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Update: Medicaid Program Eligibility Changes under the Affordable Care Act

By [Sara Rosenbaum](#)

Introduction

This update to the Medicaid Implementation and health insurance Exchange Briefs reviews a [Notice of Proposed Rulemaking](#) (NPRM) implementing the Medicaid and CHIP eligibility, enrollment simplification, and coordination provisions of the Affordable Care Act. Issued by the United States Department of Health and Human Services on August 17, 2011,¹ the rule is comprehensive in scope; its public comment period ends October 31, 2011.

The Medicaid NPRM is part of a group of three regulations,² all of which will be summarized this week at **HealthReformGPS.org**. Together the rules are designed to implement both the Medicaid eligibility expansions, the process of determining eligibility for premium tax credits and cost sharing assistance in the Exchange individual market, and standards for employers purchasing coverage in Exchanges. Collectively, the rules are designed to allow individuals and families to acquire and keep coverage and move more seamlessly among publicly-supported sources of health insurance as family income and circumstances change.

The Medicaid NPRM implements the ACA's Medicaid eligibility expansions as well as its simplified enrollment and retention procedures. The proposed rule also makes changes in pre-existing Medicaid eligibility, enrollment, and retention standards in order to simplify state plan administration while better aligning state Medicaid and Exchange practices. Thus, the rule addresses reforms aimed at not only expanding Medicaid coverage but improving performance for all beneficiaries. The integration of Medicaid and Exchange functions is crucial given the large number of individuals and families who can be expected to move across the Medicaid and Exchange markets as financial and family circumstances change.³

Background

Pre-ACA Medicaid eligibility is tied to membership in a recognized categorical eligibility group (e.g., children, pregnant women, persons with disabilities, elderly), satisfaction of other eligibility requirements related to state residency and citizenship or legal status, and financial eligibility (which may vary depending on the categorical basis of eligibility).⁴ For example, eligibility for "poverty-level" pregnant women and children under 6 is mandatory up to 133 percent of the federal poverty level (FPL),

¹ 76 Fed. Reg. 51148 (August 17, 2011)

² 76 Fed. Reg. 51148 (Medicaid eligibility); 76 Fed. Reg. 50931 (IRS premium tax credit); 76 Fed. Reg. 51202 (Exchange functions in the individual market: eligibility determinations; Exchange standards for employers)

³ Benjamin Sommers and Sara Rosenbaum, Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges, 230 Health Affairs 228 (Feb. 2011).

⁴ For a general overview of Medicaid eligibility under current law see Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer* <http://www.kff.org/medicaid/upload/7334-04.pdf> (August 18, 2011).

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while eligibility for poverty-level children ages 6-18 is mandatory up to 100 percent FPL. States may, at their option, extend Medicaid eligibility to children and pregnant women whose incomes exceed these mandatory minimums through either Medicaid, a separately administered CHIP program, or a combination of the two.

Eligibility for the elderly and persons with disabilities is subject to separate categorical and financial eligibility standards. Eligibility for adults who are parents or caretaker relatives of “dependent” children under age 18 (meaning that children are deprived of one or both parental supports by reason of death, incapacity, or unemployment) and who are not themselves children, pregnant, or disabled is tied to state-defined poverty levels that may be as low as 1996 AFDC payment standards. In some states, financial eligibility standards for this last population can be less than 17 percent of FPL.⁵ No recognized federal eligibility category exists for nonelderly adults who are neither pregnant nor disabled nor elderly nor a parent of a child. Some states have extended coverage to these adults using special authority under §1115 of the Social Security Act.

Financial eligibility for groups other than persons who are elderly or disabled is evaluated using standards and methods that have been part of federal Medicaid law virtually since enactment. Income is evaluated in the month it is received. States can use asset tests although many states have eliminated asset tests for “poverty level” children and pregnant women.

State Medicaid programs have certain outreach, eligibility determination, and enrollment obligations. Medicaid requires that states must allow all individuals wishing to do so to apply for assistance. States must promptly determine eligibility and enroll people who are determined to be eligible and also must re-determine eligibility periodically, but no less often than annually. Beneficiaries have an obligation to report changes in circumstances that might affect their eligibility for coverage. State Medicaid agencies are legally accountable for the eligibility determination and enrollment process, and the workforce that carries out this process are public employees who work for state (or local) public agencies. States must offer outstationed enrollment in certain locations, and they may outstation employees or contractual workers to assist in the application and enrollment process at locations such as public or children’s hospitals, community health centers, or local health departments. States may but are not required to offer online enrollment and redetermination procedures.

The federal government contributes to the cost of medical assistance for eligible persons. Federal medical assistance contributions range from 50 percent to 77 percent of state expenditures. The federal government also contributes to the cost of state program administration, with federal administrative contributions ranging from 50 percent to 90 percent, depending on the activity.

⁵ Kaiser Family Foundation, State Healthfacts.org <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4> (August 18, 2011).

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How the ACA Changes Medicaid

The ACA:

- extends and simplifies Medicaid eligibility beginning in Calendar Year 2014. The law replaces Medicaid's previous, multiple categorical groupings and limitations with one simplified overarching rule: all individuals under age 65 with incomes under 133 percent FPL,⁶ who meet citizenship/lawful U.S. status and state residency requirements, are entitled to medical assistance. In addition, use of an asset test is eliminated. This new eligibility category is essentially laid on top of all pre-existing eligibility groups, some of which overlap. Therefore, the ACA triggers a need for alignment and harmonization of Medicaid's fuller eligibility structure.
- replaces the current standards and methods for evaluating income eligibility for purposes of Medicaid and CHIP (in states that elect to continue a separate CHIP program rather than merging it into Medicaid and insurance Exchanges) with a "modified adjusted gross income" test (MAGI), the same income methodology used to determine eligibility for premium tax credits and cost sharing assistance in insurance Exchanges. Thus, the ACA financially aligns both the Medicaid and Exchange markets in order to enable prompt enrollment into whatever "insurance affordability program"⁷ an individual or family may qualify.
- requires alignment of eligibility determination and enrollment procedures so that individuals need apply only once and without having to make applications to separate programs if found ineligible for one program.⁸
- increases federal medical assistance contribution levels to 100 percent (phasing down to 90 percent in 2020 and thereafter) for individuals who are "newly eligible," that is, who would not have been eligible under their state Medicaid plan in December, 2009.⁹ The ACA also sets special transitional federal contribution levels for states that, as of that date, already were covering some or all low income individuals through a combination of state coverage options and §1115 demonstration waivers, with all states receiving the same federal contribution for newly eligible persons beginning in 2019 and thereafter.

As noted, these statutory changes have spillover effects on underlying federal Medicaid law, and thus, federal and state program administration. For example, the expansion eligibility category (i.e., all nonelderly persons with family incomes under 133% FPL) overlaps with certain pre-existing coverage categories such as children and pregnant women. The new MAGI methodology will apply to most under-65 applicants and beneficiaries, not just people whose eligibility is based on the expansion category, as will elimination of the asset test. Simplified enrollment and retention protections become a right of all applicants, not just those applying under the new expansion category.

⁶ This number adjusts to 138 percent once an additional, special federal income disregard is taken into account.

⁷ 76 Fed. Reg. 51150

⁸ *Id.*

⁹ *Id.*



Overview of the Medicaid Eligibility NPRM

In order to align eligibility and enrollment, the NPRM both proposes new policies while modifying existing ones.¹⁰ The NPRM thus both revises existing rules¹¹ and adds new regulations¹² in order to simplify enrollment and guide coordination with insurance Exchanges.¹³

While the NPRM makes parallel revisions in CHIP regulations, this Brief focuses on the Medicaid reforms.

Changes to Medicaid Eligibility

The NPRM proposes numerous changes in eligibility standards:

- **New mandatory adult coverage group:** The NPRM proposes revised existing regulations to reflect the new eligibility category¹⁴ consisting of nonelderly adults ages 19-65 who are not pregnant or entitled to Medicare or eligible or enrolled under another mandatory coverage category, and whose incomes are at or below 133% FPL based on MAGI. CMS clarifies that this group includes not only people who previously fell into no eligibility category (e.g., a nonelderly adult without minor children who is neither pregnant nor disabled) but also people who might have fallen into a pre-existing category (e.g., a parent of a minor child, a nonelderly person with a disability) but who failed to qualify for Medicaid because of excess income (e.g., a parent of a minor child whose income exceeds the level allowed for parents).¹⁵
- **New optional coverage group.** The NPRM proposes to add a new option under the ACA, effective beginning in CY 2014, to extend coverage to people who are eligible under the new coverage category (i.e., are under age 65) but whose MAGI exceeds 133 percent FPL.¹⁶ The NPRM clarifies that states will have the flexibility to set an income standard for this new group. The NPRM further clarifies that individuals are to be granted eligibility under this new optional category “unless the individual can be determined eligible under another eligibility group based on information available to the state from the application.” As with the new mandatory coverage group, this simplified rule allows states to shorten applications as much as possible. States can use this optional category to cover all such individuals or only certain groups (e.g., children shifted into this new option from a separate CHIP program, with enhanced CHIP FFP available; parents with incomes between 133% and 200% FPL).¹⁷

¹⁰ CMS notes that a separate request for information (RFI) will be issued for the development of policies related to the actual process by which states will convert their existing income standards and methods to the new MAGI standard. The agency also notes that a separate RFI also will be issued for state Basic Health Programs under PPACA §1331. 76 Fed. Reg. 51151.

¹¹ Proposed revisions to 42 C.F.R. part 435, subparts A, B, C and J.

¹² 42 C.F.R. part 435, new subpart M along with revisions to subpart J, related to eligibility determinations.

¹³ 42 C.F.R. Part 457.

¹⁴ Proposed 42 C.F.R. §435.119.

¹⁵ CMS offers the example in the Preamble of an individual who is eligible for SSI but who cannot qualify for Medicaid in what is known as a “Section 209(b) state” that continues to use more restrictive Medicaid eligibility standards.

¹⁶ Proposed 42 C.F.R. §435.218(b)(1)(ii) and (iii).

¹⁷ 45 C.F.R. §§435.118 and 218 as revised, 76 Fed. Reg. 51151.

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- *Streamlining existing eligibility regulations.*¹⁸ The NPRM proposes to streamline many existing eligibility groupings into a few basic groups: parents/caretaker relatives of dependent children under 18; pregnant women;¹⁹ infants and children under age 19; disability; and individuals age 65 and older.²⁰ In addition, the NPRM proposes to allow states to simplify definitions. For example, the NPRM would allow states to ease previous conditions on coverage of parents/caretakers by eliminating the concepts of “deprivation” or number of hours worked before a parent would be considered “unemployed” for Medicaid purposes.²¹ Thus, for parents/caretakers, the new category would consist simply of parents/caretakers of children under 19. The NPRM also proposes to simplify the methods used to determine eligibility to allow for a one-step process, rather than the previous two-step process required for parents.²²
- *New definitions.* The NPRM proposes a series of new definitions, paralleling the ACA, to govern the revised eligibility categories.²³

Financial Methodologies based on MAGI

The NPRM notes that the term “MAGI-based methodologies” (required under IRC §36B(d)(2)) “refers to both the rules governing the determination of MAGI of an individual or a married couple filing jointly, as well as to the determination of household income.”²⁴ MAGI differs significantly from traditional Medicaid income eligibility determination methodologies, and CMS notes that it is considering permitting states to convert to MAGI-based methodologies prior to 2014 under special §1115 waivers.²⁵

The NPRM incorporates MAGI into Medicaid while retaining certain Medicaid principles preserved by the ACA:

- *Use of pre-ACA methodologies.* The NPRM would retain pre-ACA methodologies for individuals whose basis of eligibility is the receipt of SSI, individuals found eligible based on the use of Express Lane eligibility, individuals ages 65 and older, individuals who are determined eligible based on blindness or disability, individuals whose basis of eligibility is the need for long term care, individuals whose eligibility determination is limited to Medicare cost-sharing assistance, and persons whose eligibility is tied to their medically needy (i.e., spend-down) status.²⁶
- *Point-in-time income measurement:* In keeping with a specified requirement of the ACA, the NPRM proposes to continue to apply point-in-time income measurement limiting valuation of income for

¹⁸ The NPRM notes that separate sub-regulatory guidance addresses the maintenance of effort rules that apply to children under 19 until 2019 and to pregnant women until 2014. 76 Fed. Reg. 51152.

¹⁹ For pregnant women, the new default coverage standard would be all Medicaid benefits (as opposed to coverage for pregnancy-related services only), unless the state opts for the narrower coverage standard. 42 C.F.R. §116(d), 76 Fed. Reg. 51153.

²⁰ Proposed 42 C.F.R. §§ 435.110, 116 and 118.

²¹ 76 Fed. Reg. 51154.

²² Proposed 42 C.F.R. §§435.4 and 435.110.

²³ Proposed 42 C.F.R. §435.4.

²⁴ 76 Fed. Reg. 51155.

²⁵ *Id.*

²⁶ Proposed 42 C.F.R. §435.603(i). Separate financial eligibility methods apply for the medically needy, persons with disabilities or blindness, persons in need of long term care, and persons applying only for Medicare cost-sharing, 42 C.F.R. §435.601 and 602.

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Medicaid purposes to the month in which income is received rather than using the annualized approach under MAGI.²⁷

- *Projected income over an annual budget period to allow for predictable fluctuations.* In order to reduce the likelihood of income fluctuations that elevate the risk of repeated movement across the Medicaid and Exchange markets, the NPRM proposes to permit states to project “predictable future income [or a] reasonably predictable decrease in future income . . . or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income.”²⁸
- *Annual enrollment periods.* Consistent with current Medicaid rules and in order to conform with MAGI, the proposed rule would allow states to maintain a version of an annual enrollment period, which would remain in place “as long as annual income based on MAGI methods for the calendar year remains at or below the Medicaid income standard.”²⁹ In effect, the rule would allow states to presume annual enrollment in the absence of information to the contrary, a variation of the current state option to use an annual eligibility redetermination period. The NPRM expressly seeks comments on how best to address gaps in coverage in cases in which individuals with incomes over Medicaid eligibility levels nonetheless are projected over a year to have income that falls below Medicaid eligibility and yet cannot currently gain Medicaid because their incomes are too high.
- *Methods for counting income under MAGI.* Pre-ACA, Medicaid methodologies dictate when income is received, which income is counted or disregarded, who is considered part of a “household” for eligibility determination purposes, and who is a member of a family for household and income evaluation and family size purposes. The NPRM proposes to revise these rules to conform to MAGI, while still retaining certain attributes of the traditional Medicaid program. The proposal would move the Medicaid financial eligibility determination process toward the MAGI process used in Exchanges.³⁰ The NPRM would tie the concept of family size to household rather than selected household members, with applicants evaluated against their household income rather than family income. The NPRM also introduces the concept of tax dependent, and household income becomes the “sum of the income based on MAGI-based methods of every individual who is (1) included in the individual’s household and (2) required to file a tax return under §6012 of the Internal Revenue Code.” Special rules would apply to married couples both living and not living together,³¹ child filers, and children not included in the household.³² CMS proposes to count income such as child support, business expenses and capital gains and losses for Medicaid purposes as it is counted under the Internal Revenue Code.

²⁷ Proposed 42 C.F.R. §435.603(h).

²⁸ Proposed 42 C.F.R. §435.603 (h)(2). The obligation to report actual changes that affect eligibility during an enrollment period would not change.

²⁹ 76 Fed. Reg. 51156. This proposal does not permit annual enrollment regardless of any changes in income but encourages states to use annual enrollment as the default, with reported changes as needed and with states enabled to account up front for any predictable increases or decreases in income in calculating eligibility.

³⁰ 42 C.F.R. §435.603(a)(1) and (2), 76 Fed. Reg. 51156.

³¹ Proposed 42 C.F.R. §435.603(f).

³² *Id.*

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However, the NPRM maintains special exceptions from MAGI: lump sum income is to be counted only in the month received, student scholarships and fellowships, along with student financial assistance from the Bureau of Indian Affairs, are excluded from income; and distributions from Alaska Native Corporations and Settlement Trusts are excluded, as is the income from certain property-related Indian tribes.³³ The Preamble offers multiple examples of how MAGI definitions related to family, income, and households would operate,³⁴ while also banning the use of resource tests in MAGI-governed households.³⁵ When MAGI takes effect, the NPRM notes that contrary to MAGI, children under age 19 (or under 21 if full-time students) will be treated as members of their parents' households in order to avoid coverage gaps.³⁶ The NPRM seeks comments on treatment of non-filers in relation to household composition.³⁷

- *Groups exempt from MAGI.* The NPRM proposes to exempt certain groups from MAGI, including persons for whom Medicaid agencies do not make an income determination (e.g., actual and deemed SSI recipients). Title IV-E recipients, individuals whose eligibility is determined through Express Lane eligibility, individuals who qualify based on blindness or disability (however these individuals can be determined eligible under the new mandatory adult category), individuals ages 65 and older, individuals applying for long term care, and individuals seeking Medicare cost sharing assistance only.³⁸ The proposed rule also seeks comments on children transitioning from SSI eligibility as children into adult categories.

State Residency

- *Residency.* State residency is a condition of eligibility. The proposed rule simplifies the definition of state residency in order to simply require an intent to reside in the state of application, regardless of whether the intent is indefinite, as under current law.³⁹ Employment-based residency is retained, as is the ability to demonstrate residency even in the absence of a fixed address.⁴⁰ The proposed rule also simplifies the residency test for unemancipated minors living in foster care settings, as well as for children living in another state for school purposes.⁴¹

Application and Enrollment Procedures

The NPRM proposes to revise the existing Medicaid eligibility determination and redetermination process:

³³ Proposed 45 C.F.R. 603(d).

³⁴ 76 Fed. Reg. 51157.

³⁵ Proposed 42 C.F.R. §435.603(g).

³⁶ Proposed 42 C.F.R. §435.603(f)(3).

³⁷ 76 Fed. Reg. 51158.

³⁸ Proposed 42 C.F.R. §435.603(i).

³⁹ Proposed 45 C.F.R. §435.603(h).

⁴⁰ *Id.*

⁴¹ *Id.*

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- *Electronic information.* The NPRM requires states to provide information electronically and to establish a web site, linked to the Exchange web site, that will allow “individuals to obtain information regarding coverage under Medicaid and CHIP and compare such coverage to that available through the Exchange.”⁴²
- *Applications.* The NPRM proposes to require states to use a “single streamlined application for all insurance affordability programs” (either the application to be developed by the Secretary or an alternative, Secretary-approved application).⁴³ The NPRM clarifies that social security numbers, citizenship, nationality, or immigration status cannot be asked of non-applicants within any household, nor can non-applicant information be disclosed for any purpose other than to determine an applicant’s eligibility.⁴⁴
- *Application assistance.* The NPRM clarifies the need for application assistance for persons with LEP, people with disabilities, and underserved racial and ethnic minorities and other groups. The agency notes that separate sub-regulatory guidance on application assistance will be forthcoming.

Screening for MAGI

The NPRM proposes a new and simplified process of screening for eligibility using the simplified categorical eligibility groups and MAGI.⁴⁵

- *Screen and enroll obligation.* The NPRM proposes to require state Medicaid agencies to screen every submitted application, using a process identical to the screen-and-enroll obligation under the proposed Exchange rule.⁴⁶ The NPRM also notes that Exchanges will not be required to undertake Medicaid eligibility determinations for individuals applying other than on the basis of MAGI and its related eligibility criteria (e.g., people applying for nursing home assistance).⁴⁷
- *Scope of the obligation.* The NPRM would extend the screening obligation to individuals who fall into one of the established MAGI-related categories (e.g., adult, child, pregnant woman, parent or caretaker) and who meet nonfinancial eligibility criteria such as legal status and residency (or who have been given an opportunity to submit documentation of citizenship or immigration status). The rule proposes that these individuals be reviewed against the MAGI standard.⁴⁸ If eligible, “[t]his means that states will not need to review whether an individual who meets the applicable MAGI standard (for example 133 percent FPL for the new adult group) is also eligible as a disabled or medically needy individual, both of which typically entail a more involved eligibility determination.”⁴⁹ In essence, the NPRM creates a fast-track process for applicants who appear to

⁴² Proposed 42 C.F.R. §435.905.

⁴³ Proposed 42 C.F.R. §435.907.

⁴⁴ *Id.*

⁴⁵ Proposed 42 C.F.R. §435.911.

⁴⁶ Proposed 45 C.F.R. §155.305(c).

⁴⁷ *Id.*

⁴⁸ 42 CFR §435.911(c).

⁴⁹ 76 Fed. Reg. 51162.

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fall into one of the MAGI categories. If found eligible under MAGI, the NPRM requires that the state “provide Medicaid promptly and without undue delay.”⁵⁰

- *Timelines.* The NPRM specifically notes that it establishes no timelines for this screen and enroll obligation related to MAGI (“In collaboration with states, we will be developing performance standards and metrics for the streamlined and coordinated eligibility and enrollment system. These metrics will also support the standards and conditions described in the Federal Funding for Medicaid Eligibility Determination and Enrollment Activities [final rule](#) [76 Fed. Reg. 21950, April 29, 2011].⁵¹

Coverage Months

The NPRM proposes to align coverage months with the proposed Exchange rule.

- The Exchange rule allows Exchange coverage to begin, following Medicaid termination, on the first day of the month following the date when the individual loses Medicaid and is determined eligible for Exchange enrollment. However, the NPRM also specifies that individuals determined ineligible for Medicaid and eligible for Exchange coverage after the 22d day of the month would be required to wait until the first day of the second month.⁵² The NPRM proposes to require states to continue Medicaid through the end of the month immediately preceding the first day of the month in which Exchange coverage begins.⁵³

Verification of Income and Other Eligibility Criteria

The NPRM proposes to revise existing Medicaid practices while aligning revised practices with those proposed for use in health insurance Exchanges.⁵⁴

The NPRM⁵⁵:

- requires states to use a federal verification system through which “all insurance affordability programs can corroborate or verify certain information with other federal agencies [such as] the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service.”
- allows state agencies to accept self-attestation of all eligibility criteria except citizenship and immigration status while using trusted data sources to verify information as required under Program Integrity.
- requires states to rely to the maximum extent possible in verifying both financial and nonfinancial information on electronic data matches from trusted sources to verify eligibility. The same

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Proposed 45 C.F.R. §155.410.

⁵³ 76 Fed. Reg. 51162.

⁵⁴ Proposed 45 C.F.R. §§155.315 and 155.320.

⁵⁵ 42 C.F.R. §§435.940- 435.956.

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process would apply in Exchanges in order to align information sources with those used for advance premium tax credits.

- requires notice (which would be part of the application process itself) to individuals before third party verification contacts are initiated.
- specifies the federal agencies (including SSA, DHS, and IRS) that will provide information to state agencies.
- indicates that performance metrics for real time information verification will be issued.
- prohibits requirements on individuals to provide further information unless “the agency is unable to obtain information through electronic data matching or the information obtained is not reasonably compatible with that provided by the individual.”⁵⁶ Allows agencies to simply document the contact and resolution of the non-compatibility problem without further documentation.
- requires states to terminate or deny Medicaid with notice and appeals rights in the event that an individual fails to respond to a request for information.

Periodic Redeterminations of Medicaid Eligibility

The NPRM revises existing redetermination regulations⁵⁷ to simplify the renewal process, reduce “churning,” improve continuity and quality, and make it more “data driven.” Specifically, the NPRM proposes to:

- clarify that redeterminations for populations whose eligibility is based on MAGI will be required only every 12 months.
- require states to base renewals on electronic data matching to verify continuing eligibility rather than requiring a new, signed renewal form and new information from the applicant “if able to do so based on reliable information contained in the individual’s account or more current information available to the agency.”⁵⁸
- require agencies to notify individuals of their continuing eligibility and of their obligation to notify the agency regarding inaccuracies. The NPRM bars states from requiring individuals to sign and return the notice if their eligibility has been successfully redetermined based on information available to the agency.⁵⁹ Individuals may be required to sign and return a form.
- in the event that an agency cannot redetermine eligibility based on information available to it, require that it provide the individual with a “pre-populated” renewal form containing information “available to the agency that is needed to renew eligibility.” The form must allow a 30-day response period from the date of the form and must be able to be submitted and signed electronically.⁶⁰ The NPRM allows states to use self-attestation at the renewal stage as well as at application.⁶¹

⁵⁶ 42 C.F.R. §435.952(c), 76 Fed. Reg. 51165.

⁵⁷ 42 C.F.R. §435.916.

⁵⁸ Proposed 42 C.F.R. §435.916(a)(2).

⁵⁹ Proposed 42 C.F.R. §435.916(a)(2)(i).

⁶⁰ Proposed 42 C.F.R. §435.916(a)(2)(ii) and (3).

⁶¹ 76 Fed. Reg. 51166.

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- provides for a reconsideration period for individuals who lose coverage for failure to return their forms; those who return the form within a reasonable (unspecified in the NPRM, comments are sought on a timeframe) time period after coverage is terminated would be redetermined without the need for a new application.⁶²
- in the event that the individual is no longer Medicaid-eligible, transmit the data and file to the “appropriate program” for a determination of eligibility in accordance with the NPRM’s new Medicaid/Exchange coordination standards.⁶³
- clarifies that federal financial participation for system modifications to conform to these requirements is at 90 percent FFP.

Coordination of eligibility and enrollment among insurance affordability programs

The NPRM adds a new Subpart M to the Medicaid eligibility regulations “to delineate the State Medicaid agency’s responsibilities in effectuating such coordination.”⁶⁴ The proposed rule also incorporates pre-existing Medicaid/CHIP coordination responsibilities. The NPRM:

- specifies that participation in a “coordinated eligibility and enrollment system” is a state plan requirement under Medicaid⁶⁵ in order to minimize the need for multiple applications, to “ensure that eligible applicants are enrolled in the appropriate program, no matter where their application originates,”⁶⁶ and to cut down on costs by use of a “shared eligibility service to adjudicate placement for most individuals.”⁶⁷
- clarifies the availability of federal financial participation at the 90 percent rate to develop this shared service, with 75 percent FFP thereafter to operate the system.
- provides that state Medicaid agencies enter into agreements with Exchanges “and other insurance affordability programs,” including Basic Health Programs where applicable.
- sets out the conditions that apply to this coordinated system, including shared governance and operations, as well as a website (the proposed rule does not require a single integrated website as long as there is a Medicaid website for application and redetermination purposes).⁶⁸
- clarifies governance structure options for coordination agreements, including joint operation through a single integrated entity, or delegation of operational responsibilities to one of the coordinating entities.
- provides for Medicaid enrollment without further eligibility determination by the Medicaid agency if eligibility is determined by the Exchange, using a secure electronic data exchange system.⁶⁹
- limits Exchange eligibility determination responsibilities in connection with Medicaid to applicants whose eligibility is based on MAGI.⁷⁰

⁶² Proposed 42 C.F.R. §435.916(a)(3).

⁶³ Proposed 42 C.F.R. §435.916(a)(4).

⁶⁴ 76 Fed. Reg. 51166.

⁶⁵ Proposed 42 C.F.R. §435.1200(c).

⁶⁶ 76 Fed. Reg. 51166.

⁶⁷ 76 Fed. Reg. 51167.

⁶⁸ *Id.*

⁶⁹ Proposed 42 C.F.R. §435.1200(e).

⁷⁰ Proposed 42 C.F.R. §435.1200(e).

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- clarifies the obligation of the Medicaid agency (which can be coordinated with the Exchange) to “facilitate health plan selection for enrolled individuals.” According to the NPRM, this function could be carried out by providing individuals with health plan options and transmitting information to plans.
- clarifies state agency obligations to “promptly determine the eligibility of individuals assessed as potentially Medicaid eligible by other insurance affordability programs and, if eligible, to enroll them without delay.”⁷¹
- provides that state Medicaid agencies must assess “potential” eligibility for other insurance affordability programs in cases in which an applicant is ineligible for Medicaid. The NPRM notes that:

“[w]hile the Affordable Care Act does not provide express authority for Medicaid to make eligibility determinations for coverage through the Exchanges, [it does] permit the agency to enter into a contract with the Exchange to do so. Absent such an agreement, the agency must promptly transfer the electronic account of individuals screened as potentially eligible, via secure electronic interface, to the Exchange so that such individuals can receive an immediate eligibility determination, and, if eligible, be enrolled without delay. This provision assumes that verification of any information required only for eligibility in the Exchange, such as access to affordable employer-sponsored insurance, will be completed by the applicable program once the applicant’s case is transferred.”⁷²

- specifies that the transfer of an ineligible file would include the streamlined application and its information and any Medicaid verification and prohibits an Exchange from reversing a finding of Medicaid ineligibility.⁷³
- specifies that individuals determined ineligible for Medicaid based on MAGI and who are applying for Medicaid on other bases (e.g., disability) may enroll in “other insurance affordability programs” (e.g., the Exchange, the Basic Health Program where applicable) “while a final Medicaid determination is pending.” If the individual is found Medicaid-eligible, other coverage would terminate.⁷⁴ “This avoids unnecessary delays in coverage for individuals whose Medicaid eligibility determination process may be lengthy, while avoiding any overlap in coverage for those eventually determined Medicaid eligible based on blindness or disability.”⁷⁵
- clarifies that in the case of persons found eligible for Medicaid based on blindness or disability, such individuals may apply for and enroll in an insurance affordability program (i.e., an Exchange plan with subsidies) while their Medicaid applications are pending.⁷⁶ The subsequent receipt of a retroactive Medicaid eligibility determination based on blindness or disability⁷⁷ absolves such individuals of advance credit repayment obligations given the fact that Medicaid eligibility is retroactive. Effectively the NPRM proposes to allow people with disabilities to enroll in Exchange plans (or Basic Health Programs where applicable) in order to secure rapid interim coverage

⁷¹ Proposed 42 C.F.R. §435.1200(f).

⁷² 76 Fed. Reg. 51168.

⁷³ *Id.*

⁷⁴ Proposed 42 C.F.R. §435.1200(e).

⁷⁵ Proposed 42 C.F.R. §435.1200(g).

⁷⁶ Proposed 42 C.F.R. §435.1200(g)(2).

⁷⁷ Medicaid eligibility can be retroactive up to 3 months prior to the date of application.

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while awaiting a full Medicaid eligibility determination based on disability, which can take months.

Single State Agency

- Consistent with current practice, the NPRM proposes to allow state Medicaid agencies to delegate their eligibility determination functions under certain conditions. Specifically, the NPRM proposes to allow state agencies to delegate eligibility determination functions to insurance Exchanges, while limiting such delegation powers to Exchanges that are established and operated as public agencies, as long as the Medicaid agency “retains administrative discretion in the administration or supervision of the [state Medicaid] plan.”⁷⁸

⁷⁸ Proposed 42 C.F.R. §431.10(c).