DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Keck	4-6-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10388	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: CMS file, Singleton, Deps	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Log 7. Forwarded to all Dirs —

From: Andrea Maresca <andrea.maresca@namd-us.org>
To:
CC: Matt Salo <matt.salo@namd-us.org>, Kathleen Nolan <kathleen.nolan@namd-u...
Date: 3/23/2012 2:53 PM
Subject: NAMD memo on Medicaid eligibility regulations
Attachments: NAMD memo eligibility FR 120323.doc

To All Medicaid Directors:

Attached please find a memo from NAMD regarding the final rule, "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010" [CMS-2349-F]. In the future you can also find this memo on the NAMD members' only site under "State Resources/Issue Memos."

This memo identifies some of the key changes from the proposed rule, as well as outstanding issues. Also enclosed is a more detailed summary of CMCS' responses to NAMD's comments on the proposed regulation. In addition, we are including a summary produced by the National Governors Association about the two recently published Exchange-related regulations.

We plan to provide ongoing analysis and facilitate discussion among states and with CMCS as needed. In addition we encourage Directors to submit feedback to NAMD on the final rule provisions, forthcoming guidance identified by CMCS, and other resources and tools to assist Directors as they endeavor to operationalize the rule.

If you have any questions about this document or its subject matter, please feel free to contact:
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NAMD
National Association of Medicaid Directors

To: All State Medicaid Directors
From: NAMD staff
Date: March 23, 2012
RE: Review of Final/Interim Final Medicaid eligibility regulation

On March 23, 2012, the Department of Health and Human Service's Center for Medicaid and CHIP Services (CMCS) published a final rule in the Federal Register, "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010" [CMS-2349-F]. The rule is posted at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf

This memo identifies some of the key changes from the proposed rule, as well as outstanding issues. Also enclosed is a more detailed summary of CMCS' responses to NAMD's comments on the proposed regulation. In addition, we are including a summary of the Exchange regulation produced by the National Governors Association.

We plan to provide ongoing analysis and facilitate discussion among states and with CMCS as needed. In addition we encourage Directors to submit feedback to NAMD on the final rule provisions, forthcoming guidance identified by CMCS, and other resources and tools to assist Directors as they endeavor to operationalize the rule.

Analysis of key policy changes and outstanding issues

- Verification/program integrity: In response to NAMD's comments, the final rule includes new language that requires states to develop a verification plan describing the agency's verification policies and procedures, including the standards applied by the state in determining the usefulness of the financial information described. Notably, there is no recoupment of funds between insurance affordability programs for individuals placed in the incorrect program. The verification plans, which must be available to HHS, are intended to ensure appropriate oversight and consistency between state implementation of the eligibility standards and Payment Error Rate Measurement (PERM) reviews.

  While a step in the right direction to align the changes stemming from the Medicaid eligibility rules and federal program integrity activities, gaps remain in alignment and minimizing risk for states, as discussed in the next section. Particularly in the early phases of implementation, state Medicaid agencies will likely need ongoing, intensive oversight of federal PI contractors to ensure state policies are appropriately reflected in federal PI activities and audits.

- Self-attestation: States retain flexibility to establish verification procedures to be applied in an their individual state. States have the option to accept self-attestation, where permitted by statute, but are not mandated to do so. While this policy is designed to help simplify the eligibility processes and reduce long-term administrative costs for states, in the short term states should assess administrative costs associated with this transition and what, if any, program integrity (PI) implications may arise.

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- Eligibility for non-MAGI populations. Individuals determined eligible for coverage under an eligibility group for blind or disabled individuals or for an eligibility group under which long-term services and supports (LTSS) are covered will be able to enroll for such coverage, regardless of whether or not they are determined eligible based on their MAGI household income. This exception only applies for eligibility determinations on the basis of disability or being blind or for an eligibility group under which LTSS are covered. Also, the exception from MAGI for the medically needy is only for the purpose of determining eligibility. These policy changes should help to minimize disruption and confusion for state LTSS programs and clients.

- Benchmark benefits. This rule does not provide additional guidance on benchmark benefits. The agency is working on additional guidance on Medicaid and CHIP benefit issues, which would come in the form of regulations and a letter to state health officials. CMCS also will field questions and work through benefit issues with states through the agency's new State Operations and Technical Assistance (SOTA) teams.

- Churning: The final rule includes new language to apply 36B methodologies (under the Internal Revenue Code), including use of annual income, when application of different MAGI-based methods under Medicaid than those applied under the 36B definitions otherwise would result in a gap in coverage. States may use projected annual household income for current beneficiaries for the remainder of the current calendar year. These changes are intended to help prevent a gap in coverage and churning. CMCS also clarifies that state Medicaid and CHIP programs may provide continuous coverage for eligible children, but no similar direct authority exists for adults.

  CMCS does not address other issues related to alignment of coverage between Medicaid and the Exchange insurance plans. CMCS also does not address how states could ensure continuity for families eligible for different public programs. NAMD expects additional discussion about these issues during the technical assistance to states, depending on a state's preferences and the structure of its Exchange and insurance industry generally.

- Program integrity: CMCS states rules for the PERM and Medicaid Eligibility Quality Control (MEQC) remain unchanged at this time. However, the agency is currently reviewing its program integrity programs and regulations to ensure consistency with the new eligibility standards. No timeline is provided for this analysis. This could complicate states' efforts to simultaneously develop, align, and implement new eligibility processes with program integrity protocols. In addition, NAMD continues to convey potential risks and concerns states have for coordination between the eligibility and PI efforts given states' experiences with federal PI contractors.

- FMAP methodologies and MAGI conversion: CMCS, through its contractors, continues to evaluate the proposed methodologies and issues associated with the MAGI conversion under a 10-state pilot project currently underway. Contractors are expected to begin technical assistance to all states late spring/early summer of 2012. Formal guidance on these issues is expected in the fall, possibly in October 2012. CMCS also noted states should refer to the NPRM for discussion on the collapsing of the eligibility categories. NAMD continues to convey the pressing need to expedite assistance to states and rulemaking as these issues have significant implications for Medicaid business processes.

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- Business processes: Additional details to help inform Medicaid business rules and processes were not provided in this regulation. NAMD anticipates future guidance to help inform these issues. CMCS' technical assistance and future guidance for the FMAP methodologies and MAGI conversion also will be critical to helping states get the information they need, specifically through CMCS' State Operations and Technical Assistance (SOTA) Teams which are currently being rolled out. States may wish to assess how the state Medicaid program could leverage other state, federal, or stakeholder efforts, where appropriate.

- Development of timeliness and performance standards: CMCS revised the regulation to address the issues of "timeliness of eligibility determinations" and to lay out some performance standards for efficient and accurate determinations. States must set "timeliness standards" for the maximum amount of time allowed for eligibility determinations and communicate these standards to individuals. "Performance standards" are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.

- Federally-managed data services hub fee: Fees for state access to the federal data hub are still under consideration. However, CMCS indicated it does not expect to assess such a fee to states in 2014.

- Eligibility determination: States have the option to determine whether the Medicaid agency or the Exchange (whether state or federally operated) makes the final determination for Medicaid eligibility.

- Medicaid and Exchange coordination: A written agreement is required between the Exchanges and Medicaid programs that details responsibilities and delegates authorities. The state is not required to have a single unified agency to conduct all determinations, but in the case of any sharing of responsibilities, the Medicaid agency remains responsible for the administration of the program, the setting of rules and regulations and the oversight of Medicaid-related efforts by the Exchange entities and its contractors. The agreement should include a plan for such oversight.

- Coordination with federally facilitated Exchange (FFE): CMCS discussed the FFE but did not provide significant guidance in this or related regulations.

- Medicaid coordination with Navigators: CMCS indicates that application assistance for Medicaid is distinct from that provided by the Exchange Navigators. Medicaid agencies may wish to assess the linkage between the Medicaid assistance and the Exchange Navigators and whether and how to coordinate the information and efforts, particularly if similar entities provide assistance for both programs.

Additional comment period

The following provisions of the rule were published as interim final with a 45-day comment period that ends May 8, 2012.

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- §431.300(c)(1) & (d), §431.305(b)(6) Safeguarding information on applicants/beneficiaries.
- §435.912 Timeliness and performance standards for Medicaid.
- §435.1200 Coordinated eligibility and enrollment among Medicaid, CHIP, BHP and Exchange.
- §457.340(d) Timeliness standards for CHIP.
- §457.348 – Coordinated eligibility and enrollment among CHIP and other insurance affordability programs.
- §457.350(a), (b), (c), (f), (i), (j), and (k) – Coordinated eligibility and enrollment among CHIP and other insurance affordability programs.

NAMD staff contacts

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Interim Final/Final Medicaid Eligibility Regulation: Summary of Responses to Key State Medicaid Agency Issues

Timelines

COMMENT: *NAMD's comment letter discussed challenges within the current timeline for the eligibility regulations and related efforts to comply with the statutory deadline for the Medicaid expansion. NAMD encouraged federal agencies to work with states to develop transitional, phase-in, and contingency plans, to be deployed in the event some states are unable to establish a seamless, coordinated system and networks to conduct real-time eligibility determinations and interact with the Exchange (federal or state operated) by the statutory deadlines.*

RESPONSE: CMCS did not specifically address potential challenges states may experience in meeting the statutory deadlines and other markers leading up to the effective date. The agency also did not address potential contingency plans. However, in its response CMCS encouraged and plans to work with states on testing, transitions, and phase-in of the expansion leading up to January 1, 2014.

Business rules for program integrity

COMMENT: *NAMD recommended clarifying PI rules and expectations. Specifically, we sought clarification around the shift to more streamlined, simplified eligibility processes, including CMCS' vision for increased reliance on self-attestations for eligibility determinations. NAMD raised concerns with the apparent disconnect between the proposed rules and Medicaid's federal PI standards pose significant exposure to states for aggressively adopting self-attestation. NAMD also requested CMCS consider how states that choose <u>not</u> to permit self-attestation can operate a robust and highly automated eligibility system.*

REPSONSE: In its response to comments, CMCS writes that states retain flexibility to establish verification procedures to be applied in their individual state. The proposed rule was modified to provide states the option, but states are <u>not mandated,</u> to accept self-attestation unless the statute requires other procedures (such as in the case of citizenship and immigration status). Self-attestation would be required for pregnancy.

CMCS revised §435.952(c)(2) to clarify that requests for documentation from the individual, in hard/paper copy or in other formats, are to be limited to cases where the state has determined that verification using an electronic data match, (including with another state agency) would not be effective, considering such factors as the administrative costs associated with establishing and using the data match, the administrative costs associated with relying on documentation, and the impact on program integrity and error rates in terms of the potential, both for ineligible individuals to be approved, as well as for eligible individuals to be denied coverage.

COMMENT: *NAMD encouraged federal agencies to consult with states at the front end to streamline and align program integrity rules with the proposed Medicaid and Exchange eligibility paradigms. While states do not support detailed federal requirements on appropriate databases, advance agreement on these data sources is necessary to minimize state exposure and disconnects later in the eligibility determination and redetermination processes.*

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RESPONSE: CMCS does not make specific changes to program integrity rules within this regulation. Instead, in the response to comments section, CMCS indicates its intent to ensure alignment of PERM and other program integrity rules and procedures with the new eligibility rules, including through future guidance if needed.

The agency also responded that the PERM program measures the accuracy of the agency's determinations based on the information available to the agency at the time the determination is made, not based on information that only becomes available at a later date, when the taxpayer actually files his or her tax return. CMCS writes that states remain accountable to ensure that eligibility determinations are made accurately and in accordance with state and federal policies, and their success in doing so is measured in accordance with the MEQC and PERM programs.

Regulations at §431.980(d), indicate that states are not held liable for eligibility determinations made in accordance with the state's documented policies and procedures, including self-attestation, and supported by information in the case record. The final rule does not alter these regulations or establish any new liability for states for federal financial participation (FFP) claimed on behalf of individuals erroneously determined eligible for Medicaid and enrolled in the program because the state did not take into account information not available to it at the time of the determination.

CMCS also references the State Exchange Implementation Question and Answers (http://www.medicaid.gov/Federal-Policy-Guidance/CIB-11-29-2011.pdf) and states that as long as federally-approved state procedures are followed, the PERM rules classify the case as an accurate determination. The agency writes that if a state relies on self-attestation to establish certain facts regarding eligibility consistent with federal rules, PERM audits also rely on the self-attestations provided. If federally-approved state policies require additional verifications and data collection, auditors will review cases against those standards.

COMMENT: *NAMD recommended establishing a process by which states would submit a plan to notify the federal government of the data sources it will use in its eligibility determination and renewal procedures.*

RESPONSE: CMCS adds a new paragraph to the final rule that requires state Medicaid agencies to develop, and update as appropriate, a verification plan describing the agency's verification policies and procedures, including the standards applied by the state in determining the usefulness of the financial information described in §435.948(a). The verification plans must be available to the HHS upon request, which CMCS states will enable appropriate oversight of state implementation of the eligibility standards and assure a state's policies will serve as the basis of PERM reviews. [§435.945(j)]

COMMENT: *NAMD requested that CMS provide states with a "safe harbor" from quality control and PERM reviews during the transition to the new eligibility rules and systems.*

RESPONSE: CMCS did not alter its policies or create new liability for states for FFP claimed on behalf of individuals erroneously determined eligible and enrolled in Medicaid because the state did not take into account information not available at the time of the determination. States are not held liable for eligibility determinations made in accordance with the state's documented policies and procedures, including self-attestation, and supported by information in the case record. CMCS also commented that for individuals placed in the incorrect program there is no recoupment of funds between Medicaid, CHIP, and the federal subsidies provided for Exchange-

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based coverage. The agency is reviewing its program integrity policies to ensure alignment with the eligibility regulations.

Verification and real-time eligibility determinations

***COMMENT**: NAMD requested that CMS:*

- *Define parameters for real-time while providing states flexibility to establish policies and procedures for real-time eligibility determinations.*
- *Work with states to set reasonable expectations for real-time eligibility determinations with regard to federal guidance as well as any educational and public relations activities.*
- *Facilitate collaboration between federal and state partners to appropriately convey expectations about "real-time" eligibility determinations.*

RESPONSE: CMCS revised the regulation to address the issues of "timeliness of eligibility determinations" and to lay out some performance standards for efficient and accurate determinations. States must set "timeliness standards" for the maximum amount of time allowed for eligibility determinations and communicate to individuals these standards. [§435.912] The agency did not provide additional specific timeliness standards in the regulation for the verification of new information received by states [under §435.952].

"Performance standards" are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility. However CMCS indicated it will consider, with input from states and stakeholders, standards in developing broader performance metrics relative to state eligibility and enrollment systems.
The state plan must include standards for timeliness and performance standards that:

1) Determine eligibility for Medicaid for individuals who submit applications to the single state agency or its designee.
2) Determine potential eligibility for, and transfer individuals' electronic accounts to, other insurance affordability programs [pursuant to §435.1200(e)].
3) Determine eligibility for Medicaid for individuals whose accounts are transferred from other public programs, including at initial application as well as at a regularly-scheduled renewal or due to a change in circumstances.

The timeliness and performance standards in the state plan must consider the following:

1) Capabilities and cost of generally available systems and technologies;
2) General availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility;
3) Demonstrated performance and timeliness experience of state Medicaid, CHIP and other public programs; and
4) Needs of applicants.

States must determine eligibility for disability-based coverage within 90 days and all others within 45 days of receipt of the applications. The state must also determine its "performance standards" that address the accuracy, efficiency and timeliness of the eligibility decision, as well as other aspects of enrollment process. [§435.912(c)(3)]

CMCS stated in its response to comments that states should be allowed to request, and individuals

should have the option to provide, a SSN voluntarily, as long as the conditions set out eligibility rule are met in accordance with current policy. If an SSN for a non-applicant household member is not provided, states will need to use other procedures to verify income, in accordance with CMCS' verification regulations. CMCS acknowledged that verification of income without an SSN may not occur in real time. The provisions regarding the voluntary provision of SSNs codifies policy reflected in the Tri-Agency Guidance. [§435.907(e)(3)] This will apply to the single streamlined application the Secretary develops under §435.907(b)(1), as well as other applications and supplemental forms discussed at §435.907(b) and (c).

COMMENT: *States support the flexibility afforded by the regulations to determine what is "useful" and "reasonably compatible."*

RESPONSE: CMCS added language requiring states to adopt methods of administration that are in the best interest of applicants and beneficiaries and are necessary for proper and efficient operation of the Medicaid state plan. CMCS also added new provisions to clarify that electronic sources should be consulted where possible and available and that its policy limits use of documentation only to situations when necessary and appropriate. [§435.940, §435.952]

However, CMCS also notes that states have flexibility to decide the usefulness, frequency and time-frame for conducting electronic data matches. Specifically, a state may approve eligibility based on self-attested financial information without requesting further information (including documentation from the individual) and follow up with data matching in accordance with §435.948 after enrollment, or the state can choose to conduct the match prior to finalizing the eligibility determination, subject to timeliness standards established in accordance with §435.912. States also have flexibility to determine the frequency of data matches between regular eligibility renewals and are not required to conduct data matches on an ongoing basis.

CMCS revised its language to indicate that individuals must be able to submit documents needed for verification purposes in the same manner as the application. [§435.947]

COMMENT: *NAMD raised questions about the systems and access to data necessary for real-time eligibility determination.*

RESPONSE: CMCS acknowledged that a state may use wage data to make eligibility determinations. CMCS states its requirements are intended to ensure that individuals will not be denied eligibility simply because available wage data may not be up to date. The time lag in wage data is *not* a justification for routinely relying on documentation provided by the individual. CMCS clarifies in its response to comments that if income data the state receives from the IRS is reasonably compatible with information provided by the individual, this would be considered reliable verification of income. [§435.952(d)]

CMCS clarifies that information needed to verify eligibility which is available through the federal data services hub (§435.949) must be obtained through that service. If needed information is not available through that service but can be obtained through an electronic match directly from another agency or program (§435.948), the state must obtain the information from such agency or program.

The final rule includes new language (§435.945(k)), which allows, subject to HHS approval, states to adopt alternative data sources to those listed in §435.948(a), or to obtain needed information through a mechanism other than the federal data services hub to meet certain goals. States may

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seek approval to use alternative sources either across-the-board or in specific circumstances.

CMCS clarifies the language in the rule for the consideration of cost-effectiveness when determining the usefulness of electronic data matches. States are not expected to obtain all possible electronic data. However, states must consider the costs of establishing and using the matching capability against the cost of requiring, receiving, and reviewing documentation, as well as the impact on program integrity in terms of the potential for ineligible individuals to be approved, as well as for eligible individuals to be denied coverage.

In its response to comments CMCS notes the agency is considering the treatment of fees for fiscal year 2014, but it does not anticipate charging Exchanges or state Medicaid or CHIP programs for the use of the federal hub.

COMMENT: *NAMD requested clarification and additional information concerning the quality and scope of data that will be provided by the Internal Revenue Service (IRS) or federal data that will otherwise be available to states to conduct eligibility determinations.*

RESPONSE: In its response to comments, CMCS simply states that additional information about the services available through the hub and the terms for accessing those services is under development. In the response to comments, CMCS notes that under the regulations, if verification of particular information is not available through the federal data services hub, states may continue to utilize existing electronic interfaces (SSA, DHS, etc.).

CMCS refers to the State Exchange Implementation Questions and Answers (http://www.medicaid.gov/Federal-Policy-Guidance/CIB-11-29-2011.pdf), which states that the IRS will provide the MAGI of parents or other head of household and for certain dependents who had enough income to have been required to file a tax return. This information will be taken from the most recent return (within the 2 previous years) on file. The IRS will also provide information about the size of the household shown on the returns and coding to help the state understand the information being provided and instances in which information may not be available. The IRS will not return information which can be used to verify the dependent status of a child.

CMCS removed the requirement from its proposed rule that states accept self-attestation of household size. Instead, verification of household size is now contained in §435.956(f) with age and date of birth. The IRS will not provide an individual's address.

CMCS also notes that states may not deny or terminate eligibility based on information obtained through data matches without providing the individual with an opportunity to validate or dispute such information.

COMMENT: *NAMD sought guidance regarding IRS security restrictions, and specifically whether these may limit states' access to and utilization of the data in a relevant way.*

RESPONSE: Confidentiality of return information (defined by section 6103(b)(2) of the IRC), is kept confidential under section 6103 of the IRC. No additional safeguards are proposed.

COMMENT: *States sought clarification on several issues related to income determinations, including how projected annual income relates to income averaging rules in Medicaid, requirements for point in time eligibility determinations, and how to operationalize the eligibility determination and reconciliation policies.*

RESPONSE: CMCS finalized the requirement to use current monthly income in evaluating eligibility of applicants and individuals newly enrolling in Medicaid. [§435.603(h)(1)] New language addresses concerns about unintended gaps in coverage. Specifically, the final rule applies 36B methodologies, including use of annual income, when application of different MAGI-based methods under Medicaid than those applied under the 36B definitions otherwise would result in a gap in coverage. [§435.603(i)] CMCS also revised the rule to clarify that the projected annual household income which states can opt to use for current beneficiaries is for the remainder of the current calendar year. [§435.603(h)(2)] The agency believes the revised policies should prevent a gap in coverage and "churning" between programs when current monthly income is below the Medicaid income standard, but projected annual income based on the full calendar year (including previous months) is above the Medicaid standard.

COMMENT: *NAMD requested clarification concerning when self-attestation is sufficient for the eligibility determination and that states may request additional verification should conflicts arise with an individual's attestation.*

RESPONSE: CMCS states have flexibility to decide the usefulness, frequency, and time-frame for conducting electronic data matches. A state may approve eligibility based on self-attested financial information without requesting further information (including documentation from the individual) and follow up with data matching in accordance with §435.948 after enrollment, or the state can choose to conduct the match prior to finalizing the eligibility determination, subject to timeliness standards established in accordance with §435.912.

State specific FMAP determination

COMMENT: *NAMD submitted several comments about the state-specific FMAP determination.*

RESPONSE: The FMAP methodologies and MAGI conversion processes were not addressed in this regulation. CMCS contractors are conducting a 10-state pilot study to assess these options and other potential methodologies. The contractor is scheduled to begin outreach to the broader group of states later this spring or early summer. CMCS makes clear states will not be obligated – or allowed – to operate dual or so-called shadow eligibility systems. CMCS indicated it will issue additional regulations later this year and is currently targeting release for October 2012.

Development of business requirements

COMMENT*: NAMD submitted several comments regarding the development and implementation of business rules for eligibility systems and processes.*

RESPONSE: Additional detail was not provided in this regulation, but NAMD anticipates future guidance on these topics. CMCS did discuss the issues of performance and processing standards, saying only that they would be developing additional guidance in consultation with states and

others as they develop them.

Application and enrollment forms

***COMMENT**: NAMD encouraged maximum state flexibility on the process of developing eligibility forms and related efforts.*

RESPONSE: The revised regulation did not add new requirements for things like translation of materials or additional application supports, despite many comments. Essentially, there was a stated belief that existing consumer adaptations and protections were sufficient. They also did not propose any new outreach requirements.

***COMMENT**: NAMD requested HHS consult with states in the development of the federal model application form and a streamlined approval process for the use of alternative application forms.*

RESPONSE: CMS stated it intends to take into account the many suggestions as it develops the form. There is also discussion of consultation with states and other stakeholders, but no further detail is available.

***COMMENT**: NAMD requested consideration of states that use an integrated eligibility application for Medicaid and other public assistance programs.*

RESPONSE: Although there is little further guidance on horizontal integration, CMCS does attempt to smooth the path for the use of existing applications and eligibility requirements for programs not based on MAGI. The regulation would require such forms to be submitted to the Secretary, and publicly available, but is not requiring "conversation" to MAGI or other changes to allow linkages to continue.

Eligibility determination and renewal policies

***COMMENT:** NAMD requested clarification on the process and policy for eligibility determination for certain populations.*

RESPONSE: CMCS made significant changes to the regulatory provisions regarding eligibility determinations for individuals who meet the eligibility requirements – and are determined eligible – for coverage under an eligibility group for blind or disabled individuals or for an eligibility group under which long-term services and supports (LTSS) are covered. These individuals can enroll for such coverage, regardless of whether or not they have MAGI-based household income which is at or below the applicable MAGI standard. [§435.911]

The new language provides for an exception from application of MAGI methodologies to such individuals, but only to determine eligibility on the basis of disability or being blind or for an eligibility group under which LTSS are covered. [§435.603(j)(3) and (j)(4)] The final rule clarifies that the exception from MAGI for the medically needy is only for the purpose of determining eligibility on such basis. [§435.603(j)(6)]

States may use supplemental forms in conjunction with the streamlined application to determine eligibility for non-MAGI individuals. States also may develop alternative multi-benefit

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applications which do not use supplemental forms, which must be approved by HHS. [§435.907(b)(2)] Any application or supplemental form used by a state for determining eligibility on bases other than the applicable MAGI standard is deemed to meet HHS guidelines and will not have to be approved prior to use. [§435.907(c)]

***COMMENT**: NAMD requested that states be allowed to retain the option to define renewal policies including procedures and timelines.*

RESPONSE: The regulation includes a number of tweaks and additional clarification around renewals. [§425.916]

- Redetermination (now called renewals) must occur every 12 months. Enrollees must be provided a minimum response period of 30 days.
- The renewal process should substantially mirror the original determination process. For example, if quarterly wage data was used in the original decision and is still available, it should form the basis of the renewal decision. No new information can be requested. [§435.952(c)]
- Renewal notices should include pre-populated fields to the greatest extent possible. Beneficiaries can only be asked to correct or verify available data, and additional information can be requested only if it is essential to renewal eligibility.
- The renewal form should mirror the original application around the issue of non-MAGI eligibility (e.g., checking for changes that may result in non-MAGI eligibility). An individual cannot be terminated from MAGI-based Medicaid unless it has been determined they are not eligible categorically (non-MAGI).
- In the case of no response or missing documentation during a renewal process, states must provide a minimum 90-day reconsideration period. During this time, if the renewal form/documentation is submitted, the recipient cannot be required to fill out a new application. An individual who fulfills this requirement during the reconsideration period is immediately eligible currently and retroactively.

Alignment between Medicaid and Exchanges

NAMD made a number of comments and requests around coordination and specific interactions between Medicaid and the Exchanges – whether state or federally operated. The following are some responses to these concerns. Many of these are included in [§435.1200 et seq.]

***COMMENT**: NAMD noted that enrollment periods for individuals shifting between Medicaid and Exchange did not align and could result in considerable gaps in coverage.*

RESPONSE: The regulation now requires Exchanges to cover individuals starting on the first of the month following their disenrollment from Medicaid, providing they have selected their Qualified Health Plan. Medicaid has the option, but is not required to allow individuals to remain on Medicaid through the end of the month (current regulations do not require immediate

termination). If the state provides for coverage until the end of the month in which the beneficiary becomes ineligible, FFP will be available for this extension. [§435.917]

It should be noted that the responses also clarify that there is no statutory authority for continuous eligibility in the adult population. The option for children in Medicaid and CHIP remains intact, but no authority exists for adults. CMCS clarifies that states can use projected annual salaries as the basis for income, but this is the only method for such coverage continuity.

***COMMENT**: Clarification was requested about the enrollment of applicants for non-MAGI-based Medicaid in coverage during the period of review for eligibility.*

RESPONSE: For individuals who may be eligible for Medicaid under non-MAGI categories, they can enroll in coverage for whatever program they are MAGI-eligible for, including Advanced Premium Tax Credits (APTCs) coverage in the Exchange. If they are determined to be eligible for Medicaid, the 3-month retroactive coverage Medicaid rules are in place, although Medicaid remains the secondary payer after the QHP. [§435.915].

***COMMENT**: NAMD members stressed the importance that Medicaid agencies have the capacity to maintain control of Medicaid eligibility decisions (either MAGI or non-MAGI). States also wanted to avoid the creation of multiple systems, and maintain the flexibility to allow for a single system to determine eligibility, even if housed at the Exchange.*

RESPONSE: Several different components were altered or clarified in response to this concern.

- First, the Medicaid agency can choose (regardless of who operates the Exchange) to retain the authority for determining eligibility, providing it does not request any duplicative information from the applicant.

- Second, there must be a process for the transfer of all applicant information between the Exchange and Medicaid, and a "receipt notice" must be provided back to the Exchange once the Medicaid agency receives the application. [§435.1200(d)]

- Third, the Medicaid agency can delegate eligibility determinations (MAGI, non-MAGI or both) to the Exchange entity whether it is a governmental, quasi-governmental, or private entity, but only provided that the Exchange uses the state's eligibility criteria and procedures, and that the Medicaid agency maintain oversight. This would apply in the case of a FFE as well. [§431.10(c)(3)]

***COMMENT**: NAMD stressed the importance of coordination between the Exchange and Medicaid during the eligibility determination process.*

RESPONSE: A written agreement is required between the Exchanges and Medicaid programs that details responsibilities and delegates authorities [§435.1200(b), and reflected in the Exchange regulations as well]. The state is not required to be a single unified agency, but in the case of any sharing of responsibilities, the Medicaid agency remains responsible for the administration of the program, the setting of rules and regulations and the oversight of Medicaid-related efforts by the exchange entities and its contractors. The agreement should include a plan for such oversight. In the case where the entity or its contractors demonstrate problems, the Medicaid agency must institute corrective actions. [§431.10(c)(4)]

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COMMENT: *NAMD raised concerns about conflicting or unclear direction with respect to alignment of coverage periods between Medicaid, CHIP, the Basic Health Program (where applicable), and the Exchange. We also raised concerns about the cost associated with individuals shifting or "churning" between public coverage programs and the Exchange.*

RESPONSE: Other than some clarifications about the eligibility determination process and related verification issues cited above, the new regulation does not amend the churn or split-family issues. The plan enrollment issues are cited as "beyond the scope" of the regulation. The move to make enrollment more seamless by removing the delay for exchange coverage is the only other adaptation made.

Eligibility consolidation and clarification

COMMENT*: NAMD made several requests relating to eligibility consolidation, including that CMCS provide maximum consolidation of eligibility categories and the need to make reporting and business process the least burdensome possible for states.*

RESPONSE: The new regulation does not make changes addressing these issues. However, further guidance is expected on these issues.

COMMENT*: NAMD requested clarification from the federal agencies concerning Medicaid's five-year bar rule and the interaction with eligibility for tax credits for permanent legal aliens.*

RESPONSE: The rule does not make changes for this category of individuals. CMCS does state that the requirement to furnish and verify a SSN only applies to individuals eligible for an SSN, and note that individuals not eligible for an SSN cannot be denied eligibility on that basis but still must meet the requirements related to citizenship. CMCS notes that states are still permitted to provide an exception to the SSN requirement for individuals with a well-established religious objection to obtaining an SSN. [§435.910]

Utilization of public employees in Medicaid and Exchange

COMMENT: *NAMD requested that states have the authority to determine whether public or private employees conduct the eligibility determinations for all public coverage programs.*

RESPONSE: The regulation now provides states the option to have non-state entities/employees conduct eligibility determination within a structured agreement that would continue to require the use of the state's procedures and rules, and an active oversight plan by the Medicaid agency (See discussion above on coordination). This could provide the requested flexibility for use of non-governmental agents. [§431.11(d)]

Benchmark benefit coverage

COMMENT*: NAMD commented that, under existing provisions, states are unable to require enrollment in benchmark/benchmark-equivalent coverage to optional populations above 133 percent of the FPL and requested that HHS work with Congress to advance this change.*

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RESPONSE: CMCS did not directly respond to this comment. However, they did revise the final rule to specify the statutory citations (sections 1902(a)(10)(A)(ii)(I) through (XIX)) as for the optional groups related to this requirement. Individuals eligible for the optional family planning group (section 1902(a)(10)(A)(ii)(XXI)) are not excluded from enrollment under the new optional eligibility group. [§435.218] CMCS also clarifies that only individuals eligible and enrolled as categorically needy for coverage are excluded from coverage under §435.218. The provision does not apply to individuals potentially eligible as medically needy or as spend-down beneficiaries in a 209(b) state.

In addition, the final regulations address concerns about the placement of disabled individuals and individuals needing long-term services and supports in the adult group, because individuals under the adult group would receive a benchmark benefit package that might not cover institutional services, home and community-based services, or other specialized services available under certain optional eligibility groups. [§435.911]

Cost allocation

COMMENT: *NAMD commented that the cost-allocation policies between Exchanges and Medicaid were unnecessarily burdensome.*

RESPONSE: CMCS did not make changes in this regulation based on NAMD's comment.

Regulatory Impact/Costs and Benefits

CMS' Office of the Actuary (OACT) did not change its estimate of the regulatory impact of the final rule. OACT's analysis indicates that the final rule will result in an estimated additional 24 million newly eligible and currently eligible individuals enrolling in Medicaid by 2016, including approximately 2 to 3 million individuals with primary health insurance coverage through employer-sponsored plans who would enroll in Medicaid for supplemental coverage. The OACT assumed a 95 percent take-up rate among newly eligible individuals.

OACT estimates that federal spending on Medicaid for newly and currently eligible individuals who enroll as a result of the changes made by the Affordable Care Act would increase by a total of $164 billion from FY 2012 through 2016. OACT estimates that state expenditures for individuals, who choose to enroll as a result of changes implemented by the Affordable Care Act will total approximately $14 billion for FYs 2012 through 2016. OACT notes that its estimates do not consider offsetting savings to states that will result from the final rule, to a varying degree depending on the state.

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APPENDIX A

SUMMARY OF ESTABLISHMENT AND ELIGIBILITY RULES FOR STATE EXCHANGES PREPARED BY THE NATIONAL GOVERNORS ASSOCIATION

INTRODUCTION

On March 12, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a 644-page final rule on state Exchange establishment and eligibility under the Affordable Care Act (ACA). This final rule incorporates many of the provisions originally published as two proposed rules: *Establishment of Exchanges and Qualified Health Plans*, issued July 15, 2011 and *Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers*, issued August 17, 2011.

Generally, this final rule outlines standards for:

- establishment, operation, and minimum functionality of state Exchanges, including standards for eligibility determination and enrollment in qualified health plans (QHPs) and insurance affordability programs;
- participation of health insurance issuers in an Exchange, including the minimum certification standards for QHPs; and
- participation of employers in the Small Business Health Options Program (SHOP).

EXCHANGE ESTABLISHMENT AND OPERATION

Beginning in 2014, the rule stipulates that individuals and small businesses will be able to purchase private health insurance through competitive marketplaces called Exchanges. This final rule sets forth the minimum federal standards that states must meet if they elect to establish and operate an Exchange, including the requirement that the Exchange:

- be approved or conditionally approved by HHS no later than January 1, 2013;
- be a non-profit entity established by the state, an independent public agency, or part of an existing state agency;
- have governance principles that include consumer representation, prohibit conflicts of interest and promote ethical and financial disclosure standards, unless established as part of an existing state agency;
- determine eligibility for Medicaid, CHIP, advance payments of premium tax credits, cost-sharing reductions, and the Basic Health Plan;
- certify health plans to be offered in the Exchange as qualified health plans;
- offer consumer tools and assistance to facilitate enrollment of qualified individuals, qualified employers and employees in qualified health plans, including a website to facilitate comparisons among plans, a toll-free hotline for consumer support, and a "Navigator" program for consumer outreach and education; and
- establish a Small Business Health Options Program (SHOP).

QUALIFIED HEALTH PLANS

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In order to participate in an Exchange, a health insurance issuer must be certified by the Exchange to offer qualified health plans. Exchanges must ensure health insurance issuers meet two basic requirements to be certified to offer qualified health plans:

- demonstrate compliance with minimum certification requirements and any requirement imposed by the state and the Exchange as a condition of participation or certification, including standards related to licensure and the risk adjustment program; and
- offer plans that are in the best interest of qualified individuals and have adequate provider networks to provide consumers choice.

ELIGIBLITY DETERMINATION

The state Exchange may fulfill its eligibility functions directly or indirectly though contracting arrangements with other "eligible contracting entities." Each agreement must specify the respective responsibilities of each party in connection with eligibility determination. It must also ensure applicants experience a seamless eligibility and enrollment process and that information is shared electronically via a secure interface.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

Beginning in 2014, the rule stipulates that Exchanges will operate a Small Business Health Options Program (SHOP) to provide health insurance coverage to small employers and their employees.

Exchanges will decide how a SHOP is structured and will have some flexibility to determine the size of small businesses that can participate in SHOP, including minimum participation rules and the structure of coverage choices and options for small businesses.

CHANGES AND FORTHCOMING RULEMAKING

Some provisions differ from the proposed rule. Each of these changes is outlined in the final rule under the section titled *Provisions of the Final Regulations.*

This final rule does not address all of the Exchange provisions in the ACA. Several topics are expected to be addressed through future rulemaking, including, but not limited to: the state Partnership model; certificates of exemption from the individual responsibility; appeals of individual eligibility determinations; coordination of notices between the Exchange, Medicaid, and CHIP; eligibility determination for advance payments of the premium tax credit and cost-sharing reductions (Department of the Treasury); standards for application assisters and authorized representatives; standards for multi-State plans (Office of Management and Budget); and the process and criteria by which accrediting entities will be recognized.

A portion of this rule is issued as interim final. As such, the Department of Health and Human Services (HHS) will observe a 45-day comment period on provisions related to: the involvement of agen1qxts and brokers, §155.220(a)(3); Medicaid and CHIP regulations, §155.300(b); options for conducting eligibility determinations, §155.302; eligibility standards for cost-sharing reductions, §155.305(g); timeliness standards for Exchange eligibility determinations, §155.310(e); applicants with special circumstances, §155.315(g); timeliness standards for the transmission of information for the administration of advance payments of the premium tax

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credit and cost-sharing reductions, §155.340(d); and agreements between agencies administering insurance affordability programs, §155.345(a) and §155.345(g).

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