

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Parts 406 and 435**

[CMS–2421–F]

RIN 0938–AU00

Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Final rule.

SUMMARY: This final rule simplifies processes for eligible individuals to enroll and retain eligibility in the Medicare Savings Programs (MSPs). This final rule better aligns enrollment into the MSPs with requirements and processes for other public programs. Finally, this final rule reduces the complexity of applications and reenrollment for eligible individuals.

DATES: These regulations are effective November 17, 2023. Throughout, however, we identify separate compliance dates that vary by provision, thereby giving States additional time to implement the provisions of this final rule.

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SUPPLEMENTARY INFORMATION: This final rule addresses select provisions and public comments from the proposed rule, published in the September 7, 2022 *Federal Register* (87 FR 54760). We intend to address the remaining provisions and public comments from the proposed rule in subsequent rulemaking.

I. Background

Millions of individuals with limited income and resources rely on the Medicare Savings Programs (MSPs) to help cover Medicare Parts A and B premiums and, often, cost-sharing. In accordance with section 1902(a)(10)(E) of the Social Security Act (the Act), MSPs are part of States' Medicaid programs and assist individuals who need help paying their Medicare costs.

The MSPs are essential to the health and well-being of those enrolled, promoting access to care and helping free up individuals' limited income for food, housing, and other life necessities. Through the MSPs, Medicaid pays Medicare Part B premiums each month for over 10 million individuals and Part

A premiums for over 700,000 individuals. However, millions more are eligible but not enrolled. A 2017 study conducted for the Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that only about half of eligible Medicare beneficiaries were enrolled in MSPs.¹

The Biden-Harris Administration is committed to protecting and strengthening Medicaid. On January 20, 2021, President Biden issued Executive Order 13985, charging Federal agencies with identifying potential barriers that underserved communities may face to enrollment in programs like Medicaid.² This was followed on January 28, 2021 by Executive Order 14009 with a specific call to strengthen Medicaid and the Affordable Care Act and remove barriers to obtaining coverage for the millions of individuals who are potentially eligible but remain uninsured.³ The December 13, 2021 Executive Order 14058, "Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government" supports streamlining State enrollment and renewal processes and removing barriers to ensure eligible individuals are automatically enrolled in and retain access to critical benefit programs.⁴ The April 5, 2022 Executive Order 14070, "Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage" charges Federal agencies with identifying ways to help more Americans enroll in quality health coverage.⁵ It calls upon Federal agencies to examine policies and practices that make it easier for individuals to enroll in and retain coverage. In response to these Executive Orders, we examined ways to improve access to the MSPs.

We have learned through our experiences in working with States and

¹ Caswell, Kyle J., and Timothy A. Waidmann, "Medicare Savings Program Enrollees and Eligible Non-Enrollees," The Urban Institute June 2017). <https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf>.

² E.O. 13985, 86 FR 7009. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

³ E.O. 14009, 86 FR 7793. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicare-and-the-affordable-care-act/>.

⁴ E.O. 14058, 86 FR 71357. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/12/13/executive-order-on-transforming-federal-customer-experience-and-service-delivery-to-rebuild-trust-in-government/>.

⁵ E.O. 14070, 87 FR 20689. <https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/>.

other interested parties that certain policies continue to result in unnecessary administrative burden and create barriers to enrollment and retention of coverage for eligible individuals. For example, there are no regulations to facilitate enrollment in the MSPs. In particular, we do not have regulations to link enrollment in other Federal programs with the MSPs, despite the high likelihood that individuals in such programs are eligible for the MSPs. This hinders States' ability to efficiently enroll those known to be eligible. Additionally, interested parties report that burdensome documentation requirements substantially impede eligible individuals from enrolling in the MSPs.⁶

In this rulemaking, we finalize policies to streamline MSP eligibility and enrollment processes, reduce administrative burden on States and applicants, and increase enrollment and retention of eligible individuals.

Current regulations at 42 CFR 433.112 establish conditions that State eligibility and enrollment systems must meet to qualify for enhanced Federal matching funds. Among these conditions, § 433.112(b)(14) requires that each State system support accurate and timely processing and adjudications/eligibility determinations. As States submit proposed changes to their eligibility and enrollment systems and implement new and/or enhanced functionality, we will continue to provide them with technical assistance on the policy requirements, conduct ongoing reviews of both the State policy and State systems, and ensure that all proposed changes support more accurate and timely processing of eligibility determinations.

We recognize that the COVID–19 pandemic disrupted routine eligibility and enrollment operations for Medicaid.⁷ As States have resumed

⁶ In October 2020, CMS engaged with 55 interested parties across four States to better understand experiences when applying for the MSPs. One of the main findings was that burdensome documentation requirements substantially impede eligible individuals from enrolling in the MSPs and that easing these requirements is a critical step to ensuring individuals can obtain and retain these critical benefits.

⁷ Under the Families First Coronavirus Response Act (FFCRA, Pub. L. 116–127), States did not terminate enrollment for most individuals who were enrolled in Medicaid as of or after March 18, 2020, as a condition of receiving a temporary increase in the Federal Medical Assistance Percentage. The Consolidated Appropriations Act, 2023 (CAA, 2023, Pub. L. 117–328), enacted on December 29, 2022, ended this Medicaid continuous enrollment condition on March 31, 2023, enabling States to begin the process of initiating Medicaid eligibility reviews as early as February 1, 2023.

routine operations (a process we refer to as “unwinding”) they are faced with the challenge of re-assessing eligibility for a significantly larger number of enrollees than ever before. From February 2020 through March 2023, enrollment in Medicaid increased by 35.3 percent, or over 22 million individuals. Enrollment in Medicaid has increased in every State during that period. At the same time, many States report a shortage of eligibility workers. It is our priority to ensure that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage and care.

As we considered the challenges faced by States, we sought comment on reasonable implementation timelines for the provisions in our proposed rule, which would allow States to implement these important policies without negatively impacting the resumption of routine eligibility and enrollment operations. Certain provisions designed to improve the retention of eligible individuals could reduce the likelihood of eligible individuals losing health coverage during unwinding. However, we were also concerned that the work necessary to immediately implement such provisions would divert needed resources away from critical unwinding-related activities.

Recognizing that each State faces a unique set of challenges related to unwinding, with differing needs and opportunities, we sought comment on whether an effective date of 30 days following publication would be appropriate when combined with a later date for compliance for most provisions. We also sought comment on the timeframe that would be most effective for compliance with each provision and whether the compliance date should vary by provision.

In this final rule, we establish compliance dates that allow time for States to fully comply with new requirements while balancing other immediate priorities. Many of the provisions have compliance dates of April 1, 2026, one has a compliance date of October 1, 2024, and provisions that create State options generally take effect on the effective date of this final rule. We encourage States to comply with all new requirements as expeditiously as possible because they will improve access to MSPs for eligible new applicants and improve retention of eligible individuals who are already enrolled in an MSP, while reducing administrative burden on States and individuals.

Finally, implementation of this final rule will complement other new policies to improve access to coverage and affordability of prescription drugs. Beginning January 1, 2024, section 11404 of the Inflation Reduction Act expands eligibility for the full Medicare Part D Low-Income Subsidy benefit. To the extent that this change increases the number of people who apply for the Low-Income Subsidy and are otherwise eligible for (but not yet enrolled in) the MSPs, provisions in this final rule will facilitate access to the MSPs while reducing administrative burdens. And to the extent this final rule improves access to the MSPs, it will also automatically improve access to the Low-Income Subsidy, as we describe later in this final rule. Based on the evidence that Medicare prescription drug subsidies improve access to treatment⁸ and overall access to health insurance improves health outcomes,⁹ our proposals are likely to improve the health of older adults and people with disabilities.

II. Provisions of the Proposed Rule and Analysis of and Response to Public Comments

A. Facilitating Medicaid Enrollment

1. Facilitate Enrollment Through Medicare Part D Low-Income Subsidy “Leads” Data (42 CFR 435.4, 435.601, 435.911, and 435.952)

Medicare Savings Programs and Part D Low-Income Subsidy Background. Under mandatory eligibility groups that are collectively referred to as MSPs, individuals with limited income and resources qualify for Medicaid coverage of Medicare Part A and/or B premiums and, often, cost-sharing. State Medicaid agencies receive applications and adjudicate eligibility for full Medicaid and MSP coverage. Currently, the MSP eligibility groups cover over 10 million low-income individuals. There are three primary MSP eligibility groups:¹⁰ the

⁸ Dusetzina, S. et al., “Many Medicare Beneficiaries Do Not Fill High-Price Specialty Drug Prescriptions,” *Health Affairs*. 41: no. 4 (April 2022): 487–496. <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.01742>.

⁹ Hoffman, Catherine, and Julia Paradise, “Health Insurance and Access to Health Care in the United States,” *Ann. N.Y. Acad. Sci.* 1136 (2008): 149–160. <https://nyaspubs.onlinelibrary.wiley.com/doi/pdfdirect/10.1196/annals.1425.007>.

¹⁰ There is a separate and fourth MSP eligibility group generally referred to as the “Qualified Disabled Working Individuals (QDWI) group,” or QDWI group. As described in section 1902(a)(10)(E)(ii) of the Act, eligibility in the QDWI group is limited to individuals whose incomes do not exceed 200 percent of the FPL; whose resources do not exceed twice the relevant SSI resource standard (that is, for a single individual or couple); and who are eligible to enroll in Part A under

Qualified Medicare Beneficiary (QMB) group, through which Medicaid pays all of an individual’s Medicare Parts A and B premiums and assumes liability for most associated Medicare cost-sharing charges for people with income that does not exceed 100 percent of the FPL; the Specified Low-Income Medicare Beneficiary (SLMB) group, through which Medicaid pays the Part B premium for people with income that exceeds 100 percent, but is less than 120 percent, of the FPL; and the Qualifying Individuals (QI) group, through which Medicaid pays Part B premiums for people with income of at least 120 percent but less than 135 percent of the FPL.¹¹ Individuals also must meet corresponding resource criteria to be eligible for an MSP. The income and resource requirements for coverage under the MSPs, and the benefits to which eligible individuals are entitled, are set forth at sections 1905(p)(1) and 1902(a)(10)(E) of the Act. Among other things, section 1905(p) of the Act directs that the income and resource methodologies applied by the Social Security Administration (SSA) in determining supplemental security income (SSI) eligibility per sections 1612 and 1613 of the Act be used to determine financial eligibility for the MSPs, except that States may employ less restrictive income and/or resource methodologies than those applied in determining SSI eligibility under the authority of section 1902(r)(2) of the Act.

As discussed in the proposed rule at 87 FR 54763, the MSPs are essential to the health and economic well-being of low-income Medicare enrollees, helping to free up limited income for food, housing, and other life necessities. Despite the importance of the MSPs, a 2017 study conducted for MACPAC estimated that only about half of eligible individuals enrolled in Medicare were also enrolled in the MSPs.¹² This means

section 1818A of the Act. Section 1818A of the Act permits individuals who became entitled to Part A on the basis of their receipt of Social Security disability insurance (SSDI) and who subsequently lose SSDI after returning to work (and, hence, entitlement to Part A) to enroll in Part A contingent on paying the Part A premiums. The medical assistance available to QDWIs is the coverage of the Part A premiums. The QDWI group is not included in this proposal, because the income limits of the QDWI group are significantly higher than LIS and there does not exist the flexibility to disregard resources that are available for the other MSPs.

¹¹ Unlike a subset of individuals enrolled in the QMB and SLMB groups, no individuals enrolled in the QI group are eligible for other Medicaid program benefits.

¹² Caswell, Kyle J., and Timothy A. Waidmann, “Medicare Savings Program Enrollees and Eligible Non-Enrollees,” *The Urban Institute*, June 2017. <https://www.macpac.gov/wp-content/uploads/>

that millions of Medicare enrollees living in poverty are paying over 10 percent of their income to cover Medicare premiums alone, despite being eligible for Medicaid coverage for these costs. Complex MSP enrollment processes contribute to this low participation rate.^{13 14}

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275, enacted July 15, 2008), aimed to improve low-income benefit programs for Medicare beneficiaries. MIPPA included new requirements for States to streamline enrollment of Medicare Part D Low-Income Subsidy (LIS) program enrollees into the MSPs. This final rule codifies provisions from MIPPA and builds upon its requirements to further streamline MSP enrollment for LIS enrollees and address persistent under enrollment in the MSPs.

The Medicare Part D LIS program, also sometimes referred to as “Extra Help,” is administered by SSA and pays Medicare Part D prescription drug premiums and cost-sharing for over 13 million individuals with low incomes. Most LIS enrollees are deemed eligible for LIS by virtue of their enrollment in Medicaid. Others apply for the benefit by completing an application and submitting it to SSA. Once received, SSA uses the information provided on the LIS application to determine LIS eligibility. Section 1860D–14(a)(3)(C) of the Act directs that the income methodologies for LIS are the MSP income methodologies described in section 1905(p)(1)(B) of the Act (that is, with very narrow exceptions, the SSI income methodologies). Similarly, section 1860D–14(a)(3)(D) and (E) of the Act direct that the resource methodologies for LIS are the MSP resource methodologies described in section 1905(p)(1)(C) of the Act, which are also generally aligned with the SSI resource methodologies, except that the cash value of life insurance, which is typically countable under SSI resource methodologies, is not counted as a resource for LIS. The SSA has also adopted a few additional regulatory and sub-regulatory methodological simplifications for the LIS program that

differ from SSI rules, as explained later in this section of the final rule.

The MSP and LIS programs both assist low-income individuals in accessing the Medicare benefits to which they are entitled and, as described previously in this final rule, generally use a common methodology to determine income and resource eligibility. Current regulations at 42 CFR 423.773(c) require that individuals enrolled in MSPs be automatically enrolled in LIS. However, individuals who are enrolled in LIS are not automatically enrolled in MSPs. Many people enrolled in the LIS program are not enrolled in an MSP, despite likely being eligible. As discussed in the proposed rule at 87 FR 54764, MIPPA included several provisions to promote the enrollment of LIS applicants into the MSPs.

In particular, section 113 of MIPPA requires SSA to transmit data from LIS applications (“leads data”) to State Medicaid agencies, and that the electronic transmission from SSA “shall initiate” an MSP application. MIPPA also requires States to accept leads data and “act upon such data in the same manner and in accordance with the same deadlines as if the data constituted” an MSP application submitted by the individual. As outlined under § 435.912, States have 45 days to make an MSP eligibility determination based on the LIS data. The date of the MSP application is defined as the date of the individual’s application for LIS under section 1935(a) of the Act.

Despite these statutory requirements, not all States initiate an MSP application upon receipt of leads data from SSA. Based on program experience and comments submitted on the proposed rule, some States have been unaware or unclear of the steps required to meaningfully use the leads data to streamline eligibility and enrollment in the MSPs. Our data reflects that currently over a million individuals enrolled in full LIS are not enrolled in an MSP. Given near alignment of MSP and full LIS eligibility criteria, most of these individuals are likely eligible for an MSP eligibility group.

The January 28, 2021 Executive Order on Strengthening Medicaid and the Affordable Care Act directs agencies to address policies and practices that may present unnecessary barriers to individuals and families attempting to access Medicaid coverage,¹⁵ the April 5,

2022 Executive Order on Continuing to Strengthen Americans’ Access to Affordable, Quality Health Coverage charges Federal agencies with identifying ways to help more Americans enroll in quality health coverage,¹⁶ and the December 13, 2021 Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government supports streamlining State enrollment and renewal processes and removing barriers to ensure eligible individuals are automatically enrolled in and retain access to critical benefit programs.¹⁷ As such, we have evaluated CMS’s regulatory authority to reduce barriers to enrollment of eligible individuals into the MSPs. Under the authority in section 1902(a)(4) of the Act to specify “methods of administration” that the Secretary finds to be “necessary for the proper administration” of State plans, we proposed several regulatory changes to promote efficient enrollment in the MSPs by maximizing States’ use of LIS leads data. At 87 FR 54764, we explained that we anticipated these proposals would also have a positive impact on health equity by helping to provide more low-income individuals with access to additional health coverage consistent with the January 20, 2021 Executive Order.¹⁸

Accepting LIS leads data as an MSP application. As discussed in the proposed rule at 87 FR 54764, SSA must transmit the LIS leads data to States, and States must use that data to initiate an application for the MSPs. CMS has reinforced this requirement multiple times.¹⁹

We proposed to codify in regulation the statutory requirements for States to

¹⁶ <https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/>.

¹⁷ <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/12/13/executive-order-on-transforming-federal-customer-experience-and-service-delivery-to-rebuild-trust-in-government/>.

¹⁸ <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

¹⁹ See February 18, 2010 State Medicaid Director Letter (SMDL #10–003), “Medicare Improvements for Patients and Providers Act of 2008 (MIPPA),” explaining how to treat leads data as an application for MSPs. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd10003.pdf>. We reiterated this 2010 guidance in 2020 in Chapter 1, section 1.6.2 of the Manual for the State Payment of Medicare Premiums, <https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf>, and in the November 1, 2021 Center for Medicaid and CHIP Services Informational Bulletin, “Opportunities to Increase Enrollment in Medicare Savings Programs.” <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11012021.pdf>.

¹³ [2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf](https://www.gao.gov/assets/gao-12-871.pdf).

¹⁴ Office of the Assistant Secretary for Planning and Evaluation, “Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors, and Implications,” May 8, 2019. <https://aspe.hhs.gov/basic-report/loss-medicare-medicicaid-dual-eligible-status-frequency-contributing-factors-and-implications>.

¹⁵ Government Accountability Office, “Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment,” September 2012. <https://www.gao.gov/assets/gao-12-871.pdf>.

¹⁵ <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicare-and-the-affordable-care-act/>.

maximize the use of leads data to establish eligibility for Medicaid and the MSPs. At 87 FR 54765, we foresaw that codifying these requirements would lead to more eligible individuals enrolling in MSPs because it was our understanding that some States may have been unaware or unclear of the steps required to meaningfully use the leads data to streamline eligibility and enrollment in the MSPs.

Currently, all States receive leads data from SSA each business day. Per section 113 of MIPPA, States must accept, via secure electronic transfer, the SSA leads data and process that information to initiate an MSP application. However, as discussed at 87 FR 54765, we are aware that several States do not use the leads data to begin the application process. We proposed to add a definition of LIS leads data at § 435.4 and a new paragraph (e) to § 435.911 of the regulations to clearly delineate the steps States must take upon receipt of leads data from SSA. We proposed to define LIS leads data to mean data from an individual's application for low-income subsidies under section 1860D-14 of the Act that the SSA electronically transmits to the appropriate State Medicaid agency as described in section 1144(c)(1) of the Act. We proposed at § 435.911(e)(1) to require States to accept, via secure electronic interface, the SSA LIS leads data. We proposed paragraph (e)(2) to require that States treat receipt of the leads data as an application for Medicaid and promptly and without undue delay, consistent with the timeliness standards at § 435.912, determine MSP eligibility without requiring submission of a separate application.

We proposed paragraph (e)(4) to prevent States from requesting that individuals attest or otherwise provide documentation to establish information contained in leads data, which SSA has already used for the LIS eligibility determination. We noted that a State is not in compliance with the statutory requirement in section 1935(a)(4) of the Act to initiate an application based on leads data or with the proposed regulation if it requires the individual to file a new application for MSP, since the leads data already provides much of the information that would otherwise be requested on an application.

Further, because the LIS leads data that is transferred to State agencies has just been used by the SSA for the LIS determination, State verification of this data prior to adjudicating eligibility is duplicative and inefficient. As such, under the Secretary's authority under section 1902(a)(4) of the Act (relating to establishment of such methods of

administration as the Secretary determines "necessary for proper and efficient administration" of the Medicaid program) and section 1902(a)(19) of the Act (relating to simplicity of administration and the best interests of recipients), we proposed at § 435.911(e)(5) that States be required to accept information that is provided through the leads data without further verification, with certain exceptions, as described below.

However, at 87 FR 54765, we recognized that State Medicaid agencies generally will need to obtain additional information beyond what is provided by the SSA that is necessary to determine eligibility, as some differences remain in income and resource counting methodologies between the LIS and MSPs, as described in more detail in the proposed rule. In addition, as discussed at 87 FR 54765 through 54766, the leads data transmitted to the State does not include information on an individual's citizenship or immigration status, and therefore, States will need to verify their status. In accordance with § 435.406(a) and section 1137(d) of the Act, individuals must make a declaration of U.S. citizenship or satisfactory immigration status (subject to certain verification rules at §§ 435.956 and 435.407 and exemptions for Medicare beneficiaries at § 435.406(a)(1)(iii)(B)).

As such, we proposed at paragraph (e)(3) of § 435.911 that States must obtain additional information needed to make a determination of eligibility for MSPs. We also recommended that when States request additional information from individuals, they include information on how to contact the local State Health Insurance Assistance Program (SHIP) for assistance.

Consistent with existing regulations at §§ 435.907(e) and 435.952(c), we proposed at paragraph (e)(4) of § 435.911 that States may not request that individuals attest or otherwise provide documentation to establish information that SSA has already used for the LIS eligibility determination.

Therefore, in instances in which the leads data would not support a determination of eligibility for MSPs, we proposed at § 435.911(e)(7) to require that States use the information provided by the applicant to SSA through the LIS application process and separately verify the individual's eligibility for Medicaid in accordance with the State's verification policies. Specifically, under proposed § 435.911(e)(7), the State would be required to: (1) determine whether additional information is needed to make a determination of eligibility for an MSP; (2) if additional information is

needed, notify the individual that they may be eligible for assistance with their Medicare premium and/or cost-sharing charges, but that additional information is needed for the agency to make a determination of such eligibility; (3) provide the individual with a minimum of 30 days to furnish any information needed by the agency to determine MSP eligibility; and (4) verify the individual's eligibility for an MSP in accordance with the State's verification plan developed in accordance with § 435.945(j). We noted that, in the case of an applicant who has attested to income or assets over the applicable income or resource standard, States could, but would not be required to, request additional information from the individual to confirm ineligibility for coverage.

Under our proposal, States would continue to be permitted to request from the individual information that is necessary to make an MSP eligibility determination if such information is missing from the leads data and cannot be obtained from other third-party sources consistent with current regulations, and as clarified in our proposed revisions to § 435.952(c). Similarly, States may not reach out to individuals to request information already provided through leads data unless the State has current and reliable information that is not reasonably compatible²⁰ with the leads data. We anticipate such circumstances with respect to financial eligibility would be rare since SSA has already used the leads data for the LIS determination just prior to State use, employing many of the same sources for financial eligibility data relied upon by States.

Finally, individuals eligible for the LIS program may be eligible for full Medicaid benefits, in addition to the assistance with Medicare premiums and cost-sharing available under the MSPs. Under the current regulations at § 435.911, for individuals who submit the single streamlined application for Medicaid on the basis of MAGI, but who may be eligible on a basis other than MAGI, States are required to collect any additional information that is needed to make a determination on a non-MAGI basis, and to make such determination if the individual provides the needed information. Consistent with sections 1902(a)(4) and (a)(19) of the Act, we proposed a similar requirement with

²⁰ Under § 435.952(c)(1), income information obtained through an electronic data match shall be considered "reasonably compatible" with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income thresholds.

respect to individuals whose applications were initiated by receipt of LIS leads data. Specifically, we proposed new regulatory text at § 435.911(e)(6) to require States to obtain such additional information as may be needed to determine whether individuals whose MSP applications were initiated based on receipt of LIS leads data are eligible for Medicaid in any other eligibility groups (that is, other than the MSPs), including other non-MAGI groups and MAGI-based groups as well. This proposal aimed to codify a pathway for efficient enrollment of LIS enrollees into both the appropriate MSP eligibility group, as well as into a full-benefit group if eligible without imposing undue administrative burdens on States. We anticipated this would also promote program integrity by ensuring enrollment in the appropriate eligibility group. We noted that individuals can be eligible for both an MSP and an eligibility group that confers full Medicaid benefits. Therefore, the requirement under proposed § 435.911(e)(6) was in addition to the requirement to determine the individual's eligibility for an MSP.

We received many comments on our proposals to streamline MSP determinations using LIS leads data, and our responses follow.

Comment: Many commenters applauded CMS efforts to streamline MSP determinations using LIS leads data with this new rule. They noted that large numbers of eligible older adults and individuals with disabilities are missing out on the vital financial and health benefits the MSPs provide and cited burdensome paperwork requirements as a key driver of persistent under-enrollment in these programs for individuals who are eligible for them. They pointed out that, since 2010, Federal statute (MIPPA) has required States to leverage leads data to facilitate MSP enrollment for individuals enrolled in the LIS program, and asserted that CMS's proposal to codify and build upon these requirements is needed to ensure States fully leverage leads data for MSP determinations and to promote greater uniformity among States in application processes and MSP participation rates for individuals enrolled in LIS. MACPAC generally supported these provisions, noting that they would promote MSP enrollment by simplifying eligibility and enrollment processes and would improve health equity by increasing access to care for additional low-income individuals with Medicare.

Response: We thank the commenters for their support. As we stated above,

the MSPs are essential to the health and economic well-being of those enrolled, promoting access to care and helping free up individuals' limited income for food, housing, and other life necessities. We remain committed to increasing participation in these vital programs and foresee that simplifying enrollment processes would help hundreds of thousands of eligible individuals access these critical benefits.

Comment: Some commenters expressed concerns that proposals at new § 435.911(e) to facilitate MSP enrollment through leads data would be burdensome and costly for States. For example, while MACPAC generally supported these provisions, it noted that they would likely increase costs to States and add to their administrative burden. Other commenters relayed concerns with the quality and adequacy of the leads data which they asserted would require additional manual work and system upgrades for States. For that reason, the commenters requested that CMS work with SSA to improve leads data before adopting this proposal. For example, some commenters maintained that because leads data lacks all information necessary for MSP determinations, States must follow up to obtain missing information. In addition, a commenter incorrectly contended that leads income and resource data is unusable because the commenter believed that information appears as a lump sum total, without a breakdown of sources and amounts. A few commenters noted that leads data omits citizenship and immigration status information and requested that CMS and SSA explore adding it in the future.

Response: We appreciate the commenters' perspectives and acknowledge that complying with our proposals to streamline MSP enrollment for LIS recipients could require some States to update their policy, operations, and/or systems—although we project reductions in administrative costs over the long term. We also recognize that increases in MSP enrollment as a result of our proposal could raise costs for States. However, Federal statute (MIPPA) has required States to use leads data to initiate an MSP application since January 1, 2010. Further, as we detailed in the proposed rule at 87 FR 54765, misalignments between the LIS and MSP programs may mean that leads data omits certain data needed to determine MSP eligibility. However, under § 435.911(c)(2), States are already required to obtain additional information for applicants, including LIS applicants whose data has been transferred to the State through the leads data, when current information is

insufficient to make a Medicaid eligibility determination.

With respect to the commenter's contention that LIS leads data only contains undifferentiated total amounts of the individual's income and resources, this is incorrect. We clarify that an individual's leads data record includes a breakdown of income and resources, by source and amounts.²¹ In response to commenters' questions about expanding leads data to include citizenship information, we plan to explore with SSA the feasibility of adding this information in the future, as we foresee it could streamline processes for citizenship-related eligibility under § 435.406 and reduce burden on States and individuals. With respect to the request to add immigration status information to the leads data, we plan to analyze further the feasibility and benefits of such an expansion to streamline eligibility determinations before exploring this step with SSA. In addition, as we reiterate in response to other comments below, if the State already has previously verified this information and it is included in the case record for the individual, the State must not request this information from the individual again in accordance with § 435.956(a)(4)(ii).

Overall, States' comments revealed States' lack of familiarity with the leads data. We also acknowledge that States are engaged in unwinding from the Medicaid continuous enrollment condition, and our proposal adds some new requirements for States, despite the longstanding MIPPA requirements. Therefore, we will provide States more time to comply with these provisions after this final rule's effective date, as explained below. Prior to the compliance date, we plan to focus on providing technical assistance and guidance to States to assist them in achieving full compliance with these provisions.

Comment: While supportive of this codification, a number of commenters urged CMS to pursue concerted monitoring and oversight of States' compliance with their obligations under MIPPA. These commenters reported widespread partial or full non-compliance with leads data requirements by States, including examples of States that lack the system capacity to leverage leads data and States that automatically send individuals identified through LIS leads data an MSP application or instructions on how to complete the process.

²¹ See LIS record. <https://www.ssa.gov/dataexchange/documents/LIS%20record.pdf>.

Response: We appreciate the commenters' support for codifying in regulation the MIPPA requirements for how States must use LIS leads data for determining MSP eligibility and agree with their likely benefits, including clarity and accountability for States. We also agree with the commenters on the importance of effective oversight and monitoring. We intend to implement a robust oversight and monitoring approach, and we are currently exploring options on how best to ensure the LIS leads data provisions are effectively implemented.

Comment: A commenter maintained that codifying MIPPA is unnecessary, stating that States currently use LIS leads data as required. Some commenters also noted that these proposals were already required by MIPPA.

Response: We appreciate the commenters' input but disagree that codifying the MIPPA requirements is unnecessary. As described in the proposed rule (87 FR 54764) and reiterated by commenters and noted previously in this final rule, many States have only partially implemented these requirements, and some have yet to meaningfully do so at all. We believe that codifying the requirements for States will clarify State responsibilities under MIPPA and lead to more States using leads data as required. However, while we are codifying provisions already required by law, we disagree that *all* of our proposals are already required by MIPPA. For example, in our 2010 guidance on implementing MIPPA, State Medicaid Director Letter, #10-003, "Medicare Improvements for Patients and Providers Act of 2008" (the 2010 MIPPA SMDL),²² we advised that States are *permitted* to treat leads as verified for the purposes of MSP determinations. Under our proposal, we would newly require States to accept leads data without further verification unless the State has other information that is not reasonably compatible with the leads data.

Comment: Several commenters supported proposals in § 435.911(e)(4) on accepting leads data as verified if it supports an MSP eligibility determination and § 435.911(e)(5) on refraining from requesting data already in leads data. Commenters noted that these proposals reduce duplication, reduce barriers to enrollment, and streamline the MSP determination process. A commenter stated that requiring States to treat leads data as verified would boost the share of

individuals enrolled in LIS who would also get enrolled into MSPs.

Response: We thank the commenters for their support about accepting leads data as verified and agree that these provisions reduce duplication and barriers to enrollment.

Comment: A few commenters noted their opposition to our proposal to require States to accept leads data as verified without requesting further information from the individual or separate verification by the State. A commenter expressed program integrity concerns, asserting that LIS data is less reliable than other State sources of information. Another commenter explained that its State verification procedures require individuals to produce documentation when State information sources differ from the information the applicant has supplied. The commenter noted that these requirements are stricter than SSA's LIS program procedures which allow SSA to accept an individual's verbal explanation of a discrepancy between income and resources if it is reasonable. A commenter said that CMS's proposal is inconsistent, forcing States to accept leads data as verified if it supports an MSP eligibility determination, but not allowing States to accept leads data as verified if it does not support an MSP eligibility determination.

Response: As noted in the proposed rule at 87 FR 54765, we maintain that accepting leads data as verified and not allowing States to request that the applicant provide information already sent to the State by SSA limits duplication and streamlines the MSP determination process. Additionally, we disagree with the commenters' assertion that the LIS information is inherently less reliable than other State sources of information. As we noted in the proposed rule at 87 FR 54766, States and SSA are pulling electronic data from many of the same sources of information. Additionally, as explained previously in this final rule, if States have other information not reasonably compatible with leads data, they must request additional information from the individual before enrollment.

With respect to the commenter's concerns about the differing requirements when leads data would lead to a denial, we stated in the proposed rule (87 FR 54765) that applying a different verification policy to the use of LIS leads data that supports an MSP eligibility determination versus the use of leads data that would result in an MSP denial is in keeping with provisions of the Computer Matching and Privacy Protection Act (CMPPA, Pub. L. 100-503) at 5 U.S.C. 522a(p)(1).

The CMPPA requires States to take actions to independently verify information that SSA provides before the State may terminate, suspend, reduce, deny, or take other adverse action against an individual.

Comment: A few commenters provided input about the processing of MSP applications under proposed § 435.911(e). A commenter asserted the proposal requires States to process MSP applications 45 days from the date SSA receives the LIS application and requested a longer period to align its LIS and MSP processes to comply. A few commenters questioned what State action is appropriate (for example, a denial of eligibility) if an individual does not return information requested by the State that is absent from the leads data and needed to determine eligibility for the MSPs.

Response: As we discussed in the 2010 MIPPA SMDL, States must treat the date the LIS application is filed with SSA as the date of application for purposes of establishing the effective date of eligibility for MSP benefits. However, States have flexibility regarding the calculation of the 45-day processing timeline under § 435.912(c)(3). States may either use the date that the State receives the LIS leads data from SSA or the date of the LIS application as the start of the calculation of the 45-day processing timeline under § 435.912(c)(3). This policy allows additional time to make this MSP determination based on the LIS leads data, while ensuring MSP coverage is not delayed for eligible individuals. Additionally, we clarify that for MSP applications based on leads data, if an individual fails to comply with a request for information within the requisite time, a State would issue a notice of denial consistent with 42 CFR 431.210 and 435.917(b).

Comment: Some commenters submitted suggestions regarding the proposed new § 435.911(e)(3) that requires States to request additional information that is necessary for the MSP determination. Commenters suggested that CMS require States to collect additional relevant information through a pre-populated form that contains LIS leads data. These commenters maintained that individuals may be more likely to understand and timely respond to a prepopulated form. Further, a commenter stated that while States would generally need to obtain citizenship/immigration status, which is not in leads data, it is likely that many LIS applicants have been enrolled in Medicaid in the past. The commenter recommended that CMS re-emphasize

²² <https://www.medicaid.gov/federal-policy-guidance/downloads/smd10003.pdf>.

that § 435.956(a)(4) requires States to maintain a record of having verified citizenship or immigration status and not re-verify or require MSP applicants to re-verify their status.

Response: We agree that collecting missing information through a pre-populated form may help individuals respond timelier to States' request for additional information. As such, we encourage States to use pre-populated forms as a best practice. At this time, though, we decline to make this a requirement for States because we are interested in providing States some flexibility in carrying out this particular requirement. However, we will consider this recommendation in the future based on program experience. In addition, we agree that § 435.956(a)(4) requires States to maintain a record of previously verified citizenship or immigration status, in accordance with the State's records retention policy in accordance with § 431.17(c). Further, States may not re-verify or require MSP applicants to re-verify citizenship at renewal or subsequent application when such verification is documented in the individual's case record unless the individual has reported a change in citizenship, the agency has received information indicating a potential change, and the individual is not exempt from the requirement to provide documentation of citizenship under § 435.406(a)(1)(iii). We note that consistent with current policy, States may refrain from verifying immigration status for individuals whose particular status is not subject to change if verification of such status is documented in the individual's case record, the individual has not reported a change, and the agency has not received information indicating a potential change.²³

Comment: A few commenters shared feedback on CMS's recommendation that States include information on how to contact the local SHIP when asking individuals for more information to make an MSP determination. Some commenters supported this recommendation, including a commenter that recommended that CMS make it mandatory. These commenters pointed out that SHIPs may be uniquely equipped to provide individuals one-on-one help to explain State communications and how to satisfy the State request for additional information.

Conversely, a commenter shared concerns that SHIPs may lack access to Medicaid systems or have adequate resources to assist individuals. Another commenter opposed this recommendation, asserting that SHIPs are an inappropriate resource because they lack authorization to verify applicant information.

Response: We thank the commenters for their input regarding our recommendation for States to provide contact information for SHIPs when sending information requests for MSP determinations. Our program experience and input from interested parties have indicated that individuals may struggle to understand State communications and complete documentation requests without personalized assistance from eligibility workers or counselors, such as SHIPs.²⁴ As such, we agree with the commenters that SHIPs may be a valuable resource to help individuals comprehend and complete requests for information. We acknowledge that SHIPs may lack the authority to verify data or check Medicaid systems but clarify that States would remain responsible for completing the verification processes. Further, we recognize that State-specific variables, for example, the capacity and willingness of the region's SHIPs to provide this assistance, may affect whether a State Medicaid agency pursues our recommendation to include SHIPs as a resource in their requests for information from MSP applicants. Given all these considerations, we continue to recommend—rather than require—that States include contact information for SHIPs in their requests for additional information.

Comment: Many commenters supported the proposal for States to screen MSP applications from leads data for full Medicaid benefits, indicating it would accelerate and streamline review of Medicaid eligibility for States and lower-income older adults and persons with disabilities who may not be able to separately navigate the Medicaid process. Some commenters further noted that States must screen individuals who apply for MAGI categories upon all bases and that failing to apply a similar “no wrong door” approach to MSP applications based on LIS data would disadvantage individuals who apply through the LIS application as compared to individuals

who apply for MAGI-based Medicaid. These commenters also stated that adopting different screening standards across the MAGI and non-MAGI groups risks potential confusion and duplicative administrative work for State Medicaid agencies.

Many of these same commenters, while supporting this proposal on balance, also expressed concerns that State implementation of the requirement to screen on all bases could undermine the streamlined application and enrollment processes for the MSPs that MIPPA and CMS' proposed changes aim to achieve. Some commenters indicated that requiring a full Medicaid screen could slow down the MSP determination process if CMS does not require States to extend the streamlined income and resource verification rules for the MSPs to non-MAGI groups. They explained that States with different verification rules for other non-MAGI categories must routinely request additional documentation from MSP applicants and might wait to process the MSP application until the applicant provides additional documentation needed for the full Medicaid determination. For these reasons, some commenters requested that CMS clarify that the full Medicaid screen is separate from the MSP enrollment process and that States must not delay the MSP determination and approval for benefits to obtain information necessary for the full Medicaid determination. Similarly, some commenters shared concerns that State communications that combine requests for information missing from leads data and requests for information and disclosures about estate recovery needed for the full Medicaid determination could overwhelm and confuse applicants or give a false impression that estate recovery applies to the MSPs, thus deterring them from completing the MSP application. A commenter suggested that CMS work with States to test different approaches with consumers and develop best practices and options to seek additional information for full Medicaid, making State practices subject to our review. Another commenter suggested that CMS prohibit States from using the same notice to communicate a denial of full Medicaid coverage and a request for information for the MSPs, contending that individuals who receive combined notices are less likely to read and fulfill requests for additional information for the MSPs. A commenter recommended that SSA provide more information related to full Medicaid on the LIS application, including the required rights and responsibilities for the

²³ See final rule titled “Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP” published in the November 30, 2016 *Federal Register* (81 FR 86382, 86428).

²⁴ See for example, CMS Office of Burden Reduction & Health Informatics, “Navigating the Medicare Savings Program (MSP) Eligibility Experience,” April 2022. <https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf>.

Medicaid program. A few commenters suggested that our proposal would require States to accept leads data as verified for all non-MAGI eligibility groups and requested that CMS explicitly acknowledge this requirement.

Some commenters expressed opposition to the proposal at § 435.911(e)(6) to require States to screen individuals who apply for MSPs through LIS leads data for Medicaid on all bases. They cited some of the same issues identified by those who expressed support, including that because the LIS application does not request the relevant data for full Medicaid determinations or provide rights and responsibilities and required disclosures (for example, an explanation that estate recovery applies to full Medicaid benefits), States would need to follow up with individuals, slowing down and complicating what is intended to be a streamlined process for MSP enrollment. A commenter noted that individuals may not realize that estate recovery applies to full Medicaid benefits since the LIS application does not mention full Medicaid benefits or its implications. A few commenters suggested that screening MSP applications based on leads data for full Medicaid eligibility would in effect require the completion of a full Medicaid application. Another commenter requested that CMS more clearly delineate State requirements to screen MSP applications based on leads data upon all bases. Another commenter requested that CMS clarify the proposed § 435.911(e), contending that the regulation text is disjointed and disorganized, making it unclear what is required for the MSPs versus full Medicaid groups. Similarly, the same commenter stated that CMS is inconsistent in how we refer to the Medicare Savings Programs, sometimes referring to them as the Medicare Savings Programs and other times by referencing section 1905(a)(10)(E) of the Act, for example.

Finally, some commenters, including those opposing and supporting the proposal, shared concerns that screening individuals who apply for the MSPs based on leads data on all bases would require significant policy changes, eligibility systems changes, and/or manual effort for which they would need additional implementation time.

Response: We thank the commenters for feedback about our proposal to require individuals who apply for MSPs through LIS leads data be screened for Medicaid on all bases. In the proposed rule (87 FR 54766), we indicated that

our proposal was consistent with section 1902(a)(4) and (a)(19) of the Act, as it would facilitate the efficient enrollment of LIS enrollees into both the appropriate MSP eligibility group and into a full-benefit group if eligible without imposing undue administrative burden on States. We also noted that the requirement to screen MSP applicants based on leads data was similar to the existing requirement for States to screen individuals who apply for MAGI-based Medicaid on all bases. We still share the view that requiring States to assess such applicants for full Medicaid would facilitate their access to full-scope Medicaid coverage. However, we appreciate commenters' concerns that certain ways of implementing our proposed requirement could potentially undermine the streamlined processes designed to facilitate MSP enrollment using leads data under MIPPA and this final rule.

As commenters cited, the LIS application does not inform individuals that States will screen them on all bases or provide the rights and responsibilities, such as disclosures about estate recovery, that we require for Medicaid applications. Rather, the current LIS application obtains the individual's consent to share their LIS information with the State "to start the application process for the Medicare Savings Programs."²⁵ While it may be possible to add information about full Medicaid eligibility determinations to the LIS application, as a commenter suggested, we are concerned this could make it less likely that individuals complete the LIS application and agree to share their data with the State for an MSP determination.

Under proposed § 435.911(e)(6), States would be required to both promptly complete a determination of eligibility for the MSPs and collect additional information needed to determine whether the individual is eligible for full Medicaid benefits. However, we recognize, after reviewing the comments, that the proposed rule was not clear about all of the steps States would need to make to determine eligibility for full Medicaid benefits, or all of the information they would need to make a determination for, and enroll an individual in, full Medicaid benefits. Specifically, in addition to obtaining additional information regarding eligibility criteria needed by the State for a full Medicaid determination, States would need to obtain the individual's consent to enroll in full Medicaid

benefits, which would also necessitate the State informing an individual who applied for the MSPs through the LIS application about the additional benefits that may be available, the rights and responsibilities associated with enrolling for full benefits, and the potential for estate recovery, which under section 1917(b)(1)(B) of the Act States must employ for Medicaid coverage of long-term care services and supports and related services and can employ for coverage of other Medicaid items and services, not including premium and cost-sharing assistance under the MSPs.

States may also need to reach out to individuals who are applying for the MSPs through the LIS application to obtain additional information that is needed for the MSP determination. We share commenters' concerns that a single communication that requests all of the information needed for the MSP determination and all of the information needed to determine full-benefit eligibility could overwhelm and confuse applicants and reduce their willingness and capacity to complete the steps required for States to make the MSP determination. Further, we agree with commenters that the full-benefit determination should not delay the MSP determination.

After considering all of these factors raised by the commenters, we are revising the proposed regulation at § 435.911(e)(6)(i) and (ii), redesignated at § 435.911(e)(9)(i) and (ii), to specify that the State must provide individuals effectively applying for the MSPs through an LIS application—in addition to and separate from any requests for additional information necessary for the determination of MSP eligibility—(1) information about the availability of Medicaid benefits on other bases, including the scope of such benefits and responsibilities of the individual applying for such benefits; and (2) an opportunity to furnish such additional information as may be needed to determine whether the individual is eligible for such additional Medicaid benefits. Under this final rule, a State may request CMS approval of another approach to ensuring that applicants have the opportunity to receive determinations on whether they are eligible for Medicaid benefits other than through an MSP.

This change to our proposal in response to comments would avoid delays in MSP enrollment and avoid drawbacks associated with modifying the LIS application itself, while still facilitating enrollment in full Medicaid coverage if an individual is eligible. To provide States sufficient time to make a

²⁵ See cover letter, question number 15, and signatures pages in the LIS application. <https://www.ssa.gov/forms/ssa-1020-ocr-sm-inst.pdf>.

full Medicaid determination for individuals applying for the MSPs through the LIS application, for purposes of timeliness standards under § 435.912, the process of obtaining the additional information needed for the full Medicaid determination would begin a new clock for determining timeliness, since the initial transfer of leads data only includes the applicant's authorization to initiate the application process for the MSPs and not full Medicaid.

We encourage (but do not require) States to treat leads data as verified for the full-benefit Medicaid eligibility determination. However, in all cases, the State would still need to describe rights and responsibilities and applicable estate recovery rules, obtain a signature for enrollment, and seek additional information necessary for full Medicaid determinations. Further, in light of the commenter's suggestion to clarify the regulation text, we are revising the regulation text to clarify requirements for States and to use consistent terminology for the MSPs.

Comment: Some commenters suggested that CMS provide technical assistance and education to facilitate enrollment through Medicare Part D LIS leads data. A commenter encouraged CMS to provide technical assistance on issues related to leads data and engage with SSA to ensure data feeds to States are working properly. In particular, a commenter noted that its State began using LIS leads data in March 2021 and requested that SSA and CMS support the State in reconstructing LIS leads data before March 2021 to identify individuals contained in the leads data and to assess them for past eligibility for the MSPs. Another commenter requested that CMS do more to promote alignment between LIS and MSP programs such as by creating State plan amendment (SPA) templates and providing more technical assistance to States to illustrate how to align these methodologies. A commenter also urged CMS to provide States technical assistance on getting attestations over the phone and to encourage States to use telephonic attestations, instead of paper forms, to minimize situations where individuals are denied eligibility for failing to return paperwork. Another commenter urged CMS to provide technical assistance to Medicaid directors and their staff by holding a call or series of calls to address concerns about fraud in self-attestations. A commenter also recommended that CMS allow individuals to submit information through multiple modalities during the application process to support equity and inclusion. Another commenter

recommended that CMS require States to use clear and simple language in the State's notice of the eligibility determination. Finally, a commenter noted that individuals may have had negative experiences with applying for benefits in the past and urged CMS to educate current and potential enrollees about the new, streamlined processes using outreach that is easily understood and accessible.

Response: To the extent that States need support in complying with new requirements under § 435.911(e), or are currently experiencing difficulties understanding, using, or manipulating the leads data, we are available to assist. In response to commenters' concerns, we can also facilitate State discussions with SSA should States require technical assistance to access the leads data files transferred from SSA. (State Medicaid officials can reach us through their dedicated CMS points of contact.) In addition, while SSA does not generally store LIS leads data for past years, we are available to answer questions from States and to assist them when feasible with their data needs. We also are happy to provide technical assistance and best practices to States on using telephonic attestations instead of paper forms and to address concerns about fraud regarding self-attestation. We note that SSA uses telephonic attestations, so Medicare enrollees may be familiar with this procedure already. We appreciate the recommendations on promoting alignment between LIS and MSP programs and will consider these recommendations, including SPA checklists, for future guidance to States. We also appreciate the recommendation about format flexibility during the application process and note that States must already allow individuals to submit information through multiple modalities under § 435.907(a), as explained in the proposed rule (87 FR 54780). Further, in accordance with § 435.917, State eligibility determination notices must be written in plain language and be accessible to individuals with limited English proficiency and disabilities, among other requirements. Finally, we agree with the importance of clear, accessible education and outreach regarding new streamlined MSP provisions and will explore ways to support States with their MSP education and outreach efforts.

Comment: A number of commenters provided feedback regarding the implementation timeline for the proposed provisions to streamline MSP determinations using leads data in new § 435.911(e). Several of these commenters supported a 30-day

implementation timeline, noting that the proposed provisions implement a statutory requirement to use leads data to initiate an MSP application that was enacted over 13 years ago. In contrast, some commenters, both supporting and opposing the leads data proposals, urged CMS to provide significant additional time to implement the proposed requirements in new § 435.911(e) regarding leads data, since most of them constitute new substantive requirements established through this rulemaking under the authority in the leads data provisions under section 113 of MIPPA.

Response: The general requirement to use leads data to trigger an MSP application has been in Federal statute for over 13 years, and its requirements have been interpreted in guidance issued by CMS in 2010,²⁶ 2020,²⁷ and 2021.²⁸ As such, the requirements for States to receive from SSA the LIS leads data and treat it as an MSP application as interpreted in existing guidance continue to apply as they have been applied under that guidance. However, new § 435.911(e) contains numerous new substantive regulatory requirements, and based on commenters' feedback on this proposed rule we foresee that some States will require time to come into compliance with these provisions. Therefore, in response to these comments, we are in this final rule establishing a compliance date for the requirements in new § 435.911(e) of April 1, 2026. Prior to the compliance date, we plan to provide technical assistance and guidance to States as they come into compliance with the new rules.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal at § 435.911(e) with the following modifications:

- We are replacing references to section 1902(a)(10)(E) of the Act with the term the "Medicare Savings Programs" throughout paragraph (e);
- We are adding language to paragraph (e) to clarify that the obligations in this paragraph apply to MSP eligibility determinations for

²⁶ The 2010 MIPPA SMDL. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd10003.pdf>.

²⁷ The Manual for the State Payment of Medicare Premiums, chapter 1, section 1.6.2. <https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf>.

²⁸ Center for Medicaid and CHIP Services Informational Bulletin, "Opportunities to Increase Enrollment in Medicare Savings Programs," November 1, 2021. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11012021.pdf>.

individuals who have applied for LIS and have granted permission for SSA to share LIS leads data with the Medicaid agency for the purpose of submitting an application for the MSPs;

- We are reordering the paragraphs, revising requirements, and clarifying language as follows:

++ Paragraph (e)(1): We are retaining the requirement to accept LIS leads data in paragraph (e)(1) but are removing the term “Low Income Subsidy application data” and using an acronym in place of “Social Security Administration” since “LIS leads data” and “SSA” are now established in paragraph (e);

++ Paragraph (e)(2): We are keeping the requirement to treat LIS leads data as an application for the MSPs without requiring submission of another application in paragraph (e)(2), but are moving the requirement regarding timely application processing to paragraph (e)(7).

++ Paragraph (e)(3): We are moving the requirement to accept data from SSA, which we are now specifying as LIS leads data for greater consistency in terminology throughout the regulation, without further verification, from proposed paragraph (e)(5) to paragraph (e)(3) and adding that this provision applies unless the State agency has information that is not reasonably compatible with the LIS leads data or the LIS leads data would not support a determination of MSP eligibility;

++ Paragraph (e)(4): We are retaining the requirement to not collect information or documentation from the individual in paragraph (e)(4) and are adding that this is unless the State agency has information that is not reasonably compatible with the LIS leads data;

++ Paragraph (e)(5): We are moving the requirement to request additional information from proposed paragraph (e)(3) to paragraph (e)(5), replacing the term “request” with the term “seek,” and defining additional information needed for the MSP determination as information that is not in the LIS leads data;

++ Paragraph (e)(6): We are moving the requirement to verify an individual’s citizenship and immigration status from proposed paragraph (e)(6)(iii) to paragraph (e)(6), adding a citation to § 435.406, and streamlining the regulation text;

++ Paragraph (e)(7): We are moving the requirement regarding timely application processing from paragraph (e)(2) to paragraph (e)(7);

++ Paragraph (e)(8): We are moving additional requirements if the LIS leads data does not support a determination of

MSP eligibility from proposed paragraph (e)(7) to paragraph (e)(8).

++ Paragraph (e)(9): We are moving and modifying the proposal related to screening for full Medicaid from paragraphs (e)(6)(i) and (ii) to paragraphs (e)(9)(i) and (ii) to require States to provide individuals with—in addition to and separate from any requests for additional information necessary for a determination of Medicare Savings Program eligibility, unless CMS approves otherwise—information about the availability of additional Medicaid benefits on other bases, including the scope of such benefits and responsibilities of the individual applying for such benefits, and an opportunity to furnish such additional information as may be needed to determine whether the individual is eligible for such additional Medicaid benefits.

- Finally, we are applying a compliance date of April 1, 2026 for States to come into full compliance with all the provisions in new § 435.911(e) to facilitate MSP enrollment through LIS leads data.

Streamlining Methodologies. Prior to January 1, 2024, the Federal resource limits for full LIS and the MSPs are the same (\$9,090 for an individual and \$13,636 for a couple in 2023), and the income limits for full LIS and the highest income band MSP (the QI group) are both 135 percent of the FPL. Beginning January 1, 2024, section 11404 of the Inflation Reduction Act (IRA) expands eligibility for the full LIS benefit by revising the statutory income limit to 150 percent of the FPL and increasing the resource limits for full LIS to the resource limits for partial LIS (\$15,160 for an individual and \$30,240 for a couple in 2023). The IRA did not make conforming changes to the income or resource standards for the MSPs.

While the income and resources methodologies for the MSPs and LIS are very closely aligned, certain differences prevent LIS enrollees from being seamlessly enrolled into the MSPs unless the State has elected to align the MSP methodologies with LIS methodologies by adopting certain income and resource disregards under section 1902(r)(2) of the Act. As we discussed in detail in the proposed rule (87 FR 54765), States have the flexibility to achieve full alignment of the MSP and LIS financial methodologies. If States choose to completely align MSP and LIS financial methodologies, they would disregard the following types of income: in-kind support and maintenance, dividend income, and interest income; and the value of the following types of resources: non-liquid

resources, and life insurance. States would also disregard up to \$1,500 in burial funds for an applicant (and an additional \$1,500 for their spouse) that may be co-mingled with other accounts (that is, no longer require such funds are set aside in a separate burial account).

As noted previously in this final rule, States that adopt less restrictive MSP eligibility methodologies to completely align them with the LIS methodologies would be able to use leads data to make a determination of MSP financial eligibility without requesting additional financial information from the individual.²⁹

However, States that have not fully aligned methodologies must determine financial eligibility by requesting additional information not provided through the leads data. In addition, as noted in the proposed rule at 87 FR 54766, if not already contained in the record from a prior application, all States—whether or not they have aligned their MSP financial methodologies with MSP—must request information relating to U.S. citizenship and immigration status to verify such status in accordance with the State’s usual processes in accordance with § 435.406(a) and section 1137(d) of the Act.

In accordance with the authority at section 1902(a)(4) of the Act to promote the administrative efficiency of the program and section 1902(a)(19) of the Act relating to simplicity of administration and the best interests of beneficiaries, we proposed to add a new paragraph (e) to § 435.952 to require that States adopt a number of enrollment simplification policies related to the income and resources that are counted in determining MSP, but not LIS, eligibility that would enable State agencies to use the leads data more efficiently, reduce burden on applicants and States, and increase the number of LIS enrollees successfully enrolled in the MSPs. We also anticipate these policies will have a positive health equity impact by increasing access to Medicare coverage for low-income individuals and increasing the financial security of those who successfully enroll, consistent with the January 20, 2021 Executive Order.³⁰

Finally, we anticipate that these enrollment simplifications will help reduce the high rate of churn (cycling in and out of Medicaid coverage) that

²⁹ Except, as noted previously in this final rule, information on citizenship and immigration status.

³⁰ <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

dually eligible individuals experience largely due to administrative reasons such as providing documentation of certain income and assets to demonstrate their continued eligibility. Analyses by the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services found that almost 30 percent of individuals lost Medicaid eligibility for at least one month during the first year of transitioning to full-benefit dual eligibility and more than 20 percent lost Medicaid eligibility for at least 3 months following the transition despite dually eligible individuals' relatively stable income and assets over time.³¹ ³² Experts interviewed noted that dually eligible individuals most often lost coverage because of failing to comply with administrative requirements as opposed to changes in income, assets, or functional status. We discuss our proposed simplifications for each source of income and resource below.

We received comments on our proposals to align the MSP and LIS programs in general, and our responses follow.

Comment: Many commenters supported CMS's proposed alignments of MSP and LIS programs in general, citing that the proposed changes would allow States to use LIS leads data more efficiently, increase MSP enrollment for LIS enrollees, have a positive health equity impact, and reduce churn for all dually eligible individuals. Many commenters explained that procedural hurdles, particularly documentation requirements, are among the main reasons eligible individuals fail to complete the enrollment process or that benefits are delayed for individuals who manage to complete the process. A commenter explained that collecting paper records is particularly overwhelming for low-income individuals, who disproportionately have unstable housing, low literacy, limited access and proficiency in internet usage, limited proficiency in English, and live with disabilities and chronic conditions. The commenter stated that adopting measures to reduce these unnecessary impediments falls squarely within CMS's legal authority. MACPAC supported this proposal, noting consistency with its June 2020

recommendations to Congress to align MSP and LIS income and resource requirements. A few commenters shared that their States are moving toward complete alignment of LIS and MSPs and expressed support for CMS's proposal to determine individuals eligible for the MSPs based on LIS data without seeking additional information if the LIS and MSP programs are completely aligned.

Response: As discussed in the proposed rule (87 FR 54766 & 54767), we anticipate that streamlining income and resources verification processes and improving alignment between the LIS and MSP programs will allow States to employ LIS data more effectively, reduce churn for dually eligible individuals, and increase the percentage of LIS enrollees who are enrolled in the MSPs, resulting in significant economic and health benefits and promoting health equity for low-income Medicare beneficiaries. For that reason, as explained in the proposed rule (87 FR 54766 and 54767), adopting enrollment simplifications for income and resources that are relevant to MSP determinations, but not LIS, implements our authority at section 1902(a)(4) of the Act to promote the administrative efficiency of Medicaid and section 1902(a)(19) of the Act regarding simplicity of administration and the best interests of beneficiaries. We also appreciate that some States are moving toward full alignment, which we recommended in the proposed rule (87 FR 54765). We believe that full alignment of financial eligibility rules for LIS and the MSPs is the most efficient means for States to maximize leads data and improve participation in the MSPs for LIS enrollees.

Comment: A number of commenters noted that the proposals would create different verification processes for the MSPs than for other Medicaid groups. Some commenters opposed applying different verification processes for the MSPs on the grounds that it would be administratively challenging and cause confusion and delays. Both the commenters that generally opposed and the commenters that generally supported our proposals expressed concerns that creating a separate process for the MSPs could require significant system modifications. A commenter, while supporting the proposals at new § 435.952(e) to simplify income and resources verification procedures for MSP determinations, suggested that CMS consider adopting these requirements through sub-regulatory guidance to allow States flexibility to adopt less restrictive income and resource methodologies.

Response: We generally agree with the aim of providing uniform eligibility and enrollment processes, and we are committed to ensuring their operational feasibility. However, many States already apply different rules to the MSPs than other non-MAGI populations. For example, many States have adopted disregards that effectively raise or remove the resource test for the MSPs only. Therefore, we conclude that applying separate rules for the MSPs is not an insurmountable barrier to effective implementation.

Further, in addition to comments on the proposed rule, feedback from interested parties and program experience demonstrate that documentation requirements seriously hinder the ability of eligible individuals to enroll in the MSPs, with significant economic and health impacts for individuals.³³ Reducing the burden on applicants to produce certain types of documentation prior to enrollment is warranted to meaningfully address documented under-enrollment in these programs. Through this final rule, we are allowing additional time for States to update State procedures and systems, as discussed below. In addition, with respect to the commenter's concerns that our regulations at § 435.952(e) may impede State flexibility to relax MSP eligibility requirements, we clarify that they would not impede State's ability to adopt more liberal income and resource methodologies under 1902(r)(2) of the Act.

Comment: Several other commenters opposed CMS's alignment of MSP and LIS programs, asserting that requiring States to accept self-attestation would lead to fraud. A commenter cited difficulties with having their State legislature approve self-attestations due to program integrity concerns. Another commenter requested clarification regarding how reasonable compatibility standards would apply to resources obtained through electronic sources. In addition, a commenter, while supporting CMS proposals to require self-attestation of certain income and resources for the MSPs, requested that Federal audit protocols exempt States from penalties for errors related to self-attestation.

Response: As stated elsewhere, self-attestation is an acceptable means of verification, and we note that many States have incorporated self-attestation

³¹ Assistant Secretary for Planning and Evaluation (ASPE), "Loss of Medicare-Medicaid dual eligible status: Frequency, contributing factors and implications" May 2019. <https://aspe.hhs.gov/system/files/pdf/261716/DualLoss.pdf>.

³² CMS completed an updated internal analysis of ASPE's study in 2021 using data from 2015–2018 that shows that dually eligible individuals continue to lose Medicaid at a high rate in their first year due to administrative reasons.

³³ See for example, CMS Office of Burden Reduction & Health Informatics, "Navigating the Medicare Savings Program (MSP) Eligibility Experience," April 2022. <https://www.cms.gov/files/document/navigatingmedicare-savings-program-msp-eligibilityexperience-journey-map.pdf>.

into their Medicaid verification plans. We also reiterate that, prior to enrollment, States must seek additional information if the self-attested information is not reasonably compatible with State information and that States retain the option to verify self-attested information after the individual has been enrolled. We plan to address the commenter’s question about how reasonable compatibility standards would apply to resources obtained through electronic sources in future rulemaking concerning the remaining provisions in the proposed rule published in the September 7, 2022 Federal Register.

Regardless of whether a State legislature objects to self-attestation as a means of verification, States are still required to follow Federal regulations. Further, as noted at 87 FR 54765, States also have the ability to align the MSP and LIS income and resource methodologies, which would remove the need for States to separately verify income and/or resources that are missing from leads data. In response to the question about Federal audits, we reiterate that we conduct audits based

on Federal statutory and regulatory requirements. To the extent that we review compliance with § 435.952(e), we would identify an error if a State has failed to comply with this provision and would not identify an error if the State is complying with this requirement.

Comment: A few commenters sought clarifications or additional CMS action. For example, a commenter requested clarification on why MSP and LIS income and resources standards are only aligned until January 1, 2024. Another commenter requested that CMS require States to adopt verification plans for the MSPs and other non-MAGI groups. A different commenter requested that CMS provisions to promote MSP enrollment and retention extend to the Programs of All-Inclusive Care for the Elderly (PACE) for individuals dually entitled to Medicare and Medicaid.

Response: Prior to January 1, 2024, Federal resource limits for full LIS and the MSPs are aligned, and the income limits for the full LIS benefit and the highest band MSP (the QI group) are the same. Section 11404 of the IRA expanded eligibility for the full LIS benefit beginning January 1, 2024, but

did not make any conforming changes for the MSPs. Starting January 1, 2024, individuals who previously were eligible only for partial LIS benefits may be eligible for full LIS benefits under the changes enacted under the IRA. This is because the resource limit for full LIS will increase to the current partial LIS resource limit (\$15,160 for an individual and \$30,240 for a couple in 2023).

While more individuals will qualify for full LIS beginning in 2024, and many full LIS enrollees will continue to qualify for the MSPs, beginning in 2024 there will be more full LIS enrollees who do not qualify for the MSPs. This is because the MSP resource limit will remain unchanged. Also, while the income threshold for full LIS will increase to 150 percent of the FPL beginning in 2024, the Federal income threshold for the QI group will remain at 135 percent of FPL. While we acknowledge that the income and resource limits for full LIS and MSPs will no longer align after January 1, 2024, we still expect that the methodological changes that we are finalizing in this final rule will result in streamlined enrollment into MSPs.

TABLE 1—COMPARISON OF MSP AND LIS INCOME AND RESOURCE LIMITS *

	Income limit	Resource limit
QMB	≤100% FPL	3 × SSI limit adjusted for inflation per section 1905(p)(1) of the Act.
SLMB	>100% FPL, but <120% FPL	same as QMB.
QI	≥120% FPL, but <135% FPL	same as QMB.
Full LIS before 2024	<135% FPL	same as QMB.
Full LIS beginning 2024	<150% FPL	\$15,160—Individual. \$30,240—Couple plus inflation.**

* These are the standard Federal income limits and resources. All of these income limits include a standard \$20 disregard. States may use authority under section 1902(r)(2) of the Act to implement income and/or resource methodologies that are more generous than the Federal baseline for QMB, SLMB, and QI.

** The LIS resource methodology as of January 1, 2024 is no longer tied to the 3 × SSI resource limit, which is a lower rate, but is instead tied to a flat dollar amount of \$10,000 for an individual and \$20,000 for a couple from 2006 and indexed for inflation every year. The rate listed is the 2023 rate, which will need to be adjusted upward by inflation for 2024.

In addition, we clarify that, in accordance with § 435.945(j), States must already adopt verification plans for all Medicaid eligibility groups, including the MSPs and other non-MAGI groups. Finally, we note that our proposals would apply to current and potential PACE participants.

Interest and Dividend Income. Regulations governing LIS eligibility determinations at 20 CFR 418.3350(d) exclude all interest and dividend income earned on resources owned by the applicant or their spouse. However, under the SSI income methodologies applicable to MSP determinations, States must count interest and dividend income unless they have elected to

disregard such income under section 1902(r)(2) of the Act and § 435.601(d).

In the proposed rule (87 FR 54767), citing reports from interested parties and program experience, we noted that the vast majority of individuals likely to qualify for an MSP eligibility group do not have significant interest or dividend income, whereas the requirement to timely obtain and furnish acceptable statements from financial institutions, sometimes extending back over a lengthy period of time, to document interest and dividend income earned is unduly burdensome for applicants and provides negligible program integrity value. Therefore, consistent with section 1902(a)(19) of the Act, to minimize undue administrative burden on

applicants, we proposed at § 435.952(e)(1)(i) and (ii) to prohibit States from requesting documentation of dividend and interest income prior to making a determination of MSP eligibility, except when the agency has information that is not reasonably compatible with the applicant’s attestation. Under the proposed rule, States would be required to accept self-attestation of dividend and interest income for MSP applicants and their spouse, but would retain the option to verify such income after the individual has been enrolled (a process, currently available at State option with respect to most eligibility criteria, which we refer to as “post-enrollment verification”), including the option to require the

individual to provide documentation of interest or dividend income if electronic verification is not available.

We received comments on our proposal to streamline eligibility and verification processes for dividend and interest income, and our responses follow.

Comment: A few commenters indicated particular support for this provision, explaining dividend and interest information is often difficult for applicants to obtain and constitutes an unnecessary administrative burden for applicants. One commenter noted an example in which an applicant was required to provide dividend verification based on a report from the IRS of a total annual dividend of under \$5 on a single share of stock of a former employer worth less than \$50. The agency required documentation verifying both the value of the asset and the amount of the dividend. According to the commenter, the process of clarifying the source of the dividend at issue and then obtaining documentation of the share, its current value, and the dividend payment history for the last year took several months, even with the assistance of an advocate, significantly delaying completion of the application and receipt of benefits. Lastly, another commenter requested clarification about whether consideration of interest income applies only to screening MSP applications from LIS leads data or to eligibility determinations for all individuals who apply for MAGI-based groups.

Response: Self-attestation minimizes undue administrative burden on applicants who are unlikely to have investments large enough to generate significant interest or dividend income and resources and still satisfy the resource test for the LIS or MSP benefit. States retain the option to verify the information from the self-attestation after the individual has been enrolled, including requiring the individual to provide documentation of interest or dividend income if electronic verification is unavailable.

With respect to the commenter's requests for clarifications for how consideration of interest income applies to MAGI groups, we believe the commenter was referring instead to whether this provision requiring self-attestation of interest and dividend income applies to all individuals applying to MSP or only those who use the LIS process to apply. As such, we clarify that our proposal regarding required self-attestation for MSP eligibility determinations applies regardless of whether an individual applies for an MSP directly through the

Medicaid agency or indirectly through the LIS pathway. Additionally, we note that interest and dividend income is currently counted in both MAGI and non-MAGI eligibility determinations.

After considering the comments we received and for the reasons outlined in the proposed rule under § 435.952(e)(1)(i) and (ii) and our responses to comments, we are finalizing our proposal on self-attestation for interest and dividend income, except with a modified compliance date of April 1, 2026.

Post-eligibility Verification. We also sought comment on the utility of post-enrollment verification and whether it results in unnecessary procedural denials of eligible individuals. If a State chooses to conduct post-enrollment verification checks, under proposed § 435.952(e)(1)(iii) it must allow individuals at least 90 calendar days to respond to requests for documentation. We sought comment on the proposal to require that States provide individuals with at least 90 calendar days to respond to requests for additional information in this situation and whether States should be required to provide, at a minimum, a shorter period of time, such as at least 30 or 60 calendar days. If a State found that an individual has income exceeding the income standard during the post-enrollment verification process, the State would take appropriate action consistent with regulations at § 435.916(d), which we proposed to redesignate and revise at § 435.919 in the proposed rule, including determining eligibility on other potential bases and, if not eligible on any basis, providing advance notice and fair hearing rights prior to terminating MSP coverage. We note that, consistent with current policy, when a State has information that is not reasonably compatible with the applicant's attestation of the value of any interest or dividend income, proposed § 435.952(e)(1)(ii) would require the State to seek additional information in accordance with § 435.952(c)(2), prior to enrolling the individual in Medicaid.

We received the following comments on post-enrollment verification, including the timeline for responding to requests for additional information, and our responses follow.

Comment: Some commenters requested CMS minimize post-enrollment verification as much as possible because it would be too burdensome and confusing for individuals and may lead to terminations for eligible individuals. A few commenters requested that CMS provide model notices to States because

requests for information can cause confusion or be missed by individuals who have just been approved for benefits. A commenter also requested that States include information in these post-eligibility verification notices on disputing errors. A few commenters requested clarification on how post-enrollment verification would affect eligibility for long-term care services and if a denial would trigger benefit recovery. Other commenters indicated the process would be too burdensome for States and, therefore, opposed requiring States to adopt post-eligibility verification.

Response: We acknowledge that post-enrollment verification, like other requests for additional information/documentation, could pose a burden to individuals. However, to allow self-attestation of income and resources needed for MSP eligibility determinations but missing from leads data, we believe it is essential to provide States a mechanism to ensure program integrity. To help minimize burden and assist States in making beneficiary notices as comprehensive and clear as possible, we will explore providing model language for State communications regarding post-enrollment verification, including the instructions about disputing errors contained in the post-enrollment verification notice. With regard to the commenters' recommendation that post-eligibility verifications be optional, we note that we did not propose making this mandatory for States. In response to the commenter's question about how post-eligibility verification may affect beneficiary coverage for long-term care services, we clarify that our proposal only requires self-attestation for the MSPs and not other non-MAGI groups.

Comment: A number of commenters provided feedback on the proposed 90-day minimum deadline for individuals to return information requested by a State. Several commenters supported providing at least 90 calendar days for individuals to respond with the requested information, citing longstanding barriers to verification for individuals. However, a commenter observed that 90 days was too long based on their State's experience using a 90-day timeline to resolve income discrepancies. The commenter noted that individuals forgot to supply the requested information as a result of the prolonged timeline and recommended 30 days instead. Another commenter opposed a 90-day timeline for post-enrollment verification because it could lead to 3 months of improper payments. Another commenter, while supporting the option for post-eligibility

verification, sought clarification on whether States would need to recoup Medicaid provider payments for an individual for whom the State had accepted self-attestation prior to enrollment and then determines ineligible through post-eligibility verification.

Response: We thank the commenters for their input on the appropriate minimum timeframe for individuals to respond to requests for information following enrollment. We do not agree with commenters that the 90-day timeframe is excessive given the challenges low-income individuals encounter in obtaining and furnishing paperwork, as described throughout this final rule and by commenters. Our position is also informed by our program guidelines and experience related to resolving income data matching issues (DMIs) following determinations of eligibility for Advance Premium Tax Credits (APTC) for the Exchanges that use the Federal eligibility and enrollment platform. A 90-day period aligns with the minimum deadline for individuals to respond to Exchange requests for additional information under 45 CFR 155.315(f)(2)(ii). We note that in the April 2023 final rule titled “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024” (2024 Payment Notice) published in the **Federal Register** (88 FR 25740), we adopted an automatic 60-day extension for individuals applying for coverage through Exchanges who failed to respond in the 90-day period. We adopted that change in the 2024 Payment Notice after observing that income DMI data indicates that when consumers receive additional time, they are more likely to successfully provide documentation to verify their projected household income. Between 2018 and 2021, over one third of consumers who resolved their income DMIs on the Exchange did so in more than 90 days. We also note that the Exchanges that use the Federal eligibility and enrollment platform send reminders to consumers through multiple modalities to prompt them to timely furnish the required information.

In response to the commenters’ concerns about the potential for increasing improper payments, we note that self-attestation is an acceptable means of verification and that many States have incorporated it into their verification policies as a generally reliable alternative to requiring applicants to produce documentation. As such, the period during which an individual would be enrolled in an MSP

based on self-attestation that proved to be incorrect would not be an improper payment, nor would an individual be subject to administrative benefit recovery if they are later found to be ineligible. In addition, we clarify that States would not administratively recoup payments already made on behalf of individuals if post-eligibility verification processes establish that the individual is ineligible for the MSPs. If a State suspects that an individual committed fraud or abuse in order to obtain or maintain MSP eligibility, the State should follow the processes described at 42 CFR part 455, subpart A of the regulations.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal to require States that choose to conduct post-eligibility verification to provide individuals with at least 90 calendar days to respond to requests for additional information, with a modified compliance date of April 1, 2026.

Non-liquid resources. For LIS eligibility determinations, under 20 CFR 418.3405, SSA only counts liquid resources, which it defines as cash, financial accounts, and other financial instruments that can be converted to cash within 20 business days. Non-liquid resources, such as an automobile, are not counted for LIS eligibility.³⁴ However, MSP determinations generally use a broader definition of countable resources that includes non-liquid resources; for example, while one automobile is excluded for resource-eligibility purposes, a second automobile is countable. As we noted in the proposed rule at 87 FR 54768, this can be onerous for MSP applicants because it can be difficult to timely determine, and furnish acceptable documentation of, the value of something that cannot easily be sold.

Similar to interest and dividend income, consistent with section 1902(a)(19) of the Act and to minimize administrative burdens on individuals, we proposed at § 435.952(e)(2)(i) to require that States accept applicants’ attestation of the value of any non-liquid resources, except, as described at proposed § 435.952(e)(2)(ii), when the State has information that is not reasonably compatible with the individual’s attestation. As with dividend and interest income, proposed § 435.952(e)(2)(ii) clarifies that States must request documentation prior to

³⁴ The exception to this rule is that the equity value of any real property than an individual owns other than the individual’s primary place of residence is counted as a resource.

making an initial determination of eligibility if they have information that is not reasonably compatible with the applicant’s attestation in accordance with § 435.952(c)(2). However, as with dividend and interest income, States would retain the option to conduct post-enrollment verification, including the option to require the individual to provide documentation of non-liquid resources if electronic verification is not available, and to take appropriate action, consistent with regulations at § 435.916(d), which we proposed to redesignate and revise at § 435.919 in the proposed rule, if the State determines the individual greatly undervalued or failed to disclose resources. If the agency elects to conduct verifications post-enrollment, and documentation is requested, we proposed that the agency must provide the individual with at least 90 calendar days from the date of the request to respond and provide any necessary information requested.

We received comments on our proposal to require States to accept self-attestation on non-liquid assets and prohibit States from requesting documentation except where the agency has information incompatible with a self-attestation, and our responses follow.

Comment: In addition to several commenters expressing general support for self-attestation for simplifying enrollment regarding income, one commenter supported the proposal on non-liquid assets because this information is often difficult for applicants to obtain and poses unnecessary administrative burdens on applicants.

Response: Self-attestation minimizes undue administrative burden on applicants, including identifying the value of a non-liquid asset that cannot be sold. States retain the option to verify the information from the self-attestation with new information after the individual has been enrolled, including requiring the beneficiary to provide documentation of non-liquid resources if electronic verification is not available, and take appropriate action if the State determines the individual greatly undervalued or failed to disclose resources.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal on non-liquid assets with a modified compliance date of April 1, 2026.

Burial funds. Under section 1613(d)(1) of the Act, which applies to both LIS and MSP determinations, up to

\$1,500 in burial funds are to be excluded for the applicant (and an additional \$1,500 for their spouse) so long as the burial fund is “separately identifiable and has been set aside.” The statute does not, however, prescribe how the funds must be separately identifiable. As discussed in the proposed rule at 87 FR 54768, current SSA policy allows LIS applicants to attest to having \$1,500 in burial funds, which may be co-mingled with other funds in a single account, but for MSP eligibility determinations States typically require applicants to provide documentation that their burial funds are set aside in a separate account. This creates a misalignment between LIS and MSP methodologies and imposes additional burdens on MSP applicants.

We proposed at § 435.952(e)(3)(i) to require that States, when determining eligibility for the MSPs, allow individuals to self-attest that up to \$1,500 of their resources, and up to \$1,500 of their spouse’s resources, are set aside as burial funds in a separate account, and therefore, are not countable as resources for MSP determinations. Proposed § 435.952(e)(3)(ii) clarifies that States must request documentation prior to making an initial determination of eligibility if they have information that is not reasonably compatible with the applicant’s attestation in accordance with § 435.952(c)(2). As in the proposed provisions for interest and dividend income and non-liquid resources, and described at § 435.952(e)(3)(iii), States would retain the option to conduct post-enrollment verification, including requiring documentation of resources in burial funds, and taking appropriate action, consistent with regulations at § 435.916(d), which we proposed to redesignate and revise at § 435.919 in the proposed rule. Under proposed § 435.952(e)(1)(iii), if the agency elects to conduct verifications post-enrollment and requests documentation, the agency must provide the individual with at least 90 calendar days from the date of the request to respond and provide any necessary information requested.

Finally, States may also use authority at section 1902(r)(2) of the Act to disregard all or a greater amount of burial funds or to not require that the burial funds be held in a separate set-aside account.

We received comments on our proposals related to burial funds, and our responses follow.

Comment: A few commenters specifically wrote in support of accepting self-attestation for burial funds. A commenter suggested that the rule be revised so that applicants are not

required to maintain a separate account for burial funds or that they can acknowledge in their self-attestation that they will set up a separate account within 90 days of the self-attestation. This commenter also noted that low-income individuals are disproportionately “unbanked” and thus do not have access to banks where they can segregate funds in separate accounts.

Response: Self-attestation minimizes undue administrative burden on applicants. States retain the option to verify the information from the self-attestation after the individual has been enrolled, including requiring the beneficiary to provide documentation of burial fund resources and take appropriate action if the State determines the individual greatly undervalued or failed to disclose resources. We appreciate the commenter’s concern that creating a separate account poses additional burdens on applicants, including those who are “unbanked.” However, as described previously in this final rule, section 1613(d)(1) of the Act stipulates that the burial fund exclusion applies to funds that are “separately identifiable” and have been “set aside.” Accordingly, in this final rule, we decline to incorporate the commenter’s suggestions to require States to eliminate the requirement for a separate account for burial funds. We also decline to allow 90 days post self-attestation to create a separate account in this final rule, but we may consider whether there is a basis for such a policy in the future. As noted previously in this final rule, States may choose to eliminate the requirement that burial funds be held in a separate account under section 1902(r)(2) of the Act.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal on burial funds with a modified compliance date of April 1, 2026.

Life Insurance Policies. Section 116 of MIPPA, codified at section 1860D–14(a)(3)(G) of the Act, eliminated the value of life insurance policies as a countable resource for LIS determinations. However, under the SSI resource methodologies described in section 1613(a) of the Act, which applies to MSP-related resource eligibility determinations per section 1905(p)(1)(C) of the Act, the cash surrender value of life insurance with a total face value exceeding \$1,500 is countable.

As discussed in the proposed rule at 87 FR 54768, obtaining documentation of a life insurance policy’s cash surrender value can be highly burdensome for applicants, as the cash surrender value is not knowable from the documents a policyholder is likely to have.

Under proposed § 435.952(e)(4)(i), if an individual attests to having a life insurance policy with a face value below \$1,500, States must accept the attested face value for purposes of making an initial eligibility determination for MSP coverage, unless the State has information that is not reasonably compatible with attested information. If the total face value of all of an individual’s life insurance policies does not exceed \$1,500, the cash surrender value of the individual’s policies is not counted in determining MSP eligibility pursuant to sections 1613(a)(16) and 1905(p)(1)(C) of the Act.

Under proposed § 435.952(e)(4)(i)(A), if an individual attests to having a life insurance policy with a face value in excess of \$1,500, consistent with current regulations at § 435.948, States may accept the attested cash surrender value.

In both cases, if the State has information that is not reasonably compatible with the attested face value or cash surrender value of the policy, we proposed at § 435.952(e)(4)(ii) that the State must seek additional information from the individual in accordance with § 435.952(c)(2). Per current § 435.952(c)(2), the agency may accept a reasonable explanation from the applicant or require documentation.

As with interest and dividend income, per proposed § 435.952(e)(4)(iii), States would have the option to conduct post-enrollment verification for individuals enrolled based on an attested face value. In conducting post-enrollment verification, if a State determines that the face value of the policy exceeds \$1,500, then the State must seek the cash surrender value on behalf of the individual in accordance with proposed § 435.952(e)(4)(iv)(A) and take appropriate action, consistent with regulations relating to changes in circumstances at § 435.916(d) (which we proposed to redesignate and revise at § 435.919 in the proposed rule).

We also proposed at § 435.952(e)(4)(iv)(A) that when documentation of the cash surrender value of a life insurance policy is required, the State must assist the individual with obtaining this information and documentation by requesting that the individual provide the name of the insurance company and policy number and authorize the State

to obtain such documentation on the individual's behalf. The agency may also request, but may not require, additional information from the applicant to assist the agency in obtaining documentation of the cash surrender value, such as the name of an agent. If the individual does not provide basic information about the policy and an authorization, under proposed § 435.952(e)(4)(iv)(B), the State may require that the individual provide documentation of the cash surrender value. Under proposed § 435.952(e)(4)(iv)(C), the State must provide the individual with at least 15 calendar days to provide such documentation if required pursuant to paragraph (e)(4)(i) or (ii) of this section (that is, if documentation of the cash surrender value is needed prior to the agency's making a determination of eligibility) and at least 90 calendar days if required pursuant to paragraph (e)(4)(iii) of this section (that is, post-enrollment). We note that the minimum of 15 calendar days in proposed § 435.952(e)(4)(iv)(C) for applicants to provide documentation of cash surrender value of a life insurance policy is consistent with the minimum 15 calendar days that we propose States must generally provide applicants to provide required documentation under proposed § 435.907(d).

We sought comment on whether 15 calendar days or a longer minimum period, such as 20 calendar days or 30 calendar days, appropriately balances the complexity of determining and obtaining documentation of the cash surrender value with the 45-day limit for States to complete Medicaid eligibility determinations for individuals applying on a basis other than disability status under § 435.912(c)(3).

In the proposed rule (87 FR 54768 through 54769), we acknowledged that our proposal would represent a significant change for a number of States and could present some administrative challenges to implement. However, documenting the cash surrender value of life insurance is a considerable hurdle for many applicants. Because the cash surrender value of most applicants' policies is likely very modest, we noted that the value of any life insurance policy likely would have a minimal impact on their financial eligibility for coverage, whereas obtaining documentation of the cash surrender value may pose a substantial administrative barrier to access. Implementing a process that places fewer burdens on applicants is in the interest of efficient administration of the program, consistent with section

1902(a)(4) of the Act. We also expected that States would be better able to navigate obtaining such documentation when needed.

We received comments on our proposals related to life insurance, and our responses follow.

Comment: Many commenters provided feedback on the proposals to streamline verification processes for life insurance. Some commenters supported the provision, agreeing with CMS that the need to verify the cash value of a life insurance policy is an extremely challenging hurdle for many MSP applicants. One commenter noted that obtaining a letter from the insurer providing cash value can take weeks and often longer and noted that finding the right contact can be challenging because many insurers have closed their businesses or merged or transferred portions of their insurance portfolios to other companies. Several commenters agreed with the proposal to shift the burden to States to verify the cash surrender value, concurring that States were in a better position to gather the information due to the demographics of the applicants and the complexities of tracking down the information. A commenter recommended that to obtain authorization from the applicant to reach out to the insurer, States should inform the individual of the reason for obtaining the information and that they will safeguard the information. A few commenters, while supporting the overall proposal, recommended that CMS extend the deadline for providing documentation to 20 to 30 days for individuals who must produce documentation after refusing to give consent to States to contacting life insurance companies. However, the commenters added that their primary concern is to avoid a requirement that impedes States from meeting the 45-day timeline for making eligibility determinations.

Other commenters opposed our proposal to shift the burden to States to verify the cash surrender value of life insurance, citing concerns that it would increase work for eligibility workers and that insurance companies may refuse to disclose this information to anyone except the life insurance policy holder or their authorized representative. One commenter stated that this burden shifting was unnecessary and their State already provides help with obtaining the cash surrender value to any individual who requests such assistance.

Response: We believe that our proposal appropriately balances the interests of low-income older adults and individuals with disabilities with the

needs and resources of States. At the outset, we note that we anticipate the life insurance provisions will affect only a very small number of people.

Applicants for MSPs tend to be low-income individuals who do not have many assets, especially if they have income low enough to qualify for the MSPs. Additionally, as discussed previously in this final rule, the most popular form of life insurance for lower income individuals, term life insurance, is not impacted by these proposals. Moreover, as noted previously in this final rule, several States have eliminated the asset test for the MSPs, while others have raised the asset limit to \$10,000 or more for life insurance policies.

In response to concerns about shifting the burden of verifying the cash surrender value of life insurance from individuals to States, we note that States can avoid this burden by simply disregarding life insurance as an asset or increasing the limit using authority under section 1902(r)(2) of the Act. Additionally, this policy is similar to the support that SSA provides. While commenters have stated that they prefer individuals have 30 days to provide life insurance documentation, we are doubtful that States will be able to process MSP applications in 45 days while providing 30 days to produce documents. As such, we believe 15 days strikes the more appropriate balance.

In response to the commenter's suggestion to require States to inform applicants that their personal information will be properly safeguarded when the State requests authorization to contact the applicant's life insurance company, we note that States are required to safeguard information about applicants and beneficiaries obtained or used to verify eligibility in accordance with 42 CFR 431, subpart F. States must publicize their policies governing the confidential nature of information about applicants and beneficiaries, including the legal sanctions imposed for improper disclosure and use, as well as provide copies of these policies to applicants and beneficiaries and to other persons and agencies to whom information is disclosed in accordance with § 431.304. In this context, States would be required to provide a copy of the State's policies related to confidentiality of information to the applicant and to any representative of the applicant's insurance company to whom applicant information may be disclosed during the verification process. We decline to make a new, more specific requirement, because we believe States should have flexibility with regard to how they implement this requirement.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal on life insurance, with a modified compliance date of April 1, 2026.

In-Kind Support and Maintenance. In-kind support and maintenance is assistance an applicant receives that is paid for by someone else, such as groceries or utilities paid for by an adult child. Section 1860D–14(a)(3)(C)(i) of the Act, added by section 116 of MIPPA, excludes in-kind support and maintenance as countable income for LIS determinations. Under SSI methodologies at 20 CFR 416.1131, which apply to MSP determinations, the value of in-kind support and maintenance, if both food and shelter are received by an applicant, is presumed to be one-third of the Federal benefit rate (\$914 per month in 2023 for a single person), unless the applicant provides documentation demonstrating a different amount.

We did not propose any changes to regulations relating to in-kind support and maintenance, but we sought comment on whether obtaining documentation to rebut the one-third presumption poses a barrier to eligibility and whether we should require States to accept self-attestation from individuals who seek to rebut a presumption of the amount of in-kind support and maintenance they receive subject to post-enrollment verification.

We received the following comments on in-kind maintenance and support, and our responses follow.

Comment: A commenter requested that CMS require States to accept self-attestation for individuals seeking to rebut the presumption of the amount of in-kind support and maintenance they receive, while another commenter requested that CMS make this an option for States. However, we did not receive any other specific feedback on this proposal.

Response: As we discussed in the proposed rule (87 FR 54769), States may already exercise the option of accepting self-attestation for individuals seeking to rebut the presumption of the amount of in-kind support and maintenance they receive. Alternatively, States can further streamline the MSP eligibility and enrollment process for individuals with in-kind maintenance and support by disregarding in-kind support and maintenance entirely under section 1902(r)(2) of the Act. While we decline to adopt specific requirements regarding requiring self-attestation for in-kind maintenance and support at this time,

we will consider this input for future rulemaking.

Streamlined Methodologies for Other Non-MAGI and MAGI Groups. Our proposals requiring States to apply enrollment simplifications to income and resources that are counted for MSP determinations but not for LIS only apply to MSPs. However, we sought comment on extending these proposals to all individuals seeking eligibility on a non-MAGI basis. We also sought comment on extending the proposal relating to verification of dividend and interest income to individuals seeking eligibility based on MAGI, as well as whether there are additional income or resource types to which the proposals below could be extended for all individuals.

We received the following comments, and our responses follow.

Comment: Some commenters opposed applying the proposed MSP requirements to all non-MAGI populations. Some others supported this concept, maintaining that applying uniform standards across eligibility groups would help promote clarity for applicants and enhance the utility of leads data for screening other bases of eligibility. A commenter noted that documentation barriers apply equally to these other non-MAGI groups and the need to simplify the processes for these other groups are just as urgent. A few commenters supported applying the income and dividend interest self-attestation requirements to MAGI groups.

A commenter requested clarification on whether extending the exclusion of these income types using flexibility afforded in section 1902(r)(2) of the Act would extend to post-eligibility treatment of income (PETI), which involves how income is counted for beneficiaries in a medically needy eligibility group, or if it would be similar to how Veterans Affairs' (VA) Aid and Attendance is treated (excluded for eligibility, included in PETI).

Response: We appreciate the comments and will consider them for future rulemaking. With respect to the commenter's request for clarifications about whether income disregards under section 1902(r)(2) of the Act apply to post-eligibility treatment of income (PETI) calculations, we confirm that any income excluded in an eligibility determination using section 1902(r)(2) of the Act must be counted in the PETI calculation. In the post-eligibility process, income includes all amounts of income available to an individual from all sources that are considered income for purposes of underlying eligibility, even if such income is disregarded at

the eligibility determination phase using section 1902(r)(2) authority. Only income which is expressly exempted from post-eligibility calculations under Federal law would not be included in the post-eligibility process. However, we note that the current proposal does not make any changes to how States may use section 1902(r)(2) authority.

Comment: Several commenters expressed support for the proposed changes to facilitate enrollment through Medicare Part D LIS leads data in §§ 435.4, 435.601, 435.911, and 435.952 but provided feedback on areas that were not addressed in the proposed rule. For example, a commenter requested that the definition of "retirement funds" for the LIS program be aligned with the SSI and Medicaid programs to exclude retirement funds that are in distribution status. Another commenter recommended several ways that CMS could leverage Area Agencies on Aging and SHIPs and other enrollment assistance providers to streamline the MSP application process, such as requiring States to allow such entities to access State eligibility systems and manage and submit data and verifications on behalf of applicants. In addition, a commenter recommended that CMS facilitate access to other public benefits, including by helping to create a combined application for Medicaid coverage and other benefits. A commenter recommended that CMS encourage States to share data with the Indian health care system, specifically Indian Health Services, Tribal, and Urban Indian Organizations. Another commenter urged CMS to improve MSP outreach to eligible individuals, for example, by updating CMS MSP outreach templates to allow States to enter their own income and asset limits and provide the contact information of the SHIP counselor. This commenter further recommended that CMS incentivize States to remove language access barriers for persons with limited English proficiency. A few commenters recommended that CMS consider further linkages between Medicaid applications and other social services. Another commenter sought clarification about whether an individual for whom the State had accepted self-attestation, but was later deemed ineligible would be treated as "enrolled" in Medicaid for purposes of the continuous enrollment condition under the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116–127, enacted March 18, 2020) or any subsequent continuous enrollment conditions or requirements.

Response: These areas are outside the scope of this rulemaking. With respect

to the question about the continuous eligibility condition under the FFRCA, we note that this provision expired on March 31, 2023.

2. Define “Family of the Size Involved” for the Medicare Savings Program Groups Using the Definition of “Family Size” in the Medicare Part D Low-Income Subsidy Program (§ 435.601)

To further facilitate alignment of methodologies used to determine eligibility for the Medicare Part D LIS and MSP groups and facilitate enrollment in the MSPs based on LIS data, we proposed to amend § 435.601 (“Application of financial eligibility methodologies”) to create a new paragraph (e), in which we proposed to define “family size” for purposes of MSP eligibility.

As discussed in the proposed rule at 87 FR 54770, the Act sets out income limits for MSP enrollment relative to the Federal poverty level (FPL) “applicable to a family of the size involved.” The statute does not define the phrase “family of the size involved” and CMS has historically permitted States to apply their own reasonable definition of this phrase.³⁵

However, in light of the various statutory provisions to facilitate enrollment of LIS recipients into MSPs and vice versa, it is appropriate to establish Federal standards governing the phrase “family of the size involved.”

Specifically, we proposed for purposes of determining eligibility for the MSP groups, consistent with our authority under section 1902(a)(4) of the Act to facilitate methods of administration that promote the proper and efficient administration of the Medicaid program, that “family of the size involved” be defined to include at least the individuals included in the definition of “family size” in the LIS program. Under § 423.772 (“Definitions” relating to the LIS program), “family size” is defined to include the applicant, the applicant’s spouse (if the spouse is living in the same household with the applicant), and all other individuals living in the same household who are related to the applicant and dependent on the applicant or applicant’s spouse for one-half of their financial support.

By proposing that a State’s definition of “family of the size involved” include

“at least” the individuals described in § 423.772 for purposes of the MSP groups, States would retain flexibility to include other individuals who are not described in § 423.772. Additionally, this proposal would not affect the States’ ability to adopt a different reasonable definition of the phrase for purposes of other eligibility groups. We sought comment on this proposal to define “family of the size involved” for purposes of the MSP groups.

We received the following comments on our proposals related to family size, and our responses follow.

Comment: Many commenters supported aligning the definitions of family size for MSP with LIS. A number of these commenters specifically noted that communities of color and marginalized individuals were more likely to be part of multi-generational households. For that reason, they indicated this change would better reflect the household composition of low-income Medicare beneficiaries and promote health equity. MACPAC supported this proposal, noting consistency with its 2020 recommendations to Congress to align the family size definition for the MSPs and LIS.

A few commenters, while supporting the proposed change, requested specific modifications or clarifications. A commenter requested that CMS clarify in the regulation or commentary to the regulation that “relative” includes anyone related by blood, marriage, or adoption based on 2009 CMS LIS guidance to States. The commenter further indicated that a particular State only counts the spouse in the household size if the individual’s income is below the MSP income limit and requested that CMS issue a directive to States to clarify this is not allowed.

Response: We thank the commenters for their support regarding our proposed MSP-related family size definition and agree that these provisions would promote health equity and increase access to the MSPs.

The definition of “family size” in § 423.772 includes the spouse of an applicant who is living in the same household. We therefore confirm that the requirement under the proposed rule that States use the definition of “family size” in § 423.772 to determine MSP eligibility means that States would necessarily include an applicant’s spouse in the applicant’s family, if the spouse is living in the same household. We note, however, that, while being required to include the spouse in the applicant’s household, States could exclude the spouse’s income and/or resources in the applicant’s MSP

eligibility determination. As noted previously in this final rule, States may, under the authority of section 1902(r)(2)(A) of the Act, utilize methodologies less restrictive than the SSI program in determining MSP eligibility, which includes the authority to disregard otherwise-countable income and/or resources, such as the income and/or resources of a spouse.

With regard to what constitutes a relative for purposes of the “family size” definition in § 423.772, as the commenter noted, in 2009 CMS previously confirmed for States that the LIS “family size” definition includes the applicant, the applicant’s spouse (if living with the applicant), and “[a]ny persons who are related by *blood, marriage, or adoption*, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support”³⁶ (emphasis added). Consistent with this guidance, we confirm that to comply with the proposed rule to use the “family size” definition in § 423.772 for MSP eligibility determinations, States would at least need to treat as “related to” the applicant individuals who are related by blood, marriage, or adoption. As noted previously in this final rule, however, States would retain the authority under the proposed rule to include individuals who are not required to be included in the definition of a “family of the size involved” for their MSP-related eligibility determinations. We intend to consider providing future guidance to States to further clarify this requirement.

Comment: Some commenters shared concerns with the proposal to apply the LIS family size definition to the MSPs. For example, some commenters requested more time to complete systems changes and other updates (for example, SPAs) to implement the proposal, and a few commenters opposed the changes as overly burdensome and costly for States because it would require different eligibility and enrollment processes for the MSPs than for other non-MAGI groups. Further, some commenters suggested that extending the LIS family size definition to the MSPs could have an unintentional negative impact on current MSP enrollees if additional income from the relative/dependent is deemed to them, making them no longer eligible for the MSPs. Finally, some

³⁵ Memorandum from Director, Center for Medicaid and State Operations, to Regional Administrator, re: Medicaid Eligibility—Policy Governing Family Size in Determining Eligibility for Qualified Medicaid Beneficiaries and Specified Low-Income Beneficiaries. October 2, 1997. <https://www.medicaid.gov/sites/default/files/2019-12/medicaid-eligibility-memo.pdf>.

³⁶ Centers for Medicare & Medicaid Services, Guidance to States on the Low-Income Subsidy, section 30.6 (Family Size), February 2009. <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/downloads/StateLISGuidance021009.pdf>.

commenters indicated that States may not have information about minor members of household and may find it difficult to verify dependency of non-minor household members. A few commenters questioned whether this information about household members outside of the spousal unit is contained in the LIS leads data transmitted.

Response: We acknowledge that these changes may require many programmatic updates (including SPAs) and systems changes. As such, we are extending through this final rule the timeline for States to comply with this provision.

Regarding the concern about the deeming to MSP applicants or enrollees the income of relatives or dependents, we note that preexisting non-MAGI deeming rules, under section 1902(a)(17)(D) of the Act and § 435.602(a)(2)(i), prohibit States from deeming to an applicant the income or resources of anyone who is not the spouse or parent of that individual. Thus, although the proposal to use the definition of “family size” under § 423.772 to determine MSP-related eligibility may increase the family size of MSP applicants and enrollees, it will not expand the individuals whose income and/or resources may be deemed available to an MSP applicant or enrollee, as the non-MAGI deeming rule described in section 1902(a)(17)(D) of the Act and § 435.602(a)(2)(i) continues to apply.

Finally, we clarify that because the LIS definition of family size includes dependent relatives residing in the same house, SSA collects information to determine the number of relative dependents living in the household, excluding the beneficiary and spouse, and includes it in the LIS leads data sent to States.³⁷ Again, as mentioned throughout, we plan to provide technical assistance and guidance to States to help them understand and use LIS leads data information for MSP eligibility determinations.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal at § 435.601 on family size, with a modified compliance date of April 1, 2026.

3. Automatically Enroll Certain SSI Recipients Into the Qualified Medicare Beneficiaries Group (§ 435.909)

SSI is a Federal cash assistance program that serves low-income individuals who are age 65 or older, or

have blindness or a disability. SSI recipients typically qualify for other Federal and State programs. For example, many SSI recipients are entitled to Medicare under § 406.5(a) and (b). Additionally, in most States, the receipt of SSI is a mandatory basis for Medicaid eligibility pursuant to section 1902(a)(10)(A)(i)(II)(aa) of the Act, implemented at § 435.120 (“Individuals receiving SSI group,” hereafter the “mandatory SSI group”).

Thirty-three States and the District of Columbia (DC) that cover the mandatory SSI group have an agreement with SSA under section 1634(a) of the Act under which SSA completes the determination of eligibility for the mandatory SSI group, and the Medicaid agency automatically enrolls the individual in Medicaid. We commonly refer to these States as “1634 States.” Nine States that cover the mandatory SSI group apply the SSI program’s income and resource methodologies and disability criteria but require individuals to submit a separate application to the State Medicaid agency (“criteria States”).

Eight States do not cover the mandatory SSI group. Instead, these States have elected to exercise authority provided to them under section 1902(f) of the Act to apply financial methodologies and/or disability criteria more restrictive than the SSI program in determining eligibility for individuals 65 years old or older or who have blindness or a disability, subject to certain conditions. These States are referred to as “209(b) States,” after the provision of section 209(b) of the Social Security Act Amendments of 1972 (Pub. L. 92–603), which enacted the State authority codified at section 1902(f) of the Act. The eligibility group authorized by section 1902(f) of the Act is implemented at § 435.121 (“Individuals in States using more restrictive requirements for Medicaid than the SSI requirements,” hereafter “mandatory 209(b) State group”).

As discussed in the proposed rule at 87 FR 54771, because the income and resource standards for the QMB group exceed the income and resource standards for SSI, individuals entitled to Medicare Part A who meet the income and resource requirements for the mandatory SSI group or mandatory 209(b) group will always meet the income and resource requirements for the QMB group and be eligible for the QMB group.

As discussed at 87 FR 54771, most individuals enrolled in Medicare qualify for Part A without paying a premium (premium-free Part A) and are automatically enrolled. According to internal SSA and CMS data, in 2022,

approximately 2.8 million individuals (over 75 percent) of Medicare-eligible SSI recipients were entitled to premium-free Part A.

Under § 406.20, many individuals who are not eligible for premium-free Part A may still enroll in Part A by applying for benefits at SSA and paying a premium (“premium Part A”). Individuals who are not eligible for premium-free Part A are not automatically enrolled in premium Part A and they must enroll in Part B prior to or at the same time as they enroll in Part A. For all Medicare beneficiaries, enrollment in Part B is contingent on a monthly premium, which is subject to an adjustment based on income.

All States currently have entered into a voluntary “buy-in agreement” with the Secretary authorized under section 1843 of the Act which requires them to pay the Part B premiums for certain Medicaid beneficiaries known as “(Part B buy-in),” including individuals enrolled in the QMB group and those receiving SSI (as described in the Medicare regulations at § 407.42). A buy-in agreement permits States to directly enroll eligible individuals in Medicare Part B at any time of the year (without regard to Medicare enrollment periods or late enrollment penalties if applicable) and to pay the Part B premiums on the individual’s behalf.

In 1634 States, when SSA determines an individual eligible for both the mandatory SSI group and Medicare Part B, CMS automatically initiates Part B buy-in for the individual.³⁸ In SSI criteria and 209(b) States, SSA notifies both the State and CMS that an individual has been determined eligible for SSI and Medicare Part B; however, because such individuals must submit a separate Medicaid application for determinations of eligibility, we do not automatically initiate Part B buy-in. Rather, once the State determines an individual eligible for the mandatory SSI or 209(b) group, the State must initiate Part B buy-in for the individual pursuant to its buy-in agreement.

While individuals enrolled in the mandatory SSI or 209(b) group receive full Medicaid benefits and Part B buy-in, enrollment in the QMB group provides these individuals with additional protection from out-of-pocket health care costs—specifically Medicare

³⁸ States with buy-in agreements must exchange buy-in enrollment data with CMS on a daily basis under § 407.40(c)(4), and CMS also exchanges buy-in data with SSA on a daily basis. CMS collectively refers to these data exchange processes as the “buy-in data exchange.” See Manual for the State Payment of Medicare Premiums, chapter 2, sections 2.0 and 2.1. <https://www.cms.gov/files/document/chapter-2-data-exchange-processes.pdf>.

³⁷ <https://www.ssa.gov/dataexchange/documents/LIS%20record.pdf>.

Part A premiums, if applicable, and Parts A and B cost-sharing charges. Moreover, Federal law prohibits all Medicare providers and suppliers, not just those participating in Medicaid, from charging QMBs for Medicare cost-sharing.

Maximizing the number of Medicaid beneficiaries who are also enrolled in Medicare is advantageous to such individuals, and it can also result in cost savings for States. As a third-party payer, Medicare pays primary to Medicaid for Medicare Part A (inpatient hospital and skilled nursing facility services) and Medicare Part B (outpatient medical care). In addition, Medicaid beneficiaries who are enrolled in both Medicare Parts A and B may join Medicare-Medicaid integrated care plans, which coordinate care across the two payers and may generate savings to the State by helping beneficiaries avoid institutional placement and by providing supplemental benefits, such as dental, transportation, hearing, or other benefits that otherwise would have been covered by Medicaid.

Despite the potential benefits for Medicaid beneficiaries and State agencies, our data from 2022 indicates that over 500,000 or 16 percent of SSI recipients who are eligible to enroll in Medicare are not enrolled in the QMB eligibility group. It is our understanding that a major barrier to QMB enrollment is that many States require SSI recipients to file a separate application with the State Medicaid agency to be evaluated for eligibility for the QMB group, even though they have been determined eligible for the mandatory SSI or 209(b) groups, and all SSI recipients who are entitled or able (with a premium) to enroll in Part A necessarily meet the requirements for QMB eligibility.

We proposed several changes to facilitate the enrollment of SSI recipients into the QMB eligibility group, consistent with our authority in section 1902(a)(4) of the Act to establish standards promoting the proper and efficient administration of the Medicaid program, the requirements in the January 28, 2021 Executive Order on Strengthening Medicaid and the Affordable Care Act, the April 5, 2022 Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage, and the December 13, 2021 Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government. Specifically, we proposed to add a new paragraph (b) at § 435.909 that generally would require States to deem an individual enrolled in the

mandatory SSI or 209(b) group eligible for the QMB group the month the State becomes responsible for paying the individual's Part B premiums under its buy-in agreement pursuant to § 407.47(b). We also proposed technical changes to remove reserved paragraph (a) at § 435.909, redesignate § 435.909 paragraph (b) as (a), and add a new header to new § 435.909(a).

We noted (87 FR 54772) that under section 1902(e)(8) of the Act, QMB eligibility is effective the month following the month in which the determination of eligibility for the QMB group is made. Thus, under our proposal, QMB coverage would start the month following the month the State deems an individual eligible for the QMB group and starts paying the individual's Part B premiums under the buy-in agreement. For example, if an individual is first enrolled in both the mandatory SSI or 209(b) Medicaid group and entitled to Part A in January 2025, the State would start paying the individual's Part B premiums under the buy-in agreement and deem the individual eligible for the QMB group in January 2025. The individual's QMB coverage would start February 1, 2025.

SSI Recipients Who Have Premium-Free Medicare Part A

As noted at 87 FR 54771, SSA automatically enrolls individuals who receive Social Security or railroad retirement benefits or disability benefits for 24 months into premium-free Part A. SSA data for States (including those with a 1634 agreement and those without a 1634 agreement) indicates whether an SSI recipient is entitled to premium-free Part A. As discussed previously in this final rule, because all SSI recipients meet the financial eligibility requirements for the QMB group, proposed § 435.909(b)(1)(i) would require all States to deem SSI recipients who are determined eligible for either the mandatory SSI group at § 435.120 or the mandatory 209(b) group at § 435.121 as eligible for the QMB group if they are entitled to premium-free Medicare Part A. Under the proposed rule, when a 1634 State receives from CMS the Part B buy-in enrollment for an SSI recipient who is entitled to premium-free Medicare Part A, the State would automatically enroll the individual in both the mandatory SSI group and the QMB group; such individuals would not be required to submit a separate application to the Medicaid agency to determine eligibility for the QMB group.

SSI recipients in criteria States and 209(b) States must submit a separate application to the Medicaid agency

which determines eligibility for either the mandatory SSI or the 209(b) group. Thus, under proposed § 435.909(b)(1)(i), once the State has determined an SSI recipient eligible for the mandatory SSI or the 209(b) group, the State also would start paying the Part B premiums for the individual the first month they are entitled to Part A and receiving SSI-based Medicaid and start QMB group coverage the first day of the following month.

In some instances, individuals enrolled in the mandatory SSI or 209(b) group become retroactively entitled to premium-free Medicare Part A based on a retroactive award of Social Security Disability Insurance (SSDI). Under the Medicare regulations at § 407.47(b), States generally become responsible for retroactive Part B premiums for such individuals dating back to the first month they were enrolled in the mandatory SSI or 209(b) group and eligible for Part B.³⁹ In the proposed rule entitled, "Implementing Certain Provisions of the Consolidated Appropriations Act and other Revisions to Medicare Enrollment and Eligibility Rules" (87 FR 25090) (referred to hereafter as the "2022 Medicare eligibility and enrollment proposed rule"), we proposed adding a new paragraph (f) at § 407.47 to limit State liability for retroactive Part B premiums for full-benefit Medicaid beneficiaries, including individuals receiving SSI-based Medicaid, to a period of no greater than 36 months prior to the date of the Medicare enrollment determination.

In the proposed rule, we proposed at § 435.909(b)(3) that retroactive QMB coverage for individuals in the mandatory SSI or 209(b) group be limited to the same period for retroactive Part B premium liability that was set forth in the then-proposed § 407.47(f), which we have now finalized (to take effect starting January 1, 2024) in the 2022 Medicare eligibility and enrollment final rule. For example, if SSA determines an individual enrolled in the mandatory SSI or 209(b) group eligible for premium-free Part A in January 2025 with an effective date back to January 2023, the State would deem the individual eligible for the QMB group retroactive to January 2023. Because coverage under the QMB group begins the month after the month of the eligibility determination, QMB coverage in this example would be effective February 1, 2023. Alternatively, if SSA determines an individual enrolled in the

³⁹ Individuals who are entitled to premium-free Part A are eligible to enroll in Medicare Part B under § 407.10(a)(1).

mandatory SSI or 209(b) group eligible for premium-free Part A in January 2025 with an effective date back to January 2021, the State would deem the individual eligible for the QMB group retroactive to January 2022, with QMB coverage effective February 1, 2022.

Additionally, at 87 FR 54772, we reminded States that individuals deemed eligible for Medicaid are not exempt from regularly-scheduled renewals of Medicaid eligibility in accordance with § 435.916. However, 1634 agreement States do not need to take affirmative steps to renew Medicaid for individuals who continue to receive SSI. Such individuals remain eligible for Medicaid based on their continued receipt of SSI. 1634 States can rely on information electronically transmitted by SSA (for example, the State Data Exchange (“SDX”), State Verification Exchange System (SVES), or State Online Query System (SOLQ)), to renew on an *ex parte* basis, individuals who continue to receive SSI. States may consider SSA’s original notification identifying an SSI recipient as verification that the individual is still receiving SSI and eligible for Medicaid on that basis until the State receives new information from SSA reflecting a change in circumstances. However, for an individual eligible under both the mandatory SSI and QMB groups, the State need only verify that the individual still receives SSI and is entitled to Medicare Part A to renew their eligibility in both groups. When an individual no longer meets the eligibility requirements for the eligibility group under which they have been receiving coverage, the State must determine eligibility on all bases before terminating eligibility.

We received the following comments, and our responses follow.

Comment: Several commenters expressed support for our proposal at § 435.909(b)(1) to require States to automatically enroll most SSI recipients in the QMB group as they are by definition eligible for this coverage. MACPAC stated that the proposal aligns with its goal of improving participation in the MSPs and, from a health equity perspective, could promote access to care for the lowest-income Medicare beneficiaries by improving their access to Medicare cost-sharing assistance. Similarly, some commenters anticipated that our proposal would substantially boost MSP enrollment for SSI recipients because procedural barriers to the MSPs have an outside impact on this population, who are among those least able to navigate enrollment processes due to multiple social risk factors and physical and mental disabilities.

Finally, a few commenters indicated that this proposal would reduce administrative work for State Medicaid staff and thus benefit States and SSI recipients alike.

Response: We agree that requiring automatic enrollment of certain SSI recipients in QMB is an impactful and efficient step to break down barriers to MSP enrollment and advance health equity for this extremely low-income, high-need population.

Comment: Commenters provided differing perspectives about the time and effort needed for States to comply with this provision. One commenter noted that a certain State already has plans to automate QMB enrollment for SSI recipients in late 2023, while another commenter described another State as equipped to make system updates within 30 days of a final rule’s effective date. In contrast, one commenter contended that the proposal, particularly its creation of a limited retroactive QMB benefit for individuals who become retroactively entitled to premium-free Part A, may require changes in State law, lengthy and complicated systems changes, and employee training.

Response: As noted in section II.A.1. of this final rule, we recognize that effectuating this change may require States to update to their systems and/or State laws, and that unique circumstances may affect the timeline by which States can make these changes. However, relative to other types of eligibility changes (such as implementing provisions leveraging use of LIS leads data discussed in section II.A.1. of this final rule and aligning non-MAGI enrollment and renewal requirements with MAGI requirement discussed in the proposed rule at 87 FR 54780), this proposal is less likely to require complex and lengthy systems updates. Plus, we believe that since all SSI recipients are eligible for the QMB group, it is appropriate to provide access to this vitally important benefit as soon as possible. In addition, under all State buy-in agreements, States must already have mechanisms in place to provide a period of retroactive Part B buy-in for SSI recipients who become retroactively entitled to premium-free Part A based on a retroactive SSDI award under § 407.47(b) and (f). We anticipate that States would build upon these processes to retroactively deem SSI recipients into the QMB group as well. To balance the likelihood of modest systems updates and the benefits of our proposal, we are adopting a modified compliance date of October 1, 2024.

Comment: One commenter agreed the proposal would help beneficiaries and States but requested clarification on whether SSI recipients have the option to decline QMB and, if so, whether declining QMB would affect their overall eligibility for Medicaid.

Response: Under § 435.404, individuals who may be eligible under more than one category may have their Medicaid eligibility determined under the category they select. This means that individuals who may be eligible for QMB and another eligibility group may choose to have eligibility determined only under one category. Therefore, SSI recipients can decline eligibility for QMB coverage without it impacting their eligibility for other Medicaid groups. However, we note that even if SSI recipients eligible for the mandatory SSI or 209(b) group opt out of the QMB group, States would still pay their Part B premiums under their State buy-in agreements because this is a mandatory population for buy-in, and buy-in is involuntary. See §§ 407.40(c)(1) and 407.42(b). Because declining QMB eligibility could expose these very low-income individuals to high Medicare cost-sharing, we would expect very few SSI recipients to opt out of QMB eligibility.

Additionally, while SSI recipients (and other individuals) may decline QMB enrollment without it impacting their Medicaid eligibility for other eligibility groups, they may still be required to apply for Medicare (if they have not already done so) where States have elected under their State plans to require Medicaid applicants and beneficiaries to apply for Medicare as a condition of Medicaid eligibility.

Comment: One commenter noted that CMS did not provide evidence to justify the need for automatic enrollment and requested that CMS withdraw this proposal and instead develop a pilot with States to determine the reasons why eligible individuals do not apply for benefits. The commenter also questioned whether the proposal would inappropriately limit State flexibility to enroll SSI recipients in the medically needy eligibility group.

Response: We decline the recommendation for a pilot project. As explained in the proposed rule (87 FR 54761 through 54762), our engagement with States and other interested parties⁴⁰ as well as numerous other

⁴⁰ See for example, CMS Office of Burden Reduction & Health Informatics, “Navigating the Medicare Savings Program (MSP) Eligibility Experience” April 2022. <https://www.cms.gov/files/document/navigatingmedicare-savings-program-msp-eligibilityexperience-journey-map.pdf>.

studies⁴¹ have demonstrated that burdensome documentation requirements hinder the ability of eligible individuals to enroll in the MSPs and that easing these requirements is key to ensuring individuals can obtain these benefits. Automating QMB enrollment removes the need for this low-income, high-need population to undergo a redundant application process.

Separately, we note that 209(b) States that have elected to extend eligibility to medically needy individuals under § 435.330 (“Medically needy coverage of the aged, blind, and disabled in States using more restrictive eligibility requirements for Medicaid than those used under SSI”) do not have the flexibility to enroll SSI recipients who meet a spenddown in a medically needy group. Under section 1902(f) of the Act and § 435.121(e)(5), SSI recipients (and certain other individuals) who meet a spenddown based on the deduction of incurred medical expenses must be treated as categorically needy.

Comment: Many commenters expressed support for the proposed changes but provided feedback on areas that were not addressed in the proposed rule. For example, many commenters requested that CMS require all States to automatically enroll SSI recipients in Medicaid coverage. One commenter recommended that CMS work with other agencies to streamline processes for enrolling Medicaid beneficiaries in other Federal benefits, when there is data indicating that there is a high likelihood that Medicaid beneficiaries would be eligible for those other Federal benefits.

Response: We thank the commenter for their support of the proposed changes but note that these comments are outside the scope of this rulemaking.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal to require States to deem individuals enrolled in the mandatory SSI or 209(b) group who have premium-

free Medicare Part A as eligible for the QMB group under new § 435.909(b)(1), with a modified compliance date of October 1, 2024 to allow States more time for implementation.

QMB Eligibility for Individuals Eligible for Premium Part A

As we noted previously in this final rule and in the proposed rule (87 FR 54772), individuals age 65 and over who lack the sufficient work history for premium-free Part A may qualify to pay, or have paid on their behalf, a monthly premium to receive Medicare Part A benefits.^{42 43}

All States must pay the Part A premium for individuals who are enrolled in the QMB eligibility group. However, as discussed in the proposed rule at 87 FR 54773, States can choose one of two methods to pay the Part A premium for QMBs.⁴⁴ First, States can expand their buy-in agreement with us under section 1818(g) of the Act to include enrollment and payment of Part A premiums for QMBs who do not have premium-free Part A. Currently, 36 States and the District of Columbia have chosen this option and are called “Part A buy-in States.” In Part A buy-in States, individuals determined eligible for the QMB group can enroll in premium Part A at any time of the year and without regard to late enrollment penalties. Fourteen States do not include Part A in their buy-in agreements and instead pay the Part A premiums for QMBs using a group payer arrangement, which allows certain third parties (for example, States) to pay the Part A premiums for a class of beneficiaries.⁴⁵ States that use a group payer arrangement for QMBs are known as “Part A group payer States.”

As previously noted, to qualify for the QMB eligibility group under section 1905(p)(1) of the Act, an individual must be entitled to hospital insurance benefits under Part A of title XVIII. In general, an individual becomes entitled

to Part A if: (1) they are eligible for premium-free Part A based on payment of a payroll tax; or (2) are eligible to enroll in premium Part A and do enroll (creating a Part A premium obligation).

Further, as noted in the proposed rule at 87 FR 54773, section 1905(a) of the Act specifies that payments of Medicare cost-sharing for QMBs (including Part A premiums) are “medical assistance” for purposes of FFP, if made in the month following the month in which the individual becomes a QMB. Thus, under a literal reading of the words of the statute, a State would not be able to claim or receive FFP under the QMB group for an individual without Premium-free Part A until the month after the month in which the individual is “entitled to Part A,” which would require that a Part A premium be billed to the individual until QMB coverage of the premium would begin. This would create a “catch 22” in which low-income individuals without premium-free Part A could only be eligible for QMB coverage that makes Part A enrollment affordable if they first became personally liable for the high cost of paying the Part A premium to become “entitled” to Part A, and thus eligible for QMB status.

As we explained in the proposed rule at 87 FR 54773, this result would eviscerate the purpose of sections 1843 and 1818(g) of the Act (“buy-in statute”) to avoid undue delays in QMB enrollment. Under a literal reading, States with a Part A buy-in agreement could theoretically use only 100 percent State funds to pay Part A premiums the first month to allow the individual to become entitled to Part A and start QMB coverage the next month. However, in *Harris v. McCrae*, 448 U.S. 297 (1980), the U.S. Supreme Court held that States cannot be required to provide Medicaid using only State funds. Further, while individuals can enroll in Part A at any time of the year without regard for Medicare enrollment periods or applicable late enrollment penalties if the State pays their Part A premium under its buy-in agreement, this is not the case for individuals who are paying the premium themselves. Individuals who must pay the Part A premium themselves must wait until a Medicare enrollment period to enroll in Part A and may be subject to late enrollment penalties. Thus, a literal read of the statute would defeat the purpose of buy-in statute—to avoid delays in QMB enrollment by allowing QMB-eligible individuals who reside in Part A buy-in States to enroll in Part A at any time of the year, without the imposition of Medicare enrollment penalties.

⁴¹ See, for example, MACPAC, “Improving Participation in the Medicare Savings Programs,” Report to Congress, June 2020. <https://www.macpac.gov/publication/chapter-3-improving-participation-in-the-medicare-savings-programs/>; Office of the Assistant Secretary for Planning and Evaluation, *Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors, and Implications*, May 8, 2019. <https://aspe.hhs.gov/basic-report/loss-medicare-medicicaid-dual-eligible-status-frequency-contributing-factors-and-implications>; and Caswell, Kyle J., and Timothy A. Waidmann, “Medicare Savings Program Enrollees and Eligible Non-Enrollees,” The Urban Institute, June 2017. <https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf>.

⁴² Note that all individuals receiving title II benefits based on disability who have met the 24-month waiting period to enroll in Medicare are entitled to premium-free Part A.

⁴³ To meet the requirements for premium Part A at § 406.20(b), the individual must be: age 65 or older, a U.S. resident, not otherwise entitled to Part A, entitled to Part B or in the process of enrolling in it, and a U.S. citizen or lawful permanent resident who has resided in the U.S. continuously during the 5 years immediately preceding the month they enrolled in Medicare.

⁴⁴ See chapter 1, section 1.7 of the CMS Manual for the State Payment of Medicare Premiums. <https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf>.

⁴⁵ See SSA Program Operations Manual System (POMS) HI 01001.230 Group Collection-General. <http://policy.net.ba.ssa.gov/poms.nsf/nlx/0601001230>.

Recognizing that a literal read of the statute would produce a result that essentially nullifies the impact of the QMB and buy-in statutory provisions, we instituted a policy over 30 years ago under which States can receive FFP for paying an individual's Part A premium the first month of entitlement, thereby triggering both Part A entitlement and QMB coverage. Under this longstanding policy, Part A buy-in States can determine an individual eligible for QMB status, and thus for their Part A premiums to be paid, if they are enrolled in Part B but not yet entitled to Part A.⁴⁶ Group payer States similarly can approve eligibility for individuals under the QMB eligibility group if SSA has determined them conditionally eligible for premium Part A, through a process known as "conditional enrollment." The conditional enrollment process enables low-income individuals to apply at SSA for premium Part A on the condition that they will only be enrolled in Part A if the State determines they would become eligible for the QMB group upon payment of the Part A premium.⁴⁷

For multiple decades, the conditional enrollment policy has helped hundreds of thousands of individuals, many of whom are poorer and more likely to be non-native English speakers, to obtain essential assistance with Medicare premiums and cost-sharing by allowing States to pay the first month's premium needed to trigger Medicare Part A entitlement (note that they do not actually become "entitled" to Part A until this payment is made). Without this policy, the subsidies available under the QMB group to make Part A affordable would only be available to individuals who somehow found a way to pay the initial Part A premium (including a late enrollment penalty if applicable) themselves.

We proposed to amend the regulations to reflect the foregoing longstanding approach to implementing the statute in a manner that gives full effect to our understanding of the law's

intended policy in this rare instance in which implementing the plain meaning of the words of the statute would produce a result that is at odds with this statutory purpose. As noted in the proposed rule at 87 FR 54774 through 54775, this approach is consistent with *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235 (1989) and other court opinions. We noted at 87 FR 54774 through 54775 that there also is CMS precedent for not applying the plain meaning of the words of the statute when it leads to an absurd result contrary to our understanding of the purpose of the statute.

For the reasons set forth previously in this final rule, in this case also, reversing our decades-long method of implementing the statute to instead apply the plain meaning of the words literally would be contrary to the fundamental purpose of the QMB statutory provisions. Therefore, as noted previously in this final rule, we proposed to incorporate in the regulations our longstanding practice of providing FFP for State payments of the first month of an individual's Part A premium for individuals who are eligible for the QMB group based on enrollment in Part B in Part A buy-in States or conditional enrollment in Part A in group payer States. This also would facilitate enrollment into the QMB group for SSI recipients who need to pay a premium to enroll in Part A.

We received comments on our proposed incorporation of this longstanding policy into regulations, and our responses follow.

Comment: Several commenters expressly supported our proposal to codify our decades-old practice of paying Federal matching funds to States that pay the first month's Part A premium for individuals eligible for the QMB group in Part A buy-in and group payer States, while no commenters opposed it. They concurred that a literal read of the relevant statutory provisions would create a "catch-22" in which low-income individuals cannot obtain QMB coverage that makes it affordable to enroll in Medicare until they become liable for the Part A premiums. They indicated that CMS's longstanding method of implementing the statute has helped to prevent a substantial financial barrier that is wholly inconsistent with the purpose of QMB statute. A commenter expressed hope that codifying the longstanding workaround will prompt the few Part A group payer States that have not yet recognized conditional Part A enrollments to now accept them as a valid basis for QMB eligibility.

Response: We thank the commenters for their support of the proposal to codify our longstanding practice to facilitate QMB enrollment for individuals without premium-free Part A. Over 700,000 individuals without premium-free Part A are currently enrolled in the QMB group. As indicated at 87 FR 54760 we estimated that if CMS were to remove this workaround, over 78,000 individuals without premium-free Part A each year would be prevented from enrolling in the QMB group. We anticipate that codification will provide additional clarity to States, beneficiaries, and organizations that assist them.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing without modification our proposal to codify our existing practice allowing States to receive Federal matching funds for the payment of Part A premiums the first month an individual is entitled to premium Part A.

SSI Recipients Eligible for Premium Part A

Based on the longstanding policy described previously in this final rule, in Part A buy-in States, when an SSI recipient who lacks sufficient work history for premium-free Part A has been determined eligible for the mandatory SSI or 209(b) group and is enrolled in Part B, the State can determine the individual eligible for the QMB eligibility group and enroll the individual in Part A buy-in.

To streamline QMB enrollment for SSI recipients who must pay a premium to enroll in Part A, we proposed at § 435.909(b)(1)(ii) to require Part A buy-in States to deem those individuals who are determined eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group and initiate their enrollment into Medicare Part A the month they are enrolled in Part B buy-in.

In Part A buy-in States with a 1634 agreement, once the State receives the automated Part B buy-in enrollment from CMS for an SSI recipient who lacks a sufficient work history for premium-free Part A, under proposed § 435.909(b)(1)(ii) the State would enroll the individual in the mandatory SSI group, deem the individual eligible for the QMB group, and effectuate enrollment in Medicare Part A through the buy-in agreement.

In a Part A buy-in State without a 1634 agreement (that is, a criteria or 209(b) State), once the individual applies to the Medicaid agency, some States currently only determine

⁴⁶ Chapter 1, section 1.10 of the CMS Manual for the State Payment of Medicare Premiums, <https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf>, and SSA POMS HI 00801.140.C Premium Part A Enrollments for Qualified Medicare Beneficiaries (QMBs)—Part A Buy-In States and Group Payer States. <http://policy.net.ba.ssa.gov/poms.nsf/lx/0600801140>.

⁴⁷ The conditional enrollment process is described in chapter 1, section 1.11 of the CMS Manual for the State Payment of Medicare Premiums, <https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf>, and in SSA POMS HI 00801.140 Premium Part A Enrollments for Qualified Medicare Beneficiaries (QMBs)—Part A Buy-In States and Group Payer States. <http://policy.net.ba.ssa.gov/poms.nsf/lx/0600801140>.

eligibility for the mandatory SSI or 209(b) group, as applicable, and initiate Part B enrollment per their buy-in agreement. Under proposed § 435.909(b)(1)(ii), these Part A buy-in States also would be required to deem any individuals determined by the State to be eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group and initiate enrollment in both Medicare Part A and Part B buy-in.

In the 14 group payer States, it is more challenging for SSI recipients to enroll in Medicare Part A and the QMB eligibility group. Unlike in Part A buy-in States, individuals determined eligible for the mandatory SSI or 209(b) group in group payer States who are enrolled in Part B pursuant to the State's buy-in agreement will not necessarily satisfy the eligibility requirement for the QMB group that the individual be entitled to Part A. Even though the State will initiate enrollment of the individual in Part B, pursuant to its buy-in agreement, it will not cover the individual's Part A premium or initiate Part A enrollment under the buy-in agreement. Instead, the individual must separately apply for premium Part A at SSA using the conditional enrollment process, which is administratively burdensome for both individuals and the State, and the vast majority of individuals fail to complete the process unless an eligibility worker or other application assistor provides hands-on assistance throughout.⁴⁸

Two other challenges currently make QMB enrollment harder for SSI recipients without premium-free Part A in group payer States. First, group payer States can only enroll individuals in premium Part A during the general Medicare enrollment period that runs from January through March each year. Second, group payer States are required to pay late enrollment penalties, if applicable, for those Medicaid beneficiaries who did not enroll in Medicare Part A timely when they first became eligible to do so.

To streamline QMB enrollment for SSI recipients without premium-free Part A in group payer States, we proposed to add a State option for deeming individuals eligible for the QMB group. Specifically, proposed § 435.909(b)(2) would allow, but not require, group payer States to directly initiate Medicare Part A enrollment for individuals who are not entitled to premium-free Part A without first

sending them to SSA to apply for conditional Part A enrollment. Under this proposed State option, once the State has determined the individual eligible for the mandatory SSI or 209(b) group and become liable for paying their Part B premiums under the buy-in agreement pursuant to § 407.42, the State would also be able to deem them eligible for the QMB group.

We received the following comments, and our responses follow.

Comment: Several commenters supported our proposal to require Part A buy-in States to deem as eligible for the QMB group certain SSI recipients who must pay a premium to enroll in Part A because it would meaningfully improve the ability of this low-income, at-risk population to access the benefits for which they qualify and that they distinctly need.

Response: We thank commenters for their support. We anticipate it will measurably increase the number of SSI recipients without premium-free Part A who participate in the QMB group.

Comment: Some commenters sought clarifications about our proposals to require QMB deeming in Part A buy-in States and allow it in group payer States. A few commenters questioned whether our proposal would require States to deem SSI recipients without premium-free Part A into the QMB eligibility group retroactively. One commenter inquired whether Federal statute permits retroactive coverage of Medicare Part A premiums or allows States to provide retroactive Part A buy-in coverage to SSI recipients, but not other QMB-eligible individuals. Another commenter inquired whether the proposal would require States to modify their systems to enroll SSI recipients in Part A buy-in. The commenter went on to question whether Part A buy-in States would need to align the QMB start date with the individual's Part A enrollment during the GEP and whether individuals who lose Part A buy-in may be required to pay late enrollment penalties. The commenter also noted that streamlining QMB enrollment processes for non-SSI recipients who qualify for premium Part A, including non-citizens, is equally important and suggested that CMS consider facilitating QMB enrollment for this population. The commenter indicated that LIS leads data would not include records for such individuals.

Response: At the outset, we clarify that our proposal would not permit States to retroactively enroll SSI recipients in Part A buy-in since, under section 1902(e)(8) of the Act, QMB coverage is effective the month following "the month in which the [QMB] determination first occurs" (that

is, the month the State deems the SSI recipient eligible for the QMB group). For individuals who lack premium-free Part A, deeming would occur the month they are enrolled in the mandatory SSI or 209(b) group and Part A buy-in, and QMB coverage would start the month following the deeming month. For example, if an individual were enrolled in the mandatory SSI or 209(b) group and Part B buy-in in April 2025, the State would deem the individual eligible for QMB in April 2025, with Part A buy-in and QMB coverage effective May 1, 2025. As explained at 87 FR 54772 and in our comment response in this final rule, States would only deem individuals eligible for QMB coverage during a past period if they are eligible for the mandatory SSI or 209(b) group and are retroactively determined eligible for premium-free Part A due to a delayed SSDI award.

In addition, we anticipate that States may need to modify their processes and systems to enroll SSI recipients in Part A buy-in the month after they are deemed eligible for QMB and expect that the nature and design of operations and system changes will vary by State. We are available to provide technical assistance to States as they make operational and systems changes to implement this proposal.

We clarify that Part A buy-in States would deem SSI recipients in QMB and enroll them in Part A buy-in throughout the year, not just during the GEP, since individuals covered under State buy-in agreements are not subject to Medicare enrollment periods. Further, we clarify that while residents of group payer States who lose eligibility for Part A buy-in may be subject to a late enrollment penalty, residents of Part A buy-in States who lose Part A buy-in are not liable for a late enrollment penalty even if they had been paying one prior to enrollment in Part A buy-in.⁴⁹

Finally, we agree with the importance of simplifying QMB enrollment for individuals who are not entitled to SSI and lack premium-free Part A, many of whom are otherwise ineligible for Medicaid coverage and would solely rely on Medicare for health insurance. As such, we may consider whether a basis exists to streamline QMB enrollment for non-SSI recipients who lack premium-free Part A in future rulemaking. We are also available to explore with States options to streamline their current QMB eligibility and enrollment processes for this

⁴⁸ Medicare Rights Center, "Streamlining Medicare and QMB Enrollment for New Yorkers: Medicare Part A Buy-In Analysis and Policy Recommendations," February 2011. <https://www.medicarerights.org/pdf/Part-A-Buy-In-Analysis.pdf>.

⁴⁹ CMS Manual for the State Payment of Medicare Premiums, chapter 1, section 1.15. <https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf>.

population. We also clarify that LIS leads data may include records for non-SSI recipients who lack premium-free Part A, do not already have Medicaid, and have applied for LIS.

Comment: Many commenters supported our proposal to permit group payer States to deem SSI recipients without Part A eligible for QMB by employing processes used by Part A buy-in States to directly initiate Part A entitlement for individuals enrolled in Part B (avoiding the need to first send them to SSA to enroll in conditional Part A). They agreed that it would significantly simplify QMB enrollment for beneficiaries and promote administrative efficiencies for States. A few commenters supported keeping this an option rather than a requirement because increasing QMB enrollment through streamlined processes could increase States costs and require systems updates.

Other commenters urged CMS to require group payer States to bypass the conditional enrollment process, citing numerous challenges arising from this process. These commenters indicated that the complexity of the conditional enrollment process presents an almost insurmountable obstacle for SSI recipients, who are among those least able to navigate complex application processes. They contended that requiring the lowest income, high needs older adults to first apply for conditional Part A at a separate agency is unrealistic and unfair and that getting lost in the process is the rule rather than the exception for those who lack assistance from an advocate, particularly for individuals with limited English proficiency and low literacy skills. They explained that having to wait until the GEP to file a conditional enrollment further complicates and delays the process. Some commenters noted that SSI recipients in States with group payer and 209(b) status face the steepest obstacles to obtain the benefits to which they are entitled because they must file an application for the 209(b) eligibility group with their State before completing the two-step application process to enroll in QMB. Some commenters stated that, despite the release of clearer program instructions to SSA field offices, government offices commonly provide incorrect information about the process or fail to properly enroll individuals in benefits. One commenter suggested that CMS has legal authority to mandate that group payer States deem SSI recipients without premium-free Part A eligible for QMB because doing so would still leave the administrative Part A group payment option intact. Finally, another

commenter requested that CMS require the remaining group payer States to convert to Part A buy-in status since a particular group payer State has not voluntarily taken that step despite requests from interested parties.

Response: We appreciate the commenters' support for allowing group payer States to bypass the conditional enrollment process for SSI recipients and deem them eligible for the QMB group. As we explained previously in this final rule and as noted by the commenters, although the conditional enrollment process provides a way for individuals to enroll in the QMB without paying the Part A premiums upfront, it is still extremely difficult for this very low-income, high-need population to traverse. We encourage group payer States to adopt the more streamlined processes used in Part A buy-in States. However, we recognize that the 14 group payer States may face unique challenges, with differing needs and opportunities. Therefore, we decline to adopt the commenters' recommendations to require group payer States to deem SSI recipients without Part A in QMB, or to convert to Part A buy-in status in this final rule, but we may consider whether there is a basis for such requirements in future rulemaking.

Comment: Several commenters recommended that CMS take steps to persuade group payer States to become Part A buy-in States in the event we permit—but do not require—group payer States to deem SSI recipients eligible for the QMB group. For example, some commenters suggested that CMS provide direct outreach to group payer States to explain how they would achieve savings by enrolling more Medicaid beneficiaries in Part A, which pays primary to Medicaid for Part A-covered services like inpatient hospital and skilled nursing facility care. Another commenter requested that CMS consider levers to incentivize group payer States to convert to Part A buy-in status, for example, charging group payer States for the additional administrative costs SSA incurs for processing conditional Part A applications for their residents. A commenter suggested that CMS require group payer States that decline to deem SSI recipients eligible for the QMB group to actively assist individuals in completing the conditional enrollment process at SSA rather than requiring individuals to navigate the process themselves.

Response: We agree with the importance of working with group payer States to assess the impact of entering into a Part A buy-in agreement. Part A

buy-in agreements are beneficial to individuals and may also reduce administrative burden and costs for providers and States. To that end, we commissioned a decision support tool and offered technical assistance to group payer States to help them analyze the fiscal impact of newly executing a Part A buy-in agreement with us.⁵⁰ We will continue such education and outreach to group payer States. We decline to adopt the commenter's suggestion to charge group payer States for costs associated with conditional enrollments at SSA, but we may consider other steps to promote QMB enrollment group payer States in the future. We also highly encourage States to help individuals in completing the conditional enrollment process at SSA, but we decline to make such assistance a requirement at this time.

After considering the comments received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal to require Part A buy-in States to deem individuals enrolled in the mandatory SSI or 209(b) group eligible for the QMB group and to permit group payer States to adopt the same streamlined procedures used in Part A buy-in States under new §§ 435.909(b)(1) and 435.909(b)(1) with a modified compliance date to allow States more time for implementation. This modification extends the compliance date for this provision to October 1, 2024.

4. Clarifying the Qualified Medicare Beneficiary Effective Date for Certain Individuals (§ 406.21)

We proposed to clarify the effective date of coverage under the QMB group for individuals who must pay a premium to enroll in Part A and reside in a group payer State to provide individuals with protection from Medicare premiums and cost-sharing costs on the earliest possible date.

As discussed in the proposed rule at 87 FR 54775, eligible individuals who do not enroll in premium Part A during their initial enrollment period (IEP), the 7-month period that starts the third month before the individual qualifies for Medicare, or who disenroll from premium Part A and wish to re-enroll, must generally do so during the general

⁵⁰ See Dujack, Andrew et al., "Assessing the Fiscal Viability of a Medicare Part A Buy-in Agreement in Group Payer States," *The Integrated Care Resource Center*, December 2021. <https://www.integratedcareresourcecenter.com/sites/default/files/Assessing%20the%20Fiscal%20Viability%20of%20a%20Medicare%20Part%20A%20Buy-in%20Agreement%20in%20Group%20Payer%20States.pdf>.

enrollment period (GEP). The GEP, established under section 1837(e) of the Act, is the period beginning on January 1 and ending on March 31 of each year. Section 120 of the Consolidated Appropriations Act, 2021 (CAA, 2021, Pub. L. 116–260) revised the Part A entitlement effective date for individuals who enroll during the GEP beginning on or after January 1, 2023 from the first of July following their enrollment to the first day of the month following the month in which they enroll. In the November 3, 2022 regulation entitled “Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules” (87 FR 66454), we revised § 406.21(c) to implement the GEP effective dates outlined in section 120 of the CAA.

To align with that change, we proposed at 87 FR 54775 to clarify the applicable effective date of QMB coverage for an individual who resides in a group payer State and enrolls in conditional Part A during the GEP. As discussed previously in this final rule, in the proposed rule (87 FR 54773 & 54774), in a Part A buy-in State, we consider enrollment in Part B sufficient to meet the requirement that an individual be entitled to Part A for the purposes of the QMB eligibility determination. However, in a group payer State, enrollment in QMB for individuals who need to pay a premium to enroll in Part A is always a two-step process. The State cannot determine individuals eligible for QMB and enroll them in Part A buy-in until SSA establishes actual or conditional Part A enrollment. With respect to QMB enrollment under a buy-in agreement under § 406.26, Medicare Part A coverage begins the first month an individual is entitled to Part A under § 406.20(b) and has QMB status. We consider a conditional Part A filing to be sufficient to fulfill the requirement for entitlement to Part A as applicable for QMB coverage.⁵¹

Specifically, we proposed in new § 406.21(c)(5) to codify existing policy that individuals who reside in group payer States and enroll in actual or conditional Part A during the GEP can obtain QMB as early as the month Part A entitlement begins. Beginning on or after January 1, 2023, for individuals who enroll in Medicare during the GEP, QMB coverage starts the month premium Part A entitlement begins (if

the State determines the individual has met the eligibility requirements for QMB coverage in the same month that Part A enrollment occurs), or a month later than the month of Part A entitlement (if the individual is determined eligible for QMB the month Part A entitlement begins or later).

We received the following comments on our proposed codification of the effective date in § 406.21(c)(5), and our responses follow.

Comment: Multiple commenters expressed thanks for our proposal to codify our existing policy regarding the applicable effective date of QMB coverage for an individual who resides in a group payer State and enrolls in conditional Part A during the GEP. According to the commenters, codifying the policy would aid beneficiaries and promote clarity and accountability for States as they adjust their processes to align with changes to the effective date of Part A entitlement for enrollments made during the IEP and GEP and the creation of new SEPs under the CAA, 2021. A commenter supported the policy but noted that it would take 18–24 months for a specific State to implement this change.

Response: We thank the commenters for their support for incorporating into our regulations our existing policy regarding the QMB start date in group payer States. To provide States more time to implement this proposal, we plan to modify the compliance date to April 1, 2026.

Comment: A few commenters encouraged CMS to provide technical assistance and information to States and education to SHIPs, advocates, and counselors to help ensure individuals in group payer States receive benefits at the earliest possible date. For example, a commenter suggested that CMS produce FAQs explaining how the conditional enrollment process generally works and how the change in the effective date of GEP enrollments under the CAA, 2021 (that is, the month following the month of enrollment) means that individuals will lose valuable months of benefits if they do not apply for QMB the same month they conditionally enroll in Part A. The commenter also requested that CMS clarify that individuals who enroll in conditional Part A would not become liable for Part A premiums if they are not approved for the QMB group and address uncommon occurrences, such as if an individual wants to change their conditional Part A enrollment to actual Part A enrollment if they experience a medical emergency and need Part A coverage before QMB benefits can start. The commenter further recommended

that, as group payer States update their processes, CMS act quickly to help correct any QMB enrollment delays and ensure that individuals receive refunds for any Medicare cost-sharing amounts they incur before such corrections are made. Another commenter requested clarification on whether a group payer State must provide Part A buy-in and QMB benefits to individuals who enroll in premium Part A during an SEP, such as the new SEP for formerly incarcerated individuals.

Response: We agree with the importance of providing education and assistance to promote the earliest access to QMB benefits. We will consider these issues and others as we update our existing materials to inform States, beneficiaries, SHIPs, advocates, and other interested parties about these policies. In response to the question about Part A enrollments in group payer States during an SEP, we clarify that individuals can use the new SEPs to enroll in premium Part A under existing SSA processes for the purposes of enrolling in the QMB eligibility group. As such, a group payer State must determine eligible individuals who enroll in premium Part A during an SEP eligible for Part A buy-in and QMB coverage. Further, if a group payer State recognizes conditional enrollments filed during a GEP as meeting the requirement for entitlement to Part A for the purposes of QMB eligibility, it would be required to treat conditional enrollments made during an SEP as a basis for QMB eligibility.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposal to codify existing policy that individuals who reside in group payer States and enroll in actual or conditional Part A during the GEP can obtain QMB as early as the month Part A entitlement begins under § 406.21(c)(5), with a modified compliance date to allow States more time to implement this provision. This modification extends the compliance deadline to April 1, 2026.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a “collection of information” requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purposes of the PRA and this section of the preamble, collection of information

⁵¹ See CMS Manual for the State Payment of Medicare Premiums, chapter 1, section 1.11. <https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf>.

is defined under 5 CFR 1320.3(c) of the PRA’s implementing regulations.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

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

In our September 7, 2022 (87 FR 54760) proposed rule, we solicited public comment on each of the required issues under section 3506(c)(2)(A) of the PRA for the following collection of information requirements. We did not receive comments related to any of the proposed collection of information requirements or associated burden estimates.

We have made changes from the proposed rule to this final rule to the

wages identified immediately below, the associated cost estimates, the number of States impacted by our change to the definition of family size, associated cost estimates (see discussion in section IV.C.1. of this final rule) and cost estimates impacted by changes related to the modification of our proposal to screen LIS applicants for full Medicaid (see discussion in section IV.C.1. of this final rule). At this time, we are not making changes to other proposed collection of information requirements and time estimates in this rule. As described later in this section, we are reorganizing (relative to the proposed rule) the Collection of Information and Regulatory Impact Analysis sections of this final rule. However, we discuss wage, FMAP, and other related info here in this section to match its placement in the proposed rule.

A. Wage Estimates

Wage Changes. In this final rule, we are adjusting the wage for individuals from \$28.01/hr to \$21.98/hr. The adjustment from the proposed rule is based on internal review as we changed the source of the wage figure from U.S.

Bureau of Labor Statistics’ (BLS) May 2021 National Occupational Employment and Wage Estimates at \$28.01/hr (see 87 FR 54817) to HHS guidance at \$21.98/hr (see Wages for Individuals, below). This change affects the cost estimates in sections IV.C.1. and 2. of this final rule.

We are also adjusting the wages for State government respondents. At the time of publication of the proposed rule the most recent BLS wage figures were from May 2021 (see 87 FR 54817). At the time of publication of this final rule the most recent BLS wage figures are from May 2022. This change affects the cost estimates in sections IV.C.1., 2. and 5. of this final rule.

Wages for State Governments. To derive average State-specific costs, we used data from the BLS May 2022 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 2 presents the BLS’ mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 2—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage (\$/hr)	Fringe benefits and other indirect costs (\$/hr)	Adjusted hourly wage (\$/hr)
Business Operations Specialist	13–1000	40.04	40.04	80.08
Computer Programmer	15–1251	49.42	49.42	98.84
Database and Network Administrator and Architect	15–1240	53.08	53.08	106.16
Eligibility Interviewers, Government Programs	43–4061	24.05	24.05	48.10
General and Operations Mgr	11–1021	59.07	59.07	118.14

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Cost to State Governments. To estimate State costs, it was important to take into account the Federal Government’s contribution to the cost of administering the Medicaid program. The Federal Government provides funding based on a Federal Medical Assistance Percentage (FMAP) that is established for each State, based on the per capita income in the State as compared to the national average. FMAPs range from a minimum of 50

percent in States with higher per capita incomes to a maximum of 76.25 percent in States with lower per capita incomes. For Medicaid, all States receive a 50 percent FMAP for administration. As noted previously, States also receive higher Federal matching rates for certain services and for systems improvements or redesign, so the level of Federal funding provided to a State can be significantly higher. As such, in taking into account the Federal contribution to the costs of administering the Medicaid program for purposes of estimating State burden with respect to the collection of information requirements, we elected to use the higher-end estimate that the States would contribute 50 percent of the costs, even though the burden will likely be much smaller.

Wages for Individuals. We believe that the cost for beneficiaries undertaking administrative and other tasks on their

own time is a post-tax wage of \$21.98/hr.

The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices⁵² identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for beneficiaries, we used a measurement of the usual weekly earnings of wage and salary workers of \$1,059⁵³ for 2022 and then divided by 40 hours to calculate an hourly pre-tax wage rate of \$26.48/hr. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent or \$4.50/hr (\$26.48/hr × 0.17), resulting in the post-tax hourly wage rate of \$21.98/hr.

⁵² https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/176806/VOT.pdf.

⁵³ <https://fred.stlouisfed.org/series/LEU0252881500A>.

hr (\$26.48/hr – \$4.50/hr). Unlike our State wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

B. Information Collection Requirements (ICRs)

In the proposed rule, we projected both new burdens and savings based on how our proposed rule would change burdens relative to the status quo. Because the Medicaid program predates the enactment of PRA and we viewed many longstanding basic Medicaid requirements as customary business practices for State Medicaid agencies,⁵⁴ we did not have specific PRA packages outlining these burdens inherent to the Medicaid program, including application⁵⁵ (burden on State in processing the application and burden on individual in filling out application); requests for additional information (burden on State in assessing application and burden on individual in responding to State); making eligibility determinations and providing appeal rights (burden on State in making determinations and burden on individual if filing appeal); verifying information in the application (burden on State in conducting verifications and burden on individual in supplying supporting documentation); and renewal process (burden on State in conducting renewals and burden on individual in responding to State). However, we now recognize that creating PRA packages for the longstanding Medicaid functions, plus the changes from this final rule, would improve transparency for the public. In

⁵⁴ See final rule titled "Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP" published in the November 30, 2016 **Federal Register** (81 FR 86382, 86438). <https://www.federalregister.gov/documents/2016/11/30/2016-27844/medicaid-and-childrens-health-insurance-programs-eligibility-notices-fair-hearing-and-appeal>; final rule titled "Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment" published in the July 15, 2013 **Federal Register** (78 FR 42159, 42288). <https://www.federalregister.gov/documents/2013/07/15/2013-16271/medicaid-and-childrens-health-insurance-programs-essential-health-benefits-in-alternative-benefit>; and final rule titled "Eligibility Changes Under the Affordable Care Act of 2010" published in the March 23, 2012 **Federal Register** (77 FR 17143, 17197). <https://www.federalregister.gov/documents/2012/03/23/2012-6560/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010>.

⁵⁵ There is a current package for burdens related to Medicaid application (0938–1191 (CMS–10440)), but it focuses on MAGI eligibility groups, not non-MAGI eligibility groups.

the proposed rule, we incorrectly referenced PRA packages that did not contain these longstanding provisions. As such, after publication of this final rule, we plan to develop and publish new PRA packages that consist of both the longstanding MSP application and enrollment provisions and the changes made by this final rule. In the meantime, we are moving our estimates for burden and savings to the Regulatory Impact Analysis (RIA) section.

IV. Regulatory Impact Analysis

A. Statement of Need

We have learned through our experiences in working with States and other interested parties that certain policies result in unnecessary burdens and create barriers to enrollment and retention of coverage. As a result, many older adults and people with disabilities experience administrative confusion, economic hardships, and challenges accessing health care services. In response to multiple Executive Orders, as cited in section I. of this final rule, we reviewed existing regulations for areas where access could be improved.

In this rulemaking, we finalize policies to streamline processes to enroll in (and maintain enrollment in) Medicaid through the MSPs. Together, the changes in this final rule would reduce administrative burden on States and enrollees, expand coverage of eligible applicants, increase retention of eligible enrollees, and improve health equity.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 entitled "Modernizing Regulatory Review" (April 6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The Executive Order 14094

entitled "Modernizing Regulatory Review" (hereinafter, the Modernizing E.O.) amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) having an annual effect on the economy of \$200 million or more in any 1 year (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or Tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive Order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action(s) or with significant effects (\$200 million or more in any 1 year). Based on our estimates, OMB's OIRA has determined this rulemaking is significant per section 3(f)(1) as measured by the \$200 million threshold. Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of the rulemaking.

The aggregate economic impact of this final rule is estimated to be \$26.16 billion (in real FY 2025 dollars) over 5 years. This represents additional health care spending made by Medicaid on behalf of beneficiaries, with \$10.67 billion paid by the Federal Government and \$7.89 billion paid by the States, and an additional \$7.60 billion in Medicare spending.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$8.0 million to \$41.5 million in any one year. Individuals and States are not included in the definition of a small entity. Since this final rule

would only impact States and individuals, we do not believe that this final rule will have a significant economic impact on a substantial number of small businesses.

In addition, section 1102(b) of the Act requires CMS to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. This final rule applies to State Medicaid agencies and would not add requirements to rural hospitals or other small providers. Therefore, we are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this final rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the UMRA also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. In 2023, that is approximately \$177 million. We believe that this final rule would have such an effect on spending by State, local, or Tribal governments but not by private sector entities.

Overall Assumptions

In developing these estimates, we have relied on several global assumptions. All estimates are based on the projections from the President's FY 2024 Budget. We have assumed that new enrollees would have the same average costs as current enrollees by eligibility group, unless specified in the description of the estimates (for example, some enrollees only would receive Medicare premium assistance). We have also updated the implementation dates of the provisions, with provisions to require States to automatically enroll SSI recipients as QMBs starting in October 2024 and all other provisions requiring compliance by April 2026. We have also relied on the data sources and assumptions described in the next section to develop estimates for specific provisions of this final rule.

C. Anticipated Effects

1. Facilitate Enrollment Through Medicare Part D LIS Leads Data

As described in section II.A.1. of this final rule, we are finalizing the addition of § 435.911(e), which focuses on using

the SSA data from processing LIS applications "LIS leads data" to streamline MSP eligibility determinations. Relative to our proposal, the finalized paragraph (e) has three main differences. First, we are modifying the proposed requirement at paragraphs (e)(6)(i) and (ii) for States to collect additional information to screen individuals for full Medicaid eligibility to require that distinct from the MSP enrollment process unless otherwise approved by CMS, States separately provide the individual the opportunity to authorize the Medicaid agency to determine full Medicaid eligibility and furnish any additional needed information. We decided to modify this proposal based on comments received to avoid delays in MSP enrollment and disadvantages associated with modifying the LIS application, while also ensuring that we facilitate individuals' access to full-scope Medicaid coverage. We are also moving this requirement from paragraphs (e)(6)(i) and (ii) to paragraph (e)(9). Second, we are applying a compliance date of April 1, 2026 for States to come into full compliance with all the provisions in new § 435.911(e). Third, we revised some wording and reordered the other paragraphs in § 435.911(e) for clarity and flow as noted below:

- *Paragraph (e)(1)*: We are retaining the requirement to accept LIS leads data in paragraph (e)(1), but are removing the term "Low Income Subsidy application data" and using an acronym in place of "Social Security Administration" since "LIS leads data" and "SSA" are now established in paragraph (e).

- *Paragraph (e)(2)*: We are keeping the requirement to treat LIS leads data as application for the MSPs without requiring submission of another application in finalized paragraph (e)(2), but are moving the requirement regarding timely application processing to finalized paragraph (e)(7).

- *Paragraph (e)(3)*: We are moving the requirement to accept any information provided by SSA, which we are now specifying as LIS leads data for greater consistency in terminology throughout the regulation, without further verification, from proposed paragraph (e)(5) to finalized paragraph (e)(3) and adding that this provision applies unless the State agency has information that is not reasonably compatible with the LIS leads data or the LIS leads data would not support a determination of MSP eligibility.

- *Paragraph (e)(4)*: We are retaining the requirement to not collect information or documentation from the individual in finalized paragraph (e)(4) and are adding that this is unless the

State agency has information that is not reasonably compatible with the LIS leads data.

- *Paragraph (e)(5)*: We are moving the requirement to seek additional information from proposed paragraph (e)(3) to finalized paragraph (e)(5) and defining additional information needed for the MSP determination as information that is not in the leads data.

- *Paragraph (e)(6)*: We are moving the requirement to verify an individual's citizenship and immigration status from proposed paragraph (e)(6)(iii) to finalized paragraph (e)(6), adding a citation to § 435.406, and streamlining the regulation text.

- *Paragraph (e)(7)*: We are moving the requirement regarding timely application processing from proposed paragraph (e)(2) to finalized paragraph (e)(7).

- *Paragraph (e)(8)*: We are moving additional requirements if the LIS leads data does not support a determination of MSP eligibility from proposed paragraph (e)(7) to finalized paragraph (e)(8).

- *Paragraph (e)(9)*: We are moving and modifying the proposal related to screening for full Medicaid from proposed paragraphs (e)(6)(i) and (ii) to finalized paragraphs (e)(9)(i) and (ii) to require States to provide individuals with—in addition to and separate from any requests for additional information necessary for a determination of Medicare Savings Program eligibility, unless CMS approves otherwise—information about the availability of additional Medicaid benefits on other bases and responsibilities of the individual applying for such benefits, and an opportunity to furnish such additional information as may be needed to determine whether the individual is eligible for such additional Medicaid benefits.

The clarifications in paragraph (e)(9) requiring screening of LIS applicants for full Medicaid to be separate from a request for additional information necessary for a determination of MSPs does not represent a major change to the proposal. However, we neglected to make an initial burden estimate for the proposed requirement to screen LIS applicants for full Medicaid. As such, we now make an estimate for the new requirement in paragraph (e)(9) that would require States to collect new information, provide beneficiaries with an opportunity to authorize this new information collection, and make a determination for full Medicaid based on the information collection. We are permitting significant flexibility to States for how they implement the requirement at paragraph (e)(9), and we

expect States will make varying use of automation and different forms of communication to applicants. For efficiency reasons, we believe that a State would send the required disclosures/consent for the agency to make a full Medicaid eligibility determination as well as the request for additional information needed to make a full Medicaid determination in one correspondence. Moreover, instead of asking many questions in order to gain additional information necessary to make a full Medicaid eligibility determination, we anticipate that States will instead merely highlight the additional information individuals need to fill out on the full Medicaid application form. We expect the State burden would be, an ongoing burden of, on average, 15 minutes per LIS applicant (400,000 total) to provide the required disclosures/consent and highlight the additional information individuals need to fill out on the full Medicaid application form. The full Medicaid application form will not need to be revised.

We believe most individuals would not have an additional burden associated with this provision because we assume that the vast majority (85 percent) of individuals will not respond to the States' request for additional information. In reaching this conclusion, we note that individuals are generally discouraged from applying for Medicaid by burdensome application processes and repeated requests for additional information. Given that the determination of full Medicaid for LIS applicants would inevitably require individuals to face these hurdles, we believe it is reasonable to conclude that only around 15 percent of individuals will respond to States' requests for information. States will then only need to process and make full Medicaid determinations for the remainder of individuals (15 percent or 60,000 individuals [400,000 LIS applicants \times 0.15]), which will take about 1 hour at \$48.10/hr. The annual State burden for sending individuals the new information is 100,000 hours (400,000 LIS applicants \times 0.25 hr) at a cost of \$4,810,000 (100,000 hr \times \$48.10/hr).

For processing the information received from individuals, we estimate an annual State burden of 60,000 hours (60,000 applicants \times 1 hr/application) at a cost of \$2,886,000 (60,000 hr \times \$48.10/hr).

The total State burden is 160,000 hours (100,000 hr + 60,000 hr) and \$7,696,000 (\$4,810,000 + \$2,886,000).

However, when taking into account the 50 percent Federal contribution to Medicaid program administration, the

estimated State cost is \$3,848,000 (\$7,696,000 \times 0.50).

For individuals to respond to States' request for information (that is, complete the remainder of the full Medicaid application), we estimate that it will take 4 hours at \$21.98/hr. In aggregate, we estimate an annual burden of 240,000 hours (60,000 applicants \times 4 hr/application) at a cost of \$5,275,200 (240,000 hr \times \$21.98/hr).

New requirements in this final rule at § 435.911(e)(1) require States to accept, via secure electronic interface, the SSA LIS leads data, while § 435.911(e)(2) requires that States treat receipt of the leads data as an application for the MSPs. Section 435.911(e)(3) requires States to accept information provided through the leads data relating to a criterion of eligibility without further verification unless information available to the agency is not reasonably compatible with information provided by or on behalf of the individual, while § 435.911(e)(4) requires States to refrain from requesting information from individuals already provided through leads data unless information available to the agency is not reasonably compatible with information provided by or on behalf of the individual. Sections 435.911(e)(5) and (6) require States to seek additional information as needed to determine MSP eligibility. Section 435.911(e)(7) requires State agencies to promptly determine MSP eligibility. Finally, § 435.911(e)(8) requires further steps if the leads data does not support a determination of eligibility.

We estimate that as a result of finalized provisions in § 435.911(e), States will be able to adjudicate over 90 percent of MSP applications for LIS enrollees without gathering additional documentation from the applicants. Therefore, as there are about 400,000 new LIS applicants approved annually in 51 States (all 50 States and the District of Columbia),⁵⁶ we estimate that 360,000 (400,000 \times 0.9) of those applicants will be able to enroll in an MSP without providing additional income and resource related documentation, and without the State receiving and adjudicating such data.

The finalized provisions in § 435.911(e) are associated with a reduction in burden for States and beneficiaries associated with

application completion and eligibility determinations at the State Medicaid agency, including: reduced verification work for States that do not need to adjudicate the leads data for approximately 360,000 new LIS applicants; reduced paperwork to submit for the LIS applicants applying to MSPs in 51 States; reduced burden for LIS applicants who were previously expected to obtain, print, copy, mail and fax documents to the State to support the State's verification of income and resources; and reduced LIS applicant burden related to the need for public transportation and cell phone usage in relation to said document activities (obtaining, printing, copying, mailing, and faxing).

Reduced Verification Burden. We estimate that the finalized provisions in § 435.911(e) will save an Eligibility Interviewer 25 minutes (0.42 hr) per eligibility determination at \$48.10/hr for the 360,000 new LIS applicants from reduced paperwork to review because of the provisions in § 435.952(e) that require States to accept self-attestation of interest and dividend income, non-liquid resources, burial funds, and the face value of life insurance by individuals applying to MSPs and the reduced verification work due to considering the leads data as verified.

In aggregate, we estimate an annual savings of minus 151,200 hours (360,000 applicants \times 0.42 hr) and minus \$7,272,720 (151,200 hr \times \$48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State savings is approximately minus \$3,636,360 (\$7,272,720 \times 0.5).

Reduced LIS Applicant Burden for Applying to MSPs. We estimate these provisions will reduce the time needed for LIS applicants applying to MSPs to submit paperwork from 4 hours to 15 minutes, for a savings of 3.75 hours per applicant per year across all 51 States. In aggregate, we estimate an annual savings of minus 1,350,000 hours (360,000 applicants \times 3.75 hr) and minus \$29,673,000 (1,350,000 hr \times \$21.98/hr).

Reduced Burden for LIS Applicants to Support the State's Verification of Income and Resources. We also estimate LIS applicant non-labor savings from the changes to § 435.911(e) from public transportation, printing, copying, postage, and fax expenses to be about \$10 [((\$4.50 postage for small package or \$1.75/page for faxing) + \$4 roundtrip bus ride (from home to printing or copying place to post office and back home) + \$0.13/page for printing or copying)] per LIS applicant per year for all 51 States (including DC). In

⁵⁶ Over the past 5 years (2017–2021), SSA approved an average of 394,025 LIS applications annually. <https://www.ssa.gov/open/data/Data-about-Extra-Help-with-Medicare-Prescription-Drug-Plan-Cost.html>. We do not have estimates for any potential increases in application volume or approval rates based on changes to LIS eligibility criteria in the Inflation Reduction Act.

aggregate, we estimate an annual non-labor savings of minus \$3,600,000 (360,000 enrollees \times \$10/enrollee).

Finalized § 435.952(e)(1) through (4) is unchanged from the proposed rule, except for applying a delayed compliance date of April 1, 2026 for States to come into full compliance with all of these provisions, and newly requiring States to accept self-attestation of certain income and resources for MSP applicants and beneficiaries—including dividend and interest income, burial funds of spouse and individual, and the face value of life insurance policy unless the State has information that is not reasonably compatible with the applicant's attestation. Because around 10 States (including DC) (about 20 percent of all 51 States, including DC) do not have asset tests and do not require documentation to complete an eligibility determination or redetermination at the State Medicaid agency, we expect the savings from the self-attestation provisions would only apply to approximately 8.4 million individuals (80 percent of 11 million applications/renewals⁵⁷ minus 400,000 individuals who applied to LIS counted previously in this final rule) in the other 41 States. We estimate that under § 435.952(e)(1) through (4), these 8.4 million individuals will see a reduction from 4 hours to 2 hours, for a savings of 2 hours per individual, to complete an application/renewal in all 41 States. In aggregate, we estimate an annual savings of minus 16,800,000 hours (8,400,000 individuals \times 2 hr) and minus \$369,264,000 (16,800,000 hr \times \$21.98/hr).

We also estimate the non-labor savings under § 435.952(e)(1) through (4) to be about \$10 [(\$4.50 postage for small package or \$1.75/page for faxing) + \$4 roundtrip bus ride (to/from post office, printing/copying place and home) + \$0.13/page for printing/copying] per MSP applicant/renewal per year for all 51 States. In aggregate, we estimate an annual non-labor savings of minus \$84,000,000 (8,400,000 individuals \times \$10/individual).

Reduced State Burden for Verification of New MSP Applicants. We also estimate that § 435.952(e)(1) through (4) will save an Eligibility Interviewer 15 minutes (0.25 hr) per eligibility determination or renewal for these

8,400,000 applicants/beneficiaries. In aggregate, we estimate an annual labor savings for States of minus 2,100,000 hours (8,400,000 applications \times 0.25 hr) and minus \$101,010,000 (2,100,000 hr \times \$48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State savings is approximately minus \$50,505,000 (\$101,010,000 \times 0.5).

State Burden for Verification of the Face Value of Life Insurance. We are also finalizing § 435.952(e)(4) to require States to develop a verification process to determine the cash surrender value of life insurance policies over \$1,500. We anticipate this will be a change for 10 States in their process for verifying the cash surrender value of life insurance policies over \$1,500. We do not anticipate an impact in around 16 States that are using authority in section 1902(r)(2) of the Act to disregard the cash surrender value of life insurance in whole or part. We estimate that 25 of the remaining 35 States (51 States – 16 States) will choose to use authority in section 1902(r)(2) of the Act to disregard the cash surrender value of life insurance rather than opting to verify the cash surrender value of life insurance. As noted previously in this final rule, we expect that this change will only impact 20 percent or approximately 10 States (51 States \times 0.2).⁵⁸ Based on enrollment in past years, we anticipate that all 51 States will adjudicate 1,000,000 new MSP applications a year plus 10 million renewals. However, we anticipate this policy will only affect 2 percent of applicants and beneficiaries, or 44,000 individuals across 10 States (11,000,000 individuals \times 0.02 of applicants \times 0.2 of States) because of the small number of people who could both afford this type of life insurance (which is much more expensive than term life insurance) and are also likely to apply for MSPs (which tends to be lower-income individuals).

The burden associated with § 435.952(e)(4) will consist of the time and effort for eligibility workers in 10 States to collect information regarding the cash surrender value of life insurance from 44,000 applicants. The savings associated with § 435.952(e)(4) consists of eligibility workers in 10 States not having to spend time coaching 44,000 applicants how to

gather and find information on the cash surrender value of life insurance and eligibility workers in 10 States not having to review life insurance documents for individuals with life insurance less than \$1,500.

Under § 435.952(e)(4), we estimate that it will take an Eligibility Interviewer 1 hour at \$48.10/hr to verify the cash surrender value of each life insurance policy over \$1,500. In aggregate, we estimate an annual burden of 44,000 hours (1 hr \times 44,000 individuals) at a cost of \$2,116,400 (44,000 hr \times \$48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State share is approximately \$1,058,200 (\$2,116,400 \times 0.5).

Reduced State Burden for Verification of the Face Value of Life Insurance. We estimate the changes under § 435.952(e)(4) will save Eligibility Interviewers an average 45 minutes (0.75 hr) per applicant from not needing to coach applicants on how to gather and find information on the cash surrender value of life insurance. In aggregate, we estimate an annual savings of minus 33,000 hours (44,000 applicants \times 0.75 hr) and \$1,587,300 (33,000 hr \times \$48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State savings is approximately minus \$793,650 (\$1,587,300 \times 0.5).

We also estimate State savings under § 435.952(e)(4) from eligibility workers not having to review life insurance documents for individuals with life insurance less than \$1,500. We anticipate it will take an eligibility worker about 10 minutes (0.167 hr) to review a life insurance document and that this savings will affect 3 percent or 66,000 applicants and beneficiaries or individuals (11,000,000 individuals \times 0.03 \times 0.2) across 10 States. In aggregate, we estimate an annual savings of minus 11,022 hours (66,000 individuals \times 0.167 hr) and minus \$530,158 (– 11,022 hr \times \$48.10/hr). Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State savings is approximately minus \$265,079 (\$530,158 \times 0.5).

As indicated in Table 3, we estimate a net State annual burden reduction of minus 2,091,222 hours and minus \$50,293,889.

⁵⁷ Based on States adjudicating 1.5 million new applications and 10 million for redetermination annually.

⁵⁸ We are not including impacts for territories in these estimates because territories do not have any enrollment in MSPs.

TABLE 3—SUMMARY OF STATE BURDEN FOR FACILITATING MEDICAID ENROLLMENT THROUGH LIS LEADS DATA AND SELF-ATTESTATION PROVISIONS

Regulation section(s)	Number of respondents	Total number of responses	Time per response (hours)	Total time (hours)	Hourly labor cost (\$/hr)	Total labor cost (\$)	Total state share (\$)	Total non-labor cost (\$)	Frequency
§ 435.911	51 States	400,000	0.25	100,000	48.10	4,810,000	2,405,000	0	Annual.
§ 435.911	51 States	60,000	1	60,000	48.10	2,886,000	1,443,000	0	Annual.
§§ 435.911 and 435.952	51 States	(7,059)	0.42	(151,200)	48.10	(7,272,720)	(3,636,360)	0	Annual.
§ 435.952	51 States	(8,400,000)	0.25	(2,100,000)	48.10	(101,010,000)	(50,505,000)	0	Annual.
§ 435.952	10 States	4,400	1	44,000	48.10	2,116,400	1,058,200	0	Annual.
§ 435.952	10 States	(4,400)	0.75	(33,000)	48.10	(1,587,300)	(793,550)	0	Annual.
§ 435.952	10 States	(6,600)	0.167	(11,022)	48.10	(530,158)	(265,079)	0	Annual.
Total	51 States	(7,953,659)	Varies	(2,091,222)	48.10	(100,587,778)	(50,293,889)	0	Annual.

As indicated in Table 4, for individuals, we estimate an annual burden reduction of minus 17,910,000 hours and minus \$481,261,800.

TABLE 4—SUMMARY OF INDIVIDUAL BURDEN FOR FACILITATING MEDICAID ENROLLMENT THROUGH LIS LEADS DATA AND SELF-ATTESTATION PROVISIONS

Regulation section(s)	Number of respondents	Total number of responses	Time per response (hours)	Total time (hours)	Hourly labor cost (\$/hr)	Total labor cost (\$)	Total state share (\$)	Total non-labor cost (\$)	Frequency
§ 435.911	60,000 individuals	60,000	4	240,000	21.98	5,275,200	0	5,275,200	Annual.
§§ 435.911 and 435.952	360,000 individuals	(360,000)	(3.75)	(1,350,000)	21.98	(29,673,000)	0	(29,673,000)	Annual.
§§ 435.911 and 435.952	360,000 individuals	(360,000)	0	n/a	n/a	0	(3,600,000)	(3,600,000)	Annual.
§ 435.952	8,400,000 individuals	(8,400,000)	(2)	(16,800,000)	21.98	(369,264,000)	0	(369,264,000)	Annual.
§ 435.952	8,400,000 individuals	(8,400,000)	0	n/a	n/a	0	(84,000,000)	(84,000,000)	Annual.
Total	8,820,000 individuals	(17,580,000)	Varies	(17,910,000)	Varies	(393,661,800)	(87,600,000)	(481,261,800)	Annual.

When combined (see Table 5), we estimate an annual burden reduction of minus 20,001,222 hours and minus \$531,555,689.

TABLE 5—SUMMARY OF STATE AND INDIVIDUAL BURDEN FOR FACILITATING MEDICAID ENROLLMENT THROUGH LIS LEADS DATA AND SELF-ATTESTATION PROVISIONS

Respondent type	Number of respondents	Total number of responses	Total time (hours)	Hourly labor cost (\$/hr)	Labor cost (\$)	Non-labor cost (\$)	Total cost (\$)	Frequency
States	51	(7,953,659)	(2,091,222)	Varies	(50,293,889)	0	(50,293,889)	Annual.
Individuals	8,760,000	(17,580,000)	(17,910,000)	Varies	(393,661,800)	(87,600,000)	(481,261,800)	Annual.
Total	8,820,051	(25,533,659)	(20,001,222)	Varies	(443,955,689)	(87,600,000)	(531,555,689)	Annual.

2. Defining “Family of the Size Involved” for the Medicare Savings Program Groups Using the Definition of “Family Size” in the Medicare Part D Low-Income Subsidy Program

As described in section II.A.2. of this final rule, § 435.601 aligns the definition of “family size” for purposes of MSP eligibility with that of the LIS program. Specifically, we newly define “family of the size involved” to include at least the individuals included in the definition of “family size” in the LIS program: the applicant, the applicant’s spouse, and all other individuals living in the same household who are related to and dependent on the applicant or applicant’s spouse. While some States

either already define family size to match the LIS definition or use a family size that is less restrictive than this definition, we estimated in the proposed rule that 10 States use SSI methodologies to determine family size, which means that these States only use an individual or couple and any other deemed individuals as part of the family size. As such, we estimated in the proposed rule that 10 States will need to submit a SPA to change their definition of family size for MSP eligibility groups to comply with this regulation. However, based on subsequent internal analysis, we believe our proposed estimate of 10 States was too low and that 35 States may be

impacted by the changes to this definition of family size. As such, we have revised our active estimate to reflect a higher impact.

We estimate that it will take each State 3 hours to submit a SPA to update the definition of “family size” in their Medicaid State plans. Of those 3 hours, we estimate it will take a Business Operations Specialist 2 hours at \$80.08/hr and a General Operations Manager 1 hour at \$118.14/hr to update and submit each SPA to CMS for review. In aggregate, we estimate a one-time burden of 105 hours (35 States × 3 hr) at a cost of \$9,741 (35 States × [2 hr × \$80.08/hr] + [1 hr × \$118.14/hr]) for completing the necessary SPA updates.

Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State cost is approximately \$4,871 (\$9,741 × 0.5). Under § 423.772, “family size” is defined to include the applicant, the applicant’s spouse (if the spouse is living in the same household with the applicant), and all other individuals living in the same household who are related to the applicant and dependent on the applicant or applicant’s spouse for one-half of their financial support. By requiring that a State’s definition of “family of the size involved” include “at least” the individuals described in § 423.772 for purposes of the MSP groups, States would retain flexibility to include other individuals who are not described in § 423.772. Additionally, this requirement would not affect the States’ ability to adopt a different reasonable definition of the phrase for purposes of other eligibility groups.

As such, we estimate that it will take each State on average 200 hours to

develop questions and code the changes to its Medicaid application(s) to identify other third parties in the households of MSP applicants. These changes will impact any of the State’s applications that focus on non-MAGI eligibility groups only and do not collect information about other household members. As such, it would apply to both a non-MAGI-only application or an MSP-only application. On the other hand, a single streamlined application that individuals use to apply both to Medicaid and the Marketplace already captures information about third parties in the applicant’s household and would not be impacted. We will be revising the model MSP-only form to take into account these changes to family size, which States have the option to use as well. As such, each individual State may have greater or lesser impact depending on what application form(s) it uses. Of the 200 hours, we estimate it will take a Database and Network Administrator and Architect 50 hours at

\$106.16/hr and a Computer Programmer 150 hours at \$98.84/hr. In aggregate, we estimate a one-time burden of 7,000 hours (35 States × 200 hr) at a cost of \$704,690 (35 States × [(50 hr × \$106.16/hr) + (150 hr × \$98.84/hr)]) for completing the necessary updates to the Medicaid application. Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State cost is approximately \$352,345 (\$704,690 × 0.5).

These changes do not revise or create additional burden on applicants as the new questions will be in lieu of prior questions regarding “family size.” As such, the removed/added questions require programming changes that have a neutral impact on applicants.

Summary: As demonstrated in Table 6, when taking into account the Federal contribution, we estimate a one-time State burden of 7,105 hours at a cost of \$357,216.

TABLE 6—SUMMARY OF STATE BURDEN FOR MSP FAMILY SIZE DEFINITION CHANGES

Regulation section(s)	Number of respondents	Total number of responses	Time per response (hours)	Total time (hours)	Hourly labor cost (\$/hr)	Total labor cost (\$)	Total state share (\$)	Total non-labor cost (\$)	Frequency
§ 435.601	35 States	35	3	105	Varies	9,741	4,871	0	One time.
§ 435.601	35 States	35	200	7,000	Varies	704,690	352,345	0	One time.
Total	35 States	70	203	7,105	Varies	714,431	357,216	0	One time.

MSP Enrollment Increases as a Result of Facilitating Enrollment Through Medicare Part D LIS Leads Data

To calculate the impact of streamlining enrollment for persons in the LIS program, we analyzed data from the Medicare Integrated Data Repository (IDR) from July 2020. We determined the number of people who were enrolled in the LIS program by: (1) State; (2) the category of LIS benefit they received; and (3) whether or not they were also enrolled in Medicaid. We identified 13.1 million persons receiving the Part D LIS, of which 11.1 million were enrolled in Medicaid and 2.0 million were not.

We developed a regression using the percentage of LIS enrollees who were also dually eligible as the dependent variable, and used several policy factors as independent variables: State use of LIS leads data to make MSP eligibility determinations; verification policies and procedures; grace period for providing verifications after initial denial;

redetermination grace period; counting children towards income; income disregard; and asset disregard. While the latter three policies would not change under this final rule, we believed that they may explain some of the variation in the percentage of LIS recipients who are dually eligible. We found that this model explained some amount of the variation in the percentage of LIS enrollees who are enrolled as dually eligible, and that the most significant variable was the State use of LIS leads data to make MSP eligibility determinations. Other policies appeared to have weak correlations. The model suggested that the use of these policies—and in particular the use of the Part D LIS leads data—would result in an average increase in the percentage of LIS recipients who are dually eligible from 84.6 percent to 88.0 percent (an increase of 3.4 percentage points). We estimated that about 0.44 million additional persons would have been enrolled in the QMB eligibility group as

a result of these changes, had they been made in 2020. We assume that the increase in enrollment will be among people who do not qualify for full Medicaid benefits.

We assumed these enrollees, as QMBs, would receive coverage of their Medicare Part B premium. The premium is \$164.90 per month in 2023. We also assumed that beneficiaries would receive Medicaid coverage for cost sharing for Medicare services.

To calculate future impacts to enrollment, we assumed that the increase in enrollment due to this provision would grow at the same rate as Medicaid enrollment among aged persons and persons with disabilities. We estimate that this would increase enrollment by about 0.54 million persons by FY 2029 and would increase total Medicaid spending for Medicaid coverage of Medicare premiums and cost sharing by \$6.26 billion from FY 2025 through FY 2029. Detailed estimates are shown in Table 7.

TABLE 7—IMPACT OF FACILITATING MEDICAID ENROLLMENT THROUGH MEDICARE PART D LIS LEADS DATA ON MEDICAID EXPENDITURES AND ENROLLMENT

[Expenditures in millions of dollars, enrollment in millions of person-year equivalents]

	2025	2026	2027	2028	2029	2025–2029
Enrollment	0.12	0.38	0.52	0.53	0.54	.....
Total Spending	380	1,160	1,560	1,570	1,590	6,260
Federal Spending	220	670	900	900	920	3,610

3. Automatically Enroll Certain SSI Recipients Into the QMB Group

As described in section II.A.3. of this final rule, § 435.909 newly requires that States deem certain individuals who are eligible for Medicare Part A, and who are SSI beneficiaries eligible for QMB coverage, without requiring an application. In particular, § 435.909 newly requires that: (1) States with 1634 agreements must deem SSI recipients eligible for QMB coverage who are entitled to premium-free Medicare Part A; (2) States without 1634 agreements must deem SSI recipients eligible for QMB coverage who are entitled to premium-free Medicare Part A and have been determined eligible for Medicaid under either § 435.120 or § 435.121; and (3) Part A buy-in States must deem individuals eligible for QMB coverage if the individual is determined eligible for Medicaid under either § 435.120 or § 435.121, entitled to SSI, only qualifies for premium Part A, and is enrolled in Part B.

To implement these new requirements, States will need to identify Medicare-eligible SSI recipients to enroll them in the MSPs. States will also need to trigger deeming of Medicare-eligible SSI recipients to QMB by making eligibility systems changes to trigger QMB enrollment once the SSI-individual is Medicare eligible. Current regulations do not allow State Medicaid agencies to forgo an eligibility determination for Medicaid beneficiaries who are eligible for SSI when they become newly eligible for Medicare Part A and B. Therefore, this new requirement will require system changes for all 51 States (including DC).

While these deeming provisions are intended to enroll more SSI recipients in QMB, this rulemaking will not reach all SSI recipients eligible for QMB. We estimate currently 16 percent or 566,556 (3,540,975 × 0.16) SSI recipients are eligible but not enrolled in QMB, and nearly 500,000 new SSI recipients who are enrolled in Medicaid under either § 435.120 or § 435.121 will enroll in QMB as a result of the changes to § 435.909(b).

As discussed in section II.A.3. of this final rule, in the 34 States with a 1634

agreement, the Medicaid agency automatically enrolls the SSI recipients in Medicaid following a data exchange with SSA and then we automatically initiate Part B buy-in for the individual through the “buy-in data exchange.” In the remaining States, individuals must submit a separate application to the State Medicaid agency to be determined eligible for Medicaid.

We do not automatically initiate Part B buy-in for SSI individuals who live in SSI criteria and 209(b) States; rather, States must initiate Part B buy-in once the SSI recipient has separately applied for and been determined eligible for the mandatory SSI or 209(b) group. Additionally, SSI recipients who live in group payer States and are eligible for premium Part A are still required to go through a complicated two-step application process to establish QMB eligibility once an individual is determined eligible for the mandatory SSI or 209(b) groups and has been enrolled in Part B pursuant to the State’s buy-in agreement.

Under this final rule, the application process for SSI recipients who live in criteria and 209(b) States will remain the same and so will the two-step application process to establish QMB eligibility for SSI recipients living in group payer States and having premium Part A.

Based on SSA data and internal CMS analysis of the 566,556 SSI recipients eligible for QMB but not enrolled, we estimate almost 83 percent (469,820 = 566,556 × 0.829257) were likely eligible for premium-free Part A, while approximately 17 percent (96,736 = 566,556 × 0.170744) were eligible for premium Part A. Of the 469,820 who were eligible for premium-free Part A, we estimate that approximately 86 percent (405,963 = 469,820 × 0.864082) reside in States with 1634 agreements, and approximately 14 percent (63,857 = 469,820 × 0.135918) reside in 209(b) or SSI criteria States. Because Medicaid is automatic in States with 1634 agreements, we estimate that 405,963 individuals (all of the previously-mentioned SSI recipients in 1634 States) will be automatically enrolled in QMB under this new provision.

In contrast, we estimate that only 65 percent of the previously-mentioned 63,857 SSI recipients in 209(b) States or SSI criteria States, or 41,507 individuals (63,857 individuals × 0.65), will be enrolled under the new provision. This is because it is unlikely that all SSI recipients who live in SSI or 209(b) States will complete the Medicaid application process in their State.

Of the 96,736 individuals eligible for premium Part A, we estimate 33 percent (31,923 = 96,736 × 0.33) are in Part A buy-in States and 67 percent (64,813 = 96,736 × 0.67) of those eligible for premium Part A are in group payer States, where deeming will be optional. We estimate that 95 percent (30,327 = 31,923 × 0.95) of individuals in Part A buy-in States who are eligible for premium Part A will enroll as a result of the new provision because we estimate that all of those individuals live in States with 1634 agreements. However, for the individuals eligible for premium Part A in group payer States where deeming will be optional, we expect some more populous States will use this option, so we are estimating 33 percent (21,388 = 64,813 × 0.33) of all individuals with premium Part A living in group payer States will newly enroll.

Therefore, we estimate a total of 499,185 individuals (405,963 + 41,507 + 30,327 + 21,388) will newly enroll without the need to complete an application. We estimate that those individuals will each save 2 hours from not filling out Medicaid applications and compiling associated documentation (going from 2 to 0 hours) at \$21.98/hr. We estimate an annual savings of minus 998,370 hours (499,185 individuals × 2 hr) and minus \$21,944,173 (998,370 hr × \$21.98/hr).

All 51 States (including DC) will need to make eligibility systems changes to deem an SSI individual in QMB once they are eligible for Medicare. We estimate it will take a Computer Programmer an average of 180 hours per State at \$98.84/hr to make systems changes to set their systems to search for Medicare eligibility in Federal systems and then enroll that individual in QMB. In aggregate, we estimate a one-time burden of 9,180 hours (51 States × 180

hr) at a cost of \$907,351 (9,180 hr × \$98.84/hr). Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State share is approximately \$453,676 (\$907,351 × 0.5).

We also estimate that this provision will result in an annual reduction of burden for the State to no longer review and adjudicate QMB applications from SSI recipients. We estimate this will save an Eligibility Interviewer 1 hour

(going from 1 hour to 0) per QMB determination at \$48.10/hr. We also estimate that States conduct QMB eligibility determinations for approximately 250,000 SSI individuals across 51 States, which will no longer be necessary. In aggregate, we estimate an annual burden savings of minus 250,000 hours (250,000 individuals × − 1 hr/response) and minus \$12,025,000 (− 250,000 hr × \$48.10/hr). Taking into account the 50 percent Federal

contribution to Medicaid program administration, the estimated State savings is approximately minus \$6,012,500 (\$12,025,000 × 0.5).

Summary: As demonstrated in Table 8, when taking into account the Federal contribution, we estimate a State savings of minus 240,820 hours and minus \$5,558,824. We also estimate individual savings of minus 998,370 hours minus \$21,944,173.

TABLE 8—SUMMARY OF STATE AND INDIVIDUAL BURDEN FOR AUTOMATIC ENROLLMENT OF CERTAIN SSI RECIPIENTS INTO QMB

Regulation section(s)	Number of respondents	Total number of responses	Time per response (hours)	Total time (hours)	Hourly labor cost (\$/hr)	Total labor cost (\$)	Total state share (\$)	Total non-labor cost (\$)	Frequency
\$ 435.909	51 States	51	180	9,180	98.84	907,351	453,676	0	One-time.
\$ 435.909	51 States	(250,000)	(1)	(250,000)	48.10	(12,025,000)	(6,012,500)	0	Annual.
<i>Subtotal: States</i>	<i>51 States</i>	<i>(249,949)</i>	<i>Varies</i>	<i>(240,820)</i>	<i>Varies</i>	<i>(11,117,649)</i>	<i>(5,558,824)</i>	<i>0</i>	<i>Varies.</i>
\$ 435.909	499,185 individuals.	(499,185)	(2)	(998,370)	21.98	(21,944,173)	n/a	0	Annual.
Total	499,236	(749,134)	Varies	(1,239,190)	Varies	(33,061,822)	(5,558,824)	0	Varies.

QMB Enrollment Increases as a Result of Automatically Enrolling Certain SSI Recipients Into the QMB Group

To calculate the impact of automatically enrolling SSI recipients into QMB Medicaid coverage, we examined data on SSI recipients and their health care coverage.⁵⁹ As of 2017, about 17 percent of all SSI recipients had Medicare coverage but were not dually enrolled in Medicaid.

First, we estimated how many persons would enroll who already receive Medicare Part A without paying a premium. We estimated that there are 2.6 million people enrolled in SSI who are enrolled in Part A and do not pay the premium. Of these, we estimated about 82 percent reside in “1634 States” (about 2.1 million) and therefore are automatically enrolled in Medicaid. Of the remaining 0.48 million, we have assumed that 90 percent would enroll in the QMB group and receive Medicare Part B premium and cost-sharing assistance. We estimated those benefits to be about \$5,000 per enrollee per year for 2023.

Second, we estimated how many persons would enroll who receive Medicare Part A but have to pay a premium. We estimate that there are 5.2 million such people enrolled in SSI. We estimated that 34 percent of this population lives in States that do not automatically enroll these individuals in the QMB group. Of States that do not automatically enroll these individuals in the QMB group, we assumed that about 20 percent of States would use the option provided in this final rule, and that about 50 percent of this population would be enrolled in the QMB group as a result.

Third, we also considered that many of these individuals are already enrolled as dually eligible in Medicare and Medicaid, but not as QMBs. For current dually eligible individuals, we assumed that they were already receiving Medicaid coverage for the Part B premium and most Medicare cost sharing. For those not currently enrolled as a dually eligible, we assumed that they would be eligible for Medicaid to pay for the Part B premium and

Medicare cost sharing, and the Part A premium if they are required to pay it. We estimated that 75 percent of new QMBs were already enrolled as dually eligible.

To calculate future impacts to enrollment, we assumed that the increase in enrollment due to this provision would grow at the same rate as Medicaid enrollment among aged persons and persons with disabilities.

We estimate that this provision would increase QMB enrollment among persons who are not currently dually eligible by 0.16 million by FY 2029. We also estimate about 0.50 million additional QMBs who are already dually eligible, of whom 0.14 million would have their Part A premiums paid by Medicaid under this provision. We estimate that this provision would increase total Medicaid spending by \$10.23 billion from FY 2025 through FY 2029 for Medicaid coverage of Medicare premiums and cost sharing and, in some cases, other Medicaid benefits. Detailed estimates are shown in Table 9.

TABLE 9—IMPACT OF AUTOMATICALLY ENROLLING CERTAIN SSI RECIPIENTS INTO QMB PROGRAM ON MEDICAID EXPENDITURES AND ENROLLMENT

[Expenditures in millions of dollars, enrollment in millions of person-year equivalents]

	2025	2026	2027	2028	2029	2025–2029
Additional QMB Enrollees	0.28	0.30	0.30	0.30	0.30	.....
Previous Dual Eligibles	0.13	0.14	0.14	0.14	0.14	.....
New Medicaid Enrollees	0.15	0.16	0.16	0.16	0.16	.....
Total Spending	2,010	2,020	2,040	2,060	2,100	10,230

⁵⁹ <https://www.census.gov/content/dam/Census/library/publications/2021/demo/p70br-171.pdf>.

TABLE 9—IMPACT OF AUTOMATICALLY ENROLLING CERTAIN SSI RECIPIENTS INTO QMB PROGRAM ON MEDICAID EXPENDITURES AND ENROLLMENT—Continued

[Expenditures in millions of dollars, enrollment in millions of person-year equivalents]

	2025	2026	2027	2028	2029	2025–2029
Federal Spending	1,150	1,160	1,170	1,190	1,200	5,870

4. Other Provisions To Facilitate Medicaid Enrollment

For other provisions that would facilitate Medicaid enrollment (including the definition of family size; and making the QMB effective date earlier), we assumed that these

provisions would increase enrollment by about 0.1 percent among aged enrollees and enrollees with disabilities and would have a negligible impact on other categories of enrollees. We estimate that this would increase enrollment by about 0.02 million person-year equivalents by 2029. These

provisions are estimated to increase Medicaid spending by \$2.07 billion from FY 2025 through FY 2029 for Medicaid coverage of Medicare premiums and cost sharing and, in some cases, other Medicaid benefits. Detailed estimates are shown in Table 10.

TABLE 10—IMPACT OF OTHER PROVISIONS TO FACILITATE ENROLLMENT ON MEDICAID EXPENDITURES AND ENROLLMENT

[Expenditures in millions of dollars, enrollment in millions of person-year equivalents]

	2025	2026	2027	2028	2029	2026–2029
Enrollment	0.01	0.02	0.02	0.02	0.02	0.02
Total Spending	120	380	510	530	530	2,070
Federal Spending	70	220	290	300	310	1,190

5. Impacts on Medicare

It is likely that those SSI enrollees newly gaining Medicaid coverage would also have higher Medicare costs following enrollment. Primarily, receiving cost-sharing assistance for Medicare would lead to these individuals seeking out more care that may have been difficult to afford previously, also known as induction.

To estimate these impacts, we reviewed research on the effects of changing out-of-pocket costs on total health care costs, and specifically on Medicare. In general, we have historically estimated that reductions in out-of-pocket costs would increase total spending by \$0.60 to \$1.30 for every \$1.00 reduction in out-of-pocket costs. Among research on health care costs, we relied primarily on research that examined the impacts on changing Medicare out-of-pocket costs.⁶⁰

This research is useful, particularly because of the analysis reviewing cost-sharing among those Medicare enrollees without any other coverage, those with supplemental coverage (such as “Medigap” plans or retiree health benefits), and those with Medicaid. First, the analysis found that Medicare enrollees without other coverage had an average of \$13,693 in costs, of which

\$2,399 was paid out of pocket (18 percent). Among those with supplemental coverage, average costs were \$14,349, with \$594 paid out of pocket (4 percent) and \$2,095 paid through supplemental coverage (15 percent). Enrollees with Medicaid coverage had \$26,181 in average costs, with \$209 paid out of pocket (1 percent) and \$3,190 paid by Medicaid (12 percent). A significant amount of cost differences is likely due to health status. Most notably, those with Medicaid coverage are on average older and more likely to have a disability or chronic condition, which would result in higher costs regardless of who pays for care.

The analysis also examines the effect of changing Medicare cost-sharing structures on total, Medicare, and out-of-pocket spending. While the specific proposed benefit changes are not related to this final rule, it does provide the relative magnitude of changes between Medicare and out-of-pocket costs. The analysis found a larger change in costs for those without any other coverage than those with supplemental coverage. For those without other coverage, out-of-pocket costs decreased by \$428 while total costs increased by \$764 (or \$1.80 for every \$1.00 reduction in out-of-pocket costs). For those with supplemental coverage, there was a decrease of \$158 in out-of-pocket costs and an increase of \$130 in total costs (or \$0.80 for every \$1.00 reduction in out-of-pocket costs).

We also reviewed how many Medicare enrollees have supplemental

coverage or Medicaid. Research from the Kaiser Family Foundation recently looked at this.⁶¹ This analysis found that 26 percent of Medicare beneficiaries had annual income of less than \$20,000 (which is reasonably close to the SSI income limit of \$1,767 monthly, which would be \$21,204 annually). Of these beneficiaries, 37 percent had Medicaid and 11 percent had supplemental coverage. Excluding those with Medicaid and assuming the two groups are mutually exclusive, 17 percent of low-income beneficiaries without Medicaid had supplemental coverage. We believe it is reasonable to assume that very few beneficiaries had both Medicaid and other supplemental coverage.

We estimated the impact assuming that the overall increase in total costs would be \$0.80 for every \$1.00 reduction in out-of-pocket costs. For those without supplemental coverage, this would be expected to result in an increase of 14 percent in total costs and 20 percent in Medicare costs, and for those without supplemental coverage, increases of 3 percent for total costs and 10 percent for Medicare costs. Using the analysis on SSI enrollees and coverage, this is a weighted average of an 18 percent increase in Medicare costs for those newly gaining Medicaid.

⁶⁰ B Garrett, A Gangopadhyaya, A Shartzter, and D Arnos, “A Unified Cost-Sharing Design for Medicare: Effects on Beneficiary and Program Spending,” The Urban Institute, July 2019. https://www.urban.org/sites/default/files/publication/100528/a_unified_cost-sharing_design_for_medicare_effects_on_beneficiary_an_1.pdf.

⁶¹ W Koma, J Cubanski, and T Neuman, “A Snapshot of Coverage Among Medicare Beneficiaries in 2018,” Kaiser Family Foundation, March 23 2021. <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018/>.

To calculate the annual impacts, we multiply the Medicare per enrollee costs each year by 18 percent and by the number of SSI enrollees newly receiving Medicaid, and then adjust for cost-sharing to calculate the Federal Medicare spending amounts. This excludes those who were previously dually eligible but not QMBs. Using total Medicare per enrollee costs (as projected in the 2022 Trustees Report⁶²), we project that this would increase Medicare spending by \$7.6 billion over 2025 to 2029 under this

⁶² “2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.” <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>.

final rule. Annual impacts are shown in Table 11.

TABLE 11—PROJECTED CHANGE IN MEDICARE EXPENDITURES FROM ADDITIONAL SSI ENROLLEES RECEIVING MEDICAID

[In millions of real dollars]

	Medicare expenditures
2025	600
2026	1,400
2027	1,800
2028	1,900
2029	1,900
Total	7,600

There is a wide range of possible costs due to this effect of this final rule. Most notably, and described previously in this section, is that the impact of reducing out-of-pocket costs could have different impacts than estimated here. Thus, individuals could use greater or lesser levels of additional services, resulting in different levels of Medicare spending changes than estimated here. This uncertainty is addressed in the high and low range estimates provided in the accounting statement (see section IV.F. of this final rule).

6. Summary of Administrative Impacts

Table 12 summarizes this rule’s requirements and associated burden estimates.

TABLE 12—SUMMARY OF ADMINISTRATIVE ESTIMATES

Regulation section(s)	Number of respondents	Total number of responses	Time per response (hours)	Total time (hours)	Hourly labor cost (\$/hr)	Total labor cost (\$)	Total state share (\$)	Total beneficiary cost (\$)	Total non-labor cost (\$)	Frequency
§ 435.601	35 States	35	200	7,000	Varies	704,960	352,345	n/a	n/a	One-Time.
§ 435.909	499,185 individuals	499,185	(2)	(998,370)	21.98	n/a	n/a	(21,944,173)	n/a	Annual.
§ 435.909	51 States	51	180	9,180	98.84	907,351	453,676	n/a	n/a	One-Time.
§ 435.909	51 States	250,000	(1)	(250,000)	48.10	(12,025,000)	(6,012,500)	n/a	n/a	Annual.
§ 435.911	51 States	400,000	0.25	100,000	48.10	4,810,000	2,405,000	n/a	n/a	Annual.
§ 435.911	51 States	60,000	1	60,000	48.10	2,886,000	1,443,000	n/a	n/a	Annual.
§ 435.911	60,000 individuals	60,000	4	240,000	21.98	5,275,200	0	5,275,200	n/a	Annual.
§§ 435.911, and 435.952	360,000 individuals	360,000	(3.75)	(1,350,000)	21.98	n/a	n/a	(29,673,000)	n/a	Annual.
§§ 435.911, and 435.952	360,000 individuals	360,000	0	n/a	n/a	n/a	n/a	(3,600,000)	(3,600,000)	Annual.
§ 435.952	51 States	8,400,000	(2)	(16,800,000)	21.98	n/a	n/a	(369,264,000)	n/a	Annual.
§ 435.952	8,400,000	8,400,000	0	n/a	n/a	n/a	n/a	—	(84,000,000)	Annual.
§ 435.911, and 435.952	51 States	7,059	(0.42)	(151,200)	48.10	(7,272,720)	(3,636,360)	n/a	n/a	Annual.
§ 435.952	51 States	8,400,000	(0.25)	(2,100,000)	48.10	(101,010,000)	(50,505,000)	n/a	n/a	Annual.
§ 435.952	10 States	4,400	1	44,000	48.10	2,116,400	1,058,200	n/a	n/a	Annual.
§ 435.952	10 States	4,400	(0.75)	(33,000)	48.10	(1,587,300)	(793,550)	n/a	n/a	Annual.
§ 435.952	10 States	6,600	(0.167)	(11,022)	48.10	(530,158)	(265,079)	n/a	n/a	Annual.
Subtotal	9,679,165	27,211,730	Varies	(21,253,412)	Varies	(105,725,267)	(55,500,268)	(415,605,973)	—	Varies.
§ 435.601	35 States	1	3	105	Varies	9,741	4,871	n/a	n/a	One-Time.
Subtotal	35 States	1	3	105	Varies	9,741	4,871	n/a	n/a	One-Time.
		Total—annual		(21,249,592)	.....	(107,337,578)	(56,306,289)	(415,605,973)	(87,600,000)	
		Total—one-time.		16,285	.....	1,622,052	810,892	n/a	n/a	

7. Summary of Medicaid Spending and Enrollment \$18.56 billion and Federal Medicaid spending by \$10.67 billion from 2025 through 2029. Medicaid enrollment is projected to increase by 0.70 million by 2029, with an additional 0.16 million individuals who are currently dually eligible gaining coverage as QMBs.

In total, these provisions are projected to increase Medicaid spending by

TABLE 13—IMPACT OF ALL PROVISIONS ON MEDICAID EXPENDITURES AND ENROLLMENT
 [Expenditures in millions of dollars, enrollment in millions of person-year equivalents]

	2025	2026	2027	2028	2029	2025–2029
Additional Medicaid Enrollees	0.26	0.53	0.68	0.69	0.70	.....
Additional QMBs	0.15	0.16	0.16	0.16	0.16	.....
Total Spending	2,510	3,560	4,110	4,160	4,220	18,560
Federal Spending	1,440	2,050	2,360	2,390	2,430	10,670

We received comments on our estimated impacts on Federal and State spending for this final rule, and our responses follow.

Comment: Some commenters expressed concern with the projected increase in State spending estimated in the regulatory impact analysis. These commenters noted that the magnitude of additional State spending projected over the next five years would impose significant burden on State budgets including State reserve funds. Conversely, a few commenters that opposed provisions in the proposed rule cited the modest fiscal impact projected in the regulatory impact analysis as evidence of limited benefit and the rationale for their opposition.

Response: We appreciate the commenters’ perspectives and acknowledge that this final rule may require programmatic updates and systems changes, and lead to increases in Medicaid and MSP enrollment, that could raise costs for States. To mitigate these concerns, and to allow more time to provide technical assistance to States, we are extending through this final rule the timeline for States to comply with many provisions.

Comment: One commenter expressed concern that we did not appropriately factor social benefits and other distributional impacts attributable to increased enrollment in the Medicaid and MSPs into the regulatory impact analysis. This commenter noted that factoring social benefits, including reduced income- and race-based health disparities, in the regulatory impact analysis would strengthen the economic justification for the provisions in this rule. This commenter also highlighted that the provisions to streamline enrollment in Medicaid and the MSPs would result in a transfer of \$61.9 billion over 5 years to Medicaid and CHIP beneficiaries through additional healthcare spending by those programs.

Response: We note that in section IV.F of this final rule we classify the

impacts of this final rule as transfers, with the Federal Government and States incurring additional costs and beneficiaries receiving medical benefits and reductions in out-of-pocket health care costs (although the dollar value differs from the comment because we have updated our estimates and are only finalizing certain provisions of the proposed rulemaking in this final rule). Further, we acknowledge the potential benefit of factoring in social benefits into the regulatory impact analysis, but note that our current analysis does not include any potential economic effects associated with the impact of our provisions on social determinants of health. Lastly, we do believe the regulatory impact analysis accounts for distributional impacts in its discussion of transfers and total impacts.

D. Alternatives Considered

In developing this final rule, we considered the following alternatives:

1. Not Finalizing the Rule

We considered not finalizing this rule and maintaining the status quo. However, we believe this final rule will lead to more eligible individuals gaining access to coverage and maintaining their coverage across all States.

2. Providing States With Discretion Regarding the Date of Application for QMBs

Section 406.26 describes enrollment in Medicare Part A through the buy-in process. We considered proposing modifications to § 406.26(b) to provide States with discretion to use the Part A conditional enrollment filing date as the date of the Medicaid application for QMB eligibility. As background, the QMB eligibility group covers Part A premiums for individuals who do not qualify for premium-free Part A. However, to apply for the QMB eligibility group, an individual must be entitled to Part A and many cannot afford the monthly premium (\$499 in 2022). Such individuals have to

navigate a complex two-step process where they first apply for conditional enrollment in Part A at SSA, then go to the State Medicaid agency to apply for the QMB eligibility group. Providing States the option to use the date of application at SSA for conditional enrollment as the date of application for a QMB application could permit States to offer an earlier effective date for QMB. We chose not to propose a regulatory change because we did not have enough information to accurately assess its impact. However, we sought comments on this alternative considered that might be adopted in this final rule based on comments received. In this final rule, we are not finalizing any such alternatives and instead, are finalizing what we proposed (albeit with a compliance date in 2026) for the reasons we cited in section II.A.1. of this final rule.

E. Limitations of the Analysis

There are a number of caveats to these estimates. Foremost, there is significant uncertainty about the actual effects of these provisions. Each of these provisions could be more or less effective than we have assumed in developing these estimates, and for many of these provisions we have made assumptions about the impacts they would have. In many cases, determining the reasons why a person may not be enrolled despite being eligible for Medicaid is difficult to do in an analysis such as this. Therefore, these assumptions rely heavily on our judgment about the impacts of these provisions. While we believe these are reasonable estimates, we note that this could have a substantially greater or lesser impact than we have projected.

Second, there is uncertainty even under current policy in Medicaid. Due to the COVID–19 pandemic and legislation to address the pandemic, Medicaid has experienced significant increases in enrollment since the beginning of 2020. Actual underlying

economic and public health conditions may differ than what we assume here.

In addition to the sources of uncertainty described previously, there are other reasons the actual impacts of these provisions may differ from the estimates. There may be differences in the impacts of these provisions across eligibility groups or States that are not reflected in these estimates. There may also be different costs per enrollee than we have assumed here because those gaining coverage altogether or keeping coverage for longer durations of time may have different costs than those who were already assumed to be enrolled in the program. Lastly, to the extent that States have discretion in provisions that are optional in this final rule or in the administration of their programs more broadly, States' efforts to implement these provisions may lead to larger or smaller impacts than estimated here.

To address these limitations, we have developed a range of impacts for Medicaid spending. We believe that the actual impacts would likely fall within a range 50 percent higher or lower than

the estimates we have developed. While this is a significant range, we would note that in the context of the entire Medicaid program (\$743 billion in FY 2021), this is still a relatively narrow range.

F. Accounting Statement

As required by OMB Circular A-4 (available at https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf), we have prepared an accounting statement in Table 14 showing the classification of the transfer payments with the provisions of this final rule. These impacts are classified as transfers, with the Federal Government and States incurring additional costs and beneficiaries receiving medical benefits and reductions in out-of-pocket health care costs.

This provides our best estimates of the transfer payments outlined in section IV.C. (Anticipated Effects) of this final rule. To address the significant uncertainty related to these estimates,

we have assumed that the costs could be 50 percent greater than or lesser than we have estimated here. We recognize that this is a relatively wide range, but we note several reasons for uncertainty regarding these estimates. First, there are numerous provisions that affect Medicaid in this rule. For several provisions, we have limited information, analysis, or comparisons to prior experience to use in developing our estimates. Thus, the range reflects that impacts of these provisions could be greater or lesser than we assume. We also note that there are expected impacts on Medicare; we believe this range adequately accounts for the potential variation in costs or savings to that program as well. Finally, given the significant effects of the COVID-19 pandemic and legislation intended to address it, the current outlook for Medicaid is less certain than typical. We provide this wider range to account for this uncertainty as well. This range provides the high cost and low cost ranges shown in Table 14.

TABLE 14—ACCOUNTING STATEMENT
[Expenditures in millions of 2025 dollars]

Category	Primary estimate	Low estimate	High estimate	Units		
				Year dollars	Discount rate (%)	Period covered
Annualized Monetized Transfers from Federal Government to beneficiaries ...	\$3,579	\$1,790	\$5,369	2025	7	2025–2029
	3,622	1,811	5,433	2025	3	2025–2029
Annualized Monetized Transfers from States to beneficiaries	1,555	777	2,332	2025	7	2025–2029
	1,568	784	2,352	2025	3	2025–2029

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on September 15, 2023.

List of Subjects

42 CFR Part 406

Diseases, Health facilities, Medicare.

42 CFR Part 435

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

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

■ 1. The authority citation for part 406 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395i-2, 1395i-2a, 1395p, 1395q and 1395hh.

■ 2. Section 406.21 is amended by adding paragraph (c)(5) to read as follows:

§ 406.21 Individual enrollment.

* * * * *

(c) * * *

(5) If an individual resides in a State that pays premium hospital insurance for Qualified Medicare Beneficiaries under § 406.32(g) and enrolls or reenrolls during a general enrollment period after January 1, 2023, QMB

coverage is effective the month entitlement begins (if the individual is determined eligible for QMB before the month following the month of enrollment), or a month later than the month entitlement begins (if the individual is determined eligible for QMB the month entitlement begins or later).

* * * * *

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

■ 3. The authority citation for part 435 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 4. Section 435.4 is amended by adding a definition for “Low Income Subsidy Application data (LIS leads data)” in alphabetical order to read as follows:

§ 435.4 Definitions and use of terms.

* * * * *

Low-Income Subsidy Application data (LIS leads data) means data from an individual's application for low-income subsidies under section 1860D-14 of the Act that the Social Security Administration electronically transmits to the appropriate State Medicaid agency as described in section 1144(c)(1) of the Act.

* * * * *

■ 5. Section 435.601 is amended by adding paragraph (e) to read as follows:

§ 435.601 Application of financial eligibility methodologies.

* * * * *

(e) *Procedures for determining eligibility for the Medicare Savings Program groups.* When a State determines eligibility for a Medicare Savings Program group, for income eligibility the agency must include at least the individuals described in § 423.772 of this chapter in determining family of the size involved.

* * * * *

■ 6. Revise § 435.909 to read as follows:

§ 435.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

(a) *Automatic enrollment of certain individuals in Medicaid.* The agency must not require a separate application for Medicaid from an individual, if the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act for determining Medicaid eligibility; and—

- (1) The individual receives SSI;
- (2) The individual receives a mandatory State supplement under either a federally-administered or State-administered program; or
- (3) The individual receives an optional State supplement and the agency provides Medicaid to beneficiaries of optional supplements under § 435.230.

(b) *Automatic enrollment of SSI recipients in the Qualified Medicare Beneficiary group.* (1) The agency must deem individuals eligible for the Qualified Medicare Beneficiary group as described in § 400.200 of this chapter if the individual receives SSI and is determined eligible for medical assistance under § 435.120 or § 435.121; and—

- (i) The individual is entitled to Part A under part 406, subpart B, of this chapter; or
- (ii) The individual is entitled to Part A under § 406.20 of this chapter and the agency has a State buy-in agreement authorized under section 1843 of the

Act and modified under section 1818(g) of the Act.

(2) The agency may deem individuals eligible for the Qualified Medicare Beneficiary group as described in § 400.200 of this chapter if the individual receives SSI and is determined eligible for medical assistance under §§ 435.120 or 435.121; and—

- (i) The individual is entitled to Part A under § 406.5(b) of this chapter; and
- (ii) The agency uses the group payer arrangement under § 406.32(g) of this chapter to pay Part A premiums for Qualified Medicare Beneficiaries.

(3) The automatic enrollment of SSI recipients in the Qualified Medicare Beneficiaries group described in paragraphs (b)(1) and (2) of this section is effective no earlier than the effective date of coverage under a buy-in agreement for individuals described in § 407.47(b) of this chapter.

■ 7. Section 435.911 is amended by adding paragraph (e) to read as follows:

§ 435.911 Determination of eligibility.

* * * * *

(e) For each individual who has applied for the Part D Low Income Subsidy through the Social Security Administration (SSA) and granted permission for the Social Security Administration to share Low Income Subsidy application data (LIS leads data) with the Medicaid agency for the purpose of submitting an application for the Medicare Savings Programs, the agency must—

- (1) Accept, via secure electronic interface, LIS leads data transmitted to the agency from SSA;
- (2) Treat received LIS leads data relating to an individual as an application for eligibility under the Medicare Savings Programs, without requiring submission of another application;
- (3) Accept LIS leads data, without further verification, unless—

- (i) The agency has information that is not reasonably compatible with the leads data; or
- (ii) The information provided through the LIS leads data does not support a determination of eligibility for the Medicare Savings Programs;
- (4) Not request information or documentation from the individual already provided to SSA through the LIS application and included in the transmission to the agency by SSA unless the agency has information that is not reasonably compatible with the LIS leads data;
- (5) Seek additional information that is not in the LIS leads data if needed by the agency to make a determination of

eligibility for the Medicare Savings Programs;

(6) Verify an individual's U.S. citizenship or satisfactory immigration status in accordance with §§ 435.406 and 435.956;

(7) Determine the eligibility of the individual for the Medicare Savings Programs promptly and without undue delay, consistent with timeliness standards established under § 435.912; and

(8) If any of the LIS leads data does not support a determination of eligibility under the Medicare Savings Programs—

- (i) Determine what additional information is needed to make a determination of eligibility for the Medicare Savings Programs;
- (ii) Notify the individual that they may be eligible for assistance with their Medicare premium and/or cost sharing charges, but that additional information is needed for the agency to make a determination of such eligibility;
- (iii) Provide the individual with a minimum of 30 days to furnish any information needed by the agency to make such determination of eligibility; and
- (iv) Verify the individual's eligibility for the Medicare Savings Programs in accordance with the agency's verification plan developed in accordance with § 435.945(j).

(9) Provide the individual with, in addition to and separate from any requests for additional information necessary for a determination of Medicare Savings Program eligibility, unless CMS approves otherwise,—

- (i) Information about the availability of additional Medicaid benefits on other bases, including the scope of such benefits and responsibilities of the individual applying for such benefits; and
- (ii) An opportunity to furnish such additional information as may be needed to determine whether the individual is eligible for such additional Medicaid benefits on other bases.

■ 8. Section 435.952 is amended by adding paragraph (e) to read as follows:

§ 435.952 Use of information and requests for additional information from individuals

* * * * *

(e) When determining eligibility for individuals applying for the Medicare Savings Programs specified in sections 1902(a)(10)(E)(i), (iii) and (iv) and 1905(p) of the Act, the agency must accept attestation (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1)

of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) of the following income and asset information without requiring further information (including documentation) from the individual:

(1) *Income and interest income.* (i) Except as provided in paragraph (e)(1)(ii) of this section, the agency must accept an applicant's attestation of the value of any dividend and interest income earned on resources owned by the applicant or the applicant's spouse.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify interest and dividend income after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(2) *Non-liquid resources.* (i) Except as provided in paragraph (e)(2)(ii) of this section, the agency must accept an applicant's attestation of the value of any non-liquid resources owned.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify the value of non-liquid resources after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this

paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(3) *Burial funds.* (i) Except as provided in paragraph (e)(3)(ii) of this section, the agency must accept an applicant's attestation that up to \$1,500 of their resources, and up to \$1,500 of their spouse's resources, are set aside in a separate account and are not countable as resources when determining eligibility for the Medicare Savings Programs.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify resources in burial funds after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(4) *Life insurance policies.* (i) Except as provided in paragraph (e)(4)(ii) of this section, the agency must accept an applicant's attestation of the face value of life insurance.

(A) If an individual attests to a face value of life insurance policy that is above \$1,500, the State may accept an attestation of the cash surrender value of the life insurance policy for the purpose of determining resource eligibility for the Medicare Savings Programs.

(B) [Reserved]

(ii) If the agency has information about either the face value or the cash surrender value that is not reasonably

compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section, which may include a reasonable explanation of the discrepancy or documentation.

(iii) The agency may verify the face value of a life insurance policy after the agency has determined that an applicant is eligible for a Medicare Savings Program, in accordance with paragraph (c) of this section.

(iv)(A) When an individual must provide documentation of the cash surrender value of a life insurance policy, the agency must assist the individual with obtaining this information and documentation by requesting that the individual provide the name of the insurance company and policy number and authorize the agency to obtain such documentation from the issuer of the policy on the individual's behalf. The agency may also request, but may not require, additional information from the applicant to assist the agency in obtaining the needed documentation, such as the name of an agent.

(B) If the individual does not provide the information and authorization in paragraph (e)(4)(iv)(A) of this section, the agency may require that the individual provide documentation of the cash surrender value.

(C) The agency must allow the individual to submit documentation through any of the modalities described in § 435.907(a) and provide the individual with at least 15 days to provide information or documentation described in this paragraph if such information or documentation is requested pursuant to paragraph (e)(4)(i) or (ii) of this section and at least 90 days if required pursuant to paragraph (e)(4)(iii) of this section.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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