating health professional.

Changes to §435.214

- Revised section heading to be more descriptive.
- Redesignated paragraph (b) as paragraph (b)(1).

- Removed the phrase “meet all of the following requirements”, added a phrase to describe that eligibility is limited to the covered services under paragraph (d), and added a parenthetical clarifying that this coverage is provided to individuals “of any gender”.

Changes to §435.215

- Revised paragraph (b)(2) to clarify that an individual is only eligible for this group (which only covers treatment for tuberculosis) if the individual is not eligible for full coverage under the state plan.

Changes to §435.226

- Revised paragraphs (b) and (c) to clarify that a state may elect to have no income standard for this group or may elect any income standard that is equal to or more than the state’s income standard for parents and other caretaker relative under §435.110.

Changes to §435.227

- Revised paragraph (b)(3)(i) to specify eligibility “under the Medicaid state plan of the state with the adoption assistance agreement”.
- Revised paragraph (c) to remove reference to the state’s AFDC payment standard as of 1996 and made other streamline revisions for increased readability.

Changes to §435.229

- Revised paragraph (c)(2) to clarify that the income standard established by a state under this group is a MAGI-equivalent standard.
- Revised paragraph (c)(3) to reference a CHIP State plan or 1115 demonstration, in addition to Medicaid, as a technical correction consistent with state flexibility provided by federal statute.

Changes to §435.406

- Revised paragraph (a)(1)(iii)(E) to require states to allow states to exempt deemed newborns from another state from the citizenship verification requirements if the state has verified that the individuals were eligible as deemed newborns in the other state.

- Revised paragraphs (a) and added a new paragraph (c), to clearly state that the declaration of citizenship and immigration status must be presented and verified in accordance with §435.956(b), redesignated from §435.956(g) in this final rule.

Changes to §435.407

- Added paragraph (a)(6) to allow a data match with SSA as stand-alone evidence of citizenship and identity.

- Revised paragraph (b)(7) to read as, “A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency).”

- Removed the proposed language requiring the individual having to be born in the CNMI before November 4, 1986, because only collectively naturalized citizens who were born in the CNMI before that date will be issued such a card.

Changes to §435.603

- Made a technical streamlining revision to use the word “parent” in place of reference to “natural, adopted or step parent” in §435.603(d)(2)(i)

- Made a technical modification to clarify that the exception from mandatory application of MAGI-based methods described in §435.603(j)(4) applies only to individuals who are seeking coverage either in an eligibility group that requires applicants to meet a level-of-care need or that covers long-term care services and supports not otherwise available through a MAGI-based group.

Change to §435.901--

- Revised to provide clarity that information provided to applicants and beneficiaries and eligibility standards and methods must reflect all appropriate federal laws.

Changes to §435.905

- Revised the requirement to provide taglines in paragraph (b)(1) to include this requirement in paragraph (b)(3) of this section.
- Modified the current title of the regulation to clarify that the regulation is also related to providing accessible information to applicants and beneficiaries by adding the term “accessibility” in the title. The finalized regulation title of §435.905 reads “Availability and accessibility of program information.”

Changes to §435.911

- Made a technical revision to include a cross-reference to §435.912 at §435.911(c)(2).
- Replaced “and” with “or” at the end of paragraph (b)(2)(i).

Change to §435.952

- Modified the proposed regulation to clarify who can provide attestation of information when there is a special circumstance.

Changes to §435.956

- Added an option for states to verify citizenship status through the electronic service established in accordance with §435.949 or an alternative mechanism authorized in accordance with §435.945(k).
- For purposes of exemption of the 5-year waiting period, added a new §435.956(a)(3) to require states to verify that an individual is an honorably discharged veteran or in active military status, or the spouse or unmarried dependent child of such person as described in 8 U.S.C. 1612(b)(2), through the FDSH or other electronic data source if and when available and permitting states to accept self-attestation if electronic verification is not available.

- Redesignated paragraph (g) as paragraph (b) and revised paragraph (b) to clarify that the agency must provide a reasonable opportunity period to otherwise eligible individuals who have made a declaration of citizenship or immigration status in accordance with §436.406(a), to limit the option for states to extend the reasonable opportunity if the individual is making a good faith effort to provide documentation or the agency needs more time to complete the verification to only those individuals attesting to satisfactory immigration status, and to allow states to place reasonable limits on the number of reasonable opportunity periods if the agency demonstrates a program integrity risk.

Changes to §435.1200

- Added new paragraph at §435.1200(i) in the final rule, to provide that the notice of applicability date for the compliance of §§435.1200(g)(2), 431.221(a)(1)(i), and 431.244(f)(3)(i) and (ii) of this chapter is 6 months from the date of a published **Federal Register**, which at its earliest, will be published May 30, 2017.

- In paragraph (a)(2)(iii), added a cross-reference to the definition of “joint fair hearing request” in §431.201.

- Revised paragraph (g)(1) to provide that the agency must include in the agreement consummated per §435.1200(b)(3) between the agency and the Exchange that, if the Exchange or other insurance affordability program provides an applicant or beneficiary with a combined eligibility notice which includes a denial of Medicaid eligibility, the Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity) will (1) provide the applicant or beneficiary with an opportunity to submit a joint fair hearing request; and (2) notify the Medicaid agency of such request for a Medicaid fair hearing (unless the hearing will be conducted by the Exchange appeals entity per a delegation of authority under §435.10(c)(1)(ii).

- Revised proposed §435.1200(g)(2), redesignated at §435.1200(g)(4) in the final rule, to

establish a more dynamic standard in this final rule such that, in conducting a fair hearing in accordance with subpart E or part 431, the agency must minimize, to the maximum extent possible consistent with guidance issued by the Secretary, any requests for information or documentation from the individual which are already included in the individual's electronic account or which have been provided to the Exchange or Exchange appeals entity.

- Revised proposed §435.1200(g)(1)(i), redesignated at §435.1220(g)(2)(i), to provide that the state agency establish a secure electronic interface through which the Exchange or Exchange appeals entity can notify the agency that it has received a joint fair hearing request.

- Added new paragraph (g)(3), which requires the agency to accept and act on a joint fair hearing request submitted to the Exchange or Exchange appeals entity in the same manner as a request for a fair hearing submitted to the agency in accordance with §431.221.

- Added new paragraph (g)(6) to provide that, if the Exchange made the initial determination of Medicaid ineligibility in accordance to a delegation of authority under §431.10(c)(1)(i)(A)(3), the agency must accept a decision made by the Exchange appeals entity that an appellant is eligible for Medicaid in the same manner as if the determination of Medicaid eligibility had been made by the exchange.

- Included a cross-reference in new paragraphs (g)(6) and (g)(7) in the introductory text of §435.1200(c) to require that the agency also accept a determination of Medicaid eligibility by the Exchange appeals entity in the situations described.

Change to §457.50

- Amended to include periodic updates to CHIP state plan format.

Change to §457.60

- Amended to include periodic updates to the format of CHIP state plan amendments.

Change to §457.110

- Amended paragraph (a)(1) to clarify that it is a requirement that the state provide, at beneficiary option, notices to applicants and beneficiaries in electronic format.

Change to §457.342

- Clarified, in paragraph (a), that continuous eligibility in CHIP is subject to a child remaining ineligible for Medicaid, as required by section 2110(b)(1) of the Act and §457.310 (related to the definition and standards for being a targeted low-income child) and the requirements of section 2102(b)(3) of the Act and §457.350 (related to eligibility screening and enrollment).

- Clarified, in paragraph (b), that the continuous eligibility period may be terminated for failure to pay premiums or enrollment fees, subject to a premium grace period of at least 30 days and the disenrollment protections at section 2103(e)(3)(C) of the Act and §457.570.

Change to §457.355

- Made technical revisions to the wording for consistency with the Medicaid regulation at §435.1102.

Changes to §457.360

- Made organizational revisions to be consistent with the changes in Medicaid at §435.117.
- Redesignated the proposed paragraph (b)(2) as a new paragraph (b)(3).
- Moved the content of the proposed paragraph (c) to a new paragraph at §457.360(b)(2).
- Added a new paragraph at §457.360(b)(2)(ii) to provide that states may elect the CHIP optional newborn deeming provisions only if they have also elected the same options in Medicaid.
- Redesignated the proposed paragraph (d) regarding the CHIP identification number as paragraph (c).

Changes to §457.380

- Made technical revisions to expand the proposed paragraph (b)(1) to include introductory text and new paragraphs at §457.380(b)(1)(i) and (ii).
- Amended the regulatory cross-reference to newborns exempt from citizenship verification to be consistent with changes made to §435.406 in Medicaid.
- Clarified that benefits must be provided during the reasonable opportunity period.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 et seq.), we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

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

We solicited public comment on each of these issues for the following information collection requirements (ICRs) within our January 22, 2013 (78 FR 4594) proposed rule. While extensive comments were received on various provisions within that rule, we did not receive any PRA-specific comments.

This final rule codifies provisions set out in the January 22, 2013 (78 FR 4594) proposed rule that were not adopted in the July 15, 2013 (78 FR 42159) final rule. Overall, this final rule

will result in a reduction in burden for individuals applying for and renewing coverage, as well as for states, since the Medicaid program and CHIP will be made easier for states to administer and for individuals to navigate by streamlining and simplifying Medicaid and CHIP eligibility rules for most individuals. Even though there are short-term burdens associated with the implementation of this final rule, the Medicaid program and CHIP will be easier for states to administer over time due to the streamlined eligibility and coordinated efforts for Medicaid, CHIP, and the new affordable insurance exchanges.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics’ May 2015 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 2 presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 2: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefit (\$/hr)	Adjusted Hourly Wage (\$/hr)
Business Operations Specialist	13-1000	35.48	35.48	70.96
Computer Programmer	15-1131	40.56	40.56	81.12
General and Operations Managers	11-1021	57.44	57.44	114.88
Lawyer	23-1011	65.51	65.51	131.02
Training and Development Manager	11-3131	53.69	53.69	107.38
Training and Development Specialist	13-1151	30.03	30.03	60.06
Management Analyst	13-1111	44.12	44.12	88.24

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no other practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Burden Related to ICRs Carried Over from the January 22, 2013 Proposed Rule

Many provisions codified in this final rule do not set out any new or revised burden estimates because the burden is exempt from the PRA or is currently approved by OMB. Additional information on these provisions can be found below under section IV.D. The burden associated with all other provisions codified in this final rule is set out below.

1. ICRs Regarding Individuals who are Ineligible for AFDC Because of Requirements that do not Apply Under Title XIX of the Act (§435.113), Individuals Who Would be Eligible for AFDC Except for Increased OASDI Income Under Pub. L. 92-336 (July 1, 1972) (§435.114), and Individuals Who Would be Eligible for AFDC if Coverage Under the State's AFDC Plan Were as Broad as Allowed Under Title IV-A (§435.223).

We are removing the following state plan amendment (SPA) related provisions from current regulation: The provision of Medicaid to individuals denied AFDC based on certain policies (§435.113), the provision of Medicaid to certain individuals entitled to OASDI (§435.114), the provision of Medicaid to certain group or groups of individuals (§435.223), and the determination of dependency for families with certain dependent children who are not receiving AFDC (§435.510). Because we are eliminating these regulations, states will no longer be required to submit these SPAs to CMS. The SPA provisions are approved by OMB under control number 0938-0193 (CMS-179). This final rule will remove the portion of the burden

related to the requirements of §§435.113, 435.114, 453.223, and 435.510.

2. ICRs Regarding Adverse Action (§431.210), Notice of Agency's Decision Concerning Eligibility (§435.917), and Application for and Enrollment in CHIP (§457.340)

In §431.210, 435.917, and 457.340, the agency is required to provide a timely combined notice to individuals regarding their eligibility determination or any adverse action.

Current §431.210(a) has been amended to require that the notice provide the effective date of the action. In §431.210(b), the notice must provide a clear statement that supports the reasons for the intended action. In §431.210(d)(1), the explanation must communicate the right to request a local evidentiary hearing.

Section 435.917(b) has been added to clarify the agency's responsibilities to communicate specific content in a clear and timely manner when issuing a notice of approved eligibility, denial, or suspension. In §435.917(c), the notice must contain information regarding the basis of eligibility (other than MAGI) so individuals can make an informed choice as to whether they should request a determination on another basis. The notice must include reasons for the action, the specific supporting action, and an explanation of hearing rights.

Section 457.340(e) has been revised to align the content of CHIP notices with that of Medicaid notices.

The burden associated with the preceding requirements is the time for the state staff to: review the requirements related to notices; develop the language for approval, denial, termination, suspension, and change of benefits notices; and program the language in the Medicaid and CHIP notice systems so that the notice can be populated and generated based on the outcome of the eligibility determination or adverse action.

We estimate 56 state Medicaid agencies (the 50 states, the District of Columbia, and 5 Territories) and 42 CHIP agencies (in states that have a separate or combined CHIP), totaling

98 agencies are subject to the preceding requirements. We estimate that it will take each Medicaid and CHIP agency 194 hours to develop and automate the notice of eligibility determination or adverse action. Of those hours, we estimate it will take a business operations specialist 138 hours at \$70.96/hr, a general and operations manager 4 hours at \$114.88/hr, a lawyer 20 hours at \$131.02/hr, and a computer programmer 32 hours at \$81.12/hr to complete the notices. The estimated one-time cost for each agency is \$15,468.24. In aggregate, the total estimated cost is \$1,515,888 (rounded), while the total time is 19,012 hours.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 6,337 hr (19,012 hours/3 years) at a cost of \$505,296 (\$1,515,888/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires. The preceding requirements and burden estimates will be submitted to OMB for approval under control number 0938-New (CMS-10456).

The provision of the written notices under §431.206(b) and (c)(2) is an information collection requirement that is associated with an administrative action pertaining to specific individuals or entities (5 CFR 1320.4(a)(2) and (c)). Consequently, the burden for forwarding the notifications is exempt from the requirements of the PRA.

3. ICRs Regarding Presumptive Eligibility (§§435.1101(b) and 457.355)

In §§435.1101(b) and 457.355 (by reference to §435.1101) states are required to provide qualified entities with training in all applicable policies and procedures related to presumptive eligibility. The burden associated with this provision is the time and effort necessary for the states and territories to develop training materials and to provide training to application assistors.

We estimate 50 states and the District of Columbia will be subject to this requirement. As part of this estimate, we assumed that state Medicaid agencies and CHIP agencies, when they are separate agencies, will develop and use the same training.

We also estimate it will take a training and development specialist 40 hours at \$60.06/hr and a training and development manager 10 hours at \$107.38/hr to develop training materials for the qualified entities, for a total time burden of 2,550 hours. The estimated cost for each state or territory is \$3,476.20 while the total estimated cost is \$177,286.20.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 17 hr (50 hours/3 years) at a cost of \$59,095 (\$177,286/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires.

We also estimate that each state or territory will offer 50 hours of annual training sessions to qualified entities, for a total burden of 2,550 hours. We also estimate it will take a training and development specialist 50 hours at \$60.06/hr to train the application assistants. While the cost for each agency is estimated at \$3,003, the total (aggregate) cost is approximately \$153,153.

The preceding burden estimates will be submitted to OMB for their approval under control number 0938-New (CMS-10456).

4. ICRs Regarding the Submittal of State Plans and Plan Amendments (§430.12), State Plan (§457.50), and [State Plan] Amendments (§457.60)

Historically, we have accepted state plan amendments on paper following paper-pre-prints. This process was not transparent to states or other stakeholders. To move to a more modern, efficient and transparent business process, in consultation with states, we are developing the MACPro (Medicaid and CHIP Program) system to electronically receive and manage state plan amendments, as well as other Medicaid and CHIP business documents.

While the amendments to §§430.12, 457.50, and 457.60 direct states to use the automated format to submit SPAs, full implementation of the MACPro system is being phased in over time. The phase-in will provide states with the time needed to successfully transition to the new system

with technical support from CMS. The burden associated with the transition from paper-based to electronic SPA processing is the time and effort necessary for states and territories to be trained on use of the MACPro system, to establish user roles and access to MACPro for each user, and to review data imported into MACPro from other formats. As new templates become available, states will be required to utilize the new electronic system if they are seeking to amend their state plans. We believe that the time, effort, and financial resources required for future SPA submissions will be incurred in the absence of this final rule during the normal course of Medicaid and CHIP agency activities, and therefore, should be considered as a usual and customary business practice.

We estimate 56 state Medicaid agencies (the 50 states, the District of Columbia, and 5 Territories) and 42 CHIP agencies (in states that have a separate or combined CHIP), totaling 98 agencies are subject to the new electronic SPA submission requirements. We estimate that it will take each agency approximately 64 hours to implement the new electronic SPA submission process. Of those hours, we estimate it will take a business operations specialist 2 hours at \$70.96/hr and a general and operations manager 2 hours at \$114.88/hr to establish user roles for the agency. We estimate that 4 hours of training will be required for each staff member utilizing the new system. With an estimated 6 business operations specialists requiring 4 hours of training at \$70.96/hr, 3 management analysts requiring 4 hours of training at \$88.24/hr and 1 general and operations manager requiring 4 hours of training at \$114.88/hr. And we estimate that it will take 2 management analysts 10 hours each at \$88.24/hr to review the data initially imported in the system. The estimated cost burden for each agency is \$5,357.92. The total estimated cost burden is \$525,076.16, while the total time is 6,272 hours.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 2,091 hours (6,272 hours/3 years) at a cost of \$175,025.39 (\$525,076.16/3 years). We

are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires. The preceding requirements and burden estimates will be submitted to OMB for approval under control number 0938-New (CMS-10456).

As new SPA templates become available in MACPro, states will be required to utilize the new electronic system when they seek to amend their state plans. We believe that the time, effort, and financial resources required for future SPA submissions will be incurred in the absence of this final rule during the normal course of Medicaid and CHIP agency activities, and therefore, should be considered as a usual and customary business practice.

5. ICRs Regarding Deemed Newborn Children (§§435.117 and 457.360)

In §§435.117(b) and 457.360(b), states have the option to cover babies (as deemed newborns under the Medicaid or CHIP state plan, as appropriate) born to mothers covered on the date of birth as targeted low-income children under a separate CHIP state plan or to mothers covered under a Medicaid or CHIP demonstration waiver under section 1115 of the Act.

In §435.117(b)(1)(ii) and (iii), states have the option to cover (as a deemed newborn) the child of a mother covered under another state's CHIP state plan on the date of birth.

In §§435.117(c) and 457.360(c), states have the option to recognize deemed newborn status from another state without requiring a new application for enrolling babies born in another state.

Eligibility for deemed newborn children is already included in both Medicaid and CHIP state plans. This information can be found at Attachment 2.2-A, page 6, of the current state Medicaid plan, which is approved under control number 0938-0193 (CMS-179), and CS13 of the current CHIP state plan, which is approved under control number 0938-1148 (CMS-10398). These templates are planned for inclusion in the electronic state plan being developed by CMS as part of the MACPro system. When the MACPro system is available, these Medicaid and CHIP

SPA templates will be updated to include all of the options described in §§435.117 and 457.360 and will be submitted to OMB for approval with the revised MACPro PRA package under control number 0928-1188 (CMS-10434).

Prior to release of the new MACPro templates, states may need to make changes to their Medicaid or CHIP state plans to reflect adoption of the new options finalized in this rule. States electing these options will use the current state plan templates. For the purpose of the cost burden, we estimate it will take a management analyst 1 hour at \$88.24 an hour and a general and operations manager 0.5 hours at \$114.88 an hour to complete, submit, and respond to questions regarding the state plan amendment. The estimated cost burden for each agency is \$145.68. We anticipate 15 state Medicaid agencies and 5 state CHIP agencies may submit amendments to reflect changes to eligibility for deemed newborn children. The total estimated cost burden is \$2,913.60, while the total time is 30 hours.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 10 hours (30 hours/3 years) at a cost of \$971.20 (\$2,913.60/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires. Because the currently approved state plan templates are not changing at this time, the preceding requirements and burden estimates will be submitted to OMB for approval under control number 0938-New (CMS-10456).

In §§435.117(d) and 457.360(d), states are required to issue separate Medicaid identification numbers to covered babies as "deemed newborns" if the mother, on the date of the child's birth, was receiving Medicaid in another state, was covered in the state's separate CHIP, or was covered for only emergency medical services. Also, the state must issue a separate Medicaid identification number to a deemed newborn prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is

sooner. Under such circumstances, a separate Medicaid identification number must be assigned to the infant so the state may reimburse providers for covered services, document the state's expenditures, and request FFP.

While states are required to issue Medicaid identification numbers to these children, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). The time, effort, and financial resources necessary to issue identification numbers will be incurred in the absence of this final rule by persons during the normal course of their activities and should, therefore, be considered a usual and customary business practice.

6. ICRs Regarding Income Eligibility (§435.831)

Section 435.831(b) has been amended by providing states with the option to apply either AFDC-based methods or MAGI-based methods for determining income eligibility for medically needy children, pregnant woman, and parents and other caretaker relatives. States electing to use an MAGI-based methodology for these populations must ensure that there is no deeming of income or attribution of financial responsibility that would conflict with the requirements that prohibit counting the income of a child in determining the eligibility of the child's parents or siblings or deeming the income of a parent to a child if the parent is not living with the child.

The financial methodologies used to determine eligibility for medically needy individuals are currently described in the Medicaid state plan on Attachment 2.6-A, page 14a, which is approved under control number 0938-0193 (CMS-179). This template is planned for inclusion in the electronic state plan being developed by CMS as part of the MACPro system. When the MACPro system is available, this Medicaid state plan template will be updated to include the new option described in §435.831 and will be submitted to OMB for approval with the revised MACPro PRA package under control number 0928-1188 (CMS-10434).

Prior to release of the new MACPro templates, states may need to make changes to their

Medicaid state plan to reflect election of the MAGI methodology and they would submit such changes using the currently approved template. For the purpose of the cost burden, we estimate it will take a management analyst 1 hour at \$88.24 an hour and a general and operations manager 0.5 hours at \$114.88 an hour to complete, submit, and respond to questions regarding the state plan amendment. The estimated cost burden for each agency is \$145.68. We anticipate 8 state Medicaid agencies may submit state plan changes to elect to utilize MAGI-based methods for determining income eligibility for medically needy children, pregnant woman, and parents and other caretaker relatives. The total estimated cost burden is \$1,165.44, while the total time is 12 hours.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 4 hours (12 hours/3 years) at a cost of \$388.48 (\$1,165.44/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires. Because the currently approved state plan templates are not changing at this time, the preceding requirements and burden estimates will be submitted to OMB for approval under control number 0938-New (CMS-10456).

7. ICRs Regarding Former Foster Care Children (§435.150), Eligibility for Family Planning Services (§435.214), Application of Financial Eligibility Methodologies (§435.601), Financial Responsibility of Relatives and other Individuals (§435.602), and [the] Determination of Eligibility (§435.911)

States must submit a state plan amendment for any new eligibility groups or changes to existing eligibility groups. Mandatory groups, such as Former Foster Care Children (§435.150), require a state plan amendment from every Medicaid agency. Optional eligibility groups, including the new Family Planning group (§435.214), only trigger the need for a state plan amendment in states that choose to offer them. Because the mandatory eligibility group for

former foster care children became effective on January 1, 2014, all states have already included this new group in their state plan on page S33, which is approved under control number 0938-1148 (CMS-10398). Similarly, the optional eligibility group limited to family planning coverage also became effective on January 1, 2014, and a number of states have elected this group in their state plan on page S59, which is approved under control number 0938-1148 (CMS-10398). The state plan templates for the former foster care children and family planning eligibility groups are planned for inclusion in the electronic state plan being developed by CMS as part of the MACPro system. When the MACPro system is available, these templates will be updated to include all of the options described in §§435.150 and 435.214 and will be submitted to OMB for approval with the revised MACPro PRA package under control number 0928-1188 (CMS-10434).

Prior to release of the new MACPro templates, amendments to the Medicaid state plan may be necessary to reflect a state's adoption of the new options finalized in this rule. States electing these options will use the current state plan templates. For the purpose of the cost burden, we estimate it will take a management analyst 1 hour at \$88.24 an hour and a general and operations manager 0.5 hours at \$114.88 an hour to complete, submit, and respond to questions regarding the state plan amendment. The estimated cost burden for each agency is \$145.68. We anticipate that 25 state Medicaid agencies may submit state plan amendments to modify their coverage of the former foster care group, and we anticipate that 3 state Medicaid agencies may submit state plan changes to elect or modify coverage of the family planning group. The total estimated cost burden is \$4,079.04, while the total time is 42 hours.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 14 hours (42 hours/3 years) at a cost of \$1,359.68 (\$4,079.04/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires. Because the currently approved state plan templates are not

changing at this time, the preceding requirements and burden estimates will be submitted to OMB for approval under control number 0938-New (CMS-10456).

C. Summary of Annual Burden Estimates

TABLE 3: Annual Reporting and Recordkeeping Requirements

Section(s) in Title 42 of the CFR	OMB Control Number (CMS ID Number)	Respondents	Responses (per respondent)	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting (\$/hr)	Total Cost (\$)
431.210, 435.917, and 457.340	0938-New (CMS-10456)	98	1	194	6,337 ¹	varies ²	505,296 ¹
435.1101(b) and 457.355 (dev. training materials)	0938-New (CMS-10456)	51	1	50	17 ¹	varies ³	59,095 ¹
435.1101(b) and 457.355 (provide training)	0938-New (CMS-10456)	51	1	50	2,550	60.06	153,153
430.12, 457.50 and 457.60	0938-New (CMS-10456)	98	1	64	2,091 ¹	varies ⁴	175,025 ¹
435.117 and 457.360	0938-New (CMS-10456)	20	1	1.5	10 ¹	varies ⁵	971 ¹
435.831	0938-New (CMS-10456)	8	1	1.5	4 ¹	varies ⁵	388 ¹
435.150 and 435.214	0938-New (CMS-10456)	28	1	1.5	14 ¹	varies ⁵	1,360 ¹
Total	--	98	1	362.5	11,023	--	898,288

¹ One-time estimate annualized over OMB's 3-year approval period (see text for details).

² 138 hr at \$70.96/hr for a business operations specialist, 4 hr at \$114.88/hr for a general and operations manager, 20 hr at \$131.02/hr for a lawyer, and 32 hr at \$81.12/hr for computer programmer.

³ 40 hours at \$60.06/hr for a training and development specialist and 10 hours at \$107.38/hr for a training and development manager.

⁴ 26 hours at \$70.96/hr for business operations specialists, 32 hours at \$88.24/hr for management analysts, and 6 hours at \$114.88 for a general and operations manager.

⁵ 1 hour at \$88.24/hr for a management analyst and 0.5 hours at \$114.88/hr for a general and operations manager.

D. Other ICRs Carried Over from the January 22, 2013 Proposed Rule

Unlike section IV.B. of this final rule, which sets out burden for this rule's final provisions, this section IV.D. does not provide any burden estimates. Instead, the burden under this section is either exempt from the PRA, is currently approved by OMB, or will be submitted to OMB at a later date (independent from this rule).

1. ICRs Regarding Informing Applicants and Beneficiaries (§431.206)

Section 431.206(b) has been amended to require any agency taking action on an eligibility claim, or setting type or level of benefits or services, to inform every applicant or beneficiary in writing of his or her right to a hearing or expedited review and the date by which the agency must take administrative action. Section 431.206(c)(2) has been amended to clarify that the responsible agency/entity must provide notice to individuals regarding adverse actions.

The burden for developing the notice is set out above in our estimates under §§431.210, 435.917, and 457.340.

The provision of the written notices under §431.206(b) and (c)(2) is an information collection requirement that is associated with an administrative action pertaining to specific individuals or entities (5 CFR 1320.4(a)(2) and (c)). Consequently, the burden for forwarding the notifications is exempt from the requirements of the PRA.

Section 431.206(e) requires that the notices issued under this subpart E are accessible to individuals who are limited English proficient and to individuals with disabilities, and may be provided in electronic format.

States must administer their programs in compliance with federal civil rights law. This includes ensuring that states receiving federal financial assistance from CMS take reasonable steps to provide persons with limited English proficiency meaningful access to States' programs. States also have specific legal obligations for serving qualified individuals with disabilities. Consequently, we believe that the time, effort, and financial resources necessary to comply with

this requirement will be incurred in the absence of the provisions in this final rule by persons during the normal course of their activities, and therefore, should be considered a usual and customary business practice.

2. ICRs Regarding the Availability of Program Information for Individuals who are Limited English Proficient (§§431.206(e) and 435.905(b))

While states are required to provide language services to individuals who are limited English proficient, this regulation clarifies the approaches to providing these services. Specifically, the identified approaches (oral interpretation, written translations, and taglines) are standard practice for the provision of services to those with limited English proficiency. We believe that the time, effort, and financial resources necessary to comply with this requirement will be incurred in the absence of this final rule by persons during the normal course of their activities and should, therefore, be considered a usual and customary business practice. Consequently, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2).

3. ICRs Regarding the Denial or Termination of Eligibility (§433.148)

Section 433.148(a)(2) has been amended to specify that individuals must agree to cooperate in establishing paternity and obtaining medical support at application as a condition of eligibility unless cooperation has been waived, but that further action to pursue support, as appropriate, will occur after enrollment in coverage. Individuals are required by §435.610 to provide information to assist in securing payment from third parties unless the individual establishes good cause for not cooperating.

The provisions do not create any new or revised reporting, recordkeeping, or third party disclosure requirements or burden. The requirements are addressed as part of the single streamlined application that is approved by OMB under control number 0938-1191 (CMS-

10440).

4. ICRs Regarding Verification Exceptions for Special Circumstances (§435.952)

Section 435.952 has been amended to permit self-attestation (on a case-by-case basis) in special circumstances for individuals who do not have access to documentation (for example: victims of natural disasters). The provisions do not create any new or revised reporting, recordkeeping, or third party disclosure requirements or burden. The requirements are addressed as part of the single streamlined application that is approved by OMB under control number 0938-1191 (CMS-10440).

5. ICRs Regarding Verification Procedures for Individuals Attesting to Citizenship or Satisfactory Immigration Status (§§435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 457.320, and 457.380)

The provisions establish guidelines for the verification of Medicaid and CHIP eligibility based on citizenship or immigration status.

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

6. ICRs Regarding Adoption Assistance Agreements (§§435.145 and 435.227)

In §§435.145 and 435.227, we have amended Medicaid eligibility group provisions to be consistent with statutory requirements. Among the eligibility requirements and alternatives for these groups is that an adoption assistance agreement must be in effect. Importantly, this final rule is not making any revision to states' adoption assistance agreements. These agreements are between state agencies and the adoptive parents and are specific to the rules and laws in place in each state. We do not govern these agreements; therefore, we are not setting out any burden

associated with these provisions.

7. ICRs Regarding Citizenship and Non-Citizen Eligibility (§435.406)

Section 435.406(a) and (c) has been amended to require that the declaration of citizenship and immigration status must be presented and verified in accordance with §435.956(g). The provisions do not create any new or revised reporting, recordkeeping, or third party disclosure requirements or burden. The requirements are addressed as part of the single streamlined application that is approved by OMB under control number 0938-1191 (CMS-10440).

8. ICRs Regarding the Types of Acceptable Documentary Evidence of Citizenship (§435.407)

Section 435.407(a)(4) has been amended by specifying that states must accept a driver's license as proof of citizenship, only if the state issuing the license requires proof of U.S. citizenship or if that state obtains and verifies a social security number from the applicant who is a citizen before issuing such license. In §435.407(b)(18), only one affidavit can be required to verify citizenship if it cannot be verified electronically and the individual does not have any of the documents listed in §435.407. In §435.407(f), states must accept copies of documents rather than limiting documentation to originals.

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

9. ICRs Regarding the Verification of Other Non-Financial Information (§435.956)

Section 435.956(a)(1)(ii) has been amended by specifying that states may accept self-attestation that an individual is an honorably discharged veteran or in active military duty status, or the spouse or unmarried dependent child of such person as described in 8 U.S.C. 1612(b)(2) for purposes of exemption from the 5-year waiting period until such time as verification can be

conducted through the Hub or through another electronic data source.

Section 435.956(g) has been amended by specifying that the agency must provide a reasonable opportunity period to otherwise eligible individuals who have made a declaration of citizenship or immigration status in accordance with §435.406(a) or (b).

Section 435.956 has been amended by specifying that states must first attempt to verify citizenship and immigration status electronically in accordance with §435.949 and, if unable, to verify citizenship in accordance with §435.407 and immigration status in accordance with §435.406 and section 1137(d) of the Act. In §435.956(a)(4), the agency must maintain a record of having verified citizenship or immigration status for each individual in a case record or electronic database.

If a reasonable opportunity period is provided, §435.956(b) has been amended by providing states with the option to furnish benefits to otherwise eligible individuals prior to the date described in §435.956(g)(2)(i). This date could extend back to and include the date the notice in §435.956(g)(1) is sent, the date of application, or the first day of the month of application.

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

10. ICRs Regarding Eligibility Screening and Enrollment in Other Insurance Affordability Programs (§457.350)

In §457.350(i)(2)(i), states must notify the other insurance affordability program of the date on which the period of uninsurance ends and the individual is eligible to enroll in CHIP. In §457.350(i)(2)(ii) states must also provide the individual with an initial notice indicating: that the individual is not currently eligible to enroll in the state's separate child health plan and the

reasons thereof; the date on which the individual will be eligible to enroll in the state's separate child health plan; and that the individual's account has been transferred to another insurance affordability program for a determination of eligibility to enroll in such program during the period of underinsurance. The notice also must contain coordinated content informing the individual of the notice being provided to the other insurance affordability program and the impact that the individual's eligibility to enroll in the state's separate child health plan will have on the individual's eligibility for such other program.

Prior to the end of the individual's period of uninsurance the individual must be provided notice that reminds the individual of the information described in §457.350(i)(2)(i)(A), as appropriate.

In §457.350(j), the notice of CHIP eligibility or ineligibility must contain coordinated content, as applicable, relating to: the transfer of the individual's electronic account to the Medicaid agency, the transfer of the individual's account to another insurance affordability program, and the impact that an approval of Medicaid eligibility will have on the individual's eligibility for CHIP or another insurance affordability program, as appropriate.

The preceding provisions do not create any new or revised reporting, recordkeeping, or third party disclosure requirements or burden. The requirements and burden are addressed under §457.340 which is approved by OMB under control number 0938-0841 (CMS-R-308).

E. Submission of PRA-Related Comments

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

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS' website at

www.cms.hhs.gov/Paperwork@cms.hhs.gov, or call the Reports Clearance Office at 410–786–1326.

We invite public comment on these potential information collection requirements. If you wish to comment, please submit your comments to the OMB desk officer via one of the following transmissions and identify the rule (CMS-2334-F2):

OMB, Office of Information and Regulatory Affairs

Attention: CMS Desk Officer

Fax Number: (202) 395-5806 OR

E-mail: OIRA_submission@omb.eop.gov.

PRA-related comments must be received on/by December 30, 2017.

V. Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011). Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects (\$100 million or more in any 1 year). The OMB has determined that this final rule is “economically significant” within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of \$100 million in any one year. Accordingly, we have prepared a Regulatory Impact Analysis that presents the costs and benefits of this final rule.

B. Estimated Impact of the Medicaid and CHIP Eligibility Provisions

The RIA published with the March 23, 2012, Medicaid eligibility final rule detailed the impact of the Medicaid eligibility changes related to implementation of the Affordable Care Act. The majority of provisions included in this final rule were described in that detailed RIA. It included a comparison of estimates prepared by the CMS Office of the Actuary (OACT) and the Congressional Budget Office (CBO) regarding the new Medicaid coverage groups, simplified eligibility policies for Medicaid and CHIP, streamlined eligibility and enrollment processes, and coordination of eligibility procedures with those of the Exchanges. OACT estimated that by 2016, an additional 24 million people would be enrolled in Medicaid, while CBO estimated that an additional 16 million people would be enrolled in Medicaid. Those impacts are not repeated in this section.

1. Anticipated Effects on Medicaid Enrollment

With the exception of the new eligibility groups for former foster care children and family planning, the Affordable Care Act's anticipated effects on Medicaid enrollment were described in the March 23, 2012, RIA of the final rule. The former foster care group and the family planning group were not covered in the March 23, 2012, Medicaid eligibility final rule, and therefore, were not included in the RIA for that rule. Estimates for both new groups are provided below. We note that the estimates for the family planning group were inadvertently left out of the proposed rule RIA. In addition, the estimates included in the March 23, 2012 RIA of the final rule, and those for the former foster care group and the family planning group, reference the Medicaid baseline for the FY 2013 President's Budget.

As described in Table 4, the CMS Office of the Actuary (OACT) estimates that by 2018, an additional 75,000 individuals will be enrolled in Medicaid under the new eligibility group for former foster care children. An additional 359,000 individuals will be enrolled under the family planning group with benefits limited to family planning and family planning related services.

TABLE 4: Estimated Effects of this Final Rule on Medicaid Enrollment, Fiscal Year 2016-2018 (in thousands)

Enrollment	2016	2017	2018
Former Foster Care Group	73	74	75
Family Planning Group	348	354	359

Source: CMS Office of the Actuary (OACT).

The estimates for the former foster care group were developed at the time of the passage of the Affordable Care Act. OACT used data from the Medicaid Statistical Information System (MSIS) for 2007, which was the most recent available data at that time. The MSIS data was used to calculate the number of children in foster care and enrolled in Medicaid up to age 18 (and up to age 21 in states that allowed children to remain in foster care at older ages), and to calculate the Medicaid expenditures per enrollee for adults ages 19 to 20 and 21 to 44.

The number of children in foster care and enrolled in Medicaid that would be eligible to receive Medicaid coverage was estimated to be about 190,000 in 2007. The number of potential persons eligible under this section was projected forward by the projected growth rate in the U.S. population (about 1 percent per year) to 2016 through 2018. To calculate the number of new Medicaid enrollees, OACT estimated the number of persons who would not be new Medicaid enrollees because they either would already have been enrolled in Medicaid (as they would have been eligible under paragraphs (I) through (VIII)) or would decline to enroll in Medicaid (which would include those who would have other forms of coverage, such as employer-sponsored insurance, or would otherwise not enroll in Medicaid). After these adjustments, OACT estimated that there would be about 55,000 new enrollees (on a person-year equivalent basis) for FY 2014 (which would include 9 months of eligibility) and about 75,000 new enrollees by FY 2018.

In projecting the new population that would be served under the family planning group, OACT used data available from Pennsylvania, allowing for assumptions about the number of states that would elect to cover this group and the proportion of the population those states that would seek coverage and would meet the income guidelines. These enrollment estimates also allow for a phase-in period. OACT notes that any enrollment estimates are inherently uncertain, since they depend on future economic, demographic, and other factors that cannot be precisely determined in advance. Moreover, the actual behavior of individuals and the actual operation of the new enrollment processes and Exchanges could differ from OACT's assumptions.

The net increase in enrollment in the Medicaid program and the resulting reduction in the number of uninsured individuals will produce several benefits. For new enrollees, eligibility for Medicaid will improve access to medical care. Evidence suggests that improved access to medical care will result in improved health outcomes and greater financial security for these individuals and families. Evidence on how Medicaid coverage affects medical care utilization, health, and financial security comes from a recent evaluation of an expansion of Oregon's Medicaid program.¹ In 2008, Oregon conducted a lottery to expand access to uninsured adults with incomes below 100 percent of the FPL. Approximately 10,000 low-income adults were newly enrolled in Medicaid as a result. The evaluation is particularly strong because it was able to compare outcomes for those who won the lottery with outcomes for those who did not win, and contains an estimate of the benefits of Medicaid coverage. The evaluation concluded that those enrolled in Medicaid had "substantial and statistically significantly higher health care utilization, lower out-of-pocket medical expenditures and medical debt, and better self-reported health."

While there are limitations on the ability to extrapolate from these results to the likely

¹ Amy Finkelstein & Sarah Taubman & Bill Wright & Mira Bernstein & Jonathan Gruber & Joseph P. Newhouse & Heidi Allen & Katherine Baicker, 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year," *The Quarterly Journal of Economics*, Oxford University Press, vol. 127(3), pages 1057-1106.

impacts of the Affordable Care Act's expansion of Medicaid coverage, these results provide evidence of health and financial benefits associated with coverage expansions for a population of non-elderly adults.

The results of the Oregon study are consistent with prior research, which has found that health insurance coverage improves health outcomes. The Institute of Medicine (2002) analyzed several population studies and found that people under the age 65 who were uninsured faced a 25 percent higher risk of mortality than those with private coverage. This pattern was found when comparing deaths of uninsured and insured patients from heart attack, cancer, traumatic injury, and Human immunodeficiency virus (HIV) infection.² The Institute of Medicine also concluded that having insurance leads to better clinical outcomes for diabetes, cardiovascular disease, end-stage renal disease, HIV infection and mental illness, and that uninsured adults were less likely to have regular checkups, recommended health screening services and a usual source of care to help manage their disease than a person with coverage. Other research has found that birth outcomes for women covered by Medicaid are not different than those achieved for privately insured patients, adjusting for risk variables.³

In addition to being able to seek treatment for illnesses when they arise, Medicaid beneficiaries will be able to more easily obtain preventive care, which will help maintain and improve their health. Research demonstrates that when uninsured individuals obtain coverage (including Medicaid), the rate at which they obtain needed care increases substantially.^{4 5 6}

Having health insurance also provides significant financial security. Comprehensive health

2 Institute of Medicine, *Care without coverage: too little, too late* (National Academies Press, 2002).

3 E. A. Anum, et al, "Medicaid and Preterm Birth and Low Birth Weight: The Last Two Decades" *Journal of Women's Health* Vol. 19 (November 2010).

4 S.K. Long, et al., "How well does Medicaid work in improving access to care?" *HSR: Health Services Research* 40:1 (February 2005).

5 Henry J. Kaiser Family Foundation, "Children's Health—Why Health Insurance Matters." Washington, DC: KFF, 2002.

6 C. Keane, et al., "The impact of Children's Health Insurance Program by age," *Pediatrics* 104:5 (1999).

insurance coverage provides a safety net against the potentially high cost of medical care, and the presence of health insurance can mitigate financial risk. The Oregon study found people who gained coverage were less likely to have unpaid medical bills referred to a collection agency. Again, this study is consistent with prior research showing the high level of financial insecurity associated with lack of insurance coverage. Some recent research indicates that illness and medical bills contribute to a large and increasing share of bankruptcies in the United States.⁷ Another recent analysis found that more than 30 percent of the uninsured report having zero (or negative) financial assets and uninsured families at the 90th percentile of the asset distribution report having total financial assets below \$13,000 – an amount that can be quickly depleted with a single hospitalization.⁸ Other research indicates that uninsured individuals who experience illness suffer on average a loss of 30 to 50 percent of assets relative to households with insured individuals.⁹

2. Anticipated Effects on States

The major state impacts from this final rule were covered in the RIA of the March 23, 2012, Medicaid eligibility final rule. However, OACT estimates that state expenditures on behalf of the additional individuals gaining Medicaid coverage as a result of the establishment of the new eligibility group for former foster care children and the new eligibility group for family planning coverage will total \$51 million in FY 2016 and \$162 million over 3 years (2016-2018), as described in Table 5.

7 D.U. Himmelstein, et al., "Medical bankruptcy in the United States, 2007: Results of a National Study," The American Journal of Medicine 122 no. 8, (2009).

8 ASPE. The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills. (2011).

9 Cook, K. et al., "Does major illness cause financial catastrophe?," Health Services Research 45, no. 2 (2010).

**TABLE 5: Estimated State Budgetary Effects of Increased Medicaid Benefit Spending
FY 2016-2018 (in millions of dollars)**

Net Effect on Medicaid Benefit Spending	2016	2017	2018	2016-2018
Former Foster Care Group	109	117	125	351
Family Planning Group	-58	-63	-68	-189
Total	51	54	57	162

Source: CMS Office of the Actuary.

In developing the estimates for the former foster care group, per enrollee costs were first estimated by calculating the per enrollee costs for adults ages 19 to 20 and 21 to 44 from the 2007 MSIS data; OACT assumed that the new enrollees under this section of the law would have similar costs. The costs were projected forward to 2016 through 2018 using the projected growth rate of Medicaid expenditures per enrollee for adults in the Mid-Session Review of the President's FY 2010 Budget (which was the basis for the estimates used by OACT to estimate the impacts of the Affordable Care Act). The average per enrollee costs for these enrollees were projected to be about \$3,000 in 2014 and about \$3,900 in 2018. The total costs for these new enrollees were calculated by multiplying the projected number of enrollees by the projected expenditures per enrollee for each year. The federal costs, which are discussed below, were calculated by multiplying the total costs by the average federal share of Medicaid expenditures (about 57 percent).

The costs of the family planning group are based on data available from Pennsylvania. Utilizing this data, OACT projected the cost of the program providing family planning services, as well as savings from reduced delivery costs and infant care services.

These cost estimates do not take into account the reduced administrative burden which will result from simplifying Medicaid and CHIP eligibility policies, such as by eliminating

obsolete and unnecessary eligibility groups and establishing streamlined verification procedures and notice and appeals processes. The coordination of Medicaid and CHIP eligibility policy and processes with those of the new Exchanges, including processes to allow for consistency in the provision of notices and appeal rights, and the movement to simplify verification processes with less reliance on paper documentation should all result in a Medicaid eligibility system that is far easier for states to administer than Medicaid's current, more complex system. These changes could generate administrative savings and increase efficiency. The new system through which states will verify certain information with other federal agencies, such as income data from the IRS, will also relieve state Medicaid agencies of some current responsibilities, creating further efficiencies for the states. Currently more than 40 states use an electronic data match with the SSA in lieu of requiring paper documentation, and many states have found savings from this electronic verification process. In addition, the option to provide electronic notices, combined with coordination of notice processes among all insurance affordability programs, may improve consumer access to information while decreasing burden and costs to the states.

These administrative simplifications are expected to lower state administrative costs, although we expect that states may incur short term increases in administrative costs (depending on their current systems and practices) as they implement these changes. States that elect new options finalized in this rule with respect to eligibility for deemed newborns (§§435.117 or 457.360), former foster care youth (§435.150), or family planning (§435.214), and those states that elect to apply MAGI-based methods when determining eligibility for medically needy children, pregnant women, and parents will need to submit a state plan amendment (SPA) to formalize those elections. Submission of a new SPA would result in minimal administrative costs for personnel to prepare the SPA submission and respond to questions, as described in section IV, Collection of Information Requirements. However, election of certain options, such as the

application of MAGI-based methods for the medically needy will also result in simplification of the application and enrollment process, which may result in future cost savings. Implementation of the electronic SPA submission process is expected to result in additional administrative simplification once fully implemented, though during the initial phase-in states will incur both administrative costs and staff training costs to complete the transition. The extent of these initial costs will depend on current state policy and practices. As described in section IV of this final rule, the estimated cost for all states is \$175,000 per year for 3 years.

Federal support is available for administrative costs and to help states finance system modifications. Notably, in previous rulemaking, we increased federal funding to states to better support state efforts to develop significantly upgraded eligibility and enrollment systems. To anticipate and support these efforts, we published the “Federal Funding for Medicaid Eligibility Determination and Enrollment Activities” final rule (75 FR 21950) in the April 19, 2011, Federal Register. That rule amended the definition of Mechanized Claims Processing and Information Retrieval Systems to include systems used for eligibility determination, enrollment, and eligibility reporting activities by Medicaid, and made this work eligible for enhanced funding with a federal matching rate of 90 percent for development and 75 percent for ongoing maintenance and operations costs. Systems must meet certain standards and conditions to qualify for the enhanced match.

3. Anticipated Effects on Providers

As expansion and simplification of Medicaid and CHIP eligibility could result in more individuals obtaining health insurance coverage, health centers, hospitals, clinics, physicians, and other providers are likely to experience a significant increase in their insured patient volume. We expect providers that serve a substantial share of the low-income population to realize the most substantial increase in insured patients. Providers, such as hospitals that serve a low-income

population, may financially benefit from having a higher insured patient population and providing less uncompensated care, and the establishment of a PE option for hospitals will further simplify access to coverage for patients. In addition, we expect continuity of coverage to improve providers' ability to maintain their relationship with patients and to reduce provider administrative burdens such as time spent helping patients to access information on coverage options and to apply for Medicaid or CHIP.

The improved financial security provided by health insurance also helps ensure that patients can pay their medical bills. The Oregon study found that coverage significantly reduces the level of unpaid medical bills sent to a collection agency.¹⁰ Most of these bills are never paid, so this reduction in unpaid bills means that one of the important effects of expanded health insurance coverage, such as the coverage that will be provided through the Exchanges, is a reduction in the level of uncompensated care provided.

Because the majority of individuals gaining coverage under this provision are likely to have been previously uninsured, we do not anticipate that the provisions of this final rule will impose new costs on providers. Medicaid generally reimburses providers at a lower rate than employer-sponsored health insurance or other forms of private health insurance. For the minority of individuals who become eligible for Medicaid under this provision who are currently covered by employer-sponsored health insurance, there is thus a possibility that their providers may experience lower payment rates. Conversely, Medicaid generally reimburses federally qualified health centers at a higher rate than employer-sponsored insurance and many new Medicaid enrollees may seek treatment in this setting, which will increase payment to these providers. At the same time, the increased federal financial support for Medicaid, the growth in Medicaid enrollment, and the potential that many plans will operate in both the Exchange and in Medicaid

10 A. Finkelstein, et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research Working Paper Series No. 17190(2011).

may result in states electing to increase Medicaid payment rates to providers.¹¹

4. Anticipated Effects on Federal Budget

Table 6 presents estimates of the federal budget effect of this final rule beyond the impact provided in the March 23, 2012, Medicaid eligibility final rule RIA. The federal financial impact of proposed changes to CHIP will be small; as CHIP expenditures are capped under current law, any increases in spending could be expected to be offset by less available funding in the future. The costs provided below are primarily attributable to the impact of the eligibility groups for former foster care children and family planning on net federal spending for Medicaid benefits. The impact of other Affordable Care Act provisions was detailed in the prior Medicaid eligibility final rule RIA. As a result of the establishment of the eligibility group for former foster care children and the new eligibility group covering family planning, OACT estimates an increase in net federal spending on Medicaid benefits for the period FY 2016 and later, with the increase estimated to be about \$135 million in 2016 and about \$429 million over the 3-year period from FY 2016 through 2018. The family planning group generates cost savings to both state and federal government because the cost of providing Medicaid-covered, pregnancy-related care is much larger than the cost of providing contraceptive services.

TABLE 6: Estimated Net Increase in Federal Medicaid Benefit Spending, FY 2016-2018 (in millions of dollars)

Net Effect on Medicaid Benefit Spending	2016	2017	2018	2016-2018
Former Foster Care Group	144	155	166	465
Family Planning Group	-9	-12	-15	-36
Total	135	143	151	429

11 D. Bachrach, et al., "Medicaid's role in the Health Benefits Exchange: A road map for States," A Maximizing Enrollment Report, National Academy for State Health Policy and Robert Wood Johnson Foundation (March 2011). Available online at <http://www.nashp.org/sites/default/files/maxenroll%20Bachrach%20033011.pdf>.

Source: CMS Office of the Actuary.

C. Alternatives Considered

The majority of Medicaid and CHIP eligibility provisions proposed in this rule serve to implement the Affordable Care Act. All of the provisions in this final rule are a result of the passage of the Affordable Care Act and are largely self-implementing. Therefore, alternatives considered for this final rule were constrained due to the statutory provisions.

In developing this final rule, we considered alternatives to some of the simplified eligibility policies proposed here, as well as to the streamlined, coordinated process and eligibility policies this rule established between Medicaid, the Exchange, and other insurance affordability programs. One alternative was to allow Medicaid agencies to provide notices to individuals independently of the notices provided by other insurance affordability programs. This option would allow states to maintain current Medicaid notice practices, but could result in multiple communications from different entities regarding each individual's eligibility determination process. This could create significant confusion for applicants and beneficiaries. Another alternative was to consolidate all notice responsibilities within the Exchanges and require one clear line of communication between applicants and the entities determining eligibility for insurance affordability programs. However, this would reduce state flexibility relative to the flexibility already offered in the prior Medicaid eligibility rule and would mandate significant coordination among insurance affordability programs that could stretch beyond just the provision of notices.

We considered several alternatives related to appeals. For example, we initially proposed an "auto-appeal" provision such that a request for a fair hearing related to eligibility for premium tax credits would trigger a Medicaid appeal. However, we determined that this policy would likely result in a substantial increase in the volume of Medicaid fair hearing requests heard by state agencies, including for many individuals not interested in appealing their Medicaid

determinations. In establishing requirements for an expedited review process, we considered several different timeframes including 3, 5, and 7 days, which would ensure adequate consumer protections for applicants and beneficiaries with urgent health care needs. Balancing the needs of the consumer with the operational challenges in implementing an expedited review process, we are finalizing a timeframe of 7 working days (with a delayed effective date) for eligibility appeals under §431.244(f)(3)(i) of this final rule, while having a 3 working day timeframe for benefits and services appeals. However, in the notice of proposed rule making published concurrently with this final rule, we are requesting comment on the 3 and 5 day timeframes for eligibility appeals.

D. Limitations of the Analysis

A number of challenges face estimators in projecting Medicaid and CHIP benefits and costs under the Affordable Care Act and the final rule. Health care cost growth is difficult to project, especially for people who are currently not in the health care system – the population targeted for the Medicaid eligibility changes. Such individuals could have pent-up demand and thus have costs that may be initially higher than other Medicaid enrollees, while they might also have better health status than those who have found a way (for example, “spent down”) to enroll in Medicaid.

There is also considerable uncertainty about behavioral responses to the Medicaid and CHIP changes. Individuals’ participation rates are particularly uncertain. Medicaid participation rates for people already eligible tend to be relatively low (estimates range from 75 to 86 percent), despite the fact that there are typically no premiums and low to no cost sharing for comprehensive services. It is not clear how the proposed changes will affect those already eligible, or the interest in participating for those newly eligible, as previously described.

E. Accounting Statement

As required by OMB Circular A-4 (available at

http://www.whitehouse.gov/omb/circulars_a004_a-4/), in Table 7 we have prepared an accounting statement table showing the classification of the impacts associated with implementation of this final rule. Consistent with standard practice, we show all direct effects as transfer payments.

TABLE 7: Accounting Statement: Classification of Estimated Net Costs, from FY 2016 to FY 2018 (in millions)

Category	Estimate	Year dollar	Discount rate	Period Covered
Annualized Monetized Transfers from Federal Government to States on Behalf of Beneficiaries	143	2016	7%	2016-2018
	143	2016	3%	2016-2018
Annualized Monetized Transfers from States on Behalf of Beneficiaries	54	2016	7%	2016-2018
	54	2016	3%	2016-2018

F. Regulatory Flexibility Analysis

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the final rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act generally defines a “small entity” as: (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.” HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

For the purposes of the regulatory flexibility analysis, we do not expect small entities to be directly affected by this final rule. The additional options for Medicaid eligibility and streamlined

eligibility and enrollment processes finalized in this rule are expected to improve access to coverage, which would be likely to have a positive indirect impact on small entities.

Additionally, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final rule may have a significant economic 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 of a metropolitan statistical area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this final rule will not have a direct economic impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2016, the threshold level is approximately \$146 million. This final rule does not mandate expenditures by state governments, local governments, tribal governments, in the aggregate, or the private sector, of \$146 million. The majority of state, local, and private sector costs related to implementation of the Affordable Care Act were described in the RIA accompanying the March 23, 2012 Medicaid eligibility final rule

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a final rule that imposes substantial direct effects on states, preempts state law, or otherwise has federalism implications. We wish to note again that the impact of changes related to

implementation of the Affordable Care Act were described in the RIA of the March 23, 2012, Medicaid eligibility final rule. As discussed in the March 23, 2012 RIA, we have consulted with states to receive input on how the various Affordable Care Act provisions codified in this final rule will affect states. We continue to engage in ongoing consultations with Medicaid and CHIP Technical Advisory Groups (TAGs), which have been in place for many years and serve as a staff level policy and technical exchange of information between CMS and the states. Through consultations with these TAGs, we have been able to get input from states specific to issues surrounding the changes in eligibility groups and rules that became effective in 2014. In accordance to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, the Department certifies that CMS has complied with the requirements of Executive Order 13132 for the attached proposed regulation in a meaningful and timely manner.

I. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the federal agency issuing the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects42 CFR Part 407

Supplemental medical insurance (SMI) enrollment and entitlement.

42 CFR Part 430

Administrative practice and procedure, Grant programs-health, Medicaid Reporting and recordkeeping requirements.

42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 433

Administrative practice and procedure, Child support Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 407—SUPPLEMENTAL MEDICAL INSURANCE (SMI) ENROLLMENT AND ENTITLEMENT

1. The authority citation for part 407 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 407.42 is amended by revising paragraph (a)(5) to read as follows:

§407.42 Buy-in groups available to the 50 States, the District of Columbia, and the Northern Mariana Islands.

(a) * * *

(5) Category E: Individuals who, in accordance with §435.134 of this chapter, are covered under the State's Medicaid plan despite the increase in social security benefits provided by Pub. L. 92-336.

* * * * *

PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

3. The authority citation for part 430 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

4. Section 430.12 is amended by revising paragraph (a) to read as follows:

§430.12 Submittal of State plans and plan amendments.

(a) Format. A State plan for Medicaid consists of a standardized template, issued and updated by CMS, that includes both basic requirements and individualized content that reflects the characteristics of the State's program. The Secretary will periodically update the template and format specifications for State plans and plan amendments through a process consistent with the requirements of the Paperwork Reduction Act.

* * * * *

PART 431--STATE ORGANIZATION AND GENERAL ADMINISTRATION

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

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

6. Section 431.200 is amended by adding paragraph (d) to read as follows:

§431.200 Basis and scope.

* * * * *

(d) Implements section 1943(b)(3) of the Act and section 1413 of the Affordable Care Act to permit coordinated hearings and appeals among insurance affordability programs.

7. Section 431.201 is amended by --

- a. Revising the definition of “Action”; and
- b. Adding the definitions of “Joint fair hearing request” and “Local evidentiary hearing”

in alphabetical order.

The revision and additions to read as follows:

§431.201 Definitions.

* * * * *

Action means a termination, suspension of, or reduction in covered benefits or services, or a termination, suspension of, or reduction in Medicaid eligibility or an increase in beneficiary liability, including a determination that a beneficiary must incur a greater amount of medical expenses in order to establish income eligibility in accordance with §435.121(e)(4) or §435.831 of this chapter or is subject to an increase in premiums or cost-sharing charges under subpart A of part 447 of this chapter. It also means a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident and an adverse determination by a State with regard to the preadmission screening and resident review requirements of section 1919(e)(7) of the Act.

* * * * *

Joint fair hearing request means a request for a Medicaid fair hearing which is included in an appeal request submitted to an Exchange or Exchange appeals entity under 45 CFR 155.520 or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in §435.1200(b)(3) of this chapter .

Local evidentiary hearing means a hearing held on the local or county level serving a specified portion of the State.

* * * * *

8. Section 431.205 is amended by adding paragraphs (e) and (f) to read as follows:

§431.205 Provision of hearing system.

* * * * *

(e) The hearing system must be accessible to persons who are limited English proficient and persons who have disabilities, consistent with §435.905(b) of this chapter.

(f) The hearing system must comply with the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act and implementing regulations.

9. Section 431.206 is amended by--

a. Revising paragraphs (b)(1), (c)(2), and (e).

b. Adding paragraph (b)(4).

c. Removing “and” at the end of paragraph (b)(2) and removing the period at the end of paragraph (b)(3) and adding in its place “; and” .

The revisions and addition read as follows:

§431.206 Informing applicants and beneficiaries.

* * * * *

(b) * * *

(1) Of his or her right to a fair hearing and right to request an expedited fair hearing;

* * * * *

(4) Of the time frames in which the agency must take final administrative action, in accordance with §431.244(f).

(c) * * *

(2) At the time the agency denies an individual’s claim for eligibility, benefits or services; or denies a request for exemption from mandatory enrollment in an Alternative Benefit Plan; or takes other action, as defined at §431.201; or whenever a hearing is otherwise required in accordance with §431.220(a);

* * * * *

(e) The information required under this subpart must be accessible to individuals who are limited English proficient and to individuals with disabilities, consistent with §435.905(b) of this chapter, and may be provided in electronic format in accordance with §435.918 of this chapter.

10. Section 431.210 is amended by revising paragraphs (a), (b), and (d)(1) to read as follows:

§431.210 Content of notice.

* * * * *

(a) A statement of what action the agency, skilled nursing facility, or nursing facility intends to take and the effective date of such action;

(b) A clear statement of the specific reasons supporting the intended action;

* * * * *

(d) * * *

(1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or

* * * * *

11. Section 431.220 is amended by --

- a. Revising paragraph (a)(1).
- b. Removing paragraph (a)(2).
- c. Redesignating paragraphs (a)(3) through (7), as paragraphs (a)(2) through (6)

respectively.

The revision reads as follows:

§431.220 When a hearing is required.

(a) * * *

(1) Any individual who requests it because he or she believes the agency has taken an action erroneously, denied his or her claim for eligibility or for covered benefits or services, or issued a determination of an individual’s liability, or has not acted upon the claim with reasonable promptness including, if applicable –

- (i) An initial or subsequent decision regarding eligibility;
- (ii) A determination of the amount of medical expenses that an individual must incur in order to establish eligibility in accordance with §435.121(e)(4) or §435.831 of this chapter; or
- (iii) A determination of the amount of premiums and cost sharing charges under subpart A of part 447 of this chapter;
- (iv) A change in the amount or type of benefits or services; or
- (v) A request for exemption from mandatory enrollment in an Alternative Benefit Plan.

* * * * *

12. Section 431.221 is amended by revising paragraph (a) to read as follows:

§431.221 Request for hearing.

(a)(1) The agency must establish procedures that permit an individual, or an authorized representative as defined at §435.923 of this chapter, to –

(i) Submit a hearing request via any of the modalities described in §435.907(a) of this chapter, except that the requirement to establish procedures for submission of a fair hearing request described in §435.907(a)(1), (2) and (5) of this chapter (relating to submissions via Internet website, telephone and other electronic means) is effective no later than the date described in §435.1200(i) of this chapter; and

(ii) Include in a hearing request submitted under paragraph (a)(1)(i) of this section, a request for an expedited fair hearing.

(2) [Reserved]

* * * * *

13. Section 431.223 is amended by revising paragraph (a) to read as follows:

§431.223 Denial or dismissal of request for a hearing.

* * * * *

(a) The applicant or beneficiary withdraws the request. The agency must accept withdrawal of a fair hearing request via any of the modalities available per §431.221(a)(1)(i). For telephonic hearing withdrawals, the agency must record the individual’s statement and telephonic signature. For telephonic, online and other electronic withdrawals, the agency must send the affected individual written confirmation, via regular mail or electronic notification in accordance with the individual’s election under §435.918(a) of this chapter.

* * * * *

14. Section 431.224 is added to read as follows:

§431.224 Expedited appeals.

(a) General rule. (1) The agency must establish and maintain an expedited fair hearing process for individuals to request an expedited fair hearing, if the agency determines that the time otherwise permitted for a hearing under §431.244 (f)(1) could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.

(2) The agency must take final administrative action within the period of time permitted under §431.244(f)(3) if the agency determines that the individual meets the criteria for an expedited fair hearing in paragraph (a)(1) of this section.

(b) Notice. The agency must notify the individual whether the request is granted or denied as expeditiously as possible. Such notice must be provided orally or through electronic means in accordance with §435.918 of this chapter, if consistent with the individual's election under such section; if oral notice is provided, the agency must follow up with written notice, which may be through electronic means if consistent with the individual's election under §435.918.

15. Section 431.232 is amended by revising paragraph (b) to read as follows:

§431.232 Adverse decision of local evidentiary hearing.

* * * * *

(b) Inform the applicant or beneficiary in writing that he or she has a right to appeal the decision to the State agency within 10 days after the individual receives the notice of the adverse decision. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice within the 5-day period; and

* * * * *

16. Section 431.241 is amended by--

- a. Revising paragraph (a);
- b. Removing paragraph (b); and
- c. Redesignating paragraphs (c) and (d) as paragraphs (b) and (c), respectively.

The revision reads as follows:

§431.241 Matters to be considered at the hearing.

* * * * *

(a) Any matter described in §431.220(a)(1) for which an individual requests a fair hearing.

* * * * *

17. Section 431.242 is amended by revising paragraph (a)(1) and adding paragraph (f) to read as follows:

§431.242 Procedural rights of the applicant or beneficiary.

* * * * *

(a) * * *

(1) The content of the applicant’s or beneficiary’s case file and electronic account, as defined in §435.4 of this chapter; and

* * * * *

(f) Request an expedited fair hearing.

18. Section 431.244 is amended by revising paragraph (f)(1) and adding paragraphs (f)(3) and (4) to read as follows:

§431.244 Hearing decisions.

* * * * *

(f) * * *

(1) Ordinarily, within 90 days from:

(i) The date the enrollee filed an MCO, PIHP, or PAHP appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing; or

(ii) For all other fair hearings, the date the agency receives a request for a fair hearing in accordance with §431.221(a)(1).

* * * * *

(3) In the case of individuals granted an expedited fair hearing in accordance with §431.224(a) –

(i) For a claim related to eligibility described in §431.220(a)(1), or any claim described in §431.220(a)(2) (relating to a nursing facility) or §431.220(a)(3) (related to preadmission and annual resident review), as expeditiously as possible and, effective no later than the date described in §435.1200(i) of this chapter, no later than 7 working days after the agency receives a request for expedited fair hearing; or

(ii) For a claim related to services or benefits described in §431.220(a)(1) as expeditiously as possible and, effective no later than the date described in §435.1200(i) of this chapter, within the time frame in paragraph (f)(2) of this section.

(iii) For a claim related to services or benefits described in §431.220(a) (4), (5) or (6), in accordance with the time frame in paragraph (f)(2) of this section.

(4)(i) The agency must take final administrative action on a fair hearing request within the time limits set forth in this paragraph except in unusual circumstances when —

(A) The agency cannot reach a decision because the appellant requests a delay or fails to take a required action; or

(B) There is an administrative or other emergency beyond the agency's control.

(ii) The agency must document the reasons for any delay in the appellant’s record.

* * * * *

PART 433--STATE FISCAL ADMINISTRATION

19. The authority citation for part 433 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

20. Section 433.138 is amended by revising paragraphs (d)(1) introductory text, (d)(3), (f), and (g)(1)(i) to read as follows:

§433.138 Identifying liable third parties.

* * * * *

(d) * * *

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under §435.945 of this chapter, from the State wage information collection agency (SWICA) defined in §435.4 of this chapter and from the SSA wage and earnings files data as specified in §435.948(a)(1) of this chapter, the agency must—

* * * * *

(3) The agency must request, as required under §435.948(a)(2) of this chapter, from the State title IV-A agency, information not previously reported that identifies those Medicaid beneficiaries who are employed and their employer(s).

* * * * *

(f) Data exchanges and trauma code edits: Frequency. Except as provided in paragraph (1) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (3) of this section, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) * * *

(1) * * *

(i) Within 45 days, the agency must follow up (if appropriate) on such information to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f); and

* * * * *

21. Section 433.145 is amended by revising paragraph (a)(2) to read as follows:

§433.145 Assignment of rights to benefits—State plan requirements.

(a) * * *

(2) Cooperate with the agency in establishing the identity of a child’s parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in §435.116 of this chapter (pregnant women), who are exempt from cooperating in establishing the identity of a child’s parents and obtaining medical support and payments from, or derived from, the non-custodial parent of a child; and

* * * * *

22. Section 433.147 is amended by revising the section heading and paragraphs (a)(1) and (c)(1) and by removing paragraph (d).

The revisions read as follows:

§433.147 Cooperation in establishing the identity of a child’s parents and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be liable to pay.

(a) * * *

(1) Except as exempt under §433.145(a)(2), establishing the identity of a child’s parents and obtaining medical support and payments for himself or herself and any other person for

whom the individual can legally assign rights; and

* * * * *

(c) * * *

(1) For establishing the identity of a child’s parents or obtaining medical care support and payments, or identifying or providing information to assist the State in pursuing any liable third party for a child for whom the individual can legally assign rights, the agency must find that cooperation is against the best interests of the child.

* * * * *

23. Section 433.148 is amended by revising paragraph (a)(2) to read as follows:

§433.148 Denial or termination of eligibility.

* * * * *

(a) * * *

(2) In the case of an applicant, does not attest to willingness to cooperate, and in the case of a beneficiary, refuses to cooperate in establishing the identity of a child’s parents, obtaining medical child support and pursuing liable third parties, as required under §433.147(a) unless cooperation has been waived;

* * * * *

24. Section 433.152 is amended by revising paragraph (b) to read as follows:

§433.152 Requirements for cooperative agreements for third party collections.

* * * * *

(b) Agreements with title IV-D agencies must specify that the Medicaid agency will provide reimbursement to the IV-D agency only for those child support services performed that are not reimbursable by the Office of Child Support Enforcement under title IV-D of the Act and that are necessary for the collection of amounts for the Medicaid program.

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

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

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

26. Section 435.3(a) is amended by –

a. Adding entries for “1902(a)(46)(B),” “1902(ee),” and “1905(a)” in numerical order;

and

b. Revising 1903(v).

The revisions and additions read as follows:

§435.3 Basis.

(a) * * *

1902(a)(46)(B) Requirement to verify citizenship.

* * * * *

1902(ee) Option to verify citizenship through electronic data sharing with the Social Security Administration.

* * * * *

1903(v) Payment for emergency services under Medicaid provided to non-citizens.

* * * * *

1905(a) Definition of medical assistance.

* * * * *

27. Section 435.4 is amended by—

a. Adding the definitions of “Citizenship”, “Combined eligibility notice”, and “Coordinated content” in alphabetical order;

b. Revising the definition of “Electronic account”; and

c. Adding the definitions of “Non-citizen”, and “Qualified non-citizen” in alphabetical order.

The revision and additions read as follows:

§435.4 Definitions and use of terms.

* * * * *

Citizenship includes status as a “national of the United States,” and includes both citizens of the United States and non-citizen nationals of the United States described in 8 U.S.C. 1101(a)(22).

Combined eligibility notice means an eligibility notice that informs an individual or multiple family members of a household of eligibility for each of the insurance affordability programs and enrollment in a qualified health plan through the Exchange, for which a determination or denial of eligibility was made, as well as any right to request a fair hearing or appeal related to the determination made for each program. A combined notice must meet the requirements of §435.917(a) and contain the content described in §435.917(b) and (c), except that information described in §435.917(b)(1)(iii) and (iv) may be included in a combined notice issued by another insurance affordability program or in a supplemental notice provided by the agency. A combined eligibility notice must be issued in accordance with the agreement(s) consummated by the agency in accordance with §435.1200(b)(3).

Coordinated content means information included in an eligibility notice regarding, if applicable –

(1) The transfer of an individual’s or household’s electronic account to another insurance affordability program;

(2) Any notice sent by the agency to another insurance affordability program regarding an individual’s eligibility for Medicaid;

(3) The potential impact, if any, of –

(i) The agency’s determination of eligibility or ineligibility for Medicaid on eligibility for another insurance affordability program; or

(ii) A determination of eligibility for, or enrollment in, another insurance affordability program on an individual’s eligibility for Medicaid; and

(4) The status of household members on the same application or renewal form whose eligibility is not yet determined.

* * * * *

Electronic account means an electronic file that includes all information collected and generated by the agency regarding each individual’s Medicaid eligibility and enrollment, including all documentation required under §435.914 and including any information collected or generated as part of a fair hearing process conducted under subpart E of this part, the Exchange appeals process conducted under 45 CFR part 155, Subpart F or other insurance affordability program appeals process.

* * * * *

Non-citizen has the same meaning as the term “alien,” as defined at 8 U.S.C. 1101(a)(3) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).

* * * * *

Qualified non-citizen includes the term “qualified alien” as defined at 8 U.S.C. 1641(b) and (c).

* * * * *

§435.113 [Removed]

28. Section 435.113 is removed.

§435.114 [Removed]

29. Section 435.114 is removed.

30. Section 435.115 is revised to read as follows:

§435.115 Families with Medicaid eligibility extended because of increased collection of spousal support.

(a) Basis. This section implements sections 408(a)(11)(B) and 1931(c)(1) of the Act.

(b) Eligibility. (1) The extended eligibility period is for 4 months.

(2) The agency must provide coverage during an extended eligibility period to a parent or other caretaker relative who was eligible and enrolled for Medicaid under §435.110, and any dependent child of such parent or other caretaker relative who was eligible and enrolled under §435.118, in at least 3 out of the 6 months immediately preceding the month that eligibility for the parent or other caretaker relative under §435.110 is lost due to increased collection of spousal support under title IV-D of the Act.

31. Section 435.117 is amended by—

a. Revising the section heading;

b. Revising paragraphs (a), (b), and (c); and

c. Amending paragraph (d) to add a paragraph heading.

The revisions and additions read as follows:

§435.117 Deemed newborn children.

(a) Basis. This section implements sections 1902(e)(4) and 2112(e) of the Act.

(b) Eligibility. (1) The agency must provide Medicaid to children from birth until the child's first birthday without application if, for the date of the child's birth, the child's mother was eligible for and received covered services under--

(i) The Medicaid State plan (including during a period of retroactive eligibility under §435.915) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in section 1903(v)(3) of the Act; or

(ii) The CHIP State plan as a targeted low-income pregnant woman in accordance with section 2112 of the Act, with household income at or below the income standard established by the agency under §435.118 for infants under age 1.

(2) The agency may provide coverage under this section to children from birth until the child's first birthday without application who are not described in (b)(1) of this section if, for the date of the child's birth, the child's mother was eligible for and received covered services under--

(i) The Medicaid State plan of any State (including during a period of retroactive eligibility under §435.915); or

(ii) Any of the following, provided that household income of the child's mother at the time of the child's birth is at or below the income standard established by the agency under §435.118 for infants under age 1:

(A) The State's separate CHIP State plan as a targeted low-income child;

(B) The CHIP State plan of any State as a targeted low-income pregnant woman or child;

or

(C) A Medicaid or CHIP demonstration project authorized under section 1115 of the Act.

(3) The child is deemed to have applied and been determined eligible under the Medicaid State plan effective as of the date of birth, and remains eligible regardless of changes in circumstances until the child's first birthday, unless the child dies or ceases to be a resident of the State or the child's representative requests a voluntary termination of eligibility.

(c) Medicaid identification number. (1) The Medicaid identification number of the mother serves as the child’s identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the State issues the child a separate identification number.

(2) The State must issue a separate Medicaid identification number for the child prior to the effective date of any termination of the mother’s eligibility or prior to the date of the child’s first birthday, whichever is sooner, except that the State must issue a separate Medicaid identification number in the case of a child born to a mother:

(i) Whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with §435.139 or §435.350;

(ii) Covered under the State’s separate CHIP; or

(iii) Who received Medicaid in another State on the date of birth.

(d) Renewal of eligibility.

* * * * *

32. Section 435.145 is revised to read as follows:

§435.145 Children with adoption assistance, foster care, or guardianship care under title IV-E.

(a) Basis. This section implements sections 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Act.

(b) Eligibility. The agency must provide Medicaid to individuals for whom --

(1) An adoption assistance agreement is in effect with a State or Tribe under title IV-E of the Act, regardless of whether adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or

(2) Foster care or kinship guardianship assistance maintenance payments are being made

by a State or Tribe under title IV-E of the Act.

33. Section 435.150 is added to read as follows:

§435.150 Former foster care children.

(a) Basis. This section implements section 1902(a)(10)(A)(i)(IX) of the Act.

(b) Eligibility. The agency must provide Medicaid to individuals who:

(1) Are under age 26;

(2) Are not eligible and enrolled for mandatory coverage under §§435.110 through 435.118 or §§435.120 through 435.145; and

(3) Were in foster care under the responsibility of the State or a Tribe within the State and enrolled in Medicaid under the State's Medicaid State plan or under a section 1115 demonstration project upon attaining:

(i) Age 18; or

(ii) A higher age at which the State's or such Tribe's foster care assistance ends under title IV-E of the Act.

(c) Options. At the State option, the agency may provide Medicaid to individuals who meet the requirements at paragraphs (b)(1) and (2) of this section, were in foster care under the responsibility of the State or Tribe within the State upon attaining either age described in paragraph (b)(3)(i) or (ii) of this section, and were:

(1) Enrolled in Medicaid under the State's Medicaid State plan or under a section 1115 demonstration project at some time during the period in foster care during which the individual attained such age; or

(2) Placed by the State or Tribe in another State and, while in such placement, were enrolled in the other State's Medicaid State plan or under a section 1115 demonstration project:

(i) Upon attaining either age described in paragraph (b)(3)(i) or (ii) of this section; or

(ii) At state option, at some time during the period in foster care during which the individual attained such age.

34. Section 435.170 is revised to read as follows:

§435.170 Pregnant women eligible for extended or continuous eligibility.

(a) Basis. This section implements sections 1902(e)(5) and 1902(e)(6) of the Act.

(b) Extended eligibility for pregnant women. For a pregnant woman who was eligible and enrolled under subpart B, C, or D of this part on the date her pregnancy ends, the agency must provide coverage described in paragraph (d) of this section through the last day of the month in which the 60-day postpartum period ends.

(c) Continuous eligibility for pregnant women. For a pregnant woman who was eligible and enrolled under subpart B, C, or D of this part and who, because of a change in household income, will not otherwise remain eligible, the agency must provide coverage described in paragraph (d) of this section through the last day of the month in which the 60-day post-partum period ends.

(d) Covered Services. The coverage described in this paragraph (d) consists of –

(1) Full Medicaid coverage, as described in §435.116(d)(2); or

(2) Pregnancy-related services described in §435.116(d)(3), if the agency has elected to establish an income limit under §435.116(d)(4), above which pregnant women enrolled for coverage under §435.116 receive pregnancy-related services described in §435.116(d)(3).

(e) Presumptive Eligibility. This section does not apply to pregnant women covered during a presumptive eligibility period under section 1920 of the Act.

35. Section 435.172 is added to subpart B to read as follows:

§435.172 Continuous eligibility for hospitalized children.

(a) Basis. This section implements section 1902(e)(7) of the Act.

(b) Requirement. The agency must provide Medicaid to an individual eligible and enrolled under §435.118 until the end of an inpatient stay for which inpatient services are furnished, if the individual:

- (1) Was receiving inpatient services covered by Medicaid on the date the individual is no longer eligible under §435.118 based on the child’s age; and
- (2) Would remain eligible but for attaining such age.

36. Section 435.201 is amended by—

- a. Amending paragraph (a)(4) by removing “;” and adding in its place “; and”;
- b. Revising paragraph (a)(5); and
- c. Removing paragraph (a)(6).

The revisions read as follows:

§435.201 Individuals included in optional groups.

(a) * * *

* * * * *

(5) Parents and other caretaker relatives (as defined in §435.4).

* * * * *

37. Section 435.210 is revised to read as follows:

§435.210 Optional eligibility for individuals who meet the income and resource requirements of the cash assistance programs.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(I) of the Act.

(b) Eligibility. The agency may provide Medicaid to any group or groups of individuals specified in §435.201(a)(1) through (3) who meet the income and resource requirements of SSI or an optional State supplement program in States that provide Medicaid to optional State supplement recipients.

38. Section 435.211 is revised to read as follows:

§435.211 Optional eligibility for individuals who would be eligible for cash assistance if they were not in medical institutions.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(IV) of the Act.

(b) Eligibility. The agency may provide Medicaid to any group or groups of individuals specified in §435.201(a)(1) through (3) who are institutionalized in a title XIX reimbursable medical institution and who:

(1) Are ineligible for the SSI or an optional State supplement program in States that provide Medicaid to optional State supplement recipients, because of lower income standards used under the program to determine eligibility for institutionalized individuals; but

(2) Would be eligible for aid or assistance under SSI or an optional State supplement program (as specified in §435.232 or §435.234) if they were not institutionalized.

39. Section 435.213 is added to read as follows:

§435.213 Optional eligibility for individuals needing treatment for breast or cervical cancer.

(a) Basis. This section implements sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals who –

(1) Are under age 65;

(2) Are not eligible and enrolled for mandatory coverage under the State's Medicaid State plan in accordance with subpart B of this part;

(3) Have been screened under the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP), established in accordance with the requirements of section 1504 of the Public Health Service Act, and found to need treatment

for breast or cervical cancer; and

(4) Do not otherwise have creditable coverage, as defined in section 2704(c) of the Public Health Service Act, for treatment of the individual's breast or cervical cancer. An individual is not considered to have creditable coverage just because the individual may:

(i) Receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian organization; or

(ii) Obtain health insurance coverage after a waiting period of uninsurance.

(c) Need for treatment. An individual is considered to need treatment for breast or cervical cancer if the initial screen under BCCEDP or, subsequent to the initial period of eligibility, the individual's treating health professional determines that:

(1) Definitive treatment for breast or cervical cancer is needed, including treatment of a precancerous condition or early stage cancer, and including diagnostic services as necessary to determine the extent and proper course of treatment; and

(2) More than routine diagnostic services or monitoring services for a precancerous breast or cervical condition are needed.

40. Section 435.214 is added to read as follows:

§435.214 Eligibility for Medicaid limited to family planning and related services.

(a) Basis. This section implements sections 1902(a)(10)(A)(ii)(XXI) and 1902(ii) and clause (XVI) in the matter following section 1902(a)(10)(G) of the Act.

(b) Eligibility. (1) The agency may provide Medicaid limited to the services described in paragraph (d) of this section to individuals (of any gender) who –

(i) Are not pregnant; and

(ii) Meet the income eligibility requirements at paragraph (c) of this section.

(2) [Reserved]

(c) Income standard. (1) The income standard established in the State plan may not exceed the higher of the income standard for pregnant women in effect under –

(i) The Medicaid State plan in accordance with §435.116.

(ii) A Medicaid demonstration under section 1115 of the Act.

(iii) The CHIP State plan under section 2112 of the Act.

(iv) A CHIP demonstration under section 1115 of the Act.

(2) The individual's household income is determined in accordance with §435.603. The agency must indicate in its State plan the options selected by it under §435.603(k).

(d) Covered services. Individuals eligible under this section are covered for family planning and family planning-related benefits as described in clause (XVI) of the matter following section 1902(a)(10)(G) of the Act.

41. Section 435.215 is added to read as follows:

§435.215 Individuals infected with tuberculosis.

(a) Basis. This section implements sections 1902(a)(10)(A)(ii)(XII) and 1902(z)(1) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals who—

(1) Are infected with tuberculosis;

(2) Are not eligible for full coverage under the State's Medicaid State plan (that is, all services which the State is required to cover under §440.210(a)(1) of this chapter and all services which it has opted to cover under §440.225 of this chapter, or which the State covers under an approved alternative benefits plan under §440.325 of this chapter), including coverage for tuberculosis treatment as elected by the State for this group; and

(3) Have household income that does not exceed the income standard established by the State in its State plan, which standard must not exceed the higher of –

(i) The maximum income standard applicable to disabled individuals for mandatory coverage under subpart B of this part; or

(ii) The effective income level for coverage of individuals infected with tuberculosis under the State plan in effect as of March 23, 2010, or December 31, 2013, if higher, converted, at State option, to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

(c) Covered Services. Individuals eligible under this section are covered for the following services related to the treatment of infection with tuberculosis:

- (1) Prescribed drugs, described in §440.120 of this chapter;
- (2) Physician's services, described in §440.50 of this chapter;
- (3) Outpatient hospital and rural health clinic described in §440.20 of this chapter, and Federally-qualified health center services;
- (4) Laboratory and x-ray services (including services to confirm the presence of the infection), described in §440.30 of this chapter;
- (5) Clinic services, described in §440.90 of this chapter;
- (6) Case management services defined in §440.169 of this chapter; and
- (7) Services other than room and board designated to encourage completion of regimens of prescribed drugs by outpatients including services to observe directly the intake of prescription drugs.

42. Section 435.220 is revised to read as follows:

§435.220 Optional eligibility for parents and other caretaker relatives.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(I) of the Act for optional eligibility of parents and other caretaker relatives as defined at §435.4.

(b) Eligibility. The agency may provide Medicaid to parents and other caretaker

relatives defined in §435.4 and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) Income standard. The income standard under this section –

(1) Must exceed the income standard established by the agency under §435.110(c); and

(2) May not exceed the higher of the State’s AFDC payment standard in effect as of July 16, 1996, or the State’s highest effective income level for eligibility of parents and other caretaker relatives in effect under the Medicaid State plan or demonstration program under section 1115 of the Act as of March 23, 2010, or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

43. Section 435.222 is revised to read as follows:

§435.222 Optional eligibility for reasonable classifications of individuals under age 21.

(a) Basis. This section implements sections 1902(a)(10)(A)(ii)(I) and (IV) of the Act for optional eligibility of individuals under age 21.

(b) Eligibility. The agency may provide Medicaid to all – or to one or more reasonable classifications, as defined in the State plan, of – individuals under age 21 (or, at State option, under age 20, 19 or 18) who have household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) Income standard. The income standard established under this section may not exceed the higher of the State’s AFDC payment standard in effect as of July 16, 1996, or the State’s highest effective income level, if any, for such individuals under the Medicaid State plan or a demonstration program under section 1115 of the Act as of March 23, 2010, or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with

guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

§435.223 [Removed]

44. Section 435.223 is removed.

45. Section 435.226 is added to read as follows:

§435.226 Optional eligibility for independent foster care adolescents.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(XVII) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20 or 19) who were in foster care under the responsibility of a State or Tribe (or, at State or Tribe option, only to such individuals for whom Federal foster care assistance under title IV-E of the Act was being provided) on the individual's 18th birthday and have household income at or below the income standard, if any, established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) Income standard. (1) The income standard established under this section may not be lower than the State's income standard established under §435.110.

(2) The State may elect to have no income standard for eligibility under this section.

46. Section 435.227 is revised to read as follows:

§435.227 Optional eligibility for individuals under age 21 who are under State adoption assistance agreements.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(VIII) 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):

(1) For whom an adoption assistance agreement (other than an agreement under title IV-E of the Act) between a State and the adoptive parent(s) is in effect;

(2) Who the State agency which entered into the adoption agreement determined could

not be placed for adoption without Medicaid coverage because the child has special needs for medical or rehabilitative care; and

(3) Who, prior to the adoption agreement being entered into –

(i) Were eligible under the Medicaid State plan of the State with the adoption assistance agreement; or

(ii) Had household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) Income standard. The income standard established under this section may not exceed the effective income level (converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act) under the State plan or under a demonstration program under section 1115 of the Act as of March 23, 2010 or December 31, 2013, whichever is higher, that was applied by the State to the household income of a child prior to the execution of an adoption assistance agreement for purposes of determining eligibility of children described in paragraphs (b)(1) and (2) of this section.

(d) Limit Eligibility The agency may limit eligibility under this section to children for whom the State, or another State identified in the State plan, has entered into an adoption assistance agreement.

47. Section 435.229 is revised to read as follows:

§435.229 Optional targeted low-income children.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(XIV) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals under age 19, or at State option within a range of ages under age 19 established in the State plan, who meet the definition of an optional targeted low-income child in §435.4 and have household income at or below the income standard established by the agency in its State plan in accordance with

paragraph (c) of this section.

(c) Income standard. The income standard established under this section may not exceed the higher of –

(1) 200 percent of the Federal poverty level (FPL);

(2) A percentage of the FPL which exceeds the State’s Medicaid applicable income level, defined at §457.10 of this chapter, by no more than 50 percentage points (converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act); and

(3) The highest effective income level for coverage of such individuals under the Medicaid State plan or demonstration program under section 1115 of the Act or for coverage of targeted low-income children, defined in §457.10 of this chapter, under the CHIP State plan or demonstration program under section 1115 of the Act, as of March 23, 2010, or December 31, 2013, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

48. Section 435.301 is amended by —

a. Removing paragraph (b)(1)(iii).

b. Redesignating paragraph (b)(1)(iv) as paragraph (b)(1)(iii); and

c. Revising paragraph (b)(2)(ii).

The revisions read as follows:

§435.301 General rules.

* * * * *

(b) * * *

(2) * * *

(ii) Parents and other caretaker relatives (§435.310).

* * * * *

49. Section 435.310 is revised to read as follows:

§435.310 Medically needy coverage of parents and other caretaker relatives.

If the agency provides Medicaid for the medically needy, it may provide Medicaid to parents and other caretaker relatives who meet:

(a) The definition of “caretaker relative” at §435.4, or are the spouse of a parent or caretaker relative; and

(b) The medically needy income and resource requirements at subpart I of this part.

§435.401 [Amended]

50. Section 435.401 is amended by removing and reserving paragraph (c)(1).

51. Section 435.406 is amended by --

- a. Revising the section heading;
- b. Revising paragraphs (a) introductory text, (a)(1) introductory text, (a)(1)(i) and (a)(1)(ii);
- c. Removing paragraphs (a)(1)(iii) and (a)(1)(iv);
- d. Redesignating paragraph (a)(1)(v) as paragraph (a)(1)(iii);
- e. Revising newly redesignated paragraph (a)(1)(iii) introductory text;
- f. Adding paragraph (a)(1)(iii)(E);
- g. In paragraph (a)(2)(i) and (ii), removing the terms “alien” and “aliens” each time they appear and adding in their place the terms “non-citizen” or “non-citizens,” as appropriate;
- h. In paragraph (a)(2)(i), removing the phrase “Qualified Alien status” and adding in its place the phrase “Qualified Non-Citizen status”;
- i. Adding paragraphs (a)(3) and (c); and
- j. In paragraph (b), removing the terms “aliens,” “qualified aliens” and “non-qualified

aliens” and adding in their place “non-citizen,” “qualified non-citizen” and “non-qualified non-citizen,” respectively.

The additions and revisions read as follows:

§435.406 Citizenship and non-citizen eligibility.

(a) The agency must provide Medicaid to otherwise eligible individuals who are--

(1) Citizens and nationals of the United States, provided that –

(i) The individual has made a declaration of United States citizenship, as defined in §435.4, or an individual described in paragraph (a)(3) of this section has made such declaration on the individual’s behalf, and such status is verified in accordance with paragraph (c) of this section; and

(ii) For purposes of the declaration and citizenship verification requirements discussed in paragraphs (a)(1)(i) of this section, an individual includes applicants under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in its expenditures.

(iii) The following groups of individuals are exempt from the requirement to provide documentation to verify citizenship in paragraph (c) of this section:

* * * * *

(E)(1) Individuals who are or were deemed eligible for Medicaid in the State under §435.117 or §457.360 of this chapter on or after July 1, 2006, based on being born to a pregnant woman eligible under the State’s Medicaid or CHIP state plan or waiver of such plan;

(2) At State option, individuals who were deemed eligible for coverage under §435.117 or §457.360 of this chapter in another State on or after July 1, 2006, provided that the agency verifies such deemed eligibility.

* * * * *

(3) For purposes of paragraphs (a)(1) and (2), of this section, a declaration of citizenship or satisfactory immigration status may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative, as defined in §435.923, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.

* * * * *

(c) The agency must verify the declaration of citizenship or satisfactory immigration status under paragraph (a)(1) or (2) of this section in accordance with §435.956.

52. Section 435.407 is revised to read as follows:

§435.407 Types of acceptable documentary evidence of citizenship.

(a) Stand-alone evidence of citizenship. The following must be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of U.S. Citizenship.

(4) A valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship, or obtains and verifies a SSN from the applicant who is a citizen before issuing such license.

(5)(i) Documentary evidence issued by a Federally recognized Indian Tribe identified in the **Federal Register** by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including Tribes located in a State that has an international border, which –

(A) Identifies the Federally recognized Indian Tribe that issued the document;

- (B) Identifies the individual by name; and
- (C) Confirms the individual's membership, enrollment, or affiliation with the Tribe.

(ii) Documents described in paragraph (a)(5)(i) of this section include, but are not limited to:

- (A) A Tribal enrollment card;
- (B) A Certificate of Degree of Indian Blood;
- (C) A Tribal census document;
- (D) Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official, that meet the requirements of paragraph (a)(5)(i) of this section.

(6) A data match with the Social Security Administration.

(b) Evidence of citizenship. If an applicant does not provide documentary evidence from the list in paragraph (a) of this section, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in paragraph (c) of this section--

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Guam, American Samoa, Swain's Island, Puerto Rico (if born on or after January 13, 1941), the Virgin Islands of the U.S. or the CNMI (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the Northern Mariana Islands before the applicable date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) Puerto Rico: Evidence of birth in Puerto Rico and the applicant's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941.

(ii) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

(A) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986, (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);

(B) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975, and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);

(C) Evidence of continuous domicile in the NMI since before January 1, 1974, and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time). Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) At State option, a cross match with a State vital statistics agency documenting a record of birth.

(3) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(4) A Report of Birth Abroad of a U.S. Citizen.

(5) A Certification of birth in the United States.

(6) A U.S. Citizen I.D. card.

(7) A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency).

(8) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth.

(9) Evidence of U.S. Civil Service employment before June 1, 1976.

(10) U.S. Military Record showing a U.S. place of birth.

(11) A data match with the SAVE Program or any other process established by DHS to verify that an individual is a citizen.

(12) Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 as amended (8 U.S.C. 1431).

(13) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(14) Life, health, or other insurance record that indicates a U.S. place of birth.

(15) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(16) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth.

(17) Federal or State census record showing U.S. citizenship or a U.S. place of birth.

(18) If the applicant does not have one of the documents listed in paragraphs (a) or (b)(1) through (17) of this section, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(c) Evidence of identity. (1) The agency must accept the following as proof of identity,

provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(i) Identity documents listed at 8 CFR 274a.2 (b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(ii) Driver's license issued by a State or Territory.

(iii) School identification card.

(iv) U.S. military card or draft record.

(v) Identification card issued by the Federal, State, or local government.

(vi) Military dependent's identification card.

(vii) U.S. Coast Guard Merchant Mariner card.

(viii) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(ix) A finding of identity from an Express Lane agency, as defined in section 1902(e)(13)(F) of the Act.

(x) Two other documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards; high school, high school equivalency and college diplomas; marriage certificates; divorce decrees; and property deeds or titles.

(2) Finding of identity from a Federal or State governmental agency. The agency may accept as proof of identity a finding of identity from a Federal agency or another State agency (not described in paragraph (c)(1)(ix) of this section), including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(3) If the applicant does not have any document specified in paragraph (c)(1) of this

section and identity is not verified under paragraph (c)(2) of this section, the agency must accept an affidavit signed, under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described in paragraph (c)(1) of this section. The affidavit does not have to be notarized.

(d) Verification of citizenship by a Federal agency or another State. The agency may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a Federal agency or another State agency, if such verification was done on or after July 1, 2006.

(e) Assistance with obtaining documentation. States must provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

(f) Documentary evidence. A photocopy, facsimile, scanned or other copy of a document must be accepted to the same extent as an original document under this section, unless information on the copy submitted is inconsistent with other information available to the agency or the agency otherwise has reason to question the validity of, or the information in, the document.

§435.510 [Removed]

53. Section 435.510 and the undesignated center heading of "Dependency" are removed.

§435.522 [Removed]

54. Section 435.522 is removed.

55. Section 435.601 is amended by--

- a. Revising paragraph (b) and (d)(1) introductory text.
- b. Removing paragraphs (d)(1)(i) and(ii); and

c. Redesignating paragraphs (d)(1)(iii) through (vi) as paragraphs (d)(1)(i) through (iv), respectively.

The revisions read as follows:

§435.601 Application of financial eligibility methodologies.

* * * * *

(b) Basic rule for use of non-MAGI financial methodologies. (1) This section only applies to individuals excepted from application of MAGI-based methods in accordance with §435.603(j).

(2) Except as specified in paragraphs (c) and (d) of this section or in §435.121 or as permitted under §435.831(b)(1), in determining financial eligibility of individuals as categorically or medically needy, the agency must apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual’s status.

* * * * *

(d) * * *

(1) At State option, and subject to the conditions of paragraphs (d)(2) through (5) of this section, the agency may apply income and resource methodologies that are less restrictive than the cash assistance methodologies or methodologies permitted under §435.831(b)(1) in determining eligibility for the following groups:

* * * * *

56. Section 435.602 is amended by--

a. Redesignating paragraph (a)(1) through (4) as paragraphs (a)(2)(i) through (iv) respectively and redesignating paragraph (a) introductory text as new paragraph (a)(2) introductory text.

- b. Adding a new paragraph (a)(1).
- c. Revising newly redesignated paragraph (a)(2)(ii).

The revisions and addition read as follows:

§435.602 Financial responsibility of relatives and other individuals.

(a) * * *

(1) This section only applies to individuals excepted from application of MAGI-based methods in accordance with §435.603(j).

(2) * * *

(ii) In relation to individuals under age 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies that apply include considering the income and resources of parents or spouses whose income and resources will be considered if the individual under age 21 were dependent under the State's approved State plan under title IV-A of the Act in effect as of July 16, 1996, whether or not they are actually contributed, except as specified under paragraph (c) of this section. These requirements and methodologies must be applied in accordance with the provisions of the State's approved title IV-A State plan as of July 16, 1996.

* * * * *

57. Section 435.603 is amended by revising paragraphs (f)(2)(i), (f)(3)(ii) and (iii), and (j)(4) and adding paragraph (k) to read as follows:

§435.603 Application of modified adjusted gross income (MAGI)

* * * * *

(f) * * *

(2) * * *

(i) Individuals other than a spouse or child who expect to be claimed as a tax dependent

by another taxpayer; and

* * * * *

(3) * * *

(ii) The individual’s children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual’s parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.

* * * * *

(j) * * *

(4) Individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group under which long-term care services and supports not covered for individuals determined eligible using MAGI-based financial methods are covered, or for individuals being evaluated for an eligibility group for which being institutionalized, meeting an institutional level of care or satisfying needs-based criteria for home and community based services is a condition of eligibility. For purposes of this paragraph, “long-term care services and supports” include nursing facility services, a level of care in any institution equivalent to nursing facility services; and home and community-based services furnished under a waiver or State plan under sections 1915 or 1115 of the Act; home health services as described in sections 1905(a)(7) of the Act and personal care services described in sections 1905(a)(24) of the Act.

* * * * *

(k) Eligibility. In the case of an individual whose eligibility is being determined under §435.214, the agency may—

(1) Consider the household to consist of only the individual for purposes of paragraph (f) of this section;

(2) Count only the MAGI-based income of the individual for purposes of paragraph (d) of this section.

(3) Increase the family size of the individual, as defined in paragraph (b) of the section, by one.

58. Section 435.610 is amended revising paragraphs (a) introductory text and (a)(2) and removing paragraph (c) to read as follows:

§435.610 Assignment of rights to benefits.

(a) Consistent with §§433.145 through 433.148 of this chapter, as a condition of eligibility, the agency must require legally able applicants and beneficiaries to:

* * * * *

(2) In the case of applicants, attest that they will cooperate, and, in the case of beneficiaries, cooperate with the agency in –

(i) Establishing the identity of a child’s parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating or is a pregnant woman described in §435.116; and

(ii) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

* * * * *

59. Section 435.831 is amended by revising paragraph (b) introductory text, (b)(1), and (c) to read as follows:

§435.831 Income eligibility.

* * * * *

(b) Determining countable income. For purposes of determining medically needy eligibility under this part, the agency must determine an individual’s countable income as follows:

(1) For individuals under age 21, pregnant women, and parents and other caretaker relatives, the agency may apply –

(i) The AFDC methodologies in effect in the State as of August 16, 1996, consistent with §435.601 (relating to financial methodologies for non-MAGI eligibility determinations) and §435.602 (relating to financial responsibility of relatives and other individuals for non-MAGI eligibility determinations); or

(ii) The MAGI-based methodologies defined in §435.603(b) through (f). If the agency applies the MAGI-based methodologies defined in §435.603(b) through (f), the agency must comply with the terms of §435.602, except that in applying §435.602(a)(2)(ii) to individuals under age 21, the agency may, at State option, include all parents as defined in §435.603(b) (including stepparents) who are living with the individual in the individual’s household for purposes of determining household income and family size, without regard to whether the parent’s income and resources would be counted under the State’s approved State plan under title IV-A of the Act in effect as of July 16, 1996, if the individual were a dependent child under such State plan.

* * * * *

(c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than that applicable income standard under §435.814, the individual is eligible for Medicaid.

* * * * *

60. Section §435.901 is revised to read as follows:

§435.901 Consistency with objectives and statutes.

The Medicaid agency's standards and methods for providing information to applicants and beneficiaries and for determining eligibility must be consistent with the objectives of the program and with the rights of individuals under the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, section 1557 of the Affordable Care Act, and all other relevant provisions of Federal and State laws and their respective implementing regulations.

61. Section 435.905 is amended by—

- a. Revising the section heading and paragraph (b)(1);
- b. Amending paragraph (b)(2) by removing the period at the end of the paragraph and adding “; and” in its place “; and
- c. Adding paragraph (b)(3)

The revision and addition read as follows:

§435.905 Availability and accessibility of program information.

* * * * *

(b) * * *

(1) Individuals who are limited English proficient through the provision of language services at no cost to the individual including, oral interpretation and written translations;

* * * * *

(3) Individuals must be informed of the availability of the accessible information and language services described in this paragraph and how to access such information and services, at a minimum through providing taglines in non-English languages indicating the availability of

language services.

* * * * *

§435.909 [Amended]

62. Section 435.909 is amended by removing and reserving paragraph (a).

63. Section 435.910 is amended by revising paragraph (g) to read as follows:

§435.910 Use of social security number.

* * * * *

(g) The agency must verify the SSN furnished by an applicant or beneficiary with SSA to ensure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

* * * * *

64. Section 435.911 is amended by—

- a. Revising paragraphs (b)(1) introductory text, and (b)(1)(i);
- b. Adding paragraph (b)(2); and
- c. Revising paragraphs (c) introductory text, and (c)(1).

The revisions and additions read as follows:

§435.911 Determination of eligibility.

* * * * *

(b)(1) Except as provided in paragraph (b)(2) of this section, applicable modified adjusted gross income standard means 133 percent of the Federal poverty level or, if higher –

(i) In the case of parents and other caretaker relatives described in §435.110(b), the income standard established in accordance with §435.110(c) or §435.220(c);

* * * * *

(2) In the case of individuals who have attained at least age 65 and individuals who have

attained at least age 19 and who are entitled to or enrolled for Medicare benefits under part A or B or title XVIII of the Act, there is no applicable modified adjusted gross income standard, except that in the case of such individuals –

(i) Who are also pregnant, the applicable modified adjusted gross income standard is the standard established under paragraph (b)(1) of this section; or

(ii) Who are also a parent or caretaker relative, as described in §435.4, the applicable modified adjusted gross income standard is the higher of the income standard established in accordance with §435.110(c) or §435.220(c).

(c) For each individual who has submitted an application described in §435.907 or whose eligibility is being renewed in accordance with §435.916 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)) of this chapter, the State Medicaid agency must comply with the following—

(1) The agency must, promptly and without undue delay consistent with timeliness standards established under §435.912, furnish Medicaid to each such individual whose household income is at or below the applicable modified adjusted gross income standard.

(2) For each individual described in paragraph (d) of this section, the agency must collect such additional information as may be needed consistent with §435.907(c), to determine, consistent with the timeliness standards in §435.912, whether such individual is eligible for Medicaid on any basis other than the applicable modified adjusted gross income standard, and furnish Medicaid on such basis.

* * * * *

§435.913 [Removed]

65. Section 435.913 is removed.

66. Section 435.917 is added to read as follows:

§435.917 Notice of agency's decision concerning eligibility, benefits, or services.

(a) Notice of eligibility determinations. Consistent with §§431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services. Such notice must--

(1) Be written in plain language;

(2) Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with §435.905(b), and

(3) If provided in electronic format, comply with §435.918(b).

(b) Content of eligibility notice. (1) Notice of approved eligibility. Any notice of an approval of Medicaid eligibility must include, but is not limited to, clear statements containing the following information--

(i) The basis and effective date of eligibility;

(ii) The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's eligibility;

(iii) If applicable, the amount of medical expenses which must be incurred to establish eligibility in accordance with §435.121 or §435.831.

(iv) Basic information on the level of benefits and services available based on the individual's eligibility, including, if applicable --

(A) The differences in coverage available to individuals enrolled in benchmark or benchmark-equivalent coverage or in an Alternative Benefits Plan and coverage available to individuals described in §440.315 of this chapter (relating to exemptions from mandatory

enrollment in benchmark or benchmark-equivalent coverage);

(B) A description of any premiums and cost sharing required under Part 447 Subpart A of this chapter;

(C) An explanation of how to receive additional detailed information on benefits and financial responsibilities; and

(D) An explanation of any right to appeal the eligibility status or level of benefits and services approved.

(2) Notice of adverse action including denial, termination or suspension of eligibility or change in benefits or services. Any notice of denial, termination or suspension of Medicaid eligibility or change in benefits or services must be consistent with §431.210 of this chapter.

(c) Eligibility. Whenever an approval, denial, or termination of eligibility is based on an applicant's or beneficiary's having household income at or below the applicable modified adjusted gross income standard in accordance with §435.911, the eligibility notice must contain—

(1) Information regarding bases of eligibility other than the applicable modified adjusted gross income standard and the benefits and services afforded to individuals eligible on such other bases, sufficient to enable the individual to make an informed choice as to whether to request a determination on such other bases; and

(2) Information on how to request a determination on such other bases;

(d) Combined Eligibility Notice. The agency's responsibility to provide notice under this section is satisfied by a combined eligibility notice, as defined in §435.4, provided by the Exchange or other insurance affordability program in accordance with an agreement between the agency and such program consummated in accordance with §435.1200(b)(3), except that, if the information described in paragraph (b)(1)(iii) and (iv) of this section is not included in such

combined eligibility notice, the agency must provide the individual with a supplemental notice of such information, consistent with this section.

§435.919 [Removed]

67. Section 435.919 is removed.

68. Section 435.926 is added to read as follows:

§435.926 Continuous eligibility for children.

(a) Basis. This section implements section 1902(e)(12) of the Act.

(b) Eligibility. The agency may provide continuous eligibility for the period specified in paragraph (c) of this section for an individual who is:

(1) Under age 19 or under a younger age specified by the agency in its State plan; and

(2) Eligible and enrolled for mandatory or optional coverage under the State plan in accordance with subpart B or C of this part.

(c) Continuous eligibility period. (1) The agency must specify in the State plan the length of the continuous eligibility period, not to exceed 12 months.

(2) A continuous eligibility period begins on the effective date of the individual's eligibility under §435.915 or most recent redetermination or renewal of eligibility under §435.916 and ends after the period specified by the agency under paragraph (c)(1) of this section.

(d) Applicability. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) The child attains the maximum age specified in accordance with paragraph (b)(1) of this section;

(2) The child or child's representative requests a voluntary termination of eligibility;

(3) The child ceases to be a resident of the State;

(4) The agency determines that eligibility was erroneously granted at the most recent

determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child’s representative; or

(5) The child dies.

69. Section 435.940 is amended by revising the first sentence to read as follows:

§435.940 Basis and scope.

The income and eligibility verification requirements set forth at §§435.940 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), and 1943(b)(3) of the Act, and section 1413 of the Affordable Care Act.

§435.945 [Amended]

70. Section 435.945(g) is amended by removing the reference “§435.910, §435.913, and §435.940 through §435.965 of this subpart” and adding in its place the reference “§435.910 and §435.940 through §435.965”.

71. Section 435.952 is amended by adding paragraph (c)(3) to read as follows:

§435.952 Use of information and requests of additional information from individuals.

* * * * *

(c) * * *

(3) Exception for special circumstances. The agency must establish an exception to permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or renewal, or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster. This exception does not apply if documentation is specifically required under title XI or XIX, such as requirements for verifying citizenship and immigration status, as implemented at §435.956(a).

* * * * *

72. Section 435.956 is amended by adding paragraphs (a) and (b) to read as follows:

§435.956 Verification of other non-financial information.

(a) Citizenship and immigration status. (1)(i) The agency must –

(A) Verify citizenship status through the electronic service established in accordance with §435.949 or alternative mechanism authorized in accordance with §435.945(k), if available; and

(B) Promptly attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and information from an electronic data source, and resubmit corrected information through such electronic service or alternative mechanism.

(ii) If the agency is unable to verify citizenship status in accordance with paragraph (a)(1)(i) of this section, the agency must verify citizenship either –

(A) Through a data match with the Social Security Administration; or

(B) In accordance with §435.407.

(2) The agency must –

(i) Verify immigration status through the electronic service established in accordance with §435.949, or alternative mechanism authorized in accordance with §435.945(k);

(ii) Promptly attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and information from an electronic data source, and resubmit corrected information through such electronic service or alternative mechanism.

(3) For purposes of the exemption from the five-year waiting period described in 8

U.S.C. 1613, the agency must verify that an individual is an honorably discharged veteran or in active military duty status, or the spouse or unmarried dependent child of such person, as described in 8 U.S.C. 1612(b)(2) through the electronic service described in §435.949 or alternative mechanism authorized in accordance with §435.945(k). If the agency is unable to verify such status through such service the agency may accept self-attestation of such status.

(4)(i) The agency must maintain a record of having verified citizenship or immigration status for each individual, in a case record or electronic database in accordance with the State's record retention policies in accordance with §431.17(c) of this chapter.

(ii) Unless the individual reports a change in citizenship or the agency has received information indicating a potential change in the individual's citizenship, the agency may not re-verify or require an individual to re-verify citizenship at a renewal of eligibility under §435.916 of this subpart, or upon a subsequent application following a break in coverage.

(5) If the agency cannot promptly verify the citizenship or satisfactory immigration status of an individual in accordance with paragraph (a)(1) or (2) of this section, the agency –

(i) Must provide a reasonable opportunity in accordance with paragraph (b) of this section; and

(ii) May not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable opportunity period, in accordance with §435.911(c).

(iii) If a reasonable opportunity period is provided, the agency may begin to furnish benefits to otherwise eligible individuals, effective the date of application, or the first day of the month of application, consistent with the agency's election under §435.915(b).

(b) Reasonable opportunity period. (1) The agency must provide a reasonable opportunity period to individuals who have made a declaration of citizenship or satisfactory

immigration status in accordance with §435.406(a), and for whom the agency is unable to verify citizenship or satisfactory immigration status in accordance with paragraph (a) of this section.

During the reasonable opportunity period, the agency must continue efforts to complete verification of the individual's citizenship or satisfactory immigration status, or request documentation if necessary. The agency must provide notice of such opportunity that is accessible to persons who have limited English proficiency and individuals with disabilities, consistent with §435.905(b). During such reasonable opportunity period, the agency must, if relevant to verification of the individual's citizenship or satisfactory immigration status –

(i) In the case of individuals declaring citizenship who do not have an SSN at the time of such declaration, assist the individual in obtaining an SSN in accordance with §435.910, and attempt to verify the individual's citizenship in accordance with paragraph (a)(1) of this section once an SSN has been obtained and verified;

(ii) Promptly provide the individual with information on how to contact the electronic data source described in paragraph (a) of this section so that he or she can attempt to resolve any inconsistencies defeating electronic verification directly with such source, and pursue verification of the individual's citizenship or satisfactory immigration status if the individual or source informs the agency that the inconsistencies have been resolved; and

(iii) Provide the individual with an opportunity to provide other documentation of citizenship or satisfactory immigration status, in accordance with section 1137(d) of the Act and §435.406 or §435.407.

(2) The reasonable opportunity period –

(i) Begins on the date on which the notice described in paragraph (b)(1) of this section is received by the individual. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice

within the 5-day period.

(ii)(A) Ends on the earlier of the date the agency verifies the individual's citizenship or satisfactory immigration status or determines that the individual did not verify his or her citizenship or satisfactory immigration status in accordance with paragraph (a)(2) of this section, or 90 days after the date described in paragraph (b)(2)(i) of this section, except that,

(B) The agency may extend the reasonable opportunity period 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 his or her status.

(3) If, by the end of the reasonable opportunity period, the individual's citizenship or satisfactory immigration status has not been verified in accordance with paragraph (a) of this section, the agency must take action within 30 days to terminate eligibility in accordance with part 431 subpart E (relating to notice and appeal rights) of this chapter, except that §431.230 and §431.231 of this chapter (relating to maintaining and reinstating services) may be applied at State option.

(4)(i) The agency may establish in its State plan reasonable limits on the number of reasonable opportunity periods during which medical assistance is furnished which a given individual may receive once denied eligibility for Medicaid due to failure to verify citizenship or satisfactory immigration status, provided that the conditions in paragraph (b)(4)(ii) of this section are met.

(ii) Prior to implementing any limits under paragraph (b)(4)(i) of this section, the agency must –

(A) Demonstrate that the lack of limits jeopardizes program integrity; and

(B) Receive approval of a State plan amendment prior to implementing limits.

* * * * *

73. Section 435.1001 is amended by revising paragraph (a)(2) to read as follows:

§435.1001 FFP for administration.

(a) * * *

(2) Administering presumptive eligibility.

* * * * *

74. Section 435.1002 is amended by revising paragraphs (c)(1) and (4) to read as follows:

§435.1002 FFP for services.

* * * * *

(c) * * *

(1) During a presumptive eligibility period to individuals who are determined to be presumptively eligible for Medicaid in accordance with subpart L of this part;

* * * * *

(4) Regardless of whether such individuals file an application for a full eligibility determination or are determined eligible for Medicaid following the period of presumptive eligibility.

75. Section 435.1004 is amended by revising paragraph (b) to read as follows:

§435.1004 Beneficiaries overcoming certain conditions of eligibility.

* * * * *

(b) FFP is available for a period not to exceed--

(1) The period during which a recipient of SSI or an optional State supplement continues to receive cash payments while these conditions are being overcome; or

(2) For beneficiaries, eligible for Medicaid only and recipients of SSI or an optional State supplement who do not continue to receive cash payments, the second month following the month in which the beneficiary's Medicaid coverage will have been terminated.

76. Section 435.1008 is revised to read as follows:

§435.1008 FFP in expenditures for medical assistance for individuals who have declared citizenship or nationality or satisfactory immigration status.

(a) This section implements sections 1137 and 1902(a)(46)(B) of the Act.

(b) Except as provided in paragraph (c) of this section, FFP is not available to a State for expenditures for medical assistance furnished to individuals unless the State has verified citizenship or immigration status in accordance with §435.956.

(c) FFP is available to States for otherwise eligible individuals whose declaration of U.S. citizenship or satisfactory immigration status in accordance with section 1137(d) of the Act and §435.406(c) has been verified in accordance with §435.956, who are exempt from the requirements to verify citizenship under §435.406(a)(1)(iii), or for whom benefits are provided during a reasonable opportunity period to verify citizenship, nationality, or satisfactory immigration status in accordance with section §435.956(b), including the time period during which an appeal is pending if the State has elected the option under §435.956(b)(3).

77. Section 435.1100 is revised to read as follows:

§435.1100 Basis for presumptive eligibility.

This subpart implements sections 1920, 1920A, 1920B, 1920C, and 1902(a)(47)(B) of the Act.

78. Remove the undesignated center heading "Presumptive Eligibility for Children" that immediately precedes §435.1101.

79. Section 435.1101 is amended by—

- a. Revising the section heading;
- b. Adding introductory text for the section;
- c. Adding the definition of “Application”;
- d. Removing the definition of “Application form”;
- e. Amending the definition of “Qualified entity” by amending paragraph (9)(iii) by removing “; and” and adding in its place “;”, redesignating paragraph (10) as paragraph (11), and adding a new paragraph (10).

The revision and additions read as follows:

§435.1101 Definitions related to presumptive eligibility.

For the purposes of this subpart, the following definitions apply:

Application means, consistent with the definition at §435.4, the single streamlined application adopted by the agency under §435.907(a); and

* * * * *

Qualified entity * * *

(10) Is a health facility operated by the Indian Health Service, a Tribe or Tribal organization under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or an Urban Indian Organization under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.).

* * * * *

80. Section 435.1200 is amended by –

- a. Revising the section heading and paragraphs (a), (b), (c) introductory text, (d), and (e)(1);

- b. Amending paragraph (e)(2) introductory text by removing the comma after “electronic interface”;

- c. Revising paragraph (e)(3); and
- d. Adding paragraphs (g) through (i).

The additions and revisions to read as follows:

§435.1200 Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs.

(a) Statutory basis, purpose, and definitions.

(1) Statutory basis and purpose. This section implements section 1943(b)(3) of the Act as added by section 2201 of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs.

(2) Definitions. (i) Combined eligibility notice has the meaning as provided in §435.4.

(ii) Coordinated content has the meaning as provided in §435.4.

(iii) Joint fair hearing request has the meaning provided in §431.201 of this chapter.

(b) General requirements and definitions. The State Medicaid agency must--

(1) Fulfill the responsibilities set forth in paragraphs (d) through (h) of this section and, if applicable, paragraph (c) of this section.

(2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.

(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 program;

(ii) Ensure compliance with paragraphs (d) through (h) of this section and, if applicable, paragraph (c) 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; and

(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 part155 subpart F and a fair hearing of a denial of Medicaid eligibility which is conducted by the Exchange or Exchange appeals entity.

(c) Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program. If the agency has entered into an agreement in accordance with §431.10(d) of this chapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange (including as a result of a decision made by the Exchange or Exchange appeals entity in accordance with paragraph (g)(6) or (7)(i)(A) of this section) or other program, the agency must--

* * * * *

(d) Transfer from other insurance affordability programs to the State Medicaid agency. For individuals for whom another insurance affordability program has not made a determination of Medicaid eligibility, but who have been assessed by such program (including as a result of a

decision made by the Exchange appeals entity) as potentially Medicaid eligible, and for individuals not so assessed, but who otherwise request a full determination by the Medicaid agency, the agency must --

(1) Accept, via secure electronic interface, the electronic account for the individual and notify such program of the receipt of the electronic account;

(2) Not request information or documentation from the individual in the individual's electronic account, or provided to the agency by another insurance affordability program or appeals entity;

(3) Promptly and without undue delay, consistent with timeliness standards established under §435.912, determine the Medicaid eligibility of the individual, in accordance with §435.911, without requiring submission of another application and, for individuals determined not eligible for Medicaid, comply with paragraph (e) of this section as if the individual had submitted an application to the agency;

(4) Accept any finding relating to a criterion of eligibility made by such program or appeals entity, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the agency or approved by it in the agreement described in paragraph (b)(3) of this section; and

(5) Notify such program of the final determination of the individual's eligibility or ineligibility for Medicaid.

(e) * * *

(1) Individuals determined not eligible for Medicaid. For each individual who submits an application or renewal to the agency which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed in accordance to a change in circumstance in accordance with §435.916(d), and whom the agency determines is not eligible

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, determine potential eligibility for, and, as appropriate, transfer via a secure electronic interface the individual's electronic account to, other insurance affordability programs.

* * * * *

(3) The agency may enter into an agreement with the Exchange to make determinations of eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit and cost-sharing reductions, consistent with 45 CFR 155.110(a)(2).

* * * * *

(g) Coordination involving appeals entities. The agency must --

(1) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that, if the Exchange or other insurance affordability program provides an applicant or beneficiary with a combined eligibility notice including a determination that the individual is not eligible for Medicaid, the Exchange or Exchange appeals entity (or other insurance affordability program or other program's appeals entity) will --

(i) Provide the applicant or beneficiary with an opportunity to submit a joint fair hearing request, including an opportunity to a request expedited review of his or her fair hearing request consistent with §431.221(a)(1)(ii) of this chapter; and

(ii) Notify the Medicaid agency of any joint fair hearing request and transmit to the agency the electronic account of the individual who made such request, unless the fair hearing will be conducted by the Exchange or Exchange appeals entity in accordance to a delegation of authority under §431.10(c)(1)(ii) of this chapter; and

(2) Beginning on the applicability date described in paragraph (i) of this section,

establish a secure electronic interface the through which –

(i) The Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity) can notify the agency that an individual has submitted a joint fair hearing request in accordance with paragraph (g)(1)(ii) of this section;

(ii) The individual's electronic account, including any information provided by the individual as part of an appeal to either the agency or Exchange appeals entity (or other insurance affordability program or appeals entity), can be transferred from one program or appeals entity to the other; and

(iii) The agency can notify the Exchange, Exchange appeals entity (or other insurance affordability program or appeals entity) of the information described in paragraphs (g)(5)(i)(A), (B) and (C) of this section.

(3) Accept and act on a joint fair hearing request submitted to the Exchange or Exchange appeals entity and transferred to the agency as if the request for fair hearing had been submitted directly to the agency in accordance with §431.221 of this chapter;

(4) In conducting a fair hearing in accordance with subpart E or part 431 of this chapter, minimize to the maximum extent possible, consistent with guidance issued by the Secretary, any requests for information or documentation from the individual included in the individual's electronic account or provided to the agency by the Exchange or Exchange appeals entity.

(5)(i) In the case of individuals described in paragraph (g)(5)(ii) of this section who submit a request a fair hearing under subpart E of part 431 of this chapter to the agency or who submit a joint fair hearing request to the Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity), if the fair hearing is conducted by the Medicaid agency, transmit, through the electronic interface established under paragraph (g)(1) of this section, to the Exchange, Exchange appeals entity (or other insurance affordability program

or appeals entity), as appropriate and necessary to enable such other entity to fulfill its responsibilities under 45 CFR part 155, 42 CFR part 457 or 42 CFR part 600 –

(A) Notice that the individual has requested a fair hearing;

(B) Whether Medicaid benefits will be furnished pending final administrative action on such fair hearing request in accordance with §431.230 or §431.231 of this chapter; and

(C) The hearing decision made by the agency.

(ii) Individuals described in this paragraph include individuals determined ineligible for Medicaid—

(A) By the Exchange; or

(B) By the agency and transferred to the Exchange or other insurance affordability program in accordance with paragraph (e)(1) or (2) of this section.

(6)(i) In the case of individuals described in paragraph (g)(6)(ii) of this section, if the agency has delegated authority under §431.10(c)(1)(i) to the Exchange to make Medicaid eligibility determinations, the agency must accept a determination of Medicaid eligibility made by the Exchange appeals entity and comply with paragraph (c) of this section in the same manner as if the determination of Medicaid eligibility had been made by the Exchange.

(ii) Individuals described in this paragraph are individuals who were determined ineligible for Medicaid by the Exchange in accordance with 45 CFR 155.305(c), who did not request a fair hearing of such determination, and whom the Exchange appeals entity determines are eligible for Medicaid in deciding an appeal requested by the individual in accordance with 45 CFR part 155 subpart F.

(7)(i) In the case of individuals described in paragraph (g)(7)(ii) of this section, the agency must either –

(A) Accept a determination of Medicaid eligibility made by the Exchange appeals entity

and comply with paragraph (c) of this section in the same manner as if the determination of Medicaid eligibility had been made by the Exchange; or

(B) Accept a determination of Medicaid eligibility made by the Exchange appeals entity as an assessment of Medicaid eligibility made by the Exchange and make a determination of eligibility in accordance with paragraph (d) of this section, taking into account any additional information provided to or obtained by the Exchange appeals entity in conducting the Exchange-related appeal.

(ii) Individuals described in this paragraph are individuals who were determined ineligible for Medicaid by the Medicaid agency in accordance with paragraph (e) of the section, who did not request a fair hearing of such determination of Medicaid ineligibility, and whom the Exchange appeals entity determines are eligible for Medicaid in deciding an appeal requested by the individual in accordance with 45 CFR part 155 subpart F.

(h) Coordination of eligibility notices. The agency must –

(1) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that, to the maximum extent feasible, the agency, Exchange or other insurance affordability program will provide a combined eligibility notice, as defined in §435.4, to individuals, as well as to multiple members of the same household included on the same application or renewal form.

(2) For individuals and other household members who will not receive a combined eligibility notice, include appropriate coordinated content, as defined in §435.4, in any notice provided by the agency in accordance with §435.917.

(3) For individuals determined ineligible for Medicaid based on having household income above the applicable MAGI standard, but who are undergoing a Medicaid eligibility determination on a basis other than MAGI in accordance with (e)(2) of this section, the agency

must--

(i) Provide notice to the individual, consistent with §435.917--

(A) That the agency--

(1) Has determined the individual ineligible for Medicaid due to household income over the applicable MAGI standard; and

(2) Is continuing to evaluate Medicaid eligibility on other bases, including a plain language explanation of the other bases being considered.

(B) Include in such notice coordinated content that the agency has transferred the individual's electronic account to the other insurance affordability program (as required under paragraph (e)(2) of this section) and an explanation that eligibility for or enrollment in such other program will not affect the determination of Medicaid eligibility on a non-MAGI basis; and

(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 --

(A) The notice being provided to the Exchange or other program in accordance with paragraph (e)(2)(ii) of this section;

(B) Any impact that approval of Medicaid eligibility may have on the individual's eligibility for such other program; and

(C) The transfer of the individual's electronic account to the Exchange in accordance with paragraph (e)(1) of this section.

(i) Notice of applicability date. The date described in this paragraph is 6 months from the date of a published **Federal Register** document alerting States of the requirement to comply with paragraphs (g)(2) of this section and §§431.221(a)(1)(i), 431.244(f)(3)(i) and (ii) of this chapter. The earliest we will publish such notice will be May 30, 2017, which would result in an earliest effective date of November 30, 2017.

PART 457—ALLOTMENTS AND GRANTS TO STATES

81. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

82. Section 457.10 is amended by --

- a. Adding the definitions of “Combined eligibility notice”, and “Coordinated content”;
- b. Revising the definition of “Electronic account”; and
- c. Adding the definition of “Joint review request” in alphabetical order.

The additions and revision read as follows:

§457.10 Definitions and use of terms.

* * * * *

Combined eligibility notice means an eligibility notice that informs an individual, or multiple family members of a household of eligibility for each of the insurance affordability programs and enrollment in a qualified health plan through the Exchange, for which a determination or denial of eligibility was made, as well as any right to request a review, fair hearing or appeal related to the determination made for each program. A combined notice must meet the requirements of §457.340(e) and contain the content described in §457.340(e)(1), except that information described in §457.340(e)(1)(i)(C) may be provided in a combined notice issued by another insurance affordability program or in a supplemental notice provided by the State. A combined eligibility notice must be issued in accordance with the agreement(s) consummated by the State in accordance with §457.348(a).

* * * * *

Coordinated content means information included in an eligibility notice regarding, if applicable –

- (1) The transfer of an individual’s or household’s electronic account to another insurance

affordability program;

(2) Any notice sent by the State to another insurance affordability program regarding an individual's eligibility for CHIP;

(3) The potential impact, if any, of –

(i) The State's determination of eligibility or ineligibility for CHIP on eligibility for another insurance affordability program; or

(ii) A determination of eligibility for, or enrollment in, another insurance affordability program on an individual's eligibility for CHIP; and

(iii) [Reserved]

(4) The status of household members on the same application or renewal form whose eligibility is not yet determined.

* * * * *

Electronic account means an electronic file that includes all information collected and generated by the State regarding each individual's CHIP eligibility and enrollment, including all documentation required under §457.380 and including any information collected or generated as part of a review process conducted in accordance with subpart K of this part, the Exchange appeals process conducted under 45 CFR part 155, subpart F or other insurance affordability program appeals process.

* * * * *

Joint review request means a request for a review under subpart K of this part which is included in an appeal request submitted to an Exchange or Exchange appeals entity or other insurance affordability program or appeals entity, in accordance with the signed agreement between the State and an Exchange or Exchange appeals entity or other program or appeals entity in accordance with §457.348(b).

* * * * *

83. Section 457.50 is revised to read as follows:

§457.50 State plan.

The State plan is a comprehensive written statement, submitted by the State to CMS for approval, that describes the purpose, nature, and scope of the State's CHIP and gives an assurance that the program is administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program. The Secretary will periodically specify updated requirements on the format of State plan through a process consistent with the requirements of the Paperwork Reduction Act.

84. Section 457.60 is amended by revising the first sentence and adding a new second sentence in the introductory text to read as follows:

§457.60 Amendments.

A State may seek to amend its approved State plan in whole or in part at any time through the submission of an amendment to CMS. The Secretary will periodically specify updated requirements on the format of State plan amendments through a process consistent with the requirements of the Paperwork Reduction Act. ***

* * * * *

85. Section 457.110 is amended by revising paragraph (a) to read as follows:

§457.110 Enrollment assistance and information requirements.

(a) Information disclosure. The State must make accurate, easily understood, information available to families of potential applicants, applicants and enrollees, and provide assistance to these families in making informed decisions about their health plans, professionals,

and facilities. This information must be provided in plain language and is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.

(1) The State must provide individuals with a choice to receive notices and information required under this subpart and subpart K of this part, in electronic format or by regular mail, provided that the State establish safeguards in accordance with §435.918 of this chapter.

(2) [Reserved]

* * * * *

86. Section 457.310 is amended by revising paragraph (b)(2)(i) to read as follows:

§457.310 Targeted low-income child.

* * * * *

(b) * * *

(2) * * *

(i) Found eligible or potentially eligible for Medicaid under policies of the State plan (determined through either the Medicaid application process or the screening process described at §457.350), except for eligibility under §435.214 of this chapter (related to coverage for family planning services);

* * * * *

87. Section 457.320 is amended by—

- a. Redesignating paragraphs (c) (d), and (e) as paragraphs (d), (e), and (f), respectively.
- b. Reserving paragraph (c); and
- c. Revising newly redesignated paragraph (d).

The addition and revisions read as follows:

§457.320 Other eligibility standards.

* * * * *

(c) [Reserved]

(d) Citizenship and immigration status. All individuals seeking coverage under a separate child health plan must make a declaration of United States citizenship or satisfactory immigration status. Such declaration may be made by an adult member of the individual's household, an authorized representative, as defined in §435.923 of this chapter (referenced at §457.340), or if the individual is a minor or incapacitated, someone acting responsibly for the individual provided that such individual attests to having knowledge of the individual's status.

* * * * *

88. Section 457.340 is amended by—

- a. Revising paragraph (a);
- b. Revising paragraph (e);
- c. Redesignating paragraph (f) as paragraph (g); and
- d. Adding a new paragraph (f).

The revisions and addition read as follow:

§457.340 Application for and enrollment in CHIP.

(a) Application and renewal assistance, availability of program information, and website.

The terms of §§435.905, 435.906, 435.908, and 435.1200(f) of this chapter apply equally to the State in administering a separate CHIP.

* * * * *

(e) Notice of eligibility determinations. The State must provide each applicant or enrollee with timely and adequate written notice of any decision affecting his or her eligibility, including an approval, denial or termination, or suspension of eligibility, consistent with §§457.315, 457.348, and 457.350. The notice must be written in plain language; and accessible

to persons who are limited English proficient and individuals with disabilities, consistent with §435.905(b) of this chapter and §457.110.

(1) Content of eligibility notice.

(i) Any notice of an approval of CHIP eligibility must include, but is not limited to, the following –

(A) The basis and effective date of eligibility;

(B) The circumstances under which the individual must report and procedures for reporting, any changes that may affect the individual's eligibility;

(C) Basic information on benefits and services and if applicable, any premiums, enrollment fees, and cost sharing required, and an explanation of how to receive additional detailed information on benefits and financial responsibilities; and

(D) Information on the enrollees' right and responsibilities, including the opportunity to request a review of matters described in §457.1130.

(ii) Any notice of denial, termination, or suspension of CHIP eligibility must include, but is not limited to the following —

(A) The basis supporting the action and the effective date,

(B) Information on the individual's right to a review process, in accordance with §457.1180;

(iii) In the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the child's parent or other caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.

(2) The State's responsibility to provide notice under this paragraph is satisfied by a combined eligibility notice, as defined in §457.10, provided by an Exchange or other insurance affordability program in accordance with paragraph (f) of this section, except that, if the

information described in paragraph (e)(1)(i)(C) of this section is not included in such combined eligibility notice, the State must provide the individual with a supplemental notice of such information, consistent with this section.

(f) Coordination of notices with other programs. The State must –

(1) Include in the agreement into which the State has entered under §457.348(a) that for individuals who are transferred between the State and another insurance affordability program in accordance with §457.348 or §457.350, the State, Exchange or other insurance affordability program will provide, to the maximum extent feasible, a combined eligibility notice to individuals, as well as to multiple members of the same household included on the same application or renewal form.

(2) For individuals and other household members who will not receive a combined eligibility notice, include appropriate coordinated content, as defined in §457.10, in any notice provided by the State in accordance with paragraph (e)(1) of this section.

* * * * *

89. Section 457.342 is added to read as follows:

§457.342 Continuous eligibility for children.

(a) A State may provide continuous eligibility for children under a separate CHIP in accordance with the terms of §435.926 of this chapter, and subject to a child remaining ineligible for Medicaid, as required by section 2110(b)(1) of the Act and §457.310 (related to the definition and standards for being a targeted low-income child) and the requirements of section 2102(b)(3) of the Act and §457.350 (related to eligibility screening and enrollment).

(b) In addition to the reasons provided at §435.926(d) of this chapter, a child may be terminated during the continuous eligibility period for failure to pay required premiums or enrollment fees required under the State plan, subject to the disenrollment protections afforded

under section 2103(e)(3)(C) of the Act (related to premium grace periods) and §457.570 (related to disenrollment protections).

90. Section 457.348 is amended by revising paragraphs (a), (b), and (c) to read as follows:

§457.348 Determinations of Children’s Health Insurance Program eligibility by other insurance affordability programs.

(a) Agreements with other insurance affordability programs. The State must enter into and, upon request, provide to the Secretary one or more agreements with an Exchange 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--

(1) Minimize burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for one or more insurance affordability program;

(2) Ensure compliance with paragraphs (b) and (c) of this section and §457.350;

(3) Ensure prompt determination of eligibility and enrollment in the appropriate program without undue delay, consistent with the timeliness standards established under §457.340(d), based on the date the application is submitted to any insurance affordability program, and

(4) Provide for coordination of notices with other insurance affordability programs, consistent with §457.340(f), and an opportunity for individuals to submit a joint review request, as defined in §457.10, consistent with §457.351.

(5) Provide for a combined appeals decision by an Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity) for individuals who requested an appeal of an Exchange-related determination in accordance with 45 CFR part 155 subpart F (or of a determination related to another program) and an appeal of a denial of CHIP eligibility

which is conducted by an Exchange or Exchange appeals entity (or other program or appeals entity) in accordance with the State plan.

(b) Provision of CHIP for individuals found eligible for CHIP by another insurance affordability program. If a State accepts final determinations of CHIP eligibility made by another insurance affordability program, for each individual determined so eligible by the other insurance affordability program (including as a result of a decision made by an Exchange appeals entity authorized by the State to adjudicate reviews of CHIP eligibility determinations), the State must--

(1) 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;

(2) Comply with the provisions of §457.340 to the same extent as if the application had been submitted to the State; and

(3) Maintain proper oversight of the eligibility determinations made by the other program.

(c) Transfer from other insurance affordability programs to CHIP. For individuals for whom another insurance affordability program has not made a determination of CHIP eligibility, but who have been screened as potentially CHIP eligible by such program (including as a result of a decision made by an Exchange or other program appeals entity), the State must --

(1) Accept, via secure electronic interface, the electronic account for the individual and notify such program of the receipt of the electronic account;

(2) Not request information or documentation from the individual in the individual's electronic account, or provided to the State by another insurance affordability program or appeals entity;

(3) Promptly and without undue delay, consistent with the timeliness standards established under §457.340(d), determine the CHIP eligibility of the individual, in accordance with §457.340, without requiring submission of another application and, for individuals determined not eligible for CHIP, comply with §457.350(i) of this section;

(4) Accept any finding relating to a criterion of eligibility made by such program or appeals entity, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the State in accordance with §457.380 or approved by it in the agreement described in paragraph (a) of this section; and

(5) Notify such program of the final determination of the individual’s eligibility or ineligibility for CHIP.

* * * * *

91. Section 457.350 is amended by—

- a. Revising paragraphs (b) introductory text;
- b. Amending paragraph (h)(1) by removing “; and” and adding in its place “.”;
- c. Revising paragraph (h)(2);
- d. Adding paragraph (h)(3);
- e. Revising paragraph (i) introductory text;
- f. Adding paragraph (i)(2);
- g. Revising paragraph (j)(2) and (3); and
- h. Adding paragraph (j)(4).

The additions and revisions read as follows:

§457.350 Eligibility screening and enrollment in other insurance affordability programs.

* * * * *

(b) Screening objectives. A State must, promptly and without undue delay, consistent with the timeliness standards established under §457.340(d), identify potential eligibility for other insurance affordability programs of any applicant, enrollee, or other individual who submits an application or renewal form to the State which includes sufficient information to determine CHIP eligibility, or whose eligibility is being renewed due to a change in circumstance in accordance with §457.343 or who is determined not eligible for CHIP in accordance to a review conducted in accordance with subpart K of this part, as follows:

* * * * *

(h) * * *

(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 (i) 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

(i) Individuals found potentially eligible for other insurance affordability programs. For individuals identified in paragraph (b)(3) of this section, including during a period of uninsurance imposed by the State under §457.805, the State must—

* * * * *

(2) In the case of individuals subject to a period of uninsurance under §457.805 and transferred to another insurance affordability program in accordance with paragraph (i)(1) of this section, the State must –

(i) Notify such program of the date on which such period ends and the individual is eligible to enroll in CHIP; and

(ii) Consistent with §457.340(e), provide the individual with –

(A) An initial notice that the individual is not currently eligible to enroll in the State’s separate child health plan and the reasons therefor; the date on which the individual will be eligible to enroll in the State’s separate child health plan; and that the individual’s account has been transferred to another insurance affordability program for a determination of eligibility to enroll in such program during the period of underinsurance. Such notice also must contain coordinated content informing the individual of the notice being provided to the other insurance affordability program per paragraph (i)(3)(i) of this section and the impact that the individual’s eligibility to enroll in the State’s separate child health plan will have on the individual’s eligibility for such other program.

(B) Prior to the end of the individual’s period of uninsurance (sufficient to enable the individual to disenroll from the insurance affordability program to which the individual’s account was transferred per paragraph (i)(1) of this section), notice reminding the individual of the information described in paragraph (i)(2)(A) of this section, as appropriate.

(j) * * *

(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 (j)(1) of this section;

(ii) The transfer of the individual’s account to another insurance affordability program in accordance with paragraph (i)(1) of this section, if applicable; and

(iii) The impact that an approval of Medicaid eligibility will have on the individual's eligibility for CHIP or another insurance affordability program, as appropriate.

(4) Dis-enroll the enrollee from CHIP if the State is notified in accordance with §435.1200(d)(5) of this chapter that the applicant has been determined eligible for Medicaid .

* * * * *

92. Section 457.351 is added to read as follows:

§457.351 Coordination involving appeals entities for different insurance affordability programs.

(a) The terms of §435.1200(g) of this chapter apply equally to the State in administering a separate CHIP. References to a “fair hearing” and “joint fair hearing request” in §435.1200(g) of this chapter are treated as references to a “review” under subpart K of this part and to a “joint appeal request” as defined in §457.10. Reference to “expedited review of a fair hearing request consistent with §431.221(a)(1)(ii) of this chapter” is considered a reference to “expedited review of an eligibility or enrollment matter under §457.1160(a)”. Reference to §435.1200(b)(3), (c), (d) and (e) are treated as a reference to §457.348(b), (c) and (d) and §457.350(c), respectively.

(b) [Reserved.]

93. Section 457.355 is revised to read as follows:

§457.355 Presumptive eligibility for children.

The State may provide coverage under a separate child health program for children determined by a qualified entity to be presumptively eligible for the State's separate CHIP in the same manner and to the same extent as permitted under Medicaid under §435.1101 and §435.1102 of this chapter.

94. Section 457.360 is added to read as follows:

§457.360 Deemed newborn children.

(a) Basis. This section implements section 2112(e) of the Act.

(b) Eligibility. (1) The State must provide CHIP to children from birth until the child's first birthday without application if—

(i) The child's mother was eligible for and received covered services for the date of the child's birth under the State plan as a targeted low-income pregnant woman in accordance with section 2112 of the Act; and

(ii) The child is not eligible for Medicaid under §435.117 of this chapter.

(2)(i) The State may provide coverage under this section to children who are not eligible for Medicaid under §435.117 from birth until the child's first birthday without application if the requirement in paragraph (b)(2)(ii) of this section is met and if, for the date of the child's birth, the child's mother was eligible for and received covered services under –

(A) The State plan as a targeted low-income child;

(B) CHIP coverage in another State; or

(C) Coverage under the State's demonstration under section 1115 of the Act as a Medicaid or CHIP population.

(ii) For purposes of paragraph (b)(2)(i) of this section, the State may only elect the optional populations described if it elects to cover the corresponding optional populations in Medicaid under §435.117(b)(2)(ii) of this chapter.

(3) The child is deemed to have applied and been determined eligible under the State's separate CHIP State plan effective as of the date of birth, and remains eligible regardless of changes in circumstances (except if the child dies or ceases to be a resident of the State or the child's representative requests a voluntary termination of the child's eligibility) until the child's first birthday.

(c) CHIP identification number. (1) The CHIP identification number of the mother

serves as the child’s identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the State issues a separate identification number for the child.

(2) The State must issue a separate CHIP identification number for the child prior to the effective date of any termination of the mother’s eligibility or prior to the date of the child’s first birthday, whichever is sooner, except that the State must issue a separate CHIP identification number for the child if the mother was covered in another State at the time of birth.

95. Section 457.380 is amended by adding paragraph (b) to read as follows:

§457.380 Eligibility verification.

* * * * *

(b) Status as a citizen, national or a non-citizen. (1) Except for newborns identified in §435.406(a)(1)(iii)(E) of this chapter, who are exempt from any requirement to verify citizenship, the agency must –

(i) Verify citizenship or immigration status in accordance with §435.956(a) of this chapter, except that the reference to §435.945(k) is read as a reference to paragraph (i) of this section; and

(ii) Provide a reasonable opportunity period to verify such status in accordance with §435.956(a)(5) and (b) of this chapter and provide benefits during such reasonable opportunity period to individuals determined to be otherwise eligible for CHIP.

(2) [Reserved]

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§457.616 [Amended]

96. Section 457.616 is amended by removing and reserving paragraph (a)(3).

§457.805 [Amended].

97. Section 457.805 (b)(3)(vi) is amended by removing the word “and” and by adding in its place the word “or”.

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Dated: October 24, 2016

Andrew M. Slavitt,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: November 8, 2016

Sylvia M. Burwell,

Secretary,

Department of Health and Human Services.

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