Center on Budget and Policy Priorities

1275 First Street NE, Suite 1200
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

info@cbpp.org
www.cbpp.org

September 24, 2025

Medicaid Eligibility and Enrollment Rules Lay Framework for Program Improvements States Can Still Adopt, Despite Moratorium

By Farah Erzouki

As part of historic cuts to Medicaid that will take health coverage away from millions, the Republican megabill enacted in July places a ten-year moratorium on implementing portions of two recently codified Medicaid eligibility and enrollment rules, effectively repealing them.[1] While these provisions are no longer mandatory, many remain optional. States can and should still voluntarily implement these approaches to streamline eligibility and ensure as many eligible people as possible enroll in and retain Medicaid coverage.

Congress blocked *parts* of two rules that were adopted by the Biden Administration to make it easier for eligible enrollees — particularly seniors, people with disabilities, and children enrolled in the Children's Health Insurance Program (CHIP) — to get and stay enrolled in Medicaid or CHIP. The first rule, finalized in 2023, addressed many barriers that eligible seniors experience when accessing Medicare Savings Programs (MSPs).[2] The second rule, finalized in April 2024, codified many important policies that simplify the process for eligible people, including older adults and people with disabilities (the non-MAGI population), children, and pregnant people to get and stay enrolled in Medicaid and CHIP.[3]

[1] Because the bill placed a moratorium on implementation of the rules, the Code of Federal Regulations may still show new provisions added by the two rules, even though they are not currently in effect. Throughout this paper, we refer to the provisions that are temporarily blocked by the moratoria provisions in sections 71101 and 71102 of P.L. 119-21 as "blocked" provisions.

[2] Department of Health and Human Services (HHS), "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," 88 Fed. Reg. 65230, September 21, 2023, https://www.govinfo.gov/content/pkg/FR-2023-09-21/pdf/2023-20382.pdf.

[3] HHS, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," 89 Fed. Reg. 22780, April 2, 2024, https://www.govinfo.gov/content/pkg/FR-2024-04-02/pdf/2024-06566.pdf.

States still must comply with the portions of the eligibility and enrollment rules that had already taken effect before Congress enacted the ten-year moratorium, which mostly affects parts of the rules that had not yet gone into effect.[4] The blocked provisions include amendments from the Centers on Medicare and Medicaid Services (CMS) to clarify and simplify long-standing regulatory provisions and mandates for states to follow newly created best practices. Even though some of these clarifications have been blocked, the underlying requirements remain intact, and states must follow them.

States should continue implementing optional portions of the rules to increase efficiency and further improve and streamline their programs so that eligible people can more easily get and keep their coverage.

Importantly, though the blocked policies are no longer mandatory, they remain optional and are not in conflict with other regulations, except in a handful of cases. *Because the blocked policies would have increased efficiency and improved and streamlined programs so that eligible people could more easily get and keep their coverage, states should proceed in implementing now-optional portions of the rules.* In a few cases, blocked provisions are not allowed because of how existing regulations are written.

The two tables below outline the status of each provision in the final rules and whether it is still in place and required; blocked and now optional for states; clarifications are blocked but the underlying rules are still required; or blocked and no longer allowed.[5] Additional discussion of these provisions follows the tables.

[4] While the House bill initially blocked the entire rule with minimal exceptions, the Senate Parliamentarian ruled that additional provisions could not be blocked, presumably because they were already in effect.

[5] A number of provisions in the final rules included miscellaneous changes that did not change policy, such as changing references, definitions or language used to describe something, removing headings, and removing and redesignating sections. Such sections include 42 C.F.R. §§ 431.213(d), 431.231(d), 435.4, 435.222, and 435.911(a).

TABLE 1

Status of Provisions in Final 2023 Rule

Regulation(s) Created or Modified by Final Rule	Description	Provision Not Blocked, Remains Required	Provision Blocked, Remains State Option	Clarifying Provision Blocked, Underlying Rule Remains Required	Provision Blocked, No Longer Allowed
	Streamlining MSP Enrollment				
406.21(c)(5)	**Clarifies effective date of Qualified Medicare Beneficiary (QMB) coverage for certain individuals**		x		
435.601(e)	**Aligns Low-Income Subsidy (LIS) and Medicare Savings Programs (MSP) family size definitions and income counting rules**		x		
435.909	**Automatic QMB enrollment of certain Supplemental Security Income recipients**	x			
435.911(e)	**Use of LIS leads data for MSP application**			x	
435.952(e)	**Self-attestation for certain types of income and resources**		x		

Source: Department of Health and Human Services (HHS), "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," 88 Fed. Reg. 65230, September 21, 2023, https://www.govinfo.gov/content/pkg/FR-2023-09-21/pdf/2023-20382.pdf.

TABLE 2

Status of Provisions in Final 2024 Rule

Regulation(s) Created or Modified by Final Rule	Description	Provision Not Blocked, Remains Required	Provision Blocked, Remains State Option	Clarifying Provision Blocked, Underlying Rule Remains Required	Provision Blocked, No Longer Allowed
	Alignment of Non-MAGI Policies to MAGI Practices				
435.907(c)(4)	**Allows non-MAGI applicants to provide applications and supplemental forms through all modes of submission allowed for MAGI applicants**			x	
435.907(d)	**Aligns non-MAGI enrollment requirements with MAGI policies, including:** • Providing 15 days or more for non-MAGI applicants to respond to requests for information • Allowing applicants to provide requested information through all modes of submission • Providing a 90-day reconsideration period if application was denied for not providing the requested information • Prohibiting in-person interviews as part of the application process		x		
435.916	**Aligns non-MAGI renewal requirements with MAGI policies, including:** • Renewing most non-MAGI enrollees no more frequently than every 12 months • Providing pre-populated renewal forms with a minimum of 30 days to respond • Providing a 90-day reconsideration period if coverage was terminated for not completing the renewal process • Prohibiting states from requiring an in-person interview as part of the renewal process		x		

TABLE 2

Status of Provisions in Final 2024 Rule

Regulation(s) Created or Modified by Final Rule	Description	Provision Not Blocked, Remains Required	Provision Blocked, Remains State Option	Clarifying Provision Blocked, Underlying Rule Remains Required	Provision Blocked, No Longer Allowed
435.940, 435.952(b), 435.952(c)(1)	**Apply primacy of electronic verification and reasonable compatibility standard for resources**	x			
	CHIP Improvements				
457.340(d), 457.340(f)(1)	**CHIP application and enrollment improvements, including:** • Application of (blocked) eligibility determination timeliness standards • Medicaid/separate CHIP combined eligibility notice	x			
457.480	**Prohibits lifetime or annual limits on all covered CHIP benefits**	x			
457.570(c), 600.525(b)(2)	**Eliminate CHIP and Basic Health Program (BHP) lockout periods due to non-payment of premiums**	x			
457.65(d), 457.805(b), 457.810(a)	**Eliminate CHIP waiting periods**	x			

TABLE 2

Status of Provisions in Final 2024 Rule

Regulation(s) Created or Modified by Final Rule	Description	Provision Not Blocked, Remains Required	Provision Blocked, Remains State Option	Clarifying Provision Blocked, Underlying Rule Remains Required	Provision Blocked, No Longer Allowed
431.10, 435.1200(b)(1), 435.1200(b)(3)(vi), 435.1200(b)(4), 435,1200(c), 435.1200(e)(1)(i) 435.1200(e)(4), 435.1200h(3), 457.348, 457.350, 600.330(a)	**Improve transitions between Medicaid and CHIP by:** • Requiring each program to determine eligibility for both programs • Accepting eligibility determinations made by the other program • Transitioning applicants to the coverage they are or could be eligible for	x			
435.1200(b)(3)(i)-(v), 435.1200(e)(1)(ii), 435.1200(h)(1)	**Change sub-sections focused on improving coordination between Medicaid, CHIP, and other forms of coverage, including:** • Clarifying language • Specifying actions states should take when individuals are determined ineligible for Medicaid • Detailing when states should provide a combined eligibility notice		x		
	Eliminating Barriers to Coverage				
435.223, 435.601(b)(2), 435.601(d)(1), 435.601(f)(1)	**Establish new optional eligibility group for reasonable classification of individuals under age 21 who meet criteria for another group and application of financial eligibility methodologies**	x			

TABLE 2

Status of Provisions in Final 2024 Rule

Regulation(s) Created or Modified by Final Rule	Description	Provision Not Blocked, Remains Required	Provision Blocked, Remains State Option	Clarifying Provision Blocked, Underlying Rule Remains Required	Provision Blocked, No Longer Allowed
435.407	**Simplifies verification of citizenship and identity by considering verification of birth with a state vital statistics agency or verification of citizenship with DHS SAVE as stand-alone evidence of citizenship (without requesting separate verification of identity)**				x
435.956(b)(4)	**Removes optional limitation on number of reasonable opportunity periods**	x			
435.608, 436.608	**Remove requirement to apply for all other benefits as a condition of eligibility**	x			
435.831, 436.831	**Facilitate enrollment by allowing "medically needy" individuals to deduct prospective available medical expenses**	x			
447.56(a)(1)(v)	**Implements limitations on premiums and cost-sharing, at state option, for individuals under age 19, 20, or 21, eligible under 435.222 or 435.223**		x		
457.1140(d)(4)	**Applicants and enrollees receive continued enrollment and benefits in accordance with 457.1170 (following enrollment suspension or termination, or failure to make timely eligibility determination)**		x		
435.919, 457.344	**Improve Medicaid and CHIP agency processes for updated address information by specifying requirements of state agencies:** • When updated information is received from a third party, such as mail returned by USPS • When receiving in-state or out-of-state address updates, or when returned mail has no forwarding address		x		

TABLE 2

Status of Provisions in Final 2024 Rule

Regulation(s) Created or Modified by Final Rule	Description	Provision Not Blocked, Remains Required	Provision Blocked, Remains State Option	Clarifying Provision Blocked, Underlying Rule Remains Required	Provision Blocked, No Longer Allowed
	• To make a "good-faith effort" to contact enrollees to update address information				
	Timeliness, Processing Standards, and Recordkeeping Improvements				
435.919, 457.344, 457.960	**Establish specific requirements and timeframes for acting on changes in circumstances, including:** • Creating and communicating to enrollees the process for reporting changes • Specifying the actions agencies must take when they receive a change in circumstance • Providing enrollees a minimum of 30 days to respond to requests for additional information • Providing enrollees a minimum 90-day reconsideration period		x		
435.907(d), 435.912, 457.1170	**Establish timeliness requirements, including:** • Maximum timeframes for state agencies to complete timely determinations at renewal and for changes in circumstance • Reasonable timeframes for enrollee responses at application (15 days minimum), disability determination (30 days minimum), and renewal (30 days minimum) • Inclusion of renewals and changes in circumstance within the performance and timeliness standards described in state plans • Additional clarification of timeliness standards at application, renewal, and changes in circumstance		x		

TABLE 2

Status of Provisions in Final 2024 Rule

Regulation(s) Created or Modified by Final Rule	Description	Provision Not Blocked, Remains Required	Provision Blocked, Remains State Option	Clarifying Provision Blocked, Underlying Rule Remains Required	Provision Blocked, No Longer Allowed
435.911(c)	**Revises definition for state agency requirements and processes to determine eligibility to include individuals whose eligibility is being redetermined in accordance with 435.919**		x		
457.1180	**Requires timely written notice of any determinations required to be subject to review under 457.1130 (eligibility or enrollment matter, health services matter or exception)**		x		
431.17, 435.914(a), 435.914(b),457.965	**Implement stronger recordkeeping practices in Medicaid and CHIP, including:** • Maintaining electronic records • Specifying what information should be included in the records • Maintaining records for a minimum of three years • Specifying record accessibility rules when authorized third parties request them	x			

Source: HHS, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," 89 Fed. Reg. 22780, April 2, 2024, https://www.govinfo.gov/content/pkg/FR-2024-04-02/pdf/2024-06566.pdf.

States Should Continue Implementing Simplified Processes

Most states have already implemented parts of the rules that weren't blocked, since those generally had effective dates that have already passed. Those provisions are still required, and states shouldn't make any changes to those parts of their policies and systems.

As the tables above outline, the majority of the provisions that were blocked are no longer required, but they remain optional for states. Many states are likely in the process of implementing those provisions (or have already implemented them) and should continue moving forward with these changes that streamline eligibility for seniors, people with disabilities, and others.

Streamlining MSP Enrollment

The final rule includes a number of provisions for states to better facilitate and streamline MSP enrollment.[6] MSPs, administered through state Medicaid programs, offer significant help with the costs of Medicare premiums and cost-sharing to older adults and people with disabilities who are dually eligible for Medicaid and Medicare.[7] However, many more people are eligible for MSPs than are enrolled, and these provisions were aimed at increasing MSP enrollment among those eligible but not enrolled.

Provision Not Blocked, Remains Required

Automatic enrollment of certain Supplemental Security Income (SSI) recipients in the QMB eligibility group when they enroll in Medicaid (42 C.F.R. §435.909). People enrolled in Medicare who also receive SSI benefits are eligible for the QMB MSP group in addition to full Medicaid. However, many states require a separate application for QMB, which creates an additional layer of bureaucracy that deters eligible people from enrolling. This provision is aimed at removing this layer of bureaucracy and maximizing QMB enrollment.

The final rule requires 36 states and the District of Columbia, considered Part A "buy-in" states, to automatically enroll SSI recipients in the QMB eligibility group when they enroll in Medicaid. [8]

[6] Farah Erzouki, "Federal Rule on Medicare Savings Programs Will Cut Red Tape for Older Adults and People With Disabilities," CBPP, May 3, 2024, https://www.cbpp.org/research/health/federal-rule-on-medicare-savings-programs-will-cut-red-tape-for-older-adults-and.

[7] Some individuals who are eligible for both Medicaid and Medicare receive full Medicaid benefits along with Medicare and may also receive assistance through MSPs. Partial dual eligibles are enrolled in Medicare and receive assistance from MSPs to help afford that coverage. Medicaid and CHIP Payment and Access Commission (MACPAC), Medicare Savings Programs, https://www.macpac.gov/subtopic/medicare-savings-programs/.

[8] All states must pay the Part A premium for QMB enrollees who do not receive premium-free Part A; "buy-in" states include the Part A premium cost for QMBs in their existing buy-in agreement, which helps facilitate automatic enrollment in QMB any time of the year. When states use the group payer arrangement to pay Part A premiums, certain enrollment restrictions apply, such as only being able to apply for Medicare Part A during the Medicare General Enrollment Period (January 1-March 31 of each year) if they did not enroll during their Initial Enrollment Period (three months before turning 65 and three months after the month the individual turns 65, lasting seven months total). CMS, "Program Overview and Policy: Chapter 1," https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf.

The policy remains optional for 14 states that are referred to as "group payer" states, but these states should also strive to make enrollment for SSI recipients in QMB automatic.

Provision Blocked, Remains State Option

- **Aligning LIS and MSP family size definitions and income counting rules** (42 C.F.R. §435.601(e)). CMS historically allowed states to apply their own definition of family size when determining household-based income limits for MSP eligibility. State MSP definitions that don't align with LIS make it difficult for state agencies to expedite enrollment of LIS recipients into MSPs, since agencies often have to contact applicants for additional information if the definitions don't align. The final rule required, and states can still implement, a definition of MSP family size to be "at least" those who are included in the LIS definition. States can also choose to align income counting rules for the programs to further streamline enrollment of LIS recipients into MSPs.
- **Accepting self-attestation for certain types of income and resources** (42 C.F.R. §435.952(e)). Existing Medicaid regulations provide states the option to allow an MSP applicant's self-attestation of all eligibility criteria except for citizenship and immigration status.[9] The final rule required states to accept self-attestation of certain types of income and resources such as non-liquid resources and burial funds up to $1,500 for purposes of determining eligibility for MSPs. States should accept self-attestation for these types of income and resources to further streamline MSP enrollment and reduce paperwork and documentation requests.
- **Clarifying the effective date of QMB enrollment for certain individuals living in "group payer" states** (42 C.F.R. §406.21(c)(5)). The QMB Program pays for Part A premiums and Part B premiums, deductibles, copayments, and coinsurance. QMB enrollment for those who live in "group payer" states is particularly challenging. When states use the group payer arrangement to pay Part A premiums, certain enrollment restrictions apply, such as only being able to apply for Medicare Part A during the Medicare General Enrollment Period (January 1-March 31 of each year) if applicants did not enroll during their Initial Enrollment Period. The Part A effective date was recently changed to be the first month after enrollment, and the final rule aligned the QMB effective date with the new Part A effective date for those living in group payer states. States can still align their effective dates to ensure that eligible people receive the financial assistance they need to participate in Part A.

Clarifying Provision Blocked, Underlying Regulation Remains Required

Using Low-Income Subsidy (LIS) data for MSP applications (42 C.F.R. §435.911(e)). Known as "Extra Help," LIS helps pay prescription drug costs under Medicare Part D. LIS is federally administered by the Social Security Administration (SSA). Many people who enroll in LIS are eligible for MSPs, but state Medicaid agencies do not enroll them automatically.

[9] 42 CFR § 435.945(a).

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires SSA to share data from LIS applications ("leads data") with state Medicaid agencies and requires that, based on that data, agencies "shall initiate" an MSP application. However, not all states have done so. As a result, even though most of the over 14 million LIS enrollees are eligible for MSPs, over 1 million are not enrolled.[10] Using LIS data for MSP enrollment would significantly reduce the paperwork burden that applicants often face when applying for MSPs and would eliminate verification requests for information that the state Medicaid agency could access using LIS or other data. While a provision clarifying this rule was blocked, states are still expected to use LIS leads data from SSA to initiate an MSP application based on the MIPPA provision.

Alignment of Non-MAGI Policies With MAGI Practices

The Affordable Care Act's (ACA) simplified eligibility and enrollment processes for MAGI enrollees were not extended to non-MAGI enrollees, including seniors and people with disabilities. As a result, non-MAGI enrollees often need to take additional steps to enroll and stay enrolled in coverage. The final rule sought to build on the ACA streamlining rules by aligning the enrollment and renewal processes for non-MAGI enrollees with MAGI requirements. Despite the moratorium, states can still take important steps to streamline procedures for non-MAGI enrollees.

Provision Not Blocked, Remains Required

Apply primacy of electronic verification and reasonable compatibility standard for resources (42 C.F.R. §§435.940, 435.952). The final rule also added provisions to clarify the requirements at 435.952 and 435.940 for states to implement and utilize asset verification systems to more seamlessly electronically verify non-MAGI enrollee assets at application and renewal,[11] and apply a reasonable compatibility standard for assets. Such a standard allows for self-attestation and information from data sources to be considered "reasonably compatible" if they are both below, at, or above the eligibility threshold, even if the amount of income in the attestation is different from the amount in the electronic data source.[12] This was expected of states based on how the original regulations were written, but many states did not interpret it as such. Reasonable compatibility is commonly used for income verification but was not required for asset verification. Under this policy, the client attestation and data source are considered "reasonably compatible" if they are both below the eligibility threshold, reducing requests for additional information. This provision was not blocked, so states must continue to apply primacy of electronic verification and a reasonable compatibility standard for assets.

---

[10] KFF, "Number of Low-Income Subsidy (LIS) Enrollees," https://www.kff.org/medicare/state-indicator/number-of-low-income-subsidy-lis-enrollees/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; HHS.

[11] Farah Erzouki and Jennifer Wagner, "Using Asset Verification Systems to Streamline Medicaid Determinations," CBPP, June 23, 2021, https://www.cbpp.org/research/health/using-asset-verification-systems-to-streamline-medicaid-determinations.

[12] Jennifer Wagner, "Reasonable Compatibility Policy Presents an Opportunity to Streamline Medicaid Determinations," CBPP, August 16, 2016, https://www.cbpp.org/research/reasonable-compatibility-policy-presents-an-opportunity-to-streamline-medicaid.

Provision Blocked, Remains State Option

States have always had the option of aligning their MAGI processes to non-MAGI enrollees and most states have already done so.[13] Even though the reconciliation bill blocked provisions that would have made these options requirements, states that have not already adopted these options should still implement the streamlining practices, including:

- **Aligning the application and enrollment process with MAGI requirements** (42 C.F.R. §435.907(d)). When requesting information from non-MAGI applicants, states should provide 15 days or more to respond and allow applicants to provide requested information through all modes of submission. States should also provide a 90-day reconsideration period if an application was denied for not providing the requested information, which allows for the requested information to be treated as a new application if submitted within 90 calendar days, rather than terminating an enrollee's coverage and requiring them to submit a new application. States should also prohibit in-person interviews as part of the application process to reduce burden on non-MAGI applicants, many of whom may experience difficulties participating in an in-person interview due to mobility issues, lack of transportation, among other barriers.
- **Aligning the renewal process with MAGI requirements** (42 C.F.R. §435.916). This includes renewing non-MAGI enrollees no more frequently than every 12 months, providing pre-populated renewal forms with a minimum of 30 days to respond, providing a 90-day reconsideration period[14] if an enrollee's coverage was terminated for not completing the renewal process, and prohibiting states from requiring an in-person interview as part of the renewal process.

Implementing these policies will reduce red tape and administrative burden, making the application and renewal processes more accessible for non-MAGI groups and reducing both agency and client burden.

Clarifying Provision Blocked, Underlying Regulation Remains Required

Allow non-MAGI applicants to provide applications and supplemental forms through all modes of submission allowed for MAGI applicants (42 CFR §435.907(c)(4)). Among the blocked policies was a provision that clarified an existing requirement (at 42 C.F.R. §435.907(c)) for states to accept applications and supplemental forms needed to complete an application from non-MAGI enrollees via all modalities (e.g., telephone, mail, online). Though the clarification was blocked, states still must accept applications and supplemental forms via all modalities as has been required, but not consistently applied, for non-MAGI groups.

---

[13] Alice Burns *et al.*, "Medicaid Eligibility and Enrollment Policies for Seniors and People with Disabilities (Non-MAGI) During the Unwinding", KFF, June 20, 2024, https://www.kff.org/report-section/medicaid-eligibility-and-enrollment-policies-for-seniors-and-people-with-disabilities-non-magi-during-the-unwinding-appendix/.

[14] Section 435.919(d): "If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 calendar days after the date of termination, or a longer period elected by the State, the agency must reconsider the individual's eligibility without requiring a new application."

CHIP Improvements

In addition to improvements for non-MAGI enrollees, the final rule also removed barriers to CHIP enrollment by prohibiting practices that were previously optional for states.[15] These provisions went into effect last year and were *not* blocked through reconciliation.

Provision Not Blocked, Remains Required

- **No CHIP lockout periods when premiums are not paid** (42 C.F.R. §457.570(c)).
- **No waiting periods to enroll after becoming uninsured** (42 C.F.R. §§457.65(d), 457.805(b), 457.810(a)).
- **No lifetime or annual limits to receiving coverage** (42 C.F.R. §457.480).
- **Improved transitions between Medicaid and CHIP** (42 C.F.R. §§431.10, 435.1200(b)1, 435.1200(b)(3)(vi), 435.1200(b)(4), 435,1200(c), 435.1200(e)(1)(i), 435.1200(e)(4), 435.1200h(3), 457.348, 457.350), including:
    - Requiring each program to also determine eligibility for the other program,
    - Accepting eligibility determinations made by the other program,
    - Transitioning applicants to the coverage they are or could be eligible for; and
    - Providing a single, combined eligibility determination notice to all household members.

Eliminating Barriers to Coverage

In addition to the policy improvements that addressed challenges faced by older adults, people with disabilities, and children, the final rule also made changes that better streamline Medicaid enrollment and renewal processes for all applicants and enrollees. Some of the provisions remain in place and, as with other sections of the rules, states still have opportunities to adopt many of the policies that are affected by the bill's moratorium on elements of the rule.

Provision Not Blocked, Remains Required

- **Stronger recordkeeping practices** (42 C.F.R. §§431.17, 435.914(a), 435.914(b), 457.965). The final rule modernizes recordkeeping rules that had not been changed since 1986 and includes requirements such as maintaining records in an electronic format, specifying what information related to an enrollee's application or renewal should be included in the file, maintaining records for a minimum of three years, and specifying how and when states should make the records available to outside agencies or parties authorized to review them.

[15] Tricia Brooks and Allexa Gardner, "Medicaid Eligibility and Enrollment Rule Explainer," Georgetown Center for Children and Families, April 11, 2024, https://ccf.georgetown.edu/2024/04/11/medicaid-eligibility-and-enrollment-rule-explainer/.

- **No limit on the number of reasonable opportunity periods** (42 C.F.R. §435.956(b)(4)). State agencies are required to provide a "reasonable opportunity period" of 90 days to provide satisfactory proof of citizenship or immigration status when the agency is unable to verify an individual's attestation. The final rule restricts limitations on the number of reasonable opportunity periods that an applicant may be granted, giving people more opportunity to secure documents from agencies that can be slow to respond.[16]
- **No requirement to apply for all other benefits** (42 C.F.R. §§435.608, 436.608). Old rules required Medicaid applicants and enrollees to apply for income and resources (benefits) "available" to them such as pensions, retirement, and disability benefits as a condition of their eligibility (unless they could show good cause for not doing so). This rule imposed administrative burdens on individuals seeking health coverage and often delayed the application process. The final rule removes the regulation and redefines the income and resources "available" to applicants and enrollees as only those that are within their immediate control, effectively eliminating the requirement to apply for other benefits as a condition of eligibility.
- **Facilitate enrollment by allowing "medically needy" individuals to deduct prospective available medical expenses** (42 C.F.R. §§435.831, 436.831). "Medically needy" individuals have incomes too high to be eligible for Medicaid but have medical costs so high that they are able to "spend down" to become income-eligible for Medicaid. Previously, medically needy individuals had to submit documentation of the expenses they incurred before their Medicaid coverage kicked in. In some cases, this led to people churning in and out of coverage depending on the timing of their medical costs and agency procedures to verify financial eligibility. The final rule lets state agencies project those medical expenses that are constant and predictable into the future, allowing enrollees with ongoing medical needs to remain enrolled without breaks in coverage.

Provision Blocked, Remains State Option

- **Improving Medicaid agency processes for updated address information** (42 C.F.R. §§435.919, 457.344). The final rule sought to standardize a process for state agencies to update enrollee contact information, including specifying which data sources are considered reliable, what actions agencies should take when receiving address updates (or when returned mail has no forwarding address), and requiring agencies to make a "good-faith effort" to contact an enrollee to confirm updated address information through two or more modalities,

[16] When people enroll in Medicaid they are asked under penalty of perjury if they are a citizen, and for those who aren't, if they have an eligible immigration status. In both cases the application asks applicants to provide relevant government-issued document numbers. These numbers along with other information about the applicant is shared through electronic data exchanges with either the Social Security Administration (SSA) in the case of a citizenship attestation or the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) in the case of people with eligible immigration status and citizens who completed the naturalization process. Many people can have their status verified easily and quickly through this process, but some cannot. For example, SSA can't always substantiate citizenship of people born abroad if their Social Security number (SSN) was issued prior to the late 1970s, before SSA began verifying citizenship status when issuing SSNs. Because it can take time for agencies to notify the applicant that more information is needed, for the applicant to find and send documents, and for the agency to take steps to process documents, multiple reasonable opportunity periods are sometimes necessary.

such as via text and email. While this provision of the rule was blocked through the megabill, beginning on October 1, 2029, a separate section in the new legislation requires state agencies to collect updated address information from reliable data sources, including returned mail and managed care entities, and delegates authority to the Secretary of HHS to specify what actions states can take after receiving updated address information.[17] While awaiting further guidance from CMS, state agencies should continue to implement the best practices the final rule sought to standardize around obtaining updated address information and contacting enrollees to resolve discrepancies.

- **Establishing specific requirements for acting on changes in circumstances** (42 C.F.R. §§435.919, 457.344, 457.960). Enrollees are required to report changes in circumstances that could impact their eligibility during their eligibility period, and state agencies are required to act on such reports or on data they receive that indicate a change that could impact eligibility. The final rule outlined procedures for state agencies regarding changes in circumstance, such as communicating to enrollees the process for reporting changes, and actions the agency must take when they receive information about an enrollee's change in circumstance. The rule also applied the same timeliness standards for enrollees to respond when changes are either reported by them or if the state receives data indicating a change. These include providing enrollees 30 days to submit requested information and providing enrollees a 90-day reconsideration period so the enrollee does not have to fully reapply. Though this provision was blocked, states can still implement these best practices to better streamline the process for addressing either enrollee-provided information that could affect eligibility or information received from a third party (such as through a data match).
- **Ensuring reasonable timeframes for determinations and redeterminations at application, renewal, and following changes in circumstance** (42 C.F.R. §§435.907(d), 435.912, 457.1170**)**. The final rule established more specific timeliness requirements for states to adhere to when processing renewals and changes in circumstance. The rule also required states to provide a minimum number of days for individuals to return requested information and documentation to their state agency — 15 days for information requested at application and 30 days for information requested during a renewal or for a change in circumstance. Though this provision was blocked, state Medicaid agencies can use the timeframes laid out in the rule for their application and renewal processes, and notably, they still *cannot* terminate coverage for individuals who have returned their information until their renewal is fully processed.[18]

Provision Blocked, No Longer Allowed

Simplifies verification of citizenship and identity (42 C.F.R. §435.407). Currently, states are required to verify citizenship and identity first through SSA data, and if unsuccessful, through alternative methods such as state vital statistics records or through the U.S. Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) program. When these systems are used to verify citizenship, individuals must also provide proof of identity. This provision would have considered verification of birth with a state vital statistics agency or verification of citizenship with DHS SAVE as stand-alone evidence of citizenship (similar to SSA

[17] Section 71103 of P.L. 119-21.

[18] 42 C.F.R. § 435.912(g)(2), 42 C.F.R. § 435.930(b).

data) without needing to provide additional proof of identity. Due to the moratorium, states will still have to request verification of identity when using these sources to verify citizenship.