shall not be deemed to ''control'' such generators.

* * * * *

■ 34. Section 262.232 is amended by revising the paragraphs (a)(5), (b)(4) introductory text, and (b)(4)(ii)(C) to read as follows:

§ 262.232 Conditions for a generator managing hazardous waste from an episodic event.

(a) * * *

(5) The very small quantity generator must comply with the hazardous waste manifest provisions of subpart B of this part and the recordkeeping provisions for small quantity generators in § 262.44 when it sends its episodic event hazardous waste off site to a designated facility, as defined in § 260.10 of this subchapter.

* * * * *

(b) * * *

(4) *Accumulation by small quantity generators.* A small quantity generator is prohibited from accumulating hazardous wastes generated from an episodic event on drip pads and in containment buildings. When accumulating hazardous waste generated from an episodic event in containers and tanks, the following conditions apply:

* * * * *

(ii) * * *

(C) Use inventory logs, monitoring equipment or other records to identify the date upon which each episodic event begins; and

* * * * *

■ 55. Section 266.508 is amended by revising paragraphs (a)(1)(iii)(C) and (a)(2)(i) to read as follows:

§ 266.508 Shipping non-creditable hazardous waste pharmaceuticals from a healthcare facility of evaluated hazardous waste pharmaceuticals from a reverse distributor.

(a) * * *

(1) * * *

(iii) * * *

(C) Lab packs that will be incinerated in compliance with § 268.42(c) of this subchapter are not required to be marked with EPA hazardous waste numbers (*i.e.,* hazardous waste codes), except D004, D005, D006, D007, D008, D010, and D011, where applicable. A nationally recognized electronic system, such as bar coding or radio frequency identification tag, may be used to identify the applicable EPA hazardous waste numbers (*i.e.,* hazardous waste codes).

* * * * *

(2) * * *

(i) A healthcare facility shipping noncreditable hazardous waste pharmaceuticals is not required to list all applicable EPA hazardous waste numbers (*i.e.,* hazardous waste codes) in Item 13 of EPA Form 8700–22.

* * * * *

[FR Doc. 2023–26750 Filed 12–5–23; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 430 and 435

Office of the Secretary

45 CFR Part 16

[CMS–2447–IFC]

RIN 0938–AV26

Medicaid; CMS Enforcement of State Compliance With Reporting and Federal Medicaid Renewal Requirements Under Section 1902(tt) of the Social Security Act

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with request for comments (IFC) implements reporting requirements and enforcement authorities in the Social Security Act (the Act) that were added by the Consolidated Appropriations Act, 2023 (CAA, 2023). CMS will use these new enforcement authorities as described in this rule if States fail to comply with the new reporting requirements added by the CAA, 2023 or with Federal Medicaid eligibility redetermination requirements during a timeframe that is generally aligned with the period when States are restoring eligibility and enrollment operations following the end of the Medicaid continuous enrollment condition under the Families First Coronavirus Response Act (FFCRA). The new enforcement authorities include requiring States to submit a corrective action plan, suspending disenrollments from Medicaid for procedural reasons, and imposing civil money penalties (CMPs). They also include applying a reduction to the State-specific Federal Medical Assistance Percentage (FMAP) for failure to meet reporting requirements.

DATES: These regulations are effective on December 6, 2023.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, by February 2, 2024.

ADDRESSES: In commenting, please refer to file code CMS–2447–IFC.

Comments, including mass comment submissions, must be submitted in *one* of the following three ways (please choose only *one* of the ways listed):

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2447–IFC, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2447–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:
Abby Kahn, (410) 786–4321, *Abigail.Kahn@cms.hhs.gov,* or Anna Bonelli, (443) 615–1268, *Anna.Bonelli@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

A. Enforcement Authorities Under Section 1902(tt) of the Social Security Act

Section 1902(tt)(2) of the Social Security Act (the Act) (added by section 5131(b) of Subtitle D of Title V of Division FF of the Consolidated Appropriations Act, 2023 (CAA, 2023), Public Law 117–328, enacted December 29, 2022) includes new enforcement authority for CMS to use if it determines that a State is not in compliance with the reporting requirements under section 1902(tt)(1) of the Act, Federal eligibility redetermination requirements,[1] or both.

First, if CMS determines that a State is not in compliance with the reporting requirements under section 1902(tt)(1) of the Act for any fiscal quarter that occurs during the period that begins on July 1, 2023, and ends on June 30, 2024, section 1902(tt)(2)(A) of the Act requires CMS to reduce the Federal Medical Assistance Percentage (FMAP) as determined for the State for the quarter under section 1905(b) of the Act by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the State has failed to satisfy such requirements. Per section 1902(tt)(2)(A) of the Act, the FMAP reduction is for fiscal quarters occurring in the period beginning on July 1, 2023, and ending on June 30, 2024. Therefore, CMS will not apply the FMAP reduction under section 1902(tt)(2)(A) of the Act to the quarter from April 1, 2023, to June 30, 2023, and CMS will not evaluate State-reported data reflecting activities during these months for purposes of the FMAP reduction.

Second, if CMS determines that a State is not in compliance with Federal eligibility redetermination requirements, the reporting requirements under section 1902(tt)(1) of the Act, or both, section 1902(tt)(2)(B) of the Act authorizes CMS to require a State to submit a corrective action plan (CAP) to address the noncompliance. If the State fails to submit or implement an approved CAP in accordance with section 1902(tt)(2)(B)(ii) of the Act, then, under section 1902(tt)(2)(B)(iii) of the Act, CMS may require the State to suspend some or all terminations of Medicaid eligibility that are for procedural reasons (hereinafter referred to as ''procedural disenrollments'') and may also impose civil money penalties (CMPs) of up to $100,000 for each day a State is not in compliance. In this rule, CMS defines procedural disenrollments in § 430.5 to mean, for the purposes of § 430.49 and 45 CFR part 16, a termination of a beneficiary's Medicaid eligibility after providing advance notice required under 42 CFR part 431, subpart E for reasons that are unrelated to a State's determination of whether the individual meets eligibility criteria to qualify for coverage, including for failure to return a renewal form or documentation needed by the State to make a determination of eligibility. This new authority under section 1902(tt)(2)(B) of the Act is in addition to any FMAP reduction that may also be applicable under section 1902(tt)(2)(A) of the Act or any other enforcement authority available to the Secretary. This new enforcement authority under section 1902(tt)(2)(B) of the Act relates to State conduct occurring during the period that began on April 1, 2023, and ends on June 30, 2024.

Both the new enforcement authorities in section 1902(tt)(2)(A) of the Act and in section 1902(tt)(2)(B) of the Act took effect on April 1, 2023. As noted above, the enforcement authority in section 1902(tt)(2)(A) of the Act does not apply to State conduct during the period from April 1, 2023, to June 30, 2023.

B. New Enforcement Needs and Considerations Given the Ending of the Medicaid Continuous Enrollment Condition

Section 1902(tt) of the Act applies during a period when States are conducting an unprecedented volume of Medicaid eligibility redeterminations. Under section 6008(b)(3) of the FFCRA (Pub. L. 116–127, originally enacted March 18, 2020), States were able to claim a temporary 6.2 percentage point increase in their FMAP provided that they met several conditions, including that they not disenroll most persons enrolled in Medicaid as of or after March 18, 2020, until the last day of the month in which the COVID–19 Public Health Emergency (PHE) ended. This provision is known as the Medicaid continuous enrollment condition. As of April 1, 2023, 50 States, the District of Columbia, and the five U.S. Territories (referred to as ''States'' throughout, consistent with section 1101(a) of the Act), were claiming the FFCRA FMAP increase, so this condition applied to all States.

Section 5131(a) of Subtitle D of Title V of Division FF of the CAA, 2023 made several changes to section 6008 of the FFCRA. As relevant here, section 5131(a)(2)(C) of Subtitle D of Title V of Division FF of the CAA, 2023 separated the end of the continuous enrollment condition from the end of the COVID–19 PHE by amending section 6008(b)(3) of the FFCRA to end continuous Medicaid enrollment as a condition for claiming the FFCRA temporary FMAP increase on March 31, 2023.[2] This means that, beginning April 1, 2023, all 56 States claiming the temporary FMAP increase were no longer required to comply with the continuous enrollment condition. Accordingly, States must conduct a full renewal of eligibility for each beneficiary (as part of a process referred to as ''unwinding''), in accordance with 42 CFR 435.916 and as described in State Health Official (SHO) letter #22–001, ''RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID–19 Public Health Emergency'' (March 2022 SHO letter).[3]

CMS previously released guidance describing specific requirements and recommendations for States related to unwinding from the continuous enrollment condition. As a result of the policies described in these guidance documents, State unwinding periods vary and do not necessarily overlap with the compliance period for the new enforcement tools created under section 1902(tt) of the Act. As discussed in SHO letter # 23–002, ''RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023'' (January 2023 SHO letter),[4] beginning as early as February 1, 2023, States have up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid, a period commonly referred to as a State's

[1] Medicaid regulations use both terms ''redetermination'' and ''renewal.'' For purposes of this rule, we interpret the reference to all Federal requirements applicable to eligibility redeterminations in section 1902(tt)(2)(B)(i) of the Act to include Federal renewal requirements outlined in 42 CFR 435.916, as newly defined at § 430.5 in this rule.

[2] Section 5131(a) of Subtitle D of Title V of Division FF of the CAA, 2023 also amended section 6008 of the FFCRA to revise the conditions States must meet to claim the temporary FMAP increase for each quarter beginning April 1, 2023, to extend the availability of the temporary FMAP increase until December 31, 2023, and to gradually phase down the amount of the increase for each quarter from April 1, 2023, to December 31, 2023.

[3] *https://www.medicaid.gov/Federal-policy-guidance/downloads/sho22001.pdf.*

[4] *https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf.*

''unwinding period.'' [5] Starting on or after April 1, 2023, States claiming the temporary FFCRA FMAP increase may disenroll persons determined to be ineligible by a renewal initiated during the State's unwinding period. Likewise, the March 2022 SHO letter outlines CMS' expectations for renewals during unwinding. As also discussed in the January 2023 SHO letter, States had the option to initiate the first cohort of renewals to begin their unwinding period in February, March, or April 2023.[6]

Section 1902(tt) of the Act took effect on April 1, 2023, the day after the continuous enrollment condition expired. It imposes new reporting requirements on States during a period that generally overlaps with States' unwinding periods. It also provides CMS with new authority to take enforcement action if States fail to comply with Federal requirements related to eligibility redetermination or the new reporting requirements. Notably, these new reporting requirements and CMS' authority to enforce redetermination and data reporting requirements apply to all 56 States, regardless of whether a State is continuing to claim the FFCRA FMAP increase. This rule implements the new reporting requirements in section 1902(tt)(1) of the Act and the enforcement authorities in section 1902(tt)(2) of the Act (which are further discussed in the section II).

C. Monitoring Eligibility Redetermination Activities

Section 1902(tt) of the Act authorizes CMS to closely monitor and enforce Federal redetermination requirements during a period that generally aligns with States' unwinding periods, and thus, these authorities better position CMS to take actions to prevent unauthorized disenrollments during this critical period. Section 1902(tt)(1) of the Act requires that, for each month occurring during the period beginning on April 1, 2023, and ending on June 30, 2024, States must submit on a timely basis to CMS, and CMS must make public, certain monthly data about activities related to eligibility redeterminations conducted during that same period. The January 2023 SHO letter discussed these reporting requirements under section 1902(tt)(1) of the Act in further detail and explained that all the data States must report under these new reporting requirements are included in existing data sources, including the Unwinding Data Report and State-based Exchanges (SBE) priority metrics.[7]

Based on the timeframe when the reporting requirements under section 1902(tt)(1) of the Act apply, and the title of section 1902(tt)(1) of the Act, which refers to the ''transition from [the FFCRA] FMAP increase,'' CMS interprets the statutory data collection and reporting requirements to be a means to help CMS monitor States' work unwinding from the Medicaid continuous enrollment condition and returning to regular eligibility and enrollment operations. Under our interpretation, the reporting requirements under section 1902(tt)(1) of the Act will help us monitor whether States are compliant—during a timeframe that generally aligns with their return to regular eligibility and enrollment operations—with Federal eligibility redetermination requirements (including renewal requirements at 42 CFR 435.916, strategies authorized under section 1902(e)(14) of the Act, or alternative strategies authorized by CMS, including alternative or mitigation strategies CMS has authorized States to implement under section 6008(f)(2)(A) of the FFCRA, which was added by section 5131 of Subtitle D of Title V of Division FF of the CAA, 2023). Additionally, because section 1902(tt) of the Act also includes the new enforcement authorities in section 1902(tt)(2)(B) of the Act, CMS interprets the data collection and reporting requirements under section 1902(tt)(1) to be a tool CMS can use to monitor State compliance with Federal eligibility redetermination requirements during a period that generally aligns with States' unwinding periods.

CMS has also been monitoring States' implementation of other amendments made by section 5131 of Subtitle D of Title V of Division FF of the CAA, 2023, which create new conditions for States seeking to receive the FFCRA temporary FMAP increase through December 31, 2023. These new conditions for receiving the FFCRA temporary FMAP increase also give CMS ways to incentivize States to minimize the disruption in coverage resulting from procedural disenrollments during States' unwinding periods. Specifically, the CAA, 2023 added to the FFCRA new section 6008(f)(2)(A), which conditions receipt of the FFCRA FMAP increase after April 1, 2023, on State compliance with Federal redetermination requirements, including renewal strategies authorized under section 1902(e)(14)(A) or other alternative processes and procedures approved by the Secretary. New FFCRA section 6008(f)(2)(B) conditions receipt of the FFCRA FMAP increase after April 1, 2023, on States' maintaining up-to-date contact information for a beneficiary before redetermining eligibility for such beneficiary, and new section 6008(f)(2)(C) conditions receipt of the FFCRA FMAP increase after April 1, 2023, on States' undertaking a good faith effort to contact an individual using more than one modality prior to terminating their enrollment on the basis of returned mail. The January 2023 SHO letter outlines these new conditions for receiving the FFCRA FMAP increase in greater detail. Because the same section of the CAA, 2023 that added new section 1902(tt) to the Act also included both these conditions for receiving the FFCRA FMAP increase, CMS interprets the entirety of the changes made in section 5131 of subtitle D of division FF of the CAA, 2023 to give CMS a range of enforcement mechanisms and incentives that, taken together, can be used to help minimize the disenrollment of people who otherwise continue to meet the substantive eligibility criteria and whose enrollment would be retained but for their failure to meet a procedural requirement during States' unwinding periods. One key purpose of section 1902(tt) is thus to enhance CMS' ability to take enforcement action against noncompliant States during this critical timeframe.

CMS takes seriously its responsibility to hold States accountable for resuming routine eligibility and enrollment operations and plans to fully exercise the new authorities at section 1902(tt) of the Act when appropriate to do so. Since the FFCRA was enacted, CMS has been preparing for the eventual unwinding of the FFCRA continuous enrollment condition. CMS has explained to States the conditions of the FFCRA FMAP increase, gauged States'

[5] While the requirements of section 6008 of the FFCRA do not apply to separate CHIPs or the Basic Health Program (BHP), CMS recognizes some States elected to apply certain provisions of section 6008 to their separate CHIP program or BHP. In those circumstances, subject to exceptions noted and other Federal requirements, much of CMS' guidance related to unwinding from the FFCRA continuous enrollment condition also applies to CHIP and BHP. However, neither section 1902(tt) of the Act, nor this rule, applies to separate CHIPs or BHPs.

[6] For additional guidance about State renewals of eligibility following the end of the continuous enrollment condition see *www.medicaid.gov/unwinding.*

[7] See the January 2023 SHO Letter. See also CMS, ''Consolidated Appropriations Act, 2023: FMAP Reduction for Failure to Meet Reporting Requirements under Section 1902(tt)(1) of the Social Security Act, Frequently Asked Questions for State Medicaid and CHIP Agencies,'' (June 30, 2023) (''June 2023 FAQs'') (Available at: *https://www.medicaid.gov/federal-policy-guidance/downloads/fmap-rdctn-repot-medcid-chip-agncs-06302023.pdf).*

ability to resume redeterminations on an unprecedented scale, and provided States with technical assistance to address challenges that might lead to preventable loss of coverage for procedural reasons among beneficiaries. If CMS identifies a violation of Federal redetermination requirements, then, consistent with section 6008(f)(2)(A) of the FFCRA, CMS will communicate to the State that its FFCRA FMAP increase will be withheld if the State does not ensure the issue is fully resolved or does not implement appropriate mitigations until full compliance can be achieved.

The new enforcement tools outlined at section 1902(tt) of the Act, which allow CMS to enforce existing Federal redetermination requirements as well as the reporting requirements at section 1902(tt)(1) of the Act, are a key part of the suite of CMS enforcement mechanisms and incentives added through the CAA, 2023 to minimize the disenrollment of eligible individuals during States' unwinding periods. These new enforcement tools are critical to enabling CMS to effectively monitor for, and take action to protect against, States conducting renewals that do not adhere to Federal redetermination requirements and to support continued enrollment for those individuals who remain eligible. Nothing in this rule affects other authorities that exist outside of this new enforcement framework or precludes CMS from pursuing additional enforcement action under section 1904 of the Act, including withholding Federal financial participation (FFP), or limiting payments, for States that fail to comply with requirements of the Medicaid statute.

D. Pre-Compliance Engagement With States

When CMS becomes aware of a potential violation of Federal requirements, we first attempt to work collaboratively with the State to understand the nature and scope of the problem and to identify appropriate alternative processes and procedures that the State can adopt to avoid or minimize beneficiary harm until the State can fix the problem and come into full compliance with Federal requirements, consistent with our authority to enforce compliance with section 1902 under section 1904 of the Act and 42 CFR 430.35. Consistent with this practice, as discussed in section II.A of this rule, CMS will provide technical assistance to States facing unusual circumstances that interfere with their ability to comply fully with section 1902(tt)(1) of the Act reporting requirements and will consider approving alternative timelines and processes for meeting those requirements. The statute does not give CMS the discretion to avoid taking an FMAP reduction under section 1902(tt)(2)(A) of the Act for a quarter in the period beginning July 1, 2023, and ending June 30, 2024, if a State ultimately fails to report each of the metrics required under section 1902(tt)(1) of the Act for that quarter. However, CMS will consider mitigating circumstances before taking additional enforcement action under section 1902(tt)(2)(B) of the Act if a State fails to meet the reporting requirements under section 1902(tt)(1) of the Act during the period from April 1, 2023, to June 30, 2024.

If CMS' efforts to work collaboratively with States are successful, and the State takes necessary steps to address beneficiary harm and prevent future harm (such as reinstating eligibility for affected beneficiaries and suspending procedural disenrollments, where appropriate), CMS might not initiate compliance action under section 1902(tt)(2)(B) of the Act. However, if CMS determines that a State violated the section 1902(tt)(1) of the Act reporting requirements or Federal redetermination requirements, CMS will consider exercising the enforcement authorities in section 1902(tt)(2)(B) of the Act, as implemented in this rule.

II. Provisions of the Interim Final Rule With Comment

This rule adds new 42 CFR 430.49 and 435.927 and 435.928 to the CFR and amends §§ 430.3, 430.5, and 45 CFR part 16. New § 430.49 of this rule interprets and implements section 1902(tt)(2)(B) of the Act, which authorizes CMS to do the following: (1) require States to submit and implement a CAP for noncompliance with Federal requirements applicable to eligibility redeterminations and the reporting requirements described in section 1902(tt)(1) of the Act; and (2) if the State fails to submit or implement an approvable CAP in accordance with section 1902(tt)(2)(B)(ii), require the State to suspend some or all disenrollments from Medicaid for procedural reasons until the State takes appropriate corrective action, impose CMPs of not more than $100,000 for each day the State is not in compliance, or both. New § 435.927 interprets and implements section 1902(tt)(1) of the Act, which requires that, for each month occurring during the period beginning on April 1, 2023, and ending on June 30, 2024, States must submit on a timely basis to CMS, and CMS must make public, certain monthly data about activities related to eligibility redeterminations conducted during that same period.

New § 435.928 specifies how CMS will implement the FMAP reduction required under section 1902(tt)(2)(A) of the Act. If a State does not satisfy the reporting requirements described in section 1902(tt)(1) of the Act for any fiscal quarter in the period that begins on July 1, 2023 and ends on June 30, 2024, section 1902(tt)(2)(A) of the Act requires CMS to reduce the FMAP determined for the State for the quarter under section 1905(b) of the Act by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the State has failed to satisfy such requirements.

The provisions of this rule apply to the States, District of Columbia, and all 5 territories—Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa. While the regulations in part 435 apply only to the States, the District of Columbia, the Northern Mariana Islands and American Samoa, § 436.901 provides that with one exception (not relevant here), the requirements of part 435, subchapter J, which includes §§ 435.927 and 435.928 through this rulemaking, apply to Guam, Puerto Rico, and the Virgin Islands.

The new enforcement authority granted to CMS under section 1902(tt)(2)(A) and (B) of the Act will improve State accountability for complying with Federal renewal requirements while also minimizing disruptions to coverage for eligible people during a period that generally aligns with States' unwinding activities. The additional enforcement activities authorized in section 1902(tt)(2) of the Act will reinforce and augment the routine monitoring and compliance action that CMS is already undertaking to promote State compliance with Federal enrollment and eligibility requirements, described in section I.C and D of this rule. These authorities will also help ensure that States remain accountable to CMS by requiring them to submit certain data to CMS and will increase public transparency about eligibility redeterminations between April 1, 2023, and June 30, 2024, by requiring CMS to publicly report the data.

Finally, the rule amends § 430.5 to add new definitions of the terms Federal redetermination requirements and procedural disenrollment for purposes of § 430.49, and (with respect to the definition of procedural disenrollment only) for purposes of 45 CFR part 16. And this rule creates reconsideration

and appeal rights for States under new § 430.49(f) and corresponding amendments to § 430.3 and 45 CFR part 16, to ensure States have clear avenues for appealing CMS decisions to require suspension of procedural disenrollments and/or impose CMPs under the new authorities in section 1902(tt)(2)(B)(iii) of the Act.

We have also included severability clauses at new §§ 430.49(g), 435.927(e), and 435.928(c) to emphasize our intent that, to the extent a reviewing court holds that any provision of these rules is unlawful, the remaining provisions should take effect and be given the maximum effect permitted by law. The severability clauses provide that any provision of these sections that is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, shall be severable from the relevant section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

A. Reporting Requirements (§ 435.927)

Section 1902(tt)(1) of the Act requires that, for each month occurring during the period that begins on April 1, 2023, and ends on June 30, 2024, each State submits to CMS, and that CMS make public, a report on the activities of the State relating to eligibility redeterminations conducted during such period.

New § 435.927 implements and interprets the reporting requirements in section 1902(tt)(1) of the Act. The required reporting will help CMS and others to monitor State actions during the unwinding period and beyond because it includes reporting on metrics such as the number of individuals disenrolled from Medicaid or CHIP and certain information about transitions from Medicaid or CHIP coverage to coverage through an Exchange. Reviewing and publishing these monthly data will give CMS and the public information to help hold States accountable for following redetermination requirements and will promote transparency.

CMS interprets section 1902(tt)(1) of the Act to require that States report data representing the activities conducted during each month of the designated time period.[8] However, CMS does not believe the provision requires that States must submit all the required monthly reports by June 30, 2024, because it will take States time to assemble, review, and submit data from the months for which they are reporting. For example, States must report on activities occurring in June 2024, but the submission of that monthly report could occur after June 30, 2024, to allow the State time to collect, review, and submit the data.[9] This is reflected in new § 435.927(c), which requires States to report certain data representing activities conducted by a State during the time period beginning April 1, 2023, and ending June 30, 2024.

To help ensure that CMS and the public can use and understand the data, avoid redundancy, and for purposes of practicality, CMS is interpreting the data elements required under section 1902(tt)(1) of the Act differently in § 435.927(d) depending on the element. Section 1902(tt)(1) of the Act directs the Secretary to make public reports with data ''relating to eligibility redeterminations,'' but CMS is not interpreting all the reporting elements listed in the subsequent subparagraphs to be limited to data related to such redeterminations. Specifically, CMS is interpreting the reporting elements listed in section 1902(tt)(1)(A), (B) and (D) of the Act to represent only those individuals who are subject to Medicaid or CHIP redeterminations but is not interpreting the elements listed in section 1902(tt)(1)(C) or (E) of the Act to be limited to reporting on such individuals.

Paragraphs (A) and (B) of section 1902(tt)(1) of the Act require States to report on certain data elements for persons with coverage for medical assistance, child health assistance, or pregnancy-related assistance, which CMS interprets to refer to people with Medicaid or CHIP coverage, including pregnancy-related coverage in both programs. The data elements required under paragraphs (A) and (B) are as follows: the number of eligibility renewals initiated, beneficiaries renewed on a total and *ex parte* basis (that is, based on available reliable information without contacting the individual consistent with § 435.916(a)(2)), individuals who were disenrolled for any reason, and the number of individuals disenrolled for procedural reasons. These data points are all the direct result of Medicaid or CHIP eligibility redetermination actions and thus new § 435.927(d)(1) through (5) require States to report this information only for people undergoing Medicaid or CHIP redeterminations.

Similarly, paragraph (D) of section 1902(tt)(1) of the Act requires States to report the number of individuals whom a Federal or State-based Exchange determined eligible for a qualified health plan or a Basic Health Program (BHP),[10] as well as the number of individuals who selected a qualified health plan or enrolled in a BHP (section 1902(tt)(1)(D)(i) and (ii) of the Act specifically require data related to BHPs). Paragraph (D) of section 1902(tt)(1) of the Act does not specify that these data be limited only to numbers of individuals whose eligibility had been redetermined by the Medicaid program. However, these data elements are only useful to CMS in understanding ''the activities of the State relating to eligibility redeterminations,'' as directed by section 1902(tt)(1) of the Act if the data are limited to Medicaid and CHIP beneficiaries who have undergone an eligibility redetermination. These data will help demonstrate if beneficiaries found ineligible for Medicaid and CHIP during the redetermination process are able to find other coverage on Exchanges or BHPs and will also help CMS and other interested parties identify States in which transitions to Exchange coverage are relatively successful and States in which such transitions may not be as successful. These data will be most useful for oversight of States' redetermination processes if they are limited to the numbers of individuals' accounts that were transferred to an Exchange or BHP because of a redetermination under Medicaid or CHIP. To include other transfers (those of consumers who were not enrolled in Medicaid or CHIP at the time and who newly apply directly with their State agency and are determined ineligible) would not help to illuminate ''eligibility redeterminations,'' because new applicants are not in a position to lose Medicaid or CHIP coverage. Therefore, in new § 435.927(d)(10) and (11), we require the reported data described in section 1902(tt)(1)(D) of the Act to reflect Medicaid/CHIP redeterminations.

In previous guidance,[11] we listed the reporting elements under section 1902(tt)(1) of the Act related to Exchanges and the anticipated data sources for obtaining the data for these elements. Specifically, in the January 2023 SHO letter, in the first column of ''Table 2: Reporting Elements Under Section 1902(tt)(1) for the Period from April 1, 2023, through June 30, 2024, and Corresponding Data Sources,'' we stated that for States with Exchanges

[8] See the January 2023 SHO, and the June 2023 FAQs.

[9] See the June 2023 FAQs.

[10] The Basic Health Program (BHP) is a program for specified individuals who do not qualify for Medicaid but whose household income does not exceed 200 percent of the Federal poverty level (FPL).

[11] See the January 2023 SHO Letter, and the June 2023 FAQs.

that use the Federal Exchange eligibility and enrollment platform (including Federally-facilitated Exchanges (FFEs) and SBEs on the Federal platform (SBE–FPs)) we anticipated that CMS would report these data on behalf of States and that we intended to limit the data to information that is the result of a Medicaid or CHIP redetermination (which would exclude data resulting from a new Medicaid or CHIP application). In contrast, for SBEs with their own platforms that use either a non-integrated or integrated eligibility system, we inadvertently did not make such a distinction.[12] Rather, column one in Table 2 of the January 2023 SHO letter suggests that the reporting elements would apply to Exchange activity resulting from all Medicaid or CHIP applications. However, in the ''SBE Priority Metrics: Medicaid/Children's Health Insurance Program (CHIP) Continuous Enrollment Condition Unwinding Overview and Template 1.0 User Guide (version 1.0, 5/19/2023),'' which is cited in guidance that we released on June 30, 2023,[13] we specified that SBEs will report only those required data elements that result from Medicaid or CHIP redeterminations. As a result, although the labeling in the first column of the table in the January 2023 SHO letter is inconsistent, the definitions of the required State data are consistent across types of Exchanges, and therefore the data collected and reported will be consistent across types of Exchanges, and in all cases, including for SBEs not using the Federal platform, will be limited to information related to Medicaid or CHIP redeterminations. Section 435.927(d)(10) and (11) reflect this.

As noted, in the January 2023 SHO letter, CMS identified the reporting requirements under section 1902(tt)(1) of the Act that relate to Exchanges. Consistent with CMS' stated expectations in that SHO letter, CMS will report data on behalf of States with Exchanges that use the Federal eligibility and enrollment platform (including FFEs and SBE–FPs) since CMS operates the Federal eligibility and enrollment platform. Therefore, States do not have to report the data, and we are not including in this rule any provisions implementing the requirements under section 1902(tt)(1) of the Act that apply to States with Exchanges that use the Federal eligibility and enrollment platform. Section 435.927(d)(10) and (11) describe the reporting requirements that apply to States with SBEs that do not use the Federal platform.

Section 435.927(d)(10) and (11) also reflect certain practical and operational differences between SBEs based on whether the Exchange eligibility system is integrated with the State's Medicaid and/or CHIP eligibility systems. Specifically, some SBEs have integrated eligibility systems but others do not. As Congress recognized in section 1902(tt)(1)(D)(i) and (ii) of the Act, there is no need for an Exchange with an integrated eligibility system to report account transfers from the Medicaid and/or CHIP agency to the Exchange, whereas that data point is relevant for Exchanges without integrated eligibility systems.

In contrast to how we are interpreting section 1902(tt)(1)(A), (B), and (D) of the Act, we are not interpreting section 1902(tt)(1)(E) of the Act to be limited to describing only information about a Medicaid or CHIP redetermination. States are required under section 1902(tt)(1)(E) of the Act to report data on total call center volume, average wait times, and average abandonment rate. For these reporting elements, it is impractical to limit the measures only to data related to eligibility redeterminations. States do not always identify the purpose of individual calls to call centers, calls can address multiple purposes and beneficiaries, and reprogramming call trees and retraining staff could take months for States to operationalize, if required. As the period for which States are required to report these data under section 1902(tt)(1)(E) of the Act has already begun and is time-limited, it is impractical to limit the collection of the call center data required under 1902(tt)(1)(E) of the Act to only those calls related to individuals' eligibility redeterminations. Furthermore, these call center metrics are useful because they illustrate the extent to which all beneficiaries, including those whose eligibility is being redetermined, can access assistance. Accordingly, new § 435.927(d)(7) through (9) are not limited to just call center information related to redeterminations.

CMS is also not interpreting section 1902(tt)(1)(C) of the Act to be limited to describing only information about a Medicaid or CHIP redetermination. Section 1902(tt)(1)(C) of the Act requires States to report on the number of individuals enrolled in a separate CHIP program under section 2101(a)(1) of the Act. Broadening the data collected under paragraph (C) to include the total number of enrollees in a separate CHIP, not just those enrolling subject to a Medicaid or CHIP eligibility redetermination, provides useful information. In addition to being new data that is not publicly reported elsewhere, the data helps CMS and others identify whether separate CHIP programs' total enrollment levels are changing during the applicable period, which might indicate whether individuals are transitioning to CHIP from the Medicaid program. New § 435.927(d)(6) therefore refers to reporting on total enrollment in separate CHIPs.

Despite not being limited to information on redeterminations, data elements reported under section 1902(tt)(1)(C) and (E) of the Act are still useful for purposes of providing transparency on States' activities to conduct redeterminations. State Medicaid agency operational data on call center activity—call volume, average wait times, and average abandonment rates—help illuminate beneficiaries' access to information and ability to receive assistance from the State, as well as the eligibility process generally. Information on the enrollment levels for separate CHIP programs helps identify trends in enrollment that could signal whether a State is not performing redeterminations or transitioning eligible individuals from Medicaid to CHIP.

All the data States must report under the requirements of section 1902(tt)(1) of the Act are already being reported through existing data reports collected by CMS. For efficiency and to improve standardization (and hence, comparability) of the data, and because the applicable statutes, regulations, and other guidance governing CMS' use of the data collected through those existing data sources permit this, CMS is not requiring States to submit separate or

[12] States with SBEs that operate an integrated eligibility platform have a shared operating system between the SBE and the Medicaid/CHIP agency that conducts eligibility determinations related to new and renewal applications for certain Medicaid and CHIP programs and qualified health plans. In contrast, States with SBEs that operate a non-integrated eligibility platform have separate operating systems for the SBE and the Medicaid/CHIP agency. Accounts are transferred between the separate operating systems depending on the initial eligibility determination or assessment for the programs made by either the SBE or the Medicaid/CHIP agency.

[13] The June 2023 FAQs, in Table 1, cites to CMS, ''State-Based Exchanges (SBE) Priority Metrics: Medicaid/Children's Health Insurance Program (CHIP) Continuous Enrollment Condition Unwinding; Overview and Template 1.0 User Guide,'' released May 5, 2023, *https://www.medicaid.gov/resources-for-states/downloads/sbe-medicaid-chip-con-unwind-metrics-reprt-guide.pdf.* ''The priority metrics include indicators that are specific to Medicaid/CHIP continuous enrollment unwinding activities. For those metrics, SBEs should count activities that were initiated through the Medicaid/CHIP agency's renewal process, in which a consumer was determined ineligible for limited or full benefit Medicaid or CHIP.''

additional reports to CMS to comply with section 1902(tt)(1) of the Act.[14] Rather, CMS believes the requirements of section 1902(tt)(1) of the Act can be met through compliance with the following existing, CMS-approved data reporting processes: the Unwinding Eligibility and Enrollment Data Reporting (also referred to as the Unwinding Data Report), Medicaid and CHIP Eligibility and Enrollment Performance Indicator Data (PI data), the Transformed Medicaid Statistical Information System (T–MSIS), and SBE Priority Metrics.[15] Additionally, as described previously, the required data under section 1902(tt)(1) of the Act that apply to States with Exchanges that use the Federal eligibility and enrollment platform will be reported by CMS. Under section 1902(tt)(1) of the Act, CMS will publish all required data after a period of time to allow for data quality and validation reviews.

Section 1902(tt)(1) of the Act requires States to submit the required monthly data on a timely basis but does not include a definition of timely or standards for completeness and accuracy. CMS already collects the required data via existing processes, and the timeliness, completeness, and quality specifications for data submitted via those existing processes have generally been defined previously.[16] Under this regulation, States will generally submit data in accordance with these existing timelines and specifications unless CMS has approved an alternative process or timeline for reporting, in which case the State must submit the data according to any alternative specifications CMS approved as part of the alternative process or timeline.

As specified in § 435.927(b)(1), CMS will consider data to be timely when it is submitted by the deadline outlined in the applicable existing reporting process specifications, with some variations for T–MSIS data and to permit States to submit data according to alternative processes and timelines approved by CMS. CMS will approve these alternative processes and timelines when, as discussed below, a State is making a good faith effort to meet the requirements despite facing significant challenges that interfere with its ability to do so. As an example of how a deadline outlined under other existing reporting process specifications might apply here, the specifications for PI data generally require States to submit data by the 8th of each month;[17] thus under § 435.927(b)(1), States would report these PI data on a timely basis under section 1902(tt)(1) of the Act if they reported them by the 8th of each month. The rule also, however, includes a variation on how the existing T–MSIS reporting timeline would apply for purposes of section 1902(tt)(1) of the Act data because, in order for T–MSIS data to be useful for section 1902(tt)(1) of the Act purposes, these data must be reported under a different timeline. Specifically, to publicly report data under section 1902(tt)(1)(D)(i) of the Act, CMS will use T–MSIS data to match the records of Medicaid and CHIP beneficiaries to data from the FFEs and SBEs-FPs and identify the number of accounts that are received at these Exchanges due to a Medicaid/CHIP redetermination. Using these data, CMS can determine the other metrics listed under section 1902(tt)(1)(D)(i) of the Act, such as the total numbers of these individuals who apply for and are determined eligible for a qualified health plan. CMS will also use T–MSIS data to publicly report data on the number of separate CHIP enrollees for each State, as required under section 1902(tt)(1)(C) of the Act. CMS already requires that States maintain current data submissions by submitting T–MSIS data monthly before the last day of the subsequent month, although States are not considered to be out of compliance for T–MSIS reporting until data submissions are behind by 2 or more months. As reflected in § 435.927(b)(1)(ii), due to the time-sensitive nature of these calculations and the need for up-to-date data, States that do not submit T–MSIS data monthly by the last day of the subsequent month may be subject to the FMAP reduction under section 1902(tt)(2)(A) of the Act or other corrective action under section 1902(tt)(2)(B) of the Act. For example, T–MSIS data reflecting March 2024 activities will be due by the end of April 2024, under § 435.927(b)(1)(ii).

CMS recognizes that some States might encounter unusual circumstances that interfere with reporting using existing CMS-approved processes or that impede a State's ability to meet the deadlines in § 435.927(b)(1)(i) and (ii). For example, States may experience unforeseeable or unavoidable challenges such as a natural disaster or unplanned systems outages, or may be working to resolve significant foreseeable challenges, such as a known and reported major operational or systems issue that impacts the State's ability to submit timely and accurate data and that the State is working to remediate but needs additional time to fix. As reflected in § 435.927(b)(1)(iii), (b)(3)(ii), (b)(4), and (c)(2), CMS would consider approving alternative timelines and processes for reporting required data if a State is making a good faith effort to submit the required data. For example, CMS would consider allowing such a State to submit certain summary data via email. As specified in § 435.927(b)(4), a good-faith effort means that (1) the State is experiencing significant, unforeseeable, or unavoidable challenges in complying with the reporting requirements of § 435.927(c), or is experiencing significant foreseeable challenges in complying and is working to remediate these challenges but needs additional time to address them; (2) the State requested and obtained approval from CMS to submit the data via an alternative process or timeline, and (3) the approved alternative process for submitting the data or timeline is sufficient to ensure CMS can obtain and use the data to meet CMS' obligations to report the data publicly per section 1902(tt)(1) of the Act. CMS will work with such a State to ensure that CMS has all the data it needs in order to meet its requirement to publicly report data under section 1902(tt)(1) of the Act and will only approve alternative timelines or reporting processes that permit CMS to meet this requirement.

States that are ultimately unable to submit required data or that submit data via an unapproved process or according to an unapproved timeline will be subject to the enforcement actions in section 1902(tt)(2) of the Act. Because section 1902(tt)(2)(A) requires CMS to take an FMAP reduction if States fail to meet the section 1902(tt)(1) of the Act reporting requirements for a quarter in the period beginning July 1, 2023, and ending June 30, 2024, CMS does not have the authority to exempt States from FMAP reductions for failure to meet the section 1902(tt)(1) of the Act reporting requirements during that timeframe. However, as indicated in § 430.49, CMS will consider certain mitigating circumstances before taking the various

[14] See sections 1902(a)(4), 1902(a)(6), 1902(a)(75), 1903(r)(1)(F), and 2107(b)(1) of the Act; see also 42 CFR 431.16, 42 CFR 433.112(b)(15), 45 CFR 155.260(a)(1)(ii). See also *https://www.federalregister.gov/documents/2019/02/06/2019-01157/privacy-act-of-1974-system-of-records and https://www.federalregister.gov/documents/2013/10/23/2013-24861/privacy-act-of-1974-report-of-an-altered-cms-system-of-records-notice.*

[15] See the January 2023 SHO Letter, and the June 2023 FAQs.

[16] See the January 2023 SHO Letter, and the June 2023 FAQs.

[17] CMS, ''Medicaid and Children's Health Insurance Program Eligibility and Enrollment Data Specifications for Reporting During Unwinding,'' updated December 2022. Available at *https://www.medicaid.gov/sites/default/files/2022-12/unwinding-data-specifications-dec-2022.pdf.*

additional enforcement actions described in section 1902(tt)(2)(B) of the Act.

The regulation also provides in § 435.927(b)(2) that in order to be considered ''complete'' for purposes of public reporting under section 1902(tt)(1) of the Act, States must submit every data element (although in some cases, as noted above, certain elements may be submitted on a different or later timeframe than others, subject to CMS approval). A State that ultimately fails to report one or more required data elements would be subject to the FMAP reduction under section 1902(tt)(2)(A) of the Act if the State's noncompliance was for a quarter during the period from July 1, 2023, through June 30, 2024. Such a State might also be subject to other enforcement actions under section 1902(tt)(2)(B) of the Act; these are discussed in section II. of this rule.

Furthermore, in § 435.927(b)(3), the regulation provides that to be considered of ''sufficient quality,'' the State must report data that adheres to specifications outlined in previously existing regulation or guidance for each of the CMS-approved processes, or data that adheres to the specifications outlined in an alternative process approved by CMS. Existing reporting processes are governed by detailed instructions that outline how and what States should report and help ensure that States are reporting consistent data that CMS can publicly report, consistent with requirements under section 1902(tt)(1) of the Act.

New section § 435.927(c) implements the reporting requirements in section 1902(tt)(1) of the Act in light of the interpretations that are discussed above and reflected in the other paragraphs of § 435.927. Section 435.927(c) specifies that States must submit to CMS the data described in § 435.927(d), and those data must be timely, complete, and of sufficient quality (as those terms are defined in § 435.927(b)). It further provides that States must submit the required data via existing CMS-approved processes or through alternative processes approved by CMS when a State is making a good faith effort as defined in § 435.927(b)(4).

B. Application of the FMAP Reduction (§ 435.928)

If a State does not satisfy the reporting requirements in section 1902(tt)(1) of the Act for any fiscal quarter that occurs during the period that begins on July 1, 2023, and ends on June 30, 2024, section 1902(tt)(2)(A) of the Act requires CMS to reduce the FMAP determined for the State for the quarter under section 1905(b) of the Act by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the State has failed to satisfy such requirements. We are implementing this FMAP reduction along with our interpretation of how it is to be applied in new § 435.928.[18] In § 435.928(b)(1), CMS interprets the statutory reference to the FMAP determined for the State under section 1905(b) of the Act to mean the State-specific FMAP defined in the first sentence of section 1905(b) of the Act.[19] In § 435.928(b)(4), CMS interprets the statutory language regarding the amount of the reduction to mean that when States are noncompliant in multiple quarters, the FMAP reduction will increase by 0.25 percentage points for each successive quarter of noncompliance, regardless of whether the noncompliant quarters are consecutive. For example, if a State were out of compliance for three quarters, the reduction would be: a 0.25 percentage point FMAP reduction in the first quarter of noncompliance; a 0.50 percentage point FMAP reduction in the second quarter of noncompliance; and a 0.75 percentage point FMAP reduction in the third quarter of noncompliance. In no case, however, would the FMAP reduction for any single quarter exceed 1 percentage point.

We acknowledge that the language of the statute would allow for an alternative interpretation that would require CMS to apply the same percentage point reduction to all of the quarters in which a State failed to comply with the reporting requirements. For example, if a State were out of compliance for three quarters, CMS could apply a 0.75 percentage point reduction to the State's FMAP in all three of the applicable quarters. To come to that conclusion, CMS would have to interpret the statute as requiring CMS either to apply the reduction to the relevant quarters multiple times, or to wait until the end of the period to apply the reduction. Neither of these alternative approaches supports transparency, as the total amount of the reduction would not be known until up to three quarters after the State is found to be noncompliant, making it difficult for States to budget for the amount of State share they would need for the four-quarter period.

As specified in § 435.928(b)(3), States that fail to report data according to the requirements in § 435.927 for a single month within a quarter will be subject to the FMAP reduction for the entire quarter. Section 1902(tt)(1) of the Act specifies that the FMAP reduction should be applied for each fiscal quarter. As such, the statute does not give CMS the authority to reduce a State's FMAP for a single month.[20]

C. Corrective Action Plans (§ 430.49(b))

As noted in section I.A. of this rule, section 1902(tt)(2) of the Act includes new enforcement authority for CMS to use if it determines that a State is not in compliance with the reporting requirements in section 1902(tt)(1) of the Act, Federal eligibility redetermination requirements, or both. New § 430.49(b) provides guidelines for how CMS will exercise the CAP authority created by section 1902(tt)(2)(B) of the Act. Specifically, § 430.49(b)(1) provides that if CMS determines that, during the period between April 1, 2023, and June 30, 2024, a State has been out of compliance with the reporting requirements in section 1902(tt)(1) of the Act (as implemented in § 435.927 of this rule) or Federal eligibility redetermination requirements (as defined at § 430.5, as amended by this rule), then, after considering whether mitigating circumstances (discussed in section II.E. and § 430.49(d) of this rule) apply, CMS will determine whether to require the State to submit and implement a CAP.

New § 430.49(b)(2) specifies that CMS will issue a written notice to the State informing the State of CMS' finding of noncompliance and the requirement to submit and implement a CAP, or to revise and resubmit an existing approved CAP to address newly identified violations of the Federal reporting and/or redetermination requirements, unless consideration of certain mitigating circumstances has led CMS to delay or forgo requiring a CAP. The notice will: (1) explain the violation of Federal redetermination or reporting requirements that CMS has identified and the basis for CMS' finding; (2) inform the State of the requirement to submit and implement a new CAP or to revise and resubmit an existing CAP, with instructions on the method and deadline by which the State must submit a CAP to CMS; and (3) explain the additional enforcement actions that CMS may pursue if the State fails to

[18] For additional discussion about the application of the FMAP reduction, see the January 2023 SHO Letter, and the June 2023 FAQs.

[19] In the June 2023 FAQs, CMS explained how such a decrease would be applied to expenditures that are matched at FMAPs articulated elsewhere in statute, because they use the 1905(b) State-specific FMAP as a base.

[20] See, the January 2023 SHO Letter, and the June 2023 FAQs.

submit or implement the CAP, including if CMS disapproves the State's submitted CAP or if the State fails to meet the requirements set forth in the approved CAP, in accordance with the requirements at section 1902(tt)(2)(B)(ii) of the Act, as interpreted in this rule and discussed in section II.D. and at § 430.49(b) of this rule.

As set forth in new § 430.49(b)(3), a CAP must include specific content to be approved by CMS. First, the CAP must identify actions the State will take immediately, which means as soon as feasible, if needed to prevent further harm or risk of harm to beneficiaries while it implements the CAP. Harm to beneficiaries in this context includes increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, and delays in access to coverage or care. Actions to prevent harm, or risk of harm, to beneficiaries could include, if needed and appropriate, reinstatement of coverage for impacted individuals, suspension of procedural disenrollments, and adoption of alternative processes or procedures under section 1902(e)(14)(A) of the Act or other alternative strategies approved by CMS.

Next, the CAP must detail steps the State will take to ensure compliance with Federal redetermination and/or reporting requirements, such as new policies, procedures, operational processes, or systems changes it will implement. The CAP must also include key milestones and a detailed timeline for achieving compliance, as well as a plan for communicating the steps in the CAP to: (1) State staff, including State Medicaid agency staff and staff of any agency or other entity that is determining eligibility under a delegation of authority under § 431.10(c)(1)(i), (2) CMS, and (3) beneficiaries, as applicable. CMS believes that an approvable CAP must include these elements because they will allow CMS to assess at the outset whether the State's CAP appears sufficient to resolve the noncompliance and to monitor whether the State is making sufficient progress in its implementation. Additionally, these elements are consistent with those that CMS has historically required when requesting CAPs under section 1904 of the Act and § 430.35 for failure to administer the State Plan in compliance with the provisions in section 1902 of the Act, violations of which may result in withholding of FFP.

New § 430.49(b)(4) of this rule implements section 1902(tt)(2)(B)(ii) of the Act by requiring the following timeline for submission, approval, and implementation of a CAP after the State receives notice that CMS is requiring it to implement a CAP:

(1) The State must submit a CAP that includes the minimum elements described in § 430.49(b)(3) to CMS not later than 14 calendar days after receiving CMS' written notice.

(2) CMS must approve or disapprove the proposed CAP within 21 calendar days of the date the CAP is submitted by the State. If CMS does not approve or disapprove the CAP within 21 calendar days of submission, the CAP will be deemed approved.

(3) The State must begin implementation of the CAP not later than 14 calendar days after receiving CMS approval or after the CAP is deemed approved.

We interpret the statute to refer to calendar days and to authorize CMS to provide that CAPs not expressly approved or disapproved within 21 calendar days will be deemed approved. (Henceforth in this rule, ''days'' refers to calendar days unless otherwise noted.) CMS is providing for deemed approval so that CMS and States can take quick action to implement any strategies or system changes needed to correct identified violations of the reporting or redetermination requirements to promote sustained compliant operations and beneficiary coverage.

Section 430.49(b)(5) provides that CMS will consider the following in determining whether to approve a CAP submitted by a State: (1) whether the CAP will promptly eliminate or minimize any harm or risk of harm to beneficiaries, including increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, and delays in access to coverage or care, due to the noncompliance to be addressed by the plan; and (2) whether the CAP will result in the State achieving compliance in a reasonable time, taking into account systems challenges and circumstances faced by the agencies involved. Systems challenges that could impact the timeframe in which a State can achieve compliance could include, for example, the timeframe needed to update coding for a State's eligibility system, the need to create policy manuals to guide workers on use of new system functionality, training workers on new system changes, and/or the creation and implementation of new forms or functions to receive or track information in the renewal process.

As discussed further in section II.E. and § 430.49(d)(1) and (2), CMS will consider certain mitigating circumstances before issuing a notice directing a State to submit a CAP in accordance with the requirements at § 430.49(b).

D. Suspension of Procedural Disenrollments and Civil Money Penalties (§ 430.49(c))

Under section 1902(tt)(2)(B)(iii) of the Act, as implemented at § 430.49(c) of this rule, if a State fails to submit or implement an approved CAP, including if CMS disapproves the State's submitted CAP or if the State fails to meet the requirements set forth in the approved CAP, in accordance with section 1902(tt)(2)(B)(ii) of the Act, the Secretary may, after consideration of any mitigating circumstances described in section II.E. of this rule and at new § 430.49(d)(3), and in addition to any reduction applied to the FMAP under section 1902(tt)(2)(A) of the Act, take either or both of the following actions: (1) require the State to suspend making some or all disenrollments from Medicaid that are for procedural reasons until the State takes appropriate corrective action; (2) impose CMPs of not more than $100,000 for each day a State is not in compliance.

Under new § 430.49(c)(2), prior to taking either or both of these enforcement actions, CMS will issue a notice to the State. Such notice will include: (1) a description of the enforcement actions CMS is taking and the basis for such action(s); (2) whether CMS is requiring suspension of some or all procedural disenrollments, and in the case of a partial suspension, the affected populations; (3) the date on which the State must begin suspending procedural disenrollments, if applicable; (4) the daily amount of any CMPs imposed, the date that assessment of the CMPs will begin, the timeline for payment (including information on how the timeline for payment would be affected by an appeal), and instructions on how to submit payment; (5) the steps the State must take to cure its noncompliance and for CMS to lift the enforcement action(s); (6) information on the State's appeal rights as described in section II.G and at new § 430.49(f) of this rule, including the deadline to submit an appeal request and the effect of requesting an appeal on the applicability of any enforcement actions pending the decision in such appeal.

The notice must also provide that the decision outlined in the notice is final unless it is timely appealed as described in § 430.49(f). Section 430.49(c)(2)(ii) also provides that CMS may issue additional notices to take additional actions (for example, increasing CMPs or adding or increasing the scope of a suspension of procedural disenrollments) if CMS identifies additional violations of a CAP's provisions. Such notices will meet the requirements outlined in § 430.49(c)(2)(i).

Suspension of Procedural Disenrollments. As noted in this rule, if CMS finds that a State has failed to submit or implement an approved CAP in accordance with the requirements in section 1902(tt)(2)(B) of the Act, section 1902(tt)(2)(B)(iii) of the Act provides that CMS may require the State to suspend either some or all procedural disenrollments of Medicaid eligibility. We believe it is appropriate to target any procedural disenrollment suspension to protect those beneficiaries impacted by the State's noncompliance. If CMS requires the State to suspend procedural disenrollments, the scope of that requirement will be based upon the impact of the noncompliance that led to the requirement for the CAP. Accordingly, under § 430.49(c)(3)(i), if the impact of the noncompliance requiring a CAP affects a substantial number of (meaning all or nearly all) individuals in the State who are or should have been found eligible for Medicaid, CMS may require the State to suspend all procedural disenrollments. If the impact of the noncompliance is limited, for example to a specific population or geographic area, CMS may limit the suspension only to the affected population(s). In cases where CMS initially limits the requirement to suspend procedural disenrollments to an affected population or area, CMS may later opt to require the State to suspend all procedural disenrollments if CMS subsequently determines that the impact of the noncompliance is greater than was initially determined or if the State fails to comply with the initial requirement to suspend procedural disenrollments for a targeted population or area in accordance with the notice issued under § 430.49(c)(2). In these circumstances, CMS will issue a subsequent notice under § 430.49(c)(2).

CMS believes that suspension of procedural disenrollments is an effective and necessary enforcement tool to protect beneficiaries from harm due to a State's noncompliance and, except in one limited circumstance discussed in section II.E of this rule, will always require States that have failed to submit an approvable CAP or to implement an approved CAP to suspend some or all procedural disenrollments.

After CMS requires a State to suspend procedural disenrollments, the State must continue suspending procedural disenrollments until CMS determines that the State has taken appropriate corrective action. Once CMS is satisfied that the State has taken appropriate corrective action, CMS will inform the State of the date on which it may resume procedural disenrollments. See section II.F of this rule for a discussion of the circumstances under which CMS will lift enforcement actions taken pursuant to an enforcement notice issued in accordance with § 430.49(c).

Civil Money Penalties. If CMS finds that a State has failed to submit or implement an approved CAP, including if CMS disapproves the State's submitted CAP or if the State fails to meet the requirements set forth in the approved CAP, in accordance with the requirements in 1902(tt)(2)(B)(ii) of the Act and as interpreted at § 430.49(b) of this rule, CMS may also issue notice to the State in accordance with § 430.49(c)(2) indicating that CMS will impose CMPs.

The CMPs authorized under section 1902(tt)(2)(B)(ii) are a tool to compel State compliance with corrective action as quickly as possible, given the urgency of preventing unauthorized loss of coverage for beneficiaries during a period that generally aligns with States' unwinding periods. For this reason, CMS is adopting a penalty formula that will impose a lower penalty for States with a shorter timeframe of noncompliance and increase the penalty over time for States that do not return to compliance. CMPs will start accruing 5 days after the date of the notice and become payable 60 days after the date of the notice, if not timely appealed, or 60 days after issuance of a final determination at the conclusion of any appeals pursuant to § 430.49(f). Under § 430.49(c)(3)(ii)(B) of this rule, CMS will impose CMPs for failure to submit or implement an approved CAP according to the following formula: Days 1–30 (after 5-day delay as specified in the enforcement notice): $25,000/day; Days 31–60: $50,000/day; and Days 61–until State comes into compliance with CAP requirements: $100,000/day. All CMP amounts provided in this rule will be adjusted annually in accordance with 45 CFR part 102.

New § 430.49(c)(2)(ii) provides that CMS may issue additional notices to take additional actions (including increasing CMPs or imposing or broadening the scope of a suspension of procedural disenrollments) if CMS identifies additional violations of CAP provisions. Such notices will meet the requirements in 430.49(c)(2)(i).

Noncompliant States will be charged CMPs daily until the State takes appropriate action to cure the noncompliance with the CAP requirements as outlined in § 430.49(e) and discussed in section II.F. of this rule. Under § 430.49(e)(2), once CMS is satisfied that the State has taken appropriate action to cure the noncompliance with the CAP requirements, CMS will inform the State of the total amount of CMPs that have accrued, the balance owed if the State has already begun payment, and the last day CMPs under the enforcement notice were imposed.

As provided in § 430.49(c)(4), if the State fails to suspend procedural disenrollments as required pursuant to a notice described in § 430.49(c)(2) or to pay CMPs as specified in that notice, or both, CMS may issue a subsequent notice under § 430.49(c)(2) to increase the CMPs to the maximum allowable daily amount, if not already reached, or may pursue additional enforcement action under section 1904 of the Act, including withholding some or all FFP for the period of noncompliance.

CMS intends to issue additional guidance following the issuance of this rule providing additional information regarding the process CMS will use to collect CMPs and any operational requirements for States to remit payment of CMPs.

E. Mitigating Circumstances (§ 430.49(d))

As described previously, section 1902(tt)(2)(B) of the Act, as implemented in new § 430.49, gives CMS the authority to require States to submit a CAP for failure to meet reporting or Federal redetermination requirements and, if the State fails to submit or implement such CAP, including if CMS disapproves the State's submitted CAP or if the State fails to meet the requirements set forth in the approved CAP, in accordance with section 1902(tt)(2)(B)(ii) of the Act, to suspend procedural disenrollments, impose CMPs of up to $100,000 per day, or take both actions. While section 1902(tt)(2)(B) of the Act empowers CMS to require CAPs, suspend procedural disenrollments, and impose CMPs, the statute also gives the Secretary discretion to use this authority or not and to determine the amount of CMPs up to the statutory maximum.[21]

[21] Section 1902(tt)(2)(B)(iii) of the Act provides (emphasis added): If a State fails to submit or implement an approved corrective action plan in

CMS interprets the enforcement authorities in section 1902(tt)(2) of the Act as tools to promote State accountability for compliance with the reporting requirements in section 1902(tt)(1) of the Act and Federal redetermination requirements, as defined in § 430.5 of this rule, and to maximize accurate eligibility redeterminations to promote retention of coverage for eligible people to the greatest extent feasible. CMS recognizes that the scope or impact of different violations of the reporting or redetermination requirements may vary, and there also may be an emergency or other extraordinary circumstances preventing a State from complying with a given requirement or submitting or implementing a CAP. Thus, consistent with the discretion allowed under section 1902(tt)(2)(B) of the Act, CMS will take into consideration certain mitigating circumstances related to the State's noncompliance when determining whether to require the State to submit a CAP or require suspension of procedural disenrollments or impose CMPs. These circumstances are set forth at § 430.49(d) of this rule.[22]

Mitigating Circumstances Impacting Decision to Require a CAP. In the case of State noncompliance with Federal redetermination requirements, § 430.49(d)(1) provides that CMS may elect to not require or to delay requiring submission of a CAP if either or both of the following circumstances exist:

1. *No Harm or Substantial Risk of Harm Occurred:* The noncompliance caused neither actual harm nor a substantial risk of harm to beneficiaries, including increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, or delays in access to coverage or care.

2. *Extraordinary Circumstances Exist:* There is an emergency or there are other extraordinary circumstances preventing the State's compliance—for example, a natural disaster or catastrophic systems outage.

In addition, in the case of noncompliance with the reporting requirements in § 435.927, § 430.49(d)(2) provides that CMS may delay requiring or elect not to require a State to submit a CAP if CMS has determined that the State implementing a CAP is not necessary to ensure that the noncompliance is remedied. For example, CMS might not require a CAP if a State's noncompliance is due to an error that the State commits to correcting and does immediately correct. As with violations relating to Federal redetermination requirements, CMS may also delay requiring or elect not to require a State to submit a CAP relating to a violation of reporting requirements if CMS determines that there is an emergency or other extraordinary circumstances preventing the State's compliance.

Mitigating Circumstances Impacting Decision to Suspend Procedural Disenrollments or Impose CMPs. If a State fails to submit an approvable CAP or to implement an approved CAP, including if CMS disapproves the State's submitted CAP or if the State fails to meet the requirements set forth in the approved CAP, new § 430.49(d)(3) provides that CMS will consider whether any of the following mitigating circumstances exist when deciding whether to require a suspension of procedural disenrollments, impose CMPs, or take both actions:

1. *Extraordinary Circumstances Exist:* Regardless of the type of violation that gave rise to the requirement of a CAP, CMS will consider whether there is an emergency or other extraordinary circumstance that occurred after the violation resulting in the requirement of a CAP that significantly impeded the State's ability to submit or implement the CAP. If such circumstances exist, CMS may delay or forgo imposition of CMPs but will not delay requiring a suspension of procedural disenrollments (beyond the one-month delay described below in the case of reporting violations that do not impede CMS' oversight of procedural disenrollments).

2. *Reporting Violation Does Not Impede CMS' Oversight of Procedural Disenrollments:* When a State fails to submit or implement an approved CAP that was required based on the State's violation of reporting requirements under section 1902(tt)(1) of the Act, CMS will consider whether the underlying reporting violation impedes CMS' oversight of procedural disenrollments. If so, CMS will suspend procedural disenrollments and impose CMPs. If not, CMS will delay requiring a suspension of procedural disenrollments for 1 month to allow the State an opportunity to comply with the data reporting requirements but will immediately impose CMPs (unless extraordinary circumstances exist, as discussed above).

Although all data reporting under section 1902(tt)(1) of the Act is important to support CMS oversight of State redetermination processes during a period that generally aligns with States' unwinding periods, we believe that in most cases it would be too punitive to suspend procedural disenrollments immediately if the State fails to submit or implement a CAP related to an underlying reporting requirement violation that does not impede CMS' understanding of the State's procedural disenrollment rate. In contrast, where a State fails to submit or implement a CAP related to an underlying reporting violation that impedes CMS' oversight of procedural disenrollments in that State, CMS will take immediate action to require suspension of procedural disenrollments, in addition to imposing CMPs (if not delayed or forgone by CMS due to the existence of extraordinary circumstances), to mitigate possible harm to beneficiaries at risk of disenrollment.

For example, if a State fails to submit or implement an approved CAP that CMS required based upon the State's failure to report data on the volume of calls it is receiving at a call center, CMS will examine the circumstances of the underlying reporting violation and may find that the lack of these data does not impede its oversight of procedural disenrollments and, if so, will delay requiring the State to suspend procedural disenrollments for 1 month, pending the submission or implementation of a CAP or the correction of the underlying reporting violation, but will impose CMPs according to § 430.49(c)(3)(ii) without delay (unless there has been an extraordinary circumstance after the violation occurred that prevented the State from submitting or implementing the CAP).

F. Lifting of CAP Enforcement Actions (§ 430.49(e))

Under § 430.49(e)(1) of this rule, CMS will lift any requirement to suspend procedural disenrollments and/or stop charging any CMPs imposed pursuant to § 430.49(c) when the State cures its noncompliance by submitting an approvable CAP (where the violation was a failure to submit a CAP) or initiating or resuming implementation

accordance with clause (ii), the Secretary *may* . . . require the State to suspend making all or some terminations of eligibility for medical assistance from the State plan under this title (including any waiver of such plan) that are for procedural reasons until the State takes appropriate corrective action, as determined by the Secretary, and *may* impose a civil money penalty of *not more than* $100,000 for each day a State is not in compliance.

[22] CMS has also used its discretion in setting the amount of the CMPs that will apply in certain circumstances, based on the duration of the CAP violation involved, as discussed above in section II.D.

of an approved CAP (where the violation was a failure to implement according to the terms of the CAP). In cases where the State had received a notice imposing CMPs due to failure to submit an approved CAP, CMS will continue the accrual of CMPs from the date that a State submits a CAP for CMS review in accordance with § 430.49(e)(1)(i)(A), until CMS determines whether the CAP is approvable. If CMS determines the CAP is approvable, CMS will retroactively end the accrual of CMPs on the day the CAP was submitted and cease charging CMPs prospectively. If CMS determines that the CAP is not approvable, CMS will continue charging CMPs imposed under the terms of the enforcement notice without interruption from the date specified in the original notice provided to the State under § 430.49(c)(2) and will continue charging such CMPs until an approvable CAP is submitted. Under § 430.49(e)(2), once CMS is satisfied that the State has taken appropriate action to cure the noncompliance with the CAP requirements, CMS will inform the State of the total amount of CMPs that have accrued, the balance owed, and the last day CMPs were imposed as well as the date on which the State may resume procedural disenrollments.

CMS may again require suspension of procedural disenrollments and impose CMPs that have been lifted in accordance with § 430.49(e)(1) if CMS subsequently determines that the State is not complying with the terms of the approved CAP. In such a situation, CMS will issue a new notice pursuant to § 430.49(c)(2).

G. State Reconsideration and Appeal Rights (42 CFR 430.3, 430.49(f), and 45 CFR Part 16)

Under new § 430.49(f) and amendments to § 430.3 and 45 CFR part 16, States will be able to appeal CMS' decision to require a State to suspend procedural disenrollments and/or pay CMPs under section 1902(tt)(2)(B)(iii) of the Act and new § 430.49(c). The rule amends § 430.3 and 45 CFR part 16, Appendix A, to provide that States can appeal these CMS decisions to the Departmental Appeals Board (Board) in accordance with procedures set forth in 45 CFR part 16.

The rule creates a new 42 CFR 430.49(f)(1), providing that a State dissatisfied with CMS' determination under § 430.49(c) that the State must suspend procedural disenrollments or pay CMPs will have 30 days (as counted consistent with the protocol for counting days outlined under 45 CFR 16.19) from receipt of the notice described in § 430.49(c)(2) to appeal CMS's decision to the Board. The appeal request must comply with 45 CFR 16.7, and the appeals process will be governed by 45 CFR part 16. That means that the expedited appeal procedures outlined in 45 CFR 16.12 might be available, if the conditions in 45 CFR 16.12 are met. If the State does not submit an appeal request within that 30-day timeframe, then the decision described in the notice received by the State under § 430.49(c)(2) is the final decision of the Secretary and is final agency action within the meaning of 5 U.S.C. 704.

At new 42 CFR 430.49(f)(2), we give any party to the appeal that is dissatisfied with the Board's decision under 430.49(f)(1) an opportunity to request that the CMS Administrator reconsider it, and we outline the process that will govern the Administrator's reconsideration. In particular, new § 430.49(f)(2)(i) specifies that any party to the appeal that is dissatisfied with the Board's decision on an appeal brought by a State under § 430.49(f)(1) may request reconsideration of that decision within 15 days of receiving notice of the decision under 45 CFR 16.21. The process for such reconsiderations is provided under new § 430.49(f)(2)(i)(A) through (D). Under new § 430.49(f)(2)(i)(A), we are providing that reconsideration requests must be filed with the Administrator, and must include a copy of the Board's decision, a brief statement of why the party believes it was wrong, and a statement of the amount of any CMPs in dispute. New § 430.49(f)(2)(i)(B) requires that the party requesting reconsideration send a copy of the request for reconsideration to all other parties to the appeal and other participants in the appeal (as described in 45 CFR 16.16) at the same time the request is filed. New § 430.49(f)(2)(i)(C) provides that any other party to the appeal, or other participant in the appeal, may respond to the request for reconsideration in writing and file such response with the Administrator within 15 days of the date the request for reconsideration is filed with the Administrator. Under new § 430.49(f)(2)(i)(D), the Administrator will review the Board's decision and any additional information submitted by the parties and other participants, and either affirm the Board's decision or issue a new decision within 60 days after the Board issues notice of its decision under 45 CFR 16.21. Under new § 430.49(f)(2)(ii), the Administrator may, within 60 days after the Board issues notice of its decision under 45 CFR 16.21, also modify or reverse the Board's decision without receiving a request for reconsideration under § 430.49(f)(2). In cases where the Administrator opts to review the Board's decision without a request for reconsideration, such decision must be provided within 60 days of the Board's issuance of its notice of decision under 45 CFR 16.21.

New § 430.49(f)(2)(iii) states that if there is no request for reconsideration filed under § 430.49(f)(2)(i) and the Administrator does not modify or reverse the decision within the 60-day period described in § 430.49(f)(2)(ii), then the Board's decision will be the final determination of the Secretary and final agency action, and the Administrator will provide notice to all parties and other participants of such decision as described in § 430.49(f)(2)(iv). New § 430.49(f)(2)(iv) provides that the Administrator will provide a notice to all parties and other participants of the final decision that communicates that it is the final determination of the Secretary and final agency action and § 430.49(f)(2)(v) provides that the determination of the Administrator pursuant to §§ 430.49(f)(2)(i)(D) or 430.49(f)(2)(ii) constitutes final agency action within the meaning of 5 U.S.C. 704.

Under amendments in the rule to 45 CFR 16.22, any suspensions of procedural disenrollments under 42 CFR 430.49(c) will continue in effect and CMPs imposed on a State under 430.49(c) will continue to accrue pending an appeal to the Board under § 430.49(f).

Appeals of CMS decisions to take the FMAP reduction under section 1902(tt)(2)(A) of the Act will follow a different process that is governed by already existing regulations. If CMS finds that a State is noncompliant with reporting requirements under § 435.927, CMS will calculate the amount of the FMAP reduction under § 435.928 and request that the State make a voluntary adjustment to the Form CMS–64 to return the funds to CMS. If the State does not do so, CMS will initiate disallowance proceedings, which will be governed by existing regulations at § 430.42. States may request reconsideration or appeal disallowance decisions per these existing CMS regulations at § 430.42. Under § 430.42, States wishing to request a reconsideration of the Administrator's decision to impose a disallowance must request such reconsideration within 60 days of receiving the notice of disallowance described in § 430.42(a).

We are adding new § 430.49(f) and amending § 430.3 and 45 CFR part 16 as outlined in this section to provide States

with a fair and reasonable administrative process for appealing CMS' decisions to suspend procedural disenrollments or impose CMPs and to ensure that accountability for those decisions is vested in a principal officer. These changes also will provide States with accurate information about the availability of administrative review if they are dissatisfied with a CMS decision under 42 CFR 430.49(c). These provisions also clarify when agency decisions are final agency action for purposes of 5 U.S.C. 704.

H. Definitions (§ 430.5)

This rule adds two new definitions to § 430.5 that apply to the provisions at § 430.49. One of the two new definitions will also apply to related amendments to 45 CFR part 16. First, the rule defines a ''procedural disenrollment'' for purposes of 42 CFR 430.49 and 45 CFR part 16 as a termination of eligibility and disenrollment from Medicaid for reasons that are unrelated to a State's determination of whether the individual meets eligibility criteria to qualify for coverage, including for failure to return a renewal form or documentation needed by the State to make a determination of eligibility. And second, the rule defines ''Federal redetermination requirements'' for purposes of 42 CFR 430.49 as Federal requirements applicable to eligibility redeterminations outlined in § 435.916, including renewal strategies authorized under section 1902(e)(14)(A) or other alternative processes and procedures approved by CMS under section 1902(e)(14)(A) of the Act or section 6008(f)(2)(A) of the FFCRA.

III. Good Cause

The Administrative Procedure Act (APA), at 5 U.S.C. 553(b), requires the agency to publish a notice of the proposed rule in the **Federal Register** that includes a reference to the legal authority under which the rule is proposed and the terms and substance of the proposed rule or a description of the subjects and issues involved. Section 553(c) further requires the agency to give interested parties the opportunity to participate in the rulemaking through public comment before the provisions of the rule take effect. Section 553(b)(B) provides an exception to notice-and-comment requirements, however, if the agency for good cause finds that notice-and-comment is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

Section 553(d) ordinarily requires a 30-day delay in the effective date of a final rule from the date of its publication in the **Federal Register**. However, similar to the good cause exception for notice-and-comment requirements, section 553(d)(3) excepts a rule from the 30-day delay requirement if the agency for good cause finds that the delay is impracticable, unnecessary, or contrary to the public interest. Similarly, the Congressional Review Act (CRA) also allows an agency to issue a rule that would otherwise be subject to a 60-day delayed effective date requirement with an immediate effective date in circumstances where a delay is impractical, unnecessary, or contrary to the public interest (5 U.S.C. 808(2)). CMS is forgoing the usual notice-and-comment procedures and delay in the effective date for this rule because, for the reasons discussed in this section, following such requirements would be impracticable and contrary to the public interest.

Recent data on unwinding-related renewals indicates that of the 7.1 million Medicaid and CHIP beneficiaries whose eligibility was due for renewal in July 2023, more than 1.6 million had been disenrolled.[23] The vast majority of these disenrolled individuals (71 percent) were disenrolled due to a procedural reason such as failure to return paperwork, not because of a determination that the person no longer satisfied Medicaid's substantive eligibility criteria. While we are unable to determine the proportion of individuals who were procedurally disenrolled but continued to meet substantive eligibility criteria, the high rate of procedural disenrollments suggests that the options and strategies that CMS has been working with States to implement through their mitigation plans may not be sufficient to protect the continued enrollment of individuals who continue to meet substantive eligibility criteria. For this reason, the enforcement authorities established under this rule are needed to protect access to Medicaid coverage. Any delay in implementing the enforcement tools in this rule would thwart CMS's ability to take an array of possible enforcement actions against noncompliant States under section 1902(tt) of the Act and could result in serious harm to beneficiaries.

In anticipating the likely impact of unwinding, the Assistant Secretary for Planning and Evaluation (ASPE) in HHS estimated that in the period between April 1, 2023, and June 1, 2024, 6.8 million people will lose Medicaid coverage despite still meeting substantive eligibility criteria.[24] ASPE estimated that 82.7 percent of enrollees would be determined eligible, and their eligibility would be renewed, while 17.5 percent would be disenrolled. Of those disenrolled, ASPE estimated 54 percent would be disenrolled because they were determined ineligible, and 45 percent (6.8 million) would be disenrolled for procedural reasons despite still meeting substantive eligibility criteria. Early unwinding data from May and June 2023 renewals show a higher percentage of renewals resulting in disenrollment (nearly 38 percent in May and just over 25 percent in June) and a significantly higher percentage of disenrollments occurring for procedural reasons (77 percent in May and 73 percent in June) compared to ASPE's estimates. While these early data are limited, if disenrollments continue at the June 2023 rates, the number of individuals who lose Medicaid coverage for procedural reasons will be much higher than ASPE's estimates, and many of those individuals may still meet substantive Medicaid eligibility criteria. If CMS is unable to take all actions within its authority to enforce Federal redetermination requirements, the number of individuals negatively impacted may increase.

Analyses indicate that Medicaid coverage loss could have significant detrimental consequences, resulting in forgone medical care, including preventive care, that could result in refilling prescriptions less often, more emergency department visits, and increased morbidity and mortality.[25] [26] Preventable coverage loss could result from States' failure to follow Federal requirements, which CMS cannot fully enforce without this rulemaking. Loss of coverage by individuals who still meet substantive eligibility criteria, which is likely followed by re-enrollment at a later point in time, is often referred to as ''churning.'' Because churning can lead to deferred or delayed care, it can result in greater health care costs; such disruptions in care and medication

[23] Medicaid and CHIP National Summary of Renewal Outcomes—March Through July 2023 Data; published October 2023; available at *https://www.medicaid.gov/sites/default/files/2023-10/july-2023-national-summary-renewal-outcomes.pdf.*

[24] ASPE (August 19, 2022). Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches. (Available at *https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf*).

[25] ASPE (April 11, 2021). Medicaid Churning and Continuity of Care. (Available at *https://aspe.hhs.gov/reports/medicaid-churning-continuity-care*).

[26] Abdus, S. (August 2014). Part-year Coverage and Access to Care for Nonelderly Adults. (Available at *https://journals.lww.com/lww-medicalcare/Fulltext/2014/08000/Part_year_Coverage_and_Access_to_Care_for.6.aspx*).

adherence create negative health outcomes that make care more costly down the road.[27]

By contrast, continuous enrollment permits individuals to maintain a regular source of care, including preventive care and ongoing treatment of chronic conditions. A review of the research available on continuous enrollment of children found it is related to reductions in unmet health care needs, increases in coordination of care, including monitoring and regular treatment adjustments as conditions change, and greater patient/provider engagement in treatment planning, which can lead to better health outcomes.[28] In fact, a study of health care outcomes in States that provided continuous eligibility to children prior to the FFCRA's continuous enrollment condition found reductions in insurance gaps, lower probability of children being in fair or poor health, and, for children with serious health care needs, increased access to preventive and specialty care.[29] This evidence suggests that protecting access to coverage leads to better outcomes for enrollees. The availability of these enforcement tools is critically important to ensure that CMS can act quickly, if needed, to address State noncompliance. Delaying CMS' access to the full range of the enforcement tools it could employ to require States to follow Federal eligibility redetermination requirements and the new reporting requirements in section 1902(tt)(1) of the Act, could thus cause actual harm to beneficiaries.

As discussed, State submission of renewal data is critically important to our ability to monitor State renewal processes and take action when needed to prevent unauthorized disenrollments. CMS must be able to use the compliance tools under section 1902(tt) of the Act to obtain data from States that will help us to continue to quickly identify problems with the redetermination process during the period from April 1, 2023, through June 30, 2024, and, if needed, to take timely action to require States to fix problems including, if appropriate, requiring States to halt procedural disenrollments from Medicaid.

This rule provides critical guidance to help States ensure that they are complying with the data reporting requirements under section 1902(tt)(1) of the Act and that they understand how CAPs and CMPs will be administered in the event that a State does not take all actions necessary for compliance. For example, the rule provides States with certainty regarding how CMS will interpret the requirement to report certain data under section 1902(tt)(1) of the Act *on a timely basis*. A delay in the issuance of guidance resulting from the notice-and-comment process would forestall States' ability to be compliant with Federal requirements that protect beneficiaries.

CMS sees the enforcement authorities—CAPs, suspensions of procedural disenrollments, and CMPs—as tools to promote State accountability for compliance with the reporting and redetermination requirements, and we recognize that the scope or impact of different violations of these requirements may vary. Thus, we believe it is important to consider certain mitigating circumstances when determining whether to require a State to submit a CAP or to require a suspension of procedural disenrollments or impose CMPs. This rule gives States additional information about the factors that CMS will weigh in deciding whether to require CAPs, to require States to suspend procedural disenrollments, or to impose CMPs. CMS needs to be able to focus its limited enforcement resources on the most serious noncompliance. Without this flexibility, CMS would be required to tie up our limited resources on enforcement actions in situations where mitigating circumstances would weigh against such action. This could seriously inhibit or even prevent CMS from taking truly needed enforcement action if a situation were to arise involving serious noncompliance causing harm or a substantial risk of harm.

Recognizing the importance of the guidance in this rule, CMS has moved as quickly as possible within existing constraints to complete rulemaking. Section 1902(tt) of the Act was enacted via the CAA, 2023, on December 29, 2022, took effect 3 months later, on April 1, 2023, and applies to a time-limited period, from April 1, 2023, to June 30, 2024, that began on the day that the statutory language took effect. In other words, the effective date of section 1902(tt) of the Act is the same date as the start of the compliance period, and there was only a 3-month timeframe between the passage of the CAA, 2023 and the effective date. Given the short timeframe and the evolving landscape of State needs relating to implementation, it was not feasible for CMS to have issued a final rule (with or without notice-and-comment) in that 3-month timeframe, because, as is discussed in more detail below, CMS' notice-and-comment rulemaking process ordinarily takes at least 18 months.

Moreover, given the evolving landscape of Federal guidance and State needs before and after the end of the Medicaid continuous enrollment condition, it would not have been feasible for CMS to begin the rulemaking process earlier. When the CAA, 2023 was enacted on December 29, 2022, CMS was immersed in efforts to support States as they prepared operations for the end of the Medicaid continuous enrollment condition. This included working with all 56 States individually on assessing the need for and implementing temporary strategies or plans to ensure State compliance with Federal Medicaid redetermination requirements (often referred to as mitigation plans) and issuing new guidance and flexibilities to enable States to maximize their capacity to maintain the enrollment of eligible beneficiaries at renewal during the unwinding of the Medicaid continuous enrollment condition.

Accelerating the rulemaking process was also not a viable option for CMS given resource constraints, even if doing so would have been feasible. Since enactment of the CAA, 2023, CMS has devoted an extraordinary amount of internal resources to the development of materials, review of readiness, and availability of technical assistance for States as they prepared for and began to return to normal eligibility operations following the end of the FFCRA continuous enrollment condition. We created a series of new resources designed to assist States in protecting the enrollment of eligible individuals as they restarted routine Medicaid renewals, met with every State to assess its planning for unwinding and compliance with Medicaid renewal requirements, and developed new options and strategies through which States could address areas of noncompliance and mitigate negative impacts on eligible individuals. These efforts did not stop when the unwinding process began, and they continue to strain Federal agency resources. During roughly the same timeframe, CMS was also engaged in an unprecedented amount of work to support States, health care providers, and Medicare, Medicaid, and CHIP beneficiaries in the

[27] Sommers, B.D., Gourevitch, R., Maylone, B., Blendon, R.J., Epstein, A.M. (2016). Insurance churning rates for low-income adults under health reform: Lower than expected but still harmful for many. *Health Affairs,* 35(10), 1816–1824.

[28] Guevara, J.P., Moon, J., Hines, E.M., Fremont, E., Wong, A., Forrest, C.B., Silber, H.H., & Pati, S. (2014). Continuity of public insurance coverage: A systematic review of the literature. *Medical Care Research and Review,* 71(2), 115–137.

[29] Brantley, E., Ku, L. (2022). Continuous eligibility for Medicaid associated with improved child health outcomes. *Medical Care Research and Review,* 79(3), 404–413.

transition back to regular operations when numerous access-related policies and flexibilities ended on May 11, 2023, when the COVID–19 PHE (as declared by the Secretary under section 319 of the Public Health Service Act) ended. This included waivers under section 1135 of the Act that were in place for the more than 3 years of that COVID–19 PHE.[30] Notwithstanding this unusual, extraordinary workload throughout most of 2023, CMS has developed and issued this rule as soon as was practicable under the circumstances.

Had CMS proceeded through notice-and-comment rulemaking, the resulting delay would have been significant, thereby increasing the risk that beneficiaries would be harmed by losing coverage due to States' violation of Federal redetermination requirements. CMS' rulemaking cycle from proposed rulemaking to final rule typically takes at least 18 months. This includes drafting the proposed rule and engaging in a rigorous clearance process that concludes with CMS, HHS, and the Office of Information and Regulatory Affairs leadership approval. A proposed rule is typically published in the **Federal Register** with a 60-day public comment period, and then CMS must review, categorize, and consider the public comments received, which may number in the thousands. Then the final rule can be drafted and enter the same rigorous clearance process. If this process began immediately upon enactment of the CAA, 2023 (December 29, 2022) and extended 18 months, when combined with the usual 30- or 60-day delay in effective date following publication in the **Federal Register**, the rule would not have taken effect until the beginning of August 2024 at the earliest, 1 month after the compliance period ended. In the meantime, CMS would have been significantly hampered in its efforts to enforce Federal redetermination requirements and to enforce the reporting requirements that help CMS quickly become aware of possible State violations of those redetermination requirements.

Based on CMS' early and still ongoing work with States and the information States have already reported, CMS has already observed renewal issues and has been working with States to develop mitigation plans to address them. As that work continues and new issues are uncovered, it is important for CMS to be able to draw upon the full range of its enforcement tools. Additionally, other issues may arise in the coming months that could require CMS to take swift action to the full extent of its enforcement authority under section 1902(tt) of the Act. For example, States might fail to comply with requirements to provide appropriate notice informing beneficiaries of the renewal process and the steps needed to renew eligibility, may fail to use available and reliable information sources to assess beneficiaries' eligibility on an *ex parte* basis, may make a determination of ineligibility that is inconsistent with eligibility criteria, or may fail to appropriately notify the individual of the eligibility determination and the beneficiary's right to a fair hearing. In any of these circumstances, a major State violation of requirements could lead to a substantial number of beneficiaries being unlawfully disenrolled from coverage, creating an immediate need for CMS to require States to take corrective action to restore lost benefits to prevent further harm to beneficiaries. Although States and CMS have collaboratively worked to mitigate these risks in preparing for and implementing the end of the Medicaid continuous enrollment condition, if a State in the future is unwilling or unable to comply with Federal renewal or reporting requirements, CMS will have an urgent need to be able to enforce these Federal requirements using the enforcement authority implemented by this rule. And waiting to use that enforcement authority until August 2024 would significantly undermine CMS's ability to prevent more immediate harm to beneficiaries.

In addition, unless the rule is issued without delay, States would not have administrative channels to pursue an appeal before any judicial review of the actions CMS is authorized to take under section 1902(tt)(2)(B)(iii) of the Act. Setting forth a clear administrative appeals process benefits both States and CMS by providing both parties an opportunity to resolve disputes administratively and thus potentially avoid the need for additional judicial review, and to generate a clear record for any further judicial review in Federal court, should it be necessary to resolve the dispute.

For all the reasons cited previously in this rule and summarized in Table 1, which follows, CMS believes good cause exists to exempt this rule from the notice-and-comment and delay in effective date requirements and is proceeding with this rulemaking on an expedited basis, to be effective upon publication.

TABLE 1—GOOD CAUSE

Title (regulatory citation)	Rationale
Reporting Requirements (§ 435.927).	Notice-and-comment rulemaking for § 435.927 is impracticable and contrary to the public interest for the following reasons: • The timeline for such rulemaking would extend beyond the time period during which the reporting requirements implemented by § 435.927 are in effect. • Any delay in issuing clear reporting guidance will negatively impact States' ability to comply with Federal requirements and will negatively impact CMS's ability to monitor States' redetermination processes. • These reporting requirements will help CMS to determine whether States are meeting Federal redetermination requirements. Unless CMS has this information promptly, during the applicable period, CMS will be less able to take swift enforcement action to prevent unauthorized coverage loss (or gaps in coverage) for eligible individuals. Coverage loss can lead to forgone care and adverse health outcomes.
FMAP Reduction (§ 435.928)	Notice-and-comment rulemaking for § 435.928 is impracticable and contrary to the public interest for the following reasons: • The timeline for such rulemaking would extend beyond the time period (July 1, 2023, through June 30, 2024) during which State noncompliance could trigger the FMAP reduction described in this section.

[30] See *https://www.cms.gov/files/document/frequently-asked-questions-cms-waivers-flexibilities-and-end-covid-19-public-health-emergency.pdf,* and *https://www.medicaid.gov/sites/default/files/2023-08/cib050823.pdf.*

TABLE 1—GOOD CAUSE—Continued

Title (regulatory citation)	Rationale
	• The FMAP reduction implemented in § 435.928 is an important component of the tools available to ensure that States comply with the reporting requirements. Without proper reporting, CMS may be unable to effectively monitor States' compliance with redetermination requirements during the reporting period and will be less able to take swift enforcement action to prevent unauthorized coverage loss. This may lead to disenrollment of eligible individuals (and/or gaps in their coverage) and result in adverse health outcomes.
Corrective Action Plans (§§ 430.5, 430.49(b)).	Notice-and-comment rulemaking for § 430.49(b) (along with the definitions at § 430.5 that are applicable to this provision) is impracticable and contrary to the public interest for the following reasons: • The timeline for such rulemaking would extend beyond the time period (April 1, 2023, to June 30, 2024) during which State noncompliance with either the reporting requirements described at § 435.927 or Federal renewal requirements could arise and thereafter be subjected to the CAPs implemented in 430.49(b). • The CAP provisions implemented at § 430.49(b) are an important component of the tools available to ensure that States comply with both the reporting requirements and the Federal redetermination requirements. A delay in implementing these provisions would limit CMS' authority to quickly minimize preventable loss of coverage or gaps in coverage for eligible individuals when they are identified, which may result in forgone care and adverse health outcomes.
Suspension of Procedural Disenrollments and Civil Money Penalties (§§ 430.5, 430.49(c)).	Notice-and-comment rulemaking for § 430.49(c) (along with the definitions at § 430.5 that are applicable to this provision) is impracticable and contrary to the public interest for the following reasons: • The timeline for such rulemaking would extend beyond the time period (April 1, 2023, to June 30, 2024) during which State noncompliance could arise and thereafter be subjected to the enforcement actions implemented in 430.49(c). • A delay in implementing this statutory authority would limit CMS' authority to quickly minimize preventable loss of coverage for eligible individuals, which may result in forgone care and adverse health outcomes.
Mitigating Circumstances (§§ 430.5, 430.49(d)).	Notice-and-comment rulemaking for § 430.49(d) (along with the definitions at § 430.5 that are applicable to this provision) is impracticable and contrary to the public interest, as it would prevent CMS from exercising discretion with respect to the enforcement authority provided by section 1902(tt) of the Act, minimizing its usefulness for enforcing State compliance. CMS needs to be able to focus its limited enforcement resources on the most serious noncompliance. Tying up CMS's limited enforcement resources on enforcement actions in situations where mitigating circumstances would weigh against such action could seriously inhibit or even prevent CMS from taking truly needed enforcement action in situations involving serious noncompliance causing harm or a substantial risk of harm.
State Reconsideration and Appeal Rights (§ 430.3, 430.49(f), and corresponding amendments to 45 CFR part 16).	Notice-and-comment rulemaking for State reconsideration and appeal rights is impracticable and contrary to the public interest for the following reasons: • The timeline for such rulemaking would extend beyond the time period (April 1, 2023, to June 30, 2024) during which State noncompliance could arise and thereafter be subjected to the enforcement actions implemented by this rule. • A delay in establishing appeal rights would impede States' ability to seek administrative resolution to resolve disputes regarding the enforcement actions in this rule without necessitating review in Federal court.

IV. 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 OMB for review and approval. For the purpose of the PRA and this section of the preamble, collection of information 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 the agency.

• The accuracy of the 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.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2021 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, the following table presents the BLS' mean hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 2—NATIONAL OCCUPATIONAL AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage	Fringe benefit (at 100%)	Adjusted hourly wage
Database Administrators	15–1242	$49.29	$49.29	$98.58
General and Operations Manager	11–1021	59.07	59.07	118.14
Management Analyst	13–1111	50.32	50.32	100.64

TABLE 2—NATIONAL OCCUPATIONAL AND WAGE ESTIMATES—Continued

Occupation title	Occupation code	Mean hourly wage	Fringe benefit (at 100%)	Adjusted hourly wage
Project Management Specialists	13–1082	48.85	48.85	97.70

Wages for State Governments. As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent to estimate the cost of providing fringe benefits. This is necessarily a rough adjustment, both because fringe benefits and overhead 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 the total cost including fringe benefits 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 Medicaid matching funds at a rate established in statute. All State Medicaid programs generally receive a 50 percent Federal matching rate for qualifying administrative activities. As noted previously, States also receive higher Federal Medicaid matching rates for certain activities, such as certain systems design and development, and for systems maintenance and operations, so the level of Federal Medicaid funding provided to a State can be significantly higher. As such, taking into account the Federal contribution to the costs of administering the Medicaid program for purposes of estimating State burden with respect to collection of information, we elected to use a conservative estimate that the States would contribute 50 percent of the costs, even though the burden will likely be much smaller.

B. Information Collection Requirements (ICRs)

1. ICRs Related to Reporting Requirements (§ 435.927)

The following changes will be submitted to OMB for approval under control number 0938–TBD (CMS–10875). At this time the control number has yet to be determined, but it will be assigned by OMB upon their approval of this IFC's collection of information request. The public can monitor OMB's issuance of the control number (and the control number's expiration date) at *reginfo.gov*.

Under § 435.927, States are required to submit certain monthly data to CMS. The data are already collected by States and reported to CMS under existing requirements that are approved by OMB under control numbers 0938–1119 (CMS–10371), 0938–0345 (CMS–R–284), 0938–1140 (CMS–10387), and 0938–1148 (CMS–10398 #64). However, recognizing that some States might encounter unusual circumstances that interfere with reporting using existing CMS-approved processes, CMS would consider approving alternative processes and timelines for States to report required data if a State is making a good faith effort to submit the required data, as specified in § 435.927(b)(4). For example, CMS would consider allowing States experiencing special circumstances to submit certain summary data via email rather than via T–MSIS, if T–MSIS is the existing process.

Based on CMS' ongoing work with States to report the required data, we estimate that eight States will request that CMS approve an alternative process for submitting data under § 435.927(c)(2) during the compliance period of April 1, 2023, through June 30, 2024. We estimate that for each of the eight States that request and receive approval to use an alternative process to submit required data, it will take a Project Management Specialist 8 hours at $97.70/hour and a Database Administrator 15 hours at $98.58/hour to develop an alternative process, reach agreement with CMS, and submit the required data, for an aggregate of 184 hours (8 States × 23 hours) and $18,082 [(($97.70 × 8 hours) + ($98.58 × 15 hours)) × 8 States]. Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State share would be $9,041.

2. ICRs Related to Corrective Action Plans (CAPs) (§ 430.49(b))

The following changes will be submitted to OMB for approval under control number 0938–TBD (CMS–10875). At this time the control number has yet to be determined, but it will be assigned by OMB upon their approval of this IFC's collection of information request. The public can monitor OMB's issuance of the control number (and the control number's expiration date) at *reginfo.gov*.

This rule authorizes CMS to require States to submit a CAP to CMS if the State is out of compliance with the reporting requirements in section 1902(tt)(1) of the Act or Federal eligibility redetermination requirements (including any alternative processes and procedures approved by CMS, such as renewal strategies authorized under section 1902(e)(14)(A))) of the Act during the compliance period between April 1, 2023 and June 30, 2024.

Based on CMS' ongoing work with States to unwind from the continuous enrollment condition, we estimate that 3 States will be out of compliance with data reporting requirements and 5 States will be out of compliance with Federal redetermination requirements during the compliance period of April 1, 2023, to June 30, 2024. Some States may be out of compliance with both sets of requirements and required to submit just one CAP addressing both issues, but for purposes of estimating State burden, we will assume they are mutually exclusive sets of States for a total of 8 States. We will also assume for purposes of estimating State burden that CMS will require a CAP from all of the 8 noncompliant States (and will not exercise its discretion not to require a CAP from any of them). We recognize that, if our assumptions are incorrect, the aggregate burden may be less or more than estimated here.

We estimate that for each of the 8 States required to submit a CAP to CMS, it will take a Management Analyst 20 hours at $100.64/hour and a General and Operations Manager 8 hours at $118.14/hour to write, clear, and submit a CAP that includes the criteria at § 430.49(b)(3) for an aggregate of 224 hours (8 States × 28 hours) and $23,663 [(($100.64 × 20 hours) + ($118.14 × 8 hours)) × 8 States]. Taking into account the 50 percent Federal contribution to Medicaid program administration, the estimated State share would be $11,832.

TABLE 3—SUMMARY OF PROPOSED BURDEN ESTIMATES

Regulation section(s)	OMB control No. (CMS ID No.)	Number of respondents	Number of responses per respondent	Hourly labor cost ($/hr)	Time per re-sponse (hours)	Total time (hours)	Labor cost ($)	Total state share ($)	Total beneficiary burden (hours)	Total beneficiary cost ($)	Total non-labor cost ($)	Frequency
§ 435.927	0938–TBD (CMS–10875).	8	1	varies	23	184	18,082	9,041	n/a	n/a	n/a	One-Time.
§ 430.49(b) ...	0938–TBD (CMS–10875).	8	1	varies	28	224	23,663	11,832	n/a	n/a	n/a	One-Time.
Total	0938–TBD (CMS–10875).	....	....	....	....	408	41,745	20,873	n/a	n/a	n/a	One-Time.

C. Submission of PRA-Related Comments

We have submitted a copy of this rule to OMB for its approval of the rule's information collection requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the collections previously discussed in this rule, please visit the CMS website at *https://www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at (410) 786–1326.

If you comment on these information collection requirements, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** sections of this interim final rule.

V. Response to Comments

Because of the large number of public comments normally received on **Federal Register** documents, the Department is not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

We have learned through working with States as they unwind from the continuous enrollment condition under the FFCRA and return to normal operations that States face challenges in processing an unprecedented volume of redeterminations. Through routine monitoring and technical assistance, CMS is working with States to address and mitigate policy and operational barriers to meeting all Federal eligibility and enrollment requirements. Congress has given CMS new tools to hold States accountable when States fail to meet Federal redetermination requirements during the period from April 1, 2023, to June 30, 2024.

In this rulemaking, we implement State reporting requirements and CMS' enforcement authorities under section 1902(tt) of the Act. We interpret and implement statutory language and specify parameters related to when States will be required to submit certain data. We also specify how CMS interprets and will calculate the FMAP reduction required under section 1902(tt)(2)(A) of the Act for a State's failure to comply with the reporting requirements in section 1902(tt)(1) of the Act for a quarter during the period from July 1, 2023, through June 30, 2024. We also specify parameters related to when States that are noncompliant with reporting requirements in section 1902(tt)(1) of the Act or with Federal eligibility redetermination requirements must submit a CAP, and when they will be required to suspend some or all disenrollments of eligibility for procedural reasons, and/or pay CMPs. We also specify the conditions under which CMS would lift requirements to suspend procedural disenrollments and CMPs as States come into compliance with Federal redetermination and reporting requirements via submission or implementation of their approved CAPs. Together, the changes in this rule will give States clear guidance about how to comply with the new reporting requirements and how CMS will take enforcement action for failure to comply with these new reporting requirements and Federal eligibility redetermination requirements. The new enforcement tools in section 1902(tt) of the Act are expected to help CMS prevent loss of coverage for eligible beneficiaries.

B. Overall Impact

We have examined the impacts of this rule as required by E.O. 12866 on Regulatory Planning and Review (September 30, 1993), E.O. 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), E.O. 13132 on Federalism (August 4, 1999), and the Congressional Review Act (CRA) (5 U.S.C. 804(2)). OMB has determined that this rule is non-major under 5 U.S. Code § 801, and therefore, is not subject to the CRA and has also determined that this rule is not significant under 3(f)(1) of E.O. 12866.

We have estimated the potential impacts of this rule on Medicaid enrollment and expenditures. Overall, the rule's impact is expected to be limited. States are already aware of Federal redetermination requirements and, as noted in sections I.C. and I.D of this rule, CMS provides advice and technical assistance to help States comply with these requirements and the new reporting requirements in section 1902(tt)(1) of the Act. When CMS becomes aware of a potential violation of Federal requirements, we first attempt to work collaboratively with the State to understand the nature and scope of the problem and to identify appropriate alternative processes and procedures that the State can adopt to avoid or minimize beneficiary harm until the State can fix the problem and come into full compliance with Federal requirements, consistent with our authority to enforce compliance with section 1902 of the Act under section 1904 of the Act and § 430.35. In addition, the new enforcement authorities in this rule are only applicable to State activities that occur during a time-limited period, generally from April 1, 2023, to June 30, 2024.

This rule implements new enforcement tools that CMS can use to address violations of Federal Medicaid redetermination or reporting requirements that occur during a period that generally aligns with States' unwinding periods. Beginning with the analysis of redetermination requirements, we start with an assumption that in most cases redeterminations would be accurate and follow required processes and, thus, that the new enforcement tools implemented

through this rule will not be widely needed. Even though the Federal government and States already have processes in place to ensure redeterminations are done correctly and States are already required to do so, the new enforcement authorities will give CMS additional tools to enforce compliance with these requirements. As noted in section I.D. and above, CMS attempts to work collaboratively with a State first to understand the nature and scope of any potential violation of Federal requirements and to identify appropriate alternative processes and procedures that the State can adopt to avoid or minimize beneficiary harm until the State can fix the problem and come into full compliance with Federal requirements. However, notwithstanding those efforts, it is possible that a few States might still be noncompliant, thus making it necessary for CMS to use the enforcement tools implemented in this rule.

It is possible that in the course of States coming into compliance with the requirements enforceable through section 1902(tt) of the Act absent this rule, some eligible individuals would remain enrolled who might have otherwise been disenrolled for procedural reasons due to a State's failure to comply with redetermination requirements. The impacts estimated in this section depend on the effectiveness of this rule at ensuring that eligibility redeterminations are done correctly, as well as the assumptions about how many unauthorized procedural disenrollments would have occurred absent this rule.

In the Mid-Session Review of the President's FY 2024 Budget,[31] CMS projected that Medicaid enrollment would decline by about 18 million enrollees due to the unwinding of the Medicaid continuous enrollment condition through the end of fiscal year 2024 (or about 19 percent as measured from the peak of Medicaid enrollment in March-April 2023). This does not include individuals who newly enroll over this period.

To develop the estimates, we started with the following assumptions. First, we assumed that a maximum of five States would be out of compliance with the Federal redetermination requirements under this rule and be subject to CAPs and suspensions of procedural disenrollments and/or CMPs if they did not submit or implement an approvable CAP. We assumed that all States would take the appropriate steps to submit or implement CAPs and, thus, that CMS would require no suspensions of procedural disenrollments and impose no CMPs. Second, we assumed that States out of compliance with Federal redetermination requirements would have about 5 percent more individuals found ineligible and that those individuals would still be eligible and would have remained enrolled if redeterminations were done accurately. Third, we assumed that about 40 percent of enrollees who would have been disenrolled would have ultimately re-enrolled within 12 months. We assumed that this rule would bring all States into compliance and that individuals wrongly disenrolled would be re-enrolled; in future cases, this rule would also prevent those incorrect disenrollments from occurring. We assume that any such effects would start by early 2024.

We estimate that the rule would increase Medicaid enrollment by about 7,000 individuals in fiscal year 2024 and 13,000 individuals in fiscal year 2025 (average annual enrollment). We estimate that total Medicaid spending due to increased enrollment would be about $50 million higher in fiscal year 2024 ($36 million Federal) and about $93 million higher annually in fiscal year 2025 and subsequent years ($66 million Federal).

Actual impacts could be greater than or less than estimated here. Future spending and enrollment could grow faster or slower than projected. More or fewer States could be out of compliance than we have assumed, and the number of unauthorized procedural disenrollments could also be higher or lower than we have assumed. This rule could also be more or less effective than we expect. Moreover, if one or more States did not comply with these requirements, those States could be assessed CMPs that would result in a transfer from States to CMS and could lead to additional actions.

This rule also implements a statutory FMAP reduction for noncompliance with reporting requirements under section 1902(tt)(1) of the Act. States out of compliance with these reporting requirements between July 1, 2023, and June 30, 2024, would be assessed a reduction in FMAP of 0.25 percentage points for each quarter they are out of compliance, and this would increase by 0.25 percentage points for each additional quarter they are out of compliance. States that fail to comply with reporting requirements may also be required to submit a CAP, and if the reporting violations impeded CMS oversight of procedural disenrollments, States that fail to submit or implement an approvable CAP will be required to suspend procedural disenrollments and will also be subject to CMPs. If the reporting violation did not impede CMS' oversight of procedural disenrollments, CMS will delay suspension of procedural disenrollments for 1 month but will still impose CMPs (except in extraordinary circumstances, as discussed in section II.E. of this rule). We assume that at most an additional three States would be out of compliance with reporting requirements for one quarter each. Although States that are noncompliant are at risk of additional enforcement action, we estimate that most States will correct violations without a CAP or, if a CAP is imposed, will implement the CAP to address any violations and not be subject to additional enforcement actions. We estimate that the impact of the States that are noncompliant with reporting requirements would result in a FMAP reduction of $30 million, which would be a transfer from those States to the Federal government.

In total and consistent with the assumptions noted above, the estimated net effects of this rule would be Federal costs of about $6 million in fiscal year 2024 ($36 million in costs for additional enrollment, and $30 million in collections from States assessed an FMAP reduction) and $66 million in fiscal year 2025. For States, the estimated effects are $44 million in costs in fiscal year 2024 ($14 million in costs for additional enrollment, and $30 million in payments related to the FMAP reduction) and $27 million in fiscal year 2025.

The actual impact could be more or less than we have estimated. The key uncertainties are the number of States out of compliance, which States those would be (as Federal spending varies significantly across States, depending on the Medicaid population and spending levels and the FMAP rates for each State), and the number of quarters those States are out of compliance. We anticipate that States would quickly remedy any issues that would result in an FMAP reduction, and thus would be unlikely to be assessed an FMAP reduction in more than one quarter.

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). Executive Order 14094 amends section 3(f) of Executive Order 12866. The amended section 3(f) of Executive Order 12866 defines a "significant

[31] *https://www.whitehouse.gov/wp-content/uploads/2023/07/msr_fy2024.pdf.*

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) raise 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 rules that are significant under section 3(f)(1) of Executive Order 12866 as amended by Executive Order 14094 ($200 million or more in any 1 year). Based on our analysis, OIRA has designated this rule as not significant under section 3(f)(1). In reviewing the economic effect of this rule, we have assumed that States will generally meet reporting requirements and requirements for Medicaid eligibility redeterminations and continue to meet the conditions for the temporary FFCRA FMAP increase, and thus will not be subject to FMAP reductions, suspensions of procedural disenrollments, CMPs, or loss of Federal matching funds that would rise to the level of $200 million or more in any one year. While we assume that only a handful of States would have failed to comply absent this interim final rule, even in those hypothetical cases, we assume States will come into compliance promptly and avoid the enforcement actions described in this interim final rule, further minimizing the rule's economic impact. For example, we assumed States will use existing contracts to modify systems to ensure data are reported to CMS timely.

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 $9.0 million to $47.0 million in any one year. Individuals and States are not included in the definition of a small entity. The good cause exception of the APA applicable to this rule allows CMS to waive the regulatory impact analysis typically required under the RFA.

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 rule applies to State Medicaid and CHIP agencies and will not add requirements for 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 rule will 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 rule will not mandate spending by State, local, or tribal governments nor by private sector entities over this level.

C. Administrative Burden

We do not anticipate this rule will significantly impact administrative spending by the Federal Government.

D. Alternatives Considered

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

1. Not Finalizing the Rule

We considered not finalizing this rule and considering the provisions of section 1902(tt) of the Act to be self-implementing. However, we believe the authority to require State reporting under section 1902(tt)(1) of the Act, to impose CAPs on States that fail to meet Federal redetermination requirements or the reporting requirements under section 1902(tt)(1) of the Act, and to suspend procedural disenrollments and impose CMPs on States that fail to submit or implement a required CAP, required regulation in order to enable CMS to exercise its full statutory enforcement authority fairly and uniformly. For example, we believe the mitigating circumstances outlined in this rule, which memorialize when and how CMS will exercise its discretion to take enforcement action under section 1902(tt)(2)(B) of the Act, necessitated regulation.

2. Implementing Section 1902(tt) of the Act Through Subregulatory Guidance

We considered not promulgating a regulation but instead implementing section 1902(tt) of the Act through subregulatory guidance. However, CMS believes that the policy interpretations in this rule are different enough from the statutory language to necessitate regulation. For example, while the statute gives CMS discretion regarding whether to require a State to submit a CAP and regarding whether to require suspension of procedural disenrollments or impose CMPs if a State fails to submit or implement that CAP, the rule outlines in detail how CMS will exercise this discretion.

3. Promulgating a Proposed Rule

We considered promulgating a proposed rule rather than an IFC to implement these same provisions. However, as outlined in section III. of this rule, we believe notice-and-comment procedures and a delay in the effective date of this rule are impracticable and/or contrary to the public interest.

E. Limitations of the Analysis

As described previously, we have assumed that all but three States would comply with the reporting requirements, and all but five States would comply with Federal redetermination requirements referenced in this interim final rule and be subject to the CAP requirements at 430.49(b). It is possible that one or more of these States would fail to comply with the CAP requirements, and thus be ineligible for the temporary FFCRA FMAP increase, or be subject to the other penalties discussed in this rule, including suspension of procedural disenrollments and CMPs, and thus that the economic impact of the rule would be greater. In those cases, we would also assume more individuals would be disenrolled than would occur if the State complied with these requirements. We have not attempted to quantify the non-administrative program impact (that is, changes in enrollment and/or spending on benefits, not the costs associated with training/hiring workers, programming systems, or printing notices, for example) of a State failing to comply with the CAP requirements in the interim final rule.

In accordance with the provisions of Executive Order 12866, this regulation

was reviewed by the Office of Management and Budget.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on September 27, 2023.

List of Subjects

42 CFR Part 430

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

42 CFR Part 435

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

45 CFR Part 16

Procedures of the Departmental Grants Appeals Board.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services and the Department of Health and Human Services amend 42 CFR chapter IV and 45 CFR subtitle A, subchapter A, as set forth below:

Title 42

PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

■ 1. The authority citation for part 430 continues to read as follows—

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

■ 2. Section 430.3 is amended by revising the introductory text and adding paragraph (d) to read as follows:

§ 430.3 Appeals under Medicaid.

Four distinct types of disputes may arise under Medicaid.

* * * * *

(d) *Imposition of suspensions of procedural disenrollments and civil money penalties under section 430.49 of this part.* Disputes that pertain to CMS' imposition of suspensions of procedural disenrollments and civil money penalties under § 430.49(c) of this part are heard by the Board in accordance with procedures set forth in 45 CFR part 16.

■ 3. Section 430.5 is amended by adding definitions for ''Federal redetermination requirements'' and ''Procedural disenrollment'' in alphabetical order to read as follows:

§ 430.5 Definitions.

* * * * *

Federal redetermination requirements means, for the purposes of § 430.49, Federal requirements applicable to eligibility redeterminations outlined in 42 CFR 435.916, including renewal strategies authorized under section 1902(e)(14)(A) of the Social Security Act or other alternative processes and procedures approved by CMS under section 1902(e)(14)(A) of the Act or section 6008(f)(2)(A) of the Families First Coronavirus Response Act.

Procedural disenrollment means, for the purposes of § 430.49 and 45 CFR part 16, a *termination* of a beneficiary's Medicaid eligibility after advance notice under subpart E of part 431 for reasons that are unrelated to a State's determination of whether the individual meets eligibility criteria to qualify for coverage, including for failure to return a renewal form or documentation needed by the State to make a determination of eligibility.

* * * * *

■ 4. Section 430.49 is added to subpart C to read as follows:

§ 430.49 Corrective action plans, suspensions of procedural disenrollments, and civil money penalties.

(a) *Statutory basis.* This section interprets and implements section 1902(tt)(2)(B) of the Social Security Act.

(b) *Corrective action plans*—(1) *Basis for corrective action.* After consideration of any mitigating circumstances in accordance with paragraph (d) of this section and notwithstanding whether an FMAP reduction has been imposed under § 435.928 of this subchapter, CMS will determine whether to require the State to submit a corrective action plan if CMS finds that the State is not in compliance during the period beginning on April 1, 2023, through June 30, 2024, with either of the following requirements:

(i) The requirement to submit data required under section 1902(tt)(1) of the Act in accordance with § 435.927 of this subchapter; or

(ii) Federal redetermination requirements described at § 430.5.

(2) *Notice of need for corrective action plan.* If, after considering mitigating circumstances as described in paragraph (d) of this section, the Administrator decides to require the State to submit and implement a corrective action plan for noncompliance described in paragraph (b)(1) of this section or to revise or resubmit such a plan, the Administrator will provide the State with a written notice directing the State to submit a corrective action plan to correct the identified areas of noncompliance. Such notice will—

(i) Explain the violation of Federal redetermination or reporting requirements that CMS has identified and the basis for CMS' finding;

(ii) Inform the State of the requirement to submit and implement a corrective action plan:

(iii) Include instructions on the method and deadline by which the State must submit a corrective action plan to CMS; and

(iv) Explain the enforcement actions that CMS may pursue if the State fails to submit or implement an approved corrective action plan, including if CMS disapproves the State's submitted CAP or if the State fails to meet the requirements set forth in the approved CAP, in accordance with this section.

(3) *Content of corrective action plan.* A corrective action plan must describe in detail—

(i) The actions the State will take immediately, if needed to prevent further harm or risk of harm to beneficiaries while it implements the corrective action plan, including to prevent increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, and delays in access to coverage or care;

(ii) The steps the State will take to ensure compliance with Federal requirements, including but not limited to new policies, procedures, operational processes or systems changes it will implement;

(iii) Key milestones and a detailed timeline for achieving compliance; and

(iv) A plan for communicating the steps the State will take to prevent actual harm or risk of harm to beneficiaries and to ensure compliance with Federal requirements per paragraphs (b)(3)(i) and (ii) of this section to State staff, including staff of non-Medicaid agencies or entities to which the agency has delegated authority to conduct redeterminations of eligibility in accordance with § 431.10(c)(1)(i) of this subchapter; CMS; and beneficiaries, as applicable.

(4) *Timeframes for submission, approval, and implementation of corrective action plan*—(i) *Submission.* A State that receives a notice described in paragraph (b)(2) of this section must submit a corrective action plan, including the elements in paragraph (b)(3) of this section, not later than 14 calendar days from the date of the notice of noncompliance.

(ii) *Approval.* CMS must approve or disapprove a corrective action plan submitted by the State within 21 calendar days of the date it is submitted.

If CMS does not approve or disapprove the corrective action plan within 21 calendar days of submission, the corrective action plan will be deemed approved.

(iii) *Implementation.* A State must begin implementation of the corrective action plan not later than 14 calendar days after the date that either the State receives CMS approval, or the corrective action plan is deemed approved.

(5) *Approval or disapproval of corrective action plan.* A corrective action plan will be approved if CMS determines that the plan–

(i) Meets the requirements at paragraph (b)(3) of this section;

(ii) Promptly eliminates or minimizes any harm or risk of harm to beneficiaries, including increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, and delays in access to coverage or care due to the noncompliance to be addressed by the plan; and

(iii) Results in the State achieving compliance in a reasonable time, taking into account systems challenges and circumstances faced by the agencies involved.

(c) *Suspensions of procedural disenrollments and civil money penalties.* (1) After considering any applicable mitigating circumstances in accordance with paragraph (d) of this section and notwithstanding whether the State is subject to an FMAP reduction under § 435.928 of this subchapter, CMS may take one or both of the following actions if the State fails to submit or implement an approved corrective action plan, including if CMS disapproves the State's submitted corrective action plan due to the State's failure to include required elements in accordance with the requirements described in paragraph (b) of this section, or if the State fails to meet the requirements set forth in the approved corrective action plan:

(i) Require the State to suspend some or all procedural disenrollments, in accordance with paragraph (c)(3)(i) of this section; and

(ii) Impose civil money penalties in accordance with paragraph (c)(3)(ii) of this section.

(2) *Notice.* (i) Prior to requiring the State to suspend procedural disenrollments of Medicaid eligibility or imposing civil money penalties, CMS will issue a notice to the State. Such notice will include—

(A) A description of the enforcement action(s) CMS is taking and the basis for such action(s);

(B) Whether CMS is requiring the State to suspend some or all procedural disenrollments and, in the case of a partial suspension, the affected populations;

(C) The date on which the State must begin suspending procedural disenrollments, if applicable;

(D) The daily amount owed for any civil money penalties imposed, the date the penalties will begin to be charged, the timeline for payment (including information on how the timeline for payment would be affected by an appeal), and instructions on how to submit payment;

(E) The steps the State must take to cure its noncompliance and for CMS to lift the enforcement action(s); and

(F) Information on the State's appeal rights as described in paragraph (f) of this section, including the deadline to submit an appeal request, and the effect of requesting an appeal on the applicability of any enforcement actions pending the decision in such appeal. The notice must also provide that the decision outlined in the notice is final unless it is timely appealed as described in paragraph (f) of this section.

(ii) CMS may issue additional notices requiring a State to take additional actions (including paying increased civil money penalties or implementing or broadening the scope of a required suspension of procedural disenrollments) if CMS identifies additional violations of corrective action plan provisions. Such notices will meet the requirements outlined in paragraph (c)(2)(i) of this section.

(3) *Scope of actions*—(i) *Suspensions of procedural disenrollments.* (A) If the noncompliance determined by CMS under paragraph (b)(1) of this section impacts a substantial number of (meaning all or nearly all) individuals who are or should have been found eligible for Medicaid, CMS will require the State to suspend all procedural disenrollments.

(B) If the impact of the noncompliance is limited (for example, to a specific population or geographic area), CMS may limit the suspension of procedural disenrollments to the impacted population(s). After requiring a limited suspension of procedural disenrollments, CMS may later opt to require the State to suspend all procedural disenrollments if CMS subsequently determines that the impact of the noncompliance is greater than was initially determined, or if the State fails to comply with the initial requirement to suspend some procedural disenrollments in accordance with the notice issued under paragraph (c)(2) of this section. In these circumstances, CMS will issue a subsequent notice under paragraph (c)(2).

(ii) *Civil money penalties.* CMS may require the State to pay a civil money penalty of not more than $100,000, as adjusted annually under 45 CFR part 102, for each day that the State has not submitted or implemented an approved corrective action plan in accordance with the requirements described in paragraph (b) of this section or has failed to meet the requirements of the approved plan, until the penalty is lifted due to the State meeting the conditions described in paragraph (e) of this section.

(A) Civil money penalties will start accruing five (5) calendar days after the date of the initial notice described in paragraph (c)(2) of this section and become payable 60 calendar days after the date of the notice, if not timely appealed, or 60 calendar days after issuance of a final determination at the conclusion of any appeal pursuant to paragraph (f) of this section.

(B) The amount of any applicable civil money penalties for failure to submit or implement a corrective action plan, including if CMS disapproves the State's submitted corrective action plan or if the State fails to meet the requirements set forth in the approved corrective action plan, will be determined according to the following formula, after the date specified in paragraph (c)(3)(ii)(A) of this section: Days 1–30 of noncompliance: $25,000/day; Days 31–60 of noncompliance: $50,000/day; and Days 61 or more of noncompliance until lifted in accordance with paragraph (e) of this section: $100,000/day. Each of these amounts is adjusted annually under 45 CFR part 102.

(C) Consistent with paragraph (c)(2)(ii) of this section, if CMS identifies additional violations of corrective action plan provisions, CMS may issue additional notices to increase civil money penalties more quickly than provided for by the formula in paragraph (c)(3)(ii)(B) of this section.

(4) *Noncompliance with requirements to suspend procedural disenrollments or pay civil money penalties.* If the State fails to suspend procedural disenrollments as required pursuant to a notice described in paragraph (c)(2) of this section, or to pay civil money penalties as specified in that notice, or both, CMS may issue an additional notice pursuant to paragraph (c)(2) of this section to increase the civil money penalties to the maximum allowable

daily amount, if not already reached, or may pursue additional enforcement action under section 1904 of the Act and § 430.35 of this subpart, including withholding some or all Federal financial participation.

(d) *Mitigating circumstances.* CMS will consider the following mitigating circumstances when deciding whether to take the following enforcement actions:

(1) *Requirement to submit corrective action plan for violation of redetermination requirements.* In the case of noncompliance relating to a violation of Federal redetermination requirements, CMS may delay requiring, or determine not to require, a State to submit a corrective action plan under paragraph (b) of this section if—

(i) The noncompliance caused neither actual harm nor a substantial risk of harm to beneficiaries, including increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, and delays in access to coverage or care to beneficiaries; or

(ii) CMS determines that there is an emergency or other extraordinary circumstances preventing the State's compliance.

(2) *Requirement to submit corrective action plan for violation of reporting requirements.* In the case of noncompliance relating to a violation of the reporting requirements under § 435.927 of this subchapter, CMS may delay requiring, or determine not to require, a State to submit a corrective action plan under paragraph (b) of this section if—

(i) CMS has determined that the State implementing a corrective action plan is not necessary to ensure that the noncompliance is remedied; or

(ii) CMS determines that there is an emergency or other extraordinary circumstances preventing the State's compliance.

(3) *Suspensions of procedural disenrollments and imposition of civil money penalties.* (i) In the case of a State that has failed to submit or implement an approved corrective action plan relating to a violation of either the reporting requirements under § 435.927 of this subchapter or Federal redetermination requirements, CMS may delay or forgo imposing civil money penalties if CMS determines that the State faces an emergency or other extraordinary circumstances that—

(A) Occurred after the violation resulting in CMS' requirement of a CAP for noncompliance with Federal redetermination requirements or reporting requirements under § 435.927; and

(B) Has significantly impeded the State's ability to submit or implement a corrective action plan.

(ii) In the case of a State's failure to submit or implement a corrective action plan relating to a violation of the reporting requirements under § 435.927 of this subchapter in which the underlying reporting violation does not impede CMS' oversight of the State's procedural disenrollments, CMS will:

(A) Delay suspension of procedural disenrollments for 1 month; and

(B) Impose civil money penalties, except in cases where there are also extraordinary circumstances as described in paragraph (d)(3)(i) of this section.

(e) *Lifting of enforcement actions.* (1) In cases where CMS had sent a State a notice under paragraph (c)(2) of this section for failure to submit or implement an approved corrective action plan—

(i) The State will be required to continue any suspension of procedural disenrollments required pursuant to such notice, and any civil money penalties imposed in accordance with the terms of such notice will continue to be charged, until—

(A) For a State that failed to submit a corrective action plan, the State submits a corrective action plan that CMS determines is approvable consistent with paragraph (b)(5) of this section.

(B) For a State that failed to implement an approved corrective action plan, the State has implemented or resumed implementation of such plan.

(ii) CMS will continue the accrual of civil money penalties from the date specified in the original notice provided to the State under paragraph (c)(2) of this section until CMS determines whether the plan is approvable. If CMS determines that the plan is approvable, CMS will retroactively end the accrual of the civil money penalties on the day the CAP was submitted and cease charging civil money penalties prospectively. If CMS determines that the plan is not approvable, CMS will continue charging civil money penalties imposed under the terms of the enforcement notice without interruption until the State submits an approvable plan.

(2) Where a State has met the conditions under paragraph (e)(1)(i) of this section, CMS will notify the State that the enforcement actions are being lifted. For States that were required to suspend procedural disenrollments, such notice will include the date on which the State may resume such disenrollments. For States that were subject to civil money penalties, such notice will include the date on which such civil money penalties stopped accruing, the total number of days for which civil money penalties accrued and the amount(s) of such civil money penalties, and the total amount of civil money penalties owed.

(f) *Administrative review*—(1) *Appeal to the Departmental Appeals Board.* A State that is dissatisfied with CMS's determination under paragraph (c) of this section that the State must suspend procedural disenrollments or pay civil money penalties because the State has failed to submit or implement an approvable corrective action plan may appeal, pursuant to 45 CFR part 16, the imposition of such suspensions of procedural disenrollments or civil money penalties to the Departmental Appeals Board (the Board) within 30 days after receipt of a notice described in paragraph (c)(2) of this section. The appeal request must comply with 45 CFR 16.7, and the process for counting days to submit an appeal will follow the provisions under 45 CFR 16.19. The appeals process is governed by 45 CFR part 16. If the State does not submit an appeal request within the 30-day timeframe provided for an appeal to the Board, then the decision described in the notice received by the State under paragraph (c)(2) of this section is the final decision of the Secretary and is final agency action within the meaning of 5 U.S.C. 704.

(2) *Reconsiderations by* the *Administrator.* (i) If any party to the appeal is dissatisfied with the Board's decision under paragraph (f)(1) of this section, it may seek the Administrator's reconsideration of that decision within 15 calendar days of receiving notice of the decision pursuant to 45 CFR 16.21.

(A) The request for reconsideration must be filed with the Administrator and must include a copy of the Board's decision, a brief statement of why the party believes the decision was wrong, and a statement of the amount of any civil money penalties in dispute.

(B) The party requesting reconsideration must send a copy of the request described in paragraph (f)(2)(i)(A) of this section to all other parties to the appeal and other participants in the appeal (as described in 45 CFR 16.16) at the same time that the request is filed with the Administrator.

(C) Any other party to the appeal, or other participant in the appeal, may respond to the request for reconsideration in writing and file their

response with the Administrator within 15 calendar days of the date the request for reconsideration is filed with the Administrator.

(D) The Administrator will review the Board's decision and any additional information submitted by the parties and other participants under paragraphs (f)(2)(i)(A) or (C) of this section and, within 60 calendar days after the Board issues notice of its decision under 45 CFR 16.21, will either affirm the Board's decision or issue a new decision.

(ii) Within the 60-day period that is described in paragraph (f)(2)(i)(D) of this section, the Administrator may also modify or reverse the Board's decision even if no party to the appeal has requested reconsideration of that decision.

(iii) If no request for reconsideration is filed under paragraph (f)(2)(i) of this section and the Administrator does not modify or reverse the Board's decision within the 60-day period described in paragraph (f)(2)(ii) of this section, then the decision of the Board is the final determination of the Secretary and is final agency action, as described in paragraph (f)(2)(v) of this section, and the Administrator will provide notice to all parties and other participants of such decision as described in paragraph (f)(2)(iv) of this section.

(iv) The Administrator will provide a notice to all parties and other participants of the final decision together with a notice indicating that this is the final determination of the *Secretary* and is final agency action, as described in paragraph (f)(2)(v) of this section.

(v) The determination of the Administrator pursuant to paragraph (f)(2)(i)(D) or (f)(2)(ii) of this section is the final determination of the *Secretary* and is final agency action within the meaning of 5 U.S.C. 704.

(g) *Severability.* Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further State action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

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

■ 5. The authority citation for part 435 continues to read as follows—

Authority: 42 U.S.C. 1302.

■ 6. Sections 435.927 and 435.928 are added to subpart J to read as follows:

§ 435.927 Requirements for States to submit certain data on redeterminations.

(a) *Basis.* This section implements section 1902(tt)(1) of the Social Security Act.

(b) *Definitions.* As used in this section—

(1) *Timely* means the following:

(i) Data submitted according to an existing process governed by CMS regulation or guidance (other than data submitted through the Transformed Medicaid Statistical Information System (T–MSIS)) are timely if they are reported by the deadline specified in the applicable CMS regulation or guidance.

(ii) Data submitted under the existing process for the T–MSIS are timely if they are submitted on a monthly basis, before the last day of the subsequent month.

(iii) Data that States submit according to an alternative process approved by CMS or an alternative timeline approved by CMS under the circumstances specified in paragraph (b)(4) of this section are timely if they are submitted on the deadline CMS specifies when it approves the alternative process or timeline.

(2) *Complete* means that all required elements are reported.

(3) *Sufficient quality* means the following:

(i) For data submitted according to an existing process governed by CMS regulation or guidance, the data adhere to specifications outlined in the applicable CMS regulation or guidance.

(ii) For data submitted according to an alternative process approved by CMS under the circumstances specified in paragraph (b)(4) of this section, the data adheres to the specifications approved by CMS when it approves the alternative process.

(4) *Good faith effort* means that—

(i) The State is experiencing significant, unforeseeable, or unavoidable challenges in complying with the reporting requirements of paragraph (c) of this section, or is experiencing significant foreseeable challenges in complying and is working to remediate these challenges but needs additional time to address them;

(ii) The State requested, and CMS approved an alternative process for submitting the data or an alternative timeline; and

(iii) The approved alternative process for submitting the data or timeline is sufficient to ensure CMS can obtain and use the data to meet CMS' obligations to report the data publicly per section 1902(tt)(1) of the Act.

(c) *Reporting requirement.* For data representing activities conducted by a State during the time period beginning April 1, 2023, and ending June 30, 2024, each State must submit to CMS the data described in paragraph (d) of this section, and those data must be timely, complete, and of sufficient quality (as those terms are defined in paragraph (b) of this section). To meet this requirement, a State must:

(1) Submit data via existing CMS-approved processes; or

(2) Submit data through alternative processes approved by CMS, under the circumstances specified in paragraph (b)(4) of this section.

(d) *Required data elements.* States must submit the following data to CMS in accordance with paragraph (c) of this section:

(1) Total number of Medicaid and Children's Health Insurance Program (CHIP) beneficiaries for whom a renewal was initiated.

(2) Total number of Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed.

(3) Of the Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed, the total number whose coverage is renewed on an *ex parte* basis.

(4) Total number of individuals whose coverage for Medicaid or CHIP was terminated.

(5) Total number of individuals whose coverage for Medicaid or CHIP was terminated for procedural reasons.

(6) Total number of beneficiaries who were enrolled in a separate CHIP.

(7) For each State call center, total call center volume.

(8) For each State call center, average wait times.

(9) For each State call center, average abandonment rate.

(10) For States with State-based Exchanges (SBEs) using a Non-Integrated Eligibility System and not using the Federal Exchange eligibility and enrollment platform:

(i) Total number of individuals whose accounts are received by the SBE or Basic Health Program (BHP) due to a Medicaid/CHIP redetermination.

(ii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or a BHP.

(iii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or a BHP, and who make a QHP plan selection or are enrolled in a BHP.

(11) For States with SBEs with an Integrated Eligibility System and not using the Federal Exchange eligibility and enrollment platform:

(i) Total number of individuals who apply for coverage due to a Medicaid/

CHIP redetermination who are determined eligible for a QHP or a BHP.

(ii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or BHP, and who make a QHP plan selection or are enrolled in a BHP.

(e) *Severability.* Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further State action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

§ 435.928 Reduction in FMAP for failure to submit certain data.

(a) *Basis.* This section implements section 1902(tt)(2)(A) of the Social Security Act.

(b) *Application of the FMAP reduction.* (1) FMAP means the State-specific Federal medical assistance percentage as defined in the first sentence of section 1905(b) of the Act.

(2) If CMS finds that, for a fiscal quarter in the period beginning on July 1, 2023, and ending on June 30, 2024, the State was noncompliant with the requirements of § 435.927, CMS will reduce the State's Federal medical assistance percentage (FMAP) for that fiscal quarter as described in paragraph (b)(4) of this section.

(3) A State is noncompliant in a fiscal quarter if it has failed to comply with the reporting requirements described in § 435.927 for one or more months of the quarter.

(4) The FMAP reduction under paragraph (b)(2) of this section will equal the product of 0.25 percentage points and the number of the fiscal quarters during the period from July 1, 2023, through June 30, 2024, in which the State is noncompliant with the reporting requirements described in § 435.927. When States are noncompliant in multiple quarters during that period, the FMAP reduction will increase by 0.25 percentage points for each successive quarter of noncompliance, even if nonconsecutive, but in no case will the reduction for any single quarter exceed 1 percentage point.

(c) *Severability.* Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further State action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

Title 45

PART 16—PROCEDURES OF THE DEPARTMENTAL GRANT APPEALS BOARD

■ 7. The authority for part 16 continues to read as follows:

Authority: 5 U.S.C. 301 and secs. 1, 5, 6, and 7 of Reorganization Plan No. 1 of 1953, 18 FR 2053, 67 Stat. 631 and authorities cited in the Appendix.

■ 8. Section 16.22 is amended by revising paragraphs (b)(3) and (4) and adding paragraph (b)(5) to read as follows:

§ 16.22 The effect of an appeal.

* * * * *

(b) * * *

(3) In programs listed in appendix A, B.(a)(1), to this part implement a decision to disallow Federal financial participation claimed in expenditures reported on a statement of expenditures, by recovering, withholding or offsetting payments, if the decision is issued before the reported expenditures are included in the calculation of a subsequent grant;

(4) Take other action to recover, withhold, or offset funds if specifically authorized by statute or regulation; or

(5) Take action to require a State to suspend procedural disenrollments, as defined at 42 CFR 430.5, or continue the accrual of the civil money penalties a State owes under 42 CFR 430.49(c).

■ 9. Appendix A of part 16 is amended in section B by adding paragraph (a)(7) to read as follows:

Appendix A to Part 16—What Disputes the Board Reviews

* * * * *

B. * * *

(a) * * *

(7) Decisions relating to suspensions of procedural disenrollments and civil money penalties under 42 CFR 430.49(c).

* * * * *

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2023–26640 Filed 12–4–23; 4:15 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 25

[IB Docket Nos. 22–411; 22–271; FCC 23–73; FR ID 188451]

Expediting Initial Processing of Satellite and Earth Station Applications

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Federal Communications Commission (Commission) adopts changes to its rules aimed at expediting the initial license application processing for satellite operators. The Commission establishes timeframes for placing satellite and earth station applications on public notice, eliminates a procedural rule that prevents consideration of requests for waiver of the International Table of Frequency Allocations, and removes the prohibition on licensed-but-unbuilt systems for non-geostationary orbit (NGSO) operators. Additionally, the Commission creates a new, streamlined processing framework for earth station operators to add satellite points of communication under certain circumstances. Finally, the Commission lays the groundwork for a broader Transparency Initiative led by the Space Bureau to provide clarity and access to applicants when interfacing with the Commission's license application processes and filing system.

DATES: Effective January 5, 2024.

FOR FURTHER INFORMATION CONTACT: Julia Malette, Attorney Advisor, Satellite Programs and Policy Division, Space Bureau, at 202–418–2453 or *julia.malette@fcc.gov.*

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, FCC 23–73, adopted September 21, 2023, and released September 22, 2023. The document is available for download at *https://docs.fcc.gov/public/attachments/FCC-23-73A1.pdf.* To request materials in accessible formats for people with disabilities, (*e.g.,* Braille, large print, electronic files, audio format, etc.) send an email to *FCC504@fcc.gov* or call the Consumer & Governmental Affairs Bureau at 202–418–0530 (voice), or 202–418–0432 (TTY). A proposed rule relating to further expediting satellite and earth station application processing is published elsewhere in this issue of the **Federal Register**.