Maximizing Enrollment/NASHP

Eligibility Regulatory Analysis Grid: Issues and Areas for Comment for States

A Maximizing Enrollment Analysis

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October 2011

A product of the Maximizing Enrollment Program

NATIONAL ACADEMY for STATE HEALTH POLICY

Robert Wood Johnson Foundation

This report is a product of Maximizing Enrollment: Transforming State Health Coverage, which is a $15 million, four-year initiative of the Robert Wood Johnson Foundation (RWJF). Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, Maximizing Enrollment aims to help states transform their eligibility and enrollment systems to improve enrollment and retention of children who are now eligible for Medicaid and the Children's Health Insurance Program (CHIP), and to prepare to enroll newly eligible individuals and families in public and publicly subsidized health coverage. By helping selected states improve their systems, policies and procedures — and measure the impact of these changes — RWJF hopes not only to increase the efficiency and effectiveness of these programs in enrolling and retaining those eligible, but to share knowledge about what works to increase enrollment and retention within public and publicly subsidized health coverage in all states. www.maxenroll.org

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About the Eligibility Regulatory Analysis Grid: Issues and Areas for Comment for States

This summary of the Medicaid Eligibility and IRS Health Insurance Premium Tax Credit Notices of Proposed Rulemaking (NPRMs) released on August 17, 2011 is intended to highlight key areas or issues to help states think through their comments on the proposed eligibility changes under the Affordable Care Act. While it is intended to be thorough, it does not touch on every issue important to states. This summary was developed based on our analysis and is not intended to substitute for federal interpretation.

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Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Medicaid Eligibility NPRM				
Changes to Medicaid Eligibility Categories (section A)				
New mandatory group	"Adult group" of 19-64-year-olds, with MAGI under 133% FPL. This group includes people who would have fallen into one of the preexisting categories (parent, blind, disabled), but didn't meet the income standard (e.g., in the case of a 209(b) state with more restrictive standards than SSI).	1. Is there any concern about the treatment of 19- and 20-year-olds here, in re: EPSDT? 2. Would any individuals moving from CHIP to Medicaid move into the "adult group"? Would anyone lose benefits as a result of such a move? 3. Do any of the people who will be caught in the adult group run the risk of losing out on benefits if they could have been declared disabled? How will the individual be made aware of their ability to request a full disability determination?		S. 435.119
New optional group.	Optional group over 133% FPL: Upper limit is set by state. Replaces coverage for higher-income people through income disregards. Includes both adults and children. People with disabilities: Allows states to enroll people who may have disabilities in the optional higher-income group without a full disability determination, if they meet income standards.	1. Ramifications for CHIP - would require shifting higher-income kids from S-CHIPs to Medicaid (but enhanced Title XXI funds are still claimable). How will this affect state CHIP allotments? How will states track those individuals, and is the Title XXI funding tied only to the current individuals who move, or to future enrollees (as with enhanced FMAP for "newly eligibles")? Does it continue after 2015? 2. Rule notes "medically needy" category, which seems to be a sticking point throughout the regulations.		S. 435.218

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Streamlining existing eligibility groups	Parents and caretaker relatives: replaces the "two-step" process of income determination with a single MAGI-equivalent standard, and eliminates the "deprivation" requirement (that one parent had to be absent, dead, or unemployed). If MAGI-equivalent standard (which can be tied to AFDC) is less than 133% FPL, then parents up to 133% would fall into the "adult" category. Pregnant women: all the existing groups are consolidated into a single MAGI-equivalent standard (equal to the state's highest allowable income level for any PW group), with a maximum income level of 185% FPL. States can elect to pick an income line above which they will pay only for pregnancy-related services. Infants and children: Raises minimum for 6-18's to 133% FPL. Children currently in CHIP must move to Medicaid, though states can still claim title XXI FMAP. Maximum is any higher MAGI-equivalent standard, or for infants, 185% FPL.	1. The retention of AFDC-related eligibility criteria, 15 years after the program ended, seems counterintuitive, particularly since the rule changes the definition of "families and children" to strike references to AFDC. 2. The rule consolidates lots of groups. Is there anything unique or important about those groups that get lost in the consolidation? 3. How does the option to offer pregnancy-only coverage interact with the essential benefits package?	Has CMS succeeded in preserving Medicaid eligibility for everyone who had it under the preexisting rules?	s. 435.110 and s. 435.116 and s. 435.118
Determining Medicaid Eligibility using MAGI (section B)				
Budget Period (point in time vs. annual)	Point in time v. Annual income: States should use point in time or monthly income calculated using MAGI methodology to determine eligibility for Medicaid. However, annual income calculated using MAGI will be used to determine advance tax credit payments. Alignment of budget period between Medicaid and the Exchange: NPRM offers flexibilities to address challenges of monthly Medicaid vs. annual Exchange subsidy calculations, including: 1. Allowing states to take "reasonably anticipated" future income changes into account when considering eligibility, such as a drop in income for a seasonal worker; 2. Allowing states to establish an annual eligibility period for Medicaid that aligns with the Exchanges annual eligibility period.	1. The proposed flexibilities may not be enough to minimize individuals shifting between Medicaid and the Exchange due to income fluctuations. Are there other tools CMS can offer to further support states to smoothly transition individuals between coverage programs? 2. Some states may have concerns about feasibility of asking applicants to reliably predict annual income for a year or more ahead of time.	How best to prevent a gap in coverage as a result of income changes? It is best to ensure Medicaid agencies take predictable drops in income into account?	S. 435.603(h)

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Implementing MAGI methods	Implementation of MAGI to determine eligibility: 1. For those not currently enrolled = 1/1/ 2014; 2. For those already enrolled in Medicaid, MAGI should not be applied until next redetermination after 12/31/13 *or* 3/31/14 – whichever is later *if* ind. may lose elig due to shift to MAGI MAGI methodology: aligns household composition and income with the tax definitions (referenced as 36B) that will be used for Exchanges, with some exceptions (more detail follows below) Elimination of asset tests or expense disregards under MAGI - other than a 5% disregard to FPL	1. How will the adoption of MAGI affect the redetermination of those currently enrolled in Medicaid? 2. Further guidance is forthcoming on the MAGI conversion from current Medicaid eligibility standards.		S. 435.603(a), (b), (c)
Counting Income based on MAGI	Household income under MAGI = sum of every individual's income within the household, with some exceptions Medicaid to align with 36B in treatment of certain income types: NPRM proposes to align how certain income is counted as there are differences between tax law (36B) and Pre-ACA Medicaid. When determining eligibility for Medicaid using MAGI the following income types *should be counted*: 1. Child support payments; 2. Depreciation of business expenses; and 3. Capitol gains and losses. Beginning in 2014, Medicaid should align with tax law and *no longer count*: 1. Certain Social Security benefits Exceptions: 3 types of income that should follow current Medicaid rules rather than tax law: 1. Lump sum payments, ex. inheritance, should count as taxable income only the month it is received; 2. Educational scholarships and grants should not be counted as income; 3. Maintain existing protections of American Indian and Alaska Native income	The changes in what counts as income could in some cases affect Medicaid eligibility – individuals either losing or gaining coverage, ex. no longer counting Social Security benefits as income could increase the number of individuals eligible for Medicaid. How will these changes affect those in your state?	CMS explicitly notes that not counting SSI as income could result an increase in Medicaid eligibility of those receiving SSI – this is an unintended consequence and CMS is exploring options to address it. What can CMS do to modify this section?	S. 435.603(e)

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Household Composition	Household composition under MAGI = primary taxpayer + all tax dependents, including qualifying children and relatives Alignment with tax law: In most instances, tax and Medicaid definitions yield the same household. The NPRM notes 8 situations that yield a different household, for which 4 of these, Medicaid is directed to adopt the tax definitions for sake of simplification and 4 should continue to use the Medicaid definition to minimize loss of coverage for those currently eligible. One example – a single pregnant woman should be counted as a family of 2, plus others within the household as is currently done in Medicaid.	1. Adopting the 36B definition of household for the following instances: families claiming children 21yrs or older as tax dependents; families claiming children living outside the home; families with stepchildren/stepparents; families with children filing tax returns could possibly result in the loss of Medicaid coverage. How will this affect those currently eligible in your state? Is alignment/coordination worth it? 2. There may be some issues for states in reconciling current Medicaid practice with new tax rules on household composition. Examples include children claimed as tax dependents for non-custodial parents when Medicaid now allows custodial parent to claim child in household; pregnant woman with multiples who is allowed in some states to claim all unborn children as part of household for eligibility but will only be able to claim one dependent under tax rules. Are there others in your state?		S. 435.603(f)

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Non-filers	Filing thresholds = Individuals with income below $9,350 and married couples filing jointly with one spouse 65yrs+ with income below $19,800 are not required to file taxes MAGI rules for non-filers: mirror rules for filers both in terms of calculating income and household composition under MAGI Treatment of 19-20yr olds: Under Medicaid – parents financially responsible for children up to age 21, but under 36B parents responsible for children up to age 19, unless full time students. This difference affects household composition and could result in gap in coverage for 19 – 20 years olds, so NPRM proposes – Parents (inc. stepparents) treat all children (inc. stepchildren) up to age 19yrs, or up 21yrs old if a full student, as members of their household to avoid a gap in coverage.	1. States need to consider verification of non-filers' household composition and income, as this information likely won't be available from IRS electronically. Some states are concerned there will be many non-filers seeking coverage – how will they verify eligibility under MAGI without reliable tax data? 2. Is the proposed treatment of 19 and 20 years old likely to avoid a gap in coverage? Is it possible that this proposal will result in young adults losing current Medicaid coverage?	Seeking comment of overall treatment of non-filers.	S. 435.603(f)(3)
Retention of Existing Financial Methods	Exceptions to MAGI: NPRM recognizes that MAGI will not apply in certain situations and sets out 6 eligibility category exceptions: a) Individuals eligible for Medicaid on a basis not determined by income (ex. Ind receiving SSI or determined eligibility based on ELE); b) Those blind and disabled; c) Age 65 or older; d) Eligible based on need for long term care; e) Eligible for assistance with Medicare cost sharing; and f) Medically needy individuals	In order to determine eligibility for individuals within these exception groups, will states need to retain AFDC methodologies?	CMS recognizes that the exception of all elderly individuals from MAGI, could result in states needing to maintain old methodologies and seeks input on ways to avoid this, particularly, for those over 65yrs.	S. 435.603(i)
Residency (Section C)				

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Residency Definition for Adults	Definition is simplified: NPRM proposes to strike term "permanently for an indefinite period" from residency definition. Residency will be determined based upon the state where an adult is living and has intent to reside, including if employed or is seeking employment.	Does this new proposed definition simplify or complicate the issue for states?	Seeking comment on the impact of these changes on children eligible for Medicaid based on disability.	S. 435.403(h)
Residency for children	Allows children to establish residency similar to adults. Also, there is flexibility for families whose children may be attending school in another state than where the parents reside.	Does this new proposed definition simplify or complicate the issue for states?	Seeking comment on the impact of these changes on children eligible for Medicaid based on disability.	S. 435.403(i)
Application and Enrollment Procedures (Section D)				
Availability of Program Information	Electronic, paper and oral information**:** Medicaid agencies required to provide certain information in electronic, paper and in-person/telephonic formats: eligibility requirements; Medicaid services, and rights and responsibilities of applicants and beneficiaries Accessibility of info for LEP/Disabled: Information must be provided in simple and understandable terms in must be accessible to LEP and disabled individuals	1. Rule doesn't appear to require information allowing comparison of Medicaid, CHIP and Exchange 2. Note that rights/responsibilities info needs to include rights to enrollment as disabled. 3. Not much detail (yet) on LEP/disabled requirements but translation/interpretation/accessibility standards will be important to states. Rules do not make specific making materials accessible to low-literacy populations, but also important for states.		435.905 (section D.1 of preamble, p. 51)

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Application	Single, streamlined application: Secretary to propose model application data elements after consultation with states and consumer groups - states can use or develop their own alternative, but can't be more burdensome and must link to IAPs: Alternate approaches for non-MAGI applications: 1.States can use supplemental forms to collect additional info needed to make eligibility determinations 2.States can develop and use alternative single application to capture non-MAGI data needed. Online, in person, by phone or mail: Medicaid agency must create procedures to allow application submission in all formats - no in-person interviews can be required for MAGI-eligibles. SSN/Citizenship: Non-applicants can't be required to provide SSN/citizenship status, but applicants and benefits must provide SSN if they have one: state cannot condition enrollment on submission of SSN/citizenship status but state may request SSN of non-applicants on voluntary basis Electronic/Telephonic Signatures: Medicaid agencies must accept them, along with signatures	1. Rule doesn't appear to require states to inform applicants about rights to enroll as disabled in model application, but maybe more will come in model app? 2. Secretary must approve the alternate applications, if states use - note that CMS has no plans to create standard alternate app 3. Restriction on state requirement of SSN for non-applicants may prompt concern among states about how they can verify income of dependent members of applicant's household without it. Note: lots of discussion at CMS eligibility meeting about the rights of non-applicants and concerns about immigrants being reported by Medicaid agencies - rule intends to protect immigrant rights and confidentiality of information reported from disclosure to INS	Alternate approaches for non-MAGI apps.	435.907 and 435.910
Assistance with Application and Renewal	Accessible assistance required: States must provide assistance to individuals in a manner accessible to LEP and individuals with disabilities Applicant choice: Medicaid agency must allow individual to seek assistance from anyone chosen Outreach to vulnerable/underserved: more in future sub-regulatory guidance	1. Important questions about what the accessibility standard will mean on ground for states in terms of translation and disability law compliance 2. States will probably want additional TA to support application assistance work - what forms should it take? How does assistance required for Medicaid applicants relate to navigators/CHIPRA grants?		435.908(b)

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MAGI Screen (Section E)				
Definition of "Applicable MAGI Standard"	Applicable MAGI Standard = at least 133 percent FPL but may be higher for certain individuals including parents or other caretaker relatives, pregnant women or children	State concerns about the significant percentage of non-filers or individuals whose tax information is outdated who will apply as MAGI-eligible – lack of reliable MAGI data means state will have to use other verifications, could slow down process, pose barriers		435.911(a)
MAGI Screen Eligibility Process	Screen intended to speed process: 1. Medicaid agency determines whether applicant has household income at or below applicable MAGI standard - if so, agency does not need to determine if individual is also eligible as disabled/medically needy 2. If individual meets MAGI, Medicaid must provide benefits "promptly and without undue delay"	Not entirely clear about process for non-MAGI eligibles - if individual is eligible for Medicaid due to disability or Medicaid spend-down but meet MAGI income standard, do they have to be classified as newly eligible adult? What if they want richer benefit package? Can they opt into traditional Medicaid? Also, still unclear about how individuals find out about their rights to richer benefits. Note that disabled individuals also have right to Medicare eligibility after 29 months of enrollment, so timing of enrollment important.		435.911(c)
Eligibility Process for Applicants that Fail MAGI Screen	Income too high for MAGI: If individual has income too high to meet MAGI standard, Medicaid agency will collect additional information to determine eligibility on other basis	Process is important here - note that if state is using Secretary's standard model app, agency will have to go back and ask for additional information to complete eligibility process - this feels like an opportunity for a process gap/barrier to coverage		

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Exchange Capacity to Screen for Medicaid Eligibility	Exchange can perform screen: Exchange subject to same eligibility process as Medicaid agency for MAGI screen, but not required to perform Medicaid eligibility screen for non-MAGI populations. State can delegate to Exchanges if requirements met (431.10 and 431.11)	Why can't Exchange also process applications for non-MAGI populations if given training/criteria? Not allowing this could undermine seamlessness of process for non-MAGI eligibles, could reinforce a siloed approach for this population		435.1200(c)(2)
Seamless Transfer/Assessment for non-MAGI/Tax Subsidy Coverage	Timely screening: Medicaid agencies required to follow proposed 435.1200(g) requirements to provide for seamless transfer of electronic account of those ineligible for Medicaid MAGI to ensure timely screening for blindness or disability under Medicaid or premium tax credits through QHP coverage			435.911((c)(2)
Timeframes for MAGI Eligibility Screen	No specific timeframes included here: but will be included in performance standards and metrics that are forthcoming (Also see 435.952, discussed below in Verifications (Section G)	What is the right length of time for determining eligibility? Is it the same standard for all applicants? Should it be same standard in rule over time? Could it be ok to have different standards for clean MAGI claims with electronic undisputed data vs. non-MAGI claims		

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Coverage Month (Section F)				
New Coverage Month Rules	Method to reduce coverage gaps: Enrollment through Exchange for individuals terminated from Medicaid can begin at earliest on first day of the month following date individual loses Medicaid and is determined eligible for enrollment through Exchange. If individual becomes ineligible for Medicaid and is determined eligible for Exchange coverage after the 22nd of the month, coverage would begin on the 1st day of the second month following the coverage decision. Proposal extends Medicaid coverage through the beginning of the Exchange coverage.	1. Is continuous eligibility for adults under a waiver a better means to promote continuous coverage and reduce administrative burdens? 2. Unclear if the issue of retroactive coverage under Medicaid is addressed too? There may still be an issue for states in terms of differences from QHPs.	Coverage month approach	155.410 and 435.915(b)
Verification of Income and Other Eligibility Criteria (Section G)				
General rules	Program Integrity Remains: states must continue to ensure Medicaid program integrity Self-Attestation: Clarifies that states can accept self-attestation for eligibility information (income, age, DOB, residency) without requesting paper documentation. Exceptions are citizenship and immigration status (remain subject to 1137) Information-sharing requirements: lists existing programs with which Medicaid must exchange data, including child support, Part IV-D and IAPs Notice requirements: individual must receive notice of information being requested and use before Medicaid can request information from third-party data source Secure interfaces: electronic data must be exchanged via secure interfaces Timing/Frequency of data: removes provisions prescribing timing/frequency of exchange	1. Questions about what program integrity/performance standards will be and how they will balance streamlined enrollment against accuracy as a priority 2. Questions about self-attestation, including order of how/when states can accept self-attestation for point-in-time income determination without electronic verification and hierarchy of format (self-attestation vs. electronic). 3. How can states provide effective notice for every use of 3rd party data downstream - blanket notice? What provisions to ensure notice meaningful? Does individual have option to refuse use of electronic data?		435.940 and 435.945

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Income Verification Standards	"Usefulness" of electronic data determined by states: Defers to state Medicaid agency to determine which data sources are most useful to verify financial eligibility. Required data checks: states must check data from existing list of sources at 1137, plus Public Assistance Reporting Information System (PARIS). Federal data checks: states must use federal data hub to verify income, citizenship and immigration status; if data not available through hub, can contact fed agencies directly Alternative data sources: states may request and use alternative data sources, subject to Secretary's approval. Standard is such sources should "reduce administrative costs and burdens on individuals and states, maximize accuracy and minimize delay. Must also meet applicable confidentiality, disclosure, and maintenance/use standards.	1. States may want clearer standards about when data sources can be considered "useful" 2. Does flexibility given to states create potential barrier/lack of uniformity for applicants - i.e., what's accepted in one state isn't valid in another? Is this consistent with ACA? 3. What will the process be for CMS approval of alternate data sources - streamlined approval possible? Can enrollment pend while state is getting CMS approval? 4. States have expressed concerns about whether they will have access to reliable, valuable, timely electronic data for income determinations and what role federal partners can play in facilitating access to timely wage/unemployment data (especially in states where individuals cross state lines for work).		435.948; 435.948(d)

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Federal Data "Hub"	Requires states to use federal data source or "hub", a "single inquiry" system for multiple data sources including income information from IRS, citizenship information from SSA and immigration information from DHS, in verifying information for applicants to any IAP including Medicaid. If information not available through hub, states can request information directly.	1. Questions/concerns about how this system will work, including when and how states will get specs for system, which agencies can use, any costs, etc. 2. States want to know the full extent of information they will get from the federal sources, including whether they will get specific information about dependents counted as part of household income determination, to aid in verification. States may have concerns about wanting additional detail to inform their planning and system development. 3. To what extent can states that already have MOUs in place with SSA/IRS/DHS continue to access data directly?		435.948(b); 435.948(c); 435.949
Timeliness of Decisions	Eliminates 45 day standard for determinations but includes expectation that decisions will be made in "real time whenever possible". Final standards TBD in performance metrics.	1. Will this be a single standard or one that allows for a percentage of claims to be resolved within expedited timeframe with others taking longer? 2. How/when will states participate in development of performance metrics? 3. What about non-MAGI claims - new standards/expectations?		435.952

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"Reasonable Compatibility" Standard	General rule: If information provided by individual is "reasonably compatible" with information the agency has obtained from other trusted sources, the agency must act on information and may not request additional documentation. When agency can request additional documentation: When agency unable to obtain information through electronic data match or information is not reasonably compatible with information provided by individual, agency can request additional data. If no data provided, agency can deny or disenroll from coverage after notice/appeal rights given. Reasonable compatibility: does not mean exact match, only that information is "generally consistent" - key issue in making decision is extent to which difference affects eligibility for program, also whether the differences are consistent with other information provided by the applicant.	1. Questions about how this will work in practice, how states will decide whether individual's data is "reasonably compatible" with electronic verification. 2. Opportunities for variation in treatment here, from case to case, county to county, or state-to-state, which appears inconsistent with ACA goal of greater uniformity of coverage across a state or state lines. 3. Note state concern that many applicants won't have reliable MAGI income data because non-filers or data incorrect due to change in circumstances - concern that state discretion/improvisation on verification will be more the rule than the exception.		435.952
Non-Financial Verification	Pregnancy: Self-attestation becomes the rule for pregnancy, unless agency has other information (e.g., claims history) that is incompatible with diagnosis Household composition: Self-attestation codified as means of determining this information, unless state has information not reasonably compatible Immigration documents: Cannot be used by themselves to demonstrate lack of residency	1. Questions about verification of residency - about 15 states still require documentation of residency - some concerns raised at ETAG meeting about extent to which states will have access to electronic data for residency and challenges to verify. 2. Household composition presents number of issues since states may need to understand whether individuals claimed as dependents through attestation are identical to those included in MAGI - what is best means for states to verify household composition or reconcile with MAGI data?		435.956

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Renewals (Section H)				
12 month Renewal Period for MAGI Eligibles	Codifies existing policy in most Medicaid programs to renew eligibility after a 1 -year period. No change to state obligation for program integrity or requirement that individuals report changes affecting eligibility within the year.	State getting a continuous eligibility waiver for adults could be a simpler option for ensuring continued eligibility during the year.		435.916(a)(1)
No Renewal Form Needed	Clarifies that states do not need to have a renewal form from all individuals.	This change has great potential to dramatically simplify renewal process, but note that absence of renewal form also means individuals whose coverage status has changed due to income or life changes may not know about rights to other benefits/coverage or responsibility to pay for reconciliation at end of year in case of tax subsidies.		435.916(a)(2)
Renewal Process	Agencies renewing coverage should rely first on electronic data verifications. If coverage can be renewed, agency should send notice without requiring further action. If coverage can't be renewed, agency should provide pre-populated form with option to respond by mail, in person, by phone or online within a "reasonable period" (not less than 30 days) to return information.	1. Some states are already using a procedure that automatically renews individuals who are likely to be continuously eligible for Medicaid so long as their income or eligibility status does not change. Might CMS consider including this idea in possible renewal strategies that would be acceptable under ACA provisions? 2. What about non-MAGIs? 3. Notice of renewal needs to include information about change in rights/responsibilities that may arise from income or life change. 4. Some states might be concerned about absence of adequate security with mailed pre-populated forms with sensitive data.	Renewal process - CMS wants judgment about process	435.916(a)(3)

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Coordination Among Insurance Affordability Programs - Medicaid Responsibilities (Section I)				
Coordinated Enrollment	Medicaid, CHIP and Exchange programs will follow a coordinated set of rules and work together to ensure enrollment in appropriate program, including automatic assessment for Exchange if ineligible for Medicaid.	Note that this section (and the Medicaid rule as a whole) needs to be more consistent in reference to Insurance Affordability Programs to ensure that Basic Health Program is taken into account and included in requirements.		435.1200
Shared Eligibility Service and Agreements	Shared eligibility service: CMS expects use of shared eligibility service to adjudicate placement for most individuals that coordinates determination and renewal requirements and may include data collection and verification processes for all IAPs [Note shared system eligible for enhanced FFP under 90/10 rule.] Agreements with Exchange/BHP: Medicaid agencies must enter into agreements with Exchange and other IAPs to ensure coordination of eligibility and enrollment activities, including with BHP, if applicable. 3 options for agreements based on governance: 1) shared responsibilities; 2) fully integrated system into a single unified entity; 3) siloed operations with strong connections to ensure seamless function	Note "one system" is not necessarily required, but strong coordination and maximizing efficiency implied.	Different working relationships among state agencies and best methods to facilitate states' ability to coordinate eligibility and enrollment?	435.1200
Medicaid criteria for Exchange MAGI determination	Medicaid agency must certify criteria for Exchange to use in determining Medicaid eligibility based on MAGI, including MAGI standard for parents/caretaker relatives, adults, pregnant women and children and criteria for immigration status in keeping with SPA	Medicaid agencies are going to have to make criteria more transparent, understandable, and uniform for outside agency adoption.	Other eligibility rules/criteria that should be certified by Medicaid agency for Medicaid determinations by Exchange?	435.1200

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Internet Website	Site requirement: State must allow for online application and renewal through a website - could be site for all IAPs, coordinated with other health services and supports or Medicaid presence on existing website. Enhanced FFP available if site part of overall system plan and meets 7 standards and conditions. [Further guidance forthcoming] Accessibility standards: Agency must ensure accessibility of content on site in accordance with ADA and sec. 504 of Rehab Act and must take reasonable steps to provide meaningful access for limited English proficient (LEP) individuals. [Some additional detail in rule]	Good opportunity for state input on standards and/or raising concerns about feasibility of doing this state-by-state - is there any opportunity for economies of scale at federal level that should be explored for consultation on accessibility support for disabled, LEP and literacy?		435.1200(d)
Medicaid Must Enroll Exchange-Determined Medicaid Eligibles	If Exchange finds an individual eligible for Medicaid, agency must enroll without further determination. Medicaid agency has responsibility to ensure plan selection by enrollee, but can delegate to Exchange. Agency must establish procedures to receive findings of Medicaid determinations, including applicant's information, through secure interface. Transaction to occur in real time, wherever possible.	What if Medicaid doesn't agree with finding? Opportunity for Medicaid to appeal after enrolling? What if individual doesn't want to be enrolled in Medicaid? Option to opt out and pay fee for non-compliance with mandate?		435.1200(e)
Transfer of Applications from IAPs to Medicaid	When applications for potentially eligible individuals are transferred to Medicaid agency, agency must enroll without delay. Individual's whose MAGI is below 133% FPL would be enrolled without further process or delay. If income is greater than 133% FPL, individual subject to Medicaid determination. Agency must request information to ensure no duplicate requests from individual. Once determination made, Medicaid agency must notify IAP of outcome of decision.			435.1200(f)

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Evaluation of Eligibility for other IAPs	If agency has agreement with Exchange, Medicaid can screen and determine eligibility for other IAPs. If not, Medicaid must immediately transfer to IAPs for decision. Electronic account, determination and single application form must be shared with IAP with transfer. Exchange cannot reverse finding of ineligibility by Medicaid agency.			435.1200(g)
Process for Blind/Disabled Applicants	Individuals determined ineligible for Medicaid based on MAGI where the Medicaid agency evaluating eligibility for blind/disabled coverage may enroll in IAPs while final Medicaid determination pending. Once determination made, if individual is Medicaid-eligible, IAP coverage terminates and Medicaid begins. If not Medicaid-eligible, coverage continues through other program. Individuals determined eligible for Medicaid not subject to reconciliation payments to IRS for months of coverage provided before transfer.	1. Note that language here implies Medicaid will be undertaking the process for the individual but no mention of rights/notice to individual or right to pursue determination as blind/disabled. This is a gap that warrants further discussion. 2. Protection from IRS reconciliation seems to provide a positive precedent - could we consider for other facts/circumstances to promote greater fairness and simplicity - like a de minimus coverage period in Exchange coverage?		435.1200(g)(2)

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Single State Agency Requirements (Section J)				
Delegation of Medicaid Eligibility Functions	"Public" Agency Exchanges: Medicaid agencies can delegate eligibility determination functions to Exchanges that are public entities as long as single state Medicaid agency retains discretion in administration or supervision of the plan (retains sole responsibility for setting eligibility policies and is accountable for operations consistent with policies, ensures no conflict of interest, decisions consistent with rules, corrective actions if needed, decisions made in best interest of beneficiaries, protections against improper incentives/outcomes) Agreements between Medicaid and Exchange must include quality control and oversight plans. Non-governmental Exchanges: Co-location of Medicaid eligibility workers for decision-making required to ensure coordination. Medicaid may not delegate authority for discretion: Authority to exercise administrative discretion, issues policies and rules on program matters may not be delegates and other entities may not change or disapprove of admin decisions. No substitution for Medicaid agency judgment.	1. What does "public" mean here? 2. States will have concerns about co-location requirement - coordination, staffing issues, union rules, county issues. 3. Lots of questions about how this oversight will work in practice and how much control Medicaid can assert	How should the statutory requirement that a single Medicaid agency make eligibility determinations apply in the context of exchanges making Medicaid decisions and simpler, uniform criteria?	431.10 and 431.11

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Provisions of Proposed Regulation Implementing Application of MAGI to CHIP (Section K)				
State Plan requirements	State Plan - Requires states to include income eligibility standards in state plan. Includes MAGI and household income.	1. Will State Plan templates be created?		457.305
MAGI and Household definition	Financial eligibility - Coordinates the CHIP, Medicaid and Exchange rules by requiring CHIP to use IRS household income rules and MAGI to determine financial eligibility. MAGI exceptions - Same exceptions to MAGI as listed for Medicaid in section B – Those determined eligible for SSI or using ELE; those 65 or older; those eligible because they are aged, blind or disabled; in need of long term care; those eligible for Medicare or are determined medically needy. Non-custodial parents – children are counted in the home where they live for purposes of Medicaid and CHIP eligibility. However, for the purposes of tax credit computation, the child will be counted in the household of the parent on whose tax return they are claimed, even if it is the non-custodial parent			457.315
Other eligibility standards	Asset tests, income disregards - CHIP agencies no longer may consider assets, existing income disregards will be replaced with 5% across the board disregard. Maximum CHIP income standard - either 50% above Medicaid income level, 200% of FPL or the effective income level as of December 31, 2013, when converted to MAGI income standard.	1. How will the elimination of "block of income" disregard affect enrollment? 2. What is the effect of the maximum income standard on states with higher income levels?		457.320
Unborn children	States that provide coverage through the CHIP unborn child option should continue to count unborn children in family size.	How does this relate to household make-up in tax code?		457.10

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Residency for CHIP Eligibility (Section L)				
Residency	Coordinates CHIP and Medicaid residency standard – considered a resident of the state in which he or she resides or in which a parent or caretaker is employed or seeking employment. Allows for flexibility for families in which children attend school in a state other than the parents' home state. If two or more states dispute the child's residency the physical location will be the deciding factor.	Parents must express intent to have out-of-state student covered in the state where they reside. How to operationalize in real time?		457.320
CHIP Coordinated Eligibility and Enrollment Process (Section M)				
Coordination	Various regulatory amendments made to align Medicaid and CHIP enrollment simplification standards.		Requesting comments for CHIP on issues raised by corresponding Medicaid sections.	435.905-908, 435.916, 435.917, 435.940-956, 435.1200
Applications and Outreach Standards	Single, streamlined application – As with Medicaid, CHIP agencies will be required to use a single, streamlined application.			457.330
	Program information and application assistance - Same program information and application assistance will be required and web site establishment as discussed in Medicaid sections.	Program information must be accessible to those who are disabled and with limited English proficiency.		457.335 457.340(a)
	Social Security Numbers – Non-applicants cannot be required (but may be requested) to provide a SSN. CHIP agencies must not deny or delay services to an otherwise eligible applicant pending issuance or verification of SSN.	How will states be able to access info from the federal data hub if parents applying for coverage for their children do not provide their SSN?		457.340(b)
	Enrollment Caps - NPRM eliminates the mention of enrollment caps on applications. CHIP agencies will be able to screen applicants regardless of enrollment caps.	How will this affect states with CHIP enrollment caps?		457.340(a)

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Determination of CHIP Eligibility and Coordination With Exchange and Medicaid	CHIP eligibility determinations mirrors Medicaid rules – CHIP agencies must promptly enroll individuals determined eligible for CHIP by the Exchange without requiring additional information.	1. How are states with enrollment caps or waiting periods affected? 2. CHIP agencies and Exchanges will have to develop agreements.		457.348 457.350
	Application transmission – CHIP agencies must transmit application and all information to Medicaid agency for applicants who appear categorically but not income eligible for Medicaid as well as to continue to process application for CHIP as the Medicaid agency is making the determination.	May require new or updated agreements with Medicaid agencies.		457.350(j)
Periodic Redetermin-ation of CHIP Eligibility and Coverage Months	Data-driven renewals – Same changes proposed for Medicaid are proposed for CHIP. Redetermination once every 12 months; agencies must use existing information available without requiring additional information; pre-populated forms must be used if additional contact is necessary; and if no longer eligible, the CHIP agency must screen for other IAP and transmit information as appropriate.		Seeking comment on a provision that would continue CHIP coverage until the end of the appropriate termination period – would prevent a gap in coverage for an individual or family moving from CHIP to the Exchange.	357.343

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Verification of Eligibility	Verification methods– Aligned with Medicaid – the state may use self-attestation of residency and income. Income must also be verified using third party information. If the state does not accept self-attestation, it must first attempt to verify residency using existing information. Only in the case that the information is not available should the CHP agency require documentation from the applicant.	1. Documentation of immigration status may not be used alone to determine state residency. 2. Must continue to comply with program integrity requirements. 3. What information will be available from the federal data hub and in what form?		457.380(c) 457.380(f)
	Self-attestation - CHIP agencies must accept self-attestation for pregnancy and household membership, unless there is available information that is not reasonably compatible			457.380(a) and (e)
	Flexibility to modify verification procedures used by program.		Soliciting comments on alternative verification methods that may help improve coordination between CHIP and other IAPs.	457.380(i)
Proposed FMAP Methodologies (Section N)				
Enhanced FMAP for "newly eligible" adults	Definition of "newly eligible": Enhanced FMAP is available to people eligible for the adult group if they are newly eligible -- that is, if they would not have otherwise been determined eligible under the state's State Plan, demonstrations, or waivers in effect on 12/1/2009. (So, it is NOT available for everyone whose eligibility is determined using MAGI.)	Exactly how to determine who is "newly eligible" is a big question explored in more depth below.		433.10(c)(6)
Expansion states defined	Expansion States – those states who began covering parent *and* childless adults *statewide* with at least 100% FPL, through an 1115 waiver or state-only program as of 3/23/10. Those states have a particular formula for their FMAP for non-pregnant childless adults, which will increase over time, to a point where it's equal to the "newly eligible" FMAP for other states in 2019.	Rule appears to allow you to have an "expansion" to some childless adults, and also to have "newly eligible" adults (maybe if you opt to cover to some level less than 133% FPL before 12/1/2009). In those cases, claiming FMAP could get even messier.		433.10(c)(7) and (8)

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
"Esoteric" 2.2 percentage point FMAP increase	Expansion states that do not qualify for any payments for the increased FMAP for "newly eligibles" and who have not been approved to reallocate any of their Disproportionate Share Hospital allotments can get a 2.2 point "bump" in their FMAP for all expenditures.	At conference, CMS indicated that this was an unlikely scenario, and would maybe affect one state. (Didn't specify which one.)		433.10(c)(7)
Methodology for claiming enhanced FMAP	Three methods proposed: To avoid the need for states to determine everyone's eligibility twice (once under new rules to determine benefits, and the second time under the old rules, to determine funding), CMS offers 3 alternative approaches: 1. The "threshold methodology"; 2. The "sampling methodology" and 3. The "other data sources" methodology. States should give two years' notice to CMS of which method it plans to use. First decision (for 2014) must be made by 1/1/2013. Once selected, method must be kept for 3 years.	1. All three of the proposed methods are in the NPRM -- unclear if all three will make it into the final rule, or if CMS will cut them down before that. Note: "the proposed rules would not permit FFP for the costs of maintaining dual eligibility systems for the adult group." 2. How feasible is it for states to commit to a method two years in advance?	CMS expects to narrow or combine methods. Requests other options to consider, and feedback on whether states should be able to choose among multiple methods, or CMS should identify one method. Requests comment on 3-year lock-in period for methods.	433.206(a) and (b)
Threshold methodology	Alternative 1: State would put **each** "adult group" beneficiary through a simplified version of its 2009 eligibility criteria, using MAGI-equivalents for disregards, and proxies for things like disability status and assets (CMS thinks this is possible through "simple questions"). - States must be clear with applicants that this information would not be used for an eligibility determination. - CMS also puts forward possibility of letting states develop an estimate of the percentage of applicants in each 2009 eligibility group who failed due to assets that exceeded limits. - States would only put individuals through this screen once every 12 months. - States do not need to determine eligibility through a "spend-down" pathway. (But if you would have been medically needy without a spend-down, you are not "newly eligible.")	1. Optional disabled groups are the most complicated cases here. 2. Can applicants opt not to answer questions that are not used for eligibility determinations? 3. How do the "simple questions" that are very state-specific interact with the "single streamlined" application? 4. Is 2009 really a fixed point in time? For example, if your 2009 threshold for parent coverage was 100% FPL, are you comparing a person's 2014 income against the 2009 level ($22,050 for a family of four)), or against the 2014 level (which will be higher)?	Seeking comment on whether states have reliable data on denials due to assets in 2009.	433.208

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Statistically Valid Sampling methodology	Alternative 2: State would take a random, unbiased sample of Medicaid enrollees (based on guidance in OMB Circular A-87), and put each of those people sampled through "the equivalent of a full eligibility determination" under standards in place in 12/09. Then the state takes claims for individuals found "newly eligible", and determines what percentage of this constitutes of the sample's total expenditures. This is then applied to the entire population of adults 19-64. States make claims for FFP based on most current data, and retroactively adjust claims as more recent data become available. Payments for CY 2014 and 2015 would be made on basis of either state or federal proxy data (like MEPS or MSIS).	1. Answer to CMS' question seems to depend on whether you believe "newly eligibles" are more or less expensive than other adults. 2. How would a state pursue this methodology without maintaining its old eligibility system? 3. How large is the sample required to be, and how will this affect smaller states?	1. Would use of a per-capita expenditure, with spending assumed to be the same across individuals, and the simple proportion of individuals in the sample that are "newly eligible", be easier or fairer? 2. Comments on 2014/2015 "interim" approach.	433.210
"Reliable Data Sources" methodology	Alternative 3: Uses state-specific estimates established by the Secretary, based on sources like MEPS or MSIS, to make prospective estimates of the proportions of enrollees who would be "newly eligible." Thus, no need for retroactive adjustments. First estimates would be provided by CMS no later than 10/1/12.	With no retroactive adjustments, what happens if a state thinks the central model is coming up with the wrong numbers for it? 2. What are the opportunities for state comment, feedback, and input into the formation of the estimates? 3. The timeline gives states only 3 months to see this estimate before they must make a decision on a claiming methodology (that they are locked into for 3 years).	1. What data sources should be included in a prospective model, in addition to MEPS/MSIS? 2. How can CMS compensate for the limitations of state-specific data to create robust and accurate state-level estimates?	433.212
Other methods	Alternative 4: CMS is seeking comments and suggestions for hybrid approaches.	We know CMS let a contract to help with this work -- will that consultancy be completed in enough time to be factored in to final rulemaking?	1. How can each of the methods (or a hybrid) be operationalized? What are the challenges and obstacles? 2. How should CMS evaluate the feasibility, validity, and reliability of the methods proposed above?	Preamble

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Program integrity	Goals for FMAP methods are: 1. No systematic bias in favor of the states or feds; 2. Minimally burdensome; 3. Transparency; 4. Practicality; 5. Any methods used by states should include sufficient data to identify, associate and reconcile expenditures with the related eligibility group to which the FMAPs apply (that is, keep documentation to support your claims to enhanced FMAPs)	States probably would like some assurance that the program integrity push won't be too severe in the initial period as the new methods are being introduced.		Preamble

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Exchange Eligibility NPRM				
Part A: Exchange Establishment Standards and Other Related Standards under the ACA				
Eligibility Standards	Criteria to be eligible for QHP enrollment: 1) Individual must be a citizen, national or lawfully present and "reasonably expect to remain so during enrollment period (does not have to be entire year) - aligns with Medicaid and CHIP; 2) Individual must be not incarcerated; Residency: To enroll in QHP, individual must reside in the State that established the Exchange. Residency definition - same as Medicaid, except in case of student residency where Medicaid has more flexibility. Medicaid, CHIP, Basic Health Program eligibility determination: Exchange responsible for determining Medicaid, CHIP and Basic Health Program (BHP) eligibility using MAGI methodology. Exchange should screen for eligibility for these programs before considering if eligible for QHP. Advance payment of premium tax credit: Exchange responsible for determining advance payment of premium tax credit based on *annual* MAGI income calculation. Advance credit may be made to QHP issuers on behalf of eligible individuals. The primary taxpayer of the household receives the tax credit based on his/her tax return for the benefit year. To be eligible for credit the primary taxpayer must: a) Have household income using MAGI at least 100% FPL - 400% FPL; b) Meet eligibility requirements for QHP; c) Enroll in QHP coverage; d) Not eligible for "minimum essential coverage" through employer coverage; and e) Must file tax return for previous year (as info from tax return used to determine eligibility) *Any differences in advance payment calculation and end of year tax return will be subject to reconciliation. Individuals may choose to accept less than the expected tax credit advance to reduce the potential amount owed	1. Members of household may reside in different areas serviced by different exchanges - NPRM allows choice of enrolling in primary taxpayer Exchange or local Exchange - how will this affect coordination with State Medicaid/CHIP programs? 2. There is no requirement that the Exchange is responsible to determine Medicaid eligibility for individuals in non-MAGI categories - likely this will affect the goal of a unified, streamlined, coordinated eligibility process. Also possible that some individuals eligible for Medicaid under non-MAGI methodologies will not understand that he/she could be eligible for a richer benefit package and enroll in less coverage through the Exchange. 3. There are significant questions about how these eligibility rules will apply to CHIP programs with waiting periods. If a child enrolls in Exchange coverage during the waiting period before enrolling in CHIP, does the child become ineligible for CHIP because they are no longer uninsured? If so, how does a state enforce a waiting period but maintain eligibility for CHIP-eligible children in an environment where an individual mandate requires families to make	1. Goal is to align definitions, such as residency, across insurance affordability programs to enable a uniform eligibility process – comments on best way to do so. 2. "Reasonably expect" to remain a citizen during enrollment period - how to ensure this is implemented so people understand it? 3. Are there in-network adequacy standards for our-of-State dependents that should considered? 4. Maintain different rules for student residency for Medicaid and Exchange or unify them? 5. Concern that fear of reconciliation of advance tax credit will reduce participation - will the flexibility to accept less than the expected tax credit mitigate this fear?	S. 155.305

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
	back to the gov't at reconciliation. Cost-sharing reductions: Exchange determines eligibility for cost sharing reductions: a) Eligible for enrollment in QHP and enrolls in at least a silver-level plan; b) Eligible for advance tax credit; c) Has household income that does not exceed 250% FPL for the year. *There are special eligibility standards for Indians. Eligibility categories for cost-sharing = individuals with incomes 100-150% FPL; 150-200% FPL; 200-250% FPL	sure their children are covered?		
Eligibility Determination Process	Key difference b/t Medicaid and Exchange eligibility determinations: While both will use MAGI, Medicaid determination is based on point in time/monthly income, while advance tax credit is based on annual MAGI calculation Process Notes: 1. Individual not seeking coverage does not need to provide SSN. 2. Individuals are allowed to decline eligibility determination for Medicaid, CHIP, and Basic Health and proceed directly to selecting and enrolling in QHP. However, if an individual is eligible for Medicaid, CHIP or Basic Health Program, he/she is not eligible to receive the advance tax credit or cost sharing reduction. 3. If Exchange determines individual eligible for Medicaid or CHIP, Exchange will notify State agency and transmit relevant info Written Notices from Exchange: Upon determination of eligibility, Exchange must provide applicant with timely written notice of determination. 1. While more guidance forthcoming, notice = record and should provide appeal info 2. If applicant eligible for advance tax credit and cost sharing reductions - notice to both applicant and employer with finding that ESI coverage doesn't meet minimum standard. *There will be additional guidance in regards to the content of this notice.	1. Annualized process to determine income may affect those with unexpected major decline income - individual will receive less assistance. 2. Written notices will very important – will CMS be providing model notices that are simple and accessible? 3. Do the notices have to paper or could they be electronic?	1. How can eligibility process maximize accuracy to minimize gaps in coverage? 2. Comments on process for enrolling an individual determined eligible, but he/she doesn't enroll in a QHP – suggested approach or start anew?	S. 155.310

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
	Determined eligible, but doesn't immediately enroll in QHP: If an individual is determined eligible for QHP, but doesn't enroll and seeks new enrollment during his/her enrollment period, Exchange will require an attestation of eligibility information. If the individual seeks to enroll after his/her enrollment period ends, Exchange will an annual redetermination of his/her eligibility.			
Verification Process	Exchange to split verification into 2 main sections: 1) Verify eligibility for enrollment in Medicaid, QHP; 2) Verify if applicant is an American Indian General Note: Exchange must first rely on electronic data sources to verify information and if unable to verify through such sources, then request additional info from applicant. Exchange verification align with Medicaid: Exchange will use a verification process that supports eligibility determinations for Medicaid, CHIP, Basic Health Program considering - citizenship, household income and size, etc. 1. Citizenship: Mirrors Medicaid - applicant attests to citizenship, provides SSN - Exchange to send to SSA, if needed to DHS (Homeland Security) for Alien Verification for Entitlement (SAVE) - if unable to verify, Exchange allows 90 days for applicant to document citizenship or resolve inconsistency. 2. Residency: Exchange to use HHS data sources, such as - SNAP, tax return, etc. available to verify attestation of residency 3. Income: As different from Medicaid - if applicant projecting increase in income, Exchange can use attestation only. If anticipating a drop in income that could result in higher advance tax credit, NPRM requires additional verification beyond attestation. *Individual is required to share changes in eligibility criteria within 30 days of the change occurring with the Exchange throughout his/her enrollment period. Income Verification for IAPs: Exchange responsible for verifying eligibility based on MAGI for Medicaid, CHIP and advanced tax credits, so available data sources need to provide pt. in time income (for Medicaid and CHIP) and	1. Ensuring states have access to appropriate data sources will be very important. What will be part of the federal data hub? What kinds of information will states have access to through the hub, especially from the IRS? 2. Assistance in this process is crucial, ensuring that application assistance available not only through the Exchange, but from Medicaid and CHIP is important as well. It will be important to ensure assistance training covers all insurance affordability plans.	1. What data sources should HHS authorize to verify eligibility criteria - residency? 2. Template v. Database? How should the template be designed? Is a central database an attractive option to employers to share plan specific information? 3. How can Exchange help applicants understand the validation of their household composition and income?	S. 155.315, S. 155.320

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
	annual income (for tax credits). NPRM suggests: 1. Safe and secure connection between the Exchange and the US Dept. of Treasury for tax information 2. Medicaid Agencies must request State quarterly wage information as well as other income sources and make the info available to the Exchange for verification purposes Employer plan information: Exchange needs specific information on employers' plans to determine individual eligibility for the insurance affordability plans, advance tax credits and cost sharing reductions. Statutory reporting provisions require employees to share information on the coverage they offer employees. The NPRM offers suggestions for collecting such information: 1. Exchange develops template for both employers and employees to provide info needed; 2.Establish a central database that employers could voluntarily populate			
Redetermining Eligibility	Redeterminations: Exchange must re-determine eligibility annually and during the year if new info is received through enrollee update or via data matching. Exchange must periodically examine - DHS, SSA data to identify changes, such as death and data on Medicaid, CHIP and Basic Health Program enrollment. Enrollees are required to provide Exchange notice of the following changes: a) Incarceration status; b) Residency; c) Household income or size; d) Availability of ESI coverage Changes resulting from a redetermination of coverage take effect the 1st day of following month in which notice is given, though advance tax credit or cost sharing reduction is impacted immediately. Process: Exchange is to send redetermination notice to enrollees annually that includes most recent eligibility info and requires it be returned with a signature within 30 days only if there are changes. If Exchange receives no	1. Is 30-day review period enough? Plan for return mail? 2. Could Exchange have option for non-paper based re-determination? Ex. rather than requiring returned paper with signature, could enrollee provide updated information online? By telephone?	1. Relying on the individual to provide changes in income or household composition could eliminate the need for periodic data- matching initiated by the Exchange – CMS seeks state comment on this. Allow state flexibility in this area? 2. Should Exchanges require notice of income change only within certain perimeters?	S. 155.330

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
	return in 30 days - enrollee re-determined eligible. Enrollee will remain in the QHP he/she selected the previous unless he/she takes action to change it.			
Coordination with Medicaid, CHIP and Basic Health Program	Exchange obligations: 1. Enter into agreements to ensure coordination, including maintaining consistent methods, standards and procedures; data sharing; etc. 2. If applications submitted to Medicaid, et al., Exchange needs to establish process to determine eligibility for QHP 3. Establish integrated IT systems that include electronic exchange interfaces between Medicaid, CHIP, Basic Health and Exchanges 4. Exchange must perform a "screen and refer" function for those applicants who may be eligible for Medicaid in MAGI-exempt categories - transmit information promptly	1. Will HHS develop a model data-sharing agreement that states can use to create their own agreements? 2. What about states not establishing a state exchange - will the coordination between the state Medicaid, et al programs be the same between the federal exchange?		S. 155.345
Special Eligibility Standards and Process for Indians	Special rules applying to cost-sharing for Indians: 1.QHP issuers may not impose any cost-sharing on an Indian who has household income at or below 300% FPL and is enrolled in a QHP at any level coverage (bronze, silver, gold or platinum) 2. QHP may not impose any cost-sharing on an Indian for services furnished by: a) The Indian Health Service; b) An Indian tribe; c) Tribal Organization; d) Urban Tribal Organization; or e) Through a referral under contract health services Definition of an Indian: Any individual defined section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA) Verification of attestation: 2 Phases – use relevant documentation verified to support attestation of citizenship or lawful presence & rely on available electronic data sources	Given the important protections created for AI/AN populations, states will want to consult with tribes regarding the best sources for electronic data to ensure speedy and easy to use verification process.	CMS is seeking input on the availability and usability of data sources as well as best practices for accepting and verifying documentation related to Indian status.	S. 155.350

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Right to Appeal	Exchange must offer appeal process: Secretary will establish a process for a Federal official to hear and make decisions on appeals of eligibility determinations, including: eligibility for QHP enrollment, advance tax credits, cost-sharing reductions Exchange must provide notice of appeal to applicants and employers **CMS will provide details of the individual appeal process in future rulemaking	Significant issues will need to be sorted out about how individuals understand and can pursue multiple rights to appeal under Exchange, BHP and Medicaid/CHIP Note: Medicaid is an entitlement and includes right to due process, fair hearing, so ensuring that individuals who are screened for Medicaid eligibility and denied coverage understand rights to appeal denial is extremely important, especially where this function is being carried out by the Exchange. This is a set of issues that will warrant attention by states and may be addressed in the forthcoming appeals rule.		S. 155.355
Part B: Employer Interactions with Exchanges and SHOP Participation				
Eligibility of Qualified Employers	Qualified Employers: Defined in proposed Exchange NPRM 1. Qualified employer may continue to participate in the SHOP if it ceases to be a "small employer" solely because of increase in employees. 2. Small employers may have employees in multiple States or SHOP service areas to allow flexibility in covering their employees. 3. SHOP has no residency standards			S. 157.200

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Employer Participation Process	Participation in SHOP: Employer needs to adhere to the standards, process, and deadlines set by the SHOP to maintain eligibility as a qualified employer. As proposed in Exchange NPRM the SHOP will set a uniform process and timeline for each employer. Disseminating information: Employer responsible for disseminating info to its employees about methods for selecting and enrolling in a QHP. At a minimum this information should include: a) Timeframes for enrollment; b) Instructions to access SHOP website and other tools to compare QHPs; and c) SHOP toll-free hotline. Eligibility changes for employees: Employers are responsible for providing information about employees and dependents whose eligibility changes (i.e. new hire, employment ending, etc.) to the SHOP within 30 days of the change. Period of coverage 1.Employer can begin participating at any time, but must adhere to annual election period thereafter. 2. If an employer remains eligible for SHOP participation, but takes no action during annual election period, such employer will continue to offer the same plan, coverage level or plans selected for next year – unless QHP is no longer available.			S. 157.205

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
IRS Health Insurance Premium Tax Credit NPRM				
Eligibility for Premium Assistance Tax Credits				
Taxpayer	Eligibility: Eligible for a tax credit if taxpayer is an applicable taxpayer and the taxpayer or one member of his/her family is enrolled in one or more QHP through an exchange and is not eligible for minimum essential coverage except in the individual market. Lawfully Present Aliens May have income below 100% FPL Unlawfully present or incarcerated: Are not eligible for a credit but may be an applicable taxpayer if a family member is eligible and enrolled in a QHP.	Individuals who are incarcerated, pending disposition of charges are considered eligible taxpayers. Is this common? Is information on the status of an individual's charges available to government entities?		26 CFR Part 1 S. 1.36B-2
Family make up	Household: Taxpayer and any individual the taxpayer claims as dependents - qualified children, qualified relatives, unrelated individuals living in the same house.	1. How does the tax definition of household affect states with horizontally integrated systems (states using the same eligibility system for health coverage, SNAP, TANF, WIC, etc.) 2. How do pregnancies affect family size when determining the tax credit?		S. 1.36B-2
Income	MAGI of those in household who are required to file taxes: - Generally 100-400% FPL - Lawfully present aliens with income below 100% will be treated as if their income were 100%.			S. 1.36B-2
Minimum Essential Coverage – Government Sponsored Insurance	Eligibility for ESI: Individual is treated as eligible for government -sponsored program on the first day of the first full month in which the individual may receive benefits. If an advance credit is paid for a month when an individual has retro Medicaid coverage, they are treated as eligible for minimum essential coverage no sooner than the first calendar month after the approval.		Comments requested on whether rules should provide additional flexibility if operational challenges prevent timely transition from coverage under a qualified health plan to coverage under a government sponsored program.	S. 1.36B-2

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Minimum Essential Coverage – Employer Sponsored Insurance	Definition: Individual is treated as eligible for employer sponsored coverage only if the employee's share of the premiums is affordable and the coverage provides a minimum value, or if the employee enrolls in the plan, regardless of affordability and value. Affordability: A plan is considered affordable if the contribution required for self-only does not exceed 9.5% of the household income. Employee affordability Safe Harbor: employees will be eligible for tax credits even if the ESI was ultimately affordable if, at the time of eligibility to purchase, it was not affordable. Employer affordability Safe Harbor: Gives employers the ability to base affordability calculations on their employees' wages only – without the burden of considering wage information they wouldn't normally have.	1. Questions regarding income considered when determining coverage affordability – wages, other sources, i.e. child support, etc. How to bring in other systems to electronically verify? 2. Affordability standard is based on individual coverage, but family coverage usually requires a greater contribution though will not be eligible for the affordability clause. This could create challenges for families in affording coverage for the entire family and could leave dependents without coverage. For low-income children, states may need to do more outreach to enroll eligible children in Medicaid and /CHIP. Applying the 9.5% of income test to the cost of family coverage would minimize some of the coverage issues.		S. 1.36B-2
Minimum Value	Minimum Value: If the plan's share of the total allowed costs of benefits provided under the plan is at least 60 % of those costs.	1. Additional regulations coming out "later this year."		S. 1.36B-2

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Credit Computation				
Premium assistance credit amount	Premium assistance credit amount: The sum of premium assistance amounts for all coverage months - not included are months when the individual is eligible for minimum essential coverage – either employer or government sponsored coverage.			S. 1.36B-3
Credit Computation	Premium assistance amount: either the premium for the qualified health plan in which a taxpayer or family member enrolls, or the excess of the premium for the benchmark plan over the applicable percentage of the taxpayer's household income - whichever is less. The applicable percentage of the income increases as income increases. Up to 133%: 2% 133-149%: 3-4% 150-199%: 4-6.3% 200-249%: 6.3-8.05% 250-299%: 8.05 - 9.5% 300-400%: 9.5% _____ Ex: Single Filer Income (level) - $27,225 (250%) Benchmark - $5,200 Applicable % - 8.05% Contribution - $2,192 (8.05%) Credit - $3,008 Taxpayers pay the difference between the premium assistance amount and the premium of the plan they choose. Premiums paid by or for household members not lawfully present are not computed in the premium assistance amount.	1. Helping applicants to predict their credit and determine how much they will be required to pay is a challenge. Will the federal calculator be adaptable for all states? Will all states have to come up with their own? 2. Out of pocket contributions for CHIP premiums are not factored into the percentage of household income a family is required to pay for exchange coverage. A family may be required to pay up to 5% of income in CHIP premiums in addition to the cost sharing requirements listed above. The effective out of pocket cost sharing would exceed 9.5%.		S. 1.36B-3
Premiums paid on behalf of the tax payer	If the premiums are paid by someone else, they are treated as if they were paid by the taxpayer.			S. 1.36B-3

Section	Brief Description	Key Questions/Issues	Specific request from CMS for comment	Sections of CFR affected by rules
Applicable benchmark plan	Multiple categories of coverage offered on exchange: The monthly premium for the applicable second lowest cost silver plan offered through an Exchange is the benchmark for computing the monthly premium assistance amount.			S. 1.36B-3
Multiple categories of Coverage Offered on an exchange	Contingencies: Families who purchase more than one qualified health plan, one QHP covering more than one family, applicable Benchmark Plan that terminates or closes to enrollment.	Are these details/contingencies important to states or just tax preparers?		S. 1.36B-3
Pediatric Dental Coverage	Computing the premium: The portion of the premium for the separate pediatric dental coverage is added to the premium for the benchmark plan in computing the credit.		Comments requested on methods od determining the amount of the premium properly allocable to pediatric dental benefits.	S. 1.36B-3
Reconciliation				
Define/explain	In general: The amount of credit a taxpayer was eligible for and the amount of advance payments the taxpayer received will be reconciled on the income tax return. Excess credit not paid as an advance payment will be refunded. Excess advance payments would be added to a taxpayer's tax liability. The amount of repayment required is limited based on income – range is $600-2,500.	1.How can states ensure reconciliation won't be a barrier to individuals obtaining coverage? 2.States will need support and resources to educate applicants about advance credit options.		S. 1.36B-4
Changes in filing status	Contingencies: Marital Status change, divorce, marriage, married and filing separately.	Are these issues the states have to deal with?	Many requests for comments on how to protect individuals whose filing status changes throughout the year. Is this something states can/should weigh in on considering the knowledge of tax code required?	
Requirement to file a return	In general: Every taxpayer that receives a credit will have to file a tax return.	Similar to EITC and other tax credits. Partner with VITA sites and other low-income tax preparers.		