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CMCS Informational Bulletin

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SUBJECT: Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace")

This CMCS Informational Bulletin (CIB) reminds states about federal requirements related to coordination of eligibility and enrollment among insurance affordability programs under section 1943 of the Social Security Act (the Act), added by section 2201 of the Affordable Care Act and implementing regulations at 42 CFR §§435.1200, 457.348, and 457.350. As CMS and states served by the FFM have made significant improvements to the Account Transfer process, this CIB provides an overview of current regulations to ensure timely determination of eligibility and coordination across insurance affordability programs. We also highlight a simplified approach to assessing potential eligibility for enrollment in coverage through the Marketplace. This approach is designed to minimize administrative burden on states.

Regulations require that determinations of eligibility and enrollment in the appropriate insurance affordability program are made promptly and without undue delay. In particular, this CIB addresses the requirements for Medicaid and the Children's Health Insurance Program (CHIP) agencies to transfer the electronic accounts, for both applicants and beneficiaries, to the FFM when they are determined ineligible for Medicaid and CHIP, as well as the actions states should take when accounts are transferred from the FFM to the state agency.

Streamlined, Coordinated Eligibility and Enrollment

The Affordable Care Act and implementing regulations established a coordinated system of eligibility and enrollment across all insurance affordability programs. Consumers must be able to submit a single streamlined application to either the Marketplace serving their state or the state Medicaid or CHIP agency, receive an eligibility determination, and be enrolled in the appropriate program. This "no-wrong-door" approach requires effective coordination between state Medicaid and CHIP agencies and Marketplaces to ensure that consumers have a seamless, streamlined path to coverage in the program for which they are eligible.

Per regulations at §435.1200(b) and §457.348(a), state Medicaid and CHIP agencies utilizing the FFM must enter into an agreement with the FFM describing the responsibilities of each entity to coordinate applications for all programs in a manner that minimizes consumer burden and ensures prompt determinations of eligibility and enrollment in the appropriate program. States have the option to delegate authority to make Medicaid and CHIP final eligibility determinations based on Modified Adjusted Gross Income (MAGI) to the FFM ("determination states"), or to

use the FFM to make an initial assessment of potential Medicaid and CHIP eligibility based on MAGI ("assessment states"). This election will be reflected in the agreement between the agency and the FFM; a delegation of authority to make eligibility determinations must be reflected in a state plan amendment approved by CMS. The agreements between the state agencies and the FFM are updated on a regular basis.

Consumers Applying at the FFM and Determined or Assessed as Potentially Eligible for Medicaid or CHIP

When an individual submits an application to the FFM and is assessed or determined eligible for Medicaid or CHIP, the application information is transferred to the state Medicaid or CHIP agency via account transfer. The account will contain all of the information the individual provided on the application as well as indication as to whether information was verified through the Hub. The account transfer will also identify individuals who should be screened for eligibility on a basis other than MAGI and, in assessment states, whether an individual has requested a full eligibility determination from the state.

Consumers Determined Eligible for Medicaid or CHIP by the FFM (§435.1200(c) and §457.348(b))

In determination states, the FFM makes a final determination of MAGI-based Medicaid or CHIP eligibility and sends the account to the state for enrollment in coverage. Per the agreement, the MAGI-based eligibility determination made by the FFM is accepted as final by the Medicaid or CHIP agency. Consumers should be enrolled in Medicaid or CHIP, as appropriate, without delay (42 CFR §435.1200(c)(2)).

If an individual appears likely to be eligible for Medicaid or CHIP, but the FFM has identified an inconsistency between information on the application and information obtained through the Federal Data Services Hub (Hub), or no information is available through the Hub, that application is transferred through the Hub to the state Medicaid/CHIP agency for resolution and final eligibility determination.

State Agency responsibilities

The state agency must establish procedures to receive the electronic account. When the FFM transfers an individual's electronic account, the state agency must:

1. Notify the FFM of the receipt of the electronic account;
2. Promptly enroll the individual in Medicaid or CHIP, as appropriate;
3. Provide a reasonable opportunity for the applicant to document citizenship or immigration status, if needed;
4. Collect additional information for any application that is transferred with an inconsistency regarding other eligibility criteria and complete the final eligibility determination; and

5. For applications/accounts for which potential eligibility on a basis other than MAGI is flagged, collect additional information to determine eligibility on a non-MAGI basis in accordance with §435.911(c)(2).

Consumers Assessed as Potentially Eligible for Medicaid or CHIP by the FFM (§435.1200(d) and §457.348(c))

In an assessment state, if the FFM assesses an individual as potentially eligible for Medicaid or CHIP based on MAGI, or if the individual is screened as potentially eligible for Medicaid on a non-MAGI basis, based on the information contained on the application, the FFM transfers the individual's electronic account through the Hub to the state agency for a final eligibility determination. If the FFM does not assess someone as potentially eligible for Medicaid on any basis, the individual can request that his or her account be transferred to the state agency for a final MAGI eligibility determination.

State Agency responsibilities

The state agency must establish procedures to receive the electronic account. When the FFM transfers an individual's electronic account, the state agency must:

1. Notify the FFM of the receipt of the electronic account;
2. Not request information from the individual that is included in the individual's electronic account;
3. Accept any finding relating to a criterion of eligibility made by the FFM, without further verification, if such finding was made in accordance with policies and procedures applied by the agency or approved by it in the agreement between the agency and the FFM;
4. Promptly determine the individual's Medicaid or CHIP eligibility based on MAGI and, if appropriate, non-MAGI, in accordance with §435.911, without requiring a new application and begin providing coverage, if eligible; and
5. Notify the FFM of the final determination of the individual's eligibility or ineligibility for Medicaid or CHIP.

Consumers Applying at the State Agency and Determined Not Eligible for Medicaid or CHIP (§435.1200(e) and §457.350(i)-(k))

When an individual submits an application to a state Medicaid or CHIP agency, or the agency is processing a current beneficiary's renewal, no coordination with the Marketplace is needed if the agency determines that the individual is or remains eligible for Medicaid or CHIP. (See discussion below if the individual is eligible for Medicaid that is not Minimum Essential Coverage). If the agency determines the individual is not eligible for Medicaid and/or CHIP, the agency must promptly assess the individual's potential eligibility for other insurance affordability programs and transfer the individual's electronic account to the appropriate program (see examples below). The account must include all of the information collected and generated by the state, regarding the individual's Medicaid and/or CHIP eligibility.

For states that are served by the FFM or which do not use a shared eligibility service to determine eligibility for all insurance affordability programs, a simplified approach to the assessment of potential eligibility for enrollment in a Qualified Health Plan (QHP) and receipt of Advance Payments of the Premium Tax Credit (APTC) is described below.

The timing of a transfer from Medicaid to another program differs depending on whether the determination of ineligibility is at application or renewal. The path that an individual's account will follow also depends on his or her circumstances and whether the Medicaid and CHIP programs are jointly administered. In the discussion that follows, we assume joint administration of Medicaid and CHIP with respect to eligibility determinations. We also assume that Medicaid, CHIP and coverage through the Marketplace are the only insurance affordability programs available in the state (i.e., the state has not adopted a Basic Health Program, authorized under section 1331 of the Affordable Care Act).

Application

If an individual submits an application to a state Medicaid or CHIP agency and the agency determines the individual is ineligible for Medicaid based on MAGI and CHIP, or is subject to a CHIP waiting period imposed by the state, the agency must assess potential eligibility for coverage through the Marketplace and transfer the individual's electronic account to the FFM. The electronic account must include all information collected and generated by the state, including documentation described in §435.914, which is relevant to the individual's Medicaid or CHIP eligibility and enrollment (see definition of "electronic account" provided in §435.4 and §457.10).

In the case of an individual subject to a CHIP waiting period, information transferred to the FFM must also include the end date of the waiting period. The state agency must also notify the applicant of the end date of the waiting period, when the individual is eligible to enroll in CHIP.

In the case of an individual who is determined not eligible for Medicaid on a MAGI basis or for CHIP, and for whom the agency is determining eligibility on a basis other than MAGI, the agency must determine potential eligibility for coverage through the Marketplace and transfer the individual's electronic account to the FFM and provide notice to the FFM as well as the individual that the individual is not Medicaid-eligible based on MAGI, but a final determination of Medicaid eligibility is still pending. This provides the individual with the opportunity to obtain QHP coverage, while waiting for a final determination of eligibility for Medicaid on all bases. Once the agency makes a final determination, it must inform the individual and the FFM of the agency's final determination of eligibility or ineligibility for Medicaid. The notice to the individual should include information and instructions about ending QHP coverage and APTC.

Renewal

Before terminating Medicaid coverage for a current beneficiary and transferring the electronic account to the FFM, the agency must determine whether the individual is eligible in any other eligibility category (See 42 CFR §435.916(f)(1)). This may require the agency to obtain additional information from the beneficiary. The beneficiary remains enrolled in Medicaid, and the account is not transferred, until the agency completes the eligibility determination. For individuals determined

ineligible for Medicaid and CHIP, the agency must determine potential eligibility for coverage through the Marketplace and transfer the account to the FFM.

Streamlining the Assessment of Eligibility for Coverage through the Marketplace

Medicaid and CHIP agencies may have insufficient information to assess an individual as potentially eligible for APTC or Cost-Sharing Reductions (CSR) through the Marketplace, as such assessment requires application of different financial methodologies, evaluation of access to or enrollment in employer-sponsored or other forms of coverage, and, in some cases, non-citizen eligibility criteria. States are not required to conduct individual assessments, but instead may implement a streamlined approach that will reduce administrative burden for states and ensure timely transfer of individuals potentially eligible for QHP enrollment. States can treat anyone who is determined ineligible for Medicaid or CHIP as potentially eligible for QHP enrollment at their option, other than individuals denied or terminated for a procedural reason and individuals who do not attest to U.S. citizenship or lawful presence. This simplifies the assessment required under the regulations and ensures that consumers have the ability to purchase a QHP even if they are not determined eligible for APTC. The agency would then transfer the electronic account of anyone screened as potentially eligible for QHP enrollment using this streamlined approach to the FFM.

Medicaid and CHIP agencies should not transfer accounts for consumers whose eligibility has been denied or terminated for procedural reasons to the FFM. Procedural reasons include failure to respond in a timely manner to requests for information necessary to determine Medicaid or CHIP eligibility, including failure to document citizenship or eligible immigration status during a reasonable opportunity period, failure to comply with assignment of rights or medical child support cooperation requirements, and failure to apply for other benefits for which the individual may be eligible.

Examples of Accounts to Transfer to the FFM using the Streamlined Approach

1: The parents have verified income over the applicable Medicaid or CHIP standard; children are determined eligible for Medicaid or CHIP. A family submits an application to the agency. The children are determined eligible for Medicaid or CHIP, but the parents are determined to be ineligible based on MAGI for either program. There is no indication of Medicaid eligibility on a non-MAGI basis, and neither parent has requested a determination on a non-MAGI basis. The agency would transfer account information for the parents to the FFM.

2: An applicant has been determined ineligible for Medicaid based on MAGI, but is being evaluated for coverage on a non-MAGI basis. The agency has determined that an applicant has income over the applicable MAGI-based standard. However, the applicant has indicated potential disability on the application. The agency would transfer the account to the FFM for a determination of eligibility for enrollment in a QHP. Once the agency has made a final determination of eligibility for Medicaid on all bases, the agency would notify the FFM

of its final determination. The agency also would provide appropriate notice to the applicant of his or her initial denial based on MAGI as well as the final Medicaid eligibility determination.

3: A child has been determined ineligible for CHIP during a period of uninsurance ("waiting period"). A child is determined to meet all eligibility criteria for CHIP, but is subject to a CHIP waiting period imposed by the state. The agency would transfer the child's account to the FFM for a determination of eligibility to enroll in a QHP with APTC for the duration of the waiting period and inform the FFM of the date on which the waiting period ends and the child will be eligible to enroll in CHIP. The agency also would provide appropriate notice to the applicant of his or her initial denial based on the waiting period, as well as the date on which the waiting period ends.

4: An applicant is lawfully present in the United States, but has been determined ineligible for Medicaid or CHIP based on immigration status. Non-citizens who are lawfully present in the United States, but are not eligible for Medicaid or CHIP based on immigration status (for example, during the 5-year waiting period) may be eligible to enroll in a QHP and to receive APTC and CSRs. Since this individual verified lawful presence, the agency would transfer him to the Marketplace for determination of eligibility for APTC in a QHP. If the agency was not able to verify a qualified immigration status for Medicaid or CHIP eligibility purposes and does not have the capacity to assess all lawfully present statuses, the agency also would transfer the individual's account to the Marketplace.

Examples of Accounts NOT to Transfer to the FFM:

1: An applicant has been determined ineligible for Medicaid for failure to respond to a request for additional information to verify eligibility. Individuals who are required to provide documentation of income (i.e., due to an inconsistency between attested income and information available via electronic data sources) and/or documentation of citizenship or immigration status, and who fail to respond in a timely manner, may be denied eligibility. These individuals should not have their accounts transferred to the FFM.

2: An applicant does not attest to citizenship or to lawful presence in the US. An individual who is not a citizen, and not lawfully present in the US is not eligible to purchase coverage on the Marketplace. The account should not be transferred to the FFM.

Individuals Determined Eligible for Coverage in a Medicaid Program that is Not Minimum Essential Coverage (MEC)

Medicaid and CHIP coverage generally is recognized as MEC. The Internal Revenue Service (IRS) has determined, however, that limited-benefit Medicaid coverage and coverage authorized under a section 1115 demonstration project is not recognized as MEC under IRS regulations. For example, coverage limited to family planning services or other limited-benefit programs is not recognized as MEC under IRS regulations.

However, under section 5000A(f)(1)(E) of the Internal Revenue Code, the HHS Secretary, in coordination with the Treasury Secretary, has authority to determine that coverage which is not recognized as MEC under the IRS regulations will be recognized as MEC. In a November 7, 2014, State Health Official Letter (SHO #14-002), CMS described the criteria we would consider in determining whether Medicaid coverage not recognized as MEC under IRS regulations would be recognized as MEC under section 5000A(f)(1)(E). A list of state programs that were required to be evaluated by CMS to determine whether they are MEC, as well as a copy of SHO #14-002, can be found on Medicaid.gov. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/minimum-essential-coverage.html.

Individuals enrolled in Medicaid coverage that is not considered MEC are eligible to enroll in a QHP with APTC/CSRs if otherwise eligible. Accounts for individuals determined eligible for coverage that is not considered MEC should be transferred to the FFM for assistance in obtaining comprehensive coverage without requiring that Medicaid be denied.

Additional Resources

CMS will continue to work with states to ensure timely determinations of eligibility for all insurance affordability programs. States should refer to the Federal Data Services Hub Account Transfer (AT) Business Service Definition (BSD) Version 2.4 (July 2016) for technical guidance and specifications related to the transferring accounts between states and the FFM.

For additional information about coordination with the FFM, please contact your state SOTA lead or Judith Cash, Director, Division of Eligibility and Enrollment, Children and Adults Health Programs Group, at judith.cash@cms.hhs.gov or 410-786-4473.