



Center for Medicaid and CHIP Services

May 22, 2012

Medicaid/CHIP Affordable Care Act Implementation

Answers to Frequently Asked Questions

Coordination Across Insurance Affordability Programs

Q1: How is CMS envisioning the “shared eligibility service” that will support interactions between insurance affordability programs and help ensure a seamless enrollment experience for consumers?

A: The process for making a MAGI-based eligibility determination is largely the same for all insurance affordability programs. The Affordable Care Act requires a single, streamlined application, accompanied by a similar set of business rules and verification processes, and an adjudication work flow that is largely identical between Exchanges, Medicaid and CHIP programs.

It is expected that State agencies that receive Federal funds from CMS to establish State-based Exchanges and provide for Medicaid and CHIP expansions coordinate efforts to produce a shared eligibility service or system that relies on a shared IT infrastructure and as such, cost allocate this service.

A shared eligibility service is not the same as one system. We define an eligibility service as a set of IT functions that produce an eligibility determination based upon MAGI. (For more information, see IT Guidance 2.0, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaiditguidance.pdf>.) The service incorporates an application, a set of verifications (for citizenship, income, residency, etc.) and business rules that together determine how much financial assistance a consumer should receive to acquire affordable health insurance.

While policies codified in final regulations allow legal authority for eligibility determinations to remain with state Medicaid agencies (for Medicaid) and Exchanges (for premium tax credits and cost-sharing reductions), the underlying business rules and processes are nearly identical, and should, to the maximum extent practical, rely upon a shared IT service(s) and infrastructure.

Q2: Will the agreements between Medicaid/CHIP agencies and Exchanges regarding coordination be subject to public disclosure and/or public comments?

A: The agreement between Medicaid/CHIP agencies and Exchanges regarding coordination must be available to the Secretary upon request and will be subject to applicable disclosure laws, such as the Freedom of Information Act.

Q3: Will the Federally-Facilitated Exchange (FFE) only do assessments of Medicaid and CHIP eligibility or if a State desires will the FFE also make eligibility determinations for Medicaid and CHIP?

A: States can work with the Federally-Facilitated Exchange (FFE) regarding Medicaid and CHIP eligibility determinations in one of two ways. The State may either establish an agreement whereby the FFE assesses applicants for Medicaid/CHIP eligibility based on MAGI and then transfers the applicants' electronic accounts to the State Medicaid or CHIP agency to complete the eligibility determination. Or the State may elect to accept MAGI-based eligibility determinations completed by the FFE as final determinations. Regardless of the approach, the process should be as seamless as possible for the applicant with most eligibility determinations completed in near real-time as specified in our eligibility final rule at 435.912.

Q4: In the case where the Exchange is conducting an eligibility assessment and then transferring the applicant's information to the State Medicaid or CHIP agency to complete the eligibility determination, what standards will the Exchange use to make the assessment for Medicaid and CHIP eligibility?

A: The Exchange will utilize the State's Medicaid and CHIP eligibility rules for conducting both eligibility determinations and eligibility assessments. This will include application of the State's MAGI income standards and related eligibility rules for the MAGI population. The Exchange will also rely on a robust verification protocol that is consistent with Medicaid and CHIP regulations but which might not be the same protocol the State is otherwise using.

If a State accepts assessments of eligibility from the Federally-Facilitated Exchange (FFE) and chooses to make the final eligibility determinations itself, once an individual has been assessed as Medicaid/CHIP eligible, their electronic account would be transferred to the State Medicaid or CHIP agency, which will complete the eligibility determination. This process will include any additional verification required by the State that is consistent with the Federal verification regulations.

Q5: Can the Exchange determine Medicaid eligibility for non-MAGI groups?

A: If the Exchange is a governmental entity, States will have the option to enable their State-based Exchange to make Medicaid eligibility determinations for non-MAGI eligibility groups. Depending on the arrangements made in each State, such an Exchange can make *all* Medicaid eligibility determinations, only eligibility determinations based on MAGI, or assessments of eligibility based on MAGI. The FFE will not be making Medicaid eligibility determinations for non-MAGI groups; the FFE will either do final determinations or assessments for the MAGI eligibility groups.

Q6: Is CMS planning to draft a standard agreement for State Medicaid and CHIP agencies to use with the State-based Exchange?

A: Yes. CMS is working with States to develop a model agreement, and it is one of the tools that the Coverage Expansion Learning Collaborative will be considering.

Q7: In situations where an Exchange makes Medicaid eligibility assessments rather than full determinations, will the determination be able to happen in real-time?

A: The goal is to have a seamless experience for consumers, with eligibility determinations made as quickly as possible regardless of which approach to eligibility determinations is in effect in a particular State. CMS will be establishing, in collaboration with States and with an opportunity for public input, data reporting measures that will allow States, CMS and the public to have information about the enrollment process including the timing of eligibility determinations under different design approaches.

Q8: Can a State require Medicaid applicants who are applying to a State Medicaid agency to apply using the single streamlined application and therefore not get screened for a non-MAGI eligibility category?

A: The single streamlined application will contain questions that are designed to identify individuals who may be eligible for Medicaid on a basis other than MAGI. Today, many States use a simplified application that includes questions about disability status or the need for long-term care. The single streamlined application will have similar questions to help identify individuals who may need a Medicaid determination on a basis other than MAGI. Once identified, the individuals would be asked to complete a supplemental application, or a separate application for non-MAGI groups. The application will be developed with State and public input; we will be interested in suggestions on how best to screen for non-MAGI eligibility.

Q9: Is there a potential conflict with the Medicaid requirement to process an application within 45 days and the Exchange rule that allows applicants 90 days to respond to requests to resolve information that is not reasonably compatible?

A: The requirements are different, but they are not in conflict. The 45-day limit for Medicaid is the outer boundary limit by which a State must determine Medicaid eligibility for all individuals who apply on a basis other than disability, and as discussed above, we expect much quicker determinations in most cases. The Medicaid program provides a reasonable opportunity period for individuals whose citizenship or immigration status cannot be verified. Medicaid provides benefits for individuals during their reasonable opportunity period, who are otherwise eligible for Medicaid. The Exchange rule provides for a 90-day reasonable opportunity period for all factors of eligibility. The Exchange determines eligibility without delay and then provides a 90-day reasonable opportunity period for the applicant to provide any additional required information.

Q10: What does it mean for an individual to withdraw their Medicaid application in order to receive a determination of eligibility for Advance Premium Tax Credits (APTCs)?

A: In a State where the Exchange makes Medicaid and CHIP eligibility assessments, but not eligibility determinations, there are certain requirements that the Exchange must follow (found at 42 CFR 155.302(b)) in order to ensure a smooth transition between programs. When an eligibility assessment reveals that an applicant is potentially eligible for Medicaid or CHIP, the Exchange must transmit the individual's electronic account to the Medicaid or CHIP agency for completion of the eligibility determination.

However, when an eligibility assessment reveals that an applicant does not appear to be Medicaid or CHIP-eligible, the Exchange does not have the authority to deny Medicaid/CHIP eligibility (because that is not the arrangement in that State). The Exchange has the responsibility to notify applicants that they do not appear to be Medicaid/CHIP-eligible and provide them with the opportunity to either seek a formal Medicaid eligibility determination (which would delay the eligibility determination for an APTC), or to withdraw their application for Medicaid/CHIP and receive a determination for an APTC and a cost-sharing reduction (section 155.305(b)(4)). We will address in further guidance how the withdrawal will be addressed in the case of an appeal of an APTC decision.