JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

ISSUE BRIEF

Final Rule to Streamline Access to Medicaid

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Rachel Gershon, Senior Attorney
Gelila Selassie, Senior Attorney

INTRODUCTION

On April 2, 2024, the Centers for Medicare and Medicaid Services (CMS) finalized a rule streamlining Medicaid eligibility and enrollment. The Streamlining Rule ("Rule") will:

- Allow states to streamline the process for individuals living in the community to stay enrolled Medicaid through spend-down and prospective budgeting; and
- Simplify the processes for individuals enrolling in and staying on Medicaid

The Rule will particularly help older individuals and people with disabilities, who have historically been left out of some efforts to simplify Medicaid processes (this population is often referred to as the "non-MAGI" population).[1] The Streamlining Rule will come into effect over time. Some rules are in effect as of June 2024; others take effect as late as June 2027.[2] This issue brief summarizes the Rule's changes to Medicaid, particularly for older adults.

In September 2023, CMS released a related final rule focused on streamlined changes to Medicare Savings Programs, and Justice in Aging summarized it in a brief entitled "Final Rule to Streamline Enrollment in Medicare Savings Programs."

EXPANDING WHEN AN INDIVIDUAL CAN PROJECT COSTS WHEN SPENDING DOWN TO MEDICAID ELIGIBILITY

The Streamlining Rule gives states the option to allow individuals living in the community to project their health and long-term costs when determining their financial eligibility for Medicaid.

Currently, the majority of states cover a "medically needy" (also referred to as "spend down" or "share of cost") population.[3] As part of a medically needy group, individuals with income above the Medicaid eligibility limit can use medical expenses, nursing facility care expenses, and home and community-based services (HCBS) expenses to

qualify for Medicaid.[4] Under current law, states can include *future* expenses for long-term care facility residents in determining eligibility for the medically needy population, allowing them to qualify for Medicaid prospectively.[5] Meanwhile, individuals in the community cannot be determined eligible for Medicaid until they actually incur their medical and HCBS costs. As a result, people living in the community cannot immediately access care when they need it and churn on and off Medicaid while residents in long-term care facilities have immediate access to care and continued Medicaid eligibility.

Example: Jorge has consistent HCBS expenses of $600 per month. Before the Streamlining Rule became effective, his state required him to incur his HCBS and other medical expenses in order to meet the spend-down and become eligible for Medicaid. Because Jorge was $500 over-income for Medicaid eligibility and his state has a spend-down budget period of three months, Jorge was required to incur $1,500 in expenses for Medicaid-covered services before becoming eligible for Medicaid. Jorge would churn on and off Medicaid every three months: He would not qualify for Medicaid in January and February, then be enrolled in Medicaid in March. Then, he would lose Medicaid in April and May, then be re-enrolled in Medicaid in June.

Under the Streamlining Rule, effective June 2024, states can now also allow individuals to count *non-institutional expenses that they will incur in the future*. These expenses include[6]:

- Reasonably constant and predictable expenses for services identified in a person-centered service plan for home and community-based services[7];
- Reasonably constant and predictable expenses for prescription drugs; and
- Other reasonably constant and predictable medical expenses.

Note that this provision may be available to individuals who are not receiving HCBS. The state can choose to include prescription drug and other expenses in prospective spend-down.

Example (continued): Under the new Rule, if Jorge's state chooses to adopt prospective budgeting for non-institutional expenses, Jorge could stay on Medicaid continuously. He would still be responsible for the spend down amount ($500/month) but could access Medicaid immediately at the start of the spend-down budget period because he can demonstrate he will incur more than $500 HCBS expenses each month.

Advocacy Opportunities

The Streamlining Rule has the potential to help Medicaid enrollees stay in the community while avoiding churning on and off of coverage. However, states are not required to implement this change since it is optional under the Rule. Advocates can educate state policymakers and urge them to adopt this state option by promptly submitting a State Plan Amendment. This practical step can reduce the risk of institutionalization by providing certainty in Medicaid coverage while living in the community. States have discretion to consider a range of expenses that are reasonably constant and predictable.[8] For instance, in addition to HCBS, expenses such as diabetic supplies, incontinence supplies, feeding tubes and supplies, oxygen, and transportation to medical appointments could all be considered to be reasonably constant and predictable. Advocates can help states identify these services and include in their state plan option.

APPLYING FOR MEDICAID

The Streamlining Rule made several changes to simplify the Medicaid application process. The Rule emphasizes and codifies for non-MAGI populations, the current requirement that state Medicaid agencies must accept all Medicaid applications, whether submitted in person, by mail, by phone, or online.[9] By June 2027, a state cannot require an interview (whether online, by phone, or in person) for anyone to enroll in Medicaid.[10] Effective June 2025, federal regulations will no longer require Medicaid applicants to apply for other benefits (including retirement and disability benefits) in order to be eligible for Medicaid.[11]

EXPERIENCING A PERIODIC RENEWAL

States must redetermine whether an individual is eligible for Medicaid through periodic renewals. The Rule streamlines this process. By December 2025, states must take a series of affirmative steps to keep addresses up to date in order to reduce the number of people who lose Medicaid at renewal due to a change in address.[12] By June 2027, periodic renewals cannot happen more frequently than once every 12 months, unless the person is a Qualified Medicare Beneficiary (in which case the renewal cannot be more frequent than every six months).[13] By June 2027, a state cannot require an interview (whether online, by phone, or in person) in order to renew their Medicaid coverage.[14] By June 2027, states will be required to send a pre-populated form to the Medicaid enrollee when the state cannot auto-renew using the *ex parte* process.[15]

Advocacy Opportunities

Even though many of the application and renewal provisions do not go into effect until 2027, states can adopt them now. For example, states can opt to not require interviews, establish 12 months of eligibility, and provide pre-populated forms for non-MAGI individuals.[16] CMS estimates that adopting these rules will save states millions of dollars in reduced administrative processes.[17] Advocates can urge their states to adopt these changes as soon as possible.

EXPERIENCING A CHANGE OF CIRCUMSTANCES

As Medicaid enrollees experience changes such as moving, turning 65, retiring, receiving increased income, developing a disability, their eligibility for Medicaid can change. The Streamlining Rule formalizes the process of reporting and responding to changes in circumstances. It covers circumstances where the enrollee reports the change, where the agency notes a change from its own information (e.g., turning 65), and where the agency obtains information from a third party.

Effective June 2027, states will be required to have a procedure in place, act promptly, and include the following enrollee protections. If the agency receives information that will negatively affect the enrollee's eligibility, then the state will be required to give the enrollee an opportunity to dispute this information.[18] If the agency receives information about a change in circumstances that would result in better coverage, the agency will not be allowed to terminate the current coverage until the better coverage is in place.[19] If the individual is denied coverage due to a change in circumstances, new regulations confirm that this is an adverse action, triggering requirements for state Medicaid agencies to review whether the person is eligible for any other Medicaid program, determine potential eligibility for other insurance affordability programs, provide advance notice, and follow fair hearing rules.[20]

SUBMITTING INFORMATION AND DOCUMENTS

Medicaid applicants and enrollees are often required to submit additional information and documents to complete their Medicaid application or renewal. Effective June 2027, the Rule sets a minimum number of days that individuals have to return the requested information and documents to the state Medicaid agency (though the state can set a higher number of days).[21] If an individual returns the required documents and information within that timeframe, the approval will be dated back to the date of application.

Table 1. Minimum Number of Days an individual has to return information and documents (effective June 2027)[22]

CIRCUMSTANCE	NUMBER OF DAYS	TO BE CODIFIED AT
Medicaid Application	15 days	42 CFR 435.907(d)(1)(i)
Change in Circumstance	30 days	42 CFR 435.919(c)(1)(i)
Renewal	30 days	42 CFR 435.916(b)(2)(i)(B)

OPPORTUNITY FOR RECONSIDERATION AFTER DENIAL

Effective June 2027, if an individual does not return requested information within the timeframe that the state Medicaid agency sets, the Rule establishes a 90-day reconsideration period from the date of denial or termination.[23] If the individual submits required documents and information back within that reconsideration period and is ultimately found eligible, then the approval will be dated back to the time that the required information was returned to the state agency. This reconsideration period applies to applications, renewals, and change of circumstance. Because the information is treated like a new application at application or renewal, retroactive coverage applies.[24]

Example: Padma is applying to Medicaid. After submitting her application, the state Medicaid agency asked her to submit a few documents verifying her income. Padma is given 15 days to submit the documents, but she does not submit until a month later. Because she submitted required documents within 90 days of denial and showed that she was eligible, the state Medicaid agency will be required to cover Padma, effective the date that Padma sent the required documentation in. Just as with a typical Medicaid application, Padma could also be eligible for up to 90 days of retroactive coverage.

Example: Edna's Medicaid agency sent her a form to fill out for her Medicaid renewal. She had 30 days to turn the form back in. Edna missed that deadline, and the state Medicaid agency sent Edna a notice terminating her Medicaid coverage. Edna then sent the required information back to the Medicaid agency. Since Edna's information was sent in within 90 days of the Medicaid termination and showed that she was eligible, the state Medicaid agency will be required to cover Edna, effective the date that Edna sent the additional information in. Since the return of information is treated as a new application, Edna is entitled to retroactive coverage and will not have a gap in coverage.

Advocacy Opportunities

Though the reconsideration requirements do not take effect until 2027, states already have the option to establish 90-day reconsideration periods.[25] In addition, some states have obtained approval from CMS to reinstate individuals back to the termination date, rather than approving them back to the date that required documents were returned to protect enrollees during the winding down of the COVID-19 public health emergency.[26] Advocates can urge their states to establish reconsideration periods before 2027 and to make the effective date of coverage earlier. Additionally, advocates can monitor to make sure their state is appropriately applying retroactive coverage to individuals who submit requested information during the 90-day reconsideration period.

STATE VERIFICATION OF INFORMATION

State Medicaid agencies are required to verify certain types of information in a Medicaid application or renewal before making an eligibility determination. The Rule streamlines verification of assets and citizenship. The Rule **confirms states cannot require the individual to provide an exact value of assets** at application or renewal.[27] Effective June 2024, states must use a "reasonable compatibility" process instead. Under this process, the asset information an individual provides on their application is considered verified if it is within a certain percentage of trusted information obtained by the state Medicaid agency.[28] The Rule also **requires states to accept additional sources as standalone proof of citizenship**.[29]

Advocacy Opportunities

While all states will be required to use reasonable compatibility threshold for assets, states can choose the percentage they will use as a reasonable compatibility threshold for assets. CMS has indicated that the threshold can be a dollar amount or a percentage, such as 10% or 20%. CMS has suggested that increasing the threshold can help with churn and administrative costs.[30] Advocates can urge their states to employ higher compatibility thresholds.

STATE DETERMINATION OF ELIGIBILITY

Currently, state Medicaid agencies are required to process applications within 45 days (unless the application is based on a disability, then it is 90 days). The Rule adds new timeframes for states to determine eligibility at renewal and due to a change in circumstance.[31] For example, under the new rule:

- States must process applications transferred from an insurance affordability program (like the Marketplace) within 90 days if the application is based on a disability; 45 days if not.
- States must process a renewal by the end of the eligibility period, as long as all necessary information is submitted at least 30 days prior.
- When a change of circumstances is reported and all necessary information received, states have until the end of the next month to process the change.

There are many more timeframes spelled out in the Rule. These timeframes are all effective June 2027.

Advocacy Opportunities

There is rampant non-compliance with existing timeliness standards, meaning that states often do not adhere to required timeframes when processing Medicaid applications. This issue has existed since before the COVID-19 pandemic, which exacerbated the delays. Advocates can push their states to provide transparency on their timeliness standards (including using dashboards developed during the COVID-19 pandemic), and support federal enforcement of timeliness standards.

CONCLUSION

The Final Rule extends several Medicaid protections to additional groups, including HCBS recipients, older enrollees, and people with disabilities. Implementation will take place over time, and may face challenges due to the complexity of Medicaid rules. If you are seeing issues with implementation of this rule, please contact Justice in Aging.

ENDNOTES

1 The Affordable Care Act (ACA) ushered in a set of streamlined processes for a subset of Medicaid enrollees. This subset of Medicaid enrollees is often called "MAGI" because their eligibility is based on a modified adjusted gross income (MAGI) standard. Many of the ACA's streamlining changes did not apply to "non-MAGI" applicants and enrollees, including older adults and people with disabilities. The final Streamlining Rule extends many of these ACA changes to non-MAGI individuals, including interviews, 12-month continuous eligibility, and pre-populated forms at renewal.

2 For a table outlining applicability dates, see 89 FR 22836.

3 KFF, "Medicaid Eligibility through the Medically Needy Pathway" (2022).

4 For more information on Medicaid spend-down, see KFF, "Medicaid Financial Eligibility in Pathways Based on Old Age or Disability in 2022: Findings from a 50-State Survey," (July 2022).

5 As long as these prospective expenses are reasonably constant and predictable.

6 To be codified at 42 C.F.R. § 435.831.

7 Including service plans as part of 1915(c), 1915(j), 1915(k) or 1915(i) authorities.

8 89 FR 22785 ("We agree that many of the services identified by commenters could be reasonably constant and predictable. However, we decline to individually evaluate each service identified against that standard here. Under the final Rule, discretion is left to each State to evaluate whether, and under what circumstances, a given service is considered reasonably constant and predictable.")

9 This is a long-standing policy for both MAGI and non-MAGI populations. The MAGI requirement currently exists at 42 C.F.R. § 435.907(a). The non-MAGI requirement currently exists in CMS guidance and is in the amended regulation 42 C.F.R. § 435.907(c)(4), effective June 2027. For discussion, see 89 Fed. Reg. 22793.

10 Interviews at application were already prohibited for MAGI individuals by 42 C.F.R. § 435.907(d). The Streamlining Rule amended 42 C.F.R. § 435.907(d) to extend the interview prohibition non-MAGI individuals. For discussion, including the clarification that phone and video interviews are prohibited, see 89 Fed. Reg. 22794.

11 This Rule currently applies to both MAGI and non-MAGI populations. See 42 C.F.R. § 435.608 (which will be deleted, effective June 2025). See 89 Fed. Reg. 22825.

12 To be codified at 42 C.F.R. § 435.919.

13 To be codified at 42 C.F.R. § 435.916(a)(1). According to CMS, at least six states - Minnesota, New Hampshire, Texas, Utah, Washington, and West Virginia – conduct renewals more frequently than 12 months. 89 FR 22845. QMB enrollees may not have periodic renewals more often than every six months. 42 C.F.R. § 435.916(a)(1). In the proposed rule, CMS explained that Section 1902(e)(8) of the Social Security Act allowed states to renew QMB enrollees as frequently as six months, though the agency urged states to adopt a 12-month renewal cycle for QMB. 87 FR 54782. Note that, even if periodic renewal will occur on an annual basis, spend-down budget periods can be much shorter (from one to six months). 89 FR 22794.

14 This was already an existing regulatory requirement for the MAGI population. 42 C.F.R. § 435.916(a)(3)(C)(iv). The Streamlining Rule amended 42 C.F.R. § 435.907(d) to extend the interview prohibition non-MAGI individuals. For discussion, including the clarification that phone and video interviews are prohibited, see 89 FR 22794.

15 To be codified at 42 C.F.R. § 435.916(b)(2)(i). *Ex parte* refers to a requirement (already in place before the Final Rule) that states use all available information to see if a Medicaid enrollee (MAGI or non-MAGI) remains eligible for Medicaid during a periodic renewal before reaching out to the Medicaid enrollee. 42 C.F.R. § 435.916.

16 89 FR 22793. For information on which states have adopted streamlining provisions already, see KFF State Health Facts, "Actions to Align Non-MAGI with MAGI Renewal Policies".

17 89 FR 22845.

18 To be codified at 42 C.F.R. § 435.919(b)(2)(ii).

19 42 C.F.R. § 435.919.

20 42 C.F.R. § 435.919(b)(5); 89 FR 22797.

21 42 C.F.R. § 435.907(d)(1)(i).

22 A similar table is available at 89 FR 22802.

23 To be codified at 42 C.F.R. §§ 435.907(d)(1)(iii); 435.916(b)(2)(iii); 435.919(d).

24 See 89 FR 22800 ("... we note that treating additional information received during the 90-day reconsideration period as a new application entitles eligible individuals to up to 3 months of retroactive coverage under Medicaid consistent with § 435.915."

25 See KFF State Health Facts, "Actions to Align Non-MAGI with MAGI Renewal Policies". Note that KFF does not specify whether the 90-day reconsideration period is for application, renewal, or change in circumstances.

26 See, e.g., CMS letter to Massachusetts (September 5, 2023) (CMS' approval of Massachusetts' 1902(e)(14) waiver request to make the effective date the date of termination (rather than the date documents were returned)). This 1902(e)(14) waiver is especially helpful in states that have waived the 90-day retroactive coverage requirement. Note that, to date, CMS has only approved 1902(e)(14) waivers in the context of an emergency, such as the COVID-19 Public Health Emergency and that these waivers are time-limited. See CMS, COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals. There may be an option to make (e)(14) waiver flexibility permanent through the submission of a state plan amendment. See CMCS Informational Bulletin re. Extension of Temporary Unwinding-Related Flexibilities (May 9, 2024).

27 To be codified at 42 C.F.R. 435.952.

28 The asset information is also considered verified if the electronic source and the application amount are both below the eligibility threshold. 42 C.F.R. § 435.952, effective June 2024.

29 Specifically, the following two data matches are now considered as standalone proof, no longer requiring the individual to also supply proof of identity: (1) The Department of Homeland Security Systemic Alien Verification for Entitlements (DHS SAVE) program; and (2) The state's vital records (record of birth). The Rule also requires states to engage in a data match with state vital statistics records if it is "available and effective". To be codified at 42 C.F.R. § 435.407.

30 CMS Informational Bulletin re: Ensuring Timely and Accurate Medicaid and CHIP Eligibility Determinations at Application (May 9, 2024) (slide 30).

31 To be codified at 42 C.F.R. 912(c)(3). See 89 FR 22802 for a detailed table with new timeframes for states to follow when making eligibility determinations.