Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems
Questions and Answers
October 5, 2012

1. ***Is there new policy in these questions and answers?***

   No, these questions and answers are intended to clarify existing guidance. This guidance is available at:

   - Tri-Agency letter released on August 10, 2011: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/Cost-Allocation-IT-Systems.pdf

   - Tri-Agency letter released on January 23, 2012: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-01-23-12.pdf

   - Guidance for Exchange and Medicaid Information Technology (IT) Systems 2.0: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaiditguidance.pdf.

2. ***Why do Exchange systems have to be cost allocated with other programs?***

   Federal grants and cooperative agreements are available to States, without any matching requirements, to fund the planning and establishment costs of Exchanges. However, consistent with longstanding federal policy and practice and as set forth in Office of Management and Budget (OMB) Circular A-87 (2 C.F.R. Part 225), in those cases where Exchanges share services and functionalities with Medicaid and the Children's Health Insurance Program (CHIP), those programs must also pay their share. Using a common set of systems and services for certain activities has the potential to reduce all programs' administrative costs over the long run, and deliver better results for consumers. We have identified a limited but critical set of such activities, relating to the need to establish a common framework and approach for determining eligibility. Further, we encourage States to consider other areas where common assets can be deployed on behalf of multiple programs.

   Once Federal establishment grant funding is no longer available,[1] Medicaid and CHIP

[1] Per guidance released on June 29, 2012 (http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html), the Secretary has determined that §1311(a) grant funds are available to fully fund Exchange-related expenses (in the State's approved work plan and budget) until: 1) the end of the start-up year that

funding (on a cost-allocated basis) will continue to be available to support operation and maintenance of shared systems benefitting the Medicaid and CHIP programs. The Medicaid program offers enhanced Federal funding in certain situations and assuming certain conditions and timeframes are met.

3. ***Can a State allocate the costs of certain "enterprise-wide" assets among the Exchange(s), Medicaid and CHIP if they are necessary for those programs, and use them for other programs and purposes in the State without having to charge those other users?***

   Yes. For Federally-funded human services programs, OMB has approved an exception to certain cost allocation principles set forth in Circular A-87, on a time limited basis, to allow States to allocate enterprise-wide assets only among the State's Exchange(s), Medicaid and CHIP even if those assets are also used for other human services programs and purposes, as long as those costs would have been incurred anyway to develop the Exchange, Medicaid, and CHIP systems. Incremental costs of adding other programs to the system must be identified and entirely borne by those other programs. This exception is only available until December 31, 2015 and only for development costs (and initial licensing and set up, if buying a Commercial Off the Shelf (COTS) product). Ongoing maintenance and operation costs must be allocated as ordinarily required under OMB Circular A-87.

   CMS has implemented a strong system development process review and oversight to monitor use of this exception, incorporating periodic, mandatory reviews of State progress during each State's development process. States will be expected to track and periodically report to CMS which costs and components are attributable to the underlying Exchange/Medicaid/CHIP system, and which are attributable to the addition of human service programs.

   For more information, see "Tri-agency letters" of August 10, 2011 and January 23, 2012 in which CMS describes the exception to OMB's Circular A-87, http://www.medicaid.gov/AffordableCareAct/Provisions/Information-Technology-Systems-and-Data.html

4. ***Does allowing an exception to Circular A-87 cost allocation principles mean that HHS is promoting integrated IT systems across health and human services programs?***

   States have the sole authority to decide the degree to which their Exchange, Medicaid, and CHIP eligibility system is integrated with the intake and eligibility determination process for other State programs. Many families will participate in both health and human services programs and both States and families can realize efficiencies if

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coverage is provided through the Exchange, 2) the time a State-based Exchange becomes self-sufficient, or 3) §1311(a) grant funds have been expended, whichever comes first.

systems are interoperable. At the same time, some States may choose to keep these systems separate; the decision rests at the State level and should be based on a realistic assessment of the current IT status and gaps, confluence of business models, and other factors. For States that want to pursue an integrated system, we encourage them to consider phasing in functionality and participation of other programs, to ensure that Affordable Care Act milestones for Exchanges and Medicaid are met.

5. ***If the participation of other human services programs adds costs to the Exchange/Medicaid/CHIP IT build, does a State have to separately identify and charge those costs to the program(s) adding those requirements?***

Yes. This exception from A-87 cost allocation principles simply allows States to "reuse" the Exchange/Medicaid/CHIP IT build. If additional costs are incurred outside of that framework due to requirements from other human services programs, those other programs must pay for the specific added costs incurred due to the additional requirements or scale.

6. ***On what basis does a State allocate costs?***

There are a number of different ways that costs can be tracked and allocated. Incremental costs that are specific to an individual program or programs and not shared with all programs should be identified and charged only to that program. Direct costs that are shared among programs should be allocated on a basis proposed by the State, subject to OMB Circular A-87 and the OMB-approved exception to Circular A-87 for Federally-funded human services programs.

Consistent with the cost allocation principles outlined in OMB Circular A-87, the methodology for allocation should have some reasoning based on expected transactions, expected program population, etc., and cannot be arbitrary (e.g., simply half and half because there are two programs sharing in the investment). Indirect costs should be identified and allocated based on a methodology that reflects the proportionate benefits received by the programs (e.g., total direct costs for administrative costs, square footage for building and operation costs, number of accounts for telecommunication costs). States may use projections for the "total population" when calculating the share among Medicaid, CHIP, and the Exchange for both development and maintenance and operations costs. This is consistent with the cost allocation principle that costs should be allocated on the basis of actual use by all participating programs. Additionally, States may propose for Federal consideration alternative allocation methods as long as they produce an equitable result that is repeatable and based on valid recorded data.

States are expected to update their cost allocation methodology and plan based on updated or better data upon which they are based. CMS will be reviewing cost allocation plans regularly through the gate review and Advance Planning Document

process, and cost allocation plans can be updated through the Advance Planning Document update process.

7. Can a State still take advantage of the exception to Circular A-87 cost allocation principles if the State does not qualify for enhanced funding from Medicaid (e.g., the State fails to meet the seven standards and conditions), or if the State fails to meet Exchange requirements?

No. Since the purpose of the exception from A-87 cost allocation principles is to allow other human service programs to benefit from a unique federal investment being made in shared eligibility systems to ensure that the Exchange, Medicaid and CHIP comply with Affordable Care Act requirements, the exception would not apply to systems that don't meet Medicaid standards for enhanced funding or Exchange grant requirements if Exchange funding is being used.

8. Is the State CHIP program eligible for enhanced funding for eligibility systems modernization?

CHIP programs may participate along with Exchanges and Medicaid in shared eligibility services, as indicated in IT Guidance 2.0, with system costs allocated across programs based on "total population," as discussed earlier. Combined Medicaid/CHIP programs may be eligible for enhanced funding. Separate CHIP programs should utilize their administrative funds to participate.

9. What if things change after the cost allocation plan has been approved? Does the State have to readjust the cost allocation plan?

Yes. CMS expects States to adjust cost allocation plans based on changing realities. CMS will be reviewing cost allocation plans regularly as part of our "gate review" process to ensure they continue to accurately represent appropriate allocations based on business and technology design and development. Changes to the cost allocation plan can be addressed in the APD update process.

10. How does cost allocation among an Exchange establishment grant and Medicaid administrative funding work if the State is using a Federally-facilitated Exchange, or engaged in a partnership model with the Federal government?

It is possible that a State relying on a Federally-facilitated Exchange or using the partnership model would still be investing in creating a modern eligibility system to serve the State's Medicaid program and to serve a State-based Exchange because the State may be using the partnership model to transition from a Federally-facilitated Exchange to a State-based Exchange. Further, modernizing the Medicaid eligibility system, even without integrating it to an Exchange system, can provide high quality and

accurate determinations for individuals based on modified adjusted gross income (MAGI) as well as those whose eligibility is not based on MAGI. A State that intends to use a Federally-facilitated Exchange or to work in partnership with one without transitioning to a State-based Exchange may seek to modernize its Medicaid systems for that reason. The key determinant in whether cost allocation is necessary in States utilizing a Partnership model or a Federally-facilitated Exchange is whether Exchange establishment grant funds are being used to invest in the long-term creation of a modern eligibility system to be shared between a State-based Exchange and the State Medicaid program.

1. Partnership Model Exchange in Transition

   A State using the partnership model initially as a transition to a State-based Exchange can still receive funding from Exchange establishment grants, as well as an enhanced funding from Medicaid (subject to the seven standards and conditions and applicable time limits related to funding availability), for developing, testing and implementing a shared (Medicaid, CHIP, and the Exchange) eligibility system. In this scenario, the State will still be required to allocate costs among Medicaid, CHIP, and the Exchange for shared services by benefitting program, consistent with OMB Circular A-87 cost allocation principles and related HHS guidance, including Guidance for Exchange and Medicaid Information Technology (IT) Systems 2.0.

2. Partnership Model or Federally-facilitated Exchange without Transition

   A State relying on Partnership long term or a Federally-facilitated Exchange entirely but modernizing its Medicaid eligibility system can still receive enhanced funding under the Medicaid program (subject to the seven standards and conditions and applicable time limits related to funding availability). In this case, Exchange funds may not be used to improve systems or processes solely related to Medicaid, CHIP, or any other program. This includes the building of interfaces from those systems to a Federally-facilitated Exchange.

11. What if a State is ready to move forward on a Medicaid IT build, but not ready to decide on an Exchange? If the State later opts to establish a State-based Exchange and therefore request grant funds to make the transformation, does it allocate costs to the Exchange grant in order to make that transformation?

Yes, if a State opts to establish a State-based Exchange later, Exchange establishment funding would be available prospectively to transform systems, subject to approval from CMS, and assuming it is properly represented and characterized in the application for grant funding. However, please note that the availability of Exchange establishment funding (and therefore ability to readjust cost allocation on a prospective basis taking that funding into account) is subject to certain timelines, and States will need to make

decisions about their intention to establish a State Exchange along that timing in order to receive such funding.

12. Does a State need to allocate core Medicaid system development costs to the Federally-facilitated Exchange (FFE) for a State-operated Medicaid system that will be used to assess eligibility for Exchange-related insurance affordability programs and then transfer the application to the Exchange?

No, these costs would not be allocated to the FFE. There is no cost allocation of the State core systems costs to the FFE. Likewise, the FFE will not allocate or charge the State the portion of FFE systems development or operations costs associated with the FFE conducting assessments or determinations of Medicaid eligibility. This is clarified in guidance issued on November 29, 2011: http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.

13. If a State requests Exchange establishment funding to design, build and test the State-based Exchange eligibility system, what services does it need to cost allocate? Similarly, if a Medicaid or CHIP agency applies for Medicaid or CHIP funds related to the business requirements, design, build and testing of the systems required to determine MAGI-based (modified adjusted gross income-based) eligibility for Medicaid or enrollment in a Qualified Health Plan (QHP) through the Exchange, what services does the agency need to cost-allocate between the programs?

While policies in interim final regulations 42 C.F.R. § 435.1200 (77 Fed. Reg. 17212 (Mar. 23, 2012)) and 45 C.F.R. § 155.302 (77 Fed. Reg. 18451 (Mar. 27, 2012) provide that final Medicaid eligibility determinations may be made by State Medicaid agencies and that Exchanges make eligibility determinations for premium tax credits and cost-sharing reductions, the underlying business rules and processes are overlapping, and should, to the maximum extent practical, rely upon a shared IT service(s) and infrastructure.

CMS views an eligibility service for the Affordable Care Act as a set of IT functions that produces an eligibility determination based upon MAGI. The service incorporates an application, a set of verifications (for citizenship, income, residency, etc.) and business rules that together determine whether, what type, and how much financial assistance a consumer is eligible to receive to acquire affordable health insurance.

In order to ensure efficient use of tax dollars, State Agencies that receive Federal funds from CMS to establish Exchanges and determine eligibility for Medicaid and CHIP must coordinate their efforts. To the extent that they produce a shared eligibility service or system that relies on a shared IT infrastructure, costs should be allocated for all programs benefitting from this service accordingly, consistent with OMB Circular A-87 cost allocation principles and the guidance available at Guidance for Exchange and Medicaid Information Technology (IT) Systems 2.0: http://www.medicaid.gov/Medicaid-

CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaiditguidance.pdf.

14. What if a State needs to expand the system to accommodate the human services programs?

Any service, expansion of service, or increase in capacity beyond that required for the health programs, must be paid for entirely by the benefitting program, consistent with regular practice under OMB Circular A-87. An example of an "increase in capacity" that would require a State to allocate to the other benefiting Federal human services programs would be the need for additional infrastructure, equipment and/or data storage capacity.

States pursuing an integrated eligibility system strategy may consider mechanisms for phasing their IT development, such that the additional functionality needed to determine eligibility for human services programs can be added after the health components are operational. States have the option to implement a shared eligibility system through a phased approach to better enable States to implement the health components of an enterprise system in accordance with the Affordable Care Act requirements.

Such phased projects would be allowed under the exception to OMB Circular A-87 cost allocation principles, which remains in place through December 31, 2015. States would need to incur costs for goods and services furnished no later than December 31, 2015 to make use of this exception. This would mean that if an amount has been obligated by December 31, 2015, but the good or service has not yet been furnished by that date, then such expenditure must be cost allocated as currently required under OMB Circular A-87.

15. Does a State need to cost allocate non-IT activities, like establishing a call center?

Yes. OMB Circular A-87 is not specific to IT activities. For example, if States are establishing a call center that will support the adjudication of eligibility for Insurance Affordability Programs (including premium tax credits and reduced cost sharing, Medicaid or CHIP based on MAGI), then cost allocation to the benefitting programs will be required for both the build and the call center operations. Those may include, but are not limited to, costs associated with any hardware, software, customer relations system, and staff that are part of the call center. Please refer to OMB Circular A-87 for more information.

16. In November 2010, HHS and the U.S. Department of Agriculture (USDA) issued guidance to States related to cost allocation methodologies for programs participating in a shared information technology (IT) system. How does the exception to OMB Circular A-87 cost allocation principles interact with this guidance?

For a State that is making use of the exception to OMB Circular A-87 cost allocation principles for human services programs, the November 2010 guidance does not apply to development costs for those programs during the time period in which the State is applying the exception.

CMS also released "Guidance for Exchange and Medicaid Information Technology (IT) Systems 2.0" (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaiditguidance.pdf). IT Guidance 2.0 clarifies that States must apply cost allocation methodologies consistent with OMB Circular A-87 requirements for an integrated IT system that includes Medicaid, CHIP, and the Exchange, and costs must be allocated to each program for activities from which each program benefits. IT Guidance 2.0 supersedes any previous guidance on cost allocation methodologies between Medicaid, CHIP, and the Exchange released by HHS.