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Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 433, 435, and 457

[CMS–2349–P]

RIN 0938–AQ62

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

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement 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 through improvements in Medicaid, the establishment of Affordable Insurance Exchanges (“Exchanges”), and coordination between Medicaid, the Children’s Health Insurance Program (CHIP), and Exchanges. This proposed rule would implement sections of the Affordable Care Act related to Medicaid and CHIP eligibility, enrollment simplification, and coordination.

In addition, this proposed rule also sets out the increased Federal Medical Assistance Percentage (FMAP) rates and the related conditions and requirements that will be available for State medical assistance expenditures relating to “newly eligible” individuals and certain medical assistance expenditures in “expansion States” beginning January 1, 2014, including a proposal of three alternative methodologies to use for purposes of applying the appropriate FMAP for expenditures in accordance with section 2001 of the Affordable Care Act.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 31, 2011.

ADDRESSES: In commenting, please refer to file code CMS–2349–P. 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–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2349–P, 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: A detailed Preliminary Regulatory Impact Analysis associated with this proposed rule is available at <http://www.cms.gov/MedicaidEligibility/downloads/CMS-2349-P-PreliminaryRegulatoryImpactAnalysis.pdf>. A summary of the aforementioned analysis is included as part of this proposed rule.

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://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be 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.

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Acronyms

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

Act	Social Security Act
AFDC	Aid to Families with Dependent Children
BBA	Balanced Budget Act of 1997
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DHS	Department of Homeland Security
EITC	Earned Income Tax Credit
EPSDT	Early and periodic screening, diagnosis, and treatment
FFP	Federal financial participation
FMAP	Federal medical assistance percentage
FPL	Federal poverty level
HCERA	Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted March 30, 2010)
HHS [U.S.]	Department of Health and Human Services
IRA	Individual Retirement Account
IRC	Internal Revenue Code of 1986
IRS	Internal Revenue Service
LEP	Limited English Proficient
MAGI	Modified adjusted gross income
MSA	Medical Savings Account
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
QI	Qualifying Individuals
QMB	Qualified Medicare Beneficiaries
SHO	State Health Official
SLMB	Specified Low-Income Medicare Beneficiaries
SMD	State Medicaid Director
SNAP	Supplemental Nutrition Assistance Program
SPA	State Plan Amendment
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
TANF	Temporary Assistance for Needy Families

I. Background

A. Introduction

The Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on

March 23, 2010), was amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010), and together these laws are referred to as the Affordable Care Act. In addition, 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. This proposed rule addresses changes to Medicaid and CHIP eligibility in the Affordable Care Act.

Prior to the implementation of the Affordable Care Act in 2014, individuals who fall into certain “categories” or “categorical groups” are eligible for Medicaid, including low-income children, pregnant women, parents and other caretaker relatives, seniors, and people with disabilities. Federal minimum income eligibility standards vary by category. All States currently cover pregnant women and children under age 6 at or below 133 percent of the Federal poverty level (FPL) (in some States the minimum eligibility level is 185 percent FPL for pregnant women and children under one), and children age 6 through age 18 with family incomes at or below 100 percent of the FPL, though many States have implemented higher standards for pregnant women and children. The Federally specified minimum eligibility levels for parents, people with disabilities and the elderly are significantly lower, although States have the option to expand coverage to people within these categories at higher income levels. Prior to the Affordable Care Act, States could not cover non-disabled, non-elderly adults who do not have dependent children, regardless of their income level, except through a Medicaid demonstration under Section 1115 of the Act. As a result of the varying Federal minimum standards and State options, eligibility for Medicaid is complicated and significant gaps continue to exist even among the lowest income Americans.

The Affordable Care Act extends and simplifies Medicaid eligibility. Starting in calendar year (CY) 2014, it replaces the complex categorical groupings and limitations to provide Medicaid eligibility to all individuals under age 65 with income at or below 133 percent FPL, provided that the individual meets certain non-financial eligibility criteria, such as citizenship or satisfactory immigration status. Children and, in some States, pregnant women will be eligible at income levels equal to or higher than the 133 percent level, depending on existing State-established

income eligibility standards. In addition, States will have a new option to expand eligibility beyond the new simplified Federal minimums.

In addition, starting January 1, 2014, eligibility for Medicaid for most individuals, as well as for CHIP, will be determined using methodologies that are based on modified adjusted gross income (MAGI), as defined in the Internal Revenue Code of 1986 (IRC). Per the Affordable Care Act, eligibility for advance payments of premium tax credits for the purchase of private coverage through the Exchange will use MAGI as it is defined in the IRC to determine eligibility as well. Medicaid, CHIP and the Exchanges will use common income methodologies and will align the rules and methodologies used to evaluate eligibility for most individuals under all three programs.

The alignment of the methods for determining eligibility is one part of an overall system established by the Affordable Care Act that allows for real-time eligibility determinations of most applicants and allows for prompt enrollment of individuals in the “insurance affordability program” for which they qualify. In this proposed rule, insurance affordability programs include Medicaid, CHIP, advance payments of premium tax credits and cost-sharing reductions through the Exchange, and any State-established Basic Health Program, if applicable.

Individuals will not have to apply to multiple programs nor will they be sent from one program to another if they initially apply to a program for which they are not ultimately eligible. To achieve coordination, this proposed rule for Medicaid and CHIP eligibility is aligned with the applicable provisions in the proposed rule establishing the Exchanges published in the July 15, 2011 **Federal Register** (76 FR 41866) (“Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans”), as well as in the accompanying proposed rule published elsewhere in this **Federal Register** implementing the Affordable Care Act provisions related to the eligibility for advance payments of premium tax credits and cost-sharing reductions and enrollment in a qualified health plan through the Exchanges (referred to hereinafter as the “Exchange proposed rule”) as well as the proposed rule developed by the Department of the Treasury regarding the health insurance premium assistance tax credit (“the Treasury proposed rule”), also published elsewhere in this **Federal Register**.

Section 2001 of the Affordable Care Act ensures that States will receive an

increased FMAP for all newly eligible individuals, defined as those who would not have been eligible in the State in December 2009. The FMAP for these newly eligible individuals will be 100 percent for Calendar Year (CY) 2014–2016, gradually declining to 90 percent in 2020 where it remains indefinitely. In addition, some States that had expanded coverage to adults (parents and adults without children) prior to December 2009, referred to as “expansion States,” shall also receive an increased FMAP that begins in 2014 between the regular FMAP and the FMAP for newly eligible individuals and equalizing with the newly eligible FMAP in 2019 and beyond. The proposed rule sets forth the definitions of newly eligible individuals and expansion States as well as the applicable FMAPs beginning in 2014.

While the new FMAPs provide significant new federal financial support for States, they could cause States significant burden to administer if States had to evaluate all applicants under the new simplified rules for purposes of determining eligibility and under their otherwise obsolete December 2009 eligibility rules for purposes of determining the appropriate FMAP. A dual system would be inefficient and likely lead to inaccuracies. To promote States’ ability to operate efficient and effective processes, this rule proposes three alternative approaches for determining the applicable FMAP. Based on the comments received through this proposed rule and the results of an upcoming CMS/HHS feasibility study, we expect to modify, narrow or combine the approaches available to States in the final rule. By establishing an alternative methodology or methodologies for use in the FMAP determination by a State, the proposed rule aims to ensure that it will not be necessary for a State to make an eligibility determination for every individual using two separate eligibility systems and thereby advancing efficient and effective operations for States, individuals, and the Federal government.

Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges. Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. And Exchanges will give individuals and small businesses the same purchasing clout as big businesses.

The Departments of Health and Human Services, Labor, and the Treasury (the Departments) are issuing regulations implementing Exchanges in several phases. The first in this series was a Request for Comment relating to Exchanges, published in the August 3, 2010 **Federal Register** (75 FR 45584). Second, Initial Guidance to States on Exchanges was published issued on November 18, 2010. Third, a proposed rule for the application, review, and reporting process for waivers for State innovation was published in the March 14, 2011 **Federal Register** (76 FR 13553). Fourth, two proposed regulations were published in the **Federal Register** on July 15, 2011 (76 FR 41866 and 76 FR 41930) to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act. Fifth, a proposed regulation for the establishment of the Consumer Operated and Oriented Plan (CO-OP) Program under section 1322 of the Affordable Care Act was published in the **Federal Register** on July 20, 2011 (76 FR 43237). Sixth, three proposed rules, including this one, are being published in the **Federal Register** on August 17, 2011 to provide guidance on the eligibility determination process related to enrollment in a qualified health plan, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and the Children’s Health Insurance Program (CHIP).

B. Legislative Overview

This proposed rule implements the Medicaid and CHIP eligibility and enrollment provisions of the Affordable Care Act including:

- Section 1413, which directs the Secretary of HHS (the “Secretary”) to establish a streamlined system for individuals to apply for and be enrolled in an insurance affordability program if eligible.
- Section 1414, which directs the Secretary of Treasury, upon written request, to provide the Secretary with certain tax return information used in determining an individual’s eligibility for all insurance affordability programs.
- Section 2001, which sets out the Medicaid eligibility changes and new optional coverage effective in CY 2014.
- Section 2002, which references the determination of financial eligibility for Medicaid for certain populations.
- Section 2101, which implements new eligibility standards for CHIP.
- Section 2201, which simplifies and coordinates eligibility and enrollment system between all insurance affordability programs.

- Section 2001(a)(3), which added a new section 1905(y) of the Act, which provides for a significant increase in the FMAP for medical assistance expenditures for individuals determined eligible under the adult group in the State and who are considered to be “newly eligible”, as defined in section 1905(y)(2)(A) of the Act.

- Section 10201(c)(4), which added a new section 1905(z) to the Act. As discussed in section N of this rule, Section 1905(z) of the Act contains two provisions, which make available additional FMAP rates for the expansion States.

In this rule, “CHIP” refers to a separate child health program operated by a State under title XXI and the regulations governing such programs at 42 CFR part 457.

C. Overview of the Proposed Rule

The proposed amendments to 42 CFR parts 431, 435, and 457 in this rule propose the Federal policies and guidelines necessary to facilitate the creation of the eligibility and enrollment system established by the Affordable Care Act. Amendments to 42 CFR part 435 subparts B and C are proposed to implement the statutory changes to Medicaid eligibility. We propose amendments to subpart A to add new or revised definitions.

Amendments to 42 CFR part 435 subpart G propose that, for most individuals, financial eligibility for Medicaid will be based on MAGI, to define the new MAGI-based financial methodologies, and to identify those individuals whose eligibility will not be based on MAGI.

Proposed amendments to subpart J and the addition of a new subpart M provide Federal rules to promote the establishment by States of a seamless and coordinated system to determine eligibility of individuals seeking assistance and to enroll them in the appropriate insurance affordability program. We propose a new subpart M to delineate the responsibilities of the State Medicaid agency in the coordinated system of eligibility and enrollment established under the Affordable Care Act, and propose comparable amendments for CHIP at 42 CFR part 457.

We propose to amend 42 CFR part 433 to add new provisions at § 433.10(c) to indicate the increases to the FMAPs as available to States under the Affordable Care Act. A number of provisions in the Affordable Care Act are not included in this proposed rule, but either have been or will be addressed in separate rulemaking or other guidance. In the April 19, 2011 **Federal Register**, we

published the Federal Funding for Medicaid Eligibility Determination and Enrollment Activities final rule (76 FR 21950) that provides details on enhanced Federal funding for Medicaid eligibility systems.

We also intend to issue additional proposed rules on related matters such as appeals, notices, presumptive eligibility, eligibility for former foster care children, deletion of existing regulations that have been rendered obsolete, and eligibility policy in the territories. In addition, we intend to release a Request for Information (RFI) related to State conversion of current income standards to MAGI-equivalent standards per section 2002 of the Affordable Care Act as well as a RFI related to the State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid under section 1331 of the Affordable Care Act.

II. Provisions of the Proposed Rule

The following descriptions are structured to explain the provisions being proposed and do not necessarily follow the order of the regulation’s text.

A. Changes to Medicaid Eligibility

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

Section 2001(a) of the Affordable Care Act adds a new section 1902(a)(10)(A)(i)(VIII) of the Act (referred to as “the adult group”), under which States will provide Medicaid coverage starting in CY 2014 to individuals under age 65 who are not otherwise mandatorily eligible for Medicaid under sections 1902(a)(10)(A)(i)(I) through (VII) or (IX) of the Act and have household income, based on the new MAGI methods described in section II.B of this proposed rule, at or below 133 percent FPL. Although the Act specifies that this new group is for individuals under age 65, individuals under age 19 are not included because such individuals with household income at or below 133 percent FPL are covered in the eligibility groups under sections 1902(a)(10)(A)(i)(IV), (VI), and (VII) of the Act.

We propose to replace the current § 435.119 (which addresses obsolete provisions for eligibility of qualified family members under section 1902(a)(10)(A)(i)(V) of the Act for which the statutory authority ended on September 30, 1998), to establish this new eligibility group.

Proposed § 435.119(a) and (b) set forth the policy, explained above. Reflected

in proposed paragraph (b), financial eligibility for the adult group will be based on MAGI, as defined in section 1902(e)(14) of the Act and implemented at proposed § 435.603; there is no resource test.

Section 1902(a)(10)(A)(i)(VIII) of the Act specifies that individuals may be eligible for the adult group if they “are not described in a previous subclause of” section 1902(a)(10)(A)(i) of the Act. Under these proposed rules, an individual is not eligible under the new adult group if the individual is otherwise eligible under section 1902(a)(10)(A)(i) of the Act and 42 CFR 435 subpart B, but may be eligible for the adult group if the individual is described in but not eligible for Medicaid under another mandatory group. This will mean that an individual who is a recipient of Supplemental Security Income (SSI) benefits, and so potentially eligible under section 1902(a)(10)(A)(i)(II) of the Act, may be eligible for coverage under the adult group in a State that has elected in accordance with section 1902(f) of the Act and § 435.121 to use more restrictive eligibility criteria for Medicaid than SSI.

The new adult group will include parents as well as adults not living with children. It will also include individuals currently eligible under an optional coverage group (such as, for individuals with disabilities) who have household income, based on the new MAGI methods, at or below 133 percent of the FPL and otherwise meet the criteria for coverage under the new group. At proposed § 435.119(c), we codify section 1902(k)(3) of the Act, which permits coverage of parents and other caretaker relatives under the new adult group only if their children under age 19 (or higher if the State has elected to cover children under age 20 or 21 under § 435.222) are enrolled in Medicaid or “other health insurance coverage.” In paragraph (c)(1), we propose to define “other health insurance coverage” to mean minimum essential coverage, as defined in § 435.4 of this proposed rule.

2. Individuals Above 133 Percent FPL (§ 435.218)

Section 2001(e) of the Affordable Care Act adds a new section 1902(a)(10)(A)(ii)(XX) of the Act, giving States the option starting in CY 2014 to provide Medicaid coverage to individuals under age 65 (including pregnant women and children) with income above 133 percent FPL. This new eligibility group provides a simplified mechanism for States to cover individuals whose income exceeds the State’s income standard for

mandatory coverage (for example, 133 percent FPL for the adult group). This option is an alternative to the use of income disregards under section 1902(r)(2) or 1931(b)(2)(C) of the Act, which have been used in the past to expand eligibility, but which will no longer be available starting in 2014.

We propose to add a new § 435.218 establishing this optional eligibility group, which covers individuals who are under 65 years old; are not eligible for and enrolled in an eligibility group under section 1902(a)(10)(A)(i) of the Act and 42 CFR 435 subpart B or under section 1902(a)(10)(A)(ii) 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 optional income standard established by the State. The basis and basic eligibility criteria for this group are set forth in proposed § 435.218(a) and (b)(1).

Section 1902(a)(10)(A)(ii)(XX) of the Act specifies that individuals may be eligible under this category if they “are not described in or enrolled under a previous subclause of” section 1902(a)(10)(A)(ii) of the Act. We interpret the language “described in or enrolled under” to mean eligible for another optional or mandatory group under section 1902(a)(10)(A) of the Act, and we propose at § 435.218(b)(1)(ii) and (iii) that this limitation applies only if the individual is eligible for or enrolled under another eligibility group that is covered by the State.

To ease administrative burden on States and to make it easier for States to enroll eligible individuals under the simplest eligibility category, we also propose in § 435.218(b)(1)(ii) and (iii) that an individual who meets the eligibility criteria at § 435.218(b)(1)(i) and (iv) would be determined eligible under this group, unless the individual can be determined eligible under another eligibility group based on information available to the State from the application. A State is not required to make determinations regarding eligibility factors such as disability, level of care, or resources first in order to decide whether an individual would be eligible for another eligibility group, unless such determination can be made based only on the information provided on the application. However, as an exception to this, if an individual appears to be eligible as “medically needy” based on information provided,

he or she could still be enrolled in this optional group. States would still have to determine eligibility under all possible categories if the individual is not eligible under this new optional group.

Section 1902(a)(10)(A)(ii)(XX) of the Act provides that, to be eligible under this optional group, an individual’s income must “not exceed the highest income eligibility level established under the State plan or under a waiver of the plan[.]” We are interpreting the statute to give States flexibility in establishing the income standard for this group, provided such standard exceeds 133 percent FPL and is approved in the State plan.

Section 1902(hh)(1) of the Act provides that States “may elect to phase-in” coverage for this optional group “based on the categorical group (including non-pregnant childless adults) or income, so long as the State does not extend such eligibility to individuals * * * with higher income before making individuals * * * with lower income eligible for medical assistance.” We propose that if a State wants to phase in coverage for this group, it submit a plan for Secretarial approval.

Children are included in this new optional group for individuals above 133 percent FPL if they are not already eligible for Medicaid. Therefore, if a State covers children above 133 percent FPL under a separate CHIP and adopts coverage under this new optional group, the State ultimately must shift coverage of children with income at or below the income standard from CHIP to Medicaid under this group. The State would still be able to claim enhanced FMAP under title XXI for such children.

Section 1902(hh)(2) of the Act limits eligibility of parents and other caretaker relatives under the new optional group to individuals whose children have coverage in the same manner as eligibility is limited for parents and caretaker relatives under the new adult group per section 1902(k)(3) of the Act. At § 435.218(b)(2)(ii), we propose to implement this provision in the same manner as proposed for the new adult group at § 435.119(c).

3. Amendments to Part 435, Subparts A Through D

Determining Medicaid eligibility prior to the Affordable Care Act changes in CY 2014 is complicated due to a

patchwork of multiple mandatory and optional eligibility groups for different “categorical populations.” Many States cover 50, 60, or more distinct eligibility groups. Financial eligibility is determined using methodologies based on other programs, such as the SSI and the former AFDC programs, adding further complexity to the eligibility determination process. In this rule, consistent with the Affordable Care Act policies, we propose 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.

In response to the President’s request, outlined in Executive Order 13563, that agencies streamline and simplify Federal regulations, we propose to use the authority of section 1902(a)(19) of the Act, which provides “that eligibility * * * be determined * * * in a manner consistent with simplicity of administration and the best interests of recipients,” to simplify and consolidate certain existing mandatory and optional eligibility groups into three categories starting in CY 2014, to complement the new adult group: (1) Parents and caretaker relatives (new § 435.110); (2) pregnant women (new § 435.116); and (3) children (new § 435.118).

As illustrated in Table 1, we are proposing to collapse existing Medicaid eligibility categories, with the goal of making the program significantly easier for States to administer and for the public to understand. In subsequent rulemaking, we will provide additional guidance on existing regulatory provisions that are effectively subsumed under the provisions contained in these proposed rules or have been rendered obsolete for other reasons. In proposing a simplified approach to eligibility for populations whose eligibility will be based on MAGI, it is our intent that eligibility for coverage will not change for any of the populations as a result of this proposal. We solicit comments on the implications of these proposed rules for individuals as well as States. Table 1 shows how the mandatory and optional groups in current regulations (the column on the left) are moved into the new broader groups (parents, pregnant women, and children) under this proposed rule.

TABLE 1

Social Security Act and Pre-ACA Regulations	Medicaid Proposed Rule		
	Parents/caretaker relatives (§ 435.110)	Pregnant women (§ 435.116)	Children < 19 (§ 435.118)
Mandatory Medicaid Eligibility Groups			
Low-income families—1902(a)(10)(A)(i)(I) and 1931 AFDC recipients—§ 435.110	X	X	X
Qualified Pregnant Women & Children < 19—1902(a)(10)(A)(i)(III)—§ 435.116		X	X
Poverty-level related pregnant women & infants—1902(a)(10)(A)(i)(IV)—No rule		X	X
Poverty-level related children 1–5—1902(a)(10)(A)(i)(VI)—No rule			X
Poverty-level related children 6–18—1902(a)(10)(A)(i)(VII)—No rule			X
Optional Medicaid Eligibility Groups			
Families & children financially eligible for AFDC—1902(a)(10)(A)(ii)(I)—§ 435.210	Keeps 435.210 for parents/caretaker relatives.	X	X
Families & children who would be eligible for AFDC if not institutionalized—1902(a)(10)(A)(ii)(IV)—§ 435.211.		X	X
Poverty-level related pregnant women & infants—1902(a)(10)(A)(ii)(IX)—No rule		X	X

a. Eligibility for Parents and Other Caretaker Relatives, Pregnant Women, and Children

(1) Parents and Other Caretaker Relatives (§ 435.110)

We propose to delete in its entirety § 435.110 for individuals receiving AFDC and to replace it with a new § 435.110 for existing eligibility that is continuing under sections 1902(a)(10)(A)(i)(I) and 1931(b) and (d) of the Act for parents and other caretaker relatives of dependent children (including pregnant women who are parents or caretaker relatives). These statutory provisions remain and are not superseded by the provisions of the Affordable Care Act establishing a new adult group for individuals not otherwise eligible under section 1902(a)(10)(A)(i) of the Act. While the parent/caretaker relative category continues to apply, our proposed rules simplify this category considerably and provides States flexibility to set their income eligibility standard under this category within allowable Federal parameters.

Under the proposed rule, each State will establish an income standard in its State plan for coverage of parents and other caretaker relatives under § 435.110. The Federal minimum and maximum income standards for this group are set forth in sections 1931(b)(2)(A) and 1931(b)(2)(B) of the Act. The minimum income standard for the new parent/caretaker relative group is a State's AFDC income standards for a household of the applicable family size in effect as of May 1, 1988. The maximum income standard would be established as set forth below. The maximum income standard for the

parent and other caretaker relative eligibility group would be the higher of:

- The State's effective income level (including any disregard of a block of income) for section 1931 families under the State plan or waiver of such plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent income standard in accordance with guidance to be issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act (The conversion of current income standards to a MAGI-equivalent standard is discussed in section II.B.3.a of this proposed rule.); and
- The State's AFDC income standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for all urban consumers since such date.

If a State's income standard for the parent/caretaker relative group is below 133 percent FPL, parents and other caretaker relatives with income above that income standard and at or below 133 percent FPL would qualify for Medicaid under the new adult group. The conversion of current income standards to a MAGI-equivalent standard is discussed in section II.B.3.a of this proposed rule.

States currently have the option to cover parents and other caretaker relatives at income levels above the standard for families under section 1931 of that Act. They can do so under the authority at section 1902(a)(10)(A)(ii)(I) of the Act and § 435.210 of the existing regulations. This option will continue under the Affordable Care Act for coverage of parents and other caretaker relatives who are not eligible for mandatory Medicaid coverage under § 435.110 or the new adult group at

proposed § 435.119. We note that parents and other caretaker relatives who are Medicare-eligible or elderly may be covered under § 435.110 and § 435.210, even though they are excluded from coverage under the adult group at § 435.119.

We are also proposing to simplify the income methods for determining eligibility under the new parent and other caretaker relative group. Pre-Affordable Care Act, section 1931 of the Act requires a two-step process in determining income eligibility: (1) The family must have gross income at or below 185 percent of the State's consolidated standard of need under its AFDC program, in effect as of July 16, 1996; and (2) the family's net countable income after subtracting various income exclusions and disregards and expenses must be at or below the State's AFDC payment standard or a higher income standard established by the State under section 1931 of the Act. Because each State's net countable income standard converted to a MAGI-equivalent income standard will be lower than its current gross income standard, we propose to eliminate the 185 percent gross income test as unnecessary and, to simplify eligibility, base income eligibility in proposed § 435.110 only on the second prong of the income test, that is, the net countable income standard converted to a MAGI-equivalent income standard.

Consistent with section 1931 of the Act, we propose Medicaid definitions of "caretaker relative" and "dependent child" at § 435.4. A caretaker relative is defined as a parent or other relative (related by blood, adoption, or marriage) living with a dependent child for whom such individual is assuming primary responsibility. Per section 1931 of the

Act, to be “dependent,” the child must be “deprived” of at least one parent’s support by reason of death, absence, or unemployment. Under the statute, a parent is considered to be unemployed if he or she is working less than 100 hours per month. However, we propose to codify in this rule the flexibility given States in a final rule amending 45 CFR 233.101 (63 FR 42270) and in a State Medicaid Director letter dated September 22, 1997 to eliminate the “deprivation” requirement altogether (which most States have done) or to establish a higher number of working hours as the threshold for determining unemployment.

In proposing this rule, we are retaining the minimum income standards specified in Federal statute for each eligibility group, while giving States flexibility to set new standards at a level that takes into account a State’s current rules regarding how income is counted. In all cases, the income standard would be applied to an individual’s MAGI-based household income. We considered whether or not States should convert the Federal minimum income standards prescribed in statute—for example, the minimum standard for pregnant women and children specified in section 1902(l) and for parents and other caretaker relatives in section 1931(b) of the Act—to a MAGI-equivalent minimum income standard based on the income exclusions and disregards currently used by the State. While doing so could result in maintaining eligibility for individuals who might otherwise lose Medicaid due to the elimination of income exclusions and disregards under MAGI, if a State were to reduce its income standard to the minimum permitted, it also would result in different minimum income eligibility standards being applied across States and reduce the amount of eligibility simplification that could be achieved. We, therefore, do not propose to require conversion of the Federal minimum income standards currently prescribed in statute to MAGI-equivalent standards.

Furthermore, we do not believe that the impact on eligibility of the proposed policy will be significant. Eligibility standards for children must be maintained through September 2019, in accordance with the maintenance of effort provisions (MOE) in section 1902(gg) of the Act, and when the MOE provision expires, eligibility for only a small number of children would be affected if a State were to drop coverage to the minimum level permitted. Parents and other caretaker relatives who could lose eligibility under section 1931 of the Act if a State were to reduce coverage

to the minimum permitted under the statute would retain eligibility under the new adult group. Pregnant women would be affected if a State were to decrease its income standard to the statutory minimum level, as the MOE for pregnant women ends with the establishment of an Exchange in 2014 and there is no other coverage group to which affected pregnant women would necessarily be transferred; instead, pregnant women affected by a State’s decision to reduce its Medicaid income standard for pregnant women to the minimum permitted under the Act would likely become eligible for advanced payments of the premium tax credit for enrollment through the Exchange.

(2) Pregnant Women (§ 435.116)

As is true for parents and caretaker relatives, the law retains eligibility based on pregnancy. To simplify the eligibility rules, we propose to replace the current § 435.116 for qualified pregnant women and qualified children under section 1902(a)(10)(A)(i)(III) of the Act with a new § 435.116 for pregnant women. In addition, under the authority of section 1902(a)(19) of the Act, we are consolidating many different eligibility categories for pregnant women and are proposing to include in the revised § 435.116 all mandatory and optional eligibility groups, except the medically needy, for which pregnancy status and income are the only factors of eligibility. The following sections of the Act are included under the proposed § 435.116: 1931 (low-income families); 1902(a)(10)(A)(i)(III) (qualified pregnant women); 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(ii)(IX), and 1902(l) (poverty-level related pregnant women); 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria); and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women).

Under the proposed rule, paragraphs (a) through (c) set forth the basis and basic provisions for coverage of pregnant women under § 435.116. We propose at § 435.116(c) that each State will establish an income standard in its State plan for coverage of pregnant women. The minimum income standard is 133 percent FPL, unless a higher income standard, at or below 185 percent FPL, was in effect for pregnant women on December 19, 1989 (section 1902(l)(2)(A) of the Act). The maximum income standard is the higher of:

- The highest effective income level (including any disregard of a block of income), converted to a MAGI-equivalent income standard, in effect under the State plan or waiver of the

State plan as of March 23, 2010 or December 31, 2013, if higher, for coverage of pregnant women under the sections of the Act identified above; and

- 185 percent FPL.

We are also codifying current law to add a definition of “pregnant woman” in § 435.4, incorporating the post partum period.

While we propose to consolidate various eligibility categories for pregnant women, States continue to have flexibility under the statute to provide different benefits to certain pregnant women or to provide all pregnant women with full Medicaid coverage, as many States do today. Thus, under clause (V) in the matter following section 1902(a)(10)(G) of the Act, pregnant women eligible for Medicaid under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(ii)(IX), and 1902(l) of the Act are only covered for services related to pregnancy or to a condition which may complicate the pregnancy. In accordance with section 1902(a)(10)(B) of the Act, all other pregnant women eligible for coverage under the sections of the Act listed in § 435.116(a) are eligible for all services that the State covers under the State plan, regardless of whether the service is related to pregnancy or to a condition that may complicate pregnancy.

However, States currently have the flexibility to provide full Medicaid coverage as pregnancy-related services for all pregnant women. Thus, we propose at § 435.116(d) that pregnant women are covered for full Medicaid coverage, unless a State elects to provide only the pregnancy-related services described at § 435.116(d)(3) for pregnant women whose income exceeds an income limit established by the State for full coverage. States have flexibility under existing regulations at § 440.210(a)(2) to establish a policy that all services covered under the State plan are related to pregnancy or to a condition that may complicate pregnancy. Therefore, States will not have to establish an income limit for full coverage for pregnant women under § 435.116(d)(4), but may elect to provide full coverage for all pregnant women. Reflected at proposed paragraph (d)(3), States also may elect to cover certain enhanced pregnancy-related services, as specified in § 440.250(p), for pregnant women only.

(3) Infants and Children Under age 19 (§ 435.118)

Section 2001(a)(4) of the Affordable Care Act amends section 1902(l)(2)(C) of the Act to provide Medicaid to children ages 6 through 18 with household income at or below at least 133 percent

FPL. This amendment eliminates certain of the age-based differences in Federal Medicaid eligibility rules for children, which currently provide for a minimum income standard of 100 percent FPL for coverage of children ages 6 through 18 (although many States have implemented optional coverage at higher levels), and means that all children and adults under age 65 with household income at or below 133 percent FPL will be eligible for Medicaid. Section 205(b) of the Medicare and Medicaid Extenders Act of 2010 clarifies that this amendment is effective January 1, 2014. If some or all of these children are covered under a separate CHIP before this provision takes effect, these children will move to coverage under Medicaid. Such a change, however, will not affect States' ability to claim enhanced FMAP under title XXI for these children.

Currently, there are many different mandatory and optional eligibility categories for children. To simplify the eligibility rules, we propose to include under § 435.118 all mandatory and optional eligibility groups for which age under 19 and income are the only factors of eligibility. The following sections of the Act are included under proposed § 435.118: 1931 (low-income families); 1902(a)(10)(A)(i)(III) (qualified children who meet AFDC financial eligibility criteria); 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) (infants); 1902(a)(10)(A)(i)(VI) (children ages 1 through 5); 1902(a)(10)(A)(i)(VII) (children ages 6 through 18); and 1902(a)(10)(A)(ii)(IV) (institutionalized children).

Proposed § 435.118(a) through (c) set forth the basis and eligibility criteria for children, as explained above. We propose in § 435.118(c) that each State will establish income standard(s) in its State plan for coverage of children by age group. There is no resource test. The minimum income standard for all age groups is 133 percent FPL, unless, for infants per section 1902(l)(2)(A) of the Act, a higher income standard, at or below 185 percent FPL, was in effect on December 19, 1989. The maximum income standard for each age group is the higher of:

- The highest effective income level for the age group (including any disregard of a block of income)—converted to a MAGI-equivalent standard—in effect under the State plan or waiver as of March 23, 2010 or December 31, 2013; or

- For infants, 185 percent FPL.

A State may not otherwise increase its income standard above the levels specified because, effective January 1, 2014, States may no longer apply new

income disregards in determining eligibility for individuals whose eligibility is based on MAGI. Coverage at higher income levels can be implemented through adoption of the new optional group at proposed § 435.218.

The maintenance of effort (MOE) provisions of the Affordable Care Act at section 2001(b) maintain the minimum income standards for children at the levels in effect on March 23, 2010; these standards are maintained for children until September 30, 2019. These proposed regulations do not address the MOE provisions specified in sections 1902(a)(74) and 1902(gg) of the Act, as added by section 2001(b) of the Affordable Care Act. As a condition of receiving Federal financial participation, States must comply with these provisions, which are being addressed through subregulatory guidance.

Other Conforming Changes to Existing Regulations

Revisions are proposed at § 435.4 to the definition of “families and children” to delete references to AFDC rules. Definitions are proposed for “agency,” “caretaker relative,” “dependent child,” and “pregnant woman.” Definitions related to implementation of the Affordable Care Act are proposed for “advance payments of the premium tax credit,” “Affordable Insurance Exchange (Exchange),” “effective income level,” “electronic account,” “household income,” “insurance affordability program,” “MAGI-based income,” “minimum essential coverage,” “modified adjusted gross income (MAGI),” “secure electronic interface,” and “tax dependent”.

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

Section 2002 of the Affordable Care Act, as amended by section 1004 of the HCERA, creates a new section 1902(e)(14) of the Act, which provides that effective January 1, 2014, financial eligibility for most individuals shall be based on MAGI and “household income,” as defined in section 36B(d)(2) of the IRC (hereinafter referred to as “section 36B definitions”). In this preamble, “MAGI-based methodologies” refers both to the rules governing the determination of the MAGI of an individual or a married couple filing a joint tax return, as well as to the determination of total household income. Similarly, reference to the determination of income eligibility “based on MAGI” refers to determinations based on household

income using MAGI-based methodologies.

The adoption of MAGI-based methodologies to determine income represents a significant simplification for the Medicaid program, eligibility for which has historically been linked to programs providing cash assistance to low-income populations. We are considering permitting States to convert to MAGI-based methodologies prior to 2014 through section 1115 demonstrations.

Proposed § 435.603 sets forth proposed methodologies to implement MAGI in determining Medicaid eligibility for affected individuals effective January 1, 2014. Our proposed methodologies codify the section 36B definitions of MAGI and household income, except in a very limited number of cases discussed below. At proposed § 435.603(i), we identify those populations excepted under the Affordable Care Act from application of MAGI-based methodologies; for these populations pre-Affordable Care Act Medicaid financial methodologies—generally set forth in existing regulations at § 435.601 and § 435.602—will continue to apply.

1. Point-in-Time Measurement of Income (Budget Periods) (§ 435.603(h))

Under pre-Affordable Care Act Medicaid rules, per section 402(a)(13)(A) of former title IV–A of the Act, income eligibility for Medicaid is based on current income actually available to the individual in any given month. MAGI, as defined in section 36B of the IRC, is determined on the basis of annual income. The Affordable Care Act addresses this issue by adding section 1902(e)(14)(H)(i) of the Act to provide that the use of MAGI in determining eligibility for Medicaid shall not be “construed as affecting or limiting the application of the requirement under this title to determine an individual’s income as of the point in time at which an application for medical assistance is processed.” Moreover, section 1902(a)(17) of the Act provides that States use eligibility standards and methodologies that are “reasonable,” “consistent with the objectives of [the Act],” and take into account only such income as is “determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient[.]”

In this proposed rule, we refer to the “point in time” rules referenced in the statute as the “budget period” (that is, monthly versus annual income) based upon which income eligibility is determined. At proposed § 435.603(h)(3), we are retaining the

current flexibility afforded States to take into account future changes in income that can be reasonably anticipated (as may be the case with certain seasonal workers or someone with a signed employment contract or layoff notice). Such anticipated changes would be determined in accordance with the verification regulations at § 435.940 *et seq.* Uncertain changes in future income (for example, someone who is looking for, but has not secured, a job) may not be considered under the option reflected at proposed § 435.603(h)(3). Actual changes in income—including deviations from reasonably anticipated fluctuations in income—must still be reported to, and acted upon by, the agency in accordance with § 435.916(c) and (d).

To promote flexibility, administrative simplification and continuity of coverage for beneficiaries already enrolled in Medicaid, we propose at § 435.603(h)(2) to give States the additional flexibility, for individuals eligible for Medicaid based on MAGI, to maintain eligibility as long as annual income based on MAGI methods for the calendar year remains at or below the Medicaid income standard. This gives States the option to align with the annual eligibility period applied in the Exchanges and to minimize the extent to which individuals experiencing relatively small fluctuations in income bounce back and forth between programs.

We believe that these flexibilities will help address some of the challenges that will arise due to the reliance on monthly income for purposes of eligibility for Medicaid versus annual income for purposes of eligibility for advance payments of premium tax credits. In particular, if a State does not opt to take into account a reasonably predictable drop in future income, someone with current monthly income above the Medicaid income standard, but projected annual income below 100 percent FPL could be determined both ineligible for Medicaid (until their monthly income actually dropped) and for advance payments of the premium tax credit for enrollment through the Exchange (because, with very limited exceptions, individuals with income below 100 percent FPL are not eligible for advance payments of the premium tax credit). We solicit comments on how best to prevent a gap in coverage, including whether to ensure that State Medicaid agencies take into account a predictable future drop in income.

2. Changes to Medicaid Financial Methods

Under pre-Affordable Care Act Medicaid rules for families and children, essentially all money received, from whatever source, is counted as income in the month in which it is received, unless explicitly excluded or disregarded under the Act, disregarded at State option, or excluded under other Federal statutes. A “household” (for purposes of determining family size and whose income is counted) generally consists of parents and the children with whom they are living. Other non-legally responsible relatives and unrelated individuals living together are not included, nor are spouses or parents living apart from the rest of the family, which means that the income of such individuals is not deemed available to the Medicaid applicant. Under pre-Affordable Care Act Medicaid rules, inclusion of stepparents in a stepchild’s household depends on State law relating to obligations to support stepchildren. A stepparent’s income is considered available to his or her spouse since spouses are legally responsible for each other.

Section 36B of the IRC, and § 1.36B-1 of the IRS proposed premium tax credit rule, define “MAGI,” “household income,” and “family size.” See also section 152 of the IRC and Internal Revenue Service (IRS) Publication 501 regarding rules for claiming “qualifying children” and “qualifying relatives” as tax dependents. To be eligible to receive advance payments of a premium tax credit for the purchase of coverage through an Exchange, married couples generally must file jointly.

As discussed in section II.I of this proposed rule, sections 1413 and 2201 of the Affordable Care Act direct the creation of a seamless, simplified system of coordinated eligibility and enrollment between insurance affordability programs, and in most instances, section 36B definitions of “MAGI” and “household income” are applied to Medicaid to promote seamless coordination. In some situations, the application of these new rules will have the impact of constraining Medicaid eligibility, but consistent with the statute, we have applied the 36B rules because of the impact on coordination. In a few limited situations in which the potential adverse impact of adopting the section 36B definitions could be significant (albeit for a relatively small group of individuals), and the impact on coordination minimal, we propose, consistent with the statute, retention of current Medicaid rules.

3. Provisions of Proposed Rule Implementing MAGI Methods

Proposed § 435.603(a)(1) and (2) set forth the basis and scope of this section. At proposed § 435.603(a)(3), we implement section 1902(e)(14)(D)(v) of the Act, as added by section 2002(a) of the Affordable Care Act, which specifies that, in determining ongoing eligibility of individuals enrolled in the Medicaid program as of January 1, 2014, the financial methodologies based on MAGI shall not be applied until the next regularly-scheduled redetermination of eligibility after December 31, 2013 or March 31, 2014, whichever is later, if such individual otherwise would lose eligibility as a result of the shift to MAGI-based methodologies before such date.

Consistent with the 36B definition, we propose in § 435.603(b) to define “family size” as equal to the number of persons in the individual’s household (as defined in paragraph (f) of this section and discussed below); “tax dependent” is defined in proposed revisions to § 435.4, and cross referenced at proposed § 435.603(b), as an individual for whom another individual properly claims a deduction for a personal exemption under section 151 of the IRC for a taxable year. Proposed § 435.603(c) sets forth the basic rule that, except for eligibility determinations exempt from MAGI methodologies, financial eligibility for Medicaid must be based on household income as defined in § 435.603(d).

Consistent with the section 36B definition of household income, proposed § 435.603(d)(1) provides that, for purposes of determining Medicaid eligibility under § 435.603, “household income” is the sum of the income based on MAGI-based methods of every individual who is: (1) included in the individual’s household; and (2) required to file a tax return under section 6012 of the IRC, except that, also consistent with section 36B definitions, the MAGI-based income of a child who files a tax return, but is not required to file, is not included in household income under proposed § 435.603(d)(2). The MAGI-based income of adults as well as children who are not included in the household of their parent(s) is always counted in determining the household income of the adult or such child as well as the household income of their spouse and children with whom they are living (if any).

a. Proposed Methods for Counting Income Based on MAGI (§ 435.603(e))

In general, we propose income counting rules at § 435.603(e) that are the same as the section 36B definitions

to ensure streamlined eligibility rules and avoid coverage gaps. There are some differences in the treatment of several types of income under the IRC as compared to pre-Affordable Care Act Medicaid rules, in which the changes occasioned by the adoption of the section 36B definitions would have varying effects on the Medicaid eligibility of potential beneficiaries. Given the general directive to apply the section 36B definitions and the value of alignment, these proposed rules generally codify the section 36B rules and definitions. This is the case with respect to the treatment of child support payments, depreciation of business expenses, and capital gains and losses.

Under this regulation as proposed, we also are applying the section 36B rules and definitions of Social Security benefits under title II of the Act. Such benefits count as income for the purpose of determining eligibility for Medicaid under pre-Affordable Care Act treatment of income, but certain amounts of Social Security benefits are not counted as income under the 36B definition of MAGI. The section 36B treatment of Social Security benefits may increase State Medicaid costs, as some individuals who receive Social Security benefits would gain Medicaid eligibility using the 36B definitions. The Administration is concerned about this unintended consequence and is exploring options to address it, including a modification of the section 36B treatment of Social Security benefits through regulation. We seek comment on this issue, including how any modification of the proposed regulation may affect eligibility for premium tax credits for enrollment in a qualified health plan through the Exchange and how any potential gaps in coverage that may be created by such modification could be minimized.

There are three types of income for which we propose to codify current Medicaid rules. We solicit comments on these proposed policies.

The first is lump sum payments, which consist of non-recurring income received on a one-time-only basis (for example, insurance settlements, back pay, State tax refunds, inheritance, and retroactive benefit payments). Under section 36B definitions, taxable "lump sum" payments are included in computing MAGI in the year the lump sum is received. Currently in Medicaid, most States count lump sum payments as income in the month received and, for any amounts retained, as a resource in months following. Because of the statutory directive to consider point-in-time (that is, current monthly) rather than annual income for determination of

Medicaid eligibility, and the challenges in amortizing a lump sum payment over time to pay for coverage, we propose in § 435.603(e)(1) to count lump sum payments of taxable income as income only in the month received.

Second, certain types of educational scholarships and grants (for example, work-study arrangements and other situations in which the individual has to provide a service) are generally counted as taxable income under the IRC, but not counted as income under current Medicaid rules. To avoid low-income students having to forgo either Medicaid or this education-related aid, we propose in § 435.603(e)(2) to retain the Medicaid rules for this type of income.

Third, American Indian and Alaska Native (AI/AN) income is the subject of special treatment and protections in multiple provisions of titles XIX and XXI of the Act. Most recently, the Recovery Act added section 1902(ff) to the Act (applied also to CHIP through the addition of section 2107(e)(1)(c) of the Act) to broaden exemptions related to certain AI/AN financial interests to ensure that low-income AI/AN individuals have access to Medicaid. There are certain instances where the IRC and the section 36B definition of MAGI are identical to or more liberal than current Medicaid rules with regard to income exclusions for AI/AN populations, and therefore, are adopted in the proposed rule. However, there are several instances in which the IRC treats as taxable income distributions from AI/AN trust properties, which are excluded from income for purposes of Medicaid and CHIP eligibility under the Recovery Act and other current law. In these instances, we propose at § 435.603(e) to codify current Medicaid treatment of AI/AN income, including distributions from Alaska Native corporations and settlement trusts; distributions from any property held in trust, or otherwise under the supervision of the Secretary of the Interior; distributions resulting from certain real property ownership interests; payments from other ownership interests or usage rights that support subsistence or a traditional lifestyle; and student financial assistance provided under the Bureau of Indian Affairs education programs.

In addition, section 1902(B)(e)(14)(B) of the Act, codified at § 435.603(g), prohibits the continued use of any asset test or income or expense disregards for individuals whose financial eligibility is based on MAGI (other than a disregard of 5 percent of the FPL to be applied to every such individual under section 1902(e)(14)(I) of the Act.) In order to account for the general elimination of

income disregards and to ensure continued coverage at pre-Affordable Care Act levels, per section 1902(e)(14)(A) and (E), States will convert current income standards for eligibility groups under which financial eligibility will be based on MAGI to a "MAGI-equivalent" income standard. Separate guidance will be issued regarding the methodologies States may employ to determine such MAGI-equivalent income standards. Application of the statutory across-the-board 5 percent disregard is reflected in proposed § 435.603(d)(1).

Detailed guidance on the treatment of all types of income under the new MAGI-based methodologies will be provided in subregulatory guidance.

b. Proposed Rules for Determining Household Composition Under MAGI-Based Methods (§ 435.603(f))

(1) Household Composition for Tax Filers (§ 435.603(f)(1)) and Their Tax Dependents (§ 435.603(f)(2))

Our proposed rules for household composition are divided into two categories: those for individuals filing taxes (§ 435.603(f)(1)) and their tax dependents (§ 435.603(f)(2)); and those for individuals who neither file a tax return nor are claimed as a tax dependent on someone else's tax return, whom we refer to as "non-filers" (§ 435.603(f)(3)).

After analyzing the differences between the section 36B definitions and current Medicaid rules, we believe that for most families, the section 36B definitions and current Medicaid rules yield the same household. However, there are a relatively small number of situations in which application of the section 36B definitions yields a different household than current Medicaid rules, including the following:

(1) Families in which the parents claim as tax dependents children age 21 or older.

(2) Families in which the parents claim as tax dependents children living outside of the home.

(3) Families with stepchildren/stepparents (in States without a law requiring stepparents to support their stepchildren).

(4) Families in which one or more children are required to file a tax return.

(5) Families in which one member is supporting and claiming as a tax dependent extended family members or unrelated individuals, including children other than their own biological or adopted children.

(6) Children claimed as a tax dependent by a non-custodial parent.

(7) Pregnant women.

(8) Married couples who do not file jointly.

In the first four types of households identified, consistent with the general statutory directive to apply the section 36B definitions to Medicaid, we are proposing at § 435.603(f)(1) to adopt the household composition rules embodied in the section 36B definitions. Doing so will result in some loss of Medicaid eligibility compared to pre-2014 Medicaid rules. However, maintaining different rules for the insurance affordability programs for these household types would undermine simplicity and coordination, which benefits consumers and States alike, and add to States' and potentially families' administrative burden.

For the fifth type of household identified (for example, a grandparent caring for a grandchild claimed as a tax dependent), the income of the claimed tax dependent is likely to be quite low, making them likely eligible for Medicaid based on their income alone. However, in such situations adoption of the section 36B definitions for household composition for determining the Medicaid eligibility of the tax dependent could significantly affect both the taxpayer and the relative or unrelated individual whom the taxpayer has no legal responsibility to support, putting such taxpayers in the position either of: (1) Forgoing a tax advantage (including, in some cases, an Earned Income Tax Credit) so as to enable the tax dependent to apply for Medicaid on his own; or (2) assuming financial responsibility for purchasing health care for such individual—a responsibility which they do not have under current law. Accordingly, we propose at § 435.603(f)(2)(i) to codify current Medicaid rules in determining the eligibility of qualifying relatives claimed as tax dependents by another taxpayer. MAGI-based definitions would be used in determining household composition for purposes of the taxpayer's eligibility, per proposed § 435.603(f)(1). It is also important to note that, reflected in proposed § 435.603(d)(3) and consistent with current Medicaid rules, actually available cash support provided by the non-legally responsible relative is counted as income to the claimed tax dependent. The purpose of retaining the Medicaid household rules as a backstop in these situations is to prevent the attribution of income from non-legally responsible relatives when that income is not in fact available to the tax dependent. We do not believe that this proposal would disrupt coordination or create a gap in coverage.

Regarding households in which a child is claimed as a tax dependent by

a non-custodial parent, we are proposing at § 435.603(f)(2)(iii) to apply rules based on pre-Affordable Care Act Medicaid principles of parents' legal responsibility for the children with whom they are living. By applying the rules for non-filers in this situation, as proposed in these rules, these children would be treated as members of the custodial parent's household for Medicaid eligibility purposes, and the income of the custodial parent (and other members of the custodial parent's household required to file a tax return) would be counted in determining the child's Medicaid eligibility. Alternatively, the child could enroll in coverage through the Exchange in the child's State of residence as a member of the non-custodial parent's household. (See discussion in section II.A.4 (b) of the preamble for the accompanying Exchange proposed rule.) We specifically solicit comments on the proposed handling of the household composition for these children.

Under pre-2014 Medicaid rules, a pregnant woman is considered as a household of two for purposes of determining eligibility. States have the option to count a pregnant woman as two in determining the family size of other members of a pregnant woman's household (for example, her spouse or other children). Under the section 36B definition of family size, pregnant women count as one person for purposes of eligibility for advance payments of the premium tax credit, but if the child is born by the end of the calendar year, the annual premium tax credit would be for two persons. Counting the pregnant woman as a household that will be comprised of two for Medicaid eligibility purposes essentially anticipates the change in household size that will occur after the birth. Applying the 36B definitions would result in some women being enrolled, with advance payments of the premium tax credit, in a qualified health plan through the Exchange who, after giving birth, will be eligible for Medicaid. Therefore, the proposed definition of family size in § 435.603(b) retains current Medicaid rules for pregnant women to promote continuity of coverage for the family and to ease State administrative burden.

Married couples who file separately are not eligible for premium tax credits. However, there is no similar provision in title XIX of the Act with respect to Medicaid eligibility. Therefore, in such situations, we propose at § 435.603(f)(4) to codify current Medicaid rules to include each spouse in the household of the other and to count the MAGI-based income of each spouse required to file

a tax return in determining the other's household income, regardless of whether the couple files a joint tax return. We recognize that at times two legally married individuals may live apart. Therefore, consistent with current Medicaid rules, the proposed rule also limits the inclusion of spouses in each other's household to those who are living together.

In some cases, a child may be living with both parents, but the parents do not file, or are not married and therefore cannot file, a joint tax return. Consistent with current Medicaid principles of legal responsibility, we propose at § 435.603(f)(2)(ii) to apply the proposed rules for non-filers in the case of children living with such parents, so that both parents, if living with the child, will be included in the child's household and their income counted in determining the child's eligibility.

(2) Household Composition for Non-Filers (§ 435.603(f)(3))

The IRC contains provisions regarding filing thresholds—ranging from \$9,350 in 2010 (86 percent FPL) for a single individual to \$19,800 for a married couple filing jointly with one spouse 65 or older (137 percent FPL)—below which individuals are not required to file. Individuals below these thresholds may file a tax return, but for non-filers, section 36B of the IRC does not specifically address household composition.

To be eligible for a premium tax credit, spouses must file jointly and (except in cases of divorce or separation in which the non-custodial parent is permitted to claim a child) parents who file can claim their children under 19 who are living with them (or under age 24 if a full time student) as a qualifying child. See IRS Publication 501. The current Medicaid principle that parents are legally responsible for their children and that spouses are legally responsible for each other is consistent with section 36B of the IRC. In the case of Medicaid, parents are assumed to be financially responsible for their children up to age 21; this does not vary with the child's student status.

Under either section 36B of the IRC or pre-Affordable Care Act Medicaid rules, spouses living together are considered to be part of the same household for eligibility purposes, and proposed paragraph § 435.603(f)(3) similarly specifies that spouses living together be included in the same household. We considered several alternatives regarding when children who are living with their parent(s), but are not claimed as a tax dependent on such parent's tax

return, should be included in the parent's household.

Applying pre-Affordable Care Act Medicaid rules making parents financially responsible for children who are under age 21 could result in a gap in coverage for children aged 19 and 20 who are not in school and are not claimed as dependents on their parents' tax return, but whose parents do file a tax return and have household income above the Medicaid income standard for 19 and 20 year-olds. (Coverage for 19 and 20-year olds, in most States, will be under the new group for adults with household income at or below 133 percent FPL). On the other hand, adopting the IRC rule allowing parents to claim as a qualifying child their children only until age 19, unless a full-time student, could result in an increase in Medicaid eligibility for 19 and 20-year olds who are not full-time students and are living with their parents, as compared to pre-Affordable Care Act Medicaid rules. Adopting the IRC rule with respect to adult children ages 21–23 who are full-time students could result in a decrease in Medicaid eligibility and an imposition of legal responsibility for certain adult children not consistent with current law.

In balancing these considerations, we propose at § 435.603(f)(3), to treat spouses/parents (including stepparents) and all children (including stepchildren and stepsiblings) under age 19 or, if a full-time student, under age 21, who are living together, as members of the same household. This proposed policy will avoid the gap in coverage for 19 and 20 year olds, discussed above, while limiting any unnecessary increase in Medicaid eligibility. Children who are not living with their parents, or who are over the specified age limit, would not be included in their parents' household, and as with tax filing households, individuals other than a spouse, biological, adopted, or step-parent, child or sibling would not be included in the same Medicaid household under this proposed rule. We specifically solicit comments on the proposed rule for household composition of non-filers at § 435.603(f)(3).

(3) Retention of Existing Financial Methods (§ 435.603(i))

Section 1902(e)(14)(D) of the Act provides that the financial methodologies based on MAGI will not apply in certain situations. In those cases, eligibility will be determined using the rules in effect prior to the Affordable Care Act, codified in existing regulations at § 435.601 and § 435.602. Proposed § 435.603(i) sets out six exceptions:

- Individuals *eligible for Medicaid on a basis that does not require a determination of income by the Medicaid agency*. This exception from use of MAGI-based methods includes, but is not limited to, individuals receiving or deemed to be receiving SSI, individuals receiving assistance under title IV–E of the Act, and individuals for whom the agency is relying on a finding of income made by an Express Lane Agency under section 1902(e)(13) of the Act.

- Individuals *who qualify for medical assistance on the basis of being blind or disabled*. This exception applies only to those individuals for whom the determination of eligibility is made on the basis of being blind or disabled. Individuals who are blind or who have disabilities can also be covered under the new mandatory eligibility group for adults (codified at proposed § 435.119) with MAGI-based household income at or below 133 percent of FPL. To the extent that their income exceeds that level, current financial methodologies will be used to determine their eligibility for coverage on the basis of being blind or disabled under an optional eligibility group for blind or disabled individuals.

In proposed § 435.603(i)(3), we identify the most common of the eligibility groups for blind and disabled individuals excepted from MAGI methods under the Act. We are not listing coverage provided to individuals receiving SSI in so-called “criteria States” because they are encompassed under proposed § 435.603(i)(1)(iii)(A). (These individuals are receiving SSI but the State does not have an agreement under section 1634 of the Act under which the Social Security Administration makes a determination of Medicaid eligibility for the State.) We also are not specifically identifying children under age 18 who were receiving SSI as of the date of enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (August 22, 1996), who would continue to receive SSI but for the enactment of section 211 of that Act and who are eligible for Medicaid in accordance with section 1902(a)(10)(A)(i)(II) of the Act. While financial eligibility for continued coverage of these children will be excepted from MAGI, most, if not all, of the affected children will have reached age 18 as of January 1, 2014, the effective date for the transition to MAGI-based methods. We seek comment as to whether there might be children still eligible under this mandatory coverage group as of 2014, and therefore, whether

they should be identified in these regulations.

- Individuals *age 65 or older* are categorically excepted from MAGI methods under section 1902(e)(14)(D)(i)(II) of the Act. We recognize that the exception of all elderly individuals from MAGI methodologies for all eligibility groups could result in States having to retain application of AFDC financial methodologies in a small number of cases in which an elderly individual is being evaluated for coverage on the basis of being a parent or caretaker relative, for which age is not a factor. We solicit comments on possible approaches we might adopt to avoid this result—for example, interpreting the exception to apply only in the case of elderly individuals when age is a condition of eligibility or of applying SSI methodologies (which will continue to be used for most MAGI-excepted groups) in determining the eligibility of elderly individuals for coverage as a caretaker relative.

- Individuals *whose eligibility is being determined on the basis of the need for long-term care services, including nursing facility services or a level of care equivalent to such services*. Similar to the exceptions from MAGI for determinations based on being blind or disabled, we propose to apply this exception in the case of individuals whose eligibility is based on the need for or receipt of such services. Individuals otherwise eligible for Medicaid under an eligibility group to which MAGI-based methods apply (for example, children eligible under proposed § 435.118) will not be excepted from application of MAGI-based methods in determining ongoing eligibility under such group simply because they may need long-term care services.

- Individuals *eligible for assistance with Medicare cost sharing under section 1902(a)(10)(E) of the Act*. We propose to interpret this exception to apply only to the determination of eligibility for Medicare cost sharing assistance.

- *Medically needy individuals eligible under section 1902(a)(10)(C) of the Act*. This exception also applies only to the determination of eligibility for medically-needy coverage. Individuals who meet the eligibility criteria for coverage under another eligibility group—for example, the new adult group—are not excepted from application of MAGI-based methods for purposes of determining their eligibility for such other groups simply because they would qualify for coverage as a

medically needy individual if not eligible under such other group.

Section 1902(e)(14)(D)(iii) of the Act provides that MAGI-based methods shall not be used in determining eligibility for Medicare Part D premium and cost sharing subsidies under section 1860D-14 of the Act. Because such subsidies are not a form of Medicaid and determinations for Part D cost sharing subsidies are not performed under the authority of the Medicaid statute, we are not proposing to include regulations regarding this exception in these rules.

C. Residency for Medicaid Eligibility Defined

We propose to simplify Medicaid's residency rules to promote achievement of the coordinated eligibility and enrollment system established under sections 1413 and 2201 of the Affordable Care Act and discussed in section II.I of this proposed rule. We propose to redesignate and revise paragraphs § 435.403(h) and § 435.403(i) to § 435.403(i) (rules for individuals under age 21) and (h) (rules for individuals age 21 and older), which set parameters for States to determine who is a State resident. These revisions are not significantly different than the current rules. We do not propose changes to our current regulations regarding individuals living in institutions, receiving Federal foster care or adoption assistance under title IV-E of the Act, or adults who do not have the capacity to state intent. Note that policies regarding verification of residency are proposed at § 435.956(c) and discussed in section II.H.5 of this proposed rule.

1. Residency Definition for Adults (Age 21 and Over) (§ 435.403(h))

We propose to strike the term "permanently and for an indefinite period" from the definition for adults in redesignated § 435.403(h)(1) and (h)(4), and replace the term "remain" with "reside." An adult's residency will be determined based upon where the individual is living and has intent to reside, including without a fixed address, or the State which the individual entered with a job commitment or seeking employment (whether or not currently employed). While proposing to remove the phrase "permanently or for an indefinite period" and use the term "reside," we are maintaining existing policy that an individual must intend to remain living in the State in which he or she is seeking coverage. Persons visiting a State for personal pleasure or purposes of obtaining medical care are not

residents of the State visited. By removing the term "living" in the State or replacing the term "remain" with "reside," we do not intend to have any policy impact on State policy. Indeed, we note that section 1902(b)(2) of the Act refers to individuals who "reside in the State". We are removing the word "living" from the definition in order to simplify the language. An individual must still maintain present intent to reside in the State being claimed as the State of residence; a State would not be required to recognize an intent to reside at some future point in time. We have retained the term "living" for individuals who do not have the capacity to state intent, as we are not modifying the regulations for that population.

Our proposal to remove language regarding permanency and "an indefinite period" will help to facilitate coordination of eligibility determinations across and between programs and is also consistent with long-standing statutory requirements. Under section 1902(b)(2) of the Act, States may not exclude from coverage an individual who resides in the State "regardless of whether or not the residence is maintained permanently or at a fixed address[.]"

2. Residency Definition for Children (Under Age 21) (§ 435.403(i))

For individuals who are emancipated or married, we propose language to align the residency rules with the proposed definition for adults. Accordingly, at redesignated § 435.403(i)(1), we propose to strike the term "permanently and for an indefinite period" and to replace the word "remain" with "reside."

We propose in § 435.403(i)(2) to combine and consolidate two different definitions of residency currently set forth in paragraphs (h)(2) and (h)(3) for unemancipated individuals under age 21: (1) those whose Medicaid eligibility is based on a disability and (2) those who are not disabled and not living in an institution or receiving foster care or adoption assistance under IV-E of the Act. We eliminate the cross-reference to the AFDC rules at 45 CFR 233.40 and for both groups of children we propose to apply a similar definition as that proposed for most adults, but without the "intent" component, as individuals under age 21 may not legally be able to express intent. Under the proposed rule, States may not determine residency of a child based solely on the residency of the parent.

Our proposal will simplify State administration and make the rules clearer to the public. Our proposal to

allow children to establish residency to the same extent as adults when a parent or caretaker is seeking or has confirmed employment is intended to ensure a consistent approach for migrant, seasonal workers and other families living in a State while employed or in search of employment. The proposed definition also allows flexibility for families in which children attend school in a State other than where the parents live; such children may be considered residents of the parents' "home State," if the parent expresses the requisite intent. However, we do not change States' current flexibility to determine whether students "reside" in a State, as long as each individual has the opportunity to provide evidence of actual residence. The proposed rule excludes children who are visitors for pleasure or for purposes of obtaining medical care. Parents, caretakers, and persons acting responsibly on behalf of a child may attest to where the child resides, under new § 435.956(c).

While we do not believe our proposed changes significantly affect Federal guidance on residency, we seek comments on the proposed modifications to § 435.403(h) and (i), particularly on the impact of this proposed rule on children eligible for Medicaid based on disability. We also seek comments on whether to change the current State residency policy with regard to individuals living in institutions and adults who do not have the capacity to express intent.

D. Application and Enrollment Procedures for Medicaid

1. Availability of Program Information (§ 435.905)

Section 2201 of the Affordable Care Act adds a new section 1943(b)(1)(A) to the Act which directs States to develop procedures that enable individuals to apply for, renew, and enroll in coverage through an Internet Web site. Section 1943(b)(4) directs States to establish a Web site (which must be linked to the Web site established by the Exchange operating in the State) that will allow individuals to obtain information regarding coverage under Medicaid and CHIP and compare such coverage to that available through the Exchange. Thus, we propose to amend § 435.905 to ensure that program information be made available electronically through a Web site in addition to providing information to applicants both orally and in writing. We propose to modify § 435.905(b) to eliminate specific requirements regarding quantity and electronic availability of bulletins and

pamphlets, as we do not believe these are necessary in regulations.

2. Applications (§ 435.907)

To support States in developing a coordinated eligibility and enrollment system for all insurance affordability programs, section 1943(b)(3) and section 1413 of the Affordable Care Act direct the Secretary to develop and provide States with a single, streamlined application. The single application, to be used for all insurance affordability programs and available through a variety of formats including on-line and phone applications, will build on the successes many States have had in developing simplified applications.

Accordingly, we propose to amend current regulations at § 435.907 to reflect use of the new single, streamlined application. The Secretary will develop the data elements for the application in collaboration with States and consumer groups. As permitted in section 1413(b)(1)(B) of the Affordable Care Act, proposed § 435.907(b)(2) provides States the option to develop and use an alternative streamlined application, subject to review and approval by the Secretary. Under the law, those who are limited English proficient (LEP) and persons with disabilities must have equal access to health care and the benefits. We intend to address the readability and accessibility of applications, forms and other communications with applicants and beneficiaries in future guidance.

In § 435.907(c), we propose two alternative approaches related to applications for individuals who may qualify for coverage on a basis other than MAGI. First, we propose that States may use supplemental forms to gather additional information, such as information pertaining to resources, needed to make an eligibility determination. This approach would permit anyone seeking coverage to begin by completing the same single, streamlined application as all other applicants. Second, we propose to permit States to develop and use an alternative single, streamlined application form designed specifically to capture information needed to determine eligibility for individuals whose eligibility is not determined based on MAGI. Under the statute and proposed 435.907(c), such supplemental and alternative forms are subject to the Secretary's approval. We seek comment on both of the proposed approaches as well as other alternatives to ensure a simple application process.

In § 435.907(d), we explain that the agency must establish procedures to allow persons seeking coverage to file

an application through a variety of means including online, in person, over the phone and by mail. Applications may be submitted in person, but under this proposed rule, particularly in light of the seamless coordination process required for enrollment in Medicaid and the Exchange, in person interviews cannot be required for the individuals whose eligibility is based on MAGI.

For individuals not seeking coverage for themselves ("non-applicants"), to ensure privacy we propose in § 435.907(e)(1) to codify the long-standing policy against requiring such individuals to provide Social Security numbers (SSNs) or information regarding their citizenship, nationality, or immigration status. To promote enrollment of eligible applicants, States may request an SSN of a non-applicant on a voluntary basis. Proposed § 435.907(e)(2) codifies existing policy grounded in Title VI of the Civil Rights Act of 1964, the Privacy Act, and Medicaid confidentiality provisions at section 1902(a)(7) of the Act to allow States to request an SSN of a non-applicant only if: (1) Providing an SSN is voluntary; (2) use of a non-applicant's SSN is limited to processing the applicant's eligibility or for other functions necessary to the administration of the State's plan; and (3) the State provides notice that provision of an SSN is voluntary and indicates how the SSN will be used.

In support of the proposed rule, we note that sections 1411(g) and 1414(a)(2) of the Affordable Care Act specify that taxpayer information may only be used for eligibility determinations and other functions directly related to the administration of benefits. Section 1902(a)(7) of the Act directs States to have safeguards that restrict the "use or disclosure of information concerning applicants and recipients only for purposes directly connected with the administration of the [State] plan * * *" Non-applicant information used to determine an applicant's eligibility is considered to be information "concerning" the applicant or recipient; thus, this information must be appropriately safeguarded.

We propose to continue the current policy that Medicaid applicants and beneficiaries must provide an SSN, if the individual has one. Under our current regulations at § 435.910, if an individual does not have an SSN, the agency must assist the individual in obtaining one. For background and a detailed discussion of the current policy on the collection of SSNs, see the *Tri-Agency Guidance* issued in conjunction with the Administration for Children and Families and the Food Nutrition

Service, in September 2000, at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/tanf/triagencyletter.html>.

Section 1943(b)(1)(A) of the Act directs Medicaid agencies to permit enrollment and reenrollment in the State plan or under a waiver through electronic signature. Accordingly, we propose in § 435.907(f) that States must accept applications signed through the use of electronic signature techniques, including telephonically recorded signatures, as well as handwritten signatures transmitted by fax or other electronic means. This is consistent with current practice in most States.

3. Assistance With Application and Redetermination (§ 435.908)

Some of the individuals eligible for coverage in 2014 may need assistance with the application and renewal process. Therefore, we propose to amend current § 435.908(b) to ensure that the agency provides assistance through a variety of means to any individual seeking help with the application or redetermination process. This is consistent with current State practice and is in accordance with section 1902(a)(19) of the Act.

We are proposing 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 who are LEP. In addition, section 1943(b)(1)(F) of the Act directs States to conduct outreach to vulnerable and underserved populations eligible for Medicaid. Such outreach and assistance will be particularly important for those who are newly eligible, as well as for people with disabilities, underserved racial and ethnic minorities and other groups. We will provide technical assistance and subregulatory guidance to further address application and renewal assistance to meet the needs of the multiple populations served by the program.

E. MAGI Screen (§ 435.911)

This section of the preamble and the proposed rules at § 435.911 describe the process for applying a new simplified test for determining eligibility based on MAGI—which is facilitated by the simplified eligibility categories, including the new adult coverage group, discussed in section II.A of this proposed rule—as well as the steps States will take to ensure that individuals who do not meet the simplified test are evaluated for Medicaid eligibility on other bases and for potential eligibility for other insurance affordability programs.

Proposed § 435.911(a) sets forth the statutory basis for this section. In proposed § 435.911(b) we set forth several pertinent definitions, including “applicable modified adjusted gross income standard,” which will be at least 133 percent FPL, but in some States may be higher for certain individuals, including parents or other caretaker relatives, pregnant women or children.

Proposed § 435.911(c) describes the key steps in the proposed streamlined eligibility process. Under § 435.911(c)(1), for every individual who has submitted an application and who meets the non-financial criteria for eligibility (or for whom the agency is providing a reasonable opportunity to provide documentation of citizenship or immigrations status in accordance with sections 1903(x), 1902(ee) and 1137(d) of the Act), the Medicaid agency would determine whether such individual has household income at or below the applicable MAGI standard. This means that States will not need to review whether an individual who meets the applicable MAGI standard (for example, 133 percent FPL for the new adult group) is also eligible as a disabled or medically needy individual, both of which typically entail a more involved eligibility determination.

For individuals with household income at or below the applicable MAGI standard, the agency would provide Medicaid benefits promptly and without undue delay. Benefits will be addressed in subsequent guidance.

Some individuals with household income above the applicable MAGI standard may be eligible for Medicaid on another basis. In some States, for example, some individuals may be eligible based on disability or need for long-term care services, even if their income exceeds the applicable MAGI standard, and individuals eligible for Medicare may be eligible for assistance with Medicare premiums and cost sharing charges. In accordance with § 435.911(c)(2), for each individual who is not eligible for Medicaid based on MAGI under § 435.911(c)(1), the Medicaid agency shall collect additional information, consistent with proposed § 435.907(c), as may be needed to determine Medicaid eligibility on other such other bases.

We note that the MAGI screen proposed for State Medicaid agencies is the same process as that at proposed 45 CFR 155.305(c) of the Exchange Proposed Rule published elsewhere in this **Federal Register**; however, the Exchange will not be required to undertake Medicaid eligibility determinations based on factors other than MAGI. Under proposed

§ 435.1200(e)(2) and the Exchange Proposed Rule at 45 CFR 155.345, the Medicaid agency will retain responsibility for making such determinations, although the State can establish procedures whereby the Exchange will undertake such other determinations in certain circumstances, consistent with regulations at § 431.10 and § 431.11, as revised in and discussed in section J of this proposed rule.

Proposed § 435.911(c)(2)(iii) specifies that the agency must follow the policies of proposed § 435.1200(g) to assess individuals determined not eligible for Medicaid based on MAGI for potential eligibility for other insurance affordability programs and to facilitate seamless transfer of the individual’s electronic account to these other programs. Under proposed § 435.1200(g)(2), evaluation of individuals for Medicaid eligibility based on blindness or disability in accordance with proposed § 435.911(c)(2) should occur at that same time as evaluation for potential eligibility for premium tax credits for enrollment through the Exchange.

We are not proposing specific timeliness standards for the determination of eligibility under proposed § 435.911. In collaboration with States, we will be developing performance standards and metrics for the streamlined and coordinated eligibility and enrollment system. These metrics will also support the standards and conditions described in the Federal Funding for Medicaid Eligibility Determination and Enrollment Activities final rule (76 FR 21950) published in the April 19, 2011 **Federal Register**.

F. Coverage Month

In proposed § 155.410 of the Exchange proposed rule, enrollment through the Exchange for individuals terminated from Medicaid can begin at the earliest on the 1st day of the month following the date the individual loses Medicaid and is determined eligible for enrollment through the Exchange. If the individual loses Medicaid eligibility and is determined eligible for enrollment through the Exchange after the 22nd day of the month, enrollment through the Exchange begins at the earliest on the first day of the second month following such date. To promote coordination with coverage through the Exchange, we are considering adding a provision to the regulations to extend Medicaid coverage until the end of the month that the appropriate termination notice period ends. Certain exceptions—such as the death of a beneficiary—

would apply. This is the current practice in many States which now end Medicaid coverage at the end of a month for administrative convenience or to align with coverage offered by participating health plans paid on a per capita per month basis, as permitted under current regulations. We believe that providing coverage through the end of the month is similar to existing regulations at redesignated § 435.915(b), which allows States to make eligibility effective from the beginning of a month.

We invite comments on this potential approach to coverage, its likely impact on maintaining continuous coverage, whether the costs of this approach outweigh the benefits, or whether we should retain the current policy that provides State flexibility to end coverage at any time during a month.

G. Verification of Income and Other Eligibility Criteria (§ 435.940 Through § 435.956)

In this section, we discuss changes to 42 CFR part 435 subpart J to make verification processes more efficient, modernized and coordinated with the Exchange. In general, the proposed rules maximize reliance on electronic data sources, shift certain verification responsibilities to the Federal government, and provide States flexibility in how and when they verify information needed to determine Medicaid eligibility. The proposed changes draw from successful State systems and are aligned with those proposed at § 155.315 and § 155.320 of the Exchange proposed rule. The major changes are:

- In accordance with section 1413(c) of the Affordable Care Act, State Medicaid agencies will use a system established by the Secretary pursuant to her authority under sections 1411(c) and 1413(c) of such Act, through which all insurance affordability programs 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.) This system will reduce administrative burden on State Medicaid agencies and Exchanges.

- Consistent with current policy, State Medicaid agencies may accept self-attestation of all eligibility criteria, with the exception of citizenship and immigration status. To ensure program integrity, States must comply with the requirements of section 1137 of the Act to request information from trusted data sources when useful to verifying financial eligibility.

• We propose that in verifying eligibility States will rely, to the maximum extent possible, on electronic data matches with trusted third party data sources. Additional information, including paper documentation, may be requested from individuals when information cannot be obtained through an electronic data source or is not “reasonably compatible” with information provided by the individual. These changes align eligibility verification methods for Medicaid with those used for advance payments of premium tax credits and other insurance affordability programs. This proposal would apply to the specific financial and non-financial information referenced in these rules, as well as to any additional information the agency finds it necessary to verify in order to determine eligibility, regardless of whether that information is specifically referenced in the regulation.

• A new section at § 435.956 relates to requests by the agency for information about non-financial eligibility factors.

• Finally, we have deleted a number of prescriptive provisions that are 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. We do not believe that this level of specificity regarding State use of data sources is necessary, nor do we believe it is appropriate to include in Medicaid regulations requirements that bind other agencies, such as State wage agencies.

These and other proposed revisions are discussed in more detail below.

1. Basis, Scope, and General Requirements (§ 435.940 and § 435.945)

At § 435.940, we add statutory citations to the basis and scope of the income and eligibility verification regulations to include, in addition to section 1137 of the Act, sections 1902(a)(4), 1902(a)(19), 1903(r)(3) and 1943 of the Act, as well as section 1413 of the Affordable Care Act.

At § 435.945(a), consistent with 42 CFR part 455, we are specifying that nothing in this proposed rule shall prevent a State from acting to ensure program integrity. Program integrity is a top priority and should be considered in commenting on the proposed rule.

Consistent with current policy, at § 435.945(b), we add language to expressly permit States to accept attestation of information related to eligibility, including income, age, birth date and State residency, without requesting paper documentation. The exceptions to this provision are

citizenship and immigration status, as these are subject to separate statutory requirements. States must continue to comply with the provisions of section 1137 of the Act relating to income information in accordance with rules set out in this section.

Redesignated § 435.945(c) directs the agency to request and use information in accordance with the appropriate sections of the regulations. We modify existing cross references to reflect other changes proposed and add cross references to the new § 435.949 and § 435.956. In addition, we have deleted references in § 435.945(c) and throughout the regulation to verifying “medical assistance payments,” “amount of medical assistance payments” and “benefit amount” as the reference to the verification of “eligibility” is sufficient.

We removed the list of programs with which the State Medicaid agency must exchange information at § 435.945(d) and instead include a reference to those programs listed in 1137(b) of the Act, as well as the child support enforcement program under Part IV–D of the Act (which is also referenced in section 1137) and SSA. Pursuant to sections 1413 of the Affordable Care Act and 1943 of the Social Security Act, we have added insurance affordability programs as programs with which the agency must exchange information.

We have not changed the rules for reimbursement arrangements between agencies for data exchanges at redesignated § 435.945(e), except for an updated cross reference and citing to section 1137(a)(7) of the Act.

Redesignated § 435.945(f) specifies that before a request for information from a third-party data source is initiated, an individual must receive notice of the information being requested and its use. Consistent with current State practice, we anticipate that this notice would be provided as part of the application process. We have deleted the current exception to this notice requirement when an individual’s eligibility has been determined by another agency because, under our revised rule, proper notice is required only when the agency itself will be requesting data from another agency or program. The reporting requirements at redesignated § 435.945(g) remain unchanged; however the regulatory citations relating to MEQC and documentation have been updated.

Existing § 435.945(g), regarding a State Wage Information Collection Agency (SWICA) that does not use the quarterly wages reported by employers under section 1137 of the Act, has been

deleted, as we believe these requirements are not within the purview of the State Medicaid agency.

Per section 1413(c) of the Affordable Care Act, we add a new § 435.945(h) (renumbering the next paragraph) to require that data exchanged electronically under this section must be sent and received via secure electronic interfaces which, as defined in proposed § 435.4, must be consistent with 42 CFR part 433.

Redesignated § 435.945(i), pertaining to written agreements between agencies engaged in data exchanges, has been modified to eliminate specific requirements regarding the precise content of such agreements and the timing and frequency of data exchanges to provide States greater flexibility. This flexibility will facilitate coordination with Exchanges and other insurance affordability programs and allow States to take full advantage of the increased automation of electronic data matching enabled through the provision of enhanced Federal funding for the development and implementation of such systems available under 42 CFR part 433 subpart C.

2. Verification of Financial Eligibility (§ 435.948)

Under sections 1137 and 1902(a)(46) of the Act, certain Federally-funded, State-administered programs, including Medicaid, are required to conduct electronic data matches to obtain income information from the State quarterly wage reports and Unemployment Insurance Benefits, the IRS, and the SSA to verify financial eligibility for benefits, if such information may be useful in verifying eligibility for Medicaid, as determined by the Secretary.

However, not all data sources are useful in all situations and under section 1137(a)(4)(C). The use of information identified in section 1137 of the Act “shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility * * * and no State shall be required to use such information to verify the eligibility of all recipients.” In addition to the data sources specifically listed in section 1137 of the Act, many States also rely on other data matches, which they find useful to verify income.

We believe that States are in the best position to determine the usefulness of the available data sources in specific cases. Therefore, we propose at § 435.948(a) to delegate to the State Medicaid agency the discretion afforded to the Secretary of the HHS under section 1137(a)(2) of the Act to determine when the information

identified in section 1137 of the Act is useful to verifying financial eligibility for an individual and must be requested. The sources of data which States much check, if useful, remain unchanged, except as follows:

- For the reasons discussed above, specific references to the timing and/or frequency with which information must be requested are deleted;
- Public Assistance Reporting Information System (PARIS) is added as a new data source given the requirement in 1903(r)(3) of the Act that all eligibility determination systems must conduct data matching through PARIS;
- We eliminate reference to the former AFDC program; and
- We replace reference to “Food Stamps” with “Supplemental Nutrition Assistance Program” to reflect the new name under the Food, Conservation and Energy Act of 2008.

As noted above and discussed in more detail below in relation to proposed § 435.949, the Secretary is required to establish a system through which all insurance affordability programs can verify certain information with other Federal agencies. At new § 435.948(b), we propose that, to the extent available, States must access needed information when available through the system established by the Secretary, consistent with sections 1943(b)(3) and 1902(a)(4) of the Act.

At § 435.948(c)(1), we provide that information not available through the service established by the Secretary under § 435.949 may be obtained directly from the agency or program housing the information. At § 435.948(c)(2), we retain the current policy in paragraph (c) of the existing regulations that information be requested by SSN, but clarify that, when an SSN is not available, the agency attempt to obtain needed information using other personally identifying information otherwise available in the individual’s account, as described in § 435.4. Note that when an SSN is not available, the agency must assist the individual in obtaining a SSN in accordance with § 435.910.

States may request and use alternate data sources, as permitted at proposed § 435.948(d), subject to Secretarial approval. Such alternative sources should reduce administrative costs and burdens on individuals and States, maximize accuracy, and minimize delay. Also, we make explicit existing policy that use of any such alternative data source must meet applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information. Finally, consistent with section 1413 of

the Affordable Care Act, we add that the use of an alternative data source facilitate coordination between all other insurance affordability programs.

3. Verification of Information From Federal Agencies (§ 435.949)

Section 1413(c) of the Affordable Care Act directs the Secretary of HHS, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security and the Commissioner of Social Security, to establish a system of verification, using secure electronic interfaces, through which all State health coverage programs can verify information needed to determine eligibility. Section 1411(c) of the Affordable Care Act specifically directs that the system enable electronic verification of household income and family size with the IRS, citizenship data with SSA, and immigration status with DHS.

By enabling access to multiple Federal sources through a single inquiry, insurance affordability programs can receive prompt, reliable data through the same service, thereby alleviating multiple data inquiries that the State might otherwise have to make. Since all of the insurance affordability programs will rely on certain common sources (that is, SSA, DHS and IRS), once such information is gathered and evaluated by one program, reevaluation or re-verification of data will not be necessary, and thus, not permitted by another program (unless an individual reports a change in circumstances).

We propose at § 435.949(a) to specify the Federal agencies from which information will be available through the Secretary, including SSA, DHS and the IRS. We propose in § 435.949(b) that, if data included in § 435.949 is available through the Secretary, States would be required to obtain such data through the service established by the Secretary. Other applicable regulations, including those set forth at § 435.948, § 435.956 and § 435.960, remain in effect for information, which cannot be requested through the Secretary.

We propose § 435.949(c) to codify section 1413(c)(3) of the Affordable Care Act, which provides that the Secretary may modify the methods used in the verification system established if she determines that modifications would reduce the administrative costs and burdens on individuals or agencies; ensure accurate and timely verification; comply with applicable requirements for the confidentiality, disclosure, program integrity, and maintenance or use of the information, including the requirements of section 6103 of the IRC; and promote coordination among

insurance affordability programs. Section 435.949(c) is proposed to be consistent and coordinated with § 155.315 of the proposed Exchange rule.

4. Use of Information and Requests for Additional Information (§ 435.952)

We are proposing changes to § 435.952, which describes the appropriate use of information. We are proposing to eliminate vague language at the end of § 435.952(a) regarding the requirement to independently verify information “* * * if determined appropriate by agency experience.” We expect processes to occur in real time wherever possible and we will be defining more detailed standards and other performance metrics, with State and stakeholder input, in subsequent Federal guidance. Accordingly, we also are proposing to delete the specific timeliness requirements contained in the current regulation at § 435.952(c), which now requires agency action within 45 days from the date new information is received.

Under § 435.952(b), as revised, if information provided by an individual is reasonably compatible with information that the agency has obtained from other trusted sources, the agency must act on such information and may not request additional information from the individual. To establish an appropriate balance between reliance on electronic verification and paper documentation, we propose to establish a “reasonable compatibility” standard governing when additional information, including paper documentation, can be requested from applicants and beneficiaries. Under proposed § 435.952(c), no further information may be required from the individual unless the agency is unable to obtain information through electronic data matching or the information obtained is not reasonably compatible with that provided by the individual. In such cases, the agency may contact the individual and accept the individual’s explanation without further documentation, if reasonable, or the agency may request additional information, including paper documentation. “Reasonably compatible” does not necessarily mean an identical match for the data, only that the information is generally consistent. Since what is “reasonably compatible” may vary depending on the particular circumstances, we are proposing to provide States flexibility to apply this standard. Under § 435.948(d), if the individual fails to respond to a request for additional information permitted under the proposed rule, the

agency shall proceed to deny, terminate, or reduce Medicaid only after notice and appeal rights have been provided in accordance with part 431, subpart E.

Sections 435.953 and 435.955 of the current regulations are deleted in the proposed rule. Provisions contained in § 435.953(a) and § 435.955(a) through (c) and (f) are revised and incorporated into § 435.948 and § 435.952, in accordance with the discussion above. We propose to remove the remaining requirements in § 435.953(b) through (d) (relating to detailed information the State must submit for the Secretary's approval to exclude specific data requests) and the detailed requirements in § 435.955(a) and (d), (e) and (g) (relating to the additional provisions regarding information released by a Federal agency, including State reporting requirements and requests for a waiver from the Federal agency's Data Integrity Board). We believe that the detailed nature of these provisions may unnecessarily hamper development of an efficient, modernized and coordinated system and that such details are best developed in collaboration with States and addressed through subregulatory guidance.

5. Verification of Other Non-Financial Information (§ 435.956)

We propose a new § 435.956 to address verifying non-financial information. As with financial information, to the extent non-financial information is available through the electronic service established by the Secretary, States would use that service under proposed § 435.949(b).

Under the proposed rule, at § 435.956(c), States may use attestation (including attestation of someone acting responsibly on behalf of the individual) or electronic data sources to determine State residency, in accordance with § 435.945(b) and § 435.952. Under proposed § 435.956(c), documents that provide information regarding immigration status should be used as a source of evidence to verify satisfactory immigration status, but may not, by themselves, be used to demonstrate lack of residency. For example, a temporary or time-limited immigration status, such as Temporary Protected Status (TPS), does not necessarily establish that the individual is not a State resident because TPS is routinely renewed. The proposed rule relating to residency does not diminish States' responsibility to ensure that only individuals with valid and satisfactory immigration status are determined eligible for and enrolled in Medicaid; if an individual has a temporary immigration status, the agency must ensure that the individual's

Medicaid eligibility is reviewed at the appropriate time.

Proposed § 435.956(d) simply cross-references current policy at § 435.910(f) and (g) regarding issuance and verification of SSNs.

Current Federal rules regarding verification of pregnancy vary based on the woman's eligibility category, but verification of pregnancy is not required in all cases under current rules.

Verification (except by self-attestation) may not be required for pregnant women eligible for pregnancy related services under section 1902(a)(10)(A)(i)(IV) or (ii)(IX) of the Act, but pregnant women must provide medical verification of pregnancy to be eligible for full Medicaid coverage as a qualified pregnant woman (with very low-income below the State's former AFDC standard) under section 1902(a)(10)(A)(i)(III) of the Act or under section 1931 of the Act, if medical verification was required under the State's AFDC program in effect on July 16, 1996.

In light of the proposed regulations at § 435.116, which combine these different eligibility categories to achieve greater simplicity in the program, we believe a verification rule for the combined group is needed. Thus, we are exercising the authority provided in section 1902(e)(14)(A) of the Act to propose application of the self-attestation verification rule under section 1902(a)(10)(A)(i)(IV) or (ii)(IX) of the Act in determining eligibility under § 435.116. Although a change in federal guidelines, we do not believe that this will have significant practical impact for States, as we believe most pregnant women today are covered under the eligibility groups for which medical verification is already not required. Proposed § 435.956(e) reflects this policy, providing that the agency must rely on the woman's attestation of pregnancy, unless the agency has other information (for example, claims history) that is not reasonably compatible with her attestation. To promote coordination of eligibility rules and procedures with the Exchange, we also propose at § 435.956(e) to codify the widespread State practice of accepting attestation of household composition unless the State has information which is not reasonably compatible with such attestation.

In proposed § 435.956(f), in the situations when age is a factor of eligibility, States may apply the same proposed verification procedures and options, as are available for other eligibility criteria verification, in accordance with § 435.945(b) and § 435.952.

When agencies obtain information regarding residency, SSN, pregnancy, age, and birth date in accordance with paragraphs (c) through (f) that is not reasonably compatible with the information or attestation provided by an individual, they must take reasonable steps to reconcile discrepancies that would affect eligibility, following the process set out in § 435.952(c) and (d).

H. Periodic Redetermination of Medicaid Eligibility (§ 435.916)

Consistent with section 1943(b)(3) of the Act and sections 1413(a) and 1413(c)(2) of the Affordable Care Act, which aim to ensure that individuals remain enrolled for as long as they meet eligibility standards, we propose to amend § 435.916 to establish simplified, data-driven renewal policies and procedures for individuals whose eligibility is based on MAGI, consistent with ensurance of program integrity.

States are increasingly re-engineering their renewal processes, recognizing that the traditional process, which involves a new application and documentation, may be unnecessary and can be burdensome for families and agencies. In addition, many eligible beneficiaries lose coverage at renewal for procedural reasons, only to reapply, and to regain eligibility, soon after losing coverage. This churning on and off of coverage is administratively costly and burdensome for the agency, health plans, and consumers, and is disruptive to continuity of care and efforts to achieve quality and efficiency in the delivery of care. This rule proposes renewal procedures that are consistent with those that will operate for the premium tax credit and that mirror the practices many States have adopted as they have sought to simplify the enrollment process and promote continuity of coverage.

Under current Federal policy, eligibility must be redetermined at least once every 12 months, and although States can have a shorter regular redetermination period, very few States do so today. According to a 2011 50-State survey by the Kaiser Family Foundation, all but two States currently have a 12-month renewal period for children and all but five also provide 12-month renewal periods to parents. Consistent with this State trend and the annual redetermination procedures for individuals eligible for tax credits to purchase coverage through the Exchange at § 155.335 of the Exchange proposed rule, we propose at § 435.916(a)(1) that States schedule regular redeterminations or renewals for beneficiaries whose eligibility is based on MAGI once every 12 months.

Consistent with current policy, eligibility should be redetermined more frequently if a beneficiary reports a change in circumstance that may affect continued eligibility, or the agency obtains information (for example, through a data match from other program records) that suggests the need for an eligibility review. States maintain authority and flexibility to establish procedures that ensure program integrity.

In recent years, States also have increasingly adopted measures to streamline the renewal process, including the use of administrative, telephone and online renewals. Consistent with this State trend, under the proposed process at § 435.916(a), States would not need a renewal form from all individuals, further streamlining the process for individuals and States. Similar to the proposed verification processes at initial application, discussed in section II.H. of this proposed rule, the proposed renewal procedures maximize the use of current third-party data matching to verify continued eligibility. Thus, at § 435.916(a)(2), we propose to codify the longstanding policy (see <http://www.cms.gov/smdl/downloads/smdl040700.pdf>) that agencies renew eligibility for beneficiaries by first evaluating information available to the agency in the electronic account or from other reliable data sources. If the information available to the agency is sufficient to make a determination of continued eligibility, including information that establishes that the individual or family continues to reside in the State, coverage shall be renewed on the basis of this information and the agency would send the appropriate notice to the beneficiary without requiring any further action. This eliminates the need for and administrative burden of a renewal form or a signed returned notice and unnecessary requests for information already on hand.

State experience with this type of renewal process shows that it reduces the number of eligible beneficiaries who lose coverage for procedural reasons while maintaining program integrity. Beneficiaries must correct any inaccurate information contained in the determination notice and would be permitted to do so through a variety of means, including online, in person, by telephone, or via mail. As noted below, if any information is missing or is not reasonably compatible with ongoing eligibility, the agency must take further action to complete the renewal process.

If the agency cannot determine that the individual remains eligible through

the process described above, we propose in § 435.916(a)(3) a process in which the agency would provide the individual with a pre-populated renewal form containing information that is relevant to the renewal and available to the agency. The agency would then provide the individual with a reasonable period—these rules propose at least 30 days—to furnish necessary information and to correct any inaccurate information either in person, online, by telephone, and via mail. We seek comments on this proposed process.

At § 435.916(a)(3)(ii), we propose that the agency verify the information reported by the beneficiary in accordance with § 435.945 through § 435.956, as revised in these proposed rules, including, at State option, reliance on self-attestation consistent with those sections. In § 435.916(a)(3)(iii), to avoid unnecessary reapplications for coverage, we also propose a reconsideration period for individuals who lose coverage for failure to return the renewal form. Individuals who return the form within a reasonable period after coverage is terminated would be redetermined without the need for a new application. We considered specifying a 90-day reconsideration period to align with the 3-month retroactive assistance period provided under section 1902(a)(34) of the Act, but did not specify a particular length of time in this proposed rule. We seek comments on the use and length of a specified reconsideration period.

Finally, consistent with section 1413 of the Affordable Care Act, we propose at § 435.916(a)(4) that for beneficiaries no longer eligible for Medicaid, the agency assess the individual for eligibility in other insurance affordability programs and transmit the electronic account and other pertinent data to the appropriate program for a determination of eligibility in accordance with proposed § 435.1200(g).

We have not proposed amending the renewal procedures for beneficiaries eligible on a basis other than MAGI (reflected in current regulations at redesignated § 435.916(b)), but seek comment on extending the renewal procedures proposed in § 435.916(a) to such individuals.

We propose to expand the standards under redesignated § 435.916(c) to include options for permitting all beneficiaries to report changes online, over the telephone, by mail or in person. Given the evolving reliance on methods for communication that go beyond the in-person interview, we solicit comment on whether more modernized procedures to report changes should be

available to both the MAGI and MAGI-excepted populations.

We note that we will be modifying the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) regulations to ensure that both the PERM Medicaid eligibility review and MEQC processes take into account these rules and procedures, including the use of authoritative data sources in redetermining eligibility. We also note that any State expenditures (before the end of 2015) for system changes necessary to adopt these renewal procedures should be subject to the enhanced (90 percent) match as outlined 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.

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

We propose to add a new subpart M, Coordination between Medicaid and other insurance affordability programs, including a new § 435.1200 to delineate the State Medicaid agency's responsibilities in effectuating such coordination. Proposed § 435.1200 also includes policies previously included in § 431.636, Coordination of Medicaid with the State CHIP. Section 435.1200(a) and (b) set forth the basis for and definitions used in the proposed section.

1. Basic Responsibilities (§ 435.1200(c))

Proposed § 435.1200(c) sets forth the basic responsibilities of the State Medicaid agency. Proposed § 435.1200(c)(1) specifies that the Medicaid agency must participate in the coordinated eligibility and enrollment system described in section 1943 of the Act. As discussed, most individuals will be evaluated for eligibility in the Exchange, Medicaid, and CHIP using a coordinated set of rules and these programs will work together to ensure that eligible applicants are enrolled in the appropriate program, no matter where their application originates. For example, an individual who directly applies for and is determined ineligible for Medicaid would be immediately assessed for eligibility for advance payment of the premium tax credit and coverage through the Exchange. That individual would not need to file a new application in order to participate in Exchange coverage, if eligible. Integration among these programs will help to avoid duplication of costs,

processes, data, and effort on the part of both the State and the individual.

We expect the use of a shared eligibility service to adjudicate placement for most individuals. The shared eligibility service would coordinate determination and renewal requirements for eligibility in each of the insurance affordability programs. It may include processes such as those used for collecting and verifying applicant information, including verification of citizenship and immigration status and certain income information as well as determining and renewing eligibility. Regardless of an applicant's point of entry (directly online at home, with a navigator or community organization/assistant, through the mail, or through a consumer assistance office established by the Exchange), this shared eligibility service would be used whenever the single streamlined application for enrollment, discussed in section II.E.2 of this proposed rule, is initiated or whenever a renewal occurs.

We note that shared systems and the Medicaid functions they perform are eligible for enhanced Federal financial participation (FFP) of 90 percent for development (through December 31, 2015) and 75 percent for operations (no time limit) if certain conditions and standards are met. For additional information, see the April 19, 2011 final rule establishing enhanced funding for Medicaid eligibility and enrollment activities. Such systems are subject to cost allocation principles, per OMB Circular A-87 and guidance from CMS. In addition, the entities and agencies performing functions on behalf of one another that involve the use or disclosure of an individual's health information will be required to comply with the applicable business associate provisions of the Privacy and Security Rules under the Health Insurance Portability and Accountability Act of 1996.

Section 435.1200(c)(2) proposes that State Medicaid agencies enter into one or more agreements with the Exchange and other insurance affordability programs as necessary to ensure coordination of eligibility and enrollment, including coordination with a Basic Health Program if applicable. Details about the Basic Health Program will be included in forthcoming guidance. States may also use such agreements to coordinate related activities, such as health plan management.

States may design these agreements in different ways that reflect their governance structures. We see three broad options. First, one or more of the

entities (the Exchange, Medicaid or CHIP agencies) could enter into an agreement whereby some or all of the responsibilities of each entity are performed by one or more of the others. Second, a State could develop a fully integrated system whereby the responsibilities of all entities are performed by a single integrated entity. Third, each entity could fulfill its responsibilities and establish strong connections to ensure the seamless exchange of information and data. We solicit public comments on these different working relationships and the best mechanisms to facilitate States' ability to coordinate eligibility and enrollment.

We note that relationships between the State Medicaid program and other insurance affordability programs must be established in accordance with section 1902(a)(5) of the Act, which specifies that a single State agency will administer or supervise the administration of the Medicaid program. When the Exchange or other entity is performing delegated functions, it must at all times conduct such business consistent with the rules adopted by the Medicaid agency. This is further discussed in section II.J of this proposed rule.

At § 435.1200(c)(3), we propose that the State Medicaid agency must certify criteria necessary for the Exchange to use in determining Medicaid eligibility based on MAGI. This includes the applicable Medicaid MAGI standard for parents and caretaker relatives, other adults, pregnant women, and children, as well as the criteria for determining satisfactory immigration status, in accordance with the Medicaid State plan. We invite public comment on other eligibility rules or criteria that should be certified by the Medicaid agency for Medicaid eligibility determinations made by the Exchange. MAGI methodologies and Medicaid eligibility based on the applicable MAGI standards are discussed in sections II.B.3 and II.E of this proposed rule.

2. Internet Web Site (§ 435.1200(d))

Section 1943 of the Act says that no later than January 1, 2014, States shall establish an Internet Web site, linked to the Web sites of other insurance affordability programs, through which individuals may obtain information, apply for, and enroll in Medicaid. To accomplish this, States could, for example, create one enrollment Web site for information and enrollment in all insurance affordability programs, or they could establish a broad health care Web site that includes health insurance coverage, health care services and

supports, and health education information from a broad array of entities. Additionally, a State could establish a Medicaid presence on an existing State Web site. This Web site must be coordinated with the Exchange Web site as described at § 155.205 of the Exchange proposed rule.

Proposed § 435.1200(d) gives individuals the option to apply for or renew their eligibility for Medicaid online. A Web site that connects an individual directly into the Medicaid eligibility determination system is eligible for enhanced FFP under the April 2011 final rule establishing enhanced funding for Medicaid eligibility and enrollment activities, if the system in its totality, including the Web site, meets certain standards and conditions. Additional information on Web site specifications will be provided in forthcoming guidance.

Because the Internet Web site may serve as the primary mechanism through which individuals communicate with the agency, it must be accessible to individuals with disabilities and persons who are limited English proficient (LEP). At § 435.1200(d)(2) we propose that the agency must ensure accessibility of Web resources in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act, and must take reasonable steps to provide meaningful access for LEP persons. Accessibility needs of LEP persons may be met by providing language assistance services, such as translated information and "taglines" that inform LEP persons of the ability to talk to a multilingual staff person or an interpreter.

Web sites, interactive kiosks, and other information systems would be viewed as being in compliance with section 504 if they meet or exceed section 508 standards, which ensure that Federal agencies' electronic information technology is accessible to people with disabilities. The latest Section 508 guidelines issued by the US Access Board can be accessed at <http://access-board.gov/sec508/standards.htm>, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 can be accessed at <http://www.w3.org/TR/WCAG20/>.

3. Provision of Medical Assistance for Individuals Found Eligible for Medicaid by an Exchange (§ 435.1200(e))

Consistent with sections 1413 and 2201 of the Affordable Care Act, under the coordinated system proposed in these rules, if the Exchange finds that an individual is eligible for Medicaid, the State Medicaid agency must enroll the

individual without further determination of eligibility. This enrollment is subject to the rules established by the agency. We note that the State Medicaid agency has the responsibility to facilitate health plan selection for enrolled individuals, but may arrange with the Exchange to undertake this function. This could include providing the individual with available health plan options and transmitting enrollment transactions to the health plan, if applicable.

As discussed in section II.B.3 of this proposed rule, for most individuals, eligibility for Medicaid would be determined based on MAGI. As described in the Exchange proposed rule, the scope of the final eligibility determinations made by the Exchanges is limited to those based on individuals having MAGI-based income at or below the applicable MAGI standard. Note that in certain circumstances the State may establish procedures whereby the Exchange will undertake Medicaid eligibility determinations on other bases. Individuals who are not eligible for Medicaid based on MAGI, would be screened, using information provided on the application, for potential Medicaid eligibility on other bases. As appropriate, their applications and other relevant information would be transmitted to the Medicaid agency for a full Medicaid eligibility determination. See section 155.345 of the Exchange proposed rule for additional information. Further, all applicants have the right to request and receive a full determination of eligibility on bases other than MAGI from the State Medicaid agency.

Section 435.1200(e) describes the standards for the Medicaid agency to promptly and efficiently enroll individuals determined to be Medicaid eligible by the Exchange. To accomplish this, we propose that the agency establish procedures to receive, via secure electronic interface from the Exchange, the finding of Medicaid eligibility and the individual's electronic account, including all application information. We recognize that an actual transfer of data may not occur, as the Medicaid agency and the Exchange may be utilizing a shared eligibility system. However, the legal responsibility for the electronic accounts and for further action, as appropriate, will transfer from the Exchange to the Medicaid agency. We expect processes to occur in real time whenever possible and, as noted earlier, we will be defining more detailed standards and other performance metrics, with State and stakeholder input, in subsequent Federal guidance.

4. Transfer of Applications From Other Insurance Affordability Programs to the State Medicaid Agency (§ 435.1200(f))

To ensure a coordinated eligibility and enrollment process as directed by the Affordable Care Act and address existing coordination rules for separate CHIP and Medicaid agencies in section 2102(b)(3)(B) of the Act, we propose a new § 435.1200(f). This provision includes and revises provisions previously covered under § 431.636(b)(1) through (b)(3). Under proposed § 435.1200(f), the State Medicaid agency must adopt procedures to promptly determine the eligibility of individuals assessed as potentially Medicaid-eligible by other insurance affordability programs and, if eligible, to enroll them without delay.

Under this proposal, individuals with household income below the applicable MAGI level who are assessed as potentially Medicaid eligible by another insurance affordability program would be quickly and easily enrolled in Medicaid. Because all insurance affordability programs will be utilizing a common process for MAGI-based eligibility determinations, an individual assessed by such a program as potentially Medicaid eligible based on MAGI should receive a seamless determination from the Medicaid agency, and no further action should be required of the applicant. For individuals with household income above the applicable MAGI standard, who are either assessed by an insurance affordability program as potentially eligible on a basis other than MAGI, or who request an eligibility determination on another basis, we propose that the Medicaid agency must conduct a full Medicaid eligibility determination in the same manner as if their application had been submitted directly to the agency.

We propose that the Medicaid agency establish procedures to receive the electronic account of any individual determined potentially Medicaid eligible by another insurance affordability program, and to promptly and without undue delay conduct an eligibility determination in accordance with the provisions set forth in § 435.911(c). The agency must not request any information already obtained, or duplicate any eligibility verifications already performed, by the other insurance affordability program and included in the individual's electronic account. Once the Medicaid determination is complete, we propose that the agency notify the insurance affordability program of the determination of Medicaid eligibility or

ineligibility. Issues related to the notices needed to effectuate coordinated eligibility will be addressed in future rulemaking.

5. Evaluation of Eligibility for Other Insurance Affordability Programs (§ 435.1200(g))

Section 1943(b)(1)(C) of the Act directs States to ensure that any individual who applies for, but is determined ineligible for, Medicaid or CHIP is screened for eligibility for advance payment of the premium tax credit, cost sharing reductions, and enrollment in a qualified health plan offered through the Exchange. Therefore, in § 435.1200(g)(1), we propose that the Medicaid agency must assess potential eligibility for other insurance affordability programs when the agency determines that an individual is not eligible for Medicaid.

While the Affordable Care Act does not provide express authority for Medicaid to make eligibility determinations for coverage through the Exchanges, sections 1943(b)(2) of the Act and 1413(d)(2) of the Affordable Care Act do permit the agency to enter into a contract with the Exchange to do so. Absent such an agreement, the agency must promptly transfer the electronic account of individuals screened as potentially eligible, via secure electronic interface, to the Exchange so that such individuals can receive an immediate eligibility determination and, if eligible, be enrolled without delay. This provision assumes that verification of any information required only for eligibility in the Exchange, such as access to affordable employer-sponsored insurance, will be completed by the applicable program once the applicant's case is transferred. (Under current law and regulations, States also have the flexibility to have the State Medicaid agency administer some or all of the administrative functions for a separate CHIP, including the determination of eligibility for such program.)

We further propose that the electronic account transferred include the determination of ineligibility made by the Medicaid agency as well as all information provided on the single streamlined application and, as appropriate, verified by the State Medicaid agency. We note again that an actual transfer of data may not be necessary, but legal responsibility for the case will transfer from Medicaid to the appropriate program. We also note that the Exchange cannot reverse a determination of Medicaid ineligibility made by the Medicaid agency.

In this and the Exchange proposed rule, we propose that individuals determined ineligible for Medicaid based on MAGI, for whom the Medicaid agency is evaluating eligibility on the basis of being blind or disabled, may enroll in other insurance affordability programs while a final Medicaid determination is pending. Once the Medicaid determination is completed, if the individual is Medicaid-eligible, such coverage would be terminated in favor of Medicaid, but if not Medicaid-eligible, coverage would continue through the other program. This avoids unnecessary delays in coverage for individuals whose Medicaid eligibility determination process may be lengthy, while avoiding any overlap in coverage for those eventually determined Medicaid eligible based on blindness or disability. Proposed § 435.1200(g)(2) reflects the Medicaid agency's responsibilities in effectuating this policy. We note that proposed 26 CFR 1.36B(2)(c)(2)(iii)(B) in the Treasury proposed rule specifies that if an individual receiving advance payments of the premium tax credit is approved for Medicaid coverage, the individual is treated for purposes of eligibility for such credit, as eligible for minimum essential coverage no earlier than the first day of the first calendar month after such coverage is approved; thus, an applicant who is being evaluated by the Medicaid agency for eligibility based on blindness or disability and who is provided with advance payments of the premium tax credit in the interim would not be liable to repay such advance payments upon retroactive approval of Medicaid during the period for which advance payments were paid.

Since it would be inefficient and confusing to transfer and enroll individuals in other coverage, only to be disenrolled from such coverage days or even a few weeks later for enrollment in Medicaid, we propose to limit application of the policy described to individuals whom the Medicaid agency, in accordance with procedures in proposed § 435.911(c)(3), is evaluating for eligibility on the basis of being blind or disabled.

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

As discussed in section II.I above, to ensure a fully coordinated eligibility determination and enrollment process, the Exchange proposed rule provides that Exchanges will make Medicaid eligibility determinations to effectuate Section 1943(b)(B). For numerous reasons, including the coordinated enrollment process, we anticipate that States will want to consider different

ways to achieve integration across Exchanges, Medicaid agencies and CHIP.

Under Medicaid's "single State agency" requirement in section 1902(a)(5) of the Act, as codified in § 431.10 and § 431.11, States must identify a "single State agency to administer or to supervise the administration" of the Medicaid program (that is, the Medicaid agency). This ensures that there is a single point of responsibility and accountability for proper administration of the State Medicaid program, including for eligibility determinations.

We note, however, that the statute at 1902(a)(5) specifically permits and in some cases requires the single State agency to delegate the authority to make eligibility determinations to certain other agencies. Current regulations provide for such delegation of eligibility functions in § 431.10(c). The regulations at § 431.10(e) provide that, in delegating any single State agency functions, the Medicaid agency retain authority to exercise administrative discretion in the administration or supervision of the plan, and that if other State or local agencies perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of the Medicaid agency, or otherwise substitute their judgment for that of the Medicaid agency in the application of policies, rules and regulations issued by the Medicaid agency. It is our understanding that the use of this delegation authority is widespread across the nation, and in some States, multiple State agencies separate and apart from the State Medicaid agency, as well as county agencies make Medicaid eligibility determinations on behalf of the single State agency and under its supervision. In all instances, the single State agency is responsible under the statute to set the rules for the program, and to ensure that the determinations made are consistent with the statute.

Related section 1902(a)(4) of the Act requires a State plan to provide for certain methods of administration, including the establishment of personnel standards on a merit basis. We have historically advised States that public employees must make Medicaid eligibility determinations. This position has been based on the premise that certain activities in the eligibility determination process cannot be delegated to private entities because they involve discretion or value judgment that are inherently governmental in nature, and in such instances we have stated that State merit system employees must be utilized. In

addition, there have been concerns about whether States that contract out their eligibility determination capacity would be able to effectively monitor and if necessary bring that capacity back "in house" if policy implementation issues arose.

Section 1413(d)(2)(B) of the Affordable Care Act reaffirms the single State agency requirement by providing that nothing in the law "changes any requirement under Title XIX that eligibility for participation in a State's Medicaid program must be determined by a public agency." The proposed regulation is consistent with this provision. Simultaneously, we solicit comments on how these statutory provisions should apply in the context of Exchanges making Medicaid eligibility determinations and simpler, more uniform eligibility criteria.

In this rule, we propose to allow Medicaid agencies to delegate eligibility determinations for individuals whose eligibility will be determined according to MAGI to Exchanges that are public agencies. Specifically, we propose to permit Exchanges that are public agencies to make Medicaid eligibility determinations as long as the single State Medicaid agency retains discretion in the administration or supervision of the plan. We note that if Exchanges are established as a non-governmental entity as allowed by the Affordable Care Act, the coordination provisions in the law may mean the co-location of Medicaid State workers at Exchanges or other accommodations to ensure coordination is accomplished. We solicit 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.

In § 431.10(c)(1)(iii), we propose to permit Medicaid single State agencies to delegate their MAGI eligibility determination function to Exchanges operated by governmental entities, provided the single State agency remains solely responsible for setting eligibility policies and is accountable for ensuring the program operates consistently with such policies. In § 431.10(c), we propose that the single State agency be responsible for ensuring that eligibility determinations are made consistent with its rules and that corrective actions are instituted as appropriate; that there is no conflict of interest by any agency delegated the responsibility to make determinations; that eligibility determinations are made in the best interest of beneficiaries; and

that it guard against improper incentives or outcomes.

We further propose to add new § 435.10(d)(l) through (5), and a conforming change to the introductory text at § 431.10(d), to provide that agreements between single State agencies and agencies making determinations must state the quality control and oversight plans by the single State agency to review determinations made by agencies making Medicaid eligibility determinations; that the agencies making Medicaid eligibility determinations report to the single State agency; that confidentiality and security requirements in accordance with sections 1902(a)(7) and 1942 of the Act for all beneficiary data are met; and that all agencies making Medicaid eligibility determinations meet the requirements of 1902(a)(4) relating to personnel standards.

Finally, we would retain the requirement in § 431.10(e) that Medicaid agencies may not delegate the authority to exercise administrative discretion or issue policies and rules on program matters; that the authority must not be impaired if subject to review by other entities; and that other entities must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency for the application of policies, rules and regulations issued by the Medicaid agency.

K. Provisions of Proposed Regulation Implementing Application of MAGI to CHIP

Section 2101(d) of the Affordable Care Act revises section 2102(b)(1)(B) of the Act to ensure that, effective January 1, 2014, that States base income eligibility for CHIP on MAGI and household income, as defined in section 36B of the IRC, consistent with section 1902(e)(14) of the Act. Below we outline proposed changes to existing sections (§ 457.10, § 457.301, § 457.305 and § 457.320) of the CHIP regulations, as well as the addition of new § 457.315, to implement the CHIP MAGI components of the law.

1. Definitions and Use of Terms (§ 457.10 and § 457.301)

We propose a nomenclature change, replacing the term “family income” with “household income” wherever it appears in 42 CFR part 457, and adding a definition for “household income.” We propose to modify the term “Medicaid applicable income level” to clarify that the 1997 Medicaid applicable income level used in CHIP will also be converted to a MAGI-equivalent income level, consistent with

guidance provided by the Secretary under sections 1902(e)(14)(A) and (E) of the Act. We are also adding other new terms related to the proposed regulations.

2. State Plan Provisions (§ 457.305)

Section 2102(a)(5) of the Act directs States to include a description of their income eligibility standards in their State plan. We propose to add a reference to the new § 457.315 on application of MAGI and household income.

3. Application of MAGI and Household Definition (§ 457.315)

Under section 2102(b)(1)(B)(v) of the Act, as added by section 2101(d)(1) of the Affordable Care Act, beginning January 1, 2014, States will use “modified adjusted gross income” (MAGI) and “household income,” as those terms are defined in section 36B(d)(2) of the IRC, to determine eligibility for CHIP, and for other purposes for which an income determination is needed, “consistent with section 1902(e)(14)” of the Act, which governs the application of MAGI and “household” income in Medicaid and which is implemented at proposed § 435.603 of these rules. In addition, section 2107(e)(1)(F) of the Act, as added by section 2101(d)(2) of the Affordable Care Act, states that section 1902(e)(14) be applied to CHIP “in the same manner” as it is applied to Medicaid.

Currently, States use different methods for defining income and household composition under CHIP. Many States operate their programs through expansions of Medicaid coverage. Among States with separate CHIP programs, some follow Medicaid financial methodologies while others rely on different methods, including gross income tests. While we recognize that the statutory application of MAGI rules to CHIP represents a change for some States, doing so is consistent with broader goals of coordination across programs. The adoption of MAGI-based methodologies to determine income for CHIP represents a necessary alignment with other insurance affordability programs and is particularly important for families both because children will be moving among different programs as family circumstances changes and because CHIP-eligible children will often be in families where the parent is eligible for a premium tax credit through the Exchange. Because the statute provides that CHIP apply the new MAGI methodologies in the same manner as Medicaid, we propose at § 457.315 that, in determining financial

eligibility for CHIP, States use the methodologies for determining household composition and income as those proposed for Medicaid at § 435.603(b)–(h), as well as the exception, codified at proposed § 435.603(i)(1), to permit States to rely on a finding of income made by an Express Lane Agency in accordance with section 2107(e)(1)(E) of the Act. As discussed in section II.B. of this proposed rule, our proposed MAGI-based methods for determining Medicaid eligibility mirror the section 36B definitions of MAGI and household income, except in a very limited number of situations.

For a more detailed discussion of the proposed financial methodologies based on MAGI to be applied to both CHIP and Medicaid, see section II.B.1 and II.B.3 of this proposed rule.

4. Other Eligibility Standards (§ 457.320)

As discussed in section II.B.3.a and consistent with current practice in almost all State CHIPs, assets will no longer be considered in determining financial eligibility for Medicaid or CHIP. Section 457.320(a) lists the various eligibility standards States may adopt for one or more groups of children. We propose eliminating “resources” and “disposition of resources” in conformance with the law.

The Affordable Care Act also eliminates the use of income disregards other than a disregard of 5 percent of income specified under section 1902(e)(14)(I) of the Act. This means that, as of 2014, States no longer will be able to raise their effective income standards for their CHIPs through the use of a “block of income” disregard. The maximum income standard will be the higher of 200 percent FPL, 50 percentage points above the applicable Medicaid income level defined in section 2110(b)(4) of the Act and § 457.301, and the effective income standard in effect in the State (taking into account any income disregards adopted) as of December 31, 2013, converted to a MAGI-equivalent income standard in accordance with section 1902(e)(14)(A) and (E) of the Act.

5. Clarifications Related to MAGI

Nothing in this regulation affects existing rules regarding family size in States that take up the CHIP “unborn child option” (per the existing definition of child at § 457.10). In States that provide coverage under the option at § 457.10, the unborn child is counted in family size.

L. Residency for CHIP Eligibility
(§ 457.320)

CHIP regulations currently allow States the option to adopt eligibility standards related to residency. The following changes to the regulations governing residency standards for separate CHIPs are proposed to ensure coordination between all insurance affordability programs. Further discussion on the rationale behind the proposed changes can be found in section II.C of this proposed rule.

We propose at § 457.320(d) to modify the definition of residency for non-institutionalized children who are not wards of the State under CHIP to reference the Medicaid definition for children at proposed § 435.403(i). As under § 435.403(i), for purposes of CHIP eligibility, a child under the proposed rule is considered a resident of the State in which he or she resides (for example, with a parent or caretaker and including without a fixed address), or in which a parent or caretaker is employed or seeking employment, including seasonal workers. The provisions of the proposed rule are not intended to effect a significant change in policy, and are discussed in more detail in section II.C.2 of this proposed rule. The provision at § 435.403(m) of the Medicaid rule, involving situations in which two or more States dispute a child's State of residence, is also applied under the proposed rule to CHIP; under that provision, physical location governs.

M. CHIP Coordinated Eligibility and Enrollment Process

Section 2101(e) of the Affordable Care Act adds section 2107(e)(1)(O) to the Act to apply to CHIP the same enrollment simplification standards described for Medicaid under the new section 1943 of the Act. These standards build on existing practices and provisions in section 2102(b)(3)(B) of the 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, § 435.917, § 435.940 through § 435.956, and § 435.1200, discussed more fully at sections II.D, II.E, II.G, II.H, II.I, and II.K of this proposed rule. We seek comments for CHIP on the issues raised in these corresponding sections for Medicaid.

1. Applications and Outreach Standards (§ 457.330, § 457.334, § 457.335 and § 457.340)

We propose revisions to § 457.330 similar to those proposed for Medicaid at § 435.907 to implement the use of a single, streamlined application for all insurance affordability programs, which builds on the successful experience many States have had with joint Medicaid-CHIP applications.

We propose adding § 457.335 and modifying § 457.340(a) to set forth standards for the availability of program information and application assistance, similar to those proposed for Medicaid at § 435.905 and at § 435.908, discussed in section II.E.3 of this proposed rule. We propose removing the mention of enrollment caps in § 457.340(a) to support the role of CHIP agencies in accepting the single streamlined application and screening for all insurance affordability programs regardless of whether CHIP enrollment is capped. To implement section 1943(b)(4) of the Act, relating to the establishment of Web sites to facilitate application and enrollment in all insurance affordability programs, we propose adding § 457.335 similar to the rule proposed for Medicaid at § 435.1200(d), discussed in section II.I of this proposed rule.

We propose to revise § 457.340(b) to specify that all CHIP agencies require applicants who have an SSN to provide it. We recognize that the Privacy Act makes it unlawful for States to deny benefits to an individual based upon that individual's failure to disclose his or her Social Security number, unless such disclosure is required by Federal law or was part of a Federal, State or local system of records in operation before January 1, 1975. However, section 1414(a)(2) of the Affordable Care Act authorizes the Secretary to collect and use SSNs where necessary to administer the provisions of, and amendments made by, the Affordable Care Act. We believe such section provides the authority for the requirement of SSNs when applicants are using the coordinated system and streamlined application designed by the Secretary under section 1413 of the Affordable Care Act. However, similar to Medicaid, non-applicants cannot be required (but may be requested) to provide an SSN. Consistent with Medicaid regulations at § 435.910, the CHIP agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of an applicant's SSN.

We propose revisions to the effective date of eligibility in § 457.340(f) to

ensure that the method adopted by the State for determining the effective date of coverage will provide for a coordinated transition of children between programs as family circumstances change, without gaps or overlaps in coverage.

2. Determination of CHIP Eligibility and Coordination With Exchange and Medicaid (§ 457.348 and § 457.350)

We propose to add new coordination rules at § 457.348 to mirror the rules for Medicaid agencies at proposed § 435.1200(e) and (f), and to coordinate with the rules in 45 CFR § 155.345 of the Exchange proposed rule. Proposed § 457.348(a) and (b) would ensure that State CHIP agencies promptly enroll individuals determined eligible for CHIP by the Exchange, without requiring additional information or making further determinations, and promptly determine the eligibility of (and, if eligible, enroll) individuals determined potentially eligible for CHIP by the State Medicaid agency. Consistent with current CHIP policy, proposed § 457.348(c) clarifies that CHIP agencies may enter into arrangements with the State Medicaid agency to accept that agency's determinations of CHIP eligibility.

We also propose revisions to regulations at § 457.350, which currently relate to the responsibilities of the CHIP agency to coordinate with Medicaid. The proposed revisions are consistent with those proposed for Medicaid agencies at § 435.1200(g), discussed in section II.I.5 of this preamble, and 45 CFR § 155.345 of the Exchange rule, discussed in section II.A.1 of the Exchange preamble.

Two of the proposed revisions to § 457.350 warrant particular mention. First, the standards at § 457.350, as revised, apply to all individuals who are included as applicants on the single application—for example, parents and other adults in the household. Second, at § 457.350(j), we propose that, for children who do not appear Medicaid eligible based on MAGI, but whom the CHIP agency identifies as potentially eligible for Medicaid on another basis, such as disability, the CHIP agency both transmit the application and all pertinent information to the Medicaid agency for a full Medicaid evaluation and continue to process the CHIP determination, enrolling the child, if eligible, in the program unless and until the child is determined eligible for Medicaid. This is consistent with the process proposed for the Exchange at 45 CFR 155.345 in the Exchange proposed rule and with the responsibilities of the

Medicaid agency at proposed § 435.1200(f).

We anticipate significant variation in how States choose to operationalize the coordination of CHIP with other insurance affordability programs, and we will work with States to achieve the high level of integration of processes, which will be needed to effectuate the coordination required and to avoid duplication of costs and reduce administrative burden on States, children, and their families. At proposed § 457.350(k), we note that CHIP agencies may enter into arrangements with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the Act.

3. Periodic Redetermination of CHIP Eligibility (§ 457.343) and Coverage Months

Under sections 1943(b)(3) of the Act and sections 1413(a) and 1413(c)(2) of the Affordable Care Act, we propose to add new policies at § 457.343 to implement the data-driven renewal procedures for CHIP proposed for Medicaid at § 435.916. For a fuller discussion of the proposed renewal process, which we believe is consistent with current renewal processes in many States; see section II.G of this proposed rule. The proposed data-driven verification system is also consistent with the system proposed for the premium tax credit determinations conducted by the Exchange.

In proposed 45 CFR § 155.410 of the Exchange proposed rule published on July 15, 2011, eligibility begins on the first day of the following month for all qualified health plan selections made by the 22nd of the previous month, and on the first day of the second following month for all qualified health plan selections made between the 23rd and last day of a given month. Similar to Medicaid, we are seeking comment on a provision that would continue CHIP coverage until the end of the month following the end of the appropriate termination notice period, subject to certain exceptions. This policy, which we believe is the policy currently in operation in most CHIPs, would prevent a gap in coverage for an individual or family moving from CHIP to the Exchange. Further discussion of this issue can be found at section II.G. of this proposed rule.

4. Verification of Eligibility (§ 457.380)

Consistent with the provisions of section 1413(c)(3)(A) of the Affordable Care Act (applicable to CHIP through sections 1943(b)(3) and 2107(e)(1)(O) of

the Act), we propose revising § 457.380, based on section 1413 of the Affordable Care Act, relating to verification of eligibility for separate CHIPs consistent with the rules proposed for the Exchanges and Medicaid. Consistent verification procedures prevent gaps in coverage caused by different programs operating under different rules.

To better align all insurance affordability programs, we reference specific verification methods for residency and income. Proposed § 457.380(c) references proposed regulations for verification of residency for purposes of Medicaid eligibility at § 435.956(c), which also align with proposed Exchange regulations at 45 CFR 155.315(c). At proposed § 457.380(d), we require separate CHIPs to verify income in accordance with proposed Medicaid regulations at § 435.948, which are coordinated with proposed Exchange regulations at 45 CFR 155.320. As described in § 435.945(b) and § 435.948, States may continue to choose to accept self-declaration of income, but must also request information from third-party data sources in accordance with § 435.948 and to continue to comply with program integrity requirements. States are not required under § 435.948 to request third-party financial eligibility information that the State determines is not useful to verifying the financial eligibility of the applicant. For other eligibility criteria, we propose in § 457.380(a) and (e) to continue to allow CHIPs to develop reasonable verification procedures, including reliance on self-declaration or attestation (except when verifying citizenship or immigration status). However, we explicitly provide that States accept self-attestation of pregnancy and household membership, as proposed for Medicaid in § 435.956(e), unless the State has other information that is not reasonably compatible with the attestation. We also provide standards for verifying age and date of birth.

The Affordable Care Act envisions a data-driven verification system in order to improve the application experience for families while maintaining strong program integrity. Mirroring standards being proposed for Medicaid at § 435.952 and the Exchange at 45 CFR 155.315, we propose adding § 457.380(f) to clarify that the State may only request additional information if it is not available electronically. Consistent with proposed Medicaid regulations at § 435.948(b), we propose in § 457.380(g) that States must use the electronic service established by the Secretary under proposed § 435.949 if reliable electronic data needed for verification is

available. In proposed § 457.380(h), we affirm that program integrity responsibilities for CHIP are not affected by this proposed regulation.

Finally, we propose adding § 457.380(i), similar to proposed § 435.948(f) and § 435.949(c) of the Medicaid regulation, and to enable States, with approval from the Secretary, to modify the verification procedures used by its program. We solicit comments on alternative verification methods that may help improve coordination between CHIP and other insurance affordability programs.

5. Ministerial Changes (§ 457.80, § 457.300, § 457.301, § 457.305 and § 457.353)

We are also proposing a number of ministerial changes necessary to bring other sections of the current CHIP into conformance with the proposed changes and revisions described above, including revisions to § 457.80, § 457.300, § 457.301, § 457.305 and § 457.353.

N. FMAP for Newly Eligible Individuals and for Expansion States

The Affordable Care Act provides for a significant increase in the FMAP for medical assistance expenditures for individuals determined eligible under the adult group in the State and who are considered to be “newly eligible”, as defined in section 1905(y)(2)(A) of the Act. The increased FMAP specified in section 1902(y)(1) of the Act is not available for the medical assistance expenditures for any individual who is not considered newly eligible. Under section 1905(y)(2) of the Act, an individual is newly eligible if the individual would not have otherwise been determined eligible for Medicaid under the eligibility provisions of the Medicaid State plan, demonstrations, or waivers in effect in the State as of December 1, 2009.

1. Availability of FMAP (§ 433.10(c))

We propose to amend 42 CFR part 433 to add new provisions at § 433.10(c) to indicate the increases to the FMAPs as available to States under the Affordable Care Act. The following describes these new FMAP provisions.

a. Newly Eligible FMAP (§ 433.10(c)(6))

In § 433.10, we propose to add a new paragraph (c)(6) to indicate the increased FMAP rates available to States beginning January 1, 2014, for the medical assistance expenditures of individuals determined eligible under the adult group who are considered to

be newly eligible, as defined in section 1905(y)(2)(A) of the Act.

b. Expansion State FMAP (§ 433.10(c)(7) and § 433.10(c)(8))

In § 433.10, we propose to add new paragraphs (c)(7) and (8) to indicate the availability of additional FMAP rates for expansion States.

(1) 2.2 Percentage Point Increase in FMAP (§ 433.10(c)(7))

Per section 1905(z)(1) of the Act, we propose to add § 433.10(c)(7) to indicate the availability of a general 2.2 percentage point increase to the base FMAP of a State (as determined under section 1905(b) of the Act) for certain expansion States, as defined in section 1905(z)(3) of the Act. The general 2.2 percentage increase to the base FMAP is available only to a State that: (1) Meets the definition of expansion State; (2) does not qualify for any payments for the full increased FMAP for individuals who are newly eligible; and (3) has not been approved by the Federal government to use amounts of their DSH allotments for the costs of providing medical assistance or other health benefits coverage under a demonstration that was in effect on July 1, 2009. Only for States that meet these 3 conditions, the base FMAP would be increased by 2.2 percentage points for all expenditures in CYs 2014 and 2015 (to which the base FMAP would apply). Since by definition, the base FMAP plus 2.2 percentage points would only be available and applicable for expenditures for individuals who are not newly eligible, such general increase would be available for all individuals in such States.

(2) Expansion State FMAP (§ 433.10(c)(8))

The increased FMAP discussed in section II.N.1.a. of this proposed rule is available for individuals in the adult group who are considered to be newly eligible. We propose to add § 433.10(c)(8) to indicate an additional FMAP rate will be available for expansion States for the expenditures for certain nonpregnant childless adults who are determined eligible under the adult group, and who are not considered to be newly eligible, as defined in section 1905(y)(2)(A) of the Act.

Beginning in CY 2014 and each year thereafter, the expansion State FMAP for medical assistance for individuals described in the adult group who are nonpregnant childless adults is equal to the base FMAP for the State increased by a certain percentage determined in accordance with a formula specified in section 1905(z) of the Act, as amended

by the Affordable Care Act. This new expansion State FMAP is equal to the base FMAP plus a “transition percentage” multiplied by the difference between the Newly Eligible FMAP provided to States beginning in CY 2014 and the expansion State’s base FMAP. The transition percentage is as follows:

- 50 percent in CY 2014;
- 60 percent in CY 2015;
- 70 percent in CY 2016;
- 80 percent in CY 2017;
- 90 percent in CY 2018; and
- 100 percent in CY 2019 and every year thereafter.

The following illustrates how the expansion State’s FMAP would be calculated:

Example. In CY 2019, assume the expansion State’s base FMAP is 60 percent. In CY 2019 the Newly Eligible FMAP is 93 percent. Therefore, in this example, in CY 2019 the expansion State FMAP would be 93 percent, calculated as follows:

$$E = F + (T \times (N - F))$$

E = Expansion State FMAP

F = Expansion State’s Base FMAP

T = Transition Percentage

N = Newly Eligible FMAP

$$93\% = 60\% + (100\% \times (93\% - 60\%))$$

Beginning in 2020 both the expansion State FMAP and the newly eligible FMAP will be 90 percent.

2. Methodology (§ 433.206(a) and § 433.206(b))

One of the key steps in simplifying the eligibility determination process for individuals and States involves developing a methodology that ensures the Federal government will pay the appropriate FMAP rate for both “newly eligible” individuals as well as for expenditures that are subject to the expansion State FMAP rate. As discussed above, the Affordable Care Act provides for streamlined eligibility and enrollment policies and processes that are a departure from the more complex pre-Affordable Care Act Federal Medicaid eligibility policy, but the pre-Affordable Care Act rules retain relevance for the purposes of determining the appropriate FMAP rate for expenditures beginning in CY 2014. Although the new MAGI rules are used for purposes of determining eligibility for the adult group, the newly eligible FMAP is not available for all individuals whose eligibility will be determined using MAGI; rather the newly eligible FMAP is only available for those members of the adult group who are determined to be newly eligible as discussed in this regulation. In order for States to determine which beneficiaries are “newly eligible” and

which are not, States must evaluate a large group of beneficiaries against the State’s pre-Affordable Care Act eligibility rules. To do so on a case-by-case basis would require States to operate two eligibility systems or processes—one simplified system for the purpose of determining eligibility, and another different and more complex system to assign the appropriate FMAP rate. The two sets of rules would, in turn, require Exchanges as well as State Medicaid agencies to collect from applicants information in excess of what is required for States to determine eligibility either for Medicaid or premium tax credits available through the Exchange.

Running two distinct eligibility systems would pose challenges to applicants, States, and the Federal government. Applicants would have to report and verify income, assets, and deductions under pre-Affordable Care Act rules, even though that information would no longer be required to determine eligibility. Similarly, States and the Federal government would have to seek and verify information not needed for eligibility determinations, resulting in excess administrative burden and inefficiency, a result counter to the goals of the Affordable Care Act.

Because a double eligibility system is burdensome and costly to States and the Federal government, a barrier to enrollment for eligible individuals and families, and would likely lead to inaccurate determinations, we have identified possible alternate approaches for determining the appropriate FMAP rate. Specifically, this proposed rule discusses the potential revision of regulatory provisions in part 433 to propose three alternative methodologies which States could use for claiming expenditures at the appropriate FMAPs: The regular FMAP, the newly eligible FMAP and the expansion State FMAP for individuals eligible for Medicaid beginning in CY 2014 under the provisions in sections 1902(a)(10)(A)(i)(VIII) and 1905(y) and (z) of the Act as amended by the Affordable Care Act. The proposed rules would not permit FFP for the costs of maintaining dual eligibility systems for the adult group. HHS plans to test, with States, each of the proposed methodologies and possibly others suggested through the comment process. Once the rules are finalized, CMS will provide technical support to States as they adopt an identified methodology.

In developing the proposed claiming methods, in consultation with States and subject matter experts, we identified and applied certain principles

to assure that each method will accurately reflect the application of the appropriate FMAP. These principles are also the criteria against which we will measure the feasibility of the approaches proposed in this proposed rule and others that may be proposed during the comment period. First, any methodology must provide as accurate and valid application of the applicable FMAPs to actual expenditures as possible in the determination of the appropriate amounts of Federal payments for such expenditures. The methodology must not include a systemic bias in favor of either the States or the Federal government. Second, any allowable methodology should minimize administrative burdens and costs to States, the Federal government, individuals, and the health care system. Third, any methodology must be developed and applied transparently by both the Federal government and States. Fourth, any method must take into consideration the practical programmatic and operational goals of the Medicaid program. Finally, in order to ensure that the States claim expenditures at the correct FMAP, any methodologies used by the States should include sufficient data to identify, associate and reconcile expenditures with the related eligibility group to which the FMAPs apply. With these principles in mind, we propose that States work in partnership with the Federal government on technical support and review as well as ongoing monitoring, verification, and adjustment by States and the Federal government. HHS plans to monitor State implementation and operations closely and could require adjustments and changes to processes as necessary to ensure that systems are implemented in an unbiased and accurate way. HHS is exploring mechanisms to verify methodology results, including on-site reviews, sampling and confirmation with outside data sources, which could identify issues resulting in improper levels of FMAP being claimed. HHS will define procedures as needed to ensure accurate reporting and verification of computations to determine the applicable FMAP potentially including enhanced monitoring and prospective or retrospective FMAP adjustments. States and the Federal government each have a strong interest in an accurate, simplified system, and we expect to undertake these efforts in full partnership with States.

Given the principles discussed above, we are considering three main approaches to identifying newly eligible individuals for purposes of applying the

correct FMAP rate in the development of States' claims for Federal funding in Medicaid: (1) Using upper income and other thresholds across categorical eligibility groups, taking into account the December 2009 eligibility standards in effect under State plans, waivers or demonstrations and applicable disregards and adjustments, to approximate, in the aggregate, the December 2009 standards; (2) using a sampling methodology across individuals in the adult group and related Medicaid expenditures to make a statistically valid extrapolation of who is newly eligible and their related expenditures; or (3) using an extrapolation from available data sources to determine the proportion of individuals covered under the new adult group who would not have been eligible under the eligibility criteria in effect under the State plan or applicable waiver as of December 1, 2009, validating and adjusting the estimate, based on sampling or some other mechanism, going forward. We seek comment on these three approaches.

At § 433.206(a), we propose that a State may opt to use any of the specified alternatives discussed below. As discussed further, these specific options may not ultimately be the methods available, as we expect to modify, narrow or combine the proposed approaches in the final rule depending upon public comment and testing for feasibility. We are specifically interested in input as to what other options should be considered, and whether it is advisable for States to choose from among different methods or for HHS to identify a single method that all States would use.

If selection is available, we propose at § 433.206(b) that a State provide notice to CMS of which methodology it plans to use at least two calendar years prior to the first day of the calendar year in which the State will use that particular method, except for 2014 as discussed below. For example, a State would provide notice to CMS of the methodology it plans to use for CY 2017 no later than December 31, 2014. For the initial year (CY 2014), States would give notice to CMS no later than one year prior to the beginning of the calendar year, January 1, 2013. This allows States time to determine which method best meets their needs in that context and to make preparations for the systems and eligibility determination modifications needed for the initial years. We further propose that once a State selects a methodology, it must use that method for a 3-year period, at a minimum, subject to necessary monitoring and adjustment. This will allow stability in

the process and allow for the provision of appropriate allocation of resources within the State and at the Federal level. We request comments on this minimum 3-year period.

As noted above, we are proposing to not provide the option of maintaining double eligibility systems and completing a determination for each individual under obsolete eligibility rules for purposes of determining the appropriate FMAP because we believe that this is neither necessary nor efficient. Rather, we propose to rely on one or more alternate methodologies.

3. Alternative 1: 2009 Eligibility Standard Threshold

The "threshold methodology" would allow States to use upper-income thresholds, as well as proxies for other eligibility criteria (such as assets or disability status) across categorical eligibility groups, taking into account the December 1, 2009 eligibility standards, to determine whether an individual is considered to be newly eligible for purposes of assigning a Federal matching rate. This methodology would use information the individual supplied on their application, and other appropriate data sources, subject to appropriate verification and documentation requirements, to assign the individual to one of the categories that the Affordable Care Act subsumed into the adult group, such as certain parents and caretaker relatives, 19 and 20 year olds, and childless adults, and to then apply simplified eligibility criteria based on the rules in effect December 1, 2009 to identify those who would have been eligible under the December 1, 2009 criteria. This option requires States to apply the December 1, 2009 eligibility criteria, but in a simplified manner, to each Medicaid beneficiary who is included in the adult group. Based on the threshold combined with proxies, the individual would be determined to be newly eligible or an individual who would have been eligible based on the December 2009 eligibility standards.

As previously noted, States will need to establish income eligibility thresholds for MAGI populations to be eligible for Medicaid under the State plan, demonstration or a waiver of the plan using MAGI that are not less than the effective income eligibility levels that applied under the State plan, demonstration or waiver on the date of enactment of the Act ("income standard conversion"). States using the threshold methodology similarly could convert the income standards in effect as of December 1, 2009 for other optional eligibility groups (for example, based on

disability) to MAGI-equivalent standards, against which the MAGI-based income of an individual eligible under the new adult group would be compared for the purpose of determining whether such individual would have been eligible under the optional group and thus is newly eligible or not. CMS will solicit State input and providing further guidance and technical support on the income standard conversion process.

We propose that States employing this threshold methodology would also establish, subject to CMS approval, proxies of eligibility criteria in place prior to CY 2014 that are not related to income, such as disability status and asset value. For disability, for example, proxies could be based on receipt of SSDI, screening questions included in the application process (for example, "Have you had an accident or illness serious enough that it has caused and is still causing you to miss work for an extended period of time?"), retroactive claims review (to determine individuals with significant medical problems), some other method, or such methods in combination (for example, use of both a screening question and retrospective claims review). States would have to be clear with applicants that this information would not be used for an eligibility determination purposes. We are requesting comments on what methods or proxies could be used by States for disability status as well as whether there are any special considerations which must be considered in the identification or use of appropriate proxies for States that apply a more restrictive definition of disability than the SSI program.

Although we are looking for proxies for disability determinations to determine whether to claim enhanced FMAP for an individual or not, we are also considering the possibility of using only actual disability determinations to ascertain the appropriate FMAP. Thus, if an individual underwent an actual disability determination and was found to be disabled, and met other criteria associated with a pre-Affordable Care Act optional eligibility category for the disabled such that he or she would have been eligible as disabled in December 2009, that individual would not be newly eligible. This proposal would be feasible to the extent that it is reasonable to expect that individuals with disabilities have sufficient incentives to undergo disability determinations, most likely to obtain disability-related cash benefits, such that a proxy is not necessary. We are soliciting comments on whether adequate incentives do exist such that

no additional proxies for a disability determination need be applied.

For the reasons noted, we are also proposing that States using the threshold methodology identify thresholds or proxies for estimating whether individuals in the adult group meet any asset test that was applied to the applicant's coverage category in December 2009. The State would also propose procedures for obtaining the information needed to compare the situation of individuals in the adult group to the proxy. For example a State might include a few simple questions during the application process to enable comparison against the proxy, for example, "Excluding your primary residence and automobile, are your assets, including any savings or checking accounts, stocks, bonds, or other liquid assets, greater than X dollars?" States could also use information on tax returns to obtain information about assets via interest or dividend income. We also are interested in comments regarding the feasibility of using the Asset Verification System (AVS), required for all States under section 1940 of the Act as a tool to obtain asset data on individuals in the adult group without asking for it directly.

We also considered proposing that the threshold methodology be limited to an individual's income and not the assets/resources when comparing the individual against the December 2009 eligibility criteria. This would allow States to not collect asset information no longer needed for eligibility purposes and it is consistent with analysis showing that only very small numbers of people with income in this range will have disqualifying assets. However, without evaluating assets, all individuals whose incomes are below the income threshold would not be newly eligible, even though it is possible that some would not have been eligible under the pre-Affordable Care Act rules. Thus, if assets are not considered there could be individuals who would be newly eligible, but for whom the State could not claim enhanced match. We believe this methodology has merit as we recognize there is a burden on States and to beneficiaries in including an asset proxy and that a significant portion of low-income individuals do not have assets in excess of those thresholds. We invite comment on both approaches.

In lieu of additional questions on an application for coverage asking about assets, we are also considering allowing States to develop an estimate based on actual data on the proportion of individuals applying for coverage who

failed eligibility for a specific group in effect as of December 1, 2009 due to possession of assets exceeding the asset limit. For example, if the State had an optional disability group in December 2009 with a resource test, and 15 percent of applicants were denied coverage in that group because their assets exceeded the resource, the State could assume that 15 percent of the disabled individuals with incomes below the converted December 2009 standard in the adult group would also fail the asset test. The State would therefore estimate the percentage of individuals who were disabled in the adult group would be newly eligible. We are interested in comments as to whether States have reliable data upon which this calculation could be made.

We also propose that once an individual is determined to be either a newly eligible individual or an individual who would have been eligible under the December 2009 standards for FMAP determination purposes, the determination would be applicable throughout the 12-month eligibility period after a person is determined eligible. Our proposal is based on the observation that changes in income occur in both directions and are not biased in one direction or the other. Our proposal is also based on the goal of achieving administrative simplicity, which can best be obtained through a single annual FMAP determination for an individual who remains enrolled in Medicaid, whether continuously enrolled or not, rather than requiring a State to potentially make many such determinations over the course of a year.

Finally, we do not believe that States need to consider whether an individual would have been eligible under a spend down for a medically needy category under section 1902(a)(10)(C) of the Act in considering whether someone would have been eligible under standards in effect in December 2009. This is because we believe that there is inherent uncertainty in determining whether and when a spend down would have been met. An individual who is not yet "medically needy" because he or she has not yet met the spenddown requirements would not be considered to be eligible for Medicaid under the December 2009 standards. However, if an individual does qualify by meeting the medically needy income standard without a spenddown, the State could not claim enhanced FMAP for that individual.

The threshold methodology would require ongoing monitoring, verification, and adjustment. States using the threshold methodology would need to work with CMS to verify this

methodology for a sample of cases within the first 2 years of use to test whether the threshold methodology is accurate and valid. We propose to undertake a periodic review, working collaboratively with States to evaluate the accuracy of the threshold methodologies and make adjustments to improve the accuracy of the threshold, as needed. We propose that adjustments to the methodology would be prospective only. Once a State has an approved methodology, that methodology would apply unless and until a review process indicated that adjustment was necessary. Finality and certainty are important for the operation of the program.

4. Alternative 2: Statistically Valid Sampling Methodology (§ 433.210)

At § 433.210, we are proposing the standards for States to use sampling to extrapolate the correct expenditures for which the State would receive the FMAP rate for newly eligible individuals established under the Affordable Care Act. Sampling is the statistical practice of selecting a random and unbiased subset of Medicaid eligible individuals and their related expenditures. We believe that a statistically valid sampling plan is a transparent, and widely accepted methodology of allocating costs. OMB Circular A-87 revised establishes principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments and Federally-recognized Indian tribal governments. We propose that States using this methodology would use a statistically valid sampling methodology meeting the requirements of OMB A-87.

To ensure consistency, we propose to specify the additional standards States would need to use to perform a statistically valid sample of the population of individuals covered under the new eligibility group created by the Affordable Care Act, to determine the proportion that would not have been eligible based on the State's December 2009 eligibility standards, and therefore be newly eligible. We propose to specify standards within this regulation as well as in accompanying guidance relating to sample size and specifics of sampling techniques, *etc.* We believe this will allow HHS to work with States to refine specific sampling requirements and procedures as we gain experience over time. For example, we anticipate the sample size requirements may evolve as we gain experience with actual data becoming available and tested over

time. We also believe that guidance on the inclusion of specific demonstration-related issues would be best provided through subregulatory guidance to allow better consideration of State-specific issues, as well as to provide an opportunity to refine the specific methodologies and requirements.

For all individuals selected for the sample, the State would perform the equivalent of a full eligibility determination using the eligibility standards in place in that State as of December 2009. Each individual in the sample would be determined to be either a newly eligible individual or an individual who would have been eligible under the December 2009 standards. We propose that States should submit their sampling plans to CMS with adequate time for review and approval in advance of implementation, preferably not later than the first day of the calendar year for which the State will implement that plan.

We propose that the State would pull the claims for each selected individual to determine actual expenditures for the sample. The State would determine the proportion of actual expenditures in the sample that were for newly eligible individuals and extrapolate this proportion to the population sampled to determine the correct allocation of expenditures for which the State would make a claim at the FMAP rate for newly eligible individuals established under the Affordable Care Act. We believe this methodology would most accurately determine a weighted expenditure proportion from actual claims to apply to the adult group.

We also considered using a methodology in which a per capita expenditure would be determined for the adult group. States would apply this per capita expenditure amount proportionately to determine the appropriate FMAP claiming. We believe this methodology may allow for greater ease of administration, but seek comment on whether this would reflect a fair allocation of expenditures to each distinct population.

We propose that States would perform a statistically valid sample for the year in which the State is claiming. This sample would be based on the entire adult group population, from which the State would randomly select Medicaid eligible individuals on a monthly basis, in accordance with CMS' sampling guidelines. Once individuals are determined in that month of review to be either a newly eligible individual or an individual who would have been eligible under the December 2009 standards, the State would apply that eligibility determination throughout the

entire year for the purpose of FMAP determination. Our proposal is based on the observation that switches occur in both directions and are not biased in one direction and the administrative simplicity that can be obtained through a single annual determination is preferred.

The State would pull all medical expenditures for the prior 12 months for the individual. If the individual is enrolled exclusively in a managed care organization (MCO), for which the State makes a capitated monthly payment to an MCO, the State would consider the risk-adjusted monthly payment to the MCO as the full medical assistance expenditure for that individual for each month the individual is so enrolled. Otherwise, the medical expenditures for each individual are equal to the actual expenditures made to providers for items and services provided to that individual. It does not include any Medicaid supplemental payments that are not associated with medical assistance payments made for specific items and services provided to a specific individual.

We propose that the State complete the sampling and related expenditure analysis no later than 2 years after the completion of the designated year. The State will retroactively apply the FMAP to the correct year and make any necessary prior period adjustments to the CMS-64 expenditure report to assure accurate Federal funding. We will work with States to meet the proposed time frame to ensure their ability to claim the enhanced funding.

We propose that the State would claim based on the most recent data for the current year. We understand that the State will not have accurate data based on the actual year's enrollment and expenditures until after the finish of that year. Therefore, we propose to allow States to make interim claims for the FMAP rate for newly eligible individuals established under the Affordable Care Act. These claims would be based on the most recent year for which a State has statistically valid data. For example, in CY 2020, if a State had a completed sample for CY 2018, but was finalizing its sample and related extrapolation for CY 2019, the State would use the data from the CY 2018 sample and apply the FMAP according to the CY 2018 findings. Once the State completes the CY 2020 sample, it will retroactively adjust the CY 2020 expenditures claimed on the CMS-64 to incorporate the actual data from 2020 (the process for CYs 2014 and 2015 is discussed below). We solicit comment on this estimation and reconciliation process.

We propose that States will continue to sample on an annual basis for the first consecutive three years the State implements a sampling methodology. For all following years, we propose that the State would sample on a 3-year basis.

For the initial years (CYs 2014 and 2015), we propose to allow States to calculate and apply a reasonable estimate of the expenditures claimed at the Newly Eligible and expansion State FMAP rates established under the Affordable Care Act and make the retroactive adjustment described above based on CY 2014 data extrapolated using the State's sampling methodology. We would allow States to create a reasonable estimate in one of two ways: (a) Based on a State's statistically valid sample of low-income populations that reasonably approximates the expected Medicaid adult group; or (b) based on a HHS developed estimate of the proportion of newly eligibles and per capita expenditures for the projected newly eligibles that HHS would develop and test in collaboration with States by, for example, using a combination of Medical Expenditure Panel Survey (MEPS) and Medical Statistical Information System (MSIS) data, or other existing data sources. In the first option, we propose to allow States to calculate the projected per capita expenditures for the newly eligible population based on a sample of the low-income population of those individuals enrolled in and appearing to be potentially eligible for Medicaid as of CY 2014. The States would use the sampling methodology guidelines applied to the population of State residents (Medicaid enrollees and other low-income individuals) that approximated the expected Medicaid eligible adult group. We propose that States submit a sampling plan demonstrating compliance with OMB Circular A-87 and, other requirements specified within this rule and other CMS sampling guidance. The methodology must include not only a description of the population from which the sample will be pulled prior to CY 2014, but also how the chosen population approximates the adult group. States would complete the sample and expenditure extrapolation in accordance with a sampling plan prior to January 1, 2014.

We propose that States use data from the sample to calculate the projected proportion of newly eligible individuals, as well as per capita expenditures for such individuals. The State would use MSIS data and Medicaid experience to estimate expenditures for the "would have been

eligible" population. The State would use this information to determine the appropriate estimated expenditure proportions to claim at the respective FMAP rates for the initial years.

We propose to allow Federal match based on the estimate until the actual data became available and sampled in accordance with the methodology established above. The State would make a retroactive claims adjustment on the CMS-64 based on the actual data from CY 2014.

Alternatively, in the second option we propose to allow States to use a CMS established estimate of the proportion and per capita expenditures for the projected newly eligible for CY 2014 based on currently available State-specific data (for example using MEPS data, a combination of MEPS and MSIS data, or other existing data sources). We propose to establish the proportion of newly eligible individuals and per capita expenditure amounts that each State could use in estimating FMAP for the initial years. We would publish the estimates for State use for CY 2014 no later than January 1, 2013 to ensure States have sufficient time to incorporate the data and create reasonable estimates.

We propose to provide Federal match based on the estimate until the actual data became available and sampled in accordance with the CMS-established sampling requirements established in this regulation and in future subregulatory guidance or validated in another way. If sampling were chosen as a validation method, we propose to require that States would implement a statistically valid sample methodology throughout CYs 2014 and 2015 to determine the correct proportion of newly eligibles and expenditures to claim at the 100 percent FMAP for CYs 2014 and 2015, respectively. The State would make a retroactive adjustment based on the actual data from CY 2014.

We consider this concept to be similar to an interim rate payment methodology. It allows for the State to receive the increased FMAP rate for a reasonable estimate of newly eligible individuals and settle to actual expenditures when the data is available. We are soliciting comments on this approach.

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

We are also proposing an option for States to use State specific estimates established by the Secretary using reliable data sources such as MEPS data or State MSIS data. This option is described in proposed § 433.212.

Under this model, States would use the estimated proportions in claiming FFP for medical assistance expenditures for newly eligible individuals. Because the model and estimated proportions would be available prior to each year, the State would claim expenditures and draw down Federal funds in real time. There would be no need for a retroactive adjustment. Rather, the verification to actual claims beginning in CY 2016 would apply to correcting for future years by adjusting the model.

We have reviewed current Federal analytic models created for other purposes to determine if they could estimate the potential impact of eligibility changes in the Affordable Care Act. We believe these models may have merit and may be an appropriate starting point for creating estimates for payment purposes beginning CY 2014. We are also considering a model in which HHS develops an algorithm to determine, for each State, the appropriate percentages of Medicaid enrollees with a given set of characteristics (such as income, age, assets, family structure, disability status) who would be considered newly eligible or not newly eligible under the December 2009 eligibility rules for purposes or applying the related FMAP. The algorithm would estimate for example, that 90 percent of the adults with a child with income between 100 percent and 110 percent of the FPL in a specific State would not have been eligible under the old rules. Then, the State would count the number of adult Medicaid enrollees in CY 2014 who had a child and whose income was between 100 percent and 110 percent of FPL, and would receive the Newly Eligible FMAP for 90 percent of their expenditures, and the base FMAP for 10 percent.

We propose to review, evaluate, and potentially expand upon existing models to develop an acceptable estimate to be the basis for determining FMAP. We are specifically interested in receiving comments on the data sources that should be considered for inclusion in the model. We believe MSIS and MEPS data likely to be the most useful and relevant data sources available consistently for all States. We propose to not limit the data sources we may choose to review and incorporate into a predictive model as long as the data sources are relevant, accurate and available in a timely manner to both the Federal government and the State. We believe the modeling process, as well as the data sources used to create the specific models must be fully tested, transparent and readily available to States.

We further propose that we would annually establish a model to reasonably predict in an unbiased way the appropriate proportion of expenditures (that is, State-specific rates) to determine the amount each State could claim using the “Newly Eligible” FMAP. We propose to solicit and integrate public input into the development of the final modeling estimate. The State-specific rates would be finalized and made public no later than October 1 of the year prior to the calendar year in which the State would implement the methodology. For CY 2014, we would establish and publish the State-specific rates by October 1, 2012.

We solicit comments on the potential of creating accurate State specific estimates given the available data sources and the limitations of each. We also are requesting comments on other possible approaches to compensate for the potential limits on State-specific data to create robust accurate estimates at the State level.

Beginning in CY 2016, we propose to integrate validation measures, such as statistically valid sampling methodologies, into the model to verify and assure the data accuracy. This verification of actual claims would apply to correcting for future years by adjusting the model. For example, we would work with selected States in each year to pull a random sample of Medicaid enrolled individuals in the adult group. We would then work with the State to apply the State’s December 1, 2009 eligibility standards to determine the proportion of individuals that are newly eligible and the proportion that would have been eligible under the standards at that time. We would then determine actual expenditures for those individuals to determine the appropriate proportion of expenditures to be claimed at the Newly Eligible FMAP rate. We propose that such sampling methodology be transparent to States. We further propose to employ a public notice and comment process to assure the integration of State and other stakeholder concerns into a final verification system.

6. Additional Methodology Approaches

We are requesting comments and suggestions on hybrid approaches that incorporate all of the alternatives listed. We believe that the above-described alternatives could be combined, so as to achieve the benefits, while mitigating the downside of each. Thus, sampling could be used to verify and improve upon the accuracy of the estimates made under the threshold methodology or as

stated above in the other data source methodology. While sampling might be necessary in the initial years, as confidence in the accuracy of the other method increased, sampling could be required on a less frequent basis (for example, once every 3 to 5 years), thereby diminishing the burden otherwise imposed by sampling, or we could see using the threshold methodology for simpler, more straightforward cases and sampling for more complicated ones. We invite comments on using a hybrid approach.

In addition, regardless of which approach is ultimately employed, we intend to monitor the effects and impact of that method over time and make refinements as necessary. We are interested in assuring that the alternatives proposed are viable in the sense that States can implement them in a meaningful way. We solicit comments on how each method may be operationalized and what challenges or obstacles a State may face in doing so. We also seek comment on analytical approaches that CMS should consider using when comparing the relative feasibility, validity, and reliability of the methods proposed above.

III. 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. In order 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.

This proposed rule would implement 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 proposed in a separate NPRM under RIN 0938–AR25); and simplify the enrollment and renewal processes. Taken together, the policies proposed in

this rule would result in a reduction in burden for individuals applying for or receiving coverage, as well as for States. Although there are short-term burdens associated with implementation of this proposed rule, over time the Medicaid program would 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.

At the same time, CMS is undertaking a number of business process, structural and system improvements designed to support modernized IT systems and streamline the manner in which it works with States and to minimize burdens in review and approval processes. A new reliance on automated information sources and data-sharing across agencies and programs will facilitate enrollment and renewal. In addition, the business process, structural and data system improvements underway at CMS are designed to create an environment where a significant proportion of the interactions between States and the Federal government can take place through a Web-based information portal. For example, we anticipate that CMS will have developed a Web-based system for States to submit the State plan amendments that will be needed to implement the Medicaid and CHIP programmatic modifications and that the system itself, for submission, review, and approval will be significantly more streamlined. It is not possible at this point to quantify the impact of these changes in terms of burden, but we believe that the estimates included in this collection of information discussion likely overstate the actual burden on States. The foundation for this is established through a final rule that enables States to receive a 90 percent Federal matching rate for design, development, installation or enhancement of eligibility determination systems through December 31, 2015, for those States meeting a series of specified standards and conditions. In addition, enhanced funding at a 75 percent Federal matching rate is available for States to maintain and operate their eligibility systems, subject to the conditions noted above. The estimates of the impact of these changes and the additional Federal support in this area are discussed in more detail in the final rule published on April 19, 2011 (76 FR

21950) entitled "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities."

Information collection requirements (ICRs) are outlined below that involve Medicaid and CHIP eligibility determinations and enrollment. We are soliciting public comment on each of these issues for the following sections of the proposed rule that contain ICRs. 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.

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

The following provisions will be addressed through separate PRA notices and comment processes:

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); 435.905(a) and (b); 435.948(d); 435.949(c); 435.1200(c), (d), (e), (f), and (g); 457.80(c); 457.305(a) and (b); 457.310(b); 457.320(d); 457.340(a), (b), and (f); 457.343; 457.348(a), (b), (c), and (d); 457.350(a), (b), (c), (f), (g), and

(j); 457.380(a), (c), (d), (e), (f), (g), (h), and (i); and 457.390;

Choice of Methodology for Determining Expenditures Claimed at FMAP Rate for Newly Eligibles:

§§ 433.206(b); 433.208(b); 433.210(a); and 433.212(a);

Single, Streamlined Application: §§ 435.907 and 457.330;

Collection of Applicant's Social Security Number: §§ 435.907(e) and 457.340(b); and

Revisions to CHIP Annual Reporting Template System (CARTS): § 435.907(e), § 457.353.

A. ICRs Regarding Program Information (§§ 435.905 and 457.335)

Amendments are proposed to § 435.905 for Medicaid and § 457.335 for CHIP that would 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 have Web sites for Medicaid and CHIP and that nearly every State already provides the information specified in this proposed 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 in keeping with the use of modern technology and, therefore, presents no new burden. 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 (§§ 435.945, 435.948, 435.956, 457.350, and 457.380)

The provisions propose guidelines for verification of certain factors for Medicaid and CHIP eligibility (for example, income, State residency, SSNs, and pregnancy status) and the sharing of data among agencies. These proposed amendments are necessary to facilitate the determination of eligibility with minimal paper documentation required from individuals.

We expect that over the long-term, these guidelines will reduce burden on

States and individuals. The State of Utah's eFIND system provides an example of a successfully streamlined verification process. eFIND gathers data from more than 15 Federal and State sources including wage reporting, SSA, the SAVE system, and child support to verify Medicaid eligibility for applicants in real time. The State has estimated that eFIND has reduced the processing time for an eligibility determination from 17 minutes down to 3 minutes, saving the State \$2.1 million in the first year.

The specific burden associated with the written agreements for data sharing is the time and effort necessary for the State to modify existing agreements with applicable agencies for the collection of this information. We estimate that 53 State Medicaid agencies (the 50 States, the District of Columbia, Northern Mariana Islands, and American Samoa) will be subject to this requirement. We estimate it will take each State an average of 30 hours to modify agreements with the appropriate agencies. For the purpose of the cost burden, we estimate it will take a health policy analyst 20 hours, at \$43 an hour, and a manager 10 hours, at \$77 an hour, to complete the agreements. The estimated cost burden for each State is \$1,630 [(\$43 × 20) + (\$77 × 10)], for a total cost burden of \$86,390 [\$1,630 × 53] and a total annual hour burden of 1,590 hours [30 × 53]. Taking into account the Federal contribution to Medicaid and CHIP program administration, the estimated State share of these costs will be no more than \$43,195 [\$86,390 × 50 percent].

D. ICRs Regarding Renewal (§§ 435.916 and 457.343)

These provisions discuss the redetermination process for individuals whose eligibility is based on MAGI. These provisions are necessary to facilitate the accurate and efficient redetermination 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 requirement is the time and effort necessary for the State to develop and automate renewal notices and perform the revised recordkeeping related to redetermining 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 redetermined using the information already available to the agency. This approach greatly simplifies the renewal process and will ultimately reduce costs for States.

For example, the State of Louisiana streamlined its renewal process through a combination of administrative renewal, ex-parte review and conducting renewals over the telephone in 2007. As a result, fewer than 10 percent of families actually complete and submit a renewal form in order to remain enrolled in Medicaid or CHIP coverage. The State reports more than \$18 million in savings each year due to these changes.

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 burden, 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 burden 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. The proposed process is much less burdensome than the processes currently in place in many States that require individuals to complete a new application at renewal. We estimate that it will take an individual 20 minutes to complete the proposed 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. We note that the number of people who need to provide additional information may be smaller than our estimate, but we used a higher end estimate to account for the greatest potential impact on States and individuals. Some States that employ a

simplified renewal approach similar to what is proposed in this rule are able to renew coverage for nearly 80 percent of beneficiaries without contacting the individual or family.

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. We estimate that it will take the State agency 3 minutes (0.05 hour) at a rate of \$25 per hour for the average State eligibility worker to conduct the required recordkeeping for each of the 51 million renewals. The total estimated annual hour burden is 2,550,000 hours or 26,562.5 hours per agency [2,550,000/96]. At a rate of \$25 per hour the total estimated cost burden for recordkeeping is \$63,750,000 [2,550,000 × \$25] or \$664,063 per agency [\$63,750,000/96]. Taking into account the Federal contribution, the total estimated State share of the costs would be \$31,875,000 [\$63,750,000 × 50 percent].

E. 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 proposed 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 burden 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 the proposed 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 for this subpart. We estimate the total cost burden 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. States that elect to pursue these activities as part of a larger systems redesign effort would have significantly lower costs due to the availability of the 90 percent FMAP.

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 burden, 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 burden of two notices for each agency is \$1,784 [\$892 × 2]. The total estimated cost burden 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 burden for each agency is \$8,100 [150 × \$54]. The total estimated cost burden 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 burden 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].

F. ICRs Regarding Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64)

This action does not revise or impose any new information collection requirements or burden that would

require additional OMB review of CMS– 64. OMB has approved the burden and information collection requirements of CMS–64 under OMB control number 0938–0067.

TABLE 2—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 (\$)
§§ 435.945, 435.948, 435.956, 457.350, and 457.380	53	1	30	1,590	1,630	86,390	43,195
§§ 435.916 and 457.343	96	1	16	1,536	892	85,632	42,816
§§ 435.916 and 457.343	25.5 million	1	.33	8.5 million	.....	.....	.....
§§ 435.916 and 457.343	96	1	26,562.5	1 2.55 million	664,063	63,750,000	31,875,000
§§ 435.1200 and 457.335	53	1	502	26,606	27,379	1,451,087	725,543
Total .....	.....	.....	.....	.....	.....	65,373,100	32,686,555

Notes: All proposed collections are new; therefore the OMB Control Number is omitted from the table. There are no capital or maintenance costs incurred by the proposed 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 proposed 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 proposed 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.

We invite public comments on these potential information collection requirements. If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS–2349–P) Fax: (202) 395–6974; or E-mail: OIRA_submission@omb.eop.gov.

IV. Response to Comments

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

with a subsequent document, we will respond to the comments in the preamble to that document.

V. Summary of Preliminary Regulatory Impact Analysis

The summary analysis of benefits and costs included in this proposed rule is drawn from the detailed Preliminary Regulatory Impact Analysis (PRIA), available at <http://www.cms.gov/MedicaidEligibility/downloads/CMS-2349-P-PreliminaryRegulatoryImpactAnalysis.pdf>.

A. 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 a PRIA that presents the costs and benefits of this rulemaking.

B. Need for This Regulation

This proposed rule would 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 eligibility restrictions and barriers to enrollment in the Medicaid program which leave millions of low-income Americans uninsured, and which contribute to poor health outcomes, financial stress, and high health care and administrative costs. In addition, this proposed rule sets out the

increased Federal medical assistance percentage (FMAP) rates relating to “newly eligible” individuals and certain medical assistance expenditures in expansion States” beginning January 1, 2014.

C. Summary of Costs and Benefits

The preliminary impact analysis uses the estimates of the CMS Office of the Actuary (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 proposed rule would result in an estimated additional 24 million newly eligible and currently eligible individuals enrolling in Medicaid by 2016.^{1 2} OACT notes that such estimates are uncertain, since they depend on future economic, demographic, and other factors that

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. These estimates have been updated using later data, revised participation assumptions, and later information on policy decisions.

² OACT’s estimates include approximately 2–3 million individuals with primary health insurance coverage through employer-sponsored plans who would enroll in Medicaid for supplemental coverage.

cannot be precisely determined in advance. Similarly, the actual behavior of individuals and the actual operation of the new enrollment processes and Affordable Insurance Exchanges will affect enrollment and costs. The Congressional Budget Office (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 as implemented through this regulation.³ Some of the difference between OACT and CBO's projections can be explained by different participation rate assumptions, which are described further in the more detailed PRIA.

Increased access to medical care and the simplified enrollment process proposed by this rule would benefit both newly eligible and currently eligible individuals by improving health outcomes and providing financial security. Additionally, the proposed rule would benefit States and providers by reducing uncompensated care costs, shifting spending on either State-funded health coverage or uncompensated care to the Federal government. Finally, the simplified Medicaid eligibility policies will over time reduce administrative burdens on State Medicaid agencies.

We anticipate that the proposed rule would impose costs on a small number of currently eligible individuals who will become ineligible for Medicaid coverage under the new eligibility methodology. These individuals would bear the cost of purchasing subsidized insurance in the Exchanges, though these costs may be offset by premium tax credits.

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 \$202 billion from 2012 through 2016. Reflecting somewhat different participation assumptions and other projection factors, CBO estimates an increase in federal spending of \$162 billion over the

³ 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.

same period of time.⁴ OACT estimates that State expenditures on behalf of the additional individuals and families gaining Medicaid coverage as a result of the Affordable Care Act will total \$2.7 billion in FY 2014, \$4.0 billion in FY 2015, and \$4.9 billion in FY 2016.⁵ For both OACT and CBO, these estimates do not consider offsetting savings to States that will result, to a varying degree depending on the State, from less uncompensated care, less need for State-financed health services and coverage programs, and greater efficiencies in the delivery of care. Indeed, an Urban Institute analysis estimates that the costs to States will be more fully offset by other effects of the legislation, for net savings to States of \$92 to \$129 billion from 2014 to 2019.⁶

D. 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, they 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 Affordable Insurance Exchanges. The estimated Medicaid coverage and financial effects are particularly sensitive to these latter assumptions. Among those 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

⁴ 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>.

⁵ OACT estimates total gross additional State expenditures of approximately \$80 billion for FYs 2012 through 2021, offset by \$35 billion in lower State costs as a result of the transitional FMAP for expansion States, for a net total increase of \$45 billion. For comparison, CBO estimates net additional State expenditures of about \$60 million for the same time frame.

⁶ M. Buettgens *et al.*, "Consider savings as well as costs: State governments would spend at least \$90 billion less with the ACA than without it from 2014 to 2019." The Urban Institute, July 2011. Available at <http://www.urban.org/uploadedpdf/412361-consider-savings.pdf>.

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. Although CBO used similar data and overall methodologies, and also anticipates that the streamlined enrollment process and Exchange enrollment assistance will improve applicants' ability to become enrolled, CBO has included a significantly smaller from this factor than assumed by OACT.⁷

E. Regulatory Options Considered

Alternative approaches to implementing the Medicaid eligibility, enrollment and coordination requirements in the Affordable Care Act were considered in developing this proposed rule. However, it was determined that these alternatives would have created substantial administrative burdens for States and individuals, and created gaps in coverage that would reduce the number of people with insurance. We welcome public comment regarding the potential economic effects of the proposed rule.

F. Accounting Statement

For full documentation and discussion of these estimated costs and benefits, see the detailed PRA, available at <http://www.cms.gov/MedicaidEligibility/downloads/CMS-2349-P-PreliminaryRegulatoryImpactAnalysis.pdf>.

⁷ 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. Holohan and I. Headen, "Medicaid coverage and spending in health reform: National and State-by-State results for adults at or below 133% 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>.

TABLE 3—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED NET COSTS, FROM FY 2012 TO FY 2016
[In millions]

Category	Transfers			Period covered
	Year dollar	Units discount rate		
	2012	7%	3%	
Annualized Monetized Transfers from Federal Government to States on Behalf of Beneficiaries.	Primary Estimate	\$35,564	\$37,324	FYs 2012–2016
Annualized Monetized Transfers from States on Behalf of Beneficiaries.	Primary Estimate	2,131	2,235	FYs 2012–2016
Annualized Monetized Transfers from Federal Government to States.	Primary Estimate	1,577	1,657	FYs 2012–2016

Source: CMS Office of the Actuary.

G. 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. It is important to understand, however, 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 PRIA 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. We invite comment on these issues from States and local governments as well as any other interested parties.

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 preliminary regulatory impact analysis. 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 proposed rule would 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 proposed 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 proposed rule would 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 also is not needed for tribal governments since the proposed rules would not impose mandates on tribal governments.

H. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a proposed rule would 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) would be impacted directly by this proposed 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 2014 and 2021 the Federal government would pay about 94 percent of the costs of benefits for new Medicaid enrollees with the States paying the remaining 6 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.⁸ To the extent that States require counties to share in these costs, some small jurisdictions could be affected by the requirements of this proposed rule. However, nothing in this rule would constrain States from making changes to alleviate any adverse effects on small jurisdictions. The Department has no way of estimating the impact of this proposed rule on small jurisdictions and requests public comment on this issue.

Because this proposed 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 proposed 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. Again, the Department cannot determine whether this proposed rule would have a significant economic impact on a substantial number of small entities, and we request public comment on this issue.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a proposed rule may have a significant economic impact on the operations of a substantial number of small rural

⁸J. Holahan and I. Headen, "Medicaid coverage and spending in health reform: National and State-by-State results for adults at or below 133% 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>.

hospitals. This analysis must conform to the provisions of section 603. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this proposed rule would 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.

I. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent 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 proposed rule have significant direct effects on States.

The Affordable Care Act requires major changes in the Medicaid and CHIP programs, which would 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 consulted with States to receive input on how the various Affordable Care Act provisions codified in this proposed rule would affect States. 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 also furnished opportunities for CMS to explore these implementation issues together with States and also provide information on an informal basis about implementation plans to the State Medicaid Directors, and for the Directors to comment informally on what they heard in the course of those conversations.

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 consultations with these TAGs, we have been able to get input from States specific to issues surrounding the changes in eligibility groups and rules that 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 433

Administrative practice and procedure, Child support Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs—health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 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).

Subpart A—Single State Agency

- 2. Section 431.10 is amended by—
A. Revising paragraph (b)(2)(ii) and the introductory text of paragraph (c)(1).
B. Adding paragraphs (c)(1)(iii) and (c)(3).
C. Revising paragraphs (d) and (e)(3).
The revisions and additions read as follows:

§ 431.10 Single State agency.

- (b) * * *
(c) * * *

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon State or other agencies that administer the plan.

* * * * *

(c) * * *

(1) The plan must specify whether the entity that determines eligibility for families, adults, and for individuals under 21 is—

* * * * *

(iii) A government-operated Exchange established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act (Pub. L. 111-148).

* * * * *

(3) The single State agency is responsible for assuring and enforcing that—

(i) Eligibility determinations are made consistent with its rules and if there is a pattern of incorrect determinations that corrective actions are instituted and/or the delegation is terminated;

(ii) There is no conflict of interest by any agency delegated the responsibility to make eligibility determinations; and

(iii) Eligibility determinations will be made in the best interest of applicants and beneficiaries and that the single State agency will guard against improper incentives and/or outcomes.

(d) Agreement with Federal or State and local agencies. The plan must provide for written agreements between the Medicaid agency and the Federal or other State or local agencies that determine eligibility for Medicaid, stating—

(1) The relationships and respective responsibilities of the agencies;

(2) The quality control and oversight plans by the single State agency to review determinations made by the delegee;

(3) The reporting requirements from the delegee making Medicaid eligibility determinations to the single State agency.

(4) The confidentiality and security requirements in accordance with sections 1902(a)(7) and 1942 of the Act for all applicant and beneficiary data; and

(5) That merit protection principles are employed by the agency responsible for the Medicaid eligibility determination.

(e) * * *

(3) If other Federal, State or local agencies or offices 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 for 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 agencies.* 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, the plan must include a description of the staff designated by those other agencies and the functions they perform in carrying out their responsibilities.

Subpart M—Relations With Other Agencies

§ 431.636 [Removed]

4. Remove § 431.636.

PART 433—STATE FISCAL ADMINISTRATION

5. The authority citation for part 433 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—Federal Matching and General Administration Provisions

6. Section 433.10 is amended by—
A. In paragraph (a), removing the phrase “and 1905(b),” and adding in its place the phrase “1905(b), 1905(y), and 1905(z)”

B. Adding new paragraphs (c)(6), (c)(7), and (c)(8).

The additions read as follows:

§ 433.10 Rates of FFP for program services

* * * * *

(c) * * *

(6)(i) Beginning January 1, 2014, under section 1905(y) of the Act, the FMAP for a State that is one of the 50 States or the District of Columbia, for amounts expended by such State for medical assistance for newly eligible individuals, as defined in § 433.204 of this part, will be an increased FMAP equal to:

(A) 100 percent, for calendar quarters in calendar years (CYs) 2014 through 2016;

(B) 95 percent, for calendar quarters in CY 2017;

(C) 94 percent for calendar quarters in CY 2018;

(D) 93 percent for calendar quarters in CY 2019;

(E) 90 percent for calendar quarters in CY 2020; and

(F) 90 percent for calendar quarters in all other CYs after 2020.

(ii) The FMAP specified in paragraph (c)(6)(i) of this section will apply to

amounts expended by a State for medical assistance for newly eligible individuals in accordance with the requirements of the methodology selected by the State under § 422.206 of this chapter.

(7)(i) During the period January 1, 2014 through December 31, 2015, under section 1905(z)(1) of the Act for a State described in paragraph (c)(7)(ii) of this section, the FMAP determined under paragraph (b) of this section will be increased by 2.2 percentage points.

(ii) A State qualifies for the general increase in the FMAP under paragraph (c)(7)(i) of this section, if the State:

(A) Is an expansion State, as described in paragraph (c)(8)(iii) of this section;

(B) Does not qualify for any payments on the basis of the increased FMAP under paragraph (c)(6) of this section, as determined by the Secretary; and

(C) Has not been approved by the Secretary to divert a portion of the Disproportionate Share Hospital Allotment for the State to the costs of providing medical assistance or other health benefits coverage under a demonstration that is in effect on July 1, 2009.

(iii) The increased FMAP under paragraph (c)(7)(i) of this section is available for amounts expended by the State for medical assistance for individuals that are not newly eligible as defined in § 433.204 of this part.

(8)(i) Beginning January 1, 2014, under section 1905(z) of the Act, the FMAP for an expansion State defined in paragraph (c)(8)(iii) of this section, for amounts expended by such State for medical assistance for individuals described in section

1902(a)(10)(A)(i)(VIII) of the Act who are not newly eligible as defined in § 433.204 of this part and who are nonpregnant childless adults for whom the State may require enrollment in benchmark coverage under section 1937 of the Act, will be determined in accordance with the following formula:
 $F + (T \times (N - F))$

F = The base FMAP for the State determined under paragraph (b) of this section, subject to paragraph (c)(7) of this section.

T = The transition percentage specified in paragraph (c)(8)(ii) of this section.

N = The Newly Eligible FMAP determined under paragraph (c)(6) of this section.

(ii) For purposes of paragraph (c)(8)(i) of this section, the transition percentage is equal to:

(A) 50 percent, for calendar quarters in CY 2014;

(B) 60 percent, for calendar quarters in CY 2015;

(C) 70 percent, for calendar quarters in CY 2016;

(D) 80 percent, for calendar quarters in CY 2017;

(E) 90 percent, for calendar quarters in CY 2018; and

(F) 100 percent, for calendar quarters in CY 2019 and all subsequent calendar years.

(iii) A State is an expansion State if, on the March 23, 2010, the State offered health benefits coverage Statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938 of the Act. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence will not be considered to be an expansion State.

(iv) For amounts expended by an expansion State as defined in paragraph (c)(8)(iii) of this section for medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act who are newly eligible as defined in § 433.201, and who are non-pregnant childless adults for whom the State may require enrollment in benchmark coverage under section 1937 of the Act, the FMAP is as specified in paragraph (c)(6) of this section.

7. Subpart E is added to part 433 to read as follows:

Subpart E—Methodologies for Determining Federal Share of Medicaid Expenditures for Mandatory Group

Sec.	
433.202	Scope.
433.204	Definitions.
433.206	Choice of methodology.
433.208	Threshold methodology.
433.210	Statistically-valid sampling methodology.
433.212	CMS established FMAP proportion.

Subpart E—Methodologies for Determining Federal Share of Medicaid Expenditures for Mandatory Group

§ 433.202 Scope.

This subpart sets forth the requirements and procedures under which States may claim for the higher Federal share of expenditures for newly eligible individuals specified in § 433.204 of this subpart.

§ 433.204 Definitions.

As used in this subpart:

Newly Eligible Individual means an individual eligible for Medicaid in accordance with the requirements of the new adult group and who would not have been eligible for Medicaid under the State's eligibility standards and methodologies for the Medicaid State plan, waiver or demonstration programs in effect in the State as of December 1, 2009.

§ 433.206 Choice of methodology.

(a) Beginning January 1, 2014, the State must determine the expenditures which may be claimed at the FMAP rate described in § 433.10 of this part using one of the following methods:

(1) Applying eligibility thresholds and proxies in accordance with § 433.208 of this part; or

(2) Conducting a statistically valid sample in accordance with § 433.210 of this part; or

(3) Electing to utilize the CMS established FMAP proportion rate established in accordance with § 433.212 of this part.

(b) The State must provide to CMS for approval a methodology that provides the description of the method it will use to determine the appropriate FMAP claim for medical assistance expenditures for newly eligible individuals including all of the following requirements:

(1) Except as provided in paragraph (b)(2) of this section, at least 2 years prior to the year in which the State will implement that method.

(2) For CY 2014, the State must notify CMS of such method no later than December 31, 2012.

(3) Changing claiming methodologies:

(i) The State must use the chosen methodology for at least 3 consecutive years before changing to another methodology;

(ii) The State must notify CMS of any change in methodology in accordance with paragraphs (b)(1) and (b)(2) of this section.

(c) To implement each methodology—

(1) The State must first determine those individuals eligible under section 1902(a)(10)(A)(i)(VIII) of the Act.

(2) The State may apply a CMS approved methodology only to expenditures for such individuals.

(d) Nothing in this section impacts the timing or approval of an individual's eligibility for Medicaid.

§ 433.208 Threshold methodology.

(a) Beginning January 1, 2014, States may elect to apply a CMS-approved State specific threshold methodology that meets all of the following requirements:

(1) Incorporates State eligibility standards, including disregards and

other adjustments that were in place as of December 1, 2009.

(2) Incorporates any enrollment caps under section 1115 demonstration programs that were in place in the State on December 1, 2009.

(3) Is applied to each individual applicant determined eligible for Medicaid under the adult group.

(4) Is used to determine whether each individual is newly eligible so that the State may claim the FMAP described in § 433.10(c) of this subpart for all expenditures for such individuals.

(b) To implement the threshold methodology, the State must submit a methodology and receive CMS approval of such methodology prior to its application to new FMAP determinations.

(1) Such methodology will specify how the State will determine the population within the adult group and describe in a format provided by CMS how it is approximating the December 1, 2009 standards and methodologies, as well as how the State will apply the established criteria.

(2) Subject to approval by CMS, a State may use criteria including but not limited to:

(i) Self-declaration.

(ii) Claims history.

(iii) Receipt of Social Security Disability Income.

(iv) Disability determination by SSA.

(v) Information from the Asset Verification System established under the DRA.

(vi) Information from tax returns.

(vii) Application of a proportion derived from historical data of the actual proportion of individuals within specific eligibility groups that were ineligible for Medicaid due to assets or eligible for Medicaid due to disability status using the eligibility standards in place as of December 1, 2009.

(viii) Other disability and asset data sources.

(c) The threshold methodology must:

(1) Not be biased in such a manner as to overestimate or over report individuals as newly eligible who were actually individuals who would have been eligible using the State's December 1, 2009 eligibility standards.

(2) Provide an accurate estimation of which individuals would have been eligible in accordance with the December 1, 2009 eligibility standards to be used for the designated year, by incorporating simplified assessments of asset and disability requirements in place at that time. Once individuals are determined to be either a newly eligible individual or an individual who would have been eligible under the December 2009 standards, the State would apply

that eligibility determination throughout the entire year.

(3) Be verified by, and adjusted prospectively to include results of, any evaluations conducted by CMS in conjunction with the State(s) of the accuracy of the threshold.

§ 433.210 Statistically valid sampling methodology.

(a)(1) A State choosing to implement a statistically-valid sampling methodology to determine the proportion of expenditures to which the FMAP specified in § 433.10(c) of this subpart will apply, must submit to CMS a methodology that details the sampling plan prior to making such claims which demonstrates compliance with the requirements established in this section as well as all additional requirements that CMS issues in subregulatory guidance.

(2) The methodology with the sampling plan must be submitted to CMS on or before January 1 of the calendar year in which the State will claim expenditures using the sampling methodology.

(3) The State may not implement the sampling methodology until CMS has reviewed and approved the State's sampling plan.

(b) A State must verify that its sampling plan follows all relevant requirements established in the most current OMB Circular A-87.

(c) The State must implement the plan as specified in the CMS-approved sampling plan for the year in which it claims expenditures based on the sampling plan.

(d) A State must draw a statistically valid sample from the population of Medicaid applicants who are eligible for Medicaid under the adult group.

(e) The State must evaluate each individual randomly selected to be included in the sample to determine whether:

(1) The individual is newly eligible; or

(2) The individual would have been eligible under the standards in place to determine eligibility under the Medicaid State plan and/or demonstration program as of December 1, 2009, including any enrollment caps under section 1115 demonstration programs that were in place in the State on December 1, 2009.

(f) The State will attribute all actual medical assistance expenditures in that calendar year for each newly eligible individual in the sample and for each individual in the sample who would have been eligible under the December 1, 2009 standards. The State will extrapolate and apply the proportion of

Medicaid expenditures attributed to the newly eligible in the sample to the expenditures of the population.

(g) The State will consider the amount determined in accordance with paragraph (f) of this section to be the expenditures of the newly eligible individuals and receive the FMAP rate described in § 433.10(c) of this subpart for such expenditures when the State claims on the CMS-64.

(h) The State may claim and receive the FMAP described in § 433.10(c) of this subpart for an estimated proportion on an interim basis as follows:

(1) States may claim expenditures in current years based on an interim FMAP proportion determined by the most recent year for which data is available.

(2) States must make a retroactive adjustment to claims on the CMS-64 for the current year once that expenditure information is finalized under the provisions of paragraph (f) of this section.

(3)(i) Results of a statistically-valid sampling methodology for any given year must be finalized and applied, and adjustments to claims on the CMS-64 must be made, within 2 years from the date of the actual expenditure.

(ii) If the State does not have supporting documentation at the end of the second year following the year at issue, the State must make a decreasing adjustment on the CMS-64 to refund the higher FMAP rates, and such claims will be regarded as untimely under 45 CFR 95.7 if resubmitted.

(iii) A State must implement the statistically valid sampling methodology in accordance with this section on an annual basis for the initial 3 consecutive years.

(A) States that have completed the requirements for 3 consecutive years, are required thereafter to verify using a sampling methodology in accordance with this section every 3 years.

(B) Any State that meets the requirements of paragraph (h)(3)(iii)(A) of this section may retroactively apply results of the sample to the rates of the calendar year expenditures for the years prior to the sample up to the last year in which the State completed and applied the results of a sampling methodology.

§ 433.212 CMS established FMAP proportion.

(a) Beginning January 1, 2014, States may elect to apply a CMS determined proportion to medical assistance expenditures for individuals eligible for Medicaid in the adult group.

(b) CMS will publish State-specific estimated FMAP proportions of eligibility under the December 2009

eligibility criteria using data sources including, but not limited to MEPS and MSIS data.

(c) CMS will meet all of the following requirements:

(1) Solicit and incorporate comments on the development of rates.

(2) Annually establish a model to predict in an unbiased way the appropriate proportion of expenditures for which each State would claim the FMAP rate described in § 433.10(c) of this subpart for newly eligible individuals taking into account any enrollment caps under demonstration programs that were in place in the State on December 1, 2009.

(3) Publish the State-specific rates by October 1 of the preceding year. For CY 2014, the model must be published no later than January 1, 2013.

(4) Incorporate results from a validation methodology in accordance with § 433.212(e) of this subpart such as a statistically valid sampling of State data of actual individuals eligible for and enrolled in Medicaid in accordance with section 1902(a)(10)(A)(i)(VIII) of the Act.

(5) Provide technical assistance to States on applying the rates established.

(d) States will apply the CMS published State-specific proportion of expenditures attributed to the newly eligible to expenditures for all individuals eligible for and enrolled in Medicaid in accordance with section 1902(a)(10)(A)(i)(VIII) of the Act. The State will consider the amount determined in accordance with this section to be the expenditures of the newly eligible individuals and receive the FMAP rate described in § 433.10(c) of this part for such expenditures when the State claims expenditures on the CMS-64.

(e) Validation measures such as statistical sampling must be incorporated into the estimate:

(1) On an annual basis beginning in CY 2016, to include expenditures related to CY 2014, and continue through CY 2021;

(2) After CY 2021, validation will be completed, and results incorporated into the model, on a 3-year basis;

(3) After CY 2030, validation will be completed, and results incorporated into the model, on a 5-year basis.

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.”

Subpart A—General Provisions and Definitions

9b. Section 435.4 is amended by—

A. Adding the definitions of “Advance payments of the premium tax credit,” “Affordable Insurance Exchange (Exchange),” “Agency,” “Caretaker relative,” “Dependent child,” “Effective income level,” “Electronic account,” “Household income,” “Insurance affordability program,” “MAGI-based income,” “Minimum essential coverage,” “Modified adjusted gross income (MAGI),” “Pregnant woman,” “Secure electronic interface,” and “Tax dependent” in alphabetical order.

B. Revising the definition of “Families and children.”

The revisions read as follows:

§ 435.4 Definitions and use of terms.

* * * * *

Advance payments of the premium tax credit means payments of the tax credit specified in section 36B of the Internal Revenue Code of 1986, which provide premium assistance on an advance basis to support enrollment of an eligible individual in a qualified health plan through the Exchange.

* * * * *

Affordable Insurance Exchange (Exchange) means a governmental agency or non-profit entity that meets the applicable requirements and makes qualified health plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

Agency means a State Medicaid agency.

* * * * *

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), including the child’s natural, adoptive, or step parent; another relative of the child based on blood (including those of half-blood), adoption, or marriage; and the spouse of such parent or relative, even after the marriage is terminated by death or divorce.

* * * * *

Dependent child means a child who is under the age of 18, or is age 18 and a

full-time student, and who is deprived of parental support by reason of the death, absence from the home, 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.

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 § 435.913.

Families and children means individuals whose eligibility for Medicaid is determined based on being a pregnant woman, a child younger than age 21, or a parent or other caretaker relative of a dependent child. It does not include individuals whose eligibility is based on other factors, such as blindness, disability, being aged (65 or more years old), or a need for long-term care services.

Household income has the meaning provided in § 435.603(d).

Insurance affordability program means:

(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) 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 of 1986; or

(5) 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).

Minimum essential coverage means coverage defined in section 5000A(f) of subtitle D of the Internal Revenue Code of 1986, 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 in

section 36B(d)(2) of the Internal Revenue Code of 1986.

* * * * *

Pregnant woman means a woman during pregnancy and the post partum period, which extends until the last day of the month in which a 60-day period, beginning on the date the pregnancy terminates, 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.

* * * * *

Tax dependent means an individual for whom another individual properly claims a deduction for a personal exemption under section 151 of the Internal Revenue Code of 1986 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 applicable the spouse of the parent or other caretaker relative, 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 a household of 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 a household of 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 a household of 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—*

(i) Consists of all services which the State is required to cover under § 440.210(a)(1) of this chapter and all services which it has opted to cover under § 440.225 of this chapter; and

(ii) May include, at State option, enhanced pregnancy-related services in accordance with § 440.250(p) of this chapter.

(3) *Pregnancy-related services*—

(i) Consist at least of services, as defined by the agency, related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and other conditions which may complicate pregnancy; and

(ii) May include, at State option, enhanced pregnancy-related services in accordance with § 440.250(p) of this chapter).

(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 a household of 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 a household of 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 § 435.118(a), 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 a household of the applicable family size.

(c) *Coverage for dependent children.*

(1) A State may not provide Medicaid 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 other 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 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 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 a household of 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 coverage of parents and other caretaker relatives specified in § 435.119(c) also applies to coverage 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.

Subpart E—General Eligibility Requirements

19. Section 435.403 is amended by—

A. Redesignating paragraphs (h) and (i) as paragraphs (i) and (h), respectively.

B. Revising newly redesignated paragraphs (h)(1) and (h)(4)

C. Revising newly redesignated paragraphs (i)(1) and (i)(2).

D. Removing newly redesignated paragraph (i)(3).

E. Further redesignating newly redesignated paragraph (i)(4) as paragraph (i)(3).

F. Amending paragraph (l)(2) by removing “paragraph (h)” and adding “paragraph (i)” in its place.

The revisions and addition read as follows:

§ 435.403 State residence.

* * * * *

(h) *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—

(i) Intends to reside, including without a fixed address or, if incapable

of stating intent, where the individual is living; or

(ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed).

* * * * *

(4) For any other institutionalized individual, the State of residence is the State where the individual intends to reside or, if incapable of stating intent, where the individual is living.

(i) *Individuals under age 21.*

(1) For an individual under age 21 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 under age 21 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, the State of residence is the State:

(i) Where the individual resides, including with a custodial parent or caretaker or without a fixed address; or

(ii) Where the individual's parent or caretaker has entered the State with a job commitment or seeking employment (whether or not currently employed).

* * * * *

Subpart G—General Financial Eligibility Requirements and Options

20. 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 (i) 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 on or before December 31, 2013 and receiving Medicaid as of January 1, 2014, application of the financial methodologies set forth in this section must not be applied until March 31, 2014 or the next regularly-scheduled redetermination of eligibility for such individual under § 435.916, whichever is later, if the individual otherwise would lose eligibility as a result of the application of these methodologies.

(b) *Definitions.* For purposes of this section—

Code means the Internal Revenue Code of 1986.

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 2 persons. 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).

Tax dependent has the meaning provided in § 435.4 of this part.

(c) *Basic rule.* Except as specified in paragraph (i) 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) 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) 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 required to file a tax return under section 6012 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.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income also includes actually available cash support 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, except that, notwithstanding the treatment of the following under the Code—

(1) An amount received as a lump sum is counted as income only in the month received.

(2) Scholarships 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, or that is subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior.

(iii) 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;

(iv) 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;

(v) 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 filing a tax return for the taxable year in which an initial determination or redetermination of eligibility is being made, and who is not claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and all tax dependents.

(2) *Basic rule for individuals claimed as a tax dependent.* In the case of an individual who is claimed as a tax dependent by another taxpayer, 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 are claimed as a tax dependent by another taxpayer;

(ii) Individuals under age 21 living with both parents, if the parents are not married; and

(iii) Individuals under age 21 claimed as a tax dependent by a non-custodial parent.

(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 file a Federal tax return and are not claimed as a tax dependent, 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 age 19 or, if such child is a full-time student, under age 21; and

(iii) In the case of individuals under age 19, or, in the case of full-time students, under age 21 the individual's natural, adopted and step parents and adoptive and step siblings under age 19 or, if such sibling is a full-time student, under 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 file a joint tax return under section 6013 of the Code or whether one spouse is claimed as a tax dependent by the other spouse.

(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.

(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 projected annual household income for the current calendar year.

(3) In determining current monthly or projected annual household income under paragraph (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 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 must be verified in the same manner as other income, in accordance with the income and eligibility verification requirements at § 435.940 *et seq.*, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

(i) *Eligibility Groups for which modified MAGI-based methods do not*

apply. The financial methodologies described in this section are not applied in determining the eligibility for individuals whose eligibility for Medicaid is being determined on the following bases or under the following eligibility groups. For individuals described in paragraphs (i)(3) through (i)(6) of this section, 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 State Medicaid agency, including, but not limited to, individuals deemed to be receiving Supplemental Security Income (SSI) benefits and eligible for Medicaid under § 435.120, individuals receiving SSI benefits and eligible for Medicaid under § 435.135, § 435.137 or § 435.138 of this subpart 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.

(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.

(4) Individuals whose eligibility is being determined on the basis of the need for long-term care services, including nursing facility services or a level of care in any institution equivalent to such services; home and community-based services under section 1915 or under a demonstration under section 1115 of the Act; or services described in sections 1905(a)(7) or (24) or in sections 1905(a)(22) and 1929 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.

Subpart J—Eligibility in the States and District of Columbia Applications

21. 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, 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 in simple and understandable terms and in a manner that is accessible to persons who are Limited English Proficient (LEP) and individuals living with disabilities.

22. Section 435.907 is revised to read as follows:

§ 435.907 Application.

(a) The agency must require an application from the applicant, an authorized representative, or someone acting responsibly for the applicant.

(b) The application must be—

(1) The single, streamlined application for all insurance affordability programs developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act; or

(2) An alternative single, streamlined application for all insurance affordability programs developed by a State and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act. The alternative application must be no more burdensome than the single streamlined application described in paragraph (b)(1) of this section and ensure coordination across insurance affordability programs.

(c) For individuals applying for coverage, or who may be eligible, on a basis other than the applicable modified adjusted gross income standard in accordance with § 435.911, the agency may use either the single, streamlined application and supplemental forms to collect additional information needed to determine eligibility on such other basis or an alternative application form approved by the Secretary.

(d) The agency must establish procedures to enable an individual, or other authorized person acting on behalf of the individual, to submit an application—

- (1) Via the Internet Web site described in § 435.1200(d) of this part;
- (2) By telephone;
- (3) Via mail;
- (4) In person; or
- (5) Via facsimile.

(e) *Information related to non-applicants.*

(1) The agency may not require an individual who is not applying for benefits for himself or herself (a “non-applicant”) to provide an SSN or information regarding such individual's citizenship, nationality, or immigration

status on any application or supplemental form.

(2) The agency may request that a household member who is a non-applicant provide an SSN, only if—

(i) Provision of the SSN to the agency is voluntary and the agency permits the completion of the application without such information;

(ii) The SSN from a non-applicant is used to determine an applicant's eligibility for Medicaid or for a purpose directly connected to the administration of the State plan; and

(iii) The agency clearly notifies the non-applicant that the provision of an SSN is voluntary and informs the individual how the SSN will be used, at the time it is requested.

(f) The initial application must be signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission must be accepted.

23. Section 435.908 is revised to read as follows:

§ 435.908 Assistance with application and redetermination.

(a) The agency must allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a redetermination of eligibility.

(b) The agency must provide assistance to any individual seeking help with the application or redetermination 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.

24. Redesignate § 435.911 through § 435.914 as § 435.912 through § 435.915 respectively.

25. 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), the income standard established in accordance with § 435.110(c);

(ii) In the case of pregnant women, the income standard established in accordance with § 435.116(c);

(iii) In the case of individuals under age 19, the income standard established in accordance with § 435.118(c);

(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 § 435.907 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) *Eligibility determination for mandatory coverage on basis of modified adjusted gross income.* For 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 or title XVIII of the Act, and whose household income is at or below the applicable modified adjusted gross income standard, the agency must promptly and without undue delay furnish Medicaid benefits to such individual in accordance with parts 440 and 441 of this chapter.

(2) *Eligibility on basis other than applicable modified adjusted gross income standard.* For each such individual not determined eligible for Medicaid in accordance with paragraph (c)(1) of this section, the agency must collect additional information as needed, consistent with § 435.907(c), to—

(i) Determine whether such individual is eligible for Medicaid on any other basis.

(ii) Promptly and without undue delay furnish Medicaid to each such individual determined eligible, in accordance with parts 440 and 441 of this chapter; and

(iii) Comply with the requirements set forth in § 435.1200(g).

26. Section 435.916 is revised to read as follows:

§ 435.916 Periodic redeterminations of Medicaid eligibility.

(a) *Redetermination of individuals whose Medicaid eligibility is based on modified adjusted gross income.*

(1) Except as provided in paragraph (d) of this section, the eligibility of Medicaid beneficiaries whose financial eligibility is based on the applicable modified adjusted gross income standard in accordance with

§ 435.911(c)(1) must be redetermined once every 12 months.

(2) 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.

(i) *Individuals redetermined eligible on the basis of information available to the agency.*

(A) If the agency determines, on the basis of information available to the agency that the individual remains eligible for Medicaid, consistent with the requirements of this subpart and subpart E of part 431 the agency must notify the individual—

(1) Of the eligibility determination, and basis therefore; and

(2) That the individual must inform the agency, through any of the modes permitted for submission of applications under § 435.907(d) of this subpart, if any of the information contained in such notice is inaccurate.

(B) Such individuals must not be required to sign and return the notice.

(ii) *Individuals not redetermined eligible on basis of information available to agency.* If the agency cannot determine, on the basis of information available to it, that the individual remains eligible for Medicaid, or if it otherwise needs additional information to complete the redetermination, the agency must comply with the requirements in paragraph (a)(3) of this section.

(3) *Use of a pre-populated renewal form.* For individuals not redetermined eligible under paragraph (a)(2) of this section, the agency must—

(i) Provide the individual with—

(A) A renewal form containing information available to the agency that is needed to renew eligibility, as specified by the Secretary;

(B) At least 30 days from the date of the renewal form to respond and provide necessary information;

(C) Notice of the agency's decision concerning eligibility in accordance with this subpart and subpart E of part 431 of this chapter; and

(D) The ability to respond to the renewal form through any of the modes permitted for submission of applications under § 435.907(d), and if required, sign the renewal electronically.

(ii) Verify any information provided by the beneficiary in accordance with § 435.945 through § 435.956.

(iii) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to respond to the renewal form, if the individual subsequently responds to the agency within a reasonable period after the date of termination without the need for the individual to file a new application.

(4) *Transmission of data on individuals no longer eligible for Medicaid.* If an individual is determined ineligible for Medicaid, the agency must assess the individual for eligibility for other insurance affordability programs and transmit the electronic account and any relevant information used to make the eligibility determination to the appropriate program in accordance with the requirements set forth in § 435.1200(g) of this part.

(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(i) of this part, for circumstances that may change, at least every 12 months. The agency may—

(1) 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) 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 in accordance with the modes required for submission of applications under § 435.907(d) of this subpart.

(d) *Agency action on information about changes.* Consistent with the requirements of § 435.952 of this subpart—

(1) The agency must promptly redetermine eligibility when it receives information about changes in a beneficiary's circumstances that may affect his or her eligibility.

(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.

27. 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.

28. Section 435.945 is revised to read as follows:

§ 435.945 General requirements.

(a) Nothing in these 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 part 455 of this subchapter.

(b) This subpart with respect to citizenship and immigration status information, and subject to the verification requirements set forth in this subpart, the agency may accept attestation without requiring further paper documentation (either self-attestation by the applicant or beneficiary or by a parent, caretaker or other person acting responsibly on behalf of an applicant or beneficiary) of all information needed to determine the eligibility of an applicant or beneficiary for Medicaid.

(c) 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.

(d) The agency must furnish, in a timely manner, income and eligibility information needed for verifying eligibility for 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.

(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 (d) of this section for reasonable costs incurred in furnishing information, including new developmental costs associated with furnishing the information to another agency.

(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) The agency must report information as prescribed by the Secretary for purposes of determining compliance with § 431.305, subpart P of part 431, § 435.910, § 435.913, and § 435.940 through § 435.965 of this chapter 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.

29. Section 435.948 is revised to read as follows:

§ 435.948 Verifying financial information.

(a) The agency must request information relating to financial eligibility from other agencies in the State and other States and Federal programs in accordance with this section. To the extent the agency determines such information is useful to verifying the financial eligibility of an individual, the agency must request:

(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, the Social Security Administration, 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 Public Assistance Reporting Information System (PARIS), the Supplemental Nutrition Assistance Program, and other insurance affordability programs. (Note: all eligibility determination systems must conduct data matching through PARIS).

(b) To the extent that the information identified in paragraph (a) 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)(1) If the information identified in paragraph (a) of this section is not available through the electronic service established in accordance with § 435.949 of this subpart, the agency may obtain the information directly from the appropriate agency or program consistent with the requirements in § 435.945 of this subpart.

(2) The agency must request the information by SSN, or if a SSN is not available, using other personally identifying information in the individual's account, if possible.

(d) *Flexibility in information collection and verification.* Subject to approval by the Secretary, the agency may request and use income information from a source or sources alternative to those listed in paragraph (a) of 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.

30. 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, including the Social Security Administration, the Department of Treasury, the Department of Homeland Security and any other Federal offices that maintain records containing information related to eligibility for Medicaid or other minimum essential coverage.

(b) To the extent that information 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.

(c) The Secretary may provide for, or approve a request from a State to utilize, an alternative mechanism through which States may collect and verify such information, if the Secretary determines that such alternative mechanism meets the criteria set forth in § 435.948(d) of this subpart.

31. 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 redetermine 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 with information provided by or on behalf of the individual.

(1) In such cases, the agency may seek additional information, including a statement which reasonably explains the discrepancy or other additional information (including paper documentation), from the individual.

(2) The agency must provide the individual a reasonable period to furnish such additional information.

(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]

32. Section 435.953 is removed.

§ 435.955 [Removed]

33. Section 435.955 is removed.

34. 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(b) of this subpart or through

other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

(2) A document that provides evidence of immigration status may not be used alone to determine State residency.

(d) *Social Security numbers.* The agency must verify Social Security numbers (SSNs) in accordance with § 435.910(f) and (g) of this subpart.

(e) *Pregnancy and household size.* The agency must accept self-attestation of pregnancy and the individuals that comprise an individual's household, as defined in 435.603(f), 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 and date of birth.* The agency may verify date of birth in accordance with § 435.945(b) of this subpart or through other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

35. 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.* This section implements sections 1943 and 2102(b)(3)(B) and (c)(2) of the Act.

(b) *Definitions.* As used in this subpart:

Applicable modified adjusted gross income (MAGI) standard is defined as provided in § 435.911(b)(1) of this part.

Application means the single streamlined application described in § 435.907(b) submitted by or on behalf of an individual.

Exchange is defined as provided in § 435.4 of this part.

Insurance Affordability Program is defined as provided in § 435.4 of this part.

Secure electronic interface is defined as provided in § 435.4 of this part.

(c) *General requirements.* The State Medicaid Agency must —

(1) Participate in and comply with the coordinated eligibility and enrollment system described in section 1943 of the Act to ensure that the agency fulfills the responsibilities set forth in paragraphs (e) through (g) of this section in partnership with other insurance affordability programs.

(2) Consistent with § 431.10(d) of this chapter, enter into one or more agreements with the Exchange and the

agencies administering other insurance affordability programs, as defined in § 435.4 of this part, as are necessary to fulfill each of the requirements of this section.

(3) In accordance with the Medicaid State plan, certify the criteria, including but not limited to applicable MAGI standards as defined in § 435.911(b) of this subpart and satisfactory immigration status, necessary for the Exchange to determine Medicaid eligibility.

(d) *Internet Web site.* The State Medicaid agency must make available to current and prospective Medicaid applicants and beneficiaries a Web site that:

(1) 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; and

(2) Is accessible to people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act and provides meaningful access for persons who are limited English proficient.

(e) *Provision of Medicaid for individuals found eligible for Medicaid by the Exchange.* For each individual found eligible for Medicaid by the Exchange based on the applicable MAGI standard, the agency must establish procedures—

(1) To receive, via secure electronic interface, the electronic account containing the finding of Medicaid eligibility, all information provided on the application, and any information obtained or verified by the Exchange in making such finding; and

(2) To furnish Medicaid to the individual promptly and without undue delay in accordance with parts 440 and 441 of this chapter, to the same extent and in the same manner as if such individual had been determined eligible for Medicaid by the agency.

(f) *Transfer of applications from other insurance affordability programs to the State Medicaid agency.* The agency must adopt procedures to ensure that it promptly and without undue delay determines the Medicaid eligibility of individuals determined to be potentially eligible for Medicaid by other insurance affordability programs. The procedures must ensure that—

(1) The agency accepts, via secure electronic interface, the electronic account for the individual screened as potentially Medicaid eligible, including all information provided on the application and any information

obtained or verified by the insurance affordability program;

(2) The agency may not request information or documentation from the individual that is already contained in the electronic account;

(3) The agency determines the Medicaid eligibility of the individual, promptly and without undue delay, in accordance with § 435.911(c) of this part in the same manner as if the application had been submitted directly to, and processed by, the agency, except that the agency must not verify eligibility criteria already verified by the insurance affordability program.

(4) The agency notifies the insurance affordability program of the final determination of the individual's eligibility or ineligibility for Medicaid.

(g) *Evaluation of eligibility for the Exchanges and other insurance affordability programs.*

(1) *Individuals determined not eligible for Medicaid.* For individuals who submit an application which includes sufficient information to determine Medicaid eligibility, and whom the agency determines are not eligible for Medicaid, the agency must establish procedures to assess such individuals for potential eligibility for other insurance affordability programs and promptly and without undue delay transfer such individuals' electronic accounts to any other program(s) for which they may be eligible. The electronic account must include all information provided on the application and any information obtained or verified by the agency, including the determination of Medicaid ineligibility.

(2) *Individuals undergoing a Medicaid eligibility determination on a basis other than MAGI.* In the case of an individual with household income, as defined in § 435.603(d) of this part, greater than the applicable MAGI standard and for whom the agency is determining eligibility on the basis of being blind or disabled, the agency must establish procedures to—

(i) Assess the individual for potential eligibility for coverage under other insurance affordability programs and, promptly and without undue delay, provide the individual's electronic account to any such program for which the individual may be eligible. The electronic account must be transmitted via secure electronic interface and must include all information provided on the application and any information obtained or verified by the agency, along with the determination 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) Notify the appropriate insurance affordability program(s) of the agency's final determination of eligibility or ineligibility.

PART 457—ALLOTMENTS AND GRANTS TO STATES

36a. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

36b. In part 457, remove the term “family income” wherever it appears and add in its place the term “household income.”

37. In part 457 remove “SCHIP” wherever it appears and add in its place “CHIP.”

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

38. Section § 457.10 is amended by—

A. Removing the definition of “Medicaid applicable income level.”

B. Adding the following definitions in alphabetical order: “Affordable Insurance Exchange (Exchange),” “Electronic account,” “Household income,” “Insurance affordability program,” “Secure electronic interface,” and “Single, streamlined application.”

The additions read as follows:

§ 457.10 Definitions and use of terms.

* * * * *

Affordable Insurance Exchange (Exchange) is defined as provided in § 435.4 of this chapter.

* * * * *

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.

* * * * *

Single, streamlined 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.

* * * * *

39. 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 there are no unnecessary gaps in coverage, including through use of the procedures described in § 457.305, § 457.350 and § 457.353.

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

40. 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 Act, which relates to coordination of CHIP with the Exchanges and the State Medicaid agency.

(5) Section 2107(e)(1)(F) of the 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.

41. Section 457.301 is amended by—

A. Adding the definitions of “Family size” and “Medicaid applicable income level” in alphabetical order.

B. Removing the definition of “Joint application.”

The additions read as follows:

§ 457.301 Definitions and use of terms.

* * * * *

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 (including for these purposes, a section 1115 waiver authorized by the Secretary or under the authority of section 1902(r)(2) 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.

* * * * *

42. 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).

43. 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 (b)(1)(iv).

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, 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; or

(iv) Is not eligible for Medicaid as a result of the elimination of income

disregards as specified under § 435.603(g) of this chapter.

* * * * *

44. Section 457.315 is added to read as follows:

§ 457.315 Application of modified adjusted gross income and household definition.

Effective January 1, 2014, the CHIP agency shall apply the financial methodologies set forth in paragraphs (b) through (h) 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(i)(1) also applies.

45. 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 and additions 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) 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

(3) In cases of disputed residency, the State must follow the process described in § 435.403(m) of this chapter.

(e) * * *

(2) [Reserved]

46. 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 § 435.907(b) of this chapter, and otherwise comply with the provisions of such § 435.907 of this chapter, 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.

47. Section 457.335 is added to read as follows:

§ 457.335 Availability of program information and Internet Web site.

The terms of § 435.905 and § 435.1200(d) of this chapter apply equally to the State in administering a separate CHIP.

48. Section 457.340 is amended by revising the section heading and paragraphs (a), (b) and (f) to read as follows:

§ 457.340 Application for and enrollment in CHIP.

(a) *Application assistance.* A State must afford families an opportunity to apply for CHIP without delay and must provide assistance to families in understanding and completing applications and in obtaining any required documentation. Such assistance must be made available to applicants and enrollees in person, over the telephone, and online, and must be provided in a manner that is accessible to individuals living with disabilities and those who are limited English proficient.

(b) *Use of Social Security number.* A State must require each individual applying for CHIP to provide a Social Security number (SSN) in accordance with § 435.910 and cannot require non-applicants to provide an SSN consistent with the requirements at § 435.907(e) of this chapter.

* * * * *

(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 programs as family circumstances change and avoids gaps or overlaps in coverage.

49. Section 457.343 is added to read as follows:

§ 457.343 Periodic redetermination of CHIP eligibility.

The redetermination 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.

50. Section 457.348 is added to read as follows:

§ 457.348 Determinations of Children's Health Insurance Program eligibility from other applicable health coverage programs.

(a) *Exchange determinations of CHIP eligibility.*

(1) For each individual found eligible for CHIP by the Exchange based on the applicable MAGI standard, the State must establish procedures—

(i) To receive, via secure electronic interface, the electronic account containing the finding of CHIP eligibility and all information provided on the application and/or verified by the Exchange which made such finding; and

(ii) To furnish CHIP to the individual promptly and without undue delay in accordance with § 457.340 of this subpart, to the same extent and in the same manner as if such individual had been determined by the State to be eligible for CHIP in accordance with such section.

(2) [Reserved].

(b) *Screening for potential CHIP eligibility by other insurance affordability programs.* The State must adopt procedures to ensure that it promptly and without undue delay determines the CHIP eligibility of individuals determined to be potentially eligible for CHIP, by other insurance affordability programs. The procedures must ensure that—

(1) The State accepts, via secure electronic interface, the electronic account for the individual screened as potentially CHIP eligible, including all information provided on the application and any information obtained or verified by the insurance affordability program;

(2) The State may not request information or documentation from the individual that is already contained in the electronic account;

(3) The State determines the CHIP eligibility of the individual, promptly and without undue delay, in accordance with § 457.340 in the same manner as if the application had been submitted directly to, and processed by, the State, except that the State must not verify eligibility criteria already verified by the insurance affordability program.

(4) The State notifies the insurance affordability program of the final determination of the individual's eligibility or ineligibility for CHIP.

(c) Option to accept CHIP eligibility determinations from the Medicaid

agency. A State may accept determinations of CHIP eligibility made by another insurance affordability program in the same manner that it accepts Exchange determinations of CHIP eligibility under paragraph (a) of this section.

(d) Certification of eligibility criteria. The State must certify for the Exchange the criteria necessary to determine CHIP eligibility, including but not limited to the income standard adopted for its separate CHIP program and the criteria related to satisfactory immigration status, as set forth in the State plan in accordance with § 457.305 of this part.

51. 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 intake 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 found to be potentially eligible for other insurance affordability programs in accordance with this section.

(b) *Screening objectives.* A State must identify any applicant, beneficiary, or other individual applying for coverage on the single, streamlined application 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 a basis other than having household income at or below the applicable modified adjusted gross income standard; or

(3) Eligibility for other insurance affordability programs, including eligibility for advanced payments for premium tax credits based on having household income above the income standard in the State for CHIP or the applicable modified adjusted gross income standard in the State for Medicaid, as appropriate, or for enrollment in a qualified health plan through an Exchange without advanced payments for a premium tax credit.

(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 part.

(d) [Reserved].

* * * * *

(f) *Applicants found potentially eligible for Medicaid based on modified adjusted gross income.* If the screening process reveals that the applicant is potentially eligible for Medicaid based on modified adjusted gross income, the State must—

(1) Promptly transmit the electronic account, and any other relevant information obtained through the application, to the Medicaid agency via 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(f)(4) 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 not likely to be eligible for Medicaid.

* * * * *

(i) *Applicants found potentially eligible for other insurance affordability programs.* If the screening process reveals that an applicant is not eligible for CHIP, is not screened as potentially eligible for Medicaid on the basis of modified adjusted gross income, and is potentially eligible for enrollment in a qualified health plan through the Exchange or other insurance affordability programs, the State must promptly transmit the electronic account, and other relevant information obtained through the application to the applicable program using secure electronic interfaces.

(j) *Applicants potentially eligible for Medicaid on a basis other than modified adjusted gross income.* If, based on information obtained through the single, streamlined application, the applicant is not screened as potentially eligible for Medicaid on the basis of modified adjusted gross income but may be eligible for Medicaid on another basis, the State must—

(1) Promptly transmit the electronic account, and any other relevant information obtained through the application to the Medicaid agency using secure electronic interfaces; and

(2) Complete the determination of eligibility for CHIP in accordance with § 457.340 of this subpart; and

(3) Disenroll the beneficiary from CHIP if the State is notified in accordance with § 435.1200(f)(4) of this chapter that the applicant has been determined eligible for Medicaid.

(k) A State may enter into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with Section 1943(b)(2) of the Act.

52. 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.

53. Section 457.380 is revised to read as follows:

§ 457.380 Eligibility verification.

(a) *General requirements.* Except with respect to verification of citizenship and immigration status, and subject to the verification requirements set forth in paragraph (d) of this section, the State may accept attestation of all information needed to determine the eligibility of an applicant or beneficiary for CHIP.

(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.* The State must verify the income of an individual by using the data sources and following the standards and procedures for verification of financial eligibility described in § 435.945(b), § 435.948 and § 435.952 of this chapter.

(e) *Verification of other factors of eligibility.* For eligibility requirements not described in paragraphs (b), (c) or (d) of this section, a State may adopt reasonable verification procedures, except that the State must accept self-attestation of pregnancy and the individuals that comprise an individual's household unless the state

has information that is not reasonably compatible with such attestation. The State may verify date of birth in accordance with § 435.945(b) or through other reasonable verification procedures consistent with the requirements in § 435.952.

(f) *Requesting information.*

(1) The State must use electronic sources of data, if available, before requesting additional information, including paper documentation, from an individual.

(2) An individual shall not be required to provide additional information or documentation unless information needed by the State cannot be obtained electronically or information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual. In such cases, the State may seek additional information, including a statement which reasonably explains the discrepancy and/or paper documentation, from the individual. The State must provide the individual a reasonable period to furnish such information.

(g) *Electronic service.* To the extent that information sought under this section is available through the electronic service established by the Secretary at § 435.949 of this chapter, the State shall access 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.

(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.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: June 29, 2011.

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*Administrator, Centers for Medicare &
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Approved: August 10, 2011.

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