

**Medicaid Program: Eligibility Changes under the Affordable Care Act
Final Rule; Interim Final Rule with Comment
[CMS 2349-F] RIN 0938-AQ62
Summary**

On March 16, 2012 the Centers for Medicare & Medicaid Services (CMS) released a final rule implementing changes to Medicaid eligibility under the Patient Protection and Affordable Care Act of 2010, which, as amended, is referred to as the Affordable Care Act (ACA.) The rule will be published in the *Federal Register* on March 23, 2012. It addresses the expansion of Medicaid eligibility in 2014 to nonelderly adults who are not otherwise eligible and who have incomes below 133% of the federal poverty level (FPL). It also modifies existing rules relating to eligibility of other individuals and responsibilities of the States so that eligibility for Medicaid and the State Children’s Health Insurance Program (CHIP) will be simplified and coordinated with eligibility for advance payment of the premium tax credit and cost-sharing reductions available to certain individuals purchasing coverage through the health insurance Exchanges beginning in 2014. Those credits are calculated based on a household’s Modified Adjusted Gross Income (MAGI), and this rule, as required by the ACA, applies MAGI to Medicaid and CHIP eligibility determinations. This final rule responds to comments on the proposed rule published in the *Federal Register* on August 17, 2011. **Several provisions of the rule are issued as interim final and open to public comment. The comment period closes on May 7, 2012.**

Some provisions of this rule relate to requirements regarding the Exchanges included in a final rule issues on March 12, 2012 which will be published in the *Federal Register* on March 27, 2012. HPA has prepared a separate summary of that final rule.

Table of Contents	
I. Background	2
II. Provisions of the Final Rule	2
A. Changes to Medicaid Eligibility	2
B. Financial Methodologies for Determining Medicaid Eligibility Based on MAGI under the Affordable Care Act	4
C. Residency for Medicaid Eligibility Defined	8
D. Timeliness Standards	8
E. Application and Enrollment Procedures for Medicaid	9
F. MAGI Screen	10
G. Coverage Month – Medicaid Terminations	12
H. Verification of Income and Other Eligibility Criteria	12
I. Periodic Renewal of Medicaid Eligibility	14
J. Coordination of Eligibility and Enrollment Among Insurance Affordability Programs- Medicaid Agency Responsibilities	15
K. Single State Agency	17
L. Implementing Application of MAGI to CHIP	18
M. Residency for CHIP Eligibility	18
N. CHIP Coordinated Eligibility and Enrollment Process	18
O. FMAP for Newly Eligible Individuals and for Expansion States	19
III. Collection of Information Requirements	20
IV. Regulatory Impact Analysis and Other Requirements	20

I. Background

The ACA includes provisions effective on January 1, 2014 to expand Medicaid eligibility and coordinate eligibility standards and enrollment procedures for Medicaid and CHIP with those for the advance payment of premium tax credits for health insurance coverage that will be available through the Exchanges. CMS received 813 comments on the proposed rule implementing the Medicaid eligibility changes which was published in the August 17, 2011 proposed rule.

The final rule amends regulations at 42 CFR Parts 431, 435 and 457.

II. Provisions of the Final Rule

A. Changes to Medicaid Eligibility

Mandatory Expansion of Coverage (§435.119)

As proposed, the final rule codifies the ACA requirement that States provide Medicaid coverage beginning on January 1, 2014 to individuals who are age 19 or older and under age 65, who are not pregnant, not enrolled in Medicare, not otherwise mandatorily eligible for Medicaid, and who have household income that is at or below 133% of the FPL. (As discussed below, eligibility for this group is based on MAGI.)

The rule also codifies the ACA requirement that parents and other caretaker relatives may only receive Medicaid coverage if their children under age 19 (or 20 or 21 in States that have elected to provide coverage for children up to these alternative ages) are covered by Medicaid or other health insurance coverage, interpreted as minimum essential coverage as defined in section 1401 of the ACA.

Optional Expansion of Coverage to Individuals Above 133% of FPL (§435.218)

Under the ACA, States may elect to provide coverage to individuals under age 65 (including pregnant women and children) with income above 133% of the FPL who are not eligible under other categorical eligibility groups. Like the mandatory expansion group, parents and other caretaker relatives are only eligible to receive coverage under this optional group if their children are covered by Medicaid or other minimum essential coverage. If a State elects to phase in coverage for this new group, it must submit a plan for Secretarial approval and may not cover individuals at a higher income level unless individuals with lower incomes are eligible.

Individuals who are eligible for and enrolled in mandatory or other optional Medicaid coverage are not eligible for Medicaid under this option. A clarifying change is made from the proposed rule to specify the optional eligibility groups to which this limitation refers. In response to comments, CMS states that individuals who could be eligible as medically needy may be eligible for optional coverage under this category, as are individuals who are eligible for coverage of family planning services only.

In responding to comments, CMS notes that the ACA makes no changes to the medically needy eligibility rules, but the coverage expansion affects which individuals are potentially eligible as medically needy, and further notes that some individuals eligible for advance payment of the premium tax credit might also be eligible for Medicaid as medically needy if they elect to spend down.

Changes to Existing Medicaid Eligibility Rules (§435.110, §435.116, §435.11)

CMS finalizes its proposal, with some modifications and clarifications, to modify existing regulations in order to streamline existing eligibility categories. The categories are those for which the ACA requires that eligibility be determined based on MAGI beginning in 2014. Specifically, numerous existing mandatory and optional eligibility groups for parents and caretaker relatives, pregnant women and children will be consolidated into three categories beginning in CY 2014. Table 1, reproduced from the proposed rule, illustrates how the existing eligibility categories will be consolidated. The proposed rule (and the HPA summary of the proposed rule) provide details on this consolidation.

Table 1			
Social Security Act and Pre-ACA Regulations	Eligibility Under Final 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 1931AFDC 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

Under the final rule, existing federal minimum income standards established in the statute for each of the three categories will be maintained, while giving States flexibility in setting new

income standards at a level that takes into account how the State currently counts income for the purpose of determining Medicaid eligibility. In all cases, the applicable eligibility standard will be applied against an individual's MAGI-based household income.

CMS discusses comments recommending that States be required to convert the federal minimum income standards for the three categories to a MAGI-equivalent minimum, taking into account the income exclusions and disregards currently used by the State. This alternative would maintain Medicaid eligibility for some individuals who will otherwise lose it when the income disregards are eliminated. CMS discusses statutory impediments to this approach and suggests that the impact of the final rule on Medicaid eligibility will be limited, noting that 1) the ACA maintenance of eligibility requirements continue existing eligibility standards for children through FY 2019; 2) parents and caretakers who lose eligibility under the existing categories may be eligible under the new adult group; and 3) if a State elects to eliminate optional coverage for pregnant women in 2014, affected pregnant women may be eligible for advance payment of the premium tax credit for enrollment in private coverage through the Exchange.

The proposed rule is modified to provide that pregnant women are covered for full Medicaid benefits, including additional services for pregnant women, unless the State limits coverage to pregnancy-related services. In the preamble, CMS indicates that if a State proposes not to cover an item or service for pregnant women that is covered for other adults, it must describe why the item or service is not pregnancy-related. This change was made in response to concerns of commenters that pregnant women who would otherwise be eligible under the new adult category will have less coverage than if they were not pregnant. CMS notes that it does not have the authority to require that pregnancy-related services must include all Medicaid benefits.

In response to comments CMS indicates that States are not required to monitor the pregnancy status of individuals enrolled as adults to determine whether they fall into the eligibility category for pregnant women. However, women should be informed of benefits available to pregnant women, and if a woman becomes pregnant and seeks eligibility under the category for pregnant women the State must make the change if she is eligible.

Changes to definitions at §435.4 are made to reference definitions in the final Exchange regulation and in response to comments. The latter changes include modifying the definition of caretaker relative to give States the option to consider as a caretaker relative any adult with whom the child lives and who assumes primary responsibility for the child. CMS notes that the definition of "minimum essential coverage" will be determined by the Treasury. CMS indicates that the process for converting current income standards under Medicaid and CHIP to MAGI-equivalent standards will be addressed in future guidance. Under the ACA this conversion process must be performed in a manner ensuring that populations in the aggregate do not lose coverage.

B. Financial Methodologies for Determining Medicaid Eligibility Based on MAGI under the ACA (§435.603)

This section of the rule implements the ACA requirement that effective on January 1, 2014, financial eligibility for Medicaid under many eligibility categories be based on MAGI and on household income as defined in section 36B(d)(2) of the Internal Revenue Code of 1986 (or

“section 36B definitions”) for the purpose of determining eligibility for advance payment of the premium tax credit for purchase of coverage through the Exchange. CMS uses “MAGI-based methodologies” to refer to both the determination of MAGI for an individual (or couple filing a joint tax return) and the determination of total household income.

For the most part, the rule codifies application of the section 36B definitions to Medicaid eligibility beginning on January 1, 2014, except for a limited number of cases where Medicaid rules are retained. Rules are also adopted for determining income of individuals who do not file tax returns. In addition, the ACA explicitly excludes application of MAGI-based methodologies for determining eligibility of certain populations described below, for which Medicaid eligibility rules are retained.

Numerous changes are made from the proposed rule, most notably with respect to adults who are disabled or in need of long-term care services and supports. CMS indicates that half the comments they received raised concerns related to this issue, which is discussed below. Many other changes are technical and clarifying. Significant changes are highlighted here. CMS intends to issue detailed guidance on the treatment of all types of income under the new MAGI-based methodologies.

The final rule modifies the language in §435.603(a)(3) to clarify that for individuals who are determined eligible for Medicaid before January 1, 2014, MAGI-based methodologies will not be applied until March 31, 2014 or the next regular eligibility renewal, whichever is later.

The definition of family size is modified to be consistent with current policy regarding the treatment of pregnant women. In determining eligibility of a pregnant woman, family size reflects the pregnant woman and the number of children she is expecting. For other individuals in her household, States have the option of counting the pregnant women as one or two persons or one person plus the number of children she is expecting.

CMS indicates willingness to work with States that seek to apply MAGI-based methodologies for eligibility groups that are not subject to MAGI under the ACA. This could be accomplished through a State Plan Amendment if the result is a less restrictive income standard. Or, States may seek a section 1115 waiver for this purpose.

Acknowledging that States cannot be certain in advance whether a child will be required to file a tax return, the final rule clarifies that the income of a dependent child is not counted if a child is not expected to be required to file a tax return for the year for which coverage is sought. Other changes are made to clarify that the income of a tax dependent other than a child who is not expected to file a tax return is not counted in determining an individual’s household income. In addition, States will be given the option, rather than required as proposed, to count actually available cash support exceeding nominal amounts as income in determining the eligibility of an individual who is claimed as a dependent.

CMS makes several modifications which are intended to prevent gaps in coverage that might result from the fact that Medicaid eligibility is determined based on current income available to an individual for a given month and MAGI is determined on the basis of annual income. Noting that that ACA explicitly retains the “point in time” principle for Medicaid eligibility, CMS

adopts as proposed standards that give States the flexibility to determine the income period for eligibility and retain current flexibility for States to take into account reasonably anticipated future changes in income and that allow States to maintain eligibility for individuals eligible based on MAGI as long as annual income based on MAGI methods for the calendar year remains at or below the Medicaid standard.

CMS will use 36B definitions of income in a case where an individual's income is determined to be above the Medicaid income eligibility standard but also determined to be below 100% of FPL for eligibility for advance payment of the premium tax credit. (By using the 36B definitions for Medicaid eligibility, an individual in this situation will be eligible for Medicaid.) In addition, CMS clarifies that the projected annual household income that States may use is for the remainder of the current calendar year. CMS also indicates willingness to work with States to develop reasonable methods for treatment of predicted future income in order to achieve the goals of efficiency and reducing churning between the programs. While there is no statutory authority for States to elect continuous eligibility for adults, CMS indicates that States may propose to do this and take other simplification measures under a section 1115 waiver.

In response to comments, CMS discusses issues related to the fact that the FPL amounts used for Medicaid eligibility are those in effect when eligibility is determined, and these will often differ from those used for determining eligibility for advance payment of the premium tax credit, which are the amounts in effect when the annual open enrollment period begins. CMS states that coverage gaps will not occur as a result of this differential, since the FPL amounts for Medicaid eligibility will be the same or higher than those used for determining eligibility for advance payment of the premium tax credits.

Retention of Medicaid rules. Despite the general application of section 36B income definitions and methodologies, as proposed the final rule retains current Medicaid rules in a few situations where adoption of the section 36B rules could be significant for a limited number of affected individuals. They are:

- Lump sum payments are counted only in the month received. Under section 36B definitions, taxable lump sum payments are included in computing MAGI in the year the lump sum is received. CMS retains the Medicaid methodology because of the statutory directive to consider current monthly income.
- Certain types of educational scholarships and grants (e.g., work-study and other arrangements in which the recipient provides a service) are not counted as income, although they are treated as taxable income under the IRC. The final rule also excludes awards used for education purposes.
- For certain American Indian and Alaska Native income, current Medicaid treatment and protections are codified, with modifications in the final rule.

The final rule codifies the ACA requirement prohibiting the continued use of any asset test or income or expense disregards for individuals whose Medicaid eligibility is based on MAGI, except for a standard disregard of 5 percent, which applies to every individual.

CMS notes that since the proposed rule was published, a law was enacted that requires all Social Security benefits, including those that are not subject to income tax, to be counted in calculating the MAGI.

In responding to comments, CMS notes that the ACA does not change the requirement that the income of a sponsor and the sponsor's spouse is deemed available to certain sponsored non-citizens. CMS intends to issue guidance on this issue.

Household composition. CMS adopts in §435.603(f) the section 36B household composition rules for tax filers, with limited exceptions. Changes are made from the proposed rule to clarify that the household composition rules applicable to non-filers will apply in the case of children living with both parents who do not expect to file a joint tax return, and to clarify the household composition rules in shared or joint custody situations. In addition, language is added to provide that when an individual cannot reasonably establish that another individual will be a tax dependent in the year that Medicaid coverage is sought, the inclusion of the other individual will be determined using the rules established for determining household size of a non-filer. CMS notes that assessing State performance in making accurate eligibility determinations is based on the information available at the time the determination is made.

The proposed rules for non-filers are adopted, with a change. The rules provide that the household of a non-filer consists of the individual and, if living with the individual, the individual's spouse and natural, adopted and step-children under age 19. In the case of a child, the household consists of the child and his or her natural, adopted and step-parents and natural, adopted and step siblings under age 19. The final rule modifies the proposed rule to provide flexibility for a State to consider children and siblings age 19 and 20 who are full-time students to be members of the same household as parents and other siblings under 19.

Retention of Existing Financial Methods/Exclusions from MAGI. CMS finalizes its proposed rules regarding the ACA requirements for exceptions to application of MAGI for certain populations with a significant change. (These appear in §435.603(i).) Under the ACA, MAGI rules do not apply to individuals eligible for Medicaid on a basis that does not require an eligibility determination by the State Medicaid agency (e.g., SSI recipients or foster children); those who qualify on the basis of being blind or disabled; individuals age 65 and older; individuals whose eligibility is determined based on the need for long-term care services, including nursing home care; determinations of eligibility for Medicare cost sharing assistance; and medically needy individuals.

In response to the concerns of numerous commenters, the final rule provides that individuals who are eligible for coverage under an eligibility group for blind or disabled individuals or one for which long-term care services and supports are covered will be able to enroll for such coverage, regardless of whether they would also be eligible for Medicaid under the MAGI standards. This reverses the proposed standard under which eligibility would first be determined using MAGI standards. (See discussion of the MAGI screen below.)

In a change from the proposed rule, CMS limits the exception from MAGI standards for individuals over age 65 to cases in which being 65 or older is a condition of Medicaid eligibility. This addresses concerns regarding the small number of cases in which an individual over age 65

is evaluated for Medicaid eligibility on the basis of being a parent or caretaker relative. In these cases, MAGI rules will apply to these individuals.

In responding to comments, CMS indicates topics which it is considering for future guidance. It is examining options for States to minimize the burden of retaining AFDC methods solely for the purpose of determining eligibility for the medically needy, who are exempt from the MAGI-based methodologies. In addition, regarding the exception for individuals eligible on the basis of SSI, CMS makes technical changes to the regulations to distinguish individuals deemed to receive SSI benefits, and indicates that it is contemplating future guidance regarding eligibility of adult disabled children.

C. Residency for Medicaid Eligibility Defined (§435.403)

The final rule adopts proposed changes regarding how States determine who is a State resident for the purpose of Medicaid eligibility (§435.403(h) and §435.403(i)). For individuals age 21 and older, residency will be determined as the State where the individual is living or intends to reside, or has entered with a job commitment or seeking employment. For individuals under age 21 who are emancipated or married, rules parallel to the adult rules apply. For unemancipated children who are not living in an institution or receiving foster care assistance, the State of residence is the State where the individual resides or where the individual's parent or caretaker has entered with a job commitment or seeking employment. CMS will consider for future guidance comments responding to its solicitation for suggestions regarding the residency of individuals living in institutions and adults who do not have the capacity to express intent. CMS notes that State flexibility is retained in determining whether students "reside" in a State as long as each individual has an opportunity to provide evidence of actual residence.

CMS reports that a number of commenters urged that Medicaid policy regarding residency of students be a single national standard that is aligned with Exchange policy rather than retaining State policy as proposed. In rejecting the suggestion, CMS responds that gaps in coverage will not occur because if there is a dispute in Medicaid residency, under the policy the individual is a resident of the State in which he or she is physically located. CMS intends to consider for future guidance and technical assistance the comments it received regarding Medicaid policy on the residency of individuals living in institutions who do not have the capacity to express intent. CMS disagrees with commenters suggesting that States provide Medicaid eligibility to individuals who enter the State for the purpose of receiving medical treatment, and points to a process it has underway for developing a model interstate coordination process.

D. Timeliness Standards (§455.912)

In response to comments, CMS adds new standards for the timeliness of making eligibility determinations and other State performance requirements. **The new requirements on the timeliness of eligibility determinations are issued on an interim final basis and subject to public comment.** Existing regulations require States to establish standards for eligibility determinations that are not to exceed 45 days, except with respect to making determinations on the basis of disability the standard is not to exceed 90 days. Under the interim final rule, CMS establishes both timeliness and performance standards. Timeliness standards relate to the maximum amount of time under which every applicant is entitled to an eligibility determination,

and performance standards apply to the State's performance across a pool of applicants and include standards for promptness, accuracy and consumer satisfaction.

Under the interim final requirements, a State plan must include timeliness standards for the eligibility determination for any applicant that do not exceed the 45- and 90-day standards specified above and must inform applicants of the standards. States must also establish timeliness and performance standards that provide for completing eligibility determinations promptly and without undue delay for 1) individuals that submit an application to the State Medicaid agency, 2) applicants whose accounts are transferred from another insurance affordability program, and 3) the transfer of electronic accounts to other insurance affordability programs. The standards must account for the capabilities and cost of available systems and technologies; the availability of electronic data matching and ease of connection to sources of information verification; the demonstrated performance experience of State Medicaid, CHIP, and other programs; and the needs of applicants including applicant preferences for mode of application. CMS intends to develop performance and processing standards for many aspects of the application and eligibility determination process in consultation with stakeholders.

E. Application and Enrollment Procedures for Medicaid (§435.905, §435.907, §435.908, §435.910)

With some changes from the proposed rule, the final rule implements the ACA requirements directing States to establish a website enabling individuals to apply for, renew, and enroll in Medicaid coverage, and to provide program information electronically as well as orally and in writing. The regulations require use of the single streamlined application developed by the Secretary for all insurance affordability programs or an alternative single application if approved by the Secretary.

With respect to applications from individuals who may qualify for coverage on a basis other than MAGI, States may use the single streamlined application with supplemental forms or may develop an alternative application form approved by the Secretary that is designed to capture information needed to determine eligibility for these individuals. CMS revises the proposed language to clarify that any non-MAGI applications and supplemental forms must meet Secretarial guidelines and be available for public review, but will not have to be approved prior to use. States may only request information that is needed to determine eligibility or for a purpose directly related to the administration of the State plan. CMS indicates that the model single streamlined application form it develops will include questions to screen for eligibility on a basis other than MAGI, such as whether the individual may be disabled. CMS intends to work with States to minimize burdens on applicants while ensuring that individuals are enrolled in the appropriate eligibility category.

States must establish procedures to permit application by a variety of means such as online, by telephone, mail, or in person. The final rule adds regulatory language, described in the preamble to the proposed rule, stating that an in-person interview may not be required for individuals whose eligibility is based on MAGI. In addition, the language is modified to accommodate changing technologies.

With respect to eligible individuals who need assistance with the application and renewal process, States must provide assistance through a variety of means. CMS gives States flexibility to design the assistance, as long as it is done in a manner that is accessible to individuals with disabilities and those with limited English proficiency. States must allow individuals chosen by an applicant or beneficiary to assist them during an application or renewal process.

CMS modifies the proposed language regarding the availability of program information to specify that information for persons who are limited English proficient or have a disability must be provided in an accessible and timely manner and at no cost to the individual. Other changes include adding references to conform to use of the term “plain language” as it appears in the Exchange final rule. CMS indicates its intention to issue specific accessibility standards in future guidance after consultation with stakeholders and in coordination with the Exchange and other insurance affordability programs and other HHS programs as appropriate.

In response to requests for clarification, CMS addresses the differences between a person who assists an individual in applying for Medicaid and an authorized representative. Assisters generally provide information on insurance affordability programs and help an individual complete an application and gather required documents. Authorized representatives may sign the application and receive notices. CMS intends to issue further guidance on this issue, but anticipates that individuals who are not recognized by a State agency or officially designated as an authorized representative will not have access to sensitive applicant and beneficiary information.

The final rule codifies what CMS indicates is long-standing policy that individuals who are not seeking coverage for themselves may not be required to provide Social Security Numbers (SSNs) or information regarding their citizenship, nationality or immigration status. States may request the SSN of a non-applicant on a voluntary basis if use of the SSN is limited to processing the applicant’s eligibility or other administrative functions and the State provides notice that this is voluntary and how the SSN will be used. CMS acknowledges that some commenters expressed concern that even a voluntary request for the SSN of a non-applicant may discourage enrollment of eligible individuals, but believes that in the interest of reducing the burden and ensuring a timely eligibility determination for applicants, States should be allowed to request voluntary submission of an SSN from a non-applicant under the conditions specified in the rule, which are in accordance with current policy. Individuals who are not eligible for an SSN, are only eligible for a non-work SSN, or who meet requirements for having well-established religious objections are not required to apply for an SSN and may be given a Medicaid identification number instead.

F. MAGI Screen (§435.911)

As discussed earlier, CMS revises its proposal to first determine eligibility under the MAGI methodology and make no further eligibility determination under another category (e.g., disabled) for individuals who are found eligible under the MAGI screen. Commenters were uniformly concerned that this approach would adversely affect individuals who are disabled or in need of long-term services and supports.

Under the revised policy in the final rule, individuals who meet the MAGI standard may nonetheless be excepted from the application of MAGI methods for the purpose of determining eligibility under an optional eligibility group that better meets their coverage needs. The State must collect the additional information needed to determine eligibility for Medicaid on a basis other than MAGI in the case of individuals who submit an application for or request a determination of eligibility for a non-MAGI based eligibility category, and for those who the State identifies as potentially eligible based on an application or renewal form or other information available to the State. Until eligibility on another basis is determined, these individuals may enroll in Medicaid under the MAGI-based eligibility group, such as the new adult category.

If an individual provides the additional information necessary for an eligibility determination under a disabled group or other category and are found eligible for that category, they would be enrolled in that category and no longer be eligible for Medicaid under the MAGI group unless their circumstances change. CMS notes that individuals who are eligible under a MAGI-based group and experience a change in circumstances may move to an optional group based on disability or long-term care needs. States must provide individuals with information about the different eligibility categories and benefit packages to enable them to make an informed decision about which eligibility category may best meet their needs. CMS notes that the entire application process (at §435.911) does not apply to individuals who are automatically eligible for Medicaid because, for example, they receive SSI benefits or are “deemed eligible” newborns. CMS notes that in addition to eligibility groups involving disability and need for long-term services and supports, individuals may seek coverage in other non-MAGI categories including medically needy, and women screened under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program.

The State is required to furnish Medicaid promptly and without undue delay and subject to the timeliness standards established in the final rule. In the case of individuals who may be eligible on a basis other than the MAGI-based methodologies, this requirement may be met by providing them with coverage under a MAGI-based group until a determination is made or, if possible, by prompt determination of eligibility on the MAGI-excepted basis. CMS notes that the requirement to determine eligibility on a non-MAGI basis also applies in the case of individuals who are found to have incomes above the applicable MAGI-based standard.

In the preamble CMS discusses how individuals will be treated the same whether they apply for coverage through the Exchange or the State Medicaid program. For example, an individual who is found by the Exchange to be ineligible for Medicaid under the MAGI-based standard may be enrolled in a QHP through the Exchange while a determination is made as to their Medicaid eligibility under a non-MAGI group.

Responding to a request for clarification, CMS states that nothing in the ACA changes the requirement that States provide emergency services to individuals who are not eligible for full Medicaid benefits because of their immigration status. States will still need to determine eligibility for emergency services for this population. CMS states that whether Medicaid coverage of emergency services meets the definition of minimum essential benefits for the

purpose of determining whether an individual qualifies for advance payment of the premium tax credit is beyond the scope of this rule.

G. Coverage Month – Medicaid Terminations

In the proposed rule CMS sought comments on whether to add a provision to the regulations that would require States to extend Medicaid coverage until the end of the month during which an individual’s eligibility is terminated, in order to avoid gaps in coverage.

In the final rule, CMS encourages but does not require States to extend Medicaid coverage through the end of the month. CMS notes that many States do so today, and that the Exchange final rule was modified to provide for faster coverage for individuals formerly covered under Medicaid and CHIP. A special enrollment period will allow individuals to enroll in an Exchange plan on the first day of the month following the month in which their eligibility for Medicaid or CHIP is terminated, as long as a plan selection is completed. This will reduce but not eliminate potential gaps in coverage for individuals terminated from Medicaid and eligible for enrollment in an Exchange plan. While many commenters supported a requirement for States to extend coverage, others expressed concern about the cost to States.

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

CMS finalizes with some modifications the proposed numerous changes to the regulations regarding verification of income and other eligibility criteria, which it believes will make verification more efficient, modern and coordinated with the Exchanges. Verification requirements apply to all Medicaid beneficiaries, not only those with eligibility determined under MAGI-based methodologies.

The major features are:

- HHS will develop an electronic service through which all State Medicaid agencies (and all insurance affordability programs) will verify information on applicants with Federal agencies (e.g., citizenship with the Social Security Administration, immigration status with Homeland Security and income with the Internal Revenue Service (IRS)).
- State Medicaid agencies may accept self-attestation of all eligibility criteria with the exception of immigration and citizenship status.
- In verifying eligibility, States will rely to the maximum extent possible on electronic data matches with trusted third party data sources. Additional information may be requested from individuals, including paper documentation, only when the information cannot be obtained through electronic sources or is not “reasonably compatible” with information supplied by the individual.
- New rules are established regarding State verification of non-financial eligibility factors including State residency, pregnancy, and date of birth.
- CMS deletes as unnecessary various prescriptive regulatory provisions such as those specifying how often States must query certain data sources.

States may not deny or terminate eligibility based on information obtained through data matches or other means under the verification process without giving the individual an opportunity to validate or dispute the information. States are also required to inform individuals of the ways and circumstances under which information will be obtained from another agency or program, but CMS states that this need not occur each time the State wants to initiate a data match.

The final rule modifies the language (§435.952) with respect to electronic sources to clarify that requests for documentation from an individual are limited to cases where verification using an electronic data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match, the administrative costs of relying on paper documentation and the impact on program integrity and error rates in terms of the potential of ineligible individuals to be approved and eligible individuals to be denied coverage.

A new requirement is added in the final rule that States must develop and update as appropriate a verification plan describing the policies, procedures and standards applied by the State in determining the usefulness of the financial information it receives.

In response to comments, the final rule modifies (at §435.952) the requirements regarding the “reasonably compatible” standard that will apply with respect to whether a Medicaid agency can request additional information from an individual after a data match. Specifically, the regulations provide that information provided by an individual is reasonably compatible with information obtained through an electronic data match if both are above or both are at or below the applicable income standard. States would be expected to address standards regarding “reasonably compatible” in the verification plan.

In addition, the final rule is changed to allow States, subject to Secretarial approval, to adopt alternative data sources or to obtain data from another mechanism provided that the alternative reduces administrative costs and burdens on individuals and States and meets various requirements including confidentiality.

CMS clarifies that attestation is not permitted where it contravenes a legal requirement. Acceptance of self-attestation is required for pregnancy, for which a State may only seek additional information if it has information that is not reasonably compatible with the attestation. In a change from the proposed rule States may, but are not required, to accept self-attestation of household size, which is now treated in the same way as date of birth. CMS notes that IRS data will provide the MAGI of tax filers and provide information about the size of the household shown on a return but will not provide information that can be used to verify the dependent status of a child.

States are given the flexibility of deciding the usefulness, frequency and time frame for conducting electronic data matches. CMS points out that States may accept self-attestation for most elements of Medicaid eligibility and may pursue a data match before or after an eligibility determination is made. CMS indicates that it is developing tools for individuals and States to use in determining MAGI-based income based on the information obtained in the application process, and anticipates that the sequencing of information may occur in different ways. For example, an individual may be asked for information up front that is confirmed later with

electronic sources or an individual may be asked to confirm information the State obtains electronically.

With respect to Social Security Numbers, as discussed above, modifications are made to the regulatory language to reflect the circumstances under which individuals are exempt from the requirement to furnish an SSN as a condition of Medicaid eligibility. This does not change the requirement that citizenship and immigration status be verified.

Language in the proposed rule prohibiting States from relying on immigration status alone to determine lack of State residency is modified to remove the word “alone” and to clarify that nothing prevents an individual from being able to present evidence of immigration status to prove State residency.

In the final rule CMS revises various provisions regarding the safeguarding of data. These changes were not in the proposed rule and clarify that data from the Social Security Administration and the IRS must be safeguarded according to the requirements of the agency furnishing the data. In addition, a new requirement protects information on a non-applicant to the same extent as information on applicants and beneficiaries. **These changes affect regulations at §431.300(c)(1), §431.300(d) and §431.305(b)(6), which are issued as an interim final rule and open to public comment.**

I. Periodic Renewal of Medicaid Eligibility (§435.916)

CMS finalizes with some changes the proposed procedures for renewal of Medicaid eligibility that is based on MAGI. The section title in the rule is changed from “redetermination” to “renewal.” Under the final rule, eligibility must be renewed once every 12 months, and no more frequently than once every 12 months. This language is modified from the proposed rule to clarify that annual renewals are required. More frequent review is required if a beneficiary reports a change in circumstances that could affect continued eligibility or if the agency has information about anticipated changes in a beneficiary’s circumstances that could affect eligibility. States must limit any review triggered by a change in circumstances to the eligibility factors affected by the change and additional factors for which information is readily available. If the State has sufficient information to renew eligibility at that time, the State may begin a new 12-month eligibility period for that individual.

A renewal form is not required from all individuals, as States must first make a redetermination of eligibility based on the information available in the Federal electronic data base or from other reliable data sources. If the individual is determined to still be eligible, notice will be sent to the beneficiary including the basis of the determination. Individuals are required to report if any information contained in the notice is inaccurate, but States may not require them to sign and return the notice.

Additional information may be requested from individuals if the information available makes it impossible to redetermine eligibility. In that case, States must provide the individual with a pre-populated renewal form containing the available information and give the individual at least 30 days to respond with the additional information that is needed. States may allow more time for

all beneficiaries or only for certain populations. Individuals may respond through any of the modes available for initial application, including telephone, mail, in person, and through commonly available electronic means. The final rule clarifies that the form may only request additional information needed to renew eligibility.

States must consider all bases of eligibility when conducting a renewal, so the renewal form will need to include basic screening questions similar to those included in the single streamlined application, to indicate potential eligibility based on disability or other bases for which MAGI-based methodologies are not used. The final rule modifies the requirements to clarify that renewal forms must not collect information that is not necessary to renew eligibility.

For those individuals who lose coverage for failure to return the pre-populated renewal form in time, the final rule provides a minimum 90 day reconsideration period. States may adopt a longer period. During this period, the individual would need to submit the information that was requested on the pre-populated renewal form and may do so by any of the modes available during renewal. CMS expects that with a 90 day reconsideration period, under current policy regarding retroactive coverage, individuals who regain Medicaid eligibility would be entitled to retroactive coverage back to the date of termination.

With respect to individuals eligible for Medicaid on a non-MAGI basis, a State must redetermine eligibility at least every 12 months, and must make a redetermination based on the information available from sources other than the individual. If more information is needed from the individual, the State may elect to use the same process as required for the MAGI-based eligibility groups involving the use of a pre-populated renewal form and other procedures.

If a beneficiary is determined no longer eligible for Medicaid, the rule requires that the State assess the individual for eligibility under other insurance affordability programs under the coordination provisions discussed in the following section.

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

Regulations pertaining to Medicaid responsibilities in coordinating enrollment with other insurance affordability programs are included in a new subpart M, specifically §435.1200. Among other requirements, Medicaid agencies must certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility. **This section has been revised and is issued as an interim final rule, subject to public comment.**

States must have systems for receiving and transferring an electronic account that includes all information collected and generated by the State regarding an individual's Medicaid eligibility and enrollment. The sharing of electronic accounts will help coordinate eligibility determinations and renewals in each of the insurance affordability programs, including determinations made through the Exchange, Medicaid, CHIP or the Basic Health Program if the State establishes one. CMS notes that States are eligible to receive Federal financial participation (FFP), or a matching rate, of 90% through the end of calendar year 2015 for developing Medicaid enrollment and

eligibility systems meeting certain requirements, and an operational matching rate of 75% with no time limit. A final rule published April 19, 2011 establishes this funding.

Under this final rule, States must enter into one or more agreements with the Exchange and other insurance affordability programs in order to ensure coordination of eligibility and enrollment, which involves the acceptance of the electronic account for individuals transferred from other insurance affordability programs for determination of Medicaid eligibility; evaluation of the eligibility of individuals found ineligible for Medicaid for other insurance affordability programs; and establishing a Medicaid website that operates in conjunction with the CHIP Exchange websites or is linked to them. CMS clarifies that the coordination requirements apply to renewals as well as initial applications for coverage.

The final rule is modified to be consistent with the Exchange final rule and previous guidance issued by CMS (“State Exchange Implementation Questions and Answers”, November 29, 2011) providing two ways for State Medicaid and CHIP agencies and Exchanges to coordinate eligibility determinations for Medicaid and CHIP. One approach is for the Medicaid or CHIP agency to make the final eligibility determination based on the initial review undertaken by the Exchange, and the other is for the agency to accept a final eligibility determination made by the Exchange using the agency’s eligibility rules and standards. CMS intends that the requirements in the final rule ensure a simple, coordinated, and timely eligibility process and accurate eligibility determinations regardless of the approach chosen by the State.

In a case where the Medicaid agency has entered into an agreement with the Exchange under which the Exchange makes the final determination of Medicaid eligibility, the agency must have procedures to accept the electronic account of individuals found eligible, treat the application as if it were submitted to the Medicaid agency, and maintain oversight of the Medicaid program.

Where the Medicaid agency makes the final determination, it must accept electronic accounts on applicants from other insurance affordability programs, and may not request additional information of the applicant or duplicate eligibility verifications already performed by the other program that are included in the individual’s electronic account. Eligibility determinations must be made in accordance with the timeliness standards and once the determination is complete, the agency must notify the other program of the final determination.

Information on individuals found ineligible for Medicaid must be transferred to other insurance affordability programs consistent with the timeliness standards. The other programs must be notified when the Medicaid agency is making a determination of eligibility for an individual on a basis other than MAGI when a determination is still pending and when a final determination is made. The Medicaid agency may enter into an agreement with the Exchange to make determinations of eligibility for advance payment of the premium tax credit and cost sharing reductions.

If an individual applies to the Medicaid agency and is found ineligible, the agency must assess potential eligibility for other insurance affordability programs. In some cases, an agency might have a contract with the Exchange to perform eligibility determinations. Absent an agreement,

the Medicaid agency would be required to transfer to the Exchange information without undue delay so that the Exchange can make an eligibility determination.

The website must allow applicants and beneficiaries to access information on insurance affordability programs in the State and to apply for and renew coverage. The website and any interactive kiosks and other systems developed by the State to support information and enrollment activities must comply with the accessibility standards discussed above that apply generally to the availability of program information. (§435.905)

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

The final rule provides that States may delegate Medicaid eligibility determinations to the Exchange, whether or not the Exchange is a governmental organization. However, if the Exchange is operated by a non-governmental entity, the authority to delegate Medicaid eligibility determinations is limited to those using MAGI-based methodologies. Exchanges may also contract with private entities to conduct eligibility determinations under MAGI-based methodologies. The proposed rule would not have permitted delegation of MAGI-based eligibility determinations to non-governmental Exchanges. In response to a comment, CMS indicates that both State-based Exchanges and federally-facilitated Exchanges may make Medicaid eligibility determinations under these rules.

Where delegation of Medicaid eligibility determinations is made, the single State Medicaid agency must supervise the administration of the plan, make rules and regulations for administering the plan, and remain accountable for proper administration of the program. The single State agency also must ensure that eligibility determinations are made consistent with its rules and institute a corrective action plan or termination of the delegation if there is a pattern of incorrect determinations; and that that eligibility determinations are made in the best interest of beneficiaries. The final rule modifies the proposed rule by specifying that the best interest of beneficiaries includes ensuring there is no conflict of interest in making eligibility determinations and prohibiting improper incentives and outcomes, which, if found, must be promptly addressed through corrective action.

Written agreements are required between the Medicaid agency and any entities to which eligibility determinations are delegated. These agreements must set out respective responsibilities, quality control and oversight plans, reporting requirements, compliance with confidentiality and security requirements, and use of merit system personnel protection principles. The final rule adds language requiring that these agreements be available upon request and requiring that beneficiaries be made aware of how they can directly contact and obtain information from the single State agency.

The final rule add a requirement that, where eligibility determinations are delegated, including to other governmental agencies, the State Medicaid plan must include a description of the staff designated by those entities and the functions they perform in carrying out their responsibilities.

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

Consistent with changes made to the Medicaid regulations, the final rule modifies regulations regarding CHIP (Part 457) to meet the ACA requirements regarding use of the section 36B MAGI and household income standards for determining CHIP eligibility beginning in 2014. Other conforming changes in this section include elimination of resource tests for eligibility and elimination of income disregards (other than the standard 5% as required under the ACA). Beginning in 2014, the maximum income standard for CHIP will be the higher of: 200% of the FPL, 50 percentage points above the applicable Medicaid income level defined in section 2110(b)(4), or the effective income standard in the State, taking into account any income disregards, as of December 31, 2013, converted into a MAGI-equivalent income standard. Guidance on the conversion to MAGI-equivalent income standard will be issued in the future.

The final rule adopts the same requirements that States must use in applying MAGI-based methods in determining Medicaid eligibility, with the same limited exceptions. The final rule clarifies that for children eligible for CHIP on or before December 31, 2013 the MAGI-based methods will not be used to determine eligibility until the next regulatory scheduled renewal or March 31, 2014, whichever is later.

In response to comments, CMS addresses the ACA requirement that States maintain coverage under a separate CHIP program for children who lose Medicaid eligibility as a result of the change to MAGI-based methodologies. The final rule clarifies that the ACA provision protects eligibility for these children until the first renewal of CHIP eligibility, which would be one year after their enrollment in CHIP.

M. Residency for CHIP Eligibility

The final rule adopts without change the proposal to apply to CHIP the same regulations with respect to determining State residency that apply to children in Medicaid, as described above. The requirements consider a child a resident of a State in which he or she resides or in which a parent or caretaker is employed or seeking employment, including seasonal workers. If two or more States dispute a child's State or residence, physical location will govern.

N. CHIP Coordinated Eligibility and Enrollment Process

Under the ACA, CHIP must meet new enrollment simplification requirements, and the CHIP regulations in this final rule parallel the requirements for Medicaid. CMS notes that these standards build on existing practices and requirements for coordinated eligibility and enrollment between Medicaid and CHIP. Many changes are made by cross reference to the Medicaid requirements.

The requirements involve use of a single, streamlined application for all insurance affordability programs, availability of program information and application assistance, collection and use of SSNs, coordination with the Exchange and Medicaid, renewals, eligibility verification, and timeliness of eligibility determinations. In addition, the final rule revises requirements regarding

the effective date of CHIP eligibility to provide a coordinated transition of children between programs if family circumstances change, without gaps or overlap in coverage.

Some of the changes made from the proposed rule are, like the Medicaid rules that they parallel, issued on an interim final basis and subject to comment. They affect regulations at §457.340(d) regarding timeliness, §457.438 regarding determinations of eligibility for CHIP made by other insurance affordability programs, and §457.350(a),(b),(c),(f),(i),(j), and (k) regarding eligibility screening and enrollment in other insurance affordability programs.

O. Federal Medical Assistance Percentage (FMAP) for Newly Eligible Individuals and for Expansion States

The proposed rule addressed options for making changes to the FMAP that are required under the ACA, but CMS defers finalizing any changes. CMS indicates that it is performing additional research and working with States to determine which approach will ensure an accurate method for implementing the FMAP and further the simplification goals of the ACA.

The FMAP changes discussed in the proposed rule relate to the higher FMAP that will apply to services provided to the newly eligible adults obtaining coverage as a result of the mandatory expansion of Medicaid, and the special treatment of “expansion states”, those who prior to enactment of the ACA were already providing coverage to at least a portion of the adult population that is the subject of the expansions.

Specifically, CMS proposed to give States a choice of three methods for claiming the higher matching rate for newly eligible individuals:

1. Threshold methodology. States would apply a simplified version of their December 2009 eligibility standards on a case-by-case basis to evaluate whether an individual eligible in the new adult group would have been eligible under the December 2009 criteria. Information on the applicant would be compared with the upper-income threshold and proxies or historical proportions could be used for other eligibility criteria (e.g., assets, disability status). CMS notes that States could convert their December 2009 income thresholds to MAGI-equivalent standards so that the MAGI on the applicant could be used in making the comparison. Proxies for other eligibility criteria would be subject to CMS approval, and could include screening questions, retroactive claims review or other methods.

2. Statistically valid sampling methodology. States would perform a full eligibility determination using December 2009 rules on a sample of individuals eligible under the adult group, and the results would be extrapolated to the larger population. The sample would be selected using a statistically valid sampling methodology meeting the requirements of OMB Circular A-87 and additional specifications. Calculations would be retroactive and adjustments made to payments based on an interim payment approach. The interim payments would reflect the most recent available data. For the initial years (2014 and 2015), the interim payments would be based either on a State’s sample of low-

income individuals that approximate the new adult group or an HHS-calculated estimate based on available State-specific data similar to option 3 below.

3. *CMS-established FMAP proportion.* A State could elect to use a State-specific estimated FMAP proportion of eligibility under the December 2009 criteria calculated by CMS using data sources such as the Medical Expenditure Panel Survey (MEPS) and Medical Statistical Information System (MSIS) data. CMS would annually publish these proportions for each State. Data verification would be used beginning in CY 2016 for the purpose of correcting the model for future years; no reconciliation of past payments would be made.

III. Collection of Information Requirements

In the final rule, CMS provides estimates of the costs to States of complying with the requirement for developing a verification plan, the renewal process for individuals eligible under MAGI-based methodologies, and modifying websites to meet the additional functionalities required under the rule. CMS received no comments on the collection of information requirements described in the proposed rule.

IV. Regulatory Impact Analysis and Other Requirements

CMS summarizes the findings of a detailed regulatory impact analysis, which is available at http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule_Regulatory-Impact-Analysis.pdf. No comments were received on the preliminary impact analysis included in the proposed rule. The major change from the preliminary impact analysis reflects the changes enacted to count all Social Security benefits as income under the MAGI. In addition, estimates provided by the CMS Office of the Actuary (OACT) have been updated.

OACT estimates that the final rule will result in an additional 24 million newly eligible and currently eligible individuals enrolling in Medicaid by 2016, including 2-3 million individuals with employer sponsored coverage who will enroll in Medicaid for supplemental coverage. Inherent uncertainties in the projection of Medicaid enrollment are discussed. Benefits to new enrollees include improved access to medical care services resulting in improved health and financial security.

Conversion to MAGI rules is not expected to result in a substantial net gain or loss in Medicaid enrollment. A small number of individuals may lose Medicaid eligibility and bear the cost of purchasing coverage through the Exchanges offset by premium tax credits. Others may gain eligibility as a result of the switch to MAGI-based methodologies.

Federal and State Medicaid spending will increase for fiscal years 2012 through 2016 by \$164 billion and \$14 billion respectively. CMS notes that these estimates do not reflect offsetting savings to States that will vary by States. States will benefit from the improved health of their residents, reduced State spending on health care, and over time, reduced administrative burden on Medicaid agencies. CMS references a study by the Urban Institute which concluded that States will experience a net savings from 2014 through 2019.

CMS indicates that because of the uncertainties of the net effects, the Regulatory Impact Analysis has been drafted to also meet the requirements under the Unfunded Mandates Reform Act. Regarding the Regulatory Flexibility Act requirements relating to the impact on small entities, CMS indicates that some small jurisdictions could be affected by the final rule to the extent States require them to contribute toward the State share of costs of the new coverage. The State share is estimated to be 5%-8% of the total costs, with the Federal government providing the vast majority of the financing. A benefit to small hospitals and other providers will be the increased prevalence of health coverage among currently uninsured populations.

Regarding the Executive Order 13132, CMS states the final rule will have significant direct effects on States, and discusses various ways in which it consulted with the States in developing the final rule. These include conference calls and meetings with State officials and ongoing Medicaid and CHIP Technical Advisory Groups comprised of expert State officials.