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Center for Medicaid, CHIP and Survey & Certification

CMCS Informational Bulletin

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SUBJECT: Recent Developments in Medicaid and CHIP Policy

This Informational Bulletin is to provide a summary of new and recent activities and guidance to the States over the past two weeks. On October 29, our colleagues at the HHS Office of Consumer Information and Insurance Oversight released a major funding opportunity announcement (FOA) for development of Information Technology (IT) systems for the new Exchanges. On November 3, CMCS and OCIIO together released an IT guidance document for Medicaid and the Exchanges, and CMS published in the *Federal Register* a notice of proposed rulemaking regarding federal support for Medicaid eligibility systems upgrades. Today, CMCS is releasing the second letter discussing the "political subdivisions" provisions included in the American Recovery and Reinvestment Act (the Recovery Act) and the Affordable Care Act, and we are also releasing a letter discussing the Affordable Care Act provision that provides States with the opportunity to receive up to a 5 year renewal period for certain types of Medicaid waivers that serve dual eligibles. Finally, this Informational Bulletin discusses the $250 rebate that was provided by the Affordable Care Act for individuals who must pay out-of-pocket drug costs under Medicare Part D. A more detailed description of each of these activities is provided below:

- **OCIIO Funding Opportunity Announcement** -- On October 29, 2010 OCIIO released an FOA for competitive funding opportunities for States to design and implement the IT infrastructure needed to operate the new Health Insurance Exchanges. The FOA offers grants to up to 5 States (or groups of States) that have been considered "early innovators" and are therefore ready to begin work on infrastructure building. The FOA can be accessed at www.grants.gov by searching for CFDA 93.525.

- **OCIIO/CMS Guidance for Exchange and Medicaid Information Technology (IT) Systems** -- On November 3, 2010, CMS and OCIIO released a joint guidance document entitled, *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 1.0* that is intended to assist States with the design, development, implementation, and operation of IT and systems projects to support the Exchanges, Medicaid, and the Children's Health Insurance Program (CHIP). This document provides an initial discussion of the direction for the effective support of business operations and processes required by the Affordable Care Act and will be followed by further guidance

based on continued collaboration with States. The IT guidance is available at http://www.hhs.gov/ociio/regulations/joint_cms_ociio_guidance.pdf.

- **Federal Funding for Medicaid Eligibility Determination and Enrollment Activities** Published on display at the *Federal Register* on November 3, 2010, this notice of proposed rulemaking (NPRM) establishes that Medicaid eligibility determination systems will be potentially eligible for an enhanced Federal matching rate of 90 and 75 percent for development and maintenance respectively, under section 1903(a)(3) of the Social Security Act. This represents a significant increase above the 50 percent match rate currently available for such systems. The proposed rule describes a set of performance standards and conditions States must meet in order for their Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced match. As proposed, the 90 percent matching rate will be available for eligibility systems until December 31, 2015, and the 75 percent match for such systems will be available beyond that date, assuming the conditions are met by December 31, 2015. The proposed rule is available at http://www.gpo.gov/fdsys/pkg/FR-2010-11-08/pdf/2010-27971.pdf. Questions regarding the Medicaid IT guidance documents may be directed to Penny Thompson, Deputy Director, CMCS at 410-786-3870.

- **Medicaid Recovery Audit Contractors (RACs)** – On November 5, 2010, CMS published a notice of proposed rulemaking on implementation of section 6411 of the Affordable Care Act, which requires State Medicaid programs to establish Recovery Audit Contractor (RAC) programs by December 31, 2010. Medicaid RACs will identify and recover provider overpayments, and will also identify underpayments. RACs are private entities that are contracted to audit providers, review claims, and identify and collect improper payments on a contingency fee basis. RACs began as a Medicare demonstration initially authorized by MMA of 2003 and were later permanently authorized and expanded nation-wide in 2006. The proposed rule follows publication of a letter to State Medicaid Directors (SMD #10-021, available at http://www.cms.gov/smdl/downloads/SMD10021.pdf) which provided guidance to States on the parameters for establishing RAC programs and includes a draft Medicaid State plan preprint States will need to submit to CMS to provide the required assurances regarding the establishment of the State's RAC program. The proposed rule is available at http://edocket.access.gpo.gov/2010/pdf/2010-28390.pdf. Questions regarding the proposed rule may be directed to Angela Brice-Smith, Director of the Medicaid Integrity Program, CMS Center for Program Integrity, at 410-786-4340.

- **Political Subdivisions –** This letter to State Medicaid Directors provides additional clarification for States regarding the "political subdivision" provisions found in both the Recovery Act and the Affordable Care Act. This guidance follows a letter on this topic released on June 21, 2010, available at http://www.cms.gov/smdl/downloads/SMD10010.pdf. The Recovery Act provided for an increase in the Federal medical assistance percentage (FMAP) for the duration of a "Recession Adjustment Period." A prerequisite for receipt of such increased federal funding is that States may not increase the percentage of the non-federal share of Medicaid expenditures that political subdivisions are required to pay. The Affordable

Care Act contains language that affects the treatment of the political subdivision provision under the Recovery Act. As such, this letter clarifies how the determination of compliance with the political subdivision provision under the Recovery Act is calculated, notes that such determinations shall take account of State law as well as State plan provisions, and updates the attestations States must make regarding compliance. Questions regarding this letter may be directed to Bill Lasowski, Deputy Director, CMCS at 410-786-3870.

- **Five Year Waiver Renewal and Approval Periods** -- This letter provides guidance to States regarding the implementation of section 2601 of the Affordable Care Act which provides for a 5-year approval or renewal period for certain Medicaid waivers -- including section 1115 and sections 1915(b) and 1915(c) of the Social Security Act -- through which a State serves individuals who are dually eligible for Medicare and Medicaid. The Medicaid statute specifies the duration for the various types of Medicaid waiver and demonstration programs. Section 1915(c) waivers are approved initially for a 3-year period and renewed for 5-year periods. Section 1915(b) waivers are approved initially for 2 years and renewed for up to 2-year periods; section 1115 demonstrations are approved initially for a period of 5 years and are typically extended for a period of up to 3 years.

  States are now permitted, at the Secretary's discretion, to receive up to a five year approval or renewal period for waivers that provide medical assistance for dually eligible beneficiaries. This new authority enhances existing tools available to improve care and services for this particularly vulnerable group of beneficiaries. In order for a State to apply for the extended approval periods, the waiver or demonstration must include a focus on the dual-eligible population and provide delivery system options or services that could not typically be provided to dually eligible individuals under the State plan. Questions regarding this guidance may be directed to Barbara Edwards, Director of the CMCS Disabled and Elderly Health Programs Group at 410-786-0325.

- **Withdrawal of Average Manufacturer's Price Regulation** -- This final rule, which is on display at the *Federal Register* today, withdraws two provisions from the final rule that addressed the Average Manufacturer's Price for prescription drugs under Medicaid -- originally published in the *Federal Register* on July 17, 2007 – known as the AMP final rule. The rule is being withdrawn due to litigation and changes resulting from the Affordable Care Act. This rule withdraws the determination of average manufacturer price and the federal upper limits for multiple source drugs and the definition of "multiple source drug" as it was revised in the final rule published in the *Federal Register* on October 7, 2008. This final rule also responds to comments we received on the September 3, 2010 proposed rule on this topic.

- **Medicare Part D "Donut Hole" Rebates.** Section 3315 of the Affordable Care Act provides for a one-time $250 rebate for certain individuals who must pay out of pocket drug costs due to the "donut hole" under the Medicare Part D prescription drug program. CMS has received questions as to whether the $250 rebate is countable as income when determining eligibility for Medicaid. For reasons explained in more detail below, the $250 rebate should not be a factor in determining income eligibility for Medicaid.

  A limited number of Medicare beneficiaries are eligible to receive the $250 rebate, because individuals who are entitled to a Low-Income Subsidy (LIS) under Medicare Part D are excluded from receiving the rebate. The Medicare statute and Part D regulations define those eligible for a LIS as:

  --Medicaid full-benefit dual eligibles;
  --Those eligible as medically needy;
  --Those eligible in 209(b) States;
  --Qualified Medicare Beneficiaries (QMB);
  --Specified Low-Income Medicare Beneficiaries (SLMB);
  --Qualifying Individuals (QI); and
  --Anyone receiving SSI benefits.

  Therefore, only Medicaid beneficiaries in an eligibility group with a limited benefit package; e.g., the optional Tuberculosis group or the optional COBRA continuation group, are likely to be eligible for the $250 rebate. In the rare instances where a Medicaid beneficiary is eligible to receive a rebate, the rebate still would not be counted as income when determining eligibility. The $250 rebates fall under the Supplemental Security Income (SSI) definition of rebates or refunds that are not countable as income.

  Since the rebates would not be counted as income under SSI rules, they also would not be countable as income under the Medicaid program. It is important to note, however, that if an individual who receives a $250 rebate retains those funds instead of spending them, any remaining funds would be countable as a resource beginning the month after the funds were received. Questions may be directed to Roy Trudel of the CMCS Family and Children's Health Programs Group at 410-786-3417, or roy.trudel@cms.hhs.gov.