DEB/ 10/27/10

Model process for the interstate coordination of enrollment, retention, and coverage of low-income children in Medicaid and the Children's Health Insurance Program (CHIP)

Background

In accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) section 213 a notice was placed in the Federal Register of Dec. 18, 2009 to solicit comments to assist in the development of a model process for the coordination of enrollment, retention, and coverage for low-income Medicaid and Children's Health Insurance Program eligible children who frequently change their State of residency or are otherwise temporarily located outside of the State of their residency. The notice included models recommended in the 2006 report to Congress "Studies Regarding Barriers to Participation of Farm Workers in Health Programs." CHIPRA required the Centers for Medicare & Medicaid Services (CMS) to develop a model process by August 4, 2010 and required the Secretary to submit a Report to Congress describing additional steps or the authority needed to make further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of low-income children who frequently move from State to State.

Relatively few responses to the Federal Register notice were received. CMS reviewed the comments that were received to identify comments regarding best practices and disadvantages to the models described in the notice. The following proposed model was developed in July 2010 after consideration of the comments received in response to the notice, as well as the information in the 2006 report to Congress. This proposal is one potential approach for meeting the requirement of CHIPRA 213 with respect to a model for interstate coordination of enrollment and coverage of children under CHIP and Medicaid.

Proposal

There are four fundamental elements to this proposal. Some of these elements may require legislation, but some elements may be achievable based on existing legislative authorities. Some elements may require rulemaking, and certainly all will require changes to IT and certain State and federal processes. Each will need to be explored in further detail if the model is to be moved forward. If this model is accepted, it will be included in the Report to Congress, which will be submitted in accordance with CHIPRA. As required by CHIPRA, the Report will include the steps and authority needed to make these improvements to coordinate enrollment and retention.

The four elements are as follows:

- Host State Activities
- Home State Activities
- FFP
- Eligibility Verification

Host State Activities
The Host State is the State where a Medicaid or CHIP eligible individual arrives seeking coverage of medical care. Upon such a request, the Host State will confirm eligibility in the Home State, and upon receipt of confirmation, issue a Guest Card to the individual and notify the Home State of the individual's guest status and current address. The Host State will enroll the individual through its MMIS with a guest status, including a code that identifies the Home State. The individual will be able to use the Guest Card to access any services covered by the Host State, subject to the Host State's limitations and requirements, from any provider enrolled with the Host State. The Guest will be exempt from enrollment in any managed care plans or benchmark plans.

Home State Activities
The Home State must confirm eligibility for the Host State, and upon notification from the Host State of individual's guest status, change the mailing address for the individual on the eligibility file and place the individual in a suspense status. The individual should be disenrolled from any managed care plans or benchmark plans, unless the benchmark plan will provide coverage in the Host State. The Home State remains responsible for eligibility for the individual while out of State, including performing redeterminations at scheduled intervals.

FFP
The Host State will be reimbursed at 100% for services provided to Guests. CMS will adjust the FFP payment to the Home State by an amount equal to the Home State's share for services that were provided to its beneficiaries as Guests.

Eligibility Verification
The timely and efficient exchange of eligibility data is fundamental to this model. There are several ways in which eligibility can be verified and data can be exchanged, however these methods vary widely with respect to their efficiency and reliability. As could be expected, the methods that can be implemented most quickly and inexpensively will most likely prove to be the least efficient, and those that require a greater investment of resources will be more efficient and reliable.

There are at least four methods that could be used for the confirmation of eligibility and the exchange of data necessary for States to keep files current and unduplicated. They are briefly discussed below.

1. Telephone/e-mail communication State to State. This is currently the most labor intensive and least efficient means for one State to confirm eligibility in another State, or to communicate data to another State. This process is cumbersome because States often have no centrally located single point of contact for this purpose, so staff must search out the appropriate contact in each State each time this information is required.

2. Use of electronic HIPPA Compliant transactions State to State. Transactions currently exist that could enable States to exchange information quickly and consistently. It is not known at this writing whether all States currently have the capability to utilize these transactions effectively. If all States were able to utilize these transactions, this would

greatly improve the efficiency of the communications. Potential inefficiencies would still exist as the process would rely both on sending and receiving States' responses quickly, taking multiple steps and ensuring all steps occurred in the proper sequence.

3. Use of a clearinghouse to assist in the gathering and distribution of data. Currently, State Medicaid programs and private insurers utilize contractors to identify beneficiaries who are covered by other plans. Similar arrangements could be made to manage the efficient and timely exchange of such data for purposes of interstate coordination. Ideally, there would be a single entity so that all States would have a single point of contact, rather than having multiple contacts throughout the country.

4. Centralized federally operated Master Beneficiary Database. This concept is similar to the existing Medicare Master Database. This would most likely be the most efficient and effective means of enabling States to exchange data on a consistent and timely basis. It has the advantages of the clearinghouse model above, but it has a significant added advantage in that it could greatly assist in preventing duplicate coverage in multiple States, since a single file would be maintained for each individual. Data exchanges could be routinized to automatically update files and notify States of pertinent information, without having to rely on each State to initiate appropriate transactions on each individual.

Next Steps

CMS invites feedback from stakeholders regarding the viability of the proposal, to identify any major impediments, to obtain suggestions for improvement of the proposal, to identify policy decisions that must be made and to identify implementation issues, including required statutory and regulatory changes and systems development issues, both for CMS and the States. We encourage those with feedback to contact Rebecca Bruno of the Division of Eligibility and Benefits at (410) 786-5568 or Rebecca.Bruno@cms.hhs.gov.