DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Supra	4-20-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-408	[ ] Prepare reply for the Director's signature DATE DUE
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Dep, CMS file cleared 5/1/12, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 5-3-12 [ ] FOIA DATE DUE [ ] 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.			

From: Jan Polatty
To: Anthony Keck; Byron Roberts; Deirdra Singleton; John Supra; Melanie ...
CC: Brenda James
Date: 4/20/2012 1:58 PM
Subject: Fwd: Medicaid Eligibility and Exchange Final Rule_Summary & Comment Request Inquiry
Attachments: Exchange Final Rule_Summary.docx; Medicaid Eligibility FR_Summary.docx

fyi.... - Will have Brenda log.

>>> "Lape, Megan" <MLape@aphsa.org> 4/20/2012 1:44 PM >>>
HSD & NWI Members,

On March 27, HHS released the "Exchange Establishment and Eligibility" final rule. The FR combines provisions of two proposed rules issued by HHS last year: the July 15, 2011, proposed rule "Establishment of HIXs and Qualified Health Plans" and the August 17, 2011, proposed rule, "Exchange Functions in the Individual Market: Eligibility Determinations and HIX Standards for Employers." The rule provides states with a framework to set up their state-based HIXs, including minimum functions of HIX and its' governance structure, principles and responsibilities. There are several Interim Final Rules within the FR that CMS is requesting comments on by May 11, 2012.

Additionally and on March 16, the Centers for Medicare and Medicaid Services (CMS) issued final regulations implementing provisions of the Affordable Care Act of 2010 (ACA) that relate to eligibility and enrollment for Medicaid and the Children's Health Insurance Program (CHIP). Several provisions of the final rule are being issued as interim final with an opportunity for comment. The rule finalizes a proposed rule published on August 17, 2011, and codifies policy and procedural changes to Medicaid and CHIP related to eligibility, enrollment, renewals, public availability of program information, and coordination across insurance affordability programs. The rule retains many of the provisions included in the proposed rule that are intended to simplify eligibility and enrollment, expand access to coverage, and help create a coordinated system of coverage across insurance affordability programs. Certain provisions of the rule are issued on an interim final basis with comments. These provisions include certain sections of the rule relating to: safeguarding information on applicants and beneficiaries; timeliness and performance standards for Medicaid; coordinated eligibility and enrollment among insurance affordability programs; timeliness standards for CHIP; and coordinated eligibility and enrollment among CHIP and other insurance affordability programs.

As we mentioned on the NWI call on 3.27.12, we encourage members and partners to review the Exchange and Medicaid final rules (summaries are provided-please see attached) at http://www.regulations.gov/#!documentDetail;D=HHS-OS-2011-0020-2420 and http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm

<http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm> , respectively. As noted above, each of these final rules have provisions on an interim final basis with an opportunity for public comment. If you would be interested in joining an ad-hoc workgroup to formulate comments on behalf of APHSA on either the Medicaid and/or Exchange IFRs, please send me an email no later than COB Tuesday, April 24.

Thank you,

Megan

Megan Lape, MSW

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Exchange Final Rule

On March 27, HHS released the "Exchange Establishment and Eligibility" final rule. The FR combines provisions of two proposed rules issued by HHS last year: the July 15, 2011, proposed rule "Establishment of HIXs and Qualified Health Plans" and the August 17, 2011, proposed rule, "Exchange Functions in the Individual Market: Eligibility Determinations and HIX Standards for Employers." The rule provides states with a framework to set up their state-based HIXs, including minimum functions of HIX and its' governance structure, principles and responsibilities. The FR is available at http://www.regulations.gov/#!documentDetail;D=HHS-OS-2011-0020-2420 and comments on the Interim Final Rules (IFR) are due by May 11, 2012.

The ACA provides that a state's plan to operate an HIX must be approved by HHS no later than January 1, 2013. However, the FR allows for conditional approval if the state is advanced in its' preparation but cannot demonstrate complete readiness by January 1, 2013. The FR also allows states that are not ready for 2014 to apply to operate their HIX for 2015 or any subsequent year. HHS will continue working with states to support their progress, including through new funding opportunities. New funding will be available for all HIX models through a final award date no later than December 31, 2014. The budget and project period for Level One HIX Establishment Grants is up to one year from the date of award and for Level Two Establishment Grants is up to three years from the date of award.

Within the FR, there are several IFRs that HHS is seeking comment on by May 11, 2012.
Interim FRs HHS is seeking comment on:

1. (155.300) – Definitions and general standards for eligibility determinations.
Based on the new Medicaid eligibility rules, the HIX is required to enter into agreements with agencies administering Medicaid, CHIP and the BHP to:

- minimize the burden on individuals;
- ensure prompt (re)determinations of eligibility and enrollment in the appropriate program *without undue delay*;
- ensure compliance with individuals requesting additional screening (HIX must notify the applicant of the opportunity for a full determination for Medicaid and provide the opportunity to them if the applicant requests it. Additionally, the HIX is required to determine an applicant eligible for Medicaid if they meet the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI-based income (e.g., pregnant women, individs under 19, parent or caretaker of dependent child, or is under 65 and not receiving Medicare Part A or B);
- Do an eligibility redetermination during a benefit y ear if new financial info is reported or received
- Do an annual redetermination (required by HIX)

2. (155.302) – Options for conducting eligibility determinations.
States have a couple of options for how they want to conduct their eligibility determinations. They can:

1) Have the HIX directly do them or contract with an eligible entity (which is codified in 155.110 as a governmental agency (independent public agency or part of a preexisting state agency) or a non-profit entity provided that they are either incorporated and subject to state or

states laws (depending on the type of HIX), and has demonstrated experience with individual and group health insurance markets and benefit coverage and is not a health insurer or 2) is a state Medicaid agency or other state entity that meets those aforementioned qualifications

OR

2) Combination approach meaning that an HIX or a contracted eligible entity or both may decide to do one or both of the following:

i. The HIX may conduct an eligibility assessment for Medicaid and CHIP, rather than an eligibility determination, as long as the HIX:

- makes the assessment on MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent w/ the Medicaid Eligibility FR;
- provides applicants and the Medicaid/CHIP agency with notices and other activities applicable with law;
- For any applicant found eligible, the HIX would transmit all the information to the appropriate agency promptly and without undue delay;
- For any applicant found ineligible, the HIX would determine them ineligible for Medicaid and CHIP and then begin the eligibility determination for the premium tax credits and cost-sharing reductions. Additionally, the HIX would provide the applicant with the opportunity to withdraw their Medicaid/CHIP application or to request a full determination
- Adheres to the eligibility determination for Medicaid/CHIP by the applicable state agency;
- HIX and state Medicaid and/or CHIP agencies enter in an agreement delineating their determination responsibilities

ii. The second part refers to the advance payment of premium tax credits and cost-sharing.

155.310: Eligibility Process

e: Timeliness Standards—

1) The HIX must determine eligibility promptly and without undue delay.

2) The HIX must assess the timeliness of eligibility determinations based on the period from the date of application to the date the HIX notifies the applicant of its decision or the date the HIX transfers the application to another agency administering an insurance affordability program, when applicable.

For human service agencies, the questions/considerations are:

1) What types of entities will be now conducting eligibility determinations?

2) If counties do remain conducting eligibility determinations, what does that mean for cost allocation and consumer flow?

3) The upgrading and/or development of state Medicaid systems not bringing along their human services systems creates different data systems and sources. How will human service caseworkers gain access to these systems and sources? (E.g., if one system is upgraded and one isn't, how do they share data?)

What other issues/concerns do states/counties see here? What are the potential issues or special considerations that need to be given to these new eligibility processes?

- **Additional IFRs w/ comment requests:**

  - 155.220 (a)(3) - Ability of a state to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for Qualified Health Plans;
  - 155.305(g) - Eligibility standards for cost-sharing reductions;
  - 155.315(g) - Verification for applicants with special circumstances

  - 155.340(d) - Timeliness standards for transmitting information for the administration of advance payments of the premium tax credits and cost-sharing reductions
  - 155.345(a) and 155.345(g) - Agreements between agencies administering the insurance affordability programs

While most of the FR is consistent w/ what was included in the proposed rule, below highlights some of the changes made to the FR that promote state flexibility.

- Consistent with APD process, HHS will consult with relevant federal agencies in the approval of a state HIX blueprint;
- Significant changes to the HIX Blueprint will be reviewed and a written approval or denial will be issued within 60 days or the approval is deemed automatic after that period;
- Establishes that other state agencies are eligible to be contracting entities;
- Removes the appeals of eligibility determinations as a minimum HIX function;
- Includes privacy and security principles based on the Fair Information Practice and Principles (FIPPs) framework adopted by ONCHIT and a list of critical security outcomes;
- Expands the scope of info to which the standards apply to information created, used, or disclosed by an HIX or other individual entity;
- Establishes that HIXs must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically;
- Adds standards for data matching and sharing arrangements that facilitate the sharing of personally identifiable information b/w the HIX and agencies administering Medicaid, CHIP or the BHP;
- Allows the HIX to expand data matching during the benefit year within certain standards w/o HHS approval;
- Adds language clarifying that applicants must provide SSNs (of which will be referred to as taxpayer identification numbers).

Medicaid Eligibility Final Rule

On March 16, the Centers for Medicare and Medicaid Services (CMS) issued final regulations implementing provisions of the Affordable Care Act of 2010 (ACA) that relate to eligibility and enrollment for Medicaid and the Children's Health Insurance Program (CHIP). Several provisions of the final rule are being issued as interim final with an opportunity for comment. The rule finalizes a proposed rule published on August 17, 2011, and codifies policy and procedural changes to Medicaid and CHIP related to eligibility, enrollment, renewals, public availability of program information, and coordination across insurance affordability programs. The rule retains many of the provisions included in the proposed rule that are intended to simplify eligibility and enrollment, expand access to coverage, and help create a coordinated system of coverage across insurance affordability programs. At the same time, there are several major changes from the proposed rule to the final rule. There are also areas where CMS indicates that additional guidance and rulemaking will be forthcoming.

Major changes include provisions regarding eligibility for people with disabilities and those needing long-term care. The final rule provides that individuals who meet the eligibility requirements for coverage based on Modified Adjusted Gross Income (MAGI) standards may still be determined eligible for optional Medicaid eligibility groups based on disability or long-term care needs. Another significant change allows Medicaid agencies to delegate eligibility determinations to nongovernmental Insurance Exchanges for MAGI populations, and strengthens safeguards that must be in place when eligibility is delegated to public or private entities. Of significance to human service agencies, the final rule clarifies that states are permitted to develop alternative multi-benefit applications, and notes that CMS looks forward to working with states interested in developing streamlined multi-benefit applications. In regards to eligibility verification, the final rule provides that states will develop verification plans that describe verification policies and procedures. For additional information on changes in the final rule, see CMS' summary at http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Medicaid-Eligibility-and-Enrollment-Final-Rule-Section-by-Section-Summary.pdf.

As noted above, the final rule identifies areas where guidance will be issued. For example, CMS will provide detailed guidance on the treatment of all types of income under MAGI-based methodologies. The Secretary of Health and Human Services will provide additional guidance on timeliness and performance standards for eligibility determinations. Additionally, the provisions in the proposed rule regarding Federal medical assistance percentages (FMAP) for newly eligible individuals and expansion states have been removed from the final rule and will be addressed in future rulemaking. The final rule also identifies several areas where states may be able to use an existing demonstration authority such as 1115 waiver authority to test approaches. For example, as noted in the rule, a state could seek to convert standards for MAGI-excepted groups to MAGI-based methods through a demonstration under section 1115.

These final regulations are effective on January 1, 2014. Certain provisions of the rule are issued on an interim final basis with comments due no later than 5 p.m. Eastern Standard Time on May 7, 2012. These provisions include certain sections of the rule relating to: safeguarding information on applicants and beneficiaries; timeliness and performance standards for Medicaid; coordinated eligibility and enrollment among insurance affordability programs; timeliness standards for CHIP; and coordinated eligibility and enrollment among CHIP and other insurance affordability programs. The final rule, published in the Federal Register on March 23, 2012, is available at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm. Additionally, CMS began hosting a series of webinars on March 22 on topics covered in the regulation. For more information, visit http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html.

Log #408

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

May 1, 2012

Senator David Thomas
The Senate of South Carolina
Suite 410 Gressette Building
PO Box 142
Columbia, South Carolina 29202

Dear Senator Thomas:

Thank you for your inquiry regarding the International Classification of Diseases, Tenth Revision (ICD-10). The timeline for implementation of a specific ICD version for the United States is determined by the U.S. Secretary of Health and Human Services (HHS). At this time, the transition to ICD-10 in the U.S. is planned for October 1, 2013. Additional information about the ICD system and work already underway in South Carolina is included below.

ICD-10 is a medical classification list for the coding of diagnoses and inpatient hospital procedures. The ICD-10 code set allows more than 14,000 different codes and permits the tracking of many new diagnoses. On January 15, 2009, HHS published the final regulation that adopted ICD-10 to replace the current medical classification, ICD-9. All health plans, clearinghouses, and health care providers using electronic transactions must transition to the ICD-10 code sets on the compliance date of October 1, 2013.

The South Carolina Department of Health and Human Services (SCDHHS) strategy for attaining ICD-10 compliance includes evaluating existing policies, processes and the Medicaid Management Information System (MMIS). SCDHHS is on schedule to implement a solution that processes ICD-10 codes on October 1, 2013.

On April 17, 2012, HHS Secretary Kathleen Sebelius announced a proposed rule that would delay the compliance date for ICD-10 from October 1, 2013 to October 1, 2014. The proposed rule has been posted to the Federal Register, which marks the beginning of a 30-day comment period. All comments are due to HHS no later than May 17, 2012.

SCDHHS will continue its process of transitioning to ICD-10 by the current compliance date until a final rule comes from HHS stating otherwise. Important information related to SCDHHS ICD-10 implementation including project status, pertinent ICD-10 links, as well as other relevant information to assist with this transition can be found at:

http://www2.scdhhs.gov/icd-10

I hope this information is clear and helpful. If you have any further questions please contact Rhonda Morrison, Program Director, Project Management Office at (803) 898-2999.

Sincerely,

Anthony E. Keck
Director

Office of the Director
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Brenda James

From: Teeshla Curtis <CURTIST@scdhhs.gov>
To: Brenda James <JAMESBR@scdhhs.gov>, Rhonda Morrison <Morrison@scdhhs.gov>
Date: 5/2/2012 1:00 PM
CC: Edmond Brown <BROWNED@scdhhs.gov>
Attachments: Ref Log 000408 Response.pdf

Brenda,

Attached is the response for Log 408.

Teeshla Curtis

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