

medicaid and the uninsured

December 2012

Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule

Executive Summary

The Affordable Care Act (ACA) increases access to health insurance beginning in 2014 through a coordinated system of “insurance affordability programs,” including Medicaid, the Children’s Health Insurance Program (CHIP), premium tax credits for coverage provided through new Health Benefit Exchanges (Exchanges), and optional state-established Basic Health Programs. It also provides for coordinated, streamlined enrollment processes for these programs. On March 23, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a final rule to implement the ACA provisions relating to Medicaid eligibility, enrollment simplification, and coordination. This brief summarizes the major provisions of the rule, which is effective January 1, 2014.

Medicaid Eligibility Under Health Reform

Beginning in 2014, the ACA expands Medicaid eligibility to a new “adult group” and collapses most existing eligibility categories into three broad groups: parents, pregnant women, and children under age 19. The “adult group” includes all non-pregnant individuals ages 19 to 65 with household incomes at or below 133% FPL. (The law includes a five percentage point of FPL disregard making the effective limit 138% FPL.) States also have an option to cover non-elderly individuals, including pregnant women and children, with incomes above 133% FPL. The Supreme Court ruling on the ACA maintains the adult Medicaid expansion, but limits the Secretary’s authority to enforce it, effectively making implementation of the expansion a state choice.

Medicaid financial eligibility for most groups will be based on modified adjusted gross income (MAGI), as defined in the Internal Revenue Code. The rule generally adopts MAGI household income counting methods, eliminating various income disregards currently used by states. CMS also generally aligns “family size” in the current Medicaid rules with the MAGI definition of “household” and provides household composition rules for individuals, such as non-tax filers, who are not addressed by MAGI methods. Certain groups are exempt from use of MAGI; their financial eligibility will continue to be determined using existing Medicaid rules.

Medicaid eligibility remains based on monthly income at the time of application, while eligibility for premium tax credits for Exchange coverage is based on annual income. However, the rule provides states new options to assess continuing Medicaid eligibility based on projected annual income or by taking into account anticipated changes in income, which would minimize coverage gaps and transitions between Medicaid and Exchange coverage due to small income fluctuations.

Application, Enrollment, and Renewal Procedures

The ACA requires the Secretary to develop a single streamlined application for all insurance affordability programs. States must use the Secretary’s application or an alternative application approved by the Secretary. The application must be available for individuals to submit online, by telephone, by mail, in person, and by fax and must be accessible to persons with limited English proficiency and people with disabilities at no cost to the individual. States may only request information that is necessary to make an eligibility determination. Non-applicants (those seeking Medicaid coverage for someone other than themselves) may not be required to provide a Social Security number or information regarding citizenship, nationality or immigration status. State Medicaid agencies must provide assistance to applicants in person, by telephone, and online, and this assistance must be accessible to people with disabilities and people with limited English proficiency.

The Medicaid eligibility determination process will begin with a MAGI screen. If an individual is not found eligible for a MAGI group, the state must collect necessary information and determine eligibility under all other Medicaid eligibility categories (i.e., MAGI-exempt groups) and potential eligibility for premium tax credits in an Exchange. Each state will be required to establish timeliness and performance standards for determining eligibility subject to an outer limit timeliness standard of 45 days for non-disability based eligibility determinations and 90 days for disability-based determinations.

States will rely, to the maximum extent possible, on electronic data matches with trusted third party sources to verify information provided by applicants. The Secretary will establish an electronic verification system to enable states to verify information with other federal agencies. States are expressly permitted to accept self-attestation of all Medicaid eligibility criteria, except for citizenship and immigration status, which must be verified. If information provided by an individual is “reasonably compatible” with information obtained from other trusted sources, the agency may not request additional information, including paper documentation, from the individual.

The rule establishes a 12-month renewal period for MAGI-based Medicaid beneficiaries. The rule further requires state agencies to seek to renew eligibility first based on available information. If the state does not have sufficient information available to determine continued eligibility, it must then provide the individual with a pre-populated form containing data available to the agency and a reasonable period of time for the individual to provide needed information online, in person, by telephone, or by mail. To avoid unnecessary reapplications, the rule provides a reconsideration period for individuals who lose coverage because a renewal form is not returned timely but who respond within a reasonable period of time after coverage terminates. For non-MAGI groups, the rule retains the existing provision that eligibility be re-determined at least every 12 months. As with the MAGI groups, states must first seek to renew eligibility based on available information and states have the option to use the same pre-populated form and reconsideration period procedures required for MAGI groups.

Coordination Between Medicaid and Exchanges

State Medicaid agencies will enter into one or more agreements with an Exchange and other insurance affordability programs to coordinate eligibility determinations and enrollment. The state Medicaid agency must ensure that any individual who is determined ineligible for Medicaid is screened for potential eligibility for benefits available through an Exchange and promptly transfer the electronic account of individuals screened as potentially eligible to the Exchange. States also have the option to enter into an agreement with an Exchange to make final determinations of eligibility for tax credits for Exchange coverage. With regard to Exchange determinations of Medicaid eligibility, states can enter into agreements to *either* have the Exchange make final Medicaid eligibility determinations or have the Exchange make assessments of potential Medicaid eligibility and transfer accounts to the Medicaid agency for final determination.

Conclusion

The final Medicaid eligibility and enrollment rule is an important step forward in the ACA implementation process. The rules lay out procedures for states to implement the Medicaid expansion and streamlined and integrated eligibility and enrollment system created by the ACA. However, successfully achieving this goal will require substantial process and system changes among state Medicaid agencies and close coordination between Medicaid, Exchanges, and other insurance affordability programs. Moreover, even with sophisticated systems in place, successful implementation will likely require substantial application assistance for individuals navigating the new process and coverage options to fully realize the potential of the ACA in expanding and simplifying access to coverage.

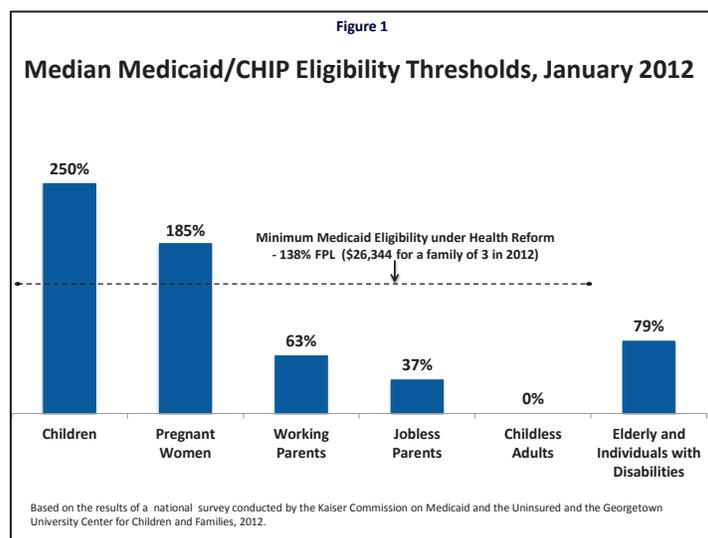
Introduction

The Affordable Care Act (ACA) increases access to health insurance beginning in 2014 through an expansion in Medicaid eligibility¹ and the creation of new Health Benefit Exchanges (Exchanges) with advance payment of premium tax credits to help purchase Exchange coverage. In addition, the ACA outlines a coordinated and streamlined enrollment process for all insurance affordability programs, including Medicaid, the Children's Health Insurance Program (CHIP), tax credits for Exchange coverage, and optional Basic Health Programs. On March 23, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a final rule (which included several sections issued as interim final) to implement the ACA provisions relating to Medicaid and CHIP eligibility, enrollment simplification, and coordination, effective January 1, 2014.² The Department of Health and Human Services has also issued a final rule (which also includes some sections that are interim final) regarding eligibility for premium tax credits and cost-sharing reductions and enrollment in Exchanges,³ and the Department of the Treasury has issued a final rule regarding health insurance premium assistance tax credits.⁴

This brief summarizes the major provisions of CMS's final and interim final rule regarding Medicaid eligibility, enrollment simplification, and coordination. (This brief does not address provisions specific to the CHIP program⁵ or the provisions included in the Exchange and Treasury rules, except as they are referenced by the Medicaid provisions.) A companion brief examines the impact of the new Medicaid rules on people with disabilities available at <http://www.kff.org/medicaid/8390.cfm>.

Changes in Medicaid Eligibility Categories

Today, there are numerous Medicaid eligibility categories and associated technical criteria. These eligibility categories include both federal core groups that states are required to cover as a condition of participation in the Medicaid program, as well as expansion groups that states may choose to cover with federal Medicaid funds. Until the passage of the ACA, states generally could not receive federal Medicaid matching funds to cover low-income childless adults who did not qualify on the basis of a disability, except through a waiver. To date, states have expanded coverage for children and individuals in need of institutional care. However, income eligibility limits for parents remain low and, in most states, other adults are not eligible for Medicaid, regardless of their income⁶ (Figure 1).



One major component of the ACA is the expansion of Medicaid eligibility to a minimum floor of 133% FPL (\$2,116 per month for a family of three in 2012), beginning in 2014. (The law also includes an income disregard of 5 percentage points of the FPL, making the effective minimum income limit 138% FPL.) This expansion would increase eligibility levels for low-income parents and other adults in many states. In addition, the ACA provides states an opportunity to get an early start on the expansion by providing a new state plan option to cover adults with incomes at or below 133% FPL, effective April 2010. Moreover, to preserve the base of coverage upon which the expansion will build, the ACA requires states to maintain eligibility thresholds that are at least as generous as those they had in place at the time the ACA was enacted until certification of state Exchanges (expected in 2014) for adults and until 2019 for children. The Supreme Court ruling on the ACA maintains the Medicaid expansion, but limits the Secretary's authority to enforce it, effectively making implementation of the expansion a state choice.⁷ If a state does not implement the expansion, poor adults in that state will not gain new affordable coverage options and likely remain uninsured.⁸

CMS's final rule on Medicaid eligibility and enrollment implements the provisions that expand eligibility for adults and consolidates most existing Medicaid eligibility groups into broader, simplified categories (Table 1, next page). Beginning in 2014, these groups will have their financial eligibility determined based on the modified adjusted gross income (MAGI) methodology, as discussed in the next section. Other existing mandatory and optional eligibility groups, including individuals with disabilities, elderly individuals, and medically needy individuals, will be exempt from use of MAGI and continue to have their financial eligibility determined using current Medicaid rules. Specifically, under the rule, beginning January 2014:

- **Medicaid eligibility will extend to a new "adult group," which includes all non-pregnant individuals ages 19 to 65 with household incomes at or below 133% FPL.**⁹ The new adult group effectuates the ACA's Medicaid expansion. Parents enrolling under this category must have their children enrolled in Medicaid, CHIP, or other "minimum essential coverage."
- **Most existing Medicaid eligibility categories will be collapsed into three broad groups: parents, pregnant women,¹⁰ and children under age 19.** States will set income eligibility standards for these groups subject to federally specified minimums and maximums. The transition to these broader groups is not intended to change current eligibility levels for these populations, but rather to streamline and consolidate existing eligibility categories. However, some individuals may lose Medicaid eligibility if a state reduces eligibility to the minimum levels when the requirement for states to maintain eligibility thresholds expires after the certification of state Exchanges (expected in 2014) for adults and in 2019 for children.
- **States may choose to cover non-elderly individuals who are not otherwise eligible for Medicaid, including pregnant women and children, with incomes above 133% FPL up to a maximum standard set by the state.** States may phase-in coverage of the new group by category (e.g., pregnant women, children), provided that the state does not cover people with higher incomes before people with lower incomes are covered.¹¹ Moreover, as with the new adult group described above, any parents enrolled under this category must have their children enrolled in Medicaid, CHIP, or other "minimum essential coverage."

**Table 1:
Minimum and Maximum Income Limits for MAGI-Based Medicaid Eligibility Categories, as of 2014**

	Minimum Income Limit	Maximum Income Limit
Parents of dependent children and caretaker relatives	State's AFDC income standard for household as of May 1, 1988	State's AFDC income standard as of July 16, 1996 (increased by no more than the percentage increase in the Consumer Price Index for urban consumers since that date) OR A higher effective income level a state had in place for Section 1931 parents as of March 23, 2010, or December 31, 2013, if higher
Pregnant women (including 60 days post-partum)	133% FPL*	185% FPL OR A higher effective income level a state had in place as of March 23, 2010, or December 13, 2013, if higher
Children under age 19	133% FPL*	For infants under age 1: 185% FPL For other children: 133% FPL OR A higher effective income level a state had in place (by age group) as of March 23, 2010, or December 31, 2013, if higher
Adults ≤133% FPL	133% FPL	133% FPL
Individuals >133% FPL	N/A (provided at state option)	A state-established standard >133% FPL

Table notes:

*The minimum standards for pregnant women and infants will be higher than the levels listed in the table in states that had higher limits in effect on December 19, 1989, or had authorizing legislation to do so as of July 1, 1989.

Minimum standards will not be converted to MAGI-equivalents based on previous disregards and deductions used by the state. However, maximum limits that are tied to states' effective income levels as of March 23, 2010 (or December 31, 2013, if higher) will be converted to MAGI-equivalents that account for previously used disregards and deductions.

Under the new MAGI method, a five percentage point of FPL income disregard will be applied to the minimum and converted maximum thresholds to determine the effective eligibility limit.

Determining Medicaid Eligibility Based on Modified Adjusted Gross Income (MAGI)

In addition to expanding Medicaid eligibility and consolidating existing eligibility categories, the ACA will also change how financial eligibility is determined for Medicaid. Beginning January 2014, financial eligibility for many groups will be based on MAGI methods, as defined in the Internal Revenue Code. The move to MAGI for many groups will result in some changes from current Medicaid rules related to calculating family size and income and will largely align Medicaid financial eligibility determinations with the standards used to determine eligibility for premium tax credits and cost-sharing reductions through the Exchanges. With regard to determining eligibility, CMS also amends the definitions of state residency for adults and children to simplify the language and coordinate with the Exchanges. Under the final rule:

Medicaid financial eligibility for most categories will be based on the MAGI definition of household income. For these groups, MAGI methods will be used to determine eligibility for new applicants beginning as of January 2014. MAGI methods will not be applied to existing beneficiaries who were determined eligible for Medicaid on or before December 31, 2013 until March 31, 2014 or the next regularly-scheduled renewal for the individual, whichever is later. Certain groups are exempt from the use of MAGI and will continue to have their financial eligibility determined based on existing Medicaid rules (Text Box 1).

**Text Box 1:
Individuals Exempt from MAGI Methods**

- Individuals eligible for Medicaid on a basis that does not require the determination of income by the Medicaid agency (e.g., SSI beneficiaries, individuals determined eligible based on a finding of income made by an Express Lane agency)
- Individuals age 65 and older (only for purposes of being evaluated for an eligibility group related to age)
- Individuals whose eligibility is determined on the basis of being blind or disabled (only for determining eligibility on such basis)
- Individuals who request coverage for long-term services and supports, including nursing facility services, home and community based services, and home health services
- Individuals eligible for Medicare cost-sharing assistance (only for determining eligibility for Medicare cost-sharing assistance)
- Medically needy individuals (only for determining eligibility for the medically needy category)

Although MAGI is determined on an annual basis, Medicaid eligibility will remain based on income at the time of application. Medicaid eligibility determinations for new applicants will continue to be based on current monthly income. For existing Medicaid beneficiaries determined eligible based on MAGI, the rule provides states the option to base continuing financial eligibility on either current monthly income or projected annual income for the remainder of the calendar year. In determining current monthly or projected annual income, a state may take into account reasonably anticipated changes in income. Actual changes in income must be reported by applicants and beneficiaries and acted upon by the state Medicaid agency.

The state option to use projected annual income for current beneficiaries enables states to better align Medicaid income counting rules with the eligibility rules for premium tax credits for Exchange coverage. Adopting this option would help prevent coverage gaps and minimize the churning of individuals between programs based on small income fluctuations. It also would prevent cases of individuals being determined ineligible for both Medicaid and tax credits as a result of income fluctuations. For example, an individual employed as a landscaper can reasonably anticipate that his or her income will be higher in the summer and lower in the winter. If this individual applies for coverage in the summer, he or she could be found ineligible for Medicaid based on current income but also determined ineligible for the premium tax credits based on a lower projected annual income of less than 100% FPL. In these cases, the rule establishes that the Medicaid financial eligibility determination will be based on the finding of projected annual income if the projected annual income is below 100% FPL, which would make the individual eligible for Medicaid.

The rule generally adopts MAGI methods for counting household income¹² and eliminates the variety of income disregards and deductions currently used by states.¹³ In addition, there are no resource tests under MAGI. Using MAGI methods, household income will be the sum of the income of every individual who is in the household, minus a standard income disregard of five percentage points of the FPL for the applicable household size. To convert current income standards for existing Medicaid eligibility groups to MAGI-equivalent income standards, states must take into account existing disregards and deductions. CMS will issue separate guidance on how to make this conversion.

The rule generally aligns references to “family size” in the current Medicaid rules with the definition of “household” used under MAGI. There are a small number of situations in which the transition from current Medicaid rules to MAGI rules will result in different household compositions. In some of these cases, the rule adopts the MAGI rules, which will result in some individuals losing Medicaid eligibility (while likely becoming eligible for Exchange coverage).¹⁴ In other cases, current Medicaid rules are retained, meaning that calculations of household size for Medicaid and premium tax credits may vary.¹⁵ The regulations also establish household rules for non-tax filers and individuals not claimed as tax dependents, who are not addressed by MAGI methods in the Internal Revenue Code.¹⁶

Application, Enrollment, and Renewal Procedures

In addition to the changes in eligibility categories and the determination of financial eligibility, the ACA includes requirements designed to create a simple, streamlined integrated enrollment process for Medicaid and other insurance affordability programs. The rule addresses a number of provisions related to Medicaid application, enrollment, and renewal procedures to achieve this new system.

Program Information, Applications, and Application Assistance

States must provide information on Medicaid eligibility requirements, covered services, and applicant/beneficiary rights and responsibilities via a website as well as orally and in writing. The information must be provided in “plain language” and be accessible to people with disabilities and people with limited English proficiency at no cost to the individual.

The ACA requires the Secretary to provide states with a single streamlined application for all insurance affordability programs. The rule does not address the contents of the application, but CMS subsequently has proposed data elements.¹⁷ States must use the application developed by the Secretary or an alternative application that has been approved by the Secretary and is no more burdensome than the Secretary’s application. CMS has indicated that alternative approved applications could include multi-benefit applications for other human services programs in addition to health insurance affordability programs, but that states also would need to make a health-only application available. To obtain additional information needed for applicants who are not eligible under a MAGI category, states may either use supplemental forms or an alternative application that minimizes the burden on applicants; the supplemental forms or alternative application must be submitted to the Secretary but do not need to be approved.

The application and any supplemental forms must be accessible to persons with limited English proficiency and people with disabilities at no cost to the individual. The rule does not include specific accessibility standards, but CMS indicates it intends to issue such standards in future guidance after seeking input from states and other stakeholders. Those standards should provide more detail regarding literacy levels, language services, and access standards.

Individuals must be able to apply online, by telephone, by mail, in person, and through other commonly available electronic means. States must assure that all initial applications are signed and allow for electronically signed applications, including telephonically recorded signatures and handwritten signatures transmitted via electronic means. States may not require an in-person interview as part of the application or renewal process for individuals who are eligible based on MAGI.

States may only request information that is necessary to make an eligibility determination or that is directly connected to administering the state Medicaid plan. States must obtain and verify a Social Security number (SSN) for all Medicaid applicants with some limited exceptions.¹⁸ However, a state may not deny or delay services to an otherwise eligible individual pending receipt and verification of the SSN. States may not require non-applicants (those seeking Medicaid coverage for someone other than themselves) to provide a SSN or information regarding citizenship, nationality, or immigration status. However, they may request SSNs from non-applicants on a voluntary basis. At the time the SSN for a non-applicant is requested, the state must provide clear notice that this is voluntary and about how the SSN will be used. The state must safeguard all information collected from applicants and beneficiaries, including information concerning a non-applicant.

State Medicaid agencies must provide assistance to individuals seeking help with the application or renewal process in person, over the telephone, and online. Such assistance must be accessible to people with disabilities and people with limited English proficiency. CMS intends to provide additional sub-regulatory guidance and technical assistance in this area.

Streamlined Eligibility Determination Process

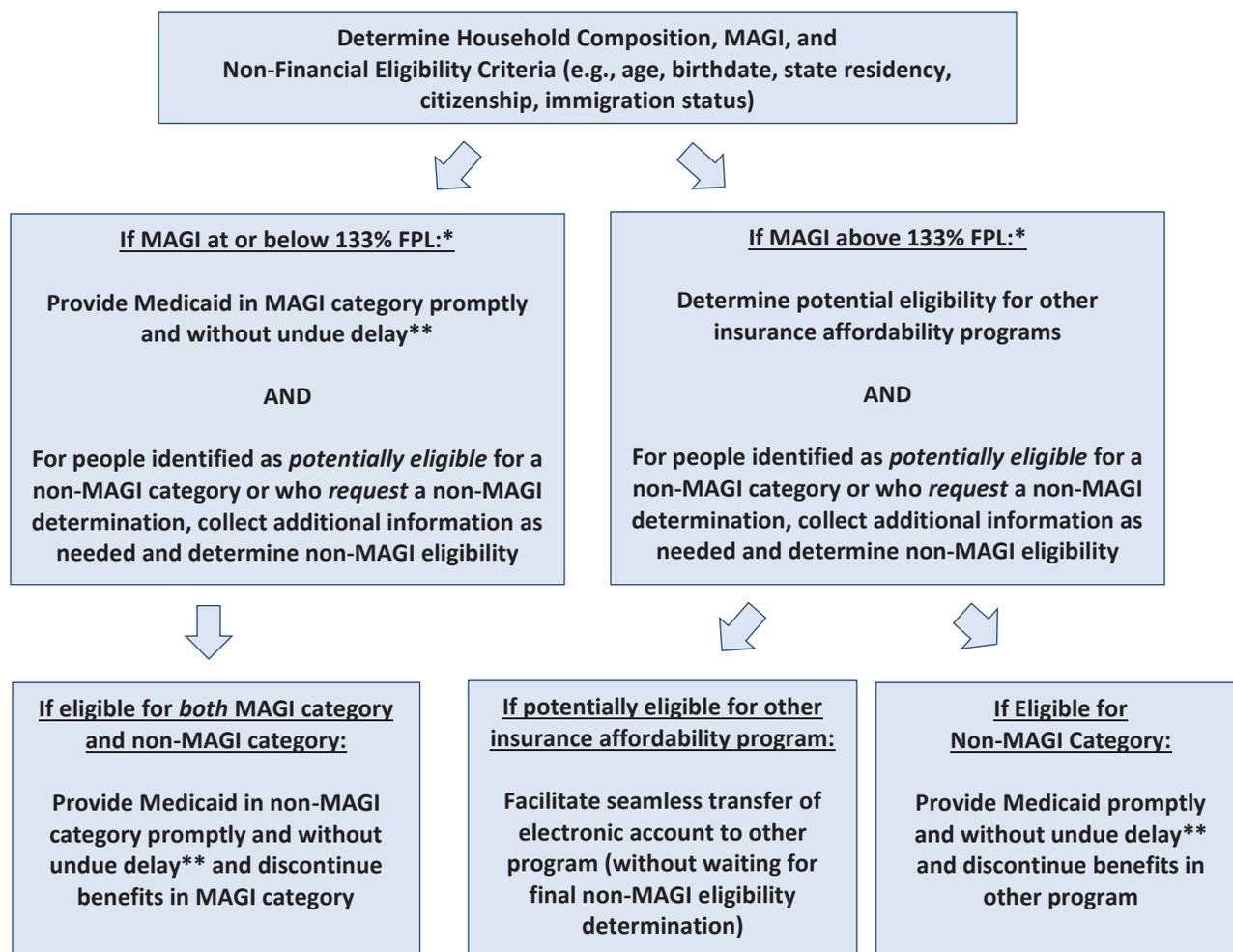
When an individual submits an application to the state Medicaid agency, the state will first determine eligibility for a MAGI category (Figure 2, next page). If an individual is determined eligible for a MAGI category, the state must provide Medicaid coverage to that individual “promptly and without undue delay, consistent with timeliness standards.” If such an individual is identified as potentially eligible on a non-MAGI basis or requests a non-MAGI eligibility determination, the state must collect necessary information to make that determination. If that individual is subsequently found eligible for both a MAGI and a non-MAGI category, the state must provide Medicaid through the non-MAGI category “promptly and without undue delay, consistent with timeliness standards” and discontinue benefits in the MAGI category.

If an individual has household income above the MAGI standard, the state must determine eligibility for non-MAGI categories and potential eligibility for other insurance affordability programs. While an individual is undergoing a Medicaid eligibility determination on a non-MAGI basis, the state must determine potential eligibility for and transfer the individual’s electronic account to the Exchange or other applicable insurance affordability program. When the account is transferred, the state must provide timely notice to the other program that a final Medicaid eligibility determination is pending and the outcome of the subsequent final Medicaid eligibility determination. If the individual is found eligible for a non-MAGI category, the state must provide Medicaid “promptly and without undue delay, consistent with timeliness standards.”

Each state must establish timeliness and performance standards for determining eligibility. Timeliness standards are the maximum period of time within which each applicant is entitled to a determination of eligibility. Performance standards are overall standards for determining eligibility across a pool of applicants. The standards will apply to Medicaid eligibility determinations for individuals who submit

applications to the state agency and for individuals whose accounts are transferred to the state agency from other insurance affordability programs. They also will apply to determining potential eligibility for and transferring individuals' electronic accounts to other insurance affordability programs. The standards cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the account to another insurance affordability program. The rule retains an outer limit timeliness standard of 45 days for non-disability based eligibility determinations and 90 days for disability-based determinations. These timeliness and performance standards were issued as interim final rules.

**Figure 2:
State Medicaid Agency Application Processing Flowchart**



*The effective MAGI Income Standard is 138% FPL because the MAGI methodology provides for a 5% FPL income disregard.

**Eligibility determinations may not exceed 90 days for disability-based applications and 45 days for other applications based on date of application OR transfer from another program.

Verification of Eligibility

The rule also streamlines and simplifies the eligibility verification process, seeking to minimize burdens on states and applicants. However, CMS reaffirms that nothing in the rule prevents states from acting to ensure program integrity.

States are expressly permitted to accept self-attestation of all Medicaid eligibility criteria, except for citizenship and immigration status. Attestation may be by the applicant or beneficiary or by a parent, caretaker, or other person acting responsibly on the individual's behalf. To ensure program integrity, states must request and use information relevant to verifying an individual's eligibility consistent with the following policies:

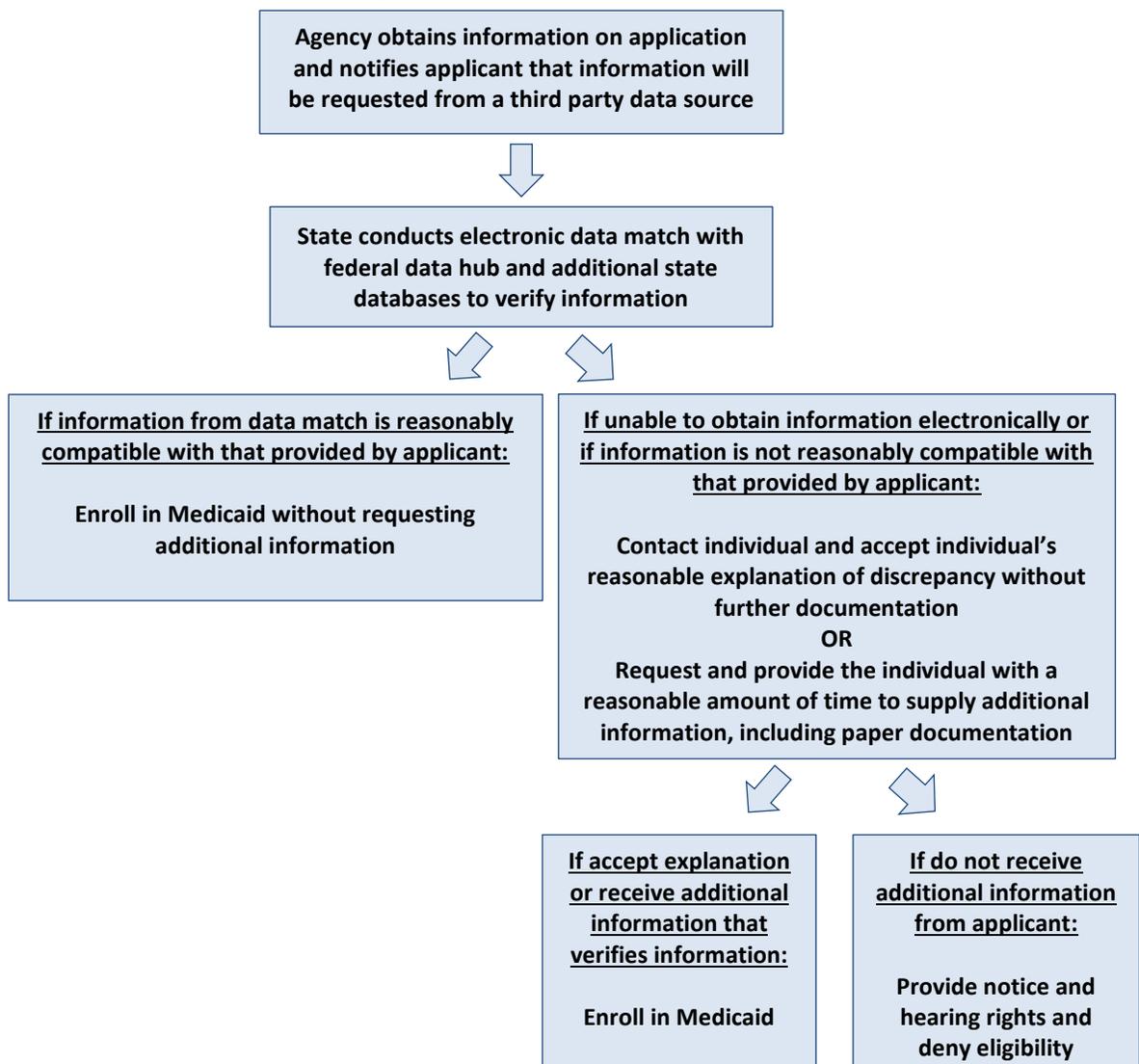
- ***Financial information.*** The state must request, electronically to the extent available, certain information related to financial eligibility from other state agencies and other state and federal programs to the extent it determines such information is useful for determining the individual's eligibility. This includes wages, earnings, and unearned income and resources and eligibility for or enrollment in the Supplemental Nutritional Assistance Program, Temporary Assistance for Needy Families Program, and other insurance affordability programs. CMS delegates the Secretary's discretion to the states to determine whether information would be useful to verify Medicaid financial eligibility and, therefore, must be requested.
- ***Age, Household Size, and State Residency.*** States may choose to verify, other than by attestation, date of birth, the individuals that comprise an individual's household, and/or state residency. However, a state may not use documentation of an individual's immigration status to determine that the individual is not a state resident.
- ***Pregnancy.*** States must accept self-attestation of pregnancy, unless the state has other information, such as claims history, that is not reasonably compatible with the attestation.

Each state agency must develop, and update as modified, a verification plan describing its verification policies and procedures and submit the plan to the Secretary upon request. States will rely, to the maximum extent possible, on electronic data matches with trusted third party data sources to verify information provided by applicants. Before a request for a third party data source is initiated, the individual must receive notice of the information being requested and its use. Information exchanged electronically between the state Medicaid agency and any other agency or program must be sent and received via secure electronic interfaces.

The Secretary will establish a secure electronic verification system, or federal hub, through which all insurance affordability programs can verify certain information with other federal agencies and data sources. These sources will allow for verification of household income and size with the IRS, citizenship with the Social Security Administration, and immigration status with the Department of Homeland Security. To the extent information related to Medicaid eligibility is available through this federal hub, states must access information through the system. Information not available through the federal hub may be obtained directly from the agency or program housing the information. Subject to approval by the Secretary, the state agency may request and use information from other data sources through a different mechanism than the federal hub so long as the alternative source or mechanism reduces costs and burdens to individuals and states.

If information provided by an individual is “reasonably compatible” with information obtained from other sources, the agency must use that information to determine or renew eligibility. The rule specifies that if income information obtained through an electronic data match and provided by the individual are either both above or below an applicable income limit for coverage, the information will be considered reasonably compatible. However, it does not further define reasonably compatible, leaving this decision up to the state. If the agency is unable to obtain information electronically, or if the information obtained is not reasonably compatible with that provided by the individual as specified in the state’s verification plan, the agency may contact the individual and accept the individual’s reasonable explanation of the discrepancy without further documentation, or the agency may request and provide the individual with a reasonable amount of time to supply additional information, including paper documentation. The agency may not deny or terminate eligibility based on information it has received from another source unless the agency has sought additional information from the individual and provided the individual with proper notice and hearing rights (see Figure 3).

**Figure 3:
Medicaid Eligibility Verification Process Flowchart**



Medicaid Eligibility Renewals

Medicaid beneficiaries whose eligibility is based on MAGI will have their coverage renewed once every 12 months. However, a state will review eligibility within the 12-month period when it receives information about a change in a beneficiary's circumstances that may affect eligibility. The state agency must have procedures in place to ensure that beneficiaries make timely and accurate reports of any change in circumstances and that enable beneficiaries to report these changes online, by phone, in person, or through other electronic means.

For MAGI-groups, state agencies will first seek to renew eligibility by evaluating information from the individual's electronic account or from other more current reliable data sources (Figure 4). If the available information is sufficient to determine continued Medicaid eligibility, the state will renew coverage based on that information and send an appropriate notice without requiring the individual to sign and return the notice. Beneficiaries must correct any inaccurate information in the notice online, in person, by telephone or by mail. If the agency cannot determine that the individual remains eligible based on available information, it must then provide the individual with a pre-populated form containing the information relevant to renewal that is available to the agency and a reasonable period of time, at least 30 days, for the individual to provide the necessary information and correct any inaccuracies online, in person, by telephone or by mail. The agency will verify the information reported by the individual and has the state option to rely on self-attestation. The state cannot require an in-person interview as part of the redetermination process.

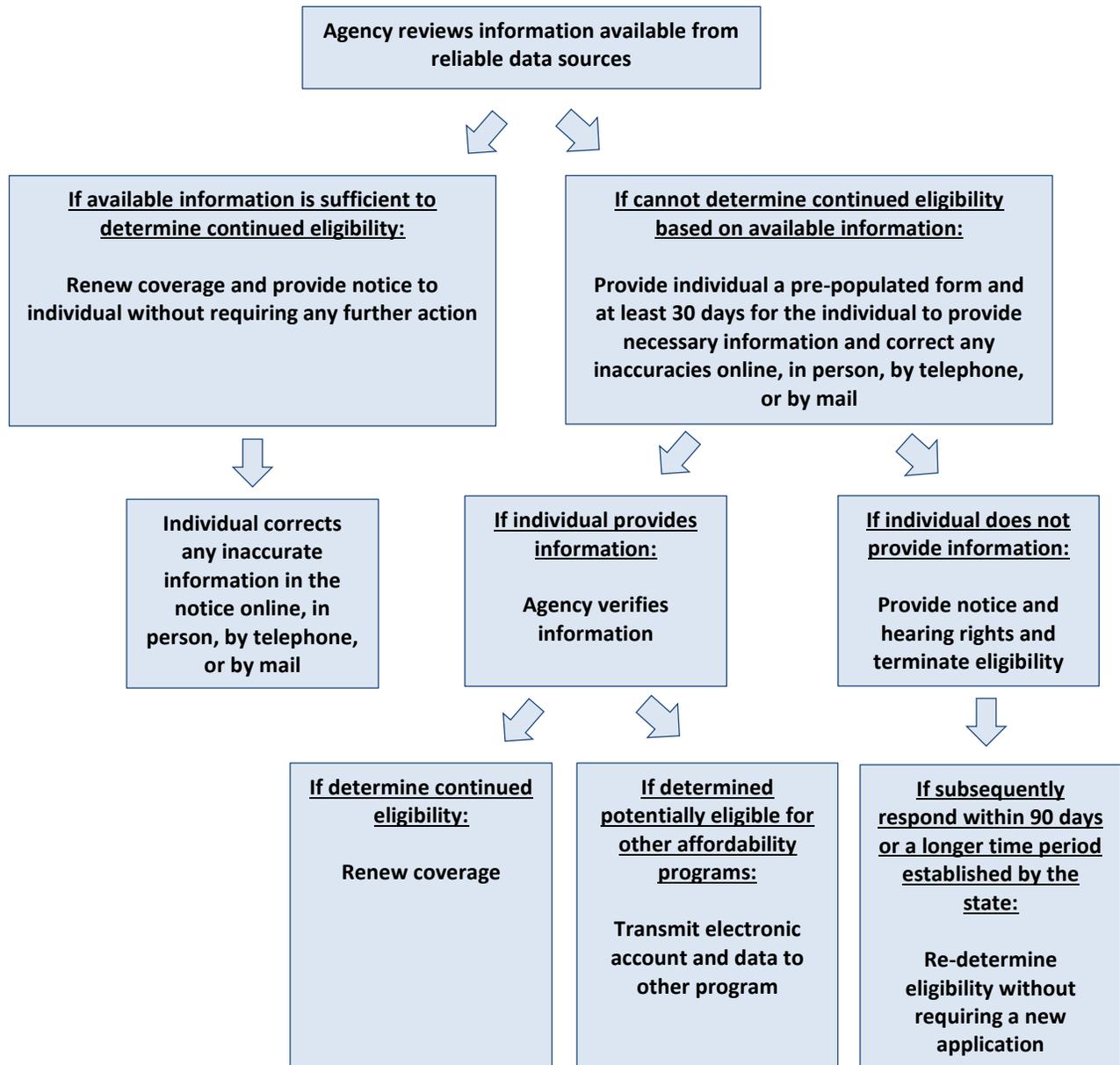
To reduce unnecessary applications, the rule provides a reconsideration period for individuals who lose coverage due to failure to submit the renewal form or information. If an individual's eligibility is terminated due to failure to submit the renewal form or necessary information that the individual subsequently submits within 90 days after the date of termination, or a longer timeframe established by the state, the state will redetermine the individual's eligibility without requiring a new application.

For non-MAGI groups, the rule retains the provision that eligibility must be redetermined "at least every 12 months." As with the MAGI groups, states must first seek to renew eligibility based on information available in the individual's electronic account or other more current data sources. States also have the option to use the pre-populated form and reconsideration period procedures for non-MAGI groups but are not required to do so. The rule does extend the new requirements for available change reporting methods (online, by telephone, by mail, and in person) to non-MAGI groups.

Renewals of eligibility will be subject to the same timeliness and performance standards that apply to initial eligibility determinations. These standards include an outer limit of 45 days for non-disability based eligibility determinations and 90 days for disability-based determinations. Additional details on performance standards will be released in subsequent guidance.

At renewal, the state must consider all potential bases of eligibility prior to determining an individual ineligible. The proposed rule had invited comments on extending Medicaid coverage until the end of the month in which a Medicaid termination notice period ends to prevent gaps in coverage that might occur between a Medicaid coverage termination and the beginning of Exchange coverage. However, this provision was not included in the final rule.

**Figure 4:
Medicaid Renewal Process for MAGI-Related Groups Flowchart**



Coordination Between Medicaid and Exchanges

State Medicaid agencies must participate in a coordinated eligibility and enrollment system with other insurance affordability programs. The rule addresses a number of provisions related to how Medicaid will coordinate with Exchanges and other programs to determine eligibility and enroll individuals in coverage.¹⁹

Each state Medicaid agency will enter into one or more agreements with the Exchange and other agencies administering insurance affordability programs. These agreements will be provided to the Secretary upon request, but they are not subject to approval and there is no requirement for them to be made publicly available. These agreements will clearly delineate each program's responsibilities to: minimize the burden on individuals, ensure compliance with other eligibility coordination requirements, and ensure prompt determinations of eligibility consistent with timeliness standards. Moreover, state Medicaid agencies must certify the criteria necessary for an Exchange or other insurance affordability program to use when determining Medicaid eligibility.

For each individual who is determined ineligible for Medicaid upon an initial application or at redetermination, the state Medicaid agency must determine potential eligibility for Exchange or other insurance affordability program coverage. The state Medicaid agency must promptly transfer the electronic account of individuals screened as potentially eligible to the Exchange; however, there is no specified time limit in the regulations within which this transfer must occur. For an individual who is determined ineligible for Medicaid based on MAGI but who is still undergoing a non-MAGI eligibility determination, the state agency must transfer the individual's electronic account to the Exchange and provide notice that the individual is not eligible based on MAGI but that a final Medicaid eligibility determination is still pending and of the agency's subsequent final determination. States also have the option to enter into an agreement with an Exchange to make final determinations of eligibility for advance payments of the premium tax credits and cost sharing reductions for coverage under an Exchange rather than transferring accounts to the Exchange for final determination.

States can enter into agreements to either have the Exchange make final Medicaid eligibility determinations or have the Exchange make assessments of potential Medicaid eligibility and transfer accounts to the Medicaid agency for final determination. This option for Exchanges to make assessments of potential Medicaid eligibility rather than final Medicaid eligibility determinations was issued as interim final.

- **Exchange makes final Medicaid determinations.** If the state enters into an agreement with the Exchange to make final determinations of Medicaid eligibility, for each individual determined eligible for Medicaid by the Exchange, the state agency must establish procedures to receive the electronic account containing the determination of Medicaid eligibility and promptly provide Medicaid using the same procedures and subject to the same timeliness standards as if the determination had been by the agency itself. If an Exchange is operated by a non-governmental agency, the authority to conduct final Medicaid determinations is limited to MAGI-based determinations. In some cases in which the Exchange is operated by a governmental agency, the Exchange may be able to make non-MAGI determinations or enter into contracts with other government agencies to do so.

- **Exchange makes assessments of potential Medicaid eligibility.** States may also enter into an agreement for the Exchange to make assessments of potential Medicaid eligibility, rather than final determinations. In these cases, Exchanges must assess Medicaid eligibility consistent with federal verification rules and procedures, although they may vary from state-specific options in certain cases. The state agency must accept the electronic account for each individual determined potentially eligible for Medicaid by the Exchange and, promptly and without undue delay, consistent with timeliness standards, make a final determination of Medicaid eligibility. The agency may not request any information or documentation from the individual that has already been provided to the Exchange or require an individual to submit another application. However, the agency may request additional verifications consistent with state-specific verification requirements. The state agency must notify the Exchange of receipt of the electronic account.

If during an assessment for potential Medicaid eligibility, the Exchange determines that an individual is not eligible for Medicaid based on MAGI standards, the Exchange must consider the individual as ineligible for Medicaid for purposes of determining eligibility for advance payments of the premium tax credit and cost sharing reductions. The Exchange also must notify the individual of the option to have a full determination of Medicaid eligibility, including on a non-MAGI basis, or to withdraw the application for Medicaid. If the individual withdraws the application, he or she will not be assessed by the state agency for Medicaid eligibility. Individuals determined ineligible for Medicaid based on MAGI, who receive a full Medicaid eligibility determination may enroll in a qualified health plan through an Exchange while their final Medicaid determination is pending. The state agency must notify the Exchange of the final Medicaid determination, and, if the individual is ultimately found eligible for Medicaid on a non-MAGI basis, the other coverage would terminate in favor of Medicaid.

Looking Ahead

This final rule from CMS implements the ACA's Medicaid expansion and new eligibility and enrollment requirements, which will have significant impacts on applicants, enrollees, and state Medicaid agencies. In examining the potential impacts of the rule, there a number of key issues to consider, including the following:

- **While the transition to the new Medicaid eligibility categories and use of MAGI is not intended to affect the eligibility of existing groups, some individuals will lose Medicaid due to the transition.** These individuals will likely become eligible for premium tax credits in an Exchange. As the rule is implemented, it will be important to assess the impacts on individuals who lose Medicaid eligibility, including their access to needed services if they enroll in qualified health plans through Exchanges.
- **The rule provides states with a range of options and flexibilities related to implementation of the new eligibility and enrollment system.** For example, states can choose to extend eligibility to individuals at higher incomes, can seek approval to use a different application than the one developed by the Secretary, have flexibility to determine verification policies for certain eligibility criteria, can establish their own timeliness and performance standards, and have choices related to how they will coordinate eligibility determinations with Exchanges. State responses to each of these options will have a significant impact on the eligibility and enrollment process and experience in each state, including the simplicity and timeliness of the process and the risk for coverage gaps between Medicaid and other insurance affordability programs.

- **The goal of the Medicaid rule, along with the Exchange and Treasury rules, is to create an integrated and aligned eligibility and enrollment system, but there are a number of areas in which differences in processes and rules remain.** For example, within Medicaid, a number of the proposed changes and simplifications will apply to MAGI-groups but not necessarily to groups exempt from MAGI. Moreover, Medicaid eligibility remains based on monthly income at the time of application, while eligibility for premium tax credits for Exchange coverage is based on annual income, and there are some differences in the rules for counting of household size and income between Medicaid and Exchange coverage. Developing effective methods to address these distinctions in ways that do not cause confusion or additional complexities for applicants and beneficiaries will be key for achieving the goal of a simple and coordinated eligibility and enrollment system.
- **Achieving a simple and streamlined process for individuals will require development of systems that can operationalize and automate the new eligibility rules and adequate application assistance.** The new system will determine eligibility based on a number of factors including a person’s tax filing status, household composition, and the specific rules and policies for the program for which eligibility is being assessed. Achieving a no wrong door system that appears simple and seamless to individuals will require state Medicaid agencies, working with the Exchanges, to create systems that can operationalize and automate the new eligibility determination rules. Moreover, even with such a system in place, it will be important for individuals to have timely access to assistance in a variety of formats to help them complete the application and enrollment process.
- **There are a number of provisions in the proposed rule that require further information and clarification.** For example, the regulations direct states to convert their existing maximum income standards for Medicaid and CHIP eligibility groups to MAGI-equivalents, but more guidance is needed regarding how states will make this conversion. Moreover, the rule references performance standards for state systems that have not yet been developed. In addition, the rule includes a “reasonable compatibility” standard that governs when states may request additional information, including documentation, from individuals to verify eligibility criteria. While the rule provides some clarity on when income will be considered reasonably compatible, more information is needed about how states will define reasonable compatibility for other eligibility criteria. Finally, while the rule generally does not address the benefits individuals will receive, it is important to note that eligibility rules and processes may have a significant impact on individuals’ benefits, since states may choose to provide individuals in some eligibility categories more limited benefit packages.

The final Medicaid eligibility and enrollment rule is an important step forward in the ACA implementation process. The rule lays out procedures for states to implement the Medicaid expansion and streamlined and integrated eligibility and enrollment system created by the ACA. However, successfully achieving this goal will require substantial process and system changes among state Medicaid agencies and close coordination between Medicaid, Exchanges, and other insurance affordability programs. Moreover, even with sophisticated systems in place, successful implementation will likely require substantial application assistance for individuals navigating the new process and coverage options to fully realize the potential of the ACA in expanding and simplifying access to affordable insurance.

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ENDNOTES

¹ The Supreme Court ruling on the ACA maintains the Medicaid expansion but limits the Secretary's authority enforce it. If a state does not implement the expansion, the Secretary cannot withhold existing federal program funds. Kaiser Commission on Medicaid and the Uninsured, *Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision* (Aug. 2012), available at <http://www.kff.org/healthreform/8348.cfm>.

² 77 Fed. Reg. 17144-17217 (March 23, 2012), available at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf>

³ 77 Fed. Reg. 18310-18475 (March 27, 2012), available at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>.

⁴ 77 Fed. Reg. 30377-30400 (May 23, 2012), available at <http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf>.

⁵ Note that CMS's CHIP regulations apply to states with separate CHIP programs, while state CHIP programs that are part of a Medicaid expansion are governed by the applicable Medicaid regulations.

⁶ See Kaiser Commission on Medicaid and the Uninsured, *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults* (July 2012), available at <http://www.kff.org/medicaid/7993.cfm>; Kaiser Commission on Medicaid and the Uninsured, *How Will the Medicaid Expansion for Adults Impact Eligibility and Coverage?* (July 2012), available at <http://www.kff.org/medicaid/8338.cfm>.

⁷ States historically have accepted federal funds to provide coverage. See Kaiser Commission on Medicaid and the Uninsured, *A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage* (Aug. 2012), available at <http://www.kff.org/medicaid/8349.cfm>.

⁸ The premium tax credits and cost-sharing reductions to purchase qualified health plans through the Exchanges are available to people with household income between 100% and 400% FPL; people who are eligible for Medicaid are ineligible for Exchange subsidies.

⁹ Eligibility for this group is limited to adults who are not otherwise eligible for and enrolled in another mandatory eligibility category.

¹⁰ CMS's rule addresses only one area related to the benefits package to be provided to Medicaid beneficiaries under the new system. Currently, states may limit Medicaid coverage to only pregnancy-related services for pregnant women at higher incomes. CMS's rule provides full Medicaid coverage to all pregnant women, unless the state elects to provide only pregnancy-related, or enhanced pregnancy-related, services to pregnant women with incomes above a certain limit established by the state in accordance with specified federal minimum and maximum standards.

¹¹ The preamble to the proposed rule provides that if a state currently covers children with household incomes above 133% FPL in a separate CHIP program and elects this new optional Medicaid eligibility group, the state must transition the affected children from CHIP to Medicaid but still would be able to claim the enhanced CHIP FMAP for those children. 76 Fed. Reg. 511481, available at <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/html/2011-20756.htm>.

¹² CMS retains the current Medicaid income counting rules in three instances: lump sum payments would continue to be counted as income in the month received rather than in the year received; scholarships and grants for educational purposes, and not living expenses, would continue to be excluded from countable income; and certain types of American Indian and Alaskan Native income would continue to be excluded from countable income.

¹³ Because each state's net countable income standard converted to a MAGI-equivalent will be lower than its current gross income standard (at or below 185% of the state's consolidated standard of need for the AFDC program as of July 16, 1996), the gross income test for parents/caretaker relatives also is eliminated under MAGI.

¹⁴ Groups that may lose Medicaid eligibility as a result of the transition to MAGI include children age 21 or older whose parents claim them as tax dependents; families with step-parents and step-children in states where step-parents are not legally required to support step-children; and families in which one or more children are required to file a tax return, where the child's income would not count under existing Medicaid rules.

¹⁵ For more detail on the specific groups affected, see 76 Fed. Reg. 51157-51158 and 42 C.F.R. § 435.603(f)(1), (2).

¹⁶ Specifically, spouses living together and spouses/parents (including step-parents) and all children (including step-children and step-siblings) under age 19 (or if a full-time student, under age 21), who live together are counted in

the same household. Non-tax filers, other than spouses or biological, adoptive or step-parents, children or siblings, are not included in the same household.

¹⁷ Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children’s Health Insurance Program Agencies, Appendix A, available at http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Downloads/508CMS-10440_Supporting_Statement_Part_A.pdf; see also 77 Fed. Reg. 40061-40063 (July 6, 2012).

¹⁸ Individuals who are not eligible to receive an SSN, who do not have an SSN and may only be issued an SSN for a non-work reason, or who refuse to obtain an SSN because of well-established religious objections are exempt from this requirement and may be provided a Medicaid identification number by the state. The identification number may be either an SSN obtained by the state on the applicant’s behalf or another unique identifier.

¹⁹ Coordination also is required between Medicaid, a separate CHIP program, and the Exchanges.

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