FEDERAL REGISTER

Vol. 77 Friday,
No. 57 March 23, 2012

Part III

Department of Health and Human Services

Centers for Medicare and Medicaid Services

42 CFR Parts 431, 435 and 457
Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 435, and 457

[CMS–2349–F]

RIN 0938–AQ62

Medicaid Program; Eligiblity Changes Under the Affordable Care Act of 2010

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

ACTION: Final rule; Interim final rule.

SUMMARY: This final rule implements several 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). The Affordable Care Act expands access to health insurance coverage through improvements to the Medicaid and Children's Health Insurance (CHIP) programs, the establishment of Affordable Insurance Exchanges (''Exchanges''), and the assurance of coordination between Medicaid, CHIP, and Exchanges. This final rule codifies policy and procedural changes to the Medicaid and CHIP programs related to eligibility, enrollment, renewals, public availability of program information and coordination across insurance affordability programs.

DATES: *Effective Date:* These regulations are effective on January 1, 2014.

Comment Date: Certain provisions of this final rule are being issued as interim final. We will consider comments from the public on the following provisions: § 431.300(c)(1) and (d), § 431.305(b)(6), § 435.912, § 435.1200, § 457.340(d), § 457.348 and § 457.350(a), (b), (c), (f), (i), (j), and (k).

To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Standard Time (EST) on May 7, 2012.

ADDRESSES: In commenting, please refer to file code CMS–2349–F. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed)

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2349–F, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2349–F, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period: a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period. For information on viewing public comments, see the beginning of the ''**SUPPLEMENTARY INFORMATION**'' section.

FOR FURTHER INFORMATION CONTACT: Sarah delone, (410) 786–0615. Stephanie Kaminsky, (410) 786–4653.

SUPPLEMENTARY INFORMATION:

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

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

In addition, several sections in this final rule are being issued as interim final rules and we are soliciting comment on those sections. Given the highly connected nature of these provisions, we are combining provisions that are being issued as an interim final rule and provisions that are being issued as a final rule into a single document so that a reader will be able to see the context and interrelationships in the overall regulatory framework.

Table of Contents

I. Executive Summary

The legal authority for this final rule comes from the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010), and together referred to as the Affordable Care Act of 2010 (Affordable Care Act).

This final rule implements several provisions of the Affordable Care Act related to Medicaid eligibility, enrollment and coordination with the Affordable Insurance Exchanges (Exchanges), the Children's Health Insurance Program (CHIP), and other insurance affordability programs. It also simplifies the current eligibility rules and systems in the Medicaid and CHIP programs. This final rule: (1) Reflects the statutory minimum Medicaid income eligibility level of 133 percent of the Federal Poverty Level (FPL) across the country for most non-disabled adults under age 65; (2) eliminates obsolete eligibility categories and collapses other categories into four primary groups: children, pregnant women, parents, and the new adult group; (3) modernizes eligibility verification rules to rely primarily on electronic data sources; (4) codifies the streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for most individuals; and (5) ensures coordination across Medicaid, CHIP, and the Exchanges.

Several provisions of this rule are issued on an interim final basis. As such, we will consider comments from the public on the following provisions:

§ 431.300(c)(1) and (d) and § 431.305(b)(6)—Safeguarding information on applicants and beneficiaries.

§ 435.912—Timeliness and performance standards for Medicaid.

§ 435.1200—Coordinated eligibility and enrollment among insurance affordability programs.

§ 457.340(d)—Timeliness standards for CHIP.

§ 457.348—Coordinated eligibility and enrollment among CHIP and other insurance affordability programs.

§ 457.350(a), (b), (c), (f), (i), (j), and (k)—Coordinated eligibility and enrollment among CHIP and other insurance affordability programs.

II. Background

The Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), and amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010), are together referred to as the Affordable Care Act of 2010 (Affordable Care Act). Section 205 of the Medicare & Medicaid Extenders Act of 2010 (Pub. L. 111–309, enacted December 15, 2010) made technical corrections to the Social Security Act (the Act) to implement the Affordable Care Act. The Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112–56, enacted November 21, 2011), changed the MAGI definition of income to include all Social Security benefits.

In the August 17, 2011 **Federal Register** (76 FR 51148), we published a proposed rule entitled ''Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010,'' (hereinafter referred to as ''Medicaid Eligibility proposed rule''). This Medicaid Eligibility proposed rule was published in concert with three other proposed rules: the July 15, 2011 rule titled ''Establishment of Exchanges and Qualified Health Plans;'' the August 17, 2011 rule titled ''Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers;'' and the August 17, 2011 rule titled ''Health Insurance Premium Tax Credit Proposed Rule.'' These rules proposed eligibility and enrollment provisions for the Affordable Insurance Exchanges and the accompanying changes to the Internal Revenue Code (IRC) needed to implement the calculation of modified adjusted gross income (MAGI) for purposes of determining eligibility for assistance with purchasing health coverage. Together, these proposed rules were designed to implement the eligibility and enrollment-related provisions of the Affordable Care Act that expand access to health coverage through improvements in Medicaid and CHIP and the establishment of the new Affordable Insurance Exchanges. In addition, the proposed rules simplify and streamline the enrollment and renewal processes and create alignment across insurance affordability programs.

III. Summary of Proposed Provisions and Analysis of and Responses to Public Comments

We received a total of 813 comments from State Medicaid and CHIP agencies, policy and advocacy organizations, health care providers and associations, Tribes, Tribal organizations, and individual citizens. In addition, we held many consultation sessions with States and interested parties, including three sessions with Tribal governments (August 22, 2011, September 7, 2011, and September 15, 2011), to provide an overview of the Medicaid Eligibility proposed rule where interested parties were afforded an opportunity to ask questions and make comments. At these consultation sessions, the public was reminded to submit written comments before the close of the public comment period that was announced in the Medicaid Eligibility proposed rule.

The vast majority of commenters supported the policies we proposed, although, as discussed below, there were concerns about some specific policies. In particular, a large number of comments focused on the need for coverage options for individuals with disabilities. Summaries of the public comments that are within the scope of the proposals and our responses to those comments follow.

We have revised the proposed regulation to reflect our final policies. However, some comments were outside the scope of the Medicaid Eligibility proposed rule, and therefore, are not addressed in this final rule. In some instances, commenters raised policy or operational issues that will be addressed through regulatory and subregulatory guidance subsequent to this final rule; therefore some, but not all, comments are addressed in the preamble to this final rule.

The Medicaid Eligibility proposed rule proposed to amend 42 CFR parts 431, 435, and 457 to implement an eligibility, enrollment, and renewal system required by the Affordable Care Act. We proposed amendments to 42 CFR part 435 subparts B and C to implement the changes to Medicaid eligibility. We proposed amendments to subpart A to add new definitions or revise current definitions.

Under our proposed amendments to 42 CFR part 435 subpart G, most individuals would have financial eligibility for Medicaid determined based on MAGI. The proposed regulations also defined the new MAGI-based financial methodologies and identified individuals whose eligibility would not be based on MAGI. Subpart E included proposed eligibility requirements regarding residency.

Proposed amendments to subpart J established Federal guidelines for States to establish a seamless and coordinated system for determining eligibility and enrolling in the appropriate insurance affordability program. Subpart M delineates the responsibilities of the State Medicaid agency in the coordinated system of eligibility and enrollment established under the Affordable Care Act, and proposed

comparable amendments for CHIP at 42 CFR part 457.

We proposed to amend 42 CFR part 433 to add new provisions at § 433.10(c) to specify options for establishing the increased Federal Medicaid matching rates available to States under the Affordable Care Act; these amendments will be finalized in future rulemaking. A number of other provisions in the Affordable Care Act were not included in the Medicaid Eligibility proposed rule, but either have been or will be addressed in separate rulemaking or other guidance.

Responses to General Comments

Generally, comments were supportive of the policies in the Medicaid Eligibility proposed rule to simplify, streamline, and align the eligibility and enrollment process, coordinate with other insurance affordability programs, reduce or eliminate burdensome requirements on States, and build on successful State practices that are currently underway. Throughout this rule, we summarize comments received that pertain to this rule: comments on policies not contained in this rule are not addressed.

Comment: We received several comments (nearly half of all comments received) raising concerns about coverage of individuals with disabilities or in need of long-term services and supports under the new eligibility group for low-income adults.

Response: We acknowledge and have responded to these concerns as discussed in detail in sections III.B. and III.E. of this preamble and at § 435.603 and § 435.911 of the regulation text.

Comment: We received some comments, questions, and scenarios related to how States will operationalize the policy changes to Medicaid and CHIP that were set forth in the Medicaid Eligibility proposed rule.

Response: As we have done in these regulations, we plan to rely on and build upon State experience with implementing new policies and program changes as a means of ensuring a successful partnership between the States and the Federal government. We also intend to provide intensive technical assistance and support to States, as well as facilitate sharing and collaboration across States as implementation continues. The public comments received will inform the development of future operational guidance and tools that will be designed to support State implementation efforts.

The effective date for this final rule is January 1, 2014. However, it should be noted that States may, and are encouraged to, conduct activities in preparation for the policy and programmatic changes that will need to take place in order to implement the provisions of this final rule. Federal administrative matching funds will be available for such activities.

Comment: Some commenters requested additional information for the data reporting requirements for States to ensure adequate oversight of the administration of the program.

Response: Under existing Medicaid regulations at § 431.16, § 431.17, and § 457.720, States must maintain records, collect data and submit to the Secretary such reports as are needed by the Secretary to monitor State compliance with the regulations and ensure the proper and efficient operation of the Medicaid program. In the Medicaid Eligibility proposed rule, as well as this final rule, we have noted several types of data that States will need to provide, including data to ensure compliance with single State agency regulations at § 431.10, and we will issue guidance on the specific data to be submitted, as well as the format and method for such submission.

Comment: We received some comments regarding the need for program integrity and Payment Error Rate Measurement (PERM) rules to be clarified and aligned with the policies in the proposed rules.

Response: We agree that PERM and other program integrity rules and procedures must be aligned with the new eligibility rules, and also must account for the role that Exchanges may play in determining eligibility in a particular State. We will address these issues in subsequent guidance.

A. Changes to Medicaid Eligibility

To establish a foundation for a more simplified, streamlined Medicaid eligibility process in the context of the new eligibility group for low-income adults that will become effective in 2014, we proposed a more straightforward structure of four major eligibility groups: children, pregnant women, parents and caretaker relatives, and the new adult group.

1. Coverage for Individuals Age 19 or Older and Under Age 65 at or Below 133 Percent of the FPL (§ 435.119)

We proposed to implement section 1902(a)(10)(A)(i)(VIII) of the Act, referred to as ''the adult group,'' under which States will provide Medicaid coverage starting on January 1, 2014 to non-pregnant individuals between 19 and 64 years old who are not otherwise eligible and enrolled for mandatory Medicaid coverage; are not entitled to or enrolled in Medicare; and have household income, based on the new MAGI-based methods (described in more detail in 76 FR 51155 through 51160), at or below 133 percent of the FPL.

Comment: One commenter requested clarification of the requirement at § 435.119(c) that a parent or other caretaker relative living with a dependent child may not be covered by Medicaid under the adult group if the child is not enrolled in Medicaid, CHIP, or other minimum essential coverage. The commenter was uncertain whether this requirement applies to a custodial parent when the child is claimed as a tax dependent by the non-custodial parent and to a non-custodial parent who is required to pay for all, or part, of the child's medical support. Several commenters pointed out the difficulty and unfairness of applying this requirement to a parent in custody situations if the other parent is legally responsible for the child's medical support. Also, the commenters pointed out the difficulty in applying the requirement to a non-parent caretaker relative who is not financially responsible for the child. Another commenter recommended that the requirement be revised to include an exception to the prohibition on coverage for parents and caretaker relatives if an application for a child's coverage is pending. Finally, other commenters were unclear about the eligibility groups to which this requirement applies.

Response: We are finalizing § 435.119(c) without modification. We believe the requirements for coverage of parents and other caretaker relatives under § 435.119 and § 435.218 are clear and consistent with the statutory requirements at sections 1902(k)(3) and 1902(hh)(2) of the Act. The requirements are limited to custodial parents and other caretaker relatives who live with dependent children, because non-custodial parents are not taken into account in determining a child's Medicaid eligibility according to § 435.603 of this final rule. We do not provide an exemption from the requirement if an application for a child's coverage is pending because if a child's pending application is denied for all insurance affordability programs or the parent or caretaker relative fails to enroll the child in such program, the child must be enrolled in other minimum essential coverage for the custodial parent or other caretaker relative to be covered by Medicaid under the § 435.119 or § 435.218. In virtually all cases, if the parent or other caretaker relative is eligible for Medicaid, the child also will be eligible for Medicaid, and the adjudication of

eligibility for the child should not delay the eligibility determination for the parent or caretaker relative.

Comment: Numerous commenters expressed concern about the placement of disabled individuals and individuals needing long-term services and supports in the adult group, because individuals under the adult group will receive a benchmark benefit package that might not cover institutional services, home and community-based services, or other specialized services available under certain optional eligibility groups.

Response: We agree with the commenters' concerns. As discussed further in section III.F. of this preamble, we have revised the policy in § 435.911 of this final rule to address the needs of this population consistent with the statute.

2. Individuals With MAGI-Based Income Above 133 Percent of the FPL (§ 435.218)

We proposed at § 435.218 to implement section 1902(a)(10)(A)(ii)(XX) of the Act that gives States the option, starting on January 1, 2014, to provide Medicaid coverage to individuals under age 65 (including pregnant women and children) with income determined based on MAGI to be above 133 percent of the FPL. We proposed to establish this optional eligibility group for individuals who are not eligible for and enrolled in an eligibility group under section 1902(a)(10)(A)(i) of the Act and 42 CFR part 435 subpart B or under section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and 42 CFR part 435 subpart C; and have household income based on MAGI that exceeds 133 percent of the FPL but does not exceed the income standard established by the State for coverage of this optional group.

Comment: Several commenters recommended that we revise proposed § 435.218 to provide that an individual who appears, based on information provided on the application, to be eligible for Medicaid as medically needy or as a spend down beneficiary in a 209(b) State may be enrolled in the optional group under this section. Another commenter recommended that an individual enrolled in an optional Medicaid group that does not provide minimum essential coverage should not be prohibited from enrollment in the group under § 435.218, which provides full Medicaid benefits.

Response: We believe the rule is clear that only individuals eligible and enrolled as categorically needy for coverage are excluded from coverage under this section. The provision does not apply to individuals potentially eligible as medically needy under section 1902(a)(10)(C) of the Act or as spend down beneficiaries in a 209(b) State eligible under section 1902(f) of the Act. However, we are revising the final rule to specify sections 1902(a)(10)(A)(ii)(I) through (XIX) of the Act as statutory citations for the optional groups related to this requirement, because individuals eligible for the optional family planning group under section 1902(a)(10)(A)(ii)(XXI) of the Act are not excluded from enrollment under the new optional eligibility group at § 435.218. The determination as to whether this coverage constitutes minimum essential coverage is governed by section 5000A of the Code, and the determination as to when an individual is considered eligible for minimum essential coverage is governed by section 36B(c)(2)(b).

Comment: Several commenters requested that we clarify the intended Federal financial participation (FFP) rate for this optional coverage group and whether the enhanced Federal medical assistance percentage (FMAP) rates specified in proposed § 433.10 apply.

Response: As discussed in section III.O. of this preamble, the enhanced FMAP for ''newly eligible'' individuals under section 1905(y) of the Act, as added by section 2001 of the Affordable Care Act, is only available for individuals covered under the new adult group. However, enhanced FMAP rates under CHIP specified at § 433.11 may apply for children younger than age 19 covered under § 435.218 who meet the definition of optional targeted low-income child at § 435.4.

3. Simplified Eligibility Rules for Parents and Caretaker Relatives, Pregnant Women, and Children—Amendments to Part 435, Subpart B (§ 435.110, § 435.116, and § 435.118)

We proposed to streamline and simplify current regulations governing Medicaid eligibility for children, pregnant women, parents, and other caretaker relatives whose financial eligibility, beginning in CY 2014, will be based on MAGI. Consistent with section 1902(a)(19) of the Act, we proposed to simplify and consolidate certain existing mandatory and optional eligibility groups into three categories: (1) Parents and other caretaker relatives (§ 435.110); (2) pregnant women (§ 435.116); and (3) children (§ 435.118). The Medicaid Eligibility proposed rule (76 FR 51152 through 51155) provided a detailed description of the proposed consolidation and explained how certain mandatory and optional groups in current regulations would be moved into the new broader groups for parents and other caretaker relatives, pregnant women, and children under age 19.

Comment: Many commenters supported the proposal. A few commenters recommended that CMS consolidate eligibility categories beyond what was already proposed in this regulation. One commenter suggested having one eligibility group for all individuals with MAGI-based income up to 133 percent of the FPL, one for individuals with MAGI-based income above 133 percent of the FPL, and another for the MAGI-exempt populations. Another recommended eliminating the proposed minimum and maximum income standards and requiring a common income standard of 133 percent of the FPL for parents and other caretaker relatives at § 435.110, pregnant women at § 435.116, and children under age 19 at § 435.118. One commenter stated that nothing about the proposed structure can credibly be described as simplified because it maintains all the old categorical and optional eligibility groups and standards in addition to an entirely new array of ''simplified'' eligibility groupings.

Response: We will consider future rulemaking or issuance of guidance to address further simplification of Medicaid eligibility groups not addressed in this rule. We do not have the statutory authority to eliminate the maximum permissible income standards specified for each eligibility group in this final rule, nor do we think it would be appropriate to eliminate State flexibility to cover each of these groups at a higher income standard up to the maximum permitted.

Comment: Some commenters questioned whether guidance will be issued for the new eligibility group for former foster care children and for the new options of presumptive eligibility provided by the Affordable Care Act starting on January 1, 2014. The commenters also questioned whether certain existing Medicaid mandatory and optional coverage and eligibility groups will remain after January 1, 2014 such as Transitional Medical Assistance; deemed newborn eligibility; optional coverage for parents and other caretaker relatives; women needing treatment for breast or cervical cancer; non-IV–E State subsidized adoption children; continuous eligibility for children; and presumptive eligibility for children and pregnant women.

Response: The Affordable Care Act did not eliminate or change the requirements of existing Medicaid eligibility groups, except to require the use of MAGI-based financial methodologies for the populations

included under MAGI. These eligibility categories and coverage options, as well as the other new eligibility pathways created by the Affordable Care Act will be addressed in future guidance.

Comment: Several commenters questioned whether there is any reason to keep medically needy coverage for Aid to Families of Dependent Children (AFDC) related populations and stated that this is especially a problem because States must cover pregnant women and children under age 18 as medically needy to cover the aged, blind, or disabled (ABD) populations as medically needy. Some commenters were concerned that eligibility for medically needy coverage under Medicaid would preclude eligibility for the advance payments of premium tax credits (APTCs) through the Exchange. Another commenter stated that States should have the option to provide medically needy coverage under section 1902(a)(10)(C) of the Act and 42 CFR part 435 subpart D for the population of adults described in paragraph (xiv) of the matter preceding sections 1905(a) and 1902(a)(10)(A)(i)(VIII) of the Act.

Response: The Affordable Care Act did not change any current requirements for medically needy eligibility under section 1902(a)(10)(C) of the Act, including the requirement that States covering medically needy individuals must cover medically needy pregnant women and children under age 18. However, by expanding coverage to adults under age 65, the Affordable Care Act also provides States with the option to cover as medically needy those adults under age 65 who have incomes above the Medicaid income levels but otherwise meet the eligibility requirements of the adult group or the optional group for individuals with income over 133 percent of the FPL, provided that they meet spend-down requirements. Individuals otherwise eligible for APTCs through the Exchange who can spend down to medically needy eligibility under Medicaid could potentially enroll in either program, depending on whether they elect to spend down to Medicaid eligibility as medically needy. Individuals who do not spend down to Medicaid eligibility may be eligible to receive APTCs for enrollment through the Exchange.

Comment: Many commenters disagreed with the policy in the Medicaid Eligibility proposed rule that States will not be required to convert the statutory minimum income standards set forth in sections 1931 and 1902(l) of the Act for coverage under § 435.110(c)(1), § 435.116(c)(1) and (d)(4)(i), and § 435.118(c)(1) to a MAGI-equivalent standard, to account for disregards and exclusions currently used by the State that are not permitted under MAGI. The commenters stated that some individuals would lose eligibility if a State lowers its income standard for a group to the minimum once the maintenance of effort requirement ends for that population; for others, the scope of benefits could be reduced. Several commenters requested clarification about the conversion of States' income standards to MAGI-equivalent standards and whether income conversion applies for the eligibility groups exempt from MAGI.

Response: We are not revising the final rule to require MAGI conversion of the statutory minimum income standards for each eligibility group, to which a State may reduce its income standard once maintenance of effort ends. Section 1902(e)(14)(A) and (E) of the Act, as added by section 2002 of the Affordable Care Act, provides only for the conversion of the income standards in effect in the State prior to the Affordable Care Act. The Act does not provide for conversion of the Federal statutory minimum income standards. Further, by raising the statutory minimum standard for children ages 6 to 18 to 133 percent of the FPL under section 1902(a)(10)(A)(i)(VII) of the Act, according to section 2001 of the Affordable Care Act, we believe the Congress indicated an intent to align the minimum statutory standards for all age groups of children at 133 percent of the FPL, along with adults under age 65. Since the statutory increase in the minimum standard for older children would not be converted from MAGI, conversion of the minimum standards for younger children would defeat such alignment and result in children in the same family potentially being eligible for different insurance affordability programs depending on their age. (The only exception to complete alignment would be for infants and pregnant women, in States required to cover pregnant women and infants at a higher income standard under section 1902(l)(2)(A) of the Act.) We note that the potential for a State to reduce its income standard for a children's eligibility group to the minimum standard permitted under statute will not occur until the maintenance of effort for children ends on October 1, 2019, in accordance with section 1902(gg) of the Act as added by section 2001 of the Affordable Care Act. In States that reduce coverage of parents and caretaker relatives under § 435.110 to the minimum permitted under statute, the affected individuals may be eligible under the new adult group. Pregnant women affected by a reduction of coverage to the minimum permitted may be eligible for APTC for enrollment through the Exchange.

a. Parents and Other Caretaker Relatives (§ 435.110)

Comment: One commenter stated that CMS should provide clarifying information on how the ''1931 program'' should be administered through both MAGI and AFDC rules.

Response: The rules for Medicaid coverage under section 1931 of the Act are set forth in § 435.110 and the related definitions of ''caretaker relative'' and ''dependent child'' at § 435.4. AFDC methodologies for determining financial eligibility under section 1931 will be superseded effective January 1, 2014 by methodologies based on MAGI (set forth in § 435.603), and therefore, no longer will be relevant to eligibility under section 1931 of the Act.

b. Pregnant Women (§ 435.116)

Comment: Many commenters urged that we revise proposed § 435.116(d) to eliminate the State option to establish an applicable income limit for full Medicaid coverage of pregnant women and only cover services related to pregnancy or to other conditions which may complicate pregnancy (hereinafter referred to as ''pregnancy-related services'') for pregnant women with income above that limit. The commenters recommended that we not permit each State to define pregnancy-related services, but that we amend § 440.210(a)(2) to broadly define ''pregnancy-related services'' as full Medicaid coverage. The commenters noted that this would be consistent with the current practice in most States. Commenters stated that, otherwise, pregnant women with incomes above that limit but with income no more than 133 percent of the FPL might be covered for lesser benefits than non-pregnant adults covered under the adult group at § 435.119, from which pregnant women are excluded by statute. These commenters stated that the Congress did not intend to make low-income pregnant women eligible for a more limited scope of benefits than other adults with the same income.

Response: Clause VII in the matter following section 1902(a)(10) of the Act expressly limits the medical assistance for which pregnant women are eligible under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act to pregnancy-related services. Eligibility for all pregnant women—including those eligible under these sections, as well as sections 1931 and 1902(a)(10)(A)(i)(III) of the Act—is

codified at § 435.116. Pregnant women with income no more than the applicable income limit for full Medicaid coverage defined in § 435.116(d)(4) are eligible under section 1931 or 1902(a)(10)(A)(i)(III) of the Act, while those with income above such limit are eligible under section 1902(a)(10)(A)(i)(IV) or 1902(a)(10)(A)(ii)(IX) of the Act. While we appreciate the commenters' concern, we do not have the authority to specifically require that pregnancy-related services be considered to mean full Medicaid coverage. However, because it is difficult to identify what is ''pregnancy-related'' and because the health of a pregnant woman is intertwined with the health of her expected child, the scope of such services is necessarily comprehensive, as reflected in current regulation at § 440.210(a)(2). Therefore, we are revising § 435.116(d)(3) to clarify that a State's coverage of pregnancy-related services must be consistent with § 440.210(a)(2) and § 440.250(p), which allows States to provide additional services related to pregnancy to pregnant women. If a State proposes not to cover certain services or items for pregnant women that it covers for other adults, the State must describe in a State plan amendment for the Secretary's approval its basis for determining that such services are not pregnancy-related.

Comment: One commenter supported the elimination of the ''third trimester rule,'' which permitted States to deny full-scope Medicaid to pregnant women in the first or second trimester of pregnancy who have no dependent children, for pregnant women's eligibility under section 1931 of the Act.

Response: States have the option under section 1931 of the Act (in accordance with section 406(g)(2) of the Act as in effect prior to enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)) to provide full Medicaid coverage for pregnant women with no dependent children during the third trimester of pregnancy. States are required to cover ''qualified pregnant women'' during all trimesters of pregnancy for full Medicaid benefits, in accordance with sections 1902(a)(10)(A)(i)(III) and 1905(n) of the Act, if they meet the statutory minimum income and resource requirements or more liberal methodologies implemented by the State for this group under section 1902(r)(2) of the Act. These coverage requirements are incorporated into the consolidated group for pregnant women at § 435.116.

Comment: Several commenters raised a question about whether a woman covered under the adult group must be transferred to coverage under § 435.116 when she becomes pregnant, and whether, when the post-partum period ends, the woman would then be transferred back to coverage under the adult group. Commenters were concerned that this could result in lesser coverage at a time when the woman is more vulnerable. Also, these commenters were concerned that this transferring back and forth could impact continuity and quality of care and the receipt of medically necessary services during pregnancy.

Response: While continuity is important, States are not required to monitor the pregnancy status of women covered under the adult group. However, women should be informed, in accordance with § 435.905 related to the availability of program information discussed later in this preamble at section III.E.1, of the benefits afforded to pregnant women under the State's program. If a woman becomes pregnant and requests a change in coverage category, the State must make the change if she is eligible. But, we will not otherwise expect States to monitor pregnancy status and to shift women into the group for pregnant women once they become pregnant.

c. Infants and Children Under Age 19 (§ 435.118)

Comment: Many commenters supported the expanded minimum income standard for children aged 6 through 18 from 100 to 133 percent of the FPL. The commenters also supported States' ability to continue to claim enhanced match from their CHIP allotment for children transferred from a separate CHIP to Medicaid as a result of this Medicaid expansion. One commenter expressed concern about quality, access, and continuity of care when children are moved from coverage under a separate CHIP to coverage under Medicaid, and proposed that children be allowed to remain with their medical home rather than being shifted from one program to another.

Response: States may claim enhanced match from their CHIP allotment for children who meet the definition of an ''optional targeted low-income child'' at § 435.4 and become eligible for Medicaid as a result of the amendment of section 1902(1)(2)(C) of the Act to increase the income standard for mandatory coverage of children aged 6 through 18 under section 1902(a)(10)(A)(i)(VII) of the Act from 100 to 133 percent of the FPL.

4. Other Conforming Changes to Existing Regulations (§ 435.4)

We proposed several definitions specific to the Medicaid eligibility changes under the Affordable Care Act (listed in more detail in 76 FR 51155) and received the following comments.

Comment: One commenter recommended that the definition of ''Affordable Insurance Exchanges (Exchanges)'' be revised to include a ''quasi-governmental agency.'' Another commenter recommended that the definition be revised to include an ''individual market Exchange'' and a ''SHOP Exchange,'' and that ''refer'' be changed to ''may refer'' because some references to an Exchange just refer to certain types of Exchanges.

Response: The definition of ''Exchange'' is outside the scope of the Medicaid regulations and governed by the Exchange regulations. Therefore, we are revising the definition of ''Affordable Insurance Exchanges (Exchanges)'' in this final rule to reference the definition of ''Exchange'' in 45 CFR 155.20 of the final Exchange regulation. We are making a similar revision to the definition of ''advance payment of the premium tax credit (APTC).''

Comment: One commenter recommended that the definition of ''caretaker relative'' include the domestic partner of a child's parent or other caretaker relative, and also a parent or relative standing ''in loco parentis.'' Another commenter pointed out that, under the AFDC rules, a caretaker relative had to be a certain degree of relationship to a dependent child.

Response: States should have the option to consider the domestic partner of a child's parent or relative as a ''caretaker relative'' of a dependent child. We are also revising the final rule to offer States the option to consider any adult with whom a child is living and who assumes primary responsibility for the dependent child's care to be a caretaker relative. However, since caretaker relatives are, in essence, standing in the shoes of a parent to assume primary responsibility to care for a child, we do not see the need to add a reference to relatives standing ''in loco parentis.'' Moreover, the term ''in loco parentis'' could be read overly broadly to include relatives who have only temporary or fleeting custody of the child (such as in the provision of day care or babysitting). We are also revising the definition of ''caretaker relative'' in this final rule to specify the degrees for relationship of relatives, for consistency with current policy based

on section 406(a) of the Act, as in effect prior to enactment of PRWORA. However, we have revised the regulation text to provide States with the option to expand the definition of caretaker relatives to cover additional degrees of relationship to a dependent child.

Comment: Many commenters supported the codification of the definition of ''dependent child,'' including the State option either to eliminate the ''deprivation'' requirement altogether or to establish a higher number of working hours as the threshold for determining unemployment if deprivation is considered. One commenter pointed out that the definition omitted a parent's physical or mental incapacity as a reason for a child to be considered ''deprived'' of parental support and so ''dependent.'' Another commenter expressed concern that the proposed definition of ''dependent child'' would change the longstanding option for States to include as ''dependent children'' 18-year olds who are full-time students to a requirement.

Response: We unintentionally omitted a parent's physical or mental incapacity as a reason for a child to be considered ''deprived'' of parental support, and are adding this to the definition of ''dependent child'' for consistency with 45 CFR 233.90(c)(i), as required by section 1931(b) of the Act. We also revised the final rule to clarify that the 18-year old full-time students included as ''dependent children'' at § 435.4 are those in a secondary school (or equivalent level of vocational or technical training), consistent with the definition of ''dependent child'' in section 406(a) of the Act, as in effect prior to passage of PRWORA. Also, we revised the final rule to clarify that coverage of 18-year old full-time students as ''dependent children'' is a State option, rather than a requirement, consistent with current policy.

Comment: One commenter recommended that the definition of ''insurance affordability program'' be amended to include the Medicare Part D Low Income Subsidy (LIS) program.

Response: The definition of ''insurance affordability program'' mirrors the definition of ''applicable State health subsidy program'' in section 1413(e) of the Affordable Care Act and is limited to the programs included by statute in the streamlined eligibility and enrollment system required by the Affordable Care Act, eligibility for which can be determined based on MAGI. The LIS program does not meet this definition.

Comment: Several commenters stated that the definition and application of the term ''minimum essential coverage'' are unclear. The commenters questioned whether an individual who is covered by Medicaid for limited benefits is considered enrolled in minimum essential coverage and so is ineligible for subsidized full benefits from the Exchange. Commenters pointed to several situations in which Medicaid-eligible individuals receive a limited benefit package including: pregnant women eligible for pregnancy-related services only (if the State does not cover all State plan benefits as pregnancy-related); individuals eligible under the State plan or a waiver for family planning services; individuals eligible under section 1902(a)(10)(A)(ii)(XII) of the Act for tuberculosis-related services only; and certain immigrants who are eligible only for emergency medical services. The commenters recommended that CMS clarify that limited-benefit coverage under Medicaid is not considered ''minimum essential coverage,'' so that individuals would be permitted to receive APTCs to enroll in a qualified health plan (QHP) through the Exchange. For individuals who so choose, commenters suggested that Medicaid would serve as a secondary payer to the Exchange plan.

Response: We do not have authority to define ''minimum essential coverage,'' which is defined in section 5000A(f) of the Internal Revenue Service (IRS) Code (IRC) and is subject to implementing regulations issued by the Secretary of the Treasury, as referenced in the definition at § 435.4. Providing further guidance on the meaning of this term is beyond the scope of this rule, but will be addressed by the Secretary of the Treasury in future guidance. However, we affirm that to the extent that an individual is enrolled in any insurance plan, including an Exchange plan, Medicaid would be a secondary payer. No change has been made to section 1902(a)(25) of the Act, which provides generally that Medicaid pays secondary to legally liable third parties.

Comment: Several commenters recommended that we drop the word ''properly'' from the definition of ''tax dependent'' because the agency cannot and should not determine whether an individual is or will be properly claimed as a tax dependent for tax purposes. The commenters noted that only the IRS can make such a determination.

Response: We made this revision in the final rule to drop the word ''properly'' from the definition of ''tax dependent.'' Also, we revised the definition to reference both sections 151 and 152 of the IRC.

B. Financial Methodologies for Determining Medicaid Eligibility Based on MAGI Under the Affordable Care Act (§ 435.603)

In the Medicaid Eligibility proposed rule, we set forth proposed methodologies to implement MAGI in determining financial eligibility for Medicaid for most individuals effective January 1, 2014. Consistent with section 1902(e)(14) of the Act, our proposed methodologies codify the definition of MAGI and household income in section 36B of the IRC (''36B definitions''), except in a limited number of situations.

We received the following comments concerning the proposed provisions for determining financial eligibility based on MAGI methods. We also received many questions from commenters asking how MAGI applies in specific scenarios. We will continue to provide information and assistance for such scenarios as we work with States to implement these final regulations.

1. Basis, Scope, and Implementation (§ 435.603(a))

Comment: Some commenters suggested that the final regulation should permit a State to convert its current income levels for eligibility groups to which MAGI-based methodologies do not apply to a MAGI-equivalent threshold using a process that is the same as or similar to that provided under section 1902(e)(14)(A) and (E) of the Act for groups to which MAGI-based methodologies will apply. Commenters were concerned that States would have to maintain two eligibility systems, but would not receive Federal funds to maintain the necessary legacy systems.

Response: We do not have the statutory authority to permit States to apply MAGI-based methodologies and convert current income standards to equivalent MAGI-based standards for MAGI-excepted individuals and eligibility groups described under section 1902(e)(14)(D) of the Act. However, if a State is able to demonstrate that application of MAGI-based methods to an income standard converted for such methods is less restrictive than the methodologies and standard otherwise applied, a State may be able to accomplish the goal sought by the commenters by proposing a State plan amendment in accordance with section 1902(r)(2) of the Act. Alternatively, a State could seek to convert standards for MAGI-excepted groups to MAGI-based methods through a demonstration under section 1115 of

the Act. We are available to work with any State interested in exploring this possibility.

We do not believe States will need to maintain two eligibility systems, even with the different income methodologies for the MAGI and non-MAGI populations, nor will Federal matching funds be available to operate two eligibility systems. We note that State eligibility systems currently must support eligibility categories using different financial methodologies, based on the rules applied under either the AFDC or Supplemental Security Income (SSI) programs. Enhanced funding is available to States to develop, design, and maintain eligibility systems supporting the full range of eligibility categories, as long as certain conditions and standards ensuring high performance are met. States can also use the enhanced funding to transform their eligibility systems in phases, since 90/10 match is available through the end of CY 2015 for design and development activities. Legacy systems unable to meet those conditions and standards are still eligible for a 50/50 match.

Comment: Many commenters recommended that current beneficiaries be converted to MAGI as of their first redetermination on or after January 1, 2014, so that everyone's eligibility would not have to be redetermined as of January 1, 2014 to see if the grace period applies, which would place an enormous burden on States.

Response: Section 1902(e)(14)(D)(v) of the Act, as added by section 2002 of the Affordable Care Act, provides for a temporary grandfathering of coverage for beneficiaries who are enrolled in Medicaid on January 1, 2014 and would lose eligibility due to the application of MAGI-based methodologies prior to March 31, 2014 or their next regularly-scheduled renewal, whichever is later. We proposed this provision in the Medicaid Eligibility proposed rule at § 435.603(a)(3); however, we are deleting in the final rule the phrase in the Medicaid Eligibility proposed rule that provides for the delay of the application of MAGI-based methodologies to current beneficiaries ''if the individual otherwise would lose eligibility as the result of the application of these methods,'' as we believe that this phrase is unnecessary and may be the source of the commenters' concern. We revised § 435.603(a)(3) in the final rule to clarify that MAGI-based methodologies will not be applied to current beneficiaries who were determined eligible for Medicaid on or before December 31, 2013 until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 435.916, whichever is later. However, according to § 435.603(a)(2), MAGI will be applied to individuals whose eligibility for Medicaid is determined effective on or after January 1, 2014.

2. Definitions (§ 435.603(b))

Comment: Many commenters recommended that, in the case of a pregnant woman expecting more than one child, States be required to count each expected child in determining family size when making an eligibility determination for a pregnant woman, as well as when determining eligibility for other household members. A few other commenters recommended that States be provided with the option to count each expected child, especially for the family size of other household members.

Response: Our intent was to codify current Medicaid policy for household size for pregnant women, but the Medicaid Eligibility proposed rule did not accomplish this intent. Therefore, we are revising the definition of ''family size'' in § 435.603(b) to be consistent with current policy, as intended. Under the final rule, for the purpose of determining a pregnant woman's eligibility, family size will reflect the pregnant woman plus the number of children the woman is expecting. For the family size of other individuals in the pregnant woman's household, States will have the option to count the pregnant woman as either one or two persons or to count her as one person plus each expected child, if more than one.

3. Financial Methodologies Based on MAGI § 435.603(c) Through (i)

Comment: Many commenters believed that, in attempting to strike the proper balance between using 36B policies and current Medicaid policies, the Medicaid Eligibility proposed rule is too complex. Others supported the exceptions from 36B definitions provided in the Medicaid Eligibility proposed rule—including the treatment of certain types of income and the treatment of individuals claimed as qualifying relatives by someone other than a parent or spouse, children claimed as a tax dependent by a non-custodial parent, and spouses who do not file a joint tax return—but believed that we should go further to retain current Medicaid principles in all instances. Some commenters expressed concern about the impact of using the 36B definitions on States' budgets because the 36B definitions are more generous in the treatment of several types of income from the perspective of individuals seeking eligibility as compared to current Medicaid methods. Other commenters stated that we are not justified in deviating from the 36B definitions, and that the rule should be simplified by adopting the 36B definitions without exception. One commenter stated that the proposed regulations violate a clear Congressional mandate at section 1902(e)(14) of the Act to use MAGI as defined by the IRC for determining Medicaid and CHIP eligibility. Several commenters recommended that CMS first apply the 36B definitions and then apply current Medicaid rules if the individual is ineligible based on the 36B definitions, or give individuals a choice as to which rules are applied.

Response: After consideration of all of these comments, we are not modifying our policy. As explained in the Medicaid Eligibility proposed rule (76 FR 51155 through 51159), eligibility for most individuals for Medicaid, as well as for APTCs, is based in the statute on the 36B definitions and we do not have flexibility to retain current Medicaid rules across the board. While there are some modest differences between the 36B definitions and the MAGI-based household and income counting rules adopted for Medicaid, due to statutory requirements at section 1902(e)(14)(H) of the Act for continued application of Medicaid rules regarding point-in-time income and sources of income, the rules adopted are for the most part fully consistent with the 36B definitions and we believe that overall, simplicity has been achieved relative to current Medicaid household and income counting rules. Where there are differences, we believe that they can be handled without compromising seamless coordination. We believe that by using targeted solicitation of information and computer programming tools, States can implement these requirements efficiently. We will work closely with States to provide technical assistance on this and other issues as we work together to implement this final rule.

Comment: Many commenters expressed concern about potential gaps in coverage due to application of different MAGI-based methods for determining financial eligibility for Medicaid and APTCs for enrollment through the Exchange. Several commenters recommended a ''safe harbor'' to ensure coverage in Medicaid for individuals who otherwise would fall into a coverage gap because their household income based on the MAGI-based methodologies in § 435.603 is above the applicable Medicaid income standard, but household income based on the 36B definition of MAGI and

household income is below the floor of 100 percent of the FPL for APTC eligibility.

Response: We believe that such potential coverage gaps will be rare, but agree that eliminating any potential gap is important. Therefore, we are redesignating proposed paragraph (i) of § 435.603 to paragraph (j) in this final rule and are adding a new paragraph (i) to provide that States apply the 36B definitions in the situation described above.

Comment: Several commenters questioned how States or applicants can be expected to determine and verify prospectively for the current calendar year who will file for taxes, what dependents will be claimed, and whether children or other tax dependents will be required to file a tax return. Commenters pointed out that such determinations may affect eligibility and questioned whether the State needs to verify whether an individual is properly claiming someone as a dependent or whether an individual must file taxes; if so, the commenters were concerned that this would interfere with the IRS's authority. Several commenters stated that such attestations would be prone to fraud, abuse, and error. One commenter expressed concern about a State's potential liability when making Medicaid determinations regarding tax dependency that is later proved wrong when the individual files his or her tax return.

Response: As with other factors of eligibility, States must make their best determination as to whether an individual's attestation or statement regarding the tax dependency status of another individual is reasonable, based on the information available at the time. However, there may be circumstances in which such status cannot be reasonably ascertained. We have added a new paragraph (f)(5) in § 435.603 to provide that when a taxpayer cannot, consistent with the procedures adopted by the State in accordance with § 435.956(f), reasonably establish that another individual will be a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of the other individual in the household of the taxpayer is determined in accordance with the rules for non-filers set forth in paragraph (f)(3) of § 435.603. Finally, the PERM program, which identifies improper payments, measures the accuracy of the agency's determinations based on the information available to the agency at the time the determination is made, not based on information that only becomes available at a later date, when the taxpayer actually files his or her tax return. We will be working to ensure that all PERM rules and instructions conform to this principle and will issue additional guidance for States as needed.

4. Household Income (§ 435.603(d))

Comment: Several commenters recommended using current Medicaid policies for determining whether a child's income is counted, rather than requiring the applicant and the agency to determine whether a minor or adult child who is included in the parent's household will be required to file taxes for the current calendar year. The commenters questioned how States can determine prospectively whether an individual will earn enough during the year for which eligibility is being determined to be required to file a tax return.

Response: Except in cases where the statute provides for use of a different rule for Medicaid, we must apply the 36B rules for household income when States determine Medicaid financial eligibility for MAGI-included populations. The statute calls for reliance on the 36B household definition. We have clarified the regulation text at § 435.603(d)(2)(i) to provide that the income of a child included in his or her parent's household is not counted if the child is not expected to be required to file a tax return for the year in which coverage is sought. We expect that States will be able to make a reasonable determination as to whether an individual will be expected to be required to file a tax return, based on the individual's current income for the applicable budget period (current monthly income for applicants; current monthly, or projected annual income for beneficiaries if the State exercised the option provided at § 435.603(h)(2)). Such determinations would be based on information available at the time of application and renewal, not based on information only available at a later date, and States will not be held accountable for reasonable determinations made at the time of the determination, even if later proven wrong. Filing requirements are contained in section 6102 of the IRC and are discussed in IRS Publication 501.

However, we are revising § 435.603(d)(2) to make a technical correction in the language so as to implement the intent behind the proposed regulation to clarify when the income of tax dependents is and is not counted in total household income. Specifically, we are redesignating § 435.603(d)(2) of the Medicaid Eligibility proposed rule at paragraph (d)(2)(i) of this final rule and adding language at § 435.603(d)(2)(ii) to clarify that the income of tax dependents other than the taxpayer's children also is not counted in determining household income of the taxpayer if such dependent is not expected to be required to file a tax return. The income of such tax dependents, who are described in § 435.603(f)(2)(i), is counted in determining the tax dependent's household income. For example, consider Taxpayer Joe, an adult (not himself claimed as a tax dependent) who claims his Uncle Harry as a tax dependent. Harry is not expected to be required to file a tax return. Consistent with the 36B definitions, Harry is included in Joe's family size for purposes of Joe's eligibility per § 435.603(f)(1), but Harry's income is not counted in Joe's household income under § 435.603(d)(2)(ii). Under § 435.603(f)(2)(i) and (f)(3) of our regulations, Harry will be considered for Medicaid eligibility as a separate household, and under § 435.603(d)(1), Harry's income will be counted in determining his own eligibility.

Comment: Many commenters supported the exception at § 435.603(f)(2)(i) to the use of 36B definitions for individuals claimed as a tax dependent by someone other than a parent or spouse, and the application of the household composition rules for non-filers in determining such individuals' eligibility. However, some of the commenters opposed inclusion of the requirement at § 435.603(d)(3) to count as household income for such individuals any actually available cash support received from a taxpayer who claims the individual as a tax dependent. Several commenters stated that this policy would be difficult to implement and that obtaining and verifying information about such support would interfere with real-time eligibility determinations, while not making much of a difference in the eligibility result. One commenter suggested counting such support only if it exceeds a certain amount, but not counting insignificant sums.

Response: After considering the comments received, we are revising this provision in the final rule to make it a State option, rather than a requirement, to count actually available cash support, exceeding nominal amounts, provided by a taxpayer to a tax dependent in determining the latter's eligibility.

5. MAGI-Based Income (§ 435.603(e))

Comment: In the Medicaid Eligibility proposed rule (76 FR 51157), we proposed income counting rules at § 435.603(e) that are, in general, the

same as the section 36B definitions, to ensure streamlined eligibility rules and avoid coverage gaps. We solicited comments on the application of the treatment of non-taxable Social Security benefits under the section 36B definitions for purposes of Medicaid eligibility. We received many such comments.

Response: When the Medicaid Eligibility proposed rule was published, section 36B of the IRC did not include non-taxable Social Security benefits in MAGI. Public Law No. 112–56, signed into law on November 21, 2011, amended section 36B(d)(2)(B) of the IRC to modify calculation of MAGI to include in MAGI Social Security benefits which are not taxed. Therefore, all Social Security benefits under Title II of the Act, including those that are not taxable, will be counted in determining MAGI for Medicaid and other insurance affordability programs.

Comment: We also solicited comments on our proposal to retain current Medicaid rules for the treatment of income in three limited circumstances: Lump sum payments; certain educational scholarships and grants; and certain American Indian and Alaska Native (AI/AN) income.

While many commenters supported the proposed policy for consideration of lump sum income, several commenters opposed counting a lump sum as income only in the month received and not prorating lump sum income to count such windfalls of potentially large amounts of money (for example, lottery earnings or gambling profits) over the period under consideration.

Response: The policy specified in the Medicaid Eligibility proposed rule reflects the methodology already applied in many States. It also reflects the SSI policy that is used for many non-MAGI eligibility groups. No commenter provided evidence and we are not aware of any evidence that this policy will have a significant impact on Medicaid eligibility. We believe that the potential for individuals who receive large windfalls of money in a lump sum payment to become eligible for Medicaid under the rule is outweighed by the likelihood that many more low-income individuals would lose Medicaid eligibility under the commenters' proposal due to receipt of a small lump sum payment that is not in fact available to purchase coverage through the Exchange throughout the year.

Comment: A number of commenters requested that the rule specify that if an individual is determined ineligible due to lump sum income, the individual's eligibility should be considered for the next month when the lump sum income is not taken into consideration, and the individual should not be required to file a new application.

Response: We are not requiring States to reconsider applicants' eligibility in a subsequent month without a new application if lump sum income in the month of application results in financial ineligibility for Medicaid. However, doing so is permitted under the statute and regulations.

Comment: Some commenters supported our proposed policy at § 435.603(e)(2) for certain educational scholarships and grants to be excluded as MAGI-based income; no commenters opposed the proposed policy.

Response: We are finalizing § 435.603(e)(2) as proposed, except that we are also excluding awards used for education purposes. It was an oversight that such awards were not mentioned in the Medicaid Eligibility proposed rule.

Comment: Several commenters recommended clarifying revisions in the exemption of certain AI/AN income specified at § 435.603(e)(3) to reflect section 5006 of the American Recovery and Reinvestment Act of 2009 (Recovery Act) (Pub. L. 111–5, enacted on February 17, 2009) and other legislative and statutory requirements. Several commenters supported the provisions proposed in § 435.603(e)(3) to use the most beneficial (that is, least restrictive) exemptions of AI/AN income from the current Medicaid and 36B rules, to maximize these individuals' access to Medicaid coverage while maintaining enrollment simplification and coordination.

Response: We are finalizing § 435.603(e)(3) with some modifications for consistency with Federal statutory requirements about certain AI/AN income and with the guidance issued by CMS on January 22, 2010 in State Medicaid Director Letter #10–001, available at *http://www.cms.gov/smdl/downloads/SMD10001.PDF.*

Comment: Several commenters suggested that we replace the words ''distributions'' and ''payments'' with the term ''income derived'' throughout § 435.603(e)(3).

Response: Section 5006(b) of the Recovery Act specifies that these properties and ownership interests are excluded resources for Medicaid and CHIP. Monies that result from converting excluded resources are not considered income, but are still considered resources. Therefore, changing ''distributions'' and ''payments'' to ''income derived'' would reclassify exempted resources as income that would need to be counted under MAGI, which we do not believe is the commenter's intent. Resources are not counted in determining financial eligibility using MAGI-based methods. Therefore, we are not accepting the comment.

Comment: Several commenters recommended adding exclusions for Judgment Funds distributions due to their exclusion from taxable income under the Judgment Fund Use and Distribution Act (25 U.S.C. 1401, *et seq).*

Response: We are finalizing § 435.603(e)(3) without adding a specific exclusion for Judgment Funds because the IRC and the section 36B definition of MAGI treat Judgment Fund distributions either identically to or more liberally than current Medicaid rules for exclusions from consideration for AI/AN populations. In § 435.603(e)(3), we are only listing the specific types of distributions that the IRC treats as taxable income, but which are excluded from consideration as income for purposes of Medicaid and CHIP eligibility under the Recovery Act and current law.

Comment: Several commenters stated that proposed § 435.603(e)(3) narrows the exclusion under section 1396a(ff) of the Act of distributions from ownership interests and real property usage rights relating to off-reservation hunting, fishing, gathering, harvesting, or usage rights not tied to real property ownership from consideration for purposes of Medicaid eligibility.

Response: We have added a new paragraph (iii) at § 435.603(e)(3) (and have renumbered paragraphs (iii) through (v) in the Medicaid Eligibility proposed rule as (iv) through (vi) in this final rule) to exclude distributions and payments derived from the ownership interests and real property usage rights at issue.

Comment: Several commenters inquired whether alien sponsor deeming will still apply under MAGI policies for Medicaid.

Response: Nothing in the Affordable Care Act changed the requirements in section 421 of PRWORA, as amended, which require that the income of a sponsor and the sponsor's spouse be deemed available to certain sponsored non-citizens. We expect to provide subsequent guidance on this matter.

Comment: Several commenters mentioned that the proposed rules are silent on how to treat other types of income, and requested clarification as to whether current Medicaid rules or the 36B rules will apply to those types of income in determining Medicaid eligibility.

Response: Unless there is an exception provided at § 435.603(e) of the regulation, 36B definitions are

applied to all types of income. We will provide subsequent detailed guidance on the treatment of all types of income under the new MAGI-based methodologies.

Comment: Several commenters requested guidance regarding how States will obtain different MAGI income calculated for various household members.

Response: Section 1902(e)(14) of the Act, as added by section 2002 of the Affordable Care Act, provides for application of a new set of rules—or methodologies—to determine financial eligibility for Medicaid. While the new Medicaid MAGI-based financial methodologies differ somewhat from current Medicaid AFDC-based methodologies, the need to determine countable income for different household members is similar to the process used today for obtaining information and calculating countable income for eligibility determinations. States generally will need to obtain information through the application process, as well as from electronic data sources to calculate the MAGI-based income of each person in the household whose income will be included in total household income.

6. Household (§ 435.603(f))

Comment: One commenter encouraged the Federal agencies to come up with a common, workable definition of household and fully reimburse States for the cost of implementing the new definition, including the costs resulting from any increased Medicaid and CHIP enrollment.

Response: While we understand the commenters' interest in having a single definition of household across all Federal programs, the statutory provisions governing the definitions and methodologies for each program necessitate some variation. State options, such as Express Lane eligibility, offer ways that States can look beyond differences in program definitions. Enhanced funding at a 90/10 matching rate is available for systems development needed to implement the new rules subject to certain standards and conditions, under the ''Federal Funding for Medicaid Eligibility Determination and Enrollment Activities'' final rule published on April 19, 2011 (76 FR 21950). Under section 1905(y) of the Act, increased FFP, set at 100 percent for the first 3 years of implementation and phasing down to 90 percent in 2020 and beyond, also is available for ''newly-eligible'' individuals eligible for coverage under the adult group at § 435.119.

Comment: One commenter questioned whether States can permit an applicant to exclude certain household members (for example, a stepparent or a sibling with income) to make other members eligible for Medicaid, as is permitted currently under Medicaid.

Response: Individuals cannot choose who is to be included or excluded from their household under § 435.603(f).

Comment: Some commenters see no reason to apply different policies for tax filers versus non-filers or based on who files and claims someone else in the family as a tax dependent. These commenters stated that whether and how families file taxes should not have such a direct impact on their eligibility for health insurance.

Response: As explained in the preamble of the Medicaid Eligibility proposed rule (76 FR 51156–51159), section 1902(e)(14)(A) of the Act generally requires application of tax relationships in determining household composition, except as provided in section 1902(e)(14) (D) and (H) of the Act. However, in the case of non-filers, there are no tax relationships upon which to determine the household for purposes of Medicaid eligibility. Therefore, separate rules are needed. As explained in the Medicaid Eligibility proposed rule (76 FR 51158 through 51159), we are issuing rules for non-filers which, for most families, will result in the same outcome as the rules for tax filing families. Also, we are revising language at § 435.603(f)(1), (f)(2), and (f)(3) to replace language about who ''files'' a tax return with who ''expects to file'' and to replace language about who ''is claimed'' with who ''expects to be claimed'' as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made. Similarly, consistent with tax-filing rules, we are providing at § 435.603(d)(2)(i) and (ii) that the income of a child or other tax dependent is not counted in the taxpayer's household income if such dependent does not expect to be required to file a tax return for the year in which coverage is sought.

Comment: Many commenters expressed particular concern about stepparent deeming under § 435.603(f)(1) and (f)(2) of the rule, especially in States where stepparents are not financially responsible for stepchildren or if the stepparent does not claim the stepchild as a tax dependent. Many commenters also opposed counting a child's income in determining the eligibility of other household members, including parents and siblings. Some commenters opposed inclusion in the parents' household of children aged 21 and older and those living outside the parents' home if such child is claimed as a tax dependent. The commenters feel that adopting the 36B definitions in such cases will result in a loss of eligibility that cannot be justified by a desire for consistency between Medicaid and Exchange policies. Several commenters mentioned the *Sneede v. Kizer* and related court decisions which prohibit income deeming for individuals besides the spouse or a minor child's parents.

Response: Some individuals' eligibility will be affected by the inclusion of children in their stepparents' household, the inclusion of older children and those living outside of the home in the parents' household if they are claimed as tax dependents, and the inclusion of stepparent income, as well as the income of a child or sibling when required to file a tax return. However, the law generally requires that Medicaid apply the 36B household and income definitions beginning in 2014. Therefore, for the reasons specified in the Medicaid Eligibility proposed rule (76 FR 51157 through 51159), we are finalizing without modification the provisions relating to the inclusion of stepchildren and stepparents in the household and the counting of child and sibling income when such income exceeds the filing threshold defined in the IRC. We do not comment on specific existing court orders. Parties affected by such orders must determine whether they need to seek relief or modification from the appropriate court in light of the changes to Federal law affected by the Affordable Care Act.

Comment: Several commenters stated that the agency should not have to determine whether an individual aged 19 or 20 is a full-time student for purposes of the household composition rules at § 435.603(f)(3) because doing so will increase the administrative burden and time required for determining eligibility.

Response: While determining student status may add to administrative burden and complexity, we do not think it appropriate to prohibit States from counting parental income for full-time students age 19 and 20 whom the parents can claim as qualifying children on their tax return. To accommodate both these concerns, we are revising the final regulations at § 435.603(f)(3)(ii) and (iii) and adding a new paragraph at § 435.603(f)(3)(iv) to provide States with the flexibility to consider children and siblings age 19 or 20 who are full-time

students to be members of the same household as the parents and other siblings under age 19. Conforming revisions to the exceptions to the application of the 36B definitions at § 435.603(f)(2)(ii) (relating to children living with both parents who do not expect to file a joint tax return) and § 435.603(f)(2)(iii) (relating to children expected to be claimed as a tax dependent by a non-custodial parent) also are made to align the ages of children specified in those paragraphs with the option now afforded States under § 435.603(f)(3)(iv).

Comment: Regarding the exception to the application of the 36B definition of household at § 435.603(f)(2)(ii) for children living with both unmarried parents, some commenters recommended that we follow the 36B definition to count only income of the parent claiming the child as a tax dependent. The commenters were concerned that similarly-situated families will be treated differently depending on their tax filing and marital status, such as a child living with married parents compared with a child living with unmarried parents. These commenters stated that under the Medicaid rule, the income of both parents will be counted in determining the child's Medicaid eligibility; whereas under the Treasury rule, only the income of the parent claiming the child as a tax dependent will be counted in determining eligibility for APTC through the Exchange. Although the income of both parents in this situation is considered for the child's Medicaid eligibility under current Medicaid rules, the commenters were concerned that counting both parents' income for the child's Medicaid eligibility could cause a gap in coverage if the Exchange only counts the income of one parent and both parents have income below the Medicaid standard for coverage under the adult group.

Response: We do not believe that the gap about which the commenters are concerned will, as a practical matter, exist. If one parent has income above the applicable MAGI standard for the child's Medicaid eligibility, that parent can receive an APTC for the child, as long as the parent claims the child when filing his or her tax return for the year in which coverage is sought. If both parents' income is below 100 percent of the FPL, we believe that the child's household income for a family size including both parents, as well as the child, will be at or below the lowest possible applicable MAGI standard possible for children under Federal law—133 percent of the FPL, so the child will be eligible for Medicaid. However, new § 435.603(i) eliminates any inadvertent gaps in coverage resulting from a difference in methodologies applied under the Medicaid and Exchange regulations.

Additionally, we are making a technical change to the proposed regulation at § 435.603(f)(2)(ii) to except a child from the general rule applicable to children expected to be claimed as a tax dependent by a parent in paragraph (f)(1). The Medicaid Eligibility proposed rule applied this exception to children under 21 who are living with both parents when the parents are not married. The intent, as explained in the Medicaid Eligibility proposed rule (76 FR 51158), was to apply this exception in the case of children living with both parents when the parents cannot (because they are not married) or do not choose to file a joint tax return. We are revising paragraph (f)(2)(ii) to reflect this intent in this final rule. Under the final rule, the rules applicable to non-filers at § 435.603(f)(3) will apply to children living with both parents, when the parents do not expect to file a joint tax return.

Comment: Commenters generally supported proposed § 435.603(f)(2)(iii) for recognizing that custodial parents need to be able to apply for and obtain, based on that parent's income, coverage for the child, regardless of which parent claims the child as a tax dependent. However, commenters also expressed concern that different policies applied for purposes of determining Medicaid eligibility versus eligibility for APTCs (for which the child is always counted in the household of the parent who claims the child as a tax dependent) would be difficult to administer and may result in a gap in coverage in some situations. Some commenters stated that the proposed Medicaid policy for custody situations does not address joint or shared custody arrangements. Many commenters suggested more flexibility in the rules, such as permitting parental choice. Some commenters recommended that if the custodial parent refused to apply for Medicaid for the child, the non-custodial parent should be able to apply for the child. Some commenters recommended that the non-custodial parent's income rather than the custodial parent's income be counted for the child's eligibility if that would make the child eligible. A few commenters pointed out that if a court requires a non-custodial parent to provide medical support for the child, the non-custodial parent may not know whether the custodial parent has filed an application for coverage under Medicaid or other insurance affordability programs.

Response: We agree with the commenters that the rule regarding shared or joint custody situations needs clarification. We are revising § 435.603(f)(2)(iii) to provide that, for purposes of Medicaid eligibility, the custodial parent is established based on physical custody specified in a court order or binding separation, divorce, or custody agreement; or if there is no such order or agreement or in the event of a shared custody agreement, based on with whom the child spends more nights. This definition is consistent with the rule applied by the IRS for determining which parent may claim a child as a tax dependent. (See IRS Publication 501.)

We do not agree that a gap is created by the lack of alignment in the rules. A divorced or separated parent is not required to claim a child in the current tax year simply because he or she did so in the year before coverage is sought. Under sections 151 and 152 of the IRC (and as explained in IRS Publication 501), the custodial parent has the right to claim the child as a tax dependent, and only with the custodial parent's agreement can the non-custodial parent do so. Thus, by claiming the child on his or her tax return, the custodial parent can avoid any potential coverage gap that might otherwise result. We also do not agree that parents should be able to choose which parent claims the child as a member of his or her household for purposes of Medicaid eligibility, or that the non-custodial parent should be able to claim the child as part of his or her household whenever the custodial parent does not file an application for Medicaid, which would create a potential for gaming the rules (by allowing the parents to include the child in whichever household would make the child Medicaid eligible).

Comment: One commenter requested that we clarify the meaning of ''living with'' in the context of the non-filer household composition rule and questioned whether the State would have the flexibility to determine this in the context of students and in other situations.

Response: This provision, which relates to whether spouses, parents, and children are members of the same household for purposes of determining financial eligibility and reflects longstanding Federal policy derived from the former AFDC program, is a different matter than the State residency rules addressed in section III.C. of this preamble and § 435.403 of this final rule. We will consider providing future guidance on the meaning of this term.

Comment: A commenter questioned whether a child under age 21 not living with the child's parents may file an application without the parent being informed or involved (even if the parent claims the child as a tax dependent), consistent with current practice in many States.

Response: State law and regulation establish who may file an application for an insurance affordability program on behalf of a child under age 21, and nothing in the Affordable Care Act or these regulations alters State authority or flexibility on this matter.

Comment: One commenter asked whether the omission of the word ''natural'' related to siblings in § 435.603(f)(3)(iii) was an oversight.

Response: The omission of ''natural'' before ''adoptive and stepsiblings'' in § 435.603(f)(3)(iii) was an oversight which we are correcting in this final rule.

Comment: Several commenters recommended retaining current Medicaid policies for a minor child who is pregnant or a custodial parent and is living with the minor child's parent, so the minor child may be considered as a separate household from the minor child's parent if otherwise the minor child would be ineligible, even if the minor child's parent is claiming the child as a tax dependent.

Response: Under section 1902(a)(17)(D) of the Act, States currently are generally required to count the income of a minor child's parent in determining the child's eligibility. However, prior to the implementation of MAGI in 2014, States may use the authority of section 1902(r)(2) or 1931 of the Act to adopt a more generous financial methodology and disregard a parent's income to make a pregnant teen or teen parent eligible. Such income disregards will not be possible under the MAGI-based financial methodologies.

7. No Resource Test or Income Disregards (§ 435.603(g))

Comment: Many commenters supported the proposal to prohibit consideration of assets in determining financial eligibility for Medicaid and CHIP. A few commenters recommended retaining the asset test because eliminating the test entirely could incentivize people with significant assets to stop working and could result in others with significant assets, but minimal income, being enrolled in Medicaid at the taxpayer's expense.

Response: Section 1902(e)(14)(C) of the Act, as added by section 2002 of the Affordable Care Act, expressly prohibits consideration of assets in determining eligibility for individuals whose financial eligibility is based on MAGI methods. We do not have the flexibility to issue regulations to the contrary and are finalizing the regulation at § 435.603(g) as proposed. We note that currently almost all States do not consider assets when determining children's eligibility for Medicaid and nearly half of all States have also dropped the asset test for parents.

8. Budget Period (§ 435.603(h))

Comment: In the Medicaid Eligibility proposed rule (76 FR 51156), we solicited comments on how best to prevent a gap in coverage between eligibility for Medicaid and for APTCs through the Exchange when eligibility for APTCs is based on annual income, whereas eligibility for Medicaid is based on current monthly income. Many commenters expressed concern that the goals of coordination and simplicity will be undermined if the budget periods used by Medicaid, CHIP, and the Exchange are not aligned, and that confusion on the part of consumers and gaps in coverage might result. Many commenters recommended either requiring the use of annual income for new applicants or providing this as a State option. One commenter suggested requiring use of annual income, but giving applicants a choice to use current monthly income if less than annual income. A number of commenters also recommended requiring use of annual income for current beneficiaries, rather than doing so at State option. Some commenters urged that the annual income previously reported to, and available through, a data match with the IRS be used by all programs. A number of commenters recommended that annual projected income for beneficiaries under the option afforded States in proposed § 435.603(h)(3) be based on each individual's 12-month redetermination period established under § 435.916, rather than the current calendar year, as proposed in § 435.603(h)(2). Several commenters stated that a mechanism is needed to cover individuals in Medicaid if their current monthly income exceeds the Medicaid limits but they are ineligible for APTCs through the Exchange because their projected annual income is less than 100 percent of the FPL.

Response: The Medicaid ''point in time'' principle is explicitly retained in the Affordable Care Act. Thus, we are finalizing § 435.603(h)(1) as proposed to require the use of current monthly income in evaluating eligibility of applicants and individuals newly enrolling in the program, as provided under section 1902(e)(14)(H) of the Act. However, we agree with the commenters that unintended gaps in coverage should be avoided. As discussed above, we are adding new language at § 435.603(i) of the final rule to apply 36B methodologies, including use of annual income, when application of different MAGI-based methods under Medicaid than those applied under the 36B definitions otherwise would result in a gap in coverage. We also are revising § 435.603(h)(2) to clarify that the projected annual household income which States can opt to use for current beneficiaries is for the remainder of the current calendar year. This will prevent a gap in coverage and someone bouncing back and forth between programs when current monthly income is below the Medicaid income standard, but projected annual income based on the full calendar year (including previous months) is above the Medicaid standard.

Comment: Several commenters expressed concern about how to determine applicants' MAGI-based income for a monthly budget period, as some of the line items on the Federal tax return, reported as an annual figure, are not easily translated to a monthly amount.

Response: While we are not addressing this issue in this rulemaking, we understand the need for further information and will provide ongoing technical assistance on the determination of current monthly income using MAGI-based methodologies in the context of working with States on implementing this final rule.

Comment: Several commenters stated the potential difference in FPL amounts used by Medicaid as compared with the Exchange for determining eligibility.

Response: Because Medicaid eligibility is determined at a point in time, Medicaid uses the FPL amounts that are published and in effect when eligibility is determined. Under 45 CFR 155.300(a) of the final Exchange regulation and § 1.36B–1(h) of the proposed Treasury regulation, eligibility for APTCs is based on the most recently published FPL amounts as of the first day of the annual open enrollment period for applying for coverage in a QHP through the Exchange. Since Medicaid will always use the same or more recent FPL amounts, which are adjusted for inflation, than those used for purposes of the APTC, the FPL amounts for Medicaid will be either the same as or higher than the amounts used for purposes of APTC eligibility. Therefore, no gap in coverage will result. In addition, we are adding a

definition of FPL to § 435.4 of the Medicaid final rule.

Comment: Many commenters supported the flexibility offered to States at § 435.603(h)(3) to adopt a reasonable method for including a prorated portion of reasonably predictable future income when determining eligibility for applicants and current beneficiaries, to account for seasonal workers, changes in employment contracts, or layoffs. Many commenters recommended that this method be required to prevent churning in and out of coverage, rather than offered to States as an option. A few commenters recommended that States be required to take into account predictable decreases, but not increases, in income. One commenter recommended that States not be given the option to include future increases in income, which may never come to pass. Several commenters recommended that the rule provide examples of what CMS would consider to be a ''reasonable method.'' Several commenters recommended that proposed § 435.603(h)(1) be amended to make it clear that paragraph (h)(3) is an exception to the use of monthly income under paragraph (h)(1).

Response: We are finalizing proposed § 435.603(h)(3) without modification. The policy is designed to provide States with flexibility to reduce churning between programs, which results from the fluctuations in income experienced by many Medicaid beneficiaries, and thereby to promote continuity of coverage for individuals and reduce administrative burden on States. States may make different choices in how best to achieve the goals of efficiency and continuity of coverage, so we are not making this policy a requirement. We also do not believe it is necessary to indicate in § 435.603(h)(1) that paragraph (h)(3) is an exception to the rule. Section 435.603(h)(3) clearly states that the option it affords States can be applied in determining monthly income under § 435.603(h)(1). Section 435.603(h)(3) provides that a prorated portion of a predictable change in income may be included or excluded in determining current monthly income. States will have flexibility to develop reasonable methodologies which make sense in the context of their State eligibility and enrollment systems. We will work with States to ensure the reasonableness of any method adopted. We will also collect and analyze data to inform States, the Federal government, and others as to the extent to which churning occurs and the policies and procedures that are effective in reducing churning.

Comment: Many commenters supported providing States with the flexibility to ignore temporary fluctuations in income when determining eligibility for current beneficiaries by using annual income rather than average monthly income. Several commenters recommended that States be offered the option to cover adults for a continuous eligibility period, similar to the option for children's coverage at section 1902(e)(12) of the Act.

Response: Use of the option to project annual income for current beneficiaries can help States minimize the churning between programs that each of the strategies proposed by the commenters seeks to address. However, there is no statutory authority for States to elect continuous eligibility for adults. In addition, section 1902(e)(14)(B) of the Act does not permit States to disregard fluctuations in income experienced by beneficiaries. However, States may propose section 1115 demonstration projects to apply continuous eligibility for adults and to adopt other simplification measures for parents or other adults.

9. Eligibility Groups for Which MAGI–Based Methods Do Not Apply (§ 435.603(j))

Comment: Numerous commenters were concerned about the eligibility of individuals with disabilities and those needing long-term services and supports under the Medicaid Eligibility proposed rule. Commenters were concerned that such individuals would be adversely affected if they are evaluated for coverage under optional eligibility groups only after they fail to establish eligibility based on MAGI-based methodologies.

Response: The expansion of eligibility to all adults under 65 under the Affordable Care Act was not intended to keep anyone from being able to access coverage under Medicaid that is more appropriately suited to their needs. Therefore, we are revising our policy under the final rule such that individuals who meet the eligibility requirements, and are determined eligible, for coverage under an eligibility group for blind or disabled individuals or for an eligibility group under which long-term services and supports are covered will be able to enroll for such coverage, regardless of whether or not they have MAGI-based household income which is at or below the applicable MAGI standard (133 percent of the FPL for the new adult group). Revisions to implement this change in policy being made to the MAGI screen regulation at § 435.911 are discussed in section III.F. of the preamble. Conforming revisions to the exceptions from application of MAGI-based methodologies for blind and disabled individuals and those needing long term care services also are being made in the final rule at § 435.603(j)(3) and (j)(4) (redesignated from paragraph (i) in the Medicaid Eligibility proposed rule) to provide for exception from application of MAGI methodologies to such individuals, but only for the purposes of determining eligibility on the basis of disability or being blind or for an eligibility group under which long term care services are covered. We also clarify in the final rule at § 435.603(j)(6) that the exception from MAGI for the medically needy is only for the purpose of determining eligibility on such basis.

Comment: One commenter requested clarification regarding the methodologies to be applied when eligibility is being determined based on the need for long term care services. The commenter specifically inquired about the applicability of spousal impoverishment rules.

Response: Our reference to eligibility ''on the basis of the need for long-term care services'' in the Medicaid Eligibility proposed rule would have too narrowly limited the MAGI exception contemplated by 1902(e)(14)(D)(iv) of the Act to individuals eligible under 1902(a)(10)(A)(ii)(V) and (VI) of the Act, and certain section 1115 waivers. We have revised the language relating to this exception in § 435.603(j)(4) of this final rule to except from application of MAGI methods individuals seeking coverage of long term care services for the purpose of determining eligibility under a group that covers such services. In making such determinations, all current methodologies, including spousal impoverishment rules, will apply to the same extent as such methodologies apply today.

Comment: Individuals over the age of 65 are exempt under the Affordable Care Act from application of MAGI-based methods, but determinations of eligibility for parents/caretaker relatives is based on MAGI methodologies. In the Medicaid Eligibility proposed rule (76 FR 51159), we solicited comments on what methodology should be used in determining eligibility for elderly parents and caretaker relatives over the age 65. Many commenters believe it would be burdensome for States to have to apply existing AFDC methodologies in the small number of cases in which an individual age 65 or older is being evaluated for eligibility on the basis of being a parent or caretaker relative. The commenters suggested that we limit the MAGI exemption for individuals age 65

and older to determinations where age is a condition of eligibility.

Response: We are revising § 435.603(j)(2) to except individuals age 65 or older from application of MAGI-based methods only when being 65 or older is a condition of Medicaid eligibility.

Comment: Some commenters suggested that we explicitly identify newborns automatically deemed eligible for Medicaid under section 1902(e)(4) of the Act (''deemed newborns'') as an exception to MAGI-based methodologies in § 435.603(j)(1) (§ 435.603(i)(1) in the Medicaid Eligibility proposed rule) because the Medicaid agency does not need to make a determination of income for these babies.

Response: Deemed newborns are excepted from application of MAGI-based methodologies as noted by the commenters. However, we are not modifying the Medicaid Eligibility proposed rule, as we do not find it necessary to list every situation in which the agency is not required to make an income determination in the regulation.

Comment: § 453.603(i)(6) provides that MAGI-methodologies do not apply to the determination of financial eligibility for the medically needy. One commenter questioned whether States will have flexibility to choose to apply some or all of the MAGI methodologies in determining medically needy eligibility for simplicity of administration.

Response: The Affordable Care Act expressly exempts medically needy individuals, whose eligibility is based on either AFDC or SSI financial methodologies, from application of MAGI-based financial methodologies. States which cover medically needy individuals are required under section 1902(a)(10)(C) of the Act to cover medically needy pregnant women and children, financial eligibility for whom currently is determined using AFDC methods. We recognize that retention of AFDC methods solely for the purpose of determining medically needy eligibility for these populations could be administratively burdensome for States. We are examining the options that may be available to avoid such burden.

Comment: One commenter questioned whether aged, blind and disabled individuals in section 209(b) States would be required to spend-down income to the traditional standard of need or 133 percent of the FPL. This same commenter suggested that the current policy of spending down to the standard of need forces a result contrary to the intent of Affordable Care Act because it places higher financial burden on access to coverage for ABD individuals.

Response: States which have elected to apply more restrictive methods than those applied for determining eligibility for SSI under section 1902(f) of the Act and § 435.121 of the regulations (''209(b) States''), but which do not cover medically needy aged, blind and disabled individuals, must allow aged, blind and disabled individuals whose income exceeds the income standard established for eligibility under § 435.121 to spend down to such standard and receive coverage. Nothing in the Affordable Care Act changes this provision. However, as explained in the preamble to the Medicaid Eligibility proposed rule (76 FR 51151), blind and disabled individuals whose income exceeds the standard established in a 209(b) State for coverage under § 435.121 are not required to spend down to such standard to become eligible for Medicaid. Such individuals are eligible for and can enroll in coverage under the new adult group without meeting a spend-down, provided that their MAGI-based income is at or below the applicable MAGI standard (133 percent of the FPL for the new adult group). However, such individuals have the choice to spend-down to establish eligibility under § 435.121 if coverage on such basis better meets their needs. Individuals age 65 and over are not eligible for Medicaid under the new adult group. Such individuals may be able to spend-down to Medicaid eligibility under § 435.121.

Comment: One commenter supported the policy that the exemption from MAGI only applies to the determination of eligibility for medically needy coverage and suggested that this policy be extended to individuals spending down to eligibility under § 435.121 in 209(b) States.

Response: An exception from application of MAGI-based methods applies in both circumstances. Eligibility for medically needy coverage under section 1902(a)(10)(C) of the Act is excepted from application of MAGI-based methods per section 1902(e)(14)(D)(IV) of the Act, as codified at § 435.603(j)(6) in this final rule. Eligibility for mandatory coverage for blind and disabled individuals in 209(b) States under sections 1902(a)(10)(A)(i)(II) and 1902(f) of the Act and § 435.121 of the regulations, including the ability to spend down to such eligibility, is excepted from application of MAGI-based methods per section 1902(e)(14)(D)(i)(III) of the Act, as codified at § 435.603(j)(3) in this final rule.

Comment: One commenter questioned why proposed § 435.603(i)(5) excludes from MAGI-based methods only the determination of Medicaid eligibility for Medicare cost sharing assistance and not individuals who are in receipt of Medicare generally.

Response: The Affordable Care Act does not provide for an exception from application of MAGI-based methods for individuals eligible for Medicare. The exception at section 1902(e)(14)(D)(i)(III) is limited to individuals eligible for Medicare cost-sharing assistance under section 1902(a)(10)(E) of the Act. We are interpreting the exception to apply only to determinations of eligibility for Medicare cost sharing so that States can apply the same MAGI-based methods used to determine such individuals' eligibility for full Medicaid benefits under other eligibility groups as are used for other individuals who are not eligible for Medicare cost-sharing assistance.

Comment: For the exception for foster care children from MAGI-based methods in section 1902(e)(14)(D)(i)(I) of the Act, one commenter questioned what ''being deemed to be a child in foster care under the responsibility'' of the State means. The commenter questioned whether ''under the responsibility of the State'' requires only that the State provide State-funded foster care assistance, or whether the State must exercise additional legal responsibility for the child.

Response: The exception to MAGI-based methods at section 1902(e)(14)(D)(i)(I) of the Act, as codified at § 435.603(j)(1) in the final rule, applies to children receiving Federal foster care, guardianship or adoption assistance payments under title IV–E of the Act and children eligible under an optional eligibility group for children receiving State foster care payments or in State-funded foster care, if the State covers such optional group under its State plan and does not apply an income test. Key to the application of the MAGI exception to such children is whether the State Medicaid agency is required to make a determination of income for a child in foster care to determine eligibility for Medicaid. The precise legal or custodial status of the child in relationship to the State is not material.

Comment: One commenter noted that children as a group are omitted from the list of exceptions from MAGI proposed § 435.603(i), which the commenter believes is inconsistent with section 1902(e)(14)(H)(ii) of the Act and section 2101(f) of the Affordable Care Act. The commenter recommended that the regulations should provide a

''secondary'' screening for children who would be eligible using current standards and methodologies, but who are not eligible when MAGI-based income is compared to the MAGI-equivalent income standard determined by the State under section 1902(e)(14)(A) and (E) of the Act.

Response: We disagree that the policy in the Medicaid Eligibility proposed rule is inconsistent with section 1902(e)(14)(H)(ii) of the Act or section 2101(f) of the Affordable Care Act. Section 1902(14)(H)(ii) of the Act—which provides that the application of the definitions of MAGI and household income in section 36B of the IRC ''shall not be construed as affecting or limiting the application of any rules established under'' the Medicaid statute or under a State plan or waiver of the State plan ''regarding sources of countable income''—must be read in conjunction with the general directive in section 1902(e)(14)(A) of the Act that financial eligibility for Medicaid be determined based on the section 36B definitions. We interpreted the whole of section 1902(e)(14) of the Act in the Medicaid Eligibility proposed rule as requiring that the section 36B definitions of ''MAGI'' and ''household income'' apply, except as expressly provided in section 1902(e)(14)(D) of the Act, or under the authority of section 1902(e)(14)(H)(ii) of the Act, where the impact on beneficiaries of applying the 36B definitions would be significant and where departing from the 36B definitions in favor of retaining the current Medicaid rule would not undermine the seamless and coordinated eligibility and enrollment system established under section 1413 of the Affordable Care Act and section 1943 of the Act. Section 1902(e)(14)(D) does not provide for a general exception from application of MAGI-based methodologies for children. Finally, the commenters' reliance on section 2101(f) of the Affordable Care Act is misplaced. As explained in section III.L. of the preamble, that section relates to the CHIP eligibility of children who lose Medicaid eligibility due to the elimination of income or expense disregards under section 1902(e)(14)(B) of the Act. Section 2101(f) of the Affordable Care Act does not provide for the retention of current financial methodologies for children in determining their eligibility for Medicaid.

Comment: One commenter disagreed that individuals who are deemed to be receiving SSI should be excepted from application of MAGI-based methods because an income determination for Medicaid is not required. The commenter stated that, except for eligibility under section 1619(a) and (b) of the Act, a determination of income must be made by the State Medicaid agency to determine if someone is deemed to be receiving SSI. The commenter also believes that a regulatory citation for disabled adult children should be included in the list of regulatory cross references included in § 435.603(j)(1), (§ 435.603(i)(1) in the Medicaid Eligibility proposed rule) for individuals who are deemed to be receiving SSI.

Response: The statute specifically includes the eligibility groups for deemed SSI recipients, along with individuals actually receiving SSI, in the list of individuals to whom the MAGI rules will not apply under section 1902(e)(14)(D)(i)(I) of the Act, which we proposed to codify at § 435.603(i)(1). Therefore, we are retaining the exception from MAGI-based methods for deemed SSI recipients in the final rule at § 435.603(j)(1). However, we are making a technical correction at § 435.603(j)(1) to indicate accurately which of the regulations cross referenced relate to eligibility based on receipt of SSI benefits and which relate to eligibility based on being deemed to receive such benefits.

Eligibility for disabled adult children under section 1634(c) of the Act is not codified in the Medicaid regulations at this time. Therefore, we will take the suggestion under consideration for possible future guidance.

Comment: Commenters agreed with the proposal (discussed at 76 FR 51159) not to identify at § 435.603(j)(3) (§ 435.603(i)(3) in the Medicaid Eligibility proposed rule) as excepted from MAGI-based methods children who are under age 18 who were receiving SSI on the basis of disability as of August 22, 1996, and would continue to receive SSI but for changes made by section 211 of PRWORA. Although such children are excepted from MAGI methods, there will be no—or virtually no— such children eligible for Medicaid on this basis as of January 1, 2014.

Response: We are not specifically identifying these children in this final rule.

C. Residency for Medicaid Eligibility Defined (§ 435.403)

As part of our overall effort to promote the coordinated eligibility and enrollment system established under sections 1413 and 2201 of the Affordable Care Act (discussed in greater detail in the Medicaid Eligibility proposed rule (76 FR 51160 and 51166)), we proposed to simplify Medicaid residency rules and to align those rules with those that will apply under the other insurance affordability programs.

Comment: Many commenters supported our proposal to remove the term ''permanently or for an indefinite period'' from the residency definition for adults in § 435.403(h)(1) and (h)(4), and replace the term ''intention to remain'' with ''intends to reside, including without a fixed address.'' Another commenter requested that CMS provide guidance for residency determinations for individuals who live in or visit multiple States or countries.

A few commenters expressed concern that the proposed term ''intends to reside'' introduces an element of ambiguity to the definition that may result in inconsistent application across States. A few of these commenters recommended that CMS add regulatory language consistent with the discussion in the preamble to the Medicaid Eligibility proposed rule to clarify that visitors are not considered residents of the State they are visiting.

Response: We believe that the proposed term ''intends to reside,'' when read within the context of the preamble clarifications, limits any such potential for ambiguity. In the preamble to the Medicaid Eligibility proposed rule, we explained that we interpret this language to mean that persons who are visiting the State, including for the purpose of obtaining medical care, are not considered residents of the State (76 FR 51150). Also, current regulations at § 435.403(j)(3) address a temporary absence and § 435.403(m) provides guidance regarding cases of disputed residency between States. For these reasons, we believe that further clarification in the regulatory text to preclude visitors from being considered residents of a State in which they are visiting is unnecessary.

Thus, we are adopting our proposal to strike the term ''permanently or for an indefinite period'' and replace the term ''intention to remain'' with ''intends to reside, including without a fixed address'' without substantive modification in § 435.403(h)(1) and (h)(4). Note that the language that appears in the Medicaid Eligibility proposed rule at § 435.403(h)(1)(i) regarding individuals who do not have capacity to state intent is now found at paragraph (h)(2) in the final rule, without any substantive modification. Therefore, we redesignated paragraphs (h)(2) through (h)(4) as paragraphs (h)(3) through (h)(5). We have also added clarifying language to paragraph (h) to specify that State residency of individuals receiving State

supplementary payments is addressed in paragraph (f) of this section.

Comment: Many commenters supported the proposed inclusion of individuals who have entered the State with a job commitment or are seeking employment (whether or not currently employed) as satisfying the State residency requirement for adults as proposed at § 435.403(h)(1)(ii). However, a few commenters expressed concern that such inclusion could create a burden for States to cover those seeking work, but not living in the State. One commenter recommended we limit this provision to migrant or seasonal workers. A few commenters raised a concern that removal of ''living'' in the State from § 435.403(h)(1)(i) would have the unintended effect of eliminating the physical presence requirement from the definition of residency. In contrast, one commenter recommended inclusion of a *future* intent to reside in a State in limited circumstances, such as when a disabled individual desires to relocate but cannot safely do so until Medicaid services are in place.

Response: We are retaining our proposed language in § 435.403(h) regarding individuals who have secured employment or are seeking employment and we are revising our regulation text consistent with commenters' recommendations so our intent is clear that to be a resident, an individual must be living in the State. As explained in the Medicaid Eligibility proposed rule preamble, we proposed to remove the word ''living'' from the definition of residency to simplify the language, not to change the policy. We are revising the proposed regulation at § 435.403(h)(1) and § 435.403(h)(4) (redesignated to § 435.403(h)(5) in the final rule), to clarify its application to only those individuals who are living in the State.

With regard to an individual's ability to initiate the application and enrollment process when such individual is not present in the State, we may address in future guidance ways in which States might facilitate the determination of eligibility for individuals moving into the State, particularly for those whose health care needs are such that a gap in coverage occasioned by a move would be detrimental to their health.

Comment: In response to our proposal to maintain States' current flexibility to determine whether students ''reside'' in a State for families in which children attend school in a State different than their parents, many commenters urged CMS to establish a clear policy on student residency that aligns with Exchange policy, which allows taxpayers to choose State of residency for tax dependents who live in another State to prevent potential gaps in coverage. These commenters strongly recommended that States should not be given flexibility, but be required to allow parents to choose the State of their child's residence for purposes of Medicaid eligibility as well. Another commenter suggested that individuals age 18 and older be allowed to express their own intent, rather than relying on their parents. Several commenters expressed concern about access to services when American Indian/Alaskan Native (AI/AN) youth reside apart from their parents in boarding schools operated by the Bureau of Indian Education.

Response: As stated in the Medicaid Eligibility proposed rule, while States will have flexibility for students attending school in States different from their parents, States must still provide individuals with the opportunity to provide evidence of actual residency (76 FR 51160). If there is a dispute in Medicaid State residency, the individual is a resident in the State in which the individual is physically located under our current regulations at § 435.403(m). If the individual's household income is under the applicable MAGI standard in the Medicaid State of residency (at least 133 percent of the FPL), the individual will be eligible for Medicaid based on MAGI in that State. If the individual's household income is over the applicable MAGI standard in the Medicaid State of residence, the individual will be eligible for Exchange-based coverage in the State of residency determined in accordance with Exchange regulations at 45 CFR 155.305(a)(3)(iv). Thus, there should be no gap in coverage. Permitting taxpayers or parents/guardians to decide in which State an individual is a State resident could have significant cost implications for States, particularly with large student populations, and also could be challenging to operationalize. Note that students who are under age 21 and who are married or emancipated will be considered State residents using the same rules as adults (see § 435.403(i)(1)), enabling them to express their own intent about their State of residence. Thus, we are not modifying our regulation text, but will work with States and other stakeholders on the application and enrollment information that applicants will need to apply and enroll in coverage. Finally, access to care for individuals temporarily physically located in a State other than their State of residence is a concern that is not unique to AI/AN students going to a school in a State other than where their parents live. Coordination and cross-State payment arrangements are important mechanisms to address this and we will continue to work on this issue (see more information below).

Comment: Many commenters supported the consolidation of two existing definitions of residency for children (disabled children with non-disabled, non-institutionalized, non-IV–E foster care/adoption assistance children) as proposed in § 435.403(i)(2), primarily for stated simplification purposes. One commenter noted that such prohibition would eliminate the current problem with States denying Medicaid for newborns residing in the State born to parents who may not be considered State residents.

Response: We are finalizing the Medicaid Eligibility proposed rule without significant change, as set forth at § 435.403(i)(2). We agree that consolidation of the two existing definitions of residency for children, application of a similar residency definition as that proposed for most adults without the ''intent'' component simplifies the regulation. We have also made minor modifications to the regulation text to clarify that States cannot determine a child's residency based solely on the parent's residency at § 435.403(i)(2). We have also added clarifying language to paragraph (i) to specify that State residency of individuals receiving State supplementary payments and individuals receiving IV–E assistance are addressed in paragraphs (f) and (g) of this section, respectively.

Comment: In response to our solicitation for comments for whether we should change the current State residency policy with regard to individuals living in institutions and adults who do not have the capacity to express intent, we received many comments urging CMS to determine residency for institutionalized individuals based on the intent of the parent or guardian, rather than current policy that determines residency based on State residency of the parent or guardian at time of the individual's placement in the institution even after a parent or guardian has moved to another State. One commenter recommended that CMS consider amending § 435.403 to provide that the State of residence for all individuals who lack the capacity to form intent be chosen by the parent or guardian, irrespective of an individual's age.

Response: We will consider these suggestions in our development of

future guidance and technical assistance.

Comment: Several commenters recommended that CMS modify the proposal to include as residents individuals who enter the State seeking medical treatment, particularly in the context of persons who are members of Tribes who receive services at Youth Residential Treatment Centers (YRTCs), federally-managed boarding schools for tribal members, Indian Health Service (IHS) or other tribal providers. The commenters also raised concerns about the administrative burdens and barriers that providers serving these individuals experience entering into provider agreements with multiple States and receiving Medicaid payments for services rendered to individuals who reside in those States. Some commenters suggested that we develop a rule that would provide State residency for AI/AN children in the State in which the provider or facility is located.

Response: In general, we do not believe it is reasonable to require a State to administer benefits to individuals who are present in the State only to receive medical care, and thus we are not modifying the Medicaid Eligibility proposed rule. We believe such a policy would be inconsistent with the common understanding of State residency, which is focused on individuals who live and intend to remain living in the State. Requiring a State to cover individuals who were solely present in the State to seek medical treatment would have a differential financial impact on States with medical institutions that attract individuals from across the country. That said, it is important to address interstate coordination of enrollment, retention, and access to services for low-income Medicaid and CHIP children. In accordance with section 213 of the Children's Health Insurance Program Reauthorization Act (CHIPRA), we published a notice in the December 18, 2009 **Federal Register** (74 FR 67232) soliciting comments to assist in the development of a model interstate coordination process. The model process is available at *http://www.cms.gov/CHIPRA/Downloads/InterstateCoordination.pdf* and we have invited feedback from interested parties regarding the viability of the proposal.

We intend to consider whether there is a need for further rulemaking to address the situation of individuals who are receiving services at entities that are federally-managed or operated under the authorities established by the Indian Self-Determination and Education Assistance Act, such as YRTCs operated under the Indian Health Care Improvement Act and boarding schools operated by the Bureau of Indian Education, whether operated by the Indian Health Service, Bureau of Indian Education, or by an Indian Tribe or Tribal organization. We welcome information on the impact such policy might have on States, federally-managed providers, Tribal governments, and Tribal members. We also plan to consult with Tribes as we consider this issue.

Comment: One commenter recommended that § 435.403 codify the definition of ''lawfully residing'' currently in use in Medicaid and CHIP, under CHIPRA. Additionally, the commenter recommended the inclusion of the additional categories to the current CHIPRA definition.

Response: The definition of ''lawfully residing'' is outside the scope of this final rule.

Comment: We received one comment asking whether our proposed revisions to the State residency definition affect children receiving foster care or adoption assistance under title IV–E of the Act or State-funded programs.

Response: Our proposed revisions to the State residency definition have no impact on IV–E foster care or subsidized adoption children, as we did not propose to amend the rules governing State residency of individuals who receive IV–E assistance at § 435.403(g). All other individuals under the age of 21, who are not institutionalized or emancipated or receiving a State supplementary payment, would be treated under our rules at redesignated § 435.403(i) in our final rule.

D. Timeliness Standards (§ 435.912)

Comment: A number of commenters requested additional information regarding timeliness and performance standards that will assure a seamless consumer experience, minimize administrative burdens, and otherwise ensure compliance with various provisions of this final rule. We also received comments requesting additional information with respect to the data reporting requirements for States to ensure adequate oversight of the administration of the program.

Response: We recognize the need to provide parameters within which performance will be measured and to outline the areas where data and other information will need to be provided to monitor compliance with this final rule. We have revised current regulations at § 435.911 (redesignated at § 435.912) to provide additional guidance on the timeliness standards for making eligibility determinations. We are soliciting additional comment and issuing as interim final § 435.912.

Under the current regulations, States are directed to establish standards not to exceed 90 days in the case of individuals applying for Medicaid on the basis of disability and 45 days for all other applicants. The revised regulation at § 435.912 distinguishes between performance and timeliness standards, and States are directed to establish both. Under § 435.912(a), ''timeliness standards'' refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, subject to the exceptions in § 435.912(e); ''performance standards'' are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.

Section 435.912(b) also includes the expectation, set forth in the proposed § 435.911(c) and § 435.1200(e) and (f), that the State agency determine eligibility and, where appropriate, transfer the electronic account of individuals to other insurance affordability programs, promptly and without undue delay. Section 435.912(c) sets forth criteria which the agency must account for in establishing timeliness and performance standards, including: (1) The capabilities and cost of generally available systems and technologies; (2) the general availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility; (3) the demonstrated performance and timeliness experience of State Medicaid, CHIP and other insurance affordability programs, as reflected in data reported to the Secretary or otherwise available; and (4) the needs of applicants and their preferred mode of application submission and communication, as well as the relative complexity of adjudicating the eligibility determination based on household, income, or other relevant information. Note that the standards to be adopted pursuant to proposed § 435.912(c) are expected to reflect the systems and technological capabilities and electronic data matching which are generally available for use by States at reasonable cost. Our expectations are that these systems and technological capacities generally make it possible for real time determinations of eligibility in most cases. Standards shall be set reflecting this expectation as well as the pace and experience of States that are making ongoing and reasonable investments in systems improvements and technology

supported by Federal matching payments. Finally, we clarify in the regulation at § 435.912(b) that the Secretary will provide additional guidance on the timeliness and performance standards, with which the standards established by States under the regulation also will need to comply.

Not addressed in § 435.912 are performance standards relating to other aspects of States' eligibility and enrollment systems to ensure accountability, consistency, and coordination. Guidance regarding such other performance standards is forthcoming.

E. Application and Enrollment Procedures for Medicaid (§ 435.905, § 435.907, and § 435.908)

The Affordable Care Act directs the Secretary to establish a model, streamlined application and enrollment process for use by States. The sections that follow summarize the key elements of the process.

1. Availability of Program Information (§ 435.905)

We proposed to implement section 1943(b)(1)(A) of the Act directing States to develop procedures that enable individuals to apply for, renew, and enroll in coverage through an internet Web site through amendments to § 435.907 and § 435.908. In conjunction with those procedures, we also proposed to revise § 435.905 to require that information be available in electronic formats, as well as in paper formats (and orally as appropriate).

Comment: Many commenters advised that the list of information that the agency must furnish, as described in § 435.905(a)(1) through (a)(3), needs to be expanded to include information on application/renewal processes, assistance, appeals, and benefits including the benchmark benefit package. One commenter also requested that § 435.905(a) be revised to state that applicant information should be confidential in all circumstances.

Response: We do not believe that any revision to the proposed regulation is required. We are strongly committed to ensuring applicants and beneficiaries have the information they need as well as to ensuring the confidentiality of applicant and beneficiary information. Most of the information identified must be furnished to applicants and other parties under the existing regulation at § 435.905, and that requirement was not changed by the Medicaid Eligibility proposed rule. The remaining requested information is required to be provided to applicants and other parties in other parts of the regulations governing the Medicaid program. Applications and assistance must be available under § 435.907 and § 435.908. Regulations governing confidentiality of applicant and beneficiary information are set forth in existing regulations at subpart F of part 431 of the regulations.

Comment: Many commenters suggested that the information in § 435.905 needs to be publicly available online, not just to those ''who request it.'' Several commenters specifically recommended that we add a cross-reference to § 435.1200(d), relating to the Internet Web site required under the Affordable Care Act. One commenter requested that we clarify that States only need to mail applicants program information upon request.

Response: Our intention is for program information to be widely available in ''electronic'' formats, meaning that such information must be available to the public via the Internet Web site, not just upon request. We are adding a cross-reference to the regulation at § 435.1200(f) as a helpful clarification of this policy. Under § 435.905, States are only required to mail program information upon request.

Comment: A few commenters stated that Medicaid agencies should be required to provide information regarding all insurance affordability programs, not just Medicaid, to promote consistency and coordination across programs.

Response: It is our expectation that all insurance affordability programs will coordinate and make available the basic information needed for individuals to understand all programs and make informed choices about applying for coverage. The Internet Web site required under § 435.1200(f) must promote access to information on all insurance affordability programs, which includes Exchange, Medicaid, CHIP, and the Basic Health Program (BHP) if applicable. Section 1943(b)(4) of the Act, as added by section 2201 of the Affordable Care Act, requires that such Web site be linked to the Web site established by the Exchange, and under § 435.1200(b)(3), the State Medicaid agency must enter into an agreement with the other insurance affordability programs operating in the State to implement the requirements of § 435.1200, including paragraph (f).

Comment: The large majority of commenters support our proposed regulation that program information be provided in simple and understandable terms and accessible to persons who are limited English proficient and people with disabilities. Many commenters made specific recommendations that we include in the regulation standards and thresholds for translation of written information. For example, many suggested that we require written translations where at least 5 percent or 500 limited English proficient individuals reside in the State or service area of the Medicaid program, whichever is less. Many commenters also recommended we add to this rule specific requirements to provide oral interpretation, such as for all languages free of charge to the individual, and to inform individuals how to access these services, such as requiring ''taglines'' in a specified number of languages. (A tagline is a brief statement in the individual's language that informs the person how to obtain language services.) Many of these commenters recommended that we add to the final rule more detailed requirements on accessibility, including providing written materials such as large print and Braille documents and information about obtaining sign language interpretation. One commenter recommended that we have a specific section of regulation that addresses access for people with disabilities. A number of other commenters suggested that accessibility standards be required in all modalities that individuals may wish to communicate with States, that is, paper, online, oral communication, and that applications and renewal forms meet the same accessibility standards. A few commenters requested flexibility for States in developing language services requirements as States' populations and needs differ, and one commenter expressed concern that requiring a specific standard for States could pose an unreasonable burden.

Response: We are finalizing, with some modifications, our proposed regulations at § 435.905 and § 435.1200(d) (redesignated at § 435.1200(f)) to provide information and make Web sites accessible to persons who are limited English proficient or have disabilities. Section 435.901 already requires States to comply with the Civil Rights Act of 1964, as well as section 504 of the Rehabilitation Act of 1973, and all other relevant provisions of Federal and State laws, which would include relevant provisions of the Americans with Disabilities Act. Guidance issued in 2003 (68 FR 47311) provides some parameters on language assistance services for persons who are limited English proficient, including oral interpretation and written translation services; this guidance is at *http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf.* On July 1, 2010 we also issued a State Health

Official Letter (#10–007), available at *http://www.cms.gov/smdl/downloads/SHO10006.pdf,* explaining the enhanced match available for translation and interpretation services in connection with improving outreach to, enrollment of, and use of services by children in Medicaid and CHIP.

In addition to the Civil Rights Act, we believe that the requirements reflected in section 1413 of the Affordable Care Act and section 1943 of the Act, as added by section 2201 of the Affordable Care Act, to establish a coordinated system of eligibility and enrollment across all insurance affordability programs, as well as the specific requirement in section 1943(b)(1)(F) of the Act that States establish procedures for conducting outreach to and enrolling vulnerable underserved populations, including racial and ethnic minorities, would support requiring written translation and oral interpretation.

We modified our proposed § 435.905(b), accordingly, to specify that information for persons who are limited English proficient or have a disability be provided in an accessible and timely manner and at no cost to the individual. For people with disabilities, we specify that accessibility includes auxiliary aids and services. We clarify that application and renewal forms meet the same accessibility standards at § 435.907(g) and § 435.916(g). Note that we make a minor modification to our proposed language in § 435.905(b) to replace the term ''simple and understandable terms,'' with ''plain language'' to align with the language in the Exchange final rule at 45 CFR 155.205(c).

We are not adding specific accessibility standards and thresholds in this final rule, but intend to issue such standards in future guidance, seeking input first from States and other stakeholders about appropriate standards and thresholds. Such guidance will coordinate our accessibility standards with the Exchange, other insurance affordability programs, and across HHS programs, as appropriate, providing more detail regarding literacy levels, language services and access standards.

2. Applications (§ 435.907)

To support States in developing a coordinated eligibility and enrollment system for all insurance affordability programs, we proposed to implement section 1943(b)(3) of the Act, which directs the Secretary to develop and provide States with a single, streamlined application. Accordingly, we proposed to amend the existing ''Application'' provisions at § 435.907 to reflect use of the new single, streamlined application.

Comment: Many commenters requested that we specify that States can continue to use multi-benefit applications. One commenter recommended that CMS only approve State-developed supplemental forms that collect enough information to qualify individuals for any human service program for which they may be eligible.

Response: The intent of the rule is to codify the statutory requirement that there be a single streamlined application for timely enrollment of all eligible individuals in the appropriate health insurance affordability program. An individual must have an option to apply for Medicaid using the Secretary-developed or a Secretary-approved single streamlined application which asks questions relevant only to the eligibility and administration of insurance affordability programs. The regulations do not prohibit use of multi-benefit applications, which may be approved in accordance with § 435.907(b)(2). Use of supplemental forms in conjunction with the streamlined application would be one acceptable approach to assure access to a range of benefits, but States also are permitted to develop alternative multi-benefit applications which do not use supplemental forms. We look forward to working with States interested in developing streamlined multi-benefit applications.

Comment: Some commenters stated that applicants should be able to submit the alternative and supplemental forms for determination of non-MAGI eligibility through the submission modes proposed at § 435.907(d).

Response: States must make application processes accessible for all individuals, and maximize the submission options for individuals being evaluated for eligibility on a basis other than MAGI. All individuals must be able to begin the application process via the Internet Web site, telephone, mail, or in person using the single, streamlined application in accordance with § 435.907(a). States have the option to use supplemental or separate forms for approval of eligibility under a non-MAGI category, as described in § 435.907(c). To the extent practical, those forms should also be accepted by the agency through all submission modes described in § 435.907(a).

Comment: Most commenters supported the requirement for Secretarial approval of a State's alternative single, streamlined application and requested that if a State wishes to make substantive changes, we require an additional approval. Some commenters requested that the Secretarial approval process be flexible.

Response: For States opting to develop an alternative single, streamlined application the statute requires that such applications be approved by the Secretary. To implement this provision, under § 435.907(b)(2), the regulations specify that the Secretary approve the initial application and any substantive change to such application. We intend to be flexible and timely in working with States to secure Secretarial approval of alternative applications that meet the relevant regulations and guidance.

Comment: Some commenters mentioned specific criteria or questions that should be included on the model application and alternate applications, such as information that captures information to elicit eligibility for other Medicaid categories, including coverage under section 1115 waivers, Medicaid Buy-In programs, medically frail criteria or for long-term services and supports, as well as vital applicant information such as AI/AN status. Several commenters provided recommendations on the functioning of an online application, such as using decision tree logic to ask minimum questions, pre-populating the form with information available electronically, and providing a printable copy to applicants.

Response: This input will help inform our work to develop the application and accompanying guidance.

Comment: Some commenters supported the provision in the proposed regulation that alternative and supplemental forms for determination of non-MAGI eligibility must be approved by the Secretary in a manner similar to the single, streamlined application. Other commenters urged against requiring such approval, stating that such forms are already in use and do not require changes in 2014. One commenter suggested that the Secretary publish required data elements for these non-MAGI forms and facilitate best practices via review, but not approval, of non-MAGI applications and supplemental forms. Another commenter suggested delaying requirements for approval until after 2014, given the implementation demands on States over the next two years.

Response: We have revised § 435.907(c) to specify that any application or supplemental form used by a State for determining eligibility on bases other than the applicable MAGI standard meet Secretarial guidelines. These forms must be submitted to the Secretary, and will be available for

review by the public, but will not have to be approved prior to use.

Comment: Many commenters requested that the single streamlined application include a question to screen for potential eligibility on a basis other than MAGI, such as whether an applicant may be disabled, and a notification that applicants have the right to a full Medicaid determination on all bases if desired. A few commenters requested that the application also include an explanation of the benefits of obtaining a non-MAGI determination. Many noted concerns that the Exchange proposed rules would require a screen for non-MAGI eligibility, while this is not explicitly required in the Medicaid Eligibility proposed rule.

Response: We intend to include such questions on the model application, which will support State agencies in fulfilling provisions for appropriate eligibility determinations under § 435.911.

Comment: One commenter advised that the blind and disabled should not be required to complete any forms or provide any information beyond the single streamlined application. The commenter advised that the single, streamlined application ''should include all information necessary to determine eligibility whether based on income or some other criteria.''

Response: Including all questions necessary for non-MAGI determinations on the single, streamlined application would make the application unnecessarily burdensome for the many applicants who will be eligible based on MAGI. We will work with States to design approaches to minimize burdens on all applicants and to help ensure that all eligible individuals are enrolled in the appropriate eligibility category.

Comment: Some commenters questioned and raised concerns about logistics and expense of the requirement for telephonic applications and signatures and requested clarification on CMS' expectations. One commenter mentioned a concern with the requirement to accept applications via facsimile in proposed § 435.907(d)(5) due to a possible lack of privacy inherent in fax submissions. Finally, a commenter expressed concern that the proposed regulations do not account for potential technological changes that may make new submission channels viable.

Response: We anticipate that telephonic applications may be implemented in different ways by States, including through use of a call center that completes the online application in real-time with information obtained from the applicant on the phone. This may reduce expense and logistical difficulty as compared to implementing a new fully-automated telephonic application process. We recognize the need for State flexibility and will be issuing subsequent guidance on this issue that permits States flexibility to design their telephonic application process. In addition, we have deleted specific reference to accepting applications by facsimile in revised § 435.907(a)(5), and have broadened this provision to include acceptance of applications via ''other commonly available electronic means,'' to accommodate changing technologies. Such electronic means may include scanning, imaging, and email processes as well as facsimile. Under the final rule, States are expected to discontinue the use of technologies as they are superseded by newer and more commonly employed mechanisms. Acceptance of signatures along with an application accepted by facsimile may also continue under the authority to accept signatures via other electronic means in § 435.907(f). Requirements to safeguard applicant information at part 431 subpart F apply equally to all applicant information, regardless of the mode of submission.

Comment: Many commenters supported the policy to prohibit in-person interviews as a requirement of eligibility, as discussed in the preamble to the Medicaid Eligibility proposed rule, but requested that the policy be included in regulation text.

Response: We have revised § 435.907(d) to state that ''the agency may not require an individual to complete an in-person interview as part of the application process for a determination of eligibility using MAGI-based income.'' We are also adding corresponding language to § 435.916 to clarify that face-to-face interviews cannot be required as part of a MAGI-based renewal.

Comment: Many commenters strongly supported our proposed regulation to codify previous guidance prohibiting States from requiring an individual who is not applying for an eligibility determination for him or herself (a non-applicant) from providing a Social Security Number (SSN) or information about his or her citizenship or immigration status. Many commenters also supported codification of this policy in CHIP. However, a few commenters noted that verification of MAGI income through the IRS will require an SSN, and expressed concern that without an SSN it may not be possible to determine eligibility for these applicants through real-time processes. A few commenters requested that States be permitted to require an SSN from non-applicants to electronically verify household income of all applicants. A few other commenters requested guidance on how to verify income if a non-applicant has not provided an SSN.

Response: As stated in the preamble of the Medicaid Eligibility proposed rule (76 FR 51161), we are codifying the longstanding policy regarding use of an SSN contained in the Tri-Agency Guidance for Medicaid and CHIP, which is available at *http://www.hhs.gov/ocr/civilrights/resources/specialtopics/tanf/triagencyletter.html.* The Guidance states that individuals not seeking coverage for themselves who are included in an applicant's or beneficiary's household to determine eligibility of such applicant or beneficiary, may not be required to provide either an SSN or information about their citizenship, nationality or immigration status to avoid deterring enrollment of eligible applicants. Provision of an SSN may occur on a voluntary basis, as discussed below. That policy is grounded in section 1902(a)(7) of the Act, Title VI of the Civil Rights Act of 1964, and the Privacy Act.

If an SSN for a non-applicant household member is not provided, States will need to use other procedures to verify income, in accordance with our verification regulations, as done in States today. We recognize that, in some cases, verification of income without an SSN may not occur in real-time. We also codify this rule in CHIP at § 457.340(b) and have added a definition of ''non-applicant'' at § 435.4.

Comment: Many commenters supported our proposed regulation that sets out conditions if States choose to ask for SSNs of non-applicants on a voluntary basis, stating these conditions are helpful to avoid deterring eligible individuals from applying for coverage and requested that we retain these requirements. A few other commenters noted their concern that in an online application, a non-applicant's SSN would be voluntary and that individuals be provided notice that providing this information is voluntary. A few commenters expressed concern that even permitting States to voluntarily ask for SSNs of non-applicants may deter eligible individuals and their families from applying.

Response: We note that the Medicaid Eligibility proposed rule regarding the voluntary provision of SSNs codifies longstanding policy reflected in the Tri-Agency Guidance discussed above. We are retaining in this final rule the

codification of this policy at § 435.907(e)(3), which will apply to the single streamlined application the Secretary develops under § 435.907(b)(1), as well as other applications and supplemental forms discussed at § 435.907(b) and (c) of this section. We understand the concern that some individuals may be deterred from seeking coverage, even when provision of the SSN for non-applicants is voluntary. However, given the importance of electronic verification of income and other information to reduce burden and achieve real time eligibility determinations for applicants who may have non-applicant household members, we believe that States should be allowed to request, and individuals should have the option to provide, an SSN voluntarily, as long as the conditions set out in our Medicaid Eligibility proposed rule are met in accordance with current policy.

Comment: A number of commenters requested that CMS codify in regulation text the discussion in the preamble of the Medicaid Eligibility proposed rule (76 CFR 51161) that information provided by a non-applicant necessary to determine eligibility of an applicant is considered information ''concerning'' the applicant or beneficiary, and therefore, is protected under confidentiality and safeguard provision of 1902(a)(7) of the Act. Commenters noted that this policy will avoid deterring family members that have eligible applicants.

Response: In § 431.300(b) of this final rule, we have codified our interpretation that information provided by a non-applicant, such as a parent, will be information ''concerning'' the applicant or beneficiary and will be protected to the same extent as applicant or beneficiary information under section 1902(a)(7) of the Act. We also clarify that information of applicants and beneficiaries includes information submitted by a non-applicant. Note that we have replaced the term ''recipient'' with ''beneficiary'' in our final rule, and we intend the terms to have the same meaning. At § 431.305(b), we add SSNs to the list of information for which a State must have criteria and a plan to safeguard, consistent with current policy and other privacy law protections. In the final rule, we also revise proposed § 435.907(e)(2)(ii), redesignated as § 435.907(e)(3)(ii) in this rule, to permit a non-applicant's SSN to be shared with other insurance affordability programs for the purposes of an eligibility determination for those programs.

Comment: A number of commenters requested that we codify in regulation that a State cannot require information that is not necessary to determine eligibility, including asking that we amend our regulations to preclude a State from ''requesting'' information from a non-applicant about his or her citizenship or immigration status. A number of commenters expressed concern that any inquiry about citizenship or immigration status will have a chilling effect on eligible applicants living with household members who are not applying for coverage.

Response: States may only require information that is necessary to make an eligibility determination or that is directly connected to administration of the State plan and we are codifying this longstanding policy in regulation text in revised § 435.907(e)(1) of the final rule. In § 435.907(e)(2), we clarify that, in addition, a State may request information necessary to determine eligibility for another insurance affordability program or other benefit program. States may not request information regarding a non-applicant's citizenship or immigration status under this rule. We also have amended § 435.916(e) to clarify that renewal forms must not collect information that is unnecessary to renew eligibility and that the provisions at § 435.907(e) apply to the renewal process.

Comment: One commenter questioned if proposed § 435.907(e) conflicts with proposed § 435.948(c)(2) (redesignated at § 435.948(c) in the final rule) which requires the agency to request income information by submitting an individual's SSN when it is available.

Response: We do not believe there is a conflict between these provisions. Section 435.948(c) takes into account the possibility that an SSN may not be available, which is consistent with § 435.907(e).

Comment: One commenter suggested that we include in regulation the legal sources and bases for the policy outlined in § 435.907(e), such as the section 1902(a)(7) of the Act, the Civil Rights Act of 1964, Privacy Act, and Tri-Agency Guidance. The commenter suggested we also include those sources in Medicaid and CHIP regulation for application and redetermination at § 435.907, § 435.916, § 457.330, and § 457.335.

Response: The applicability of section 1902(a)(7) of the Act to non-applicant information is specified at § 431.300. Further, our current regulation at § 435.901 requires compliance with Title VI of the Civil Rights Act of 1964 and other Federal laws. Thus, while we have discussed the statutes and guidance in the preamble to this final rule, we do not think that it is necessary to further cite the other recommended statutes and guidance in our revisions to the regulations.

3. Assistance With Application and Renewal (§ 435.908)

We proposed to amend the provisions of § 435.908 to ensure that the agency provide assistance through a variety of means to aid individuals seeking help with the application or redetermination process. We also proposed that States have flexibility to design the available assistance, while assuring that such assistance is provided in a manner accessible to individuals with disabilities and individuals who are limited English proficient. In this final rule, we are switching the order of § 435.908 (a) and (b).

Comment: Some commenters requested that we clarify the difference between assisters and authorized representatives and specify what authorized representatives can do.

Response: There is a difference between an application assister and an authorized representative both in the way that they are designated by the applicant, as well as the permissions that are given within the application and renewal processes. In general, application assisters are staff and volunteers of organizations authorized by the State Medicaid agency or State CHIP agency to provide assistance to individuals with the application and renewal process, at the request of the applicant/beneficiary. The activities of assisters generally include providing information on insurance affordability programs and coverage options, helping individuals complete an application or renewal, and gathering required documentation. In contrast, an applicant may designate an authorized representative who may act on behalf of the applicant or beneficiary including signing the application and receiving notices. Regardless of whether an applicant or beneficiary has selected an assister or designated an authorized representative, the agency must provide the assistance described in § 435.908(a). Additional information about the potential roles and responsibilities of authorized representatives and assisters will be provided in subsequent guidance. We anticipate that if individuals who help with application and renewal processes as provided in § 435.908(b) are not recognized by a State agency, not officially designated as authorized representatives and not permitted to submit an application as provided in § 435.907(a), then such individuals will not have access to sensitive applicant and beneficiary

information, consistent with confidentiality regulations in 42 CFR part 431 subpart F and the statutory protections that apply to IRS data.

Comment: One commenter noted that in their State a doctor's note is currently required for an individual to appoint an authorized representative.

Response: Such a requirement is not consistent with current longstanding regulations at § 435.907 and § 435.908 as revised in this rulemaking. Legally competent applicants and beneficiaries must be permitted to designate representatives of their choosing and authorization from a physician is not a prerequisite for such a designation. In addition, we have further clarified at § 435.907(a) the situations in which the State Medicaid agency must accept an application from someone acting responsibly on behalf of an applicant.

Comment: Most commenters expressed strong support for the requirements in proposed § 435.908(b) for agencies to provide assistance in multiple modes. Some commenters requested that we specify that assistance must be provided during and outside normal business hours, or through specific mechanisms such as internet kiosks. One commenter stated that assistance from community-based organizations is far more effective than a State's customer service telephone line.

Response: While it is important to have a range of assistance opportunities available, we do not believe that our regulations should be revised to provide additional specificity as to the manner in which the Medicaid agency provides assistance. Assistance provided by other entities is outside the scope of this rulemaking.

Comment: Some commenters suggested that the rule should codify outreach requirements to vulnerable and underserved populations, as required by section 1943(b)(1)(F) of the Act. Some emphasized the importance of addressing the unique needs of certain populations, such as those with mental illness and substance abuse disorders. Others asked that certain organizations and places be specifically recognized as key providers of application assistance and outreach, such as hospitals, Federally Qualified Health Centers (FQHCs), and correctional facilities. Some commenters noted the potential to leverage Medicaid outstationing requirements to provide outreach. Some commenters inquired about Federal funding for outreach.

Response: We did not propose any new outreach requirements and, at this time, we are not codifying new outreach requirements. We recognize the importance of outreach, and we intend to inform States of all available options to obtain Federal funding for outreach activities as we work together to move ahead with implementation of these changes.

Comment: One commenter noted that if an individual is found ineligible for all insurance affordability programs, then he or she should be referred to a consumer assistance program or navigator who can provide information on obtaining coverage outside the Exchange.

Response: We do not have the authority to require agencies to provide assistance in obtaining coverage other than through the Exchange, Medicaid and CHIP and the BHP, if applicable.

Comment: Several commenters wrote about the relationship between § 435.908 and the requirements in 45 CFR 155.205 on Medicaid and CHIP assistance via Exchange Navigators. Some commenters suggested a requirement that Medicaid and CHIP application and renewal assistance meet the same criteria required for Exchange assistance. One commenter inquired whether States may combine these programs.

Response: The Medicaid agency is responsible for fulfilling the requirements of the Medicaid regulations at § 435.908. The assistance which Medicaid agencies provide under § 435.908 is distinct from that provided by Exchange Navigators in accordance with 45 CFR 155.210 of the final Exchange regulation. Some aspects of applicant and beneficiary assistance may be integrated with the consumer assistance tools and programs of the Exchange. For example, a State may choose to operate one application assistance call center or one applicant assistance online chat feature.

Comment: Many commenters encouraged the Secretary to measure the effectiveness of the assistance efforts and State agency performance by looking at criteria including call abandonment, call wait times, number of days to wait for an in-person assistance appointment, and waiting time for online assistance.

Response: As noted in the preamble to the Medicaid Eligibility proposed rule, we intend to develop performance and processing standards for many aspects of the application and eligibility determination process in consultation with States, consumer groups and other stakeholders. We will consider these recommendations in developing such standards.

Comment: Many commenters expressed strong support for our proposed regulation at § 435.908(b) to have States provide assistance to persons with disabilities and those who are limited English proficient who seek help with the application or redetermination process. Some commenters made recommendations to make the types of assistance required more specific, such as including oral interpretation, sign language interpreters, Braille and large print, and translated materials. A few commenters also suggested that we require that any assistance to persons who are limited English proficient be provided in a culturally competent manner. A few commenters recommended codifying a duty to assist when an applicant reports the existence of a disability, consistent with the requirements of the Americans with Disabilities Act.

Response: We have revised § 435.908 to align with our modifications in § 435.905. Individual who are limited English proficient or have disabilities should be provided assistance in an accessible manner. We are not addressing specific components of assistance such as cultural competence or a duty to assist in this rule, but will consider these comments as we develop subsequent guidance on these issues. For more detail regarding accessibility, see the discussion in section III.E.1. of the preamble.

F. MAGI Screen (§ 435.911)

Consistent with sections 1902(a)(4), (a)(8), (a)(10(A), (a)(19), and (e)(14) and section 1943 of the Act, in § 435.911, we described a new simplified test for determining eligibility based on MAGI. We also proposed several pertinent definitions, including ''applicable MAGI standards,'' which will be at least 133 percent of the FPL, but in some States, based on State-established standards, may be higher for pregnant women, children, or in a few States, parents and caretaker relatives. These and other proposed provisions are discussed in more detail in the Medicaid Eligibility proposed rule (76 FR 51161 and 51162).

Comment: We received many comments on the eligibility of individuals with disabilities and those needing long-term services and supports under the Medicaid Eligibility proposed rule. Under the Medicaid Eligibility proposed rule, if an applicant is eligible based on the applicable MAGI standard, a State would not determine whether that person is also eligible under an optional group (for example, for blind or disabled individuals). Many commenters appreciated the ability of everyone with income below the applicable MAGI standard to be quickly and efficiently determined eligible for coverage without regard to disability

status or need for institutional or other long-term services and supports. However, commenters uniformly were concerned that individuals who qualify for coverage using current methodologies under an optional group for disabled individuals or an optional group covering institutional or other long-term services and supports would be adversely impacted under the Medicaid Eligibility proposed rule, because such individuals would be required to enroll for coverage in the adult group at § 435.119 and the commenters were concerned that eligibility under the adult group would not meet their benefit needs to the same extent as eligibility under the optional eligibility groups.

A few commenters noted the operational difficulty States may have in ensuring that persons needing long-term services and supports are placed in the most appropriate eligibility category. Many commenters stated that the Medicaid Eligibility proposed rule was inconsistent with Medicaid requirements that beneficiaries eligible for more than one category may choose to have their eligibility determined under either category and that States determine eligibility in the ''best interest'' of Medicaid beneficiaries. At least one commenter suggested that all individuals in need of long-term services and supports be exempted from using the MAGI methodology or be given the option to apply for long-term services and supports under existing methodologies.

Response: We have revised the policy in this final rule to ensure that individuals who meet the eligibility requirements for coverage based on the applicable MAGI standard (for example, under the new adult group at § 435.119) and who also meet the requirements for coverage under an optional eligibility group excepted under section 1902(e)(14)(D) of the Act from the application of MAGI methods may enroll in the optional eligibility group. As discussed in Section B of the preamble, we are interpreting the exception from application of MAGI-based methods at sections 1902(e)(14)(D)(i)(III) and 1902(e)(14)(D)(iv) of the Act, codified at § 435.603(j)(3) and (j)(4) of this final rule, to apply for the purpose of determining eligibility on the basis of disability or being blind or for an eligibility group under which long-term services and supports are covered. Individuals who meet the eligibility requirements for coverage based on the applicable MAGI standard nonetheless may be excepted from application of MAGI methods for purposes of evaluation under an optional eligibility group which better meets their coverage needs. Until eligibility on such other basis is determined, such individuals are not precluded from enrolling in the program under the new adult group (or other eligibility group, such as for children or pregnant women) based on MAGI. However, while no individual may be required to provide additional information needed to determine eligibility based on disability or another MAGI-excepted basis, once eligibility on such basis is established, the individual would no longer be eligible for Medicaid on the basis of MAGI (unless his or her circumstances changed), but would enroll in the program on the MAGI-excepted basis.

Under this final rule, individuals who meet the eligibility criteria for coverage based on the applicable MAGI standard will be able to receive coverage on that basis while they undergo a final determination of eligibility based on eligibility for an optional group covering long-term services and supports. Beneficiaries enrolled in coverage under a MAGI-based eligibility group also will be able to move to an optional group based on a disability or long-term care needs should their circumstances change. Consistent with current rules at § 435.905(a) and in accordance with § 435.911(c)(2), States must determine eligibility under a basis other than MAGI for an individual described in § 435.911(d), which includes individuals who indicate such potential eligibility on the single streamlined application, alternative application or renewal forms, as well as those who request such a determination. In addition, in accordance with current regulations at § 435.905, States must provide information to applicants and beneficiaries about the different eligibility options and benefit packages to enable them to make an informed decision about seeking coverage under other eligibility groups which may better meet their needs.

This policy change is implemented through revisions to the regulatory provisions relating to the MAGI screen at proposed § 435.911 and to the regulatory provisions relating to the exceptions from MAGI-based financial methodologies proposed at § 435.603(i)(3) and (i)(4) in the Medicaid Eligibility proposed rule (redesignated at § 435.603(j)(3) and (j)(4) in this final rule). Revisions at § 435.603(j) are discussed in section III.B. of the preamble. For § 435.911, paragraphs (a) and (b), which set forth the statutory basis and applicable MAGI standards for the eligibility categories described at § 435.110, § 435.116, § 435.118, § 435.119, and § 435.218, remain unchanged. In § 435.911(c), we retain our proposed language that this paragraph applies to individuals who submit an application described in § 435.907 and meet the non-financial eligibility criteria or are determined eligible for Medicaid under a reasonable opportunity period to verify citizenship or immigration status. We have also added language to paragraph (c) to clarify the responsibility of the agency to apply § 435.911 to individuals whose eligibility is being renewed in accordance with § 435.916. Note that the process for determining eligibility set forth in § 435.911 will not apply at initial enrollment to so-called ''auto-eligibles'' who are not required to file an application described in § 435.907—for example, individuals who are automatically eligible for Medicaid due to receipt of SSI or benefits under title IV–E of the Act and newborns deemed eligible under section 1902(e)(4) of the Act and § 435.117 of the regulations.

We are revising § 435.911(c)(1) to provide that the State must furnish Medicaid promptly and without undue delay, consistent with timeliness standards established under § 435.912, to individuals (including children, pregnant women, parents and caretaker relatives and certain adults under age 65 not eligible for Medicare) who are at or below the applicable MAGI standard. In the case of individuals who may be eligible on a basis other than the applicable MAGI standard (for example, based on disability), the obligation under § 435.911(c)(1) can be met either by promptly determining an individual eligible based on the applicable MAGI standard and providing benefits on such basis and then exploring eligibility for other eligibility categories excepted from MAGI methods, as appropriate, or, if possible to achieve promptly and without undue delay, by first determining eligibility on the MAGI-excepted basis.

Paragraph (c)(2) of § 435.911 is revised to ensure that States also determine eligibility for Medicaid on a basis other than the applicable MAGI standard in the case of the following individuals, described in a new paragraph (d) which includes: (1) Individuals whom the agency identifies on the basis of information contained in the single streamlined application used for all insurance affordability programs or renewal form described in § 435.916(a)(3), or on the basis of other information available to the State, as potentially eligible on a basis other than the applicable MAGI standard; (2) Individuals who submit an alternative application designed for MAGI-excepted

populations; and (3) Individuals who otherwise request a determination of eligibility on a basis other than the applicable MAGI standard. Under § 435.911(c)(2), the Medicaid agency will need to collect such additional information as may be needed to determine eligibility on such other basis in accordance with our regulations at § 435.907(c). Note that § 435.911(c)(2) applies to both individuals with MAGI-based household income at or below the applicable MAGI standard, as well as to those with MAGI-based household income above the applicable MAGI standard. In the case of individuals with income above the applicable MAGI standard, paragraph (c)(2) also applies to the determination of eligibility under optional eligibility groups subject to MAGI-based methods—for example, optional coverage of children receiving State adoption assistance in families with income above the applicable MAGI standard for children in the State, as well as optional groups excepted from MAGI methods.

Finally, although the comments received and the discussion above focus on the implications of § 435.911 for individuals with disabilities and those needing long-term services and supports, we note that § 435.911(c) applies also in the case of individuals who may be excepted from the application of MAGI-based methodologies on other bases, including medically needy individuals eligible under section 1902(a)(10)(C) of the Act and 42 CFR part 435, subparts D and I of the regulations, excepted from MAGI-based methods at § 435.603(j)(6) and women screened under the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program, eligible under sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act, excepted from MAGI-based methods at § 435.603(j)(1).

Section § 435.911(c)(3), redesignated from § 435.911(c)(2)(iii), relates to coordination of eligibility with the Exchange when an individual is ineligible for Medicaid based on the applicable MAGI standard, but is undergoing a Medicaid determination on another basis. In paragraph (c)(3), we have revised the cross-reference to our regulations at § 435.1200(e) to reflect revisions to § 435.1200 in this final rule, and the text at paragraph (c)(3) is not substantively modified.

Comment: Some commenters requested that State Medicaid agencies be required to screen for the Part D Low-Income Subsidy (LIS) program, although they acknowledged that LIS is not included in the insurance affordability program definition. One commenter stated that required screenings should include potential Medicare Savings Program (MSP) eligibility.

Response: Since LIS is not defined in the Affordable Care Act as an insurance affordability program, these rules cannot require a State to screen for it. In addition, nothing in our regulation changes already existing requirements for States to determine an individual's eligibility on the most advantageous basis including eligibility for Medicare Savings Programs.

Comment: One commenter suggested the final rule should require States to screen for pregnancy-related coverage, eligibility for women with breast or cervical cancer, eligibility for family planning services, and that States otherwise should provide information to individuals about all of the available coverage options.

Response: Eligibility for pregnant women with income below the applicable MAGI standard is included in determination of eligibility under § 435.911(c)(1). As noted above, § 435.911 applies to all individuals described in § 435.911(d), including individuals such as women with breast or cervical cancer, and States will be expected in accordance with § 435.905, to provide individuals with sufficient information to make an informed choice about requesting a determination on a basis other than the applicable MAGI standard.

Comment: A few commenters requested clarification regarding the treatment of parents and caretaker relatives who may be eligible under an optional group for parent or caretaker relatives or for better benefits under section 1931 of the Act and § 435.110 than the benchmark benefits that may be offered to individuals in the adult group.

Response: In furnishing medical assistance to individuals whose MAGI-based income is at or below the applicable MAGI standard in accordance with § 435.911(b) and (c)(1), States will need to ensure that individuals are enrolled in the categories for which they are eligible and covered for the relevant benefits. Parents and caretaker relatives with income below the standard applied by the State under § 435.110, should be enrolled for coverage in accordance with that section. Parents and caretaker relatives who meet both the eligibility requirements for coverage under an optional group for parents and caretaker relatives and for coverage under the new mandatory adult group will be enrolled under the new adult group. If the State covers optional parents and caretaker relatives up to an income standard higher than 133 percent of the FPL, such individuals would be enrolled in the optional group in accordance with § 435.911(c)(2).

Comment: Several commenters also requested clarification on how eligibility under the new optional group for individuals above 133 percent of the FPL under section 1902(a)(10)(A)(ii)(XX) of the Act, codified at § 435.218 of the regulations, fits into the MAGI screen in § 435.911.

Response: If a State has elected to cover the optional group codified at § 435.218 for individuals with income above 133 percent FPL, the income standard applied by the State to this group is incorporated into the applicable MAGI standard under § 435.911(b)(1)(iv).

Comment: One commenter asked for clarification of whether proposed § 435.911(b)(1)(i) contradicts § 435.110(c) that describes the income standard for parents and caretaker relatives.

Response: Parents and caretaker relatives certainly will be eligible if their MAGI-based income is below 133 percent of the FPL—under either the new adult group at § 435.119 or under the mandatory group for parents and caretaker relatives at § 435.110. Typically, the income standard for coverage of parents and caretaker relatives under § 435.110(c) will be less than 133 percent of the FPL, but if higher, the applicable MAGI standard under § 435.911(b)(1) will be such higher standard.

Comment: Some commenters stated that the proposed regulations have constructed two different doors to access health care which will result in different outcomes for the applicant depending on which door the applicant enters through. The commenters stated that the proposed rules for the Exchange generally require a basic screening for Medicaid on bases other than the applicable MAGI standard, whereas the proposed Medicaid rules at § 435.911 require a full Medicaid eligibility determination only when an applicant is not found eligible for ''MAGI-based Medicaid,'' by which we assume the commenters mean that the applicant's income exceeds the applicable MAGI standard. The commenters question the utility of the ''basic screen'' by the Exchange, since all cases in which the Exchange screens individuals as potentially eligible on a basis other than the applicable MAGI standard will be referred to Medicaid for further evaluation, but the Medicaid agency will not evaluate eligibility on such other bases if the individual has income at or below the applicable MAGI

standard. In addition, the commenters stated that even if the Exchange's screening questions are identical to Medicaid's eligibility questions, a person who could have been found Medicaid eligible may not complete the Medicaid eligibility determination process after he or she has enrolled in a QHP with subsidized premiums.

Response: The ''basic screen'' is designed to allow a streamlined eligibility process by which individuals applying through the Exchange can get real-time eligibility determinations, either by the Exchange or the Medicaid agency, without having to wait for the Medicaid agency to review and make a determination based on disability or other MAGI-excepted bases that may take longer to complete. Regardless of which entity initially handles the application, all individuals will be treated the same. Under § 435.911 and § 435.1200(d) and the Exchange final regulation at 45 CFR 155.345, both individuals with income at or below the applicable MAGI standard as well as those with income above the applicable MAGI standard will be considered on other bases by the Medicaid agency, consistent with § 435.911(c)(2). Under the Exchange final regulation at 45 CFR 155.345, for an applicant who is not eligible for Medicaid based on the applicable MAGI-based standard, using the single streamlined application, the Exchange will assess the information provided by the applicant on his or her application for potential Medicaid eligibility based on factors other than the applicable Medicaid MAGI-based income standard. In accordance with 45 CFR 155.345(e) of the Exchange regulation and § 435.911(c)(3) and § 435.1200(e)(2) of the Medicaid regulation, such individuals will be permitted to enroll in a QHP through the Exchange and receive APTCs until Medicaid notifies the Exchange that the applicant is eligible for and enrolled in Medicaid. Similarly, under § 435.911(c)(3) and § 435.1200(e)(2), individuals who submit a streamlined application to the Medicaid agency and who have MAGI-based income above the applicable MAGI standard, but who may be eligible for Medicaid on another basis, will be able to enroll through the Exchange and receive APTCs pending completion of the Medicaid determination on bases other than the applicable MAGI standard. Individuals with MAGI-based income at or below the applicable MAGI standard also will be treated the same regardless of which program receives the initial application, as the Medicaid agency will be responsible, under § 435.1200(c)(2) and (d)(3) of this final rule, for ensuring that individuals who apply to the Exchange but have income at or below the MAGI standard are evaluated for coverage on other bases in accordance with § 435.911(c)(2) to the same extent as similarly-situated individuals who submit an application directly to the Medicaid agency.

Comment: One commenter requested clarification of the retention of the provisions at § 435.608 that require applicants to take necessary steps to obtain other benefits such as any annuities, pensions, retirement, and disability benefits, to which they are entitled. The commenter requests that CMS consider these requirements when creating the single, streamlined application.

Response: There is nothing in this rule that changes § 435.608, but we note that States may not delay approval of an individual's eligibility for the Medicaid program based on this provision.

Comment: Several commenters asked who bears the financial liability for benefits costs incurred for individuals incorrectly determined eligible for Medicaid by another insurance affordability program.

Response: Nothing in this rule affects the financial liability requirements under the Medicaid program. The Medicaid agency is responsible for assuring quality in the Medicaid program, including exercising oversight and taking any necessary actions to correct errors in the program, as affirmed in the single State agency regulation at § 431.10. For more discussion of the oversight responsibilities of a State agency, see the discussion in section III.K. of this preamble. Regulations governing the MEQC or PERM programs also remain in effect and, as noted, we will be reviewing these rules to ensure alignment with the rules issued under this regulation and the development of a coordinated eligibility and enrollment system involving all insurance affordability programs. There is no recoupment of funds between insurance affordability programs for individuals placed in the incorrect program.

Comment: One commenter understands that individuals with household income at or below the applicable MAGI standard could be declared presumptively eligible for Medicaid benefits promptly and without undue delay. One commenter asked about costs incurred during a presumptive eligibility period.

Response: Coverage provided to an individual based on MAGI who might then be moved to a different eligibility category, for example based on disability, is not based on presumptive eligibility. These individuals are fully eligible for Medicaid based on MAGI standards, even if they ultimately might be found eligible under another eligibility category. These rules do not modify the presumptive eligibility rules that currently apply under the Medicaid program, or address new rules relating to presumptive eligibility enacted under the Affordable Care Act.

Comment: Many commenters requested clarification as to whether the term ''as needed'' in § 435.911(c)(2) is meant to limit what additional information may be collected from an applicant to that information that is required to make a determination of eligibility on a basis other than the applicable MAGI standard, as opposed to limiting States' discretion to request information that is not relevant to the determination of Medicaid eligibility on such bases.

Response: Information that is not necessary to make an eligibility determination cannot be required. The phrase ''as needed'' in § 435.911(c)(2) (revised to read, ''as may be needed'' in the final rule) refers specifically to information that the agency does not have—for example, based on the information received through the single, streamlined application used by all insurance affordability programs—but which is needed to determine eligibility on a basis other than the applicable MAGI standard. Collection of additional information needed to determine eligibility on a basis other than the applicable MAGI standard, in accordance with § 435.907(c), would be appropriate.

Comment: A number of commenters requested further guidance on what ''promptly and without undue delay'' means, and how such standard relates to the current 45 and 90 days application processing timeframes set forth in existing regulations at § 435.911 (redesignated as § 435.912 in this rule), and of the impact on the MAGI-exempt populations.

Response: Existing regulations at § 435.911 (redesignated at § 435.912 in this rule as interim final for which we soliciting comments), provide that State Medicaid agencies establish timeliness standards for determining eligibility, not to exceed 90 days in the case of individuals applying for coverage on the basis of disability, and 45 days in the case of all other applicants. As discussed in section III.D. of this preamble, we are revising § 435.912 to provide further parameters on the standards regarding the adjudication of eligibility which States are directed to establish under the regulations. Revised

§ 435.912(b) and (c) provide that such standards both may not exceed the current 90 and 45 day limit for any individual applicant and must also provide for prompt eligibility determinations across the pool of individuals seeking coverage.

Comment: One commenter requested clarification of whether States still need to determine eligibility for emergency services for non-qualified immigrants who do not qualify for full Medicaid benefits but are eligible for enrollment in coverage through the Exchange with APTC. The commenter stated that it is inappropriate for taxpayers to cover both Federal emergency services and subsidized insurance premiums for non-qualified immigrants.

Response: Nothing in the Affordable Care Act changes the requirement that States provide emergency services to individuals not eligible for full Medicaid benefits due to their immigration status, and States will still need to determine eligibility for emergency services for such populations. To the extent that any such individuals have insurance, either through the Exchange or otherwise, Medicaid would pay secondary to that insurance, so there would be no duplication of coverage. Whether immigrants who are enrolled in Medicaid for coverage of emergency services only can qualify for APTC is a separate question relating to the definition of ''minimum essential coverage'' under section 5000A(f) of the IRC, and is beyond the scope of this rulemaking.

G. Coverage Month (§ 435.917)

In the Medicaid Eligibility proposed rule, we noted that under the Exchange proposed rule at § 155.410, enrollment in the Exchange for individuals terminated from Medicaid would begin at the earliest on the first day of the month following the date the individual loses Medicaid eligibility and is determined Exchange-eligible. Under the Exchange proposed rule, if the individual was terminated from Medicaid or CHIP after the 22nd of the month, Exchange enrollment would begin at the earliest on the first day of the second month after the termination date. To help address the potential for a gap in coverage, the final Exchange rule at 45 CFR 155.420(b)(2)(ii) will allow individuals enrolling through a special enrollment period, including those losing Medicaid or CHIP, to enroll by the first day of the following month, provided plan selection is completed by the end of the month of termination from Medicaid or CHIP. Therefore, beneficiaries terminated, for example, on the 31st of the month may be able to enroll as early as the next day in Exchange coverage. Nonetheless, for beneficiaries terminated earlier, a gap in coverage could still occur for a period that could last close to a full month if States do not extend Medicaid or CHIP coverage until the end of the month.

We noted that directing State Medicaid and CHIP programs to extend coverage until the end of the month in which coverage is terminated could help promote continuity of coverage, and requested comments on whether the benefits of doing so outweigh the costs of imposing such a requirement. Current Medicaid and CHIP regulations are silent regarding whether a State must end eligibility on the day that an individual is determined no longer eligible for assistance, subject to the Medicaid and CHIP notice provisions, or whether coverage may continue until the end of the month, although in practice we believe many States continue coverage until the end of the month.

Comment: Comments on this issue were mixed, with some commenters expressing support for and others opposition to a policy requiring coverage to the end of the month in which eligibility otherwise would terminate. Numerous commenters voiced strong support for a policy of extending coverage to align with Exchange coverage months to prevent gaps in coverage. The commenters noted that even small disruptions in coverage can have significant medical and financial consequences, especially for individuals with chronic conditions and/or needing medication. Some commenters stated that additional time would also allow States to correct for inaccurate terminations (for example, if a pre-populated renewal form goes to the wrong address). A few commenters noted that many States already operate in this manner for managed care enrollees. One commenter stated that there are precedents for such a policy, already including pregnant women, whose coverage extends at least 60 days post-partum; parents who are provided Transitional Medical Assistance (TMA) for several months after becoming ineligible; and children in States with continuous eligibility policies. Some commenters familiar with States that already have a health insurance exchange urged extending the coverage month, citing communication and systems problems for individuals moving between Medicaid and an Exchange and urged that Medicaid coverage be extended until the individual is actually enrolled in the Exchange. Several commenters cited to churning studies. One commenter suggested that extending coverage was consistent with Medicaid's role as a safety net provider.

Conversely, several commenters stated that States must have flexibility to end coverage at any time during the month. They were concerned that the costs could be significant if we required otherwise. One commenter urged that the Federal government provide 100 percent FFP for gaps in coverage if Medicaid is extended to smooth transitions. Another commenter suggested we adopt exceptions to any coverage month requirement in the event of beneficiary death, fraud (allowing termination with a 5-day notice as in current policy), extension of eligibility pending appeal if the beneficiary does not prevail in the appeal (immediate termination), incarceration, when an individual moves out of State has been determined eligible in the new State, and if private insurance is available and the person can be enrolled in such coverage.

Finally, some commenters gave alternative suggestions to solve the potential gap in coverage. Some commenters suggested extending the notice period for termination—so that termination does not take effect until at least the last day of the current month, if such notice is provided prior to the 12th, or the last day of the subsequent month if notice is on the 12th or later. One commenter also suggested that CMS offer to defray medical expenses for patients who experience gaps in coverage when they move from Medicaid to the Exchange. The same commenter also suggested requiring Exchange coverage to begin the day after Medicaid coverage terminates, rather than the first day of the subsequent month—even if the individual forgoes premium credits or cost-sharing until the following month. Another commenter suggested allowing individuals ineligible for Medicaid but eligible for premium subsidies to continue enrollment in their Medicaid health plan on an opt-out basis, even after a determination of ineligibility for Medicaid, without requiring the plan to meet Exchange requirements to minimize disruptions in coverage.

Response: The final Exchange rule has been revised at 45 CFR 155.420(b)(2)(ii) to allow an individual to enroll in an Exchange plan, regardless of what point in the prior month the individual has been terminated, will partially close the coverage gap. In this final rule, we will not require the extension of Medicaid and CHIP through the end of the month, but we encourage States to fill the gap by providing coverage through the end

of the month that an individual is terminated from coverage, as many States do today. We note that for States that choose to do this, FFP at the applicable match rate will be available for this extended coverage.

Comment: One commenter requested that CMS consider allowing extensions of coverage through the end of the month for individuals terminated from Exchange coverage who become Medicaid eligible. Allowing a recipient to remain in the Exchange until the end of the month and permitting Medicaid to start at the beginning of the next calendar month would prevent duplication in eligibility periods and possible double payment of Federal funds.

Response: The Exchange final rule at 45 CFR 155.430(d)(2)(iv) provides that the last day of coverage is the day before coverage in Medicaid, CHIP, or the BHP if applicable begins. This rule is intended to minimize gaps in coverage for individuals moving from Exchange coverage to Medicaid.

Comment: One commenter suggested that retroactive coverage is no longer needed and that CMS should remove this requirement.

Response: The Affordable Care Act did not make any change to the retroactive coverage provisions in the Act. For MAGI populations applying for Medicaid coverage, retroactive eligibility means that the effective date of such coverage can be up to three months prior to the date of the application if covered services have been rendered at any time during that time period, in accordance with § 435.914.

H. Verification of Income and Other Eligibility Criteria (§ 435.940, § 435.945, § 435.948, § 435.949, § 435.952, and § 435.956)

In the Medicaid Eligibility proposed rule, we proposed amendments to 42 CFR part 435 subpart J to make verification processes more efficient, modern, and also coordinated with the Exchange policies in proposed 45 CFR 155.315 and 155.320 (76 FR 51231 through 51234). In general, our proposed rules maximized reliance on electronic data sources, shifted certain verification responsibilities to the Federal government, and provided States flexibility in how and when they verify information needed to determine Medicaid eligibility. The proposed changes drew from successful State verification systems and strategies. The major changes proposed included:

- In accordance with section 1413(c) of the Affordable Care Act, all insurance affordability programs will use an electronic service established by the Secretary (''Federal data services hub'') through which they can corroborate or verify certain information with other Federal agencies (for example, citizenship with the Social Security Administration (SSA), immigration status through the Department of Homeland Security (DHS), and income data from the IRS).
- Consistent with current policy, State Medicaid agencies may accept self-attestation of all eligibility criteria, with the exception of citizenship and immigration status. States would continue to comply with the requirements of section 1137 of the Act to request information from data sources when determined useful by the State to verifying financial eligibility. (In this final rule, we also clarify that self-attestation would not be permitted in contravention of any legal requirement.)
- In verifying eligibility States would rely, to the maximum extent possible, on electronic data matches with trusted third party data sources rather than on documentation provided by applicants and beneficiaries. Additional information, including documentation, may be requested from individuals only when information cannot be obtained through an electronic data source or is not ''reasonably compatible'' with information provided by the individual.
- A new provision at § 435.956 relating to verification of non-financial eligibility criteria was added that similarly places primacy on electronic third party data sources.
- A number of prescriptive provisions in current regulations as to when or how often States must query certain data sources, or when certain State wage agencies must provide data to the State Medicaid agency were deleted.

These and other proposed revisions are discussed in more detail at 76 FR 51162 through 51165.

Comment: One commenter believed that the verification requirements for predictable changes in income in § 435.603(h) should be no more cumbersome than those required for income at initial application or redetermination, and recommended that individuals be able to provide verification through such means as a signed employment contract or a history of fluctuations (for example, past small-business revenue statements).

Response: The verification regulations apply both to current, as well as predictable future changes in income so States should apply the same standards to both. In appropriate circumstances, and depending on State policies, the verification suggested by the commenter would be permitted under the regulation.

Comment: One commenter suggested that the final regulations should expressly permit States to use Express Lane eligibility for adults, as well as children, and that there should be no sunset to the option.

Response: Section 1902(e)(13) of the Act provides States with an option to accept findings relating to a factor of eligibility made by an ''Express Lane agency'' in determining the eligibility of a child for Medicaid. Findings of income made by an Express Lane agency under this option are excepted from application of MAGI-based methodologies in section 1902(e)(14)(D)(i)(I) of the Act, codified at § 435.603(j)(1) in the final rule. The authority under section 1902(e)(13) of the Act is scheduled to sunset on September 30, 2013. Extending this authority to adults or beyond the sunset date provided in the Act is not authorized by the statute, and therefore, is beyond the scope of this regulation; however, subject to CMS approval, States may be able to develop a process similar to that provided under section 1902(e)(13) of the Act through a demonstration if the requirements of section 1115 of the Act are met.

Comment: We received many comments that paragraph (a) under § 435.945 should be removed because restating the objective of program integrity in such broad terms weakens the regulation by allowing a broad and vague exception to all provisions of the regulation if any program integrity interest can be identified by a State. While the commenters support program integrity, they are concerned that a State could use proposed § 435.945(a) to justify creating burdensome barriers in enrollment procedures, such as requiring paper documentation, which may result in preventing even larger numbers of eligible individuals from obtaining coverage. A number of other commenters suggested that any State which chooses to not implement provisions in the verification regulations to maintain program integrity should be required to demonstrate that program integrity is threatened, document how the alternative process will improve program integrity, and get approval from the Secretary.

Response: Compliance with the verification regulations is not at State option and we do not believe reference to existing program integrity provisions in these regulations will in any way undermine the verification regulations. However, to make it clear that program integrity regulations apply broadly and

independently and do not undermine the regulations relating to verification, we have moved the reference to program integrity to § 435.940 in the final rule and redesignated the paragraphs in § 435.945 accordingly. We also added language at § 435.940 that States must provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the plan, consistent with § 431.15 of this subchapter and section 1902(a)(19) of the Act. We also have added provisions to clarify the intent of the Medicaid Eligibility proposed rule that electronic sources be consulted where possible and available—this policy limits use of documentation only to situations when necessary and appropriate and we revised § 435.952 accordingly, as discussed below.

Comment: Some commenters believed that the Medicaid Eligibility proposed rule requires reliance on self-attestation and electronic data sources to a greater extent than is required today and that this will undermine program integrity and impede States' ability to achieve local policy and operational objectives, as well as meet Federal error rate standards. Other commenters support the express permission to rely on self-attestation provided in the proposed regulations, and many believed that the regulations did not go far enough in limiting the use of paper or other documentation, especially for vulnerable populations, and that States should have to show a program integrity concern before requesting paper documentation. One commenter urged that we provide guidance on how a highly automated eligibility system can function in the absence of a considerable degree of self-attestation.

Response: Within the boundaries established under the statute and these regulations, States retain flexibility to establish verification procedures to be applied in their States. However, self-attestation should not be permitted where the law would not permit it. We have modified our regulations so that States would have the option, but are not mandated to accept self-attestation unless the statute requires other procedures (such as in the case of citizenship and immigration status). As explained further below, self-attestation would be required for pregnancy, for which a State may seek additional information only if it has information not reasonably compatible with the individual's attestation.

The proposed regulations would place greater reliance on data-based verification as opposed to documentation required from individuals, consistent with the direction that many States have been taking and the requirements in the Affordable Care Act for a streamlined and efficient eligibility determination system. The increased availability of electronic data matching together with the 90 percent Federal match that may be available if certain conditions are met for systems investment under 75 FR 21950, and the provisions in the Affordable Care Act to create a coordinated and efficient eligibility and enrollment system across insurance affordability programs, all support increased reliance on electronic verification. States that simply fail to access or pay for access to electronic data sources, even when cost effective and efficient, may undermine this policy of electronic primacy, and continue a reliance on paper documentation in a way that was not envisioned by either our Medicaid Eligibility proposed rule or section 1413 of the Affordable Care Act and section 1943 of the Act.

Therefore, in this final rule, we are revising § 435.952(c)(2) to clarify that requests for documentation from the individual, whether in hard (paper) copy or in other formats, are to be limited to cases where the State has determined that verification using an electronic data match, (including with another State agency) would not be effective, considering such factors as the administrative costs associated with establishing and using the data match, the administrative costs associated with relying on documentation, and the impact on program integrity and error rates in terms of the potential both for ineligible individuals to be approved, as well as for eligible individuals to be denied coverage. We have also removed the reference to ''paper'' in § 435.945(a), as redesignated in the final rule. These modifications are consistent with the policies we proposed to modernize verification systems and align them with the systems used to verify eligibility for APTC.

Comment: Many commenters recommended that the regulation provide specific protections, such as requiring States to accept self-attestation, for vulnerable populations who may not have documents and for whom the State may not be able to verify information using electronic sources.

Response: Under the regulations, States may accept self-attestation, except for where the law would require a separate set of procedures (such as in the case of citizenship and immigration status) for individuals who do not have documentation and the State cannot verify the individual's information using electronic data sources.

Comment: A number of commenters were concerned about the interaction of these regulations with PERM. The commenters believed that, absent audit and quality control protection being afforded in these regulations, States often would need to verify income using paper documentation. One commenter recommended that States submit a plan to notify the Secretary of the data sources it will use in verifying eligibility, which the commenter believed would help to address State concerns about compliance with PERM.

Response: As noted above, we intend to ensure alignment of PERM and other program integrity rules and procedures with the new eligibility rules. As explained in the State Exchange Implementation Question and Answers published on November 29, 2011, available at *http://www.medicaid.gov/Federal-Policy-Guidance/CIB-11-29-2011.pdf,* under the recently modified PERM rules, as long as federally-approved State procedures are followed, the PERM rules classify the case as an accurate determination. Thus, if a State relies on self-attestation to establish certain facts regarding eligibility consistent with Federal rules, PERM audits also rely on the self-attestations provided. If federally-approved State policies require additional verifications and data collection, auditors will review cases against those standards.

We also are adding a new paragraph § 435.945(j), under which State Medicaid agencies will develop, and update as appropriate, a verification plan describing the agency's verification policies and procedures, including the standards applied by the State in determining the usefulness of the financial information described in § 435.948(a). The verification plans must be available to the Secretary upon request, thereby enabling appropriate oversight of State implementation of the standards established in the regulations and assuring policies adopted by the State will serve as the basis of PERM reviews.

Comment: One commenter questioned if States are expected to maintain electronic information from the data match from trusted third party sources for income verification for some period of time for PERM/MEQC verification of eligibility determination.

Response: Current regulations at § 435.913(a) require the Medicaid agency to include in each applicant's case record facts to support the agency decision on the application, which would include information obtained from a data match.

Comment: Two commenters suggested that accepting self-attestation could result in retroactive liability for States and managed care organizations if, later, some eligibility determinations were found to be erroneous. One commenter recommended that CMS hold States harmless through 2014 for all quality control and audit errors in the event that the annual reconciliation for the APTC conducted by the IRS uncovers inconsistencies about which the State had no way of knowing. Another commenter suggested that if States accept self-attestation, they should be allowed to recover funds if subsequent verification shows the individual was not eligible for Medicaid. One commenter expressed concern that applicants will be approved, without delay, pending receipt of verifications, and if later are determined ineligible, the agency must give them proper notice while receiving coverage at the taxpayer expense.

Response: States are accountable to ensure that eligibility determinations are made accurately and in accordance with State and Federal policies, and their success in doing so is measured in accordance with the MEQC and PERM programs. Under our regulations at § 431.980(d), States are not held liable for eligibility determinations made in accordance with the State's documented policies and procedures, including self-attestation, and supported by information in the case record. This rulemaking does not alter these regulations or establish any new liability for States for FFP claimed on behalf of individuals erroneously determined eligible for Medicaid and enrolled in the program because the State did not take into account information not available to it at the time of the determination. For individuals' rights and responsibilities, under current regulations, once an individual is determined eligible, the agency must provide proper notice and hearing rights prior to termination in accordance with 42 CFR part 431 subpart E. Recovery from individuals erroneously determined eligible is generally not permitted, with the possible exception of fraud on the part of the individual, or in the case listed under § 431.230(b). In the case of potential fraud, the regulations at 42 CFR part 455 subpart A would continue to apply. Regulations at 42 CFR part 431 subpart E and part 455 subpart A are not affected by this rulemaking.

Comment: One commenter indicated that the rules are not clear as to whether the Medicaid agency may make a determination based on self-attested information or whether the self-attested financial information must first be verified through the data matches described in § 435.948 and § 435.949. The commenters requested clarification that a determination may be made based on self-attested information subject to a later request for further information if financial information cannot otherwise be verified. Another commenter suggested that data resources be utilized at initial application to support self-attested statements.

Response: The regulations provide States with the flexibility to decide the usefulness, frequency and time-frame for conducting electronic data matches. Thus, a State may approve eligibility based on self-attested financial information without requesting further information (including documentation from the individual) and follow up with data matching in accordance with § 435.948 after enrollment, or the State can choose to conduct the match prior to finalizing the eligibility determination, subject to timeliness standards established in accordance with § 435.912. Section 435.945(a) permits States to accept self-attestation of most elements of Medicaid eligibility; § 435.945(b) provides that States must request and use information relevant to determining eligibility in accordance with § 435.948 through § 435.956. (See our above response regarding our amendments to clarify that self-attestation will not be permitted when the law would require a separate set of procedures.)

Comment: Another commenter had concerns regarding the level of subjectivity that will be permissible if the applicant is not required to enter any specific income information into an application as a first step in the verification process. The commenter was concerned that the income retrieved from the Federal data services hub or other electronic data sources no longer would be verified against data entered by applicant.

Response: We are working to develop tools for individuals and States to use to determine current MAGI-based income based on the information obtained as part of the application process. We anticipate that the process and sequence by which this occurs could be structured in different ways, including by asking an individual for income information up front and confirming it with electronic sources afterward, or by asking an individual to confirm information that the agency obtains electronically.

Comment: One commenter indicated that the 90-day timeframe for resolving discrepancies conflicts with rules for other public assistance programs, and could have a significant administrative impact on States. One commenter recommended that the rule should specify that Medicaid is to be considered correctly paid and no recovery should be sought during the time period that the Medicaid agency enrolls an applicant for 90 days while awaiting information to resolve an incompatibility through to the effective date of proper notification in instances resulting in a discontinuance of coverage.

Response: There is no 90-day reasonable opportunity period addressed in this regulation. The 90-day reasonable opportunity period related to the APTCs is addressed in the Exchange final rule at 45 CFR 155.315(f).

Comment: A number of commenters suggested that the regulations encourage States to explore alternatives such as self-attestation of income and/or assets for applicants whose eligibility is not based on MAGI methodologies. A few commenters also suggested that the data matching required under § 435.948 apply to applicants being evaluated for eligibility on a basis other than MAGI.

Response: The verification regulations at § 435.940 through § 435.956 apply to the determination of eligibility of all individuals; they are not specific to individuals whose financial eligibility is based on MAGI methodologies.

Comment: A few commenters recommended allowing for acceptance of self-attestation of citizenship and immigration status. One commenter expressed concern that the Medicaid and Exchange regulations were inconsistent with regards to verification of citizenship.

Response: Verification of citizenship and immigration status were not addressed in our Medicaid Eligibility proposed rule. However, we note that such verification is governed by sections 1902(a)(46), 1903(x), and 1137(d) of the Act, which require verification of citizenship and immigration status. Also, under our final rule, where citizenship and immigration status can be verified with the SSA or DHS through the electronic service to be established by the Secretary under § 435.949, the rule requires use of that service.

Comment: One commenter believed that proposed § 435.945(b) implied that paper documentation of citizenship and satisfactory immigration status is always required for Medicaid when, in fact, citizenship may be established based on data matches with SSA or State birth certificate records, without the applicant providing any paper documentation.

Response: Section 435.945(a), as redesignated in this final rule states that self-attestation alone can never be used for citizenship or immigration status, verification of which are governed by sections 1137, 1902(a)(46) and 1903(x) of the Act which require either electronic verification or other documentation (not paper documentation exclusively).

Comment: We received many comments that the regulation should clarify that, while electronic data matching is required at initial application and redeterminations, such data matching is not required on an on-going basis, as this could be burdensome for States. One commenter suggested that State Medicaid agencies only be required to act on changes in household size, State residency and loss or gain of employment that impact eligibility.

Response: The regulations do not change current policy, under which States have flexibility to determine the frequency of data matches between regular eligibility renewals. States are not required to conduct data matches on an ongoing basis. States are subject to all the verification requirements of § 435.952 when responding to changes in an individual's circumstances. Under § 435.916(d), for MAGI-based determinations, when an individual reports a change in circumstance that affects their eligibility, the State must limit its review of third-party data sources to eligibility factors affected by the changed circumstances.

Comment: One commenter recommended that proposed § 435.945(d) be modified to allow the child support enforcement unit more freedom to share information with the Medicaid agency, and that other necessary changes be made to permit the Office of Child Support Enforcement (OCSE) to release information from the National Directory of New Hires to the agency, as intended by the CHIPRA legislation.

Response: While our final regulations allow State Medicaid agencies to rely on additional data from other agencies, as long as the requirements of § 435.945(e) through (i), as redesignated in the final rule, are met, we believe that rules governing release of information by the OCSE are beyond the scope of this rule.

Comment: One commenter questioned whether § 435.945(e) ensures that beneficiaries will not bear the costs of any information matching conducted by the State Medicaid agency.

Response: Section 435.945(e) relates to the financial responsibility of different agencies to bear the cost of data matching requested by them. Beneficiaries cannot be asked to bear any of the costs for data matching; this is an administrative cost.

Comment: One commenter questioned why the States must reimburse another agency for reasonable costs incurred for furnishing information to another agency.

Response: The reimbursement is for costs incurred by the other agencies in providing information to the Medicaid agency, and is required under section 1137 of the Act.

Comment: Many commenters inquired or made specific recommendations about the content and format of the information that must be provided to individuals under proposed § 435.945(f) prior to initiating an electronic request for data. The recommendations included providing written information in plain language, providing an explanation of the alternative data sources (if any) and consequences should the individual choose not to have one of the data sources contacted, and that notices be easily accessible. Another commenter requested clarification about how States are supposed to notify individuals prior to initiating an electronic data match.

Response: The regulation requires that individuals be informed of the ways and circumstance in which the agency may be requesting information, as is the case under current regulations. This information must be provided in a manner that is simple and accessible. States are not required under the regulation to provide the required information to individuals every time the State wants to initiate a data match. A State could, for example, provide the required information at application and regular renewals of eligibility.

Comment: One commenter asked if an individual can decline to have States check IRS data because they know it is inaccurate or want to keep it private and instead provide income verification to the agency.

Response: As part of the application process, under section 1137 of the Act, applicants must provide their SSN and must be advised how the SSN will be used, including obtaining IRS data. Applicants do not have an opportunity to decline that process, but do have an opportunity to present alternative documentation if IRS data do not reflect their current circumstances. Non-applicants are not required to provide an SSN to enable an IRS match, although they may do so voluntarily. Statutory privacy and confidentiality protections apply to the disclosure, use, and maintenance of the IRS data.

Comment: Many commenters were concerned that individuals would not have an opportunity to review and either validate or correct data that is imported into their application.

Response: Under § 435.952(d), States may not deny or terminate eligibility based on information obtained through data matches without providing the individual with an opportunity to validate or dispute such information.

Comment: Many commenters supported the requirement in proposed § 435.945(h) regarding information exchanged between the Medicaid agency and other agencies and programs, but recommended that the regulation specify that information can only be requested, shared or used for purposes strictly relevant to eligibility verifications, and that the use of such information meet existing requirements relating to the confidentiality, disclosure and maintenance of information regardless of the source from which it is received. Another commenter strongly recommended that any confidential or especially sensitive information sought, such as information relating to specific diagnoses, illnesses, treatments or disability, should have protections built in and an exceptions process for the individual to avoid having that information accessed and potentially subject to wider data sharing. Another commenter recommended that the obligation to provide secure interfaces for data-matching be explicitly codified by reference to specific statutes that prohibit requesting unnecessary information, such as the Privacy Act of 1974, throughout these regulations. Many commenters commended the requirement under § 435.945(i) that States establish formal agreements to protect information but recommended that information can only be used for narrow and relevant verification purposes, and meet confidentiality thresholds to earn trust in the system.

Response: Confidentiality of information is essential. Existing regulations at 42 CFR part 431 subpart F protect the confidentiality and safeguarding of applicant, non-applicant and beneficiary information, including medical information, and we have added a cross reference to these regulations in § 435.945(c). Recognizing the specific confidentiality and security requirements that attach to MAGI information obtained from the IRS under section 6103(l)(21) of the IRC, as added by section 1414 of the Affordable Care Act, we have also revised § 431.305(b)(6) to clarify that data from SSA and IRS must be safeguarded according to the requirements of the agency that furnished the data, which includes provisions of section 6103 of

the IRC as applicable. We also update the basis for the regulations at 42 CFR part 431 in § 431.300 (adding a new paragraph (d)) and clarify that the reference to section 6103(l) of the IRC in § 431.300(c)(1), as redesignated in this final rule, is limited to section 6103(l)(7). Finally we updated the cross references in § 431.300(c) and § 431.305(b)(6) to § 435.945 through § 435.956 to reflect all the relevant regulations. We are issuing the revisions to § 431.300(c)(1), § 431.300(d), and § 431.305(b)(6) as an interim final rule and are soliciting comments on these provisions.

Section 435.945(h) requires that information exchanged electronically between programs must be sent and received through a secure electronic interface. In addition, § 435.945(i), as redesignated in the final rule, requires the Medicaid agency and other entities to enter into written agreements which must provide for appropriate safeguards limiting the use and disclosure of information as is required by State and Federal law or regulations, including, as applicable, the requirements under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, enacted on August 21, 1996) (HIPAA), the Privacy Act, and section 1942 of the Act, as well as 42 CFR part 431 subpart F and the Exchange final regulations at 45 CFR 155.260.

Comment: Many commenters recommended that the reporting required by § 435.945(g) for the purposes of determining compliance with regulations and evaluating the effectiveness of the income and eligibility verification system be made publicly available and include a consumer and consumer advocate survey component as to the effectiveness of the verification process. One commenter suggested that the reported information also address whether the income and eligibility verification system results in eligible persons being denied eligibility as a result of gaps, omissions, time lags or other failings or inaccuracies of the queried databases.

Response: We will take the comments under advisement in considering what information can and should be made available to the public.

Comment: One commenter questioned why the regulations require written agreements under proposed § 435.945(i). Instead, they recommended that protections could be built into the regulations. Another commenter questioned if the written agreements between the Medicaid agency and the Exchange will allow both entities to exchange taxpayer information or other information, such as protected health information, for the purposes of administering eligibility for the programs.

Response: Use of written agreements between agencies exchanging information is a commonly accepted way to ensure that required confidentiality and privacy protections are provided, including those set forth in existing regulations in part 431 subpart F. The written agreements between the Medicaid agency and Exchange should allow both entities to share information which is needed to determine eligibility or for other purposes directly related to the administration of the respective programs. Section 1137 of the Act ensures that necessary safeguards are in place for information exchanged among agencies. In addition, 45 CFR 155.260 in the Exchange final rule provides for privacy, information security, and data sharing requirements for Exchanges.

Comment: Many commenters commended the requirement under § 435.948(a) that State agencies must request financial eligibility information from other agencies. However, they expressed concern that by providing States with discretion to not make these requests if the State deems that they are not ''useful,'' the rule creates too broad an exception and places undue burden on individuals. Some recommended that the authority to determine usefulness should remain with the Secretary. Others recommended that States be required to collect information from other agencies ''unless there is no information materially relevant to an eligibility determination'' and that the language ''relating to financial eligibility'' be changed to ''necessary for financial eligibility determinations.'' Still other commenters recommended that the final rule provide stronger parameters or minimum standards for States in determining when to use data sources to process eligibility so that States do not define ''useful'' in such a way that all available databases are not tapped. Some commenters recommended replacing the word ''useful'' in paragraph (a) with ''available, accurate, and timely.'' One other commenter was concerned that many eligible individuals will be denied coverage in real time simply because the databases to be used in verifying wages and other income do not rely on ''point in time'' information, are out-of-date, incomplete, or inaccurate. Other commenters supported the flexibility afforded by the regulations for States to determine what is ''useful.''

Response: We do not believe it is possible or preferable for the Secretary to prescribe all the situations in which financial data sources are useful and believe that States are in the best position to make such a determination. States currently use wage data that lags behind in making eligibility determinations and the data often is sufficient, notwithstanding the time lag, for the State to confirm the information provided by the applicant. The requirements at § 435.952(d) ensure that individuals will not be denied eligibility simply because available wage data may not be up to date, as States must request additional information if necessary before denying or terminating eligibility based upon a data match.

The time lag in the availability of quarterly wage data would not justify a State concluding that such data is not useful to verifying income eligibility and routinely relying instead on documentation provided by the individual. Conversely, a State could determine that accessing quarterly wage data is not useful if income data received from the IRS is reasonably compatible with information provided by the individual. In that situation, the agency would have obtained reliable verification of income.

Comment: One commenter sought confirmation that States may consider the cost effectiveness of a data match in determining its usefulness under § 435.948(a).

Response: We agree that cost-effectiveness is an appropriate consideration in determining the usefulness of electronic data matches under § 435.948(a) of the regulations. States cannot be expected to obtain all possible electronic data, but, at the same time, State agencies should rely on electronic data when it is cost-effective to do so. Under proposed § 435.952(c) documentation from an individual is permitted only when electronic data are not available or information obtained from an electronic data source is not reasonably compatible with information provided by or on behalf of an individual. In the final rule, we are clarifying this provision to provide that, in determining whether electronic data are available, States need to consider the costs of establishing and using the matching capability against the cost of requiring, receiving, and reviewing documentation, as well as the impact on program integrity in terms of the potential for ineligible individuals to be approved, as well as for eligible individuals to be denied coverage.

Comment: One commenter believed that § 435.948 is unduly narrow because it limits data-based verification required of States to financial elements of Medicaid eligibility, rather than

including all other eligibility elements, such as State residence. The commenter believed that this limitation is inconsistent with section 1413(c)(3)(A) of the Affordable Care Act, which requires the use of data matches to establish eligibility to the maximum extent practicable, without any limitation to the financial components of eligibility.

Response: Section 435.948 codifies section 1137 of the Act, which requires specific data matching arrangements in verifying financial eligibility for several Federal means-tested benefit programs, including for purposes of Medicaid. Section 435.956 of our regulations addresses verification of non-financial criteria. Section § 435.952 applies to both financial and non-financial verification, and section (c) of the Medicaid Eligibility proposed rule required that, if self-attestation is not accepted for criteria other than citizenship/immigration status, States must access available electronic data bases prior to requiring additional information (including documentation) in verifying all factors of eligibility.

Comment: A few commenters recommended that States be required to accept income information verified by SNAP to determine Medicaid income eligibility.

Response: Section 435.948(a)(2) requires States to request information related to financial eligibility from SNAP when useful to verifying financial eligibility. The standards set out in these rules establish an appropriate basis for States to assess the usefulness of SNAP, as well as other data in verifying financial eligibility. We note that the reference to the Title IV–A program (TANF) was inadvertently admitted from § 435.945(a)(2) in the Medicaid Eligibility proposed rule so we have added it back in this final rule.

Comment: One commenter proposed that the data sources under § 435.948(a) include the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

Response: The Medicaid agency does not need to conduct an income determination for individuals eligible for Medicaid as a result of being covered under the BCCPTA eligibility group (see section 1902(aa) of the Act). Therefore, this would be an unnecessary addition to § 435.948(a).

Comment: One commenter believed it is confusing to include Public Assistance Reporting Information System (PARIS) in § 435.948(a) in the list of possible data sources. Since States must conduct data matching with PARIS, they have no discretion to determine it is not useful to do so.

Response: PARIS is not necessarily related to income verification. Therefore, we have moved the requirement related to PARIS to a new § 435.945(d).

Comment: One commenter noted that changes that affect eligibility must still be reported within 10 calendar days but there is no electronic database that will provide current income.

Response: We are unsure of what 10-day requirement the commenter is referring to; perhaps this relates to a particular State's rules. Under existing Federal regulations, States need to establish procedures to ensure that beneficiaries make timely and accurate reports of changes that may affect their eligibility; this is retained in § 435.916(c). Under § 435.952, States must evaluate any such information received, consistent with the standards and protections established in that section.

Comment: Many commenters suggested that proposed § 435.948(c) be revised to reflect that the agency ''must'' obtain the information directly from the appropriate agency or program consistent with the requirements in § 435.945 of this subpart when such information is not available through the Federal data services hub described at § 435.949.

Response: Information needed to verify eligibility which is available through the Federal data services hub described in § 435.949 must be obtained through that service. If needed information is not available through that service but can be obtained through an electronic match directly from another agency or program, as is the case with the information described in § 435.948, the State must obtain the information from such agency or program. To avoid any confusion that the proposed regulation may have caused, we have deleted proposed § 435.948(c), as we believe these requirements are already included in other parts of the regulation (that is if information cannot be obtained through the hub, then it would be obtained directly from the agency or program). We also have moved the provisions at proposed § 435.948(d) and proposed § 435.949(c) to a new § 435.945(k) in the final rule, which allows, subject to Secretarial approval, States to adopt alternative data sources to those listed in § 435.948(a), or to obtain needed information through a mechanism other than the Federal data services hub described in § 435.949(a), to ensure that the goals of maximizing administrative accuracy and efficiency, minimizing consumer burden, meeting confidentiality requirements, and promoting coordination.

Comment: We received a number of comments related to the provision of an SSN by non-applicant household members. One commenter believed it would be difficult to verify the dependent status of a child without the parent's SSN. A few commenters were also concerned that if non-applicant SSNs may not be required it will be difficult to verify income and suggested that proof of income by non-applicants be required. Others were concerned about undue burden on applicants if non-applicant household members do not provide an SSN.

Response: We are codifying this current policy at § 435.907(e) and as discussed in section III.E. of the preamble, States are prohibited from requiring non-applicants' SSNs as a condition of another household member's eligibility for Medicaid or CHIP. In the case of non-applicant household members, such as a parent, who do not provide an SSN and whose income is material to the eligibility determination of the applicant, States are directed in § 435.948(c) to use other personally identifying information in conducting data matches if it is possible to do so. In order for the IRS to return income information relating to any individual, including a non-applicant, the individual's SSN is required. If data matches are not possible, States may accept self-attestation or request additional information to verify income or tax dependency status, consistent with the regulations. The IRS will not return information which can be used to verify the dependent status of a child.

Comment: One commenter questioned how discrepancies will be resolved when an SSN cannot be validated through a data match or is validated as someone else's SSN.

Response: The requirement to validate an applicant's SSN with the SSA is not new and is currently codified at § 435.910(g), though States must utilize the Federal data services hub described in § 435.949 for this purpose if the information is available through such service. The Affordable Care Act did not change the process for resolving inconsistencies. Individuals may also continue to contact SSA to resolve any discrepancies with their SSN that could not be resolved by the State Medicaid agency.

Comment: Many commenters recommended that we provide in the regulation text a reference to § 435.910, which requires States to assist individuals in obtaining an SSN. One commenter suggested that the requirement to furnish an SSN only apply to those who are eligible for an SSN, and that the State not be required

to assist individuals who are not eligible for SSNs because the requirement to apply for an SSN creates an administrative burden. Many commenters believed States should be required to assist lawfully-residing individuals not eligible for a regular SSN with obtaining a ''non-work'' SSN.

Response: Under existing regulations at § 435.910, individuals seeking coverage are required, as a condition of eligibility, to furnish an SSN, unless the individual has a well-established religious objection to obtaining an SSN. States have long had the responsibility under § 435.910(e) to assist individuals who do not have an SSN with obtaining one, and may not deny or delay benefits pending the issuance of such a number. To clarify, we have revised the cross-reference to § 435.910 in § 435.956(d) to clarify that States not only must verify SSNs in accordance with § 435.910(f) and (g), but are subject to all the requirements in § 435.910.

The requirement to furnish and verify an SSN only applies to individuals eligible for an SSN, and note that individuals not eligible for an SSN cannot be denied eligibility on that basis, and have revised § 435.910 accordingly in the final rule, but still must meet the requirements related to citizenship. States have long been permitted to provide an exception to the SSN requirement for individuals with a well-established religious objection to obtaining an SSN. While SSA will issue an SSN for a non-work reason, in accordance with 20 CFR 422.104, to individuals not otherwise eligible for a ''work-related'' or ''regular'' SSN, the purpose of requiring an SSN is to facilitate verification of income, citizenship and other eligibility criteria. Since an SSN issued for a non-work reason cannot be used to obtain data from other programs or agencies needed to verify eligibility for Medicaid, there is no practical purposes to requiring that individuals eligible only for a non-work SSN obtain such an SSN, or that State Medicaid agencies assist the individual in doing so. Therefore, based on our understanding of current practice in many States, we are codifying in this final rule that the exception to furnishing an SSN set forth in paragraph (h) of § 435.910 applies also in the case of individuals who are not eligible to receive any SSN as well as to individuals who do not have an SSN and are only eligible to receive an SSN issued for a non-work reason. We have also revised the language in paragraph (h) to clarify that the exceptions in paragraph (h) mean, not only that the agency may issue a different identification number to someone excepted from the requirement to provide an SSN, but also that individuals described in paragraph (h) are excepted from the requirement to furnish an SSN as a condition of eligibility, as otherwise required in § 435.910(a). (The current regulation at § 435.910(h) only references the permissibility of the agency to issue a different identification number for the individuals described.) Conforming revisions are made to the general requirement to furnish an SSN in § 435.910(a). In addition, we have made small modifications to § 435.910(f) and (g) to clarify that such an individual would not need an SSN verified and that the general rule that a State should not delay or deny an otherwise eligible individual for Medicaid, would also apply to an individual who is not eligible for an SSN or who does not have an SSN and may only be issued an SSN for a valid non-work reason. We have also clarified in § 435.910(g) that a State is only required to verify the SSN of those who must furnish one. We are not changing or limiting the responsibility of States to assist individuals seeking coverage in applying for an SSN that can be used for work. Nor does this change affect the requirement that citizenship and immigration status be verified.

Comment: A few commenters recommended that the regulation explain how alternative sources under proposed § 435.948(d) would be used. A number of commenters also indicated that it is unclear whether agencies would be approved to use alternative data sources under § 435.948(d) for all applicants, on a case-by-case basis, or only when other data sources do not yield useable results. Some recommended that the regulation explicitly allow the agency to contact the individual's employer to obtain financial information when such information is not available through the Federal data services hub or through the sources mentioned in § 435.948(a). Others also recommended that proposed § 435.948(d) include and cross-reference proposed § 435.945(f), which requires individuals be notified of the information States will request from other agencies and how it will be used.

Many commenters recommended that the regulation at proposed § 435.949(c) clarify that States should not be able to use an alternative process to verify information available through the hub if doing so would be more burdensome for individuals. Other commenters believed that States should be able to use alternative processes or sources as long as the information is as accurate and timely as, or can be obtained more efficiently than, that provided through the Federal data services hub described in § 435.949. One commenter recommended that the process for obtaining Secretary approval to use alternative data sources required under § 435.948(d) be streamlined and efficient.

Response: As mentioned above, we have moved the proposed regulations at § 435.948(d) and § 435.949(c) to a new § 435.945(k). States may utilize alternative sources in lieu of those listed in § 435.948(a) or an alternative mechanism other than the Federal data services hub described in § 435.949(a) if such alternative source or mechanism will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, and use of information, and promoting coordination with other insurance affordability programs.

States may seek approval to use such alternative sources either across-the-board or in specific circumstances. Under § 435.945(j), States would describe the circumstances for using alternative sources or mechanisms in their verification plans. States are not required to seek approval from the Secretary to access data sources in addition to those identified in § 435.948. The notice required under § 435.945(f) of this final rule applies to the entire subpart—that is, to all data matching conducted by the agency. We do not believe it is necessary to include a specific cross-reference to § 435.945(f) in § 435.945(k).

Comment: One commenter suggested that, given the uncertainty regarding the information that will be available to States through the Federal data services hub and States' experience using alternative data sources, we should not issue further regulations, but should permit States maximum flexibility in utilizing data sources of their choice. One commenter believed that States should be permitted to continue to use existing electronic interfaces with SSA and DHS that provide the necessary data matches and should not be required to use the Federal data services hub.

Response: We are establishing a federally-managed data services hub to support information exchanges between States (Exchanges, Medicaid and CHIP agencies) and relevant Federal agencies. In many cases, Federal agencies other than CMS will be providing information through the hub. Additional information about the services available through the hub and the terms for accessing those services is under development. Under

the regulations, if verification of particular information is not available through the Federal data services hub, States may continue to utilize existing electronic interfaces. We have revised the regulation text to clarify that, should the data services hub establish a secure interface with other Federal, State or other data bases, States would then use such interface to access such additional data sources when needed. We will provide additional guidance should such additional electronic interfaces be established.

Comment: A few commenters asked whether the mandated use of the Federal data services hub established by the Secretary will be provided free of charge to the States. One commenter indicated that the development of the electronic transfer by the States could be very costly so CMS should provide reimbursement or a cost-effective mechanism to States. Two commenters questioned how the Federal data services hub will affect existing State agreements to access information from SSA or from DHS through SAVE.

Response: While the agency is considering the treatment of charges for fiscal year 2014, we do not anticipate charging Exchanges or State Medicaid or CHIP programs for the use of the hub. Section 435.949(a) clearly delineates the agencies (IRS, SSA and DHS) with which States will obtain certain electronic information through the Federal data services hub, under section 1413(c) of the Affordable Care Act.

Comment: Many commenters asked us to clarify whether the Federal data services hub would provide all the necessary income and household composition information for States to determine an applicant's MAGI. One questioned whether IRS data can be used to verify residency. One commenter also requested further guidance regarding IRS security requirements, and whether these may limit States' access to and utilization of the data.

Response: As explained in the State Exchange Implementation Questions and Answers issued November 29, 2011, available at *http://www.medicaid.gov/Federal-Policy-Guidance/CIB–11–29–2011.pdf,* the IRS will provide the MAGI of parents or other head of household and for certain dependents who had enough income to have been required to file a tax return. This information will be taken from the most recent return (within the 2 previous years) on file. The IRS will also provide information about the size of the household shown on the returns and coding to help the State understand the information being provided and instances in which information may not be available. The IRS will not return information which can be used to verify the dependent status of a child.

In the Medicaid Eligibility proposed rule, we proposed to codify widespread State practice of accepting attestation of household composition, to promote coordination of eligibility rules and procedures with the Exchange. Due to the uncertainty flagged by the commenters, which may sometimes exist regarding the tax filing and tax dependency status of individuals for the tax year in which Medicaid is sought, we are removing the requirement that States must accept self-attestation of household size. Instead, verification of household size is now contained in § 435.956(f) with age and date of birth. An individual's address is not among the information which will be provided by the IRS. Return information, as such term is defined by section 6103(b)(2) of the IRC, is kept confidential under section 6103 of the IRC. The disclosure, use, and maintenance of return information is strictly governed by section 6103.

Comment: One commenter believed that States should not be required to continue reconciling PARIS matches because this process currently must be done manually and is burdensome for States and PARIS does not return information about whether Medicaid eligibility is correctly established in other States.

Response: Data matches with PARIS are required as a condition of FFP under section 1903(r) of the Act.

Comment: One commenter interpreted § 435.952(a) to mean that eligibility must be determined promptly using electronic verifications identified under sections § 435.940 through § 435.960 and that § 435.945 of the proposed regulation appears to allow self-attestation for identity, whereas, § 435.407(e) of the current regulations requires verification of identity other than by self-attestation. One commenter questioned whether the use of electronic data matches removes the requirement for applicants to verify identity.

Response: Section 435.407 pertains to verification of identity when it is a component of verifying citizenship. Reliance on self-attestation of citizenship is not permitted under § 435.945(a), as redesignated in the final rule, or the underlying statutory provision at section 1902(a)(46)(B) of the Act. States will be required to verify citizenship in the first instance through the Federal data services hub under § 435.949. To the extent that such verification fails, States would employ the verification processes established under sections 1902(ee) or 1903(x) of the Act and § 435.407 of the regulations. Changes to these statutory and regulatory provisions enacted in CHIPRA will be addressed in subsequent rulemaking.

Comment: Many commenters expressed concern with the deletion of the requirement in § 435.952 for States to request verification within 45 days of when new information is received. Commenters are concerned that without timeliness standards, access to coverage could be delayed and there will be no accountability for States. Some commenters asked what it means to ''promptly evaluate information received'' in the context of real-time eligibility determinations. A few commenters recommended that the States be required to complete verifications as quickly as possible, not to exceed 30 days. One commenter questioned whether deletion of the 45-day requirement would preclude States from setting their own timeliness requirements, and whether States will be able to set different time standards for different populations or circumstances. One commenter requested that CMS define parameters within which States would have flexibility to establish policies and procedures for real-time eligibility determinations.

Response: First, we note that 45 and 90 days relating to timely eligibility determinations at redesignated § 435.912 remains, and that additional parameters relating to the timely determination of eligibility are included in the final rule (see discussion in section III.D. of the preamble). However, we removed the 45-day standard to request verification and determine whether the information affects eligibility from § 435.952 because we expect the verification process to occur faster, often in real time where electronic verification is available. Beyond the timeliness standards which States establish in accordance with § 435.912, we are not providing additional specific timeliness standards in these regulations for the verification of new information received by States under § 435.952, but will consider, with input from States and stakeholders, such standards in developing broader performance metrics relative to State eligibility and enrollment systems.

Comment: One commenter questioned how Medicaid requirements regarding third party liability can be operationalized in the context of ''real time'' eligibility and enrollment determinations.

Response: Third party liability is primarily governed by sections

1902(a)(25) and 1912 of the Act, and 42 CFR part 433 subpart D and § 435.610 of the regulations. The Affordable Care Act did not alter these provisions, which will remain in effect in 2014. Based on State experience today, compliance with third party liability rules, which can be handled following a determination of eligibility, should not impede prompt processing of applications.

Comment: Many commenters including States, as well as consumer advocates, supported the concept of reasonable compatibility in § 435.952(b) but recommended that CMS further define how this concept should be applied. Some commenters were concerned that the language in the Medicaid Eligibility proposed rule was too broad, and that States could interpret it in an overly restrictive way. Many of these commenters recommended that when the information provided by or on behalf of the individual is different from that obtained through electronic sources, but does not affect the eligibility, the information should be considered reasonably compatible. One commenter emphasized the need to interpret the reasonable compatibility standard consistently across States and insurance affordability programs to facilitate administrative simplicity and ensure comparable treatment of applicants regardless of where they submit their application.

Response: To maintain State flexibility while providing greater consistency, we have revised § 435.952(c) to provide that household income information obtained through an electronic data match is reasonably compatible with income information provided by or on behalf of an individual if both are above or both are at or below the applicable income standard or other relevant income threshold. As discussed above, we also are adding a new paragraph § 435.945(j), under which Medicaid agencies will set forth their policies in verification plans which will include the circumstances in which information obtained through an electronic data match is considered by the State to be reasonably compatible with information provided by or on behalf of an applicant or beneficiary, or obtained through another source. We will be working with States to develop a template for such plans.

Comment: A few commenters recommended that States should not be permitted to ask individuals for additional information if the State's data match that triggered the apparent incompatibility is more than 90 days old.

Response: Data that is more than 90 days old (such as IRS data) may be relied upon to verify eligibility criteria if reasonably compatible with an individual's attestation. Where such data is not reasonably compatible, the regulations do not require States to accept the attested information. Instead, States may accept a reasonable explanation provided by the individual explaining the discrepancy (for example, that there has been a change in circumstances) or, where other electronic data is not available under the standard set forth at § 435.952(c)(2)(ii), the State may request additional information from the individual.

Comment: A number of commenters urged that otherwise eligible individuals be provided benefits during a ''reasonable opportunity period'' in which the agency works with the individual to resolve any discrepancies when information obtained through electronic data matching is not reasonably compatible with that provided on the application. Some suggested that the ''reasonable period'' referenced in § 435.952 be 90 days to be consistent with the Exchange; one commenter recommended 30 days. A number of commenters indicated the Medicaid and Exchange verification rules should be identical in allowing for a good-faith extension.

Response: Section 1411(e)(3) and (4) of the Affordable Care Act requires that to the extent there is an inconsistency between the data obtained by the Exchange and applicant information, the Exchange provide an applicant with a ''reasonable opportunity period'' of 90 days during which he or she may present documentation to resolve such inconsistency, and provide the applicant with advance payments of the premium tax credit and cost-sharing reductions to which he or she has attested.

However, for purposes of Medicaid eligibility, this ''reasonable opportunity period'' does not apply to all eligibility criteria.

The reasonable period referenced in our proposed § 435.952 does not require the provision of benefits pending receipt of additional information requested by the agency from the individual nor does it specify a 90-day period. We do not believe it is necessary for inter-program coordination to align the length of this period with the 90-day ''reasonable opportunity'' provided in the Exchange regulations at 45 CFR 155.315(f), and therefore, are retaining the discretion afforded States to determine the length of this period.

Comment: A few commenters recommended that when attestation is not possible, Medicaid agencies need to accept different types of documentation, such as letters from employers, or applicant-approved telephone contact with a reliable third party, and applicants must be able to submit documentation online, by phone, mail or fax, in person, or other electronic means such as sending photographs of documents from a smart phone.

Response: In accordance with section 1943 of the Act, section 1413 of the Affordable Care Act, and sections 1902(a)(4) and 1902(a)(19) of the Act, individuals must be able to submit documents needed for verification purposes in the same manner as the application. We have revised § 435.907(a) accordingly.

Comment: One commenter believed that proposed § 435.952(d) means that the States cannot use the electronic verification sources as true verification if it results in eligibility because this section states that an agency may not deny or terminate eligibility based on an electronic verification source unless the agency has requested additional information from the individual and provided proper notice.

Response: Section § 435.952(d) cites all the verification regulations, not just the ones requiring matches with electronic data sources. This section provides that States may not deny or terminate an individual's eligibility based on the information obtained through the verification process unless and until the State has provided an opportunity for the individual to provide additional information, and proper notice and hearing rights to the individual in accordance with part 431. It does not preclude States from approving eligibility based on electronic data sources.

Comment: Many commenters recommended that the word ''delay'' be added to § 435.952(d), so that this paragraph would provide, ''The agency may not deny, reduce, *delay* or terminate eligibility * * * for any individual on the basis of information received * * * unless the agency has sought additional information from the individual * * * and provided proper notice and hearing rights * * *'' The commenters believed this is particularly important given the proposed change to the 45-day eligibility determination timeline and to allow States very broad flexibility in the verification process.

Response: We have provided additional guidance at redesignated § 435.912 regarding the timeliness standards which States are required to establish. We note also that current

regulations at § 435.911(e), redesignated at paragraph (g) of § 435.912 in this final rule, already provide that any time standards adopted by the State agency may not be used as a waiting period to delay eligibility. Therefore, we do not think it is necessary to add ''delay'' to the § 435.952(d).

Comment: Many commenters recommended maintaining language from the deleted § 435.955(f)—that ''the agency must certify to the Federal agency that it will not take adverse action against an individual until the information has been independently verified and until 10 days (or sooner if permitted by § 431.213 or § 431.214) after the individual has been notified of the findings and given an opportunity to contest.''

Response: The language cited by the commenters is maintained in § 435.952(d), which provides that the agency may not deny or terminate eligibility or reduce benefits for any individual unless it has sought information from the individual, and provided proper notice and hearing rights in accordance with subpart E of part 431 of the regulations. Section § 431.211 of that subpart contains the protection at issue in the comment.

Comment: A few commenters recommended that when applicants or beneficiaries fail to respond to a request for information in accordance with § 435.952(d), they should be suspended rather than terminated from eligibility.

Response: The appropriate process is outlined in this provision and also through the notice and hearing provisions in 42 CFR part 431 subpart E. We do not believe it is appropriate to require States to suspend rather than terminate Medicaid eligibility once timely and appropriate notice has been provided. If a beneficiary seeks a timely hearing, benefits are continued in accordance with § 431.230.

Comment: Many commenters supported the prohibition on State agencies from relying on immigration status to determine lack of State residency. To avoid confusion many commenters further recommended that we delete the word ''alone'' from § 435.956(c)(2).

Response: We have struck the word ''alone'' from § 435.956(c)(2) of this final rule. We also clarify that this provision applies generally to evidence of immigration status, removing the reference to ''a document,'' as a State may obtain such information from an electronic data match or other source. We have also revised the language to clarify that, although a State cannot use such evidence to determine someone is not a State resident, nothing in these regulations prevents an individual from being able to present evidence of immigration status to prove their State residency, for example, by providing an immigration document that indicates their address. States may request additional information in accordance with § 435.952 to verify residency if an immigration document gives a State reason to question an individual's residency.

Comment: Some commenters expressed concern that § 435.956(c) allows parents in a shared custody situation to attest to where a child resides. The commenters were concerned that parents who live in different States both could attest to the child residing in their State, potentially resulting in Medicaid eligibility being approved in two States.

Response: Self-attestation of residency is permitted today and is currently utilized in many States, even in shared custody situations. States may enter into interstate agreements and access data sources, such as PARIS. Further as, permitted under the regulations, States may seek further information if the State has information indicating potential residency in another State.

Comment: Many commenters supported self-attestation for pregnancy; however, one commenter suggested that for States that provide full Medicaid benefits to this population, verification of pregnancy should be an option. One commenter disagreed with allowing self-attestation for pregnancy.

Response: To promote a streamlined system, we maintain self-attestation of pregnancy as a requirement for States regardless of the benefit package provided by the State; however under § 435.956(e) if a State has information that is not reasonably compatible with the attestation, the State may verify pregnancy in a manner consistent with § 435.952. States have flexibility whether to accept self-attestation of multiple births which relates to household size, verification of which is codified at § 435.956(f) of this final rule.

Comment: One commenter noted that the proposed Exchange regulation requires the Exchange to verify through electronic data sources that an applicant is not incarcerated, but the Medicaid rule is silent on this topic. The commenter urged that self-attestation of incarceration of a family member be sufficient so that children will not be subject to delays in coverage due to a parent's incarceration.

Response: Incarceration is not a factor of eligibility which needs to be verified for purposes of determining eligibility, and therefore, is not addressed in the verification rules. However, as discussed below, payment for medical services provided to individuals during incarceration is generally prohibited under subparagraph (A) of the matter following section 1905(a)(29) of the Act.

I. Periodic Renewal of Medicaid Eligibility (§ 435.916)

In the Medicaid Eligibility proposed rule, we proposed to amend the provision entitled ''Periodic Redetermination of Medicaid Eligibility'' to establish simplified, data-driven renewal policies and procedures for individuals whose eligibility is based on MAGI, consistent with assuring program integrity. In this final rule, we have altered the title of this section by replacing the word ''redetermination'' with the word ''renewal'' and making corresponding language edits in the regulation text. The use of the word renewal rather than redetermination is consistent with the usage in many States. We also received the following comments concerning the proposed periodic renewal of Medicaid eligibility provisions.

Comment: Many commenters supported the requirement for an annual redetermination no more often than once every 12 months. One commenter wrote that States should have discretion to decide how often to evaluate newly eligible individuals. Some commenters suggested that we be more explicit by adding the word ''only'' to § 435.916(a)(1).

Response: As explained in the preamble of the Medicaid Eligibility proposed rule, scheduling regular renewals no more often than once every 12 months for beneficiaries whose eligibility is based on MAGI is consistent with current practice for parents and children in most States and aligns with the annual renewal process for individuals who are eligible for APTCs through the Exchange. We have revised § 435.916(a) to clarify that the renewal policy described in that paragraph applies to all Medicaid beneficiaries whose eligibility is based on MAGI methods, rather than just those beneficiaries described in § 435.911(c)(1) who are eligible on the basis of the applicable MAGI standard.

In response to comments, we have revised the regulation text at § 435.916(a)(1) to clarify that eligibility must be renewed once every 12 months, and no more frequently than once every 12 months under that paragraph. We chose this wording to clarify that renewals do need to occur on an annual basis. We note that as provided in § 435.916(d), eligibility should be renewed more frequently if a beneficiary reports a change in circumstance that

may affect eligibility, or if the agency receives information that suggests the need to review eligibility.

Comment: Many commenters supported the proposed annual renewal process in § 435.916(a)(2), which requires Medicaid agencies to use electronic data to renew eligibility if sufficient information is available. Some commenters expressed concerns about the reliability of the data sources available to the State for this purpose. Others expressed concern that if renewals are performed on the basis of data-matching without requiring a response from the individual, the State is more likely to be liable for inappropriate costs or experience poor results on quality control measures and audits. Two commenters wrote that, for all beneficiaries, State Medicaid agencies should pre-populate renewal forms and ask for response annually, to match up with the process proposed for the Exchange. Some commenters requested that the Medicaid Eligibility proposed rule clarify the interaction of the renewal process with program integrity measures such as PERM.

Response: Proposed § 435.916(a)(2) sought to codify a longstanding policy, explained in a letter to State Medicaid Directors on April 7, 2000, available at *http://www.cms.gov/smdl/downloads/smd040700.pdf,* that States must rely on information that is available and that the State considers to be accurate to renew eligibility. However, if available information suggests that a beneficiary is no longer eligible, if information is subject to change is missing, or if the State has information that suggests that available information is inaccurate, then a State must seek information from the individual before renewing eligibility. For example, if a family has recently verified income, household size, and residency as part of a recent SNAP review, then the Medicaid agency would typically use that information to renew Medicaid eligibility. However, if the SNAP review indicates a different household size, or income information is not available from SNAP or another human service program, State wage reporting or IRS data the State would follow the process in § 435.916(a)(3) to request needed information from the individual. As stated in the Medicaid Eligibility proposed rule, a State's decision on whether to conduct a renewal without requesting further information from the individual may depend on the State's verification policy on certain eligibility criteria, such as residency. States that follow procedures outlined in the regulations will not be cited for a PERM error for lack of further documentation. As discussed in section III.H. of the preamble, PERM regulations issued in 2010 provide that PERM will measure errors relative to the State's own policies and procedures as long as those policies and procedures are consistent with Federal policy and regulations. As also noted, we will continue to review and analyze all of our error rate measurement programs to ensure consistency between these programs and regulations covering eligibility and enrollment.

Comment: Many commenters supported the proposal at § 435.916(a)(3) that, in cases where sufficient electronic information is unavailable, States must send a renewal notice that is pre-populated with any information already known to the agency and require Medicaid beneficiaries to respond with information that is missing or incorrect. Some commenters requested State flexibility on the timelines and procedures for sending a pre-populated form, as well as flexibility on what that form may include. One commenter inquired whether States may require individuals to provide information regarding third party liability at renewal.

Response: We have added language to § 435.916(a)(3)(i)(A) to clarify that the pre-populated renewal forms may only request additional information needed to renew eligibility. Information and documentation of eligibility criteria subject to change need not be requested if it can be obtained from a reliable data source available to the State. For example, a State would not request additional income information from the beneficiary if income information at the initial determination was verified fully by a quarterly wage report, and the quarterly wage report for the most recent quarter remains reasonably compatible with income at the initial determination. Nothing related to assignment of rights and third party liability is altered by the Affordable Care Act nor by these regulations. Today, many States use contractors to determine information regarding third party liability and such an approach may facilitate a State's ability to limit the information asked of beneficiaries at renewal. We will be providing additional guidance.

Comment: Many commenters supported our proposal that beneficiaries have the option to respond to renewals via any of the submission modes used at initial application. Some commenters requested clarification on when a signature is required and the submission modes that can be used. Some commenters requested additional flexibility for States to require signatures from all applicants at renewal.

Response: We are retaining the proposed policy that if the agency has data available that are sufficient to continue eligibility, then no signature may be required. If available data is not sufficient to continue eligibility, then the beneficiary must sign and return a form with missing or corrected information. The individual must be able to submit and sign the renewal form via the same modes available at application-that is, through the internet Web site, mail, telephone, in person, or other electronic means as described in § 435.907(a).

Comment: Some commenters suggested that specific information be included in notices sent to beneficiaries in advance of a renewal. Several commenters advised that an eligibility worker's name and a telephone number to call for information or questions should be required on the notice. One commenter wrote that if an individual is determined ineligible for Medicaid at renewal, the individual should be notified of his or her eligibility for other insurance affordability programs. Some commenters recommended specifically that agencies should request health status updates on renewal forms to screen for non-MAGI categories at renewal, while another commenter requested that no protected health information be contained in a pre-populated renewal form. One commenter also inquired about the effect on the appeals process of using the data-driven renewal system.

Response: We will take these suggestions into account in future guidance we are developing on notices and appeals. We have added § 435.916(e) to clarify that the agency may not request information at renewal which is not necessary to redetermine eligibility. We have added a new paragraph to § 435.916(f)(1), to clarify that, in accordance with longstanding policy the agency must consider all bases of eligibility when conducting a renewal of eligibility. To meet this requirement, renewal forms will need to include basic screening questions, similar to those that will need to be on the single streamlined application, to indicate potential eligibility based on disability or other basis other than the applicable MAGI standard. We note that the addition of paragraph (f)(1) to § 435.916 is consistent with the application in the final rule of the MAGI screen regulations at § 435.911 to the eligibility renewal process, discussed in section III.E of the preamble.

Comment: We received comments that there should be a specified

reconsideration period following a termination of Medicaid eligibility at renewal. Most commenters supported the codification of the 90-day reconsideration period suggested in the preamble to the Medicaid Eligibility proposed rule. Some commenters requested a 120-day reconsideration period, while other commenters suggested making the definition of a time period a State option. One commenter questioned whether a reconsideration period would be required even when discontinuance was for ''good cause.''

Response: We have altered the proposed § 435.916(a)(3)(iii) to provide a minimum of 90 days as a period when the State would reconsider eligibility without a new application and renew eligibility if necessary information is provided. States may adopt a longer reconsideration period if desired. Reconsideration periods are only required for beneficiaries who did not return the pre-populated renewal form as described in § 435.916(a)(3) or the required documentation and are terminated on that basis. At State option, agencies may adopt reconsideration periods for other types of terminations as well.

Comment: Some commenters asked questions about termination and retroactive eligibility during the reconsideration period. One commenter suggested that eligibility be suspended, rather than terminated, during a reconsideration period.

Response: During a reconsideration period, an individual may not be required to submit a full new application to be determined eligible for benefits, which avoids unnecessary application processing for the individual, as well as the agency. During the 90-day period (or a longer period at State option), the individual only needs to supply the information requested in the pre-populated renewal form (including missing documentation, if any), and may do so by mail, phone, in person, or through electronic means. The renewal form in this case serves as an application, and an individual who regains coverage during a reconsideration period is entitled to retroactive coverage under § 435.915 (redesignated from § 435.914 prior to issuance of this final rule) to the same extent and in the same way as if a new application had been filed. With a 90 day reconsideration period, we would expect that in most cases, retroactive coverage will extend back to the date of the termination. States have flexibility in how they design their eligibility systems to implement this provision for the suspension versus termination of eligibility during the reconsideration period.

Comment: Some commenters recommended that the final rule clarify that States continue to be subject to the current requirement that Medicaid agencies are required to screen any individual who loses Medicaid coverage for eligibility under any other Medicaid eligibility categories. Some commenters suggested that for individuals transitioning out of MAGI eligibility, the State should be required to continue Medicaid coverage during the pendency of a Medicaid application for non-MAGI Medicaid coverage. Several commenters asked questions about transfers to other programs when Medicaid eligibility is terminated, and suggested that Medicaid coverage continue until enrollment in another program can be implemented.

Response: In response to these comments, we are finalizing § 435.916(f) to codify our longstanding policy that beneficiaries must be considered for all Medicaid categories prior to termination. This addition also conforms to the policy for executing appropriate eligibility determinations as established at § 435.911. For example, when an individual loses eligibility under a MAGI-based Medicaid eligibility group due to an increase in income, the individual must not be terminated from Medicaid before it is determined whether the individual is eligible under another eligibility group. If it is determined that the individual is not eligible under other Medicaid categories and Medicaid eligibility is terminated, then § 435.916(f) provides that the agency must assess potential eligibility for other insurance affordability programs and transmit data pertaining to potentially eligible individuals to the appropriate program. As noted above, the renewal form will need to contain basic screening questions to enable such assessment.

The rules regarding transfers of beneficiaries' electronic accounts to other insurance affordability programs are at § 435.1200. As described in regulations at 45 CFR 155.420(b)(2)(ii), the Exchange must ensure coverage on the first day of the next month for qualified individuals who have selected a QHP. Medicaid agencies are allowed to extend Medicaid coverage to the end of the month in which notice of termination is given and note that State agencies can receive FFP to do so. States have broad flexibility to design their process for renewals and terminations in ways that promote seamless coverage among eligible individuals.

Comment: Some commenters noted that some populations, such as people who are homeless may need an extended deadline to return the forms. Another commenter noted that some beneficiaries may need agencies to send their renewal forms to authorized representatives.

Response: Section 435.916(a)(3)(i) provides that beneficiaries must be provided a minimum of 30 days to return the pre-populated renewal form. States have the authority to increase that time period for all beneficiaries or for particular populations and to design other strategies to assure ongoing coverage of eligible individuals. As noted in Section III. E of the preamble, applicants may designate an authorized representative who may act on behalf of the applicant including through receipt and submission of renewal forms.

Comment: Though the Medicaid Eligibility proposed rule did not make substantial changes to existing provisions regarding change reporting and agency action on available data between annual renewals, we received many comments on whether such reporting and action should be limited. Many commenters suggested that Medicaid beneficiaries should continue to be required to report all changes to household size and residency, but that Medicaid beneficiaries should not need to report all income changes. Some suggested that the State should notify the beneficiary that he or she only needs to report income changes that cause household income to exceed a threshold in the form of a dollar amount specified by the agency. One commenter suggested that reports should not be required until income changes substantially. Another commenter recommended that if the State's initial income determination was based on an annual income prediction, then it should not be necessary to report actual changes that have already been accounted for at the time of the initial eligibility determination.

Response: We believe we have struck the appropriate balance in § 435.916(c), which provides that beneficiaries must report changes that affect their eligibility. It would be reasonable for States to identify a dollar threshold or other general rule as a way to help families know when to report material changes in income. However, the agency may not discourage reporting of a change in income that could affect a beneficiary's eligibility, benefits, or cost-sharing. In addition, States should not remove all change reporting requirements, except with respect to circumstances that cannot affect eligibility, such as income changes for children in States which have adopted continuous eligibility for children. We note that some changes, such as a

change in address, or addition of a family member, are critical to ensuring that the family remains eligible and is able to access services. To be consistent with the new 12-month renewal policy, in between regular renewals, States must limit any review triggered by a change in circumstance to the eligibility factor(s) affected by the changed circumstances, and additional factors for which information is readily available. The agency must wait until the next regularly scheduled renewal to request information from beneficiaries regarding eligibility factors not related to the change in circumstance, as provided in § 435.916(d)(1) of this final rule. For example, if a parent reports new earnings 3 months after the family's most recent renewal, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. It must wait until the next regularly scheduled renewal to review other factors of eligibility if it does not have sufficient information available to it to review those other factors. However, if the agency does have enough information to adjudicate all factors of eligibility at the time when the change in circumstances is reported without seeking more information from the family, the State may conduct a full renewal and, if the individuals in the family remain eligible, schedule the next regular renewal to occur 12 months later.

Comment: Some commenters expressed concern about the requirement at proposed § 435.916(d)(2) that agencies act on information they have received when it indicates a change to eligibility or anticipated changes to eligibility. We received many comments requesting limits on data matching, or elimination of the requirements at § 435.916(d). Some commenters requested that the rule specify that data must be used when available, timely, and accurate. Other commenters wrote that if a State conducts data matching in addition to the 12-month renewal, it must be required to use the same third-party sources to verify income as it uses as part of the annual renewal process.

Response: Section 435.916(d) requires the agency to act on information that becomes available that may affect eligibility, in accordance with regulations at § 435.952. States must have flexibility to determine whether it is useful to obtain electronic data as described in § 435.948 between regularly-scheduled renewals, and whether some sources of data are useful at different times, although States should check data sources both at and between scheduled renewals when there is an indication of fraud.

Comment: Some commenters suggested a continuous eligibility model wherein changes may be reported but not acted upon. A few commenters believed that there was authority to do so because section 1137 of the Act does not specify the frequency of the use of data from the sources identified in the statute. The commenters also believed the Secretary has rulemaking authority under section 1102 of the Act to authorize a State plan option for continuous eligibility for adults. One commenter referenced SNAP rules, which provide that the State may choose not to act on a change that reduces benefits, but must act on a change that increases benefits. Another commenter requested clarification on whether or not States are required to use point-in time income verifications for annual renewals.

Response: Continuous eligibility is a State plan option for maintaining continuous coverage and retention for eligible children in Medicaid and CHIP and remains in effect under the Affordable Care Act, but there is no statutory authority for providing continuous eligibility for adults. We also note the option, discussed in section III.B of the preamble, that under § 435.603(h)(2), a State agency may choose to base continued financial eligibility for current beneficiaries on either projected annual income or on current monthly income.

Comment: We received many comments on whether renewal of eligibility for individuals whose Medicaid eligibility is determined on a basis other than MAGI should follow the procedures outlined in § 435.916(a). Many commenters wrote that these simplified processes are beneficial to beneficiaries and State agencies and should be extended to all Medicaid beneficiaries. Other commenters suggested such an extension should be a State option or should only apply to certain categories of non-MAGI eligibles. Some commenters wrote that portions of the process, including the need to check databases and the right to reconsideration without a new application, should apply to all beneficiaries.

Response: We have revised § 435.916(b) to codify the longstanding policy that the agency must renew eligibility for all beneficiaries using information available to the agency without asking for additional information from the individual, if that available information is sufficient to support continued eligibility. We also have revised § 435.916(b) to provide that, in cases where sufficient information is not available to continue eligibility, the State has the option to adopt the same procedures set forth at § 435.916(a)(3) applicable to individuals eligible on the basis of MAGI to beneficiaries eligible on non-MAGI bases.

Comment: One commenter expressed a concern that a data-driven renewal process will not be possible because a data matching system is as yet undeveloped, and the system may not be functional at the time of the implementation of the new rules.

Response: Data matching is not new and many States have data-driven enrollment and renewal processes. States currently are required to conduct data matching, in accordance with section 1137 of the Act, and most States already do much of the data matching that will be needed to implement data-driven processes, including matches with CHIP, SNAP, TANF, SSA, and State Unemployment Compensation and Wage Reporting. However, systems modernization will be needed in many States, and we note that any State expenditures before the end of 2015 for system changes necessary to adopt the renewal procedures described in § 435.916 are eligible for the 90 percent Federal matching rate outlined in the in the Federal Funding for Medicaid Eligibility Determination and Enrollment Activities final rule published in the April 19, 2011 **Federal Register** (76 FR 21950), provided these systems meet the standards and conditions set forth in that rule.

Comment: One commenter suggested that States create systems that enable beneficiaries to opt for on-going income reporting on a weekly or monthly basis by phone or online.

Response: The regulation text at § 435.916(c) states that individuals must report changes that affect their eligibility, and must be able to do so through all the submission modes described at § 435.907(a). States may not routinely require monthly or weekly income reporting, but individuals have the obligation to submit changes that may affect eligibility. We will be working with States and the Exchange to explore ways for simple reporting.

Comment: One commenter wrote that to prevent wrongful terminations, an automatic termination should not be allowed without a human touch review by the agency.

Response: We believe that the regulations set forth in § 435.916 and § 435.952 provide beneficiaries with appropriate protections against wrongful termination. In addition, under current rules at § 431.210 and

§ 431.211, States must provide advance notice of termination and the reason. Under § 431.10(c)(3) published in this rule, the Medicaid agency must assure that eligibility determinations are made properly and timely and are consistent with the Medicaid agency's rules. If there is a pattern of incorrect terminations, the Medicaid agency is responsible for taking corrective action. Beneficiaries also have the right to appeal any termination that they believe is erroneous, as described in § 431.220. We note that the coordinated streamlined system calls for an increased use of technology and that with proper oversight automated processes can be a part of an eligibility system that works well for both agencies and beneficiaries.

Comment: One commenter wrote that the final rule should also provide safeguards to ensure that Medicaid enrollees do not lose coverage for failure to comply with requirements of another program, such as SNAP.

Response: Under longstanding policy and Medicaid regulations, States are required to maintain eligibility for beneficiaries who meet Medicaid eligibility criteria. While a change in circumstances affecting eligibility under another program may also affect ongoing Medicaid eligibility, an individual's decision not to receive benefits from another program or his or her noncompliance with the requirements of another program may not serve as grounds for termination of Medicaid eligibility.

Comment: One commenter questioned whether it will be acceptable for the State to assume that no changes to household composition have occurred unless the household has contacted the agency. A few commenters expressed questions and concerns about the liability for recovery from beneficiaries who do not report changes and no longer meet Medicaid eligibility criteria.

Response: Our rules do not prescribe if or when a State must conduct data matching between scheduled renewals. Nothing in the Affordable Care Act changes Medicaid rules regarding liability and recovery for overpayments, which are outside the scope of this regulation.

J. Coordination of Eligibility and Enrollment Among Insurance Affordability Programs—Medicaid Agency Responsibilities (§ 435.1200)

We proposed to implement section 1943 of the Act and sections 2102(b)(3)(B) and (c)(2) of the Affordable Care Act that involve coordination between Medicaid and other insurance affordability programs, including a new requirement to delineate the State Medicaid agency's responsibilities in effectuating such coordination. This new provision also included policies previously included in § 431.636, Coordination of Medicaid with the State CHIP. These and other proposed revisions are discussed in more detail in the Medicaid Eligibility proposed rule (76 FR 51166 through 51169).

Comment: Many commented on the responsibility of the Medicaid agency for determining individuals' Medicaid eligibility based on MAGI when the single, streamlined application is submitted to the Exchange and many supported the coordination policies outlined in the Medicaid Eligibility proposed rule. Some commenters believed that State Medicaid agencies should retain responsibility over all Medicaid determinations. Others emphasized the importance of the Medicaid agency exercising supervision and oversight over Exchange determinations of Medicaid eligibility, at times focusing particularly on situations involving an Exchange operated by a private agency. Other commenters supported a fully integrated system in which all eligibility determinations are performed by a single entity.

Response: As discussed in the State Exchange Implementation Questions and Answers issued by CMS on November 29, 2011, and consistent with the Exchange final rule at 45 CFR 155.305 and 45 CFR 155.345, State Medicaid and CHIP agencies and Exchanges will have two ways of coordinating eligibility determinations. State Medicaid and CHIP agencies may make the final Medicaid and CHIP eligibility determination based on the Exchange's initial review; or the State Medicaid and CHIP agencies may accept a final eligibility determination made by an Exchange that uses State eligibility rules and standards.

We are revising § 435.1200(c), accordingly, to reflect this new flexibility and to establish the standards and guidelines to ensure a simple, coordinated and timely eligibility determination process and accurate eligibility determinations regardless of the option elected by the State. Consistent with the discussion in the preamble to § 431.10 and § 431.11, we are revising paragraph (c) to require, in States in which the Exchange will make Medicaid eligibility determinations, that the State Medicaid agency shall comply with provisions at revised § 435.10 to ensure it maintains the oversight for the Medicaid program. We also are revising paragraph (c), consistent with revised § 435.911 to ensure that individuals determined eligible for Medicaid by the Exchange based on the applicable MAGI standard are considered by the agency for eligibility on other bases which may be more advantageous to the individual, as appropriate.

To ensure a highly coordinated system of eligibility and enrollment regardless of whether the Exchange or the Medicaid agency makes the final eligibility determination, we are amending paragraphs (b) and (d) of § 435.1200. Specifically, we are amending paragraph (b)(3), which requires an agreement between the agency and the Exchange and other insurance affordability programs, to include a delineation of the responsibilities of each program to minimize burden on individuals, as well as to ensure timely determinations of eligibility and enrollment in the appropriate program based on the date the application is submitted to any insurance affordability program and compliance with paragraphs (d) through (f) and, if applicable, § 435.1200(c) to achieve a coordinated system of eligibility and enrollment among the programs. Paragraph (d), which describes the transfer of applications from an insurance affordability program to the State Medicaid agency, includes procedures to ensure that the Medicaid agency benefits from the information already collected by the other program and does not request information or documentation already provided, determines Medicaid eligibility of the individual promptly and without undue delay, consistent with the timeliness standards established under § 435.912 and in accordance with § 435.911, without requiring submission of another application; accepts findings of specific eligibility criteria made by the other insurance affordability program without further verification if such findings were made in accordance with the same policies and procedures applied by the agency (as would be the case where the Exchange makes a finding based on verification received through the hub) or approved by it; and notifies the insurance affordability program of the receipt of the individual's account information.

Because coordination between insurance affordability programs is equally important at renewals of eligibility, we have amended § 435.1200 to clarify its applicability to renewal processes. We also have added a definition of ''eligibility determination'' at § 435.4 to include an initial determination of eligibility for applicants, a renewal of eligibility for beneficiaries, and a redetermination of

eligibility for beneficiaries based on a change reported or identified. Consequently, the provisions set forth in paragraphs (b) and (d) apply not only to eligibility determination at initial application, but also at renewal and when a change in eligibility criteria is reported or identified.

For the reasons set forth in section V. of the preamble, § 435.1200 is being published as an interim final rule. We are soliciting comments on the provisions in this section to ensure a seamless and coordinated eligibility determination process regardless of the implementation choices exercised by the State.

Comment: One commenter wrote that the Exchange should consider all categories of potential Medicaid eligibility, including working disabled, medically needy, and transitional Medicaid, before determining that the applicant should not be enrolled in Medicaid. Other commenters believed that the Exchange should not make Medicaid determinations on a basis other than MAGI. One commenter stated that a basic screening by the Exchange for non-MAGI eligibility is futile because it will either be too broad or too narrow. One commenter wrote that any individual who submits an application to the Exchange should receive the same basic screening as would occur if the application were submitted to the Medicaid agency, including individuals who are ineligible for subsidies such as applicants over the age of 65.

Response: Under the final rule, the Exchange would not be required to perform a detailed evaluation of all Medicaid eligibility categories even if the Exchange is making final Medicaid eligibility determinations based on the applicable MAGI standard. However, these rules do not prevent States from designing its system in a way that enables one entity to make all eligibility determinations for all insurance affordability programs. Otherwise the Exchange will be responsible for transferring the electronic account of an individual whom it screens as potentially eligible for Medicaid on a basis other than MAGI to the State Medicaid agency for a full assessment, as described in 45 CFR 155.345(b). In addition, per 45 CFR 155.345(c), applicants who submit a single, streamlined application to the Exchange will be informed of the option to undergo a full Medicaid evaluation, and assisted in doing so using the same coordinated and streamlined procedures and without the need to submit duplicate information.

Comment: A few commenters wrote that Medicaid and CHIP agencies should be able to make binding eligibility decisions for all insurance affordability determinations.

Response: There is no statutory authority to require Medicaid and CHIP agencies to make binding determinations of Exchange and APTC eligibility; however the Exchange may contract with the Medicaid or CHIP agency to make such determinations per 45 CFR 155.110(a)(2).

Comment: A few commenters wrote that Medicaid agencies should be required to enter into agreements with other insurance affordability programs. Some commenters asked for CMS to provide model agreements. Others requested clarification on § 435.1200(c)(3), under which Sates must certify criteria needed by the Exchange to determine Medicaid eligibility. Some commenters requested that we articulate the importance of a ''CMS compliance review'' when other insurance affordability programs are determining potential Medicaid eligibility.

Response: The Medicaid agency must enter into an agreement with the Exchange operating in the State under § 435.1200(c). We have moved the requirement that the agency certify eligibility criteria needed by the Exchange to determine Medicaid eligibility to paragraph (b). We note that this provision is also identified in the Exchange final rule at 45 CFR 155.305(c). Ensuring assessments of potential eligibility for all insurance affordability programs will be considered in the development of process standards and measures for the coordinated eligibility system.

Comment: Two commenters recommended that States be able to set an annual open enrollment period for Medicaid to align with the Exchange.

Response: The statute does not permit restricting enrollment in Medicaid to an annual open enrollment period. Individuals have the right to apply for Medicaid and can be determined eligible for Medicaid at any time.

Comment: A number of commenters suggested that, to ensure that beneficiaries do not get lost in the transition between programs, the program to which the beneficiary is transferred should be required to acknowledge receipt of the information and enrollment of the individual, once completed.

Response: In the case where one eligibility system is being used to support adjudication for all programs, such acknowledgment may be unnecessary. However, where the system for adjudicating eligibility for Medicaid, CHIP, and the Exchange are not fully integrated, is important. Accordingly, we are amending § 435.1200(d) to incorporate the recommendation.

Comment: One commenter suggested that if the State Medicaid or CHIP agency determines an individual is ineligible for coverage based on evidence of fraud, no further eligibility screening for other insurance affordability programs need be completed for that individual.

Response: States are required to terminate eligibility in situations involving erroneous determinations of eligibility based on inaccurate information, as in cases involving fraud. In such circumstances, the agency would be able to reliably assess potential eligibility for another insurance affordability program, and therefore, it would not be consistent with the regulations for it to transfer the individual's application to another program.

Comment: We received several comments supporting the required coordination among insurance affordability programs, but also advocating that we require adoption of a shared eligibility service to eliminate the need for electronic transferring of an individual's account information among programs.

Response: In accordance with § 435.1200, States must adopt a coordinated business process and supporting systems to permit an efficient and seamless evaluation of an individual's eligibility for APTCs and reduced cost sharing through the Exchange, Medicaid, CHIP and the Basic Health Plan if applicable. This could be accomplished through the use of a common system or shared eligibility service to adjudicate placement of most individuals. We have issued guidance about how programs should allocate costs for shared systems and services. We are supporting multiple architectures and pathways which reflect both States' intentions regarding their Exchanges, the current architecture and performance of existing eligibility systems, desire for integrated solutions that include other State programs, and other considerations.

Comment: One commenter requested that States be required to obtain permission from an individual before any individual information is transferred to another insurance affordability program for evaluation of eligibility for such program.

Response: Applicants filing a single, streamlined application have the option of applying only for enrollment in a qualified plan in an Exchange without an APTC. If the applicant seeks a

determination of eligibility for an insurance affordability program, he or she must apply for all insurance affordability programs and will be informed that information may be shared with such programs.

Comment: Many commenters supported providing the opportunity for applicants to enroll in other insurance affordability programs while a determination of Medicaid eligibility on a non-MAGI basis is pending. A few commenters opposed this policy and a few others requested clarification of the interaction of Exchange coverage pending determination of Medicaid eligibility based on disability with retroactive Medicaid eligibility. One commenter questioned whether an insurer could recoup payments made on behalf of an individual and bill Medicaid for those costs when someone who has been enrolled through the Exchange is subsequently determined to be eligible for Medicaid and is eligible for retroactive eligibility.

Response: Individuals who are eligible for Medicaid on the basis of MAGI but may be eligible on another basis should have access to coverage pending completion of a sometimes more time-consuming process of determining Medicaid based on such basis. Therefore, we are retaining the policy at § 435.1200(e)(2) of this final rule to enable individuals who are otherwise eligible for coverage through the Exchange and other insurance affordability programs to enroll in such coverage while a determination of Medicaid eligibility is pending. Once determined, the effective date of Medicaid eligibility is defined in accordance with current regulations at renumbered § 435.915, including up to 3 months of retroactive eligibility prior to the month of application, as applicable under current law. During such period of retroactive coverage, customary rules regarding third party liability apply and Medicaid would serve as a secondary payer to the coverage provided through the Exchange. The QHP in which the individual has been enrolled will not be able to recoup payments from the Medicaid program.

Comment: Some commenters wrote that the proposal to provide Exchange coverage pending a determination based on disability should be extended to all pending determinations of Medicaid eligibility on a basis other than the applicable MAGI standard.

Response: We have revised § 435.1200(e)(2) to permit State agencies to transmit to other insurance affordability programs the electronic accounts of individuals undergoing eligibility determinations on any basis other than the applicable MAGI standard as appropriate.

Comment: One commenter wrote that we should issue guidance that any ''insurance affordability assistance,'' including APTCs and cost sharing subsidies, be counted toward meeting spend down requirements under Medicaid.

Response: Incurred medical expenses are defined as Medicare and other health insurance premiums, deductibles and coinsurance charges, as well as medical and remedial care, that are not subject to payment by a third party. In other words, an incurred medical expense is an expense the individual has a legal obligation to pay. The only exception is for expenses paid entirely with State or local program funds, which can be considered to be incurred medical expenses for spend-down purposes. Assistance such as APTCs and cost-sharing subsidies are not expenses for which an individual has incurred an obligation to pay. However, expenses for premiums and other cost sharing obligations that an individual is liable to pay for obtaining coverage through the Exchange may be considered an incurred medical expense for purposes of spend-down.

Comment: We received many comments on the Internet Web site described at proposed § 435.1200(d), redesignated as § 435.1200(f). Many commenters wrote that we should require a single enrollment Web site with information on all insurance affordability programs rather than allow multiple Web sites with information from an array of entities. Some commenters suggested specific Web site functions such as portals to personalized application assistance and plan enrollment capacity. Another commenter requested model Web site content. One commenter suggested that our regulation should include all functions listed in section 1561 of the Affordable Care Act.

Response: The Affordable Care Act provides that Web sites shall be accessible and support the range of applicant and beneficiary services required, including accessing information on the insurance affordability programs available in the State, and applying for and renewing coverage. States can and are encouraged to operate a single Web site, but are not required to do so as long as the Web sites of the different insurance affordability programs are linked to enable individuals to access the information and range of services required. We believe that States can adhere to the regulations in § 435.1200(f) in conjunction with complying with the recommendations adopted by the Secretary in September 2010 on the interoperable and secure standards and protocols that facilitate electronic enrollment, as required by section 1561 of the Act. Additional guidance will be released on standards. We also note that § 435.908(b) requires States to make application assistance available through an Internet Web site, among other venues.

Comment: Some commenters expressed preferences for the plan enrollment process after Medicaid eligibility had been determined. One commenter suggested that the Exchange be required to support informed choice of a Medicaid health plan if it has made the Medicaid eligibility determination. A few commenters requested that agencies be required to provide an online plan enrollment option, regardless of which entity makes the Medicaid determination. Some commenters requested that the enrollment process be clearly separated from the application process.

Response: The responsibility of the Medicaid agency over enrollment activities is addressed at § 431.10. While we encourage States to maximize the accessibility and simplicity of the plan enrollment process, plan enrollment activities are beyond the scope of this rule.

Comment: One commenter suggested that because Exchanges do not require SSNs of non-applicants, the agency would not have an appropriate personal identifier, complicating the ability to establish interfaces to share data between different insurance affordability programs.

Response: The requirements for a transfer of an electronic account as described in § 435.1200(f) and (g)(2) are to transmit all relevant information related to an applicant which is obtained by the agency through the application, including information obtained through the verification process and any relevant non-applicant information. The lack of an SSN for a non-applicant member of the applicant's household should not affect the transfer of applicant information.

Comment: A number of commenters noted the importance of readability and understandability particularly for the Web site in our Medicaid Eligibility proposed rule at § 435.1200(d), and suggested that the Web site should be written at no greater than a 4–5th grade reading level.

Response: We will consider it as we develop guidance that will address readability and literacy standards.

Comment: Many commenters articulated the importance of accessibility of the Web site for persons who are limited English proficient, as well as people with a disability in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Many commenters recommended that the Web site should be available in languages other than English, including Spanish, and the second most prevalent language in service area. Commenters also suggested that vital documents should be translated, depending on the numbers of limited English proficient persons served and importance of the information provided, and that the Web site include tag lines to obtain oral interpretation of what is on the Web site. Other commenters stated that Web sites and kiosks should meet disability accessibility standards.

Response: We have provided that information be conveyed accessibly for individuals who are limited English proficient and individuals with disabilities in § 435.1200(f) by referencing revised language at § 435.905(b), discussed in section III.E. of the preamble We had noted in the preamble of the Medicaid Eligibility proposed rule that Web sites, interactive kiosks and other information systems would be viewed as being in compliance with section 504 if such technologies meet or exceed section 508 of the Rehabilitation Act standards. We encourage States to review Web Content Accessibility Guidelines (WCAG) 2.0 level AA Web site standards when designing their Web sites and other systems. These standards promote increased accessibility in information and communication technology for people with disabilities and thus, have been considered for adoption as section 508 standards in the recent proposed rule issued by the Architectural and Transportation Barriers Compliance Board (Access Board) (76 FR 76640, December 8, 2011). See *http://www.gpo.gov/fdsys/pkg/FR–2011–12–08/pdf/2011–31462.pdf#page=1.*

Comment: A number of commenters expressed concern about the treatment of incarcerated individuals. Some commenters believed that greater alignment between the eligibility of incarcerated individuals under the Medicaid and Exchange regulations should be achieved. Several commenters noted that incarceration is not a factor of eligibility, and suggested that State Medicaid agencies be required to suspend Medicaid eligibility rather than terminate individuals who are incarcerated. One commenter suggested States be required to automatically reinstate eligibility once incarcerated individuals are discharged. Other commenters believed that we should achieve alignment with the Exchange rules by amending § 435.1010 to provide that an individual is not considered to be ''an inmate of a public institution'' for purposes of § 435.1009 if he or she is in a public institution pending disposition of charges. One commenter requested clarification on the availability of FFP in expenditures for treatment provided to incarcerated individuals outside of the prison system.

Response: The issues raised by the commenters are beyond the scope of this rulemaking. Subparagraph (A) of the matter following section 1905(a)(29) of the Act excludes from the definition of ''medical assistance'' payments for care or services for any individual who is an inmate of a public institution, except as a patient in a medical institution. Therefore, FFP is available only for inpatient services in a medical institution that is not part of the penal system. An individual is considered an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities, regardless of adjudication status. Nothing in the Affordable Care Act alters this section of the Act.

Comment: Several commenters suggested that we amend § 435.907 to expressly provide that ''other authorized persons acting on behalf of an applicant'' includes corrections department employees and others working on behalf of incarcerated individuals.

Response: Corrections department employees and others working on behalf of incarcerated individuals are not precluded from serving as an authorized representative of incarcerated individuals for purposes of submitting an application on such individual's behalf. § 435.908 of the regulations provides that the agency must allow any individual of the applicant's choice to assist in the application or renewal process.

Comment: One commenter requested clarification regarding the inclusion of incarcerated individuals in the household of other family members.

Response: Incarcerated individuals are treated no differently than non-incarcerated individuals in determining the household composition of individuals seeking coverage.

K. Single State Agency (§ 431.10 and § 431.11)

We proposed to allow Medicaid agencies to delegate to Exchanges that are public agencies authority to make Medicaid eligibility determinations as long as the single State Medicaid agency retains authority to issue policies, rules and regulations on program matters and to exercise discretion in the administration or supervision of the plan. Our proposal was based in part on the Exchange proposed rule, which provided that Exchanges would make Medicaid eligibility determinations to implement section 1943(b)(1)(B) of the Act. We note that this is still a relevant consideration although in the Exchange final rule, Exchanges may make Medicaid eligibility determinations, or Medicaid agencies may make such determinations, subject to certain policies designed to ensure a timely and coordinated eligibility determination that are set forth in § 435.1200 of our final rule.

In the Medicaid Eligibility proposed rule (76 FR 51169), we noted that if Exchanges are established as a non-governmental entity as allowed by the Affordable Care Act, the coordination provisions in the law may be more challenging and, for example, could require the co-location of Medicaid State workers at Exchanges or other accommodations to ensure coordination is accomplished. We solicited comment on approaches to accommodate the statutory option for a State to operate an Exchange through a private entity, including whether such entities should be permitted to conduct Medicaid eligibility determinations consistent with the law.

Comment: Commenters provided a wide spectrum of comments regarding the single State agency requirement. In general, commenters supported some delegation to Exchanges of authority to make Medicaid eligibility determinations. However, many commenters expressed the view that eligibility determinations are inherently governmental (involving confidential information and having fiscal implications) and that the final rule should prohibit non-profit Exchanges, or any private entities under contract to Exchanges, from making Medicaid eligibility determinations. They stated that the eligibility and enrollment function should be conducted by State or county agencies utilizing merit system personnel protections and/or that non-profit Exchanges should contract with State Medicaid agencies to conduct Medicaid eligibility determinations. They commented that if a Medicaid agency delegates eligibility to private entities, it will not be in a position to resume the function if anything goes acutely wrong; and that eligibility determinations necessarily

require worker discretion. One commenter advocated that for program integrity and fairness, only government employees should make Medicaid eligibility determinations. However, other commenters advocated modifying the current single State agency policy to allow non-governmental entities, including nonprofits, to make Medicaid eligibility determinations. They sought maximum flexibility for State Exchanges to use private contractors. They further wanted clarification that the single State agency responsibility does not compromise the ability of Exchanges, including quasi-governmental entities, to make eligibility determinations. These commenters strongly endorsed a coordinated system such as having one application, and one verification process for multiple programs and noted that not allowing Exchanges operating as a nonprofit to make Medicaid eligibility determinations would undermine coordination. One commenter requested that we delete the requirement for merit system protection employees to make eligibility determinations. Another urged HHS to consider options for allowing nonprofit operated Exchanges and other third parties to make final Medicaid eligibility determinations without the requirement of State employee co-location.

Response: We anticipate that States that are establishing Exchanges will employ various organizational structures, including non-profits and quasi-governmental organizations, and that those entities may employ private contractors that are ''eligible entities'' in accordance with section 1311(f)(3) of the Affordable Care Act and 45 CFR 155.110(a) for some eligibility functions. To promote coordination and a positive customer experience and ensure that Exchanges are able to make Medicaid eligibility determinations, even when they are non-governmental, we are adding a new § 431.10(c)(3) to allow the delegation of Medicaid eligibility determinations to Exchanges, whether they are governmental or non-governmental organizations. However, if the Exchange is operated by a non-governmental entity, the authority to delegate Medicaid eligibility determinations is limited to MAGI cases only. Similarly, we are also extending authority for Exchanges that contract with private entities in § 431.10(c)(3) to conduct eligibility determinations for MAGI cases. We believe that the simplified eligibility policies and processes applicable to MAGI determinations support this policy, particularly as we anticipate that much of the process will be automated.

As is true whenever a single State agency delegates authority to another entity to make eligibility determinations, we continue to require that the single State agency must supervise the administration of the plan, is responsible for making the rules and regulations for administering the plan, and is accountable for the proper administration of the program. These are inherently governmental aspects of Medicaid program administration. In light of the new types of delegations that may arise and the importance of oversight and protections, we have also added provisions to the regulation that require the single State agency to assure that eligibility determinations are made consistent with State policies and in the best interests of applicants and beneficiaries, including by prohibiting improper incentives and avoiding conflict of interests. For example, compensation for entities making such determinations may not be linked to a pre-set target for eligibility determinations. The delegation authority also applies to any Exchange operated by the Federal government, in which case the federally-facilitated Exchange (FFE), like any other entity with delegated authority, would follow the single State agency's eligibility rules. If the Exchange is a public entity, the single State agency will be allowed to delegate eligibility determination to the Exchange for MAGI-excepted individuals. Alternatively, whether the Exchange is a public or nongovernmental entity, the single State agency may arrange to have the Exchange screen for possible Medicaid eligibility for MAGI-excepted individuals as set forth in § 435.911 and coordinate the transfer of the application to the Medicaid agency, as set forth in § 435.1200.

To conform the rules, we also broaden the requirement in § 431.10(e) to include nongovernmental entities (including contractors and agents) performing services for the Medicaid agency.

Comment: The overwhelming majority of commenters sought rules that strengthen the oversight role of the single State agency in any delegation situations, whether Medicaid delegated eligibility determination functions to another governmental or to a non-governmental entity. They noted that even when determinations are made by government-operated Exchanges, it will be important for the single State agency to set the policies and to assume responsibility for accurate determinations in accordance with its policies and urge the Secretary to assure that this happens. They sought regulatory language that ensures that the single State agency ban fiscal incentives that discourage enrollment (including standards to ensure that eligibility is not influenced by differences in available Federal matching rates), ensure that improper incentives/outcomes are not permitted to monitor the entities' performance to identify any such improprieties, and if found, that they be properly addressed. They sought co-location requirements for public employees if eligibility functions are being conducted by non-governmental entities. They urged requirements that Medicaid eligibility determinations be made by State merit system personnel, and that there be transparency regarding staff making determinations, as well as for any guidance issued by the single State agency for a delegated entity.

In addition, many commenters wanted to see a larger role for CMS oversight in cases where the single State agency delegates its eligibility function to another entity, including ensuring that CMS review compliance with this provision in its oversight and audits of States, as well as including compliance with this provision in future performance standards CMS will be issuing. One commenter sought a requirement for the single State agency to obtain HHS approval of a plan that details how eligibility determinations will be made. Several commenters sought a requirement that States submit all contracts with a value exceeding $5 million to CMS for approval as is done by SNAP. Commenters further sought mechanisms for advocates to provide information to CMS on the status of State compliance with the Federal requirements.

Response: We are strengthening applicable safeguards in § 431.10, which would apply whether governmental or non-governmental entities are making eligibility determinations. The regulations intend to ensure that State agencies maintain their responsibility to oversee eligibility activities and ensure that Medicaid eligibility rules are implemented properly. These provisions apply not just when Exchanges conduct Medicaid eligibility determinations, but also when State Medicaid agencies allow other State agencies or county agencies, for example, to make eligibility determinations. In particular, § 431.10(c)(4) will require the single State agency to be responsible for ensuring that eligibility determinations are made consistent with its policies, and if there is a pattern of incorrect, inconsistent, or delayed determinations

that corrective actions are promptly instituted and/or the delegation, or contract, is terminated. In this context, oversight and corrective actions would pertain to the overall implementation of the single State agency's rules by the entity making eligibility determinations, not to case-by-case reviews. This could include corrective action plans, financial sanctions, and even termination of agreements if warranted.

As previously described, § 431.10(c)(5) will require that the single State agency be responsible for assuring eligibility determinations will be made in the best interest of applicants and beneficiaries and specifically for assuring that there is no conflict of interest by any entity making eligibility determinations, whether by delegation or contract; and improper incentives and/or outcomes are prohibited, monitored, and if found properly and promptly addressed through corrective actions. Thus, the rule is prohibiting any arrangements that link the results of eligibility determination dispositions to remuneration. Moreover, the agreement between the Medicaid agency and Federal or State and local agencies is being broadened to include agreements with ''entities'' as well, to account for non-governmental entities. To ensure accountability, we are requiring that such agreements be in writing and available upon request. Such agreements may be subject to State FOIA laws that require disclosure, but to ensure uniform accountability for such arrangements, we are including this requirement in our regulation. We believe that transparency will strengthen program operations. To ensure that each parties' responsibilities are clearly designated, we are setting out the following minimum components of such agreements:

- The relationships and respective responsibilities of the parties (including responsibilities regarding identification of potential and transfer of non-MAGI cases);
- The quality control and oversight plans by the single State agency to review determinations made by the delegee to ensure that overall determinations are made consistent with the State agencies' eligibility polices;
- The reporting requirements from the delegee making Medicaid eligibility determinations to the single State agency to permit such oversight.
- An assurance that the delegee will comply with all confidentiality and security requirements in accordance with sections 1902(a)(7) and 1942 of the Act and part 431, subpart F, for all applicant and beneficiary data; and
- An assurance that merit system personnel protection principles are employed by the entity responsible for the Medicaid eligibility determination.

In light of the provisions described above, which will support the integrity and accuracy of the Medicaid eligibility process, we do not agree that requiring physical co-location for public employees is necessary. However, States may provide for co-location if they choose to do so. While we are not requiring that public employees review each determination, coordination between other entities and the single State agency staff can help the State agency implement its oversight role when it delegates eligibility determinations. Moreover, we are adding a requirement to the agreements between the single State agency and the entity that has been delegated eligibility for ''an assurance that applicants and beneficiaries are made aware of how they can directly contact and obtain information from the single State agency'' to respond to commenters concerns about applicant and beneficiary access to public employees.

Finally, we are making conforming changes at § 431.11(d) to already existing requirements to include situations when eligibility has been delegated to non-governmental Exchanges and/or private contractors that are providing eligibility services. State plans will still require explicit descriptions of the staff and functions of the entity that is being delegated eligibility determinations as they must today.

Comment: Some commenters questioned the rules regarding using automated eligibility systems to make Medicaid eligibility determinations. They sought clarification that States be permitted to use automated systems to apply Medicaid validated logic through system-based eligibility algorithms to make Medicaid eligibility determinations based on MAGI. One commenter opposed using ''co-location policies'' and wanted Medicaid agencies to have the flexibility to employ the merit protection principles by approving a system-based eligibility algorithm developed and implemented by a private or non-profit entity contracting for eligibility determinations with periodic sampling of Medicaid determinations by public employees.

Response: Whether conducted by a public or private entity, we anticipate that eligibility determinations using MAGI-based standards will be highly automated, utilizing business rules developed by the State Medicaid agency. In the most simplified cases, which can be determined without human intervention or discretion, we are clarifying that automated systems can generate Medicaid eligibility determinations, without suspending the case and waiting for an eligibility worker (public or private) to finalize the determination, provided that the Medicaid agency retains oversight responsibilities for all decisions made through the automated system. We will be issuing future guidance on this topic.

Comment: One commenter requested clarification on the range of public agencies that can perform MAGI and non-MAGI eligibility determinations.

Response: Our regulations provide that public agencies, including Exchanges, may make MAGI and non-MAGI eligibility determinations. Longstanding Medicaid regulations have allowed Medicaid agencies to delegate to other State agencies (such as agencies administering TANF and SNAP programs) as well as to local Medicaid offices (such as those administered by counties). These delegations will continue to be permitted under our final rule, although the Single State agency's authority and oversight responsibilities are identified with greater specificity.

Comment: One commenter requested that we clarify what ''best interest'' of the applicant/beneficiaries and ''improper outcomes'' mean in § 431.10(c)(4). Another requested detail on the term ''corrective action'' and ''conflict of interest.''

Response: ''Best interest of applicants and beneficiaries,'' and ''corrective action'' are not new terms for the Medicaid program. They are not used as technical terms but to connote their plain meaning. How these terms apply may depend on circumstances. ''Improper outcomes'' and ''conflict of interest'' are intended to convey certain specific circumstances that are not in the best interest of applicants and beneficiaries, and may require corrective action. We believe States have experience with and are able to properly interpret these provisions but will continue to work with States in the context of implementing this final rule.

Comment: One commenter requested that CMS resolve the conflict with SNAP that prohibits private eligibility determinations.

Response: We will work with States and the SNAP program to consider ways to promote coordination.

Comment: One commenter sought a clearer statement that FFEs would be required to follow State eligibility rules and policies.

Response: Under the Exchange eligibility rule at § 155.305, Exchanges will be able to make final Medicaid eligibility determinations, provided that

they follow the policies set forth by the single State agency. This applies equally to State-based Exchanges and to FFEs.

L. Implementing Application of MAGI to CHIP (§ 457.10, § 457.301, § 457.305, § 457.315, and § 457.320)

We proposed that States base income eligibility for CHIP on MAGI consistent with section 1902(e)(14) of the Act. Because section 2107(e)(1)(F) of the Affordable Care Act applies MAGI methodologies to CHIP ''in the same manner'' as they are applied to Medicaid, we proposed applying the Medicaid MAGI methodologies to CHIP without modification.

We outlined proposed changes to following existing sections of the CHIP regulations:

- Definitions and use of terms (§ 457.10).
- Definitions and use of terms (§ 457.301).
- State plan provisions (§ 457.305).
- Other eligibility standards (§ 457.320).

In addition, we proposed the addition of new ''Application of MAGI and household'' section (§ 457.315), to implement the CHIP MAGI components of the law. These proposed revisions are discussed in more detail in the Medicaid Eligibility proposed rule (76 FR 51170 through 51171).

Comment: We received several general comments concerning the proposed application of MAGI to CHIP that mirrored comments concerning the proposed application of MAGI to Medicaid. Some commenters expressed support for the proposed MAGI definitions, including the exception to MAGI provided for Express Lane eligibility determinations. One commenter noted a general concern about the complexity of the MAGI definition, and other commenters raised concerns about the potential impact of the proposed MAGI rules on families in particular circumstances, such as families with stepparent income.

Response: Our responses to general comments on the application of MAGI to Medicaid apply also to CHIP. See section III.B of this preamble.

Comment: We received several comments requesting that the proposed grace period for applying the MAGI methodology to current Medicaid enrollees described in § 435.603(a) should equally apply to CHIP enrollees.

One commenter requested clarification about whether CHIP children who become eligible for Medicaid in 2014 would be entitled to 12 months of continuous eligibility if the CHIP plan offers continuous eligibility, but the Medicaid plan does not.

Response: We are adding a paragraph to § 457.315 to clarify that the MAGI grace period for Medicaid described in § 435.603(a)(3) applies equally to CHIP. This section clarifies that ongoing eligibility for children determined eligible for CHIP on or before December 31, 2013, will not be determined according to MAGI until March 31, 2014 or the next regularly-scheduled renewal, whichever is later.

Regarding 12 months of continuous eligibility, a child who is enrolled in CHIP with 12- month continuous eligibility as of January 1, 2014 would be able to retain CHIP coverage until the end of their 12 month continuous eligibility period, as that is when the child's next regular renewal would occur.

Subsequent renewals for Medicaid-eligible children would be conducted in accordance with § 435.916.

Comment: We received several comments regarding the conversion of CHIP income standards to a MAGI-based income standard. Some commenters recommended that CMS limit the ability of States to set their own income standards and that the income standard conversion ensure that no child who would have been eligible under current CHIP income standards would become ineligible under the new MAGI standard.

Additionally, a few commenters recommended that CMS indicate that the Affordable Care Act's maintenance of effort (MOE) provision requires that the CHIP MAGI standard be greater than or equal to the income level applied as of March 23, 2010. Some commenters also recommended that the CHIP regulations include a provision to clarify that the Medicaid MAGI standard must be greater than or equal to the standard applied on March 23, 2010.

Response: Guidance regarding the process for converting current income standards under Medicaid and CHIP to MAGI-equivalent standards is beyond the scope of this rule and will be provided in future guidance, which will require States to convert net income standards to MAGI-equivalent standards in a manner that ensures that affected populations, in the aggregate, do not lose coverage. Issues around applicability of the MOE are outside the scope of this Medicaid Eligibility proposed rule.

Comment: We received some general comments about the provision of continued coverage for children made ineligible for Medicaid as a result of the MAGI conversion under section 2101(f) of the Affordable Care Act, as proposed in § 457.310(b)(1)(iv). Some commenters recommended that pre-MAGI coverage levels be continued indefinitely, but one commenter felt that this approach would undermine the consistency in eligibility standards and methods envisioned under the Affordable Care Act.

Response: Section 2101(f) of the Affordable Care Act provides that States maintain coverage under a separate CHIP program for children who lose Medicaid eligibility due to the elimination of income disregards as a result of the conversion to MAGI. The statute limits the application of section 2101(f) of the Affordable Care Act to individuals who are made ineligible for Medicaid directly ''as a result'' of the elimination of income disregards under MAGI-based financial methods. We interpret this provision as relating to children enrolled in Medicaid as of December 31, 2013, so that the protection afforded under section 2102(f) will take effect on the date of the child's Medicaid first renewal, after the MAGI grace period described in § 435.603(b)(3). This provision does not apply to individuals made ineligible for a separate CHIP as a result of the elimination of income disregards. Thus, the eligibility of children who become eligible for CHIP under section 2101(f) of the Affordable Care Act will be protected from the impact of the elimination of disregards under MAGI methods until the child's first renewal of CHIP eligibility in accordance with § 457.343 (that is, one year after the child's enrollment in CHIP).

We have deleted § 457.310(b)(1)(iv) and added a new paragraph § 457.310(d) to provide additional clarification regarding the protection afforded by section 2101(f) of the Affordable Care Act.

Comment: We received a few comments requesting clarification about the applicability of the CHIP enhanced FMAP rate after the conversion to MAGI. Several commenters requested clarification on whether States that currently claim the CHIP enhanced FMAP for child health expenditures for children with incomes above 300 percent of the FPL may continue to do so after the MAGI conversion or whether these States will be subject to the requirements at section 2105(c)(8) of the Act, which limits the CHIP FMAP rate for expansions of CHIP above 300 percent of the FPL after February 4, 2009.

One commenter asked CMS to clarify whether block of income disregards applied to the CHIP income standard prior to 2014 will be incorporated into a State's MAGI CHIP income standard,

and whether this would be considered permissible in light of the preclusion of block of income disregards under the Affordable Care Act after 2014.

One commenter recommended that all CHIP children who become eligible for Medicaid as a result of the conversion to MAGI and the expansion of Medicaid coverage for children up to 133 percent of the FPL should be eligible for CHIP enhanced FMAP. Another commenter specifically recommended that CHIP children made eligible for Medicaid because of changes in *Sneede* vs. *Kizer* budgeting should retain Title XXI funds.

Response: States that currently claim the CHIP enhanced matching rate for coverage of children with effective family income above 300 percent of the FPL, based on State plan provisions in effect on February 4, 2009, will continue to be eligible for CHIP enhanced FMAP for such children after the conversion to MAGI even if the converted MAGI income standard exceeds 300 percent of the FPL. States that have expanded CHIP through the use of block of income disregards prior to 2014 will continue to cover these children because the law requires that the MAGI-converted income standard take into account existing disregards, including block of income disregards.

In terms of the claiming of Title XXI funds for separate CHIP children who become eligible for Medicaid, CHIP enhanced FMAP will continue to be available for children whose income is greater than the Medicaid applicable income level (defined in § 457.301 and based on the 1997 Medicaid income standard for children), regardless of whether those children are enrolled in Medicaid or CHIP. This standard will be converted for MAGI and States will qualify for CHIP enhanced FMAP for expenditures on behalf of children whose MAGI-based household income is above the converted MAGI standard. Guidance about the conversion of the Medicaid applicable income level for MAGI will be provided in the future.

M. Residency for CHIP Eligibility (§ 457.320)

We proposed to modify the definition of residency under CHIP for non-institutionalized children who are not wards of the State to reference the Medicaid definition for children at proposed § 435.403(i) for individuals under age 21. Aligning residency standards was proposed to ensure coordination between all insurance affordability programs, including advanced premium tax credits.

Comment: Many commenters supported our efforts to align residency definitions for all insurance affordability programs. Some commenters provided suggestions similar to those made regarding the Medicaid residency definition to achieve further alignment. One commenter specifically recommended more clarity on how the residency definition would be applied in States that adopted 12-month continuous eligibility in CHIP.

Response: We have kept residency definitions aligned in the final rule. To promote further alignment, we have also adopted the Medicaid residency standards for adults for any adult pregnant women determined eligible under the CHIP State plan. Our responses to general comments on residency regulations for Medicaid also apply to CHIP. See section III.C of this preamble.

Changes in State residency (that is, a move out of State) are an acceptable exception to a 12-month continuous eligibility period, as described in our December 16, 2009 State Health Official Letter regarding CHIPRA Performance Bonus Payments, available at *http://www.cms.gov/smdl/downloads/sho09015.pdf.*

Comment: One commenter recommended that we use the term ''in the custody and care of a State'' rather than ''ward of the State'' to align our terminology with the Administration for Children and Families.

Response: We do not believe this change is necessary and we are concerned that it could be seen as reflecting an unintended change in the current meaning of the regulation. Thus, we will be retaining the term ''ward of the State'' to avoid any confusion.

N. CHIP Coordinated Eligibility and Enrollment Process (§ 457.330, § 457.340, § 457.343, § 457.348, § 457.350, § 457.353, and § 457.380)

We proposed to implement section 2107(e)(1)(O) of the Affordable Care Act which applies to CHIP the same enrollment simplification standards described for Medicaid under the new section 1943 of the Act, including standards for applications, coordination with other insurance affordability programs, renewals, and verification. These standards build on existing practices and provisions in section 2102(b)(3)(B) of the Affordable Care Act relating to coordinated eligibility and enrollment between Medicaid and CHIP. The regulatory amendments proposed correspond to proposed changes and additions to Medicaid at § 435.905 through § 435.908, § 435.916, § 435.940 through § 435.956, and § 435.1200 (these proposed provisions are discussed fully in the Medicaid Eligibility proposed rule (76 FR 51160 through 51162; 51165 through 51166; and 51170)).

We note that any references to ''State'' in this section refer to the CHIP agency, and that any references to ''enrollee'' in CHIP have the same meaning as ''beneficiary'' in Medicaid.

Comment: We received several comments about the application and enrollment process in CHIP that mirrored comments concerning the application and enrollment process for Medicaid, including comments about meaningful access for individuals with limited English proficiency, the Internet Web site, use of the single, streamlined application for multi-benefit applications, and the timeliness of application processing. Many commenters supported the overall establishment of a unified application and enrollment process for all insurance affordability programs.

Response: We recognize the value of clear guidance and consistent standards and procedures to support this alignment without limiting State flexibility to design implementation strategies, and in this final rule, we retained alignment of the application and enrollment procedures between insurance affordability programs. Our responses to general comments on application and enrollment procedures for Medicaid apply also to CHIP. See sections III.D and H of this preamble.

Changes that have been made to the Medicaid standards for applications and enrollment in the final rule generally apply to CHIP through cross-reference, but we have also updated CHIP language where appropriate to ensure continued alignment. Specifically, we have added and/or revised definitions for ''Advance payments of the premium tax credit (APTC),'' ''application,'' ''eligibility determination,'' and ''non-applicant.'' Moreover, we have adopted the term ''renewal'' instead of ''redetermination,'' consistent with Medicaid. Also, we have added cross-references to § 435.906 and § 435.908 to replace proposed text at § 457.340(a) and have moved § 457.335 to § 457.340(a) to further clarify the alignment of standards for application and renewal assistance. As described in section III.D of this preamble, we are adding additional standards for timely eligibility determinations for Medicaid at § 435.912. These also are adopted for CHIP by cross-reference in § 457.340(d) in the final rule.

Consistent with our request for comments on the interim final Medicaid regulations at § 435.912 and § 435.1200, we are soliciting additional comment and issuing as an interim final rule

paragraphs (c)(1) and (d) of § 431.300, paragraph (b)(6) of § 431.305, paragraph (d) of § 457.340, § 457.348, and the paragraphs (a), (b), (c), (f), (i), (j), and (k) of § 457.350 that are added or revised in this rule.

Comment: Several commenters expressed concerns with the proposal in § 457.340(b) to require SSNs as a condition of eligibility in CHIP because of the potential barriers it could impose on some individuals. A few commenters noted that this requirement may be problematic for States that have elected the CHIP option to provide prenatal care for pregnant women. Commenters recommended that CMS continue to retain State flexibility regarding the SSN requirements in CHIP, or at a minimum, that CMS clarify that SSN requirements only apply to individuals who have SSNs. One commenter supported the requirement for an SSN and expressed concern that data systems might not be able to process applications in real time without this information. We also received comments about the use of SSNs for non-applicants in CHIP, which mirrored comments about the use of SSNs for non-applicants in Medicaid.

Response: We do not believe that aligning the SSN policy for CHIP with the policy in Medicaid will pose a significant burden on families or States. In fact, many separate CHIPs have successfully implemented SSN requirements without imposing a significant burden on families. The Medicaid regulations at § 435.910(e) and (f), incorporated by cross-references in the CHIP regulations at § 457.340(b), clarify procedures for applicants who have not yet been issued an SSN and emphasize that the State may not deny or delay services to otherwise eligible applicants pending the issuance of a SSN. SSNs are not required from individuals who are not eligible for an SSN.

Our responses to general comments on the use of SSNs of non-applicants in Medicaid apply also to CHIP. See section III.D of this preamble. Changes that have been made to the Medicaid regulations regarding non-applicant SSNs in the final rule are adopted for CHIP via cross-reference at § 457.340(b).

Comment: We received one comment concerning our proposal to remove the mention of enrollment caps in § 457.340(a). The commenter requested confirmation that States are able to retain their authority to implement enrollment caps and recommended that CMS issue additional clarification about the extent of application assistance that CHIP agencies are required to provide if CHIP enrollment is capped.

Response: Nothing in the Medicaid Eligibility proposed rule addresses a State's ability to implement enrollment caps. However, the existence of an enrollment cap does not relieve a CHIP agency to accept the single streamlined application and screen for all insurance affordability programs regardless of whether CHIP enrollment is capped, or to otherwise comply with the regulations regarding CHIP's role in the coordinated eligibility and enrollment system.

Comment: We received several general comments about coordination between insurance affordability programs, including concerns about the process for transferring application data, suggestions for screening metrics and requests for clarification about the implication of the Medicaid Eligibility proposed rule on a State's PERM. These comments mirrored comments that were received on the corresponding Medicaid provisions and are addressed in section III.J. of the preamble.

In addition, we received several CHIP-specific comments. Some commenters requested that CMS require CHIP agencies to allow Medicaid agencies to make CHIP determinations to reduce potential gaps in coverage. One commenter was concerned about the allocation of the CHIP enhanced FMAP for children who were enrolled in CHIP but subsequently determined eligible for Medicaid on a basis other than MAGI, according to the process outlined in § 457.350(j). One commenter recommended a slight rewording of § 457.350(i) and (j) to clarify that screening for Medicaid eligibility is required before an individual is found potentially eligible for other insurance affordability programs. One commenter questioned whether States needed to give applicants a choice to enroll in CHIP or the Exchange.

Response: Our responses to general comments on the coordination among other insurance affordability programs for Medicaid apply also to CHIP. See section III.J of this preamble. We have also revised the final CHIP regulations where appropriate to ensure continued alignment with Medicaid regulations, including revisions to § 457.348 to provide further flexibility for States in developing their implementation strategies with respect to the determination of eligibility for CHIP by the Exchange. As we noted, we are soliciting additional comment and issuing as interim final § 457.348 and the paragraphs of § 457.350 that are added or revised in this rule.

States already permit Medicaid agencies to make CHIP eligibility determinations to promote coordination between programs. We do not have the authority to require that States must enable their Medicaid agencies to make final CHIP eligibility determinations and, under the final regulation, States will continue to have flexibility in this regard. Other provisions of the regulation will help to ensure seamless coordination between Medicaid and CHIP.

Regarding the Federal reimbursement rates for children enrolled in a separate CHIP who are identified according to § 457.350(j) as potentially eligible for Medicaid on a basis other than MAGI, States are able to claim the CHIP enhanced FMAP for these children pending final determination of Medicaid eligibility.

We have also revised § 457.350(i) and (j) for improved clarity and alignment with Medicaid and the Exchange. As noted in the Medicaid Eligibility proposed rule, these provisions apply not only to children but also to all parents and other household members applying for coverage on the single, streamlined application.

Finally, regarding the coordination between CHIP and the Exchange, the Affordable Care Act does not permit giving applicants a choice between receiving the APTC available for coverage obtained through the Exchange and receiving CHIP coverage. Individuals who are eligible for CHIP are not eligible for APTCs although, individuals who are eligible for CHIP may choose to enroll into a QHP in an Exchange without an APTC. We also note that there are several ways that States can promote the ability of families to enroll in the same plan. States may contract with the same plans that participate as QHPs in the Exchange to deliver covered services in their CHIP programs. States also may offer CHIP eligible individuals the choice of receiving premium assistance through a QHP offered in the Exchange consistent with the standards and requirements of section 2105(c)(3) of the Act. Guidance about the use of premium assistance and coordination of coverage with QHPs in Exchanges is forthcoming.

Comment: We received comments about our proposal for CHIP to adopt the coverage month policy proposed in 45 CFR 155.410 of the Exchange proposed rule, which mirrored comments related to coverage months in Medicaid. Some commenters offered specific recommendations regarding our proposal to update the definition of the effective date of coverage in CHIP in § 457.340(f) to promote better coordination across insurance affordability programs. One commenter recommended that we explicitly require

that the application date be the effective date of coverage, rather than retain flexibility for States. One commenter recommended that we delete the word ''unnecessary'' from § 457.340(f) and § 457.80(c), and add additional clarifying language to emphasize that gaps in eligibility or coverage are not permissible. This commenter also wanted CMS to clarify that in addition to eligibility, CHIP coverage must be furnished promptly.

Response: Our responses to general comments on coverage month for Medicaid also apply to CHIP. See section III.G of this preamble. We encourage CHIP programs to continue to use existing flexibility to continue coverage until the end of the month to reduce gaps in coverage, but we are not requiring a specific approach at this time.

We note that some States use this flexibility to minimize gaps in coverage in different ways. For example, some States retroactively enroll children to the beginning of the month of application. The phrase ''furnish CHIP promptly'' in § 457.348 refers to both CHIP eligibility and CHIP benefits.

Comment: One commenter raised several concerns related to coverage of pregnant women and deemed newborns covered in CHIP. First, the commenter requested that CMS clarify that part 457 applies in full when CHIP services are received by a pregnant women through the CHIP State plan or a waiver of the plan. The commenter also expressed concern that the deletion of existing § 457.350(b)(2) could create problems for determining eligibility for families with deemed newborns. Lastly, the commenter recommended that § 457.343 be modified to require that States routinely renew eligibility near the expected delivery date of a pregnant woman to avoid gaps in coverage, or retroactive disenrollment, particularly for pregnant women eligible for CHIP coverage under the prenatal expansion option.

Response: The option to provide CHIP to pregnant women under the CHIP State plan or waiver of the State plan is beyond the scope of this rule. However, we direct readers to our May 11, 2009 State Health Official Letter, available at *http://www.cms.gov/SMDL/downloads/SHO051109.pdf,* for guidance on this issue.

The specific screening objectives identified in existing regulations at § 457.350(b) are encompassed in the broader screening objectives reflected in § 457.340(b) of this final rule, which direct CHIP agencies to conduct broader screening for potential Medicaid eligibility both based on the applicable MAGI standard for children, pregnant women, parents, and other non-elderly adults as well as on other bases. Deemed newborn eligibility for babies born to mothers eligible for CHIP will be addressed in future guidance.

Finally, as suggested, we would expect States to routinely renew eligibility near the expected delivery date of a pregnant women based on the standard in § 435.916(d)(2), as cross referenced to CHIP at § 457.343, which requires States to renew eligibility at the appropriate time if the agency has information about anticipated changes in an enrollee's circumstances that may affect her eligibility.

Comment: We received several general comments about verification of eligibility for CHIP that mirrored comments received on the verification process in Medicaid, such as concerns about the ability to access data through the electronic service established by the Secretary, requests for clarification regarding the time period to furnish documentation, and questions regarding the use of alternative data sources.

Many commenters expressed strong support for our proposed policy to allow States to accept self-attestation of most eligibility information, and some commenters recommended that we require all States to accept self-attestation of income. One commenter recommended that the CHIP regulation text regarding self-attestation be more closely aligned with proposed § 435.945(b). Other commenters wanted CMS to clarify that self-attestation of pregnancy was acceptable. One commenter requested that CMS clarify whether it was necessary for States to accept self-attested data if subsequent third-party data contradicted the applicant's statement.

We also received some comments about § 457.380(h), regarding the interaction between our verification policies and program integrity requirements. Some commenters indicated that this paragraph was unnecessary and other commenters thought that this policy could have adverse consequences for enrollees.

Response: Our responses to general comments on verification for Medicaid also apply to CHIP. See section III.H of this preamble. Changes that have been made to the Medicaid standards in the final rule generally apply to CHIP via cross-reference, but we have also updated CHIP language where appropriate to ensure alignment. Specifically, we have revised the language of § 457.380(e) to remove the requirement to accept self-attestation of household size, consistent with revisions to the Medicaid regulations at § 435.956; we have cross-referenced paragraph (f) to § 435.952 to ensure an alignment of standards between Medicaid and CHIP; and we have added paragraph (j) to § 457.380 to require States to develop a verification plan similar to the verification plan required by Medicaid agencies in § 435.945(j).

We are modifying our regulation text to mirror Medicaid to further ensure consistency. The acceptance of self-attestation is an option for States (unless not permitted by law), with the one exception that States must accept self-attestation of pregnancy for purposes of Medicaid and CHIP eligibility unless the State has information that is not reasonably compatible with the attestation.

As discussed in section III.H of this preamble, we will be reviewing and analyzing all of our error rate measurement program rules and procedures to ensure consistency with the streamlined eligibility and enrollment rules established in this regulation, and will provide additional guidance as needed. We are revising § 457.380(h) to reflect the changes made to proposed § 435.945(a) (moved to § 435.940 in this final rule) and will work with States to ensure that program integrity policies at the Federal and State levels support the goals of minimizing consumer and State administrative burden while also ensuring accurate eligibility determinations.

Comment: We received several comments expressing concern that the Department of Treasury's proposed rules for the premium tax credit could adversely affect families with children in CHIP. These commenters noted that Treasury's definition of affordable employer-based coverage, in which the affordability test for the entire family would be determined based on the premium cost for self-only coverage for the primary taxpayer, would result in many families not qualifying for premium tax credits. Also, commenters noted that the Treasury's rules for calculating the premium tax credit do not consider the cost of CHIP premiums and would consequently impose an additional premium burden on families that are split between CHIP and the Exchange. Some commenters recommended that if the Department of Treasury does not modify its proposed rule, then CMS should require States to waive CHIP premiums for children whose parents are enrolled in the Exchange or take other measures to minimize the financial burden placed on families with children in CHIP.

Response: Under the existing CHIP statute and regulations, States may vary

premiums for different groups of children and may elect not to impose premiums for children who have parents that are enrolled in the Exchange, consistent with § 457.530, and we encourage States to consider the impact of all premiums paid by the family in designing their CHIP premium policies. However, consistent with the flexibility accorded States under the Act, we are not requiring this approach. Rules relating to the calculation of the premium tax credit are beyond the scope of this rule, but will be discussed in the final rule to be promulgated by the Department of the Treasury.

Comment: Several commenters noted a variety of CHIP specific issues that were not addressed in this regulation, such as the policy for waiting periods, maintenance of effort requirements, essential health benefits, the increase in the CHIP FMAP in 2014, and the possibility for future expansions in CHIP coverage after 2014.

Response: These comments are outside the scope of this rule, but we will consider the comments in future guidance.

O. FMAP for Newly Eligible Individuals and for Expansion States (§ 433.10, § 433.206, § 433.210, and § 433.212)

In the Medicaid Eligibility proposed rule, we proposed to implement section 1905(y) of the Act that provides for a significant increase in the Federal Medical Assistance Percentage (FMAP) for medical expenditures for individuals determined eligible under the new adult group in the State and who will be considered to be ''newly eligible'' in 2014, as defined in section 1905(y)(2)(A) of the Act. Specifically, we proposed to add new provisions for the ''Rates of FFP for program services'' to indicate the increases to the FMAPs as available to States under the Affordable Care Act. We also proposed that States may elect one of three options as a methodology for calculating the newly eligible FMAP:

(1) 2009 Eligibility Standard Threshold.

(2) Statistically Valid Sampling Methodology (§ 433.210).

(3) Use of a FMAP Methodology Based on Reliable Data Sources (§ 433.212).

These and other proposed provisions are discussed in more detail in the Medicaid Eligibility proposed rule (76 FR 51172 through 51178). We received a number of comments concerning the proposed FMAP methodologies for newly eligible individuals and for expansion States provisions.

We are in the process of performing additional research on this topic and are working with States to better understand which approaches will ensure an accurate method for implementing the FMAP and further the simplification goals of the Affordable Care Act. Given that this work is continuing, we will finalize the FMAP methodology for newly eligibles in future rulemaking.

IV. Provisions of the Final Regulations

This final rule incorporates many of the provisions set forth in the Medicaid Eligibility proposed rule. The provisions of this final rule that substantively differ from the Medicaid Eligibility proposed rule are as follows:

A. Revised § 435.4 as follows:

- Revised the definition of the following terms: ''advance payment of the premium tax credit (APTC),'' ''Affordable Insurance Exchanges (Exchanges),'' ''agency,'' and ''tax dependent.''
- Added the definition of the following terms: ''Affordable Care Act,'' ''applicable modified adjusted gross income (MAGI) standard,'' ''applicant,'' ''application,'' ''beneficiary,'' ''eligibility determination,'' ''family size,'' ''Federal Poverty Level (FPL),'' ''non-applicant,'' and ''shared eligibility service.''
- Revised the definition of ''caretaker relative'' to specify the degree of relationship to the dependent child, for consistency with section 406(a) of the Act as in effect prior to enactment of the PRWORA and to provide the option for States to consider other relatives to be caretaker relatives.
- Revised the definition of ''caretaker relative'' to provide the option for States to include the domestic partner of the parent or other caretaker relative or to include another adult with whom the child is living and who assumes primary responsibility for the dependent child's care.
- Revised the definition of ''dependent child'' to add another reason for a child to be considered deprived of parental support. Clarified which 18 year old, full-time students are included under this definition, for consistency with the definition of ''dependent child'' in section 406(a) of the Act as in effect prior to passage of PRWORA, and clarified that it is a State option rather than a requirement to consider 18 year old full-time students as dependent children.

B. Other Revisions

- Revised § 431.10 to allow the Medicaid agency to delegate eligibility determinations to an Exchange (whether operated by a public authority, non-governmental entity or private contractor) or to a private entity, for MAGI populations and strengthens safeguards that the single State agency must have in place when it delegates or contracts eligibility.
- Clarified in § 431.10 certain terms for agreements with delegees/contractors. Adds a requirement that the Medicaid agreements with delegees and/or with its private contractors be available to the public upon request.
- Revised language at § 431.300(b) to clarify that non-applicant information is protected under confidentiality rules, just as information concerning applicants and beneficiaries is protected.
- Removed subparts A and E from part 433–State Fiscal Administration, ''FMAP for Newly Eligible Individuals and for Expansion States (§ 433.10, § 433.206, § 433.210, and § 433.212)'' from the final rule. These issues will be addressed in future rulemaking.
- Revised the description of pregnancy-related services at § 435.116(d)(3) by referencing § 440.210(a)(2), which defines the requirements for coverage of pregnancy-related services.
- Revised § 435.218(b)(1)(iii) to clarify that an individual is not eligible under this optional group if the individual is eligible and enrolled for optional coverage under sections 1902(a)(10)(A)(ii)(I) through (XIX) of the Act.
- Revised § 435.403 to confirm that an individual must be living in the State to be eligible for Medicaid and to clarify that State residency for individuals who receive State supplementary payments or title IV–E assistance are addressed in paragraphs (f) and (g) of this section, respectively.
- Revised § 435.603 (and § 435.911) regarding how MAGI rules apply to individuals with disabilities and those needing long-term services and supports to enable them to enroll under an optional Medicaid eligibility group which better meets their needs if they meet eligibility requirements.
- Revised § 435.603(a)(3) to clarify that MAGI does not apply to beneficiaries eligible and enrolled for Medicaid on or before December 31, 2013 until the later of March 31, 2014 or the next regularly-scheduled renewal.
- Revised § 435.603(b) to specify that the family size for pregnant women includes the woman plus the number of children she is expecting and that the family size of other individuals when a pregnant women is included in their household counts the pregnant woman, at State option, as either one or two person(s) or as herself plus the number of children she is expected to deliver.

• Revised § 435.603(d)(2) to add a heading for this paragraph of ''Income of children and tax dependents'' and to add paragraphs (i) and (ii) with revised policy for consideration of income of children and tax dependents who are not expected to be required to file a tax return and are included in the household of the individual's parent or a taxpayer other than the individual's parent or spouse. Also revised the language to replace ''is not required'' with ''is not expected to require'' to file a tax return for the taxable year in which eligibility for Medicaid is determined.

• Revised § 435.603(d)(3) to make counting cash support, exceeding nominal amounts, a State option rather than a requirement for tax dependents receiving such support from a taxpayer other than the individual's parent.

• Revised § 435.603(e)(2) to add awards as a type of income excluded from MAGI-based income, if used for education purposes.

• Revised § 435.603(e)(3) to clarify the types of income received by American Indians and Alaska Natives excluded from MAGI-based income.

• Revised § 435.603(f)(1), (f)(2), and (f)(3) to replace the language ''file'' with ''expects to file'' a tax return and ''claimed as a tax dependent'' with ''expects to claim as a tax dependent'' for the taxable year in which an initial determination or renewal of eligibility is being made.

• Revised § 435.603(f)(2)(ii) to address children who expect to be claimed by one parent as a tax dependent and are living with both parents who do not expect to file a joint tax return, regardless of whether the parents are married.

• Added definition of ''custodial parent'' to § 435.603(f)(2)(iii) to resolve ambiguity of rules for children claimed as a tax dependent by a non-custodial parent in cases involving shared custody. This definition is the same as that used by the IRS for purposes of claiming a child as a qualifying child.

• Revised § 435.603(f)(3)(ii) and (iii) and (f)(3)(ii) and (iii) and added a new (f)(3)(iv) to provide States with the option to include under these policies for children, 19 and 20-year old full-time students living in their parents' household.

• Added new § 435.603(f)(5) relating to household composition to provide that, when tax dependency for purposes of applying 36B rules at the point of application cannot be determined with reasonable certainty, non-filer rules at paragraph (f)(3) are applied.

• Revised § 435.603(h)(2) to clarify that beneficiaries' projected annual household income, if a State elects this option, is determined for the remainder of the current calendar year, not for the full calendar year.

• Revised § 435.603(h)(3) to clarify that a State may also adopt a reasonable method to project a reasonably predictable future increase or decrease in income and/or family size.

• Added a new paragraph (i) to § 435.603 to use 36B financial methodologies and determine an individual Medicaid-eligible if the individual is ineligible for Medicaid using MAGI-based household income and also ineligible for APTC based on MAGI income below 100 percent FPL.

• Renumbered § 435.603(i) as (j), which specifies the eligibility categories for which MAGI-based methods do not apply.

• Revised § 435.603(j)(2) to exempt individuals age 65 or older from application of MAGI-based methods in determinations of eligibility for which age is a condition of eligibility.

• Added language at § 435.905(b) clarifying that information must be provided accessibly and in a timely manner for persons who are limited English proficient and persons who have a disability. We made small modifications to § 435.907, § 435.916, and § 435.1200 to ensure that the application, renewal form, web sites, kiosks, or other information systems will be provided accessibly.

• Removed the requirement for agencies to accept applications via facsimile in § 435.907(a), and signatures via facsimile in § 435.907(g) in favor of acceptance via other commonly available electronic means.

• Revised § 435.907(c)(2)(i) to provide that applications and forms for non-MAGI populations must be submitted to the Secretary and meet the criteria established by the Secretary for such applications and forms, but do not need approval prior to use.

• Added language to § 435.907(d) and § 435.916 to specify that the agency may not require individuals to complete an in-person interview as part of an application or renewal process for an eligibility determination based on MAGI methods.

• Modified language at § 435.907(e) to clarify that a State may only require information that is necessary to make an eligibility determination or that is directly related to the administration of the State plan.

• Revised § 435.910(a) and (h) to clarify the SSN requirement for applicants that individuals who are not eligible for an SSN or do not have one and are only able to be issued an SSN for a non-work purpose, do not need to provide it. Modified § 435.910(f) and (g) to clarify that such an individual would not need an SSN verified, but would need citizenship or immigration status verified, and that the general rule that a State should not delay or deny an otherwise eligible individual for Medicaid, also applies to such individuals.

• Added § 435.912 to specify timeliness standards for making eligibility determinations. The revised regulations at § 435.912 are published as an interim final regulation, and we welcome comments on them.

• In § 435.916, added a provision to generally allow but not require States to adopt renewal simplifications for applicants being determined using financial methods other than MAGI; codified at § 435.916(f) the agency must renew eligibility on the basis of available information for non-MAGI based renewals as well as MAGI-based renewals.

• Added provisions to § 435.916(a)(3)(iii) and § 435.916(f) to clarify that the agency must consider all bases of eligibility in accordance with § 435.911.

• Added language at § 435.916 (d)(1) to clarify that for Medicaid beneficiaries whose financial eligibility is based on MAGI methods when a State receives new information between regular renewals that relates to an eligibility factor, the State may request additional information from the individual only with respect to such factor to determine ongoing eligibility. However, if the State otherwise has access to information needed to recertify all other eligibility criteria, the State may begin a new 12-month renewal period for that individual.

• Clarified at § 435.916(e), that agencies may only ask for information necessary for renewal; also added a provision at § 435.907(e) to apply the limitations related to non-applicants to renewals.

• Added a new paragraph to § 435.945(j) that directs to describe, update, and submit, upon request, verification policies and procedures adopted by the State agency to implement the provisions set forth in § 435.940 through § 435.956.

• Moved the language in § 435.948(a) related to program integrity to § 435.940 and added language that a State must provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the Medicaid State plan. Redesignated the paragraphs in § 435.945 accordingly.

• Added paragraphs to § 435.952(c)(2) to clarify that paper documentation may

be requested by the State only to the extent electronic data are not available and establishing a data match would not be effective.

• Removed the word ''alone'' from § 435.956(c)(2) to clarify that States cannot rely on immigration status to determine lack of State residency. States may request additional information in accordance with § 435.952 to verify residency if evidence of immigration status gives the State reason to question an individual's residency.

• Removed the requirement in § 435.956(e) that States must accept self-attestation of household size. Moved verification of household size to § 435.956(f) along with age and date of birth, which may be verified in accordance with § 435.945(a), including the option to accept self-attestation, or through other reasonable verification procedures consistent with requirements in § 435.952.

• In § 435.1200(b), added that the agreement between the Medicaid agency and the Exchange must include a clear delineation of the responsibilities of each program to (i) minimize the burden on individuals; (ii) ensure compliance with the other requirements established in paragraphs (d) through (f) of this section, and if applicable paragraph (c); and (iii) ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under § 435.912.

• In § 435.1200, specified that if an agency accepts a determination of Medicaid eligibility by another insurance affordability program, the agency must comply with the provisions of § 435.911 to the same extent as if the individual had submitted an application directly to the Medicaid agency and comply with the provision of § 435.10 to ensure it maintains the oversight for the Medicaid program.

• In § 435.1200, added provisions to address cases where an agency makes the final determination of Medicaid eligibility for applications submitted to the Exchange or other insurance affordability programs.

• Modified all relevant CHIP provisions in subpart 457 to align with Medicaid policy changes and final provisions.

• Modified § 457.310 to specify that the scope and applicability of separate CHIP coverage for children who lose Medicaid due to the elimination of income disregards under MAGI.

• Added to § 457.315 to clarify that the MAGI grace period described in § 435.603(a)(3) applies to CHIP.

• At § 457.320, for CHIP, added a definition of residency for a targeted low-income pregnant woman enrolling in CHIP to mirror Medicaid residency definition for adults.

• Clarified at § 457.340 that enrollment assistance for CHIP should be provided at application and renewal. Clarified the SSN requirement with Medicaid regulation at § 435.910.

• At § 457.348, clarified that the State may accept final determinations of CHIP eligibility made by the Exchange and set standards regarding agreements with other insurance affordability programs, consistent with Medicaid.

• At § 457.350, streamlined language regarding screen and enroll standards to promote clarity and better coordination with Medicaid.

• At § 457.380, made changes to CHIP to align with the changes in Medicaid verification, including the standards for a State verification plan.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. However, this procedure can be waived if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

In light of the magnitude and scope of the Medicaid expansion and the changes in the eligibility determination system required by the Affordable Care Act, and the statutory implementation date of January 1, 2014, it is critical to provide final rules to guide States in making necessary program changes to prepare for implementation. States will need to make changes to their electronic and manual systems, will need to amend their Medicaid State plans, and may need to enact authorizing legislation on the State level. Because of the short time needed to make necessary changes, we find that it would be contrary to the public interest to delay issuance of comprehensive final rules.

In considering the public comments received in response to the Medicaid Eligibility proposed rule, however, we found that the commenters identified options and policies that we did not specifically address in the proposed rule, in the areas of eligibility determination, coordination with the Affordable Insurance Exchanges, and timeliness and performance standards. While the comments indicated that these options and policies were a logical outgrowth of the proposed rule, we are concerned that there could be a perception that we did not provide a full and fair opportunity for public input since the issues were not specifically addressed in the proposed rule. We have thus determined to provide an additional opportunity for public comment by issuing the affected provisions as an interim final rule with opportunity for comment within the context of the overall comprehensive rule. We are adopting this approach because we find that it would be contrary to the public interest to delay issuance of comprehensive final rules in order to issue a new proposed rule to address issues that we may not have specifically addressed in the proposed rule. We believe that the public interest is served by issuing a single consolidated rule instead of issuing a separate proposed rule, to enable readers to see the context and interrelationships in the overall regulatory framework. There will be no adverse effect from this approach because the new requirements will not be effective until January 1, 2014. And there will be a full and fair opportunity prior to the effective date for public comment and any necessary revisions to the interim final provisions. As this approach will provide an equivalent opportunity for public comment, we also believe that issuance of a separate proposed rule is unnecessary.

In sum, in light of the time constraints for States to implement system changes to implement the required Medicaid expansion, we have found that it would be contrary to the public interest to delay the issuance of comprehensive final rules, and to fragment the regulatory framework, to address potential concerns that certain policies or options were not specifically addressed in the Medicaid Eligibility proposed rule. We also have found that issuance of a new proposed rule would be unnecessary in light of the approach we have adopted, which will provide a full and fair opportunity for public comment, and any necessary revisions, prior to the effective date of new regulatory requirements. We are thus instead issuing certain provisions as an interim final rule, and are soliciting comments on the specific issues listed in the ''Comment Date'' section of this final rule.

Therefore, for the reasons stated above, we find good cause to waive the notice of proposed rulemaking and to issue a portion of this final rule as an interim final rule. Certain provisions of this final rule are being issued as

interim final, and we will consider comments that we receive by May 7, 2012.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 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.

In the Medicaid Eligibility proposed rule, we solicited public comments for 60 days on the information collection requirements (ICRs). No PRA-related comments were received. This final rule implements provisions of the Affordable Care Act that expand access to health coverage through improvements in Medicaid and CHIP; ensure coordination between Medicaid, CHIP, and the new Affordable Insurance Exchanges (which are included in a separate final rule under RIN 0938–AR25); and simplify the enrollment and renewal processes. Although there are short-term burdens associated with implementation of these provisions, over time the Medicaid program will be made substantially easier for States to administer and for individuals to navigate by streamlining Medicaid eligibility, simplifying Medicaid and CHIP eligibility rules for most individuals, and creating a coordinated process that results in a seamless enrollment experience across Medicaid, CHIP, and the new Affordable Insurance Exchanges.

Information collection requirements (ICRs) are outlined below that involve Medicaid and CHIP eligibility determinations and enrollment. We used data from the Bureau of Labor Statistics to derive average costs for all estimates of salary in establishing the information collection requirements. Salary estimates include the cost of fringe benefits, calculated at 35 percent of salary, which is based on the March 2011 Employer Costs for Employee Compensation report by the U.S. Bureau of Labor Statistics.

The following provisions of this final rule will have their PRA implications reviewed under CMS–10398, OMB 0938–1148:

Medicaid and CHIP State Plans: §§ 431.10(c) and (d); 431.11(d); 435.110(b); 435.116(b); 435.118(b); 435.119(b); 435.218(b); 435.403(h) and (i); 435.603(a); 435.908, 435.916, 457.305(a) and (b); 457.310(b); 457.315, 457.320(d); 457.340(f); 457.343; and 457.350.

We will also be addressing items related to the development and adoption of the single streamlined application as well as alternate applications and supplemental forms for the Exchanges, Medicaid and CHIP under a separate PRA package. Provisions of this final rule that will be addressed in that package include, § 435.907, § 435.910, § 457.330; § 457.340. Information collection requests for these sections are under development and there will be a separate opportunity for public notice and comment on these materials once they have been developed.

A. ICRs Regarding Disclosure of Program Information (§§ 435.1200(f) and 457.340(a))

Amendments to § 435.1200(f) for Medicaid and § 457.340(a) for CHIP require Medicaid and CHIP State agencies to disclose program information to the public electronically. These provisions are necessary to ensure that Medicaid and CHIP program information is available on the internet Web site where individuals and families can explore their coverage options and submit an application.

In a review of State Web sites, we found that all 50 States and the District of Columbia currently have Web sites for Medicaid and CHIP and that nearly every State already provides the information specified in this final rule. We also found that all States offer access to their health insurance applications online.

While these provisions are subject to the PRA, we believe that the requirement above is a usual and customary practice under 5 CFR 1320.3(b)(2) and, as such, the burden associated with it is exempt from the PRA. States have always been required to assure that applicants, providers, other interested parties, and the general public have access to information about Medicaid and CHIP eligibility requirements, available Medicaid services, and the rights and responsibilities of applicants and beneficiaries.

B. ICRs Regarding Verification and Verification Plans (§§ 435.945, 435.948, 435.949, 435.952, 435.956, and 457.380)

This final rule includes guidelines for the verification of certain financial and non-financial information to determine Medicaid and CHIP eligibility (for example, income, State residency, and SSNs). These amendments in §§ 435.945, 435.948, 435.949, 435.952, 435.956, and 457.380 are necessary to facilitate the determination of eligibility with minimal paper documentation required from individuals. States will need to analyze current verification procedures to determine the policy and systems modifications that will be needed in order for States to achieve this streamlined verification process.

In § 435.945(j) and § 457.380(j) the agency must develop, and update as modified, a verification plan that describes the verification policies and procedures adopted by the State agency to implement the provisions set forth in § 435.940–§ 435.956 for Medicaid and in § 457.380 for CHIP. The Secretary will prescribe the format and elements of the plan, and such plans must be submitted to the Secretary upon request. These amendments are necessary to facilitate the determination of eligibility with minimal documentation required from individuals.

We estimate 53 Medicaid agencies (the 50 States, District of Columbia, Northern Mariana Islands, and American Samoa) and an additional 43 CHIP agencies (States that have a separate or combination CHIP) will be subject to the provision above, for a total of 96 agencies.

We estimate that it will take each Medicaid and CHIP agency 20 hours to analyze current verification procedures, make policy and systems modifications, and develop, review, and submit the verification plan. For the purpose of the cost burden, we estimate it will take a health policy analyst 17 hours at $43 an hour, and a senior manager 3 hours at $77 an hour, to complete the verification plan. The estimated cost for each agency is $962 ([17 × 43] + [3 × $77]). The total estimated cost is $92,352 (96 × $962). Taking into account the Federal contribution, the total estimated State costs would be $46,176 ($92,352 × 50 percent).

C. ICRs Regarding Periodic Renewal of Medicaid and CHIP Eligibility (§§ 435.916, 457.343 and 457.350)

The final rule sets out the renewal process for individuals whose eligibility is based on MAGI. These provisions are

necessary to facilitate the accurate and efficient renewal of Medicaid and CHIP eligibility.

We estimate 53 Medicaid agencies (the 50 States, District of Columbia, Northern Mariana Islands, and American Samoa) and an additional 43 CHIP agencies (States that have a separate or combination CHIP) will be subject to the provision above, for a total of 96 agencies.

The burden associated with this provision is the time and effort necessary for the State to develop and automate renewal notices and perform the revised recordkeeping related to renewing eligibility. Individuals whose eligibility is based on MAGI would need to provide any additional information for the State to complete a redetermination of eligibility.

Research has indicated that 33–50 percent of people experience a change in circumstance that may impact their eligibility for coverage (Sommers and Rosenbaum, *Health Affairs* 2011). Based on this research we conservatively estimate that of the approximately 51 million individuals enrolled in Medicaid and CHIP whose eligibility will be based on MAGI, half (25.5 million individuals) will have their eligibility renewed using the information already available to the agency.

We estimate that it will take each Medicaid and CHIP agency 16 hours annually to develop, automate and distribute the notice of eligibility determination based on use of existing information. For the purpose of the cost, we estimate it will take a health policy analyst 10 hours, at $43 an hour, and a senior manager 6 hours, at $77 an hour, to complete the notice. The estimated cost for each agency is $892 [(10 × $43) + (6 × $77)]. The total estimated cost burden is $85,632 [96 × $892], and the total annual hour burden is 1,536 hours [(10 + 6) × 96]. Taking into account the Federal contribution, the total estimated State costs would be $42,816 [$85,632 × 50 percent].

The remaining half of the individuals (25.5 million) will need to provide additional information to the State so that their eligibility can be renewed. We estimate that it will take an individual 20 minutes to complete the streamlined renewal process. The total annual hour burden is 8.5 million hours [(20 minutes × 25.5 million individuals)/60 minutes] for 25.5 million individuals. Note that this is shorter than the time taken to complete the renewal process in most States today.

States will keep records of each renewal that is processed in Medicaid and CHIP. The amount of time for recordkeeping will be the same for renewals based on information available to the agency and renewals that require additional information from individuals. In addition, States will have to program and distribute the pre-populated renewal form every year at renewal time. We estimate that it will take the State agency 15 minutes (0.25 hours) at a rate of $25 per hour for the average State eligibility worker to conduct the required record keeping for each of the 51 million renewals. The total estimated annual hour burden is 12,750,000 hours or 132,812.5 hours per agency [12,750,000/96]. At a rate of $25 per hour the total estimated cost for recordkeeping is $318,750,000 [12,750,000 × $25] or $3,320,312.5 per agency [$318,750,000/96]. Taking into account the Federal contribution, the total estimated State share of the costs would be $159,375,000 [$318,750,000 × 50 percent].

D. ICRs Regarding Web Sites (§ 435.1200 and § 457.335)

Sections 435.1200 and 457.335 require Medicaid and separate CHIP agencies to have a Web site that performs the functions described in this rule.

We estimate that 53 Medicaid agencies and an additional 43 CHIP agencies (in States that have a separate or combination CHIP) would be subject to the provisions above. To achieve efficiency, we assume that States will develop only one Web site to perform the required functions. Therefore, we base our estimates on 50 States, the District of Columbia, the Northern Mariana Islands, and American Samoa (53 agencies) and do not include the 43 separate CHIP programs.

The burden associated with this ICR for information disclosure is the time and effort necessary for the State to develop and disclose information on the Web site, develop and automate the required notices, and transmit (report) the application data to the appropriate insurance affordability program.

We know that all States have Web sites and printable applications online and that 19 States have some ability to enable individuals to renew their coverage online. We estimate that it will take each State an average of 320 hours to develop the additional functionality to meet these requirements, including developing an online application, automating the renewal process and adding a health plan selection function. We estimate that it will take a health policy analyst 85 hours (at $43 an hour), a senior manager 50 hours (at $77 an hour), and various network/computer administrators or programmers 185 hours (at $54 an hour) to meet the reporting requirements under this subpart. We estimate the total cost for a State to be $17,495 [(85 × $43) + (50 × $77) + (185 × $54)] for a total estimated burden of $927,235 [53 × $17,495] and a total annual hour burden of 16,960 hours for all 53 entities [(85 + 50 + 185) × 53]. Taking into account the Federal contribution to Medicaid and CHIP systems development and administration efforts, we estimate that the total State share of costs would be $463,618 [$927,235 × 50 percent] at most. We estimate that it will take each State entity 16 hours annually to develop and automate each of the two required notices (32 total hours). For the purpose of the cost, we estimate it will take a health policy analyst 10 hours, at $43 an hour, and a senior manager 6 hours, at $77 an hour, to complete each notice. The estimated cost of two notices for each agency is $1,784 [$892 × 2]. The total estimated cost is $94,552 [$1,784 × 53], and the total annual hour burden is 1,696 hours [16 × 2 × 53] for the notices.

We estimate that it will take network/computer administrators or programmers 150 hours (at $54 an hour) to transmit the application data of ineligible individuals to the appropriate insurance affordability program and meet this information reporting requirement for each State (53). The estimated cost for each agency is $8,100 [150 × $54]. The total estimated cost for 53 States is $429,300 [53 × $8,100], and the total annual hour burden is 7,950 hours [150 × 53]. Taking into account the Federal contribution, the estimated total State share of costs would be $214,650 [$429,300 × 50 percent].

The total estimated cost of the provisions described above is $1,451,087 [$927,235 + $94,552 + $429,300], and the total annual hour burden is 26,606 hours [16,960 + 1,696 + 7,950].

TABLE 1—ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section(s)	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Labor cost of reporting ($)	Total cost ($)	State share of costs ($)
Medicaid and CHIP State Plan provisions regarding §§ 431.10(c) and (d); 431.11(d); 435.110(b); 435.116(b); 435.118(b); 435.119(b); 435.218(b); 435.403(h) and (i); 435.603(a); 435.908; 435.916; 457.305(a) and (b); 457.310(b); 457.315; 457.320(d); 457.340(f); 457.343; and 457.350 are under development and will be submitted to OMB for review/approval under control number 0938–1148 (CMS–10398).							
§§ 435.907, 457.330, and 457.340(b).	These information collections are currently under development. A separate notice and comment process for information collections required under these sections will be conducted at a later date.						
§§ 435.945, 435.948, 435.956, 457.350, and 457.380.	96	1	20	1,060	962	92,352	46,176
§§ 435.916 and 457.343	96	1	16	1,536	892	85,632	46,816
§§ 435.916 and 457.343	25.5 million	1	.33	8.5 million			
§§ 435.916 and 457.343	96	51 million	.25	12,750,000	3,320,313	318,750,000	159,375,000
§§ 435.1200 and 457.335	53	1	502	26,606	27,379	1,451,087	725,543
Total						320,379,071	160,193,535

Notes: All collections are new therefore the OMB Control Number is omitted from the table.
There are no capital or maintenance costs incurred by the collections, therefore it is omitted from the table. Capital costs resulting from the development or improvement of new electronic systems were addressed in the Federal Funding for Medicaid Eligibility Determination and Enrollment Activities final rule (76 FR 21950).
Labor Cost figures are indicated here on a per Respondent basis.
The 1.4 average responses per agency (that is, Respondent) are based on the total estimated number of agreements divided by the number of respondents. The number of actual agreements will vary by State based on the governance structure of the State's Medicaid, CHIP, and Exchange programs.

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

To obtain copies of the supporting statement and any related forms for the paperwork collections referenced above, access CMS' Web site at *http://www.cms.hhs.gov/Paperwork@cms.hhs.gov,* or call the Reports Clearance Office at 410–786–1326.

VII. Summary of Regulatory Impact Analysis

The summary analysis of benefits and costs included in this final rule is drawn from the detailed Regulatory Impact Analysis (RIA), available at *www.Medicaid.gov/AffordableCareAct/downloads/CMS-2349-F-RegulatoryImpactAnalysis.pdf.*

A. Summary of Comments and Changes

We received no comments on the anticipated effects of the Medicaid Eligibility proposed rule. Overall, the major provisions included in the Medicaid Eligibility proposed rule are maintained in the final rule. The only significant change in this impact statement reflects the enactment of Public Law 112–56, signed into law on November 21, 2011, changing the MAGI definition of income to include all Social Security benefits. Previously, nontaxable Social Security benefits were not included when calculating MAGI for Medicaid eligibility. In addition, this RIA utilizes revised estimates from the CMS Office of the Actuary (OACT). These estimates have been updated with the most recent economic and health care expenditure and enrollment data and projected trends and with further refinements to the methodology.

B. Introduction

The Office of Management and Budget has determined that this rule is ''economically significant'' for the purposes of Executive Order 12866. Therefore, we have prepared an RIA that presents the costs and benefits of this rulemaking.

C. Need for This Regulation

This final rule will implement provisions of the Affordable Care Act related to Medicaid eligibility, enrollment and coordination with the Exchanges, CHIP, and other insurance affordability programs. It also addresses the current complexity of and barriers to enrollment in Medicaid and CHIP which contributes to millions of eligible low-income Americans remaining uninsured.

D. Summary of Costs and Benefits

The RIA uses the estimates of OACT and the estimates prepared by the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation. It provides both estimates to illustrate the uncertainty inherent in projections of future Medicaid financial operations. Analysis by OACT indicates that the final rule will result in an estimated additional 24 million newly eligible and currently eligible individuals enrolling in Medicaid by 2016, including approximately 2–3 million individuals with primary health insurance coverage through employer-sponsored plans who would enroll in Medicaid for supplemental coverage.[1] This is the same estimate as was in the regulatory impact analysis of the Medicaid Eligibility proposed rule (August 2011). OACT notes that such estimates are uncertain, since they depend on future economic, demographic, and other factors that cannot be precisely determined in advance. Similarly, the actual behavior of individuals and the actual operation of the new enrollment processes and Exchanges will affect enrollment and costs. The CBO has estimated a net increase of 16 million newly and previously eligible people enrolled in Medicaid and CHIP in 2016 as a result of the new law, less 500,000 to 1 million due to the change in the definition of

[1] OACT's original estimates for the financial impact of the expansion of Medicaid eligibility under the Affordable Care Act are documented in an April 22, 2010 memorandum, ''Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended,'' available at *https://www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf.*

MAGI to include Social Security income.[2]

Overall, we do not expect that the conversion to MAGI rules will result in many currently eligible individuals losing eligibility. However, there may be a relatively small number of currently eligible individuals who would no longer be eligible based on the MAGI methodology. For these individuals, there will be a cost of obtaining coverage through Exchanges, but this cost could be mitigated by premium tax credits and cost-sharing reductions. At the same time, the use of the MAGI definition of income may have the effect of increasing Medicaid eligibility for a small number of individuals and families who would not have been previously eligible. We anticipate no substantial net gain or loss in enrollment due to conversion to MAGI rules.

For new enrollees, eligibility for Medicaid will improve access to medical care, resulting in improved health outcomes and greater financial security. Research demonstrates that when uninsured individuals obtain coverage (including Medicaid), the rate at which they obtain needed care increases substantially.[3] [4] [5] Individuals with insurance coverage are more likely to have regular checkups, recommended health screenings, and a usual source of care to help manage their health.[6] In addition, people with health insurance coverage have less out of pocket costs and are less likely to have unpaid medical bills.[7]

OACT estimates that Federal spending on Medicaid for newly and currently eligible individuals who enroll as a result of the changes made by the Affordable Care Act would increase by a total of $164 billion from FY 2012 through 2016.[8] Reflecting different data, assumptions, and methodology, CBO estimates an increase in Federal spending of $162 billion over the same period of time, less $7.9 billion resulting from the November 2011 legislative changes to the definition of MAGI.[9] [10] OACT estimates that State expenditures for individuals, who choose to enroll as a result of changes implemented by the Affordable Care Act, will total approximately $14 billion for FYs 2012 through 2016.[11] (While the increased FMAP for expansion States is not included in this final rule, it is estimated that $9.1 billion will be transferred from the Federal government to the relevant States between FY 2012 and 2016, reducing the net impact of the Medicaid coverage provisions on those States.[12]) These estimates do not consider offsetting savings to States that will result, to a varying degree depending on the State, from this final rule.

This final rule will benefit States and providers by improving the health of their residents and patients, reducing uncompensated care costs, and allowing States to receive FFP on spending for health coverage that currently is paid for with State and local funds. In addition, the simplified Medicaid eligibility policies will, over time, reduce administrative burdens on State Medicaid agencies. An Urban Institute analysis estimates that the costs to States from Medicaid expansion will be more than fully offset by other effects of the legislation, for net savings to States of $92 to $129 billion from 2014 to 2019.[13]

E. Methods of Analysis

OACT prepared its estimate using data on individuals and families, together with their income levels and insured status, from the Current Population Survey and the Medical Expenditure Panel Survey. In addition, OACT made assumptions as to the actions of individuals in response to the new coverage options under the Affordable Care Act and the operations of the new enrollment processes and the Exchanges. The estimated Medicaid coverage and financial effects are particularly sensitive to these latter assumptions. Among those newly-eligible for Medicaid under the expanded eligibility criteria established by the Affordable Care Act, and who would not otherwise have health insurance, OACT assumed that 95 percent would enroll. This assumption, which is significantly higher than current enrollment percentages, reflects OACT's consideration of the experience with health insurance reform in Massachusetts and its expectation that the streamlined enrollment process and enrollment assistance available to people through the Affordable Insurance Exchanges will be very effective in helping eligible individuals and families become enrolled. Researchers have approximated the participation rate assumed by CBO at a much lower level.[14]

F. Regulatory Options Considered

Alternative approaches to implementing the Medicaid eligibility, enrollment and coordination requirements in the Affordable Care Act were considered in developing this final rule. Because the majority of provisions in this rule are statutorily required, we did not have significant flexibility to choose alternative policies. However, based on comments, we did revise the policy regarding the relationship between Medicaid and the Exchange

[2] CBO. Analysis of Major Health Care Legislation Enacted in March 2010. Statement of Douglas W. Elmendorf. March 30, 2011—*http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf* The CBO estimates exclude individuals with primary coverage through employer-sponsored plans who enroll in Medicaid for supplemental coverage. See also CBO Cost Estimate. H.R. 2576: A bill to amend the Internal Revenue Code of 1986 to modify the calculation of modified adjusted gross income for purposes of determining eligibility for certain healthcare-related programs. October 14, 2011. *http://cbo.gov/ftpdocs/124xx/doc12484/hr2576.pdf.*

[4] SK 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.

[5] C. Keane, *et al.,* ''The impact of Children's Health Insurance Program by age,'' Pediatrics 104:5 (1999).

[6] Institute of Medicine, *Care without coverage: too little, too late* (National Academies Press, 2002).

[7] Amy Finkelstein, et al, ''The Oregon Health Insurance Experiment: Evidence from the First Year,'' National Bureau of Economic Research Working Paper No. 17190, July 2011.

[8] FY 2013 President's Budget.

[9] CBO. Analysis of the Major Health Care Legislation Enacted in March 2010. Statement of Douglas W. Elmendorf. March 30, 2011—*http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.*

[10] CBO Cost Estimate. H.R. 2576: A bill to amend the Internal Revenue Code to modify the calculation of modified adjusted gross income for purposes of determining eligibility for certain healthcare-related programs. October 14, 2011. *http://cbo.gov/ftpdocs/124xx/doc12484/hr2576.pdf.*

[11] CBO did not publish the impact on States by year, so estimates for a comparable period are not available.

[12] FY 2013 President's Budget. We note that these estimates are dependent upon which States are ultimately determined to be expansion States under the Affordable Care Act.

[13] M. Buettgens et al., ''Consider savings as well as costs: State governments would spend at least $90 billion less with the Affordable Care Act than without it from 2014 to 2019,'' The Urban Institute, July 2011. Available at *www.urban.org/uploadedpdf/412361-consider-savings.pdf.*

[14] CBO's specific take-up assumptions are not available. Researchers at the Urban Institute have approximated the participation rate assumed by CBO. The Kaiser Family Foundation has characterized this assumption as follows: ''These results assume moderate levels of participation similar to current experience among those made newly eligible for coverage and little additional participation among those currently eligible. This scenario assumes 57 percent participation among the newly eligible uninsured and lower participation across other coverage groups.'' J. Holahan and I. Headen, ''Medicaid coverage and spending in health reform: National and State-by-State results for adults at or below 133 percent FPL,'' Kaiser Commission on Medicaid and the Uninsured, May 2010, available online at *http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.*

give States additional flexibility for eligibility determinations based on MAGI.

G. Accounting Statement

For full documentation and discussion of these estimated costs and benefits, see the detailed RIA, available at *www.Medicaid.gov/AffordableCareAct/downloads/CMS-2349-F-RegulatoryImpactAnalysis.pdf.*

TABLE 2—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED NET COSTS, FROM FY 2012 TO FY 2016

(In millions)

Category	Transfers			
	Year dollar	Units discount rate		Period covered
	2012	7%	3%	
Annualized Monetized Transfers from Federal Government to States on Behalf of Beneficiaries.	Primary Estimate	$30,211	$31,705	FYs 2012–2016.
Annualized Monetized Transfers from States on Behalf of Beneficiaries.	Primary Estimate	$2,568	$2,694	FYs 2012–2016.

Source: CMS Office of the Actuary.

H. Unfunded Mandates Reform Act

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. In 2011, that threshold is approximately $136 million. However, it is important to understand that the UMRA does not address the total cost of a rule. Rather, it focuses on certain categories of cost, mainly costs resulting from (A) imposing enforceable duties on State, local, or Tribal governments, or on the private sector, or (B) increasing the stringency of conditions in, or decreasing the funding of, State, local, or Tribal governments under entitlement programs.

We believe that States can take actions that will largely offset the increased medical assistance spending for newly enrolled persons. Because the net effects are uncertain and the overall costs significant, we have drafted the RIA to meet the requirements for analysis imposed by UMRA, together with the rest of the preamble. The extensive consultation with States we describe later in this analysis was aimed at the requirements of both UMRA and Executive Order 13132 on Federalism.

1. State and Local Governments

Our discussion of the potential expected impact on States is provided in the benefits, costs, and transfers section of the RIA. As noted previously, the Affordable Care Act requires States that participate in the Medicaid program to cover adults with incomes below 133 percent of the Federal poverty level, and provides substantial new Federal support to nearly offset the costs of covering that population.

2. Private Sector and Tribal Governments

We do not believe this final rule will impose any unfunded mandates on the private sector. As we explain in more detail in the Regulatory Flexibility Act analysis, the provisions of the Affordable Care Act implemented by the final rule deal with eligibility and enrollment for the Medicaid and CHIP programs, and as such are directed toward State governments rather than toward the private sector. Since the final rule will impose no mandates on the private sector, we conclude that the cost of any possible unfunded mandates would not meet the threshold amounts discussed previously that would otherwise require an unfunded mandate analysis for the private sector. We also conclude that an unfunded mandate analysis is not needed for Tribal governments since the final rules will not impose mandates on Tribal governments.

I. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a final rule will have a significant economic impact on a substantial number of small entities. Few of the entities that meet the definition of a small entity as that term is used in the RFA (for example, small businesses, nonprofit organization, and small governmental jurisdictions with a population of less than 50,000) will be impacted directly by this final rule. Individuals and States are not included in the definition of a small entity. There are some States in which counties or cities share in the costs of Medicaid. OACT has estimated that between FY 2012 and FY 2016 the Federal government will pay about 92 percent of the costs of benefits for new Medicaid enrollees with the States paying the remaining 8 percent. An Urban Institute and Kaiser Family Foundation study estimated that the Federal government will bear between 92 and 95 percent of the overall costs of the new coverage provided as a result of the Affordable Care Act, with the States shouldering the remaining five to eight percent of the costs.[15] To the extent that States require counties to share in these costs, some small jurisdictions could be affected by the requirements of this final rule. However, nothing in this rule will constrain States from making changes to alleviate any adverse effects on small jurisdictions.

Because this final rule is focused on eligibility and enrollment in public programs, it does not contain provisions that would have a significant direct impact on hospitals, and other health care providers that are designated as small entities under the RFA. However, the provisions in this final rule may have a substantial, positive indirect effect on hospitals and other health care providers due to the substantial increase in the prevalence of health coverage among populations who are currently unable to pay for needed health care, leading to lower rates of uncompensated care at hospitals.

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. For

[15] J. Holahan and I. Headen, ''Medicaid coverage and spending in health reform: National and State-by-State results for adults at or below 133 percent FPL,'' Kaiser Commission on Medicaid and the Uninsured, May 2010, available online at *http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.*

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. As indicated in the preceding discussion, there may be indirect positive effects from reductions in uncompensated care.

J. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct effects on States, preempts State law, or otherwise has Federalism implications. As discussed previously, the Affordable Care Act and this final rule have significant direct effects on States.

The Affordable Care Act requires major changes in the Medicaid and CHIP programs, which will require changes in the way States operate their individual programs. While these changes are intended to benefit beneficiaries and enrollees by improving coordination between programs, they are also designed to reduce the administrative burden on States by simplifying and streamlining systems.

We have received input from States on how the various Affordable Care Act provisions codified in this final rule will affect them. We have participated in a number of conference calls and in person meetings with State officials in the months before and since the law was enacted. These discussions have enabled the States to share their thinking and questions about how the Medicaid changes in the legislation would be implemented. The conference calls and meetings also furnished opportunities for State Medicaid Directors to comment informally on implementation issues and plans (although to be considered comments on the Medicaid Eligibility proposed rule, written comments using the process described in the Medicaid Eligibility proposed rule were required).

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. In particular, we have had discussions with the Eligibility TAG (E–TAG) and the Children's Coverage TAG. The E–TAG is a group of State Medicaid officials with specific expertise in the field of eligibility policy under the Medicaid program. The Children's Coverage TAG is a combination of Medicaid and CHIP officials that convene to discuss issues that affect children enrolled in those programs. Through meetings with these TAGs, we have been able to get input from States specific to issues surrounding the changes in eligibility groups and rules that will become effective in 2014.

List of Subjects

42 CFR Part 431

Grant programs—health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs—health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 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 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

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

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

■ 2. Section 431.10 is amended by—
■ A. Adding paragraphs (c)(3), (c)(4), and (c)(5).
■ B. Revising paragraphs (d) and (e)(3).

The revisions and additions read as follows:

§ 431.10 Single State agency.

* * * * *

(c) * * *

(3) The plan must specify whether the entity that determines eligibility is an Exchange established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act (Pub. L. 111–148), provided that if the Exchange is operated as a nongovernmental entity as permitted under 45 CFR 155.110(c), or contracts with a private entity for eligibility services, as permitted under 1311(f)(3) of the Affordable Care Act and 45 CFR 155.110(a), final determinations of eligibility are limited to determinations using MAGI-based methods as set forth in § 435.603 of this subchapter.

(4) The single State agency is responsible for ensuring eligibility determinations are made consistent with its policies, and if there is a pattern of incorrect, inconsistent, or delayed determinations for ensuring that corrective actions are promptly instituted.

(5) The single State agency is responsible for ensuring that eligibility determinations are made in the best interest of applicants and beneficiaries, and specifically ensuring that:

(i) There is no conflict of interest by any entity delegated the responsibility to make eligibility determinations or performing eligibility services; and

(ii) Improper incentives and/or outcomes are prohibited, monitored, and if found, properly and promptly addressed through corrective actions.

(d) *Agreement with Federal or State and local entities.* The plan must provide for agreements between the Medicaid agency and the Federal or other State or local agencies or nongovernmental entities that determine Medicaid eligibility on behalf of the Medicaid agency. Such agreements, which shall be in writing and available upon request, must include provisions for:

(1) The relationships and respective responsibilities of the parties;

(2) The quality control and oversight plans by the single State agency to review determinations made by the delegee or its contractor to ensure that overall determinations are made consistent with the State agencies' eligibility policies;

(3) The reporting requirements from the delegee making Medicaid eligibility determinations to the single State agency to permit such oversight;

(4) An assurance that the delegee and its contractors will comply with the confidentiality and security requirements in accordance with sections 1902(a)(7) and 1942 of the Act and subpart F of this part for all applicant and beneficiary data;

(5) An assurance that merit system personnel protection principles are employed by the entity responsible for the Medicaid eligibility determination and for any contractor performing eligibility services; and

(6) An assurance that applicants and beneficiaries are made aware of how they can directly contact and obtain information from the single State agency.

(e) * * *

(3) If other Federal, State, local agencies or offices or non-governmental entities (including their contractors) perform services for the Medicaid agency, they must not have the

authority to change or disapprove any administrative decision of, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations issued by the Medicaid agency.

■ 3. Section 431.11 is amended by revising paragraph (d) to read as follows:

§ 431.11 Organization for administration.

* * * * *

(d) *Eligibility determined by other entities.* If eligibility is determined by Federal or State agencies other than the Medicaid agency or by local agencies under the supervision of other State agencies, or by nongovernmental entities, or if eligibility functions are performed by an Exchange contractor, the plan must include a description of the staff designated by those other entities and the functions they perform in carrying out their responsibilities.

■ 4. Section 431.300 is amended by:

■ A. Redesignating paragraph (b) as paragraph (c).

■ B. Adding a new paragraph (b).

■ C. Revising newly designated paragraphs (c) introductory text and (c)(1).

■ D. Adding a new paragraph (d).

The revisions and additions read as follows:

§ 431.300 Basis and purpose.

* * * * *

(b) For purposes of this subpart, information concerning an applicant or beneficiary includes information on a non-applicant, as defined in § 435.4 of this subchapter.

(c) Section 1137 of the Act, which requires agencies to exchange information to verify the income and eligibility of applicants and beneficiaries (see § 435.940 through § 435.965 of this subchapter), requires State agencies to have adequate safeguards to assure that—

(1) Information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information, and information received under section 6103(l)(7) of the Internal Revenue Code is exchanged only with agencies authorized to receive that information under that section of the Code; and

* * * * *

(d) Section 1943 of the Act and section 1413 of the Affordable Care Act.

■ 5. Section 431.305 is amended by—

■ A. Revising paragraph (b)(6).

■ B. Adding paragraph (b)(8).

The revisions and addition read as follows:

§ 431.305 Types of information to be safeguarded.

* * * * *

(b) * * *

(6) Any information received for verifying income eligibility and amount of medical assistance payments (see § 435.940 through § 435.965 of this subchapter). Income information received from SSA or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data, including section 6103 of the Internal Revenue Code, as applicable.

* * * * *

(8) Social Security Numbers.

■ 6. Section 431.306 is amended by revising paragraph (g) to read as follows:

§ 431.306 Release of information.

* * * * *

(g) Before requesting information from, or releasing information to, other agencies to verify income, eligibility and the amount of assistance under § 435.940 through § 435.965 of this subchapter, the agency must execute data exchange agreements with those agencies, as specified in § 435.945(i) of this subchapter.

* * * * *

§ 431.636 [Removed]

■ 7. Remove § 431.636.

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

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

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 9a. Remove the term ''family income'' wherever it appears in part 435 and add in its place the term ''household income''.

■ 9b. Section 435.4 is amended by—

■ A. Adding the definitions of ''Advance payments of the premium tax credit (APTC),'' ''Affordable Care Act,'' ''Affordable Insurance Exchanges (Exchanges),'' ''Agency,'' ''Applicable modified adjusted gross income (MAGI) standard,'' ''Applicant,'' ''Application,'' ''Beneficiary,'' ''Caretaker relative,'' ''Dependent child,'' ''Effective income level,'' ''Electronic account,'' ''Eligibility determination,'' ''Family size,'' ''Federal poverty level (FPL),'' ''Household income,'' ''Insurance affordability program,'' ''MAGI-based income,'' ''Minimum essential coverage,'' ''Modified adjusted gross income (MAGI),'' ''Non-applicant,'' ''Pregnant woman,'' ''Secure electronic interface,'' ''Shared eligibility service,'' and ''Tax dependent'' in alphabetical order.

■ B. Removing the definition of ''Families and children.''

The additions read as follows:

§ 435.4 Definitions and use of terms.

* * * * *

Advance payments of the premium tax credit (APTC) has the meaning given the term in 45 CFR 155.20.

* * * * *

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112–56).

Affordable Insurance Exchanges (Exchanges) has the meaning given the term ''Exchanges'' in 45 CFR 155.20.

Agency means a single State agency designated or established by a State in accordance with § 431.10(b) of this subchapter.

Applicable modified adjusted gross income (MAGI) standard has the meaning provided in § 435.911(b)(1) of this part.

Applicant means an individual who is seeking an eligibility determination for himself or herself through an application submission or a transfer from another agency or insurance affordability program.

Application means the single streamlined application described at § 435.907(b) of this part or an application described in § 435.907(c)(2) of this part submitted by or on behalf of an individual.

* * * * *

Beneficiary means an individual who has been determined eligible and is currently receiving Medicaid.

Caretaker relative means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes), and who is one of the following—

(1) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

(2) The spouse of such parent or relative, even after the marriage is terminated by death or divorce.

(3) At State option, another relative of the child based on blood (including those of half-blood), adoption, or marriage; the domestic partner of the

parent or other caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

* * * * *

Dependent child means a child who meets both of the following criteria:

(1) Is under the age of 18, or, at State option, is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

(2) Is deprived of parental support by reason of the death, absence from the home, physical or mental incapacity, or unemployment of at least one parent, unless the State has elected in its State plan to eliminate such deprivation requirement. A parent is considered to be unemployed if he or she is working less than 100 hours per month, or such higher number of hours as the State may elect in its State plan.

Effective income level means the income standard applicable under the State plan for an eligibility group, after taking into consideration any disregard of a block of income applied in determining financial eligibility for such group.

Electronic account means an electronic file that includes all information collected and generated by the State regarding each individual's Medicaid eligibility and enrollment, including all documentation required under § 435.914 of this part.

Eligibility determination means an approval or denial of eligibility in accordance with § 435.911 as well as a renewal or termination of eligibility in accordance with § 435.916 of this part.

Family size has the meaning provided in § 435.603(b) of this part.

Federal poverty level (FPL) means the Federal poverty level updated periodically in the **Federal Register** by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as in effect for the applicable budget period used to determine an individual's eligibility in accordance with § 435.603(h) of this part.

Household income has the meaning provided in § 435.603(d) of this part.

Insurance affordability program means a program that is one of the following:

(1) A State Medicaid program under title XIX of the Act.

(2) A State children's health insurance program (CHIP) under title XXI of the Act.

(3) A State basic health program established under section 1331 of the Affordable Care Act.

(4) A program that makes coverage in a qualified health plan through the Exchange with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.

(5) A program that makes available coverage in a qualified health plan through the Exchange with cost-sharing reductions established under section 1402 of the Affordable Care Act.

MAGI-based income has the meaning provided in § 435.603(e) of this part.

* * * * *

Minimum essential coverage means coverage defined in section 5000A(f) of subtitle D of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act, and implementing regulations of such section issued by the Secretary of the Treasury.

Modified adjusted gross income (MAGI) has the meaning provided at 26 CFR 1.36B–1(e)(2).

Non-applicant means an individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or beneficiary's household to determine eligibility for such applicant or beneficiary.

* * * * *

Pregnant woman means a woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 60 days, and then ends on the last day of the month in which the 60-day period ends.

Secure electronic interface means an interface which allows for the exchange of data between Medicaid and other insurance affordability programs and adheres to the requirements in part 433, subpart C of this chapter.

Shared eligibility service means a common or shared eligibility system or service used by a State to determine individuals' eligibility for insurance affordability programs.

* * * * *

Tax dependent has the same meaning as the term ''dependent'' under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.

Subpart B—Mandatory Coverage

■ 10. The heading for subpart B is revised as set forth above.

■ 11. Section 435.110 is revised to read as follows:

§ 435.110 Parents and other caretaker relatives.

(a) *Basis.* This section implements sections 1931(b) and (d) of the Act.

(b) *Scope.* The agency must provide Medicaid to parents and other caretaker relatives, as 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 the State plan, in accordance with paragraph (c) of this section.

(c) *Income standard.* The agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size.

(2) The maximum income standard is the higher of—

(i) The effective income level in effect for section 1931 low-income families under the Medicaid State plan or waiver of the State plan 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; or

(ii) A State's AFDC income standard in effect as of July 16, 1996 for the applicable family size, increased by no more than the percentage increase in the Consumer Price Index for all urban consumers between July 16, 1996 and the effective date of such increase.

■ 12. Revise the undesignated center heading that is immediately before § 435.116 to read as follows:

Mandatory Coverage of Pregnant Women, Children Under 19, and Newborn Children

■ 13. Section 435.116 is revised to read as follows:

§ 435.116 Pregnant women.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Act.

(b) *Scope.* The agency must provide Medicaid to pregnant women 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 agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is the higher of:

(i) 133 percent FPL for the applicable family size; or

(ii) Such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989

for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so.

(2) The maximum income standard is the higher of—

(i) The highest effective income level in effect under the Medicaid State plan for coverage under the sections specified at paragraph (a) of this section, or waiver of the State plan covering pregnant women, 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; or

(ii) 185 percent FPL.

(d) *Covered services.* (1) Pregnant women are covered under this section for the full Medicaid coverage described in paragraph (d)(2) of this section, except that the agency may provide only pregnancy-related services described in paragraph (d)(3) of this section for pregnant women whose income exceeds the applicable income limit established by the agency in its State plan, in accordance with paragraph (d)(4) of this section.

(2) Full Medicaid coverage consists of all services which the State is required to cover under § 440.210(a)(1) of this subchapter and all services which it has opted to cover under § 440.225 and § 440.250(p) of this subchapter.

(3) Pregnancy-related services consists of services covered under the State plan consistent with § 440.210(a)(2) and § 440.250(p) of this subchapter.

(4) *Applicable income limit for full Medicaid coverage of pregnant women.* For purposes of paragraph (d)(1) of this section—

(i) The minimum applicable income limit is the State's AFDC income standard in effect as of May 1, 1988 for the applicable family size.

(ii) The maximum applicable income limit is the highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) of the Act or under section 1931(b) and (d) of the Act in effect under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard.

■ 14. Section 435.118 is added to read as follows:

§ 435.118 Infants and children under age 19.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Act.

(b) *Scope.* The agency must provide Medicaid to children under age 19 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.* (1) The minimum income standard is the higher of—

(i) 133 percent FPL for the applicable family size; or

(ii) For infants under age 1, such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for infants, or, as of July 1, 1989 had authorizing legislation to do so.

(2) The maximum income standard for each of the age groups of infants under age 1, children age 1 through age 5, and children age 6 through age 18 is the higher of—

(i) 133 percent FPL;

(ii) The highest effective income level for each age group in effect under the Medicaid State plan for coverage under the applicable sections of the Act listed at paragraph (a) of this section or waiver of the State plan covering such age group 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; or

(iii) For infants under age 1, 185 percent FPL.

■ 15. Revise the undesignated center heading that is before § 435.119 to read as follows:

Mandatory Coverage for Individuals Age 19 Through 64

■ 16. Section 435.119 is revised to read as follows:

§ 435.119 Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

(a) *Basis.* This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.

(b) *Eligibility.* The agency must provide Medicaid to individuals who:

(1) Are age 19 or older and under age 65;

(2) Are not pregnant;

(3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;

(4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and

(5) Have household income that is at or below 133 percent FPL for the applicable family size.

(c) *Coverage for dependent children.* (1) A State may not provide Medicaid under this section to a parent or other caretaker relative living with a dependent child if the child is under the age specified in paragraph (c)(2) of this section, unless such child is receiving benefits under Medicaid, the Children's Health Insurance Program under subchapter D of this chapter, or otherwise is enrolled in minimum essential coverage as defined in § 435.4 of this part.

(2) For the purpose of paragraph (c)(1) of this section, the age specified is under age 19, unless the State had elected as of March 23, 2010 to provide Medicaid to individuals under age 20 or 21 under § 435.222 of this part, in which case the age specified is such higher age.

Subpart C—Options for Coverage

■ 17. The heading for subpart C is revised to read as set forth above.

■ 18. Section 435.218 is added to read as follows:

§ 435.218 Individuals with MAGI-based income above 133 percent FPL.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(XX) of the Act.

(b) *Eligibility*—(1) *Criteria.* The agency may provide Medicaid to individuals who:

(i) Are under age 65;

(ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and

(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.

(2) *Limitations.* (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

(3) *Phase-in plan.* A State may phase in coverage to all individuals described in paragraph (b)(1) of this section under a phase-in plan submitted in a State

plan amendment to and approved by the Secretary.

■ 19. Section 435.403 is amended by—
■ A. Redesignating paragraphs (h) and (i) as paragraphs (i) and (h), respectively.
■ B. Adding introductory text for newly redesignated paragraphs (h) and (i).
■ C. Further redesignating newly redesignated paragraphs (h)(2), (h)(3), and (h)(4) as paragraphs (h)(3), (h)(4), and (h)(5), respectively.
■ D. Adding new paragraph (h)(2).
■ E. Revising newly redesignated paragraphs (h)(1) and (h)(5).
■ F. Revising newly redesignated paragraphs (i)(1) and (i)(2).
■ G. Removing newly redesignated paragraph (i)(3).
■ H. Further redesignating newly redesignated paragraph (i)(4) as paragraph (i)(3).
■ I. Amending paragraph (l)(2) by removing the phrase ''paragraph (h)'' and adding the phrase ''paragraph (i)'' in its place.

The revisions and addition read as follows:

§ 435.403 State residence.

* * * * *

(h) *Individuals age 21 and over.* Except as provided in paragraph (f) of this section, with respect to individuals age 21 and over —

(1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence is the State where the individual is living and—

(i) Intends to reside, including without a fixed address; or

(ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed).

(2) For an individual not residing in an institution as defined in paragraph (b) of this section who is not capable of stating intent, the State of residency is the State where the individual is living.

* * * * *

(5) For any other institutionalized individual, the State of residence is the State where the individual is living and intends to reside.

(i) *Individuals under age 21.* For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under title IV–E of the Act, as addressed in paragraph (g) of this section, and is not receiving a State supplementary payment, as addressed in paragraph (f) of this section, the State of residence is as follows:

(1) For an individual who is capable of indicating intent and who is emancipated from his or her parent or who is married, the State of residence is determined in accordance with paragraph (h)(1) of this section.

(2) For an individual not described in paragraph (i)(1) of this section, not living in an institution as defined in paragraph (b) of this section and not eligible for Medicaid based on receipt of assistance under title IV–E of the Act, as addressed in paragraph (g) of this section, and is not receiving a State supplementary payment, as addressed in paragraph (f) of this section, the State of residence is:

(i) The State where the individual resides, including without a fixed address; or

(ii) The State of residency of the parent or caretaker, in accordance with paragraph (h)(1) of this section, with whom the individual resides.

* * * * *

§ 435.407 [Amended]

■ 20. Amend § 435.407(k) by removing the reference ''and 435.911'' and adding in its place the reference ''and 435.912''.

§ 435.541 [Amended]

■ 21. Amend § 435.541(a)(2) by removing the reference ''§ 435.911'' and adding in its place the reference ''§ 435.912''.

■ 22. Section 435.603 is added to read as follows:

§ 435.603 Application of modified adjusted gross income (MAGI).

(a) *Basis, scope, and implementation.* (1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 435.916 of this part, whichever is later.

(b) *Definitions.* For purposes of this section—

Code means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver.

Tax dependent has the meaning provided in § 435.4 of this part.

(c) *Basic rule.* Except as specified in paragraph (i) and (j) of this section, the agency must determine financial eligibility for Medicaid based on ''household income'' as defined in paragraph (d) of this section.

(d) *Household income*—(1) *General rule.* Except as provided in paragraphs (d)(2) and (d)(3) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household, minus an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size.

(2) *Income of children and tax dependents.* (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(e) *MAGI-based income.* For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions—

(1) An amount received as a lump sum is counted as income only in the month received.

(2) Scholarships, awards, or fellowship grants used for education

purposes and not for living expenses are excluded from income.

(3) *American Indian/Alaska Native exceptions.* The following are excluded from income:

(i) Distributions from Alaska Native Corporations and Settlement Trusts;

(ii) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from—

(A) Rights of ownership or possession in any lands described in paragraph (e)(3)(ii) of this section; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) Distributions resulting from real property ownership interests related to natural resources and improvements—

(A) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(v) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(f) *Household*—(1) *Basic rule for taxpayers not claimed as a tax dependent.* In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent.

(2) *Basic rule for individuals claimed as a tax dependent.* In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of—

(i) Individuals other than a spouse or a biological, adopted, or step child who expect to be claimed as a tax dependent by another taxpayer;

(ii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and

(iii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this section—

(A) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(B) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(3) *Rules for individuals who neither file a tax return nor are claimed as a tax dependent.* In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's natural, adopted and step 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 natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

(4) *Married couples.* In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the Code or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with § 435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

(g) *No resource test or income disregards.* In the case of individuals whose financial eligibility for Medicaid is determined in accordance with this section, the agency must not—

(1) Apply any assets or resources test; or

(2) Apply any income or expense disregards under sections 1902(r)(2) or 1931(b)(2)(C), or otherwise under title XIX of the Act, except as provided in paragraph (d)(1) of this section.

(h) *Budget period*—(1) *Applicants and new enrollees.* Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) *Current beneficiaries.* For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at § 435.940 through § 435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

(i) If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the

household income of such individual determined in accordance with 26 CFR 1.36B–1(e) is below 100 percent FPL, Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B–1(e).

(j) *Eligibility Groups for which MAGI-based methods do not apply.* The financial methodologies described in this section are not applied in determining the Medicaid eligibility of individuals described in this paragraph. The agency must use the financial methods described in § 435.601 and § 435.602 of this subpart.

(1) Individuals whose eligibility for Medicaid does not require a determination of income by the agency, including, but not limited to, individuals receiving Supplemental Security Income (SSI) eligible for Medicaid under § 435.120 of this part, individuals deemed to be receiving SSI and eligible for Medicaid under § 435.135, § 435.137 or § 435.138 of this part and individuals for whom the State relies on a finding of income made by an Express Lane agency, in accordance with section 1902(e)(13) of the Act.

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals eligible under § 435.121, § 435.232 or § 435.234 of this part or under section 1902(e)(3) of the Act, but only for the purpose of determining eligibility on such basis.

(4) Individuals who request coverage for long-term services and supports for the purpose of being evaluated for an eligibility group under which long-term services and supports are covered. ''Long-term services and supports'' include nursing facility services, a level of care in any institution equivalent to nursing facility services; 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.

(5) Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance.

(6) Individuals who are being evaluated for coverage as medically needy under subparts D and I of this part, but only for the purpose of determining eligibility on such basis.

§ 435.831 [Amended]

■ 23. Amend § 435.831(a)(2) by removing the reference ''§ 435.914'' and adding in its place the reference ''§ 435.915''.

■ 24. Section 435.905 is revised to read as follows:

§ 435.905 Availability of program information.

(a) The agency must furnish the following information in electronic and paper formats (including through the Internet Web site described in § 435.1200(f) of this part), and orally as appropriate, to all applicants and other individuals who request it:

(1) The eligibility requirements;

(2) Available Medicaid services; and

(3) The rights and responsibilities of applicants and beneficiaries.

(b) Such information must be provided to applicants and beneficiaries in plain language and in a manner that is accessible and timely to—

(1) Individuals who are limited English proficient through the provision of language services at no cost to the individual; and

(2) Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

■ 25. Section 435.907 is revised to read as follows:

§ 435.907 Application.

(a) *Basis and implementation.* In accordance with section 1413(b)(1)(A) of the Affordable Care Act, the agency must accept an application from the applicant, an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility—

(1) Via the internet Web site described in § 435.1200(f) of this part;

(2) By telephone;

(3) Via mail;

(4) In person; and

(5) Through other commonly available electronic means.

(b) The application must be—

(1) The single, streamlined application for all insurance affordability programs developed by the Secretary; or

(2) An alternative single, streamlined application for all insurance affordability programs, which may be no more burdensome on the applicant than the application described in paragraph (b)(1) of this section, approved by the Secretary.

(c) For individuals applying, or who may be eligible, for assistance on a basis other than the applicable MAGI standard in accordance with § 435.911(c)(2) of this part, the agency may use either—

(1) An application described in paragraph (b) of this section and supplemental forms to collect additional information needed to determine eligibility on such other basis; or

(2) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard. Such application must minimize burden on applicants.

(3) Any MAGI-exempt applications and supplemental forms in use by the agency must be submitted to the Secretary.

(d) The agency may not require an in-person interview as part of the application process for a determination of eligibility using MAGI-based income.

(e) *Limits on information.* (1) The agency may only require an applicant to provide the information necessary to make an eligibility determination or for a purpose directly connected to the administration of the State plan.

(2) The agency may request information necessary to determine eligibility for other insurance affordability or benefit programs.

(3) The agency may request a non-applicant's SSN provided that—

(i) Provision of such SSN is voluntary;

(ii) Such SSN is used only to determine an applicant's or beneficiary's eligibility for Medicaid or other insurance affordability program or for a purpose directly connected to the administration of the State plan; and

(iii) At the time such SSN is requested, the agency provides clear notice to the individual seeking assistance, or person acting on such individual's behalf, that provision of the non-applicant's SSN is voluntary and information regarding how the SSN will be used.

(f) The agency must require that all initial applications are signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission must be accepted.

(g) Any application or supplemental form must be accessible to persons who are limited English proficient and persons who have disabilities, consistent with § 435.905(b) of this subpart.

■ 26. Section 435.908 is revised to read as follows:

§ 435.908 Assistance with application and renewal.

(a) The agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient, consistent with § 435.905(b) of this subpart.

(b) The agency must allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a renewal of eligibility.

■ 27. Section 435.910 is amended by—

■ A. Redesignating paragraphs (h)(2) and (h)(3), as (h)(3) and (h)(4), respectively.

■ B. Adding a new paragraph (h)(2).

■ C. Revising paragraphs (a), (f), (g), and (h)(1) to read as follows:

§ 435.910 Use of Social Security number.

(a) Except as provided in paragraph (h) of this section, the agency must require, as a condition of eligibility, that each individual (including children) seeking Medicaid furnish each of his or her Social Security numbers (SSN).

* * * * *

(f) The agency must not deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN by SSA or if the individual meets one of the exceptions in paragraph (h) of this section.

(g) The agency must verify the SSN furnished by an applicant or beneficiary to insure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

(h) *Exception.* (1) The requirement of paragraph (a) of this section does not apply and a State may give a Medicaid identification number to an individual who—

(i) Is not eligible to receive an SSN;

(ii) Does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

(iii) Refuses to obtain an SSN because of well-established religious objections.

(2) The identification number may be either an SSN obtained by the State on the applicant's behalf or another unique identifier.

* * * * *

■ 28. Redesignate § 435.911 through § 435.914 as § 435.912 through § 435.915 respectively.

■ 29. Add new § 435.911 to read as follows:

§ 435.911 Determination of eligibility.

(a) *Statutory basis.* This section implements sections 1902(a)(4), (a)(8), (a)(10)(A), (a)(19), and (e)(14) and section 1943 of the Act.

(b)(1) *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) of this part, the income standard established in accordance with § 435.110(c) of this part;

(ii) In the case of pregnant women, the income standard established in accordance with § 435.116(c) of this part;

(iii) In the case of individuals under age 19, the income standard established in accordance with § 435.118(c) of this part;

(iv) The income standard established under § 435.218(b)(1)(iv) of this part, if the State has elected to provide coverage under such section and, if applicable, coverage under the State's phase-in plan has been implemented for the individual whose eligibility is being determined.

(2) [Reserved]

(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 provide documentation of citizenship or immigration status, in accordance with sections 1903(x), 1902(ee) or 1137(d) of the Act), 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 who is under age 19, pregnant, or age 19 or older and under age 65 and not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, and 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 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.

(3) For individuals not eligible on the basis of the applicable modified adjusted gross income standard, the agency must comply with the requirements set forth in § 435.1200(e) of this part.

(d) For purposes of paragraph (c)(2) of this section, individuals described in this paragraph include:

(1) Individuals whom the agency identifies, on the basis of information contained in an application described in § 435.907(b) of this part, or renewal form described in § 435.916(a)(3) of this part, or on the basis of other information available to the State, as potentially eligible on a basis other than the applicable MAGI standard;

(2) Individuals who submit an alternative application described in § 435.907(c) of this part; and

(3) Individuals who otherwise request a determination of eligibility on a basis other than the applicable MAGI standard as described in § 435.603(j) of this part.

■ 30. Newly redesignated § 435.912 is amended by—

■ A. Revising paragraphs (a) and (b).

■ B. Redesignating paragraphs (c), (d), and (e) as paragraphs (e), (f), and (g), respectively.

■ C. Adding new paragraphs (c) and (d).

The revisions and additions read as follows:

§ 435.912 Timely determination of eligibility.

(a) For purposes of this section—

(1) ''Timeliness standards'' refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, subject to the exceptions in paragraph (e) of this section.

(2) ''Performance standards'' are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.

(b) Consistent with guidance issued by the Secretary, the agency must establish in its State plan timeliness and performance standards for, promptly and without undue delay—

(1) Determining eligibility for Medicaid for individuals who submit applications to the single State agency or its designee.

(2) Determining potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to § 435.1200(e) of this part.

(3) Determining eligibility for Medicaid for individuals whose accounts are transferred from other insurance affordability programs, including at initial application as well as at a regularly-scheduled renewal or due to a change in circumstances.

(c)(1) The timeliness and performance standards adopted by the agency under paragraph (b) of this section must cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program in accordance with § 435.1200(e) of this part, and must comply with the requirements of paragraph (c)(2) of this section, subject to additional guidance issued by the Secretary to promote accountability and consistency of high quality consumer experience among States and between insurance affordability programs.

(2) Timeliness and performance standards included in the State plan must account for—

(i) The capabilities and cost of generally available systems and technologies;

(ii) The general availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility;

(iii) The demonstrated performance and timeliness experience of State Medicaid, CHIP and other insurance affordability programs, as reflected in data reported to the Secretary or otherwise available; and

(iv) The needs of applicants, including applicant preferences for mode of application (such as through an internet Web site, telephone, mail, in-person, or other commonly available electronic means), as well as the relative complexity of adjudicating the eligibility determination based on household, income or other relevant information.

(3) Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed—

(i) Ninety days for applicants who apply for Medicaid on the basis of disability; and

(ii) Forty-five days for all other applicants.

(d) The agency must inform applicants of the timeliness standards adopted in accordance with this section.

* * * * *

■ 31. Section 435.916 is revised to read as follows:

§ 435.916 Periodic renewal of Medicaid eligibility.

(a) *Renewal of individuals whose Medicaid eligibility is based on modified adjusted gross income methods (MAGI).* (1) Except as provided in paragraph (d) of this section, the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months.

(2) Renewal on basis of information available to agency. The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under § 435.948, § 435.949 and § 435.956 of this part. If the agency is able to renew eligibility based on such information, the agency must, consistent with the requirements of this subpart and subpart E of part 431 of this chapter, notify the individual—

(i) Of the eligibility determination, and basis; and

(ii) That the individual must inform the agency, through any of the modes permitted for submission of applications under § 435.907(a) of this subpart, if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(3) Use of a pre-populated renewal form. If the agency cannot renew eligibility in accordance with paragraph (a)(2) of this section, the agency must—

(i) Provide the individual with—

(A) A renewal form containing information, as specified by the Secretary, available to the agency that is needed to renew eligibility.

(B) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 435.907(a) of this part, and to sign the renewal form in a manner consistent with § 435.907(f) of the part;

(C) Notice of the agency's decision concerning the renewal of eligibility in accordance with this subpart and subpart E of part 431 of this chapter;

(ii) Verify any information provided by the beneficiary in accordance with § 435.945 through § 435.956 of this part;

(iii) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination, or a longer period elected by the State, without requiring a new application;

(iv) Not require an individual to complete an in-person interview as part of the renewal process.

(b) *Redetermination of individuals whose Medicaid eligibility is determined on a basis other than modified adjusted gross income.* The agency must redetermine the eligibility of Medicaid beneficiaries excepted from modified adjusted gross income under § 435.603(j) of this part, for circumstances that may change, at least every 12 months. The agency must make a redetermination of eligibility in accordance with the provisions of paragraph (a)(2) of this section, if sufficient information is available to do so. The agency may adopt the procedures described at § 435.916(a)(3) for individuals whose eligibility cannot be renewed in accordance with paragraph (a)(2) of this section.

(1) The agency may consider blindness as continuing until the reviewing physician under § 435.531 of this part determines that a beneficiary's vision has improved beyond the definition of blindness contained in the plan; and

(2) The agency may consider disability as continuing until the review team, under § 435.541 of this part, determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

(c) *Procedures for reporting changes.* The agency must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility and that such changes may be reported through any of the modes for submission of applications described in § 435.907(a) of this part.

(d) *Agency action on information about changes.* (1) Consistent with the requirements of § 435.952 of this part, the agency must promptly redetermine eligibility between regular renewals of eligibility described in paragraphs (b) and (c) of this section whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility.

(i) For renewals of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income, the agency must limit any requests for additional information from the individual to information relating to such change in circumstance.

(ii) If the agency has enough information available to it to renew eligibility with respect to all eligibility criteria, the agency may begin a new 12-month renewal period under paragraphs (a) or (b) of this section.

(2) If the agency has information about anticipated changes in a

beneficiary's circumstances that may affect his or her eligibility, it must redetermine eligibility at the appropriate time based on such changes.

(e) The agency may request from beneficiaries only the information needed to renew eligibility. Requests for non-applicant information must be conducted in accordance with § 435.907(e) of this part.

(f) Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for Medicaid.

(1) Prior to making a determination of ineligibility, the agency must consider all bases of eligibility, consistent with § 435.911 of this part.

(2) For individuals determined ineligible for Medicaid, the agency must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in § 435.1200(e) of this part.

(g) Any renewal form or notice must be accessible to persons who are limited English proficient and persons with disabilities, consistent with § 435.905(b) of this subpart.

■ 32. Section 435.940 is revised to read as follows:

§ 435.940 Basis and scope.

The income and eligibility verification requirements set forth at § 435.940 through § 435.960 of this subpart are based on sections 1137, 1902(a)(4), 1902(a)(19), 1903(r)(3) and 1943(b)(3) of the Act and section 1413 of the Affordable Care Act. Nothing in the regulations in this subpart should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits, consistent with parts 431 and 455 of this subchapter, or its obligation to provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the plan, consistent with § 431.15 of this subchapter and section 1902(a)(19) of the Act.

■ 33. Section 435.945 is revised to read as follows:

§ 435.945 General requirements.

(a) Except where the law requires other procedures (such as for citizenship and immigration status information), the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

(b) The agency must request and use information relevant to verifying an individual's eligibility for Medicaid in accordance with § 435.948 through § 435.956 of this subpart.

(c) The agency must furnish, in a timely manner, income and eligibility information, subject to regulations at part 431 subpart F of this chapter, needed for verifying eligibility to the following programs:

(1) To other agencies in the State and other States and to the Federal programs both listed in § 435.948(a) of this subpart and identified in section 1137(b) of the Act;

(2) Other insurance affordability programs;

(3) The child support enforcement program under part D of title IV of the Act; and

(4) SSA for OASDI under title II and for SSI benefits under title XVI of the Act.

(d) All State eligibility determination systems must conduct data matching through the Public Assistance Reporting Information System (PARIS).

(e) The agency must, as required under section 1137(a)(7) of the Act, and upon request, reimburse another agency listed in § 435.948(a) of this subpart or paragraph (c) of this section for reasonable costs incurred in furnishing information, including new developmental costs.

(f) Prior to requesting information for an applicant or beneficiary from another agency or program under this subpart, the agency must inform the individual that the agency will obtain and use information available to it under this subpart to verify income and eligibility or for other purposes directly connected to the administration of the State plan.

(g) Consistent with § 431.16 of this subchapter, the agency must report information as prescribed by the Secretary for purposes of determining compliance with § 431.305 of this subchapter, subpart P of part 431, § 435.910, § 435.913, and § 435.940 through § 435.965 of this subpart and of evaluating the effectiveness of the income and eligibility verification system.

(h) Information exchanged electronically between the State Medicaid agency and any other agency or program must be sent and received via secure electronic interfaces as defined in § 435.4 of this part.

(i) The agency must execute written agreements with other agencies before releasing data to, or requesting data from, those agencies. Such agreements must provide for appropriate safeguards limiting the use and disclosure of information as required by Federal or State law or regulations.

(j) *Verification plan.* The agency must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State agency to implement the provisions set forth in § 435.940 through § 435.956 of this subpart in a format and manner prescribed by the Secretary.

(k) *Flexibility in information collection and verification.* Subject to approval by the Secretary, the agency may request and use information from a source or sources alternative to those listed in § 435.948(a) of this subpart, or through a mechanism other than the electronic service described in § 435.949(a) of this subpart, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs.

■ 34. Section 435.948 is revised to read as follows:

§ 435.948 Verifying financial information.

(a) The agency must in accordance with this section request the following information relating to financial eligibility from other agencies in the State and other States and Federal programs to the extent the agency determines such information is useful to verifying the financial eligibility of an individual:

(1) Information related to wages, net earnings from self-employment, unearned income and resources from the State Wage Information Collection Agency (SWICA), the Internal Revenue Service (IRS), the Social Security Administration (SSA), the agencies administering the State unemployment compensation laws, the State-administered supplementary payment programs under section 1616(a) of the Act, and any State program administered under a plan approved under Titles I, X, XIV, or XVI of the Act; and

(2) Information related to eligibility or enrollment from the Supplemental Nutrition Assistance Program, the State

program funded under part A of title IV of the Act, and other insurance affordability programs.

(b) To the extent that the information identified in paragraph (a) of this section is available through the electronic service established in accordance with § 435.949 of this subpart, the agency must obtain the information through such service.

(c) The agency must request the information by SSN, or if an SSN is not available, using other personally identifying information in the individual's account, if possible.

■ 35. Section 435.949 is added to read as follows:

§ 435.949 Verification of information through an electronic service.

(a) The Secretary will establish an electronic service through which States may verify certain information with, or obtain such information from, Federal agencies and other data sources, including SSA, the Department of Treasury, and the Department of Homeland Security.

(b) To the extent that information related to eligibility for Medicaid is available through the electronic service established by the Secretary, States must obtain the information through such service, subject to the requirements in subpart C of part 433 of this chapter, except as provided for in § 435.945(k) of this subpart.

■ 36. Section 435.952 is revised to read as follows:

§ 435.952 Use of information and requests of additional information from individuals.

(a) The agency must promptly evaluate information received or obtained by it in accordance with regulations under § 435.940 through § 435.960 of this subpart to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.

(b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency in accordance with § 435.948, § 435.949 or § 435.956 of this subpart, the agency must determine or renew eligibility based on such information.

(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948, § 435.949 or § 435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j) with information provided by or on behalf of the individual.

(1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.

(2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, the agency must seek additional information from the individual, including—

(i) A statement which reasonably explains the discrepancy; or

(ii) Other information (which may include documentation), provided that documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage;

(iii) The agency must provide the individual a reasonable period to furnish any additional information required under paragraph (c) of this section.

(d) The agency may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under § 435.940 through § 435.960 of this subpart unless the agency has sought additional information from the individual in accordance with paragraph (c) of this section, and provided proper notice and hearing rights to the individual in accordance with this subpart and subpart E of part 431.

§ 435.953 [Removed]

■ 37. Section 435.953 is removed.

§ 435.955 [Removed]

■ 38. Section 435.955 is removed.

■ 39. Section 435.956 is added to read as follows:

§ 435.956 Verification of other non-financial information.

(a) [Reserved]

(b) [Reserved]

(c) *State residency.* (1) The agency may verify State residency in accordance with § 435.945(a) of this subpart or through other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

(2) Evidence of immigration status may not be used to determine that an individual is not a State resident.

(d) *Social Security numbers.* The agency must verify Social Security numbers (SSNs) in accordance with § 435.910 of this subpart.

(e) *Pregnancy.* The agency must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation, subject to the requirements of § 435.952 of this subpart.

(f) *Age, date of birth and household size.* The agency may verify date of birth and the individuals that comprise an individual's household, as defined in § 435.603(f) of this part, in accordance with § 435.945(a) of this subpart or through other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

§ 435.1002 [Amended]

■ 40. Amend § 435.1002(b) by removing the reference ''§§ 435.914 and'' and adding in its place the reference ''§§ 435.915 and''.

§ 435.1102 [Amended]

■ 41. Amend § 435.1102(a) by removing the term ''family income'' and adding in its place the term ''household income''.

■ 42. Subpart M is added to read as follows:

Subpart M—Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs

§ 435.1200 Medicaid agency responsibilities.

(a) *Statutory basis and purpose.* This section implements sections 1943 and 2102(b)(3)(B) of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs.

(b) *General requirements.* The State Medicaid agency must—

(1) Fulfill the responsibilities set forth in paragraphs (d) and (e) and, if applicable, paragraph (c) of this section in partnership with other insurance affordability programs.

(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 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;

(ii) Ensure compliance with paragraphs (d) through (f) 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.

(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 subchapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange or other program, the agency must—

(1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;

(2) Comply with the provisions of § 435.911 of this part to the same extent as if the application had been submitted to the Medicaid agency; and

(3) Comply with the provisions of § 431.10 of this subchapter to ensure it maintains oversight for the Medicaid program.

(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 screened as potentially Medicaid eligible, the agency must—

(1) Accept, via secure electronic interface, the electronic account for the individual;

(2) Not request information or documentation from the individual already provided to another insurance affordability program and included in the individual's electronic account or other transmission from the other program.

(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 of this part, without requiring submission of another application.

(4) Accept any finding relating to a criterion of eligibility made by such program, 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) of this section;

(5) Notify such program of the receipt of the electronic account.

(6) Notify such program of the final determination of eligibility made by the agency for individuals who enroll in the other insurance affordability program pending completion of the determination of Medicaid eligibility.

(e) *Evaluation of eligibility for other insurance affordability programs*—(1) *Individuals determined not eligible for Medicaid.* For each individual who submits an application or renewal form to the agency which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed pursuant to a change in circumstance in accordance with § 435.916(d) of this part, and whom the agency determines is not eligible for Medicaid, the agency must, promptly and without undue delay, consistent with timeliness standards established under § 435.912 of this part, determine potential eligibility for, and, as appropriate, transfer via a secure electronic interface the individual's electronic account to, other insurance affordability programs.

(2) *Individuals undergoing a Medicaid eligibility determination on a basis other than MAGI.* In the case of an individual with household income greater than the applicable MAGI standard and for whom the agency is determining eligibility in accordance with § 435.911(c)(2) of this part, the agency must promptly and without undue delay, consistent with timeliness standards established under § 435.912 of this part, determine potential eligibility for, and as appropriate transfer via secure electronic interface, the individual's electronic account to, other insurance affordability programs and provide timely notice to such other program—

(i) That the individual is not Medicaid eligible on the basis of the applicable MAGI standard, but that a final determination of Medicaid eligibility is still pending; and

(ii) Of the agency's final determination of eligibility or ineligibility for Medicaid.

(3) The agency may enter into an agreement with the Exchange to make determinations of eligibility for advance payments of the premium tax credit and cost sharing reductions, consistent with 45 CFR 155.110(a)(2).

(f) *Internet Web site.* (1) The State Medicaid agency must make available to current and prospective Medicaid applicants and beneficiaries a Web site that—

(i) Operates in conjunction with or is linked to the Web site described in § 457.340(a) of this subchapter and to the Web site established by the Exchange under 45 CFR 155.205; and

(ii) Supports applicant and beneficiary activities, including accessing information on the insurance affordability programs available in the State, applying for and renewing coverage, and other activities as appropriate.

(2) Such Web site, any interactive kiosks and other information systems established by the State to support Medicaid information and enrollment activities must be in plain language and be accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this subpart.

PART 457—ALLOTMENTS AND GRANTS TO STATES

■ 43. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302)

■ 44a. In part 457, remove the term ''family income'' wherever it appears and add in its place the term ''household income''.

■ 44b. In part 457, remove the term ''Family income'' wherever it appears and add in its place the term ''Household income''.

■ 45. In part 457 remove ''SCHIP'' wherever it appears and add in its place ''CHIP''.

■ 46. Section § 457.10 is amended by—

■ A. Removing the definition of ''Medicaid applicable income level.''

■ B. Adding the following definitions in alphabetical order ''Advanced payments of the premium tax credit (APTC),'' ''Affordable Insurance Exchange (Exchange),'' ''Application,'' ''Electronic account,'' ''Household income,'' ''Insurance affordability program,'' ''Secure electronic interface,'' and ''Shared eligibility service.''

The additions read as follows:

§ 457.10 Definitions and use of terms.

* * * * *

Advanced payments of the premium tax credit (APTC) has the meaning given the term in 45 CFR 155.20.

Affordable Insurance Exchange (Exchange) has the meaning given the term ''Exchange'' in 45 CFR 155.20.

Application means the single, streamlined application form that is used by the State in accordance with

§ 435.907(b) of this chapter and 45 CFR 155.405 for individuals to apply for coverage for all insurance affordability programs.

* * * * *

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 of this part.

* * * * *

Household income is defined as provided in § 435.603(d) of this chapter.

Insurance affordability program is defined as provided in § 435.4 of this chapter.

* * * * *

Secure electronic interface is defined as provided in § 435.4 of this chapter.

Shared eligibility service is defined as provided in § 435.4 of this chapter.

* * * * *

■ 47. Section § 457.80 is amended by revising paragraph (c)(3) to read as follows:

§ 457.80 Current State child health insurance coverage and coordination.

* * * * *

(c) * * *

(3) Ensure coordination with other insurance affordability programs in the determination of eligibility and enrollment in coverage to ensure that all eligible individuals are enrolled in the appropriate program, including through use of the procedures described in § 457.305, § 457.348 and § 457.350 of this part.

■ 48. Section 457.300 is amended by—

■ A. Republishing paragraph (a) introductory text.

■ B. Adding paragraphs (a)(4) and (a)(5)

■ C. Revising paragraph (c).

The addition and revision reads as follows:

§ 457.300 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

* * * * *

(4) Section 2107(e)(1)(O) of the Affordable Care Act, which relates to coordination of CHIP with the Exchanges and the State Medicaid agency.

(5) Section 2107(e)(1)(F) of the Affordable Care Act, which relates to income determined based on modified adjusted gross income.

* * * * *

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program. Regulations relating to eligibility, screening, applications and enrollment that are applicable to a Medicaid expansion program are found at § 435.4, § 435.229, § 435.905 through § 435.908, § 435.1102, § 435.940 through § 435.958, § 435.1200, § 436.3, § 436.229, and § 436.1102 of this chapter.

■ 49. Section 457.301 is amended by—

■ A. Adding the definitions of ''Eligibility determination,'' ''Family size,'' ''Medicaid applicable income level,'' and ''Non-applicant'' in alphabetical order.

■ B. Removing the definition of ''Joint application.''

The additions read as follows:

§ 457.301 Definitions and use of terms.

* * * * *

Eligibility determination means an approval or denial of eligibility in accordance with§ 457.340 as well as a renewal or termination of eligibility under § 457.343 of this subpart.

Family size is defined as provided in § 435.603(b) of this chapter.

Medicaid applicable income level means, for a child, the effective income level (expressed as a percentage of the Federal poverty level and converted to a modified adjusted gross income equivalent level in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act) specified under the policies of the State plan under title XIX of the Act as of March 31, 1997 for the child to be eligible for Medicaid under either section 1902(l)(2) or 1905(n)(2) of the Act, or under a section 1115 waiver authorized by the Secretary (taking into consideration any applicable income methodologies adopted under the authority of section 1902(r)(2) of the Act).

Non-applicant means an individual who is not seeking an eligibility determination for him or herself and is included in an applicant's or enrollee's household to determine eligibility for such applicant or enrollee.

* * * * *

■ 50. Section 457.305 is revised to read as follows:

§ 457.305 State plan provisions.

The State plan must include a description of—

(a) The standards, consistent with § 457.310 and § 457.320 of this subpart, and financial methodologies consistent with § 457.315 of this subpart used to determine the eligibility of children for coverage under the State plan.

(b) The State's policies governing enrollment and disenrollment; processes for screening applicants for and, if eligible, facilitating their enrollment in other insurance affordability programs; and processes for implementing waiting lists and enrollment caps (if any).

■ 51. Section 457.310 is amended by—

■ A. Republishing paragraph (b) introductory text.

■ B. Revising paragraphs (b)(1)(i), (b)(1)(ii), (b)(1)(iii) introductory text, and (b)(1)(iii)(B).

■ C. Adding paragraph (d).

The revisions and addition read as follows:

§ 457.310 Targeted low-income child.

* * * * *

(b) *Standards.* A targeted low-income child must meet the following standards:

(1) * * *

(i) Has a household income, as determined in accordance with § 457.315 of this subpart, at or below 200 percent of the Federal poverty level for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level;

(iii) Resides in a State that has a Medicaid applicable income level and has a household income that either—

* * * * *

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under policies of the State plan under title XIX on June 1, 1997.

* * * * *

(d) A targeted low-income child must also include any child enrolled in Medicaid on December 31, 2013 who is determined to be ineligible for Medicaid as a result of the elimination of income disregards as specified under § 435.603(g) of this chapter, regardless of any other standards set forth in this section except those in paragraph (c) of this section. Such a child shall continue to be a targeted low-income child under this paragraph until the date of the child's next renewal under § 457.343 of this subpart.

■ 52. Section 457.315 is added to read as follows:

§ 457.315 Application of modified adjusted gross income and household definition.

(a) Effective January 1, 2014, the State must apply the financial methodologies set forth in paragraphs (b) through (i) of § 435.603 of this chapter in determining the financial eligibility of all individuals for CHIP. The exception to application of such methods for individuals for whom the State relies on a finding of income made by an Express Lane agency at § 435.603(j)(1) of this subpart also applies.

(b) In the case of determining ongoing eligibility for enrollees determined

eligible for CHIP on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 457.343, whichever is later.

■ 53. Section 457.320 is amended by—
■ A. Removing paragraphs (a)(4) and (a)(6).
■ B. Redesignating paragraphs (a)(5), (a)(7), (a)(8), (a)(9), and (a)(10) as paragraphs (a)(4), (a)(5), (a)(6), (a)(7), and (a)(8), respectively.
■ C. Revising paragraph (d).
■ D. Removing and reserving paragraph (e)(2).

The revisions read as follows:

§ 457.320 Other eligibility standards.

* * * * *

(d) *Residency.* (1) Residency for a non-institutionalized child who is not a ward of the State must be determined in accordance with § 435.403(i) of this chapter.

(2) Residency for a targeted low-income pregnant woman defined at 2112 of the Act must be determined in accordance with § 435.403(h) of this chapter.

(3) A State may not—

(i) Impose a durational residency requirement;

(ii) Preclude the following individuals from declaring residence in a State—

(A) An institutionalized child who is not a ward of a State, if the State is the State of residence of the child's custodial parent or caretaker at the time of placement; or

(B) A child who is a ward of a State, regardless of where the child lives

(4) In cases of disputed residency, the State must follow the process described in § 435.403(m) of this chapter.

(e) * * *

(2) [Reserved]

■ 54. Section 457.330 is added to read as follows:

§ 457.330 Application.

The State shall use the single, streamlined application used by the State in accordance with paragraph (b) of § 435.907 of this chapter, and otherwise comply with such section, except that the terms of § 435.907(c) of this chapter (relating to applicants seeking coverage on a basis other than modified adjusted gross income) do not apply.

■ 55. Section 457.340 is amended by—
■ A. Revising the section heading.
■ B. Revising paragraphs (a), (b), (d), and (f).

The revisions read as follows:

§ 457.340 Application for and enrollment in CHIP.

(a) *Application and renewal assistance, availability of program information, and Internet Web site.* 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.

(b) *Use of Social Security number.* The terms of § 435.910 and § 435.907(e) of this chapter regarding the provision and use of Social Security Numbers and non-applicant information apply equally to the State in administering a separate CHIP.

* * * * *

(d) *Timely determination of eligibility.* (1) The terms in § 435.912 of this chapter apply equally to CHIP, except that standards for transferring electronic accounts to other insurance affordability programs are pursuant to § 457.350 and the standards for receiving applications from other insurance affordability programs are pursuant to § 457.348 of this part.

(2) In applying timeliness standards, the State must define ''date of application'' and must count each calendar day from the date of application to the day the agency provides notice of its eligibility decision.

* * * * *

(f) *Effective date of eligibility.* A State must specify a method for determining the effective date of eligibility for CHIP, which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between CHIP and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage.

■ 56. Section 457.343 is added to read as follows:

§ 457.343 Periodic renewal of CHIP eligibility.

The renewal procedures described in § 435.916 of this chapter apply equally to the State in administering a separate CHIP, except that the State shall verify information needed to renew CHIP eligibility in accordance with § 457.380 of this subpart, shall provide notice regarding the State's determination of renewed eligibility or termination in accordance with § 457.340(e) of this subpart and shall comply with the requirements set forth in § 457.350 of this subpart for screening individuals for other insurance affordability programs and transmitting such individuals' electronic account and other relevant information to the appropriate program.

■ 57. Section 457.348 is added 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 the 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;

(2) Ensure compliance with paragraph (c) of this section, § 457.350, and if applicable, paragraph (b) of this section;

(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.

(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, the State must—

(1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of CHIP eligibility; and

(2) Comply with the provisions of § 457.340 of this subpart to the same extent as if the application had been submitted to the State.

(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, the State must—

(1) Accept, via secure electronic interface, the electronic account for the individual.

(2) Not request information or documentation from the individual already provided to the other insurance affordability program and included in the individual's electronic account or other transmission from the other program;

(3) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d) of this subpart, determine

the CHIP eligibility of the individual, in accordance with § 457.340 of this subpart, without requiring submission of another application;

(4) Accept any finding relating to a criterion of eligibility made by such program, 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 of this subpart or approved by it in the agreement described in paragraph (a) of this section;

(5) Notify such program of the receipt of the electronic account.

(d) *Certification of eligibility criteria.* The State must certify for the Exchange and other insurance affordability programs the criteria applied in determining CHIP eligibility.

■ 58. Section 457.350 is amended by—

■ A. Revising the section heading.

■ B. Revising paragraphs (a), (b), (c), and (f).

■ C. Removing and reserving paragraph (d).

■ D. Adding paragraphs (i), (j), and (k).

The additions and revisions read as follows:

§ 457.350 Eligibility screening and enrollment in other insurance affordability programs.

(a) *State plan requirement.* The State plan shall include a description of the coordinated eligibility and enrollment procedures used, at an initial and any follow-up eligibility determination, including any periodic redetermination, to ensure that:

(1) Only targeted low-income children are furnished CHIP coverage under the plan; and

(2) Enrollment is facilitated for applicants and enrollees found to be potentially eligible for other insurance affordability programs in accordance with this section.

(b) *Screening objectives.* A State must promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d) of this subpart, identify 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 under a change in circumstance in accordance with § 457.343 of this subpart, and whom the State determines is not eligible or CHIP, but who is potentially eligible for:

(1) Medicaid on the basis of having household income at or below the applicable modified adjusted gross income standard, as defined in § 435.911(b) of this chapter;

(2) Medicaid on another basis, as indicated by information provided on the application or renewal form provided;

(3) Eligibility for other insurance affordability programs.

(c) *Income eligibility test.* To identify the individuals described in paragraphs (b)(1) and (b)(3) of this section, a State must apply the methodologies used to determine household income described in § 457.315 of this subpart or such methodologies as are applied by such other programs.

(d) [Reserved]

* * * * *

(f) *Applicants found potentially eligible for Medicaid based on modified adjusted gross income.* For individuals identified in paragraph (b)(1) of this section, the State must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d) of this subpart, transfer the individual's electronic account to the Medicaid agency via a secure electronic interface; and

(2) Except as provided in § 457.355 of this subpart, find the applicant ineligible, provisionally ineligible, or suspend the applicant's application for CHIP unless and until the Medicaid application for the applicant is denied; and

(3) Determine or redetermine eligibility for CHIP, consistent with the timeliness standards established under § 457.340(d) of this subpart, if—

(i) The State is notified, in accordance with § 435.1200(d)(5) of this chapter that the applicant has been found ineligible for Medicaid; or

(ii) The State is notified prior to the final Medicaid eligibility determination that the applicant's circumstances have changed and another screening shows that the applicant is no longer potentially eligible for Medicaid.

* * * * *

(i) *Applicants found potentially eligible for other insurance affordability programs.* For individuals identified in paragraph (b)(3) of this section, the State must promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d) of this subpart, transfer the electronic account to the applicable program via a secure electronic interface.

(j) *Applicants potentially eligible for Medicaid on a basis other than modified adjusted gross income.* For individuals identified in paragraph (b)(2) of this section, the State must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d) of this subpart, transfer the electronic account to the Medicaid agency via a secure electronic interface;

(2) Complete the determination of eligibility for CHIP in accordance with § 457.340 of this subpart; and

(3) Disenroll the enrollee from CHIP if the State is notified in accordance with § 435.1200(d)(5) of this chapter that the applicant has been determined eligible for Medicaid.

(k) A State may enter into an arrangement with the Exchange for the entity that determines eligibility for CHIP to make determinations of eligibility for advanced premium tax credits and cost sharing reductions, consistent with 45 CFR 155.110(a)(2).

■ 59. Section 457.353 is revised to read as follows:

§ 457.353 Monitoring and evaluation of screening process.

States must establish a mechanism and monitor to evaluate the screen and enroll process described at § 457.350 of this subpart to ensure that children who are:

(a) Screened as potentially eligible for other insurance affordability programs are enrolled in such programs, if eligible; or

(b) Determined ineligible for other insurance affordability programs are enrolled in CHIP, if eligible.

■ 60. Section 457.380 is revised to read as follows:

§ 457.380 Eligibility verification.

(a) *General requirements.* Except where law requires other procedures (such as for citizenship and immigration status information), the State may accept attestation of information needed to determine the eligibility of an individual for CHIP (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this subchapter, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

(b) [Reserved]

(c) *State residents.* If the State does not accept self-attestation of residency, the State must verify residency in accordance with § 435.956(c) of this chapter.

(d) *Income.* If the State does not accept self-attestation of income, the State must verify the income of an individual by using the data sources and

following standards and procedures for verification of financial eligibility consistent with § 435.945(a), § 435.948 and § 435.952 of this chapter.

(e) *Verification of other factors of eligibility.* For eligibility requirements not described in paragraphs (c) or (d) of this section, a State may adopt reasonable verification procedures, consistent with the requirements in § 435.952 of this chapter, except that the State must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation.

(f) *Requesting information.* The terms of § 435.952 of this chapter apply equally to the State in administering a separate CHIP.

(g) *Electronic service.* Except to the extent permitted under paragraph (i) of this section, to the extent that information sought under this section is available through the electronic service described in § 435.949 of this chapter, the State must obtain the information through that service.

(h) *Interaction with program integrity requirements.* Nothing in this section should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits or its obligation to provide for methods of administration that are in the best interest of applicants and enrollees and are necessary for the proper and efficient operation of the plan.

(i) *Flexibility in information collection and verification.* Subject to approval by the Secretary, the State may modify the methods to be used for collection of information and verification of information as set forth in this section, provided that such alternative source will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs.

(j) *Verification plan.* The State must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State to implement the provisions set forth in this section in a format and manner prescribed by the Secretary.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: March 2, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: March 5, 2012.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2012–6560 Filed 3–16–12; 11:15 am]

BILLING CODE 4120–01–P