Health Advocate

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Health Reform Moving Forward: Recent Medicaid and Exchange Regulations

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Key Resources

In early May, NHeLP submitted comments on both the Medicaid and exchange eligibility regulations, which can be found here and here respectively. NHeLP's earlier comments on these regulations can be found here.

Upcoming comment deadlines:

- Medicaid - Payments for Services by Primary Care Physicians and Charges for Vaccine Admin for Children; due 6/11/12.
- Hospital Inpatient and long term care prospective payment system; Quality Reporting Requirements; due 6/12/12 by 5pm EDT.
- State Home and Community Based Services; 5 Yr Waiver Period; due 7/2/12.
- Notice of Opportunity to Provide Comments - Reauthorization of Ryan White Program; due 7/31/12.

In seventeen months, the first open enrollment period for health insurance exchanges begins. In March, the Centers for Medicare & Medicaid Services (CMS) issued regulations addressing the exchanges, the Medicaid expansion that occurs in 2014, and the coordination required between exchanges, Medicaid, Children's Health Insurance Programs (CHIPs), and Basic Health Plan (BHP) programs. These rules provide significant details for those working on full implementation of health reform. But they also raise concerns for those who work on behalf of low-income and underserved populations.

WHY ARE THESE REGULATIONS IMPORTANT?

A major goal of health reform is to create a streamlined process to determine the eligibility of applicants for a range of health insurance programs and financial assistance. Under the new regulations, a single coordinated application will collect sufficient information to determine eligibility for most government-sponsored insurance programs (with the notable exception of Medicare). Between now and 2014, implementing this "one stop" application will require both significant coordination between federal and state agencies and across-the-board improvements in information technology. If the pieces of the puzzle are not ready by 2014, the result could be confusion, frustration and the inability of millions of individuals to obtain health insurance.

WHAT DO THESE REGULATIONS ADDRESS?

Medicaid and CHIP Eligibility and Application Regulations

The Medicaid regulations address requirements for state Medicaid and CHIP programs to streamline their application and eligibility processes to coordinate with the new exchanges, including:

- condensing income standards for existing Medicaid eligibility categories;
- determining eligibility under the new category enacted in the ACA; and
- ensuring coordination among and between Medicaid, CHIP and the exchanges.

Eligibility

Approximately 17 million individuals will become Medicaid eligible in 2014 through a new Medicaid category that covers most adults under 138% of the federal poverty level (FPL) who are not already eligible. States will evaluate income using a "modified adjusted gross income" standard (MAGI) using available federal databases linked through a federal "hub" (including information from the IRS, SSA and the

Department of Homeland Security). MAGI-eligible individuals will receive benefits based on certain defined "benchmark" plans that may offer a limited package of benefits.

Many individuals who apply under MAGI may also be eligible for "traditional" Medicaid (i.e., are elderly, pregnant, have disabilities or otherwise qualify) and require evaluation using current Medicaid eligibility rules. This will likely include individuals with disabilities or those who meet a definition of "medically frail." Eligibility for traditional Medicaid brings with it the "traditional" package of covered benefits which, in many states, will be broader than services available to the MAGI population. While benefits offered in traditional and MAGI Medicaid may have significant differences, states can offer both groups the same benefits. A single set of benefits for all Medicaid enrollees will reduce state oversight and administrative costs.

NHeLP Recommends: States should adopt similar benefit packages for MAGI and traditional enrollees offering the broadest scope of services to meet enrollees' needs.

Those eligible pursuant to MAGI will automatically receive Medicaid for one year. Unfortunately, a state may limit eligibility under other categories to less than a year (although enrollees can apply to renew their eligibility). This disproportionately affects non-MAGI enrollees, such as children and people with disabilities, who may have to go through multiple redeterminations each year. Multiple redeterminations result in inefficient and wasteful administration. Since every individual must have health insurance after 2014, continuous eligibility for every Medicaid enrollee for 12 months would result in more efficiencies and cost-effectiveness.

NHeLP Recommends: CMS and advocates should strongly encourage states to adopt 12-month continuous eligibility for all Medicaid and CHIP enrollees.

Verification

As part of the new streamlined eligibility, states will access and verify much information electronically through the federal hub or other electronic sources before seeking information directly from individuals. The regulations specifically prohibit states from asking applicants for information that:

- is not needed for eligibility determinations;
- can be obtained electronically; or
- is not already provided on an application to another insurance affordability program.

For example, if an individual submits an application to an exchange reporting income that is relatively consistent with what is verified through the federal hub, the Medicaid agency cannot then also ask for paystubs to determine Medicaid eligibility. This should help prevent individuals from being denied eligibility merely due to a lack of documentation.

Timely Eligibility Determinations

The regulations also include new timeliness standards to ensure states make application decisions for most individuals within 45 days and for individuals with disabilities within 90 days. NHeLP recommends strengthening these timeliness standards in a number of ways, including shortening timeframes and adding standards for transfers of applications and for requesting additional information from applicants.

ACA by the Numbers

- Individuals who will be newly eligible for Medicaid in 2014: **17 million**
- Individuals who are expected to purchase insurance through exchanges by 2019: **24 million**
- Individuals who are expected to purchase insurance through exchanges who would otherwise be uninsured: **16 million**
- Percent of exchange enrollees receiving subsidies to purchase coverage: **81**
- States that have already enacted legislation to establish exchanges: **10** (CA, CO, CT, HI, MD, NV, OR, VT, WA, WV)

NHeLP recommends:

- 30 day time limit for determining regular Medicaid eligibility;
- 60 day time limit for determining Medicaid eligibility based on a disability;
- one business day for transferring application information between Medicaid, CHIP, BHPs and exchanges when another entity needs to make a determination; and
- three business days for the receiving agency to contact an applicant if additional information is needed.

We especially support the assurances in the regulations that an individual who applies for coverage in another insurance affordability program need not submit the same information or provide the same verifications to Medicaid. We also believe it is critical that the same timeliness standards apply to all health insurance programs for which a single application will be used – Medicaid, CHIP, Basic Health Programs, and subsidies for health insurance purchased through exchanges.

Performance Standards

In addition to specific timeliness requirements, CMS will also establish performance standards for states. For example, a state should be able to evaluate a certain number of applications in "real time." With the new streamlined systems, we believe the performance standards should recognize the ability of states to easily transfer information from one entity to another and verify information electronically.

NHeLP recommends: States should process non-disability applications based on a standard such as:

- 25% in real time;
- 70% within 15 days;
- 90% within 20 days; and
- 100% within 30 days.

Exchange Eligibility Regulations

The exchange regulations govern eligibility determinations made by health insurance exchanges. Over 24 million individuals will likely seek insurance through exchanges between 2014 and 2019. These regulations address how exchanges should determine eligibility, including eligibility for the Advanced Premium Tax Credits (APTC), the subsidies that will help individuals with incomes up to 400% FPL to purchase private insurance.

Three different types of exchanges may exist:

1. A state health insurance exchange established and wholly operated by a state or by a designated private not-for-profit entity;
2. A "federally-facilitated" exchange (FFE) run by the federal government for states that do not establish their own exchanges; and
3. A partnership exchange that divides responsibility between the federal and state governments (e.g. the state may undertake plan management and consumer outreach but rely on a federally-facilitated exchange for other functions).

While the regulations address all three options, the Administration is expected to release more detailed information on the FFE and partnership model in coming months.

Medicaid Assessments

One major change from earlier exchange rules is a state option for exchanges to conduct a preliminary Medicaid eligibility "assessment" rather than make a final Medicaid eligibility determination. This raises numerous concerns about whether low-income individuals who may be eligible for Medicaid may lose out from the benefits of a streamlined process if a state opts not to have its exchange fully evaluate Medicaid eligibility. An individual may find herself potentially eligible for Medicaid but the exchange will have to transfer her application to be evaluated by Medicaid. Yet, if Exchanges do not transfer cases to Medicaid then we have concerns that exchanges may use private employees to make Medicaid determinations.

NHeLP Recommends: CMS and advocates should strongly encourage states to use public employees to make final Medicaid determinations so that the benefits of a streamlined application process are available to everyone.

Timely Eligibility Determinations

As discussed above, NHeLP recommends coordinating the timeliness standards between exchanges, Medicaid and CHIP so that final eligibility determinations must occur within 30 days, an application transfer must happen within twenty-four hours and the total time available for making determinations remains applicable rather than restarting a new time period when a transfer occurs.

Enrollees' Rights

Unfortunately, the regulations do not outline the rights of enrollees when untimely or adverse decisions are made (i.e. "due process"). NHeLP has advocated for strong due process requirements for both eligibility determinations and denials of services in the exchanges. We expect more information from CMS in the coming months, but strong due process protections are particularly important for lower-income individuals applying for the APTC tax credits and assistance since receipt of a tax credit (or assistance with cost-sharing) will directly affect an individual's ability to afford health insurance. An estimated 81% of individuals applying through the exchanges will be lower income and eligible for tax credits.

NHeLP Recommends: CMS should base the due process protections in the exchanges on the same protections currently available to Medicaid enrollees.

NEXT STEPS

CMS issued a number of the provisions in both regulations as "interim final rules" and accepted comments on these provisions. NHeLP has submitted comments to both regulations and will continue to work to ensure the promises of health reform translate into real and meaningful coverage in 2014 and beyond.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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