

Event Title: CMCS Webinar Series: Overview of Medicaid/CHIP Eligibility and Enrollment Final Rule

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>>Jennifer Ryan: Good afternoon everyone. I'm really glad you can be with us today to hear the first in our series of webinar presentations related to our Medicaid and CHIP Eligibility and Enrollment Final Rule. Very pleased that we have with us today the CMS Deputy Administrator and Director of the Center for Medicaid and CHIP Services, Cindy Mann. And she is going to present an overview of the Final Rule. So without further adieu, I'll turn it over to Cindy.

>>Cindy Mann: Thanks so much Jennifer and thank you all for joining us today. So as Jennifer noted, we have a webinar series ahead 'cause we're very excited about our new rule and know that its important ground rules for some of all the changes that people are working on across the country. So we want to be as helpful as we can as you all sift through these rules and think about how it affects your implementation of these provisions in the Affordable Care Act.

So today's session is really an overview of the rules. And then we'll dig in, according to the schedule that that hopefully you've all seen, to some of the specifics.

So as everybody knows, I think, under the Affordable Care Act, millions of uninsured Americans will gain coverage. And they'll do so through a variety of means. Many will gain coverage through their employer and through employer-sponsored health insurance. Some will gain coverage by purchasing insurance through the Affordable Insurance exchanges, many with the benefit of premium tax credit subsidies, and many will gain coverage through the Medicaid and the Children's Health Insurance Program.

In order to really create -- to meet the goals of the Affordable Care Act which is to ensure that people have coverage, to ensure that quality is improved, and to try to lower costs through improvements in care, the programs and these different sources of coverage will really need to work together. First, to ensure that coverage happens, that that people are actually able to get insurance. And then working together to improve quality and to lower costs.

So the Final Rules, Eligibility Rules that we put out that will actually formally will be published tomorrow, March 23rd, codify the Affordable Care Act

provisions relating to Medicaid and CHIP, and those provisions specifically around what happens in 2014.

So, if we move to the first slide, the importance, of course, of Medicaid and CHIP I think is demonstrated by this slide which we're moving to get to you.

>>Jennifer Ryan: Sorry. Nic, it doesn't appear to be advancing. Can I ask for your help?

There we go. There we go. Sorry.

>>Cindy Mann: If you look and it's, ya'know, no surprise I think to anybody whose been uninsured or thought about the uninsured, is that lack of affordability is such a key reason why people are uninsured; and hence, as a result, most of the people who are uninsured have lower incomes. And this graph indicates and breaks down children and parents, other adults by income level.

If you look generally at this chart, you see that about two-thirds of the non-elderly uninsured have incomes below 200% of the poverty line. And, about 50%, actually a little bit more than 50% of people have --who are uninsured have incomes below about 133% of the poverty line, which is the income eligibility level that will be in effect for adults in the Medicare program and the minimum standard for children come 2014. So Medicaid and CHIP certainly have a major role to play as we move forward on the goals of the Affordable Care Act.

We go to the next slide. This is sort of an overview slide to give you a sense of really what's in these rules and where, how, how the various aspects of the Affordable Care Act – they're codified through these rules and through the rules that were put out by the by CCIIO on the Exchange and the rules that will be finalized soon by Treasury on the premium tax credit - work together to assure a seamless, streamlined system of eligibility and enrollment.

First, what happens if you look at the box on the left, is people get to submit a single, streamlined application. And, the point here, of course, is that people won't necessarily know whether they are eligible for Medicaid or eligible for CHIP or eligible for the premium tax credit. And, and so we ought not to expect them to know and the law doesn't expect them to know. So it calls for, and the regulations talk about, a single, streamlined application that will apply to all of those programs. Of course, somebody may also end up going to the Exchange and not seek any kind of financial assistance and that, that will be a, a direct route for them to go forward as well. The law also provides, and so does the regulations, for an ability to apply online, by phone, by mail or in person depending upon what works

best for the individual. So, there's a good deal about, in these regs, about that application process and application procedure.

Secondly, eligibility is determined and verified. So, if you have a single application, but potentially serving people eligible for different programs, there has to be a system coordinated so that eligibility is determined and verified in a simple way, in a timely way, and in an accurate way for all of those programs: for Medicaid and CHIP, for enrollment in a qualified health plan, for advanced premium tax credits and cost-sharing reductions that may be available to some people. And, if a state is also administering a basic health plan for that basic health plan to – in other words, you've got a single application, but you also need to have a coordinated and simplified method of determining eligibility for all of those various programs that assures a really positive consumer experience.

And then finally, you enroll in a, in a health coverage program. And so there will be a number of – there'll be an online tool available to help people with their selection. People – um, states will be able to arrange the enrollment process in different kinds of ways once eligibility is determined. These regs do not specifically deal with the enrollment part of the, the activity and that will be an area, I think, a lot of work will be going on certainly at the, at the state and local level on implementation that will be working with states and other stakeholders and providing some guidance as we go forward.

So, let's get into what is in this, in this new rule. The Final Rule covers three particular areas as indicated in this slide. It expands access to affordable coverage, it simplifies Medicaid and CHIP and it ensures a seamless system of coverage.

So if we go the next slide going to the issue of expanding access to coverage, the first element of, of the rule. And, this is probably the area that people are most familiar with which is that the Affordable Care Act eliminates long-standing gaps in eligibility rules in the Medicaid program. As many of you know, people who are low income adults not living with children are often not eligible for Medicaid no matter what their income is, and in many states even very low income parents are not eligible for Medicaid depending upon how a state has designed their program. This - the Affordable Care Act eliminates those gaps in eligibility and does so by expanding coverage for adults up to 133% of the poverty line and this is for all adults who are under age 65. There's also some additional non-financial eligibility criteria, for example, relating to residency, immigration status and citizenship.

I should just note for those of you who are - dig more into the details, there is a 3 – 5% disregard that applies. The effective income level is 133% of

the poverty line. 138% of the poverty line. Sorry. But it is commonly referred to as 133% of the poverty line.

The, the regulations also simplify eligibility rules in the Medicaid program by consolidating what is a proliferation of eligibility categories that have developed over the years. And, we've really consolidated a large number of those categories into four main groups. We have children. We have pregnant women. We have parents and then other adults.

Enrollment into the new income-based category is gonna be possible under our final regs as it was proposed in the proposed regs without having first to screen for other eligibility categories. So let me, let me point you particularly to the, the idea of somebody with a disability, for example. If you have an individual who may be eligible in Medicaid based on a disability, but his income is under 133% of the poverty line, the question is do they have to be evaluated based on disability in order to gain coverage? Or, what if there's - the eligibility for people with disabilities in that state doesn't go as high as 133% of the poverty line. That individual, whether or not they're disabled, will be eligible under the new adult category without having to prove the disability or have the agency establish disability.

However, one of the big changes in the new reg is identified in the fourth bullet here, which is an area that we heard a lot from people on, in, through our comments, which is that if somebody is eligible based on a disability or if somebody is potentially eligible for Medicaid benefits because of their need for long term care services and support, the new regulations, the final regulations promulgated allow them to enroll in the group that best meets their needs. So, if they may have income under 133% of poverty, what our proposed regs said is that they would enrolled in that group and if there was an optional category that they may also be eligible for that would provide broader benefits, for example, along long term care and supports, under the way the proposed regs had designed the eligibility categories, that individual wouldn't be able to access those broader benefits. We have changed that in these final regs and clarified that an individual who may be eligible for those broader benefits through a different eligibility category can enroll in that category. And as you'll hear in our subsequent webinars, there's ways in which we're assuring that they can get into coverage quickly in order - while that further determination is, is going on.

So, if you look at the next chart, what it really does is sum up what the income eligibility levels will be in 2014. For children, income eligibility is at a minimum wherever a state was in March 2010, the date of enactment. And, that varies, of course, by state and on average is about 241% of the poverty line. Pregnant women, the minimum level is 133% of the poverty

line. For some states that's going also to be higher. For parents, the minimum level covered is 133% of the poverty line. And again, referencing my point before, even if you're a person with disabilities, you still will be eligible up to 133% of the poverty line based on your income even if the state doesn't have a category specifically for people with disabilities that goes up to that income level. And, all other adults, again eliminating these complex eligibility categories that divide people based on whether you're pregnant or a parent or based on disability, other adults too will be eligible up to 133% of poverty. In other words, we get to a point where there is an income-based eligibility route to the Medicaid program for adults up to 133% of poverty and for children at higher income levels depending upon where their state was.

Very important to note as we go forward is that the expansions in coverage that I just described are strongly supported with additional federal investments. For the first three years of implementation - 2014, 2015, 2016 - states will receive full federal matching payments, 100% FMAP, for covering the newly-eligible people, people who are in categories of eligibility that make them eligible in a way they weren't before. And that that higher matching rate stays very high. It gradually declines from 100% but only to - it goes down only by ten percentage points to 90% by 2020 and beyond; so very strong federal support. The new Final Rule that we are just issuing, however, does not include, I just want to note, the FMAP related provisions that were in the NPRM and that was actually intended. We knew we needed to spend some more time working through some of the methodologies that we had proposed in the NPRM about how states might be able assign FMAP to the appropriate individual without having a double eligibility system: one that operates the old rules; one that operates the new rules so a state could tell who was newly eligible. We had proposed some methodologies in the NPRM and we're now working with a contractor and with ten states to test simple and reliable methods to make sure we can assign FMAP in ways that don't require that kind of shadow eligibility system. So stay tuned for that, we're gonna have more information over the next couple of months on how that testing is going and then we we'll be issuing final rules later this year.

If you look, I'm going to move now to the second area of our Final regs which is simplifying Medicaid and CHIP. There's many different ways in which the program has been simplified. Some of the eligibility changes that I mentioned before which is just eliminating the gaps in, in eligibility categories and collapsing some of those eligibility categories are certainly part of our simplification of the program. In addition, though, the law directs

us to - the program to move both Medicaid and CHIP, to move to a modified adjusted gross income standard replacing many of the complex rules that have been in place, that have been in place for many years and in place today and eliminating all of the income deductions and disregards, other than that 5% across-the-board disregard that I mentioned earlier. States will have to convert their current net income standards to MAGI standards and we'll be providing technical assistance to states on that conversion method. The contractor that I just mentioned a minute ago around the FMAP methods is also looking, looking with those ten states into different conversion methods and we'll be working with states on how to do that.

In addition to moving to the modified adjusted gross income standard, we – the regulations also following state-lead over the last ten or so years really modernizes the eligibility verification system to rely primarily on electronic data. That's really where states have been going increasingly over the, the last decade and are, are gonna to be moving forward consistently over the next period of time. The notion in the verification rules, and, and we'll go through these in more detail in a subsequent webinar, is that those electronic data should always be primary. We can – states can rely on self-attestation, but before going to paper - verification from individuals - always look first to electronic data and go to other sources only when that data aren't available or when there's some conflict – there's, the data that that has been developed is not reasonably compatible with other information available.

It's also important to note when the federal rules describes these, that the federal government will start to perform some of the data matches for states on, in areas that the states now do it, relieving a lot of administrative burden. This is really a common sense advance that if there's a number of federal sources of data, for example, from the Social Security Administration, Department of Homeland Security, and IRS, which will be available for states and is much easier for HHS to really coordinate that and service the data hub so states don't have to independently ping each of those data sources.

Another simplification measure goes to the issue of renewals. Renewals will be every twelve months for the group of people whose income is determined under MAGI. And, again it is a data-based renewal system. And, in fact, if eligibility can be renewed based on available data, no renewal form is needed in order to accomplish that twelve month renewal.

I'm gonna to move now to the third area covered by our final regulations, which is that seamless system of coverage. And this slide is really intended

to show how we envision – how the Affordable Care Act, more precisely, envisions how the availability of subsidization for health coverage will work. Which is that you see there's Medicaid coverage available for adults. Medicaid and CHIP coverage available for children. Sometimes depending upon a state and different income levels when you're not eligible for Medicaid either as an adult or as a child, you may be eligible if you don't have employer-sponsored insurance. You may be eligible for a qualified health plan coverage on the Exchange with premium tax credits. You may be eligible, depending upon your income, in addition to cost-sharing reductions. And then if your income is above what's available for either of those two subsidizations, the premium tax credit and the cost-sharing reduction, you can still be eligible to purchase coverage throughout the Exchange without financial assistance which can still give you a significant advantage because of the market-place established by the Exchange. So in order to make all this work, as noted earlier, it all really has to all fit together. And it does fit together in many respects by the way in which the Affordable Care Act Provides new tools and as well as rules for assuring that these programs can fit together in ways that will make sense both for those that are operating the programs as well as certainly for consumers.

So if we go to the coordination and the system of coverage, there's many elements that go into the issue of coordination. Some are identified here, but there's really a multitude of, of matters. For example, just the whole idea of Medicaid and CHIP moving to MAGI is really a, a key method of assuring coordination because that's the same income calculation that the Exchanges will use, use when they consider whether somebody is eligible for premium tax credit or for cost-sharing reduction. So by having the same income rules in effect for all of these programs, the idea of being able to sort through whose eligible for one program or another becomes much more simple to do.

Other aspects of the seamless system of coverage is that there will be single, streamlined application for all insurance affordability programs. That is required by the statute and the rules generally around the single, streamlined application are put forth in both the Exchange rules and in our Medicaid and CHIP rules. It doesn't mean that a state can't use a multi-benefit application. Our rules – the Final Rules clarify that a state certainly can use a multi-benefit application, meaning, ya'know, for example, if they want to also have an application that addresses TANF for child care or, or SNAP benefits, they can do that. But they must also have a single, streamlined application for the insurance affordability program so allowing families and individuals to apply for those programs with an application that

-- better limited to the health insurance programs. The Secretary's actually directed to come out with a model application for use and we'll be working on that, have been working on that, and we'll be involving states and other stakeholders.

The coordination is also enhanced by requiring that there's a website that provides information and facilitates enrollment in all the insurance affordability programs. Also coordination is enhanced by the fact that the verification policies that you will see in these Final Rules are very much aligned with the verification policies that you will see in the Final Rules in the, that operate under the Exchange with respect to getting the premium tax credit, rules of verification about income, state residency, requesting Social Security numbers. We have in all instances fully aligned those policies where they are needed to be aligned in order to assure coordination. We also in the, in the Rules and previous IT guidance, and as we're working with states moving forward, have a, have also made clear that part of coordination is that there be a shared eligibility service. It doesn't mean that states' Exchanges and Medicaid and CHIP agencies have the same eligibility system. But shared services not only cut down on duplicative IT investments but also ensure that if you're figuring out MA --- you do your MAGI rules, you do them once, and you do them once initially and then as they're updated and changed they're updated for all programs together. So shared eligibility service ensures that coordination through your IT system.

And then there's a number of different provisions, some new in these Final Rules, around standards and guidelines for assuring a coordinated, accurate and timely process for the eligibility determinations and, when necessary, for transferring information back and forth across insurance affordability programs.

I'm gonna turn to the next issue which is really a key change also in the Final regulations relative to what was in the NPRM. And this is that there's now an additional way that that states will have for accomplishing coordination with respect to eligibility determinations. The NPRM laid out a process which is still a, a available for states, and still described in our Final regulations, which is that an Exchange is, is able make final Medicaid/CHIP eligibility determinations with respect to the population that is subject to the modified adjusted gross income standards. They will do so using the Medicaid and CHIP rules of standards. So they're not gonna be making up their own rules to the extent that there's different options that states have for the MAGI populations. The Exchange in making that -- those Medicaid and CHIP eligibility determinations will stand in the shoes of the Medicaid

agency and apply their rules. And, of course, it's a shared eligibility service and so they'll be applying what we expect will be rules that have been programmed into their automated eligibility system. So Exchange can make the final eligibility determinations. And one change that is in our Final Rules, that I want to call attention to, is that, as, as you know may know, Exchanges can be run by non-profit entities as well as by governmental entities. And we've made clear in these Final regs that, that Exchanges run by non-governmental entities are, in fact, those who contract out with non-governmental entities can also make those Final Medicaid and CHIP eligibility determinations. Again, using those Medicaid and CHIP rules and standards as they do so.

The second way, however, that states can arrange to do their coordinated eligibility determination is for the Exchange to make the initial assessment of eligibility. This is, of course, in the instance where the single application finds its way to the Exchange. They can make the single assessment of eligibility. Again, they'll have a shared eligibility service. They'll have a single set of rules around modified adjusted gross income. So when they look at any family, they're really looking at what, what income level using modified adjusted gross income that family or that, those individuals have. In making that initial assessment, they again will apply much of the rules from the Medicaid and CHIP agencies. And if they then determine that the individual that their, whose application they're reviewing appears to be eligible for Medicaid and CHIP, then they will transfer the information over to the Medicaid and CHIP agency. Medicaid and CHIP agency, under these rules, will be required to accept that electronic account sent over by the Exchange. The Exchange rules deal, of course, with the Exchange's responsibilities to send that information over to the Medicaid agency or the CHIP agency.

The rules also include a number of protections to assure that this process works smoothly. And, so some of the rules that are included in the Final Rule require that there be no duplication of requests for information by applicants or that agencies themselves don't spend time and money looking for information that's already been developed; for example, by the Exchange before it transmits the electronic account over to the Medicaid or CHIP agency.

And also in these Final rules are, are standards for the states to establish timeliness standards and -- for determining eligibility generally and then also specifically with respect to applications that are transferred over from the Exchange to the Medicaid and CHIP agency. There's also a few different provisions in the rules relating to what, what happens if there's

some conflict in determination of eligibility and income between Medicaid, CHIP and the Exchange and how does that get resolved so we make sure that again, people end up in the appropriate program and they end up on the appropriate coverage program in a timely and easy way.

I want to call attention to the fact that the set of rules around the coordinated eligibility enrollment and some of the provisions around it regarding timeliness standards and the rules around duplication, and so forth, have been issued part of this Final Rule as an interim final with comment. There's, there's somewhat new and important provisions and we wanted to make sure we get public comment on them. So we urge you to look at those carefully and to provide that comment. It's a 45 day comment period which ends, I believe on May 6<sup>th</sup>.

>> 8<sup>th</sup>

>> Cindy Mann: 8<sup>th</sup>. Thank you. May 8<sup>th</sup>. Whoop...and there it is on the next steps. So, so I don't make mistakes, we've written it down for you. Next steps is the regulation will actually be formally – has been available on display and will be formally published in the Federal Register tomorrow March 23<sup>rd</sup> 2012, an important date in the history of the Affordable Care Act. It actually marks the second anniversary of the Affordable Care Act. You will have a 45 day comment period on those items that are subject to – are noted as interim Final Rules, until May 8<sup>th</sup>, not May 6<sup>th</sup>. And here we've provided the particular sections, and you'll see that also outlined in the beginning of the Rule, that are subject to that comment period. And, we really, again, invite you to comment.

The next slide just gives you some information as to where you can find more information on the Final Rule. We've made it available on our website, Medicaid.gov, in our Affordable Care Act sections of our website. And, you will also see below that where the schedule for further webinar information in terms of getting into a deeper dive, as we say, on some of the very specific area of the regulations. The next webinar will be on March 29<sup>th</sup> at 3 o'clock. We're trying to do them regularly at 3 o'clock. After this initial overview, they'll be regularly on Thursdays at 3 o'clock. And, you'll see the whole schedule if you go to the website. But please join us for the next one.

But, before I wrap up, let me just talk about a couple of next steps. And, we, we at CMS will be working with our partners on operational guidance. We've been doing a lot of close work with states and other stake-holders on verification procedures, streamlined application, data and performance measures. So, those will be moving forward through subregulatory guidance, through other mechanisms to share that with you. And, as I

mentioned, also we'll be working through -- first through a webinar and other mechanisms around some of the methodologies. We're also gonna be working at the federal level with our federal agencies to assure coordination across programs. First, and foremost, of course, we work closely within CMS with our colleagues at CCIIO to make sure there's close coordination as we're helping everyone through the implementation phase. But, in addition, there's many other federal agencies that have much to add to the changes that are going on and can really facilitate, for example, USDA around the SNAP program.

And we're also setting up state operations and technical assistance teams, fondly know recently as SOTA, which are new teams that we've -- we are putting together to really provide a single point of contact for states, that, that are working through a number of different areas -- of course, systems eligibility, benefits, financing and access work force. And, a single point of contact through the SOTA teams will allow them to, hopefully, get their questions answered in a very timely and responsive way. And, we'll bring together subject matter experts, as well as our colleagues at CCIIO as needed.

And, let me just sort of conclude my opening remarks by just reminding us all, I guess, that it's really about making sure that we're working together to, in the end, to provide better care for people that are helped and also to lower costs through these care improvements. These are really our goals going forward. I think they are universally shared goals going forward. And, the changes that are codified in these, in these regulations are really one step towards moving forward to those, to that three-part goal.

So I will stop there and am I turning it back over to Nick or to Jennifer? To Jennifer.

>>Jennifer Ryan: Thank you very much Cindy.

So as, as Cindy was making her presentation, many of you were submitting some questions through the webinar vehicle. And, I invite you to, if you have additional questions that come up while you were listening, please type your question in and submit it to the webinar vehicle, the Q & A function.

Cindy, we have a number of questions here. People are particularly interested in the, the change for the long-term care populations. And, so can you just explain how the screening process works for individuals who might need a disability determination. What happens to them while they're waiting for that determination?

>>Cindy Mann: Okay. Sure. So, first of all, the context in which this is likely to occur is you have a state that has, either through home and community-

based waiver or an optional eligibility category, they may have the possibility of somebody qualifying for benefits, including long-term care benefits and support through this optional eligibility category or optional waiver. But that's -- they're also somebody who has income below 133% of the poverty line. So, if they applied through any mechanism -- and really that the answer should not vary based on which, which way they come into the system. If they applied for health insurance coverage through the single streamlined application, let's say they go through the Medicaid agency in this case, and the, the application will be designed so it solicits some initial information, not detailed information, but initial information around disability. A state may also provide supplemental forms to the application to solicit more information around whether somebody might be eligible under another category, including somebody who is eligible based on disability or need of long-term care supports. And, if it appears that that person may be interested or somehow they've indicated through any other mechanism that they need those kinds of additional services, they will be evaluated in a timely way for eligibility under those other categories. Often that evaluation does take more than a very short period of time. And, so what our regs provide is that they can be processed under the MAGI category so if their income is below 133% of poverty they can get into coverage quickly while that deeper evaluation is going on. And they can do that whether or not they initially approach coverage through the Exchange or approach coverage through the Medicaid agency.

>>Jennifer Ryan: And, Cindy how are parents treated when, when screened, being screened for MAGI? Do parents have to be screened first for the parent care-taker relative group or can they enroll directly under the new adult group?

>>Cindy Mann: Ya'know, the way it really is, is likely going to work is the parents group, which is retained for a variety of technical reasons and have some, some ancillary implications around the benefits side for parents. But, the parent group and the new adult group will all use MAGI as their income standard. They will all have exactly the same income and household and verification rules. So, really what happens is somebody comes in and the agency will evaluate their income. And, let's say, in a state, that the parent eligibility category goes up to 70% of the MAGI. But, and then, the adult groups picks up from there or, or picks up somebody who's not eligible as a parent group up to 133% of the poverty line. It's really, you look at the income eligibility. It's the same analysis that goes on. You look at somebody's income information, other information and you'll say: 'Ah, there's, there's somebody who's 40% of poverty or there's somebody who's

80% of poverty.’ And by determining what their modified adjusted gross income level is, the same determination will then answer the question as to whether they belong in the parent group or whether they belong in the adult group. It again may have some implication for benefits, but it’s really one single review of eligibility information.

>>Jennifer Ryan: Couple of questions about the renewal process and the twelve month, the twelve month eligibility period. So does renewals every 12 months mean that there’s a requirement for a twelve month continuous eligibility?

>>Cindy Mann: No, there’s not a requirement for twelve month continuous eligibility. There is an option for twelve month continuous eligibility for children. And, for adults what we have proposed and finalized is that states have the option, once somebody is in the program, to, to basically review if there’s a change in circumstances that might for that particular month put them over the eligibility for Medicaid. But, if they look at their situation and it appears they would remain eligible for the remainder of that calendar year, then they can keep them in the Medicaid or CHIP program, depending upon which program we’re talking about. So, it’s really more of a common sense: ‘Well, let’s look at budgeting more broadly.’ You don’t have to get into state option. You don’t have to move somebody out of the program, for example, if they’ve picked up a part-time job or they’re doing overtime more for this month, but, but the agency is satisfied that their income overall remains under the Medicaid or CHIP income eligibility limit. So, states all have long-standing discretion to, if somebody comes into the program, to look at income and to evaluate based on what they, what they think the average will be if they moved forward. So there’s a number of different flexibilities that states, states have long-standing and some new ones that we’ve put in this regulation to be able to limit the instances where people’s change in income, other circumstances will force them to move into a different insurance program. But, there’s not a twelve month continuous eligibility.

>>Jennifer Ryan: And, Cindy, does this, does this twelve months eligibility period apply for non-MAGI populations as well as MAGI?

>>Cindy Mann: Yes, it does.

>>Jennifer Ryan: Across the whole program?

>>Cindy Mann: Let me double-check on that actually.

>>Jennifer Ryan: Okay. We’ll come back to that.

>>Cindy Mann: Okay.

No. Sorry. It doesn't. For the non-MAGI population, I believe the renewal frequency is as it has been. At least that they, they can be renewed every twelve months but a state can determine to renew more frequent times.

>>Jennifer Ryan: Okay. Cindy if, if Exchanges decide to conduct, conduct that initial eligibility screen would, would the screening be for any potentially Medicaid eligibility group or, again, would it be for just based on MAGI standards? So...

>>Cindy Mann: That's really what can be worked out between the state Medicaid agency and the Exchange. The, the requirement in the rules, both the Exchange rules and the Medicaid and CHIP rules, is that the initial assessment be at least with respect to MAGI populations. If, if depending upon how a state organizes its health insurance programs, if it has, you know, one agency that does everything, it's certainly not precluded from doing the broader analysis, but the, the requirement of the screen is limited to the MAGI cases. And I, I should also say with respect to non-governmental entities doing eligibility determinations, as I mentioned, Exchanges run by or contracting with non-governmental entities, can do final Medicaid eligibility and CHIP eligibility determinations under the regulations. That is limited to MAGI cases where, where there's really, you know, minimal limited amount of discretion and much simpler and straight forward eligibility determinations.

>>Jennifer Ryan: Cindy we have a quite a few a questions here about the FMAP rules and when the enhanced federal matching funds will apply. Do you want say a little bit about the status of our work in that area since it's not addressed in the Final Rule.

>>Cindy Mann: Sure. And, ya'know, it doesn't obviously change anything in terms of states getting the appropriate FMAP that, that they need to get. What we had proposed in the NPRM is a, a few different methods for how states could determine who was and who was not newly eligible; and, therefore, who did and did not get the higher match rate that I mentioned before, the 100% match for the first three years, and so forth And, so what we are doing is working with a contractor with the Rand corporation and, and ten states who have, to their credit, volunteered for the good of the nation, to work with us and our contractor to test out the methodologies. We're looking at, ya'know, variations on methodologies that states and others have, have put forth. And, we're actually at the stage where we're reviewing some data that came in from the states that we're well along in that, in that effort and, will be perhaps, ya'know, certainly I was going to say in April, if not April, May we expect we'll be able to have a broader webinar. We want to be very transparent about how these methodologies are testing

out and what the data availability are. So we'll be sharing information about those testing --our testing efforts in the next couple of months. And, then we expect we will have the Final Rules on how states will be assigning FMAP to different groups by later this year, in the Fall.

>>Jennifer Ryan: On the issue of who's doing the eligibility determination, if the Medicaid agency is doing the final determination of eligibility for Medicaid, with reference to the merit employee protect rules, will there be alignment between the Exchanges and Medicaid or are there going to be separate rules for, for -- will the Medicaid agency have to continue to use merit employees even though the Exchange might be using a contractor?

>>Cindy Mann: The merit protection rules apply throughout and a, a we, we think, they, they continue to apply. We think they actually apply to, to the Exchanges and contractors to determining and we think they are, are -- I think the question is, is whether public employees have to do the determinations which is a little bit different than the merit protection principles. The merit protection principles continue to, to apply across the board as required by the statute. We have not made any changes in these, in these rules with respect to the Medicaid agency's authority to rely on non-governmental entities to determine eligibility. We did note, in the Final regs, that it's an area that we did hear from with respect to the comments and may be a subject for some future rule-making. But there's no change in terms of the Medicaid agency. I should say, and I didn't mention before, that there are new provisions that people should look at with respect to the single state agencies oversight authority and obligation with respect to any delegation of Medicaid eligibility determination function. So whether it's a sister state agency or a county or the Exchange, and whether the Exchange is governmental or non-governmental, we want the single state agencies rules to, to rule the day, as well as their oversight, to make sure that the rules of the Medicaid program are being properly carried out. There's also a couple of additional provisions in that section relating to assuring no conflict of interest and, and program integrity as we move forward.

>>Jennifer Ryan: Staying with this question, now with the Exchange doing the initial assessment and then Medicaid doing the final determination, can you say a little more about what we are envisioning by that initial assessment by the Exchange?

>>Cindy Mann: Ya'know, it, it may vary somewhat and you'll look also to the Exchange rules for this as well. But, the, -- again it goes back to the parents question before. If we're using the same rules in the Medicaid and CHIP program, by and large it's being used in the Exchange to determine

advanced premium tax credit eligibility. So, to do an assessment of initial eligibility, the Exchange would be looking at the income sources, evaluating the information that comes in on the, on the, the application. Ya'know, there'll be a memorandum of understanding that we lay out in the regulations that will define the respective roles of the Exchange and the Medicaid and the CHIP agency. And, exactly the dimensions of that assessment, I think will be worked out as we go forward in our sub-regulatory guidance, as we go forward in working with states on implementation. It's to, ya'know, it's to everybody's advantage to have a pretty robust assessment so that mistakes aren't made and then have to be caught later on. So, we certainly don't want the situation where somebody is sent over inappropriately to the Medicaid or CHIP agency and then sent back to the Exchange. That may happen, but we want to avoid those situations. Similarly, we don't want a situation where the Exchange goes forward, determines -- determine eligibility for the advanced premium tax credit and when it gets far down the line it determines, 'Hmm, oh no, this actually is somebody eligible for Medicaid.' The initial assessment is really part and parcel, I think, of looking at MAGI and other factors of eligibility common to both the Exchange and Medicaid and, and CHIP and then making a sensible cut as to which ones get sent over to Medicaid and CHIP.

>>Jennifer Ryan: This is just a clarifying question. Can you clarify whether the optional populations, for example, people above 133% of the poverty level, will receive regular or enhanced FMAP?

>>Cindy Mann: The optional populations over 133 do not receive the enhanced FMAP; it's newly eligible populations, but within the new adult group. So, it's the group within the 133.

>>Jennifer Ryan: A question about, sort of, our operational guidance and when that will be coming out and there's interest in when we'll be releasing more information about the crafting of the eligibility categories and how that will all play out?

>>Cindy Mann: Well, I think there's quite a bit of information about the collapsing of the eligibility categories, particularly laid out in our NPRM. But, we will be providing further, further guidance working closely with states, ya'know, to the extent that states are working on their programming of their systems we have a number of different mechanisms by which we're working with states and, and don't want states to have to duplicate that activity. And, and so we wanna provide, provide some business rules so that states can rely on those as they move forward. But also, as I mentioned, the SOTA teams will be a way for us to work, ya'know,

immediately and directly with states. And, ya'know, each state's current eligibility categories vary. Most states don't follow exactly what the - the categories laid out in the federal rules, but have developed their own categories over time. And, and so some of that is gonna be pretty idiosyncratic with each state. And, so the SOTA team will be the perfect place to funnel that, those questions and be able to get some hands-on assistance to the states in thinking that through.

>>Jennifer Ryan: We have a request for an explanation of the merit system protection principles. But, I think we don't have that in front of us so we can circle back with more information on that at a later point.

Will premium assistance for low income applicants be available only through the Exchange or will it be available through Medicaid and CHIP as well? How will premium assistance be treated going forward?

>>Cindy Mann: There's no change in the law with respect to premium assistance so it continues to be an available option. The Medicaid and CHIP program has, has been, and, I know a number of states are, thinking about different ways they might think about using premium assistance to, to provide some bridge between Medicaid and the Exchange and for people whose income might fluctuate and to, to limit the transfer from one plan to another and to promote continuity of plans. But there's, there's no change in that and the rules continue to be available for people to, to explore premium assistance options.

>>Jennifer Ryan: For the Exchanges, are states obligated to evaluate people for medically needed coverage before they can be found ineligible for Medicaid and enrolled in the Exchange, enrolled to the Exchange?

>>Cindy Mann: No, no.

>>Jennifer Ryan: And, I think – can you share a little more about the contact information for the, for the SOTA team? We've got a few questions on, on how to reach out , if you're from a state agency, how to reach out to, to CMS to get in touch with the SOTA team?

>>Cindy Mann: So, I'll let you answer that because you are the contact.

(LAUGHTER )

>>Jennifer Ryan: I'm just trying to be the interviewer here.

(LAUGHTER)

Certainly folks who are interested in working with us through the SOTA process, and we'll be reaching out directly to states as well, but you're, you're welcome to contact me directly at [jennifer.ryan@cms.hhs.gov](mailto:jennifer.ryan@cms.hhs.gov).

Okay. I think we're running a little bit low on time here. Bear with me while I scroll through questions here.

Can you say a little bit about the data exchange and the interactions between the different sources of data and what our expectations are for the hub to the extent we can share anything about that at this point?

>>Cindy Mann: Well, I'm, I'm not quite sure what the question refers to but – or what aspect of that data exchange. So, let me take a stab at it. The, the hub, as, as its called, will be available to state-based Exchanges, to the Medicaid and the CHIP programs to the federally-facilitated Exchange as well. It's a mechanism to, in my non-technical way I will say, ping different data sources available at the federal level. So, at, at a minimum, it will include federal agencies, such as Social Security, and the Department of Homeland Security and the Internal Revenue Service. And, it really is a one-stop shopping mechanism for, for states and Exchanges to be able to get the kind of – to get verification of information that they need to proceed with eligibility determinations. So, there's work that's going on now. And will, will accelerate in terms of IT needs and systems development for, for states and Exchanges and Medicaid and CHIP programs connecting to the hub. And people will be hearing a lot more about that.

>>Jennifer Ryan: Great. And here's kind of a more specific question again getting back again to that -- the disability categories. If an individual with a disability elects to be placed in an optional category but is also eligible for the eight group, the new adult group, which FMAP rate will apply for that individual?

>>Cindy Mann: Which FMAP. They will get the non-newly eligible FMAP.

>>Jennifer Ryan: If you're eligible for both groups. If you're eligible for an optional group or the eight group (INAUDIBLE)

>> (Sarah deLone): You would be – you would get – you would not be newly eligible, but the state wouldn't actually -- so you -- the FMAP will not be available – but the state wouldn't -- That would be a situation in which somebody didn't want to go through that deeper dive. Sorry this is Sarah deLone talking. It doesn't sound like Cindy anymore. So – but the methodology that will be, that will be utilized other than having to actually run a shadow eligibility system, the methodology for determining the appropriate FMAP for people covered under that new adult group would take into account individuals such as that who would have been eligible under the terms of the optional eligibility group in existence when ACA was passed.

>>Cindy Mann: Right. So, so just to – This is Cindy again. Just to be clear, the state had an optional eligibility group at the time of enactment, actually December 2009. They would not be a newly eligible person no matter which -- even under the, the formulation that we had in the NPRM. So,

we're not taking away any FMAP. The, the determination of FMAP is really without regard to which category that person ultimately ends up in, it's with regard to whether that person would have been eligible under a category that existed in, in December 2009.

>>Jennifer Ryan: Great. Cindy can you say anything about when we might be really seeing some guidance on the benchmark benefits?

>>Cindy Mann: Yeah, there was a, a a set of Q's & A's that were released - I've lost track of time, maybe a few week ago, that supplemented the EHB bulletin that was released by CCIIO earlier this year. And, we will be releasing additional guidance on, on specifically on some of the Medicaid and CHIP issues. We will—there are some matters that we'll be doing through regulation and some matters that will be addressed through state health official letters. So, that will be -- we're working on that now. And, there is also a website, or an email, I'm sorry, address, a place where people can get -- submit questions to us. So, if you look on the website in our Affordable Care Act materials for those FAQ's. They have the web -- the, the place where you can submit questions to us. Those questions have actually been very helpful as we've been formulating our responses to questions, our guidance as we go forward. So, please continue to do that. There's no, there's no deadline or time period by which we won't look at those questions -- and, and again, for states working with a, a, SOTA teams. We will also be able, to the extent that we have answers to those questions, we will be able to field those questions as we work individually with states.

>>Jennifer Ryan: Cindy, I imagine that the set of Q's & A's is available on Medicaid.gov; probably in the What's New box which is on the upper right corner of the home page. So, if you scroll through there, you'll be able to find those fairly easily...hopefully.

Okay, I think that we've reached the end of our time for today. I want to thank everyone for joining us, for joining us and thank you to Cindy for her great presentation and her open exchange of questions and answers. You, you all sent in a lot of really thoughtful questions. I would say it was impossible for us to get through all of them today. But, I invite you to join us for our series of webinars which are going to be, as we said, getting into, delving into some of the more specific issues that you're raising in your general -- in your questions here. So, I encourage you to join us again and resubmit your questions. And, we'll also be, ya'know, we'll keep track of the questions that are coming in. I don't think we'll be providing written responses. We're not going to attempt that this time But, the audio file and transcript of this webinar will be posted on Medicaid.gov, hopefully within a

week. And, we'll continue to do that throughout this series. So, thank you very much and we'll look forward to talking with you next week. The next webinar, as Cindy said, is next Thursday, the 29<sup>th</sup> at 3 p.m. Thanks very much.