

medicaid and the uninsured

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Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's August 17, 2011 Proposed Rule and Key Issues to Consider

Executive Summary

The Affordable Care Act (ACA) increases access to health insurance beginning in 2014 through a coordinated system of "insurance affordability programs," including Medicaid, the Children's Health Insurance Program (CHIP), premium tax credits for coverage provided through new Affordable Insurance Exchanges (Exchanges), and optional state-established Basic Health Programs. On August 17, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to implement the ACA provisions relating to Medicaid eligibility, enrollment simplification, and coordination. This brief summarizes the major provisions of CMS's proposed rule.

Medicaid Eligibility Under Reform

CMS's proposed rule implements the ACA provisions that expand Medicaid eligibility and simplify existing eligibility groups. Most existing eligibility categories are collapsed into three broad groups: parents, pregnant women, and children under age 19. As of January 2014, states must extend eligibility to a new "adult group," which includes all non-pregnant individuals ages 19 to 65 with household incomes at or below 133% FPL. Further, beginning in January, 2014, states may choose to cover non-elderly individuals, including pregnant women and children, with incomes above 133% FPL.

Under the ACA, Medicaid financial eligibility for most groups will be based on modified adjusted gross income (MAGI), as defined in the Internal Revenue Code. The proposed rule generally adopts MAGI methods for counting household income, eliminating all of the various income exclusions and disregards currently used by states. CMS also proposes to generally align references to "family size" in the current Medicaid rules with the MAGI definition of "household" and proposes household composition rules for individuals, such as non-tax filers, who are not addressed by MAGI methods. The change to MAGI methods will result in some individuals losing Medicaid eligibility. Certain groups are exempt from the use of MAGI and will continue to have their financial eligibility determined based on existing Medicaid rules. CMS also proposes to amend the definition of state residency for adults and children to simplify the language and coordinate with the Exchanges.

Under the ACA, Medicaid eligibility remains based on monthly income at the time of application, while eligibility for premium tax credits for Exchange coverage is based on annual income. The proposed rule provides states new options to assess continuing Medicaid eligibility based on projected annual income or by taking into account anticipated changes in income, which would minimize coverage gaps and transitions between Medicaid and Exchange coverage due to small income fluctuations.

Application, Enrollment and Renewal Procedures

The ACA requires the Secretary to develop a single streamlined application for all insurance affordability programs. The application must be available for individuals to submit online, by telephone, by mail, in person, and by fax. In addition, certain information about the Medicaid program must be made available via a website as well as orally and in writing. Non-applicants (seeking Medicaid coverage for someone other than themselves) may not be required to provide a Social Security number or information regarding citizenship, nationality or immigration status. CMS proposes that state Medicaid agencies must provide assistance to applicants in person, by telephone, and online.

The Medicaid eligibility determination process will begin with a MAGI screen. If an individual is not found eligible for a MAGI group, the state must collect necessary information and determine eligibility under all other Medicaid eligibility categories (i.e., MAGI-exempt groups) and potential eligibility for premium tax credits in an Exchange. CMS proposes that it develop a set of performance standards in collaboration with the states for eligibility and enrollment in addition to the existing rule requiring non-disability based eligibility determinations to be completed within 45 days.

States will rely, to the maximum extent possible, on electronic data matches with trusted third party sources to verify information provided by applicants. The Secretary will establish an electronic verification system to enable states to verify information with other federal agencies. States are expressly permitted to accept attestation of all Medicaid eligibility criteria, except for citizenship and immigration status, which must be verified. If information provided by an individual is “reasonably compatible” with information obtained from other trusted sources, the agency may not request additional information, including paper documentation, from the individual.

The rule proposes a 12-month renewal period for MAGI-based Medicaid beneficiaries. The rule further proposes that state agencies seek to renew eligibility first based on available information. To avoid unnecessary reapplications, CMS proposes a reconsideration period for individuals who lose coverage because a renewal form is not returned timely, but who respond within a reasonable period of time after coverage terminates. CMS contemplates adding a provision (not included in the proposed rule) to extend Medicaid coverage until the end of the month in which the termination notice period ends. CMS does not propose to extend the changes in the redetermination process to MAGI-exempt populations.

Coordination Between Medicaid and Exchanges

State Medicaid agencies will enter into one or more agreements with an Exchange and other insurance affordability programs to coordinate eligibility determinations and enrollment. The state Medicaid agency must ensure that any individual who is determined ineligible for Medicaid is screened for potential eligibility for benefits available through an Exchange. The state Medicaid agency must determine Medicaid eligibility “promptly and without undue delay” for any individual determined potentially Medicaid-eligible by an Exchange. If an Exchange finds an individual eligible for Medicaid under MAGI, the state agency must enroll the individual “promptly and without undue delay,” as if the decision had been made by the state Medicaid agency. CMS proposes allowing the state Medicaid agency to delegate MAGI eligibility determinations to Exchanges that are public agencies and seeks comment on how to address this issue for private entity Exchanges.

Proposed Methodologies for Applying Increased Federal Medical Assistance Percentage (FMAP)

CMS proposes to allow states to choose among three methodologies to determine newly eligible individuals whose expenditures are eligible for increased FMAP. The proposed rule also specifies the federal matching rates for newly eligible individuals as well as the increased FMAP for expansion states that already had opted to cover certain adults prior to the implementation of health reform.

Looking Ahead

The proposed Medicaid rule seeks to create a simple, streamlined enrollment experience for individuals. The proposed regulations are subject to revision based upon input received during the comment period. In reviewing the rules, it will be important for stakeholders to consider a number of issues, including the balance of preserving Medicaid eligibility versus promoting simplicity of administration, areas where differences in program rules or processes remain, state options versus national standards, potential implementation challenges, as well as areas that require further information.

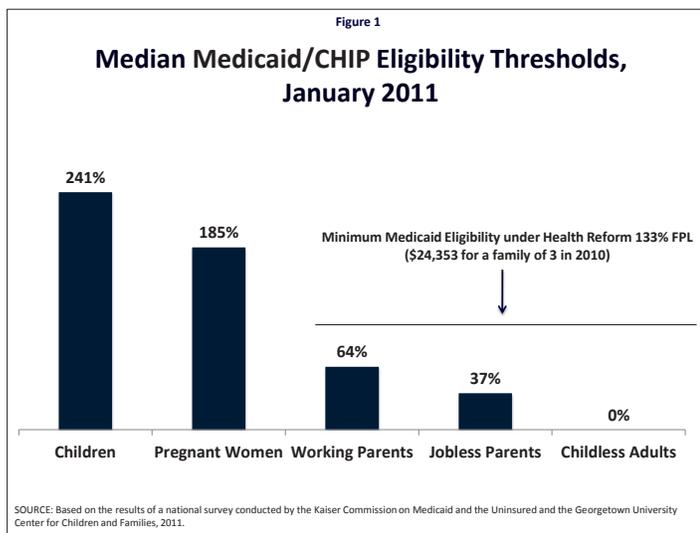
Introduction

The Affordable Care Act (ACA) increases access to health insurance beginning in 2014 through a coordinated system of “insurance affordability programs,” including Medicaid, the Children’s Health Insurance Program (CHIP), premium tax credits for coverage provided through new Affordable Insurance Exchanges (Exchanges), and optional state-established Basic Health Programs. On August 17, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to implement the ACA provisions relating to Medicaid and CHIP eligibility, enrollment simplification, and coordination.¹ It also proposed several methodologies to determine the increased federal matching payments that will be available for state expenditures for “newly eligible” individuals and “expansion states.” Simultaneously, the Department of Health and Human Services issued a proposed rule regarding eligibility for premium tax credits and cost-sharing reductions and enrollment in Exchanges, and the Department of the Treasury issued a proposed rule regarding the health insurance premium assistance tax credit.

This brief summarizes the major provisions of CMS’s proposed rule regarding Medicaid eligibility, enrollment simplification, coordination and the proposed federal matching payment methodology.² (This brief does not address provisions specific to the CHIP program or the provisions included in the Exchange and Treasury proposed rules, except as they are referenced by the Medicaid provisions.)

Medicaid Eligibility Categories Under Reform

The current Medicaid eligibility system is complex with numerous eligibility categories and associated technical criteria. These eligibility groups include both federal core groups that states are required to cover as a condition of receiving federal Medicaid matching funds, as well as state expansion groups that states may choose to cover with federal funds. Until the passage of the ACA, states could not receive federal Medicaid matching funds to cover low-income non-disabled, non-elderly adults without dependent children, unless the state obtained a waiver. Under the current system, states have largely expanded coverage of children and individuals in need of institutional care. However, income eligibility limits for parents remain low and, in the large majority of states, other non-disabled adults are not eligible for Medicaid, regardless of their income (Figure 1).



One major component of the ACA is the expansion of Medicaid eligibility to low-income adults who were previously excluded from the program. Effective April 2011, the ACA provided a new option for states to cover these adults. Moreover, beginning in 2014, it establishes a new minimum eligibility floor of 133% of the federal poverty level (FPL) for adults.

CMS's proposed rule implements the ACA provisions that expand eligibility and consolidate most existing Medicaid eligibility groups into broader simplified categories (Table 1). Specifically, under the proposed rule:

Most existing Medicaid eligibility categories are collapsed into three broad groups: parents, pregnant women,³ and children under age 19. States would set income eligibility standards for these three groups, subject to federally specified minimums and maximums. The movement to these groups is not intended to change current eligibility levels for these populations, but rather to streamline and consolidate existing eligibility categories.⁴

As of January 2014, states must extend eligibility to a new "adult group," which includes all non-pregnant individuals ages 19 to 65 with household incomes at or below 133% FPL. The new adult group effectuates the ACA's "Medicaid expansion." Moreover, it includes parents, adults who do not live with dependent children, and individuals with disabilities with incomes below 133% FPL who are currently covered at state option. Parents enrolling under this category must have their children enrolled in Medicaid, CHIP, or other "minimum essential coverage."

Further, beginning January 2014, states may choose to cover non-elderly individuals, who are not otherwise eligible for Medicaid, including pregnant women and children, with incomes above 133% FPL. Under this category, states may cover individuals up to a maximum standard set by the state. Pursuant to an approved state plan amendment, states may phase-in coverage of the new group by category (e.g., pregnant women, children), provided that the state does not cover people with higher incomes before people with lower incomes are covered.⁵ Moreover, as with the new adult group described above, any parents enrolled under this category must have their children enrolled in Medicaid, CHIP, or other "minimum essential coverage."

**Table 1:
Medicaid Eligibility Categories Under the Proposed Rule**

	Minimum Income Limit	Maximum Optional Expansion Income Limit
Parents of dependent children and caretaker relatives	State's AFDC income standard for household as of May 1, 1988, plus 5 percentage points FPL income disregard	State's AFDC income standard as of July 16, 1996 (increased by no more than the percentage increase in the Consumer Price Index for urban consumers since that date) OR A higher effective income level a state had in place for Section 1931 parents as of March 23, 2010, or December 31, 2013 if higher
Pregnant women (including 60 days post-partum)	133% FPL, plus 5 percentage points FPL income disregard	185% FPL OR A higher effective income level a state had in place as of March 23, 2010, or December 13, 2013 if higher
Children under age 19	133% FPL, plus 5 percentage points FPL income disregard	For infants under age 1: 185% FPL For other children: 133% FPL OR A higher effective income level a state had in place (by age group) as of March 23, 2010, or December 31, 2013 if higher
Adults ≤133% FPL	133% FPL, plus 5 percentage points FPL income disregard	133% FPL, plus 5 percentage points FPL income disregard
Individuals >133% FPL	N/A (provided at state option)	A state-established standard >133% FPL (including 5 percentage points FPL income disregard)
<p>Table notes: Under the proposed rule, the minimum standards will <u>not</u> be converted to MAGI-equivalents based on income disregards used by the state. However, the maximum limits that are tied to states effective income levels as of March 23, 2010 (or December 31, 2013 if higher) will be converted to MAGI-equivalent thresholds that include income disregards. The minimum standards for pregnant women and infants under age 1 will be higher for some states that had higher limits in effect on December 19, 1989, or had authorizing legislation to do so as of July 1, 1989.</p>		

Determining Medicaid Eligibility Based on Modified Adjusted Gross Income (MAGI)

In addition to expanding Medicaid eligibility and consolidating existing eligibility categories, the ACA will also change how financial eligibility is determined for Medicaid. As of January 2014, financial eligibility will be based on modified adjusted gross income (MAGI) methods, as defined in the Internal Revenue Code. The move to MAGI will result in some changes from current Medicaid rules related to calculating family size and income and will largely align Medicaid financial eligibility determinations with the standards used to determine eligibility for advance payments of premium tax credits and cost-sharing reductions through the Exchanges. With regard to determining eligibility, CMS also proposes to amend the definitions of state residency for adults and children to simplify the language and coordinate with the Exchanges. As put forth in the proposed rule:

Medicaid financial eligibility for most eligibility categories will be based on the MAGI definition of household income. Certain groups are exempt from use of MAGI and will continue to have their financial eligibility determined based on existing Medicaid rules (Text Box 1). CMS proposes that states must use MAGI methods at the next regularly scheduled eligibility determination after December 31, 2013, or March 31, 2014, whichever is later, if the individual would lose eligibility as a result of the change to MAGI. The preamble to the proposed rule indicates that CMS may allow states to convert to MAGI methods under a Section 1115 waiver prior to 2014.

**Text Box 1:
Individuals Exempt from MAGI**

- Individuals eligible for Medicaid on a basis that does not require the determination of income by the Medicaid agency (e.g., SSI beneficiaries)
- Individuals age 65 and older
- Individuals who qualify for Medicaid as blind/disabled (if income exceeds 133% FPL, and they, therefore, do not fall into the new adult group)
- Individuals whose Medicaid eligibility is based on the need for institutional or home and community-based long-term care services, including nursing home or another level-of-care equivalent (if income exceeds standards for new MAGI eligibility groups)
- Individuals eligible for Medicare cost-sharing assistance (only for determining eligibility for Medicare cost-sharing assistance)
- Medically needy individuals (only for determining eligibility for the medically needy category)

Although MAGI is determined on an annual basis, states still must determine Medicaid eligibility based on income as of the point in time of application. Thus, initial Medicaid eligibility for new applicants and other individuals not receiving Medicaid at the time of their eligibility determination will continue to be based on the current income actually available to an individual in a given month. For current Medicaid beneficiaries subject to MAGI, CMS proposes that states may elect to base financial eligibility determinations on either current monthly income or projected annual income, taking into account reasonably anticipated changes in income. Actual changes in income still must be reported by applicants and beneficiaries and acted upon by the state Medicaid agency. The option to rely on projected annual income for current beneficiaries enables states to align Medicaid income counting rules with the rules used to determine eligibility for premium tax credits through the Exchanges. This would, if adopted by states, prevent coverage gaps and minimize individuals cycling between programs

based on small income fluctuations. CMS notes, however, that if a state does not take up this option, individuals could be determined both ineligible for Medicaid as well as for tax credits as a result of income fluctuations. For example, an individual employed as a landscaper can reasonably anticipate that his income will be higher in the summer and lower in the winter. Accounting for these seasonal fluctuations would help ensure that such individuals have continuous coverage.

The proposed rule generally adopts MAGI methods for counting household income⁶ and eliminates all of the various income exclusions and disregards currently used by states.⁷ In addition, there are no resource tests under MAGI. Using MAGI methods, household income will be the sum of the income of every individual who is in the household, minus a standard income disregard of 5 percentage points of the FPL for the applicable family size. To account for the elimination of income disregards, states must convert their current income standards for existing Medicaid eligibility groups to MAGI-equivalent income standards. CMS will issue separate guidance on how to make this conversion.

CMS proposes to generally align references to “family size” in the current Medicaid rules with the definition of “household” under MAGI. CMS has determined that there are a small number of situations in which MAGI rules and current Medicaid rules result in different household compositions. In some of these cases, CMS has proposed to adopt the MAGI rules, noting that doing so will result in some individuals losing Medicaid eligibility (while likely becoming eligible for coverage through an Exchange), but promote simplicity of administration. In other cases, CMS has proposed retaining the current Medicaid rules.⁸ Groups that may lose Medicaid eligibility as a result of the transition to MAGI include children age 21 or older whose parents claim them as tax dependents; families with step-parents and step-children in states where step-parents are not legally required to support step-children; and families in which one or more children are required to file a tax return, where the child’s income would not count under existing Medicaid rules. CMS also has proposed household rules for non-tax filers and individuals who are not claimed as tax dependents, who are not addressed by MAGI methods in the Internal Revenue Code.⁹

Application, Enrollment, and Renewal Procedures

In addition to the changes in eligibility categories and the eligibility determination rules, the ACA includes requirements designed to create a simple, streamlined integrated enrollment process for Medicaid, CHIP, and Exchange coverage. The proposed rule addresses a number of provisions related to Medicaid application, enrollment, and renewal procedures to achieve this new system.

Applications and Application Assistance

The ACA requires the Secretary to develop and provide states with a single streamlined application for all insurance affordability programs. CMS’s proposed rule does not address the contents of the single streamlined application; rather, the preamble indicates that the Secretary will develop the data elements for the application in consultation with states and consumer groups. CMS also proposes that states may develop and use an alternative single streamlined application for all insurance affordability programs, subject to the Secretary’s approval, that is no more burdensome than the Secretary’s application. Future guidance will address issues related to accessibility of the application for people with Limited English Proficiency and people with disabilities. For applicants who are not eligible under a MAGI category, the proposed rule offers two options for gathering necessary additional information, including using supplemental forms or developing an alternative application, subject to Secretarial approval.

The application must be available for individuals to submit online, by telephone, by mail, in person, and by fax. Moreover, states must accept applications signed electronically, including telephonically recorded signatures, by fax, and other electronic means. Information on Medicaid eligibility requirements, covered services, and applicant/beneficiary rights and responsibilities also must be made available via a website as well as orally and in writing. The information must be provided in “simple and understandable terms” and be accessible to people with disabilities and people with Limited English Proficiency. The website must allow individuals to obtain information about, apply for, enroll in, and renew eligibility for Medicaid and other insurance affordability programs and other activities as appropriate

Non-applicants (seeking Medicaid coverage for someone other than themselves) may not be required to provide a Social Security number or information regarding citizenship, nationality, or immigration status. However, states may request Social Security numbers from non-applicants on a voluntary basis, so long as the information is safeguarded and used only for purposes directly connected to administration of the state Medicaid plan, such as to determine the non-applicant’s potential Medicaid eligibility. Medicaid applicants and beneficiaries must supply Social Security numbers. Current Medicaid regulations provide that Medicaid agencies must assist applicants with obtaining a Social Security number if they do not have one.

CMS proposes that state Medicaid agencies must provide assistance to applicants in person, over the telephone, and online. Such assistance must be accessible to people with disabilities and people with Limited English Proficiency. Specifically, the proposed regulations require the state Medicaid agency to assist “any individual seeking help with the application or redetermination process.” CMS will provide additional sub-regulatory guidance and technical assistance in this area, and notes that the ACA includes a directive for states to conduct outreach to vulnerable underserved populations, with a particular focus on the newly eligible, people with disabilities, and underserved minorities.

Streamlined Enrollment Process

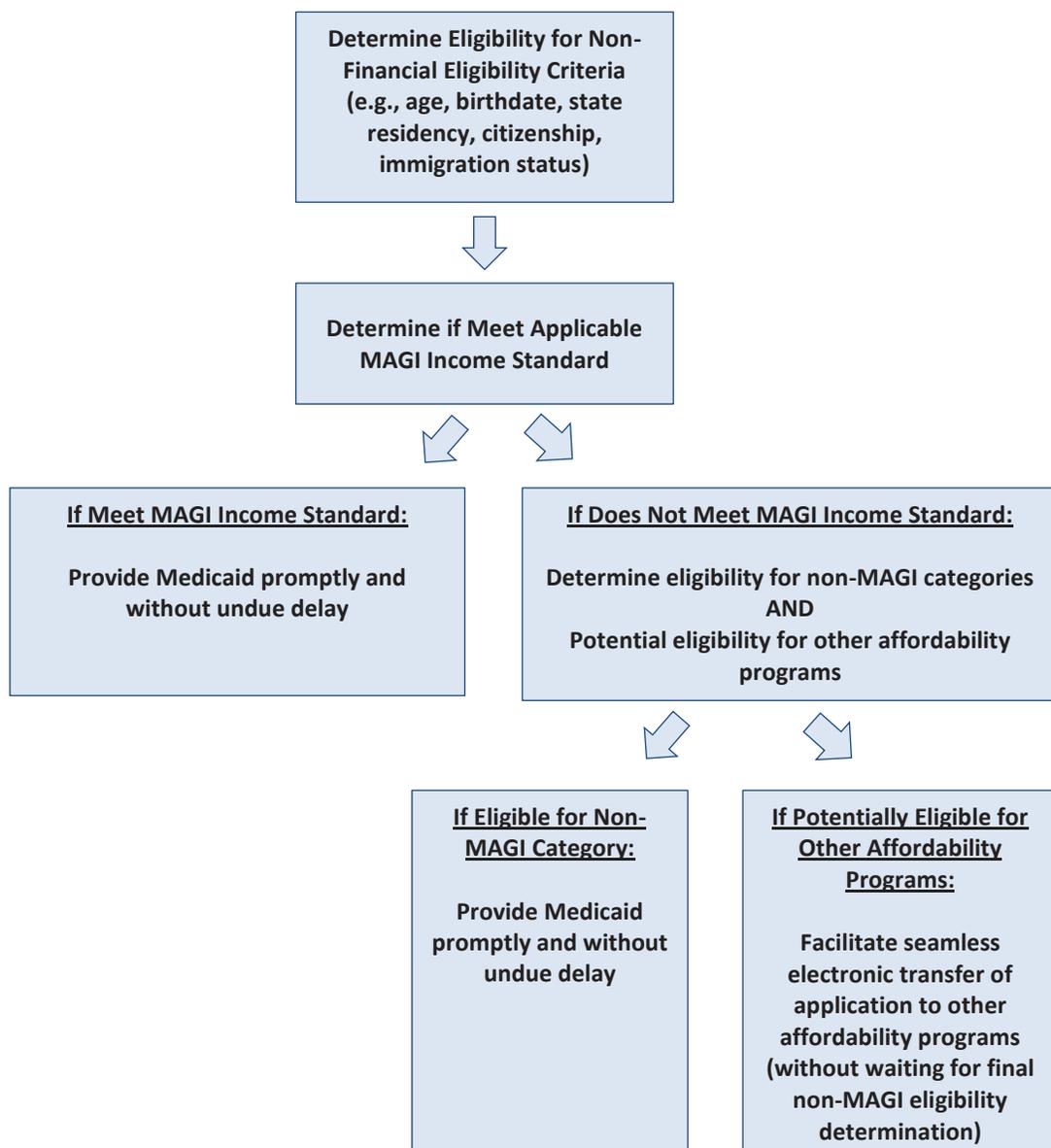
The Medicaid eligibility determination process will begin with a MAGI screen (see Figure 1, next page). For every individual who submits an application and meets the non-financial eligibility criteria, the state Medicaid agency first must assess whether the individual has household income at or below the applicable MAGI standard. Based on this initial screen, the state must provide Medicaid “promptly and without undue delay” to individuals with household income at or below the applicable MAGI standard. If the state provides coverage to the new optional group of individuals with household income above 133% FPL, it must determine individuals eligible under that group, unless the state can determine eligibility for another optional coverage group (e.g., disability, level of care, resources) based solely on the information available in the application.

If an individual is not found eligible for a MAGI group, the state must then collect the necessary information and determine eligibility under all other Medicaid eligibility categories (i.e., MAGI-exempt groups) and potential eligibility for premium tax credits in an Exchange. Medicaid eligibility determinations based on blindness or disability status should occur at the same time as the state Medicaid agency’s assessment of potential eligibility for premium tax credits in an Exchange. Those determined eligible through another Medicaid category must be provided benefits “promptly and without undue delay.” For those found to be potentially eligible for premium tax credits in an Exchange, the state Medicaid agency must provide the individual’s electronic account to the other program

“promptly and without undue delay.” If eligible, individuals should receive premium tax credits while their eligibility for Medicaid based on disability status is being determined.

CMS proposes that it collaborate with states to develop performance standards and metrics for the streamlined coordinated eligibility and enrollment system, which are not contained in the proposed rule. While the existing rule that state agencies must determine eligibility on a Medicaid application within a maximum of 45 days for non-disability-based applicants is retained (and redesignated) in the proposed rule, that standard does not explicitly apply as an outside limit for enrolling eligible applicants, nor is it clear that the existing standard applies to MAGI populations.

**Figure 1:
State Medicaid Agency Application Processing Flowchart**



Verification of Eligibility

CMS's proposed rule streamlines and simplifies the eligibility verification process, seeking to minimize burdens on states and applicants. However, CMS reaffirms that nothing in the proposed rule shall prevent states from acting to ensure program integrity.

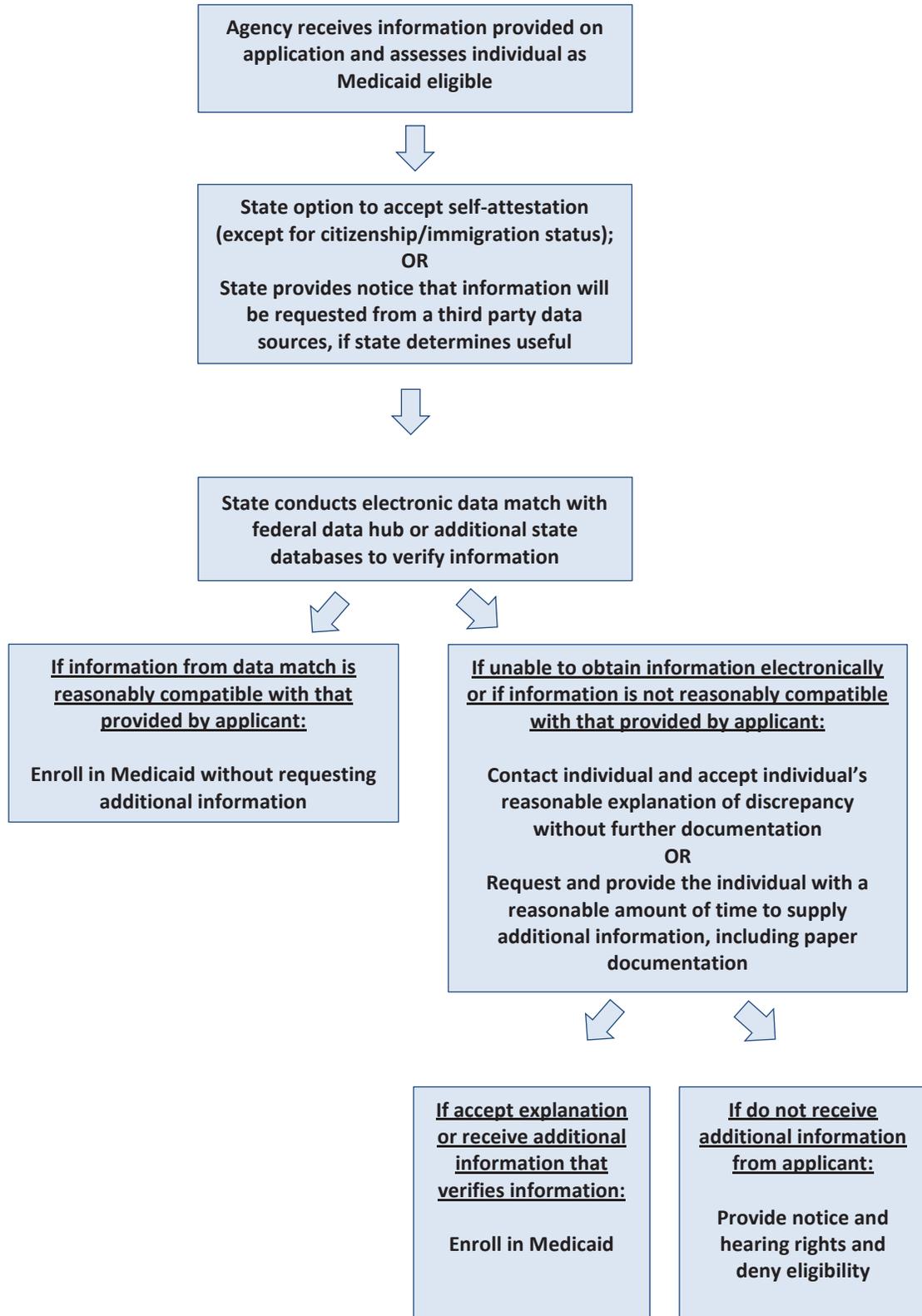
States will rely, to the maximum extent possible, on electronic data matches with trusted third party data sources to verify information provided by applicants. Before a request for a third party data source is initiated, the individual must receive notice of the information being requested and its use. The ACA provides that state Medicaid agencies must conduct electronic data matches to obtain income information from state quarterly wage reports, unemployment compensation, the IRS and the Social Security Administration, if such information would be useful to verify Medicaid eligibility as determined by the Secretary. CMS proposes delegating to the states the Secretary's discretion regarding whether information would be useful to verify Medicaid financial eligibility and therefore must be requested. Moreover, the proposed rule eliminates a number of current prescriptive provisions regarding when and how often states must query certain data sources and deletes current language requiring independent verification of information "if determined appropriate by agency experience."

The Secretary must establish a secure electronic verification system through which all insurance affordability programs can verify certain eligibility information with other federal agencies. At a minimum, this system will allow for verification of household income and family size with the IRS, citizenship with the Social Security Administration, and immigration status with the Department of Homeland Security. CMS proposes that, to the extent available, states must access needed financial and non-financial information through the Secretary's system. Information not available through the Secretary's system may be obtained directly from the agency or program housing the information.

States are expressly permitted to accept attestation of all Medicaid eligibility criteria, except for citizenship and immigration status. Attestation may be by the applicant/beneficiary or by a parent, caretaker, or other person acting responsibly on the individual's behalf. To ensure program integrity, states must request information from trusted data sources when useful to verify financial eligibility. Pregnancy should be verified by self-attestation, unless the state has other information, such as claims history, that is not reasonably compatible. The proposed rule also specifies that documents that provide information regarding immigration status may not alone be used to determine lack of state residency, because some temporary or time-limited statuses may be routinely renewed.

If information provided by an individual is "reasonably compatible" with information obtained from other trusted sources, the agency may not request additional information from the individual. The proposed rule does not define "reasonably compatible." However, the preamble explains that it does not necessarily mean an identical match, but only that the information is generally consistent, and that states will have flexibility in applying the standard, which may vary depending upon particular circumstances. If the agency is unable to obtain information electronically, or if the information obtained is not reasonably compatible with that provided by the individual, the agency may contact the individual and accept the individual's reasonable explanation of the discrepancy without further documentation, or the agency may request and provide the individual with a reasonable amount of time to supply additional information, including paper documentation. The agency shall not deny or terminate eligibility based on information it has received from another source unless the agency has sought additional information from the individual and provided the individual with proper notice and hearing rights.

**Figure 2:
Medicaid Eligibility Verification Process Flowchart**



Medicaid Eligibility Redeterminations

The rule proposes a 12-month renewal period for Medicaid beneficiaries whose eligibility is based on MAGI. However, eligibility should be redetermined more frequently if a beneficiary reports a change in circumstances that may affect eligibility or if the agency obtains information, such as through a data match, that indicates the need for review. CMS proposes deleting the existing standard requiring agency action within 45 days of the date new information is received, and instead proposes that the agency redetermine eligibility “promptly” when it receives information about changes in a beneficiary’s circumstances that may affect eligibility and “at the appropriate time” when it receives information about anticipated changes in circumstances.

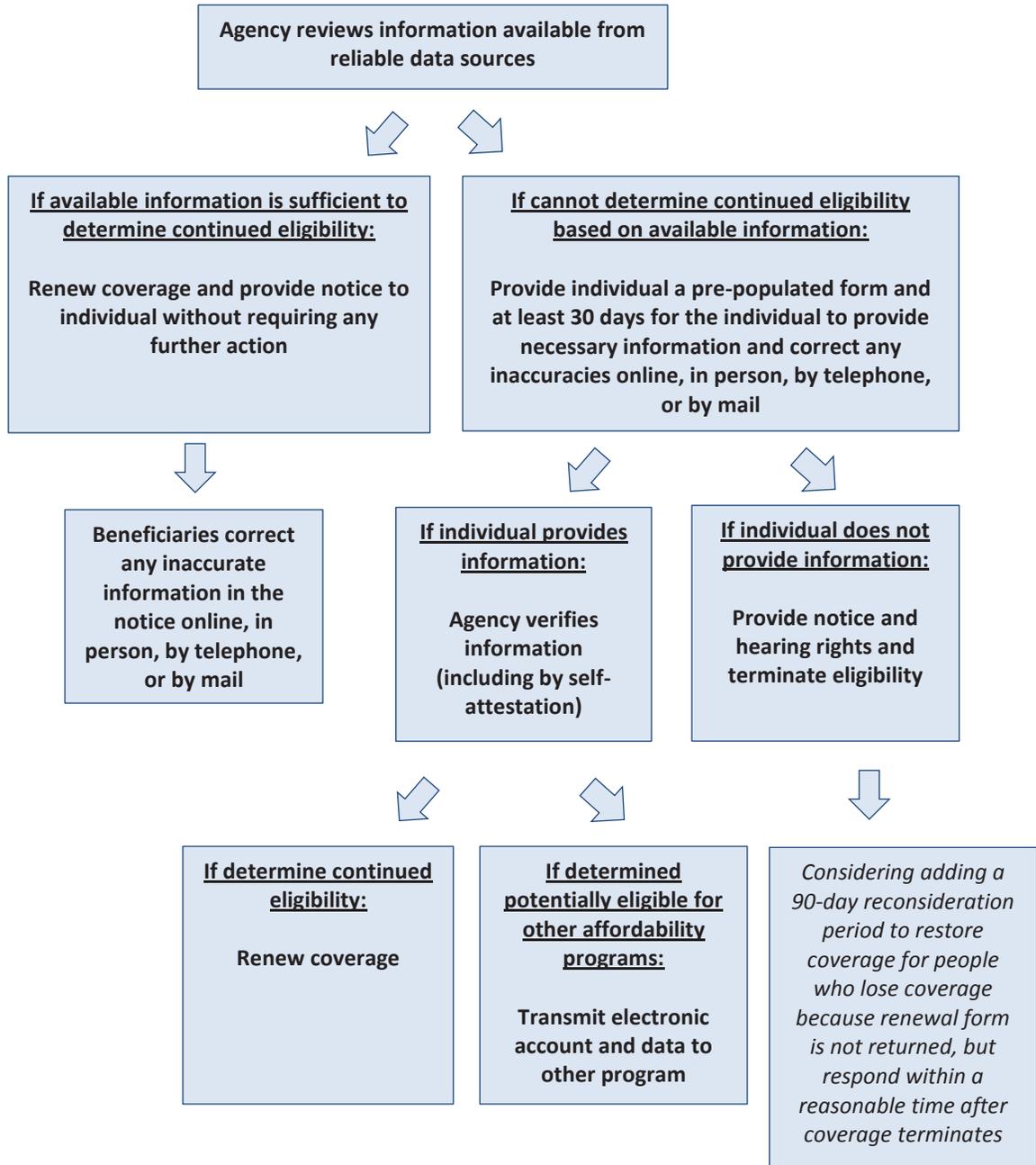
The rule further proposes that state agencies seek to renew eligibility first by evaluating information from the individual’s electronic account or from other more current reliable data sources. If the available information is sufficient to determine continued Medicaid eligibility, coverage shall be renewed, and the agency would send an appropriate notice without requiring the individual to sign and return the notice. Beneficiaries must correct any inaccurate information in the notice online, in person, by telephone or by mail. If the agency cannot determine that the individual remains eligible based on available information, it must then provide the individual with a pre-populated form containing the information relevant to renewal that is available to the agency, and a reasonable period of time, at least 30 days, for the individual to provide the necessary information and correct any inaccuracies online, in person, by telephone or by mail. The agency is to verify the information reported by the individual, including a state option to rely on self-attestation.

To avoid unnecessary reapplications, CMS proposes a reconsideration period for individuals who lose coverage because the renewal form is not returned timely, but who respond within a reasonable period of time after coverage terminates. CMS is considering a 90 day reconsideration period but has not specified a particular time period in the proposed regulations.

CMS has not proposed amending the redetermination process for MAGI-exempt Medicaid beneficiaries. Instead, the proposed rule retains the provision that eligibility must be redetermined “at least every 12 months” for non-MAGI groups. However, the agency is seeking comment on whether the new proposed renewal procedures described above also should apply to MAGI-exempt beneficiaries. CMS’s proposed rule does extend the new change reporting methods (online, by telephone, by mail, and in person) to MAGI-exempt populations.

CMS contemplates adding a provision (which is not included in the proposed rule) to extend Medicaid coverage until the end of the month in which the Medicaid termination notice period ends. Current law requires the state agency to provide at least 10 days advance notice of termination actions. Under the proposed Exchange rule, individuals who lose Medicaid eligibility can enroll in an Exchange on the first day of the month following the date of Medicaid termination and determination of Exchange eligibility. However, if the individual loses Medicaid eligibility and is determined eligible for an Exchange after the 22nd day of the month, enrollment through the Exchange would begin on the first day of the second month following such date. The proposed rule invites comment on extending Medicaid coverage until the end of the month in which the Medicaid termination notice period ends to prevent gaps in coverage for those receiving notice after the 22nd of the month.

**Figure 3:
Medicaid Renewal Process for MAGI-Related Groups Flowchart**



Coordination Between Medicaid and Exchanges

State Medicaid agencies must participate in the coordinated eligibility and enrollment system under the ACA. The proposed rule addresses a number of provisions related to how Medicaid will coordinate with eligibility for premium tax credits in the Exchanges¹⁰ to determine eligibility and enroll individuals in coverage.

The state Medicaid agency must determine Medicaid eligibility promptly and without undue delay for any individual determined potentially Medicaid-eligible by an Exchange. The Medicaid agency may not request any information already obtained or duplicate any eligibility verifications already performed by an Exchange and included in the individual's electronic account. Once the Medicaid determination is complete, the state Medicaid agency should notify the Exchange of the individual's Medicaid eligibility or ineligibility. Future rule-making will address notices about coordinated eligibility.

If an Exchange finds an individual eligible for Medicaid based on the applicable MAGI standard, the state agency must enroll the individual promptly and without undue delay, as if the decision had been made by the state Medicaid agency. The preamble clarifies that, in such circumstances, the state Medicaid agency shall not make any further determination. The state agency must establish procedures to receive, via secure electronic data interface from an Exchange, the finding of Medicaid eligibility and the individual's electronic account, including all application information. While an actual data transfer may not occur if the Medicaid agency and Exchange use a shared electronic eligibility system, legal responsibility for the electronic account and for taking further action would transfer from the Exchange to the state Medicaid agency.

The state Medicaid agency must ensure that any individual who is determined ineligible for Medicaid upon an initial application or at redetermination is screened for potential eligibility for premium tax credits, cost-sharing reductions, and enrollment in a qualified health plan through an Exchange.

Absent an agreement through which the state Medicaid agency makes Exchange eligibility determinations, the state Medicaid agency must promptly transfer the electronic account of individuals screened as potentially eligible to an Exchange so that such individuals can receive an immediate eligibility determination by the Exchange and, if eligible, enroll without delay. The electronic account information transferred should include the Medicaid ineligibility determination, all information provided on the single streamlined application and any appropriate verifications obtained by the state Medicaid agency. An Exchange or other entity with delegated authority to render Medicaid eligibility decisions cannot reverse a determination of Medicaid ineligibility made by the state Medicaid agency. Individuals determined ineligible for Medicaid based on MAGI, for whom the Medicaid agency is evaluating eligibility under blindness or disability, may enroll in a qualified health plan under an Exchange while the final Medicaid determination is pending. If the individual is ultimately found Medicaid eligible, the other coverage would terminate in favor of Medicaid.

To implement these arrangements, state Medicaid agencies will enter into one or more agreements with the Exchanges and other insurance affordability programs that determine Medicaid eligibility. In the preamble to the proposed rule, CMS envisions three broad options for the design of such agreements: one or more entities could agree to have some or all of the responsibilities of each to be performed by one or more of the others; a single integrated entity that performs all responsibilities could be established; or each entity could fulfill its own responsibilities and establish strong connections to the other entities to ensure the seamless exchange of information and data. Regardless, the single state Medicaid agency must retain authority to administer and supervise the Medicaid program and

ensure that an Exchange or other entity performing delegated functions acts consistently with the state Medicaid agency's rules. Moreover, state Medicaid agencies must certify the criteria necessary for an Exchange to use when determining Medicaid eligibility under MAGI, including income standards and criteria for determining satisfactory immigration status. CMS invites comment on other rules that should be so certified.

The scope of final Medicaid eligibility determinations made by Exchanges is limited to MAGI groups.

The preamble notes that, in certain circumstances, the state may establish procedures whereby an Exchange will undertake Medicaid eligibility determinations on other bases, and the proposed Exchange rules provide that all applicants have the right to request and receive a full determination for eligibility on bases other than MAGI from the state Medicaid agency.

CMS proposes allowing the state Medicaid agency to delegate MAGI eligibility determinations to Exchanges that are public agencies. In these cases, the Medicaid agency would retain discretion for administering and supervising the state Medicaid plan and implementing quality control and oversight procedures. For Exchanges that are non-governmental entities, the preamble notes that Medicaid state workers may need to be co-located at the Exchange or other accommodations may be necessary to both meet the ACA's coordination requirements and to fulfill the single Medicaid state agency requirements, including that state Medicaid plans be administered pursuant to merit based personnel standards. CMS solicits comments on whether a private entity Exchange should conduct Medicaid eligibility determinations, which historically have not been permitted as they involve discretion that is inherently governmental in nature.

Proposed Methodologies for Applying Increased Federal Matching Rates

The ACA provides a significant increase in the federal medical assistance percentage (FMAP) for federal matching funds for newly eligible individuals. For 2014 through 2016, states would receive an FMAP of 100% for newly eligible individuals, which would phase down to 90% in 2020 and beyond. A separate match rate formula applied to "expansion states" (certain states that had opted to cover parents and childless adults with incomes at or above 100% of poverty on March 23, 2010).

The proposed rule specifies the federal matching rates for newly eligible individuals as well as the increased FMAP for expansion states. There are some differences in how newly eligible individuals have been defined in the proposed rule versus the legislation, which could result in fewer individuals qualifying as newly eligible and receiving the increased FMAP.

CMS proposes to allow states to choose among three methodologies to determine newly eligible individuals whose expenditures are eligible for increased FMAP. The first proposed methodology assesses whether individuals are "newly eligible" based on an approximation of the state's 2009 eligibility standards that have been converted to a MAGI-equivalent standard. The second proposal uses a statistically valid sampling methodology across individuals in the new adult group and their related Medicaid expenditures to make a statistically valid extrapolation of which individuals are newly eligible. The third proposal calculates the proportion of individuals covered under the new adult group who are newly eligible, as compared to December 2009 eligibility standards, by extrapolating from reliable data sources, such as the MEPS or MSIS. CMS seeks comments on alternative methods that should be considered, if it is advisable to allow states to choose a method or if HHS should identify a single method for all states and on methods or proxies that could be used in identifying new versus current eligible for matching purposes related to assets and disability determinations. The goal is to establish a system for

determining the appropriate matching rates for states without interfering with other goals of simplifying and streamlining the enrollment process.

An increased FMAP also is available to expansion states that already had opted to cover certain adults as of March 2010. The expansion state enhanced FMAP is determined by increasing the expansion state's base FMAP by a specified "transition percentage," multiplied by the difference between the newly eligible FMAP available in 2014 and the expansion state's base FMAP, with a goal of reaching a 90 percent enhanced FMAP in both newly eligible and expansion states by 2020. Expansion states also are eligible for a 2.2 percent increase in their base FMAPs for all Medicaid expenditures (not only those for newly eligibles) in 2014 and 2015.

Looking Ahead

Overall, the proposed rule from CMS implements the ACA's vision of a simplified, integrated enrollment system for all insurance affordability programs that is technology-driven and relies on electronic data-matching to the greatest extent possible. The rule effectuates the ACA's transformative change to Medicaid eligibility rules and enrollment and renewal processes, which will have significant impacts on applicants, enrollees, and state Medicaid agencies. In examining the potential impacts of the rule, there are a number of key issues to consider, including the following:

- **Balancing interests to preserve Medicaid coverage and promote simplicity of administration.** As noted in the preamble to the proposed rule, the transition to the new Medicaid eligibility categories and to MAGI methods to determine financial eligibility is not intended to affect the eligibility status of existing populations. However, some individuals will lose Medicaid coverage as a result of the transition, while likely becoming eligible for premium tax credits in an Exchange. CMS notes that in developing the proposed rule, it sought to balance the sometimes competing interests of preserving existing Medicaid eligibility with its goal of promoting simplicity of administration through coordination and alignment of Medicaid rules and processes with the Exchanges. As such, in reviewing the proposed rule, it will be important to consider what may happen to groups losing Medicaid eligibility under the proposed rule and whether their loss of coverage is balanced by the benefits of administrative simplicity.
- **Differences in program eligibility and enrollment rules.** The overarching goal of the proposed Medicaid rule, along with the accompanying Exchange and Treasury rules, is to create an integrated and aligned eligibility and enrollment system. However, there are a number of areas in which distinctions and differences in processes and rules remain. For example, within Medicaid, a number of the proposed changes and simplifications will apply to MAGI-groups but not to groups exempt from MAGI. Moreover, under the ACA, Medicaid eligibility remains based on monthly income at the time of application, while eligibility for premium tax credits for Exchange coverage is based on annual income. The proposed rule seeks to address this distinction in timing by providing states options to assess income eligibility for Medicaid in ways that more closely align to annual income. However, if states do not take up these options, there is the potential for some individuals to be determined ineligible simultaneously for both Medicaid and Exchange coverage as a result of the distinction in the time period for financial eligibility. As the proposed rule is reviewed, it will be important to identify areas in which differences exist and assess the potential impacts of these differences and whether there are any opportunities for further alignment and/or coordination.

- **State options versus nationwide standards and processes.** There are also some areas of the proposed rule that provide states options with regard to eligibility and enrollment processes. While providing options gives states flexibility to implement processes in ways that meet their specific interests or situations, it also results in increased state variation in rules and processes, which can contribute to increased administrative complexity and have implications for individuals. For example, relying on projected annual income to assess Medicaid eligibility is an option for states, which some states may choose to utilize while others may not. As noted in the preamble to the rule, in states that do not take up the option, individuals will be more likely to experience coverage gaps due to small fluctuations in income. Moreover, providing states options with regard to the methodology used to track newly eligible individuals for federal matching purposes would likely result in significant administrative complexities.
- **Potential implementation challenges.** While the proposed rule creates an eligibility and enrollment process that is designed to be simple and streamlined for individuals, achieving that system will require state Medicaid agencies, working with the Exchanges, to make significant process and systems changes and to create systems that can operationalize and automate the new eligibility determination rules. Application of the new rules is dependent on a number of factors including a person’s tax filing status, household composition, and the program for which eligibility is being assessed. As such, operationalizing and automating the rules may present challenges and complexities that will be important to identify and help states develop methods to address.
- **Provisions requiring further clarification and information.** There are a number of provisions in the proposed rule that require further information and clarification. For example, the proposed regulations direct states to convert their existing maximum income standards for Medicaid and CHIP eligibility groups to MAGI-equivalents, but more guidance is needed regarding how states will make this conversion. Moreover, the proposed rule eliminates certain timeliness standards to be replaced with performance standards that have not yet been developed. In addition, CMS proposes a “reasonable compatibility” standard that governs when states may request additional information, including documentation, from individuals to verify eligibility criteria. While this proposal seeks to minimize burdens on states and individuals, it could be subject to various interpretations, and CMS’s explanation of what it considers “reasonably compatible” is not included in the proposed rule. In some cases, further information on the provisions is necessary to understand the full implications of the proposed policies and/or changes. Finally, while the proposed rule generally does not address the benefits individuals will receive, it is important to note that eligibility rules and processes may have a significant impact on individuals’ benefits, since states may choose to provide individuals in some eligibility categories more limited benefit packages.

In conclusion, CMS’s proposed Medicaid eligibility and enrollment rules are an important step forward in the ACA implementation process. The final regulations are subject to revision based upon input received during the comment period. In reviewing the proposed rules, it will be important for stakeholders to consider a number of issues, including the balance of preserving Medicaid eligibility versus promoting simplicity of administration, areas where differences in program eligibility rules or enrollment processes remain, state options versus national standards, potential implementation challenges facing states, as well as areas that require further clarification or information.

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ENDNOTES

¹ 76 Fed. Reg. 51148, available at <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/html/2011-20756.htm>

² Note that CMS's proposed CHIP regulations apply to states with separate CHIP programs, while state CHIP programs that are part of a Medicaid expansion are governed by the applicable proposed Medicaid regulations.

³ CMS's proposed rule addresses only one area related to the benefits package to be provided to Medicaid beneficiaries under the new system. Currently, states may limit Medicaid coverage to only pregnancy-related services for pregnant women at higher incomes. CMS's proposed rule would provide full Medicaid coverage to all pregnant women, unless the state elects to provide only pregnancy-related, or enhanced pregnancy-related, services to pregnant women with incomes above a certain limit established by the state in accordance with specified federal minimum and maximum standards.

⁴ For a summary of how current mandatory and optional groups would be moved into the proposed new groups, see Table 1 at 76 Fed. Reg. 51153.

⁵ The preamble to the proposed rule provides that if a state currently covers children with household incomes above 133% FPL in a separate CHIP program and elects this new optional Medicaid eligibility group, the state must transition the affected children from CHIP to Medicaid but still would be able to claim the enhanced CHIP FMAP for those children.

⁶ CMS recommends retaining the current Medicaid income counting rules in three instances: lump sum payments would continue to be counted as income in the month received rather than in the year received; scholarships and grants for educational purposes, and not living expenses, would continue to be excluded from countable income; and certain types of American Indian and Alaskan Native income would continue to be excluded from countable income.

⁷ Because each state's net countable income standard converted to a MAGI-equivalent will be lower than its current gross income standard (at or below 185% of the state's consolidated standard of need for the AFDC program as of July 16, 1996), the gross income test for parents/caretaker relatives also is eliminated under MAGI.

⁸ For more detail on the specific groups affected, see 76 Fed. Reg. 51157-58 and proposed 42 C.F.R. § 435.603(f)(1), (2).

⁹ Specifically, CMS proposes to include spouses living together and spouses/parents (including step-parents) and all children (including step-children and step-siblings) under age 19 (or if a full-time student, under age 21), who live together in the same household. Non-tax filers, other than spouses or biological, adoptive or step-parents, children or siblings, are not included in the same household.

¹⁰ Coordination also is required between Medicaid, a separate CHIP program, and the Exchanges.

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