Maximizing Enrollment
Transforming State Health Coverage

10 Things for States to Know About the Final Eligibility Rules[1]
May 4, 2012

The Centers for Medicare and Medicaid Services (CMS) published the Final and Interim Final rule on eligibility changes under the Affordable Care Act (ACA) to Medicaid and CHIP on March 23, 2012. And shortly thereafter on March 27, 2012, CMS published the Exchange establishment Final and Interim final rule that includes eligibility requirements for exchanges. The Treasury Department has yet to release final rules that are expected to include important provisions about the advance premium tax credit (APTC), which are not included in the CMS eligibility rules or our review. In reviewing the eligibility provisions of these rules, NASHP set out to identify the 10 things states should know as they prepare eligibility and enrollment systems, policies and procedures for 2014. This brief is not intended to summarize the rules, but instead is meant to highlight 10 major changes from prior rules and current policy that states will need to understand to implement new eligibility systems effectively. The interim provisions for which CMS is currently soliciting feedback, as well as a number of areas where further federal guidance is still expected are at the top of our list because the comment period for both rules closes on May 7, so states should act quickly to provide input to CMS.

1. Interim Final Sections and More Guidance Forthcoming:

The final rule includes several interim final provisions that are noted below. Comments on the following provisions are requested by the Centers for Medicare and Medicaid Services (CMS) and are due ***May 7, 2012.***

- **Safeguarding Information:** The final rule includes interim final requirements for agencies to exchange information to verify the income and eligibility of applicants and beneficiaries. State agencies are required to have adequate safeguards to assure that information exchanged by the state agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information. Also, information received from the IRS may be exchanged only with agencies authorized (431.300(c)(1) and (d)). Income information received from the Social Security Administration (SSA) or the Internal Revenue Service (IRS) must be safeguarded according to the requirements of the agency that furnished the data. This includes section 6108 of the IRS Code, as applicable. (413.305 (b)(6))

- **Timeliness and Performance Standards for Medicaid:** The final rule's description of timeliness is described in more detail below. In short, the interim final rule directs state

[1] This analysis was created with support from the Robert Wood Johnson Foundation's Maximizing Enrollment Program and was produced by National Academy for State Health Policy/Maximizing Enrollment staff, including Maureen Hensley-Quinn, Alice Weiss, Katie Baudouin, Mary Henderson, Andy Snyder and Nicole Dunifon.

Medicaid agencies to establish both timeliness and performance standards to "promptly and without undue delay" determine individuals' eligibility for Medicaid. States' standards should reflect the use of systems and technology that allow for electronic data matching and transfers. These standards will apply for applications for Medicaid determinations, renewals, and transfer of individual's electronic accounts to and from other insurance affordability programs (IAPs)[2]. (435.912)

- **Medicaid Agency Responsibilities:** The final rule outlines a number of new responsibilities for Medicaid agencies, including: providing Medicaid to individuals found eligible for Medicaid by another IAP; accepting the transfer of an individual's electronic account from other IAPs to determine Medicaid eligibility; accepting the findings of another IAP regarding eligibility criteria without requiring further verification if the other agency's process was the same as the Medicaid agency's or approved of by agreement; evaluating eligibility for other IAPs of individuals determined not eligible for Medicaid, and for individuals undergoing a Medicaid eligibility determination on a basis other than modified adjusted gross income (MAGI)); and, providing an Internet web site which must facilitate enrollment and provide information on IAPs. Websites, kiosks and other information systems must be written in plain language and accessible to individuals with disabilities and limited English proficiency. (435.1200)

- **Determinations of CHIP eligibility by other IAPs:** CHIP determinations made by other IAPs may be accepted by the CHIP agency. States must identify those ineligible for CHIP as potentially eligible for Medicaid (whether MAGI or non-MAGI) or another IAP, appropriately transfer the electronic account, and observe the process in the regulation designed to assure children determined ineligible for Medicaid are reconsidered for CHIP. Specifically, the information should be transferred securely using an electronic interface and the case should be found ineligible, provisionally ineligible or be suspended for CHIP eligibility unless or until the Medicaid application is denied. (457.348)

- **Eligibility screening and enrollment in other IAPs**: New to this section in the final rule is a requirement that CHIP agencies screen all applications and renewals to determine if children are eligible for Medicaid - based on income, household size or anything else as indicated on the application or renewal – or any other IAPs based on MAGI or on the methodologies used by those programs. (457.350)

[2] Insurance Affordability Programs are defined in the Medicaid and CHIP eligibility rules to include Medicaid, CHIP, Basic Health Program (if one exists in the state) and publicly-subsidized exchange coverage. (Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Parts 431, 435, and 457, Medicaid Program; Eligibilty Changes Under the Affordable Care Act of 2010, Final rule; Interim Final Rule)

***More Guidance Forthcoming**: In the final rules and on webinars to discuss the rules, CMS has stated that further guidance will be coming in the following areas:*

FMAP Methodology/MAGI Conversion (Section O): While CMS is not providing final rules relating to FMAP methodology (how states determine which individuals will qualify as "newly eligible" and therefore receive a higher federal matching assistance percentage (FMAP)) or how states will convert existing eligibility levels to a MAGI-equivalent standard, CMS has signaled that further guidance and technical assistance will be available to states soon through the RAND/SHADAC contract providing technical assistance and models from work with 10 states on these issues.

Other topics of potential future CMS guidance include: Eligibility pathways for certain groups (for example, former foster children, deemed newborn eligibility, the Breast and Cervical Cancer program group, children with continuous eligibility, Transitional Medical Assistance and people with presumptive eligibility); Single-state agency and data reporting; timeliness and performance standards; Deeming of income to non-citizens; PERM (Payment Error Rate Measurement) rules; Single streamlined application and state-designed applications; Application assisters and personal representatives; Notices; Appeals; Electronic enrollment standards and protocols; CHIP premium assistance for qualified health plans; Newborn eligibility for CHIP-enrolled mothers; Accessibility standards for limited English proficiency (LEP) and disabled populations.

2. Determining Eligibility for Medicaid:

The final Medicaid and Exchange rules are different from the proposed in that they allow more flexibility in the agreement between the Medicaid agency and the Exchange. States can execute agreements allowing the exchange to assess eligibility for Medicaid, allowing the Medicaid agency to make the actual eligibility determination. Also included in the final rule is language stating that the exchange must adhere to Medicaid or CHIP eligibility determinations even if different from that of the exchange. The exchange must notify applicants that they can request a full Medicaid determination, even if found eligible for APTC, as he/she may be eligible for non-MAGI Medicaid. (Final Medicaid rule, 431.10 and final Exchange rule, 155.302)

3. Verification

- **Reliance on Self-Attestation and "Useful" Electronic Data Sources:** The final rule requires Medicaid and CHIP eligibility determinations to rely on self-attestation and information obtained from electronic data sources states find "useful". Post-enrollment verifications are permitted under the rule, but should be completed only where electronic data is not timely enough for determination. The final rule indicates the exchange can conduct follow-up post-enrollment verification but must show doing so is not burdensome or costly to state. The final rule provides a list of state/federal agencies from which Medicaid must request information for income verification, including the IRS, State Wage Information Collection Agency (SWICA), SSA, and state programs. States must also use information from the data hub and Public Assistance Reporting Information System (PARIS) data in eligibility determinations. While the final rule

removes the requirement to accept self-attestation for household size requirement, it remains an option for states. (435.948; 435.949)

- **Paper Documentation Limited:** States can only require documentation when either the electronic data is not reasonably compatible with information provided by an applicant or when electronic data is not available and creating an electronic match would not be effective, taking into account the administrative costs of establishing a data match, the administrative costs of documentation and the impact on determining coverage accurately for both the eligible and ineligible. (435.952(c)(2))

- **New Standards for Reasonable Compatibility:** If both the information provided by the applicant and through the data match are above or below eligibility level, the information should be considered reasonably compatible. If there is a discrepancy that would impact eligibility, states should seek additional documentation. Two things to note: the state has discretion to allow a certain percentage grace amount above or below eligibility threshold to consider information reasonably compatible; the exchange rule requires states to use 10 percent grace amount above or below the threshold. (435.952)

- **Verification Plan:** State must have a verification plan and provide it to the Secretary upon request. The plan should include policies, procedures and standards to determine usefulness of data and reasonable compatibility standards. This plan will be the basis for payment error rate measurement (PERM) audits. (435.945)

4. MAGI Screen

- **Screening Requirements:** The final rule requires states to ask for information that would indicate potential eligibility for Medicaid on a non-MAGI basis. States are also required to promptly enroll an applicant who may be eligible for a non-MAGI category into MAGI coverage pending determination of more appropriate non-MAGI category. Alternatively, the final rule allows states to enroll applicants directly in the appropriate group if they can do it promptly. This significant change from the proposed rule is in response to many comments concerned about assuring appropriate access to Medicaid coverage and benefits for people with disabilities or needing long-term services and supports (LTSS). (435.911 and 435.912)

- **Application:** The final rule affirms the requirement that states will have to provide a special application for those being screened for Medicaid eligibility on a basis other than the new MAGI-related categories (child, parent/caretaker relative, pregnant women and adults). For these individuals, states may use either the model application for IAPs with a supplemental form to gather information about non-MAGI eligibility criteria or they may create a special non-MAGI application. The final rule clarifies that these non-MAGI applications must be submissible in the same ways as MAGI applications – by mail, in person, by phone and online. (435.907)

5. CHIP

- **Block of Income:** The final rule provides that states can no longer use block of income disregards for CHIP. The preamble to the final rule clarifies that states currently receiving enhanced CHIP match for children who are eligible above 300% of the poverty level will continue to do so after the conversion to MAGI, which will take into account the disregard of the necessary block of income. (77 F.R. at 17190-17191)

- **Enrollment Caps:** The preamble says that enrollment caps are not addressed in the rule but, if there is one in place, CHIP agencies still have to accept the single streamlined application and screen for all insurance affordability programs regardless of whether CHIP enrollment is capped. (77 F.R. at 17190-17191)

- **Affordability of Premiums:** Although there was no change from the proposed rule, CMS clarified in the final rule that if states are concerned about affordability for children with parents in the exchange or other coverage, they may opt not to charge premiums for those children. (77 F.R. at 17193-17194)

- **Temporary Eligibility for Separate CHIP Program:** Children enrolled in Medicaid as of December 31, 2013 who lose eligibility for Medicaid at their first renewal in 2014 as a direct result of the elimination of income disregards (other than the 5% across the board) must be covered in a separate CHIP program - regardless of the existence of or eligibility requirements of the state's existing separate CHIP program. Exceptions include children who have access to public employee coverage or are in institutional care. The protection does not apply for children enrolled in CHIP so if at their first renewal following placement in the new separate CHIP they are no longer eligible for CHIP due to MAGI income they would be eligible for a qualified health plan (QHP) through the exchange. (457.310(d))

- **Enhanced CHIP match for children potentially eligible for non-MAGI Medicaid:** The preamble clarified that when a child is enrolled in CHIP who is potentially eligible for non-MAGI Medicaid (e.g., based upon disability), the state will receive the enhanced CHIP match pending the Medicaid determination. (77 F.R. at 17190-17191)

6. Alignment Between Medicaid, CHIP, and the Exchange

- **Eligibility Standard Differences among IAPs:** Although eligibility standards for most individuals for Medicaid, CHIP and APTC and cost sharing reduction (CSR) are based on section 36B of the tax code and the IRS definitions of income and household, there are some exceptions. Therefore the IAPs eligibility standards are not completely aligned. The following are three key differences in how income and household composition must be determined for Medicaid/CHIP compared to the APTC/CSR:

- **Budget period:** In determining Medicaid and CHIP eligibility, income is based on a "point in time" or monthly period, but annual income is used to determine eligibility for and the amount of APTC/CSR. To decrease the possibility of individuals moving between Medicaid and a QHP, states may elect to use projected annual income for current beneficiaries. (435.603(h)(See also discussion in preamble of final Medicaid eligibility rule, 77 F.R. at 17156).

- **Household composition:** For purposes of determining Medicaid eligibility, there are some differences in the 36B or IRS household composition rules. In particular, unlike the IRS, CMS had to establish rules for determining Medicaid and CHIP eligibility standards for individuals who don't file taxes, known as non-filers, in the final rule. These non-filer rules will often, but not always, align with a typical tax household. In addition, even for tax filers, although CMS generally defines the household as the tax filer and his or her dependents, there are exceptions. For instance, a single pregnant woman's household for determining Medicaid eligibility is considered to be the woman plus the number of children she is expecting. However, a single pregnant woman is counted as a household of one in determining APTC based on her tax household (435.603(b)). The final rule also treats spouses who file separate tax returns as being in the same household even though their tax households are separate. Finally, the final rule also offers flexibility to Medicaid to count 19 and 20 year olds as part of household, while APTC /CSR adheres to the tax household. (See 435.603(f)) and the preamble, 77 F.R. at 17154).

- **Income:** Medicaid includes some exceptions to tax code's section 36B or IRS income counting rules. Medicaid counts a lump sum payment in the month it was received rather than prorating it over the year, which is different from the way it will be counted for the APTC/CSR eligibility determinations. Some scholarships, education grant awards, and fellowships that are not counted as income for Medicaid eligibility, are counted in determining APTC/CSR eligibility. And finally, certain listed income of Native Americans and Alaska natives is not counted in Medicaid although it would be for the APTC/CRS. (435.603(e)).

7. Timeliness

- **Real Time Decisions in Most Cases:** The expectation in the final rule is that eligibility determinations will be made "promptly and without undue delay." The rule includes a four-part test for real-time decision-making.

- **Return to 45/90-day limits:** There's also an understanding that states will need an outer boundary for decisions, both for due process and fairness reasons, and so the rule reinstates the requirement that all decisions not exceed 45 days for non-disabled and 90 days for disabled applicants.

- **New Standards Expected:** Medicaid agencies will be expected to include in their state plans timeliness standards that take into account the capacity of the state's electronic

data matching and the pace and experience of states that are investing in systems improvements and technology. While the time limits are an outer boundary, states are expected to strive for more timely determinations and be held accountable as part of performance standards.

8. Pregnant Women

- **Family Size for Household Income Determination:** Different from the proposed rule, t**he** final rule provides different rules for how states need to count pregnant women depending on whether the pregnant woman is the applicant. When the pregnant woman is applying for her own coverage, the household will include the pregnant woman plus the number of children she is expected to deliver. When the applicant is a member of the pregnant woman's household, states have the option to count the pregnant woman herself, count her plus one child, or count her plus the number of expected children. Note that the Exchange standard for eligibility for the advance premium tax credit (APTC) is based on the tax household so does not count the unborn child(ren) and includes the pregnant woman only for either her own or her family's eligibility. (435.603(b))

- **Scope of Benefits:** The final rule allows states to provide only pregnancy-related services to pregnant woman with income of 138% FPL or below, which could result in a lesser benefit package than those in the adult group receiving benchmark benefits. However, as stated within the preamble of the final rule, if a state chooses to provide fewer benefits for pregnant women than it does for adults it must justify the situation to the Secretary. The language in the final rule was revised from the proposed rule to emphasize that pregnancy related services include treatment for conditions that could complicate a pregnancy. (Preamble, 77 F.R. at 17148 - 17149)

- **No Duty to Monitor:** The final rule does not require state Medicaid or CHIP agencies to monitor pregnancy status. However, if there is a difference in benefit packages, women should be informed and if they request a change, they should be shifted. (Preamble, 77 F.R. at 17149).

9. Accessibility for Populations with Disabilities and Limited English Proficiency (LEP)

- **Codification of Required Compliance with Federal and State Law:** The final rule maintains its requirement that states comply with the Civil Rights Act of 1964, Section 504 off the Rehabilitation Act of 1973 and other relevant provisions of federal and state laws, including the Americans with Disabilities Act (ADA). This section of the rule also references Justice Department guidelines issued in 2003 regarding language assistance services for LEP individuals including oral interpretation and written translation services, as well as CMS' 2010 state health official letter implementing the enhanced match available under the Children's Health Insurance Program Reauthorization Act (CHIPRA)

for translation and interpretation services to improve outreach to and enrollment of children in Medicaid and CHIP. (77 F.R. at 17162-17163).

- **More Specificity on Access Requirements; Specific Standards Later:** The final rule provides more detail on what accessibility means for these populations. For LEP individuals, information must be provided "in an accessible and timely manner and at no cost to the individual." For individuals with disabilities, "accessibility includes auxiliary aids and services." Both application and renewal forms must meet the same accessibility standards. The rule also requires materials be provided in "plain language" to promote consistency with standard under Exchange rules. The rules stop short of setting specific standards for translation of materials or interpretation, other services, but signal that further guidance will be forthcoming. (435.905(b) and the preamble, 77 F.R. at 17162-17163)

10. Waivers: Throughout the preamble of the final rule, CMS suggests that states submit waivers to achieve specific policy goals for which CMS doesn't have explicit statutory authority under ACA to include in the final rule. While not an all-inclusive list, examples include: twelve-month continuous eligibility for adults as well as children ((77 F.R. at 17157); using Express Lane Eligibility to help achieve or maintain integrated eligibility with other human service programs (77 F.R. at 17171); and using a MAGI methodology for some MAGI-exempt populations (77 F.R. at 17150-17151).