HealthReformGPS
NAVIGATING IMPLEMENTATION
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CMS State Resources FAQ: Medicaid Eligibility Determinations, Medicaid/Exchange Interactions, and §1115 Demonstrations that Use Enrollment Caps

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Introduction

The interaction between Medicaid and Exchanges around eligibility determination issues represents one of the most important and complex aspects of the ACA. An estimated 28 million adults, along with 19 million children, can be expected to transition at least once annually between insurance affordability programs, as Medicaid and premium subsidies are termed under implementing CMS regulations. Collaboration between Medicaid agencies and Exchanges is essential in order to avert unnecessary delays in eligibility determinations and breaks in coverage that in turn can affect not only the affordability of care but access itself, given the link between coverage and health care access through plans' provider networks.

On April 25, 2013, CMS issued FAQs that address issues related to Medicaid/Exchange alignment—including the availability of federal Medicaid funding for the information systems needed to support eligibility determinations and plan alignment—and other matters, including Medicaid eligibility under §1115 demonstrations.

FAQ Excerpts

Enhanced funding for Medicaid Eligibility Systems

Question 1. Availability of 75% federal funding for ongoing operational costs in connection with Medicaid eligibility determinations

The FAQs clarify that enhanced funding may be available for operations related to staffing, equipment, and software, and to transactional costs associated with mechanized eligibility determination systems, just as enhanced funding is available for claims processing and information retrieval systems. Question 1 lays out a table designed to show the functions that do and do not qualify for enhanced (75% versus 50%) operational match on an ongoing basis. Eligibility-related matters fall on both sides of the equation (some at 75%, others at 50%), while plan enrollment assistance (as opposed to insurance affordability eligibility determinations) is to be funded at a lower FFP rate of 50%.

For example, the receipt of application data, acceptance of the data into the system, eligibility determinations, call center activities (including outstationed eligibility determination services), and ongoing case maintenance for redetermination purposes all qualify for 75% FFP. By contrast, general outreach and marketing and "community based" application assistance (presumably by workers not employed by call centers), even though equally hands-on and linked to eligibility determination, will qualify for 50% FFP. CMS further indicates that it will require call center staff to apportion their time between 50% and 75% activities. So time spent on "customer service" and "outstationed enrollment" would qualify for 75% FFP; on the other hand, if call center personnel also counsel for plan choice and plan enrollment, the federal contribution, according to Table 1, would be 50%.

Questions 3 -5. When does the enhanced rate for eligibility workers directly involved in the operation of the new eligibility system begin, and what other costs can be included? Can Program Integrity costs be included?

CMS indicates that costs associated with training workers will be eligible for 75% FFP rates beginning "three months (or less) prior to the start of operations." CMS notes that states must be able to demonstrate their eligibility determination system will be ready to operate, in compliance with federal standards (known as the Seven Conditions and Standards), and "meet minimum critical success standards" by October 1, 2013. This means that hiring at the enhanced FFP rate could begin August 1, 2013.

CMS indicates that it will permit the enhanced 75% rate for certain other costs directly connected with eligibility operations such as utilities, rent, telephone services, and the like. Costs not "specifically identified with development or operation of an MMIS (including Medicaid eligibility determination system)" will qualify for 50% FFP. Verification activities related to eligibility determinations would be paid at 75%, while post-eligibility sampling activities for compliance purposes would be paid at the 50% rate.

Medicaid/Exchange Coordination

Question 1. How will FFEs apply Medicaid policy and verification procedures?

CMS points out that FFEs will use "the same set of eligibility criteria, including selected state-specific options and standard verification procedures" regardless of whether the FFE operates under a "determination" or "assessment" model (in the latter, the FFE screens and assesses but does not have delegated formal eligibility determination powers). CMS clarifies that even in an assessment state, as long as the FFE "applies the same policies and verification procedures as those the state employs," the state must accept the FFE assessment.

CMS further clarifies that Medicaid and CHIP agencies may use different approaches (assessment versus determination) but may not make the decision on a case-by-case basis.

Question 2. Exchange of information from Medicaid to the FFE

CMS states that in assessment states, Medicaid must communicate with the FFE where the FFE assesses eligibility but the Medicaid agency later determines ineligibility. CMS states that "once received, the state Medicaid Marketplace determination will be accepted and the account will be assessed by the [FFE] for enrollment in a QHP and eligibility for advanced premium tax credits and cost-sharing reductions."

Question 3. Post Eligibility Determination Procedures

CMS clarifies that once a case is transferred to Medicaid or CHIP for a final determination following an assessment, the state agencies then become responsible for "updates, redeterminations, and renewals" as the "enrolling entity," "regardless of where the initial application was submitted." At this point "[n]o further coordination would be needed with the [FFE] except when an individual is found ineligible for Medicaid or CHIP during the redetermination process." Where this happens, the agency would transfer

the account back to the FFE for enrollment determinations. CMS states flatly that "the FFE will not handle redeterminations or renewals for Medicaid/CHIP and will refer individuals to the appropriate site in the state as appropriate."

Question 4. Integration of Enrollment Files

CMS clarifies that the FFE will not integrate its client registries with those maintained by state programs, nor will it routinely check Medicaid/CHIP enrollment files to determine whether client overlap exists.

Section 1115 Demonstrations

Question 1. Will CMS approve §1115 enrollment caps?

CMS indicates that no more enrollment caps will be approved under §1115:

> The Affordable Care Act provides significant federal support to ensure the availability of coverage to low-income adults. Enrollment caps limit enrollment in coverage on a first come, first serve basis. Periods of ineligibility delay or deny coverage tor otherwise eligible individuals. These policies do not further the objectives of the Medicaid program, which is the statutory requirement for allowing §1115 demonstrations. As such we do not anticipate that we would authorize enrollment caps or similar policies through §1115 demonstrations for the new adult population or similar populations.

Question 2. Enhanced federal funding for service delivery reforms for people covered through §1115

CMS clarifies that service delivery reforms for §1115 participants, even those who otherwise would qualify as enhanced rate beneficiaries if covered as an expansion group under the ACA, would be funded at the state's normal FFP rate.

Issues

FFE/State Agency conflicts in individual cases? The FAQs, like the regulations on which they are based, contemplate the potential for conflicts to arise in which both the FFE and the state agency determine that an individual is ineligible for either premium subsidies or Medicaid. Will federal dispute resolution timeframes come into play at this point? How will applicants be apprised? Will they be able to participate in the resolution, particularly if the basis for the denial is allegedly disqualifying evidence in the possession of the applicant?

Confusion for individuals? Supportive services? The FFE/Medicaid coordination process creates the potential need for additional support in order to guard against people getting lost in the eligibility determination system. Will 75% FFP be available to states to supply case workers to applicants who have been told that their applications have been assessed by the FFE and sent to Medicaid for eligibility determinations? How will applicants be assisted when their applications for Medicaid or CHIP are denied and are then transmitted to the FFE? Will FFE call centers or Navigators play this role?

Section 1115 enrollment caps. CMS makes clear that it will no longer approve enrollment caps for populations who would be eligible as part of the expansion group, and potentially other populations as

well. As states' §1115 demonstrations expire, how will the issue of enrollment caps be resolved? Will states expand their demonstrations (funded at normal rates) to all eligible persons? Will states shift to state plan coverage of the expansion group? Or might states abandon their §1115 eligibility expansion demonstrations? In light of the presence of the new eligibility group as a state plan coverage option, does any §1115 eligibility waiver affecting this population qualify as a demonstration that furthers Medicaid objectives? Or should §1115 demonstrations now be limited to coverage, system delivery and payment demonstrations, or to eligibility demonstrations testing coverage for groups whose entitlement to assistance is not addressed as part of the 2014 Medicaid eligibility expansion group?