NAMD
National Association of Medicaid Directors

March 23, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Slavitt,

We are writing on behalf of the National Association of Medicaid Directors to request that the Centers for Medicare and Medicaid Services (CMS) prioritize modifications that will further improve interaction and alignment between state Medicaid agencies and the Exchange program. State Medicaid agencies are developing budgets and work plans to address these issues and require additional information in order to align with CMS' plans to improve systems, processes and policies.

NAMD is a bipartisan organization which represents Medicaid Directors in the fifty states, the District of Columbia and the territories. We are committed to ensuring there is a strong partnership between the federal and state agencies involved in the enrollment processes pertaining to the Medicaid and Exchange program.

We appreciate the tremendous work and progress CMS has achieved over the past year to address inconsistencies and failures with the Federally Facilitated Marketplace (FFM), the federal data services hub and other back end systems that contribute to the eligibility determination and enrollment processes for health insurance coverage in public programs. Like our federal partners, states have made significant, prudent investments to ensure that consumers receive accurate, timely information about their eligibility for Medicaid.

We believe that the partnership between the federal and state agencies resulted in a vastly improved consumer experience during the 2015 open enrollment period. This is particularly true for low-income consumers who apply directly through the state Medicaid agency's portal and those who were redirected to the state Medicaid program via the Exchange portals, whether federal or state. We still expect, however, that the challenges experienced in the early years of the Exchange programs could distort information about the accuracy and overall processes for Medicaid eligibility determinations, particularly assessments provided through the Medicaid and CHIP Eligibility Review Pilots.

States share CMS' goal to continue to enhance the outward facing technology and the back-end system functionality. We also fully appreciate that complex technology improvements that involve multiple systems and agencies at multiple levels of government necessarily require prioritization of improvements through an iterative process.

As CMS turns its attention to the 2016 open enrollment period and beyond, we urge your agency to prioritize modifications specific to the Medicaid program, particularly those that impact the accuracy of the FFM's eligibility assessments and determinations and efficiency of operations. In addition, we ask that CMS use the full extent of its authority to work with states to address policies which create disconnects and inefficiencies in the eligibility processes that cross the Medicaid and Exchange programs. Enclosed we provide you with several high-priority improvements and items for longer-term planning.

We are eager for your response regarding which of the recommendations are feasible for CMS to implement in the short term. We are also seeking the agency's response regarding our recommendations that may require a longer-term commitment and, in turn, your process for engaging states to develop and operationalize these.

We appreciate your consideration of NAMD's recommendations which we believe would benefit consumers and smooth the business interactions between state Medicaid programs and the FFM or State Based Marketplaces (SBM). Please do not hesitate to contact Andrea Maresca, NAMD's Director of Federal Policy and Strategy (andrea.maresca@medicaiddirectors.org) to discuss how our association and its members can be of further assistance to you on this matter.

Sincerely,

Thomas J. Betlach
Arizona Health Care Cost
Containment System Director
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President, NAMD

John B. McCarthy
Director
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State of Ohio
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Cc:
Kevin Counihan, Director & Marketplace Chief Executive Officer, Center for Consumer Information and Oversight

Victoria Wachino, Acting Director, Center for Medicaid and CHIP Services
David Nelson, Deputy Chief Operating Officer, Chief Information Officer & Office of Enterprise Information Director

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Medicaid and Marketplace Interactions: Recommendations to Improve to Efficiency and Communication

Stabilize FFM-Medicaid Timelines and Testing

States want to continue to improve upon the Account Transfer process between state Medicaid agencies and the FFM. While the testing process for 2015 was much improved compared to 2014, some states continued to experience a number of challenges associated with testing. We urge CMS to prioritize timelines that allow states to complete more thorough testing so that we may have greater confidence in system functionality.

1. Establish a "lock down" date for file layout and policy changes. States urge CMS to set a cut-off point after which no further file layout and policy changes will be effectuated. The agency should also notify states of this date as soon as possible so that they can plan and allocate plan resources accordingly. **A *minimum* of six weeks is needed to make program changes and conduct testing to ensure the systems respond appropriately.**

2. Provide more robust and controlled end-to-end testing for the so-called "determination" and "assessment" states. Enhancing the states' ability to conduct ongoing, end-to-end testing from the FFM and hub front end will greatly increase the resiliency of the state applications to process data received from the FFM. States recommend that CMS provide an environment where test applications can be created and states have the ability to view Account Transfers when they go back to CMS.

   In addition, some states continue to identify inaccuracies in FFM determination and referral files and wish to work with CMS to enhance the federal agency's review of Medicaid eligibility criteria. To do so, states must have the ability to test the accuracy of the state-specific eligibility rules utilized by the FFM eligibility.

   These processes require CMS to maintain associated support staff for the test process with states.

3. Engage the Internal Revenue Service to support testing. States seeking to leverage Internal Revenue Service (IRS) data require more support for testing of transactions between the state and that federal agency. We urge CMS to engage the IRS to provide support to complete the testing for Medicaid. For example, to use IRS data for testing, states may need access to a master index of well-defined test cases created with known IRS service responses. If this is not possible, the federal government should hold states

harmless for any discrepancies in the financial transactions that occur due to errors in the untested software in coming years.

Reduce Duplication of Effort

States noted some progress in the accuracy of FFM determinations as compared to 2014. However, additional attention is required to resolve those issues that still pose a challenge. These modifications are needed to enable states to process applications more accurately and more quickly, reduce the follow-up states are required to do with each applicant, and to minimize confusion and frustration for the consumer.

1. Perform the Medicaid Check prior to referring individuals to the state. One of highest priority requests for states is that the FFM perform the "Medicaid Check" for applicants identified as Medicaid Eligible at the FFM. If the individual is already enrolled in Medicaid or has a pending application with the state, the FFM should *not* transfer to the state the person's account requesting Medicaid coverage. Currently every application is sent to the state which leads to additional overhead without generating any additional individuals with health care.

2. Provide the ability to highlight individual data field level changes that leads to a Change in Circumstance (CiCs). The FFM should highlight new incomes or new household members, or changes in address, and other common status changes. This would reduce overall complexity and increase the ability of states systems and workers to more accurately and efficiently process these changes. It also would reduce manual inspection required and reduce the risk of error in identifying changed information. This approach would be consistent with the HIPAA 834 file format approach.

File Format Improvements

The following changes would help to reduce the amount of manual effort required of states to conduct consumer outreach and confirm the accuracy of information received from the federal data hub and/or the FFM. In turn, effectuating these changes could help minimize the burden on consumers.

1. Resolve inconsistencies in immigrant status information and referrals. Verification of immigration through the federal data services hub continues to be challenging for many state Medicaid agencies, regardless of the type of Marketplace that exists. Some states report that they do not receive a verified date of entry and they do not receive information about immigrant type (refugee, etc.). States also have identified that it would be helpful for them to receive the Alien Registration Number. The lack of sufficient information requires manual verification by the states.

NAMD requests that CMS continue to focus on the immigration portion of the federal services hub, with the goal of streamlining eligibility and ensuring that eligible individuals and families receive coverage without additional barriers. For states with an FFM, we recommend that CMS not rely on the existing "Medicaid block" question as a permanent solution since it still may cause a delay as immigrants wait for a Medicaid denial. Rather, CMS should undertake a holistic evaluation of the application process to ensure there are no inconsistences in immigrant status and referrals.

2. Improve the residency information data fields. Some states continue to report that they have cases transferred from the FFM where the home address for the applicant is in another state and/or where the application incorrectly identifies the state where the county is located.

3. Improve address field standardization. The FFM should address the following:
   a. Residential and mailing addresses that have duplicate lines, missing apartment and suite numbers, and other issues that do not seem to meet United States Postal Service requirements.
   b. Employer addresses are mandatory and when consumers do not enter information, the FFM fills the field with the consumer's address, which presents challenges for state verification and follow-up.

4. Improve the income data accuracy. CMS should address issues related to income data in the FFM account transfers, such as high income amounts, duplicate income records and income date information with only year (as opposed to day-month-year).

5. Include Federal Tax Information (FTI) data in the Account Transfer file. Some states report that verified income data is not included in all files transferred from the FFM to states which adds complexity to the state's eligibility determination process. It would reduce the burden on states if the FFM used FTI in its eligibility decision processes, and states were informed of this fact. If this piece of information was provided, it would assist states with understanding the basis upon which the FFM believes someone is eligible. This would provide states with greater confidence that more of the assessments were reasonable, in turn accelerating the determination process.

6. Address issues with presumptive eligibility. Currently CMS lacks a method to inform states that an application has been submitted via the FFM for a presumptive pregnant woman. These same issues apply for hospital presumptive eligibility determinations. Several states report this makes it difficult for Medicaid agencies to expedite or queue these applications and assign the consumers to the most appropriate health plan provider.

7. Collect and provide to states information that enables assignment of consumers to appropriate eligibility categories. The FFM performs a basic determination for Medicaid eligibility, but states often must follow-up to collect information to assign the consumer to the appropriate eligibility category. Collecting certain additional information at initial application would help to minimize the follow-up that states must conduct with the consumer. Specifically, as part of its longer-term planning effort, states request that the FFM:
    a. Include a field for "estimated due date" when pregnancy is indicated. As noted in the previous recommendation, this would help with prioritization, and in some cases with accurate MAGI determinations.
    b. Add a question regarding joint physical custody.
    c. If the applicant seeks coverage through the FFM portal and does not wish to undergo a Medicaid eligibility determination or assessment, there should be an option where they can decline Medicaid determination.

Clarify Notices and Improve Information Flow

Clear, consistent communication between the FFM and state Medicaid agencies as well as with consumers is critically necessary to the effective, efficient operation of these programs. States have extensive experience developing a range of materials and employing different modes of communication to meet the needs of a diverse consumer population. Their experience spans the point in time of outreach and enrollment to the next steps that are critical to ensuring that consumers are connected with appropriate services and states' fiduciary responsibilities are met. Based on this expertise and the two years of on-the-ground experience with the new Marketplaces, states recommend the following improvements.

1. Add functionality to improve care coordination. States continue to establish processes and systems that improve access to high-quality coordinated services and ensure that Medicaid remains the payer of last resort. The FFM can contribute to these efforts by adding functionality to send information back to the state Medicaid agency regarding which consumers enroll with an FFM product and the plan in which they are enrolled.

2. Improve CMCS-CCIIO-State FFM communications. States appreciate that CMS has convened state agencies for discussions with CMS through the FFM Learning Collaborative. This type of forum should continue as needed. In order to maximize the utility of these calls, we strongly recommend that a CCIIO representative have a consistent presence and engage in these discussions as items are reported and addressed.

3. Provide states with information necessary to protect the integrity of the Medicaid program. As with any new program implementation, states are working to ensure appropriate controls are in place to protect the integrity of federal and state taxpayer dollars. States request that CMS provide a feedback file which identifies individuals

enrolled in the FFM. This would help states – and their Medicaid health plan partners – to ensure consumers are not simultaneously enrolled in Medicaid and a Qualified Health Plan, thereby allowing states to fulfill their fiduciary responsibility.

4. Clarify the Medicaid assessment eligibility notice language. CMS should clarify the Medicaid assessment eligibility notice language. Confusion among beneficiaries and workload issues have proven to be a particular challenge in states where Medicaid determinations are not automated and follow-up information may be requested via postal mail.

5. Modify the FFM appeals-related communications to consumers. Some states report spending an inordinate amount of time trying to resolve complex cases involving an appeal of Medicaid eligibility. To mitigate this burden, states request that the FFM modify the "notice of action" which approves consumers for a subsidy to purchase insurance on the Exchange. Such notices should explicitly state, not simply imply, that the individual is not eligible for the state's Medicaid program.

6. Communicate with consumers about cancellation of FFM plans. As you know, states are required to notify the FFM once a consumer has been determined Medicaid eligible. Upon receiving such notification, the FFM in turn should notify its enrollees that they are no longer eligible for advanced premium tax credits and may wish to cancel enrollment in their Marketplace plan. This would help to mitigate confusion and financial burden for consumers who may be enrolled in both programs.

Align and Streamline Eligibility Policies

States are interested in further streamlining Medicaid and Exchange eligibility policies as well as opportunities to integrate their eligibility systems. Many states, however, have identified disconnects and inefficiencies in federal eligibility policy and rules for these programs which impede further progress towards their goals and impact the integrity of the programs. Addressing these issues requires a thoughtful process and ongoing collaboration with state Medicaid agencies. Specifically, a sufficient transition period and resources are necessary since states have designed their existing systems to accommodate the current system of rules. Additionally, states encourage CMS to enhance cross agency coordination in the federal rulemaking process to ensure future rules are not contradictory.

1. Align the modified adjusted gross income (MAGI) calculation across the Marketplace and Medicaid populations. Several disconnects in the MAGI calculation result in administrative inefficiencies from a system perspective and burden on consumers and

assistors. For example, Medicaid eligibility policy includes exceptions to the rules for determining household size whereas the Exchange always uses the tax household size.

2. Address challenges with the income indicator that result in consumers "looping" between Medicaid and the FFM. Similar to the previous item, challenges arise for states and for consumers due to different units that Medicaid and the Exchange are required to use to determine income eligibility -- Medicaid utilizes monthly income while the Exchange uses annual income. Some Medicaid agencies in states where an FFM exists have found it particularly difficult to resolve the "gap-filling" income indicator issue because the FFM makes the assumption that states screened the individuals using annual income. It is NAMD's understanding, however, that states are only screening for Medicaid income, that is, their screen is based on monthly income. This is resulting in a situation where individuals are looped back and forth between Medicaid and the FFM without getting appropriate coverage. While the underlying issue may have its roots in statutory construction, we encourage CMS to work with states to minimize confusion for enrollees to the greatest extent possible.

3. Align administrative processes for mixed households. Current federal rules have different standards that make it more burdensome for mixed households to obtain and maintain coverage. We request that CMS work with states on policies that would achieve alignment for administrative processes for mixed households. Alignment would be particularly useful around renewal timelines and verification processes. For example, CMS may wish to allow an administrative "safe harbor" where mixed households that are verified by either the Medicaid agency or the Exchange entity would be considered verified by the other.

   Additionally, regarding renewals, the information about individuals and families enrolled in a Qualified Health Plan (QHP) is refreshed as part of the lead up to the Marketplace open enrollment period, whereas Medicaid renewals occur on a rolling basis. For mixed households, this requires sending renewal information twice per year instead of once. States recommend that CMS consider alignment of the rules or possibly reliance on one set of renewal data by the Medicaid and Exchange agencies as a way to reduce the burdens on families.

4. Align the federal poverty level (FPL) tables. Medicaid updates the FPL levels annually on March 1st while the Exchange switches on the first day of Open Enrollment. Keeping the whole of a qualified health plan (QHP) policy year determined under the same FPL range is important, but states find this adds complexity to the determination process.