Supporting Statement Part A
Medicaid Program; Medicare Savings Program Application and Eligibility Determinations
CMS-10891, OMB 0938-TBD

Note: This is a new collection of information request. At this time the OMB control number has yet to be determined (TBD) but will be issued by OMB upon their approval of this proposed collection of information request along with the control number's expiration date. The issuance of both can be monitored at www.Reginfo.gov.

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), P.L. 110-275 was enacted on July 15, 2008.

Relevant to this Supporting Statement, MIPPA included new policy and grants that support targeted outreach and education for helping enroll individuals into the Medicare Savings Programs (MSPs). In particular, MIPPA created new requirements for states to leverage the Medicare Part D Low-Income Subsidy (LIS) program to help enroll likely-eligible individuals in MSPs.

The MSPs consist of several mandatory Medicaid eligibility groups that cover Medicare Part A and/or B premiums and, often, cost-sharing. State Medicaid agencies receive applications and adjudicate eligibility for Medicaid coverage, including through the MSP eligibility groups. Currently, the MSP eligibility groups cover over 10 million low-income individuals. There are three primary MSP eligibility groups:[1] the Qualified Medicare Beneficiary (QMB) group, which pays all of an individual's Medicare Parts A and B premiums and assumes liability for most associated Medicare cost-sharing charges for people with income that does not exceed 100 percent of the federal poverty level (FPL); the Specified Low-Income Medicare Beneficiary (SLMB) group, which pays the Part B premium for people with income that exceeds 100 percent, but is less than 120 percent, of the FPL; and the Qualifying Individuals (QI) group, which pays Part B premiums for people with income at least 120 percent but less than 135 percent of the FPL. Individuals also must meet corresponding resource criteria in order to be eligible for an MSP. Many individuals in the MSP eligibility groups are also eligible for Medicaid services through concurrent enrollment in other Medicaid eligibility groups.

The Medicare Part D LIS program, also sometimes referred to as "Extra Help," is administered by the Social Security Administration (SSA) and subsidizes Medicare Part D prescription drug premiums and cost-sharing for over 13 million individuals with low income. Prior to January 1, 2024, full premium subsidy LIS (or "full LIS") generally paid the Part D premiums and

[1] There is a separate and fourth MSP eligibility group generally referred to as the "Qualified Disabled Working Individuals (QDWI) group," or QDWI group. As described in 1902(a)(10)(E)(ii), eligibility in the QDWI group is limited to individuals whose incomes do not exceed 200 percent of the FPL; whose resources do not exceed twice the relevant SSI resource standard (that is, for a single individual or couple); and who are eligible to enroll in Part A under section 1818A of the Act. Section 1818A of the Act permits individuals who became entitled to Part A on the basis of their receipt of Social Security disability insurance (SSDI) and who subsequently lose SSDI after returning to work (and, hence, entitlement to Part A) to enroll in Part A contingent on paying the Part A premiums. The medical assistance available to QDWIs is the coverage of the Part A premiums.

deductibles in full and set co-payments for drugs at between $0 and $10.35 (in 2023) for people with incomes below 135 percent of the FPL who also met certain resource criteria.[2] Beginning on January 1, 2024,[3] full LIS covers the Part D premiums and deductibles in full and set co-payments for drugs at between $0 and $11.20 (for 2024) for people with incomes below 150 percent of the FPL who also meet certain resource criteria.

Most LIS enrollees are deemed eligible for LIS by virtue of their enrollment in Medicaid. Others apply for the benefit by completing an application and submitting it to SSA. Once received, SSA uses the information provided on the LIS application (OMB control # 0960-0696 (SSA-1020)) to determine LIS eligibility.

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

First, MIPPA increased the resource limit for the QMB, SLMB, and QI MSP eligibility groups to the same resource limit that applied for full LIS at the time of MIPPA's enactment.[4] Second, MIPPA required states to exempt Medicare-cost sharing and other benefits paid under the MSPs from estate recovery that is otherwise applicable to Medicaid benefits.

Third, MIPPA required SSA to transmit data from LIS applications ("leads data") to state Medicaid agencies for determination of eligibility for MSPs. Fourth, MIPPA further required states to treat the leads data as an application for MSP and act on the data in the same manner and under the same deadlines as if it constituted an initial application for MSPs submitted by the individual.

Fifth, MIPPA required CMS to make available to SSA and states translations for an MSP model application[5] that can be provided to the public upon their request. However, under MIPPA, the use of the MSP model application remains a state option.

Sixth, MIPPA created grants for states to support targeted outreach and education to eligible Medicare beneficiaries.

---

[2] Partial premium subsidy LIS (or "partial LIS") generally pays for premiums on a sliding scale, from 100 percent to 25 percent paid, and sets deductibles and co-payments for drugs at a reduced level for people with income below 150 percent of the FPL who meet certain resource criteria.

[3] Section 11404 of the Inflation Reduction Act of 2022 (P.L.117–169) increases the income limit for the full LIS program to income below 150 percent of the FPL beginning January 1, 2024 and effectively sunsets the partial LIS program.

[4] Section 11404 of the Inflation Reduction Act of 2022 (P.L. 117–169) increases the resource limit to the same resource limit as applied to the partial LIS program at section 1860D–14(a)(3)(E) of the Act beginning January 1, 2024.

[5] Section 709 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554) created the MSP model application.

On September 21, 2023 (88 FR 65230), CMS published a final rule (CMS-2421-F; RIN 0938-AU00) entitled "Streamlining Medicaid: Medicare Savings Program Eligibility Determination and Enrollment" ("MSP final rule"). Finalized provisions include facilitating enrollment into the MSPs by reducing the documentation requirements prior to enrollment, better aligning the income and resource methodology of the MSPs with the LIS program, and requiring auto-enrollment of most Medicare-entitled Supplemental Security Income (SSI) recipients into QMB.

CMS did not previously estimate several costs for implementing the provisions of MIPPA related to MSPs as well as costs related to MSPs predating MIPPA. Therefore, we estimate these costs now. These costs include accepting leads data from SSA; using leads data to create MSP applications; state option to create MSP-only application; CMS model application for MSP; and verification processes for reviewing MSP applications and making MSP eligibility determinations.

In addition, we estimate costs for the new provisions in the MSP final rule, including requiring individuals applying for MSPs through the LIS pathway to be informed of responsibilities and benefits of applying for full Medicaid and asking individuals applying for MSPs through the LIS pathway for additional information necessary for states to make a full Medicaid eligibility determination; and requirements that states help individuals obtain life insurance information when documentation is required.

Finally, we calculate savings related to implementing the new provisions in the MSP final rule, including requiring states to accept MSP applicant's self-attestation for interest and dividend income, non-liquid resources, burial funds, and life insurance policies; allowing states to deem LIS enrollees into MSP when fully aligning MSP and LIS methodologies; prohibiting states from asking individuals for information already contained in LIS data; and auto-enrolling certain SSI recipients into QMB.

We refer to burden derived from following longstanding rules of the Medicaid program that were never previously calculated for MSPs as well as for implementing MIPPA as the "baseline" and refer to "savings" as reduced burden as a result of implementing the MSP final rule. In section 12 of this Supporting Statement we estimate baseline burden of 12,411,708 hours and $392,871,034 (see Table 2). We also estimate a savings of minus 6,894,551 hours and minus $180,810,509 (see Table 3). Overall (see Table 4), we estimate a burden of 5,517,157 hours at a cost of $80,267,994.

A. Justification

1. Need and Legal Basis

Millions of individuals with limited income and resources rely on the MSPs to cover Medicare Parts A and B premiums and, often, cost-sharing. MSPs are part of states' Medicaid programs and assist individuals who need assistance paying their Medicare costs.

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

individuals and Part A premiums for over 700,000 individuals.

MIPPA aimed to streamline enrollment in MSPs by creating new requirements for states to leverage the LIS program to help enroll likely-eligible individuals in MSPs.

Section 113 of MIPPA required SSA to transmit data from LIS applications ("leads data") to state Medicaid agencies for determination of eligibility for MSPs. Section 113 also required states to treat the leads data as an application for MSP and act on the LIS data, even if the LIS application was denied by SSA.

MIPPA also required CMS to make available to SSA and states translations for an MSP model application[6] that can be provided to the public upon their request. Section 118 of MIPPA required CMS to translate the MSP model application form into at least the 10 languages, other than English, that are most often spoken by those applying for Medicare. Under MIPPA, it continues to be a state option whether the state will accept the model MSP application.
While the implementation of MIPPA helped enroll individuals in MSPs, millions remain eligible but not enrolled. A 2017 study conducted for the Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that only about half of eligible Medicare beneficiaries were enrolled in MSPs.[7] This means that millions of Medicare enrollees living in poverty are paying over 10 percent of their income to cover Medicare premiums alone, despite being eligible for Medicaid coverage for these costs. Complex MSP enrollment processes contribute to this low participation rate.

We have learned through our experiences in working with states and other interested parties that certain policies continue to result in unnecessary administrative burden and create barriers to enrollment and retention of coverage for eligible individuals. For example, before 2023 there were no regulations to facilitate enrollment in the MSPs. In particular, we did not have regulations to link enrollment in other federal programs with the MSPs, despite the high likelihood that individuals in such programs are eligible for the MSPs. This hindered states' ability to efficiently enroll those known to be eligible. Additionally, interested parties reported that burdensome documentation requirements substantially impeded eligible individuals from enrolling in the MSPs.[8]

As we were considering ways to improve MSP enrollment, the Biden-Harris Administration issued several Executive Orders focused on protecting and strengthening Medicaid. On January 20, 2021, President Biden issued Executive Order 13985, charging federal agencies with identifying potential barriers that underserved communities may face to enrollment in programs

---

[6] Section 709 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554) created the MSP model application.

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

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

like Medicaid.[9] This was followed on January 28, 2021 by Executive Order 14009 with a specific call to strengthen Medicaid and the Affordable Care Act and remove barriers to obtaining coverage for the millions of individuals who are potentially eligible but remain uninsured.[10] The April 5, 2022 Executive Order 14070, "Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage" charges federal agencies with identifying ways to help more Americans enroll in quality health coverage.[11] It calls upon federal agencies to examine policies and practices that make it easier for individuals to enroll in and retain coverage. Additionally, the December 13, 2021 Executive Order 14058, "Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government" supports streamlining state enrollment and renewal processes and removing barriers to ensure eligible individuals are automatically enrolled in and retain access to critical benefit programs.[12]

Based upon these Executive Orders and the challenges with MSP eligibility and enrollment processes, we proposed and then finalized a rule to streamline MSP eligibility and enrollment. The MSP final rule, once fully implemented, will streamline MSP eligibility and enrollment processes, reduce administrative burden on states and applicants, and increase enrollment and retention of eligible individuals.

The MSP final rule added a new paragraph (e) to § 435.911, codified longstanding statutory requirements on how to process leads data, and added new requirements on verifying leads data.

We also created a new paragraph (e) at § 435.952 that required states to adopt a number of enrollment simplification policies related to the income and resources that are counted in determining MSP, but not LIS, eligibility. These policies would enable state agencies to use the leads data more efficiently, reduce burden on applicants and states, and increase the number of LIS enrollees successfully enrolled in the MSPs. We also anticipated these policies would have a positive health equity impact by increasing access to Medicare coverage for low-income individuals and increasing the financial security of those who successfully enroll, consistent with the January 20, 2021, Executive Order.[13]

Further, we anticipated that these enrollment simplifications would help reduce the high rate of churn (cycling in and out of Medicaid coverage) that dually eligible individuals experience largely due to administrative reasons such as providing documentation of certain income and assets to demonstrate their continued eligibility. Analyses by the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services found that almost 30 percent of individuals lost Medicaid eligibility for at least one month during the first year of transitioning to full-benefit dual eligibility, and more than 20 percent lost Medicaid eligibility for

---

[9] E.O. 13985, 86 FR 7009. *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/*.
[10] E.O.14009, 86 FR 7793. *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/*.
[11] E.O. 14070, 87 FR 20689. *https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/*.
[12] E.O. 14058, 86 FR 71357. *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/12/13/executive-order-on-transforming-federal-customer-experience-and-service-delivery-to-rebuild-trust-in-government/*.
[13] E.O. 13985, 86 FR 7009. *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/*

at least 3 months following the transition despite dually eligible individuals' relatively stable income and assets over time.[14] [15] Experts interviewed noted that dually eligible individuals most often lost coverage because of failing to comply with administrative requirements as opposed to changes in income, assets, or functional status.

In paragraph (e) at § 435.952, we required states to accept an applicant's attestation of the following: the value of any dividend and interest income earned on resources owned by the applicant or the applicant's spouse; the value of any non-liquid resources owned by the applicant or the applicant's spouse; up to $1,500 of the applicant's resources, and up to $1,500 of their spouse's resources, that are set aside in a separate account as burial funds; and the face value of life insurance policies below $1,500. Individuals would be required to provide documentation if the agency has information that is not reasonably compatible with the attestation. Individuals would also be required to provide documentation during an optional post-eligibility verification process if electronic verification is unavailable for those particular resources.

At § 435.952(e)(4)(iv)(A), we required states to assist the individual with obtaining documentation of the cash surrender value of life insurance policies when the state requires such documentation for making an MSP eligibility determination. In this circumstance, the state must assist the individual with obtaining this information and documentation by requesting that the individual provide the name of the insurance company and policy number and authorize the state to obtain such documentation on the individual's behalf. The agency may also request, but may not require, additional information from the applicant to assist the agency in obtaining documentation of the cash surrender value, such as the name of an agent. If the individual does not provide basic information about the policy and an authorization, under finalized § 435.952(e)(4)(iv)(B), the state may require that the individual provide documentation of the cash surrender value.

We added a new paragraph (b) at § 435.909 that generally would require states to deem an individual enrolled in the mandatory Medicaid SSI or 209(b) group[16] eligible into the QMB group. Under § 435.909(b)(2), we provided an option for group payer states[17] to directly initiate Medicare Part A enrollment for individuals who are not entitled to premium-free Part A without first sending them to SSA to apply for conditional Part A enrollment. Under this state option, once the state has determined the individual eligible for the mandatory SSI or 209(b) group and become liable for paying their Part B premiums under the buy-in agreement pursuant to § 407.42,[18] the state would also be able to deem them eligible for the QMB group.

---

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

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

[16] For most states, receipt of SSI confers Medicaid eligibility. However, for other states that are referred to as 209(b) states, they apply financial methodologies and/or disability criteria more restrictive than the SSI program in determining Medicaid eligibility for individuals 65 years old or older or who have blindness or a disability.

[17] These are states that do not have a Part A buy-in agreement with CMS. The Part A buy-in agreement allows for states to pay for and enroll Medicare-eligible individuals in Part A at any time of year.

[18] All states have a buy-in agreement with CMS that covers payment of Part B premiums and enrollment in Part B for individuals in either the mandatory SSI eligibility group or 209(b) eligibility group.

We also made changes at § 435.601 to better align the definition of family size for purposes of MSP eligibility with that of the LIS program. Most states use the SSI definition of family size for MSP eligibility, which is either the applicant or the applicant and the applicant's spouse. We required states to at least use the LIS definition, which is broader. The LIS definition includes the applicant, the applicant's spouse (if living with the applicant), and other relatives who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support. However, we will discuss implementation of this provision in a different information collection request.

The provisions discussed in this collection of information request are necessary for helping enroll individuals into the MSPs as directed by MIPPA and for implementing the MSP final rule.

2. Information Users

States use information collected by SSA on LIS applications, transmitted to states with the consent of an individual completing an application, to determine eligibility for the MSPs. The state Medicaid agency accepts and verifies the information provided on the LIS application (to the extent allowable under the MSP final rule); communicates with the applicant or the authorized representative about any additional information needed to make an MSP determination; makes the MSP eligibility determination; enrolls the individual in an MSP, if eligible; and informs the individual about the rights and responsibilities for applying for full Medicaid eligibility. Applicants include anyone who chooses to apply for LIS and provides consent for their application to be considered for MSPs.

Information collected by state Medicaid agencies on an MSP-only application will be used to determine eligibility for MSPs. Applicants are anyone who wants to apply for MSPs.

Information collected by the CMS model application for MSPs can be used to determine eligibility for MSPs if a state accepts the model application form. Applicants are anyone who wants to apply for MSPs and lives in a state that accepts the model application.

Life insurance information collected by state Medicaid agencies such as the name of the insurance company and policy number is used to help individuals obtain the cash surrender value of life insurance policies in order to determine eligibility for MSPs. Affected individuals are those who apply for MSPs and need to provide documentation for states to evaluate whole life insurance policies. Individuals may refuse to provide consent.

The information collection requirements will assist the public to understand information about the MSPs and will assist CMS in ensuring a simplified system of MSP application, eligibility determination, and enrollment.

3. Use of Information Technology

The information collection related to the LIS and MSP application will be available in electronic form. Additional information collected as needed for determining MSPs will be collected electronically if the applicant chooses to receive communication electronically. While the informational collection will utilize various types of technology, it is at the discretion of each

state as to which types will be used since CMS does not mandate the use of specific electronic media. The information collection is designed to take advantage of information technology and be completed in a user-friendly format, in order to minimize burden to the greatest extent possible.

4. Duplication of Efforts

This information collection does not duplicate any other federal effort.

5. Small Businesses

This information collection does not impact small businesses or other small entities. The information collection only applies to individuals and state Medicaid agencies.

6. Less Frequent Collection

An individual may apply for Medicaid, including MSPs, at any time of the year. If information was collected less frequently or not at all, individuals would not be able to gain access to MSPs in the way envisioned by MIPPA.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

The 60-day notice published in the Federal Register on April 18, 2024 (89 FR 27764). Comments were received. A summary of the comments and our response are attached to this collection of information request.

The 30-day notice published in the Federal Register on November 27, 2024 (89 FR 93607). Comments must be received by December 27, 2024.

9. Payments/Gifts to Respondents

No payments and/or gifts will be provided to respondents.

10. Confidentiality

All information will be kept private pursuant to applicable laws/regulations, including state privacy laws, Medicaid confidentiality laws under section 1902(a)(7) of the Social Security Act and federal privacy laws.

11. Sensitive Questions

Information about citizenship or immigration status are needed to help verify eligibility for MSP coverage.

12. Burden Estimates

Wage Estimates

Wage Estimates for State Governments. To derive average state-specific costs, we used data from the BLS May 2023 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/2023/may/oes_nat.htm*). In this regard, Table 1 presents the BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of hourly wage), and our adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	42.33	42.33	84.66
Computer Programmer	15-1251	51.80	51.80	103.60
Database and Network Administrator and Architect	15-1240	54.67	54.67	109.34
Eligibility Interviewers, Government Programs	43-4061	24.92	24.92	49.84
General and Operations Mgr.	11-1021	62.18	62.18	124.36
Management Analyst	13-1111	55.54	55.54	111.08

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

Cost to State Governments. To estimate state costs, it was important to take into account the federal government's contribution to the cost of administering the Medicaid program. For Medicaid, all states receive a federal financial participation (FFP) of 50 percent for administration. As noted previously, states also receive higher federal matching rates for certain services and for systems improvements or redesign, so the level of federal funding provided to a state can be significantly higher. As such, in taking into account the federal contribution to the costs of administering the Medicaid program for purposes of estimating state burden with respect to the collection of information requirements, we generally elected to estimate that the states would contribute 50 percent of the costs. However, we have estimated that states would contribute 25 percent of the costs for some system builds.

Wages for Individuals. We believe that the cost for applicants and beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $21.98/hr. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices[19] identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for applicants and beneficiaries, we used a measurement of the usual weekly earnings of wage and salary workers of $1,059[20] for 2022 and then divided by 40 hours to calculate an hourly pre-tax wage rate of $26.48/hr. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent or $4.50/hr ($26.48/hr x 0.17), resulting in the post-tax hourly wage rate of $21.98/hr ($26.48/hr - $4.50/hr). Unlike our state wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

Collection of Information Requirements and Associated Burden Estimates

Overall, we anticipate substantial savings both to individuals and from state Medicaid agencies as a result of new provisions in the MSP final rule. However, because CMS did not previously estimate several longstanding costs of the Medicaid program in determining MSP eligibility or implementing the provisions of MIPPA related to MSPs, if we simply presented all costs together, it would appear as though all the provisions were misleadingly expensive. As such, in an effort to distinguish these older costs from newer costs and savings associated with the MSP final rule, we separate out the two sections. We refer to the older costs as our baseline costs, while we refer to the costs and savings from the MSP final rule as our costs and savings from the MSP final rule.

Baseline Burden for MSPs and Implementation of MIPPA

The MSPs are part of the Medicaid program in every state and Washington, DC (but not the territories). Therefore, processes that are inherent to the Medicaid program – such as individuals applying for Medicaid, states verifying individuals' financial information, and states making eligibility determinations – all apply with equal force to the MSPs. However, these baseline costs were never previously estimated for MSPs, so we estimate them below. In addition, we estimate costs related to implementation of MIPPA that apply to MSPs that were not previously estimated.

[19] *https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//176806/VOT.pdf*.

[20] *https://fred.stlouisfed.org/series/LEU0252881500A*.

Applications
Most individuals applying for the MSPs do so through the single-streamlined Medicaid application, which includes sections on evaluating individuals for other insurance affordability programs on a Modified Adjusted Gross Income (MAGI) as well as supplemental forms to evaluate individuals on a non-MAGI basis. However, some states have created MSP-only applications that only evaluate individuals for eligibility for MSPs. These MSP-only applications are by nature much shorter and less complicated than the full Medicaid application. A smaller portion of individuals apply for MSP through the LIS application process that was created by MIPPA. While CMS also created a model MSP application, we are not aware of any states that accept that application.

Full-Medicaid application
All states have a single-streamlined Medicaid application, and most individuals apply for MSPs through that mechanism. One reason most individuals use the single-streamlined application is that individuals can then be determined for other insurance affordability programs such as qualifying for Advance Payments of the Premium Tax Credit (APTC) or Cost-Sharing Reductions (CSR) on the Marketplace as well as the CHIP program in addition to Medicaid. Moreover, individuals can be determined both for MSP and another full-benefit Medicaid eligibility group at the same time and without needing to provide further information. In fact, around 80 percent of individuals enrolled in MSPs are enrolled in both an MSP eligibility group and another full-benefit Medicaid eligibility group. For individuals who receive SSI and live in certain states ("1634 states"),[21] SSA makes their Medicaid eligibility determinations for an SSI-based full Medicaid eligibility group and then they would need to separately apply for MSPs. Approximately 1.5 million individuals who are enrolled in Medicare apply for Medicaid eligibility on the basis of non-MAGI yearly, with 400,000 originating from LIS. We estimate that 17 states use MSP-only applications and that about 25 percent of non-MAGI Medicare enrolled applicants in those states use them. Thus, rounding up, approximately 8.4 percent or 92,000 ((1.5 million – 400,000) x (17/51) x 0.25) of the MSP applications received annually outside of the LIS process are MSP-only applications, while the remainder of 91.6 percent are single-streamlined applications. To be considered for MSPs and other non-MAGI eligibility groups, individuals need to complete both the single-streamlined application as well as all the supplemental forms necessary for an eligibility determination on a non-MAGI basis. The supplemental forms can be quite lengthy because they generally include information needed for long-term care determinations as well. As such, we estimate that to complete this full Medicaid application, it takes individuals about 2 hours.

MSP-only applications
Because MSP-only applications are optional, we estimate that only about one-third of states (17 states) make them available to individuals. We estimate it takes a business operations specialist 40 hours at $84.66/hr to create an MSP-only application, a general operations manager 2 hours at $124.36/hr to review and approve it, a computer programmer 150 hours at $103.60/hr to program the information into its eligibility system and a database and network administrator 50 hours at $109.34/hr to oversee implementation into the eligibility systems. In aggregate, we estimate a one-time burden of 4,114 hours (242 hr x 17 states) at a cost of $418,916 ([40 hr x 17 states x

[21] 34 states and the District of Columbia are 1634 states.

$84.66/hr] + [2 hr x 17 states x $124.36/hr] + [150 hr x 17 states x $103.60/hr] + [50 hr x 17 states x $109.34/hr]). Accounting for the 50 percent federal contribution to Medicaid program administration, we estimate state cost of approximately $209,458.

Because MSP-only applications are much shorter than the full Medicaid application, we estimate it only takes each individual an average of 30 minutes or 0.5 hours to complete the application at $21.98/hr. As noted above, we estimate that 8.4 percent of the total number of individuals applying for MSPs use an MSP-only application, which is 92,000. We estimate that the MSP-only application represents a burden of 46,000 hours (92,000 responses x 0.5 hr/response) at a cost of $1,011,080 (46,000 hr x $21.98/hr) on individuals.

Transferring of Leads Data and LIS to MSP applications
Currently, all states receive data from LIS applications from SSA each business day.[22] Per section 113 of MIPPA, states must accept, via secure electronic transfer, the leads data and process that information to initiate an MSP application. To establish a secure electronic transfer with SSA for collection of leads data, we estimate a one-time system update of 150 hours is needed by computer programmer at $103.60/hr plus 50 hours by a database and network administrator at $109.34/hr. This provision applies to all 50 states plus Washington, D.C. (hereafter "51 states").[23] In aggregate, we estimate a one-time year 1 burden of 10,200 hours (200 hr x 51 states) at a cost of $1,071,357 ([150 hr x 51 states x $103.60/hr] + [50 hr x 51 states x $109.34/hr]). There is a 50 percent federal contribution to Medicaid program administration in the first year of a system build. Thus, we estimate state cost of $535,679 ($1,071,357 x 0.5) in the first year.

For subsequent years, we estimate an on-going burden for maintaining this system of 50 hours by computer programmers at $103.60/hr. In aggregate, we estimate an annual burden of 2,550 hours (50 hr x 51 states) at a cost of $264,180 (2,550 hr x $103.60/hr). There is a 75 percent federal contribution to Medicaid program administration for approved systems. Thus, we estimate state cost of $66,045 ($264,180 x 0.25) in subsequent years.

As noted above, section 113 of MIPPA requires states to treat receipt of the leads data from the LIS application as an application for MSPs, which we interpret to not require submission of another application. However, we do not believe most states are in compliance with this statute. Even states in compliance are submitting such lengthy follow-up questions that it is the equivalent of applying for an MSP-only application. While around half of people currently applying through the LIS process will ultimately apply through the full Medicaid application due to their state's non-compliance, we are not estimating the costs from applying for the full Medicaid application here. Instead, we estimate the costs of the other 200,000 people applying through the LIS process completing either the MSP-only application or the significant follow-up stemming from the LIS leads data, which we estimate to be around 0.5 hours per application. Thus, we estimate that the burden to individuals of this provision are 100,000 hours (200,000 applicants x 0.5 hr) at a cost of $2,198,000 (100,000 hr x $21.98/hr).

Model MSP applications
We are not aware of any state currently using the MSP model application. As such, we think it is

[22] The LIS program is not available to the territories, so we do not include costs here for territories.
[23] We do not estimate cost for territories in this package because no territories have adopted the MSPs.

mainly a tool for states to review to help update their MSP-only application or to consider adopting an MSP-only application in their state. We estimate it takes a management analyst 1 hour at $111.08/hr to review the MSP-only application for updates. This would apply to all 51 states. In aggregate, we estimate a burden of 51 hours (1 hr x 51 states) at a cost of $5,665 (51 hr x $111.08/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, we estimate state cost of approximately $2,833 ($5,665 x 0.5).

Verifications

Under § 435.948, states are required to verify financial information when determining MSP eligibility, while under § 435.956, states are required to electronically verify immigration and citizenship information for MSP applicants. Similarly, under § 435.916(b), states are required to re-verify eligibility at least yearly for MSPs. While states are allowed to accept self-attestation to verify income and resources of MSPs, we are unaware of states that actually permit this policy. If any information either cannot be verified or is not reasonably compatible with the information provided by the individual, the state reaches out to the individual for more information.

As such, we estimate that MSP applicants and enrollees are required to produce resource documentation, except in 10 states that have used authority under section 1902(r)(2) of the Social Security Act ("Act") to disregard assets entirely for MSP eligibility and, thus, do not require documentation to complete an eligibility determination or redetermination at the state Medicaid agency. We expect the burden would only apply to approximately 1.9936 million individuals (80 percent of 2.492 million applications/renewals[24]) in the other 41 states. We estimate that it takes individuals about 4 hours to produce documentation. This includes time spent finding documentation, talking on the phone with institutions that have their assets as well as travel time. Because applicants and beneficiaries generally do not have copying machines at home, they must either go to the library or some other place to copy documents as well as to the post office to mail their documents. In aggregate, we estimate an annual burden of 7,974,400 hours (1,993,600 individuals x 4 hr) at cost of $175,277,312 (7,974,400 hr x $21.98/hr).

We also estimate the non-labor costs of transportation to a copying place as well as the cost of mailing documents to be about $10 [($4.50 postage for small package or $1.75/page for faxing) + $4 roundtrip bus ride (to/from post office, printing/copying place and home) + $0.13/page for printing/copying)] per MSP applicant/renewal per year for the 41 states that have not used authority under section 1902(r)(2) of the Act to disregard assets entirely on MSPs. We estimate annual non-labor cost of $19,936,000 (1,993,600 enrollees x $10/enrollee).

We estimate state burden on reviewing individuals' documentation is 1 hour in states that have a resource limit for MSPs, whereas it is 10 minutes in states that have used authority under section 1902(r)(2) of the Act to disregard assets entirely. The 10 minutes (or 0.167 hr) represents the time that it takes a state eligibility interviewer to perform electronic pings for income and citizenship information and review it, at a rate of $49.84/hr. We estimate an annual burden of 2,076,833 hours ([1,993,600 enrollees x 1 hr] + [498,400 individuals x 0.167 hr]) and $103,509,347 (2,076,833 x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, we estimate state cost of $51,754,673 ($103,509,347 x 0.5).

[24] Based on states adjudicating 400,000 LIS applications, 92,000 new MSP-only applications and 2 million MSP-only beneficiaries for redetermination annually.

498,400 individuals who are applying for MSP-only Medicaid and who have no asset test = 2,492,000 total MSP-only applicants - 1,993,600 individuals who retain the asset test.

Eligibility determinations
After an individual applies for MSP coverage and the state verifies the individual's information, state eligibility workers must complete the following steps, if necessary: reach out to the individual for missing information or information that the individual submitted that is not reasonably compatible with electronic data; review any supplemental documentation submitted by the individual; make an eligibility determination; and issue a notice of decision. We think the amount of time spent on these activities is dependent on the state's current processes. For example, states that have a streamlined *ex parte* renewal process combined with either using authority under section 1902(r)(2) of the Act to disregard assets entirely or a robust asset verification system are able to quickly review beneficiaries' available data without needing to ask the beneficiary for additional information. In turn, this decreases the amount of time necessary for these functions. We estimate that in order to complete these steps, it takes a state eligibility worker about 1 hour per applicant/renewal for states that do not have either a robust asset verification system or *ex parte* renewal process and have not used authority under section 1902(r)(2) of the Act to disregard assets entirely, but only 20 minutes or 0.33/hr at $49.84/hr for states that do have one or more of the above policies/processes in place. We estimate that 75 percent of states fall into the former category and 25 percent of states fall into the latter category. We estimate an annual state burden of 2,074,590 hours ([2,492,000 MSP-only applicants x 0.75 x 1 hr] + [2,492,000 MSP-only applicants x 0.25 x 0.33 hr]) at a cost of $103,397,566 (2,074,590 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, we estimate state cost of $51,698,783 ($103,397,566 x 0.5).

Miscellaneous costs – assistance with applying for Medicaid
Under § 435.908, state Medicaid agencies are required to assist individuals with the Medicaid application process. Because current regulations require individuals to calculate the cash surrender value of life insurance, instead of the face value, individuals generally need help in understanding and providing the documentation. As such, we believe MSP applicants currently contact the Medicaid agency for help in how to obtain the documentation and eligibility workers explain how to calculate the cash surrender value of life insurance. We anticipate this assistance takes an average 45 minutes (0.75 hr) per applicant. However, we anticipate most individuals applying for MSPs do not own life insurance policies and as such, it will only affect 5 percent of applicants and beneficiaries (2,492,000 x 0.05) or 124,600 individuals. In aggregate, we estimate an annual burden of 93,450 hours (124,600 applicants x 0.75 hr) at a cost of $4,657,548 (93,450 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, the state cost is approximately $2,328,774 ($4,657,548 x 0.5).

Miscellaneous costs – interview as part of eligibility determination
As part of making eligibility determinations, states are allowed to require interviews. We are not aware of states currently requiring in-person interviews, but a few states require interviews over the phone. We estimate that 3 states currently have interview requirements for MSPs (or around 6 percent of all states) affecting approximately 29,520 individuals (0.06 x 492,000 individuals

who newly apply[25]). We estimate that each interview takes about 30 minutes or 0.5 hr. In aggregate, we estimate a burden of 14,760 hours (0.5 hr x 29,520 individuals) at a cost of $324,425 (14,760 hr x $21.98/hr) for individuals. For the 3 states, we estimate an aggregate burden of 14,760 hours (29,520 individuals x 0.5 hr) at a cost of $735,638 (14,760 hr x $49.84/hr) for states. Accounting for the 50 percent federal contribution to Medicaid program administration, the estimated state cost is approximately $367,819 ($735,638 x 0.5).

Total Baseline Burden

In total, we estimate the baseline burden and MIPPA related implementation burden for states in reviewing and making available MSP applications, conducting verifications and making MSP eligibility determinations as 4,276,548 hours, $214,060,217 in labor costs and $106,964,064 (state share).

We estimate baseline burden and MIPPA related implementation burden for individuals in applying and being reviewed by the state to determine MSP eligibility as 8,135,160 hours, $178,810,817 in labor costs, and $19,936,000 in non-labor costs.

When combined, the total baseline burden is 12,411,708 hours (4,276,548 hr for states + 8,135,160 hr for individuals), $278,512,692 in labor costs ($106,964,064 for state share + $178,810,817 for individuals), and $19,936,000 in non-labor costs (individuals).

[25] Out of the 2.492 million individuals, approximately 492,000 newly apply for MSPs and 2,000,000 million are renewed annually.

Table 2- Summary of Baseline Burden

Statutory/Reg section and title	Number of Respondents	Total number of responses	Time per response (hours)	Total time (hours)	Hourly Labor cost ($/hr)	Total labor cost ($)	State share ($)	Non-labor costs ($)	Frequency
State Burden									
§ 435.907-MSP-only applications	17	17	Varies	4,114	Varies	418,916	209,458	N/A	Once
Section 1144(c)(3) of the Act- Transfer of LIS leads data	51	51	Varies	10,200	Varies	1,071,357	535,679	N/A	Once
Section 1144(c)(3) of the Act- Maintenance of LIS leads data	51	51	50	2,550	103.60	264,180	66,045	N/A	Annual
Section 1905(p)(5) of the Act-Model MSP applications	51	51	1	51	111.08	5,665	2,833	N/A	Once
§ 435.948- Verifications	51	2,492,000	Varies	2,076,833	49.84	103,509,347	51,754,673	N/A	Annual
§ 435.911-Eligibility determinations	51	2,492,000	Varies	2,074,590	49.84	103,397,566	51,698,783	N/A	Annual
§ 435.908-Miscellaneous costs- assistance with Medicaid application	51	124,600	0.75	93,450	49.84	4,657,548	2,328,774	N/A	Annual
§ 435.911-Miscellaneous costs- interview	3	29,520	0.5	14,760	49.84	735,638	367,819	N/A	Annual
Subtotal: States	*51*	*5,138,290*	*Varies*	*4,276,548*	*Varies*	*214,060,217*	*106,964,064*	*N/A*	*Varies*
Burden on Individuals									
§ 435.907-MSP-only applications	92,000	92,000	0.5	46,000	21.98	1,011,080	N/A	N/A	Annual
Section 1144(c)(3) of the	200,000	200,000	0.5	100,000	21.98	2,198,000	N/A	N/A	Annual

Act- Transfer of LIS leads data									
§ 435.948- Verifications	1,993,600	1,993,600	4	7,974,400	21.98	175,277,312	N/A	N/A	Annual
§ 435.948- Verifications	1,993,600	1,993,600	N/A	N/A	N/A	N/A	N/A	19,936,000	Annual
§ 435.911-Miscellaneous costs- interview	29,520	29,520	0.5	14,760	21.98	324,425	N/A	N/A	Annual
Subtotal: Individuals	*4,308,720*	*4,308,720*	*5*	*8,135,160*	*21.98*	*178,810,817*	*N/A*	*19,936,000*	*Annual*
TOTAL	**4,308,771**	**9,447,010**	**Varies**	**12,411,708**	**Varies**	**392,871,034***	**106,964,064**	**19,936,000**	**Varies**

*Includes costs to the federal government via State match.

MSP Burden (Costs and Savings) as a Result of MSP Final Rule

As we discussed above, CMS is imposing new requirements on states in the MSP final rule. Most of these new requirements will reduce both applicant/beneficiary and state burden resulting in savings, but a few will add some new costs. However, states have the opportunity to reduce these costs by taking advantage of options that are currently available to states. For example, states can use authority under section 1902(r)(2) of the Act to disregard all assets or a subset of assets in determining eligibility for MSPs. If a state uses this authority to disregard life insurance policies, then the state would not have any new burden with regard to the life insurance verification provisions in the MSP final rule.

Reduced LIS Applicant Burden for Applying to MSPs and Submitting Documentation for Verification

At § 435.911(e)(2), we codified the policy of states treating receipt of leads data as an application for MSPs without requiring submission of another application under MIPPA and expect to enforce it more robustly. At paragraph (e)(3) of § 435.911, we required states to accept LIS leads data without further verification unless the state agency has information that is not reasonably compatible with the LIS leads data or the LIS leads data would not support a determination of MSP eligibility. At paragraph (e)(4), we prohibited states from requesting that individuals attest or otherwise provide documentation to establish information contained in LIS leads data unless the state agency has information that is not reasonably compatible with the LIS leads data. At paragraph (e)(7), we required that states must promptly and without undue delay, consistent with the timeliness standards at § 435.912, determine MSP eligibility without requiring submission of a separate application. We previously estimated in the MSP final rule[26] these provisions together would reduce the time needed for LIS applicants applying to MSPs to submit paperwork from 4 hours to 15 minutes, for a savings of 3.75 hours per applicant per year across all 51 states. However, that estimate did not account for the decrease in documentation requirements stemming from § 435.952(e)(1) through (4), which newly requires states to accept self-attestation of certain income and resources for all MSP applicants and beneficiaries—including dividend and interest income, burial funds of spouse and individual, and the face value of life insurance policy unless the state has information that is not reasonably compatible with the applicant's attestation. The estimate also did not account for the fact that some individuals may still need to submit some documentation. For example, we have heard about individuals who collect social security from another account (e.g. spouse) often have to provide such documentation. As such, we believe the provisions will result in a reduction of paperwork from 4.5 hours to 2 hours and save 2.5 hours for individuals applying through the LIS application. We estimate an annual savings of minus 1,000,000 hours (2.5 x 400,000) and minus $21,980,000 (1,000,000 hr x $21.98/hr).

Reduced Applicant Burden during Verification Process for Non-LIS Applicants

Finalized § 435.952(e)(1) through (4) newly requires states to accept self-attestation of certain income and resources for all MSP applicants and beneficiaries—including dividend and interest income, burial funds of spouse and individual, and the face value of life insurance policy unless the state has information that is not reasonably compatible with the applicant's attestation.

[26] "Streamlining Medicaid: Medicare Savings Program Eligibility Determination and Enrollment" 88 FR 65230, 65259 (2023).

Because 10 states have used authority under section 1902(r)(2) of the Act to disregard assets entirely and do not require documentation to complete an MSP eligibility determination or renewal at the state Medicaid agency, we expect the savings from the self-attestation provisions would only apply to approximately 1.5936 million individuals (80 percent of 2.492 million applications/renewals minus 400,000 individuals who applied to LIS counted previously above) in the other 41 states. We estimate that under § 435.952(e)(1) through (4), these 1.5936 million individuals will see a reduction from 4 hours to 2 hours, for a savings of 2 hours per individual, to complete verifications for applications/renewals in all 41 states. In aggregate, we estimate an annual savings of minus 3,187,200 hours (1,593,600 individuals × 2 hr) and minus $70,054,656 (3,187,200 hr × $21.98/hr).

Reduced State Burden during Verification Process for Non-LIS Applicants
We also estimate that § 435.952(e)(1) through (4) will save an Eligibility Interviewer 15 minutes (0.25 hr) per eligibility determination or renewal for these 1,593,600 applicants/beneficiaries. In aggregate, we estimate an annual labor savings for states of minus 398,400 hours (1,593,600 applications x 0.25 hr) and minus $19,856,256 (398,400 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, the estimated state savings is approximately minus $9,928,128 ($19,856,256 x 0.5).

Reduced State Burden during Verification Process for LIS Applicants
We estimate that the finalized provisions in § 435.911(e) and § 435.952(e)(1) through (4) will save an Eligibility Interviewer 25 minutes (0.42 hr) per eligibility determination at $49.84/hr for the 300,000 (400,000 x 0.75) new LIS applicants from reduced paperwork to review because of the provisions considering leads data as verified and the self-attestation requirements. In aggregate, we estimate an annual savings of minus 126,000 hours (300,000 applicants x 0.42 hr) and minus $6,279,840 (126,000 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, we estimate state savings of approximately minus $3,139,920 ($6,279,840 x 0.5).

State Verification Costs for Post-Enrollment Verification for MSP-only and LIS Applicants
At paragraph § 435.952(e), we also finalized a provision allowing for optional post-enrollment verification of any income or resource information that we required the state to accept self-attestations for, including dividend and interest income, non-liquid resources, burial funds and life insurance policies. Under this provision, the Medicaid agency requests documentation of the individual after they are already enrolled. We anticipate this option will not be chosen by most states because we believe the requirement that information provided by individuals be reasonably compatible to the information states access regarding individuals prior to enrollment is already sufficient to ensure ineligible individuals are not enrolled in MSPs. However, the post-enrollment verification option may be used by some states. We estimate 7 states or around 14 percent of states will select this option and it will impact approximately 68,880 individuals newly applying for MSPs each year (0.14 x 492,000 individuals). We estimate it will take state eligibility workers 1 hour at $49.84/hr to perform this verification. In aggregate, we estimate a burden of 68,880 hours (68,880 individuals x 1 hr/response) at a cost of $3,432,979 ($49.84/hr x 68,880 hr). Accounting for the 50 percent federal contribution to Medicaid program administration, we estimate state cost of approximately $1,716,490.

Applicant Labor Costs for Post-Enrollment Verification for MSP-only and LIS Applicants

For post-enrollment verification under § 435.952, we estimate this will require 2 hours for individuals. In aggregate, we estimate a burden of 137,760 hours (68,880 individuals x 2 hr/response) at a cost of $3,027,965 ($21.98/hr x 137,760 hr).

Reduced Non-Labor Costs for MSP-only and LIS Applicants
We also estimate the non-labor savings under § 435.911(e) and § 435.952(e)(1) through (4) to be about $10 [($4.50 postage for small package or $1.75/page for faxing) + $4 roundtrip bus ride (to/from post office, printing/copying place and home) + $0.13/page for printing/copying)] per MSP applicant/renewal per year for all 51 states. In aggregate, we estimate an annual non-labor savings of minus $19,936,000 (1,993,600 individuals × $10/individual).

State Burden for Verification of the Face Value of Life Insurance for MSP-only and LIS Applicants and MSP beneficiaries
We finalized § 435.952(e)(4) to require states to develop a verification process to determine the cash surrender value of life insurance policies over $1,500. We anticipate this will be a change for 10 states in their process for verifying the cash surrender value of life insurance policies over $1,500. We do not anticipate an impact in around 16 states that are using authority in section 1902(r)(2) of the Act to disregard the cash surrender value of life insurance in whole or part. We estimate that 25 of the remaining 35 states (51 states−16 states) will choose to use authority in section 1902(r)(2) of the Act to disregard the cash surrender value of life insurance rather than opting to verify the cash surrender value of life insurance. As noted previously, we expect that the regulation change will only impact 20 percent or approximately 10 states (51 states x 0.2). Based on enrollment in past years, we anticipate that all 51 states will adjudicate 492,000 new MSP applications a year plus 2 million renewals. However, we anticipate this policy will only affect 2 percent of applicants and beneficiaries, or 9,968 individuals across 10 states (2,492,000 individuals x 0.02 of applicants x 0.2 of states) because of the small number of people who could both afford this type of life insurance (which is much more expensive than term life insurance) and are also likely to apply for MSPs (which tends to be lower-income individuals).

At § 435.952(e)(4)(iv)(A), we finalized the requirement for states to assist the individual with obtaining documentation of cash surrender value when documentation of the cash surrender value of a life insurance policy is required. In this circumstance, the state must assist the individual with obtaining this information and documentation by requesting that the individual provide the name of the insurance company and policy number and authorize the state to obtain such documentation on the individual's behalf. The agency may also request, but may not require, additional information from the applicant to assist the agency in obtaining documentation of the cash surrender value, such as the name of an agent. If the individual does not provide basic information about the policy and an authorization, under finalized § 435.952(e)(4)(iv)(B), the state may require that the individual provide documentation of the cash surrender value. The burden associated with § 435.952(e)(4) will consist of the time and effort for eligibility workers in 10 states to collect information regarding the cash surrender value of life insurance from 9,968 applicants.

Under § 435.952(e)(4), we estimate that it will take an Eligibility Interviewer 1 hour at $49.84/hr to verify the cash surrender value of each life insurance policy over $1,500. In aggregate, we estimate an annual burden of 9,968 hours (1 hr x 9,968 individuals) at a cost of $496,805 (9,968 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program

administration, we estimate state costs of approximately $248,403 ($496,805 x 0.5).

Reduced State Burden for Verification of the Face Value of Life Insurance for MSP-only and LIS applicants and MSP beneficiaries
We estimate state savings under § 435.952(e)(4) from eligibility workers not needing to review life insurance documents for individuals with life insurance less than $1,500. We anticipate it will take an eligibility worker about 10 minutes (0.167 hr) to review a life insurance document and that this savings will affect 3 percent or 14,952 applicants and beneficiaries across 10 states or 20 percent of all states (2,492,000 individuals x 0.03 x 0.2). In aggregate, we estimate an annual burden of minus 2,497 hours (14,952 individuals x 0.167 hr) and minus $124,450 (2,497 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, the estimated state savings is approximately minus $62,225 ($124,450 x 0.5).

Finalized § 435.952(e)(4) generally requires that a state accept the individual's attestation of the face value of life insurance policy if it is below $1,500. We estimate the changes under § 435.952(e)(4) will save Eligibility Interviewers an average 45 minutes (0.75 hr) per applicant from not needing to coach applicants on how to gather and find information on the cash surrender value of life insurance. In aggregate, we estimate an annual savings of minus 7,476 hours (9,968 applicants x 0.75 hr) and minus $372,604 (7,476 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, the estimated state savings is approximately minus $186,302 ($372,604 x 0.5).

State burden on screening for full Medicaid eligibility through LIS application
In paragraph (e)(9) of 435.911, we require states to provide individuals with—in addition to and separate from any requests for additional information necessary for a determination of Medicare Savings Program eligibility, unless CMS approves otherwise—information about the availability of additional Medicaid benefits on other bases and responsibilities of the individual applying for such benefits, and an opportunity to furnish such additional information as may be needed to determine whether the individual is eligible for such additional Medicaid benefits. This new requirement would require states to collect new information, provide beneficiaries with an opportunity to authorize this new information collection, and make a determination for full Medicaid based on the information collection. We are permitting significant flexibility to states for how they implement the requirement at paragraph (e)(9), and we expect states will make varying use of automation and different forms of communication to applicants. For efficiency reasons, we believe that a state would send the required disclosures/consent for the agency to make a full Medicaid eligibility determination as well as the request for additional information needed to make a full Medicaid determination in one correspondence. Moreover, instead of asking many questions in order to gain additional information necessary to make a full Medicaid eligibility determination, we anticipate that states will instead merely highlight the additional information individuals need to fill out on the full Medicaid application form. We expect the state burden would be, an ongoing burden of, on average, 15 minutes per LIS applicant (400,000 total) to provide the required disclosures/consent and highlight the additional information individuals need to fill out on the full Medicaid application form. The full Medicaid application form will not need to be revised.

We believe most individuals would not have an additional burden associated with this provision because we assume that the vast majority (85 percent) of individuals will not respond to the

states' request for additional information. In reaching this conclusion, we note that individuals are generally discouraged from applying for Medicaid by burdensome application processes and repeated requests for additional information. Given that the determination of full Medicaid for LIS applicants would inevitably require individuals to face these hurdles, we believe it is reasonable to conclude that only around 15 percent of individuals will respond to states' requests for information. States will then only need to process and make full Medicaid determinations for the remainder of individuals (15 percent or 60,000 individuals [400,000 LIS applicants x 0.15]), which will take about 1 hour at $49.84/hr. The annual state burden for sending individuals the new information is 100,000 hours (400,000 LIS applicants x 0.25 hr) at a cost of $4,984,000 (100,000 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, the estimated state cost is $2,492,000 ($4,984,000 x 0.5).

For processing the information received from individuals, we estimate an annual state burden of 60,000 hours (60,000 applicants who respond to the states' request for information x 1 hr/application) at a cost of $ 2,990,400 (60,000 hr x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, the estimated state cost is $1,495,200 ($2,990,400 x 0.5).

The total state burden is 160,000 hours (100,000 hr to send new information + 60,000 hr to process information received from individuals) and $3,987,200 ($2,492,000 + $ 1,495,200).

For individuals to respond to states' request for information (that is, complete the remainder of the full Medicaid application), we estimate that it will take 1.5 hours at $21.98/hr. In aggregate, we estimate an annual individual burden of 90,000 hours (60,000 applicants x 1.5 hr/application) at a cost of $1,978,200 (90,000 hr x $21.98/hr).

State burden on not being able to deny LIS applicants MSP eligibility solely based on LIS data
In the MSP final rule at paragraph (e)(8) of § 435.911, we stated that if any of the LIS leads data does not support a determination of eligibility under the Medicare Savings Programs, states would be required to—(i) Determine what additional information is needed to make a determination of eligibility for the Medicare Savings Programs; (ii) Notify the individual that they may be eligible for assistance with their Medicare premium and/or cost sharing charges, but that additional information is needed for the agency to make a determination of such eligibility; (iii) Provide the individual with a minimum of 30 days to furnish any information needed by the agency to make such determination of eligibility; and (iv) Verify the individual's eligibility for the Medicare Savings Programs in accordance with the agency's verification plan developed in accordance with § 435.945(j).

Currently, we believe states deny individuals eligibility for MSP eligibility based on LIS data. Therefore, under this new regulation, states need to send additional information to individuals prior to denying MSP eligibility. We estimate that only about 250,000 individuals who apply yearly are ineligible for LIS.[27] We estimate it would take about 10 minutes for an eligibility

[27] This number is generally derived from Government Accountability Office report indicating that 1.9 million individuals were transferred to states from LIS over three years with a slight increase and subtracting the number of individuals eligible noted above. Government Accountability Report # 12-871. "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment." September 2012. https://www.gao.gov/assets/gao-12-871.pdf.

worker to send this new information to the individual at a burden of 41,750 hours (0.167 x 250,000) and a cost of $2,080,820 (41,750 x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, the estimated state cost is $1,040,410. We are not anticipating any individuals to respond to this request from the state as we expect that if the individual was denied LIS, they are unlikely to be eligible for MSPs.

State burden related to SSI-QMB

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

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

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

In the 35 States with a 1634 agreement, the Medicaid agency automatically enrolls the SSI recipients in Medicaid following a data exchange with SSA and then we automatically initiate Part B buy-in for the individual through the “buy-in data exchange.” In the remaining states, individuals must submit a separate application to the state Medicaid agency to be determined eligible for Medicaid.

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

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

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

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

Of the 96,736 individuals eligible for premium Part A, we estimate 33 percent (31,923 = 96,736 x 0.33) are in Part A buy-in states and 67 percent (64,813 = 96,736 x 0.67) of those eligible for premium Part A are in group payer states, where deeming will be optional. We estimate that 95 percent (30,327 = 31,923 x 0.95) of individuals in Part A buy-in states who are eligible for premium Part A will enroll as a result of the new provision because we estimate that all of those individuals live in states with 1634 agreements. However, for the individuals eligible for premium Part A in group payer states where deeming will be optional, we expect some more populous states will use this option,[28] so we are estimating 33 percent (21,388 = 64,813 x 0.33) of all individuals with premium Part A living in group payer states will newly enroll.

Reduced individual burden based on deeming QMBs
We estimate a total of 499,185 individuals (405,963 in states with 1634 agreements + 41,507 in 209(b) states + 30,327 in part A buy-in states + 21,388 with premium part A in group payer states) will newly enroll in QMB without the need to complete an application. We had previously estimated that those individuals would each save 2 hours from not filling out Medicaid applications and compiling associated documentation (going from 2 to 0 hours) at $21.98/hr. However, based on our other estimates in this package, we revise these estimates for consistency to provide for a reduction of 0.5 hr for application burden (for MSP-only applications) as well as reducing the documentation burden by 4 hours for individuals living in most states (41). However, there is no documentation burden for individuals living in states that have used authority under section 1902(r)(2) of the Act to disregard all assets (10). We estimate an annual savings of minus 1,849,593 hours ([400,000 individuals x 4.5 hr] + [99,185 individuals x 0.5 hr]) and minus $40,654,054 (1,849,593 x $21.98/hr).

State burden on deeming QMBs

[28] In particular, we expect California to use this option until it becomes a Part A buy-in state in 2025 where deeming will be required under § 435.909.

All 51 states will need to make eligibility systems changes to deem an SSI individual into QMB once they are eligible for Medicare. We had previously estimated it would take a computer programmer 180 hours to make these systems changes. However, after discussion with systems experts, we are revising our estimates upwards. We now estimate it will take a computer programmer an average of 200 hours per state at $103.60/hr to make systems changes to set their systems to search for Medicare eligibility in federal systems and then enroll that individual in QMB. We estimate it will take a data and network engineer about 50 hours at $109.34/hr to implement the systems changes into the eligibility systems. We also estimate an ongoing maintenance cost of 100 hours a year for a computer programmer at $103.60/hr. In aggregate, we estimate a one-time burden of 12,750 hours (51 states x 250 hr) at a cost of $1,335,537 ([200 hr x 51 states x $103.60/hr] + [50 hr x 51 states x $109.34/hr]). In aggregate, we also estimate an ongoing burden of 5,100 hours (51 states x 100 hr) and $528,360 (5,100 hr x $103.60/hr). Accounting for the 50 percent federal contribution to the Medicaid program administration for initial costs and a 75 percent federal contribution to the Medicaid program for an ongoing costs, the estimated state share is approximately $667,769 ($1,335,537 x 0.5) for initial burden and $132,090 ($528,360 x 0.25) for ongoing burden.

Reduced state burden on deeming QMBs
We previously estimated this provision would save eligibility workers 1 hour. However, based on other estimates here, we are revising. We now estimate eligibility workers will save 1 hour from not making eligibility determinations and 1 hour from not verifying eligibility for individuals receiving SSI, but instead automatically enrolling them in QMB in most states. However, we estimate eligibility workers will save 30 minutes or 0.5 hours in states that have that have used authority under section 1902(r)(2) of the Act to disregard assets entirely. We estimate this will save states minus 849,593 hours ([400,000 individuals x 2 hr] + [99,185 individuals x 0.5 hr]) and $42,343,715 (849,593 x $49.84/hr). Accounting for the 50 percent federal contribution to Medicaid program administration, the estimated state share is approximately minus $21,171,858 ($42,343,715 x 0.5).

Total Burden (Costs and Savings) from MSP Final Rule

For individuals, we estimate a burden of minus 5,809,033 hours, minus $127,682,545 in labor costs, and minus $19,936,000 in non-labor costs.

For states, we estimate a burden of minus 1,085,518 hours and minus $26,696,070 (state share).

Combined, we estimate a burden of minus 6,894,551 hours (-5,809,033 hr – 1,085,518 hr), minus $154,378,615 in labor costs, (-$127,682,545 - $26,696,070) and minus $19,936,000 in non-labor costs.

Table 3- Summary of Burden (Costs and Savings) in MSP Final Rule

Reg section and title	Number of Respondents	Total number of responses	Time per response (hours)	Total time (hours)	Hourly Labor cost ($/hr)	Total labor cost ($)	State share ($)	Non-labor costs ($)	Frequency
Burden on Individuals									
§ 435.911(e) and § 435.952(e)- savings for applying for MSP and submitting documentation	(400,000)	(400,000)	2.5	(1,000,000)	21.98	(21,980,000)	N/A	N/A	Annual
§ 435.952(e)- savings for verification	(1,593,600)	(1,593,600)	2	(3,187,200)	21.98	(70,054,656)	N/A	N/A	Annual
§ 435.952(e)- post-enrollment verification	68,880	68,880	2	137,760	21.98	3,027,965	N/A	N/A	Annual
§ 435.911(e) and § 435.952(e)- non-labor savings	(1,993,600)	(1,993,600)	N/A	N/A	N/A	N/A	N/A	(19,936,000)	Annual
§ 435.911(e)(9)- full Medicaid screen for LIS applicants	60,000	60,000	1.5	90,000	21.98	1,978,200	N/A	N/A	Annual
§ 435.909- deeming SSI recipients into QMB	(499,185)	(499,185)	Varies	(1,849,593)	21.98	(40,654,054)	N/A	N/A	Annual
Subtotal: Individuals	*n/a*	*(4,357,505)*	*Varies*	*(5,809,033)*	*21.98*	*(127,682,545)*	*N/A*	*(19,936,000)*	*Annual*
State Burden									

§ 435.952(e)-savings for verification	(41)	(1,593,600)	0.25	(398,400)	49.84	(19,856,256)	(9,928,128)	N/A	Annual
§ 435.911(e) and § 435.952(e)-savings for verification	(41)	(300,000)	0.42	(126,000)	49.84	(6,279,840)	(3,139,920)	N/A	Annual
§ 435.952(e)-post-enrollment verification	7	68,880	1	68,880	49.84	3,432,979	1,716,490	N/A	Annual
§ 435.952(e)(4)- life insurance verification	10	9,968	1	9,968	49.84	496,805	248,403	N/A	Annual
§ 435.952(e)(4)- life insurance verification savings	(10)	(14,952)	0.167	(2,497)	49.84	(124,450)	(62,225)	N/A	Annual
§ 435.952(e)(4)- life insurance verification savings	(10)	(9,968)	0.75	(7,476)	49.84	(372,604)	(186,302)	N/A	Annual
§ 435.911(e)(9)- full Medicaid screen for LIS applicants	51	400,000	0.25	100,000	49.84	4,984,000	2,492,000	N/A	Annual
§ 435.911(e)(9)- full Medicaid screen for LIS applicants	51	60,000	1	60,000	49.84	2,990,400	1,495,200	N/A	Annual
§ 435.911(e)(8)- denial of MSP eligibility for denied LIS applicants	51	250,000	0.167	41,750	49.84	2,080,820	1,040,410	N/A	Annual

§ 435.909-deeming SSI recipients into QMB (systems)	51	51	250	12,750	Varies	1,335,537	667,769	N/A	One-time
§ 435.909-deeming SSI recipients into QMB (systems)	51	51	100	5,100	103.60	528,360	132,090	N/A	Annual
§ 435.909-deeming SSI recipients into QMB	51	(499,185)	Varies	(849,593)	49.84	(42,343,715)	(21,171,857)	N/A	Annual
Subtotal: States	*n/a*	*(1,628,755)*	*Varies*	*(1,085,518)*	*Varies*	*(53,127,964)*	*(26,696,070)*	*N/A*	*Varies*
TOTAL	n/a	(5,986,260)	Varies	(6,894,551)	Varies	(180,810,509)	(26,696,070)	(19,936,000)	Varies

Overall, we estimate a burden of 5,517,157 hours, $212,060,525 ($392,871,034-$180,810,509) in labor cost, and $0 in non-labor costs.

Table 4 Burden Summary

	Total number of responses	Time per response (hours)	Total time (hours)	Hourly Labor cost ($/hr)	Total labor cost ($)	State share ($)	Non-labor costs ($)
Baseline Burden	9,447,010	Varies	12,411,708	Varies	392,871,034	106,964,064	19,936,000
Costs and Savings in MSP Final Rule	(5,986,260)	Varies	(6,894,551)	Varies	(180,810,509)	(26,696,070)	(19,936,000)
TOTAL	+3,460,750	Varies	+5,517,157	Varies	+212,060,525	+80,267,994	0

Collection of Information Instruments and Instruction/Guidance Documents

Other than the model MSP application, CMS does not have available any collection/reporting instruments regarding these collections. Each state maintains their own instruments for collections and reporting information from applicants and beneficiaries.

For the model MSP application, per MIPPA requirements, CMS needs to translate it into the top 10 languages other than English spoken by Medicare applicants. Based on comments received, CMS has translated the model MSP application into the following 16 languages: Arabic, French, German, Haitian Creole, Hindi, Italian, Japanese, Korean, Polish, Portuguese, Russian, Simplified Chinese, Spanish, Tagalog, Traditional Chinese and Vietnamese. CMS chose these languages based on the languages used in the Medicare Advantage multi-language insert (MLI) and reflect the top 15 non-English languages used in the United States.[29] We have revised the model MSP application based on public comments received and our internal review. We discuss all of those changes in a separate response to comments document.

13. Capital Costs

There are no new capital and maintenance costs incurred by these collections.

14. Cost to Federal Government

Section 12 of this Supporting Statement presented the total costs and the state share of those costs. The total cost minus the State share equals the federal share.

Information Collection	Total Cost ($)	State Share ($)	Federal Share ($)
Baseline state and federal costs of MSP applications, verifications, eligibility determinations	214,060,217	106,964,064	107,096,153
Costs and savings from MSP Final Rule, state and federal	(53,127,969)	(26,696,070)	(26,431,899)
Total	**160,932,248**	**80,267,994**	**80,664,254**

15. Changes to Collections of Information and Burden

As this is a new collection of information request, all changes are set out in section 12 of this Supporting Statement.

16. Publication/Tabulation Dates

[29] One of the top 15 languages is referred to as "Chinese," so we have elected to translate the two most popular dialects to ensure we are appropriately capturing all of the top languages.

There are no plans to publish the information for statistical use.

17. Expiration Date

The expiration date is displayed.

18. Certification Statement

There is no exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-1.

B. Collection of Information Employing Statistical Methods

This collection does not employ any statistical methods.