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Charting the Road to Coverage

POLICY BRIEF
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Overview of Final Medicaid Eligibility Regulation

Prepared by ***Manatt Health Solutions***

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INTRODUCTION

On March 16, 2012, the Department of Health and Human Services (HHS) issued final and interim final rules ("the Medicaid final rule") codifying Medicaid eligibility and enrollment provisions of the Patient Protection and Affordable Care Act (ACA).[1] Specifically, the Medicaid final rule: (1) expands Medicaid eligibility for non-disabled adults; (2) simplifies Medicaid eligibility categories; (3) modernizes eligibility verification rules, relying primarily on electronic data sources; (4) streamlines Medicaid and Children's Health Insurance Program (CHIP) applications and renewals; and, (5) coordinates eligibility across Medicaid, CHIP, and the Health Insurance Exchange (Exchange). While providing states with additional flexibility, the final regulation requires Medicaid/CHIP agencies to ensure that the eligibility determination process for all Insurance Affordability Programs (IAPs) and Medicaid programs for non-modified adjusted gross income (non-MAGI) individuals is coordinated, seamless and conducted promptly and without undue delay.

The purpose of this document is to provide an overview of the final rule. Section I provides a high level overview of important highlights, focusing on key areas where HHS has changed or expanded upon previous guidance. Section II provides a section-by-section summary of the regulation.

OVERVIEW AND KEY TAKEAWAYS

The rule makes final a proposed rule published August 17, 2011 entitled "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010" ("the Medicaid proposed rule").[2] The Medicaid proposed rule was published in concert with three other proposed rules,[3] which together were designed to implement the eligibility and enrollment-related provisions of the Affordable Care Act. Collectively, the four rules addressed expanded access to health coverage through Medicaid and CHIP, the establishment of the new Exchanges and the creation of premium tax credits. In addition, the proposed rules sought to simplify and streamline the enrollment and renewal processes and create alignment across IAPs.

Implementation of the final Medicaid eligibility rule similarly requires integration with the companion final regulation governing Exchange eligibility determination and premium tax credits. On March 12, 2012, HHS issued final and interim final rules governing the Establishment of Exchanges and Qualified Health Plans; and Exchange Standards for Employers ("the final Exchange rule").[4] However, the final rule on premium tax credits has not been issued, and the timing of its release is unclear.

In addition to finalizing proposed policies, the Medicaid final rule includes a number of "interim final" provisions, generally where provisions in the proposed rule evolved significantly in response to public comment. Interim final rules take effect at the same time as final rules; however public comment may be submitted on interim final rules through May 7, 2012, with the possibility of HHS promulgating subsequent final guidance at a later date. The specific provisions that are characterized as interim final are summarized in the chart below.

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[1] *CMS-2349-F*, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010". The regulations are effective 60 days after publication in the Federal Register.
[2] 76 FR 51148.
[3] *CMS 9898-P*, "Establishment of Exchanges and Qualified Health Plans," (July 15, 2011); *CMS-9974-P*, "Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers," (August 17, 2011); *REG-131491-10*, "Health Insurance Premium Tax Credit Proposed Rule," (August 17, 2011).
[4] Manatt's analysis of the final exchange rule published in concert with this analysis is available at www.statenetwork.org.

Interim Final Rules	
§ 431.300(c)(1) and (d)	Basis and Purpose
§ 431.305(b)(6)	Types of information to be safeguarded
§ 435.912	Timely determination of eligibility
§ 435.1200	Medicaid Agency responsibilities
§ 457.340(d)	Application for and enrollment in CHIP: Timely determination of eligibility
§ 457.348	Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs
§ 457.350(a), (b), (c), (f), (i), (j), (k)	Eligibility screening and enrollment in other insurance affordability programs

Coordination of Eligibility Determinations

Consistent with the final Exchange regulation, the final Medicaid rule describes three ways in which the Medicaid agency (and the CHIP agency) may coordinate eligibility decisions with the Exchange: (i) the Medicaid agency may make the final eligibility determination based on an initial assessment by the Exchange; (ii) the Medicaid agency may accept a determination of eligibility made by the Exchange where the Exchange uses the state's eligibility rules and standards; or, (iii) the Medicaid agency may make final eligibility determinations for all IAPs, including premium tax credits, by assuming full responsibility for this Exchange function.

The regulation sets out the procedures that must be followed regardless of the option selected so as to ensure simple, highly-coordinated, timely (based on the date the application is first submitted to any IAP) and accurate determinations of eligibility at initial application and also at renewal. Among other things, the regulation requires that the Medicaid agency enter into an agreement with the Exchange delineating the respective areas of responsibility. Information and findings must be transferred between the Exchange and the Medicaid agency through a secure electronic interface. The Medicaid agency may not request duplicative information and must accept the Exchange's findings of specific eligibility criteria if such findings were made in accordance with the policies and procedures of the Medicaid agency.

Timeliness

Both the Exchange and Medicaid regulations require that eligibility determinations are conducted "promptly and without undue delay." Both sets of regulations indicate that HHS will issue further guidance on timeliness requirements; however, the Medicaid regulation provides some further direction to states. Notably, the Medicaid rule reinstates the requirement that eligibility determinations must not exceed 45 days for non-disabled applicants and 90 days for those seeking a determination based on disability. The proposed regulation had eliminated the existing processing timeframes, reasoning that eligibility determinations would be conducted in near real-time. The preamble notes that the return of the 45-day eligibility period balances due process protections and maintains an outer limit for when eligibility determinations must be made. The expanded timeliness requirements are particularly apt in light of new provisions that allow Exchanges to conduct an eligibility assessment rather than an eligibility determination.

Medicaid agencies must include in their State Plans timeliness and performance standards. In crafting these standards, the regulation requires states to take into account, among other things, the capability of electronic data matching services. The preamble notes that it is HHS's expectation that "these systems and technological capacities generally make it possible for real time determinations of eligibility in most cases. Standards shall be set reflecting this expectation as well as the pace and experience of states that are making ongoing and reasonable investment in systems improvement and technology supported by Federal matching payments." In other words, while the regulation includes a 45-day outer limit, it appears that the State Plan is expected to adopt a more expeditious process for most applicants.

Verification

The Medicaid rules for verifying eligibility are consistent with, but not identical to, those applicable to Advance Payment of Premium Tax Credits (APTCs)/Cost Sharing Reductions (CSRs) eligibility determination. In order to assure a seamless, coordinated, streamlined and timely eligibility process, the Medicaid verification rules, like those applicable to APTC determinations, rely on self-attestation plus information obtained from electronic sources, relying on post-enrollment

verifications only where electronic data is not up-to-date. These Medicaid verification rules also apply to CHIP and to the determination of eligibility of individuals whose financial eligibility is based on non-MAGI methodologies, as well those based on modified adjusted gross income (MAGI) methodologies.

Documentation - The use of documentation is limited under the final rule. States may only require documentation when: (i) the electronic data is not reasonably compatible with the information provided by the applicant (or beneficiary on renewal); or, (ii) electronic data are not available, and establishing a data match would not effectively balance:

- the administrative costs of establishing a data match;
- the administrative costs of documentation; and
- the impact in terms of ineligible individuals getting coverage and eligible individuals being denied coverage.

In short, the preamble notes that the intent of the regulation is to require that electronic sources be consulted where possible and generally to modernize verification systems and align them with the systems used to verify eligibility for APTCs.

Electronic Data - The regulation provides a long list of state and federal agencies and programs from which the Medicaid agency must request information relating to financial eligibility but only "to the extent the agency determines such information is useful to verifying the financial eligibility of an individual." The data sources listed include the Internal Revenue Service (IRS), the State Wage Information Collection Agency, the Social Security Administration (SSA) and various social services programs. The regulation specifically requires states to access information available through the federal data hub and also requires data matching through the Public Assistance Reporting Information System (PARIS).

Reasonably Compatible - The regulation provides that where the Medicaid agency finds that the information provided by the individual (i.e., the information to which the individual self-attests) is reasonably compatible with the information obtained through electronic sources, the agency must determine Medicaid eligibility based on the information. Information obtained through an electronic data match "shall" be considered reasonably compatible with the information provided by the individual where both are either above or below the Medicaid income level. While the "reasonably compatible" standard also applies to CHIP, premium assignment based on a family's income will also be a factor in the verification process. Where information is not reasonably compatible, the agency is required to seek additional information explaining the discrepancy and/or seek additional documentation from the individual.

The Medicaid guidance for reasonable compatibility is consistent with the definition in the Exchange regulation. However, the Exchange regulations, unlike the Medicaid regulations, specifically require an Exchange to accept an individual's attestation of household income as reasonably compatible, where it is no more than 10 percent below the annual household income reflected in tax data. There is nothing in the Medicaid regulations that would prevent the Medicaid agency from adopting comparable standards for Medicaid.

Verification Plan - The Medicaid agency must develop and make available to the Secretary a verification plan which describes the agency's verification policies and procedures and, among other things, articulates the standards it applies in determining the usefulness of data as well as the circumstances under which it will consider information provided by an applicant to be reasonably compatible with information obtained through an electronic data match. The policies articulated in the state's verification plan will serve as the basis for payment error rate measurement (PERM) audits.

Pregnant Women

Limited Coverage for Pregnancy Related Services - The final Medicaid rule and preamble confront an apparent statutory drafting glitch that permits states to offer some pregnant women lesser benefits than non-pregnant adults at the same income level. Federal law permits states to limit coverage for pregnant women with incomes above May 1, 1988 Aid to Families with Dependent Children (AFDC) levels to pregnancy related services. The ACA expands full coverage for adults to 133 percent of the Federal Poverty Level (FPL), but explicitly excludes pregnant women from this new coverage category. Thus, in theory, a pregnant woman below 133 percent FPL could be entitled to fewer health benefits under Medicaid than other non-pregnant adults at the same income level. In other words, becoming pregnant could cause a woman to lose health benefits

under Medicaid. While HHS notes in the preamble it lacks statutory authority to require states to provide pregnant women full Medicaid benefits, it suggests a desire to mitigate the impact. HHS notes that because the health of the pregnant woman is intertwined with that of her expected child, the scope of pregnancy related services is necessarily comprehensive. Thus, the preamble notes that states seeking to exclude coverage of services for pregnant women that is available to other adults must describe in their State Plan why such non-covered services are not pregnancy related, and receive Secretary approval. In addition, the preamble notes that HHS does not expect states to monitor pregnancy status and to shift women into the group for pregnant women once they become pregnant, unless the woman requests a change.

Eligibility Determinations of Non-MAGI Applicants

Noting that nearly half of all comments raised concerns about coverage of individuals with disabilities or in need of long term care, HHS offers new guidance regarding enrollment of individuals exempt from MAGI methodologies.

Application - Individuals who may be eligible for Medicaid under a non-MAGI determination may use either the IAP application with supplemental forms or an application specifically designed for MAGI-exempt eligibility. Such applications must minimize the burden on applicants and meet Secretarial guidelines. The commentary notes that to the extent practical, MAGI-exempt applications should be accepted by the agency through all submission modes required for the IAP application (in person, by mail, by phone and electronically).

Eligibility Determinations - In a new interim final rule, in response to considerable feedback regarding the enrollment pathway for non-MAGI eligible populations, the agency is required to collect additional information to determine whether an individual is eligible for Medicaid on a non-MAGI basis. The preamble notes that an Exchange would not be required to perform a detailed evaluation for all Medicaid categories even if the Exchange is charged with making final Medicaid eligibility determinations. Until their non-MAGI eligibility is determined, applicants are not precluded from enrolling in Medicaid under the new adult group. They will be eligible for Medicaid on a MAGI basis, until a final determination is made on the basis of their non-MAGI eligibility.

Verification Methods - As noted above, the Medicaid verification rules apply to eligibility determinations for individuals whose financial eligibility is based on non-MAGI methodologies as well those based on MAGI methodologies.

Renewal Processes - The final rule requires that non-MAGI beneficiaries renew eligibility at least every 12 months and that the state agency re-determine eligibility for non-MAGI populations using the same administrative renewal procedures described for MAGI populations. For non-MAGI beneficiaries who cannot be renewed administratively, the agency may, but is not required, to adopt the same renewal processes as it employs for MAGI beneficiaries who cannot be administratively renewed, including use of the pre-populated form and a “failure to renew” grace period.

Budget Periods

Medicaid MAGI income determinations are based on “point-in-time” income, while tax credits are based on projected annual income, paid in advance (at the consumer’s option) and reconciled at year-end based on tax returns. The final rule incorporates new mechanisms to mitigate potential coverage gaps that may result from maintaining these different budget periods for Medicaid and APTC eligibility. The rule provides flexibility for states to use current or projected annual income methods for current Medicaid beneficiaries and to take into account reasonably predictable income changes for both new and current enrollees. States also are required to default to the IRS MAGI projected annual income methodology to determine Medicaid eligibility for individuals who appear Medicaid ineligible based on Medicaid budget methods, but have income below 100 percent FPL based on APTC budget methods.

FMAP of Newly Eligible Individuals

Finally, noting that HHS is in the process of performing additional research, the preamble indicates that future guidance on potential Federal Medical Assistance Percentage (FMAP) methodologies for newly eligible individuals is forthcoming.

Future Guidance

The final rule notes several issues that HHS intends to address through future guidance. The preamble specifically notes that HHS will release forthcoming guidance with regard to eligibility categories and coverage options, treatment of types of income under MAGI-based methodologies, single-state agency, and timeliness and performance standards. The preamble also notes the intention of providing ongoing technical assistance to states on a wide-range of issues including determination

of current monthly income using MAGI-based methodologies, the telephonic application process, and the potential roles and responsibilities of authorized representatives and assisters.

SUMMARY OF REGULATION

The following is a summary of a number of the key provisions in the final rule issued by HHS entitled "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010" (CMS-2349-F). The final rule amends Parts 431, 435 and 457 of Title 42 of the Code of Federal Regulations. The summary describes the provisions as captured in the regulatory text as well as in the discussions contained in the preamble.

Single State Agency (§§ 431.10, 431.11)

In an effort to promote "a positive consumer experience and ensure that Exchanges are able to make Medicaid eligibility determinations," the final rule includes a new provision governing delegation of Medicaid eligibility authority to Exchanges. The new language requires that each State's Medicaid Plan specify whether the entity responsible for determining Medicaid eligibility is an Exchange (governmental or non-governmental) or a contracted private entity of the Exchange. The rule restricts non-governmental Exchanges and contracted private entities of Exchanges to making final eligibility determinations in MAGI cases only. The single state Medicaid agency is responsible for ensuring eligibility determinations are made consistent with its policies, taking corrective action where there is a pattern of "incorrect, inconsistent or delayed determinations," and ensuring there is no conflict of interest or improper incentives among designated entities. The preamble cites as an example of improper incentives linking compensation for entities making eligibility determinations to a pre-set target.

The final regulation requires the execution of written agreements with non-governmental entities as well as federal, state or local agencies determining Medicaid eligibility on behalf of the Medicaid agency. The agreement must address the following:

- Relationships and respective responsibilities of the parties;
- Quality control and oversight by the single state agency;
- Reporting requirements from the "delegee" to the state agency;
- Compliance with confidentiality and security requirements;
- Assurances that "merit system personnel protection principles" are employed by the contractor and any subcontractors; and
- Assurances that all applicants and beneficiaries will be informed on how to directly contact and obtain information from the single state agency.

The preamble notes that the rule does not require public employees review each eligibility determination and that physical co-location for public employees is not necessary, though remains a state option. The preamble also clarifies that "automated systems are permitted to generate Medicaid eligibility determinations, without suspending the case and waiting for an eligibility worker (public or private) to finalize the determination, provided the Medicaid agency retains oversight responsibilities for all decisions made through the automated system." HHS will issue future guidance on this topic.

Finally, the rule makes conforming changes to ensure State Plans continue to require explicit descriptions of the staff and functions of the entity delegated to conduct eligibility determinations.

Safeguarding Information (§§ 431.300, 431.305, 431.306)

In new interim final rules, HHS makes several conforming changes to ensure state agencies have adequate safeguards for information shared across agencies. The interim final rules establish that protections apply to information gathered about non-applicants as well as applicants and beneficiaries, and adds Social Security Numbers (SSNs) to the category of information that must be protected.

Medicaid Categories (§§ 435.119, 435.110, 435.116, 435.118, 435.218)

The final rule codifies a new eligibility category created under the ACA for non-pregnant, non-disabled adults over the age of 19 and under the age of 65 with incomes below 133 percent FPL. In addition, under the final rule, the complex framework of existing Medicaid mandatory and optional eligibility groups for children and parents is collapsed into three main categories: (1) parents and caretaker relatives; (2) pregnant women; and, (3) children. The rule further codifies the state option to establish a category for adults with incomes above 133 percent FPL.

(1) Mandatory Coverage for Individuals Age 19 or Older and Under Age 65 at or Below 133 percent FPL (§ 435.119)

The final regulation (without any modification from the proposed rule) codifies ACA provisions that extend mandatory Medicaid coverage to non-pregnant individuals with incomes below 133 percent FPL, who are between the ages of 19 and 65, not entitled to or enrolled in Medicare Parts A or B, and not eligible under any of the other mandatory eligibility categories.[5] The preamble notes that the ACA establishes the option to cover this new group as medically needy if their incomes fall above Medicaid income levels, they otherwise meet the eligibility requirements of the adult group and they meet spend-down requirements.

(2) Parents and Caretaker Relatives (§ 435.110)

Medicaid must be provided to parents and other caretaker relatives (and spouses if living with such parent or other caretaker relative), whose household income is at or below the income standard established by the state. The income standard must fall between the following limits:

Minimum Income Standard - The state's AFDC income standard in effect as of May 1, 1988.

Maximum Income Standard - The higher of: (1) income level in effect for Section 1931 Low Income Families as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI equivalent; or (2) the state's AFDC income standard in effect as of July 16, 1996, adjusted by no more than the Consumer Price Index.

The final regulatory language for parents and caretaker relatives is nearly identical to the proposed category consolidation framework for parents and caretaker relatives with only minor language modifications.

(3) Pregnant Women (§435.116)

Medicaid must be provided to pregnant women (for the duration of pregnancy through the last day of the month following the 60th day post partum) with household income at or below the income standard established by the state. The income standard must fall between the following limits:

Minimum Income Standard - The higher of: (1) 133 percent FPL; or, (2) such higher income standard up to 185 percent FPL, as the state had established as of December 19, 1989 or if there was authorizing legislation, as of July 1, 1989.

Maximum Income Standard - The higher of: (1) the highest income level in effect as of March 23, 2010 or December 31, 2013, if higher, converted to MAGI equivalent; or, (2) 185 percent FPL.

Minimum and Maximum Income Standard for Full Medicaid Coverage - The regulation further specifies the minimum and maximum income limits for states that establish an applicable income standard for pregnant women eligible for full Medicaid coverage. Full Medicaid coverage is defined as all mandatory Medicaid services (codified under § 440.210(a)(1)) and those optional services which the state has elected to cover (under §§ 440.225 and 440.250(p)). The state's applicable income standard for full Medicaid coverage must fall between: (i) the state's AFDC income standard in effect as of May 1, 1988, and (ii) the highest effective income level for coverage under the Qualified Pregnant Women category or under the Low Income Families category in effect as of March 23, 2010 or December 31, 2013, if higher, and converted to a MAGI-equivalent.

[5] SSA § 1902(a)(10)(A)(i)(VIII).

Income Standard for Pregnancy-Related Services - Women whose incomes are above the applicable limits for full Medicaid coverage, but within the income eligibility standards for pregnant women outlined above, may only receive pregnancy-related services. The preamble notes that this may result in pregnant women with incomes below 133 percent FPL being entitled to lesser benefits than non-pregnant adults covered under the adult group, from which pregnant women are excluded. While acknowledging multiple requests to define "pregnancy related services" as full Medicaid coverage to avoid this conundrum, HHS notes that no statutory authority exists to do so. However, the preamble notes that because the health of pregnant women is intertwined with that of her expected child, the scope of pregnancy related services is necessarily comprehensive. The preamble indicates that states seeking to exclude coverage of services for pregnant women will be required to describe in their State Plans why such services are not pregnancy related, and receive Secretary approval. The final rule also provides that a State's pregnancy related services must be consistent with § 440.210(a)(2) (which defines pregnancy related services)[6] and § 440.250(p) (which allows States to provide services of a greater amount, duration or scope to pregnant women than other Medicaid recipients). Finally, the preamble notes that HHS does not expect states to monitor pregnancy status and to shift women into the group for pregnant women once they become pregnant, unless the woman requests a change.

(4) Infants and Children Under Age 19 (§435.118)
Medicaid must be provided to children and infants under the age of 19 if they meet the applicable income standards. Under the ACA, there is a maintenance of effort requirement for children's eligibility levels until 2019.

Minimum Income Standard - The minimum income standard for children ages one to 19 is 133 percent FPL. For infants under the age of 1, the minimum income eligibility levels is up to 185 percent FPL, if the state established eligibility levels as of December 19, 1989 or had authorizing legislation to do so as of July 1, 1989.

Maximum Income Standard - For all children the maximum income standard is the higher of: (1) 133 percent FPL; (2) the highest effective income level for each group in effect as of March 23, 2010 or December 31, 2010, if higher, and converted to a MAGI-equivalent; or (3) for infants under age 1, 185 percent FPL.

(5) Individuals With MAGI-based Income Above 133 percent FPL (§ 435.218)
States also have the option to provide Medicaid coverage to individuals at income levels above 133 percent FPL, as long as the individual is not eligible for, or enrolled under, another Medicaid mandatory or optional eligibility category covered by the state, based on information in the individual's application. The preamble notes that individuals who are potentially eligible as medically needy or as spend-down beneficiaries in a 209(b) state (states that use more restrictive Medicaid eligibility criteria for their medically needy populations than are used in the SSI program) are not excluded from enrollment under this new optional category. The preamble also notes that enhanced FMAP for "newly eligibles" is only available for individuals under the new adult group with incomes below 133 percent FPL. However, enhanced CHIP FMAP rates may apply to children under age 19 who are covered under this category and who meet the definition of optional targeted low-income children.

Residency (§ 435.403)[7]

The final regulation provides a new residency standard for children and adults in Medicaid, aligning with the residency standard for the Exchange.

Adults (21 and over) - The state of residence is where the individual is living and: (a) intends to reside, including without a fixed address; or, (b) has entered with a job commitment or seeking employment.

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[6] 42 CFR 440.210(a)(2) defines pregnancy-related services and services for other conditions that might complicate the pregnancy. Pregnancy-related services are "those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services." Services for other conditions that might complicate the pregnancy "include those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus."

[7] The CHIP regulations propose alignment to Medicaid eligibility rules for residency at § 457.320.

Children (under age 21) - The state of residence is: (a) where the individual resides, without a fixed address; or, (b) the state of residency of the parent or caretaker with whom the individual resides. If a child is emancipated or married, the adult residence standard applies.

The new "intent to reside" standard is a departure from prior Medicaid requirements that the individual reside "permanently or for an indefinite period."

Application of Modified Adjusted Gross Income (§ 435.603)[8]

Effective Dates - Application of MAGI financial methodologies for new applicants will be effective January 1, 2014. For current Medicaid beneficiaries, the new financial methodologies will be applied on March 31, 2014 or the next regularly scheduled renewal, whichever is later.

Family Size and Pregnant Women - Family size is defined as the number of persons counted as members of an individual's household. The final rule includes new guidance on counting pregnant women for the purposes of determining family size. In the case of determining the family size of a pregnant woman, her household includes herself plus the number of children she is expected to deliver, including twins or triplets. This is a change from the current Medicaid practice which counts a pregnant woman as two people. States have the option to apply this standard when determining the household size of someone living with a pregnant woman. For example, a state could determine that a husband living with his pregnant wife expecting twins has a family size of 2 (the husband and the wife), 3 (the husband and the wife counting as 2) or 4 (the husband and his wife counting as 3).

MAGI-based Income - As provided under the ACA and set forth in IRS proposed rule,[9] all IAPs will use a MAGI standard to determine income eligibility. However, the Medicaid final regulation provides three exceptions to the MAGI income counting methodology for Medicaid, excluding the following from consideration as income: (1) lump sum payments are counted in the month received; (2) educational scholarships, awards, or fellowships are excluded from consideration as income (awards were newly added in the final regulation); and (3) certain types of income for American Indian/Alaska Native individuals.

Household Income - Household income is the sum of the MAGI-based income of every individual in the household minus five percentage points of the FPL. Income of children who are not expected to file taxes is not included. The MAGI-based income of a tax dependent that is not the child or spouse of the tax payer and is not expected to file taxes is also excluded from the household income of the taxpayer. At state option, income of children and tax dependents may include actual available cash support, exceeding nominal amounts, provided by the person claiming such child as a tax dependent.

Household - Under the Medicaid final rule, the household definition for those who file taxes starts with the tax filing unit, which includes the tax payer and individuals for whom a taxpayer expects to claim a personal exemption for a taxable year. For families who do not file taxes, the Medicaid rule defines the household as consisting of the applicant as well as any spouse and natural, adopted and step-children living with the applicant. Children include those under 19, and at state option, those under age 21 who are full-time students. If the applicant is a child, his or her natural, adoptive and step-siblings or natural, adoptive and step parents residing with the applicant also must be included in the household. The regulation provides for several Medicaid-specific exceptions to these rules. Each of these exceptions has the practical effect of preserving existing Medicaid policy:

- Children living with caretaker relatives who are not their parents, such as grandparents, may apply for Medicaid without consideration of the relatives' income, whether or not the caretaker relative claims the child as a dependent.
- In the case of married couples living together, each spouse is included in the household of the other, regardless of their filing status.

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[8] The CHIP regulations propose alignment to Medicaid eligibility rules for MAGI and household definition at § 457.315.

[9] *REG-131491-10*, "Health Insurance Premium Tax Credit Proposed Rule," (August 17, 2011).

- When non-custodial parents claim children as tax dependents, the Medicaid household rules for families that do not file taxes apply. The final regulation further clarifies the definition of custodial parent to include: (1) an individual who was granted a court order or binding separation, divorce, or custody agreement; or, (2) in the absence of such an agreement, the custodial parent is the parent with whom the child spends most nights.

- When a child is: (1) living with both parents; (2) is expected to be claimed as a dependent by one parent; and, (3) the child's parents are not expected to file a joint tax return, the Medicaid household rules for individuals that do not file taxes apply.

- Finally, for a tax dependent who is not a child or spouse of the taxpayer, the Medicaid household rules for individuals that do not file taxes apply.

In a new clarification in the final regulation, if a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, then the Medicaid household rules for individuals that do not file taxes apply.

Finally, the regulation explicitly eliminates a resource test and income disregards for Medicaid MAGI populations.

Budget Periods (§ 435.603(h))
The final regulation provides budget period definitions for determining Medicaid financial eligibility. The rule articulates distinct approaches to budget periods for new Medicaid enrollees versus current Medicaid beneficiaries:

- New Medicaid enrollees (applicants and individuals who are otherwise not receiving Medicaid benefits at the time of the Medicaid determination) must have their financial eligibility for Medicaid based on current monthly income and family size. This codifies §1902(e)(14)(H) of the ACA.

- Current Medicaid beneficiaries (those beneficiaries who have been determined MAGI Medicaid eligible and are receiving Medicaid benefits at the time of the determination) may have their financial eligibility for Medicaid based on either current monthly income and family size, or projected annual income and family size. Use of projected annual income in determining eligibility of current beneficiaries would help mitigate situations in which individuals are found ineligible for Medicaid based on current monthly income, and ineligible for APTCs based on projected annual income. The final rule clarifies that projected annual income is for the remainder of the calendar year (versus the entire calendar year), allowing coverage stability for beneficiaries whose current monthly income is below the Medicaid income standard, but projected annual income for the full calendar year is above the Medicaid standard.

To further mitigate coverage gaps that may result from different budgeting methodologies, the final rule adds a new provision requiring that an applicant's or beneficiary's financial eligibility for Medicaid must be based on the MAGI methodology for APTCs when: (i) application of the Medicaid income methodologies results in a determination of financial ineligibility for Medicaid; and, at the same time, (ii) application of the MAGI projected annual income methodology for APTCs appears to indicate that the individual's income is below 100 percent FPL.

Final regulation also provides states the option for both new and current enrollees to take into account reasonably predictable changes in income (i.e., seasonal work, a promise of future employment, or an anticipated layoff notice) in determining current monthly or projected annual income.

Individuals for Whom MAGI-based Methods Do Not Apply (§ 435.603(j))
Medicaid MAGI-based methods do not apply for the following:

- Individuals whose eligibility does not require a determination of income, such as individuals receiving SSI or individuals for whom eligibility was determined by an Express Lane agency;

- Individuals who are 65 or older when age is a condition of eligibility;

- Individuals whose eligibility is based on being blind or disabled;
- Individuals who request coverage for long-term services and supports for the purpose of being evaluated for an eligibility group under which long term care or supports are covered (including nursing facilities, home and community-based services furnished under a waiver, home health services and personal care services);
- Individuals who are being evaluated for Medicare cost-sharing eligibility; and
- Individuals who are being evaluated for medically needy coverage.

Availability of Program Information (§ 435.905)
The Medicaid agency must furnish by paper, electronically (including online) and orally, as appropriate, the following information to all individuals who request it: (1) eligibility requirements; (2) available Medicaid services; and, (3) the rights and responsibilities of applicants and beneficiaries.

Information must be provided in "plain language" and in a manner timely and accessible to individuals who with limited English proficiency (LEP) and to individuals living with disabilities, at no cost the individual, in accordance with the Americans with Disabilities Act.

Application (§ 435.907)[10]
The final Medicaid rule requires that states utilize either a federal model single streamlined application for all IAPs, or an alternative state-specific form for which the state has received federal approval. Applications and documentation must be accepted via Internet website, by telephone, by mail, in person; and through other commonly available electronic means.

Individuals who may be eligible for Medicaid under a non-MAGI determination may use either the IAP application with supplemental forms or an application specifically designed for MAGI-exempt eligibility. According to the preamble, any application or supplemental form for non-MAGIs must meet Secretarial guidelines and must be available for review by the public; however, non-MAGI application materials do not require Secretary approval. The commentary notes that to the extent practical, these forms should also be accepted by the Medicaid agency through all submission modes required for the IAP application.

The final regulation, like the proposed rule, explicitly eliminates the face-to-face interview requirement at application and renewal for determinations of eligibility using MAGI-based income.

The agency may only require information necessary to make a Medicaid determination but may request information necessary to determine an applicant's eligibility for other insurance affordability or benefit programs. SSNs may be requested of non-applicants only: (i) to determine an applicant or beneficiary's eligibility for an IAP; and, (ii) if the agency provided clear notice to the individual that provision of the SSN is voluntary. However, the commentary notes that failure of a non-applicant to provide an SSN may necessitate alternative verification requirements that impact the ability of the agency to issue real time determinations.

Electronic signatures will be accepted telephonically or electronically (not via facsimile).

Assistance with Application and Renewal (§ 435.908)[11] - The Agency must provide assistance to any individual seeking help with an application or renewal in person, over the telephone, and online and in a manner that is accessible to individuals with disabilities or who are LEP.

Use of Social Security Number (§435.910) - In a new interim final rule, all applicants (including children) who are seeking Medicaid must furnish a SSN except those who do not have a SSN, are not eligible for one, and individuals who have not obtained one for a well-established religious objection. This new condition of eligibility is also included in the Exchange

[10] The CHIP regulations propose alignment to Medicaid Application rules at §457.330.
[11] The CHIP regulations propose alignment to Medicaid application assistance, timely determination of eligibility and effective dates of eligibility at § 457.340.

regulation. Eligibility must not be denied or delayed to an individual who would otherwise have been eligible pending the verification of a SSN.

Determination of Eligibility and MAGI Screen (§ 435.911) - Medicaid must be provided to MAGI-eligible individuals promptly and without undue delay. In a new interim final rule, and in response to considerable feedback regarding the enrollment pathway for non-MAGI eligible populations, the agency is also required to collect additional information to determine whether an individual is eligible for Medicaid on a non-MAGI basis. This provision applies to those who are eligible under an optional category such as on the basis of being disabled, blind, medically needy or eligible for long-term care services. The preamble notes that an Exchange would not be required to perform a detailed evaluation for all Medicaid categories even if the Exchange is charged with making final Medicaid eligibility determinations.

According to the preamble, until their non-MAGI eligibility is determined, such individuals are not precluded from enrolling in Medicaid under the new adult group. They will be eligible for Medicaid until a final determination is made on the basis of eligibility for an optional group.

Timely Determination of Eligibility (§ 435.912) - In a new interim final rule, each State Plan must include timeliness and performance standards for processing applications promptly and without undue delay. Timeliness and performance standards apply to eligibility or potential eligibility determinations conducted by a single state agency or transferred to or received from another IAP.

Timeliness and performance standards in the State Plan must account for:

- Capabilities and costs of available systems and technologies;
- Availability of electronic data matching and ease of connections to electronic information sources;
- Demonstrated performance and timeliness of other IAPs; and
- The needs of applicants including preference for enrollment pathway (Internet, telephone, mail, in-person, or other electronic means) as well as relative complexity of adjudicating the eligibility determination.

Eligibility determinations must not exceed 45 days for all non-disabled applicants and 90 days for those seeking determinations based on disability. And, applicants must be informed of the agency's timeliness standards.

Coverage Month - While not in the Medicaid regulation, the Medicaid preamble notes that while states are not required to extend Medicaid/CHIP to the end of the month, they are encouraged to do so to mitigate gaps in coverage between for individuals transition between Medicaid/CHIP and a Qualified Health Plan (QHP). States that extend coverage to the end of the month will receive federal financial participation (FFP) at the applicable match for extended coverage.

Periodic Renewal of Medicaid Eligibility (§ 435.916)[12]

The Medicaid final rule requires renewal for MAGI populations at least, but not more frequently than, every 12 months.

The Medicaid rule establishes an administrative renewal process for MAGI beneficiaries, requiring a state to use any available information, including databases accessed by the Medicaid agency, to renew beneficiary eligibility. The state agency is not permitted to require additional information from the beneficiary if eligibility can be determined with available information and data.

If the state agency is able to renewal a MAGI beneficiary's eligibility with such information, the agency must notify the individual that: (i) they have been found eligible for Medicaid (and of the basis for the determination); and, (ii) that the

[12] The CHIP regulations propose alignment to Medicaid renewal rules at § 457.343.

individual is required to notify the agency (online, by phone, by mail, in person or other electronic means) if any information is inaccurate. The beneficiary is not otherwise required to take any action, such as signing or returning the notice.

If a state agency is unable to determine MAGI Medicaid eligibility through the administrative renewal process, the agency is required to send a pre-populated renewal form to the beneficiary, who is given 30 days to provide any necessary information through the modes of submission permissible for an application. The agency must limit any requests for additional information to eligibility factors that are subject to a change. For example, if an individual has not moved, they are not required to provide information regarding their residency. If an individual is found ineligible for Medicaid, the agency must determine his or her eligibility for other IAPs.

Finally, the regulation codifies a 90-day grace period following eligibility termination for failure to complete the renewal process, during which states would be required to reconsider and renew a MAGI beneficiary's eligibility without requiring a new application. States may also adopt a longer grace period for "failure to renew" at their option.

Notably, the final rule requires that non-MAGI beneficiaries renew eligibility at least every 12 months, and that the state agency must re-determine eligibility for non-MAGI populations using the same administrative renewal procedures described for MAGI populations. For non-MAGI beneficiaries who cannot be renewed administratively, the agency may, but is not required, to adopt the same renewal processes as it employs for MAGI beneficiaries who cannot be administratively renewed, including use of the pre-populated form and "failure to renew" grace period.

Change Reporting (435.916 (c))

Applicants must be able to report changes online, by telephone, by mail, in person or through other electronic means. Once changes are reported, the agency is required to promptly re-determine eligibility.

Verification (§§ 435.945, 435.948, 435.949, 435.952, 435.956))

General Requirements (§ 435.945)[13] - The rule notes that a Medicaid agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid without requiring further information (including documentation). However, self-attestation, without verification, is not an option with respect to citizenship and immigration status. On the other hand, self attestation is mandatory with respect to pregnancy, unless the Exchange or the Medicaid agency has information not reasonably compatible with the individual's attestation.

The Medicaid agency will request from other state and federal agencies and programs information needed to verify eligibility. Upon request, the Medicaid agency must reimburse such agencies and programs for the reasonable costs incurred in furnishing the information. All information must be exchanged electronically via secure interfaces and the Medicaid agency must execute written agreements with the other agencies before releasing information to or requesting data from these agencies.

The Medicaid agency must develop, and upon request make available to the Secretary, a verification plan describing the verification policies and procedures the agency has adopted. The preamble notes that the verification plan must include the standards applied by the state in determining the usefulness of financial information available from the agencies and programs listed in § 435.948 discussed below, and also the circumstances under which information obtained through an electronic data match will be considered by the state to be reasonably compatible with information provided by an applicant or beneficiary.

A Medicaid agency, subject to approval by the Secretary, may use alternate information sources and verification processes provided that such alternatives reduce administrative costs and burdens while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance or use of information and promoting coordination with other IAPs.

[13] The CHIP regulations propose alignment to Medicaid verification rules at § 457.380.

Verifying Financial Information (§ 435.948) - The Medicaid agency must request information relating to financial eligibility from the following state and federal programs "to the extent the agency determines such information is useful to verifying the financial eligibility of an individual:"

- Information related to wages, net earnings from self-employment, unearned income from State Wage Information Collection Agency, the IRS, the SSA, agencies administering state unemployment compensation laws, state administered supplementary payment programs, programs administered under section 1616(a) and Titles I, X, XIV, or XVI of the Social Security Act; and

- Information from the Supplemental Nutrition Assistance, a program funded under Title IV-A and other IAPs.

Where the information is available through an electronic service, the agency must obtain the information through such service.

Verification of Information Through an Electronic Service (§ 435.949) - The regulation formally establishes the "federal hub" through which states may verify or obtain by electronic means certain information from SSA, the Department of Treasury (Treasury), the Department of Homeland Security (DHS).

Use of Information and Requests for Additional Information (§ 435.952) - The Medicaid agency must promptly review the eligibility information it has received to determine the effect of the information on the eligibility of an individual or the benefits to which he or she entitled.

If information provided by an applicant (or by a beneficiary renewing coverage) is reasonably compatible with information obtained through electronic data matches, the agency must determine or renew eligibility based on such information. The rule further provides that the income information obtained through an electronic data match must be considered reasonably compatible with the income information provided by an applicant or beneficiary where both are below or above the applicable income standard. In other words, if an individual attests to income at 90 percent FPL and the electronic data match indicates an income at 120 percent FPL, the information shall be considered reasonably compatible (both are below the Medicaid MAGI standard of 133 percent FPL).

If the information provided by the individual is not reasonably compatible with the information obtained through an electronic data match, the agency must seek additional information as follows:

- A statement which reasonably explains the discrepancy (for example, an explanation that describes a change in circumstances); or,

- Other information (which may include documentation). However, an agency may only request documentation where electronic data are not available and establishing such a data match would not be effective, considering such factors as the administrative costs for establishing and using a data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity, both in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage.

An agency may not deny or terminate eligibility or reduce benefits unless additional information is sought in accordance with the above and the applicant was provided proper notice and hearing rights.

Verification of Other Non-Financial Information (§ 435.956) - The following procedures are established for verifying non-financial eligibility.

Residency - The agency may accept attestation without further verification. Alternatively, a state may use other reasonable verification procedures consistent with § 435.952 described above.

Social Security Number - The agency must verify SSNs with SSA.

Pregnancy - The agency must accept attestation without further verification, unless the state has information that is not reasonably compatible with the attestation.

Age, Date of Birth and Household Size - The agency may accept attestation without further verification. The agency may verify date of birth and household composition consistent with the procedures described in § 435.952 above, or through other reasonable verification procedures.

Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs (§ 435.1200)

Introduced as an interim final rule, § 435.1200 establishes the standards and guidelines for ensuring simple, coordinated and timely eligibility determinations between state Medicaid agencies and Exchanges, whether the Medicaid agency is accepting an eligibility determination from an Exchange or whether the Exchange is conducting an initial assessment and transferring the information and findings to the Medicaid agency.

State Medicaid agencies must certify for the Exchange and other IAPs the criteria that will be applied in determining Medicaid eligibility. Further, the Medicaid agency must enter into agreements with the Exchange and other agencies or programs administering IAPs delineating the agency and program responsibilities so as to: minimize the burden on the individual; comply with eligibility information sharing requirements; and, ensure prompt determinations of eligibility and enrollment without undue delay.

Provision of Medicaid where Medicaid Eligibility Determined by Another IAP - Where the Medicaid agency has entered into an agreement whereby the Exchange or another IAP is making final Medicaid eligibility determinations, the agency must establish procedures to receive the information from the Exchange or other program via secure electronic interface and ensure compliance with the rules and procedures otherwise applicable to Medicaid applications.

Provision of Medicaid where another IAP Screens for Potential Medicaid Eligibility - Where the Exchange or another IAP determines that an applicant is potentially eligible for Medicaid, the Medicaid agency must accept the information via a secure electronic interface; may not request information or documentation that the individual already provided to the other program; must accept any finding relating to a criterion of eligibility made by the other program, so long as it follows the policies and procedures previously approved by the Medicaid agency; and, must promptly and without undue delay determine Medicaid eligibility.

Evaluation of Eligibility for Other IAPs - Where the Medicaid agency determines that an applicant or beneficiary is not eligible for Medicaid, it must promptly and without undue delay determine potential eligibility for another IAP and, as appropriate, transfer the individual's electronic account to the other IAP. Where the Medicaid agency has determined an individual ineligible for Medicaid under the applicable MAGI standard and is reviewing the individual's eligibility on a non-MAGI basis, the Medicaid agency must send the individual's information to other IAPs and advise them that the individual is not Medicaid eligible on the basis of the MAGI standard, but that a final determination of Medicaid eligibility is pending. The regulation further provides that the Medicaid agency may enter into an agreement with the Exchange whereby the Medicaid agency assumes responsibility for the premium tax credit eligibility determination functionality of the Exchange.

Internet Website - The Medicaid agency must establish a website available to applicants and beneficiaries that links to the Web site established by the Exchange and supports applicant and beneficiary applications and renewals.

Finally, the provisions with regard to coordination of IAP eligibility reiterate requirements with regard to eligibility determination timeliness, streamlined verification and coordination of non-MAGI determinations that are referenced throughout the rule.

CHIP Eligibility and Enrollment (§§ 457.10, 457.80, 457.300, 457.301, 457.305, 457.310, 457.315, 457.320, 457.330, 457.340, 457.348, 457.350, 457.353, 457.380)

The final and interim CHIP eligibility and enrollment rules align with Medicaid standards. Specifically, the CHIP eligibility rules mirror the Medicaid provisions addressing: definition of household, MAGI, residency requirements, application

and renewal processes including the use of SSNs, timeliness requirements for determinations/re-determinations, verification of financial eligibility, and coordination of screening, enrollment and information sharing across IAPs. The CHIP rules also require state CHIP programs to cover children enrolled in Medicaid on December 31, 2013 who become ineligible as a result of the elimination of the Medicaid income disregards until the date of the child's next renewal. Finally, the commentary notes that States may claim enhanced match from their CHIP allotment for children who become eligible for Medicaid as a result of the expansion of mandatory Medicaid coverage of children aged 6 through 18 from 100 to 133 percent of the FPL.

ABOUT THE PROGRAM
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

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For more information, please contact Deborah Bachrach at DBachrach@Manatt.com or at (212) 790-4594.