SELLERS DORSEY COVERAGE

Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

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Executive Summary

On April 2, 2024, CMS published a final rule titled, "Medicaid Program: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes." This final rule addresses the remaining provisions from the September 2022 proposed rule and also responds to President Biden's Executive Orders from January 2021 and April 2022 to strengthen Medicaid and improve access to affordable, quality healthcare coverage. CMS received a total of 7,055 comments during the Federal comment period from state agencies, advocacy groups, healthcare providers, associations, insurers and plans, and the general public. The rule is effective June 3, 2024, though different provisions are phased-in over time. A table of effective dates is included in this summary. Through the final rule, CMS aims to help eligible individuals enroll in and retain Medicaid, CHIP, or BHP coverage. The provisions are intended to standardize and align enrollment and renewal processes, reduce coverage disruptions, improve access to care in CHIP, modernize recordkeeping requirements, and enhance program integrity. The summary of the provisions below aligns with the preamble from the final rule.

Key Takeaways[i]

- Allows states to deduct prospective, predictable medical expenses for individuals living in the community and seeking eligibility under the medically needy category.
- Clarifies that the primacy of electronic verification and reasonable compatibility standard apply to the verification of resources.
- Adds the verification of birth with a state's vital statistics records and U.S. citizenship with the Department of Homeland Security (DHS) Systematic Alien Verification Entitlements (SAVE) system to the list of primary verifications of U.S. citizenship that do not require additional proof of identity.
- Aligns non-MAGI (Aged, Blind, and Disabled) enrollment and renewal requirements with MAGI policies. For individuals who are non-MAGI, the state must:
    - Conduct beneficiary renewals no more than once every 12 months, with the exception of Qualified Medicare Beneficiaries (QMBs) renewals.
    - Use prepopulated renewal forms.
    - Eliminate mandatory in-person interviews at application and renewal. If a state uses phone or video interviews in lieu of an in-person interview, this is prohibited as well.
    - Limit requests for information on a change in circumstances to only information on the change.
    - Renewals must be accepted through multiple modalities including online, through the mail, by phone, or in-person.

    - Provide at least 30 days for beneficiaries to return a signed renewal form or information needed to confirm a change in circumstance.
    - Provide at least a 90-day reconsideration period for procedural terminations due to a failure to respond to requests for information.
- Sets minimum timelines and establishes protections for determination and redetermination of eligibility for applicants and at renewals as follows:
    - At least 15 calendar days for new applicants to return needed information.
    - At least 30 calendar days for beneficiaries to return information needed for renewal.
    - At least a 90-day reconsideration period for procedural terminations due to a failure to respond to requests for information
- Describes the actions for responding to updated address information for in-state and out-of-state address changes, when mail is returned with no forwarding address, and identifies "reliable data sources" that no longer require beneficiary verification.
- Streamlines transitions between Medicaid, CHIP, and BHP agencies.
- Creates the option to provide coverage to a new group of qualified individuals under age 21 whose eligibility is excepted from use of the MAGI-based methodology (i.e., those living with a disability), or whose MAGI-based eligibility is not otherwise described, and for which such coverage is not already permitted in regulation.
- Allows CHIP beneficiaries to re-enroll without a lock-out period when a family fails to pay a CHIP premium or enrollment fee.
- Prohibits use of a waiting period prior to CHIP enrollment as a substitution for coverage prevention strategy.
- Prohibits annual and lifetime limits on CHIP benefits.
- Defines what eligibility information/documentation is to be maintained by the state.
- Requires the retention of Medicaid/CHIP records and case documentation for at least 3 years after beneficiary disenrollment, except for estate recovery cases.
- Requires states to make records available within 30 days upon request unless there are administrative or emergency circumstances beyond the state agency's control.
- Establishes minimum standards for states to complete a timely determination of beneficiary eligibility at application, renewal, and when there is a change in circumstances.
- Removes references to outdated technology and requires storage of records in electronic format.

Major Provisions

A. Facilitating Medicaid Enrollment

Provision #1: Facilitate Enrollment by Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses (42 CFR 435.831 and 436.831). **Finalized as proposed.**

§ 435.831(g)(2) allows states to project the incurred medical expenses of noninstitutionalized individuals who look to establish eligibility for Medicaid as medically needy. These expenses will be projected at the Medicaid reimbursement rate for duration of the medically needy budget period set by the state but cannot be longer than six months as specified under § 435.831(a)(1). CMS provides some examples of recurring expenses that qualify such as those in a person-centered home and community based service plan and prescription drugs.

Effective Date: Option is available on June 3, 2024

Provision #2: Application of Primacy of Electronic Verification and Reasonable Compatibility Standard for Resource Information (42 CFR 435.940 and 435.952). **Finalized as proposed.**

Clarifies that the use of electronic data sources to determine or renew eligibility and the reasonable compatibility standard apply to the verification of resources. Since this revision impacts electronic data sources, such as asset verification systems (AVS), CMS has also finalized a corresponding technical change and adds section 1940 of the Social Security Act (relating to asset verification) to § 435.940.

Effective Date: June 3, 2024

Provision #3: Verification of Citizenship and Identity (42 CFR 435.407 and 457.380). **Finalized as proposed.**

Adds the verification of birth with a state's vital statistics records and U.S. citizenship with DHS SAVE system to the list of primary verifications of U.S. citizenship that do not require additional proof of identity. To simplify the verification procedures, the state option for use of these data sources is removed. These regulations may require some states to change or modify their eligibility and enrollment systems, operational eligibility processes, and/or verification plan revisions.

Effective Date: 24 months from June 3, 2024

B. Promoting Enrollment and Retention of Eligible Individuals

Provision #1: Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies (42 CFR 435.907(c)(4) and (d) and 435.916). **Finalized as proposed.**
Several policies are finalized without modification. These regulations result in changes to the eligibility application and renewal process for non-MAGI populations to better align with the requirements for MAGI individuals. States are now required to:

- Conduct beneficiary renewals no more than once every 12 months, with the exception of qualified Medicare beneficiaries (QMBs) renewals.
- Use prepopulated renewal forms and provide at least 30 days for return of the signed renewal form.
- Provide at least a 90-day reconsideration period after termination for insufficient information for eligibility.
- Eliminate mandatory in-person interviews at application and renewal. Using phone or video interviews to fulfill the requirement of an in-person interview is also prohibited.
- Limit requests for information on a change in circumstances to only information on the change.
- Accept applications and supplemental information through all modalities (mail, phone, in-person, and email).

Effective Date: 36 months from June 3, 2024, with the exception of acceptance of applications through all modalities, which has an immediate effective date.

Provision #2: Acting on Changes in Circumstances Timeframes and Protections (42 CFR 435.916, 435.919, and 457.344). **Finalized with modifications.**

- Redesignates current § 435.916(c) and (d) as the new §§ 435.919 and 457.344 for Medicaid and CHIP, respectively.
- § 435.919(b) streamlines the already-existing requirements for different types of changes in circumstances and establishes a single set of actions that are required when a state receives reliable information about a change in circumstances that may impact a beneficiary's eligibility:
- Combines § 435.919(b)(1)(i) and 435.919(b)(2)(i) and finalizes § 435.919(b) to require that states redetermine eligibility between regularly scheduled intervals whenever they have obtained or received reliable information about a change in circumstances that may impact the beneficiary's eligibility for Medicaid, amount of medical assistance, or premiums or cost sharing charges.

    - Reliable information includes changes reported by beneficiaries or their authorized representatives or information from third-party data sources identified in states' verification plans.
- Finalizes the requirement at § 435.919(b)(1) that the agency must complete the determination based on available information whenever possible. If the state does not have all the necessary information, it must request that information from the beneficiary.

When a Reported Change Results in Increased Medical Assistance:

- Combines proposed § 435.919(b)(1)(iii) and (b)(2)(iii) in the final rule as § 435.919(b)(2) and (3) to describe the requirements when a reported change may result in additional medical assistance, including reduced cost sharing:
    - If the change was reported by the beneficiary, the state must verify the change.
    - If the change was reported by a third-party data source, the state can verify the change with the beneficiary prior to completing the determination but is not required to do so.
- § 435.919(b)(3) prohibits states from terminating coverage for a beneficiary who does not respond to a request for information to verify eligibility for increased medical assistance.

When a Reported Change Results in an Adverse Action:

- At § 435.919(b)(4), originally proposed as § 435.919(b)(2)(ii), the state must provide a beneficiary the opportunity to provide additional information to verify or dispute information that would adversely affect eligibility when a change is reported from a third-party source.
    - An adverse action includes termination, suspension, reduction in benefits, services, or eligibility, or an increase in cost sharing.
- At § 435.919(b)(5), originally proposed as § 435.919(b)(4), the state must consider eligibility on all other bases, determine potential eligibility for other insurance affordability programs, and provide advance notice and fair hearing rights when a change in circumstances results in an adverse action.

For an Anticipated Change in Circumstances:

- § 435.919(b)(3) is finalized as proposed, although a cross reference to paragraphs (b)(1) through (5) is added to clarify that the same steps apply when states are reevaluating a beneficiary's eligibility based on an anticipated change in circumstances.

    - Anticipated changes are described as age changes, such as a beneficiary turning 65 and becoming eligible for Medicare or a child aging out of the eligibility group for children under age 19.
- §§ 435.919(c)(1) and 457.344(c)(1) require states to provide beneficiaries with at least 30 calendar days to respond to requests for additional information following a change in circumstance.
- § 435.919(b)(3)) prohibits states from terminating coverage of a beneficiary who fails to respond to a request for information to verify eligibility for increased coverage.
- §§ 435.919(d)(2) and 457.344(d)(2) require states to provide a 90-day reconsideration period for disenrolled beneficiaries who did not timely respond are finalized as proposed to align the policies for reconsideration periods following a change in circumstances with those at renewal.
- States are not be required to send a notice to beneficiaries that the information they reported was received but did not impact their eligibility.
- CMS revised CHIP regulations at § 457.344 in the final rule to align with the changes above, with exceptions for Medicaid requirements that do not apply to CHIP.
- In cases where a change in circumstances has no practical impact on a beneficiary's coverage, such as moving to a different eligibility group with no change in coverage, the requirements at §§ 435.919(b)(2) and 457.344(b)(2) in the final rule apply. Under these rules, the beneficiary can be moved to a new group if the change is reported by the beneficiary and verified by the state. If the state receives information from a third-party data source and elects to verify the information with the beneficiary but is unable to confirm the change with the beneficiary the individual must remain in the original eligibility group and cannot be terminated consistent with §§ 435.919(b)(3) and 457.344(b)(3).

Effective Date: 36 months from June 3, 2024

Provision #3: Timely Determination and Redetermination of Eligibility (42 CFR 435.907, 435.912, 457.340(d), and 457.1170). **Many provisions were finalized as proposed, as noted below.**

- Requires states to provide at least 15 days for individuals to return information needed to verify eligibility and a 90-day reconsideration period for applicants who return needed information after being determined ineligible for failure to respond (procedural terminations).

- §§ 435.907(d)(1)(i), 435.916(b)(2)(i)(B), and 435.919(c)(i) are finalized as proposed. Requires states to begin an applicant or beneficiary's 30-day response timeframe on the date that the agency sends the notice or form.
- §§ 435.907(d), 435.912, and 457.340(d) are finalized as proposed with some exceptions to modify the number of calendar days.
- §§ 435.912(c)(1), (c)(2), and (g)(3) are finalized as proposed. Specifies the period covered by the timeliness and performance standards; the criteria for establishing these standards; and explains the prohibition on using the timeliness standards to delay an adverse action.
- §§ 457.1140, 457.1170, and 457.1180 are finalized as proposed for CHIP.

<u>At Application:</u>

- Finalizes a single minimum standard for all applicants at § 435.907(d)(1)(i).
    - Requires states to provide all applicants with a reasonable amount of time of no less than 15 calendar days to respond to a request for additional information.
    - Provides flexibility to create a single minimum timeframe for all requests for information at application above the 15-day minimum.
    - Provides flexibility to tailor the timeframes, provided that they are not below the 15-day minimum, depending on the circumstances and can vary the timeframes based on the circumstances of the request.
- The reconsideration period at application is increased from 30 to a minimum of 90 calendar days at § 435.907(d)(1)(iii) for procedural terminations for failure to return needed information; and, the effective date of coverage is based on the date the requested information is received. This is to align with policies for reconsideration periods at renewal and following a change in circumstances.
- A limited exception for an information request is the 15-day minimum for certain Medicare Shared Savings (MSP) determinations based on Low Income Subsidy (LIS) application data. § 435.911(e)(8) requires states to provide individuals with a minimum of 30 days to provide information if the LIS application data is not sufficient for an MSP determination.

<u>At Renewal:</u>

- § 435.912(c)(2) is finalized as proposed and requires that states demonstrate their timeliness standards address certain criteria including prior state experience, availability of information, the needs of beneficiaries, and advance notice requirements.

- § 435.912(c)(4) is finalized with some modifications. CMS finalized three timeframes for completing timely renewals, depending on the circumstances:
    - If the beneficiary's renewal can be completed with available information or a renewal form was returned with at least 30 calendar days remaining in the eligibility period, the state is required to complete the renewal prior to the end of that individual's eligibility period (§ 435.912(c)(4)(i)).
    - If a renewal form is returned with less than 30 calendar days before the end of the eligibility period, the state must complete the renewal by the end of the following month.
    - If the state is redetermining eligibility on another basis other than disability, the state has an additional 45 calendar days to complete the eligibility determination. The state has up to 90 additional calendar days to complete a disability-related determination from the date that the individual is determined ineligible (§ 435.912(c)(4)(ii)).
    - Reminds states of current regulatory requirements at § 435.930(b) which require states to continue to furnish Medicaid benefits to all eligible individuals until the state completes a redetermination and finds an individual to be ineligible.

<u>At Changes in Circumstances:</u>

- § 435.912(c)(6) requires that a redetermination of eligibility based on an anticipated change may not exceed the end of the month in which the change occurs, except when a beneficiary returns needed information late in the process or the state needs to determine eligibility on a different basis.
- § 435.912(c)(6)(i) describes the 30-calendar day threshold, similar to the previous sections. If a beneficiary returns information after the 30-day threshold, the state must complete the determination by the end of the following month.
- § 435.912(c)(6)(ii) applies the existing timeliness standards for new applications when a state must consider eligibility for a beneficiary on a different basis following a change in circumstances.
- Table 1 included with the final rule at 89 FR 22802 (April 2, 2024), summarizes Provisions in B. 1, 2, and 3:

TABLE 1: Enrollment-related Timeframes in this Final Rule

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

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

Effective Date: 36 months from June 3, 2024

Provision #4: Agency Action on Updated Address Information (42 CFR 435.919 and 457.344). **Finalized as proposed.**

Paragraphs (f) and (g) of proposed § 435.919 are combined in the final rule at § 435.919(f).

§ 435.919(f)(1) describes the requirements for obtaining updated address information from third-party data sources and paragraphs (f)(2) through (4) describe the actions required by the state depending on the type of address information received. Paragraph (f)(5) describes the good-faith effort requirements for contacting beneficiaries needed to confirm updated

information. Other changes within § 435.919(f) provide greater flexibility for states and remove some of the details for operationalizing regulatory requirements.

- States must provide beneficiaries with at least 30 calendar days to respond to a good-faith effort request for an updated address. The requirements for handling in-state address changes are the same for CHIP at § 457.344(f)(2).

The state is required to establish a process to regularly obtain updated address information from reliable third-party data sources (§ 435.919(f)(1)(i)). CMS defines four types of data sources as always reliable for this purpose (§ 435.919(f)(1)(iii)):

1. Mail returned by USPS with a forwarding address;
2. The USPS National Change of Address (NCOA) database;
3. Managed care plans under contract with the state, provided that the information came directly from the beneficiary, or the plan verified it with the individual;
4. Other data sources identified by the state and approved by the Secretary.

<u>In-State Address Changes:</u>

- When a state receives information from a reliable data source (as defined above) regarding an in-state address change, the state does not have to separately verify with the beneficiary. The state must accept the information as reliable, update the case record, and notify the beneficiary of the update (§ 435.919(f)(2)(i)).
- When an in-state address change comes from a third-party data source that is not considered reliable, the state must check its Medicaid Enterprise System (MES) along with the most recent information obtained from the reliable data sources before taking any further action (§ 435.919(f)(2)(ii)).
    - If the state is unable to confirm the new address, the state must make a good-faith effort to contact the beneficiary to verify the new address (§ 435.919(f)(3)(i)).
    - The requirements for a good-faith effort are:
        - A minimum of two attempts to contact the beneficiary using at least two different modalities with a reasonable period of time between contact attempts.
        - If the state does not have the necessary contact information to fulfill these requirements, the state must make a note of this in the case record.
    - However, even if the beneficiary does not respond to either request, the state may not terminate their eligibility in accordance with § 435.919(f)(2)(ii)(C).

Out-of-State Address Changes:

- § 435.919(f)(3)(i) revises and redesignates the requirements proposed at § 435.919(f)(2) and (3) and (g)(3) requiring the state to make a good-faith effort to contact the beneficiary to confirm an out-of-state address change received from any third-party data source by mail and through at least one alternative modality to verify an out-of-state address update.
    - If the state is unable to confirm the accuracy of an out-of-state address or state residency requirements, the state must provide the beneficiary with advanced notice of termination and fair hearing rights consistent with 42 CFR part 431, subpart E. (435.919(f)(3)(ii)).

Mail Returned with No Forwarding Address:

- If a state receives returned mail with no forwarding address, the state must check its MES and the most recently available data from the reliable sources for additional contact information. If the updated address information cannot be found and confirmed through these sources, the state must make a good-faith effort to contact the beneficiary. If the state is unable to identify and confirm a beneficiary's current address after these steps, the state must either move the beneficiary to fee-for-service or take the necessary steps to terminate or suspend coverage (§ 435.919(f)(4)(i), (ii), and (iii)).

Effective Date: 18 months from June 3, 2024.

Provision #5: Transitions between Medicaid, CHIP and BHP Agencies (42 CFR 431.10, 435.1200, 457.340, 457.348, 457.350, and 600.330). **Finalized with modifications.**

CMS finalizes the proposed changes to Medicaid at §§ 431.10 and 435.1200 and CHIP regulations at §§ 457.340, 457.348, and 457.350 with some minor modifications for clarification and to make the process more seamless for beneficiaries. These regulations require Medicaid agencies and separate CHIPs to:

- Make determinations of eligibility on behalf of the other program.
- Accept determinations of eligibility made by these programs.
- Transition individuals to the insurance affordability program for which they are determined eligible or potentially eligible based on available data.
- Provide a single, combined notice to all members of a household with information about each individual's eligibility status for each applicable insurance affordability program.

The technical changes to the BHP regulations are finalized at § 600.330 to maintain the current policy for the BHP. There is one change to § 457.350(b)(1)(ii) to clarify that information provided on the application or renewal form by or on behalf of the beneficiary includes information obtained through trusted electronic data sources.

CMS notes that state Medicaid agencies are not required to accept eligibility determinations that are not made on the basis of MAGI. § 435.1200(b)(4) provides agencies with several options for accepting eligibility determinations based on MAGI that are made by CHIPs.

Effective Date: June 3, 2024

Provision #6: Optional Group for Reasonable Classification of Individuals Under 21 Who Meet Criteria for Another Optional Group (42 CFR 435.223 and 435.601). **Finalized as proposed.**

§ 435.223 adds a new eligibility option, "Other optional eligibility for reasonable classifications of children under 21," for states to provide coverage to individuals under age 21, 20, 19, or 18, or to reasonable classifications of such individuals, who meet the requirements of any clause of section 1902(a)(10)(A)(ii) of the Social Security Act. In addition, CMS confirmed that states, in determining eligibility under the proposed § 435.223, could except individuals who are described in § 435.603(j) from MAGI financial eligibility methodologies.

This addition allows states to establish an optional eligibility group for all or a reasonable classification of individuals under age 21 whose eligibility is excepted from use of the MAGI-based methodology (individuals living with a disability), or whose MAGI-based eligibility is not otherwise described, and for which such coverage is not already permitted in regulation.

§§ 435.601(b)(2), (d), and (f)(1)(i) and (ii) are finalized as proposed and allows agencies to apply either: (1) the financial methodologies of the Aid to Families and Dependent Children (AFDC) program; or, (2) the MAGI-based methodologies defined in § 435.603, except to the extent that MAGI-based methods conflict with the terms of § 435.602 in the case of individuals for whom the cash assistance program most closely categorically-related to the individual's status is AFDC.

Effective Date: Option is available upon June 3, 2024

C. Eliminating Barriers to Access in Medicaid

Provision #1: Remove Optional Limitation on the Number of Reasonable Opportunity Periods (42 CFR 435.956 and 457.380). **Finalized as proposed.**

§ 435.956 removes the option to limit the number of "reasonable opportunity periods" for eligible applicants while they complete verification of their U.S. citizenship or satisfactory immigration status, in accordance with the requirements of § 457.380.

Effective Date: June 3, 2024

Provision #2: Remove Requirement to Apply for Other Benefits (42 CFR 435.608 and 436.608). **Finalized as proposed.**

Removes § 435.608 in its entirety. State Medicaid programs will no longer be allowed to require applicants or beneficiaries to apply for every benefit they may be eligible for, such as retirement, disability, and pensions. Additionally, CMS is redefining the term "available" in section 1902(a)(17)(B) of the Social Security Act to specify that it only pertains to income and resources under a beneficiary or applicant's immediate control.

§ 436.608 is also rescinded for the same reasons noted regarding § 435.608 so that the rule is applicable to Medicaid programs and their applicants in Guam, Puerto Rico and the Virgin Islands.

With the removal of § 435.608 and § 436.608, CMS notes that Medicaid applicants and beneficiaries will not be required to apply for social security or retirement benefits, as a condition of their eligibility for the program. If they choose to, states can require that individuals apply for Medicare as a condition of Medicaid eligibility.

Effective Date: 12 months from June 3, 2024

D. Recordkeeping

CMS finalizes recordkeeping requirements proposed at § 431.17, § 435.914 and § 457.965 with the following modifications:

- Finalizes changes to § 431.17 that relate to format, content, availability of records, and minimum retention period for Medicaid.
- Finalizes changes to § 435.916 for Medicaid related agency decisions regarding application, redetermination, and renewal processes.
- Finalizes changes to § 457.965 with similar revisions for CHIP.
- Finalizes requirements for § 431.17(d)(1) and § 457.965(d)(1) in regard to requiring Medicaid and CHIP agencies to keep records electronically.
- Finalizes the content requirements for applicant and beneficiary records in § 431.17(b)(1) and § 457.965(b)(1) to include the following: applications, renewal

forms, any changes submitted by an individual or household, information from other insurance affordability programs, income data, eligibility verification, appeals or fair hearing records, and past instances of medical assistance.

- Modifies § 435.914(b) to include information on redetermination to ensure that in the circumstance that any changes occur, applications and annual renewals are kept in the same manner.
- In alignment with Section 1902(a)(7) of the Social Security Act and 42 CFR part 431 subpart F, which requires Medicaid agencies to restrict the use and disclosure of beneficiary information, CMS adds a new subparagraph (e) to § 431.17. This subparagraph specifies that records must be safeguarded to follow the requirements of 42 CFR part 431, subpart F.
- §§ 431.17(d)(2) and § 457.965(d)(2) revised to include a requirement for states to have records available within 30 days of being requested, unless there is an administrative or unforeseeable emergency. Additionally, a technical revision to these sections is made to allow a state a longer period of time to respond to a record request in instances where the requesting party specifies a longer period of time in the request itself.
- Finalizes a 3-year retention time-frame in § 431.17(c)(1) and § 457.965(c), for which Medicaid and CHIP agencies must retain an individual's records after the individual's case is no longer active.

CMS notes the following:

- States are not be confined to one standardized format for recordkeeping.
- Per a state's request, federal funding can be allocated for the development of recordkeeping systems. States can find program standards, regulations and best practices in the Streamlined Modular Certification process and Conditions for Enhanced Funding in § 433.112.
- § 95.621 addresses the requirements of state agencies in ensuring proficient security of data processing systems, which must be evaluated every two years.
- States are expected to follow federal and state laws regarding privacy, security, and confidentiality of records.
- The content requirements of § 431.17(b)(1) and § 457.965(b)(1) will aid state agencies to make justified decisions regarding eligibility, defend any decision if an individual decides to challenge them, and allow auditors to conduct reviews at their discretion.
- States are required to specify the usage of data, who will use it and situations where the agency will disclose data.
- At their discretion, states can provide extra protection processes for individuals who ask. States can also require proof of identity for an individual to access records.
- CMS advises states to find ways to encourage program applicants to provide helpful demographic information and not mandate the information to be supplied to avoid barriers to enrollment processes.

Effective Date: 24 months from June 3, 2024

E. Eliminating Access Barriers in CHIP and BHP

Provision #1: Prohibition on Premium Lock-out Periods (42 CFR 457.570 and 600.525(b)(2)). **Finalized as proposed.**

Finalizes § 457.570 for CHIP and § 600.525(b)(2) for BHP to prevent states from disenrolling or locking-out beneficiaries for failing to pay premiums. Presently, states can utilize premium lock-out periods to define a period that individuals must follow before re-enrolling in CHIP and BHP. CMS believes that prohibiting premium lock-out periods aligns with the statutory authority of CHIP and BHP.

CMS further elaborates that states will not be required to continue coverage of services for an individual once terminated unless they re-enroll. While states will not be allowed to collect past due payments, if the family chooses to re-enroll, states can require a new enrollment or premium fee.

CMS advises that in place of premium lock- out periods, states charge an annual enrollment fee that varies based on the beneficiary's family income level.

Effective Date: June 3, 2024 or 12 months from June 3, 2024 for states sunsetting lock-out periods.; extension of 24 months may be requested by a state when legislative action if necessary for the change.

Provision #2: Prohibition on Waiting Periods in CHIP (42 CFR 457.65, 457.340, 457.350, 457.805, and 457.810). **Finalized as proposed.**

Finalizes the proposed changes in CHIP to:

- Revise § 457.805(b) and § 457.810(a) to remove mention of using waiting periods as a substitution of coverage for a procedure, regarding CHIP or premium assistance.
- Revise § 457.65(d) to remove any reference to waiting periods.
- Remove § 457.340(d)(3)
- Revise § 437.350(i), and rename to § 457.350(g).
- Revise § 457.805(b)(2) and § 457.805(b)(3) to remove limitations that no longer make sense after the elimination of waiting periods.

CMS' decision to eliminate waiting periods aligns with President Biden's Executive Order 14070, "Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage."

Effective Date: 12 months after effective date

Provision #3: Prohibit Annual and Lifetime Limits on Benefits (42 CFR 457.480). **Finalized as proposed.**

CMS is finalizing § 457.480, to prohibit the placement of annual and lifetime limits on medical and dental services covered under CHIP plans. Currently CHIP regulations ban dollar limits on mental health and substance use disorder benefits.
CMS advises states to work with their actuaries, to ensure that they are following the necessary federal principles and standards for rate development within the CHIP landscape.

Effective Date: 12 months from June 3, 2024

F. Compliance Timelines

CMS believes that an early effective date with phased in compliance provides the best balance between making the streamlined processes available as soon as possible and providing states with the needed time to implement the rules properly. The final rule is effective 60 days after publication, June 3, 2024. Compliance for each provision is phased-in over time as shown in Table 2 below, included with the final rule at 89 FR 22836 (April 2, 2024). Full compliance for the final rule is required 36 months from June 3, 2024, (June 3, 2027).

TABLE 2: Compliance Timeframes

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

[1] The policy will be effective 60 days after publication of this final rule. At that time, States will no longer be permitted to adopt a new premium lock-out period. States with an existing lock-out period will have 12 months to remove it.
[2] States with biennial legislatures that require legislative action to implement these requirements can request an extension of up to 24 months following the effective date of this final rule.
[3] The policy will be effective 60 days after publication of this final rule. At that time, States will no longer be permitted to adopt a new waiting period. States with an existing waiting period will have 12 months to remove the waiting period and establish a substitution monitoring strategy.
[4] The policy will be effective 60 days after publication of this final rule. At that time, States will no longer be permitted to adopt new annual or lifetime limits. States with existing annual or lifetime limits will have 12 months to remove the limits.

[i] Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule Fact Sheet | CMS