Overview of Eligibility & Enrollment II Final Rule – Medicaid and CHIP

Center for Medicaid & CHIP Services

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Overview

- On Friday, July 5, CMS put on display at the Federal Register
- Builds on the March 2012 Medicaid/CHIP Eligibility rule
- Finalizes a subset of provisions included in the notice of proposed rulemaking (NPRM) released on January 22, 2013, but not all proposed provisions
  - In order to best assist states in preparation for the availability of new coverage beginning January 1, this rule focuses only on provisions most important for implementation
  - We intend to address remaining provisions of January NPRM in future rulemaking
    - These include: appeals processes, electronic submission of state plan amendments, citizenship verification, eligibility groups, etc.
  - Transition policies for 2014, as applicable, are included to ease implementation issues

Medicaid and CHIP Overview

- Key Provisions
  - Medicaid eligibility appeals delegation
  - Electronic notices
  - Cost-sharing and premiums
  - Open enrollment
  - CHIP waiting periods
  - Medicaid benefits

Coordinated Appeals Options Medicaid and CHIP

- Integrated/delegated appeals:
  Medicaid/CHIP agency delegates authority to make appeals decisions to Exchange or Exchange appeals entity
- Bifurcated appeals/no delegation:
  State retains appeals function

Integrated/Delegated Appeals

- Limited to MAGI-based determinations
- Individuals must be able to opt out of delegated hearing processes to have their fair hearing conducted instead by the Medicaid agency
- State can establish a review process of the legal conclusions of Exchange appeals decision
- Exchange or Exchange appeals entity must be governmental agency with merit protections
- Note: Medicaid programs that want to delegate appeals to other state agencies can do so by seeking a waiver of single state agency requirements

Electronic Notices

- Current regulations require paper-based, mailed notices
- Medicaid and CHIP agencies must offer beneficiaries and applicants the option to receive notices electronically
- Consumer protections must be in place:
  - Ability to opt-in and opt-out
  - Notices posted to a secure electronic account
  - Electronic communication to alert individual notice was posted
  - If electronic alert/communication undeliverable, send notice by regular mail
- Required implementation date of January 1, 2015, but states may implement as soon as October 1, 2013 if systems are ready

Medicaid Cost Sharing and Premiums

- Replaces all the current premium and cost sharing rules at 42 CFR 447.50-82 with new 447.50-57 to consolidate and coordinate the rules outlined in sections 1916 and 1916A of the Act
- Clarifies rules for individuals with income under 100% of the FPL as well as state flexibility to impose premiums and cost sharing on individuals with higher income.

Cost Sharing and Premiums

- Updates the maximum allowable nominal cost-sharing levels to be a flat $4 for outpatient services and preferred drugs, and $75 for an inpatient stay
- Allows states to charge up to $8 for non-preferred drugs and non-emergency use of the ED for individuals with income at or below 150% of the FPL
- Applies the 5% aggregate limit to all cost sharing incurred by all individuals in the household

Open Enrollment Medicaid and CHIP

- Initial open enrollment period for Exchange begins 10/1/13
- Beginning 10/1/13 Medicaid/CHIP agencies need to:
  - Accept the single streamlined application and application currently in use
  - Accept electronic accounts transferred from Exchange
  - States to make timely eligibility determinations effective 1/1/14 based on single streamlined application
- Applicant can also be evaluated based on current rules
- Authority to delegate eligibility determinations to Exchange for purposes of open enrollment

Open Enrollment

- For 2013 eligibility
  - Determine eligibility based on information on single streamlined application or in the electronic account; or
  - Request additional information from the applicant to determine eligibility
- For 2014 eligibility
  - Determine eligibility based on MAGI and furnish Medicaid effective January 1, 2014

Provisions for Separate CHIPs
Limits on Waiting Periods

- Limit CHIP waiting periods to no more than 90 days
- Nothing in the final rule precludes states from opting to eliminate waiting periods
- Certain exemptions to waiting periods (most common types employed by states today) required
- Children moving to CHIP from other insurance affordability programs are not subject to a waiting period

Limits on Waiting Periods

- Children in a waiting period may be eligible for APTC. States need to track the child and notify Exchange when APTC should end and when child should be enrolled in CHIP
- CHIP agencies must also implement processes to ensure a smooth transition for children from coverage through the Exchange to CHIP at the end of a waiting period, and facilitate enrollment of otherwise CHIP-eligible children who have satisfied the waiting period, but were not covered in the Exchange
- The FFE will not determine final CHIP eligibility for a child subject to a waiting period but will transfer the case to the state to determine if exemptions to waiting period apply

Premium Lock-Out Periods

- A premium lock out period is defined as no more than 90 days
- Lock–out periods would not be applicable to a child who has paid outstanding premiums or fees
- The collection of past due premiums or fees cannot be a condition of eligibility for reenrollment once the lock out period has expired (in alignment with Exchange)

Presumptive Eligibility

- Codifies state options for all populations now provided under statute
- Hospital Presumptive Eligibility (Medicaid only)
  - Consistent with other PE options
  - Tools/state flexibility
    - Attestation of citizenship/immigration status and residency
    - Performance standards – e.g., based on number of regular applications submitted and/or approved
    - Corrective action for hospitals not following state policies or meeting established standards

5 Percent MAGI Disregard

- Changes application of 5% MAGI disregard which previously applied to everyone in all circumstances
- Rule finalizes that 5% disregard only applies when it matters for eligibility; not to determine specific eligibility group
- Effect is that it applies to the highest eligibility group for which an individual can be determined eligible for either Medicaid or CHIP

Single State Agency

- Modifies previous final rule issued March 23, 2012
- Permits Medicaid eligibility determinations to be delegated, including to an Exchange, but only to a government agency which maintains personnel standards on a merit basis
- Delegation subject to safeguards

Additional Provisions Medicaid and CHIP

- Application Counselors and Authorized Representatives:
  - Address security and confidentiality of information
- Premium Assistance:
  - Establishes rules regarding premium assistance to support enrollment of individuals eligible for Medicaid in health plans in the individual market, including enrollment in QHPs doing business on the Exchange